

School of Public Health
Collaboration for Evidence, Research, and Impact in Public Health

**Developing a Framework for Community-Based Sexual Health
Interventions for Youth in the Rural Setting**

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Doctor of Philosophy
of
Curtin University

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Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made. This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) – updated March 2014. The proposed research study received human research ethics approval from the Curtin University Human Research Ethics Committee (EC00262), Approval Number # HR96/2015-06

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Abstract

Background

Young people experience a significant burden of sexually transmissible infections (STIs) in Australia and have been identified as a priority population within the *Fourth National Sexually Transmissible Infections Strategy 2018–2022*. The sexual health needs of rural based priority populations are identified as action areas within the strategy however there is a lack of clear guidance as to how rural communities can address sexual health at a community-based level; which stakeholders to engage; and what strategies to implement.

Following an expressed need, driven by health care and youth services in a small rural community, to address youth sexual health needs, this project was developed in collaboration with community-based stakeholders and rural young people to develop an appropriate response. There was limited literature providing guidance on how to address rural youth sexual health and a lack of consistency as to how to implement interventions that address multiple socioecological levels within the setting. This Participatory Action Research (PAR) project aimed to develop a framework for planning, implementing and evaluating community-based sexual health interventions in the rural setting, in collaboration with stakeholders and young people

Methods

PAR methodology was adopted as it was identified as an effective methodology for engaging community. This enabled the researcher to work with the community, empower participants and give them a voice. PAR allowed the project to be developed from community-voiced concern; to involve stakeholder analysis of the issues faced by community and to focus on finding a solution to the current situation.

Three PAR cycles were conducted between 2016 and 2019. The initial phases of the project focussed on understanding the context of the setting and creating a response in the form of a draft Framework. PAR Cycle 1 included semi-structured one-on-one interviews with stakeholders (n = 16), focus groups with young people aged 16-24 years (n = 15), community mapping with young people (n = 14), and a literature review to inform the development of a draft Framework.

PAR Cycle 2 involved returning to local participants (n = 18) to request expert feedback on the draft Framework through a localised Delphi study.

PAR Cycle 3 utilised a targeted Delphi study to gather evaluation feedback on the developed draft Framework from stakeholders and experts (n = 16) in sexual health provision and rural health who had not been involved in the study, to allow refinement and revision of the Framework and improve its practical application and potential transferability to other contexts.

Results

Data collected within PAR Cycle 1 from stakeholders and young people were analysed to identify threats, opportunities, weaknesses and needs that existed within the setting. From this analysis a draft Framework was developed to inform the planning, implementation and evaluation of community-based youth sexual health interventions in the setting. Through the process of developing the Framework with stakeholders and youth, four key concepts emerged for improving the planning, implementation and evaluation of community-based youth sexual health interventions in the rural setting.

Data collected via the Delphi study within PAR Cycle 2 were used to evaluate the validity of and collect feedback on the draft Framework document. Feedback on the Framework was received and consensus on key statements relating to evaluation of the validity of the Framework was achieved. A finalised phase two version of the Framework was then returned to all invited participants alongside the collected, de-identified participant qualitative feedback and the direct researcher responses to this feedback.

PAR Cycle 3 involved another embedded Delphi study and focused on collecting expert analysis from participants who were experienced in delivering youth sexual health interventions and education within the rural setting. This final evaluation of the draft Framework allowed for further refinement, while testing potential transferability and confirmability. The same iterative process was repeated from the initial Delphi study, with evaluation of the Framework invited from participants.

The developed Framework identifies four key factors for rural sexual health provision:

1. Consistent and credible relationships and sexuality education and information

2. Health service accessibility and competing priorities
3. Discreet condom supply
4. Communication and collaboration.

Conclusion

This project developed and validated a Framework for planning, implementing and evaluating multi-level community-based sexual health interventions for young people in the rural setting. The methodology allowed the opportunity to test the application of embedded Delphi studies within PAR, contributing to a growing body of literature that utilises PAR in the rural Australian setting as a research methodology that connects with the rural population; encourages action within that community and provides a platform for an authentic rural voice.

The Framework represents the output of a collaborative development process that produced localised knowledge with value to the wider community following a community expressed need to address youth sexual health. Implementation of the Framework in new communities is possible providing there is care in addressing the limitations of the Framework and acknowledgement that further testing will enhance inter-contextual reliability.

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Thank you to my supervisors across the course of this project: Associate Professor Sharyn Burns, Dr Roanna Lobo and Dr Ruth McConigley. You are a talented group of academics that provided such clear, detailed and accurate guidance and support. Thank you for your understanding of my level of family involvement, your critical analysis of my work, the regular reminders to ensure my writing language was scholarly – but most of all the generosity in sharing your knowledge. I could not have achieved such high-level work without it.

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To the participants in this research: the young people; my stakeholders (the accidental experts of rural sexual health); the Delphi participants – thank you. I hope our work goes someway to address the sexual health needs of rural youth and can be put in to action around the country. Thank you for lending your rural voice to a rural issue.

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To Jack and Henrik: yes, my PhD is finished; I can come outside and play now – I'm sorry it took so long – I'm certain yours will be faster. To Anne and Iss: this could not have happened without your help; I hope I've done you both proud. To Buddy: you came at just the wrong time, created havoc and made me finish – welcome! To my trusted informal research assistant Jasmine – thank you for your unwavering support, love, belief and patience. You know this work as well as I do and deserve just as much recognition.

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Here's to local solutions, rural research being conducted by rural researchers, and community spirit.

Publications

The following publications are included as part of this thesis:

1. Heslop, C. W., S. Burns, R. Lobo and R. McConigley (2017). *"Developing a framework for community-based sexual health interventions for youth in the rural setting: protocol for a participatory action research study."* BMJ Open 7(5).
2. Heslop, C. W., S. Burns and R. Lobo (2018). *"Managing qualitative research as insider-research in small rural communities."* Rural and Remote Health 18.
3. Heslop, C. W., S. Burns and R. Lobo (2019). *"'Everyone knows everyone': youth perceptions of relationships and sexuality education, condom access and health services in a rural town."* Sex Education: 1-17.
4. Heslop, C. W., S. Burns and R. Lobo (2019). *"Stakeholder perceptions of relationships and sexuality education, backlash and health services in a rural town."* Sex Education: 1-16.

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Statement of contribution of others

This study was conducted by the Collaboration for Evidence, Research, and Impact in Public Health. This project was a unique project developed in response to a community expressed need. It is an example of rural insider-research. The author of this present thesis was involved in the conceptualising the study design; collection, analysis and interpretation of data; and all other facets of the project.

Publications 1-4 were written by the thesis author with input from co-authors as outlined below.

The following people were directly involved as thesis supervisors and/or co-authors for the publications arising from this research project.

Associate Professor Sharyn Burns: contributed as a supervisor of the PhD. Ass/Prof Burns had an ongoing close involvement with the research, including contributing to the project proposal, discussing the structure of publications, the reading of drafts and making suggestions for improvements to all publications.

Dr Roanna Lobo: contributed as a co-supervisor of the PhD. Dr Lobo had an ongoing close involvement with the research, including contributing to the project proposal, discussing the structure of publications, the reading of drafts and making suggestions for improvements to all publications.

Dr Ruth McConigley: contributed as a co-supervisor of the PhD from its conception through to 2017. Dr McConigley had close involvement with the initiation of the research, including contributing to the project proposal, discussing the structure of publications, the reading of drafts and making suggestions for improvements to publication 1.

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Abbreviations

RSE – Relationships and Sexuality Education

PAR – Participatory action research

STI – Sexually Transmissible Infection

AIDS - acquired immunodeficiency syndrome

HIV - human immunodeficiency virus

NHMRC: National Health and Medical Research Council

GP -general practitioner

LGBTI - lesbian, gay, bisexual, transgender and intersex

CALD – Culturally and linguistically diverse

MSM - men who have sex with men

RuSHY Framework – **R**ural **S**exual **H**ealth in **Y**outh Framework

Exegesis

Chapter 1: Introduction

Background

'Rurality' is a concept used to describe rural, regional and remote communities. Rural communities in Australia are diverse in terms of demographics, service access, employment and industry, and community engagement. Rurality within the context of this project relates to the interconnection, social proximity, lack of specialist services, community profile and level of community participation within the town the study is set in. There is regular debate over the nature of what constitutes and defines rural, regional and remote communities and many models (Rural, Remote and Metropolitan Areas Classification, Modified Monash Model, Australian Statistical Geography Standard, Accessibility/Remoteness Index of Australia) have sought to provide definition and clarity. These methodological models focus on the formal definition and categorisation of population centres in relation to population size, service, access and remoteness, but often fail to consider the community characteristics that provide the basis of the rurality.

Rurality can provide several barriers to young people looking to access sexual health services and education – but also provide strengths and benefits. Rural communities are generally interconnected with close social contact¹⁻³. This social proximity presents several barriers when addressing youth sexual health in the rural setting, such as issues managing confidentiality³⁻⁸, role duality of health professionals^{9,10}; and the limited availability of personnel and resources¹¹.

While social proximity within rural towns can be a barrier, it can also be protective, where the community is connected to its young people and has a desire to support and provide for them. Within this study stakeholders were required to find localised solutions to barriers to ensure the needs of young people are being met and were willing to explore solutions beyond their regular duties. The community nature of many rural communities also provides opportunities for stakeholders to utilise existing relationships, connections and community engagement to improve services and explore localised and low cost solutions that bring immediate change. The exploration of how

rural communities can respond to a localised need, in this instance the need for improved sexual health promotion, education and service provision within the setting provides the basis for this project.

Sexual health promotion in the rural area requires the consideration of how to address the need for primary prevention and the need to provide testing and treatment for sexually transmissible infections (STIs). In terms of primary prevention measures, the responsibility for the provision of relationships and sexuality education (RSE) within the rural setting regularly falls on schools¹⁶⁻¹⁸, with teachers recognised as the most sustainable option for rural RSE¹⁹. Broadly, as is seen in other similar countries²⁰, Australian school-based RSE lacks standardisation^{21,22}, and is generally heteronormative in terms of content^{19,23,24} with a biological focus¹⁶. With rural teachers being a fundamental source of RSE and sexual health information for young people, they require the skills and knowledge base to deliver high quality RSE^{16,25,26} that is differentiated to student needs and experiences^{25,27}.

Despite testing rates lower than 10%, chlamydia is the most common bacterial STI in young Australian adults aged 16-24 years¹², while the highest gonorrhoea notification rates are represented within the 20-29 year old male and 15-24 year old female age categories¹³. The structural barriers that rural youth face in terms of sexual health care access⁵, combined with the high prevalence of STIs among youth^{6,14} means this is an area that must be addressed to meet targets in the *Fourth National Sexually Transmissible Infections Strategy 2018–2022*¹⁵.

Efforts must be made to improve rural youth sexual health outcomes and evidence-based guidelines for guiding the planning, implementation, and evaluation of interventions will assist in that endeavour. There is a current lack of guidance within the literature on how to effectively address youth sexual health in the rural setting, and a lack of literature about RSE and health provision in rural Australia in general²⁸.

Significance

Young people experience a significant burden of STIs in Australia and have been identified as a priority population within the *Fourth National Sexually Transmissible Infections Strategy 2018–2022*. Within this Australian strategy, meeting the sexual

health needs of rural-based priority populations is identified as an action area but there is a lack of clear guidance as to how rural communities can address sexual health at a community-based level. This project was developed following an expressed need from a rural community to address the sexual health needs of young people within the community^{29, 30}. This is explained in greater detail in Chapter 6: Setting

While rural practitioners may be aware of which stakeholders need to be engaged, and what potential strategies could be implemented within their community, there is no clear framework or guideline to allow systematic planning and evaluation of interventions and initiatives. For rural stakeholders, the planning, implementation and evaluation of community-based sexual health interventions is often a case of trial and error.

Participatory Action Research

A participatory action research (PAR) methodology was adopted in this study to develop and validate a framework for planning, implementing and evaluating community-based youth sexual health interventions in the rural setting. The research is conducted from an insider-research positionality to engage rural youth and stakeholders with the research process. Study participants were given voice to offer real-world solutions on how to better address youth sexual health in the rural setting.

PAR methodology was chosen for this research as it was identified as an effective methodology for engaging community. There was also a strong desire from the lead researcher to conduct research with the rural community rather than ‘on it’ and PAR methodology aims to empower participants and give them a voice³¹.

PAR can be characterised by the “shared ownership of research projects, community-based analysis of social problems, and an orientation toward community action”³². It was considered appropriate for a project that developed from community-voiced concern; involved stakeholder analysis of the issues faced by community and was focused on finding a solution to the current situation^{29, 30}. Despite PAR being used in Toronto, Canada and Perth, Western Australia, in the development, implementation and evaluation of youth sexual health programs^{33, 34} there was limited available evidence in the rural setting of PAR being used to improve youth sexual health services.

Structure of exegesis

This research project is presented in the form of an exegesis comprising of chapters explaining the project and peer-reviewed research papers. The format of this exegesis follows contemporary presentation of doctoral research and represents the complete documentation of a PAR project conducted in a rural Western Australian town.

The research includes four published papers:

1. Chapter 5: Developing a framework for community-based sexual health interventions for youth in the rural setting: protocol for a participatory action research study: The protocol paper describing the methodology of the project ³⁵;
2. **Chapter 7: Managing qualitative research as insider-research in small rural communities.** A discussion of the management of insider-research in the rural setting ¹;
3. Chapter 9: ‘Everyone knows everyone’: youth perceptions of relationships and sexuality education, condom access and health services in a rural town: findings from the youth focus groups ³⁶; and
4. Chapter 10: Stakeholder perceptions of relationships and sexuality education, backlash and health services in a rural town: Research findings from the stakeholders interviews ³⁷.

The chapters provide additional background, explain the methodology in more detail, report results not described in the published papers and provide further discussion and recommendations.

The chapters will link the published papers and provide a deeper level of explanation where required. Discussion relating to each phase of research (community mapping, youth focus groups, stakeholder interviews, Delphi studies and Framework development) is included within either the corresponding chapter or the published paper. The discussion chapter at the end of this exegesis discusses the project in its entirety.

The included chapters are:

Chapter 1: Introduction: This chapter provides the background, significance and detail of the structure of this exegesis.

Chapter 2: Aim, Objectives and Significance: This chapter provides the explicit aims and objectives of this research project while highlighting the important space that this project occupies both in addressing rural practice and research needs.

Chapter 3: Literature Review: A review of the current literature available detailing any sexual health interventions and initiatives that target young people aged 16 to 24 years living in rural Australia either directly or indirectly is included as a chapter within this exegesis. This comprehensive search of the literature was limited to English language studies and to the past 10 years of publication, but searches were not limited to Australia. There was a paucity of recent literature that specifically addressed sexual health for rural youth in Australia and no literature that discussed effective implementation of sexual health interventions in the rural setting. There is a clear gap within the literature for work that guides or supports the rural community on how to address sexual health within their setting and how to advance on the *Fourth National Sexually Transmissible Infections Strategy 2018–2022* targets.

Chapter 4: Introduction to Methodology: This brief introductory chapter explains how the following chapters relate to the PAR methodology utilised to develop the framework.

Chapter 6: Setting: This chapter provides greater detail and background on the setting and the lead researcher's entry in to the research project.

Chapter 8: Community Mapping: Within the youth focus groups, an ice-breaker community mapping exercise was conducted to triangulate stakeholder data and explore youth participants' perspectives of the characteristics of the setting (detailed in Chapter 6). This process and the subsequent data analysis informed the developed draft framework (Appendix H: Frameworks). This chapter provides a brief report on the methodology, findings and discussion of the community mapping exercise.

Chapter 11: Delphi Study to Validate the Framework: The second and third PAR cycles aimed to evaluate the validity of the developed Framework using two separate Delphi studies. Embedding two Delphi studies within this PAR project further strengthened the participatory nature of the project. There were few examples within the literature of embedding Delphi technique within PAR studies and a lack of consistency

of the Delphi technique in terms of sample population, size and consensus measures ³⁸⁻⁴¹. However, Fletcher and Marchildon ⁴² used a modified Delphi method within their PAR project on health leadership, and Delphi method is well suited to health promotion research ³⁸.

Chapter 12: Development of the RuSHY Framework: After the three PAR cycles, the developed RuSHY (Rural Sexual Health in Youth) Framework document was completed. The product of extensive community engagement and consultation, this Framework represents a working document for the rural community. This chapter overviews its complete development. The completed RuSHY Framework document is found in Appendix F: Frameworks. The transcontextual credibility of the Framework could not be evaluated fully in other communities within the scope of a PhD project – and lends itself to greater review through implementation studies.

Chapter 13: Discussion: A discussion that focuses on the project as a whole and examines the implementation of PAR in the rural area and embedding Delphi studies within PAR and the research outcomes is in Chapter 13. This chapter contains detailed discussion on the project, the use of PAR in the rural setting, the embedding of Delphi within PAR, the positionality of the researcher and the participatory nature of the research and the overall research outcomes within the RuSHY Framework.

Chapter 14: Recommendations: The final chapter contains recommendations for practice, policy and research; including recommendations for the implementation of the Framework.

Chapter 2: Aim, Objectives and Significance

Aims and objectives:

The overall aim of this study was to use a participatory action research (PAR) methodology to develop and validate a framework for planning, implementing and evaluating community-based youth sexual health interventions in the rural setting. To achieve this aim, the study comprised the following objectives:

1. Conduct an analysis in relation to evidence-based practice, settings, key stakeholders and interventions to understand the context of the setting.
 - Conduct community consultation to identify and assess key settings, stakeholders, activities, and interventions that are currently active or planned to promote youth sexual health (see Chapter 9: ‘Everyone knows everyone’: youth perceptions of relationships and sexuality education, condom access and health services in a rural town Chapter 10: Stakeholder perceptions of relationships and sexuality education, backlash and health services in a rural town ^{36, 37})
 - Identify needs, gaps, weaknesses and opportunities that currently exist within the setting.
2. Develop a framework in consultation with key stakeholders and the target group for planning, implementing and evaluating community-based youth sexual health interventions in the rural setting using a PAR methodology (see Chapter 12: Development of the RuSHY Framework)
3. Evaluate the validity of the framework (see Chapter 11: Delphi Study to Validate the Framework).
 - Validate the framework with key stakeholders within the setting using a Delphi technique.
 - Evaluate the acceptability and validity of the framework through wider consultation with youth-focussed professionals using a Delphi technique.

Significance

This project aimed to develop and validate a framework that is effective for planning, implementing and evaluating multi-level community-based sexual health interventions for young people aged 16-24 years in the rural setting. Young people aged 16-24 years are a priority population in the *Fourth National Sexually Transmissible Infections Strategy 2018 – 2022*¹⁵.

This research built on an expressed community need to address youth sexual health in a rural setting with limited specialist services, and evolved during pre-project discussions with stakeholders. Before formally deciding on the exact nature of this project there were several suggested iterations examined in consultation with community stakeholders– from development of a localised app or social network solution; to a series of localised sexual health interventions; to widespread participatory intervention programs that sought to bring communities together in assessing what sexual health interventions would work in other towns. Additionally, while the literature does suggest the involvement of stakeholders⁴³⁻⁴⁵ in addressing the target group¹⁵, there was difficulty in identifying stakeholders and how to engage them when the setting lacks specialist sexual health services.

Early discussion with stakeholders involved exploration of an implementation trial within the setting reliant on the lead researcher delivering interventions. As planning evolved, the lack of guidance within the literature on how to implement an intervention project of this style in the rural setting informed the need to develop a project that would instead seek to provide clarity and direction for rural based stakeholders in delivering sexual health interventions in the rural setting. These stakeholders, many of whom have become ‘accidental’ advocates for sexual health in their areas, lack clear guidance on how to effectively plan, implement and evaluate community-based youth sexual health interventions in the rural setting. By engaging in this research as an “insider” the lead researcher was able to develop, in consultation with rural stakeholders and youth participants, the first Australian rural sexual health framework that addresses and outlines key concepts relating to sexual health delivery in the rural area. This framework aligns closely with several key action areas within the *Fourth National Sexually Transmissible Infections Strategy 2018 – 2022*¹⁵ to address the priority youth population

and provides a practical document for the rural workforce.

The key benefits of this research include:

1. Development of a practical document based on the active research participation of a rural community. This is the first evidence-based framework for addressing sexual health promotion in the rural Australian setting and provides clarity and direction for communities lacking in specialist services. The rural workforce involved in sexual health promotion consists of many generalists working in isolation with a lack of formalised qualifications or previous experience in sexual health⁴⁶. The wide variety of backgrounds of participants in this study is demonstrative of a setting where sexual health is “nobody’s priority”; generalists provide the basic services young people need and become ‘accidental’ experts and advocates for RSE. This framework gives that workforce a structural reference point to improve current practice.
2. Giving voice to rural workers and volunteers that provide relationships and sexuality education (RSE) and sexual health interventions for young people, by default or necessity. There is limited research on the perspectives of rural Australian sexual health providers.
3. The provision of research that has been undertaken as rural-based insider-research. This work does not only provide a voice to the rural workforce, volunteers and youth – but as research undertaken by a native of the setting, it provides research centred in a rural perspective, rather than from the perspective of an outsider looking in.
4. The opportunity for research participants to develop personal skills through the examination of current practice and policy. Through being involved in this study, research participants have taken steps to reorient and improve connections between services⁴⁷. The practice of health promotion supports personal and social development in the individual and community and also has a strong focus on multi-level change, including educational, organisational, political, structural and legislative changes⁴⁸. Despite many participants providing some level of RSE or sexual health intervention – prior to this study

there had been minimal collaboration or communication between stakeholders within the setting and limited focus on how to address community and organisation level needs or indeed how individual, interpersonal, organisational, community and societal interrelationships may be achieved. Involvement within the study led to several participants taking personal initiative to commence interventions or create new connections with other stakeholders.

5. Practical improvements in sexual health promotion in the setting and beyond. The findings of the stakeholder and youth consultations provide practical insights on sexual health provision in the rural setting. These findings have been disseminated to the wider sexual health community via publications and conferences and have led to the opportunity to implement the recommendations within practice, specifically those relating to condom access, networking of community stakeholders with health and education stakeholders and the necessity to improve youth and interagency communication.
6. Examining the feasibility of embedding the Delphi method within a PAR study. There is limited literature relating to the use of the Delphi method. This study demonstrates how a Delphi study can be embedded within PAR to gather information and involvement from participants.
7. The contributions to the literature as an example of PAR in the rural Australian setting. This project provides a contemporary example of insider-research that connects with stakeholders to develop solutions via PAR within the setting. By involving participants in the problem-solving nature of the research, the recommendations and key concepts of the RuSHY Framework document provide evidence that is grounded in current practice.
8. The lack of focus or prioritisation towards targeting rural sexual health at socioecological levels beyond the individual is highlighted within this research. This work provides rural communities with guidance on how to focus organisational and community level interventions and supports greater advocacy towards greater funding and focus for the rural workforce.
9. This work provides a platform for further testing of the RuSHY Framework in

other settings to evaluate the transcontextual validity of the framework. There are limitations relating to the transferability of the framework to other settings without further study, as it must be acknowledged that no two rural contexts are exactly the same⁴⁹ and transferability from one context to another in the rural setting can be problematic⁵⁰.

Chapter 3: Literature Review

A review of sexual health interventions and initiatives that target young people aged 16 to 24 years living in rural Australia.

Background

Sexual health education, provision and access to contraception, sexual health promotion and information provision are areas of importance in addressing sexual health, but there is a lack of quality evidence in Australia exploring sexual health interventions in the rural area. This lack of a rural voice within the literature leads to policy and practice decisions that must rely on evidence from outside Australia, from urban settings, or from remote Indigenous community focussed research.

Young people aged 16-24 years were identified in Australia as a priority population for sexually transmissible infection (STI) prevention strategies⁵¹ and represented 75% of identified chlamydia infections in 2017¹³. While most Australians (71%) live in major cities, one in 10 live in small towns with populations of less than 10,000. There is restricted availability of sexual health and relationships and sexuality education (RSE) providers in small rural towns with less youth-specific services and limited numbers of doctors. Non-specialist trained teachers deliver RSE as part of a broad health curriculum, and limited pharmacy services restrict options for processing prescriptions or purchasing contraceptives^{3,24}. The responsibility of providing RSE in many countries, particularly in the rural setting, regularly falls upon schools^{16-18,52,53}. Within the Australian setting, significant gaps in students' sexual health knowledge and dissatisfaction with the relevance of RSE that is provided have been reported^{45,54,55}.

Teachers of RSE have been found to struggle in their ability and willingness to address gender and sexuality diverse content or other content that may be seen to be controversial such as pleasure, pornography and non-reproductive sex^{56,55,57}. In an overcrowded curriculum, RSE can often be delivered in a tokenistic or superficial manner that ensures the topic is delivered in some manner, but not extensively⁵⁸⁻⁶⁰. This is despite effective RSE being strongly associated with increased odds of young people using contraception and gaining higher levels of STI knowledge⁶¹. This lack of prioritisation, particularly in the rural setting with a paucity of specialist services, presents a risk in RSE and youth sexual health service provision.

School-based sexual health education is not standardised nor mandatory across Australia, often lacks a focus on negotiating consensual sex²¹, and often fails to include same-sex attraction^{23, 24, 62}. Hillier and Mitchell²⁴ surveyed same-sex-attracted young people (n=1,749) and found that in comparison with heterosexual groups, these young people experienced higher rates of STIs (10% vs. 2%) and 40% (n=576) felt that school-based sex education was not useful at all due to a lack of same-sex content.

Sexual health campaigns and education targeting youth often assume that safe sex decisions are made by independent, consenting individuals^{3, 21}. An Australian study by Powell exploring young women's experiences around safe-sex practices and negotiating safe sex also highlighted gaps in school-based education²¹. This large qualitative study (n=94) set in rural and urban Australia found that few participants had received education regarding the law and sexual consent and most wanted more information on negotiating safe and consensual sex rather than the biological aspects of sexual activity. Powell noted that while school-based education and health promotion is important, schools do not have the sole responsibility for sexual health education, stressing that safe and consensual sex requires a community-wide response.

The aim of this present review is to synthesise the available evidence on sexual health interventions and initiatives that target young people aged 16 to 24 years living in rural Australia, either through explicit interventions or indirectly through interventions that influence peers, communities or schools.

Methods

Search strategy

A systematic search was conducted in January through to March 2019 to identify relevant publications from the following databases: CINAHL, EMBASE, ERIC, PsychINFO, Science Direct, Scopus, Web of Knowledge, and Cochrane Library of Systematic Reviews. In addition, grey literature was searched using Dissertation Abstracts International and Mednar. Meta-analysis, systematic reviews and quick reviews were also searched for additional publications, as were reference lists of found publications.

Search terms included: (“relationship* and “sexuality education” OR “relationship* and

sex* education” OR “sex* education” OR “sex* AND relationship* education OR “RSE”” OR “sex and relationship education OR sre” OR “sexual health” OR “health education” OR “sexual health education” OR “condom access” OR “condoms AND sexually-transmitted infections” OR “condom distribution” OR “condoms” OR “sexual health services” OR “sexual health promotion” OR “sexual health” OR “Students, High School” OR “Schools, Middle” OR “School Policies” OR “Schools, Secondary” OR “school” OR “School Health Nursing” OR “School Health Education” OR “Schools”) AND (“rural” OR “rural areas” OR “rural health” OR “rural population” OR “non-urban” OR “regional”).

Searched fields were keyword, title and abstract. Searches were narrowed to include only human studies (CINAHL, PsycINFO, EMBASE) in databases that allowed the limitation. In addition, the PsycINFO and EMBASE search strategy was restricted by age to include adolescents and adults but to exclude children under the age of 12 years old. Searches were limited to English language studies and limited to the past 10 years of publication. Searches were not limited to Australian studies.

Eligibility criteria

Studies were included in this review if they collected quantitative or qualitative data which reported one or more of the following in the rural setting: sexual health promotion; sexual health education provision; condom provision or distribution; sexual health primary provision, sexual health care access. A broad approach was taken in terms of inclusion of studies and studies that collected data from both urban and rural settings were included for initial assessment with the detailed criteria for inclusion and exclusion found in ***Table 1*** **Error! Reference source not found.** Studies that evaluated programs or interventions that targeted youth; studies that asked health or youth service providers about youth sexual health provision; and studies that asked young people about sexual health were included.

Table 1 Table of search domains and inclusions/exclusion criteria

Search domain	Inclusion criteria	Exclusion criteria
Setting	Rural	Remote Aboriginal communities
	Regional	Urban only
	Urban and rural/regional	
	Remote and rural/regional	
	Australian	
Topics		
	Relationships and sexuality education	Maternal care
	Sexual health promotion	Mental health
	Sexual health education	Alcohol and other drugs
	Sexual health primary care	Obesity
	Access to sexual health	
	Condom access or provision	
	Sexual health knowledge	
Intervention Target		
	Primarily young people aged 16-24 years	Children under 16 years
		Young people aged 16-24 years only representing a small part of a larger targeted population

Studies were excluded if they did not include rural or regional Australian populations; did not focus in any way on young people aged 16 to 24 years; or if they were not explicitly studies that involved sexual health, but had combined sexual health as a smaller component of mental health or other youth health outcomes. Studies that solely reported on remote Aboriginal community interventions or studies that focussed on primary school aged children were also excluded.

Selection of studies

All citations were downloaded into Endnote software. Titles (and abstracts where available) were screened for relevance using the inclusion criteria. Citations were categorised into two groups: i) possibly relevant studies; and ii) excluded studies (clearly irrelevant as they were not human studies or not focussed on sexual health). The full-text of any potential studies was obtained, using a low threshold for inclusion if there was any doubt. These studies were then screened against the inclusion criteria to determine eligibility.

Data extraction and management

A standard data recording form was used to extract information from each included study. The data extracted, where available, included: i) participant characteristics (sample size, mean age, sex and location); ii) methods (study design, recruitment mode, incentive use and response rate); iii) outcomes (units of measurement and instruments used); and iv) results (summary data and author conclusions).

Assessment of bias in included studies

Studies were assessed for threats to external validity through risk of selection bias by determining whether the study respondents were selected randomly or through a convenience sample, where the respondents were recruited from, and what incentives were offered or used to recruit students.

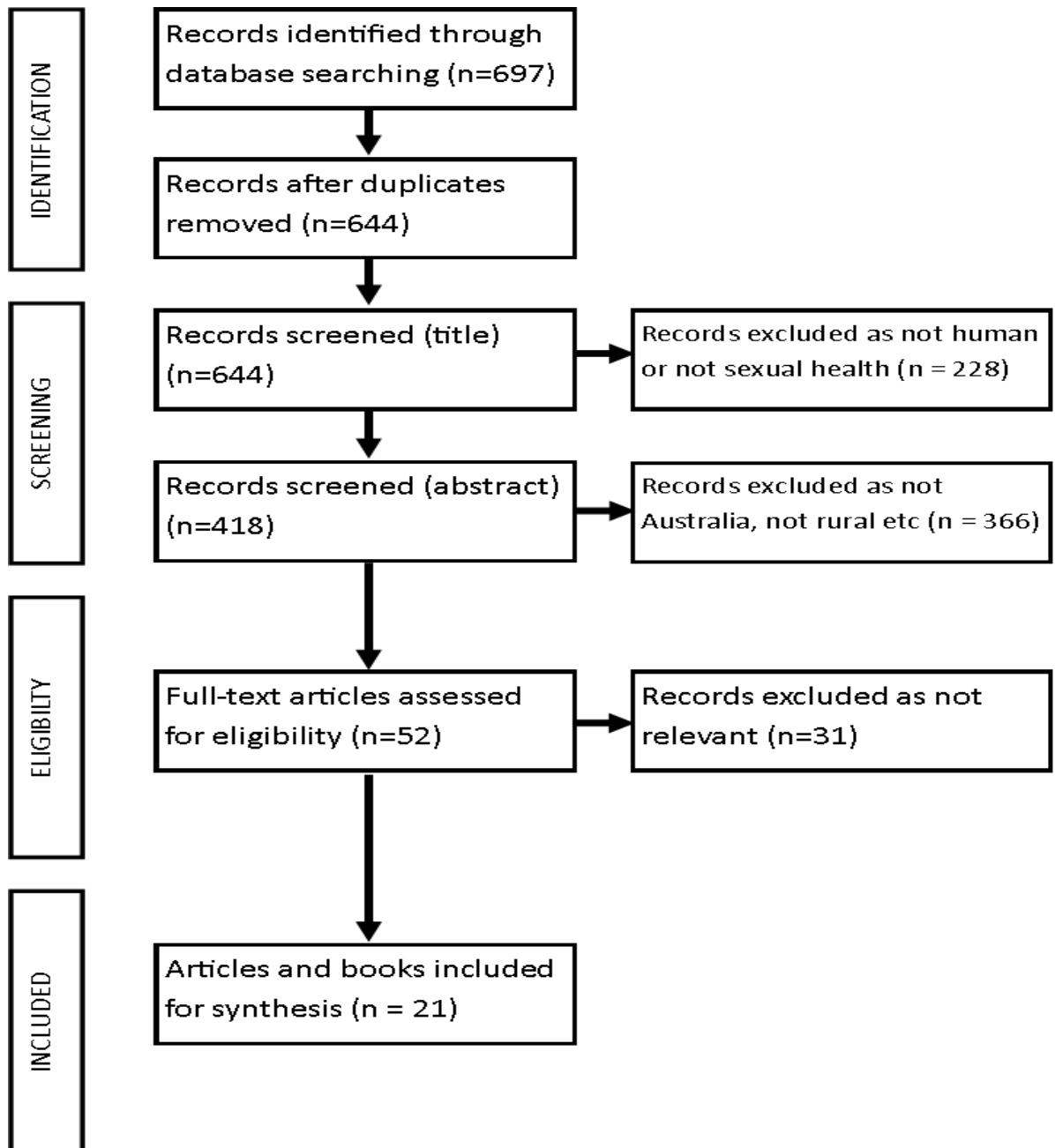
Results

Study selection

Figure 1 outlines the number of articles involved in this present review. The search process identified 697 articles from the ten databases leaving 646 after duplicates were removed. After titles were screened for irrelevance (not human studies; n = 2; and not

sexual health related; n = 226), 418 remained for abstract screening. This resulted in 52 articles appearing relevant and a further 31 were then excluded through full text review that found they did not report on relevant outcome measures. Twenty articles reporting on studies and one book reporting on two studies met the inclusion criteria and detail on their characteristics are included in Appendix C: Data extraction table ^{14, 24, 28, 60, 63-79 80}.

Figure 1 Review flow chart



Study characteristics

Participants

The earliest studies included in this review were published in 2009^{74, 80} and the latest in 2018^{71, 72}. Of studies reporting location of data collection, the largest proportion was conducted in Victoria (n = 11) with much smaller numbers in other Australian states and the territories. Twelve studies recruited participants from a self-described “rural” or “regional” population sample, while two studies recruited participants from a mixed “rural and regional” sample population. A further six studies collected data from mixed rural-urban sample populations. Studies with participants focussed on all genders. Of these mixed or comparative studies, only one presented separately reported rural data⁸⁰. Sample sizes in studies with participants varied greatly from 13⁷⁸ to 4,284¹⁴, explained through the varied methodology utilised. Twelve studies recruited young people only as their sample population^{14, 60, 65, 67, 69, 70, 73-76, 79, 80}, while a further three combined data collected from young people and health service providers or stakeholders^{63, 72, 78}. Three studies only collected data from health service or education stakeholders^{28, 66, 71}, one recruited parents of young people as their sample population⁶⁸ and two studies were program evaluations without a sample population^{64, 77}.

Study methods

There were no examples of participatory action research or Delphi studies with stakeholders. The two program evaluations focused on the cost-effectiveness of the interventions described based on data collected^{64, 77}. One study invited participation from all undergraduate students at a regional university⁷³, another invited participation from all attendees training at regional sporting clubs^{74, 75}. Yeung¹⁴ invited participation from all young people who attended a sexual health screen at 156 clinics around the country. All other studies involved a convenience sample with participants sourced from within schools, service provider networks or involvement in programs, with many using purposive sampling to evaluate a program or provide situational detail on a specific setting or issue.

Four studies collected focus group data from participants for qualitative analysis,^{28, 68, 72, 76}; while two collected focus group data and interactive body mapping data^{60, 69}. Two

studies described collection of data through purely interview^{66,71}. Within the same publication, Carmody outlines the collection of data in two separate studies, one using in-depth interviews another using pre- and post-test survey⁸⁰. Survey was solely used in a further four studies^{67,70,73,80}, while being combined with interviews⁶⁵, semi-structured interviews⁶³, reference group discussion⁷⁹, urine sample collection^{74,75} and an STI screen¹⁴. Of those studies that included survey, Kong^{74,75} was the only paper-collected survey; all others relied on online or electronic survey collection, with Johnston, Harvey, Matich, Page, Jukka, Hollins⁶³ using a mixture of online and peer facilitated electronic survey collection with young people administering surveys to other young people. One retrospective case study combined clinician reports, client feedback and self-reflective journaling⁷⁸.

Incentives

Kong highlighted that food refreshments were provided to participating sporting clubs for all club members, prizes were available to participants, all participants received a merchandise bag with lollipops and condoms; and testing was free of charge in the program that yielded both papers^{74,75}. Tomnay, Bourke and Fairley⁷⁶ stated that a \$40 voucher was offered to participants in their focus groups; while participants were placed in to a draw for an electronic tablet in another study⁷⁹; and participants received free professional training in another study⁶⁶. The remaining studies reviewed did not explicitly state if incentives were or were not offered to participants.

Outcomes

There were no studies that measured outcomes of interventions against a control or random sample and only one⁸⁰ that measured pre- post- intervention outcomes. Two studies were purely descriptive evaluations, one of advertising STI health services for rural young people⁶⁴ and suitability and cost-effectiveness of condom-vending machines in rural towns⁷⁷. Of other evaluation studies, there was a summative evaluation of the *Smart and Deadly* initiative⁷²; a post-intervention evaluation of the effectiveness of a university-based sexual health education program for under-graduate students⁷³ and an evaluation of a webcam sexual health service⁶⁵. Several studies aimed to examine or describe the suitability of various interventions including online testing⁷⁶, acceptability of nurse-led clinics⁶⁶; and a case review of an outreach youth clinic at a

rural secondary school ⁷⁸.

Several papers examined attitudes, knowledge or understanding of young people on topics such as understanding of relationships, first sexual encounters, pregnancy, domestic violence and STIs ⁶⁰; how decisions were made about potential sexual partners and STI knowledge ⁶⁹; what young people wanted in sexuality and violence prevention education ⁸⁰; views and preferences for presenting to general practitioners ⁶⁷; perceptions on sexuality and relationships education content ⁷⁰; and access to sexual health services⁷⁹. One paper compared youth perceptions to stakeholders in terms of youth access to sexual health services ⁶³ while others examined stakeholder perceptions on youth sexual health promotion interventions, such as the potential role of male adolescents in pregnancy prevention and unintended pregnancy ⁷¹ or what was needed to support good sexual health for secondary school students ²⁸. One study examined parental attitudes towards sexual health education in schools ⁶⁸.

A cross-sectional study provided an analysis on chlamydia prevalence in rural versus urban communities ¹⁴; while others provided chlamydia prevalence data ⁷⁴ and sexual health decision making data ⁷⁵ from participants from rural sporting clubs. There was no use of validated tools, or large-scale interventions.

Risk of bias

The risk of bias was high across most studies, with most relying on convenience or purposive sampling of participants and utilising small sample sizes ranging between n = 8 and n= 50 participants. The risk of bias was not addressed within the reporting of most studies, with only two ^{14, 63} explicitly acknowledging the possibility of selection bias within their studies; while another acknowledged potential recall bias ⁷⁰.

Discussion

This review synthesises evidence from studies addressing rural youth sexual health in the Australian setting. There was a paucity of literature that specifically addressed sexual health for rural youth in Australia. Three themes of research were evident in the available literature: – young people’s access to sexual health services; the sexual health education and information that is provided to young people; and the provision of STI testing services for young people. There were limited studies that examined the

provision of sexual health information, services, education or testing beyond an individual focus and addressed community or organisational level needs.

Research focus

There is limited Australian literature on youth sexual health provision in the rural setting. The limited number of papers found across the entire scope of sexual health provision and interventions that focusses on rural Australia presents a clear opportunity for additional research. There is a distinct lack of a rural voice in sexual health research in the Australian setting, especially within Western Australia, beyond remote, particularly northern, predominately Aboriginal communities. More than half of the recent research was conducted in the state of Victoria.

Within research that is easily accessible on this topic, there is a lack of evaluative or intervention style studies in the rural area. There was a single study conducted in New South Wales that attempted to examine undergraduate sexual behaviours and attitudes and to measure exposure to a university-wide sexual health intervention⁷³. This study was the largest attempted intervention study found within the literature – but in the views of the researchers, failed to achieve an adequate number of participants (n = 956) to measure pre to post intervention effectively. Researchers used the collected data as a cross-sectional study rather than to evaluate the effectiveness of the intervention. Other evaluative studies were small in scale and focussed on non-probability sampling or convenience sampling for participants and while delivering interesting insights into the interventions or programs initiated^{72, 80}, may have limited transferability to other settings, or were evaluation studies examining why an intervention failed to be effective^{64-66, 78}. There was a lack of standardisation in terms of data collection instruments, questionnaires or interview guides, limiting the opportunity for comparative analyses.

The largest studies in terms of participants found in the research provide interesting insights in to what is happening situationally in terms of cross-sectional analysis of both attendees to primary health care (n = 4,284)¹⁴ or attendees to a once-off STI screening program run through sporting clubs (n = 709)^{74, 75}. The implementation of STI screening in sporting clubs saw an impressive participation rate (95%), captured a number of undiagnosed cases of chlamydia (5.1% of sexually active participants) and was reported

to be an acceptable setting for STI screening for young people ⁷⁴. In the 10 years since that intervention was tested, there is no evidence in the literature of follow-up research involving STI screening of a similar population in rural sporting clubs either in the original setting (Victoria) or any other states. There has been rural research on trialling web-cam consultations ⁶⁵, direct marketing of STI testing services to young people ⁶⁴, and online testing initiatives ⁷⁶ with all of these programs reporting limited success and uptake of services.

Education and knowledge

RSE provision in the rural setting is primarily the role of teachers, with support from outside organisations. There was no research found that examined the perspectives or needs of rural teachers in the Australian setting and what support they need to effectively deliver the sexual health component of the Australian curriculum. A recent study that did examine the structural supports that are needed to provide good sexual health education for rural secondary school students ²⁸ called for improved government policy direction to signal the importance of relationships and sexuality education to teachers and schools.

Dyson examined parental attitudes towards relationships and sexuality education; finding varied attitudes towards what parents considered important or required in this subject area. It was suggested that a cautious approach was required when advocating for relationships and sexuality education in the school setting ⁶⁸. While the needs and desires of parents must be considered, this should not be at the detriment of a child's education, with the Australian Curriculum Standards⁸¹ and the Western Australian School Curriculum and Standards Authority⁸² setting clear guidelines on what should be taught in this area. Beyond education delivered from school settings, one study highlights the lack of recognition towards potential peer education roles for adolescent males in the prevention of pregnancy ⁷¹, which suggests that there is a clear opportunity for further investigation of the appropriateness of peer education in the rural setting and to explore what is required to support stakeholders in recognising these opportunities. The *Smart and Deadly* intervention, while focussed on rural Aboriginal community members provides a strong example of effective peer education and community engagement towards sexual health provision ⁷².

The acquisition and retention of sexual health education in the rural setting has also seen limited research. There has been some examination of school-based knowledge acquisition for rural students⁷⁰ and research that has gathered knowledge on current knowledge of young people towards STIs, sexual health and sexual relationships^{60, 69, 80}. There is a lack of consistency in what is asked of young people, how this knowledge is assessed and what support is required to provide adequate relationships and sexual health education.

Intervention design

Important research has been done in the rural setting that focusses on individual level interventions, but there are limited examples of multi-level programs that address broader socio-ecological levels. There is a clear opportunity for rural-focussed research that examines multi-level interventions or investigations that have been shown to be effective in producing positive youth sexual health outcomes in other settings^{83, 84} and that are able to be sustained longer term through incorporation and assimilation to community and structural contexts⁸⁵. While most available literature examined individual or interpersonal level interventions, there were some examples of research that moved beyond these socio-ecological levels.

The evaluation study on feasibility of condom-vending machines for rural towns, is an intervention that addressed individual level access to condoms. However, the research evaluation focussed on the economic and community level acceptance of the condom vending machines within the rural setting⁷⁷. Other research that examined sexual health provision via a multi-level focus includes the examination of what community level supports ensured the effective implementation of a sexual health program from the perspectives of both participants and stakeholders and what would be required in the future to improve its implementation⁷²; and what community and societal level structural support is required to provide adequate relationships and sexuality education in the rural setting²⁸. Mac Phail and colleagues⁷³, attempted to evaluate an organisation wide intervention that focussed on creating a supportive sexual health environment and address multiple social-ecological levels but failed to recruit adequate participant numbers to accurately evaluate the program.

Conclusion

Given the paucity of data available on Australian rural sexual health provision implementation, the lack of consistency in interventions or initiatives and limited evaluation within the research, there is a need to further examine how to better plan, implement and evaluate sexual health services in the rural setting. Research that focusses on systematic implementation and evaluation of sexual health interventions will provide evidence for further rural research to build upon. There is an absence of a rural-based voice on sexual health provision in the rural setting and without providing rural stakeholders and young people a voice, their needs will not be met.

Chapter 4: Introduction to Methodology

Within the project, several sources of data were collected and analysed. Participatory action research (PAR) is an iterative and interactive methodology and at the time that the research protocol (detailed in Chapter 5) was written and published, the exact nature of the second and third stages of the project had not yet evolved.

The following chapters:

- outline the methodological stages of the three PAR cycles of this research project (Chapter 5: Developing a framework for community-based sexual health interventions for youth in the rural setting: protocol for a participatory action research study)
- give context on the setting of the project (Chapter 6: Setting); and
- provide an insight in to how the research process was managed in a socially proximate insider-research setting (Chapter 7: Managing qualitative research as insider-research in small rural communities.).

The first PAR cycle of the project sought to understand the setting and context, and develop a draft framework addressing the threats, opportunities, weaknesses and needs highlighted by youth and stakeholder participants. This was achieved through an early scoping literature review that informed:

- The development of the research protocol (Chapter 5: Developing a framework for community-based sexual health interventions for youth in the rural setting: protocol for a participatory action research study)
- A series of youth focus groups and interviews (Chapter 9: ‘Everyone knows everyone’: youth perceptions of relationships and sexuality education, condom access and health services in a rural town³⁶)
- A community mapping exercise (Chapter 8: Community Mapping)
- Stakeholder interviews (Chapter 10: Stakeholder perceptions of relationships and sexuality education, backlash and health services in a rural town³⁷).

