



Impact Evaluation Study

on the professional development course for teachers in sexual health education and the use of the **'Growing and Developing Healthy Relationships Curriculum Support Materials'** and preferred models of teacher professional development in sexual health education



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Prepared for Department of Health
by



Contents

1. Executive summary and key recommendations	3
2. Introduction and acknowledgements	7
3. Part A: Impact evaluation of the professional development course for teachers	9
A snapshot overview of the findings of Part A	9
3.1 The professional development course for teachers in WA	9
3.2 The aims of the course delivered to WA teachers	10
3.3 Participants' individual PD course evaluation surveys	11
3.4 2005 audit and impact assessment of the GDHR materials	13
3.5 Impact evaluation survey of program participants	14
3.6 Background information about respondents	16
3.7 Results of telephone interviews	18
3.8 Personal and professional views about sexual health education	18
3.9 Participation in the professional development course run by Concord for the Department of Health	20
3.10 School(s) environment including policies related to relationship and sexual health education.	24
3.11 The effect and impact of the course on teaching	27
3.12 Participation in the course and flow-on effects: impact on colleagues and other members of staff.	30
3.13 Participants' general observations about how to attain better teacher professional development in this field.	34
3.14 Comparison between Concord and Estill surveys	35
3.15 Key findings: what impact did the professional development course have?	37
3.16 Part A: Recommendations and conclusions.	41
4. Part B: Preferred models of teacher professional development and training in sexual health education	43
A Snapshot overview of the findings of Part B	43
4.1 The Desktop literature review	43
4.2 Models of professional development delivery in sexual health education.	46
4.3 A framework for professional development delivery models	51
4.4 Internationally found professional development courses in sexual health education	52
4.5 The Australian context	55
4.5.1 <i>The foundation: a curriculum in sexual health education</i>	55
4.5.2 <i>The Western Australian situation.</i>	56
4.5.3 <i>Other issues affecting the delivery of professional development</i>	56

4.6 Professional development courses in sexual health education for Australian teachers and schools	58
4.7 Recommendations arising from reviewed national and international models of PD and the impact evaluation study of the WA program	61
4.8 Ongoing structural implementation considerations	62
4.9 Part B Preferred models of PD: summary of recommendations for future programmes	64
5. References	66
Appendix 1. Letter	68
Appendix 2. Telephone survey questions	69
Appendix 3. T-test results Concord pre-post test data	72
Appendix 4. Frequency table	74
Appendix 5. ANOVA results for differences between groups	77
Appendix 6. Comparison T-test	80

1. Executive summary and key recommendations

The Department of Health (DoH) Communicable Disease Control Directorate (CDCD) contracted Estill and Associates to review the impact on the teaching and work practices of those teachers and community health nurses in schools who participated in the professional development (PD) courses in sexual health education and the use of the resource *Growing and Developing Healthy Relationships Curriculum Support Materials* (GDHR). These courses are funded by the DoH, approved by the Department of Education and Training (DET) and have been conducted by contracted specialist consultants Concord Training Services since 2002.

Purpose

The purpose of the evaluation was to review and assess the PD program and conduct a review of the literature to make recommendations about preferred models of teacher PD in this area of health education.

The evaluation process consisted of:

- A review of the current literature both national and international;
- Examination and analysis of the previous evaluation surveys completed by participants before and after each PD course; and
- A follow-up telephone interview evaluation survey with teachers, community health nurses in schools and other non-teaching professionals who had previously undertaken this PD.

Evaluation of the effectiveness and impact of this model of PD was predominantly assessed through the follow-up survey designed to elicit feedback from course participants. The survey was designed by Estill and Associates in consultation with the Health Department of WA and the Study Reference Group. Out of the more than 450 teachers and school nurses who had participated in the PD a total of 209 interviews were conducted, an overall response rate of 79.5% of contactable teachers and nurses. Results from the survey were also assessed against the qualitative data collection of evaluation surveys from all workshops conducted since 2002.

Findings

Evaluation of impact

Results obtained in this study from the **telephone interview survey and analysis of previous course evaluations** indicate that teachers and school nurses believe this course to be a very valuable contribution to their professional development and practice. The course was seen to provide high quality training, good content and the information given was easily able to be translated into actions in the classroom. Those surveyed believe the course would benefit all teachers and that it offers useful instruction about and better understanding and use of the GDHR materials.

Most importantly the gains in professional confidence reported at the conclusion of the course have been maintained over time, with teachers/school health nurses suggesting that they **still** felt as confident as they had at the completion of the course from the knowledge and skills learned to teach sexual health, up to five years later. **One of the stated main aims of the PD course was to increase teacher confidence and competence in this area and this has been achieved.**

More specifically 33% of those surveyed said that they spend more time teaching sexual health education and 64% of participants said that their teaching practices had changed for the better since undertaking the course. **There was a general view that the PD had also inspired teachers to change their teaching behaviours in other curriculum areas, taking on more of a student centred teaching style that they found both personally satisfying and more motivating for the students.** These gains cannot be understated; they are a critically important impact of this professional development training course.

Recommendation 1: Continue to provide the face to face workshop course as an available teacher PD option.

The majority of respondents stated that they had been able to help other teachers to use the GDHR resource, that other staff members were interested in hearing about the training and that they still continue to share course information and expertise several years later.

Recommendation 2. Continue to use Concord Training Services to conduct the PD program

Recommendation 3. Continue the provision of the follow-up workshops;

Recommendation 4. Continue the provision of teachers being able to have ongoing contact with the PD facilitators and the dissemination of information and updates to teachers by the same facilitators;

The clear evidence obtained in this evaluation points to the success of this PD program. It demonstrates not only the quality but also cost-effective nature of a relatively small financial outlay through to external specialist consultants, Concord Training Services, and well supports the continuation of this service.

Future models of PD

The **review of current research literature** component of the evaluation found that there were no systematic evaluations of the effectiveness of different models of delivery of teacher PD in the relationship and sexual health education field. However it was apparent that this WA PD and training course is in keeping with national and international best practice in its design, structure and implementation.

Though the model of PD utilised by Concord was found to be equal if not superior to other models cited in the research literature, this evaluation study is able to recommend additional specific actions for incorporation into planning and development of future teacher PD in this area. Recommendations provided are based upon a vision for future PD programs to include flexible delivery modes, which will enable teachers to access professional development experiences in a variety of ways such as face-to-face workshops, online, computer-based programs and peer mentoring.

The following Recommendations are made regarding the conduct of future courses:

Recommendation 5. Utilise a combination of three of the flexible learning PD categories, traditional (face-to-face workshops), technology (online or computer-based courses) and collegial relationships and work roles (mentoring support/discussion groups) in planning for future PD.

- Recommendation 6. Encourage and support the participation of more than one teacher from each school in the PD to secure ongoing peer support and contact with immediate colleagues.
- Recommendation 7. Investigate the possibility of offering PD courses outside teaching hours (e.g. school holidays or weekends).
- Recommendation 8. Build mentoring approaches into future PD including within technology based methodology.
- Recommendation 9. Run two separate PD courses, one for primary and one for secondary school teachers, or alternatively, combine the first half of the course for both groups then divide into two separate groups in second half according to content needs.
- Recommendation 10. Run PD workshops at individual primary or secondary schools, to promote and enable a whole-of-school uptake of the GDHR materials.
- Recommendation 11. Work with Education sectors and appropriate professional bodies to target school principals with information about the importance of sexual health education, the GDHR resource and the need for supporting PD.
- Recommendation 12. Work with the Education sectors to:
- find ways to extend teacher access to this training
 - arrange for PD promotion and advertising material to be sent to individual teachers as well as to school administrators/principals.
- Recommendation 13. Provide teachers with continual opportunities to upgrade their skills and knowledge and offer other forms of ongoing training such as half-day courses in specialist content knowledge e.g. puberty, date rape, body image, hypersexualisation and the media etc.
- Recommendation 14. Investigate means of rewarding those teachers who participate in PD in this field.
- Recommendation 15. Incorporate ongoing systematic evaluation into all PD to enable assessment of effect and continue to guide program implementation.

Other alternative models for consideration

If the DoH and DET saw the need to examine other possible approaches to providing teacher PD, the following options could be investigated:

- Assess advantage of moving conduct of the PD to the non-profit sector, for example, with the right kind of staff expertise, the Family Planning Association of Western Australia (FPWA) could conduct PD in this area with teachers and community health nurses in schools. The South Australian Family Planning Association has a successful schools model which could be adapted to suit WA. Further investigation of costs and benefits of this approach would be needed.

- There may be benefits gained in delivery of the PD 'in-house' through either the establishment of a training presence within the DET and/or a shared arrangement between the DoH and the DET. Such a model would be similar to the approach used by the WA School Drug Education and Road Aware (SDERA) organisation in their conduct of teacher PD. SDERA is supported by a cross-sector management board and currently accommodated within the DET. Another variation of this option could be the incorporation of sexual health into the SDERA program. Given the close link between alcohol, sex and drugs, such a partnership seems both logical and appealing.
- The university sector in WA has support structures in place to facilitate flexible learning methodologies and thus may be well placed to deliver teacher PD as suggested in this report. Such an option would require greater investigation of cost benefits.

Recommendation 16. Undertake negotiations with those universities that provide pre-service teacher training to include a compulsory component of relationship, sexuality and sexual health education into this training.

Recommendation 17. Work to increase the priority given to health education (particularly sexual health education) in schools.

Recommendation 18. Join with other appropriate intra and inter state organizations e.g.; SHine SA to advocate for a national policy or national curriculum for the promotion of sexual health education in schools.

Conclusion

Teachers want to engage in PD in sexual health education and they need both pre-service and in-service training. This study has shown that PD has a definite and positive impact on teacher willingness and effectiveness as educators in this area. The findings also demonstrate that the challenge in promoting quality sexual health education for all students is not related to the availability of first-rate curriculum material, nor to the nature of the conducted supporting PD. What has been revealed is the obvious current limitations in the number of teachers able to be trained, hence **a key future task is to ensure that as many as possible current and potential teachers of sexual health education have access to PD.** There is therefore also need to utilise additional models of PD so that different groups and greater numbers of teachers, particularly in remote and rural regions can be reached.

2. Introduction and acknowledgements

The Western Australian Department of Health (DoH) Communicable Disease Control Directorate (CDCD) conducted a tender process and contracted Estill and Associates to review the impact on teaching practices of the teachers and school health nurses who have participated in the professional development (PD) course in sexual health and relationship education and the use of the *Growing and Developing Healthy Relationships School Curriculum Support Materials* (GDHR). The courses have been funded by CDCD and conducted by Concord Training Services since 2002. A review of national and international models of teacher PD in this field was also required with a recommendation(s) of a preferred model(s).

As described in the brief provided by the DoH, the purpose of the evaluation was to review and assess the impact of this PD program in sexual health education on teacher and school health nurse educational practice to:

- Determine if and how teachers and school health nurses have changed their practices as a result of attending the training;
- Find out if teachers devote more time to sexual health education topics as a result of attending the training;
- Determine if participation in the training provided the confidence and skills teachers needed to deliver sexual health education;
- Find out if peer education occurred and to what extent;
- Document the barriers that prevent teachers making full use of the knowledge and skills learnt in the training; and
- Assess the impact of the professional development and the subsequent delivery of sexual health education in WA schools.

This evaluation set out to:

- Consider the effectiveness of the current model of professional development;
- Identify alternative models; and
- Make recommendations for the future continuation of teacher professional development in sexual health education.

The evaluation process consisted of:

- A review of the current literature;
- An examination of previous studies of the conducted PD program; and
- A survey of the participants of the program.

Acknowledgements

The Project Reference Group steered this study from the outset in establishing the scope and detail of the terms of reference, appointment of the evaluator, providing advice throughout the research as well as extensive review of and feedback on all Drafts. Their time, expertise and persistent commitment to quality has been massive in the creation of this Report.

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Extensive additional involvement in the preparation of this report has been provided by CDCD officers Maryrose Baker and Erin McKay.

3. Part A: Impact evaluation of the professional development course for teachers

A Snapshot overview of the findings of Part A

Teachers who have completed this PD have greatly benefited, continue to do so and view the training as high quality.

The strengths of the course identified by participants are:

- Good teaching strategies/activities;
- Useful introduction to the GDHR materials; and
- Valuable opportunity for professional discussions, collaboration, support and networking.

Recommendations by the participants about ways to improve the course include:

- Hold separate sessions for focus on primary and secondary school concerns;
- Spend more time working on the GDHR materials; and
- Include more practice and update sessions.

The evaluator, Estill, offers the following additional recommendations:

- Offer more support for teachers within their workplaces (for example, in supporting them implement school sexual health policies);
- Offer more flexible modes of training such as after-school, online, etc.; and
- Conduct further investigation of PD models which can better influence teachers' ability to achieve the 'flow-on effect' of their passing learning on to peers and enable capacity building in sexual health education within their schools.

3.1 The professional development course for teachers in WA

The implementation of the new GDHR resource for teachers in 2002 was supported and facilitated by the establishment and promotion of a teacher professional development course in sexual health education and the use of the GDHR materials. This was recognised as being essential to both teacher uptake of the resource and to enhance the quality of relationship and sexual health education students received. It is vitally important that teachers are enabled to become trained, knowledgeable, confident and comfortable in providing sexuality and sexual health education.

The health and sexuality education expert consultants Concord Training Services were contracted by the Department of Health to deliver the professional development training for teachers and they used a partial 'train-the-trainer' model to encourage the transfer of information and skills to teacher colleagues and peers at their school. The originally planned professional development model was to take place over an initial three-day period with a one-day follow-up session and aimed to recruit a couple of people from the same school to attend together (e.g. teachers and/or other school support staff such as school nurse or counsellor). This was a model that the School Drug Education and Road Aware program had used extensively and the concept of establishing a school 'team' of education and support for sexual health education was proposed. However once underway contingencies meant that this model soon

needed to be reduced in length and there was a corresponding reduction in the expected numbers attending from any one school.

The GDHR materials were primarily designed for teachers and the original PD implementation was commissioned and designed to target them, however, once the PD courses were promoted and advertised for teachers, community nurses in schools responded and strongly appealed about the need for them to get training in this area. CDCD therefore agreed to fund PD for community health nurses in schools and approved that Concord design and present an extra program, one day in duration, appropriate for their needs. This course was very well received by school health nurses and many received training (one third of the telephone interview respondents were school health nurses) and hence they are included in this evaluation. However the main focus in the PD was teachers.

The first professional development course was conducted in August 2002 and as at January 2008 training had been delivered to:

- Over 390 teachers;
- 60 school health nurses; and
- Officers from various health and community agencies including:
 - District Education Office representatives;
 - Public Health Unit officers;
 - School psychologists; and
 - Aboriginal community leaders.

3.2 The aims of the course delivered to WA teachers

Concord's PD model ultimately became one which was conducted over two consecutive days for teachers. School health nurses participated in a shorter one-day version of the course; however both courses had a one-day follow-up workshop. Schools were notified of an upcoming course and teachers (and/or school health nurses) registered their interest. The course was usually attended by 20 to 25 individuals. The aim of the course was to provide effective PD in sexual health (relationships) education. More specifically the course aimed to help teachers:

- Feel supported to plan and implement practical sexual health education;
- Learn strategies using an outcomes focus;
- Be aware of the importance of school health and blood-borne virus related policies;
- Have strategies for monitoring the effectiveness of the school's sexual health education program and have strengthened links with health agencies and other health-promoting schools;
- Feel supported to advocate for sexual health education and to provide school-based training in their school;
- Have increased knowledge, skills and comfort levels; and
- Have strategies for providing parent workshops in sexuality education.

The courses were conducted by highly qualified trained teachers who had experience in health and sexuality education. The course design was based on the principles of best practice in professional learning.

3.3 Participants' individual PD course evaluation surveys

A component of the quality assurance process instigated by Concord Training was the administration of an individual participant pre- and post-course survey. The data obtained from each course was used by Concord to gain feedback on the course. This feedback has been consistently positive hence changes made to the course over time have been about natural updating rather than as a consequence of feedback from course participants.

The pre-test survey consisted of ten statements (to which participants were asked to rate the strength of their agreement on a five-point scale: strongly agree, agree, neither agree nor disagree, disagree and strongly disagree):

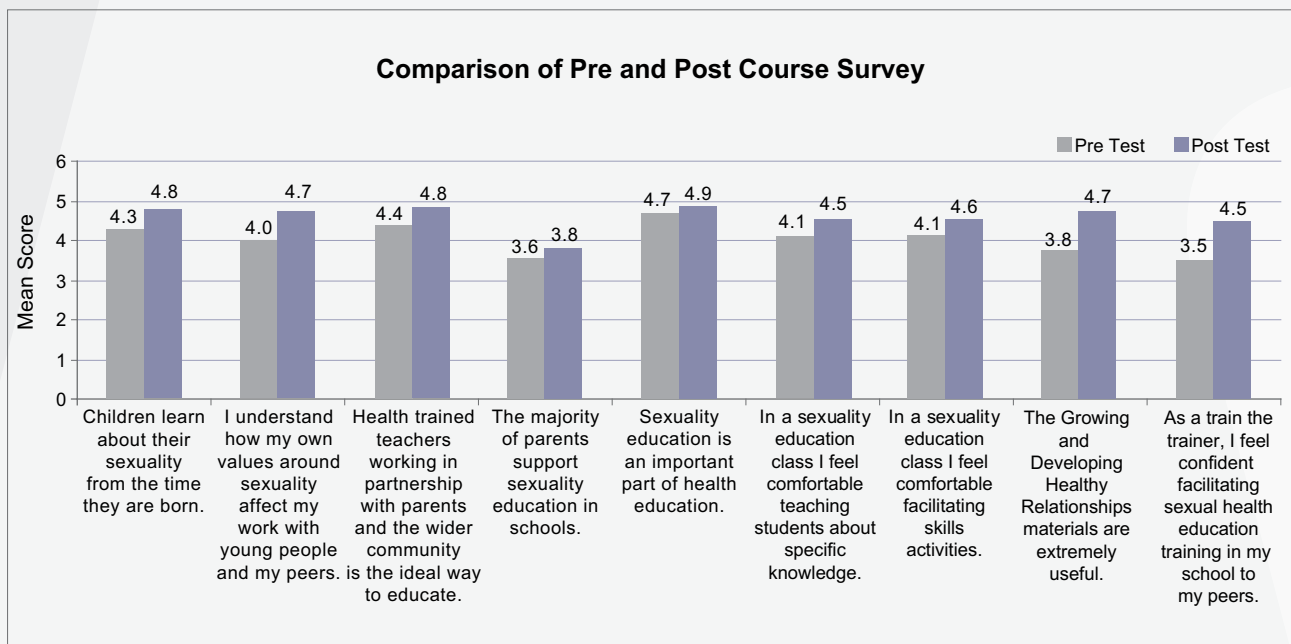
- Children learn about their sexuality from the time they are born;
- I understand how my own values around sexuality affect my work with young people and my peers;
- Health trained teachers, working in partnership with parents and the wider community, is the ideal way to educate young people about sexuality education;
- The majority of parents support sexuality education in schools;
- Sexuality education is an important part of health education;
- In a sexuality education class I feel comfortable teaching students about specific knowledge;
- In a sexuality education class I feel comfortable teaching students about attitudes and values;
- In a sexuality education class I feel comfortable facilitating skills activities;
- The GDHR materials are extremely useful; and
- As a train-the-trainer, I feel confident facilitating sexual health education training in my school to my peers.