- A photovoice project was proposed in the development of this project but removed in consultation with young people who participated in the youth focus groups.

The data collected and analysed from the above methods informed the development of the draft framework. This framework and data themes were shared with a wide range of stakeholders to provide feedback on the thematic analysis and validate early findings and assertions via member checking. Once the draft framework was fully developed, the second PAR cycle, a localised Delphi study was initiated to gather feedback and refine the document. At the completion of this process, the refined framework document was evaluated by participants of an Australia wide Delphi study, with this process detailed in Chapter 11: Delphi Study to Validate the Framework

Chapter 5: Developing a framework for community-based sexual health interventions for youth in the rural setting: protocol for a participatory action research study

This paper was written as the formal protocol for the project and was published in BMJ Open in 2017.

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BMJ Open Developing a framework for community-based sexual health interventions for youth in the rural setting: protocol for a participatory action research study

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ABSTRACT

Introduction There is limited research examining community-based or multilevel interventions that address the sexual health of young people in the rural Australian context. This paper describes the Participatory Action Research (PAR) project that will develop and validate a framework that is effective for planning, implementing and evaluating multilevel community-based sexual health interventions for young people aged 16–24 years in the Australian rural setting.

Methods and analysis To develop a framework for sexual health interventions with stakeholders, PAR will be used. Three PAR cycles will be conducted, using semistructured one-on-one interviews, focus groups, community mapping and photovoice to inform the development of a draft framework. Cycle 2 and Cycle 3 will use targeted Delphi studies to gather evaluation and feedback on the developed draft framework. All data collected will be reviewed and analysed in detail and coded as concepts become apparent at each stage of the process.

Ethics and dissemination This protocol describes a supervised doctoral research project. This project seeks to contribute to the literature regarding PAR in the rural setting and the use of the Delphi technique within PAR projects. The developed framework as a result of the project will provide a foundation for further research testing the application of the framework in other settings and health areas. This research has received ethics approval from the Curtin University Human Research and Ethics Committee (HR96/2015).

INTRODUCTION

There is limited research examining community-based or multilevel interventions that address the sexual health of young people in the rural Australian context. This target group is a priority population in the Third National Sexually Transmissible Infections Strategy 2014–2017.¹ While efforts must be made to improve youth sexual health, barriers to establishing appropriate sexual health services in rural areas present additional challenges relating to access, anonymity and service availability.^{2–5}

Strengths and limitations of this study

- As Participatory Action Research (PAR) is systematic and rigorous, this method will enable stakeholders and researchers to explore and discover effective solutions within the research process.
- Using PAR will enable increased engagement and the collaboration with research participants and stakeholders.
- The methods of this project will provide further literature on the use of PAR in the rural setting and the use of the Delphi process within PAR.
- PAR is time intensive and will require prolonged engagement with the research setting and stakeholders.
- This PAR project will be conducted as ‘insider-research’, presenting significant challenges such as managing bias, maintaining confidentiality and anonymity.

This project will use Bronfenbrenner’s Ecological Framework for Human Development to identify and evaluate how the different socioecological levels are addressed by current services.⁶ A systematic review of 15 sexual behaviour interventions targeting US Latina adolescents found that while different socioecological levels were often included, individual and interpersonal levels were the most common focus.⁷ The review authors’ recommended interventions should address community and societal level issues influencing youth sexual health.⁷ Similarly in their rapid review Brown *et al*⁸ found preventative programmes that targeted multiple domains of a young person’s life were most effective in increasing protective behaviours, increasing awareness and knowledge around sexually transmitted infection (STI) prevention and reducing STI among young people. A review of STI prevention interventions suggests maintaining these interventions in the



longer term may require the incorporation of a variety of community components and societal levels to ensure sustainability.⁶

Multilevel programmes based within broader socio-ecological systems have been found to be effective in enhancing positive youth sexual health outcomes,⁸ although application in rural Australia is yet to be tested. Primary prevention strategies and education, combined with voluntary STI testing and early treatment, are highlighted in the Third National Sexually Transmissible Infections Strategy 2014–2017⁷ as the most effective response to the spread of STI; however, there is no suitable framework or model for provision and coordination of these strategies and interventions in the rural setting.

This PAR project takes place in a small rural town in Western Australia. A community health organisation forum within the town¹⁰ highlighted that healthcare providers viewed themselves as ‘*not youth friendly*’, with low youth engagement and expressed a desire to improve youth health services. A series of interviews with 20 rural-based youth participants were conducted early in 2014 with feedback showing that young people in the town were unaware of the necessity to be tested for STIs, how infections are transmitted and participants raised issues relating to condom access and use.¹¹ Within the rural setting, sexual education and services are often delivered by non-specialist services and may lack coordination, planning and evaluation. A framework that identifies the key stakeholders, education and services—and how they interact within the setting—will be developed through this PAR project. This framework will provide a foundation for further research testing the application of the framework in other settings and health areas.

Participatory Action Research (PAR) has been used in Toronto, Canada, and Australia to work in direct consultation with young people and service providers to improve the ways in which sexual health promotion and sexual health services are delivered.^{12–15} There is a lack of evidence in the rural setting of PAR being used to improve the delivery of sexual health services such as sexual health promotion, primary prevention strategies or STI testing and interventions. This project aims to engage stakeholders within the rural community setting by using PAR to examine and explore ways to improve the delivery of sexual health promotion education; sexual health-related interagency communication and sexual health service provision for young people. This PAR process will lead to the development of a draft framework that communities can use. This draft framework will identify key stakeholders, key settings, services and potential interventions within the community.

The developed draft framework will be further evaluated and refined through targeted Delphi studies. Delphi studies are a method of group communication used to gain consensus and feedback from a group of identified experts.¹⁴ There is limited literature relating to the use of the Delphi method within PAR. Fletcher and Marchildon¹⁵ used a modified Delphi method within

their PAR project on health leadership with an increased emphasis on the qualitative nature of the open-ended questionnaire and suggest that the method is appropriate for PAR studies. This project seeks to contribute to the literature regarding PAR in the rural setting and the use of the Delphi studies within PAR projects.

AIM AND OBJECTIVES

This PAR project will develop and validate a framework that is effective for planning, implementing and evaluating multilevel community-based sexual health interventions for young people aged 16–24 years in the Australian rural setting.

Study objectives

The objectives of the project will be:

1. to conduct an analysis in relation to evidence-based practice, settings, key stakeholders and interventions to understand the context of the setting;
2. develop a framework in consultation with key stakeholders and the target group for planning, implementing and evaluating community-based youth sexual health interventions in the rural setting using a PAR methodology; and
3. evaluate the validity of the framework.

METHODS AND ANALYSIS

PAR is a systematic and rigorous approach to investigation that enables stakeholders and researchers to explore and discover effective solutions to everyday life problems.¹⁶ PAR involves giving stakeholders the opportunity to be involved with multiple recurrent stages (cycles) of community-based observation, reflection, planning and action,¹⁷ with each cycle following on from and influencing subsequent cycles.^{16,18,19} This research method has an orientation towards community action and analysis to address social problems.¹⁸ Using PAR in the community is beneficial in increasing engagement and the collaborative nature of the research.^{20–22} Bronfenbrenner’s Ecological Framework for Human Development provides a framework for highlighting and examining individual, interpersonal, organisational and community inter-relationships.⁶

Three PAR cycles will be conducted as per figure 1. PAR Cycle 1 will include semi-structured one-on-one interviews, focus groups, community mapping and photovoice to inform the development of a draft framework. Cycle 2 and Cycle 3 will use targeted Delphi studies to gather evaluation and feedback on the developed draft framework by experts in sexual health provision and rural health to allow refinement and revision and improved practical application. Effort will be made to use innovative and engaging data collection methods to ensure participant engagement and high data quality, particularly with youth participants¹⁷ as using tools other than survey-based tools may increase the detail of response from participants in

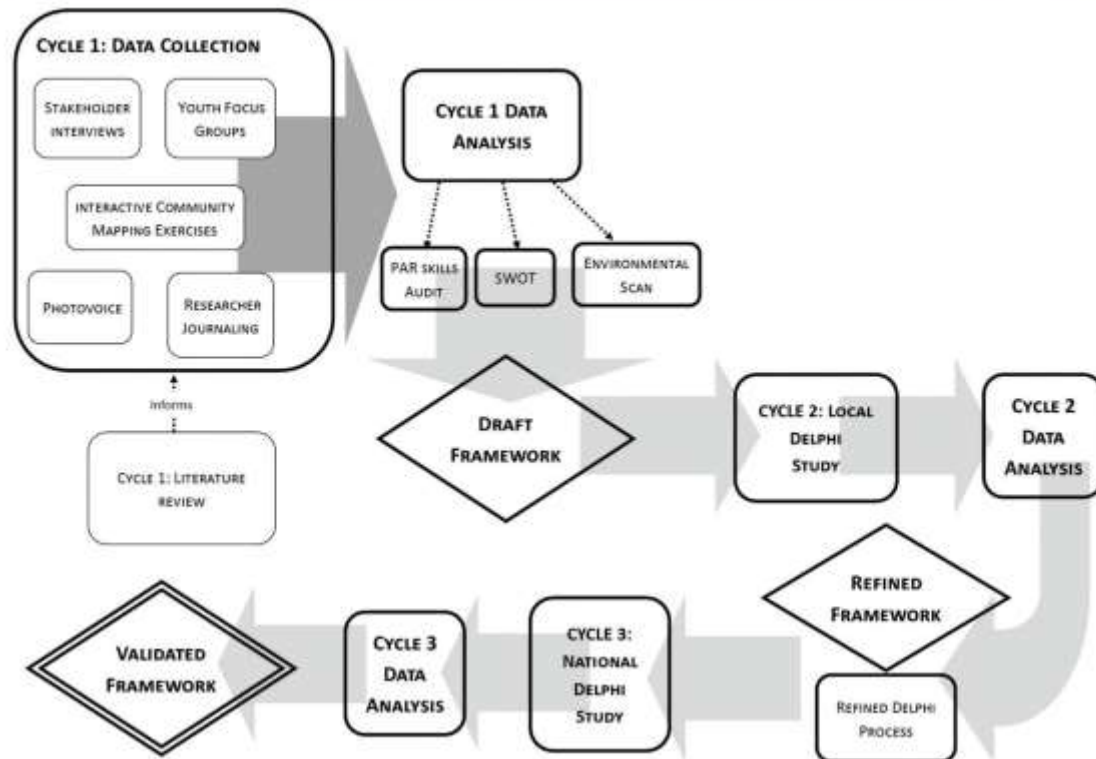


Figure 1 Participatory action research framework development flowchart.

such a small sample size while reducing social desirability bias.²⁰

SETTING

This project will take place in a small rural community in Western Australia. The researcher lives and works within the community and will manage potential impacts of conducting insider research within their own community. There are benefits of conducting insider research, including holding a greater understanding of history and culture within the setting²¹ and the opportunity to gather a greater volume and depth of data from known informants.²⁴ There are also significant challenges such as bias, maintaining confidentiality and anonymity and established informant relationships.^{25–26} There is current literature available that provides guidance on managing the challenges of insider research,^{25–26} although this literature focuses on organisational structure or workplace research, rather than an entire small community.

The research setting is a Western Australian town, with a population of approximately 5500 people. It is located approximately 50 km from the nearest regional centre (population approximately 40 000) and 400 km from the nearest major city. Young people aged between 16 and 24 years comprise around 10% of the overall population.²⁹

No regular public transport exists between this town and the regional centre, aside from school bus services. No sexual health-specific services are provided within the town beyond generalist healthcare, though regional umbrella support is provided from the regional centre.

Participants in this study will be community stakeholders and young people. Youth participants will be engaged to ensure that the implications of implementing the framework and any suggested interventions are youth-friendly, appropriate and reflect the needs of the target population.

PAR CYCLE 1

Recruitment and sample size

The researcher will be using existing professional networks and a local understanding of services and knowledge of the setting to identify potential participants. A purposive sample of key professional and community stakeholders will be recruited for the initial interviews. Approximately 15–20 community stakeholders will participate in the context setting observation cycle in PAR Cycle 1.

Youth participants (16–19 years) will also be recruited through snowball sampling technique to participate in the context setting observation cycle in PAR Cycle 1. Approximately 30 young people will be recruited to



participate in three focus groups. Purposive selection of focus group participants for one-on-one interviews will be used if more in-depth data are required, and these participants will be invited to participate in the photovoice component of the research. Additional recruitment will take place through peer referral and advertising through existing social media networks (sporting club pages, youth centre pages and community organisation pages).

Youth participants (n=10) from the focus groups will be purposively selected to attend training on the photovoice project and will be asked to take photographs to provide further context to the study.

Data collection

The data collected in PAR Cycle 1 will be used to identify and analyse the needs, gaps, weaknesses and opportunities within the setting relating to current and potential settings, stakeholders and interventions for youth sexual health. These data will also inform the development of the draft framework.

Throughout the project, the researcher will keep a comprehensive reflective research journal, cataloguing the progress, obstacles and successes of the research process. This journal will be kept to acknowledge the researcher's experiences and context within the research, analysis and interpretation.^{30, 31} The journal will also act as a component of the audit trail for the study.³² Reflective journals can also increase research validity by making subjective processes transparent for those outside the research project.³⁰

Stakeholders

Data will be collected through semistructured one-to-one interviews with stakeholders. A semistructured interview guide will be developed using the socioecological health model to identify barriers, facilitators and opportunities associated with each level of the model. Semistructured interviews have been chosen to allow stakeholders the freedom to express their views in their own terms³³ while allowing for the discovery or elaboration of information provided within the interview.³⁴ The interview questions will address an environmental scan and strength, weakness, opportunity and threat (SWOT) analysis for youth sexual health interventions within the setting. Consistent with qualitative research methodology, interview questions will be modified and refined throughout the data collection process as unexplored phenomena are exposed.³⁵

Youth (16–19 years)

Data from youth focus groups and one-on-one interviews will be combined with stakeholder data to inform environmental scan and SWOT analysis of the community. This community analysis will provide participants with the opportunity to highlight what is already available and what is required to address youth sexual health needs. Community mapping exercises will be used within focus groups and interviews as an interactive visual and

relational data gathering technique.³⁶ Participants will be asked to draw maps that graphically display their perception of services within the town, the interaction with and between services and their ideals regarding service location.

Photovoice is a participatory research method that can be used to contribute to an enhanced understanding of community assets and needs.³⁷ Photovoice will be used to triangulate the interview and focus group data³⁷ and has been previously used effectively to engage with youth participants in other studies.^{38, 39} Youth participants (n=10) from the focus groups will be purposively selected to attend training on the photovoice project and will be asked to take photographs using their own smartphones to provide further context to the study. Different themes will be explored,³⁸ from the general nature of the town to access points of sexual health services and resources, to other themes relating to sexual health within the rural town context. Smartphone ownership in Australia is high,⁴⁰ particularly among young people, with 91% of Australian teens aged 14–17 years owning a mobile phone and 94% of those youth mobile phone owners having a smartphone.⁴¹ Participants will be asked to take photographs on their own devices that capture information and the discussed themes from their own personal perspective. The photography topics will be developed with participant involvement and be guided by early focus groups and interviews with young people.³⁷

Interviews, focus groups and photovoice sessions will be facilitated by the lead researcher and will be conducted in private, quiet, places that are convenient and appropriate to the participants (eg, clubs, youth centres and health centres) and will be organised directly with each participant or group. Interviews and focus group sessions will take between 40 and 60 min. Photovoice sessions will be facilitated by the researcher and are anticipated to take between 45 and 90 min per session with the duration, number and frequency of the sessions to be negotiated with participants.^{39, 42} Interviews, focus group discussions and photovoice analysis will be audio-recorded and transcribed verbatim to assist with data analysis.

Analysis

All data collected will be reviewed and analysed in detail and coded as concepts become apparent at each stage of the process and reported as part of the PAR process.³⁵ All will be managed using NVivo software.

Interviews and focus groups

A grounded theory approach to data analysis will be used involving constant comparison analysis of the interview and focus group transcription data that will commence with the first interview. Constant comparison analysis requires the researcher to continually sort through the data collected, coding the information to identify key themes and reinforce theory generation.^{43, 44} Constant comparison analysis of focus groups and interviews will assist the researcher in assessing data saturation as it is

possible to assess if the themes that emerged from one participant or group also emerged in others.^{35–40} The stages of analysis will involve open coding of manuscripts to reduce the data into small units, axial coding to group these units into categories followed by selective coding to develop themes that express the content.^{35–44–47}

Community mapping

Visual mapping data will be summarised through transference into written descriptive data explaining each participant's community map. These data will be sorted and categorised as themes develop using a grounded theory approach.³⁶ The newly categorised data will be analysed in a subsequent session with participants to review categories for consistency and to identify key themes.

Photovoice

Participants will be involved with the early analysis of photographs, selecting photographs that most accurately reflect the project aims and contextualising the photography and initial identification of issues, themes and theories that emerge. Ensuring participant involvement will avoid distortion of the data to fit the researcher's needs.³⁸ Issues, themes and theories will be further analysed by the researcher and assigned codes.

PAR CYCLE 2

It is planned that PAR Cycle 2 will use a Delphi study to further develop and refine the draft framework; however, PAR is an iterative process, featuring revision and exploration of issues and themes as they evolve within the research process. The exact nature of Cycles 2 and 3 of this PAR study cannot be completely known prior to the commencement of the study, because the study participants and their needs will influence how the study progresses.^{16–40} Additional ethics approval will be sought for any additional processes required.

Recruitment and sample size

There is a lack of consensus on what represents adequate sample size for Delphi studies.^{50–51} Delphi panel size does not depend on statistical power but relies on the dynamics of a group for arriving at consensus with the literature recommending 10–18 experts on a Delphi panel.⁵¹

The initial community organisations and stakeholders involved in Cycle 1 will be invited to provide feedback on the developed draft framework. Any individuals and organisations that were identified in the initial cycle but who were not approached or unable to participate will also be invited. Additional health workers from primary healthcare (general practitioners and practice nurses) and youth services (support officers) may be approached to provide feedback on the framework if required.

It is anticipated that approximately 80% of participants from PAR Cycle 1 will participate in the initial Delphi study, alongside additional recruited participants

in the second cycle of the PAR study. It is anticipated that approximately 30 local participants will need to be approached to provide feedback on the framework, to allow for refusals, non-responses and withdrawals. The number to be recruited in PAR Cycle 2 will be influenced by community involvement in the first cycle of the project.

Data collection

The Delphi technique is a group communication process as well as a method of achieving a consensus of opinion.¹⁴ The Delphi technique process for this study is displayed in figure 2. During PAR Cycle 2 participants will be invited to provide feedback on how appropriate and effective the framework developed in PAR Cycle 1 will be for implementing and coordinating community-based youth sexual health interventions in the setting. To collect this information, an open-ended questionnaire, informed by PAR cycle 1 data, will form the first stage of the Delphi study, while subsequent cycles of inquiry will provide participants with a series of opportunities to offer further feedback on the framework.¹⁴ Data will be grouped and verified with participants to ensure that the data are fairly represented. Further iterations of the Delphi study will enable the most important factors to be identified and ranked using a 7-point Likert scale.^{15–51} Iterations of the survey will continue until participants reach 80% consensus on the framework.^{15–51}

Analysis

Data collected in the first round of Delphi questionnaires will be qualitative in nature and will be analysed using content analysis techniques.^{14–50} This process will be informed by the concepts of the socioecological model.

Subsequent iterations of the Delphi study will provide participants with their earlier responses to compare with the new data that has been summarised and edited. Participants will then rate or rank the new statements using 7-point Likert scales.^{14–15–50–51} Statistical analysis will be performed on the ranked Likert scales to identify statements that achieve group consensus.¹⁴ Measures of central tendency (means, mode and median) and level of dispersion (SD and IQR) will be calculated, and a third questionnaire consisting of the statements and their statistical ratings from the previous Delphi round will be presented to participants.^{14–50} Further statistical analysis of the 7-point Likert scales will be used to judge the level of consensus to the statements.

PAR CYCLE 3

Cycle 3 is an expanded consultation on the refined framework using the Delphi method as informed by the localised Delphi study. Primary healthcare professionals, youth workers, health promotion professionals and other youth-focused professions involved with sexual health interventions in the rural setting will be approached to provide feedback on the refined framework. Participants from Cycle 2 will also be invited to participate in this final

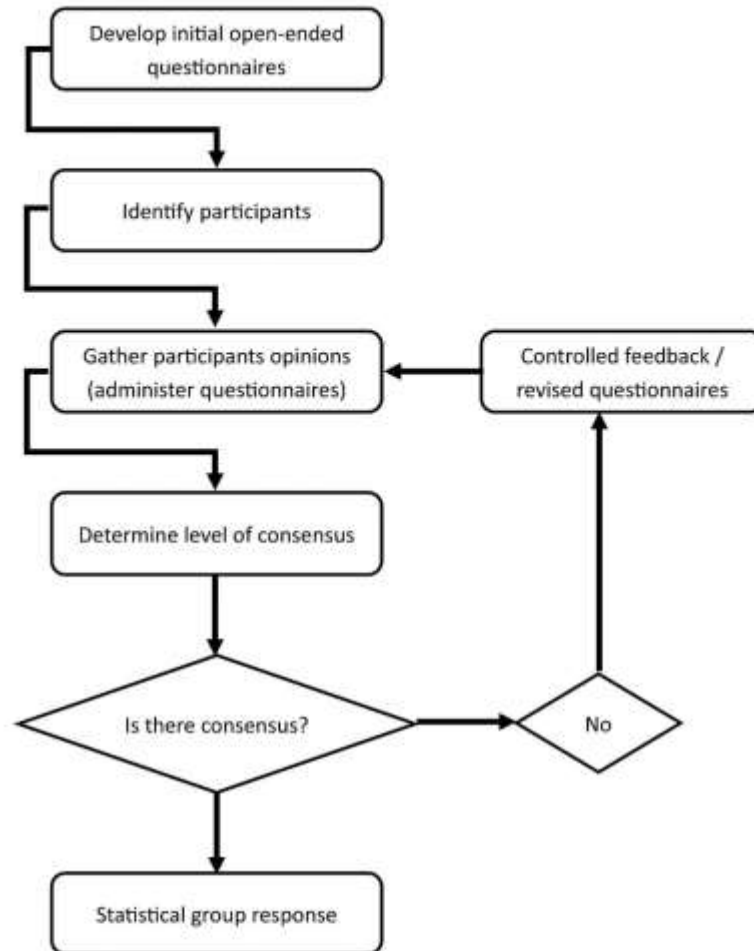


Figure 2 Delphi flowchart for provision of stakeholder feedback on draft framework in PAR Cycles 2 and 3.

cycle, with feedback compared with the findings of the Cycle 2 Delphi study.

Recruitment and sample size

The PAR Cycle 3 Delphi study will engage approximately 30 expert participants with a background of primary health, youth work, health promotion and other youth-focused professions in the rural setting. A non-probability sampling technique will be used to select a panel of national and international expert participants based on their ability to generate insight into community-based sexual health interventions in the rural setting. Professional primary healthcare and youth work networks will be used initially to contact national and international participants.

Data collection

Data collection for Cycle 3 will follow a similar approach to Cycle 2, with an open-ended questionnaire to be

administered with participants to provide feedback on how appropriate and effective the developed framework will be for implementing and coordinating community-based youth sexual health interventions in the rural setting.

Analysis

Data analysis of the Cycle 3 Delphi study will mirror the analysis method in the earlier Cycle 2 Delphi study.

RIGOUR

Several measures will be employed to increase the rigour of this research. To reduce bias, data will be collected and coded by the researcher and discussed regularly with the research team.⁵² The researcher will acknowledge and record sources of potential personal bias that could influence the processes of data collection and analysis as a result of existing networks and connections. This level

of documentation will increase confirmability of the research by providing an audit trail allowing observers to confirm the veracity of the study.^{16,33} Increased credibility will be achieved through prolonged engagement with the setting and regular member checking of raw data, analyses and reports.¹⁶ Detailed descriptions of the contextual data and activities of the study, through immersion, reflective journaling and detailed documentation will provide transferability through allowing others to analyse the situation and research outcomes based on setting and context.^{33,34} Triangulation across data sources and data collection procedures will allow the determination of congruence of findings.^{16,32} Stakeholders may be reinterviewed to further clarify or examine points if necessary.

To reduce bias and enhance conformability, the coding and themes will be analysed by the research group (n=3). This will involve a reflective practice whereby the lead author will code, then codes will be discussed by the research group and further refined to ensure the themes reflect the dataset. This process will enhance dependability and intercoder reliability, while the Delphi process will also provide an opportunity for research participants to check the meanings they intended are included in the themes. The research group will be involved in the development of all interview guides and further refinement of the guide will occur as a team. While there are advantages to all interviews being conducted by one researcher, this process can also reduce interviewer bias. The research group discussions will reduce subjectivity.³⁵

ETHICS AND DISSEMINATION

This research has received ethics approval from the Curtin University Human Research and Ethics Committee (HR96/2015).

Given the small size of the community in which the project will be undertaken, there are ethical considerations in relation to protecting the anonymity of participants and confidentiality of data, particularly regarding interviews and focus groups. The connected nature of small communities will be acknowledged in consent forms and care will be taken in analysis and presentation of data to ensure participant confidentiality. Data that may overtly identify participants will be excluded.³⁶

Consent will be required from all participants prior to their involvement in the project. The project will target young people and will involve young people below the age of 18 years. Participants under the age of 18 years, but over the age to consent to sexual activity in Western Australia (16 years), as per the Criminal Code Act Compilation Act 1913 (Section 321)³⁷ and who are judged to be mature enough to understand the research study and provide consent without parental consent,³⁸ will be considered as mature minors. Consistent with other studies,³⁹ a standardised procedure for establishing mature minor status has been developed.³⁹

This is a supervised doctoral research project, and the results of this research project will be used by the

researcher to obtain a Doctor of Philosophy. Several papers relating the results of the project will be published over the course of the project. In an effort to ensure the wider community is aware of the project, its methods and objectives, information on the study will be released via the local community newspaper, community centres and community social media networks. The progress and findings of the study will also be communicated to stakeholders and the community through local media and resource centres, forums, social media and electronic newsletters.

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Contributors This protocol paper describes a supervised doctoral research project, and the results of this research project will be used by CWH to obtain a Doctor of Philosophy at Curtin University. CWH was responsible for coordinating the contribution of all authors to this paper. All authors made significant contributions to the development and conceptualisation of the protocol. CWH was responsible for drafting this paper. SB, RL and RM were responsible for editing and guidance on the paper. All authors were responsible for critically revising the paper. All authors approved the final version of this paper for submission.

Competing interests None declared.

Patient consent Obtained

Ethics approval Curtin University Human Research and Ethics Committee.

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Chapter 6: Setting

The community of Denmark, Western Australia (WA), was purposively chosen as the setting for the PAR project in response to community-voiced desire for improved youth sexual health service provision, education and support from community members within the town.

Location

The Shire of Denmark is located on the south coast of WA approximately 50kms west of Albany (large regional centre) and 400kms south of Perth (capital city of WA). No regular public transport exists within the Shire, nor between Albany and Denmark, aside from school bus services. The Shire has an area of 1,859.9 square kms extending 70 kms in an east west direction and 30kms north south and is home to a community who reside across the four town sites of Denmark, Peaceful Bay, Bow Bridge and Nornalup.

Approximately 9.1% of the Shire population are employed in agriculture, compared to 9.1% of Regional Western Australia and 2.4% of Western Australia⁸⁶.

Denmark is classified by the *Australian Standard Geographical Classification System* as Outer Regional (RA3), with an *ARIA+* (Accessibility/Remoteness Index of Australia Plus) Average score of 4 (moderately accessible). The *National Strategic Framework for Rural and Remote Health*⁴⁹ classifies all RA2 and RA3 centres as “rural”.

Demographic characteristics

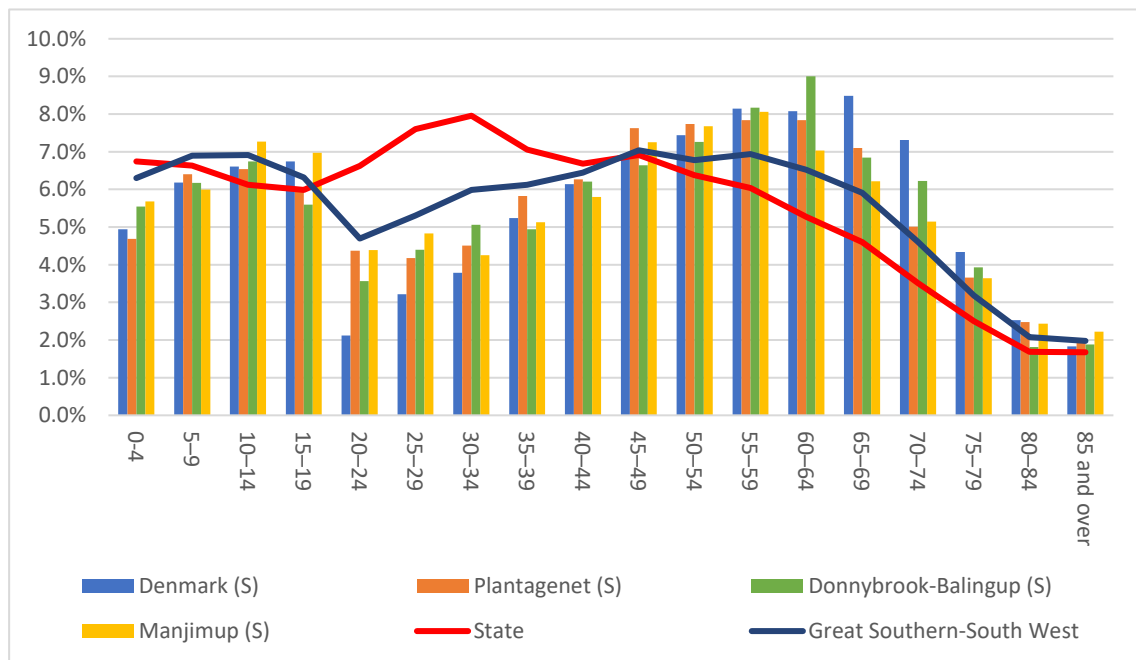
An estimated 550 young people aged 16-24 years reside in Denmark comprising approximately 8.86% of the total population⁸⁷. Of this group, only 12 individuals were recorded as Aboriginal or Torres Strait Islander (approximately 0.02% of the population). There are no dedicated Aboriginal or Torres Strait Islander services provided within the town.

Consistent with other rural towns in Australia, a lack of tertiary education and training opportunities within the Shire leads to a significant proportion of young people leaving Denmark for either larger regional centres such as Albany, or the capital city, Perth for greater opportunities⁸⁸⁻⁹¹. The Shire of Denmark is also a popular destination for rural retirement migration and therefore the Shire has a higher than average proportion of persons aged over 55 years⁹². This combined with the youth out-migration pattern,

where young people leave smaller towns for larger regional centres or cities for education and employment, impacts on community composition, service prioritisation and orientation^{93, 94}.

Denmark's age profile is not dissimilar to other small rural towns in the WA Local Government Association Great Southern/South West regions (see **Figure 2**) but it does have a considerably lower proportion of population aged 16-24 years⁸⁷. This lower proportion represents a risk to service provision towards this demographic, particularly in the area of sexual health. This is because there is a rationalisation of service provision towards the majority due to a lower proportion of population in this age bracket. While this is economically reasonable, it is not equitable. There is a concession that not all required services can be provided for young people in every small town. There is however, a responsibility to educate young people adequately, particularly in regard to sexual health knowledge, understanding of consent and contraception; acknowledgement of the need for STI testing; and how to engage with sexual health services. With youth out-migration patterns, a lack of preparation of rural young people terms of sexual health skills and knowledge become the problem of regional centre and capital city sexual health providers.

Figure 2 Percentage of Population in 5 year age scales for Selected Local Government Areas compared to WA State and Great Southern-South West Average



Community engagement

Prior to the start of this project, several stakeholders self-identified local facilities and practices as being “not youth friendly” and lacked youth engagement²⁹. A small series of health consultations were facilitated by the lead author for the Denmark Health Hub early in 2014 courtesy of Sexual Health Week funding from WA AIDS Council (WAAC), that suggested young people in the community were unaware of the necessity to be tested for sexually transmissible infections; how infections were transmitted and that there are issues over condom access relating to both availability and use³⁰. Concerns surrounding sexual health, alcohol and consent were raised by school communities, Denmark Youth Services, and the Denmark-Walpole Football Club. The germination of a project that addressed the sexual health needs of young people within the town in terms of access, education and sexual health promotion occurred and the lead researcher began examining potential intervention styles with stakeholders. Projects that were more interventionist in style were initially examined, but with further examination of the issue of sexual health within the rural context it became clear that there was both a lack of guidance for rural practitioners and a lack of resources.

The lead researcher is a health professional who resides in Denmark and works regularly with young people in both a professional and volunteer capacity within the town through roles including nursing, health promotion, tutoring, mentoring and through coaching, playing and volunteering through the local Australian Rules Football Club. Former co-supervisor Dr McConigley also resides in Denmark and was the Chairperson of the Denmark Health Hub (DHH) (a collaborative health services group) at the time that this research project was initiated. Neither the lead researcher nor the former co-supervisor were employed in the sexual health sector or youth services at the commencement of this project. Beyond the initial small WAAC Sexual Health Week grant that funded the youth consultations that preceded this project, there was no funding, scholarship or formal program support for this project.

There was significant interest and commitment from the members of the DHH, Denmark Youth Services (DYS) and local sporting clubs in addressing sexual health within the setting and the lead researcher was able to utilise existing professional networks, understandings of local services and knowledge of the setting to identify potential participants, engage the community and remain involved as an active component of the PAR method. With a lack of specialist services and a lead researcher self-funding or volunteering within the role, it became apparent to stakeholders and researchers that a research project that relied heavily on interventions driven by individuals such as the lead researcher may lack transferrability to other settings and a project that focussed on supporting existing stakeholders would be more suitable.

Sexual health services for youth

There are limited options for young people to access sexual health care and education within the Shire. Available health services include two General Practice surgeries and a small combined hospital and health service that provides emergency and inpatient medical care. There is a part-time school nurse position that provides support to the two senior high schools in the area (one Independent government grade 7-12 high school and one Agricultural College with boarding students, grades 10-12). This school nurse position also supports the three primary schools (one government, two Independent) in the town. There are no other specialist sexual health or youth health services within the town. While there are two youth private sexual health clinics operated by GP clinics in

neighbouring Albany, neither have an active presence in Denmark.

The population health unit in Albany has a regional part-time Sexual Health and Blood Borne Virus Project Officer that services the entire WA Country Health Service Lower Great Southern health district; from Denmark to Katanning (180km away). Sexual health promotion in Denmark is provided in an ad hoc manner by ‘accidental’ experts, passionate volunteers and community advocates rather than a dedicated workforce.

Relationships and sexuality education (RSE) is the role of the secondary high school Health and Physical Education teachers, with supplementation from the part-time school nurse and annual visits from the “Dr Yes” program; a program organised by the Australian Medical Association (WA) that provides medical students the opportunity to deliver harm minimisation sessions to high school students on topics including alcohol and other drugs, mental health and sexual health.

“The Denmark Study”, a 1989 project collaboration between the CSIRO and Curtin University led by Brian Bishop and Geoffrey Syme, involved interviewing 104 residents and 13 representatives of government departments as well as community consultations, focus groups and questionnaires. This study identified significant problems in youth services in the region. These were “a lack of self-reliance and motivation”, the impact of a lack of “educational opportunities”, a “lack of people working together” and a “lack of understanding of other groups” ⁹⁵ (page 65). Early discussions with stakeholders in preparation and design of this project suggests that little had changed in this area in the decades preceding this study.

Chapter 7: Managing qualitative research as insider-research in small rural communities.

This paper was published to contribute to the literature a series of recommendations on managing insider-research in small rural communities. There was a lack of relevant literature on this topic prior to the publication of this article in Rural and Remote Health in 2018.

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COMMENTARY

Managing qualitative research as insider-research in small rural communities

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ABSTRACT

Rural clinicians in small communities face the pressure of always being 'on duty', and the ethical challenges of overlapping relationships with members of the community and duality of roles. The lead author of this commentary has experience as an insider researcher living within a small rural community, and has navigated the ethical challenges and community pressures of conducting qualitative research within an interconnected network. With appropriate measures and planning, insider research can be conducted rigorously, while maintaining ongoing relationships, confidentiality and anonymity.

KEYWORDS:

health research, insider research, interconnected, qualitative, small communities, small town.

Introduction

Rural clinicians in small communities face the pressure of always being 'on-duty'¹, and the ethical challenges of overlapping relationships and role duality² while working within settings with active gossip networks³ and increased social proximity³. Conducting insider research within small rural communities poses similar challenges and pressures.

This commentary describes perspectives of insider research using the participatory action research method, focusing on improving outcomes relating to youth sexual health services in a small rural community⁴. Insider research is used to describe research where the researcher has a direct involvement or connection with the research setting⁵. There are varying degrees of 'insider', and the concept should be viewed as a continuum rather than a dichotomy⁶ or binary opposites⁷⁻⁹. The lead author of this article has experience as an insider researcher, living as a long-term resident and conducting research within their own small rural community⁴, and has navigated the ethical challenges and community pressures of conducting participatory action research within an interconnected network.

It is generally presumed that access to study participants is easily granted for the insider researcher¹⁰ and data collection is therefore less time consuming⁶. The author has found some participants very willing to assist the project based on previous personal or professional relationships, while others required extended periods of deliberation before participating, or refusing. The literature suggests there are no overwhelming advantages to being an insider or outsider researcher^{4,6,11-13} and, while insider research is not problematic in itself¹⁴, in the authors' experience the research team must maintain a safe research environment for both participants and the researcher.

The positionality of the insider researcher allows advantages relating to a greater understanding of a community's undocumented historical context¹², access to research participants¹⁰ and an intimacy or familiarity that promotes sharing¹⁵ and trust¹. This was an advantage for this research, which enabled the researcher to become embedded within the critical paradigm.

The interconnected nature of rural communities

There is literature examining the phenomena of insider research within the context of workplaces^{1,10}, professional settings⁹, education^{6,17}, subculture¹² and community¹⁸, and literature examining management of clinical work within small rural communities^{1-3,16,18-20}. There is, however, to the author's knowledge, limited literature examining the experience of insider research as conducted in a place of personal belonging or everyday life for the researcher¹².

Rural towns are interconnected in nature, individuals live with close social contact³ and professionals rarely maintain singular roles²⁰. Insiders within these communities manage the ethics of dual roles and interconnected relationships as professionals^{2,15,20} or researchers^{10,21}. It has been highlighted in workplace research that insider researchers face challenges maintaining clear boundaries with colleagues and peers⁹. In the small-town setting, this is combined with the rural workforce aspect of seeming always available¹.

Insider researchers manage the benefits of interconnected communities, such as increased approachability¹⁶ and greater access to research participants or interviews¹⁰, while ensuring confidentiality²² or informed consent¹⁰ are not compromised by pre-established professional or peer relationships⁶, or local networks³. The insider researcher explicitly acknowledged the interconnectedness of rural towns in ethics submissions, participant information and consent forms, explaining that maintaining confidentiality through anonymity may not be guaranteed in the setting⁴. This disclosure allowed participants to provide clear informed consent with an understanding of the setting. The researcher provided full disclosure of research aims and intent to all participants.

Mitigating difficulties maintaining anonymity can be achieved through having the whole research team review cases, or by forming an advisory group to give guidance and recommendations around decisions on de-identification and exclusion of data. It may be appropriate to avoid controversial lines of enquiry^{8,23}, or consider withholding information from publication or discussion that could be identifying¹¹.

Existing relationships

A rural insider researcher can leverage relationships that are already formed. This may include advantages relating to a greater understanding of setting, established relationships and key stakeholders¹². Some participants may feel obliged to participate due to pre-existing relationships^{10,24}. Coercion is addressed through the manner in which an insider researcher approaches, contacts, obtains consent from and explains research participation to a potential participant^{24,28}.

Ensuring that participants know they can withdraw at any stage of the research process, and that refusing to participate will not be detrimental to existing small town networks and opportunities, is critical in maintaining the ethical integrity of the research²⁷. In the present research, efforts were made to ensure young people did not feel coerced into participating due to their relationship with the researcher, and they were provided with opportunities and an explanation of how to withdraw from the study at any stage.

Ensuring neutrality during the interview process is important in minimising a participant's feeling that they should confirm or conform to the researcher's own opinions, particularly within the context of ongoing interaction⁶, and researchers may decide to use a third party to interview some participants. Within this research, some participants had preconceptions of possible outcomes the researcher may have wanted to achieve based on previous professional work within the community around sexual health, youth health and sporting clubs. The insider researcher actively sought participants from beyond immediate professional networks and sought out stakeholders who were known to hold opposing or contrary views to other participants. The researcher chose to mitigate researcher bias through recording existing and strained relationships when reviewing participant recruitment.

Insider researchers should disclose the aims and intent of their research¹², while ensuring participants feel they are engaged in a process that promotes sharing¹⁵ and trust¹, and that informed consent is not compromised¹⁰. To eliminate potential awkwardness after a data collection episode, the researcher explicitly stated to participants how important it was to have diversity of viewpoints.

The research team took care to minimise participants being too focused on preconceived ideas of the researcher's work¹⁸, or feelings of coercion to express views they believed match those of the wider community²⁸. For example, they took care how they portrayed their views in local and social media.

When interviewing known participants, there can be occasions where shared prior experiences may not be fully explained, and further questioning may be required to clarify a known phenomenon for data collection^{8,29}. This should be done carefully to avoid guiding the participant while acknowledging that this pre-existing knowledge may exist²⁴ and may feel contrived. In the present research, the research team checked manuscripts to reduce bias and ensured probing questions were full and complete to enhance confirmability. The insider researcher negotiates a fine balance between participant and researcher assumptions, pre-existing knowledge and the researcher's desire for data^{18,24}. Regular discussion with the research team was an important aspect of this research.

Ongoing relationships

Workplace insider research may lead to a continued interaction post-research^{9,13}. Small communities see increased role duality, where clinicians are on the same sporting teams as patients, or the teacher of a child²⁰. This directly applies to research, with the interconnected nature of small communities leading to a greater chance of continued contact beyond the researcher-participant relationship and research project^{12,24}.

At school drop-off times, sporting clubs, the aisle of the local supermarket – all became settings for continued researcher-participant interaction, where the author was met with queries on project progress. While this is not entirely problematic, maintaining a participant's right to anonymous and confidential participation²², and ethical researcher-participant boundaries can be difficult^{8,8} within the socially proximate rural setting³.

The researcher found participants generally curious about study progress, others that were consulted, and if the peer they referred participated. Informing participants at the time of data collection of the research process and how

important it is for participants not to discuss the research in informal settings until the data are fully analysed and reported can help manage continuing interactions, as can limiting the window of data collection. A scripted response that the research team is continuing to speak with participants, and that data are being analysed with results available by a set time, can allow researchers to manage relationships by providing credible information and updates while maintaining confidentiality and anonymity²⁷.

Insider researchers can feel a significant burden in trying to maintain confidentiality²⁴ and, in the case of preparing for publication, can be pressured by the knowledge that participants may read published results and recognise themselves or others despite efforts to de-identify data¹¹. The authors have chosen to withhold quotes and identifying data such as job positions in presenting data that may identify participants from this small rural setting in publication.

Conclusion

Insider researchers have an important role in generating research from within the rural area and, while not overwhelmingly advantaged or disadvantaged¹¹, they occupy a position of privilege and trust. Prior to collecting data, insider researchers should take measures to negotiate ongoing relationships and the researcher's place within a community, including managing how views are portrayed in social and local media; manage bias by approaching participants beyond obvious networks and recording existing relationships; and explicitly acknowledge the interconnected nature of rural towns in ethics submissions and participant information. With appropriate measures and planning in place, insider research can be conducted rigorously.

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Chapter 8: Community Mapping

Introduction

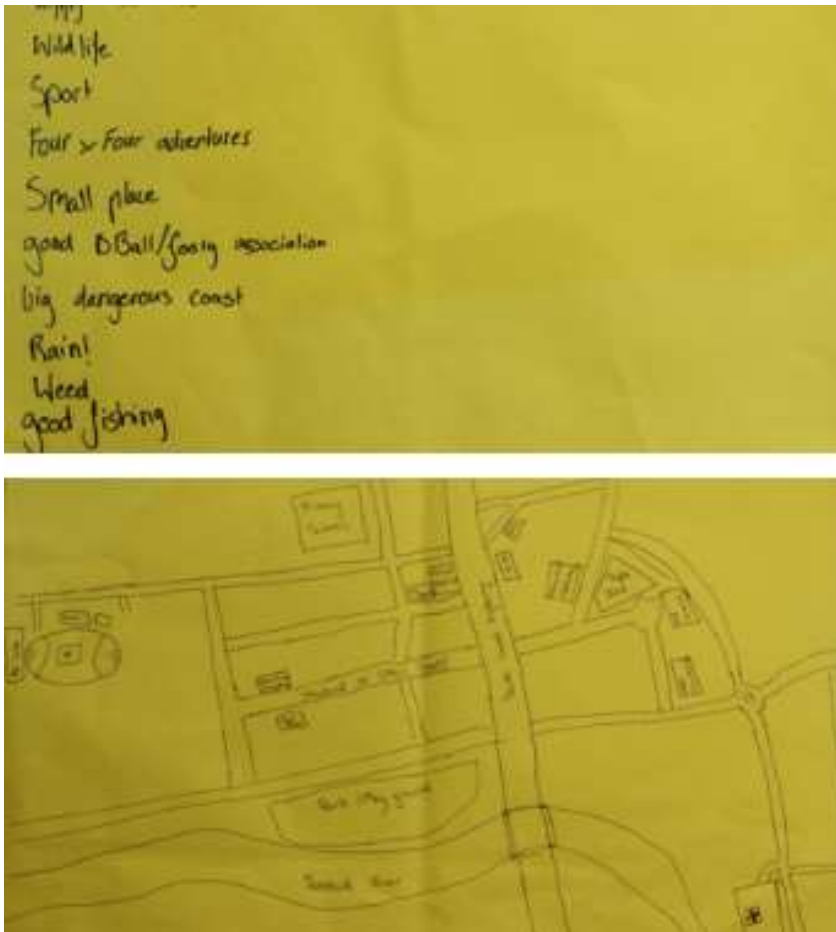
Community mapping was used in this study to triangulate stakeholder data and explore youth participants' perspectives of the characteristics of setting³⁵ through a simplified ground-truthing exercise. Ground-truthing has been utilised in participatory youth research in the past⁹⁶ and can be utilised to gather visual and relational data rather than geospatial mapping^{97,98}. The researcher held previous experience in conducting community mapping as a youth engagement exercise through a series of youth consultations for the Shire of Denmark in 2014⁹⁹. Community mapping can be used to scaffold the agency of young people to convey insight into themselves and their perspectives of the world around them⁹⁷.

Methods

Community mapping was utilised as an engagement and ice-breaker tool with youth focus group participants³⁶. Focus groups were conducted in a small rural town in Western Australia; population of approximately 5,500 and a youth population aged 16-29 years of approximately 500. Informed consent was obtained from each participant and those under 18 years were assessed on their competence to provide mature minor consent¹⁰⁰ on a case-by-case basis utilising an adapted framework¹⁰¹. Fifteen young people aged between 16 and 24 years participated in focus group sessions with 13 participating in the community mapping exercise, including eight male and five female identifying participants. Two participants (both female) declined the invitation to participate in community mapping. These two participants were involved in a focus group session, however felt they did not have time to also participate in the community mapping exercise. Participants were asked to take a piece of A3 paper and a pen or marker pen and draw the community as they saw it. All forms of expressions were acceptable, and participants were not limited in how they "mapped".

All participants were asked to identify major landmarks in Denmark, key areas that young people spent time, places to access health services and information, and any important connections or interactions between those entities. Participants were provided time and space to complete the exercise before the focus groups and transcription

Figure 3 continued: Community Mapping Participant examples



Community mapping sessions lasted up to 20 minutes with participants deciding when the sessions would cease, and the recorded focus group could commence. Community maps were discussed with participants to summarise the data and to conclude the exercise.

Mapping data were inspected and analysed by the lead author. The exercise was used primarily as an ice-breaker activity; however, analysis of the places and youth environments that participants mapped provided the author with insight in to how participants viewed their community. All maps were table top reviewed with key map data transferred into data that could be sorted and categorised ⁹⁷.

Landmarks were tallied and logged into an Excel spreadsheet with the frequency they were mapped. No allowance was made for the size that landmarks were mapped. While all participants were asked to draw connections between landmarks, only two

participants clearly linked landmarks. Data were represented in a consolidated community map created utilising *Draw io* software. Landmarks were placed on the map by the researcher to represent their location in relation to each other with a focus on relationship and frequency rather than rigid geography. Data that could easily de-identify participants were excluded from discussion¹ and “home” was mapped as a singular location.

Findings

There were key landmarks or zones that participants identified within the activity that represent ‘hubs’ for young people in this community. A total of 52 unique landmarks or places were listed, drawn or mapped by participants. Themes or descriptors were excluded from analysis in this instance. These include terms or themes that while interesting in discussion, were not easily identified as clear landmarks or centres and were excluded from analysis. These included terms like “rain”, “weed”, “good fishing”, “hippys” (sic) and “tall trees”. Similarly, graphic representations of the sun, marijuana leaves or people were excluded.

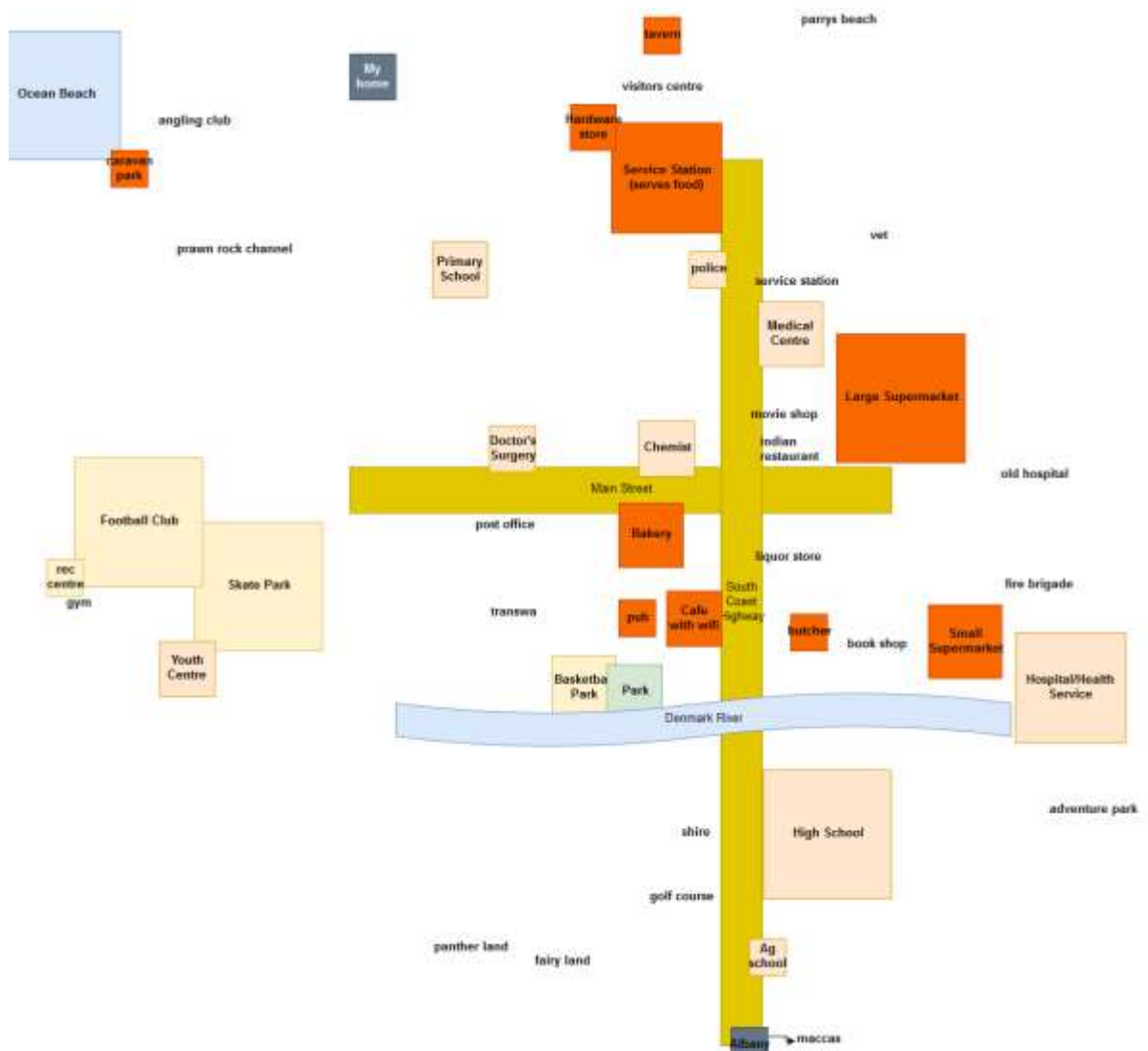
All other places were identified, including less well known “hang-outs” such as areas in bushland that had place names (i.e. “fairy land” and “panther land”) where participants reported going to consume alcohol and/or other drugs or to hold parties. “Home” was also included as a place. The neighbouring town was rarely mapped by participants and only one participant mapped or represented the available bus service that connects the two towns. Of interest, the local hardware store was identified and recognised more regularly by participants than the neighbouring regional town with its population of 40,000 people and wide range of regional youth services.

The findings highlight there are key zones or areas that young people in the town mapped and identified with. Key youth activity hubs such as school and major landmarks, including the hospital, were identified in addition to a few less well mapped places that were recognisable to participants. The recreation precinct was strongly represented in most maps, with the football club, skate park, youth centre, recreation centre and gym appearing in most participant maps. Local youth hangouts or stores that experience high levels of youth traffic were represented regularly within the mapping.

These stores attract and also employ the greatest number of young people within the town – and in the context of condom access – additionally represent the most accessible places to purchase contraceptives. The local service (petrol) station – a place of high youth employment with a range of hot food and late opening hours was mapped as a key landmark in the town as frequently as the local hospital.

The frequency of the mapped landmarks is represented in the researcher developed consolidated community map seen in *Figure 4* (a larger version is in Appendix E). Landmarks sizes are represented in the consolidated map by the rate they appeared in participant maps – with the most frequently occurring landmarks being the football club, the skate park, the high school, the supermarket, the service station, the town’s major beach and the hospital. Major roads and the river are mapped as they appeared regularly in participants’ maps in various forms, while no other roads or transport options were regularly mapped or represented.

Figure 4 Composite map from analysed data



Discussion

Many of the male participants in this study (n = 8) were engaged in sport and recreation in the town, so it was unsurprising that the sport and recreation centres of the town were well represented in the mapping of the community. Sporting clubs are an important part of rural communities and often act as a key engagement centre^{103, 104}. The mapping of non-organised recreation centres such as the “ghetto hoops”, a basketball park consisting of a set of derelict basketball hoops on some cracked bitumen courts by the river, frequented by young people after school and on weekends; the town’s nearest beach (Ocean Beach) and the skate park – a purpose built concrete park that has high use by young people; displays that non-formalised sporting centres are well recognised and

regarded within the setting. These spaces represent areas of high frequency youth attendance, particularly with young people who may not be engaged with formalised structured sports.

The stores or services that have high levels of youth employment were also well represented in the mapping process. These were seen by participants as key landmarks in the town – and represent the core venues where young people spend their money when in the setting; while major health centres were mapped as expected. It was interesting to note that while most traditional health services were mapped; the school nurse service and the wide range of complementary health services that are in the town (acupuncture, chiropractor, physiotherapist) were not. While the exclusion of the complementary health services could be explained through the framing of the exercise being on the topic of sexual health, the exclusion of the school nurse mirrors some of the discussion held during the youth focus groups relating to not being aware of the service ³⁶.

The inclusion of spaces such as “Fairy Land” and “Panther Land” that are lesser known areas where young people “wag school“ (play truant) and often consume alcohol and/or other drugs; and the references to marijuana both as text and drawings were interesting to note. Participants seemd to be comfortable disclosing their knowledge of these areas and interests to the researcher. While these settings were not directly related to health or the provision of sexual health services – they were noted as important by a few participants and are relevant in the planning for sexual health interventions within the setting given the associations or interrelationships between risk-taking sexual behaviour, alcohol and other drug use and youth ^{69, 105, 106}. While stakeholders may not be able to access these informal areas, knowledge of the risk-taking behaviours that may occur at these settings can inform delivery of information and education to young people.

Conclusions

Community mapping within the context of this project was not designed to generate large quantities of data or expose key themes. Its role within the study was to assist in triangulating other collected data, gaining perspective on how youth participants viewed their town while building rapport and engagement with the research process. The

mapping process was an effective activation tool in the focus group sessions and the researcher found that it provided a source point for several casual discussions on health services or information centres within the setting. The researcher utilised some of the collected data early in phase one of the PAR Cycle to identify any other key stakeholders who may have added insight to the development of the RuSHY Framework. Community mapping in this context also allowed for ground-truthing of the previously identified key landmarks for young people in the town from the PAR community mapping undertaken early in the research process and provided insight in to how young people perceived their own town and community.

Chapter 9: ‘Everyone knows everyone’: youth perceptions of relationships and sexuality education, condom access and health services in a rural town

This paper contains the analysis of the youth focus groups conducted as part of first cycle of the this PAR project. This article was published in Sex Education in 2019 and is a component of the formative work that was completed to inform the development of the RuSHY Framework.

An author’s original manuscript is provided unedited for this chapter.

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Carl W Heslop, Sharyn Burns & Roanna Lobo (2019): ‘Everyone knows everyone’: youth perceptions of relationships and sexuality education, condom access and health services in a rural town, Sex Education, DOI: <https://doi.org/10.1080/14681811.2019.1566120>

'Everyone knows everyone': Youth perceptions of relationships and sexuality education, condom access and health services in a rural town

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Abstract

Sexual health promotion and Relationships and Sexuality Education (RSE) are influenced by interrelated social and cultural factors, particularly in a rural setting. This paper reports findings from interviews with young people when asked about experiences and perspectives accessing RSE and sexual health services in a small rural Australian town. Fifteen young people (16 to 24 years) participated in semi-structured focus groups and interviews. Data was analysed and coded with four key themes emerging: relevant and credible sexual health education; make it easy; GP accessibility; and discreet condom supply. The findings of this study have practical implications when addressing community level sexual health and RSE needs.

Keywords: rural; sexual health; Relationships and Sexuality Education; Australia

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Carl W Heslop, Sharyn Burns & Roanna Lobo (2019): 'Everyone knows everyone': youth perceptions of relationships and sexuality education, condom access and health services in a rural town, Sex Education, DOI:

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Introduction

Sexual health promotion and service provision is often influenced by interrelated social and cultural factors (Jackson, Haw, and Frank 2010) which impact on the ability of communities to effectively meet the sexual health needs of young people, particularly in the rural Australian setting. In this study, young people living in a small rural town in Australia were interviewed about their experiences and perspectives accessing Relationships and Sexuality Education (RSE) and services. Bronfenbrenner (1979) ecological approach was utilised to examine findings and explore impacts on access and delivery of services. The research was conducted as part of a larger project aiming to improve the coordination and delivery of RSE and sexual health services in rural towns (Heslop et al. 2017).

Sexual health is a major issue for young people aged 16-24 years in Australia (DOHA 2014) and despite testing rates lower than 10%, Chlamydia is the most common bacterial sexually transmissible infection (STI) in young Australian adults (Kong et al. 2011; DOH 2017), with a high prevalence in young men and women attending rural General Practitioner (GP) clinics (Yeung et al. 2014). Rural communities are generally interconnected settings with close social contact (Heslop, Burns, and Lobo 2018) leading to problems of confidentiality (Cameron and Dupal 2009; Hillier, Scopelliti et al. 2004; Tomnay, Coelli, and Hocking 2016), professional role duality (Roberts, Battaglia, and Epstein 1999; Barnett and Yutzenka 2002; Scopelliti et al. 2004) and a scarcity of personnel and resources (Rygh and Hjortdahl 2007), predominantly for sexual health services. Rural Australians also bear an unequal burden in terms of health outcomes (Schofield, Shrestha, and Callander 2012; Hussain et al. 2015) and structural barriers to accessing sexual health services (Quine et al. 2003).

General practice primary health care is the front line of health care in Australia (Lau et al. 2016), especially regarding rural sexual health provision where the size of many towns restricts the provision of specialist services. Generalists and rural workers with broad skills sets and job descriptions (Murray and Wronski 2006; Mills, Birks, and Hegney 2010) usually deliver sexual health care (Rygh and Hjortdahl 2007). While current guidelines recommend sexually active young people are tested for Chlamydia annually (Tomnay, Coelli, and Hocking 2016), many GPs feel under-resourced, under-qualified, lack time or are concerned about embarrassing patients (Kong et al. 2011; Hocking et al. 2008; Lau et al. 2016). Rural communities are highly connected and intertwined (Morrison and Lane 2006), and limited anonymity and confidentiality can impact the adequate provision of youth sexual health services (Warr and Hillier 1997; Cameron and Dupal 2009; Bryson and Warner-Smith 1998; Lau et al. 2016). Barriers specific to young people include the cost of consultations and testing, transport, the location of pathology collection sites (Yeung et al. 2014; Quine et al. 2003), confidentiality concerns, lack of age and gender diversity amongst health professionals, and service availability (Warr and Hillier 1997; Tomnay, Bourke, and Fairley 2014). Services and communities should therefore work with young people to identify sexual health needs; and continue to explore alternative health provision settings including sporting clubs and youth groups (Tomnay, Bourke, and Fairley 2014; Kong, Hellard, and Hocking 2016).

Schools, and principally teachers, are responsible for the delivery of most RSE for young people in Australia (Collier-Harris and Goldman 2017). Good quality RSE covers a diverse range of issues, however, many teachers have little or no professional preparation in the subject (Ollis, Harrison, and Richardson 2012; Smith et al. 2011) and can be quickly

criticised when RSE is deemed to transgress societal boundaries, leading to conservative delivery (Mellanby et al. 2001; Burns and Hendriks 2018; Goldman 2008; Shannon and Smith 2015). Australian school-based RSE lacks standardisation (Powell 2007; Collier-Harris and Goldman 2017), is often heteronormative (Barnes et al. 2004; Hillier and Mitchell 2008) with a biological focus (Burns and Hendriks 2018), and pays little attention to the positive aspects of sexuality (Ollis 2016). Effective RSE requires high quality teacher training (Schaalma et al. 2004; Meyer and Leonardi 2018; Burns and Hendriks 2018); management of classroom relationships and behaviour (Wight and Abraham 2000); should not focus on a negative process (Mellanby et al. 2001); and must be sensitive to variance in students' experience, values and sexualities (DePalma and Atkinson 2006). To ensure content is relevant, schools should acknowledge young people's sexual activity and diversity (Pound, Langford, and Campbell 2016; Jones et al. 2016; Allen 2005; Grant and Nash 2018).

Young people in rural towns have been shown to lack sexual health knowledge (Kong et al. 2009; Helmer et al. 2015; Yeung et al. 2017; Senior et al. 2014), highlighting the importance of RSE in these areas (Burns and Hendriks 2018). Although teachers are considered the most appropriate professionals to deliver RSE, some young people report discomfort in having lessons delivered by their regular class teachers (Pound, Langford, and Campbell 2016). In settings where role duality is an issue (Russell and Humphreys 2016; Roberts, Battaglia, and Epstein 1999), it may be more comfortable and appropriate to have outsider providers or school nurses deliver some aspects of RSE (Burns and Hendriks 2018; Hogan 2018). Provision of high quality evidence-based RSE and health promotion in schools must include teachers; requires supportive political, administrative and community contexts (Schaalma et al. 2004; Secor-Turner et al. 2017); and collaboration and partnerships with outside providers as an important component (World Health Organization 1996).

Condom use, awareness and access are integral parts of sexual health promotion, with rural schools and GP clinics playing important roles. Young people may require more than awareness of the need for condoms, but also practise acquiring them (Wight and Abraham 2000) and increased accessibility through condom vending machines or other initiatives (Tomnay and Hatch 2013). Embarrassment plays a significant role in reducing acquisition of condoms (Wight and Abraham 2000; Bell 2009), especially for rural youth (Hillier, Harrison, and Bowditch 1999) and for young women who feel their sexual reputations are closely monitored (Warr and Hillier 1997). Young women are often seen to be responsible for their own choices and bodies (Connor, Edvardsson, and Spelten 2018), but may experience community-based restrictions or expectations towards sexuality and equitable condoms access (Hillier, Harrison, and Bowditch 1999). With condom accessibility depending on a number of socioecological levels, interventions may be required at various system levels to ensure adequate access (Wang et al. 2018; Schaalma et al. 2004).

Methods

This study took place in a small rural community in Western Australia which has a population of approximately 2,600 people and a further 3,000 people living in the surrounding shire. The town is located approximately 50 km from the nearest regional centre (population approximately 40,000) and 400 km from the nearest major city. The town has three primary schools, one Government secondary school (grades 7 to 12) and an agricultural college (grades 10 to 12); with some students travelling to a neighbouring town

to attend one of five additional secondary schools.

Purposive and snowball sampling were used to recruit participants aged 16 to 24 years to be involved in focus groups and interviews as part of a larger participatory action research doctoral research project (Heslop et al. 2017). Focus groups and interviews were conducted by the first author with research supervisors providing guidance. The first author (CH) has research experience in conducting qualitative interviews and lived within the same setting as participants. The co-authors are supervisors to the project and were involved in reviewing data and coding, providing support and advice on data analysis and reviewing the paper.

Approximately 50% of participants were informally known to the first author prior to participation and were recruited via advertising through existing networks within sporting clubs and the youth centre, and further peer referral. Of the 23 young people who expressed interest in participating, 15 did so with 14 - eight young men (mean age 16.8 years) and six young women (mean age 18.6 years) participating in one of the four single-gender focus groups and one (young man) participating in an interview. The town has a small Aboriginal or Torres Strait Islander population of approximately 1% (ABS 2012), however, no participants identified as Aboriginal or Torres Strait Islander. The single interview was conducted when the participant missed their proposed focus group and requested a one-on-one interview. Non-attenders were contacted via phone and SMS messaging and cited several reasons for not attending scheduled focus groups: including forgetting, having family or sporting commitments, and not feeling like they had anything to say. This information was recorded in a field journal.

The focus groups and interview were semi-structured and guided by the socio-ecological model (Bronfenbrenner 1979) to inform an environmental scan of stakeholders, settings and interventions in places within the setting; and a further threats, opportunities, weaknesses and needs (TOWN) analysis of the community. This scan and TOWN analysis form part of a larger project examining the development of a framework for improving sexual health delivery in rural towns and is paired with similar data collected from stakeholders. Interview guides were pilot-tested prior to data collection; these data were subsequently excluded from the analysis. Discussions focussed on young people's opinions on the access and availability of sexual health education, knowledge of local sexual health services, and barriers and enablers to effective youth sexual health services and education provision in the town.

Informed consent was obtained from each participant and those under 18 years were assessed on their competence to provide mature minor consent (Santelli et al. 2003) on a case-by-case basis utilising an adapted framework (Arora et al. 2011). All participants were given the opportunity to withdraw from the study at any time and to remove or withhold data, with the process explained in their supplied participant information sheets. The interview and focus groups were conducted in private, quiet places that participants selected as convenient and appropriate. Focus groups lasted up to 45 minutes and were conducted with flexibility in timeframes depending on the richness of the data and participant willingness to continue. Focus group discussions can be side-tracked or dominated by a few individuals: a risk that was mitigated by using an experienced and effective facilitator (Tomnay, Bourke, and Fairley 2014).

To maintain dependability, the interview and focus groups were audio-recorded and transcribed verbatim. Data were then open-coded by the first author to reduce the data into small units, followed by axial coding to group these units into categories and selective

coding to develop themes that expressed the content (Saldana 2015). Themes were examined for their alignment to Bronfenbrenner's systems levels of interaction and whether they represented threats, opportunities, weaknesses or needs for delivering sexual health interventions and RSE within the setting. Coding was undertaken using a combined method of table-top sorting with printed transcripts cut and sorted, to physically engage with data; with coded data transferred to Nvivo 11 for further constant comparison analysis until data saturation was reached.

All authors participated in the data analysis process to reduce bias and enhance confirmability (Bryman 2004). Additional rigour was provided through maintaining an audit trail, as well as discussion of both process and findings across the research team. Ethics approval was provided by the Curtin University Human Research and Ethics Committee (approval number: HR96/2015).

Findings

All young people lived in the town, but had varied experiences of accessing doctors, condoms and sexual health promotion initiatives. Four key themes emerged to explain perceptions of RSE and service provision within the town: relevant and credible sexual health education; make it easy; GP accessibility; and discreet condom supply. Themes were analysed through a socio-ecological lens to determine the focus of issues raised in relation to the levels of Bronfenbrenner's model. Consideration was given to how these levels interacted and what represented threats, opportunities, weaknesses and needs for the setting.

Some common threads and related issues ran across themes. Small-town barriers of interconnectedness, role duality and a lack of anonymity were issues in the provision of RSE, accessing sexual health information and buying of or accessing condoms. The barrier that 'everyone knows everyone' was present across all the major themes and represents the continued challenge that faces sexual health providers and young people in small towns. The lack of focus or support towards sexual health from stakeholders and the community was another thread that emerged. Insufficient time and resources available for schools to present RSE, limited advertising and cross-promotion from health providers, and limited accessible options for procuring condoms were recognised as common barriers.

Relevant and credible sexual health education

The young people in this study were either currently in high-school or had recently attended a high-school in the town and were in the local workforce. Most participants had experienced RSE delivered as part of their secondary school curriculum within the town, however the local agricultural college did not deliver any health curriculum at all. Participants suggested the school-based RSE they had received included some relevant content, however lacked much of the specific information they wanted or needed, lacked relevance or depth and/or was very biological.

Chris: ...they don't talk about it at [my school].

CH: They don't talk about it?

Evan: No.

Tim: They do like sections of it at school.

Joseph: They did in lower school.

Tim: Yeah, in lower school they go.

Sean: We played with condoms in year 10, and a dildo that was.

David: I don't think I was there.

There was further discussion about school RSE in a different focus group:

Brooke: Yeah, they'll give you like a pamphlet to fill out and you're really just staring at a woman's uterine or....

Chloe: Or a design of a man's penis.

Nicole: And like draw labels and stuff. It's like it's really like weird, it's not like the information you'd really want or need."

Participants also wanted schools to deliver content in a non-judgemental way that covered same-sex attraction and diverse sexuality. There was a consensus that same-sex attraction was not dealt with well during school RSE.

'Like if you want to like engage in a relationship with a boy or a girl of the same sex it's ok, we're not going to judge you because of that, 'cause that's your choice. That's none of our business.' (Nicole)

Young women felt young men in RSE classes spent a significant part of sessions misbehaving and felt that separating the genders would allow young women greater opportunity to ask questions. Participants felt greater depth of discussion would occur if the genders were separated, but there was no discussion on the impact this could have on gender diverse students.

Chloe: But make sure like the girls are separated from the boys so they can like get different perspectives so.

Brooke: And get the best out of the information I reckon like.

Chloe: Yeah so a male teacher can teach the guys and like two females can teach the girls.

And later within the same focus group:

Nicole: Boys always so much more immature about it, they're always the ones laughing not taking it seriously.

Chloe: No and like when we're trying to participate and actually learn we're getting confused 'cause all the guys are laughing and making immature, quirky remarks.

The experiences of young men corroborated these comments:

Chris: And it's all mostly just mucking around.

Evan: You don't take any of it seriously.

Tim: You do still get stuff out of it.

Evan: Yeah, throwing fannies around the room and shit.

Young people were content for outside providers to come into the school to deliver RSE, and in many ways, preferred this to regular teachers as it reduced embarrassment felt when rural town role duality situations occurs, such as the teacher playing community sport with the students. In addition, presenters from outside the school system were viewed as being more credible.

'Having the teacher talking to you about condoms and then going and playing basketball with him that night, and shit like that, like it's just, some of it's weird.'
(Tim)

'Seriously when it comes to sex ed you actually need a professional that knows his shit, or her shit.'
(Chloe)

Participants discussed the importance in having presenters that were not embarrassed delivering RSE, to ensure information was correct and delivered appropriately, and comfortable presenting to mixed gender classes. However, it was felt that the school system did not actively search for these professional services to come to their school enough.

'When it's a male, they like feel really awkward about teaching it to you so it's like. I think they need like a professional or something to come in...'
(Brooke)

Make it easy

Young people live busy lives with competing priorities including school, study, work, sport and social networks, and participants did not want to have to 'go out of their way' (Wes, interview) to access services or find sexual health information. Services need to find ways of ensuring information and service awareness are visible, accessible and collaborative. Participants discussed that increasing accessibility and options regarding sexual health information and services while ensuring availability of condoms is important in reaching them.

Tim: You know where are you going to get your information from?

Sean: It's like [the youth centre], and like there's stuff at [the youth centre] and like it's school

Evan: But it's like. I don't like yeah walk all the way to [the youth centre] and grab one. And even if there was like a little dedicated that's just be gay.

Sean: It'd be like no one would go there?

Tim: Why would you want to?

Evan: If you were fucking there, if you had problems, AIDS or some shit you'd go there.

And as discussed in another focus group:

Brooke: There is information it's just very limited. You know like there's only the hospital or the chemist.

Grace: Or the doctors.

It was important to participants that services worked to reduce the time young people needed to access them as they were unlikely to attend specialised information sessions. Participants would rather access information via collaboration with settings such as sports clubs.

'No one's really got the time anymore to go to a community gathering, community speech or whatever like that but. Have like clinics involved directly within doing an activity I guess. So part of footy training was a sexual health, mental health clinic I guess, instead of running out the track.' (Wes, youth interview)

High traffic youth shopping settings were potential collaboration points for providing sexual health information, however, young people were realistic about the role local businesses would be interested in playing and that some business owners would not be interested in services beyond core business.

'Like you know 'cause everyone needs to like make enough money and it's obviously pretty hard to have a business and do when you're really well. So yeah there's just not enough time to like incorporate other things.' (Chloe)

There was a perception of there being limited communication between medical services in the town and the school with very little visible collaboration. Participants noted limited advertising or promotion regarding service availability within the town and the costs associated. Sexual health and medical services in general needed to be more visible in advertising their presence and services directly to young people:

Sean: No. I don't even think there are services to be honest, I honestly, like this school, at school we do like sex ed.

Evan: There probably would be if you spoke to 'em but.

Tim: Who would you speak to, that's the problem.

David: Yeah like no one knows who to speak to.

And:

'Like I don't know how well like the medical centre say has any kind of like link to the high school. Like they don't like advertise themselves there or anything...' (Brooke)

The need for promotion was particularly relevant to services within the school itself. Some participants, depending on their school, did not know who the school nurse was or where they were located by the end of their high school education. There was also limited knowledge about the school nurse role, with it seen as treating illness only and not including involvement in RSE or health promotion:

'Well I went through 5 years and I still don't know who the school nurse is at the high school.' (Chloe)

Knowledge of the school nurse and their services was later elaborated in the same focus group amongst discussion on youth access to sexual health services:

Brooke: I still don't even know who our school nurse is.

CH: Yeah no. Why do you think that is?

Brooke: They just never liked talked about her.

Grace: They don't say anything about the nurse.

Chloe: Yeah they don't tell you.

Brooke: It's just, I don't know you have to kind of figure it out for yourself.

However, one participant within this focus group did have a different experience:

'Oh it's funny that you say that 'cause I was like "this" [very close relationship] with my school nurse.' (Nicole)

Wes reported feeling comfortable using online sources as a means of seeking credible information, while other participants were not as confident locating information:

'I think there's a fair few sites now which are quite reliable in that way, trustworthy guess. Couple of internet GP sort of lines which are set up..... It's quite obvious when they come up. What sounds right and what sounds wrong sort of thing.' (Wes)

'Like you can't just go on the Internet and then it's there. It's like you have to know where to look and know what to type in.' (Brooke)

GP accessibility

Participants discussed having significant trust in the confidentiality of GPs and feeling comfortable discussing personal issues including sexual health within those consultations. While accessing a GP was seen to be a relatively simple process, the greatest barrier was around insufficient knowledge about payment and cost. Participants trusted local GPs and felt that disclosing sensitive information and seeking sexual health advice was appropriate as they are a confidential service, although discretion was important. Some thought their peers may feel the need to hide that they are accessing the GP from others, while others may be too scared to attend.

CH: You feel comfortable talking to the doctors and things like that?

Levi: Yeah 'cause they keep it confidential, so you know that it won't go out.

Seeing a GP of your own gender was preferable, as was one that was more relatable in terms of similar age rather than significantly older. However, there was still significant embarrassment in seeking treatment for an STI or asking for contraception regardless of gender.

'Up until the last year or so I've always had a female doctor and she was quite an old lady.... Now I've got a middle aged male doctor. It's a lot more comfortable and I think like finding a doctor or someone in the town that's actually more suited to your, to who you are.' (Wes)

GPs were viewed as being readily available, with both walk-ins and booking services seen as a simple process. Nevertheless, many peers still relied on parents to book appointments.

CH: Would you know, would you guys know how to make a doctor's appointment?

Joseph: Give 'em a buzz and ask.

Tim: Call them and ask, am I able to make an appointment, I guess.

'Ah yes, but I know amongst a lot of my friends there's still a lot of calling home to ask theirs [parents], can book an appointment sort of thing. Get mum and dad to do it for them.' (Wes)

'Medical centre is really good like, like with walk-ins as well and like, and the hospital is yeah pretty ok with that sort of stuff I've heard.' (Brooke)

One access barrier was being unclear on what services were available and what would and would not be bulk-billed (with relevant costs covered entirely through the Australian Medicare System). There was a sense of surprise, or "I did not know that" (Evan) that youth STI testing was generally bulk-billed. The provision of free services including STI testing in non-clinical settings such as sports clubs was raised to help improve access.

'Is it free to go get standard checks and whatnot or not? Is it still a doctor visit technically?' (Wes)

And:

Evan: Do we get it free?

CH: You should.

Evan: In [this town]?

CH: You should.

Evan: Oh, I didn't know that.

...

CH: So, does anyone here know whether they'd have to pay?

David: No, not a clue.

Chris: No.

Discreet condom supply

Accessing condoms in a small town was highlighted as difficult. However, recent initiatives to provide free condoms in sporting clubs and GP clinics had improved accessibility and participants reported the sense that normalisation towards carrying condoms was making taking condoms less embarrassing. Participants still viewed buying condoms and pregnancy

testing kits as 'very sensitive and personal' (Brooke, FG2) and often expensive, however the recent installation of self-service retail supermarket checkouts provided young people with the opportunity to avoid the embarrassment and awkwardness when purchasing condoms.

'I guess because you're in a small town, I feel like it's really weird, like it's. I don't know like I remember when I went and brought condoms, it was just really. Like I looked the person, like I looked at the person and I knew her and she knew my girlfriend so it was weird.' (Tim)

'I really think there should be a bit of self-service places for them [condoms], even if they're not free.' (Wes)

Avoiding the embarrassment of buying condoms has seen the stealing of condoms becoming a reasonable alternative to some young people.

Sean: Buying them at the shop's even worse.

Joseph: Yeah buy them at [store]! Stealing them's easier.

Most participants were prepared to purchase condoms, provided access was youth friendly. Offering cheaper options and having condoms available in discreet and accessible places using condom vending machines was important and was likely to stop theft.

Tim: I don't mind paying, it's just like the awkward like.

Evan: Yeah, the awkward like, you know like.

Sean: Yeah, someone taking your money.

Chloe: First of all you might not have the money, second of all like you don't want anyone to see you.

Grace: Yeah especially if you're young like going to try buy one or something.

Brooke: Yeah even like the boxes of condoms they're like 10 – 14 bucks, it's like dude it's ridiculous.

Zane: Definitely like those vending machines, I reckon they'd help huge.

Levi: That'd be a good idea, it's really good idea.

Zane: You'd save kids from stealing, 'cause kids do steal if they don't want to buy them through the counter..

Young women felt concerned about being observed buying condoms due to the perceived attitudes of their peers, personal shame and fear of parents finding out they were sexually active. In a setting where it was viewed as 'more natural' (Zane, FG3) for young men to be purchasing condoms, the consensus was that the opportunity and choice should be accessible to all genders without judgement.

Brooke: One thing I find is the girls only have the tampons and the pads and the boys only have the condoms. So, the girls don't actually have a choice of being able to access condoms, you know it's only the boys.

Grace: Unless you sneakily go into the guys room and just like hey let's get some.

Brooke: But it should be supplied for both.

Chloe: What you think because we're buying condoms you think that we're skanks, hoes or sluts. Like no we're actually decent women with feelings....

Condoms were reported to be available in several places but relied on young people approaching attended counters or asking for them. These interactions were awkward and embarrassing in a setting where 'everyone knows everyone' (Nicole, FG2). Accessing condoms from settings such as a GP consulting room was viewed as less confronting, as only one person watched you and there was a greater sense of confidentiality.

Grace: When you walk into your doctor's room they should, everything, they should have all of that stuff there for you like.

Chloe: Like not out on the counter saying free condoms.

Nicole: In the waiting room.

Recent community driven initiatives to have condoms available in some sports clubs and GP surgeries has made it less embarrassing for young people to take condoms. Participants reported a perceived normalisation in terms of acquiring and possessing condoms, however it was acknowledged there were limits on where condoms could be provided.

'It's a convenience when you just come to footy and they're there so you, it's discrete as well, you can just grab one and not tell anyone.' (Levi)

'There is I know, at [the doctor] there was a bucket of condoms there. But when I was younger, why would you want to really, if your friend's mum is sitting behind there, why would you want to be like, yeah cheers for the freebies? You don't really want to do that...' (Amber)

'You can't just put condoms in every single place there is.' (Beth)

Placing condom vending machines in public toilets was recommended by participants as a strategy of improving access and reducing embarrassment. The lack of youth accessible condom vending machines currently in the setting was highlighted as a barrier, with public toilets, especially those already with tampon vending machines, seen as ideal locations if they were to be provided.

Amber: In the public toilets at all and I think that would help a lot.

Beth: You see them over, I went over east and they're everywhere, like as well as other things.

Amber: But yeah toilets definitely, and I think that people that are just going to waste them and be stupid aren't going to pay for them.

Participants acknowledged there could be opposition towards providing condom vending machine initiatives or increasing free condom access in the town, especially if these made the community look bad, or were seen to expose young children to messages their parents didn't want them to see.

'Having that information, public toilets, they're going to be like, whoa you're like diseasing my child with this information.' (Beth)

'There's always going to be people that arc up about something, that's inevitable, and it's going to happen in everything that you change in the town. Especially a small town.' (Wes)

Discussion

Participants had varied experiences in terms of school-based RSE and services, but all wanted relevant and inclusive RSE with a less biological focus delivered by credible sources. While teachers are the most sustainable option to regularly facilitate RSE in rural towns, consistent with other research (Pound, Langford, and Campbell 2016), participants stated that students and teachers were uncomfortable or embarrassed at times due to familiarity (Russell and Humphreys 2016; Roberts, Battaglia, and Epstein 1999), particularly when dealing with a different gender. Outside providers were considered more credible and preferred than teachers, however, it was suggested by participants that schools were not proactive in arranging presenters consistently. Although this may be correct, rurality and access as barriers to suitable presenters in the setting should be acknowledged.

The disruptive behaviour of some male peers during RSE was highlighted by girls as regular and unwelcome, and was often a tool used by young men to mask embarrassment or prevent exposure of sexual ignorance (Pound, Langford, and Campbell 2016). While separating the sexes may alleviate disruption, it should also be acknowledged that dividing classes in this way or ignoring sexual diversity may accentuate the difficulties rural LGBTI youth face in accessing inclusive and sensitive RSE and services (Meyer 1995; Jones et al. 2016). Recognising socio-ecological influences and student's needs in the planning and delivery of RSE includes ensuring rural LGBTI youth are supported. The key to successful RSE sessions is effective classroom management including the ability to manage mixed gender classes (Wight and Abraham 2000; Coll, O'Sullivan, and Enright 2017), highlighting the need for teacher education and support and close collaboration with outside providers.

Participants needed uncomplicated access to sexual health services and information. Rural health services should consider untangling sexual health from current service model and explore community level collaborations with other stakeholders; sporting clubs and youth groups. Rural towns lack specialist services, highlighting the need of existing services to engage with and connect to young people, and ensure that what is available is accessible and appropriate (Tomnay, Bourke, and Fairley 2014). Sporadic sexual health interventions have been provided in non-traditional locations in the setting with varied success, and most participants supported further trials providing condoms and sexual health information in settings such as sporting clubs and recreation centres. Regular outreach clinics may not be feasible, but one-off clinics or services in sports clubs have been shown to be successful in the rural area (Kong et al. 2009). Collaborations with community sports clubs rely on positive relationships with presidents and members to ensure engagement and support (Kong, Hellard, and Hocking 2016). Given the important role such clubs play in rural Australia (Tonts 2005), there is an opportunity for health providers to address community and organisational level needs through capacity building and support for coaches and key members who often act as first contacts and referral points for young people needing sexual

health advice (Edwards 2015; Kefford, Trevena, and Willcock 2005).

Participants reported significant trust in local GPs to provide a confidential service and that GPs were readily available and approachable, nevertheless, there was uncertainty towards which services were Government rebated. Given young people are typically underemployed (ABS 2016) and many GPs provide bulk-billed services to this demographic, medical services should ensure cost details are clearly advertised. There is the opportunity for services to communicate this information via schools, youth friendly settings, sports clubs and online to improve awareness, while also explaining the access process in terms of required identification and not needing parental consent to attend the GP.

Young people wanted to see services collaborate, communicate and combine to 'make things easy'. School nurses are well placed to act as conduits of information and services, and can be agents of change (Burns and Hendriks 2018; Hogan 2018), but must actively promote their role and the services they provided in their setting. Service providers need to acknowledge possibilities (Stevens et al. 2017; Fedele et al. 2017) and risks in youth Internet access (Wilson et al. 2010; Bleakley et al. 2018); should consider local direct marketing; maintaining a credible and accessible online presence; and promoting online GP booking systems. Participants spoke of the need to critically appraise and seek good quality information online, hence there is an opportunity for services to provide links and information directly to young people via schools and the local social media.

GPs consulting rooms were preferred as access points for condoms and pregnancy tests, compared to more freely available positions in waiting rooms or youth centres. This highlights the need for providers to talk with young people about their needs and current system weaknesses, as the provision of condoms in a bowl at a GP reception or in a GP waiting room was not seen as youth friendly. Limited anonymity is a documented barrier in rural youth condom access (Hillier, Harrison, and Bowditch 1999; Warr and Hillier 1997), and participants explained how stealing condoms was preferred by some young people than facing the embarrassment of buying condoms from a peer or a peer's parent. Individual level interventions, for example providing condoms without addressing community and organisational level weaknesses and threats such as lack of anonymity, will not increase condom acquisition for young people.

Participants were pleased condoms were available in some sports clubs as this created familiarity and normalised condom access (Wight and Abraham 2000). While free condoms were preferable, participants were willing to purchase condoms, provided the process was youth friendly and anonymous. Self-service supermarket options provided young people with the opportunity to buy condoms without engaging in personal contact, while condom vending machines was the preferred alternative. Participants felt young women should have equitable access to condoms and that having condom vending machines in public toilets was an ideal way of ensuring anonymous access for all genders.

Limitations

Given the context in which the study was conducted, and the sample involved, care should be taken in generalising from this study. The lack of Aboriginal or Torres Strait Islander and other ethnically diverse representation in the study also sets limitations on external validity. All the interviews and focus groups were conducted by a male facilitator which may or may not have limited the recruitment of larger numbers of female participants or impacted upon

the nature of information shared during the sessions.

Conclusion

The findings of this study have practical implications for the rural setting in which it was conducted when addressing youth sexual health needs. Targeting youth sexual health interventions at an individual level while failing to address organisational and community socio-ecological threats and weaknesses will limit effectiveness. Working closely with young people to identify the weaknesses of existing systems of provision and to identify explicit needs may allow greater opportunity for the improved provision of rural sexual health services and RSE in similar contexts in Australia.

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Chapter 10: Stakeholder perceptions of relationships and sexuality education, backlash and health services in a rural town

This paper contains the analysis of the stakeholder interviews conducted as part of first cycle of the this PAR project. This article was published in Sex Education in 2019 and is a component of the formative work that was completed to inform the development of the RuSHY Framework.

An author's original manuscript is provided unedited for this chapter.

This chapter contains an authors original manuscript.

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Stakeholder perceptions of relationships and sexuality education, backlash and health services in a rural town

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This chapter contains an authors original manuscript.

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ABSTRACT

This paper examines the provision of youth targeted Relationships and Sexuality Education (RSE) and sexual health interventions in the rural Australian context by examining the perspectives and experiences of a range of community stakeholders. Sixteen participants undertook one-on-one semi structured interviews. Four key themes emerged from the data and included: 'you're not going to get the whole town to start thinking about adolescent sexual health'; backlash, stigma and secrecy; being consistent, credible and available; and small-town communication. This study contributes to the limited literature about RSE and sexual health provision in regional and rural Australia and provides a voice for rural stakeholders who provide RSE and sexual health interventions by default or necessity. The findings of this study have practical implications for rural settings when addressing youth sexual health needs.

Keywords: rural; sexual health; Relationships and Sexuality Education; health promotion; Australia

Introduction

This paper examines experiences of stakeholders providing Relationships and Sexuality Education (RSE) and sexual health interventions for young people in the rural Australian context from a socio-ecological levels perspective (Bronfenbrenner 1979). While most Australians (71%) live in major cities, one in 10 live in small towns with populations of less than 10,000. In a setting where rural workers face multiple priorities and provide generalist services, specific focus areas such as youth sexual health become the responsibility of multiple stakeholders across multiple settings. Examination of stakeholder perspectives as they embed within different socio-ecological intrapersonal, interpersonal, organisational, community and societal levels (McLeroy et al. 1988) provides an opportunity to conduct a component level analysis of threats, opportunities, weaknesses and needs that exist within the setting.

Young people (age 16-24 years) have been identified in Australia as a priority population for sexually transmitted infection (STI) prevention strategies (ADOHA 2014) and represent 75% of identified Chlamydia infections (Kirby Institute 2018). Despite this, there are low levels of participation in testing for asymptomatic STIs among young people (Kang, Skinner, and Usherwood 2010). Most infections in this population are undiagnosed and untreated suggesting an underestimation of true prevalence and highlighting the need for routine testing among sexually active individuals (Kirby Institute 2018). Chlamydia testing rates remain low in the primary practice setting despite General Practice (GP) services being well suited to conduct opportunistic and regular testing (Yeung et al. 2015). Despite these low testing rates, Chlamydia prevalence is high in young Australian men and women attending rural GP clinics (Yeung, Temple-Smith, Fairley, et al. 2014). Opportunistic testing of young people initiated by service providers, combined with good communication and education of the importance of testing can improve young people's access to sexual health care and information (Turner et al. 2017; Collyer, Bourke, and Temple-Smith 2018; Yeung, Temple-Smith, Spark, et al. 2014).

There is restricted availability of sexual health and RSE providers in small rural towns with less youth-specific services and limited numbers of doctors. Non-specialist trained teachers deliver RSE as part of a broad health curriculum, and limited pharmacy services restrict options for processing prescriptions or purchasing contraceptives (Hillier and Mitchell 2008). The responsibility of providing RSE in Australia, particularly in the rural setting, regularly falls upon schools (Burns and Hendriks 2018; Milton et al. 2001; Smith et al. 2011) however there are significant gaps in students' sexual health knowledge and dissatisfaction with the relevance of RSE that is provided (Mitchell, Ollis, and Watson 2000; Robinson, Smith, and Davies 2017; Ezer et al. 2018). Teachers of RSE have been found to struggle in their ability and willingness to address many social issues associated with sexuality (Shannon and Smith 2015; Ezer et al. 2018) and in an overcrowded curriculum, RSE is often delivered in a tokenistic manner (Blake 2008; Goldman 2008; Smith et al. 2011; Helmer et al. 2015) despite it being strongly associated with increased odds of young people using contraception and gaining higher levels of STI knowledge (Yeung et al. 2017). This lack of prioritisation, particularly in the rural setting with a paucity of specialist services, presents a risk in RSE and youth sexual health service provision.

This paper reports findings of interviews with stakeholders from a range of

settings living and working in a small rural town in Australia. Participants were asked about experiences and perspectives on how RSE and services were provided by their own organisations and other stakeholders within the town. This research is part of a larger participatory action research (PAR) project aiming to improve the coordination and delivery of RSE and sexual health services for youth in Australian rural towns (Heslop et al. 2017) .