Two further statements (using the same five-point scale) were added to the post-test survey:

- The quality of the training was extremely high; and
- The level of the content was just right.

The data set for the courses delivered between 2002 and 2007 were obtained, combined and analysed. For this study two hundred and twelve matched-pair data points were obtained from the Concord Training database. A series of t-tests were undertaken to ascertain if changes between pre- and post-survey were significant at the 0.05 level.

The differences between the mean scores for the pre- and post-course survey were all found to be significantly different at the 0.05 level (for details see Appendix 4). Post-test scores were significantly higher than the pre-test scores for all questions. This can be seen in the graph below.



It should be noted that pre-course scores were rather high, suggesting that those who participated in the course and responded to the questionnaire already had fairly high levels of awareness of the issues surrounding sexual health education.

The significant increase in the post-course scores may reflect the level of satisfaction participants had in the course, it might reflect a long-lasting pattern of changed behaviour, or it could represent the artificial high of a positive and encouraging experience of the professional development.

To ascertain which of these positions the scores reflect, the participant's survey developed for this evaluation includes some of these statements. Although it is not possible to match the data from the Concord and Estill surveys¹ such that an individual's score at the time of training is matched to the long-term follow-up (current survey), an estimate of permanent change should be reflected in higher means in the current survey than the pre-course scores or means similar to the post-course (see section 3.15)

Analysis of the qualitative data of the Concord survey reveals the following prevalent themes identified by participants as the most useful aspects of the course:

- Practical ideas for sessions;
- Alternative ways of learning;
- Great to meet people from agencies in Perth;
- Immediately useful in the classroom;
- Ways of introducing various topics in a non-threatening and motivating way;
- Different icebreakers and games, facilitator strategies; and
- Awareness of support agencies, research, games/strategies.

¹ The Concord data set did not include names or other identifying markers with which to match the Estill data.

With regard the least useful aspects of the course the majority of participants did not comment or reiterated the quality of the course. Those who did comment suggested the following the following themes were apparent:

- Would like to look more at the package (16);
- Too much discussion for high schools which are not relevant to a primary school teacher (13); and similarly
- Sexually Transmissible Infections (STI) statistics, even though interesting, did not have that much to do with classroom (19).

However the majority of participants suggested there was nothing that was not useful in the course. Other comments included the skill of the course facilitator and the enjoyment of the course. There was also a general agreement that knowledge levels had increased as had the ability to facilitate sexual health programs in class. Most commented that they felt more prepared to teach sexual health after the completion of the course.

The results indicate that those who took part in the professional development found it to be of high quality. Comments of the participants suggest that the professional development offered participants the opportunity to develop the skills, abilities and attributes that have been found in the literature² to be necessary to acquire through sexual health education in-service training.

It was however important to determine if these gains are maintained when teachers and school health nurses return to the classroom and this was built into and assessed through the follow-up evaluation survey described in section 3.6

3.4 2005 audit and impact assessment of the GDHR materials

In 2005, the DoH commissioned an audit to determine if the distribution of the GDHR materials was having any impact on the way sexual health education was being conducted in schools. The audit was designed and administered by Concord Training Services in association with the DoH and analysed and reported on by CATALYSE. Three hundred and seven out of a possible 921 schools participated in the audit achieving a response rate of 33% hence the sample was found to be representative of schools across the state (Catalyse 2006).

The audit suggests that the distribution of the GDHR materials **did have** a positive impact on the way sexual health education is being conducted in schools.

- In 74% of schools that responded to the audit, at least one representative is aware of the GDHR materials.
- In 65% of schools that responded to the audit, at least one person knows where the GDHR materials are kept.
- In 44% of schools that responded to the audit, teachers are using the GDHR materials.

² See section 2.1 above.

Furthermore, there was convincing evidence from the audit results to suggest that participation in the PD had a direct and positive impact on awareness and use of GDHR materials.

- In 96% of schools that have participated in PD, at least one person is aware of the GDHR materials.
- In 87% of schools that have participated in PD, at least one person knows where the GDHR materials are kept.
- In 64% of schools that have participated in PD, teachers are using the GDHR materials.

3.5 Impact evaluation survey of program participants

In order to evaluate the actual impact of the professional development program on teaching practices, a survey was designed to elicit feedback from those teachers, school health nurses and other non-teaching professionals who had undertaken the course conducted by Concord Training Services.

The survey was designed by Estill and Associates in consultation with the Department of Health Western Australia and consisted of 52 questions (see Appendix 2). The majority of questions (35) were to collect quantitative data; these were a series of statements and participants were asked their level of agreement with the statements on a five-point scale where one is strongly disagree and five is strongly agree.

Twelve questions were open-ended and were designed to elicit a more complete response and five questions related to background information of the participants. Participants were encouraged to comment further on any question or statement and many took the opportunity to fully explain their responses. These comments have been included in the results section although they must be interpreted as individual responses and therefore not indicative of the reasoning behind the majority. They do however add to our understanding of some of the issues.

Survey questions were categorised into seven areas under investigation:

1. Personal and professional views about sexual health education;
2. The professional development course run by Concord and the Department of Health;
3. School(s) environment including policies related to relationship and sexual health education;
4. The effect and impact of the professional development course they attended on their teaching;
4. Flow-on effect or impact on colleagues and other members of staff; and
5. General observations about how to attain better teacher professional development.

Method

A complete list of contact details for all the participants of the training courses conducted was obtained from Concord Training.

A letter signed by the DoH and the DET (see Appendix 1) was sent to all participants based on the information in the contacts database obtained from Concord Training. The letter outlined the project and its importance and encouraged participation. The letter was sent one week before interviews commenced.

Seven qualified interviewers commenced phone surveys in the first week of June 2008 and finished the first week of July 2008. All interviewers received a detailed cover sheet to guide them in introducing the survey and its purpose to clients, and also included confidentiality issues. All questions were explained to each interviewer so that they could clarify any uncertainties with participants regarding the meaning or purpose of specific questions. Interviewers were debriefed at intervals during the interviewing process and asked to report back any difficulties/ambiguities reported by participants regarding the content of the surveys.

Course participants were contacted and briefed on the project and asked to participate in the study; where time was not available on initial contact, appointments were made for the interviewer to call back and conduct the survey at the convenience of the participant.

Due to the outdated nature of the original contacts database, interviewers made a concerted effort to track down the participants of the course. Sample dynamics are shown below. It should be noted that only four individuals contacted declined to participate in the survey. Those who gave their feedback were generous in their comments; the average length of time given to this study by participants was 20 minutes.

Sample

The original database obtained from Concord Training contained **431** contacts. During the course of the interviewing process we were able to ascertain that 71 of the participants had left the sector. A further 153 were thought to have moved within the school sector. DoH and DET were contacted and asked to supply current details of the 153, however the departments were only able to supply the correct contact details for 56 of the 153 where the original contact details were not current. The contactable database was therefore 263, of which we were able to interview **209**. The overall response rate was 79.5%.

This equated to a sampling error at 95% level of confidence of ± 3.07 . Both the response rate and the sampling error are well within the guidelines set for evaluations by the Auditor-General.

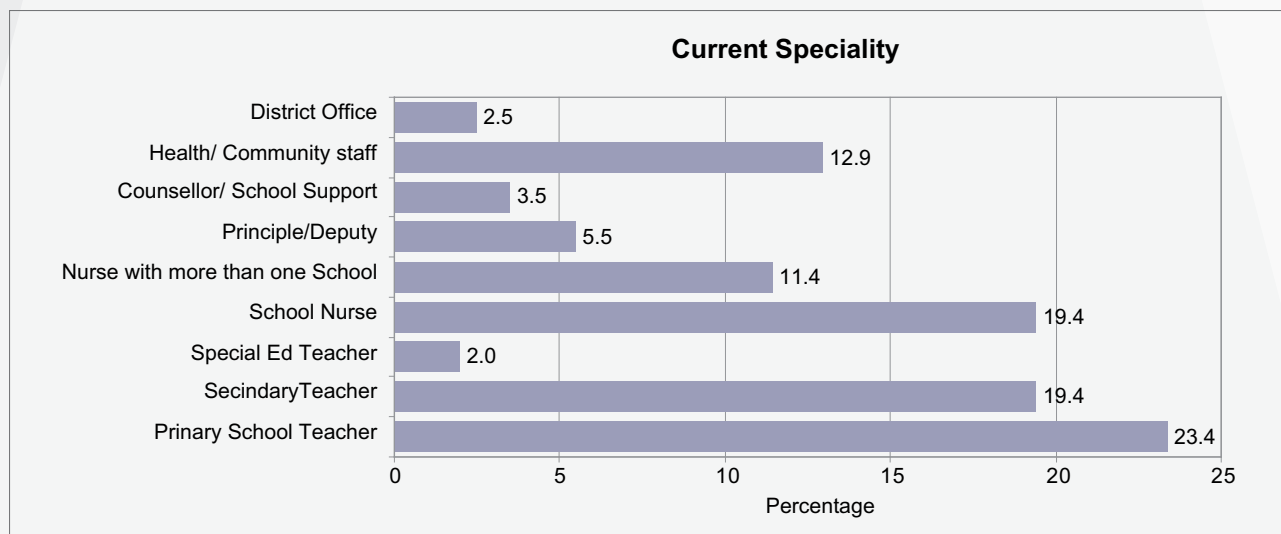
Original number of contacts	433 ³
Double-ups	2
Total original sample	431
Those we were notified had left the school sector	71
Incorrect details	153
Correct details supplied by the DoH	25
Correct details supplied by the DET	31
Total contactable database	263
Long service leave/maternity leave/sick leave	22
Refusals	4
Interviews	209
Unable to contact for an interview	28

A total of 209 Concord Training participants were interviewed. Seven of those contacted for an interview could not remember participating in the course. They did not complete the full survey but did contribute to the qualitative questions on the survey, therefore their comments have been included in qualitative sections of the report. The sample for the quantitative data was a total of 202.

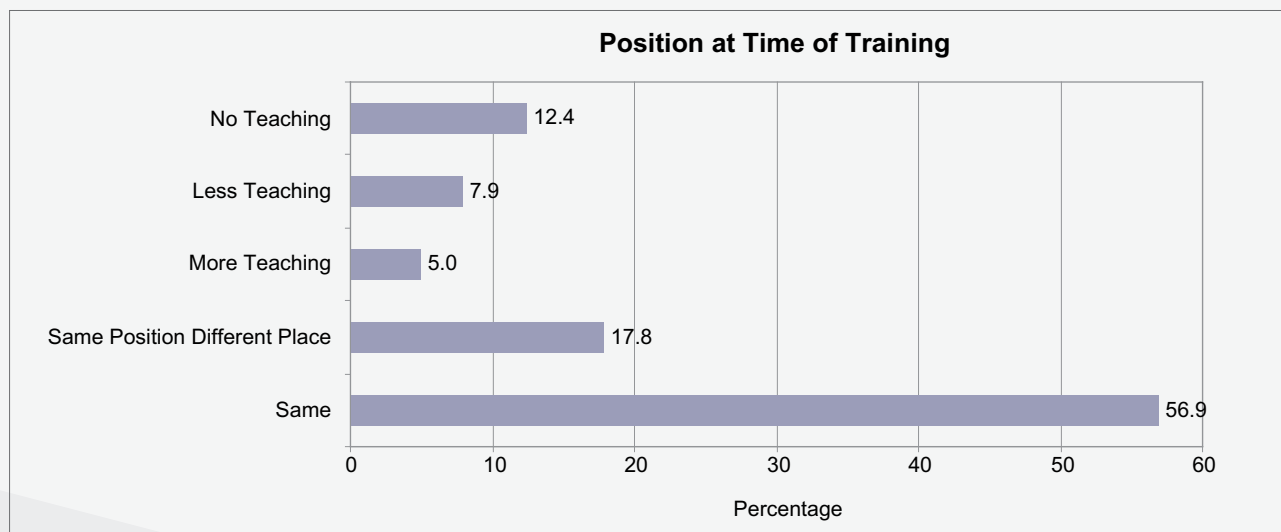
³ A response rate of 48% was obtained on the complete data set supplied from Concord and equates to a sampling error of ± 4.88

3.6 Background information about respondents

- 23% of respondents were primary school teachers;
- 19% were high school teachers;
- 19% were school health nurses servicing one school and 11% were school health nurses servicing more than one school;
- 56% of the sample was in non-teaching roles, support staff, principals and health staff;

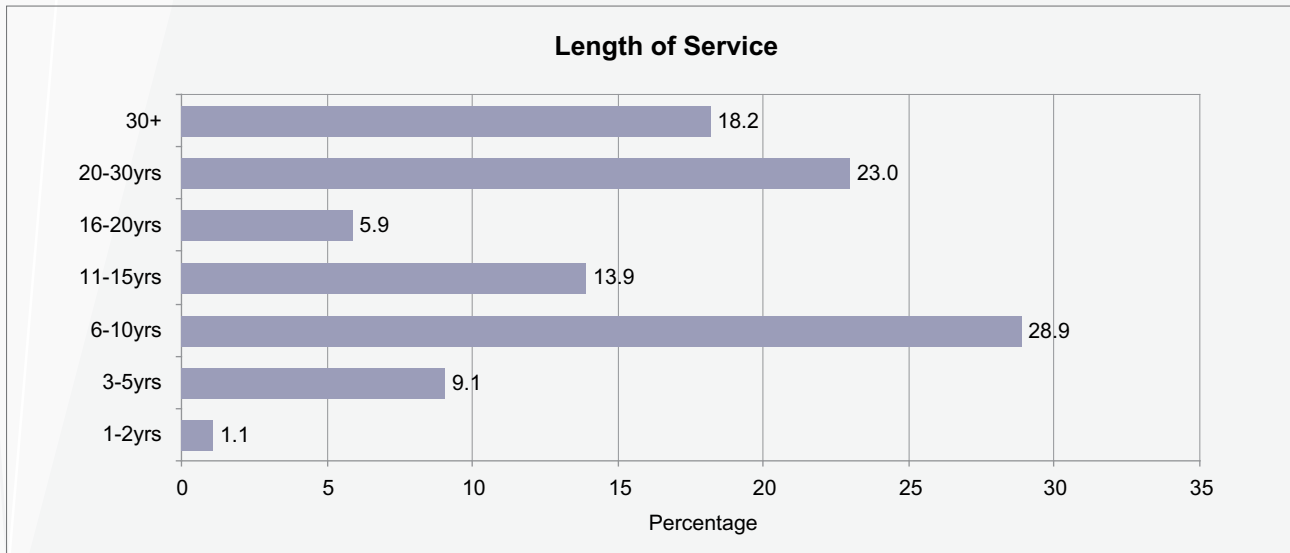


- 57% of the respondents were in the same position as when they had undertaken the course;
- 18% were in the same position at a different location;
- 5% said they were in positions with more teaching;
- 8% were in new positions with less teaching; and
- 12% said they were currently in non-teaching positions. Comments clarifying less or no teaching suggested that promotion was the most common reason for less teaching.

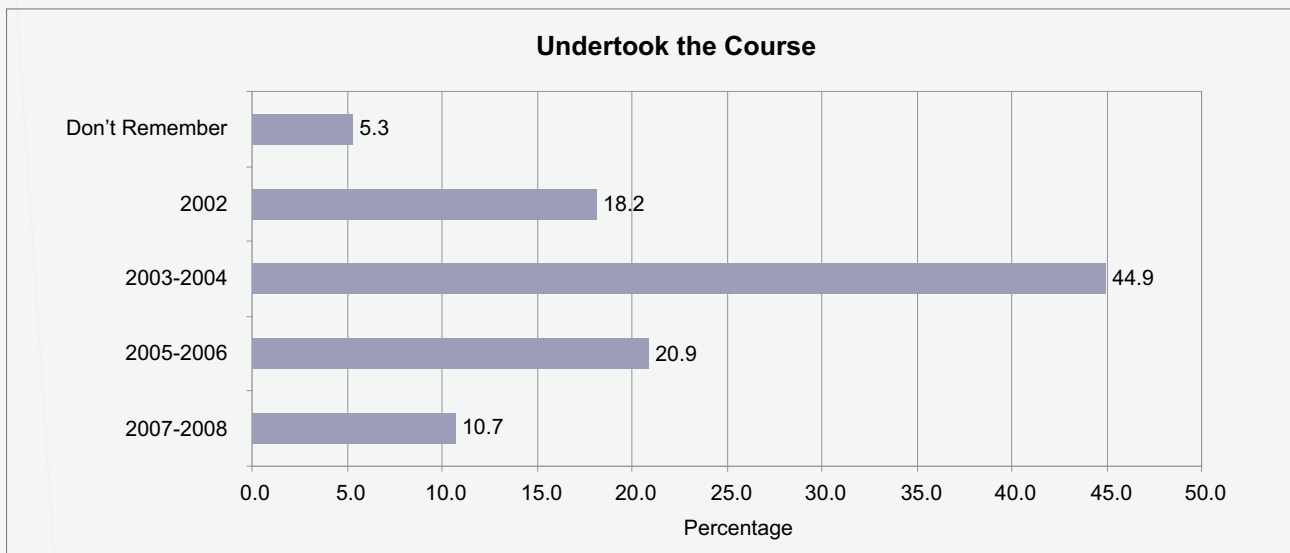


One hundred and eighty-seven participants gave information on the length of time they had been associated with teaching.

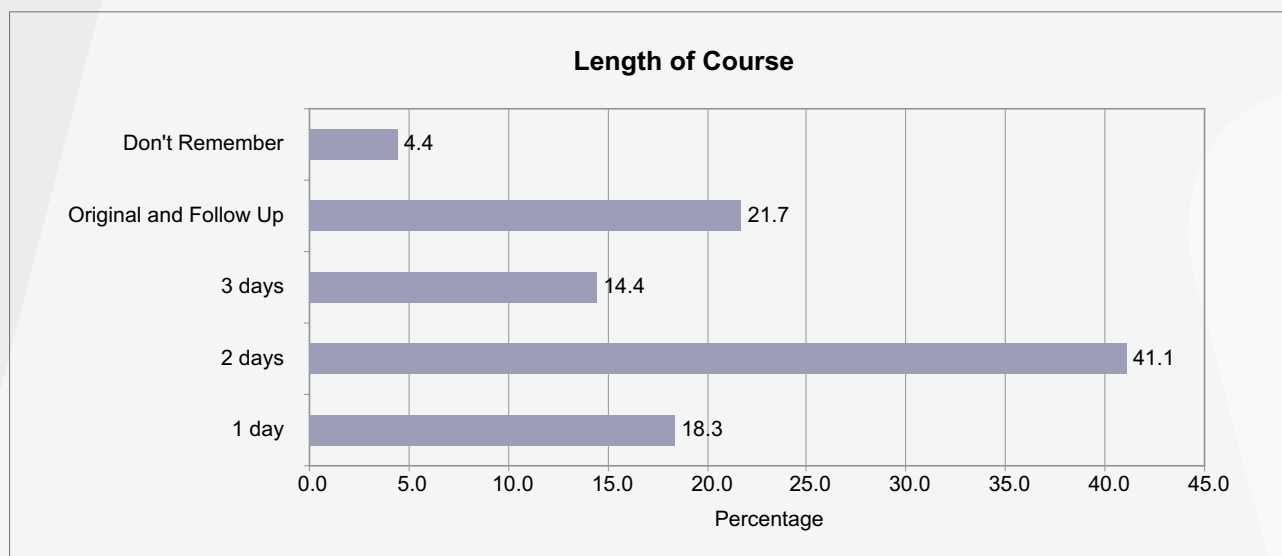
The single most prevalent group (29%) had been working in the field for between six and ten years. The majority of respondents had been working with students for over 20 years (23% between 20 and 30 years and 18% over 30 years). Ten percent of respondents reported less than five years' service.