Methods

The consolidated criteria for reporting qualitative research (Tong, Sainsbury, and Craig 2007) was employed to ensure that this study met appropriate standards. This research received ethics approval from the Curtin University Human Research Ethics Committee (HR96/2015).

Setting

The setting of the study is a small rural community in Western Australia. The community is located approximately 50km from the nearest regional centre (population approximately 40,000) and 400 km from the nearest major city. Approximately 2,600 people live in the town with a further 3,000 living in the surrounding shire; young people aged between 16 and 24 years comprise around 10% of the population (ABS 2012). The town has a small Aboriginal or Torres Strait Islander population of approximately 1.3% (national average 3.1%) (ABS 2012); with 66.9% of the population being born in Australia (national average 66.7%) and 86.9% of households only speaking English (national average 72.7%) (ABS 2016). The town has a strong history of alternative life-style communities (Bishop and Syme, 1990) and a number of openly out same-sex couples; however there are no youth support groups or services within the town specifically for LGBTI youth.

There is no regular public transport within the town nor between the town and the regional centre. There are no specialist sexual health services available beyond generalist health care, although there is regional support in the form of a part-time project officer managing sexual health, blood borne viruses and needle and syringe services. The lead author, a male doctoral candidate with qualitative research experience, resides within the community and managed insider research aspects such as confidentiality, anonymity and bias related to role duality and familiarity (Heslop, Burns, and Lobo 2018). The co-authors of this study are doctoral project supervisors who provided support on research practice and advice on data analysis, reviewed coding, and provided feedback on drafts of this paper.

Participants

A community scan was initially conducted in the setting to identify key stakeholders from traditional settings for sexual health promotion, such as health, education and youth services; and non-traditional settings, such as sport and recreation, library services, local government and local media. A purposive sample of identified key stakeholders was recruited for face to face semi-structured interviews with further

participants identified via peer referral. Twenty-one stakeholders were approached; three declined and three did not respond to follow-up communication. The 16 stakeholders that did participate in the study are indicative of the rural workforce: busy generalists balancing multiple workload priorities. Most had lived in the town for longer than five years, nine identified as female and seven as male. No participant held specialist youth sexual health qualifications or experience beyond their current role, and most viewed the provision of sexual health services as one of many priorities they were expected to deliver.

One-on-one interviews were conducted by the lead author in a public setting convenient to participants. Interview guides were pilot-tested prior to data collection; these data were subsequently excluded from the analysis. Approximately half of participants had an established personal or professional relationship with the lead author and were aware of the background to the research. Effective management of the pre-existing relationships and role duality that is common for insider researchers in the rural setting was important in maintaining ethical research practice (Heslop, Burns, and Lobo 2018). Written informed consent to participate was obtained from each participant and interviews were audio-recorded and transcribed verbatim to maintain dependability.

Interviews focused on participants' knowledge of other stakeholders in the context of sexual health provision; perspectives on the barriers young people face in accessing sexual health services; perceived community support or opposition towards sexual health; and how the community currently addresses sexual health within the setting. This project utilises an adaptation of Bronfenbrenner's Ecological Framework for Human Development to identify and evaluate how the different socio-ecological levels are addressed by current services (Bronfenbrenner 1979). McLeroy et al. (1988) adapted Bronfenbrenner's model which focuses on micro, meso and exo levels to include five levels of influence: intrapersonal, interpersonal, organisational, community and societal (McLeroy et al. 1988; Golden and Earp 2012). This adapted model is utilised in this research for focused analysis on the different socio-ecological levels by dividing the social environment into component levels. This allows assessment of influence and interaction at each level and guide the recommendation of appropriate socio-ecological level strategies and interventions (McLeroy et al. 1988).

Data analysis

The interview data were manually transcribed, and manuscripts open coded by the lead author to reduce the data into small units. Axial coding to group these units into categories was followed by selective coding to develop themes that express the content (Strauss and Corbin 1998), including how themes addressed different layers of the socio-ecological model (Bronfenbrenner 1979). The data were used to inform an environmental scan of stakeholders, settings and interventions, and a further threat, opportunities, weaknesses and needs (TOWN) analysis of the community. This scan and the TOWN analysis form part of a larger project examining the development of a framework for improving youth sexual health delivery in rural towns and will be paired with similar data collected from youth participants (Heslop, Burns, and Lobo 2019).

All three authors took part in the process of data analysis. This collaborative analysis increased the rigour and confirmability of the study (Bryman 2004). Additional

rigour was provided through an audit trail maintained by the lead author, documenting information on where research interviews took place, time spent interviewing (median duration: 20 minutes) and contacting participants, how many transcripts were analysed and thematic development. Regular discussion was conducted across the research team on both process and findings (Saldana 2015). The themes that emerged described stakeholders' key understandings of addressing youth sexual health within the rural context. These themes also provide explorations of the threats and opportunities that stakeholders identified within the setting; particularly within the wider issues of interconnected rural communities and the stigma surrounding the provision of youth sexual health services and education.

Findings

The findings describe needs, barriers and stakeholders' perspectives on community support relating to youth RSE and sexual health interventions. Four key themes emerged from the data: "you're not going to get the whole town to start thinking about adolescent sexual health"; backlash, stigma and secrecy; being consistent, credible and available; and small-town communication.

There were common threads and related issues that appeared amongst all themes, particularly relating to issues assuring confidentiality and anonymity in a small-town setting; the need to provide condoms for young people; the weakness of a lack of expert knowledge or lead agencies relating to sexual health, and an interest in exploring new opportunities and settings for service delivery.

To minimise the likelihood of participant identification, quotes have been attributed to the following broad categories: health (GPs; practice managers; school and primary care nurses; and health promotion workers); youth (youth services; local government; sport, recreation and local media) and education (teachers and school-based workers). Some data were intentionally withheld from publication to minimise the likelihood of identification (Heslop, Burns, and Lobo 2018).

"You're not going to get the whole town to start thinking about adolescent sexual health"

Most participants acknowledged sexual health and RSE provision was important for young people in the town and needed to target more than an individual level; however, participants also highlighted sexual health provision was not necessarily a priority or core business for many service providers. Youth sexual health services and RSE provision was seen to compete with other priorities and responsibilities:

'There's not a clear agency or person responsible, that if somebody was having issues in that area or wanted further information in that area that they could actually go...and see somebody.' (youth5)

'Having a multi-agency knowledge of the way that our community operates, I don't think it fits clearly into any particular area of responsibility' (health1)

'For young people education is considered the most important thing for, like in terms of their scholastic education and education sexually-wise, isn't a priority' (youth1)

Some participants did not see a clear role for themselves or their organisations in addressing sexual health or RSE beyond the individual level or questioned their role as community service providers beyond their service delivery model. There had been a lack of thought about how to address community level needs in the setting and stakeholders also felt that while resources are limited, expectations on what can be provided must also be constrained:

'It's actually a subject that I haven't really you know thought too much about' (education1)

'It's not something that's come up and has been an obvious issue that [local government] would choose to get involved in or, either directly or through an advocacy type of arrangement' (youth5)

'I'm not actually all that au fait with community services and I don't know if you count us as a community service with that sort of stuff.' (health3)

'In a small town you can't have every resource – you are limited. There has got to be a reality check' (health2)

Many community stakeholders viewed education providers as critical points of contact for RSE, however teachers themselves were unsure on the best way to deliver sexual health. Embarrassment was a factor; small towns are interconnected, so teachers often interacted with students in sporting settings as team mates or coaches. Teachers also cited a lack of skills or recent professional development relating to sexual health:

'There's me and a couple of other people who do it [RSE] and you know we're probably been out of the, you know haven't had any sort of PD [professional development] on [sexual health] for a long time.' (education1)

Some stakeholders outside of education questioned if it was the role of teachers and educators to provide inclusive RSE that went beyond biology and focussed on relationships. While some stakeholders felt sexual health was another 'topic' expected of schools, some suggested that schools were left to provide this education as parents were unwilling:

'No, I pose the question, is it the school's responsibility to educate them about sexual health? You know I think it's dumped on schools...' (health5).

'I don't really think that schools, it's their responsibility to do all of this...' (health6)

'We expect teachers to give that education where really it should be the responsibility of the parents...' (health3)

Backlash, stigma and secrecy

There was an acknowledgement of the stigma around sexual health when dealing with young people, particularly the threat of community backlash if stakeholders were perceived to be promoting sexual activity. Responses highlighted that the community's perception of what was being provided in terms of sexual health promotion was a major issue :

'I think there's always that stigma around [sexual health]; secrecy and embarrassment' (youth5)

'If we can get that message out that we're trying to encourage kids not to do it' (education1)

'If we're supporting good sexual health or contraception or access to condoms, we're promoting, we're going to increase sexual promiscuity' (health4)

Apprehension about what was considered appropriate to teach young people led to education being largely biologically focussed, with a particular emphasis on sexual abstinence, despite the Western Australian curriculum supporting more of a focus on relationships:

'We focus on [are] mainly STIs and that sort of stuff and teen pregnancy.... That's the message we do give them. You know that abstinence, you know to avoid STIs and that sort of stuff, abstinence is the way to go' (education1)

Some stakeholders discussed the reservations some community members have had regarding community level interventions that supported RSE or sexual health. These concerns focused on issues such as the age of the young people and exposure, especially in non-traditional environments. However, stakeholders also recognised the need to work with the community to enhance acceptance.

'They weren't willing to have condom machines outside [central supermarket]. Well we can't let that happen, that's encouraging them to have sex. Hey Charlie, they're already having sex' (health5)

'They thought the kids were too young or didn't want the kids to be exposed to that' (youth4)

'I know there are people in the town who are a bit anti having it but I think that's the barriers we have to break down' (health6)

Some stakeholder reluctance was generated from attitudes portrayed with the broader community, parents and even from Local Government. One local organisation felt that the promotion of sex positive messages was viewed negatively by some parents and organisations. As highlighted by the comments below, this reflects a lack of community understanding about the knowledge and skills services aimed to promote:

'I've heard along the grapevine that parents won't allow their children to go here because we promote them having sexual activities. I wouldn't agree with that at all. We promote positive sexual engagement.' (youth1)

Some stakeholders were direct in their views on individuals ensuring young people within the community received RSE and support, regardless of community sentiment:

'I mean if there's something out there that was willing to, that was going to help the kids, some people didn't agree with it, it's not going to be any different to anything else. Just do it.' (education2)

With a number of **stakeholders** identifying the threat of community opposition to interventions; delivering interventions covertly was suggested. This subversion relied on peer-networks to spread information on services rather than wider dissemination or addressing issues at a community level:

'Slide it under the radar, give it to the kids, the kids know about it, kids'll talk about it, parents of kids might. Don't necessarily have to involve large sections of the wider community.' (education2)

Conservatism towards gender and sexuality was also raised with participants emphasising the difficulties young LGBTI people face in a small, rural community. Stakeholders highlighted that despite the setting having an active and supportive adult LGBTI community, there was a lack of support for young people identifying as sexuality or gender diverse.

'Country communities are conservative, there's all this sort of hangover of sexism and you know silly attitudes' (education3)

'I certainly wouldn't want to be a young gay or lesbian person in town, I think you would be marginalised a lot.' (education2)

'We do have a very big gay sector in our community but when it comes to young people expressing that I don't think they are actually supported that well' (youth2)

Being consistent, credible and available

Stakeholders highlighted the need to be able to provide RSE to young people when and where they need it. There was a strong sense that providers cannot wait for young people to present themselves to request services and information and more needed to be done to ensure resources were available and accessible:

‘When kids want to know something, that’s when you hit, you’ve got to give them an avenue.’ (health7)

‘Work out where the kids are that you need to target and how you can get to them’ (education2)

It was seen to be important to consider ways of reaching young people where they were, rather than passively waiting to be approached at a traditional service setting, such as the GP clinic.

‘[what could happen] is for the medical fraternity to be encouraged to actually make contact with kids and demonstrate that they are confidential and that there are avenues for people to get in to see them without their parents. Even if it was you know like a pop-up clinic’ (education2)

Opportunities and ideas for collaboration with non-traditional settings and stakeholders were raised; such as sports clubs, recreation centres, libraries and art groups. Stakeholders acknowledged services should be targeted towards centres and places where young people already connect and are engaged; and that by being opportunistic, more young people could be accessed:

‘I like the idea of [researcher] engaging the young fellas down at footy. Having that open and honest discussion with a young bloke and see another footballer talking about this stuff and also – and talking about sexual health from a positive thing.....I like the idea that sporting groups – and on the same vein – basketball and soccer and possibly netball – could do exactly the same thing’ (health7)

‘Until it becomes normal you might need to do some saturation stuff to start with to really get a big, bit you know input and then you can back it off once it’s become normalised’ (education1)

Facilitation of education and provision of services through non-traditional settings was highlighted as an important potential strategy in the rural community. Several participants saw engaging sport and recreation settings as community-based approaches that moved beyond the personal level of intervention to improve access.

‘Anywhere that has access – like the rec[reation] centre – anywhere the kids are going to hang out and hang out on a casual basis – should have some sort of access to it [sexual health services/education]’ (education2)

'We've got different sorts of organisations, we've got sporting clubs, all of those sorts of things that could be supportive of sexual health.' (health4)

'I know the footy club have organised a few sexual health things I believe...That is definitely another way of engaging the youth – particularly mostly blokes – young fellas' (health7)

Within this concept of non-traditional settings there was a further opportunity of the role coaches and peers could play as community sexual health educators and referral agents.

'[young people] use the centre on a regular basis you know within mentoring situations, with coaches and you know high school kids mentoring young children through coaching their teams. So, I definitely think the venue could be used as a vehicle.' (youth3)

'We know that peer education's really important, it's really hard to sort out some sort of peer support network. That's another powerful tool that could be used and we just don't adequately do it as well.' (health4)

This community-wide approach was further supported by the concept of developing coordinated and consistent knowledge and skills across several settings providing young people with greater access to relatable content and enhancing relevant skills:

'What is there is fantastic, but it is so inconsistent' (education3)

'Maybe having more discussions outside of a health clinic and just allowing young people to hear from some of their mentors possibly about real life stories' (health7)

'I think maybe we can co-ordinate better to deliver that message.' (youth1)

The accessibility and credibility of RSE was also highlighted as being important when targeting the community and individuals; there was a perceived need to ensure young people received RSE at an earlier age.

'I think it could be started earlier but to do that it needs to have a special person doing it and it has to be somebody the kids trust and relate to, probably not a teacher.' (education2)

Small town communication

Small towns were acknowledged as settings that were 'interconnected' and 'everybody knows everybody'. There are benefits to this closeness when it comes to stakeholders being aware of each other in some instances – however not every stakeholder knew the other youth-related services or providers in the setting.

Stakeholders identified the need to know what was being implemented in the town regarding sexual health, but there was no mechanism or forum for communication or sharing of resources. Communication was ad hoc and reliant on personal and personnel connections rather than established interagency connections, channels or existing collaboration. There was a clear disparity between the stated importance of stakeholder communication and collaboration and what was happening in practice. There was a lack of knowledge on what sexual health services existed in the town or what was being taught and provided within the school setting.

'I don't specifically know what is set up for that age group. It's not something that I'm involved with at all' (health2)

'I don't know what youth sexual health services are active if any. And what's available in [nearby larger town]. So that, not having that knowledge means that I can't pass that information onto a student who needs it.' (education1)

'I don't know what else is available in town which is why this is a good thing – you asking me these good questions' (health7)

The findings highlighted a lack of current collaboration, not just in sexual health, but youth health promotion in general. This was despite many stakeholders having previous knowledge or experience of effective collaborations in other settings:

'I used to do some talks when I was a GP up in Perth – to schools – you could have heard a pin drop while you were explaining to the kids about different stuff' (health3)

'The footy guys used to organise some health talks and used to get the local doc [GP] to come in and help out and talk about sexual health and all that sort of stuff' (health7)

Discussions around what services were available led to many acknowledging their own weaknesses regarding this knowledge; but also identifying opportunities within interviews to connect and collaborate with other stakeholders or settings.

'Maybe put something into the schools to say look here, this is what you can do, this is how you can book [appointments] with us, we don't have any issues with it. Maybe we, maybe we you know we approach the schools about that.' (health1)

'If they can be supported to give kids information. So yeah your football club, your soccer club, you know whatever.' (education2)

Stakeholders identified the need to seek out further information and the need to communicate to the community how services worked, or what services were being provided. In particular, it was recognised that students may not be aware of the role of

some stakeholders; acknowledging that more needed to be done to ensure their services were promoted.

'I think the main thing is to get it out there somehow, to let the kids know that they can come in here by themselves. They can make their own appointments. That yes, we're not going to make it hard for them, we'll do everything we can' (health1)

'We don't advertise it. I may be underestimating it... – maybe they do know it's available' (health7)

'I think that there's still barriers to that 'cause students aren't sure about what [the school nurse] role is, is it confidential? All of those sorts of things' (health4)

Communication in organisations on key youth related policies was also lacking. This makes the ability to promote services or policies directly to young people difficult if services are not clear internally on what they provide. For example, differing information relating to one agency's bulk billing practices clearly demonstrated a lack of internal clarity on how young people were billed:

'I know we try and anyone under the age of 21 we bulk bill to allow them to have that access and I don't know if all the services in town do that' (health7)

'From the very first moment we started privately billing we've always agreed to bulk bill up to the age of twenty' (health3)

'Our practice bulk bills everyone under the age of 22 as a conscious thing to try and remove any financial difficulties in seeing a doctor about any of those things' (health6)

Discussion

This study provides a voice to rural stakeholders that provide RSE and sexual health interventions by default or necessity. The rural workforce involved in sexual health promotion consists of many generalists working in isolation with a lack of formalised qualifications or previous experience in sexual health (Pashen et al. 2007). The wide variety of backgrounds of participants in this study is typical of a setting in which sexual health is 'nobody's priority'; generalists provide the basic services young people need and become 'accidental' experts and advocates for RSE. Despite many participants providing some level of RSE or sexual health intervention – there was little collaboration or communication between different stakeholders.

Examining findings utilising socio-ecological levels to divide the setting into component levels for analysis highlighted a limited focus on addressing community and organisation level needs; with the majority of stakeholders focussed on individual

level interventions. Component analysis of the threats, opportunities, weaknesses and needs that stakeholders identified at socio-ecological levels (individual, interpersonal, organisational, community and societal) (Golden and Earp 2012) provides the framework for this discussion.

Providing RSE and sexual health services in a small town can be complicated without a lead agency. There is a need for greater organisation and consistency in delivering sexual health promotion in settings that lack specialist RSE services. Our study showed that with a lack of direction and a lack of prioritisation, interventions were initiated by single advocates and there were many cases of stakeholders providing interventions without collaboration or sharing of resources. While it must be acknowledged that 'you won't get the whole town to start thinking about adolescent sexual health', services should endeavour to deliver the services that young people need in their town and collaborate to address multiple socio-ecological levels needs beyond the individual. Despite highlighting schools as having a key role in RSE; consistent with other rural focused research, there was lack of consensus on the exact role schools and teachers should play (Hulme Chambers et al. 2017). Additionally, there was a clear opportunity and interest in integrating other services into RSE and sexual health delivery, but there were limited efforts to engage them and the lack of a clear framework on how to.

Many young rural Australians enter adulthood with limited RSE and sexual health knowledge (Helmer et al. 2015; Senior et al. 2014). These young people often move towards larger urban centres for employment and tertiary training opportunities after formal schooling. This knowledge and skill deficit highlight the important role rural towns play in preparing young people for adulthood and life beyond their rural town. Consistent with other research, stakeholders delivering sexual health interventions reported fear of community backlash (Johnston et al. 2015) and were therefore conservative in their approach. Rural stakeholders should aim to move forward from avoiding controversy and consider the need to deliver comprehensive curriculum (van Leent 2017; Collier-Harris and Goldman 2017), acknowledge research supportive of positive sexual health and RSE (Ferfolja and Ullman 2017; Burns and Hendriks 2018; Gegenfurtner and Gebhardt 2017) and advocate for community level systems approaches that address the setting's community and organisational socioecological levels (Hulme Chambers et al. 2017). While interventions can be provided covertly and "fly under the radar", this approach fails to address the socio-ecological system levels beyond the individual or advocate for young people's needs. Targeting community and interpersonal socio-ecological levels by addressing the educational needs of parents and the public may assist in addressing misconceptions or lack of knowledge and minimise the threat of opposition to providing RSE to the individual (Robinson, Smith, and Davies 2017; Eastman, Corona, and Schuster 2006).

Neglecting community socio-ecological level focussed advocacy and interventions also ignores the opportunity to create a safe environment for rural LGBTI youth. This group is at high risk for negative sexual health outcomes (Lyons, Hosking, and Rozbroj 2015; Morandini et al. 2015), and failure to move RSE away from a heteronormative biological focus will fail to provide LGBTI youth (and others) with RSE that is relevant, inclusive and safe (Hillier and Mitchell 2008; Jones et al. 2016). Stakeholders can actively validate and advocate for each other to ensure teachers and school leaders pursue professional development to create supportive environments

and correctly deliver RSE for rural LGBTI youth (Bartholomaeus, Riggs, and Andrew 2017).

Participants emphasised the need for consistent messages to be delivered from multiple skilled and knowledgeable sources. Ensuring teachers have recent professional development to effectively deliver the RSE component of the curriculum is critical in achieving appropriate and credible delivery (Clayton et al. 2018; Bartholomaeus, Riggs, and Andrew 2017). Outside providers or school nurses can supplement delivery and reduce embarrassment; however, teachers should be skilled and central to the development and delivery of RSE curriculum (Burns and Hendriks 2018). Health stakeholders described a desire to know what teachers were delivering in schools to assess health literacy; while teachers were interested in inviting GPs to assist in RSE delivery. Simple collaborations such as these provide an opportunity to develop consistent messaging across multiple settings and provide young people information when and where they need it. Consistent messaging from schools to GP clinics to sports clubs addresses organisational and interpersonal socioecological levels needs; and provides the opportunity of greater reach of messaging to the community. This collaborative approach may also reduce the potential threat of services or providers being singled out as encouraging sexual behaviour in young people.

Sport and recreation stakeholders saw significant benefit in equipping coaches and leaders with skills and information to support young people with respect to sexual health. Coaches and sporting clubs occupy a significant position within rural towns and often experience exceptional access and influence on the young people they coach (Pierce et al. 2010). Providing sports clubs with a platform to collaborate with established RSE stakeholders without fear of reprisal from the community or local sponsors, would help support interventions at a socio-ecological community level. Service providers should explore opportunities with clubs or community groups that build capacity as referral agents or hosts of information. This would require effective ongoing communication and collaboration between sporting clubs and health or education stakeholders to provide a framework of support; traditional youth health services should not abdicate their responsibility once sporting clubs or community groups begin supporting initiatives.

Improved communication and consistency of messaging allows greater opportunity for services to realise synergies and new collaborations. While sexual health promotion can be addressed at a high level via policy and government directives (Shannon and Smith 2015; Hulme Chambers et al. 2017), rural communities can instigate local change. Improvement in how services work together within sexual health promotion may also improve outcomes in other youth-focussed areas such as mental health and/or alcohol and other drugs. Small towns are interconnected and exploiting this opportunity to improve service delivery, consistency of messaging and networking will provide opportunities to address service awareness and improve accessibility. This interconnected personal network is important – but should not be relied upon as the primary method for connection in the long term, as this may lead to loss of linkage when a strategic individual leaves a service. Stakeholders highlighted that there should be an effort to coordinate interactions in a feasible and realistic manner that does not create an excessive workload burden.

Limitations

Although providing some important insights, this study has limitations relating to the transferability of findings due to the size of the sample and the acknowledgement that small Australia towns vary widely (DOH 2012). Each setting must consider sensitivities towards local issues and address setting specific threats, opportunities, weaknesses and needs. Additionally, there was a small population of people identifying as Aboriginal or Torres Strait Islander or culturally and linguistically diverse representation within this setting (ABS 2016). This is reflected in both the demographics of participants contributing to the study, and the research's ability to be translated to settings with higher Aboriginal or Torres Strait Islander and culturally and linguistically diverse populations.

Conclusions

The findings of this study have practical implications for the rural setting when addressing youth sexual health needs. Rural communities that are committed to deliver sexual health promotion without specialist service provision need guidance and support. A coordinated approach to sexual health promotion that addresses the multiple socio-ecological levels encourages a step away from ad hoc and personality driven interventions while collaboration between stakeholders is a key tool in both intervention provision and mitigating against community backlash. A coordinated approach allows credible and consistent messaging on sexual health within the community and new opportunities for collaboration. This research and a partner study (Heslop, Burns, and Lobo 2019) informs the development of a framework to assist rural communities in provision of sexual health and RSE services.

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Chapter 11: Delphi Study to Validate the Framework

Introduction

Two separate Delphi studies have been embedded within this PAR project to encourage feedback and refinement of the developed RuSHY Framework³⁵ developed from youth³⁶ and stakeholder research³⁷. The key outcome for both Delphi studies was to evaluate the validity of the developed Framework³⁵.

Fletcher and Marchildon⁴² used a modified Delphi method within their PAR project on health leadership, however there is limited literature relating to the use of the Delphi method within PAR and a lack of consensus on what represents an adequate sample size for Delphi studies^{40,41}. Delphi method is well suited to health promotion research³⁸; however there are significant variations in how the methodology is employed to gather consensus³⁹. Delphi method provides a platform for effective feedback from a panel of experts³⁸ through anonymity, the ability to provide subsequent iterations of the study if required, control of feedback and group response³⁹. Use of this methodology allowed prolonged engagement with stakeholders engaged in the early development of the RuSHY Framework to provide further opportunity for member checking and feedback to the research team in a confidential, systematic and efficient manner. This prolonged engagement and involvement is an important part of PAR practice³².

Methods

Delphi method was selected in this instance as part of a larger PAR project to evaluate the validity of a framework for planning, implementing and evaluating community-based youth sexual health interventions in the rural setting³⁵. PAR is an iterative process, featuring revision and exploration of issues and themes as they evolve within the research process. Delphi method was selected to enable participants to influence the development of the Framework and improve its trustworthiness¹⁰⁷. A draft Framework was initially developed following consultation and feedback from young people (Chapter 9)³⁶ and rural stakeholders (Chapter 10)³⁷. Traditionally, Delphi studies seek to canvas the opinion of expert practitioners relating to a specific field⁴⁰; however use of this methodology allowed for input from rural generalists in the town in addition to rural health and sexual health experts throughout Australia.

The first Delphi study canvassed local “experts” for their input on the Framework document (Appendix F: Frameworks). These “experts” were drawn from a range of professionals and volunteers actively engaged with young people within the rural setting, rather than specific experts in sexual health provision. While many stakeholders were engaged either directly or indirectly in providing youth sexual health services, no stakeholders worked primarily in a sexual health position or had any specific sexual health training. This opportunity also allowed participation of some experts who had expressed a desire to participate in the qualitative interviews but were unable to due to time constraints. Once feedback was collected and analysed, the draft RuSHY Framework was refined and returned to participants with a request for final comments or clarification.

Upon the completion of this first Delphi study, a second Delphi study was initiated. This was an expanded consultation that was informed by the first, localised Delphi study and included a revised survey instrument and RuSHY Framework. The second Delphi project invited participants from Western Australia, South Australia, Queensland, New South Wales and Victoria who self-identified as rural-based or rural-focussed experts involved in sexual health. Through inviting participants with no involvement in the development process or original setting, the research team were able to test the process validity and trustworthiness of the project and the RuSHY framework via triangulation and outsider evaluation^{107, 108}.

Participants

Delphi panel size does not depend on statistical power, but relies on the dynamics of a group for arriving at consensus, with the literature recommending 10–18 experts⁴¹.

The first Delphi study aimed to gather feedback and revisions on the developed Framework. The same organisations and individuals involved in the first cycle of this PAR project³⁷ were invited to provide feedback on the draft Framework, as well as individuals and organisations that were identified in the initial cycle but who were not approached or were unable to participate. Five stakeholders from the stakeholder interviews³⁷ participated in the localised Delphi study. Additional health workers from primary health care (General practitioners (GP), Practice Nurses) and youth services

(support officers) were approached to provide feedback on the Framework where services had changed. All participants in this first Delphi Study lived or worked in the town selected as the setting for the overall PAR project³⁵.

A total of 31 local stakeholders were approached to participate in the first Delphi study. Eighteen participants elected to participate, with 12 completing 100% of the survey. Eight declined citing time and work constraints and five of the 31 did not respond to further follow up after initially expressing interest in participating.

The second Delphi utilised a nonprobability sampling technique with another separate panel of national participants invited to participate (n=31). Stakeholders were approached based on their ability to generate insight into community-based sexual health interventions in the rural setting. Additionally, participants were recruited via e-mail newsletter items sent to subscribers to electronic mailing lists of the Positive Adolescent Sexual Health Consortium (PASH) and Centre for Excellence in Rural Sexual Health (CERSH) professional networks. Participants self-selected based on the requirement that they understand the delivery of youth, education or health services in rural towns and how that would relate to sexual health. There were 17 respondents to the request for feedback, with one respondent withdrawing their consent to participate (response rate 54%), a further four declining to participate citing work constraints or a perceived lack of knowledge on the topic.

Data Collection

Participants were asked to provide feedback via statements relating to the developed Framework, its key concepts and the stages of Framework implementation guide. A questionnaire was developed with stakeholder input from three stakeholders from the stakeholder interviews (Chapter 10) to provide feedback on how appropriate and effective the Framework would be for implementing and coordinating community-based youth sexual health interventions in the rural setting. The initial questionnaire utilised both Likert scales and open-ended questions with the intention of collating responses and providing feedback to participants.

The first Delphi study asked participants a series of questions that allowed qualitative feedback, questions on specific details and Likert scales to rank statements relating to

the Framework. Questions included: demographic and employment information; understanding the development of the Framework document; a series of questions on each of the Framework's four key factors; a series of questions on the four implementation guide phases; and final questions on the whole Framework (see Appendix G: Delphi Study Materials: Delphi 1 Questions). Following feedback on the first Delphi study, the second Delphi study was reduced from 87 to 70 questions (Appendix G: Delphi Study Materials: Delphi 2 Questions), directly relating to the Framework. For both studies, participants had a period of four weeks to complete the Delphi questionnaire with two follow up emails sent during this period to remind participants to complete the questionnaire. Feedback and the refined RuSHY Framework was provided to invited stakeholders regardless of participation in the concluded Delphi Study. This allowed participants that may not have had capacity to participate, with a further opportunity to supply feedback or commentary on the Framework or process.

Data were grouped and verified with Delphi participants to enhance trustworthiness. Online questionnaires were administered using Qualtrics™ software. Participants were sent a link to the questionnaires via email. No physical copies of the survey were sent to participants as electronic methods have been shown to facilitate feedback more easily⁴¹. Participants were asked to rank the list of statements using a seven-point Likert scale and provide qualitative feedback on each of the four Framework concepts and the multi-stage implementation plan. A seven-point Likert scale was selected to allow greater respondent preference and reliability¹⁰⁹. It was intended that multiple iterations of the survey would continue until participants reached 80% consensus, with “Agree” or “Strongly Agree” being considered as the affirmative threshold for consensus calculations^{41, 42}. The localised Delphi participants completed the survey in an average of 23 minutes; while the expanded Delphi took participants an average of 19 minutes.

Participants were provided with the refined Framework at the end of the first round of the Delphi and asked for further comments consistent with the approach used by other researchers^{40-42, 110}. There were limited additional suggestions or alterations made to the supplied refined Framework document within both Delphi studies. Consensus was reached within the first iteration of the Delphi process on all key question areas. It is possible that participants were reluctant to critique or that bias may have been

introduced via the framing of the Delphi questions.

Data Analysis

Data for each Delphi study were analysed independently. Statistical analysis was performed on the ranked Likert scales to identify statements that achieved group consensus¹¹⁰. Measures of central tendency (means, mode, and median) and level of dispersion (standard deviation and interquartile range) were calculated and feedback on these results given to participants^{40, 110}.

Qualitative data were analysed using content analysis techniques to identify recurring themes and core issues with the RuSHY Framework^{40, 110}. Findings from the first initial stage were largely suggestive of small changes to detail within the Framework itself rather than thematic or content issues. Subsequent iterations of the Delphi study provided participants with a collated summary of participant feedback and a response to each piece of feedback from the researcher (Appendix G: Delphi 1 and Stakeholder response table – Delphi 2 for the two tables and responses provided to participants), as well as the new RuSHY Framework that had been refined and edited for additional comment.

Results

Of the 18 participants (response rate = 58%) in the first Delphi study, eight identified as male and 10 as female. There was representation from different levels within organisations, from Chief Executive Officers and school Principals, through to youth workers and teachers. All participants worked or volunteered with an organisation that provided services to young people within the town; with seven of those providing sexual health services such as STI testing, provision of education, information or counselling. Despite several local general practitioners participating in the stakeholder interviews, and four being invited to participate in this localised Delphi, none completed the survey.

The second Delphi study included 17 respondents (response rate 55%) from around Australia, with one respondent not providing consent to participate. Six identified as male and ten as female. Of these 16 respondents, 12 completed 100% of the survey responses with the remaining six only completing approximately half of the study. Only complete survey responses were included for analysis. Participants did not necessarily

need to work specifically in sexual health services as an acknowledgement that in many rural settings, these services are not provided by specialist services. A wide range of rural based, youth focussed workers including school chaplain, teachers, youth development officers, sexual health promotion workers, coaches and a rural GP participated, see (*Table 2* for detailed breakdown). The results of nine key questions relating to the key outcome of the studies from the data set will be reported on.

Table 2 Breakdown of participants in Delphi 1 and Delphi 2 by discipline

Discipline	Delphi 1 respondents	Delphi 2 respondents
Health	4	6
Education	3	4
Youth or community services	5	4
Sport and recreation	4	2
Other	2	1
Total	18	17

Quantitative results

Through the process of developing the Framework with stakeholders and youth through the PAR project, four key concepts for improving the planning, action implementation and evaluation of community-based youth sexual health interventions in the rural setting emerged. These key concepts included: (the need for) consistent and credible sexuality and relationships education and information; health service accessibility and competing priorities; discreet condom supply and communication and collaboration^{36, 37}.

A key concept statement was developed from the thematic analysis of the PAR research, and further key guidelines on how to successfully address or achieve these four factors were developed from analysis of the youth and stakeholder consultation process. Each key Framework factor had between 10 and 12 key guidelines.

An example of what was provided to participants:

Consistent and credible relationships and sexuality education and information

Key Concept: The relationships and sexuality education delivered is relevant, acknowledges diversity and moves beyond the biological aspects of sexual health and provides young people with the skills and information that they want and need.

Key guidelines from this research:

- Consistent messaging throughout the community is important.
- Relationships and sexuality education (RSE) programs and services should be inclusive of LGBTI youth.
- Sporting coaches and club members can be educated to act as a first point of contact for youth. RSE should be delivered by a credible presenter in all settings.

The complete RuSHY Framework is included in Appendix H: Finalised framework.

Participants were asked to review these guidelines and were asked to rank the statement *“This concept area is important when delivering sexual health interventions in the rural area”* for each factor. The level of consensus reached for each key factor is displayed in **Table 3**.

Table 3 Consensus level of key Framework factors

Key Factor	Delphi 1		Delphi 2	
	Mean	Consensus Level	Mean	Consensus Level
Consistent and credible relationships and sexuality education and information	6.75	100%	6.75	100%
Health service accessibility	6.75	100%	6.75	100%
Discreet condom supply	6.58	92%	6.83	100%
Communication and collaboration	6.33	83%	6.75	100%

As detailed above there was consensus on the four key factors from participants who

returned a response to these questions in both studies, with a non-completion rate of 34% for the localised study and 25% for the second Delphi study

Participants then provided feedback on the Framework’s four implementation phases. The four phases gave background information and clear guidance on how to implement the Framework in rural settings. The four implementation phases of the Framework included:

1. Community Scan (CS) and TOWN (Threats, Opportunities, Weaknesses and Needs) analysis
2. PLAN (Plan, Listen, Allocate, Network)
3. ACT (Advocacy, Coordination, Targeted interventions)
4. Review

Participants were asked to rank their agreement that “*This phase relates well to sexual health services provision in the rural area*” on a seven-point Likert scale. Open ended questions allowed participants the opportunity to provide additional feedback and suggested amendments for each phase and the implementation guidelines. Consensus was reached across both Delphi studies and there were no major suggestions or alterations from the qualitative feedback that required significant changes or alterations to the Framework implementation phases. Consensus levels on each phase are displayed in *Table 4*.

Table 4 Consensus level of implementation phases

Implementation Phase	Delphi 1		Delphi 2	
	Mean	Consensus Level	Mean	Consensus Level
CS & TOWN analysis	6.42	100%	6.5	100%
PLAN	6.25	83.3%	6.42	100%
ACT	6.45	100%	6.58	100%
Review	6.18	81.8%	6.5	100%

Another key element of the Framework is its value to rural based workers and volunteers. Participants were asked to rank their agreement that “*This Framework document would be useful in my community*” on a seven-point Likert scale. Across both studies there was consensus from participants that this Framework document would be useful in their own community with the consensus level displayed in **Table 5**.

Table 5 Consensus response on Framework usefulness

	Delphi 1		Delphi 2	
	Mean	Consensus Level	Mean	Consensus Level
This Framework document would be useful in my community	6.41	100%	6.33	100%

Qualitative results

Open ended questions were analysed to explore emerging themes. Feedback was varied and was primarily centred around small changes to the provided guidelines to allow for improved access to services and education for disadvantaged youth, considerations around contraception other than condoms, access to abortion services and emphasising the need for youth specific training for all staff interacting with young people, including administrative and support staff to ensure youth friendly service provision. There were no clear themes that emerged across the two Delphi studies in regard to this feedback. Rather, feedback included suggestions to improve the existing guidelines rather than a missing theme or factor. Some feedback included direct questions or statements to the researcher that provided additional depth to the data:

“Schools should know this and already be implementing sexuality and relationships education”

“Do young people really want to 'buy' condoms or do they want free, discreet and easy access?”

“I think this [the Framework] is excellent, and very useful across a range of community development areas, not just sexual health.”

“This seems to be a critical outcome of the Framework, that it can be a document to gather together diverse service organisations and help strengthen relationships.”

All feedback was collated and circulated via email to the full group of invited stakeholders. Feedback that improved the quality of the guidelines or requested greater clarification of key factors or the implementation guidelines (requests for more diagrams, wording changes, more detail) was assessed for how feasible it would be to include in the document without the Framework becoming too burdensome, and if possible was included in the revised Framework document.

“It would be great to see something about reaching and communicating with hard to reach young people i.e. homelessness and disadvantage”

“The age range for 'youth' would be good to have included.”

“maybe more about involving young people in the discussions. I see that it's in there, but it would be great to learn more about this.”

Not all feedback was able to be implemented in to the Framework revisions. If this was the case, a detailed response on why feedback was not included was supplied to all stakeholders with the revised document at the end of each Delphi study. The detailed responses to all received qualitative feedback from both Delphi studies can be found in Appendix G: Delphi Study Materials. This related to either the feedback falling beyond the scope of the Framework; relating to provision of specialised health services; or corresponded to details that were addressed in other areas of the Framework document. Examples of feedback that fell beyond the scope of the Framework were suggestions relating to policy change or Federal and State funding programs. While the Framework could potentially be utilised as evidence for the necessity of additional funding, the purpose of the Framework is to assist small towns in improving the planning,

implementation and evaluation of sexual health education and service provision locally. Similarly, where feedback referred to specialist services, such as surgical termination of pregnancy, or specialised domestic violence services – it was noted as important feedback but may be beyond the capacity of a small town to provide those services. Amendments were made in light of this highlighting the necessity of knowledge relating to referral pathways for health providers, educators and youth workers. Finally, there were times that stakeholder feedback may have suggested an amendment or change to a guideline that was represented in another section of the Framework document. This feedback was noted, with the relevant section of the Framework highlighted when group feedback was provided.

Discussion

These two Delphi studies allowed the researcher to efficiently gain feedback and further develop the Framework in collaboration with rural stakeholders. The localised Delphi study allowed stakeholders to re-engage with the overall PAR Framework development project and remain active participants in its refinement. This reengagement, prolonged engagement, member checking and triangulation improves the trustworthiness of the developed Framework¹¹¹ and process validity of the research¹⁰⁸. Participants in the first Delphi study reached a consensus that the Framework would be useful in addressing youth sexual health within the community setting that it was developed. This re-engagement with a number of participants from the first cycle of the PAR cycle allowed for additional member-checking to ensure that the RuSHY Framework accurately addressed the needs identified in the PAR cycle 1 and engagement with the research. The participants in the second Delphi were from outside the setting and the research process, and confirmed that the RuSHY Framework would be useful in their own setting, provided limited transcontextual validity in both the RuSHY Framework and process validity of the research process^{108, 111}. Participants were affirmative in their support of the four major factors of the Framework.

“Communication and collaboration” factor of the Framework received the lowest level of consensus during the first round Delphi (83.3%). The examination of the qualitative feedback relating to the *“Communication and Collaboration”* factor highlighted that there was a lack of clarity amongst some stakeholders in how this factor related to the

setting – particularly from two Delphi participants who were not stakeholder participants in the initial stakeholder consultation³⁷. In light of this feedback, several small amendments were made to the phrasing of some guidelines within this factor and a complete review of all the feedback and highlighted refinement to the guidelines was reported back to stakeholders. This key feedback and refinement of the Framework document allowed a more complete document to be sent to the second round Delphi participants. The subsequent second Delphi study received a higher level of consensus on this specific Framework factor.

Utilising a pair of Delphi studies to gain feedback and allow refinement of the developed Framework was an efficient and effective way to engage and draw on expertise from local stakeholders working in the rural setting and stakeholders from around Australia. There are limited examples of utilising a Delphi within a larger PAR project^{42, 112}, and in this instance, the first Delphi study was an effective mechanism to allow local stakeholders to provide confidential and de-identified feedback on the Framework document. This ability to provide feedback that is anonymous to other stakeholder participants and confidential may be a useful tool in managing insider-research in the rural setting¹.

The researcher was not expecting to reach consensus with participants in the first iteration of the Delphi process, however this may be explained by the developed nature of the RuSHY Framework that was reviewed by participants. The pairing of the two Delphi studies as separate but concurrent forums to validate the Framework is valuable in increasing the transcontextual validity of the Framework as a tool, and process validity and trustworthiness of the two Delphi studies¹⁰⁸. The qualitative feedback provided did not suggest stakeholders had major issues with the developed Framework. Some specific qualitative feedback was able to be integrated within the Framework as it comprised of simple suggestions or slight amendments to wording or was a recurrent response from participants; however, some feedback was acknowledged within the feedback process but not included as an amendment to the Framework. An example of this was detailed feedback from a participant in the national Delphi study relating to abortion access concerns and how this was not represented within the Framework document. Abortion access had not been raised as a significant issue within stakeholder

consultation³⁷, nor the localised Delphi study, representing the localised nature of the Framework development. This feedback was noted, but as it was a single GP participant, the Framework key factors and guidelines were not significantly altered; however, an amendment was made to include more detail on stakeholder's understanding referral pathways. Similarly, references to other forms of contraception were made by participants in both Delphi studies, but not uniformly. Other forms of contraception were mentioned within the RuSHY Framework guidelines, but major changes to the key factors were not assessed to be warranted as they were not made uniformly by the group. Further testing and implementation of the Framework in other states with different issues than those faced by the original stakeholders and young people the Framework was developed with would further strengthen the validity and usefulness of the Framework

Beyond the validity of the Framework, the Delphi studies were well received by stakeholders and there was good engagement with the process. The high levels of participation in the localised Delphi may be explained through existing professional and personal relationships with the lead researcher and/or prior involvement in the initial PAR cycle that developed the Framework. However, the second Delphi also received strong positive engagement from participants who had no prior involvement in the project nor a relationship with the lead researcher, suggesting that Delphi is an acceptable method for engaging rural geographically dispersed stakeholders. Rural stakeholders are able to engage and contribute to the research process via Delphi study without needing to travel and the anonymous nature of the Delphi feedback allows rural stakeholders to participate without fear of judgement in socially proximate environments. Delphi also provides the opportunity for participants from different professional backgrounds or different levels of professional advancement to participate in an equal process, without knowing who contributes which feedback.

A large proportion of stakeholders who elected to not participate notified the research team either through the questionnaire or via direct email communication. Those that undertook the study provided useful and clear feedback on the developed RuSHY Framework and the Delphi process both via ranking Likert scales and the qualitative questions; the ability to quickly provide direct responses to stakeholder feedback was a

convenient mechanism within a participatory style project. The collection of standardised feedback was beneficial in terms of the efficacy of analysing results and developing feedback responses as the questions asked of participants are able to be very specific. The provision of direct responses also allows participants to feel connected to the study and that there is a level of engagement on both the participant and researcher side.

Strengths and limitations

There is no clear consensus on the exact number of participants a Delphi study should engage and establishing the methodological rigour of the Delphi is not straightforward¹¹³, however the process should allow results to develop group opinion and allow experts to provide judgment to confirm statements or judgements^{114, 115}. The researchers maintain that the size of the sample in the two studies, as well as the wide range of backgrounds of experts who reviewed the RuSHY Framework, provide adequate engagement and generalisability in the findings¹¹³. A limitation of the study could be the lack of iterative rounds produced within the Delphi studies however it is worth noting that participants were commenting on a Framework informed by extensive consultation and participation³⁵⁻³⁷. Questions were phrased in a positive way which may have introduced a bias, however participants were provided the opportunity to contribute qualitative feedback on each key factor of the Framework, each stage of the implementation guide and the Framework overall. These open-ended questions did enable participants to suggest if there was any factors, ideas or guidelines that needed to be removed or added, and any other general feedback on the Framework. The Delphi process was anonymous, however given the close social proximity of rural towns, participants in the localised Delphi may have felt that it would have been possible to re-identify participants via the collected data and may have regulated their feedback. The research team attempted to minimise this by collecting limited demographic data that did not directly relate to the study; and the level of constructive feedback in the first, localised Delphi study is comparable to the second, nationwide Delphi, where participants were not as socially close to the lead researcher. It is also worth noting that the lowest level of consensus was achieved within the first, localised Delphi study.

Conclusion

Further investigation and testing of the validity of the Framework would be required to ascertain a full evaluation; however, the two separate Delphi studies undertaken do provide promising early results.

Stakeholders agreed that consistent and credible RSE and information; managing health service accessibility and competing priorities; ensuring discreet condom supply and communication and collaboration were important factors in the delivery of sexual health interventions in the rural area.

Stakeholders provided feedback that assisted the researcher in further refining the key factor guidelines and the Framework implementation guide; and their evaluation of the Framework has helped confirm its validity as a potential tool in improving the planning, action implementation and evaluation of community-based youth sexual health interventions in the rural Australian setting.