Forty-five percent of respondents had undertaken the course in 2003–2004, 21% had undertaken the course in 2005–2006 and 11% had undertaken the course within the past 12 months. Five percent of participants could not remember when they had undertaken the course.



Many of the participants were unsure of the duration of the course: 41% felt the course had been two days, 21% had participated in the original and the follow-up and 18% had participated in a one-day course.



3.7 Results of telephone interviews

The analysis follows each section of the survey; percentage and frequencies will be presented. The three main discernable professional groups within the respondents are high school teachers, primary school teachers and school health nurses. Other minority respondents include district officers and health officials. Each occupational group has different general training and works in very different ways to the others. Hence, many of the questions that were designed for teachers were not easily answered by non-teachers; percentages are therefore based on those who responded to the question, not the total sample (for details see Appendix 5).

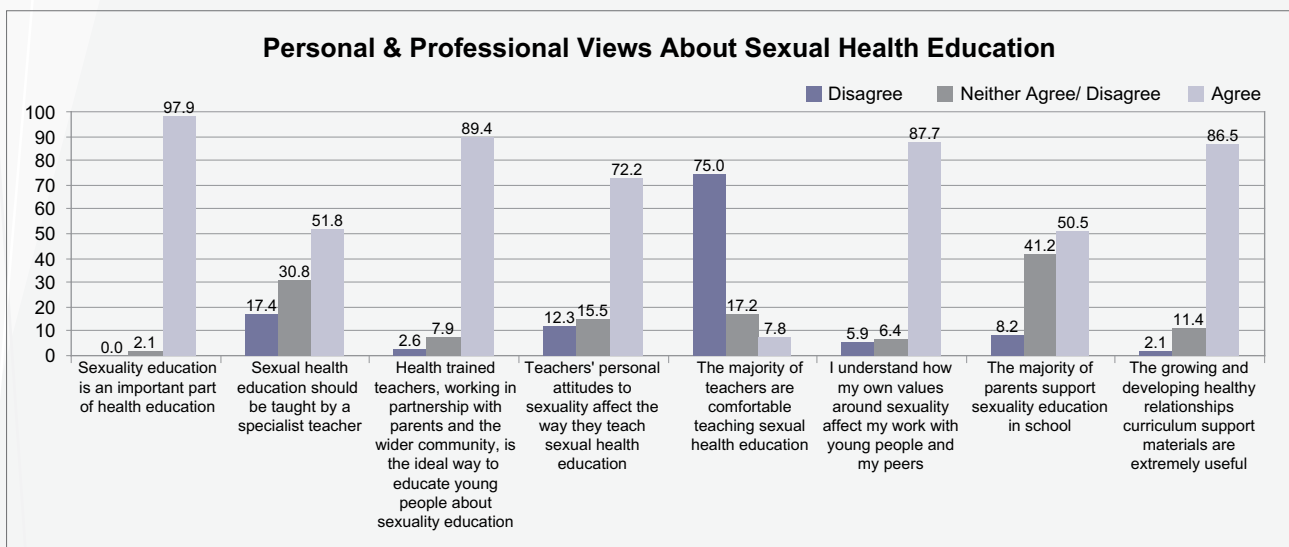
Further statistical analysis will explore underlying trends in the data.

3.8 Personal and professional views about sexual health education

The first eight questions were intended to determine personal and professional views about sexuality education. A number of these questions were used by Concord Training for their pre- and post-course evaluation on perceived immediate impact of the course. A comparison between the results obtained by Concord and those obtained with the current study are presented in section 3.4. Participants were asked their level of agreement with the following statements on a five-point scale where one is strongly disagree and five is strongly agree. The agree/strongly agree and strongly disagree/disagree data have been combined and are presented for each question in the graph below.

- No respondent disagreed with the statement *sexuality education is an important part of health education*; 8% agreed, 90% strongly agreed and 2% were neutral (n=190).
- When asked if *sexual health education should be taught by a specialist teacher*, 6% strongly disagreed, 11% disagreed, 31% were neutral, 27% agreed and 24% strongly agreed (n=195).
- Less than 3% disagreed/strongly disagreed that *health trained teachers, working in partnership with parents and the wider community, is the ideal way to educate young people about sexuality education*. 8% were neutral, 36% agreed and 53% strongly agreed (n=189).

- 39% strongly agreed and 33% agreed that *teachers' personal attitudes to sexuality affect the way they teach sexual health education*. 15% were neutral, 9% disagreed and 3% strongly disagreed (n=187).
- 55% disagreed and 20% strongly disagreed that *the majority of teachers are comfortable teaching sexual health education*. 17% were neutral, 7% agreed and less than 1% strongly agreed (n=180).
- 55% strongly agreed and 33% agreed with the statement *I understand how my own values around sexuality affect my work with young people and my peers*. 6% were neutral, 4% disagreed and 1% strongly disagreed (n=187).
- 38% of respondents agreed and 13% strongly agreed that *the majority of parents support sexuality education in schools*. 41% were neutral, 6% disagreed and 2% strongly disagreed (n=182).
- 50% strongly agreed and 37% agreed that *the GDHR Curriculum Support Materials are extremely useful*. 11% were neutral and 2% disagreed (n=193).



The majority of respondents believe that sexuality education is an important part of health education (97.9%), that health trained teachers working in partnership with parents and the wider community is the ideal way to educate young people (89.4%), that teachers' attitudes to sexuality affect the way they teach sexual health education (72.2%), that they understand the impact of their own values (87.7%) and that the GDHR material is extremely useful (86.5%).

There is a perception among participants that the majority of teachers are not comfortable teaching sexual health education (75%). There were somewhat mixed views about the role of the specialist teacher for sexual health education. 51.8% said there should be specialist teachers, 31% were neutral and 17% disagreed. Comments suggest that the interpretation of what is a specialist was one of the reasons for the mixed results; many were not prepared to agree that a 'teaching specialist', such as a maths specialist or English specialist, was required, but even those who disagreed with this definition felt that some form of training such as that offered by Concord would be needed to teach the subject.

Further analysis⁴

Analysis was undertaken to determine if differences existed between the five groups who had undertaken the professional development course. For the purpose of this analysis groups were defined as teachers (primary and secondary), school health nurses (school health nurses servicing one school and school health nurses servicing more than one school) and non-teaching professionals.

Significant differences were found for:

- Sexual health education should be taught by a specialist teacher;
- Teachers' personal attitudes to sexuality affect the way they teach sexual health education; and
- The majority of parents support sexuality education in schools.

Secondary teachers were significantly more likely to agree that sexual health education should be taught by a specialist teacher and primary school teachers were the least likely to agree.

Non-teaching professionals and school health nurses with a single school were significantly more likely to agree than teachers that a teacher's personal attitude to sexuality affects the way they teach sexual health education.

The school nurse and secondary teachers were more likely to agree than were primary school teachers and school health nurses with more than one school that the majority of parents support sexuality education in schools. This may reflect the age divide of the students represented by these two groups; school health nurses servicing a single school are more likely to be in high schools, and school health nurses with more than one school are likely to be associated with primary schools – sexuality education may be more acceptable to parents of older children. The finding may also reflect the contact with parents (primary schools generally have more parental contact than secondary schools) and therefore primary school staff may have a better knowledge of parents' reactions.