Further testing of the Framework by implementing it within additional rural settings would further examine its validity as a practical tool for the rural based sexual health workforce. This study is a key example of the utilisation of Delphi study technique within a rural-based PAR project and demonstrates that Delphi studies can be used to gather consensus data within a PAR project.

Chapter 12: Development of the RuSHY Framework

Scope of the Framework

The RuSHY Framework was developed following prolonged engagement by the lead researcher with a rural community, PAR and iterative feedback. It represents the culmination of a collaborative development process with stakeholders and young people that examined local realities and constructs to produce solutions and knowledge relevant to the setting that could be further transferred beyond that setting¹⁰⁷. This ecological¹¹⁶ and democratic¹¹⁷ validity are important in ensuring the trustworthiness^{107, 108} of the RuSHY Framework. The RuSHY Framework, along with its included recommendations and guidelines may be readily utilised with pragmatism and a thorough understanding of the applied setting and context; however application and further testing of the Framework are recommended to further establish its validity in other settings and transcontextual credibility¹¹⁸.

Developing the Framework concepts

The initial phases of the project focussed on understanding the context of the setting and creating a response in the form of a draft Framework. This involved review of the literature, collaboration and conducting community consultation to identify and assess key settings, stakeholders, activities and interventions currently active or planned to promote youth sexual health. Stakeholders (n=16) and young people aged 16-24 years (n=15) from within the setting participated in semi-structured interviews and focus groups to inform an analysis and the identification of threats, opportunities, weaknesses and needs that existed within the setting. From this analysis a draft framework was developed to inform the planning, implementation and evaluation of community-based youth sexual health interventions in the setting. Through a deepened understanding of the constructs within the setting acting as threats, opportunities, weaknesses and needs for youth sexual health; several participants acted on these needs either as part of the PAR project or independently. With a focus on examining the sexual health needs of young people with stakeholders, education of both the researcher and the participant took place within interviews and member-checking processes¹⁰⁷.

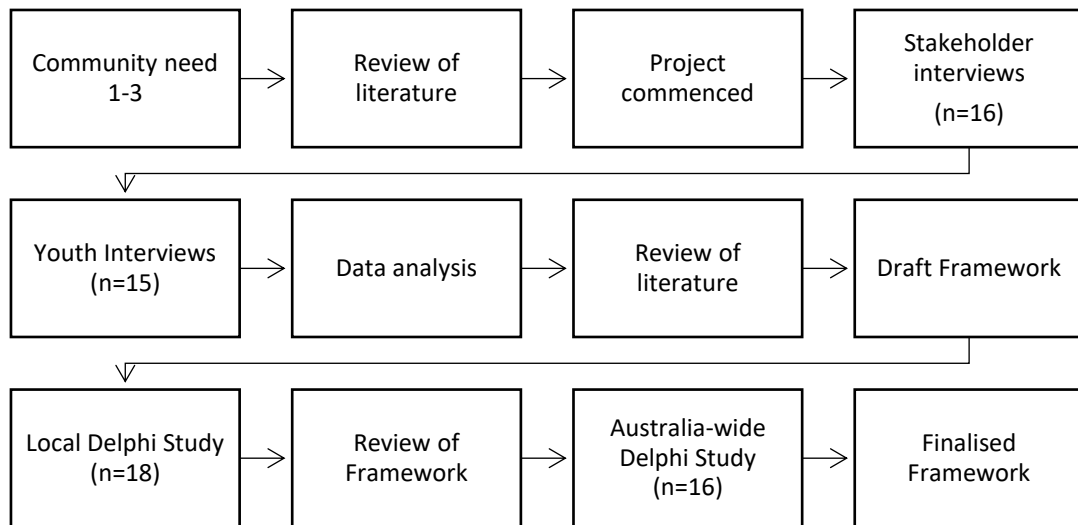
The second phase of the Framework development involved returning to local

participants to provide expert feedback on the draft Framework and provide the opportunity for prolonged engagement and further member-checking of the document¹¹¹. A Delphi study embedded within the PAR framework was utilised in this stage to encourage feedback and allow refinement of the draft Framework³⁵. Typically Delphi studies assemble a panel of experts to establish consensus on a topic⁴¹. The assembled panel did not only reflect experts in sexual health or RSE – but experts in the localised response to the needs in the setting. Action research blurs the lines between expert, participant and researcher¹⁰⁷ and the re-engagement with local stakeholders as experts to analyse the developed framework demonstrates this concept. The embedding of the Delphi technique methodology within PAR methodology provides process validity through the opportunity for refinement, participant engagement and reflection¹⁰⁷.

Once feedback on the RuSHY Framework was received and consensus on key statements relating to evaluation of its validity was achieved; a revised version was returned to all invited participants alongside the collected, de-identified participant qualitative feedback and the direct researcher responses to this feedback. This allowed a further opportunity for engagement and member-checking of the Framework¹¹¹, but also engagement in the PAR process to ensure outcome validity¹⁰⁷ via integrity¹¹⁹ and researcher skilfulness¹²⁰ through the ability to connect and re-connect with participants through the iterative process. The draft RuSHY Framework was then ready to be evaluated by a wider group of expert participants.

This third phase of the PAR project involved another embedded Delphi study and focusses on collecting expert analysis from participants with a solid grounding in delivering youth sexual health interventions and education within the rural setting. This final evaluation of the draft Framework allowed for further refinement of the document; while testing potential transferability and confirmability¹¹¹. The same iterative process was repeated from the initial Delphi study, with evaluation of the Framework invited from participants (*Figure 5*).

Figure 5 Framework development process



The rural sexual health landscape

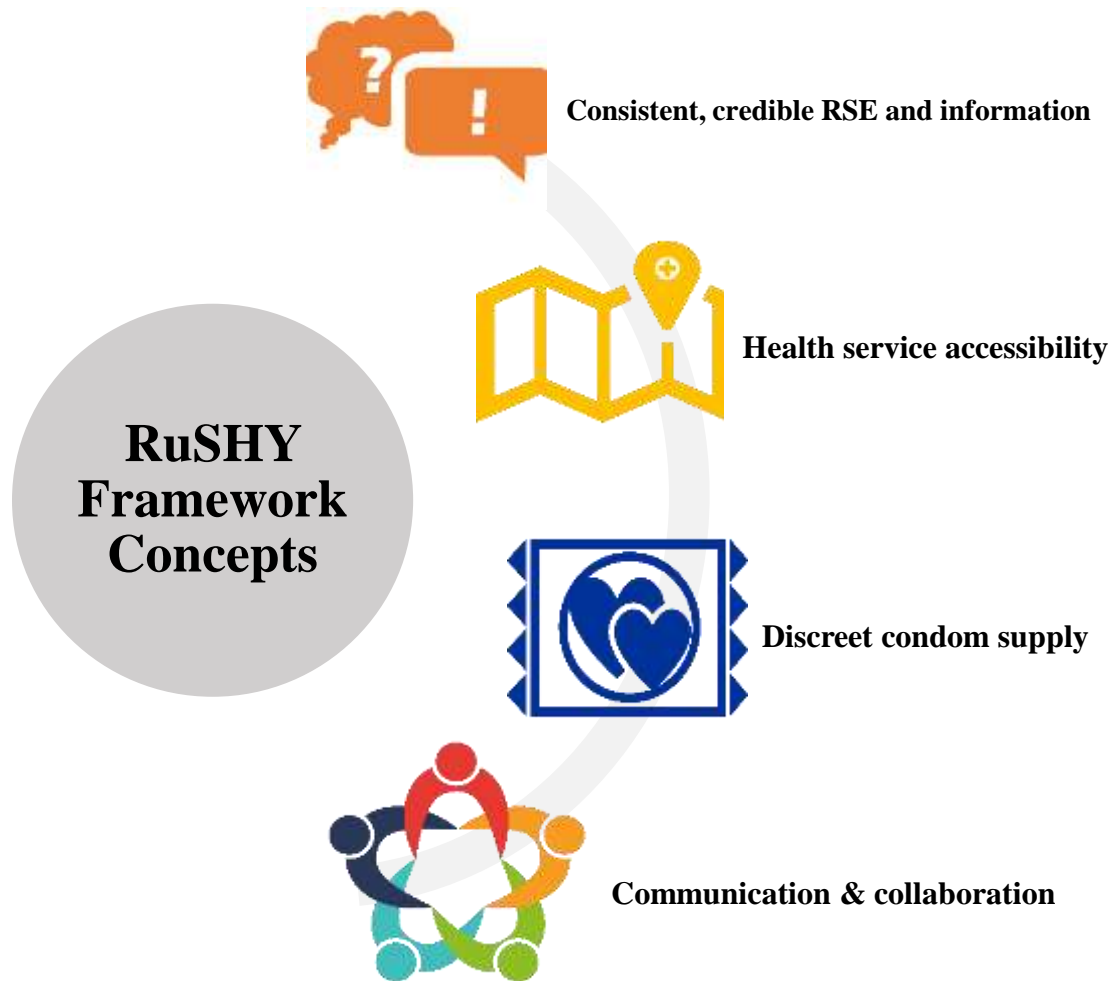
The analysis of existing rural sexual health services and RSE provision in the rural setting found:

- There is rarely a lead agency or dedicated service
- The rural workforce can lack specialist skills and recent professional development
- There is a lack of funding for sexual health
- There is a current lack of collaboration between stakeholders
- Sexual health is not a priority for many services
- There is a fear of community backlash if services are thought to be “promoting sexual activity”.

Framework concepts

Four key concepts were established from the study. These concepts represent the critical areas of implementing sexual health interventions in the rural setting as identified by participants and validated through the two Delphi studies. These key concepts do not represent every aspect of rural sexual health provision and purely represent the key themes from the research (**Figure 6**).

Figure 6 The four key RuSHY Framework concepts



Within the four concepts, there are suggested guidelines included that emerged from collected data and reviews of existing rural sexual health research literature. The researchers acknowledge there are nuances and needs that will vary from these four key concepts in every community and encourage providers to examine their own communities with a socio-ecological lens and consider how these issues could be implemented alongside or within the key concept areas. These factors and guidelines are the lived experience of the research participants and are not an exhaustive list of guidelines or suggestions for every community; however, the transferability and validity of the Framework was positively evaluated by stakeholders external to the setting, yet familiar with rural sexual health provision.

A summary of the research findings and the Framework concepts and guidelines are outlined below.

RuSHY Framework Concept 1:

Consistent and credible relationships and sexuality education and information

Throughout this PAR project, both stakeholders and young people clearly highlighted the need for consistent and credible RSE. Young people spoke of the need for RSE that was relevant and delivered by credible presenters – while stakeholders spoke of the need for consistency across multiple settings and environments and for presenters to be supported both within the community and through appropriate professional development.

The provision of consistent messages across multiple settings was highlighted as a strategy to ensure that young people experience reinforcement of messaging, information and skills facilitated by schools, health services, sporting and community settings and youth centres. This provides both a saturation approach to messaging in common language; and the opportunity for individuals and organisations to be protected from being singled out as “promoting sex” to young people or delivering inappropriate messaging. This consistent messaging must be evidence based to ensure credibility and should move beyond biological and functional education to ensure that it is relevant and meets the needs of young people within the scope and sequence of the Health and Physical Education Curriculum^{81, 82}. Inclusivity of gender and sexual diversity should also be considered to ensure the safety of rural LGBTI young people by providing a safe and inclusive environment.

Communities need to consider how to support schools and teachers in delivering the RSE curriculum and appropriate information; while schools should be well connected to external supports and providers to ensure collaboration and sharing of messages. The ability and method to reach young people who are not actively enrolled in local schools or other education institutions, or engaged in other sport or community groups, must be considered by stakeholders.

Teachers should have access and support to engage in appropriate RSE professional development opportunities to build their capacity as credible sources of information. The

capacity building of existing teachers ensures that teachers are skilled in delivery of RSE and become more confident on how to navigate role duality; become more confident in delivering the RSE curriculum content with less embarrassment and less reliance on external presenters. The supplementation of effective, credible and evidence-based RSE with external presenters should still be led and facilitated by teachers; and be a component of a comprehensive school health promotion approach that supports collaboration; rather than outsourcing the delivery of the RSE curriculum.

RuSHY Framework Concept 2:

Health service accessibility and competing priorities

Young people participating in this research wanted uncomplicated and confidential access to sexual health services and information in their community. Stakeholders highlighted the need for health services such as GP clinics to be accessible and ready to provide services to young people when they need it; however, both young people and stakeholders acknowledged the difficulties in managing competing priorities within the setting and the difficulty of a comprehensive focus on youth sexual health.

Young people within the study voiced concerns around anonymity when accessing services (waiting rooms or delivering pathology) but held significant trust in the confidentiality of medical services. This trust in confidentiality was a sentiment not shared by stakeholders who highlighted the lack of confidentiality as a major potential barrier to youth access. This apparent trust in services must be nurtured and supported; and health services have a critical obligation to maintain safe and confidential services.

Existing services also have a responsibility to cater to the sexual health needs of young people as best they can in the absence of specialist services and require ongoing training and professional development in delivering youth friendly services for both clinical and administrative staff. This training needs to include reception, administrative and support staff to ensure consistency in how youth are approached and engaged.

Stakeholders highlighted that health services need clearly articulated policies that impact on young people, such as access and booking and payment systems. Policies need to be clearly communicated to staff internally; and promoted to young people via a variety of

networks. Health services should explain access issues such as when Medicare¹ access cards and/or parental consent or presence are required; the type of identification required; booking procedures; and confidentiality. Delivery of this information requires existing services to find opportunities to engage and connect with young people and consider promoting themselves through traditional and non-traditional settings; and utilise peer-to-peer support to enhance delivery of information.

While regular outreach clinics may not be viable, one-off clinics, flexible informal services or information sessions in non-clinical settings (sporting clubs, youth clubs) have been shown to be successful and well received. With transport both within community and to other local communities cited as a barrier to access; measures to minimise this barrier for young people should be considered.

RuSHY Framework Concept 3:

Discreet condom supply

Young people participating in this study wanted to purchase condoms cheaply and anonymously from easily accessible places. Familiarity with the person serving in a store supplying condoms was highlighted as a major issue. Youth participants reported that some peers suggested stealing condoms to be a preferred option to avoid embarrassment in this situation. While free condoms were appreciated, participants were willing to purchase condoms if they were cheap and anonymously accessible; this was especially so for young women. Young women participating in the research supported the supply of condom vending machines in venues or settings that all genders can access. When this was not an option, self-serve checkout services allowed anonymous purchase of condoms in the small-town setting.

Sporting clubs, youth centres and GP consulting rooms were the most acceptable places to access free condoms – provided there was minimal interaction with peers or adults. Condoms in busy areas such as waiting rooms were less acceptable due to a sense of being watched; and young people participating in the study reported they would rather have a conversation with a GP and be offered free condoms, than take them from a busy waiting room.

¹ the publicly funded universal health care system in Australia

Some youth and education stakeholders reported administrative pressure regarding restricting the supply of free condoms in an unsupervised manner, with administrators preferring systems that relied on young people requesting condoms or condoms not being available within certain facilities. The rationale behind these restrictions included wanting to avoid parental and community backlash and wanting to minimise waste of resources. This highlights the need for localised advocacy to ensure that services can provide condoms to young people when they need them and/or have the capacity to promote local access. Community and organisational level advocacy, led by traditional services (local government, education, youth and health), promoting the need for condoms to be accessible, is important to reduce backlash or stigma from parents and conservative groups. Health, youth and education workers require support and professional development to enhance skills to enable discussion of condom use with young people.

RuSHY Framework Concept 4:

Communication and collaboration.

Small towns are interconnected and socially close, yet stakeholders reported that services often work in isolation with limited collaboration or communication. Services should initiate contact and collaboration in effective and sustainable ways that leads to a greater understanding of service provision and sharing of knowledge beyond clinical information. Clear internal communication was highlighted as an important factor that improves an organisation's ability to communicate with other stakeholders.

Communities lacking lead or specialist sexual health agencies need to identify who is involved and what is already working within their setting and engage in a process that allows orientation and awareness of sexual health services and referral pathways; a basic understanding of current RSE curriculum and where young people can access condoms, emergency contraception, pregnancy tests and other resources and services. Capacity to refer young people to other services beyond their town, along with the ability to collaborate and communicate confidentially to support needs for services such as HIV pre-exposure prophylaxis (PrEP), pregnancy termination and specialist services, are required.

Once there is a clear understanding of current community services and referral pathways, there is an opportunity for increased collaboration to ensure community needs are met; enhancing the likelihood of greater reach of messages and services, less organisational isolation and a reduced chance of duplication. These collaborative opportunities rely on clear inter-agency communication between services that should be based on organisational rather than personal connections; and be able to withstand a key individual leaving a role or the community.

Communities should explore ways to bridge gaps between agencies, services and young people. Effectively reaching young people by advertising services or information in high-traffic youth friendly shopping or recreation areas can help build an awareness of services and their relationships; while active and visible school health nurses can act as an adjunct between health and education. School nurses need to promote services that are available via teachers, stakeholders and other youth settings; and directly to young people to ensure that school nurses are recognised as the important resource that they are.

Another way of bridging gaps and exploring new possibilities includes pursuing the ability to build new connections and collaborations with non-traditional settings such as sporting clubs, youth groups and the wider community. These collaborations rely on positive relationships with club presidents and community members to ensure engagement and support and can help in building effective relationships and an interconnected network of services supporting young people within their town. These types of collaborations within the setting tended to focus on male-dominated sports but should consider sports played by all genders to ensure equal access to information, education and condoms.

Application of the RuSHY Framework

The RuSHY Framework was developed on the understanding that sexual health is often under-funded and under-supported in rural towns, with a lack of prioritisation towards sexual health from rural based services. Implementation requires staged phases that are reliant on collaboration, driven by community and possibly with minimal external funding. The RuSHY Framework guides community-based need for improving sexual

health in small towns. This may be from community-voiced need; stakeholders wanting to improve practice; a youth-driven movement; or changes in local strategy.

The RuSHY Framework consists of four implementation phases (**Figure 7**) and uses Bronfenbrenner's *Ecological Framework for Human Development* as a theoretical lens ¹²¹ to analyse the contextual forces that influence sexual health promotion within the setting. The socioecological model is utilised to divide the social environment in to component levels for focussed analysis that allows the types of influence to be assessed at each level and for the development of appropriate interventions that address each level consistent with previous health promotion research practice ¹²².

Figure 7 RuSHY Framework Implementation Phases



Implementation requires a Community Scan and TOWN (threat, opportunity, weakness and needs) analysis and is reliant on an individual or an agency taking an initial lead position. This Community Scan and TOWN analysis was used by the lead researcher in

collaboration with stakeholders to identify other key stakeholders, settings for sexual health promotion and education, and issues and solutions that informed the developed RuSHY Framework. Successful implementation requires consultation with other groups, or seeking contributions of information or time in a collaborative sense, and is dependent on the depth of understanding of the setting and community. This understanding would consider the multi-level interactions that exist and how these impact on sexual health provision in the rural area. The Community Scan and TOWN analysis is practically focussed and should address the needs of the community by allowing examination of the setting in close detail, considering internal and external threats, opportunities, weaknesses and needs.

The purpose of the second phase of implementation is to bring all stakeholders identified from the Community Scan together to consider the findings of the TOWN analysis and to prepare, listen, allocate and network (PLAN) within the setting. This may happen via meetings, emails circulars or forums – and is reliant on finding a sustainable and reliable method of two-way communication and collaboration.

The PLAN phase includes preparing, pre-planning and prioritising the findings of the TOWN analysis; listening and connecting with youth in the area to gain input and feedback on what has been identified as priority areas; allocating roles within the collaboration; and ensuring network relationships between collaborators can be easily supported. It is recommended that communities identify and set clear goals, establish clear evaluation methods time lines for implementation and evaluation cycles during this early phase.

The third phase utilises the findings of the TOWN analysis and PLAN phase direction and prioritisation to focus on advocacy, coordination and delivery of the targeted interventions that will produce outcomes linked to the four RuSHY concepts. Key components of delivering interventions are advocacy and coordination. Proactive and prepared advocacy can help control conversations and support a clear message for what is sometimes a controversial community topic. Communities implementing the Framework should develop a clear advocacy strategy, which frames their message and allows them to effectively respond to backlash or criticism. Proactively educating the

community on the need and the opportunities for sexual health is important and communities should consider engagement with local media to support advocacy.

Effective communication and focus within the collaboration are also important as it ensures communication and collaboration is sustained. Stakeholders will lose support from both young people and the community if they are not seen to be credible, collaborating in an effective manner and delivering results. The delivered targeted interventions should address the four RuSHY concepts, be achievable within the setting, and address the TOWN analysis findings.

The final implementation phase brings together the reflection and evaluation on the earlier phases. While evaluation should be continuous in nature and commence during each stage of implementation, this final stage acts as a review of all processes; including the evaluation processes. Thorough examination of the implementation of the Framework allows communities that have implemented it the opportunity to reflect, consolidate the collaboration and prepare to restart the process by performing another Community Scan and Town Analysis.

Conclusion

The RuSHY Framework represents the output of a collaborative development process that produced localised knowledge with value to the wider community following a community expressed need to address sexual health. Implementation in new communities is possible providing there is care in addressing the limitations of the Framework and acknowledgement that further testing will enhance inter-contextual reliability.

Chapter 13: Discussion

A detailed discussion relating to each research component of this PAR project is included in the respective chapters or published papers. This discussion chapter will focus on the project as a whole and examine the implementation of PAR in the rural area and embedding Delphi studies within PAR and the research study as a whole.

Significance

This research project developed and validated a framework to inform the planning, implementation and evaluation of multi-level community-based sexual health interventions for young people in the rural setting. It allowed the opportunity to test the application of embedded Delphi studies within PAR, building on previous research^{42, 123} and provided a contribution to a growing body of literature that utilises PAR in the rural Australian setting as a research methodology that connects with the rural population; encourages action within that community and provides a platform for an authentic rural voice¹²⁴⁻¹²⁷. It is also a contemporary example of rural-focussed research undertaken by a researcher ‘embedded’ rurally; living and working within the researched community as an insider-researcher.

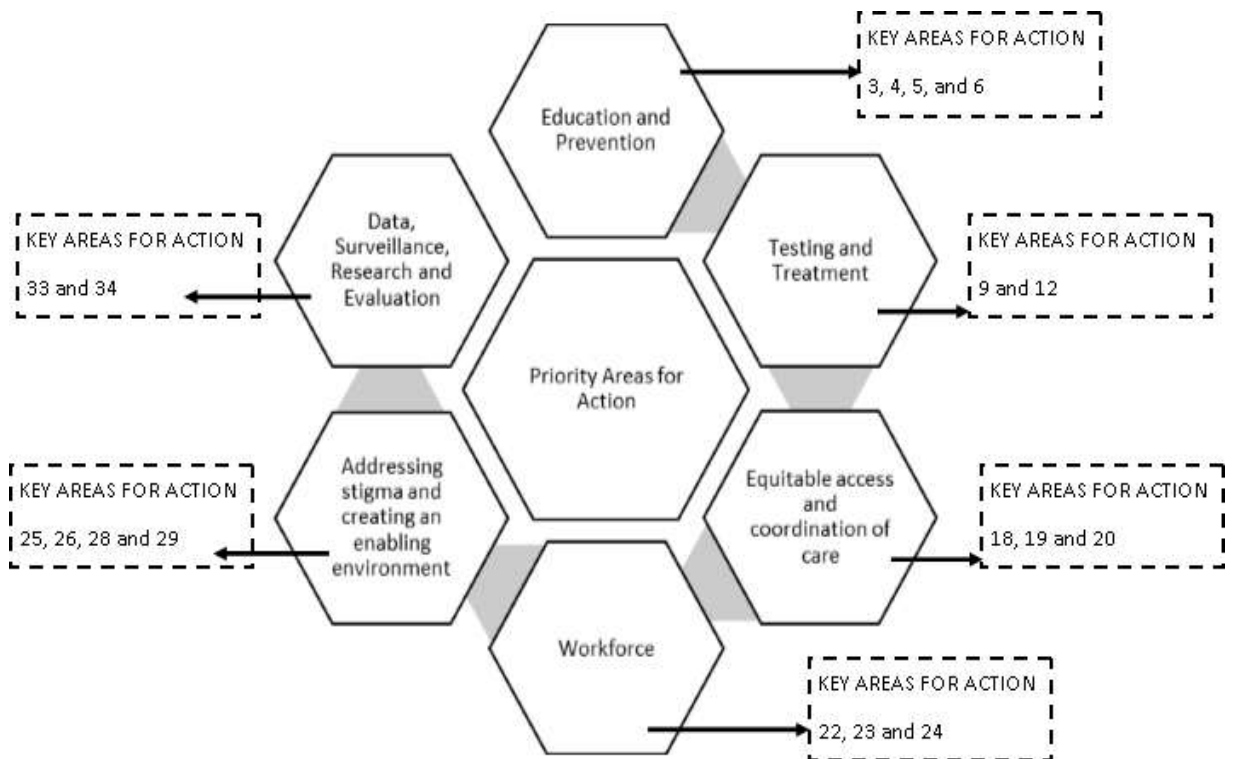
This research project provided a rural community with the opportunity to develop a localised response to addressing the sexual health needs of young people within their community. Rural sexual health is an area that is lacking current research that addresses solutions to the barriers to access for young people Warr and Hillier⁷. In the twenty years since this work, the barriers as identified by young people³⁶ and stakeholders³⁷ remain similar with a lack of guidance or consistency in how to address them. This project aimed to identify the issues that rural stakeholders and young people continue to experience regarding sexual health provision and sought to collaborate with them to create a practical framework that presents direction. A strength of this research is the empowerment of a community to provide a solution that aligns with a number of the “*Priority Areas for Action*” within the *Fourth National Sexually Transmissible Infections Strategy 2018–2022*¹⁵ (referred to for the remainder of this chapter as “*the Strategy*”).

The seven “*Priority Areas for Action*” from *the Strategy* (as presented in **Figure 8**),

contain 34 “Key Areas for Action” designed to support the achievement of the goals and targets within the *the Strategy*. **Figure 8** highlights which *Key Areas for Action* the RuSHY Framework addresses within its implementation.

Figure 8 The Seven Priority Areas for Action and the Key Areas for Action that the RuSHY Framework addresses

(Adapted from *Fourth National Sexually Transmissible Infections Strategy, 2018 Pages 24-33*¹⁵)



Young people continue to experience a significant burden of STIs in Australia¹⁵ and the RuSHY Framework provides rural communities with a functional tool to implement community based sexual health interventions and practices that enmesh closely with the seven Strategy Priority Areas for Action represented in **Figure 8**.

In a setting with limited resources and a lack of prioritisation on sexual health, the RuSHY Framework provides clear guidance in how to address *the Strategy* Priority Areas including:

- “Education and Prevention”

- “Addressing stigma and creating an enabling environment”, and
- “Workforce”

Within these *Priority Areas for Action*, the RuSHY Framework directly addresses several identified *Key Areas for Action*, including providing guidance on how to:

- “Encourage partnerships between health services, schools, educational institutions and community organisations to improve the delivery, availability and accessibility of sexual health education and services for all young people and strengthen linkages to testing and treatment (the Strategy, Key Area for Action Number 5)”¹⁵and,
- “Support the capacity and role of community organisations to provide education, prevention, support and advocacy services to priority populations (the Strategy, Key Area for Action Number 24)”¹⁵.

The RuSHY Framework identifies four key factors for rural sexual health provision:

- Consistent and credible relationships and sexuality education and information
- Health service accessibility and competing priorities
- Discreet condom supply
- Communication and collaboration.

A core outcome of implementing the RuSHY Framework is establishing collaborative relationships between traditional and non-traditional sexual health provider settings to address gaps in service and education provision in the rural area. The RuSHY framework focuses on concepts that have potential for further generalisation and modification for a range of health issues within the context of the rural setting. Significant components of the framework consider how stakeholders can work within the constraints of their current funding and service delivery models to improve sexual health promotion and education. Given the intersections in the needs for young people in terms of access, outreach, service provision and education in youth sexual health, mental health, and alcohol and other drugs – there is potential to explore the insights and recommendations from this research with other youth health issues in the rural setting.

The RuSHY Framework supports *Key Areas for Action* that focus on improving relationships and sexuality education; improving condom provision and acceptance within the community; increasing comprehensive STI testing within the rural area in priority populations; better connection to priority populations via outreach services; and innovation that addresses workforce shortages.

Participatory Action Research Methodology

The PAR process necessitates a high level of engagement with participants. Discussion and engagement with both the research process in general and the specific research question led to several participants and associated stakeholders actively seeking to find and implement localised solutions to the threats and weaknesses impacting on sexual health provision in their community. During the early interview process that informed the development of the draft RuSHY Framework, several participants took the opportunity to ask questions relating to sexual health service provision within the setting and sought new resources, developed interventions and accessed professional development. Through discussion and feedback to stakeholders at key points during the research on the themes that had developed within the youth and stakeholder research process, there were subtle changes to local practice, new connections formed between stakeholders to address issues and a response of action within the setting. These energised moments within the setting had a transformative potential that represented a deepened understanding and suggest the catalytic validity of the project using a PAR approach¹⁰⁷. At the start of this project there was a lack of emphasis on sexual health as a service priority for stakeholders within the setting.

Implementation of more streamlined methodologies for engagement of rural communities may have produced an outcome faster and more efficiently than PAR which is often described as time consuming and complicated¹²⁸ and reliant on a commitment to collaborate through iterative process¹⁰⁷. There is discussion within the literature about what level of “participation” is required for PAR to be truly participatory^{111, 116, 128, 129}. Some researchers suggest that participants, in this case rural stakeholders involved in youth sexual health, should be involved in each stage of the research process including planning, data collection and analysis and publication¹¹⁶; while others view participation as more of a continuum from simple participation in planning or instigating

the project through to deeper research involvement³¹. This research project was generated by the community and led by an insider who was volunteering time on sexual health interventions within sporting clubs. Stakeholders were engaged within the PAR process to assist in the initial planning of the project, involved as research participants and key informants and were invited to comment on early data analysis and thematic coding during the first stage of the PAR project. There are always compromises and adjustments in PAR¹²⁸, and this PAR study attempted to realise a compromise between the maximum amount of possible participation of local stakeholders other than the lead researcher and the time constraints of doctoral research.

Participants were willing to make credible changes to practice or policy and create new collaborations and relationships. However, with limited to no sexual health specific funding available during this project, the scale of these changes within the setting was limited. The lack of policy or political priority towards rural sexual health is characterised by the absence of funding at either an over-arching project officer support level or a localised intervention level. This deficit of focus and funding prohibits a sustained focus on sexual health interventions and given the time limits and competing priorities of rural communities, it is unsurprising that while participants were willing to change where condoms were located within GP centres or create connections between the GP and the school, the scale and sustainability of these interventions was limited.

The time required to implement major interventions and recommendations relating to the developed Framework was greater than the time available for this doctoral research. Therefore, these movements to action must be recognised as significant additional outcomes of a project that primarily aimed to develop a process for catalysing change in rural sexual health.

Positionality and Collaboration

The development of the Framework was reliant on collaboration, consultation and prolonged engagement with the community through the participatory action research process. The PAR process was conducted from an insider-research positionality for the lead researcher¹⁰⁷ as a resident and health worker within the town, seeking to consult with the local community; in collaboration with outsider-researchers, the PhD

supervisory team.

The entry of the researcher into the PAR project was through a prolonged process of engagement¹¹¹ and collaboration¹⁰⁷ with health stakeholders who expressed a desire to act on sexual health provision deficits within the setting. After a six month period of consultation and inquiry with initial stakeholders, this PAR project was developed to answer localised need and address the lack of guidance within the research literature to inform sexual health promotion in the rural Australian setting¹²⁰. A project focus on the development of the Framework rather than piloting a series of ad hoc sexual health interventions was determined between the lead researcher, supervisors and key initial stakeholders in the development of the project.

The practical management of this insider-research positionality within a rural community is discussed in detail earlier in Heslop, Burns and Lobo¹ (Chapter 7), including issues relating to management of power dynamics to ensure ethical practice within the course of the project. At all times the lead researcher took care to present as a relevant resource person¹¹¹ capable of providing information or resources for stakeholders and young people participating in the study and for stakeholders and individuals outside the researcher-participant relationship. Clear processes were established to ensure confidentiality and anonymity was maintained as much as possible within a socially-close, interconnected rural network¹⁰⁷ and concerted efforts were made by the lead researcher to be visible, accessible and to associate with all potential stakeholder groups prior to recruitment and after the PAR process had begun¹¹¹. The lead researcher deliberately contacted participants from a diverse range of different professional and organisational backgrounds, and young people within the community and minimised bias by including both negative and positive voices and ensuring all voices had the opportunity to be heard¹.

It must be acknowledged that even as an 'insider' there are challenges relating to outsider positionality that relate to gender, generational issues, ethnicity and sexuality. The researcher is an cisgendered heterosexual male of European descent. Much of this information can be ascertained by both youth participants and stakeholders visually upon meeting the lead researcher, or through the interconnected nature of the setting.

Efforts was made to ensure that any gender or sexuality diverse participants were aware of the allyship of the lead researcher through subtle but visible displays of LGBTI friendly badges and stickers on the researchers equipment and bags. It is noted by the lead researcher that this allyship can not replace lived experience and understanding. No data was collected on gender or sexual diversity of participants to minimise the likelihood of participants who were not “out” being exposed to the community.

In terms of generational issues, the lead researcher was able, as an “Elder Millennial” to negotiate a “least adult” identity^{130, 131} when working with youth participants. In establishing a least-adult identity, the lead researcher consciously adapted language, clothing and style to suit participants. The lead researcher did not wish to be seen as an authority figure, but also not lose the cache of being a researcher working on a project that required considered responses and engagement from participants. In contrast, when working with stakeholders, the lead researcher would highlight their background in health (acute nursing) and present in a more formalised manner in terms of appearance, language and style to ensure participants were confident in the integrity of the research.

Rural Implementation of Methodology

PAR was an effective methodology for engaging with this rural community and fostered a sense of collaboration and cooperation. It allowed for a two-way flow of information between researcher and participant that may not have been possible through other methodologies and allowed prolonged engagement from participants beyond interviews^{32, 107}. The connected nature of a small rural community also created opportunities for interaction between participants which was beyond the scope of the study and this impacted positively on practice and organisational policy. Effort was always made to ensure dependability of the project findings by following a systematic research process and maintaining an audit trail¹⁰⁷, but there were occasions that the “*messy nature*”^{128 (p 855)} of PAR created challenges in completing the development of the RuSHY Framework and engaging with collaboration with stakeholders.

Through this study it was confirmed that rural stakeholders are willing to engage with Delphi studies to provide feedback and that Delphi studies can be effectively utilised within a PAR project to gather feedback from participants. Participation and response

rates within the two embedded Delphi studies were acceptable and represented considerable engagement from stakeholders who do not necessarily engage in sexual health as a work role priority. There was no incentive, monetary or otherwise, offered to participants in either Delphi study, beyond being involved in a study that aimed to improve sexual health provision in the rural setting. The blurring of lines between expert, participant and researcher ¹⁰⁷ within PAR methodology encourages the utilisation of Delphi technique methodology by re-engaging and empowering the local stakeholders as subject area experts qualified to give feedback and analysis on the developed Framework. Re-engagement and recognition of the localised expertise of stakeholders involved in rural sexual health highlights the development of emancipatory knowledge interest within the project ¹⁰⁷. This re-engagement also provides the opportunity to increase the credibility of the research through prolonged engagement, member checking and triangulation ¹¹¹. This reflective process for the stakeholders assured process validity and trustworthiness of the RuSHY Framework ^{107, 108}.

The second Delphi process (outlined in Chapter 11) provided the opportunity to re-examine and evaluate the draft Framework, and to evaluate the effectiveness of the Delphi process with rural stakeholders from outside the insider-researcher setting. The high level of engagement with the first, localised Delphi study can be explained by a combination of the insider-research phenomena and prior engagement with the earlier phase of the study; however, the second Australia-wide Delphi study was successful in recruiting independent participants that had no prior professional or personal connection to the research team.

The Delphi method appeared to be acceptable to respondents as a process of gaining consensus on the Framework and represents a pragmatic option for engaging with multiple, geographically dispersed rural-based participants. It also provided the opportunity for stakeholders to critique certain elements of the developed Framework from their perspective. This triangulation allowed the Framework to be evaluated by experts in rural sexual health provision from other settings that were not involved in the development process; these participants had a sound understanding of the challenges that rural-based providers faced. The Delphi feedback of the developed Framework in this final stage of the PAR process reinforced the findings from earlier participatory phases,

enhancing the trans-contextual validity of the Framework while also providing a measure of the dependability of both the Delphi process and the PAR methodology used to develop the Framework ¹¹¹.

Limitations

The limitations of this study should be considered when reviewing the findings and the developed Framework. The study experienced limitations from methodological, contextual and personal levels. In designing this study, the lead researcher found a lack of published research guidance on how to conduct PAR research within the rural setting. The literature relating to PAR in the rural area described several methodological styles but there was a lack of consistency in how to manage the process, particularly as an insider-researcher ¹²⁴⁻¹²⁷. Effort was made to review literature and discuss the research design with supervisors and community stakeholders to determine the most appropriate research method for the community and to achieve the research aims. Embedding the Delphi study within the PAR study was considered to be a way of further strengthening the participatory nature of this research in refining the Framework by providing another opportunity for participants to be involved in the study. There were few examples within the literature of embedding Delphi technique within PAR studies and a lack of consistency in using the Delphi technique in terms of sample population, size and consensus measures ³⁸⁻⁴¹.

The cultural diversity of participants and stakeholders was limited, which can be attributed in some part to the setting, but the background of the lead researcher cannot be discounted. Care must be taken when considering the transferability of this research to settings with larger Aboriginal and Torres Strait Islander and/or Culturally and Linguistically Diverse communities and further research in rural settings should consider how to ensure cultural security, representation and connection. Services working with those key population groups may already have appropriate, effective and efficient multipurpose service delivery models that address youth sexual health in the rural setting but may still find components of the RuSHY Framework useful and insightful.

As an insider researcher, there is potential that bias and localised relationships may impact on selection bias of participants ^{1, 132, 133}. Managing bias as an insider-researcher

is described in more detail earlier in the published paper included in Chapter 7 ¹. Considerable effort was made to limit the personal bias of the researcher within the setting towards the selection of participants, the questioning techniques employed and the analysis of transcripts. The lead researcher developed a list of potential stakeholders in conjunction with his supervisory team, but also requested peer referral from participants to ensure that recruitment was not limited to personal and professional connections. The research team also purposefully approached stakeholders within the setting with a diverse range of views, including advocates and leaders in sexual health provision within the setting, and stakeholders that had either been vocally against supporting sexual health interventions, ambivalent towards engaging with youth sexual health at all or were conservative in their delivery of interventions approach. While not all of these stakeholders chose to participate, several did give their time to the project. In one case, a stakeholder had expressed no interest in dealing with sexual health within their setting in the past and had a limited evidence-based knowledge on best practice sexual health service provision. This individual became one of the more engaged participants in the study and implemented several subtle changes within the setting to provide sexual health knowledge and support for LGBTI youth and suggested several strategies that became part of the developed Framework. Engaging with stakeholders that were not the 'obvious' candidates in terms of youth sexual health provision was an effective and important component of this project with many beneficial outcomes: minimising selection bias; collecting diverse perspectives and solutions within the data; and providing these stakeholders with the opportunity to ask questions, participate and engage with the topic ¹.

There were also moments that being able to physically escape the setting became important to the lead researcher in terms of managing the research environment and his wellbeing. For example, the ability to avoid questions from study participants about the research process when meeting in the locality, including questions about who else had participated, or to complain about the lack of action from another stakeholder; was important in terms of sustainability of the project. These moments to escape the insider-research position within rural PAR should have been more structured, more productive and more efficient, but represented an important break from good-willed pressure from

participants and stakeholders.

One way of managing participants within this study has been via feedback. The lead researcher relied on email, phone and personal contact with participants to provide member-checking opportunities, research updates, publication or conference presentation updates or to provide follow-up resources. Upon reflection, a more formalised process via a newsletter or blog may have been a more structured method of maintaining connection and providing updates; but this would have also required more time and resources. There is a gap within this study and a recommendation of the Framework for sustained communication between stakeholders beyond the PAR study; which may represent a good continuation point for those stakeholders still engaged.

In a personal capacity, several limitations must be acknowledged for their impacts on the development and progression of this project. This particularly relates to time constraints and researcher capacity. While presenting as a resource person to participants was important¹¹¹, the “pull” of stakeholder and participant needs was at times a time management issue for the lead researcher. This “pull” was characterised as some stakeholders wanting to engage the researcher in tasks and interventions that no longer related to the original project. In these instances, some stakeholders began to see the researcher as an antagonist or driver for initiating change with other youth and health related issues and there was an expectation to become involved in some way. While being accessible is an important part of being a good PAR facilitator, the social proximity of the rural network often led to the researcher being “too accessible”. Balancing the desire to remain useful to the original group of stakeholders and participants while remaining appropriately engaged with the original research process and avoiding becoming involved in unrelated projects was a balancing act at times for the researcher. Some instances involved becoming partly involved as a referral agent or early advisor to direct stakeholders more appropriately; while other instances required a more stringent refusal due to lack of time.

Additionally, a lack of resource funding played a role in the slow development of the Framework, with this project being undertaken without a formal scholarship, and the lead researcher reliant on part-time employment to continue with the research. Given the

heavy involvement of researchers in PAR projects¹²⁸, this placed considerable burden on the project and led to a delay in publication and some stakeholders feedback processes that may have negatively impacted on participant action and understanding within the setting. A more responsive and completely immersed process may have led to the Framework being more quickly developed or for the participants to have developed an even richer understanding of both the necessity for sexual health interventions and the PAR process.

This time constraint may have also played a part in the attempted development and eventual abandonment of the photovoice component of this project with youth participants. While the depth and quality of the data collected was sufficient to inform the development of this Framework, the photovoice component would have provided further triangulation of data and further participation opportunities for youth participants. The lead researcher did ask all youth participants about further involvement in the study via the photovoice project, but had only two expressions of interest from within this group of participants. The remainder were not willing to be involved in the photovoice project citing a range of reasons including not having enough time to engage; a lack of incentives and a lack of interest in the method of engagement. Effort was made to peer recruit but there was a lack of further recruitment. Given the lack of interest from participants, the time and financial constraints of the project and the participatory nature of this project; photovoice was not seen as viable to continue pursuing.

Concluding remarks

Moving forward, it is important to acknowledge there are limitations in what can be achieved in rural communities towards sexual health provision in terms of funding and sustainability. Youth sexual health in small rural communities is currently “nobody’s priority”³⁷. This is a direct reflection on the policy, funding and research focus. There can be no argument against the need to fund programs that address the epidemic rates of STIs in Northern Australian communities¹³⁴; or the importance of preventive health approaches with men who have sex with men (MSM) and CALD communities^{15, 135}. The needs of rural youth must also be addressed. Despite being a priority population in the *Fourth National Sexually Transmissible Infections Strategy 2018–2022*¹⁵, there is a lack of effective focus or funding on how to respond to key issues for rural youth, such

as how to: bring STI screening rates towards recommended targets; provide rural based teachers with appropriate professional development; provide evidence-based RSE with skills and knowledge; or to connect rural stakeholders effectively to ensure that the gaps are covered and that rural young people are receiving the basic level of sexual health provision they deserve.

In planning this PAR project, there was a desire initially to create a complex and integrated intervention program able to transect the rural community in an effort to meet the needs of the young people in the town. While this would be a worthwhile intervention project, it was reliant on the personal skills of the lead-researcher, as insider within the community with both a clinical and health promotion background and an extensive personal and professional network. An intervention project of this type would have provided an opportunity to evaluate the effectiveness of providing multiple interventions to young people within the setting, but it would not have contributed to addressing the long-term sustainability of sexual health provision given many interventions would be required to address all needs. The interventions would have ceased at the end of the project, reliant on a central local figure, willing to champion the initiative. This is the case for many rural towns, and the service provision settings that lie within them. For example, sporting clubs that rely on a dedicated volunteer fail when the person moves on¹⁰⁴. Health services that have solid outcomes due to one or two clinical leaders –lose capacity to deliver services once these leaders eventually retire or move to the next town¹³⁶. School teachers that provide exceptional RSE or life guidance, but do it by ‘flying it all under the radar’ rather than challenging organisational or societal norms³⁷.

Individuals or groups of individuals can affect change on a personal or interpersonal level for the greater good of the community but cannot make effective long-term changes at other socio-ecological layers¹²¹ without time, energy, funding and mandate. Rather than develop an intervention style project in the lead researcher’s town –heavily reliant on their ability to pull the aspects of the project together and limited in transcontextual validity– it was decided it was more important to take a step back away from the ‘coal-face’ and examine what was lacking within the setting. Following a thorough re-examination of the range of potential interventions suggested to be

implemented within the setting, it became apparent that these interventions, settings and stakeholders were clear to those with insider-knowledge – not from reviews of the literature or previous evaluations. There was no clear guidance within the literature on how to engage a rural community. The knowledge on how and where to implement interventions was reliant on personal understanding and personal anecdote, not comprehensive evidence. Addressing this gap led to this PAR project and the goal of developing a framework to supply evidence, guidance and a research base for others to work from into the future. The developed Framework and the evidence generated during its development does not address the lack of funding for the rural setting or ensure long-term sustainability for others supplying sexual health interventions in the community; but it does provide stakeholders wanting to take action within their setting with practical evidence to work from.

Sexual health provision within the rural setting needs a champion. This champion may come from outside of traditional settings such as health, education and youth work. In a setting where “accidental experts” are the providers called upon to drive sexual health interventions within the community, having a local champion assists in maintaining momentum and in many respects, keeping everyone on task. This project worked with many “accidental experts”, who worked hard to meet the sexual health needs of young people within the community³⁷. While accidental experts do their best amongst a lack of prioritisation, training and funding it cannot be forgotten that traditional service providers are required to provide the basic level of sexual health service provision expected for young people within their town. Effort must be made to find solutions to the well-known barriers to access; because while there has been a dearth of evidence on effective processes to address these barriers, the barriers themselves are well documented within the literature^{3, 7, 137-140}. This Framework does not provide all the answers on how to address these barriers – but it does provide stages and a Framework for how to address the task. Young people must have access to appropriate and well-resourced RSE, GP services and condoms, and services working with young people should be doing all that is feasible within the constraints of the setting and funding to work together in delivering these.