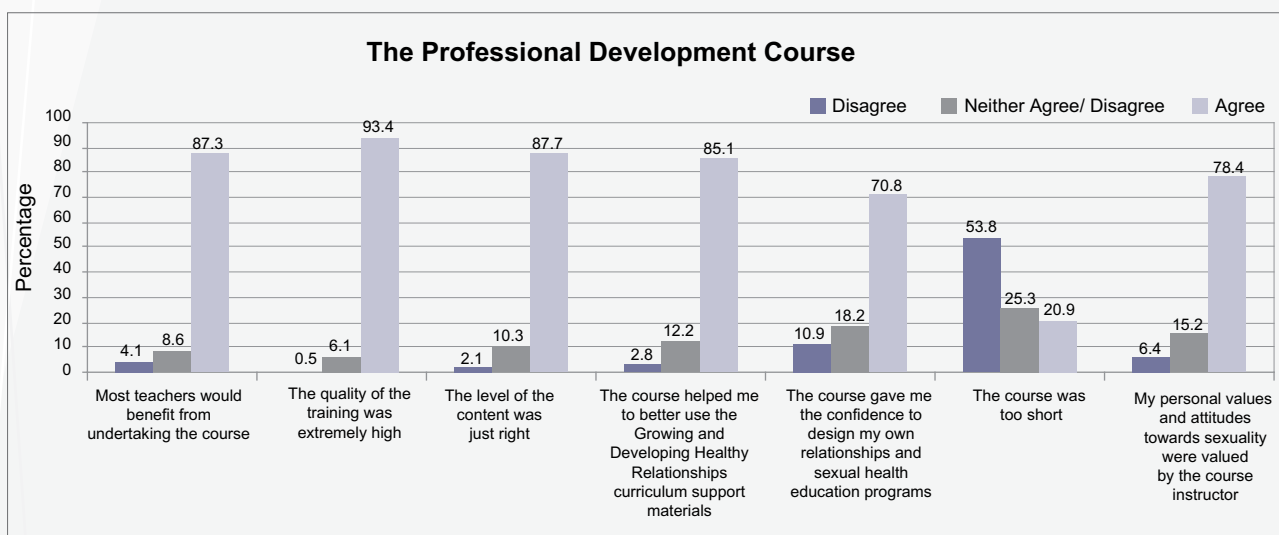
3.9 Participation in the professional development course run by Concord for the Department of Health

The second group of seven quantitative questions were intended to determine personal and professional views with regard to the professional development course conducted by Concord Training. A number of these questions were used by Concord Training for their pre- and post-evaluation of the perceived immediate impact of the course. A comparison of the results obtained by Concord and those obtained with the current study are presented in section 6.7. Participants were asked their level of agreement with the following statements on a five-point scale where one is strongly disagree and five is strongly agree. The agree/strongly agree and strongly disagree/disagree data have been combined and are presented for each question in the graph below.

- 55% of respondents strongly agree and 32% agree that *most teachers would benefit from undertaking the course*. 9% were neutral, 3% disagreed and 1% strongly disagreed (n=197).
- 64% strongly agreed and 30% agreed that *the quality of the training was extremely high*. 5% were neutral and less than 1% (n=196).

⁴ For further details see Appendix 5

- 49% strongly agreed and 39% agreed that *the level of the content was just right*. 10% were neutral and 2% disagreed (n=195).
- 51% strongly agreed and 34% agreed that *the course helped me to better use the GDHR Curriculum Support Materials*. 12% were neutral, 2% disagreed and less than 1% strongly disagreed (n=181).
- 42% agreed and 29% strongly agreed that *the course gave me the confidence to design my own relationships and sexual health education programs*. 18% were neutral, 9% disagreed and 2% strongly disagreed (n=192).
- 30% of respondents disagreed and 24% strongly disagreed that *the course was too short*. 25% were neutral, 16% agreed and 5% strongly (n=182).
- 42% strongly agreed and 36% agreed with the statement *my personal values and attitudes towards sexuality were valued by the course instructor*. 15% were neutral, 6% disagreed and 1% strongly disagreed (n=171).



There was overwhelming support for all aspects of the course. It was thought to benefit teachers due to high quality training and good content, was a useful way to better understand and use the GDHR curriculum support materials, and gave participants the confidence to design their own sexual health education programs. Although some of the school health nurses commented that the course had been too short and that they would like to have attended the two-day teachers' course there was no support for the course being too short generally, however a large number of respondents could not remember how long the course had been and therefore remained neutral.

Further analysis

Analysis was undertaken to determine if differences existed between the five groups who had undertaken the professional development course. For the purpose of this analysis groups were defined as teachers (primary and secondary), school health nurses (school health nurse with a single school and school health nurses with more than one school) and non-teaching professionals.

No significant differences were found between the groups.

Question: What aspect of the training did you find most useful? Why?

One hundred and sixty-five respondents took the opportunity to comment. Some respondents commented on more than one useful feature of the training; these comments were themed and are presented in the table below.

What aspect of the training did you find most useful? Why?	Frequency	Percentage
Teaching strategies/activities	67	32.1
Helped introduce the GDHR materials	48	23.0
The talks and information provided by experts/agencies. The statistics and the knowledge of resources available	38	18.2
Group discussions/networking	30	14.4
The use of music within lessons	17	8.1
Formalised knowledge	9	4.3
Total	209	100

The comments suggest that new teaching strategies (which might include the use of music within lessons) and the introduction to the GDHR curriculum support materials were considered most useful by respondents.

Question: What aspects were the least useful for you?

One hundred and seventeen respondents took the opportunity to comment; these comments were themed and are presented in the table below.

What aspects were the least useful for you?	Frequency	Percentage
Nothing/very little/it was all useful	70	61.4
Prior courses made elements of the course repetitive	10	8.8
Info not needed for grades (i.e. too much STI for primary school teachers)	9	7.9
Role-playing/games to involve group (not enjoyed)	5	4.4
Homosexuality (too much discussion and importance placed on homosexuality)	5	4.4
Too much information (not enough time to assimilate the information)	5	4.4
Lack of appropriate age/grade information	4	3.5
Didn't do enough with the curriculum materials	4	3.5
Having to travel to Perth (was a handicap)	2	1.7
Total	116	100

The majority of respondents felt there was very little about the course that was not useful. There were some elements of the course that individuals did not find useful including elements that had been covered in other courses and information that teachers felt were not required in their particular teaching level. However it should be noted that individual elements are mentioned by relatively few individuals.

Question: How could the training be improved?

One hundred and thirty-five respondents took the opportunity to comment; some respondents made more than one suggestion on how to improve the course. The comments were themed and are presented in the table below.

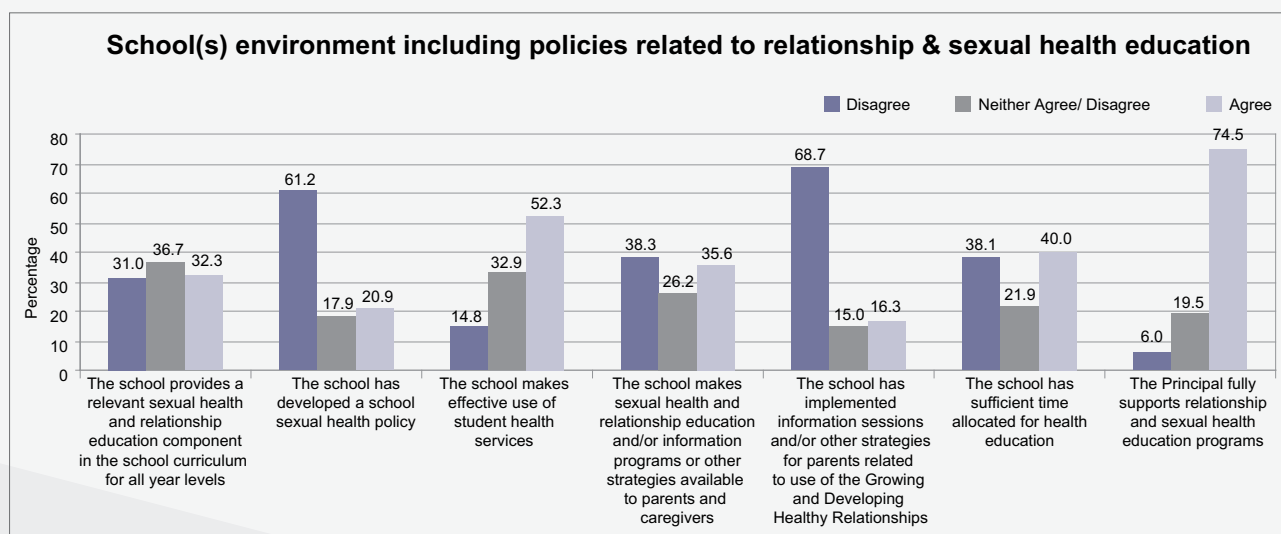
How could the training be improved?	Frequency	Percentage
General restatement of the quality of the course	28	18.5
Regular updates	24	15.8
Separate courses for different grades	14	9.3
Content – more information on the subject matter, particularly age-specific information	11	7.2
Practice sessions for teachers	10	6.6
The course should be longer	8	5.3
More teachers at the course/balance of teachers at the course	6	3.9
Use the book more within the course	5	3.3
Accessibility to materials	5	3.3
Local sessions – courses conducted in the regions	5	3.3
More on different cultures/disability	4	2.6
More group work	4	2.6
The course should be shorter	4	2.6
Keep doing it, get more teachers through	4	2.6
People who have done the course should be at the course to pass on their knowledge	4	2.6
Train-the-trainer sessions	3	2
Course structure	2	1.3
More time for teacher reflection	2	1.3
More interactive sessions	2	1.3
Separate courses for parents	2	1.3
Important for new teachers	2	1.3
Timing of the course – the time is not always appropriate	2	1.3
Emails after the course (were extremely useful)	1	0.7
Total	152	100

Again the majority of comments were concerned with restating the general support for the course in its current form. Other suggestions included regular updates or ongoing contact with the course, a separate course for primary and high school teachers and more sexuality content.

3.10 School(s) environment including policies related to relationship and sexual health education

The third group of seven quantitative questions was intended to determine the school environment within which teachers are facilitating sexual health education. Participants were asked their level of agreement with the following statements on a five-point scale where one is strongly disagree and five is strongly agree. The agree/strongly agree and strongly disagree/disagree data have been combined and are presented for each question in the graph below.

- Respondents were fairly evenly split on their views on the statement *the school provides a relevant sexual health and relationship education component in the school curriculum for all year levels*. 20% agreed, 12% strongly agreed, 20% disagreed, 11% strongly disagreed, and 37% were neutral (n=158).
- 37% strongly disagreed and 24% disagreed that *the school has developed a school sexual health policy*. 18% were neutral, 10% agreed and 11% strongly agreed (n=134).
- 34% agreed and 19% strongly agreed that *the school makes effective use of student health services*. 33% were neutral, 10% disagreed and 4% strongly disagreed (n=155).
- Respondents were fairly evenly split on their views on the statement *the school makes sexual health and relationship education and/or information programs or other strategies available to parents and caregivers*. 22% disagreed, 16% strongly disagreed, 26% were neutral and 24% agreed and 11% strongly agreed (n=149).
- Respondents strongly disagreed (38%) or disagreed (31%) with the statement *the school has implemented information sessions and/or other strategies for parents related to use of the GDHR Curriculum Resource Materials*. 15% were neutral, 10% agreed and 5% strongly agreed (n=147).
- Respondents were fairly evenly split on their views on the statement *the school has sufficient time allocated for health education*. 21% agreed, 19% strongly agreed, 22% were neutral and 22% disagreed and 16% strongly disagreed (n=155).
- 41% strongly agreed and 34% agreed with the statement *the Principal fully supports relationship and sexual health education programs*. 19% were neutral, 5% disagreed and 1% strongly disagreed.



There was strong agreement that principals fully supported relationship and sexual health education programs and agreement among participants that the schools do not have a developed sexual health policy, or that the school has implemented information sessions for parents.

However there were mixed responses to the other statements. It appears from comments that determining if a school provides: a relevant sexual health relationship education component in the curriculum; makes sexual health and relationship education and/or information programs available to parents; and provides sufficient time for health education depends on the particular school. The program varies between schools; some schools are less supportive of the program than others.

Further analysis

Analysis was undertaken to determine if differences existed between the five groups who had undertaken the professional development course. For the purpose of this analysis groups were defined as teachers (primary and secondary), school health nurses (school health nurses with a single school and school health nurses with more than one school) and non-teaching professionals.

No significant differences were found between the groups.

Question: Where does relationship and sexual health education fit within the overall curriculum at your school?

One hundred and forty-six participants took the opportunity to comment. Some respondents covered more than one issue in their comments. The comments were themed and are presented in the table below.

Where does relationship and sexual health education fit within the overall curriculum at your school?	Frequency	Percentage
Within Health Education	70	34.8
Within Health and Physical Education	19	9.5
In years 8, 9, 10	19	9.5
Within Physical Education	15	7.5
Integrated across curriculum	12	6.0
Not important/sexual health is not a priority	11	5.5
In years 6–7	9	4.5
All students are exposed	8	4.0
Varies from school to school	6	3.0
Within Health and Social Values	5	2.5
Is a high priority at the school	5	2.5
Part of pastoral care	4	2.0
In year 7	4	2.0
It is left to individual teachers/left to teachers who want to teach the program or aspects of the program. Not all teachers deliver the program	3	1.5
Not part of the curriculum	3	1.5
In year 10	2	1.0
In years 11–12	2	1.0
Within Society and Environment	2	1.0
It is a separate subject	1	0.5
In years 4–7	1	0.5
Total	201	100

The majority of respondents placed relationship and sexual health education within health and physical education. There is also evidence within the comments that not all schools are consistent in how they fit relationship and sexual health within the overall curriculum.

Question: What aspects of the school's sexual health policies and procedures are working well, could they be improved and how?

One hundred and seventeen participants took the opportunity to comment. Some respondents covered more than one issue in their comments. The comments were themed and are presented in the table below.

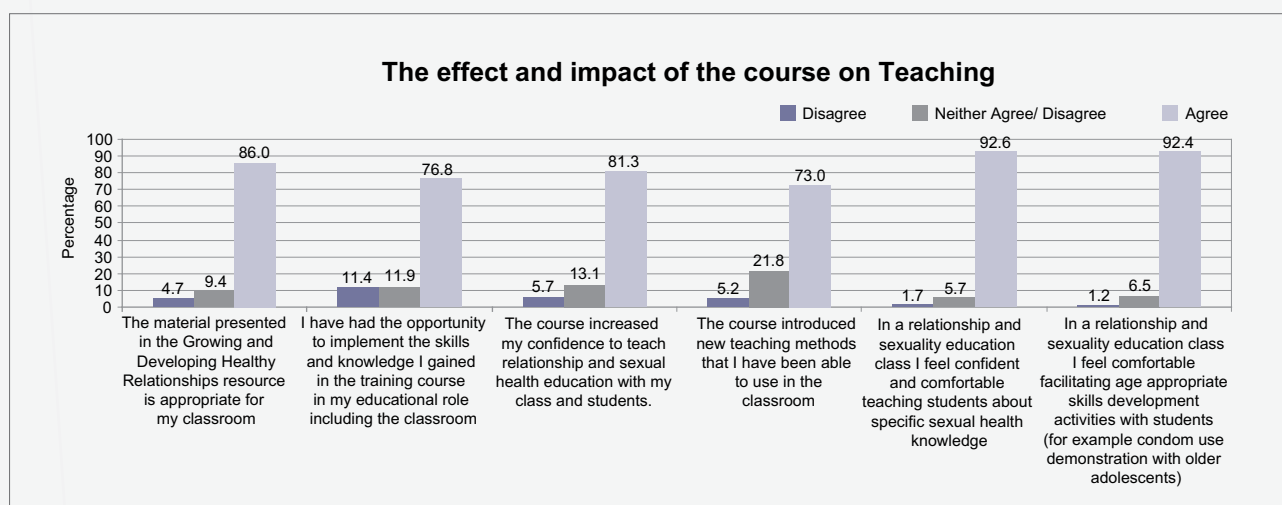
What aspects of the school's sexual health policies and procedures are working well, could they be improved and how?	Frequency	Percentage
There needs to be more teacher training/or more trained teachers (as teachers don't like teaching sexual health education)	29	17.9
All working well	24	14.8
There is no policy/no strategy. There needs to be a policy	23	14.2
The area needs to be a priority both at the school and departmental level. The area needs to be included in school planning. Should be given a higher priority within the curriculum and timetabling	14	8.6
The area needs more funding/more resources within the school	9	5.6
Topics are covered well	9	5.6
Needs more coverage in lower primary school	8	4.9
Sexual health education is a low priority (both at the school and within the DET)	8	4.9
There needs to be more parental contact	8	4.9
As part of pastoral care the policies are working well	7	4.3
The school has a good curriculum	7	4.3
More time allocated to health topics explored	6	3.7
Other health education aspects are working but not sex education	3	1.9
There needs to be a specific sexual health education program	3	1.9
Whole-of-school approach	2	1.2
School policy mirrors the department's policy	1	0.6
There needs to be more health education in the school	1	0.6
Total	162	100

The comments suggest that there is a lack of trained (or interested) teachers and that the lack of priority is reflected in the policy. For 15% of respondents the policy is working well.

3.11 The effect and impact of the course on teaching

The fourth group of six quantitative questions was intended to determine the effect of the course on participant teaching. Participants were asked their level of agreement with the following statements on a five-point scale where one is strongly disagree and five is strongly agree. The agree/strongly agree and strongly disagree/disagree data has been combined and presented for each question in the graph below.

- 44% of respondents agreed and 43% strongly agreed with the statement *the material presented in the GDHR resource is appropriate for my classroom*. 9% were neutral, 2% disagreed and 2% strongly disagreed (n=171).
- 39% of respondents agreed and 38% strongly agreed with the statement *I have had the opportunity to implement the skills and knowledge I gained in the training course in my educational role including the classroom*. 12% were neutral, 6% disagreed and 5% strongly disagreed (n=185).
- 41% of respondents agreed and 41% strongly agreed with the statement *the course increased my confidence to teach relationship and sexual health education with my class and students*. 13% were neutral, 4% disagreed and 1% strongly disagreed (n=176).
- 37% of respondents agreed and 36% strongly agreed with the statement *the course introduced new teaching methods that I have been able to use in the classroom*. 22% were neutral, 2% disagreed and less than 3% strongly disagreed (n=174).
- 71% of respondents strongly agreed and 21% agreed with the statement *in a relationship and sexuality education class I feel confident and comfortable teaching students about specific sexual health knowledge*. 6% were neutral, 1% disagreed and 1% strongly disagreed (n=176).
- 70% of respondents strongly agreed and 23% agreed with the statement *in a relationship and sexuality education class I feel comfortable facilitating age appropriate skills development activities with students (for example condom use demonstration with older adolescents)*. 6% were neutral and 1% strongly disagreed (n=170).



The majority of participants agreed that the impact of the professional development course on their teaching had been positive. They agreed that the GDHR resource is appropriate for their classroom, that they have had an opportunity to implement the skills and knowledge they gained through the course and that the course increased confidence and helped to make them feel comfortable teaching skills and specific sexual health knowledge.