Primary health care providers must make efforts to engage with local schools and school

nurses, to bridge the gap between education and health and ensure that there is consistency in messaging. Connections between youth services, health and education must be created within communities to ensure that sexual health interventions are not provided in an ad hoc style that lacks structure, and fails to follow existing framework or evaluation processes¹⁴¹. Effective programs that work in non-traditional settings such as sporting clubs or youth groups do not excuse traditional stakeholders from the responsibility of delivering their expected services. These traditional stakeholders do not need to be the local champions for sexual health – but they must be engaged and be willing to do some of the less favourable tasks in sexual health provision; such as localised advocacy. A local champion can drive action in the setting, and by utilising this RuSHY Framework, do so in a coordinated and effective manner. However, the most appropriate stakeholders within the rural setting to be central to improving sexual health provision in the rural area, the stakeholders with the greatest levels of professional respect and social cache, are the traditional stakeholders such as GPs and primary health care professionals, youth services workers, teachers and school nurses. Without their engagement, non-traditional stakeholders lack the levels of respect and authority to stand up to criticism or backlash when the community is challenged to provide appropriate RSE and condom access.

This research aimed to give rural stakeholders and rural youth a voice while engaging them to find a local solution of public interest. Through collaboration, stakeholders and the researchers were able to gather evidence that had contributed to the rural sexual health literature and provided a framework for future rural practice. Within the scope of this PAR study, the RuSHY Framework has undergone stakeholder evaluation for its credibility and transferability in the rural setting¹¹¹ to ensure dialogic and outcome validity¹⁰⁷ and integrity¹¹⁹. The RuSHY Framework produced by this PAR study is the product of consolidated and triangulated data gathered from an iterative collaborative process. While its transcontextual validity to other rural areas is yet to be fully confirmed, it represents a working document that is appropriate for immediate utilisation and application in the rural sexual health setting, particularly within the community of its development.

This RuSHY Framework which was created through the actions of this study's

participants now requires further action to implement its findings both within the community in which it was created and beyond. Rural stakeholders have lacked guidance and direction when implementing and evaluating sexual health interventions within their setting; and this Framework document provides evidence-based direction on the key areas for sexual health provision and guidelines for implementation. Rural stakeholders must take action and ensure that the young people within their community are being provided with the minimum level of sexual health services and RSE that they require. The obligation to provide equitable sexual health service provision must be addressed and this Framework provides structural guidance on how to attempt this in an environment of minimal funding and a lack of policy direction.

Fear and stigma remain key issues for rural stakeholders involved in sexual health³⁷ leading to conservative delivery of services and education rather than an effort to follow the evidence and challenge rural communities to evolve. The emphasis on avoiding backlash rather than advocating for understanding is a significant threat in the long-term sustainability of any sexual health intervention within the rural setting. Rural stakeholders can continue to “fly under the radar”, or they can implement this RuSHY Framework and proactively advocate for the sexual health needs of rural youth. The barriers to sexual health provision in the rural area, particularly around stigma and embarrassment will not be addressed without effectively focussing on the organisational and societal socio-ecological levels and attempting to reshape cultural norms and community expectations.

Chapter 14: Recommendations

The overall aim of this study was to use a participatory action research (PAR) methodology to develop and validate a framework for planning, implementing and evaluating community-based youth sexual health interventions in the rural setting. In achieving this aim, several recommendations for practice and future research have been identified.

Recommendations relating directly to the RuSHY Framework:

The RuSHY Framework represents a practical document that has been evaluated for potential usefulness and transcontextual validity by rural-based stakeholders.

1. In its current form, it is recommended the RuSHY Framework be immediately implemented within the current setting.
2. Implementation of the RuSHY Framework should be observed and evaluated for its effectiveness and potential long-term sustainability.
3. The RuSHY Framework is recommended for immediate testing and utilisation within other rural settings. While its trans-contextual validity is yet to be fully confirmed communities should acknowledge and evaluate setting specific considerations relating to population demographics, service provision and local policy.
4. The RuSHY Framework was developed for sexual health, however, could be adapted for other areas of youth health. Given the synergies with interventions that target mental health, sexual health and alcohol and other drugs; communities could utilise the RuSHY Framework to guide the better planning, implementation and evaluation of community-based interventions that target

other health areas.

5. Traditional stakeholders such as General practitioners (GPs), health service, youth services, school nurses and teachers must be active and engaged in their support of non-traditional stakeholders to ensure youth sexual health needs are comprehensively addressed within their specific community.
6. The RuSHY Framework should be disseminated broadly to allow rural communities the opportunity to utilise it in its current form. Use of open access and non-scholarly platforms such as web-page, social media and/or practice networks for dissemination should be considered to increase accessibility to the Framework.

Recommendations for policy

The RuSHY Framework provides an advocacy platform with a clear vision for improving rural sexual health outcomes.

7. Rural sexual health provision requires a multi-pronged approach with broadened responsibility and the need for strategic change can only be achieved through ensuring sexual health promotion and RSE provision is supported through adequate resourcing.
8. Ensure a suitable funding envelope alongside policy support for health promotion research that focusses on how to further reduce the burden of STIs, the improved provision of RSE in the rural area and how to increase collaboration in areas that lack specialist services.
9. There is a requirement for clear policy guidance on the provision of RSE

education in schools. There is currently a lack of uniformity in what is being taught within Australian schools and the provision of clearer policy support will provide administrators and teachers greater guidance.

Recommendations relating to practice

The RuSHY Framework provides structural guidance on the facilitation of the coordination and delivery of services and education within an environment of minimal funding and a lack of clear policy direction to the grass-roots workforce.

10. Rural stakeholders must confirm the threats, opportunities, weaknesses and needs of young people within their setting and consider the setting specific context that they are operating in. This initial assessment will inform planning and implementation of interventions and reduce the likelihood that interventions will be either ad hoc or not appropriate for the youth they target.

11. Rural stakeholders must be active within their community and ensuring young people are being provided with the minimum level of sexual health services and RSE required. Equitable sexual health service provision is reliant on the actions of the community and its stakeholders.

12. While there is a lack of prioritisation within the rural setting, there will be a lack of action towards the *Fourth National Sexually Transmissible Infections Strategy 2018 – 2022*¹⁵. Prioritisation is reliant on policy level support and funding. Rural based Local Government Agencies should explore how implementation of the Framework could be supported by Community Development or Health Promotion Officers. Within Western Australia, this could be supported through acknowledgement and implementation strategies of the RuSHY framework with Local Government Public Health Plans in line with the *Public Health Act 2016*; or in other jurisdictions through utilisation of community development

departmental funding. While this RuSHY Framework has been developed with minimal funding in mind, the supporting implementation through administrative or collaborative support from local government would reduce the administrative burden on intervention focused stakeholders and facilitate greater engagement and collaboration.

13. There is a need for greater funding in the rural area to support areas that lack specialist rural sexual health services. Achieving the key action areas that address youth from the *Fourth National Sexually Transmissible Infections Strategy 2018 – 2022*¹⁵ will not be possible without appropriate funding to activate the strategy.
14. Rural stakeholders cannot continue to “*fly under the radar*” and deliver sexual health services and RSE in a covert manner³⁷. Through avoiding backlash or embarrassment, stakeholders are also avoiding the responsibility of making change at organisational and community levels. Rural stakeholders can utilise the RuSHY Framework to proactively advocate locally for the sexual health needs of rural youth. There is a need for rural stakeholders to advocate on behalf of young people to ensure that their needs are being met for services and education that are at times embarrassing or stigmatised.
15. Rural stakeholders must be appropriately trained to deliver RSE, sexual health testing and to provide information and youth-friendly interactions. Within the scope of this research, stakeholders and young people agreed that consistent and credible RSE and information was important in delivering youth sexual health interventions. Extending this training beyond core personnel is important in ensuring consistency and credibility. For example, school administrators should ensure that not just the Health and Physical Education teacher receives training – but training is extended to teachers that may provide RSE or act as a service referral point; and administrative and support staff that may be the first point of

contact for young people.

16. Rural health services need to connect with young people, with other stakeholders and explore collaborations and outreach to improve service accessibility. Health services should examine how to focus on more than the individual and consider community level needs in service provision.
17. Rural communities need to provide condoms in a discreet and youth-friendly manner that minimises contact with adults and peers; allows anonymous access and reduces cost and gender barriers. Free condoms in appropriate locations, self-services areas, and condom vending machines should be explored with local young people to determine the most effective, appropriate and youth-friendly way to ensure access.
18. Non-traditional settings such as sporting clubs, youth groups, arts groups and clubs may be interested in supporting sexual health interventions and should be approached and supported by stakeholders. Communication and collaboration are important factors in the delivery of sexual health interventions in the rural area and a coordinated approach allows credible and consistent messaging on sexual health within the community and new opportunities for collaboration.

Recommendations for research

19. Further research be conducted from a rural insider-research positionality. This positionality has provided rural youth, rural stakeholders and rural researchers with a voice and the ability to shape practice, research and policy for the rural setting, from the rural setting. This ability to plan, conduct, analyse and publish research from not just a rural viewpoint, but a rural positionality reinforces that research does not need to be created and conducted from metropolitan areas, particularly research on and about the rural area.

20. Further research examining the suitability of Delphi study technique within rural-based research. The ability to provide anonymous feedback in a timely and responsive manner within this research was of great value to the overall project and it is suggested that Delphi methodology is appropriate for further use in the rural setting.

Appendices

A. Conference and seminar presentations

1. Heslop, C., Burns, S., & Lobo, R. (2019). Delphi study to evaluate a framework for rural sexual health provision. SexRurality, Victoria, August.
2. Heslop, C., Burns, S., & Lobo, R. (2019). Developing a framework for community-wide sexual health interventions in the rural setting. SexRurality, Victoria, August.
3. Heslop, C., Burns, S., & Lobo, R. (2019). Small towns need big thinking: Youth, condoms, communication and failed ideas. STI and BBV Quarterly Forum, WA Department of Health. 12 June.
4. Heslop, C. (2019). Participatory action research. Master of Public Health Students, Curtin University. 3rd May.
5. Heslop, C., Burns, S., & Lobo, R. (2019). Practice findings from a local PAR study on sexual health provision. WACHS Great Southern School Health Nurses. 14th May.
6. Heslop, C., Burns, S., & Lobo, R. (2019). Practice findings from a local PAR study on sexual health provision. Private Clinic General Practitioners, Denmark, WA. 5th May.
7. Heslop, C., Burns, S., & Lobo, R. Youth vs Stakeholders: Perception vs Reality in rural sexual health. SiREN Symposium, Perth, May.
8. Heslop, C., Burns, S., & Lobo, R. (2018) [Poster] Stakeholder identified barriers, opportunities and needs for youth sexual health in the rural setting. SiREN Symposium, Perth, May.
9. Heslop, C., Burns, S., & Lobo, R. (2017). Early Findings from A Participatory Action Research Study Developing A Framework for Community-Based Sexual Health Interventions For Youth In The Rural Setting. SexRurality, Victoria, August.
10. Heslop, C., Burns, S., & Lobo, R. (2017). [Poster] Developing a framework for

community-based sexual health interventions for youth in the rural setting:
protocol for a participatory action research study. *SexRurality*, Victoria, August.

11. Heslop, C., Burns, S., & Lobo, R. (2016). Developing a framework for community-based sexual health interventions for youth in the rural setting. SiREN Symposium, Perth, June.

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1. Heslop, C. W., S. Burns, R. Lobo and R. McConigley (2017). "Developing a framework for community-based sexual health interventions for youth in the rural setting: protocol for a participatory action research study." *BMJ Open* 7(5).

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2. Heslop, C. W., S. Burns and R. Lobo (2018). "Managing qualitative research as insider-research in small rural communities." *Rural and Remote Health* 18.

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3. Heslop, C. W., S. Burns and R. Lobo (2019). "‘Everyone knows everyone’: youth perceptions of relationships and sexuality education, condom access and health services in a rural town." *Sex Education*: 1-17.

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4. Heslop, C. W., S. Burns and R. Lobo (2019). "Stakeholder perceptions of relationships and sexuality education, backlash and health services in a rural town." *Sex Education*: 1-16.

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C. Data extraction table

Data Extraction Table: A review of sexual health interventions and initiatives that target young people aged 16 to 24 years living in rural Australia.

Abbreviations: HSP: Health service providers; YP: Young people; GP: General Practitioners; PN: Practice nurses; LGA: Local Government Areas; RSE: Relationships and sexuality education; WA: Western Australia; NT: Northern Territory; QLD: Queensland; VIC: Victoria; NSW: New South Wales; TAS: Tasmania; FG: Focus Groups

Study	Study design;	Study Setting;	Participant characteristics;	Sampling approach	Alms of study;	Findings	Rural/Regional/ Mix; State;
Johnston, Harvey et al. (2015)	Data collection mode Descriptive cross-sectional; Semi-structured interviews (HSP) & Surveys (YP); Face-to-face (HSP) & peer facilitated electronic (YP)	Four towns; HSP (n=32) & YP (n=391);	Convenience Four Towns; YP (n=391);	Convenience	Describe HSP views on access issues for YP and compare with YP views; Identification of key barriers (financial, social, structural)	Rural & Regional; QLD;	
Match, Harvey et al. (2015)	Face-to-face (HSP) & peer facilitated electronic (YP) Descriptive cross-sectional; Survey & reference group discussions; Electronic (Survey) & face to face (FG)	Convenience Four Towns; YP (n=391);	YP (n=391);	Convenience	Investigate access to sexual services can be improved for YP; Identification of potential solutions to improving access	Rural & Regional; QLD;	
Gamage, Fuller et al. (2011)	Descriptive evaluation; Program review;	Cross-sectional Community;	Program evaluation;	Community;	Evaluation of effectiveness of advertising methods for testing services; Advertising better/ focused on referrals from other health services	Rural; VIC	
Garrett, Kirkman et al. (2012)	N/A Evaluative Mixed methods; Survey (n=18) & interviews (n=4); Electronic (survey) & Webcam (interview)	N/A Community; Youth Web-cam tele-service clients (n=18);	Program review;	Community;	Evaluation of webcam service; Failure to involve target audience in design impacted on YP's use of service	Rural; VIC	
Tomnay and Hatch (2013)	Evaluation; Program review;	Purposeful Local government areas; 3 LGAs;	Evaluation;	Local government areas; 3 LGAs;	Evaluation of installed condom vending machines for suitability and cost-effectiveness; Machines were accessible, cost-effective and not generating complaints	Rural; VIC	
Hegarty, Parker et al. (2013)	N/A Investigative Mixed methods; Interviews & costing study; Face to face (interviews)	Review GP Clinics; PNs, GPs and administrative staff (n=15);	Evaluation;	Review GP Clinics; PNs, GPs and administrative staff (n=15);	Investigate feasibility, acceptability and costs of nurse-led youth clinics; Clinics poorly attended, lacked support, and impacted on by limited project time frame	Rural & Regional; VIC	
Stanzel (2016)	Case study review; Program report evaluation & client surveys Surveys (written)	Purposeful Secondary school; Retrospective report (review plus client feedback (n=13));	Evaluation;	Purposeful Secondary school; Retrospective report (review plus client feedback (n=13));	Evaluation of clinic service provisions; Clinic well utilised but lacks collaboration	Rural; VIC	
Hulme-Chambers, Tomnay et al. (2017)	Mixed-method study; FG;	Convenience Community;	Mixed-method study; FG;	Convenience Community;	Investigation of what is needed to support sexual health from regional stakeholder perspective;	Rural; VIC	

	Face to face	Health, education and welfare stakeholders (n=37)	Sexuality education in schools could be improved through clearer government policy direction, support from school leaders and resources.	Rural:
Turner, Spencer et al. (2017)	Descriptive Mixed-methods; Questionnaire;	Purposive Secondary school: Students aged 16-19 (n=155);	Investigate student views and preferences; A greater focus on adolescent health and communication skills might better prepare doctors	Rural: TAS
Carmody (2009) A	Electronic Qualitative interviews; Semi-structured interviews; Face-to-face	Convenience Community: YP aged 16-25 (n=56, n=35 rural); Convenience	Explore what young people wanted in sexuality and violence prevention education; Education needed to consider more than mechanics, and include provision to learn skills around consent, safe sex, addressing conflicting desires and expectations in intimate relationships	Rural & Urban; NSW
Carmody (2009) B	Descriptive quasi-experimental; Pre- and post-test surveys; Written (pre-test) and online (post-test)	Education program; YP aged 16-25 (n=47, n=29 rural); Purposive	Assess the impact of a six-week educational program based on sexual ethics on the participant's sex lives; Participants reported feeling positive about the program, highlighting negotiation skills, awareness of others needs and greater knowledge and skills	Rural & Urban; NSW
Dyson (2010)	Qualitative focus groups; Semi-structured FG;	Secondary school community; Parents (n=16 rural parents); Convenience	Describe parental attitudes towards RSE in schools; Parents have diverse views on what is desired in school-based RSE	Rural & Urban; WA
Helmer, Senior et al. (2015)	Face-to-face Qualitative focus groups and interviews; Group discussions, interviews & interactive body mapping; Face-to-face	Secondary school and wider community; YP aged 16-25 (n=171, n=107 rural/remotely); Convenience	Explore YP understandings of relationships, sexual debut, pregnancy, domestic violence and STIs	Rural, Remote & Urban; NT, WA, SA
Senior, Helmer et al. (2014)	Qualitative focus groups and interviews; Group discussions, interviews & interactive body mapping; Face-to-face	Convenience Secondary school and wider community; YP aged 16-25 (n=171, n=107 rural/remotely); Convenience	Explore how young people made decisions about potential sexual partners and STI understanding;	Rural, Remote & Urban; NT, WA, SA
Barbagallo and Boon (2012)	Descriptive Mixed-methods; Survey; Online	Four communities; YP aged 18-21 (n=110, n=95 rural/regional); Convenience	Describe recollection and usefulness of RSE; Effectiveness of RSE varied greatly school to school	Rural & Regional; QLD
Connor, Edvardsson et al. (2018)	Qualitative interviews; Semi-structured interviews;	Health services; HSP & educators (n=8); Purposive	Examine HSP perspectives of male YP role in pregnancy prevention programs in rural VIC; HSP did not consider young males to be of importance in the prevention of adolescent pregnancy	Rural; VIC
Hulme-Chambers, Tomnay et al. (2018)	Face-to-face Summative evaluation; FG (n=5) & interviews (n=13); Face-to-face	Participants, stakeholders, program partners (n=32); Rural community;	Evaluation of the Smart and Deadly initiative; Co-design and further collaboration keys in programs are more likely to be acceptable to the Aboriginal community	Rural; VIC

Author(s) (Year)	Methodology	Purpose	Findings	Location
Mac Phail, Dune et al. (2017)	Cross-sectional mixed-methods: Survey: Online	Regional university: YP aged 18-31 (n=956); Cross-sectional/Convenience	Examine YP sexual behaviours and attitudes and measure exposure to the intervention; YP had limited exposure to the intervention. YP wanted additional assistance remembering when to screen for STIs and with overcoming barriers to GP access.	Regional; NSW
Kong, Hocking et al. (2009)	Descriptive Cross-sectional: Survey and urine sample testing:	Rural sporting clubs: YP aged 16-25 (n=209); Convenience	Examine Chlamydia prevalence in test population and test feasibility of STI testing in sporting clubs; Participation rate was over 95%, chlamydia prevalence in those sexually active was 5.1%.	Rural; VIC
Kong, Hocking et al. (2010)	Face-to-face Descriptive Cross-sectional: Survey and urine sample testing:	Rural sporting clubs: YP aged 16-25 (n=209); Convenience	Examine decision making around sexual activity and alcohol use; High risk sexual behaviour common, STI knowledge was generally poor and only 25% used a condom the last time they had sex.	Rural; VIC
Tomnay, Bourke et al. (2014)	Face-to-face Qualitative focus groups:	Rural sporting clubs: YP aged 16-25 (n=20); Convenience	Exploring the acceptability of online STI testing; Three main themes: (i) readiness to seek sexual health services; (ii) barriers and facilitators to using the local GP; and (iii) barriers and facilitators to online testing	Rural; VIC
Yeung, Temple-Smith et al. (2014)	Face-to-face Comparative cross-sectional: Survey and urine sample testing: Face-to-face	Primary care services: YP 16-29 (n=284); Convenience	Examine Chlamydia prevalence in test population; Chlamydia prevalence is similar in young men and women attending general practice. Testing only those with genital symptoms or a partner with an STI would have missed three-quarters of cases.	Rural & Regional; AUSTRALIA WIDE

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D. Youth focus group materials

Information sheet

Study Title:



Developing a framework for community-wide sexual health interventions in the rural setting: a participatory action research project.

Research Team:

Mr Carl Heslop, PhD student, Curtin University School of Public Health
Dr Roanna Lobo, Research Fellow, Curtin University School of Public Health
Associate Professor Sharyn Burns, Director of Health Promotion and Sexology, School of Public Health
Dr Ruth McConigley, Senior Lecturer, Curtin University School of Nursing and Midwifery

About this project:

This is a supervised doctoral research project and the results of this research project will be used by Carl Heslop to obtain a Doctor of Philosophy at Curtin University. This project is funded by Curtin University.

Aims of the project:

The aim of this project is to understand what issues, opportunities and barriers in sexual health service provision exist for young people living in rural Western Australia. This study will be used to inform and better coordinate existing and potential programs. We would like to know what you think would improve services in your town.

What will I have to do?

Our team would like to talk to you about your views about sexual health provision in country towns for young people. You will not be asked to provide personal details of your sexual activity. Any answers you give should be of a general nature, rather than personal stories. You may also be asked to nominate other people who would be interested in participating.

If you agree to participate in the study you will need to sign a consent form if you are interviewed. The interview or discussion will be audio-recorded, transcribed and the information you provide will be analysed. The interview or focus group discussion will take approximately 45-90 minutes to complete. The results of the study will be used to write a report and will be published in national or international professional journals.

All information that you provide will remain anonymous and is only seen by the research team. Any published works will not contain any details that could identify you. You are free to decide whether or not you want to participate in this study. If at any time you wish to withdraw you are free to do so.

as confidential and used only in this project unless otherwise specified. The following people will have access to the information we collect in this research: the research team and the Curtin University Ethics Committee

Will you tell me the results of the research?

You will not be contacted individually with results of the study. Study results will be reported in professional journals. Announcements and updates on publications will be made via community newspapers and community or professional groups who were involved in the study.

Do I have to take part in the research project?

Taking part in a research project is voluntary. It is your choice to take part or not. You do not have to agree if you do not want to. If you decide to take part and then change your mind, that is okay, you can withdraw from the project. You do not have to give us a reason; just tell us that you want to stop. Please let us know you want to stop so we can make sure you are aware of any thing that needs to be done so you can withdraw safely. If you chose not to take part or start and then stop the study, it will not affect your relationship with the University, staff or colleagues. If you chose to leave the study we will use any information collected unless you tell us not to.

What happens next and who can I contact about the research?

If you have questions about the study at any time you can contact Associate Professor Sharyn Burns on 08 9266 4123 or S.Burns@curtin.edu.au.

If you decide to take part in this research we will ask you to sign the consent form. By signing it is telling us that you understand what you have read and what has been discussed. Signing the consent indicates that you agree to be in the research project and have your health information used as described. Please take your time and ask any questions you have before you decide what to do. You will be given a copy of this information and the consent form to keep.

What if I need more information?

If you have questions about the study at any time you can contact Associate Professor Sharyn Burns on 08 9266 4123 or S.Burns@curtin.edu.au.

Concerns or complaints?

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number 96/2015). All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this research project have been approved by the Curtin University HREC. This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007). If you have any concerns and/or complaints about the project, the way it is being conducted or your rights as a research participant, and would like to speak to someone independent of the project, please contact: The Curtin University Ethics Committee by

telephoning 9266 2784 or by emailing hrec@curtin.edu.au.

Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

Consent form

Consent form Interview/Focus Group



CONSENT FORM FOR PARTICIPANTS

Study title: Developing a framework for community-wide sexual health interventions in the rural setting: a participatory action research project.

I have been given clear, written information about this research project and have been given time to consider whether or not I wish to take part.

I understand this is a supervised doctoral research project and the results of this research project will be used by **Carl Heslop** to obtain a **Doctor of Philosophy at Curtin University**.

I understand and accept the nature of the project, which has been explained to my satisfaction. I understand that my interview or focus group discussion will be audio-taped and transcribed.

I know that my participation in this project is strictly voluntary. I know that I have the right to withdraw at any time.

If I have any questions about the project or about being a participant, I can contact **Associate Professor Sharyn Burns** on 08 9266 4123 or S.Burns@curtin.edu.au.

I understand that this project has been approved by Curtin University Human Research Ethics Committee (HREC number: HR96/2015) and will be carried out in line with the National Statement on Ethical Conduct in Human Research (2007) – updated March 2014.

I know that I can contact the Research Ethics Officer at Curtin University on (08)9266 2784 if I wish to discuss any aspects of the program on a confidential basis.

I agree to participate in this project.

I have been assured that my identity will not be revealed while the program is being conducted or when the program is published – however **I understand and acknowledge this research is taking place in a highly connected small rural town and others may be aware I am participating.**

.....
Participant's Name

.....
Participant's Signature

.....
Parent's Name

.....
Parent's Signature

I have supplied an Information Letter and Consent Form to the participant who has signed above, and believe that they understand the purpose, extent and possible risks of their involvement in this project.

.....
Researcher's Name

.....
Researcher's Signature

Date: _____

Please keep a copy of this form for your records

Consent evaluation form and flowchart

Step	Procedure
1.	<p>Prior to an interview each adolescent participant will be:</p> <ul style="list-style-type: none"> i. informed verbally and in writing about the study purpose and procedures, expected outcomes, potential risks if any, anticipated benefits to the adolescent or to others, stating explicitly that participation is voluntary, and how to contact the investigator after participating in the study ii. assessed on their understanding of the information provided and consequent decision-making to determine cognitive maturity levels and eligibility iii. asked to provide active informed consent by completing a consent form stipulating that their participation is voluntary, they have the right to withdraw from the study at any time, and that confidentiality and anonymity will be maintained.
2.	<p>The research student will only obtain participant consent if they are completely satisfied that, based on the information provided, the individual is able to:</p> <ul style="list-style-type: none"> i. retain an understanding ii. appreciate its importance iii. see how it applies to them iv. weigh the issues in the balance v. arrive at a decision.
3.	<p>If a young person is unable to make an autonomous decision about research participation, it will be assumed they are not eligible to participate and informed in an appropriate manner.</p>
4.	<p>The research student will ensure that participants are free from pressure, panic, pain and other 'temporary factors' that could impair judgment.</p>
5.	<p>All interviews will be conducted at locations chosen with particular care for participants' privacy and safety.</p>
6.	<p>In the event that a participant experiences distress during an interview or focus group, the session will be ceased and participants will be encouraged to seek confidential assistance following their participation if the study raises issues that create the need for further information or support.</p>
7.	<p>All interviews will be conducted by the research student. A standard protocol will be used and will include participant eligibility, ethical consent, interview administration, use of the computers, adverse response protocol and confidentiality procedures.</p>

Adapted from Arora, A., S. Rajagopalan, N. Shafiq, P. Pandhi, A. Bhalla, D. P. Dhibar, and S. Malhotra. 2011. Development of tool for the assessment of comprehension of informed consent form in healthy volunteers participating in first-in-human studies. *Contemporary Clinical Trials* 32 (6):814-817,

Katzman, D. K. 2003. Guidelines for adolescent health research. *The Journal of adolescent health :official publication of the Society for Adolescent Medicine* 33 (5): 410-415,

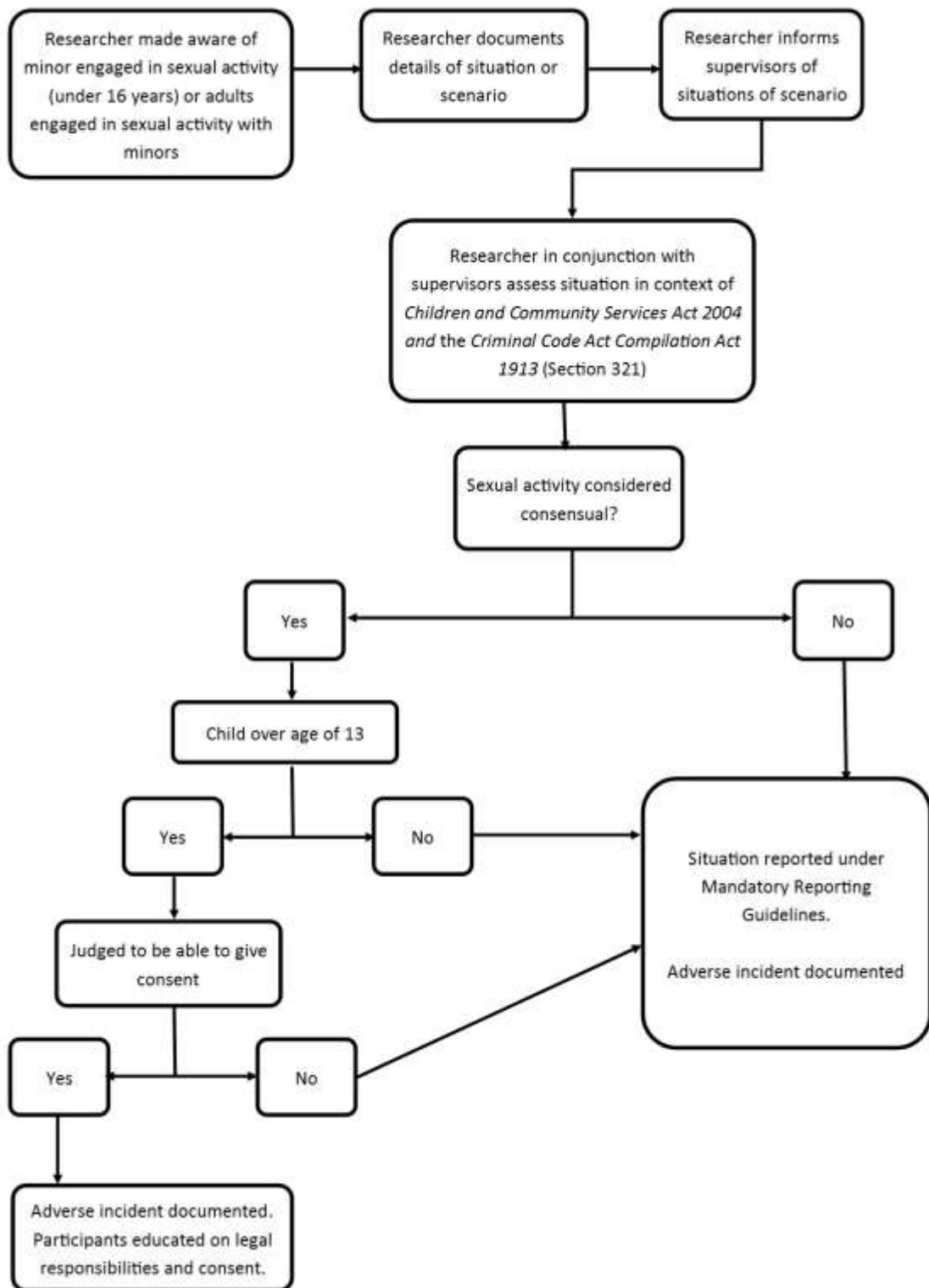
Rew, L., M. Taylor-Seehafer, and N. Thomas. 2000. Without Parental Consent: Conducting Research With Homeless Adolescents. *Journal for Specialists in Pediatric Nursing* 5 (3): 131-138, and

Shaw, M. 2001. Competence and consent to treatment in children and adolescents. *Advances in Psychiatric Treatment* 7 (2): 150-159.

MATURE MINOR STATUS CHECKLIST

Question	Acceptable Responses
<p>1. Based on what you just read and have been told what would you say is the purpose of the study?</p>	<ul style="list-style-type: none"> • Find out about what young people think/know about sexual health service: • Improve young people's health by better understanding what sexual health • Find out what barriers or opportunities exist for young people in accessing
<p>2. Based on this information what is your understanding of what you are being asked to do?</p>	<ul style="list-style-type: none"> • Participate in a focus group session or interview talking about sexual health • Participate in a community mapping exercise where I will be asked to draw
<p>3. Do you understand that it is entirely your own decision if you want to take part in this study and that you can withdraw at any stage if you wish?</p>	<ul style="list-style-type: none"> • Yes
<p>4. What is your understanding of what will be done with information we collect from you in the survey?</p>	<ul style="list-style-type: none"> • Information will be kept anonymous and confidential • No one will be able to see the responses apart from the project staff • No personal details will be recorded during the interview therefore it will not be recorded in it • Individual information will not be reported in any form, only grouped • Personal contact information will only be kept if I wish to be involved in subsequent interviews, Delphi study) • Only the person conducting the interview will have my personal contact details to this information
<p>5. What would you say about how much is time required from you to participate in the study?</p>	<ul style="list-style-type: none"> • 45 - 90 minutes once for the focus group/community mapping • 45 - 90 minutes once for any participants selected for re-interview
<p>6. Based on this information what benefits is the study likely to have for young people in general?</p>	<p>Collected information will help to:</p> <ul style="list-style-type: none"> • understand better what impacts on young people's sexual health service are • develop/improve sexual health programs
<p>Interviewer:</p>	<p>Study ID: _____ Date: _____ Location _____</p>

Mandatory reporting flowchart



Questions

Part 1. Demographics and basic information (written survey)

1. What is your Age?
2. What is your gender?
3. Are you still in school?
4. What is the highest year level of school you have completed?
5. Do you live in the town of Denmark?
6. Do you have your own Medicare card – or are you still listed on your parent's

card? Part 2. Semi-structured interview questions (framed around socio-ecological model).

1. Do you feel that young people in this town have adequate access to sexual health care services in the town?
2. Do you feel that young people in this town receive adequate sexual health education at school?
3. What barriers exist for young people in accessing sexual health services and education in this town?
4. Do you feel that services that work with young people communicate well with each other?
5. What levels of the socio-ecological model do you think this town addresses youth sexual health?
6. What things do you think the community could do to support young people regarding sexual health?
7. What things do you think the community would not be willing to do to support young people regarding sexual health?

Part 3. Community mapping exercise

Participants will be asked to draw the town and community as they see it. Participants will be asked to draw and label major landmarks in a collaborative exercise, mapping out key areas that young people spend time, key transport routes and options, places to access health services and information and how these things interact.

The nature of this activity is an interactive visual and relational data-gathering technique, rather than a geophysical mapping activity.

Supporting materials

Youth and Sexual Health Services

Denmark contacts:

Denmark Medical Centre – Doctor’s surgery for general health, sexual health and STI testing (appointments and Medicare Card required)
<http://www.denmarkmedicalcentre.com.au/>
Unit 3, 3 Mount Shadforth Road,
Denmark WA
(08) 9848 4111

Jane James Surgery - Doctor’s surgery for general health, sexual health and STI testing (appointments and Medicare Card required)
www.denmarksurgery.com.au
70 Strickland Street
Denmark WA
(08) 9848 1410

Denmark Health Service (hospital service)
50 Scotsdale Rd,
Denmark WA 6333
(08) 9848 0600

Tha’ House Youth Services (support services and counselling for young people 12-17)
McLean Oval, Brazier Street,
Denmark WA
(08) 9848 2377

Tha’ House Youth Services (support services and counselling for young people 12-17)
McLean Oval, Brazier Street,
Denmark

Denmark Police
49 South Coast Highway,
Denmark WA 6333.
(08) 9848 0500

Great Southern Contacts:

Great Southern Population Health – STI testing (Medicare Card Required)
84 Collie Street, Albany
(08) 9842 7500

headspace Albany – (General GP health, sexual health, STI testing and counselling)
<http://www.headspace.org.au/headspace-centres/headspace-albany>
3/15 Peels Place
Albany WA 6330
(08) 9842 9871

State-wide contacts:

Sexual & Reproductive Health WA
70 Roe St, Northbridge, WA, 6003
<http://www.srhwa.com.au/>
08 9227 6177

Sexual Health Helpline
1800 198 205 (country callers)
Weekdays 10am to 4pm

Sexual Assault Resource Centre (SARC) - Emergency Contact
24 hour Emergency Line for recent sexual assault (08) 9340 1828

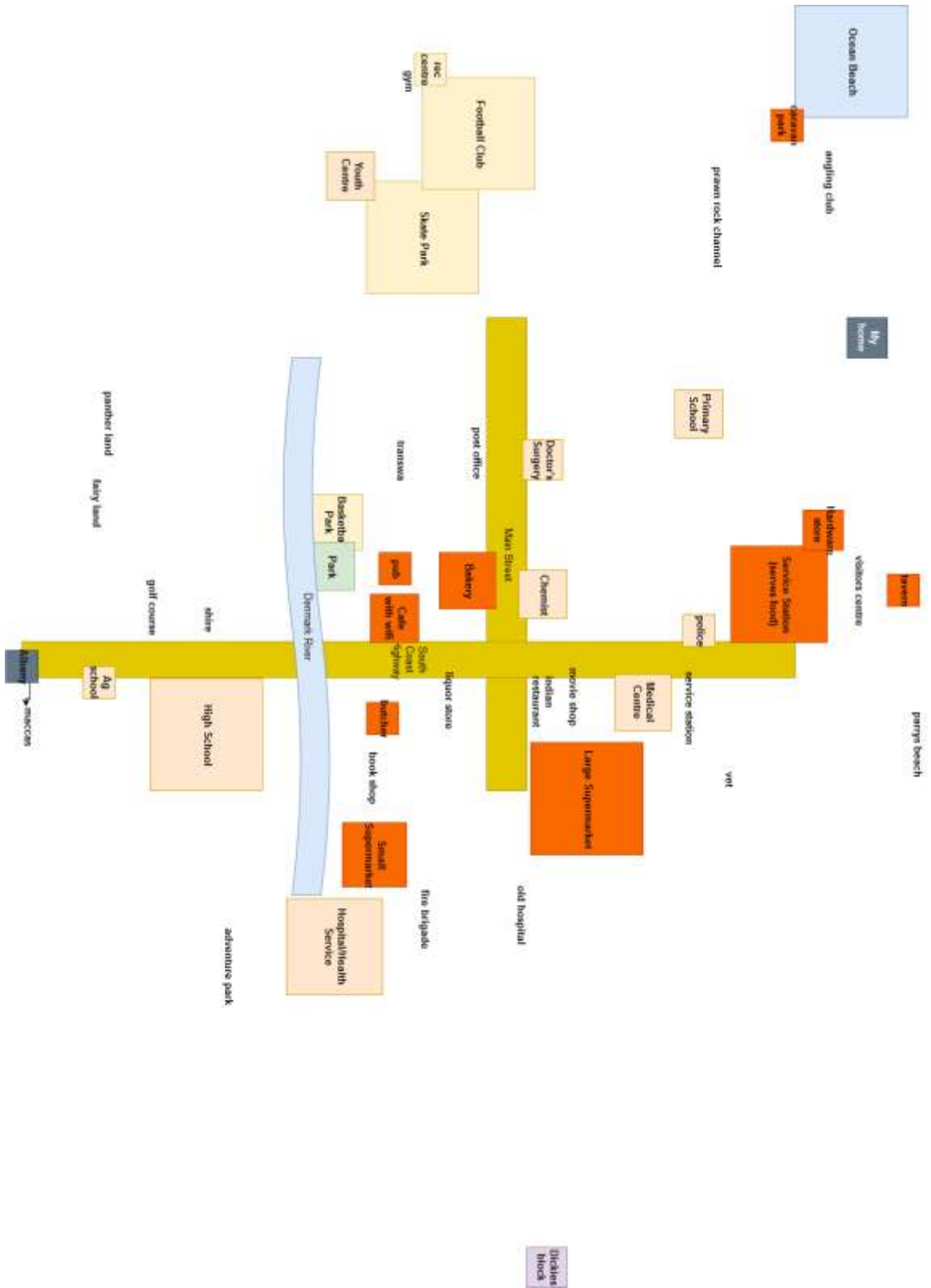
Department for Child Protection (Crisis Care)
1800 199 008 (24 hrs)

Lifeline (Crisis Support)
13 1114 (24 hrs)

Health Direct (quality health information and advice online and over the phone)
1800 022 222 (24 hrs)

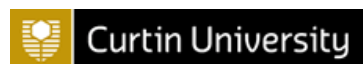
Kids Helpline (free, private and confidential, telephone and online counselling service specifically for young people aged between 5 and 25) 1800 55 1800

E. Community Mapping diagram



F. Stakeholder Interview materials

Participant Information sheet



Study Title: Developing a framework for community-wide sexual health interventions in the rural setting: a participatory action research project.

Research Team:

Mr Carl Heslop, PhD student, Curtin University School of Public Health
Dr Roanna Lobo, Research Fellow, Curtin University School of Public Health
Associate Professor Sharyn Burns, Director of Health Promotion and Sexology, School of Public Health
Dr Ruth McConigley, Senior Lecturer, Curtin University School of Nursing and Midwifery

About this project:

This is a supervised doctoral research project and the results of this research project will be used by **Carl Heslop** to obtain a **Doctor of Philosophy at Curtin University**. This project is funded by Curtin University.

Aims of the project:

The aim of this project is to understand what issues, opportunities and barriers in sexual health service provision exist for young people living in rural Western Australia. This study will be used to inform and better coordinate existing and potential programs. We would like to know what you think would improve services in your town.

Why have I contacted you?

You have been identified as a stakeholder in youth services, youth health care or youth related activities in the rural area.

What will I have to do?

Our team would like to talk to you about your views about sexual health provision in country towns for young people. You will not be asked to provide personal details of your sexual activity. Any answers you give should be of a general nature, rather than personal stories. We are interested in your views as a professional living and working in the rural setting. You may also be asked to nominate other people who would be interested in participating.

If you agree to participate in the study you will need to sign a consent form if you are interviewed. The interview or discussion will be audio-recorded, transcribed and the information you provide will be analysed. The interview will take approximately 45-90 minutes to complete. The results of the study will be used to write a report and will be published in national or international professional journals.

All information that you provide will remain anonymous and is only seen by the research team. Any published works will not contain any details that could identify you. You are free to decide whether or not you want to participate in this study. If at any time you wish to withdraw you are free to so.

You must understand and acknowledge this research is taking place in a highly connected small rural town and others may be aware you are participating in this project.

Will I be paid to participate in the study?

You will not be paid to participate in this study. However, it will not cost you anything to participate.

Are there any risks involved?

The topic of provision of sexual health, particularly to young people; can be controversial or embarrassing. The project team assures that your identity will not be revealed while the program is being conducted or when the program is published – however you must understand and acknowledge that this research is taking place in a highly connected, small rural town and your participation in this project may become public knowledge.

Who will have access to my information?

The information collected in this research will be re-identifiable (coded). This means that the stored information will be re-identifiable which means we will remove identifying information on any data or sample and replace it with a code. Only the research team have access to the code to match your name if it is necessary to do so. Any information we collect will be treated as confidential and used only in this project unless otherwise specified. The following people will have access to the information we collect in this research: the research team and the Curtin University Ethics Committee

Will you tell me the results of the research?

You will not be contacted individually with results of the study. Study results will be reported in professional journals. Announcements and updates on publications will be made via community newspapers and community or professional groups who were involved in the study.

Do I have to take part in the research project?

Taking part in a research project is voluntary. It is your choice to take part or not. You do not have to agree if you do not want to. If you decide to take part and then change your mind, that is okay, you can withdraw from the project. You do not have to give us a reason; just tell us that you want to stop. Please let us know you want to stop so we can make sure you are aware of any thing that needs to be done so you can withdraw safely. If you chose not to take part or start and then stop the study, it will not affect your relationship with the University, staff or colleagues. If you chose to leave the study we will use any information collected unless you tell us not to.

What happens next and who can I contact about the research?

If you have questions about the study at any time you can contact can contact Associate Professor Sharyn Burns on 08 9266 4123 or S.Burns@curtin.edu.au.

If you decide to take part in this research we will ask you to sign the consent form. By signing it is telling us that you understand what you have read and what has been discussed. Signing the consent indicates that you agree to be in the research project and have your health information used as described. Please take your time and ask any questions you have before you decide what to do. You will be given a copy of this information and the consent form to keep.

What if I need more information?

If you have questions about the study at any time you can contact Associate Professor Sharyn Burns on 08 9266 4123 or S.Burns@curtin.edu.au.

Concerns or complaints?

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number 96/2015). All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this research project have been approved by the Curtin University HREC. This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007). If you have any concerns and/or complaints about the project, the way it is being conducted or your rights as a research participant, and would like to speak to someone independent of the project, please contact: The Curtin University Ethics Committee by telephoning 9266 2784 or by emailing hrec@curtin.edu.au.

Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

Invitation email

Professional Contact Email/Letter details

Hi [xxxxxxx],

I would like to invite you to participate in this research project that I am undertaking, focusing on sexual health provision in the rural setting. The study title is: **Developing a framework for community-wide sexual health interventions in the rural setting: a participatory action research project.**

Research Team:

Mr Carl Heslop, PhD student, Curtin University School of Public Health

Dr Roanna Lobo, Research Fellow, Curtin University School of Public Health

Associate Professor Sharyn Burns, Director of Health Promotion and Sexology, School of Public Health

Dr Ruth McConigley, Senior Lecturer, Curtin University School of Nursing and Midwifery

Aims of the project:

The aim of this project is to understand what issues, opportunities and barriers in sexual health service provision exist for young people living in rural Western Australia. This study will be used to inform and better coordinate existing and potential programs. We would like to know what you think would improve services in your town.

The results of this research project will be used by Carl Heslop to obtain a Doctor of Philosophy at Curtin University and is funded by the University.

Why have I contacted you?

You have been identified as a stakeholder in youth services, youth health care or youth related activities in the rural area.

What will I have to do?

Our team would like to talk to you about your views about sexual health provision in country towns for young people. You will not be asked to provide personal details of your sexual activity. Any answers you give should be of a general nature, rather than personal stories. You may also be asked to nominate other people who would be interested in participating.

Do I have to take part in the research project?

Taking part in a research project is voluntary. It is your choice to take part or not. You do not have to agree if you do not want to. If you decide to take part and then change your mind, that is okay, you can withdraw from the project.

What happens next and who can I contact about the research?

If you have questions about the study at any time you can contact Carl Heslop on 0439 690 225 or carl.heslop@curtin.edu.au.

Concerns or complaints?

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number XX/XXXX). All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC).

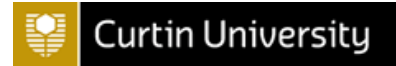
I hope that you will consider taking part in the project. If you do not wish to take part or wish to discuss why you have been contacted – please feel free to contact me directly.

Yours sincerely,

Carl Heslop, PhD Candidate

Consent form

Consent form Interview/Focus Group



CONSENT FORM FOR PARTICIPANTS

Study title: Developing a framework for community-wide sexual health interventions in the rural setting: a participatory action research project.

I have been given clear, written information about this research project and have been given time to consider whether or not I wish to take part.

I understand this is a supervised doctoral research project and the results of this research project will be used by **Carl Heslop** to obtain a **Doctor of Philosophy at Curtin University**.

I understand and accept the nature of the project, which has been explained to my satisfaction. I understand that my interview or focus group discussion will be audio-taped and transcribed.

I know that my participation in this project is strictly voluntary. I know that I have the right to withdraw at any time.

If I have any questions about the project or about being a participant, I can contact **Associate Professor Sharyn Burns** on 08 9266 4123 or S.Burns@curtin.edu.au.

I understand that this project has been approved by Curtin University Human Research Ethics Committee (HREC number: HR96/2015) and will be carried out in line with the National Statement on Ethical Conduct in Human Research (2007) – updated March 2014.

I know that I can contact the Research Ethics Officer at Curtin University on (08)9266 2784 if I wish to discuss any aspects of the program on a confidential basis.

I agree to participate in this project.

I have been assured that my identity will not be revealed while the program is being conducted or when the program is published – however **I understand and acknowledge this research is taking place in a highly connected small rural town and others may be aware I am participating.**

.....
Participant's Name

.....
Participant's Signature

.....
I have supplied an Information Letter and Consent Form to the participant who has signed above, and believe that they understand the purpose, extent and possible risks of their involvement in this project.

.....
Researcher's Name

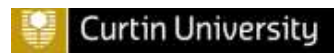
.....
Researcher's Signature

Date: _____

Please keep a copy of this form for your records

Questions

ID	
----	--



Stakeholder interview

1.0 Demographics and basic information

1.1 What is your gender? Male Female Other

1.2 What is your job or role in this organisation?

1.3 What qualifications do you hold relating to this job or role?

1.4 How many years have you working in your current job or role?

1.5 Do you live in the town of Denmark? YES or NO

1.6 Does your organisation deal directly with young people in the town? YES or NO

1.7 Does your organisation deal directly with youth sexual health? YES or NO

1.8 Is your role or job affected by WA's mandatory reporting legislation? YES or NO

What strengths does your organisation have in dealing with youth sexual health?

1.9 What weaknesses does your organisation have in dealing with youth sexual health?

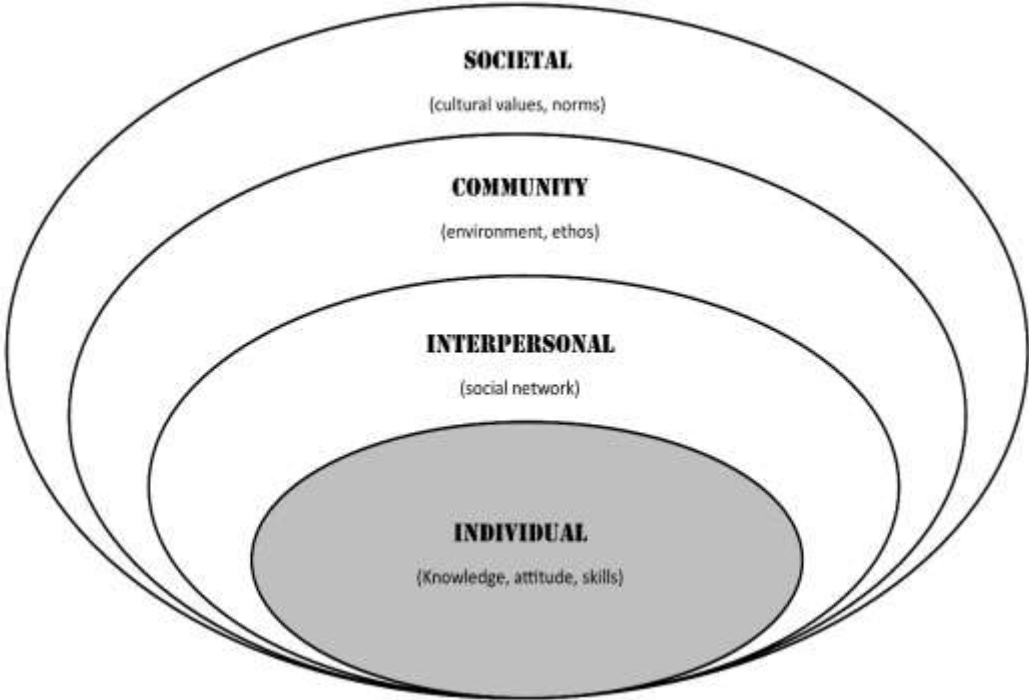
2.0 **Recorded Interview**

These questions will be recorded and transcribed.

All questions relate to the socio-ecological model adapted from Bronfenbrenner (1979)

Bronfenbrenner’s ecological framework for human development perspective provides a framework for highlighting and examining individual, interpersonal, organisational and community inter-relationships.

- 2.1 Do you feel that young people in this town have adequate access to sexual health care services in the town?
- 2.2 Do you feel that young people in this town receive adequate sexual health education at school?
- 2.3 What barriers exist for young people in accessing sexual health services and education in this town?
- 2.4 Do you feel that services that work with young people communicate well with each other?
- 2.5 What levels of the socio-ecological model do you think this town addresses youth sexual health?
- 2.6 What things do you think the community could do to support young people regarding sexual health?
- 2.7 What things do you think the community would not be willing to do to support young people regarding sexual health?



G. Delphi Study Materials

Information sheet

Study Title: Developing a framework for community-wide sexual health interventions in the rural setting: a participatory action research project.

Research Team:

Mr Carl Heslop, PhD student, Curtin University, School of Public Health
Dr Roanna Lobo, Research Fellow, Curtin University, School of Public Health
Associate Professor Sharyn Burns, Curtin University, School of Public Health
Dr Ruth McConigley, Senior Lecturer, Curtin University School of Nursing and Midwifery

About this project:

This is a supervised doctoral research project and the results of this research project will be used by Carl Heslop to obtain a Doctor of Philosophy at Curtin University. This project is funded by Curtin University.

Aims of the project:

The aim of this project is to understand what issues, opportunities and barriers in sexual health service provision exist for young people living in rural Western Australia. This study will be used to inform and better coordinate existing and potential programs. We would like to know what you think would improve services in your town.

Why have I contacted you?

You have been identified as a stakeholder in youth services, youth health care or youth related activities in the rural area.

What will I have to do?

Our team would like to invite you to participate in a Delphi study. **This is in the form of an online questionnaire that should take 15-20 minutes to complete.**

This Delphi study provides you with the opportunity to evaluate how appropriate and effective the attached Draft framework will be in addressing community-based youth sexual health interventions in the rural setting.

Your initial responses will be analysed, and you may be asked to respond to repeat cycles of the questionnaire to clarify responses. All questions will relate to the Draft framework, you will not be asked to provide personal details of your sexual activity. Any answers you give should be of a general nature, rather than personal stories.

We are interested in your views as a professional living and working in the rural setting. You may also be asked to nominate other people who would be interested in participating. All information that you provide will remain anonymous and is only seen by the research team. Any published works will not contain any details that could identify you. You are free to decide whether you want to participate in this study. You are free to withdraw at any time.

Will I be paid to participate in the study?

You will not be paid to participate in this study. However, it will not cost you anything to participate.

Are there any risks involved?

The topic of provision of sexual health, particularly to young people; can be controversial or embarrassing.

The project team assures that your identity will not be revealed while the program is being conducted or when the program is published – however you must understand and acknowledge that this research is taking place in a highly connected, small rural town and your participation in this project may become public knowledge.

Who will have access to my information?

The information collected in this research will be re-identifiable (coded). This means we will remove identifying information on any data or sample and replace it with a code. Only the research team will have access to the code to match your name if it is necessary to do so. Any information we collect will be treated as confidential and used only in this project unless otherwise specified. The following people will have access to the information we collect in this research: the research team and the Curtin University Ethics Committee.

Will you tell me the results of the research?

You will not be contacted individually with results of the study. Study results will be reported in professional journals. Announcements and updates on publications will be made via community newspapers and community or professional groups who were involved in the study.

Do I have to take part in the research project?

Taking part in a research project is voluntary. It is your choice to take part or not. You do not have to agree if you do not want to. If you decide to take part and then change your mind, that is okay, you can withdraw from the project. You do not have to give us a reason; just tell us that you want to stop. Please let us know you want to stop so we can make sure you are aware of any thing that needs to be done so you can withdraw safely. If you chose not to take part or start and then stop the study, it will not affect your relationship with the University, staff or colleagues. If you chose to leave the study, we will use any information collected unless you tell us not to.

What happens next and who can I contact about the research?

If you have questions about the study at any time you can contact can contact Associate Professor Sharyn Burns on 08 9266 4123 or S.Burns@curtin.edu.au or Carl Heslop on 0439 690 225 or carl.heslop@postgrad.curtin.edu.au

If you decide to take part in this research, we will ask you to sign the consent form. By signing it is telling us that you understand what you have read and what has been discussed. Signing the consent indicates that you agree to be in the research project and have your health information used as described. Please take your time and ask any questions you have before you decide what to do. You will be given a copy of this information and the consent form to keep.

Concerns or complaints?

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number 96/2015). All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this research project have been approved by the Curtin University HREC. This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007). If you have any concerns and/or complaints about the project, the way it is being conducted or your rights as a research participant, and would like to speak to someone independent of the project, please contact: The Curtin University Ethics Committee by telephoning 9266 2784 or by emailing hrec@curtin.edu.au.

Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

Invitation email

Dear xxxxx,

Thank you for nominating to take part in the study "*Developing a framework for community-wide sexual health interventions in the rural setting: a participatory action research project.*" The aim of this project is to understand what issues, opportunities and barriers in sexual health service provision exist for young people living in rural Western Australia.

You have been identified as a rural based or rural focussed worker or volunteer than can provide insight in to sexual health provision in the rural setting. You may not be an expert on sexual health, but your experience in this area will be an important inclusion to the study.

You will complete a Delphi study questionnaire. The Delphi technique is a widely used and accepted method for gathering data from respondents within their domain of expertise.

Attached to this email is the link to the study questionnaire, the Draft Framework and the participant information sheet.

Should you wish to participate in this study please:

1. Read the Participant Information Sheet.
2. If you agree with this information, read the Draft Framework
3. Then click on the link to complete the questionnaire

Thanks again for agreeing to participate in this study, and if you have any questions, please do not hesitate to contact the research team with the information in the Participant Information Sheet.

Sincerely,

Carl Heslop

Delphi 1 Questions

Developing a framework for community-wide sexual health interventions in the rur

Developing a framework for community-wide sexual health interventions in the rural setting.

Thank you for participating in this Delphi study and taking the time to evaluate the attached Framework. The Delphi technique is a widely used and accepted method for gathering data from respondents within their domain of expertise. The technique is designed as a group communication process which aims to achieve a convergence of opinion on a specific real-world issue.

The aim of this project is to understand what issues, opportunities and barriers in sexual health service provision exist for young people living in rural Western Australia. This study will be used to inform and better coordinate existing and potential service delivery programs through the development of the attached Framework.

This Framework has been developed after interviews with stakeholders representing health providers, educators, sporting clubs, local government and youth services; as well as youth focus groups. The data collected were used to inform the development of this Framework.

Before answering the questions, please take time to read the attached Framework for sexual health provision in the rural setting.

Once you start the questions, please complete all questions until the end of the survey. Each page of questions will relate directly to a section from the Framework for sexual health provision in the rural setting. It may help to have this open in another window on your computer or printed for you to refer to.

Please answer each question as you feel it relates to your role in your organisation. Some questions are tick box while others are free text answers. If something is not clear to you, please provide feedback within the relevant section or at the end of the survey.

Please complete the following details for consent purposes and to be emailed a finalised version of the Framework for review:

Your survey responses will be kept anonymous.

Name

Email address

Do you consent to participate in this study?

- I have read the above text and the attached Participant Information Sheet and consent to participating in this Delphi study
- I do not wish to participate in this study

Demographics and basic information

Ensure that you have read the attached [Framework for sexual health provision in the rural setting](#) or have it available to refer to before starting this section,

Please complete all questions in this section as they relate to your current role within your organisation

Click to write the question text

- Male
- Female
- Another

What sector do you work in?

- Health
- Education
- Youth or community services
- Research
- Sport and Recreation
- Other

What is your job title in this organisation (including volunteer position)?

Do hold any formal qualifications relating to this job or role?

- None
- Diploma or similar level
- Graduate Degree
- Post-graduate degree

How many years have you been working in your current job or role?

- Less than 12 months
- 12 months to five years
- Longer than five years

What is your postcode?

Does your organisation provide direct youth sexual health services?

- Yes
- No

What services does your organisation provide?

- Counselling or support
- STI testing
- Condom supply
- Education
- Pamphlets or information sheets
- Pregnancy testing or testing kits
- Other

Read the Framework

Delphi questions - "Overview of Framework"

These questions and statements relate to the section: "An introduction to the Framework"

Please read that section of the Framework and answer the questions.

Some questions require a written response, some ask for a response based on your understanding of the section.

I understand the aim of this Framework

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

It is clear that the four Framework concepts were developed from this research

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

In your opinion, is there anything else that needs to be included or excluded from this section?

- No
- Yes

Key Concepts

These questions relate to the section: "Key Concepts in the Framework".

Please refer to each Key concept to answer the questions or statements

The statements in this section relate to Key Concept:

1. Consistent and credible sex and relationships education and information

Key Concept: The sexuality and relationship education delivered is relevant, acknowledges diversity and moves beyond the biological aspects of sexual health and provides young people with the skills and information that they want and need.



This concept area is important when delivering sexual health interventions in the rural area

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

The details listed in this concept area are appropriate/important in delivering rural sexual health

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

This concept area is clear to understand

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

In your opinion, is there anything else that needs to be included or excluded from this section?

- No
- Yes

Health service accessibility

The statements in this section relate to Key Concept:

2. Health service accessibility and competing priorities

Key concept: Young people want uncomplicated access to sexual health services and information in their community.



Health service
accessibility

This concept area is important when delivering sexual health interventions in the rural area

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

The details listed in this concept area are appropriate/important in delivering rural sexual health

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

This concept area is clear to understand

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

In your opinion, is there anything else that needs to be included or excluded from this section?

- No
- Yes

Discreet condom supply

The statements in this section relate to Key Concept:

3. Discreet condom supply

Key concept: Young people want to buy condoms cheaply and anonymously from easily accessible places. Stealing condoms may be preferred to avoid interacting with others when accessing condoms.



This concept area is important when delivering sexual health interventions in the rural area

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

The details listed in this concept area are appropriate/important delivering rural sexual health

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

This concept area is clear to understand

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

In your opinion, is there anything else that needs to be included or excluded from this section?

- No
- Yes

Communication and collaboration.

The statements in this section relate to Key Concept:

4. Communication and collaboration.

Key concept: Small towns are interconnected and socially close, yet services can still operate in isolation. Initiate contact and spark collaboration in effective and sustainable ways.



This concept area is important when delivering sexual health interventions in the rural area

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

The details listed in this concept area are appropriate/important delivering rural sexual health

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

This concept area is clear to understand

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

Is there anything else that needs to be included in this section? (please type your response)

- No
- Yes

"Applying the Framework"

These questions relate to the section: "Applying the Framework".

Please refer to this section and the subheadings:

- Phase 1: Community Scan and TOWN analysis
- Phase 2: PLAN (Plan, Listen, Allocate, Network)
- Phase 3: ACT (Advocacy, Coordination, Targeted interventions)
- Phase 4: Review

Please read that section of the Framework and answer the questions.

Some questions require a written response, some ask for a response based on your understanding of the section.



Rapid Community Scan and TOWN analysis

Phase 1: Community Scan and TOWN analysis

These questions and statements directly relate to Phase 1 in the Framework document.



This phase relates well to sexual health service provision in the rural area

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

I understand the steps in this phase

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

The steps clearly relate to each other

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

Is there anything else that needs to be included in this section? (please type your response)

No

Yes

Is there anything else that could have be left out of this section? (please type your response)

No

Yes

b. Phase 2: PLAN (Plan, Listen, Allocate, Network)

Phase 2: PLAN (Plan, Listen, Allocate, Network)

These questions and statements directly relate to Phase 2 in the Framework document.



This phase relates well to sexual health service provision in the rural area

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

I understand the steps in this phase

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

The steps clearly relate to each other

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

Is there anything else that needs to be included in this section? (please type your response)

- No
- Yes

Is there anything else that could have be left out of this section? (please type your response)

- No
- Yes

c. Phase 3: ACT (Advocacy, Coordination, Targeted interventions)

Phase 3: ACT (Advocacy, Coordination, Targeted interventions)

These questions and statements directly relate to Phase 3 in the Framework document.

Is there anything else that needs to be included in this section? (please type your response)

No

Yes

Is there anything else that could have be left out of this section? (please type your response)

No

Yes

d. Phase 4: Review

a. Phase 4: Review

These questions and statements directly relate to Phase 4 in the Framework document.



This phase relates well to sexual health service provision in the rural area

Strongly agree

Agree

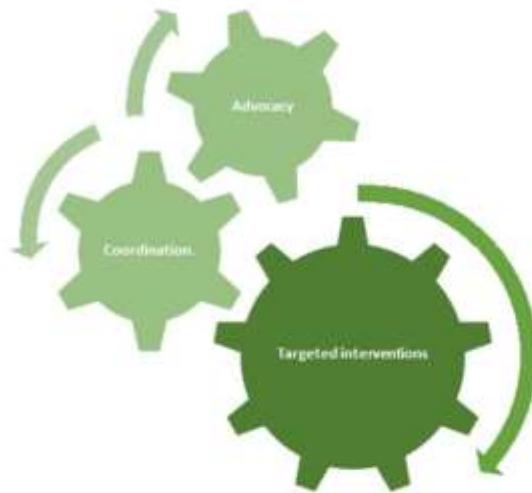
Somewhat agree

Neither agree nor disagree

Somewhat disagree

Disagree

Strongly disagree



This phase relates well to sexual health service provision in the rural area

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

I understand the steps in this phase

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

The steps clearly relate to each other

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

Is there a Key Framework Concept are that you feel is the most important?

- Consistent and credible sexuality and relationships education and information
- Health service accessibility and competing priorities
- Discreet condom supply
- Communication and collaboration

What is the most important implementation phase of the Framework for you?

- Community Scan and TOWN analysis
- PLAN (Plan, Listen, Allocate, Network)
- ACT (Advocacy, Coordination, Targeted interventions)
- Review
- None of the above

This Framework document would be useful in my community

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

Can you suggest changes that could make this Framework easier to use?

- No
- Yes

Are there any other changes would you suggest to this framework?

- Not at this stage
- Yes

Do you have any final comments on this framework document?

- No
- Yes

I understand the steps in this phase

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

The steps clearly relate to each other

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

Is there anything else that needs to be included in this section? (please type your response)

- No
- Yes

Is there anything else that could have be left out of this section? (please type your response)

- No
- Yes

4. Overall

This section relates to the entire Framework as a complete document.

I understand that the Framework is asking me to examine different levels or relationships

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

Delphi 2 Questions

Stakeholder response table – Delphi 1

Dear Participant,

Thank you for taking part in this study “*Developing a framework for community-wide sexual health interventions in the rural setting: a participatory action research project.*” If you were unable to participate in the initial stage of the Delphi questionnaire do to time constraints, workloads or any other reason – please consider sending a reply email to this with a brief note on why you could not participate, as this will assist in my data analysis.

We received some fantastic feedback on the Framework document, and I wanted to supply both the amended Framework and a list of specific responses to you all as part of the participatory process. If you could have a look at the latest version of the document and let me know if there is anything you think, that would be fantastic.

Key changes to the document that have been made on reviewing the comments and suggestions:

- Changes to the language and layout of the document to make it simpler to read
- More explanation of some of the key concepts
- More background information on why the Framework was required
- More detail on the process of the development of the document
- Some more diagrams and update of some diagrams to improve readability

We have tried to incorporate as much of the supplied feedback as possible in to the document itself and would like to thank everyone for their feedback and advice. Further development of the document and adding things such as resource lists and methods for engaging youth in your local area will be developed as part of the finalised document for circulation.

Thanks again for agreeing to participate in this study, and if you have any questions, please do not hesitate to contact the research team with the information in the Participant Information Sheet.

The next phase of the project will be sending the document further afield to get a new set of eyes on it – however, if you would like to participate in this third phase of the project, please let me know via email and I will include you in the mail out list in the coming weeks.

Additionally, if there is anything else you think you need in terms of information relating to sexual health in this setting, please let me know.

Sincerely,

Carl Heslop
PhD Candidate
Curtin University

	Q4.5 (Overview of framework) What else needs to be included in this section?	
1	Clear, direct and precise as is	Noted
2	how to increase the capacity of existing services,	This has been incorporated more clearly within the entire document.
3	how the framework can embed the requirement for community-wide sexual health interventions to remain a priority in a regional setting where population will dictate funding for health sector FTE funds	Thanks for this note. This is a critical issue and one that while we have tried to address this within the research and the document – the realities of rural health prioritisation are what they are. It is hoped that the document can provide support and guidance to stakeholders already involved in sexual health regardless of FTE or funding to improve current practice and build capacity, however we acknowledge, in a setting where sexual health is often nobody's priority – it can easily fall away.
4	The age range for 'youth' would be good to have included. Also where it refers to 'the research and literature' in the paragraph relating to The lens of the framework: ecological framework - it would be good to reference 'what' research & literature... as it's not clearly identified.	Thanks for this point. We have amended this section to clearly explain what research is being referenced; and to add a clear definition of youth for the purpose of this project.
5	Are 'opportunities' the same as 'strengths'?	Thanks for this note. Within the assessment of sexual health in this setting, we chose to focus on the community needs for this analysis of the setting as the document is focussed on practical application and meeting the needs of young people and stakeholders within the setting.
5	A few lines about why is this framework needed for those of us that dont work in the sector? Has their been an inadequacy in past services or a rise in STIs?	Noted. We have included a short background on the development of the framework and sexual health. It is envisaged a larger background will be provided with the final document.
	Q4.6 (Overview of framework) What could be left out of this section?	
7	Nothing	Noted
3	Nil	Noted
3	Nil	Noted
10	Nothing	Noted
	Q5.7 What else needs to be included within this concept area? (please type your answer) <i>Consistent and credible sex and relationships education and information</i>	
11	Again, very precise and to the point. Explains exactly what the Key Concept is.	Noted
12	Capacity building of existing services	Thanks for this point. This has been included in to the document.
13	The key guidelines consistently refer to schools, while not all young people attend school - some may be at other education institutes (TAFE, private RTOs), working or doing internships/traineeships or be home schooled.	This is a fantastic point and the document has been amended to clearly reference these areas.
13	The key guidelines consistently refer to schools, while not all young people attend school - some may be at other education institutes (TAFE, private RTOs), working or doing internships/traineeships or be home schooled.	This is a fantastic point and the document has been amended to clearly reference these areas.
14	Does diversity take into account religious beliefs?	Diversity in this context refers to sexual and gender diversity. Religious diversity and components of a community is addressed more within the community scan.
15	List of credible resources	Thanks for this. A list of resources is something that may be included in the finalised document. For the purposes of keeping this document as small as possible for review by our panel of experts, we did not include may direct links or resources.
	Q5.8 What could be left out of this concept area? <i>Consistent and credible sex and relationships education and information</i>	
16	Nothing	Noted
17	All areas are important.	Noted
18	Nothing	Noted
19	Nothing	Noted
	Q6.6 What else needs to be included within this concept area? (please type your answer) <i>Health service accessibility and competing priorities</i>	
20	uncomplicated and private access (especially in a small rural town where everyone knows everybodys business)	Thanks for this note – it mirrors what was within the research, so we have made it explicitly clear within this concept area.
21	training of staff in regards to delivering youth friendly services, Peer to peer support to enhance delivery of information	Thanks for this. We have made this clearer within this concept area.
22	transport is a big issue; clients can often live out of town without transport options and rely upon myself or another responsible adult to take them	Thanks for this. We have included this in the concept area as it is relevant in rural sexual health.
23	How is accessibility defined and what does it include?	Thanks for this note. Accessibility in this context refers to how easy it is for young people to access health services within their town. The guidelines in this concept area refer to improving accessibility.
24	Nothing	Noted
	Q6.7 What could be left out of this concept area? <i>Health service accessibility and competing priorities</i>	
25	Nothing	Noted
26	Not all are relevant in Denmark. I couldn't imagine any of my clients attending information sessions, but it would be good to have this for people who work with young people	Thanks for this. Not all interventions would work for all young people in a particular setting, but within the data collected, there was support for this style of intervention continuing.
27	Nil	Noted

28	Nothing	Noted
	Q7.6 What else needs to be included within this concept area? (please type your answer) Discreet condom supply	
29	Ability to have free condoms available for those that cannot afford them.	Thanks, we have amended some of the wording in this section so it more clearly explains this.
30	Young people can have access to condoms but there needs to be work in regards to increasing decision making abilities and resilience in order to negotiate condom use.	Thanks for this note. This is a very important point, and illustrated the need for RSE to be more than biological in focus and ensure that it incorporates all aspects of the curriculum (in this case, the WA curriculum). We have incorporated this comment in to the concept area " Consistent and credible sex and relationships education and information "
31	Include femidoms too (if available). It would be good to have something regarding parents 'concerns' about availability of condoms being seen as promoting sex or promiscuity. This is something I've come across from some parents.	Thanks for both of these comments. Within the setting and the research, there had been no mention of female condoms as an issue or an expressed need from participants. We'd like to acknowledge that there are merits in the provision of female condoms in sexual health interventions; however given that they are not as widely available, the focus of this research has been on provision of male condoms. Regarding the parental concerns, we have expanded on this topic both within this section of the document and the advocacy section of the implementation guide as it is important that it is clearly a concern.
32	hiding condoms in bathrooms is a great idea. Also encouraging health/youth workers to be open about talking about condoms and handing them out if conversation arises.	Thanks for this note. We have incorporated what you have mentioned as an expansion of what was already listed within this concept area.
33	The concept is very clear.	Noted
34	Education for the community that the purchase of condoms is not illegal/dirty/wrong. It should be embraced.	Thanks for this note. Please see the above response.
	Q7.7 What could be left out of this concept area? Discreet condom supply	
35	Understand the urge to steal, however, free quantities available in discreet area will remove this need.	Agreed. The greater access young people have, the less likely they are to steal.
36	Do young people really want to 'buy' condoms or do they want free, discreet and easy access?	Within the research conducted with young people, participants were happy to pay for condoms if there were youth-friendly options. This were particularly condom vending machines or self-service checkouts.
37	Nothing	Noted
	Q8.6 What else needs to be included within this concept area? (please type your answer) Communication and collaboration	
38	Agree with concept - have to either engage in groups for education or provide discretion such as self serve checkouts that now exist in supermarkets	Noted
39	Again students need to learn about resilience and decision making and these core concepts need to be initiated and discussed	Please see comment 30
40	confidentiality as a priority	Thanks for this comment. This has been further highlighted throughout the concept area.
41	Identifying a lead 'agency' to ensure communication is collaborative, inclusive and updated would be great.	Thanks for this comment. We have further expanded on this concept within this concept area, as well as throughout the document in the supporting information and the implementation guide.
42	not too clear on the purpose of collaboration and communication between services, and why this would be useful in this context	Thanks for this comment. Throughout the data gathered from stakeholders in the setting, there was an expressed desire for improved communication and collaboration between services that engage with young people as it was seen to be lacking in the setting. This improved collaboration may lead to exploring initiatives such as GP's supporting delivery of RSE in schools, school teachers keeping other services up to date on what is being taught to the students or what schools are doing around condom access. There is also the opportunity to collaborate with non-traditional providers such as sporting clubs or youth groups.
43	Does the concept include 'confidentiality'?	This concept largely refers to communication between services. With this in mind, we have provided as statement on confidentiality of communication within this concept area.
44	It would be great to see something about reaching and communicating with hard to reach young people ie homelessness and disadvantage	Thanks for this note. This has been incorporated in to this concept area and the implementation guide.
45	How can school nurse promote herself more re sexual health consultation.	Thanks for this note. We have amended this statement within the document slightly to provide more guidance.
46	This seems to be a critical outcome of the framework, that it can be a document to gather together diverse service organisations and help strengthen relationships - not something that needs to go into this concept area, just a comment.	Noted with thanks.
47	See previous point	Relates to
	Q8.7 What could be left out of this concept area? Communication and collaboration	
48	Nothing	Noted
49	How do you quantify services operating in isolation?	Thanks for this. Within the data collection, it was acknowledged that services had little knowledge of each other, of support services in neighbouring towns and little idea of what other services were providing, effectively operating in isolation while addressing sexual health. We have amended the key concept heading of this concept to provide greater clarity.
50	Nothing	Noted

	Q10.6 What else could be included in this phase? Phase 1: Community Scan and TOWN analysis	
51	Strengths - include what already works and is in place Results	Thanks for this. This has been amended in to the document.
52	Focus groups with young people. Focus groups to educate parents and seek their feedback. Initiatives to identify and address parental concerns (where relevant / possible).	Thanks for this. We have included a statement on collecting this level of information within he guidelines (2.n.)
53	Not totally clear on how we as an organisation plays a role here..	Thanks for this note. We have attempted to provide more clarity on this in the introduction.
54	Strengths	Noted
55	Nothing - very extensive	Noted
	Q10.7 What is missing from this phase? Phase 1: Community Scan and TOWN analysis	
56	Results	Noted
57	what is the review process	Thanks – this is covered in the review section of the document.
58	Strengths	Thanks for this. We have expanded the wording in this section to give more clarity on this.
59	Linking scanning to hard to reach young people who do not engage community group etc	Thanks for this. This has been incorporated in to the document.
50	Nothing	Noted
	Q10.8 What could be left out of this phase? Phase 1: Community Scan and TOWN analysis	
51	Nothing	Noted
52	Good information, although the purpose of our role in the phase isn't clear	Thanks for this note. Please see comment 53
53	Should the cycle elements be restructured similar to a SWOT analysis eg. Strengths, Weaknesses, Opportunities and Threats.	Thanks for this. Please see comment 5.
54	Nothing	Noted
	Q11.6 What else could be included in this phase? Phase 2: PLAN (Plan, Listen, Allocate, Network)	
55	Nothing	Noted
56	intervals for review	Thanks for this. This has been incorporated in to this section and the review section.
57	maybe more about involving young people in the discussions. I see that it's in there, but it would be great to learn more about this.	Thanks. We have expanded this in more detail.

58	I am unsure about the continuity of these elements and how they relate to one another.	Thanks for this note. We have attempted to provide greater clarity in the document to address this.
59	I think this is excellent, and very useful across a range of community development areas, not just sexual health. The 'Network' step is often missed out and ultimately its this step that allows for responsive and continuous improvement.	Thanks for this.
70	How to connect with young people in the area?	Thanks for this. We haven't provided a large amount of specific strategies on how to engage or access young people as it changes from setting to setting. We have included a statement on this within the Phase two guidelines "Seek advice on best strategies connect with young people from local youth focussed community groups." And would consider a list of potential strategies in the final (larger) document.
	Q11.7 What is missing from this phase? Phase 2: PLAN (Plan, Listen, Allocate, Network)	
71	Nothing	Noted
72	Unsure	Noted
73	How to connect with young people in the area?	See 70
	Q11.8 What could be left out of this phase? Phase 2: PLAN (Plan, Listen, Allocate, Network)	
74	Nothing	Noted
75	How does 'listen' and 'allocate' and 'network' differ in it's processes?	Thanks for this note. We have provided more information within this section to provide greater clarity on this.
76	Nothing	Noted
	Q12.6 What else could be included in this phase? Phase 3: ACT (Advocacy, Coordination, Targeted interventions)	
77	As is - Explains clearly what is required in this phase and demonstrates steps	Noted
78	again...evaluation and sub set review	Thanks for this. This is covered in more detail within the review section of the document.
79	Is there any scope to gauge success and adopt a reflective practice.	Thanks for this. We have included a section addressing this within this area and increased reference to this within the review area.
30	More complete descriptions and examples of what is being understood by Advocacy? it currently reads as advocacy though local media being a primary step and I'm unsure of the effectiveness of this in reaching the target group.	Thanks for this. We have expanded this and provided more information on the need to advocacy and some steps for stakeholders to take.
31	Nothing	Noted

	Q12.7 What is missing from this phase? Phase 3: ACT (Advocacy, Coordination, Targeted interventions)	
32	Nothing	Noted
33	see above comment	Addressed.
34	Nothing	Noted
	Q12.8 What could be left out of this phase? Phase 3: ACT (Advocacy, Coordination, Targeted interventions)	
35	Full stop at the end of coordination in the diagram!	Noted. Thanks for being so thorough!
36	Nil	Noted
37	Nothing	Noted
	Q13.6 What else could be included in this phase? Review	
38	Clear and precise	Noted
39	examples of potential service collaborations	Thanks. This is noted and added to the TOWN analysis.
30	Should this phase remain as a linear progression or should elements be represented as interrelated components?	Thanks for this note. The decision for the review process to be linear rather than interrelated allows greater depth of analysis and evaluation of each stage. Each stage of this implementation guide is unique and while there are aspects that are interrelated, they are quite separate to each other and require independent review.
31	This is great - I especially appreciate evaluate our evaluation 'you become what you measure!'	Noted with thanks.
32	Nothing	Noted
	Q13.7 What is missing from this phase? Review	
33	Nothing	Noted
34	Unsure about maintenance of network as could also incorporate enaction.	Thanks for this. We have expanded on this section to provide greater guidance on what is involved to maintain the network while also expanding on reasons that inactivity may have occurred.
35	Evaluate evaluation this is included in evaluation so seem to be maybe an required step	Noted.
36	Nothing	Noted
	Q13.8 What could be left out of this phase? Review	
37	Nothing	Noted
38	Unsure as there are to Evaluation processes.	Processes would depend on the interventions that were being implemented and the capacity of the community to undertake complex evaluation. We have not been overtly prescriptive in when referring to evaluation as some communities would not have the capacity to undertake complex scale evaluation
39	Nothing	Noted
	Q14.3 What is missing from the Framework?	
100	Nothing	Noted
101	I agree subject to the framework being implemented as part of the curriculum and not as a one off study.	Noted. Thanks for this comment. We have included a statement on this within the introduction: "The Framework is a tool designed to improve what may already be happening and explore improved coordination. It should not be applied in isolation and should incorporate local guidelines and curriculum."
102	Has consideration been given for financial and economic implications? How will the model continue without funding?	Noted. The framework is not designed to be reliant on external funding, but more as a guide for existing services wishing to improve current practice. We have included this statement in the introduction: "There is rarely funding for sexual health services in rural towns. This framework aims to assist stakeholders improve current practice to meet needs rather than act as a standalone project reliant on external funding."
103	The strategies involved to access the young people	See 70
	Q14.4 What could be changed to make this Framework easier to use?	
104	Excellent as is	Noted
105	It could be edited to be made more 'user friendly' - simpler language for those not used to this type of project (ie, engaging with sporting associations, parents, young people themselves).	Noted. We have made an effort to improve readability.
106	more details diagrams/visuals	Noted. We have made an effort to include more/clearer diagrams
107	Please see section marked as uncertain ie neither disagree or agree as this requires clarity	Noted. This is addressed above.
108	Nothing	Noted
	Q14.5 What is the most important stage of the Framework for you?	
109	Community	Noted
110	all stages however Stage 4 - Review provides the important details.	Noted
111	Each element is important. Community scan is important to ensure a baseline, engaging with target audiences is as important to ensure messages are well targeted and appropriately delivered, and evaluation is also required so continuous improvement of the strategy/framework can continue.	Noted
112	Planning, evaluation and consultation	Noted
113	The framework concepts are great and as is applying the framework and planning great work!	Noted
114	Framework concepts	Noted
115	Applying the Framework	Noted

Stakeholder response table – Delphi 2

Dear Participant,

Thank you taking the time to be a part of this study *“Developing a framework for community-wide sexual health interventions in the rural setting: a participatory action research project.”*¹

We received some fantastic feedback on the Framework document, and I wanted to supply both the amended Framework and a list of specific responses to you all as part of the participatory process. This is our chance to close the loop on the development process. I hope that your suggested amendments have improved the document where possible. We really acknowledge that it is not perfect, and look forward to the chance to test and refine it in the field in the future.

Key changes to the document that have been made on reviewing the comments and suggestions:

- Clarification to some key guidelines and areas based on your feedback
- Some expanded details based on your feedback
- Exploration of how to improve the readability of the document.

We have tried to incorporate as much of the supplied feedback as possible in to the document itself and would like to thank everyone for their feedback and advice. This document is not the sole answer on how to address sexual health in the rural area, but it helps lay some groundwork for the future.

Thanks again for agreeing to participate in this study, and if you have any questions, please do not hesitate to contact the research team with the information in the Participant Information Sheet.

Sincerely,

Carl Heslop
PhD Candidate
Curtin University

	In your opinion, is there anything else that needs to be included or excluded from this section? (“Overview of Framework”)	
1	I am interested in the degree of participation of young people in the data collection	Thanks for this comment. There were a number of youth consults conducted to further inform the information collected from stakeholders in this project. The “participants” for this participatory action project were rural stakeholders rather than rural youth. It was important to involve youth in the verification of the key issues and themes that they faced, and they provided some excellent solutions. The stakeholders were the drivers behind change within their organisations and the development of this framework.
	In your opinion, is there anything else that needs to be included or excluded from this section? (Key Concept: Consistent and credible sex and relationships education and information)	
2	In the Victorian roll out of Respectful Relationships education the developers noticed increased reporting of sexual abuse. Providers of education about healthy and unhealthy relationships need to be made aware of this and have a plan for reporting and referral to supporting agencies with this work.	Thanks for this great point. We have reviewed the framework document and attempted to reflect this information within it.
3	Negotiating and understanding consent	Noted
4	Be aware of acronyms - this is the first concept and acronyms are used, which if you are not in SRE, would be unfamiliar - eg WAAC, SRE, DR Yes and LGBTI :) Also seems there is a lot of mention of schools. Wondering if you can beef up the idea of coaches and supporting them. I feel that schools should know this and already be implementing SRE. With lots of mention of the role of the school in being responsible for this first concept, do you think that any one reading this would be thinking - "well its the schools responsibility, not mine", and they would put it down?	Thanks for the note on acronyms. We have scanned the document and made some changes. Regarding schools; we completely agree that schools should know this and already be implementing sexuality and relationships education in line with the curriculum framework in an inclusive, evidence based manner. Unfortunately, within this research and further literature, this is not the case. We want to really reinforce the role that schools must play in the rural setting. Regarding coaches and outside support sourced, we have reviewed the document and made some changes to reflect this. We have also adjusted the order of the guidelines to encourage people to not put it down.
	In your opinion, is there anything else that needs to be included or excluded from this section? (Key concepts: Health service accessibility and competing priorities)	
5	Young people don't actually need medicare cards to access services, but reception need to be training in working with young people to a access medicare. Information about privacy important, particularly in working with under 14s due to lack of privacy in medicare billing and my health records. I would frame this as an understanding of the medicare system and privacy laws. Then go onto describe how towns can support privacy in regards to accessing	Thanks for this important point. We have reworded some guidelines within this section to reflect your suggests as best we could.

5	Young people don't actually need medicare cards to access services, but reception need to be training in working with young people to a access medicare. Information about privacy important, particularly in working with under 14s due to lack of privacy in medicare billing and my health records. I would frame this as an understanding of the medicare system and privacy laws. Then go onto describe how towns can support privacy in regards to accessing further services such as pharmacy (we carry an inprest stock of contraception and morning after pills for better access and to ensure that young people worried about confidentiality at the pharmacy don't face extra barriers.	Thanks for this important point. We have reworded some guidelines within this section to reflect your suggests as best we could.
5	Clear referral pathways and options (ie termination of pregnancy)	Thanks for this point. We feel this would be better addressed in communication and collaboration and have chosen to focus on it in that section.
7	Services need the ability and capacity to provide flexible informal services to promote accessibility and engage with young people	Thanks for this note. We have reworded a section to provide greater emphasis on this.
3	Not essential, but I would be curious to know if there was any notable difference between the wishes of young men and young women	Thanks for this question. There was not major differences between young men and women within this study, however the sample group was quite small. There is a published paper on the youth interviews/focus groups available in Sex Education https://www.tandfonline.com/doi/ref/10.1080/14681811.2019.1566120?scroll=top Please contact me if you require full access.
	In your opinion, is there anything else that needs to be included or excluded from this section? (Key factors: Discreet condom supply)	
3	Condom supply is half of the equation or couples also at risk of unintended pregnancy. I think this point could include discreet access to to affordable contraception also....but I know that it is late in the piece. Did this not come up in the Youth interviews. Barrier to appropriate and affordable contraception is a huge issue for us.	Thanks for this great point. Within the youth focus groups and stakeholder consultations, the main issue was time and time again – condoms. Oral contraception was mentioned by one focus group, but only in the context that they felt comfortable asking their GP for scripts. We did approach two chemists, both locally and regionally to provide their comments on the framework to gain a greater context of the access issues in that setting, but neither were able to participate. Pregnancy tests also came up in a small way with young people, but not as a major issue or theme.
10	I would love to see something that addresses the stigma/shame of buying condoms, and break it so that young people are more likely to use them and not be embarrassed to purchase/access them. (same for the pill etc too)	Thanks for this point. We've made some of the guideline documents to make this a little more obvious.
11	Seeking external funding for supply	Thanks for this point.
12	Increase accessibility to latex free condoms, dental dams	Thanks for this. Within research there was no mention of dental dams by participants. The usage statistics of dental dams are quite low, and while promotion of these is important, within the scope of this research, the need for condom access was a more pressing theme.
13	maybe an indication of where people can access free condoms to give away . If you are not in eh sector, you may have no idea where to get 100 condoms to give away free. Might be good to mention access to lube here too.	Thanks for this point. We have modified the guidelines to reflect this.
	In your opinion, is there anything else that needs to be included or excluded from this section? (Key Factor: Communication and collaboration)	
14	PASH consortium was developed based on this concept /evidence for sustainability	Thanks for this comment. A great model for collaboration.
15	this section seems to mainly refer to health promotion activities, not inter-service communication. I think this is being left out. For young people requiring specialist services such as insertion of IUD or terminations, PREP and other services perhaps not supplied rural settings, collaboration and communication with major centres will be required. I think this goes beyond the social and peer network into formal health organisations partnerships but I'm not so sure that the details in this section cover this. Rural GPs need orientation to services in local areas. In vic, access to medical termination and surgical termination services is a huge issue.	Thanks for this point. We have reviewed the guidelines and made some adjustments to wording to hopefully reflect this. While there is a strong emphasis on sexual health promotion within the framework, collaboration and communication between groups – be that GP's using sporting club networks to run pop-up clinics, services having clearer communication between each other, services maintaining confidential communication between each other in a clinical setting should include inter-agency communication.
16	Interaction with all community groups in the area	
17	I found by this point, as some one skimming the document, I found this section a bit too long and I didn't feel like riding all the Key Guidelines :)	Thanks for the feedback. It is a bit wordy and we'd love to reduce the word count a little. We've reviewed the guidelines and tried to make it a bit easier to read.
18	Nothing Communication and collaboration is essential in rural areas - however clear delineation between clinical and consultative communication and collaboration is required to maintain confidentiality and the perception of confidentiality	Thanks for this note. We agree and feel that this guidelines sums up that sentiment: "Services must maintain confidentiality when communicating about individuals or groups."
19	check words? / interconnected and social*LY* close / Services need *to be* awareness / maybe adding access to emergency contraception could be a good example for this one too	Thanks for these notes. We've addressed the typos and included emergency contraception in the comments.
	Is there anything else that needs to be included in this section? (please type your response) - Rapid Community Scan and TOWN analysis	
20	Good prompts at each point	Thanks for that.

Definition/Further explanation about what exactly threats, opportunities, weaknesses, needs. Perhaps include what is inside own organisation/setting and what is external (ie partnerships, etc.)	Thanks for this note. While we'd love to have a lot more explanation, we are trying to balance the wordiness of the document against what needs to be included. We have included a small statement on internal/external and tried make the guiding questions reflect this.
When identifying the needs of the community is there a requirement for identification of skills (?professional) that the community may not have ready access to? and is there support for how to access these skills eg. advocacy evaluation	Thanks for this point. We have added further detail to a prompt about what skills are lacking under weaknesses.
Is there anything else that needs to be included in this section? (please type your response) - Phase 2: PLAN (Plan, Listen, Allocate, Network)	
Use Co-design with the local young people	Thanks for this. Young people are involved in the planning phase within this framework as a method of checking and defining the actions and implementation of the interventions. This involvement comes after the lead organisation has concluded the Community Scan and TOWN and could involve co-design if feasible in the setting.
Not sure how to include, but feel like this is the bit that is hard to do, under resourced and under funded!	Thanks for this note. It is the hard part and the one that does lack funding.
Is there anything else that needs to be included in this section? (please type your response) - Phase 3: ACT (Advocacy, Coordination, Targeted interventions)	
I think linking the targeted intervention section, back to the framework key concepts. I think I was reading this section as just about advocacy - rather than any delivery of SRE.	Thanks for this great point. We have made some subtle changes to the guidelines to improve this.
Is there anything else that needs to be included in this section? (please type your response) - Phase 4: Review	
Perhaps highlight that evaluation needs to happen continuously, not just at the end of each step	Thanks for this. We have added some statements that relate directly to this point.
Have to admit the - evaluate evaluation put me off a bit. Makes it sound like serious amount of evaluation ! :)	Noted!
Can you suggest changes that could make this Framework easier to use? - Yes - Text	
This document may need to be adapted to different sectors. This seems written for health promoters to enact. As service providers we would be invited into some of these activities rather than having overview. I would recommend companion guides for different frontline workers to describe some of this work from different perspectives and why you might be engaged in the project in this way. From a theoretical perspective I think its very well grounded in the relevant theory. As a practical guide....I think there is a next evolution. Well done though. Excellent work.	Thanks for this note. As you would be aware, rural sexual health is an area of multiple professions converging on a common problem from different backgrounds, training and experiences. This framework has been created from a health promotion perspective rather than a pure clinical perspective as its focus has been on primary prevention and early intervention rather than clinical services and testing. These are really important areas of rural sexual health, and would require slightly different approaches to address. I like the idea of companion guides that address how this framework would be further implemented by a frontline clinical work force to address their needs. This framework document has always aimed to be a first step in how to improve delivery and coordination in this area, rather than a complete solution – we'd love to further test the framework
28 This document may need to be adapted to different sectors. This seems written for health promoters to enact. As service providers we would be invited into some of these activities rather than having overview. I would recommend companion guides for different frontline workers to describe some of this work from different perspectives and why you might be engaged in the project in this way. From a theoretical perspective I think its very well grounded in the relevant theory. As a practical guide....I think there is a next evolution. Well done though. Excellent work.	Thanks for this note. As you would be aware, rural sexual health is an area of multiple professions converging on a common problem from different backgrounds, training and experiences. This framework has been created from a health promotion perspective rather than a pure clinical perspective as its focus has been on primary prevention and early intervention rather than clinical services and testing. These are really important areas of rural sexual health, and would require slightly different approaches to address. I like the idea of companion guides that address how this framework would be further implemented by a frontline clinical work force to address their needs. This framework document has always aimed to be a first step in how to improve delivery and coordination in this area, rather than a complete solution – we'd love to further test the framework in a couple of different rural communities to further improve, reframe and develop it. Perhaps a post-doctoral research opportunity if someone in this network is keen to host us!
29 way less text :) or text in a far more design friendly format	Thanks for this. We'd love to further reduce it – but also need the backing content. Perhaps an abridged version with the briefest of details would be a great introductory document.
Do you have any final comments on this framework document? - Yes - Text	
30 Looks good and would be a very useful tool for educators to use to inform what they should be teaching and the places they can go to collaborate in order to provide consistent messages	Thanks for this note.
31 This area is very outdated and in great need of new support.	Thanks for that.
32 nice work Carl!	Thanks.
33 Great work - I can definitely see benefits of following this process in our communities	Thanks for the comment.

H. Frameworks

This appendix contains the initial draft framework sent to stakeholders and the finalised RuSHY Framework.

Draft framework

Developing a framework for community-wide sexual health interventions in the rural setting: a participatory action research project.



Overview of a Framework for sexual health provision in the rural setting

This document consists of three sections:

1. An overview of the framework
2. The Framework for sexual health provision in the rural setting
3. The four-stage guide for implementing the framework in the community setting

Overview

Framework concepts

This framework was developed to give champions and rural sexual health leaders a clear tool-kit for implementing community-wide sexual health interventions that involve other stakeholders.

This framework was developed from analysing data collected from community based stakeholders and young people on their experiences and perspectives relating to sexual health and relationships and sexuality education provision in the rural area. The first phase of this project involved in-depth interviews with 16 community-based stakeholders either directly or indirectly involved in sexual health in the rural area and focus groups and interviews with 15 young people living in the rural area. These interviews and focus groups provided the basis for the framework and its implementation phase.

Following analysis, there are four key elements of that emerged from the data collected in the first phase of this research project and represent what was identified by participants as important in providing sexual health interventions in the rural setting.



Figure 1. The Four key elements that emerged from the data

The four elements represent the core ideals in delivering sexual health in the rural setting as identified by the research participants. Within the framework, there are several guidelines that emerged from the data that directly relate to the successful implementation of these four key concepts. These represent the lived experience of the research participants as expressed during the initial research phase.

Applying a theoretical lens to the framework: ecological framework

The framework applies Bronfenbrenner's *Ecological Framework for Human Development* as a theoretical lens to assist in highlighting and examining individual, interpersonal, organisational and community level interactions in the setting. The framework uses this lens to shine a light on how these different levels connect to the four framework implementation phases and the core concepts of the framework as identified in the data collection and relevant research literature.



Figure 2. Bronfenbrenner's socio-ecological framework

The core concept of Bronfenbrenner's framework is that an individual does not exist in isolation. There are multiple players and factors that impact on the individual. For this project, this concept is applied in the sense that interventions or initiatives that target the individual without addressing other socio-ecological levels may not be as effective in addressing youth sexual health in the rural area. In other research, it has been shown that programs recognising socio-ecological influences have been found to be most effective in improving sexual health outcomes for young people.

Applying the framework

This conceptual framework for the planning, implementation and evaluation of community-based youth sexual health interventions in the rural setting comprises of four major implementation phases:

1. **Community Scan and TOWN analysis**
2. **PLAN (Plan, Listen, Allocate, Network)**
3. **ACT (Advocacy, Coordination, Targeted interventions)**
4. **Review**

It has been highlighted within the research that there is rarely a "lead" agency for sexual health in the rural setting and that the workforce and health service provision is generalist in nature. There is a lack of prioritisation on sexual health and what is provided within the setting is often driven by individuals implementing single initiatives. This framework should be read from the perspective that there is community-based need for improving sexual health within the setting and the assumption that there is a leader or champion investigating how to improve sexual health within their community. The core concepts and guidelines are suggestions that have emerged from the research and not every community or setting will have the capacity or ability to deliver all concepts and guidelines.

Key Concepts in the framework



Consistent and credible sexuality and relationships education and information

Key Concept: The sexuality and relationships education delivered is relevant, acknowledges diversity and moves beyond the biological aspects of sexual health and provides young people with the skills and information that they want and need.

Key guidelines from this research:

- Schools are important in sexuality and relationships education (SRE) provision and interventions.
- Schools should be well connected with health providers and youth services
- Consistent messaging is important.
- SRE should be part of a comprehensive school health promotion approach
- SRE should be delivered by a credible presenter.
- If schools feel that outside presenters are more appropriate – they should actively seek or source them from either within their community (such as GPs) or beyond (WAAC, Dr YES).
- Outside presenters can enhance the SRE curriculum but teachers should lead delivery.
- Teachers should have access to SRE professional development opportunities.
- SRE programs and services should be inclusive of LGBTI youth.
- Sporting coaches and club members can be educated to act as a first point of contact for youth.



Health service accessibility and competing priorities

Key concept: Young people want uncomplicated access to sexual health services and information in their community.

Key guidelines from this research:

- Where specialist services are uncommon; existing services must deliver sexual health services as best they can.
- Young people trust the confidentiality of medical services.
- There are concerns around anonymity accessing services (waiting room or delivering pathology).
- Services should identify opportunities to engage and connect with young people.
- Regular outreach clinics may not be feasible, but one-off clinics or information sessions in non-clinical settings (sporting clubs, youth clubs) have been successful.
- Health services need clear policies (bulk-billing and youth access) that are clearly communicated internally; and advertised to young people via a variety of networks.
- Health services should explain access issues such as the need for Medicare cards or identification, parental consent or presence, booking procedures and confidentiality.
- Services should be promoted through traditional and non-traditional settings.



Discreet condom supply

Key concept: Young people want to buy condoms cheaply and anonymously from easily accessible places. Stealing condoms may be preferred to avoid interacting with others when accessing condoms.

Key guidelines from this research:

- Improving access to condoms requires community and societal level advocacy interventions.
- Traditional services (local government, education, youth and health) should lead advocacy. Credibility is critical and traditional services are respected.
- Condom vending machines are supported by young people.
- Young people prefer to access services such as self-serve checkouts when buying condoms.
- Sporting clubs, youth centres and GP consulting rooms are acceptable places to access condoms – provided there is minimal interaction with peers or adults.
- Condoms in busy areas (waiting rooms) are less acceptable due to a sense of being watched.
- Young women want access to condoms.



Communication and collaboration.

Key concept: Small towns are interconnected and social close, yet services can still operate in isolation. Initiate contact and spark collaboration in effective and sustainable ways.

Key guidelines from this research:

- Communication should rely on organisational connections rather than personal.
- Services need to be aware of current sexual health services; what students are learning about sexual health and where to access things like condoms or pregnancy tests is important.
- Active and visible school health nurses can act as an adjunct between health and education.
- Clear internal communication improves an organisation's ability to communicate with other stakeholders.
- New connections and collaborations with non-traditional settings such as sporting clubs and youth groups are possible. These collaborations rely on positive relationships with club presidents and members to ensure engagement and support.
- Collaborations often focus on male-dominated sports. Consider gender equity in seeking new collaborations to ensure equal access to information, education and condoms.
- Reach young people by advertising services or information in high-traffic youth friendly shopping or recreation areas.

Applying the framework

It is proposed that this framework is implemented in four phases.

Each phase should consider the socio-ecological system levels interaction and support and acknowledge the four key concepts of the framework.

The framework should be initiated by a lead agency, champion or collaboration and use Phase 1 to identify other stakeholders to co-opt or collaborate with for Phases 2-4. Who this lead agency or champion is will change from community to community. It may be driven from education, health, youth services or from sport and community groups – but should look to identify and engage as many other stakeholders and settings within the community as possible.



Figure 3. Framework implementation phases

Phase one –Community Scan and TOWN analysis

The improved coordination and implementation of sexual health interventions in the rural area is dependent on the understanding of the setting and community. This understanding would consider the multi-level interrelationships that exist and how these interactions impact on the ability to address sexual health in the rural area. The Community Scan and TOWN analysis allows the examination of the setting in close detail.



1. **Community Scan - Understand the context**
 - a. What is already happening in our community?
 - b. What has our community done in the past relating to sexual health?
 - c. What history and past events will affect how we encourage stakeholder involvement in a local intervention sexual health strategy?
 - d. What characteristics and cultural values in our community will affect how we encourage involvement in a local intervention sexual health strategy?
2. **Community Scan – Involvement and relationships**
 - a. What/who are the key youth or health related agencies or organisations in our community?
 - b. Who is already involved in providing sexual health for young people in our community? (Include education; sexual health services; youth services)
 - c. Where do young people spend their time in our community? What groups? Schools? Stores? Venues? Places?
 - d. Where can people access condoms and pregnancy tests? Are they affordable for young people? Are they accessed anonymously?
 - e. Where can young people access STI tests? Where do they have to deliver pathology?

- f. How many GPs are available in the community? How many have sexual health training? How many specialise in youth? What does it cost to see a GP? What is the booking process?
- g. Do the schools in the community provide RSE? Who delivers it? Do teachers have access to regular RSE professional development? Is the school connected to the GPs? Is there a school nurse? What is the role of the school nurse? Is there a sick bay?
- h. What clubs, groups and organisations connect with young people on a regular basis?
- i. What outside experts and regional services are already involved or active in our community?
- j. How can we communicate? How can we connect with or communicate with young people?
- k. What networking/collaborative mechanisms already exist between stakeholders and organisations?

3. TOWN Analysis (Threats, Opportunities, Weaknesses, Needs)

- a. Threats:
 - i. What threats could prevent our collaboration/s?
 - ii. What threats need to be addressed immediately?
 - iii. What threats pose the greatest risk towards the provision of sexual health education and services for young people in this community?
 - iv. What relationships already exist with local press?
 - v. How active is our local community on social media?
- b. Opportunities:
 - i. What opportunities are already available to us?
 - ii. What opportunities are possible through our collaboration?
 - iii. What community strengths and resources could we mobilise?
 - iv. What relationships could be developed?
- c. Weaknesses:
 - i. What weaknesses do we have as a group? As a community?
 - ii. How can these be addressed?
 - iii. Do we need outside help?
 - iv. Who is 'on board' already? Who isn't?
 - v. How do young people view our services right now?
- d. Needs:
 - i. What does our community need?
 - ii. What needs to happen right now?
 - iii. What other relationships with key stakeholders will be important to acknowledge and develop?
 - iv. What is our communication strategy to facilitate greater understanding of and engagement with this process?

Phase two – PLAN (Prepare, Listen, Allocate, Network)

The purpose of stage two is to bring all identified stakeholders from the Community Scan together, consider TOWN analysis and prepare the intervention program. All analysis considers the socio-ecological system levels and how these will impact on the delivery of interventions.



1. Prepare

- a. Review the *TOWN analysis* and consider the goals of your collaboration.
- b. Investigate **Threats** and **Weaknesses**. Identify how collaborative partners will address.
- c. Prepare advocacy strategy – ensure key messages are clear and evidence-based.
- d. Investigate **Opportunities** and gather resources and stakeholders.
- e. Prepare consistent messaging for all stakeholders to use within their interventions.
- f. Prioritise the **Needs** of your community and identify strategies for how and when these will be met. Can the stakeholders meet these needs?
- g. Identify clear goals the collaboration will seek to achieve.
- h. Establish a list of interventions that collaborative partners will undertake.
- i. Set clear methods for evaluating the activity of the collaboration.

2. Listen

- a. Connect with young people within your community and gain their feedback on the *TOWN analysis*. Are your needs similar? Are you addressing their needs? Are the weaknesses identifying the same?
- b. Gather feedback on proposed interventions from the youth feedback group. Identify missing interventions. Incorporate youth feedback into your preparation.
- c. Communicate within your collaboration to establish what is possible

3. Allocate

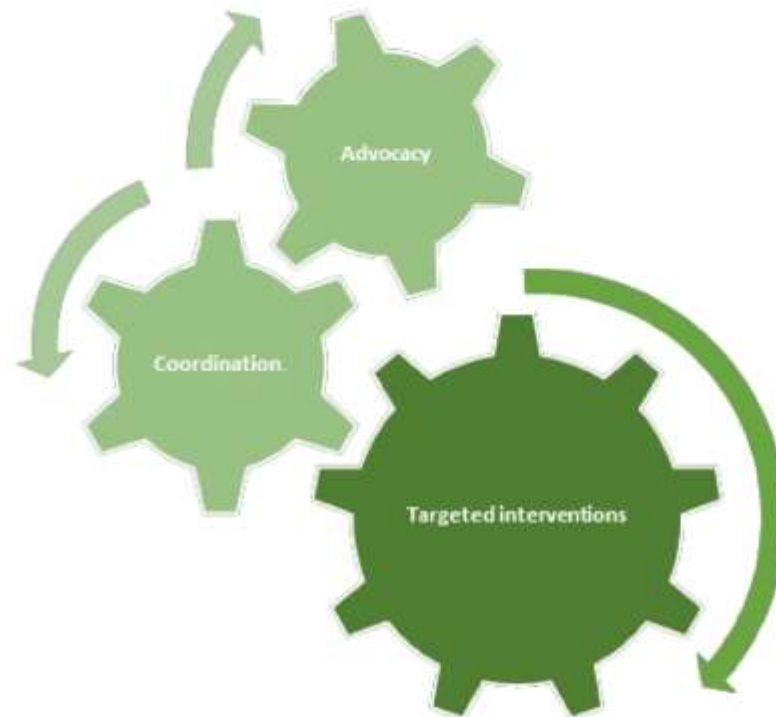
- a. Allocate a time frame for the intervention project.
- b. Who is driving the collaboration? Who oversees maintaining communication? Who is providing resources? Who will provide support or expertise?
- c. Allocate roles within the collaboration. Which interventions will each partner deliver?
- d. Who oversees evaluation of the intervention? Is evaluation support needed?
- e. Who is the advocacy lead for the collaboration? Who will monitor and respond to local media and social media issues on behalf of the collaboration?

4. Network

- a. Ensure relationships between collaborative partners can be easily maintained.
- b. Provide opportunities for collaborative partners to easily connect and share.
- c. Allow new stakeholders and new partners to be easily integrated into the collaboration.
- d. Ensure connection with youth so they can provide additional feedback when required.
- e. Ensure all collaborative partners are aware of the goals and evaluation methods.

Phase Three – ACT (Advocacy, Coordination, Targeted interventions)

The purpose of Phase three is to implement and action the planned inventions. A key component of Phase Three is advocacy and coordination. Care should be taken to ensure that coordination and communication is maintained, and all information is consistent, relevant and credible.



1. Advocacy

- a. Commence advocacy strategy prior to commencement of interventions.
- b. Connect with local media to initiate advocacy within the local media.
- c. Ensure advocacy opportunities are responded to swiftly using the clear messages.

2. Coordination

- a. Maintain communication between collaborative partners.
- b. Ensure co-ordinated response is prioritised by collaborative partners.
- c. Ensure collaborative partners are aware of what is happening throughout the network.

3. Targeted interventions

- a. Deliver the targeted interventions in our community.
- b. Ensure interventions are delivered in the agreed manner. If variation is needed, ensure coordination is maintained and evaluation processes are acknowledged.

Phase Four – Review

The purpose of Phase Four is to reflect and evaluate on the previous phases, examine what worked and what didn't and maintain the group. All evaluation should consider the systems at all levels.



1. Evaluate Phase Three

- a. Was the Advocacy Strategy effective? What was missing? Was criticism addressed appropriately? Were responses from the collaboration timely and evidence-based?
- b. Did partners maintain communication and coordination for the entire program?
- c. How successful were targeted interventions in meeting the collaborative goals for our community? Which goals were not met? What needs remain unmet?

2. Evaluate our evaluation

- a. Did we successfully evaluate our interventions?
- b. Were our evaluation processes effective?
- c. What other layers of evaluation could have been implemented?
- d. What support did we need for our evaluation?

3. Review Phase Two

- a. What did we miss during the PLAN phase of our project?
- b. Was our network effective in delivering our goals?
- c. What preparation could be improved upon within the next phase of the project?
- d. Did the allocated collaborative partners deliver their roles?

4. Maintain Network

- a. Who is still engaged? Who isn't?
- b. Who do we need to bring into our collaboration?
- c. How can we improve communication within our network? What worked and what didn't?
- d. Who needs to take control of this process? What needs to happen next for our community?

5. Recommence Phase One

- a. Perform another Rapid Community Scan and TOWN analysis.

Finalised framework

The Rural Sexual Health in Youth (RuSHY) Framework

This document has three sections:

1. The introduction and background to the RuSHY Framework
2. The RuSHY Framework
3. The implementation guide

An introduction to the Framework

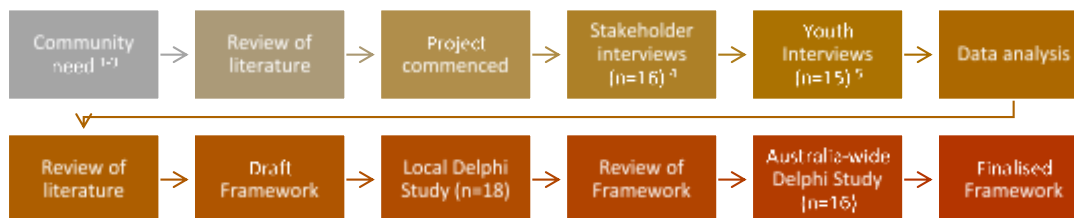
Background

The *RuSHY Framework* was developed as part of a participatory action research project¹ in a small rural town in Western Australia after an expressed need from the community to address sexual health²⁻⁵. It aims to improve coordination of sexual health in small towns and provide guidance to rural communities in how to meet the needs of young people (age 16-24) in their towns. With limited literature about relationships and sexuality education (RSE) and health provision in rural Australia⁶, this study gives voice to rural workers providing these services – at times through circumstance rather than planning⁴. The rural workforce often consists of generalists who work in isolation with limited formalised qualifications or previous experience⁷. There is a lack of clear guidance and a lack of consistency in how to implement community level sexual health interventions.

Sexual health is a major issue for young people aged 16-24 years in Australia⁸ and despite testing rates lower than 10%, chlamydia is the most common bacterial sexually transmissible infection (STI) in young Australian adults⁹, with a high prevalence seen in young men and women attending rural General Practitioner (GP) clinics¹⁰. Finding strategies to improve implementation of sexual health interventions and RSE in small communities is important in addressing this issue. The responsibility of providing rural RSE regularly falls upon schools¹¹⁻¹³ however there are often gaps in students' sexual health knowledge and dissatisfaction with the relevance of the provided RSE¹⁴⁻¹⁷. While small towns have limited ability to deliver many services, this framework aims to give workers or volunteers guidance and when addressing sexual health in their own community.

Developing the RuSHY Framework concepts

The RuSHY Framework development involved analysing data collected from community-based stakeholders and young people. Participants explained experiences and perspectives relating to sexual health and relationships and sexuality education provision in the rural area.



This collected data on rural sexual health and RSE provision suggests:

- There is rarely a lead agency or dedicated service

Figure 1. Process of developing this Framework

- The workforce can lack specialist skills and recent professional development
- There is a lack of funding for sexual health
- There is a current lack of collaboration
- Sexual health not a priority for many services
- There is a fear of community backlash if services are “promoting sexual activity”

Framework concepts

There are four key concepts that appeared from the collected data. These concepts are what was named by participants as important in providing sexual health interventions in the rural setting:

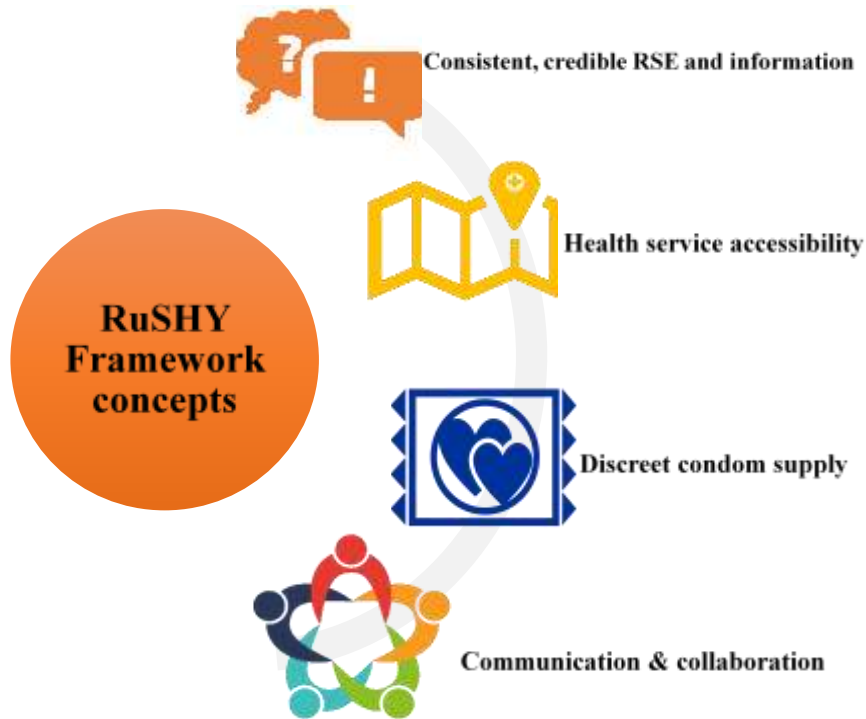
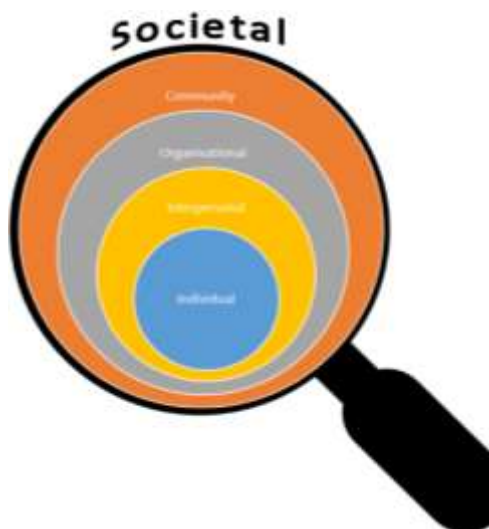


Figure 1. The Four key elements that emerged from the data

Within the four concepts, there are suggested guidelines included that emerged from collected data and reviews of contemporary rural sexual health research literature. These guidelines are the lived experience of the research participants and are not an exhaustive list of guidelines or suggestions for every community.

Applying a theoretical lens to the framework: ecological framework



The Framework applies Bronfenbrenner's *Ecological Framework for Human Development* as a theoretical lens¹⁸. The Framework uses this lens to shine a light on how different the levels of interaction connect to the four concepts.

In Bronfenbrenner's framework an individual does not exist in isolation. There are multiple layers and factors that impact on the individual's lived experience.

When applying this idea to this Framework, it is suggested stakeholders and communities target more than the individual and consider the all levels of the socio-ecological model:

- Individual
- Interpersonal
- Organisational
- Community
- Societal

Figure 2. Bronfenbrenner's socio-ecological framework

How to apply the framework

The Framework guides community-based need for improving sexual health in small towns. This may be from community-voiced need; stakeholders wanting to improve practice or changes in local strategy. The Framework consists of four implementation phases. Each phase should consider each socio-ecological level and respond to the four key concepts of the framework:

1. **Community Scan and TOWN analysis**
2. **PLAN (Plan, Listen, Allocate, Network)**
3. **ACT (Advocacy, Coordination, Targeted interventions)**
4. **Review**



Figure 1. The framework implementation in four phases

Each implementation phase has steps and guidelines giving greater detail.

Understanding the setting

This Framework development gives rural sexual health leaders clearer direction in implementing community-wide sexual health interventions. In developing the Framework and suggesting its implementation, we acknowledge:

- 1. The Framework needs an initial leader, champion or collaboration. This will change community to community and may be driven from education, health, youth services or from sport and community or volunteer groups.
- 2. Not every community or setting has the capacity or ability to deliver all concepts and guidelines. The recommendations are not prescriptive nor exhaustive.
- 3. The Framework is a tool designed to improve what may already be happening and improve coordination. It should not be applied in isolation and should incorporate local actions, guidelines and curriculum.
- 4. There is rarely funding for sexual health services in rural towns. This framework aims to assist stakeholders improve current practice to meet needs rather than a tool for a standalone project reliant on external funding.

The Framework: key concepts



Consistent and credible relationships and sexuality education and information

Key Concept: The relationships and sexuality education delivered is relevant, acknowledges diversity and moves beyond the biological aspects of sexual health and provides young people with the skills and information that they want and need.

Key guidelines from this research:

- Consistent messaging throughout the community is important.
- Relationships and sexuality education (RSE) programs and services should be inclusive of LGBTI youth.
- Sporting coaches and club members can be educated to act as a first point of contact for youth. RSE should be delivered by a credible presenter in all settings.
- Schools are important in sexuality and relationships education provision and interventions.
- Schools should be well connected with health providers and youth services
- Communities must also consider how to reach young people not in school.
- Relationships and sexuality education should be part of a comprehensive school health promotion approach
- Relationships and sexuality education should be led by the curriculum and not biologically focussed.
- Young people need education and support around negotiating relationships and consent, resilience, etc
- If schools feel that outside presenters are more appropriate – they should actively seek or source them from either within their community (such as GPs or school nurses) or beyond (Aids Councils, Youth Doctor programs).
- Outside presenters can enhance the RSE curriculum but teachers should lead delivery.
- Teachers should have access to RSE professional development opportunities to build capacity.



Health service accessibility and competing priorities

Key concept: Young people want uncomplicated and confidential access to sexual health services and information in their community.

Key guidelines from this research:

- Where specialist services are uncommon; existing services must deliver services as best they can.
- Maintaining confidentiality is critical. Young people trust the confidentiality of medical services.
- There are concerns around anonymity accessing services (waiting rooms or delivering pathology).
- Services should find opportunities to engage and connect with young people.
- Regular outreach clinics may not be workable, but one-off clinics, flexible informal services or information sessions in non-clinical settings (sporting clubs, youth clubs) have been successful.
- Health services need clear policies (bulk-billing and youth access) clearly communicated internally; and advertised to young people via a variety of networks.
- Health services should explain access issues such as when Medicare cards are or are not needed; what identification is needed; parental consent or presence; booking procedures; and confidentiality.
- Services should promote themselves through traditional and non-traditional settings.
- Consider transport to services as a barrier.
- Services need training and professional development in delivering youth friendly services and can utilise peer-to-peer support to enhance delivery of information. This includes reception, administrative and support staff.



Discreet condom supply

Key concept: Young people want to buy condoms cheaply and anonymously from easily accessible places. Stealing condoms may be preferred to avoid interacting with others when accessing condoms.

Key guidelines from this research:

- Young women want access to condoms.
- Young people are willing to buy condoms if they are cheap and anonymously accessible.
- Improving access to condoms needs community and organisational level advocacy.
- Communicating the need for condoms to the community is important to reduce backlash or stigma.
- Traditional services (local government, education, youth and health) should lead advocacy. Credibility is critical and traditional services are respected.
- Health, youth and education workers should have support in talking about condoms with young people.
- Young people prefer to access self-serve checkout services when buying condoms.
- Young people support condom vending machines.
- Sporting clubs, youth centres and GP consulting rooms are acceptable places to access free condoms – provided there is minimal interaction with peers or adults. External funding to source condoms and lubricant is often available.
- Condoms in busy areas (waiting rooms) are less acceptable due to a sense of being watched.



Communication and collaboration.

Key concept: Small towns are interconnected and socially close, yet services can still work in isolation with limited collaboration or communication. Services should initiate contact and spark collaboration in effective and sustainable ways.

Key guidelines from this research:

- Communities lacking lead or specialist sexual health agencies need to identify who is involved and what is working.
- Increased collaboration ensures needs are met, there is less isolation and less chance of duplication.
- Communication between services should rely on organisational rather than personal connections.
- Services must maintain confidentiality when communicating clinical information.
- Collaboration increases the reach of messages.
- Services need orientation and awareness of sexual health services and referral pathways; what SRE students are learning and where young people can access condoms, emergency contraception or pregnancy tests.
- Services need to know how to refer young people to other services beyond their town – and how to collaborate and communicate confidentially to support these needs (PrEP, termination, specialist services).
- Active and visible school health nurses can act as an adjunct between health and education. School nurses need to promote services that are available via teachers, stakeholders and other youth settings; and directly.
- Clear internal communication improves an organisation's ability to communicate with other stakeholders.
- New connections and collaborations with non-traditional settings such as sporting clubs and youth groups and the wider community are possible. These collaborations rely on positive relationships with club presidents and community members to ensure engagement and support.
- Collaborations often focus on male-dominated sports. Consider gender equity in seeking new collaborations to ensure equal access to information, education and condoms.
- Reach young people by advertising services or information in high-traffic youth friendly shopping or recreation areas.

Applying the framework

Phase one –Community Scan and TOWN analysis

Phase one is reliant on someone or an agency seeing a need to improve sexual health and RSE delivery in the community. It needs consultation with other groups; or seeking contributions of information or time.

The improved coordination and implementation of sexual health interventions in the rural area is dependent on the understanding of the setting and community. This understanding would consider the multi-level interactions that exist and how these impact on how sexual health is provided in the rural area.

The Community Scan and TOWN analysis allows the examination of the setting in close detail. It is practically focussed and should address the needs of the community. It should consider internal and external threats, opportunities and weaknesses and be collaborative and open to innovation.



1. **Community Scan - Understand the context**
 - a. What is already happening in our community?
 - b. What has our community done in the past relating to sexual health?
 - c. What budget (if any) is there for sexual health in our community?
 - d. What history and past events will affect how we encourage stakeholder involvement in a local intervention sexual health strategy?
 - e. What characteristics and cultural values in our community will affect how we encourage involvement in a local intervention sexual health strategy?
2. **Community Scan – Involvement and relationships**
 - a. What/who are the key youth or health related agencies or organisations in our community?
 - b. Who is already involved in providing sexual health for young people in our community? (Include education; sexual health services; youth services)
 - c. What is working in our community?
 - d. Where do young people spend their time in our community? What groups? Schools? Stores? Venues? Places?
 - e. How do we reach homeless or hard to reach young people? What agencies work with this groups?
 - f. Where can people access condoms and pregnancy tests? Are they affordable for young people? Are they accessed anonymously?

- g. Where can young people access STI tests? Where do they have to deliver pathology?
 - h. How many GPs are available in the community? How many have sexual health training? How many specialise in youth? What does it cost to see a GP? What is the booking process?
 - i. Do the schools in the community provide RSE? Who delivers it? Do teachers have access to regular RSE professional development? Is the school connected to the GPs? Is there a school nurse? What is the role of the school nurse? Is there a sick bay?
 - j. What clubs, groups and organisations connect with young people on a regular basis?
 - k. What outside experts and regional services are already involved or active in our community?
 - l. How can we communicate? How can we connect with or communicate with young people?
 - m. What networking/collaborative mechanisms already exist between stakeholders and organisations?
 - n. Do we have enough information? Do we need to conduct forums or focus groups with young people, parents or the community to gather more information?
3. **TOWN Analysis: How will local and external Threats, Opportunities, Weaknesses, Needs impact on our ability to address the four key concept areas of the framework?**
- a. **Threats:**
 - i. What threats could prevent our collaboration/s?
 - ii. What threats need to be addressed at once?
 - iii. What threats pose the greatest risk towards the provision of sexual health education and services for young people in this community?
 - iv. What relationships already exist with local press?
 - v. How active is our local community on social media?
 - b. **Opportunities:**
 - i. What opportunities are already available to us?
 - ii. What opportunities are possible through our collaboration?
 - iii. How can we involve young people in our planning?
 - iv. What collaborations are possible in our setting? Could GP's visit the schools to help in delivering RSE? Can health teachers communicate with youth and health services about what is being taught to students? Could sporting clubs have clear information on how to refer young people to health or youth services? Who could supply condoms for free in our area? Would local government support condom vending machines?
 - v. What community strengths and resources could we mobilise?
 - vi. What relationships could be developed?
 - c. **Weaknesses:**
 - i. What weaknesses do we have as a group? As a community?
 - ii. How can these be addressed?
 - iii. Do we need outside help? What skills are we lacking? Where can we source them?
 - iv. Who is 'on board' already? Who is not?
 - v. How do young people view our services right now?
 - d. **Needs:**
 - i. What does our community need?
 - ii. What needs to happen right now?
 - iii. What other relationships with key stakeholders will be important to acknowledge and develop?
 - iv. How will we communicate with parents? How will we communicate with young people? How will we manage parental concerns?

Phase two – PLAN (Prepare, Listen, Allocate, Network)

The purpose of stage two is to bring all identified stakeholders from the Community Scan together, consider the TOWN analysis and prepare an intervention program. This may happen via meetings, emails circulars or forums. All analysis considers the socio-ecological system levels and how these will affect on the delivery of interventions.



1. Prepare – pre-planning and prioritising

- a. Review the *TOWN analysis* and consider the goals of your collaboration.
- b. Consider what is feasible. Do not plan to do too much or too big.
- c. Investigate **Threats** and **Weaknesses**. Identify how collaborative partners will address.
- d. Prepare advocacy strategy to target parents and community – ensure key messages are clear and evidence-based. Consider utilising an advocacy toolkit for guidance.
- e. Investigate **Opportunities** and gather resources and stakeholders.
- f. Prepare consistent messaging for all stakeholders to use within their interventions.
- g. Prioritise the **Needs** of your community and find strategies for how and when these will be met. Can the stakeholders meet these needs?
- h. Name clear goals the collaboration will seek to achieve.
- i. Establish a list of interventions that collaborative partners will undertake.
- j. Set clear methods for evaluating the activity of the collaboration and clear time lines for evaluation cycles.

2. Listen – reach out to young people and gather feedback

- a. Connect with young people in your community and gain feedback on the *TOWN analysis* and interventions. Seek advice on best strategies connect with young people from local youth focussed community groups.
- b. Consider advice from diverse groups of young people from your community – school age, new to workforce, engaged in sport, hard to reach, homeless. Are needs similar? Are you addressing their needs? Are weaknesses showing the same? Are hard-to-reach youth supported?
- c. Analyse feedback the youth group. Identify missing interventions. Incorporate feedback into preparation.
- d. Communicate within your collaboration to establish what is possible when addressing youth needs.

3. Allocate – provide clarity in roles

- a. Allocate a period for the intervention project.
- b. Allocate a period for evaluation. Who oversees evaluation? Is evaluation support needed?
- c. Who is the lead for the collaboration? Who oversees supporting communication? Who is supplying resources? Who will supply support or expertise? Who does not see a role for themselves?
- d. Allocate roles within the collaboration. Which interventions will each partner deliver?
- e. Who is the advocacy lead? Who checks and responds to local and social media issues for the collaboration?

4. Network – support your collaborative network

- a. Ensure relationships between collaborative partners can be easily supported.
- b. Provide opportunities for collaborative partners to easily connect and share.
- c. Allow new stakeholders and new partners to easy integrated into the collaboration.
- d. Ensure ongoing connection with youth so they can supply additional feedback when required.
- e. Ensure all collaborative partners are aware of the goals and evaluation methods.

Phase Three – ACT (Advocacy, Coordination, Targeted interventions)

The purpose of Phase three is to implement and action the planned inventions.

Key components of delivering interventions are advocacy and coordination. Care should be taken to ensure that coordination is supported, and all information communicated as part of advocacy is consistent and relevant. Stakeholders will lose support from both young people and the community if they are not seen to be credible.



1. **Advocacy: Sexual health can be a controversial community topic – control the conversation and be prepared with facts, support and a clear message**
 - a. Have a clear advocacy strategy. Consider using advocacy guides to help your group if you lack experience. Frame your message. Be prepared. Plan for small wins and small gains.
 - b. Commence advocacy strategy prior to commencement of interventions. Proactively educating the community on the need and the opportunities for sexual health is important.
 - c. Focus advocacy on the four key framework concepts.
 - d. Connect with local media to start advocacy. Local media can hold strong power in small communities. While local media may not be the most effective way to reach young people – ensuring you have a good working relationship with before letters to the editor appear may help minimise backlash.
 - e. Ensure advocacy opportunities are responded to swiftly using the clear, prepared messages.
2. **Coordination: Ensure communication and focus on Communication and Collaboration framework concept is sustained**
 - a. Maintain communication between collaborative partners. Communication needs to be simple and effective. Consider and adjust to what is right for your community (meetings, emails, newsletters, workshops, seminars, working groups, etc.)
 - b. Ensure co-ordinated responses are prioritised by collaborative partners. A lack of collaboration and cooperation can lead to duplication of services.
 - c. Ensure collaborative partners are aware of what is happening throughout the network.
3. **Targeted interventions: Interventions should address the four key framework concepts**
 - a. Deliver the targeted interventions in our community that address the key framework concepts.
 - b. Ensure interventions are delivered in the agreed manner. If variation is needed, ensure coordination is supported and evaluation processes are acknowledged.
 - c. What interventions are successful so far? What is not working? What needs to be changed now to improve the current interventions? What factors have not been addressed?
 - d. Document what is happening. Document for your evaluation. Is the evaluation method forgotten?

Phase Four – Review

The purpose of Phase Four is to reflect and evaluate on the earlier phases, examine what worked and what didn't and maintain the group. All evaluation should consider the systems at all levels and be continuous in nature.



1. Evaluate Phase Three

- a. Was the Advocacy Strategy effective? What was missing? Was criticism addressed appropriately? Were responses from the collaboration prompt and evidence-based?
- b. Did partners keep communication and coordination for the entire program?
- c. How successful were targeted interventions in meeting the collaborative goals for our community? Which goals were not met? What needs are still unmet?
- d. What key framework factors require greater focus?

2. Evaluate our evaluation

- a. Was evaluation carried out continuously as we worked?
- b. Did we successfully evaluate our interventions?
- c. Were our evaluation processes effective?
- d. What other layers of evaluation could have been implemented?
- e. What support did we need for our evaluation?

3. Review Phase Two

- a. What did we miss during the PLAN phase of our project?
- b. What is still needed?
- c. Was our network effective in delivering our goals?
- d. What preparation could be improved upon within the next phase of the project?
- e. Did the collaborative partners deliver their roles?

4. Maintain Network

- a. Who is still engaged? Who is not? Who needs to move on? Why did people leave or not take part as they indicated they would?
- b. Who do we need to bring into our collaboration?
- c. How can we improve communication within our network? What worked and what did not?
- d. Who needs to take control of this process? What needs to happen next for our community?

5. Recommence Phase One

- a. Perform another Rapid Community Scan and TOWN analysis.

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I. Statements of contribution



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29 September 2019

To Whom It May Concern,

I, **Sharyn Burns**, contributed as Supervisor of the PhD. I had an ongoing close involvement with the research, including contributing to the project proposal, discussion structure of publications, the reading of drafts and making suggestions for improvement to the publications entitled:

1. Heslop, C. W., S. Burns, R. Lobo and R. McConigley (2017). "Developing a framework for community-based sexual health interventions for youth in the rural setting: protocol for a participatory action research study." *BMJ Open* 7(5).
2. Heslop, C. W., S. Burns and R. Lobo (2018). "Managing qualitative research as insider-research in small rural communities." *Rural and Remote Health* 18.
3. Heslop, C. W., S. Burns and R. Lobo (2019). "'Everyone knows everyone': youth perceptions of relationships and sexuality education, condom access and health services in a rural town." *Sex Education*: 1-17.
4. Heslop, C. W., S. Burns and R. Lobo (2019). "Stakeholder perceptions of relationships and sexuality education, backlash and health services in a rural town." *Sex Education*: 1-16.

Sharyn Burns (supervisor, co-author)

Carl Heslop (candidate)

1 of 1

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CRICOS Provider Code 00301J (WA), 026376 (NSW)



29 September 2019

To Whom It May Concern,

I, Roanna Lobo, contributed as Co-Supervisor of the PhD. I had an ongoing close involvement with the research, including contributing to the project proposal, discussion structure of publications, the reading of drafts and making suggestions for improvement to the publications entitled:

1. Heslop, C. W., S. Burns, R. Lobo and R. McConigley (2017). "Developing a framework for community-based sexual health interventions for youth in the rural setting: protocol for a participatory action research study." *BMJ Open* 7(5).
2. Heslop, C. W., S. Burns and R. Lobo (2018). "Managing qualitative research as insider-research in small rural communities." *Rural and Remote Health* 18.
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Roanna Lobo (co-supervisor, co-author)




27 September 2019

To Whom It May Concern,

I, Ruth McConigley, contributed as Co-Supervisor of the PhD contributed as a co-supervisor of the PhD from its conception through to 2017. During that time, I had an ongoing close involvement with the research, including contributing to the project proposal, discussion structure of publications, the reading of drafts and making suggestions for improvement to the publication entitled:

1. Heslop, C. W., S. Burns, R. Lobo and R. McConigley (2017). "Developing a framework for community-based sexual health interventions for youth in the rural setting: protocol for a participatory action research study." *BMJ Open* 7(5).



Ruth McConigley (Co-Supervisor, co-author)



Carl Heslop (candidate)

J. Ethics approval

MEMORANDUM



To:	A/Prof Sharyn Burns School of Public Health	Office of Research and Development Human Research Ethics Office
CC:	Mr Carl Heslop	
From:	Professor Peter O'Leary, Chair Human Research Ethics Committee	TELEPHONE 9266 2784 FACSIMILE 9266 3793 EMAIL hrec@curtin.edu.au
Subject:	HREC review outcome for project: 5918	
Date:	20-Apr-15	

Thank you for your application submitted to the Human Research Ethics Office for the project: 5918

Developing a framework for community-based sexual health interventions for youth in the rural setting

Your application was reviewed by Curtin University Human Research Ethics Committee on: 14/04/2015

Your project was reviewed as: Approved subject to

You are not authorised to commence data collection.

The Committee has asked for further clarification on the points below.

Please respond to this request promptly. Please ensure your response includes a covering letter, outlining your response to the above queries, a signed revised application and all supporting documentation. If your response satisfies the concerns raised by the HREC you will be issued with an approval letter.

- Amend the recruitment material to include:
 - 1.1 The Curtin University Logo consistent with the Curtin Brand Toolkit.
 - 1.2 A Curtin University phone number in place of the student's personal mobile phone number.
 - 1.3 The Principal Investigator's contact details.
- Amend the contact details on the consent form and participant information sheet by removing the student's personal mobile phone number and include the contact details of the Principle Investigator.
- Amend the participant information sheet to explicitly state that this is a supervised doctoral research project.
- Amend the youth participant information sheet to explicitly acknowledge the socio-emotional risks of participation becoming public knowledge due to the small sample size in a rural community.
- Develop a handout with appropriate referral services independent of the research team.
- Develop a separate participant information sheet for the stakeholder participants.
- The HREC recommends a review of the mandatory reporting requirements in regard to the adverse events procedure. The participant information sheet must clearly state reporting requirements of possible illegal activities:
See http://www.health.wa.gov.au/mandatoryreport/docs/Protection_of_Children_Policy.pdf
- Develop an adverse events protocol for any non-age of consent issues with respect to the participant's sexual health that the research team may become inadvertently aware of including the contact details of appropriate service independent of the research team.
- Amend the data storage to ensure that electronic data will be stored on a remotely accessible R drive folder rather than a "secure private server"

Yours sincerely,

Professor Peter O'Leary
Chair Human Research Ethics Committee

15-Oct-2018

Name: Sharyn Burns
Department/School: WA Centre for Health Promotion Research
Email: S.Burns@curtin.edu.au

Dear Sharyn Burns

RE: Amendment approval
Approval number: HR96/2015

Thank you for submitting an amendment request to the Human Research Ethics Office for the project **Developing a framework for community-based sexual health interventions for youth in the rural setting**.

Your amendment request has been reviewed and the review outcome is: **Approved**

The amendment approval number is HR96/2015-06 approved on 15-Oct-2018.

The following amendments were approved:

The amendment is associated with the Delphi Panel data collection. As this project adopts a Participatory Action Research approach it was not possible to provide the details about the framework and the associated questions for the Delphi panel at the time of submission.

The use of the Delphi panel was described in the original application.

Panel members will be provided the Participant Information sheet initially. If they agree to participate they will be provided the Framework and a link to the online survey (via Qualtrics).

Any special conditions noted in the original approval letter still apply.

Standard conditions of approval

1. Research must be conducted according to the approved proposal
2. Report in a timely manner anything that might warrant review of ethical approval of the project including:
 - proposed changes to the approved proposal or conduct of the study
 - unanticipated problems that might affect continued ethical acceptability of the project
 - major deviations from the approved proposal and/or regulatory guidelines
 - serious adverse events
3. Amendments to the proposal must be approved by the Human Research Ethics Office before they are implemented (except where an amendment is undertaken to eliminate an immediate risk to participants)

4. An annual progress report must be submitted to the Human Research Ethics Office on or before the anniversary of approval and a completion report submitted on completion of the project
5. Personnel working on this project must be adequately qualified by education, training and experience for their role, or supervised
6. Personnel must disclose any actual or potential conflicts of interest, including any financial or other interest or affiliation, that bears on this project
7. Changes to personnel working on this project must be reported to the Human Research Ethics Office
8. Data and primary materials must be retained and stored in accordance with the [Western Australian University Sector Disposal Authority \(WAUSDA\)](#) and the [Curtin University Research Data and Primary Materials policy](#)
9. Where practicable, results of the research should be made available to the research participants in a timely and clear manner
10. Unless prohibited by contractual obligations, results of the research should be disseminated in a manner that will allow public scrutiny; the Human Research Ethics Office must be informed of any constraints on publication
11. Ethics approval is dependent upon ongoing compliance of the research with the [Australian Code for the Responsible Conduct of Research](#), the [National Statement on Ethical Conduct in Human Research](#), applicable legal requirements, and with Curtin University policies, procedures and governance requirements
12. The Human Research Ethics Office may conduct audits on a portion of approved projects.

Should you have any queries regarding consideration of your project, please contact the Ethics Support Officer for your faculty or the Ethics Office at hrec@curtin.edu.au or on 9266 2784.

Yours sincerely



Catherine Gangell
Manager, Research Integrity

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EXEGESIS REFERENCES:

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