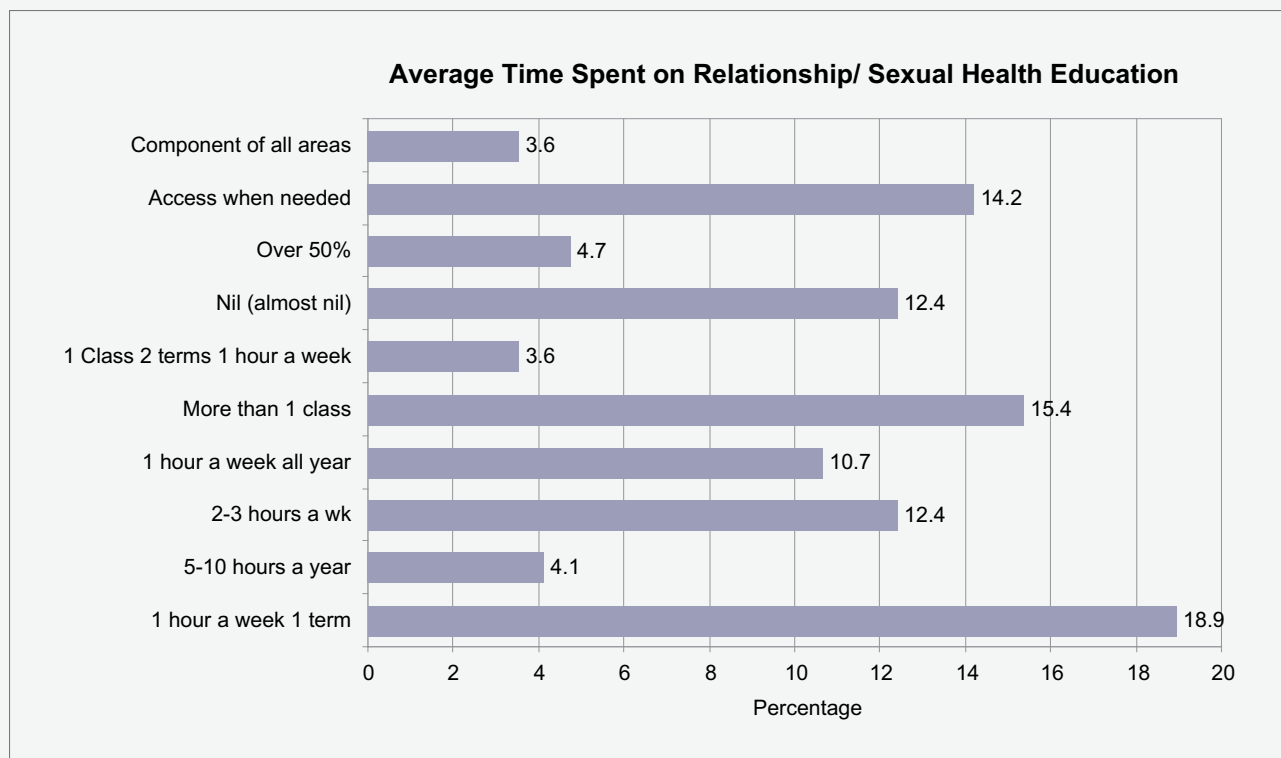
Further analysis

Analysis was undertaken to determine if differences existed between the groups who had undertaken the professional development course. For the purpose of this analysis groups were defined as teachers (primary and secondary), community health nurses in schools both primary and secondary (school health nurses with a single school and school health nurses with more than one school) and non-teaching professionals.

No significant differences were found between the groups.

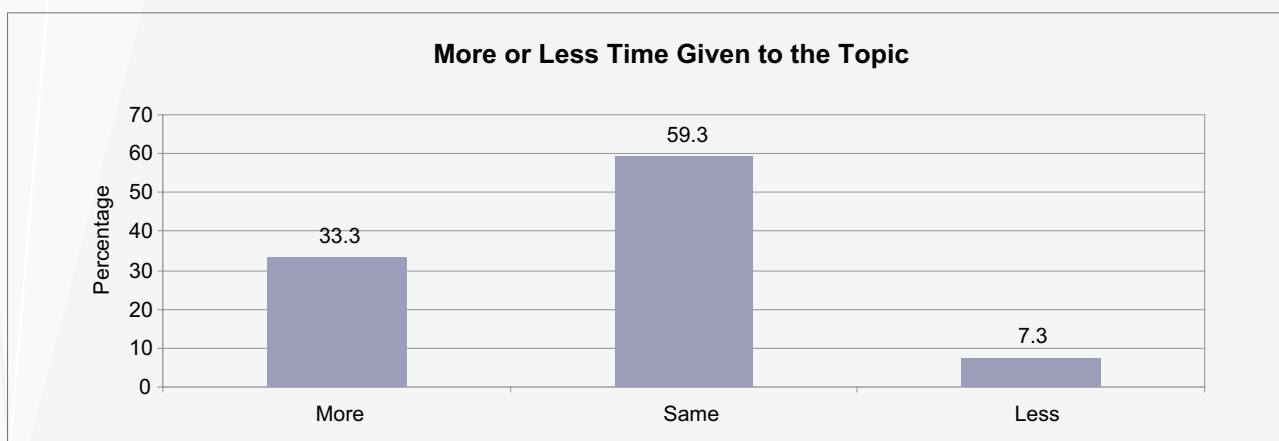
Question: On average how much time do you spend on relationship and sexual health education per week, per month, per term or per year?

One hundred and sixty-nine participants took the opportunity to comment. The comments were themed and percentage calculated; they are presented in the graph below. The most common category for teaching sexual health classes was one hour a week for one term per year, followed by teaching more than one class one hour a week for one or two terms. 14.2% (mainly school health nurses) said they were accessed whenever needed and 12% of respondents do not teach at all. 3.6% (primary school teachers) said that it was taught as a component of all areas.



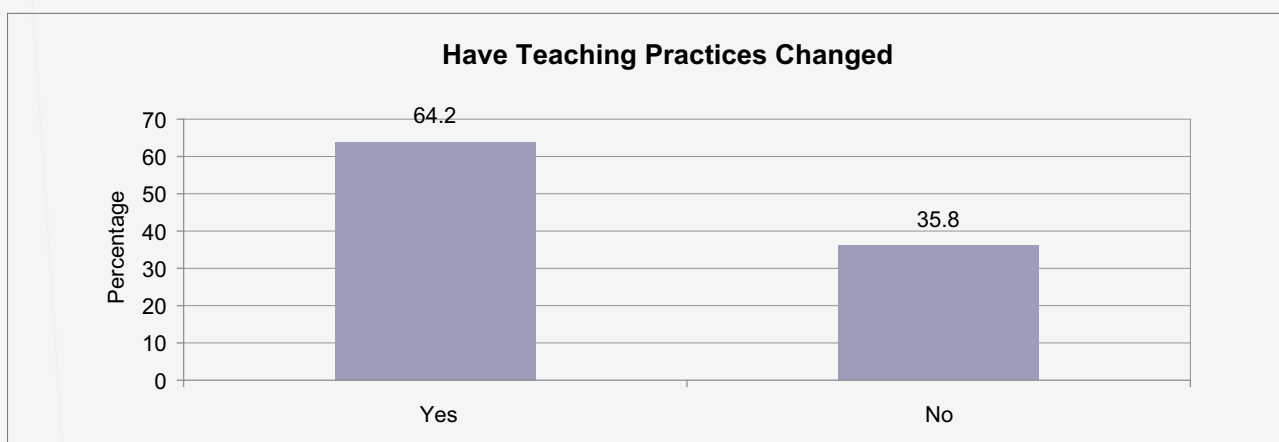
Question: Is this more or less time than you would have given to this subject area than before undertaking the course?

One hundred and fifty participants took the opportunity to comment. 59% of respondents felt that the time spent teaching sexual health was the same as that prior to undertaking the course. 33% felt that they spend more time and 7% said they spent less time teaching the subject than prior to the course. For those who said they spent less time teaching, comments suggest this is primarily due to changes in the requirements of new positions rather than a decrease in desire.



Question: Have your teaching practices changed since undertaking the course and if so, how?

One hundred and seventy-three participants took the opportunity to comment. As can be seen in the graph below 64% of participants felt that their teaching practices had changed since undertaking the course.



Those who said that their teaching practices had changed (111) clarified their answers; some respondents covered more than one issue in their comments. These were themed and are presented in the table below.

Have your teaching practices changed since undertaking the course and if so, how?	Frequency	Percentage
Incorporating activities and strategies learned in the course	62	44.0
More confident/more relaxed	22	15.6
More student-centred	19	13.5
The course enhanced and reinforced existing information/teaching styles	14	9.9
Teaching now consists of more group work/cooperative learning strategies	13	9.2
Better understanding of the role of attitudes and beliefs/increased cultural sensitivity	10	7.1
Used to get the nurse now incorporate the subject in a wider variety of topics	1	0.7
Total	141	100

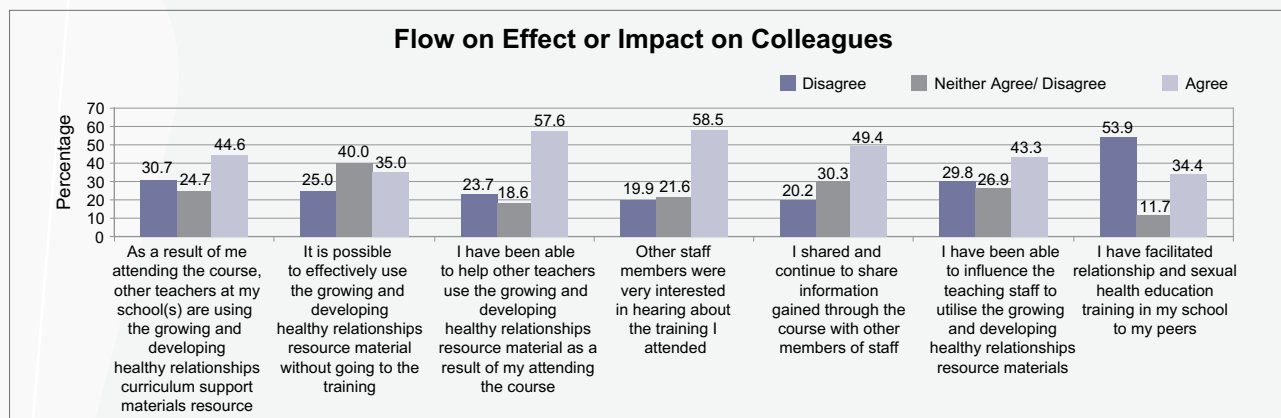
Respondents said they had incorporated the activities and strategies into their teaching, they were more confident and were more student-centred.

3.12 Participation in the course and flow-on effect: impact on colleagues and other members of staff

The fifth group of seven quantitative questions was intended to determine the flow-on effects of the course to colleagues and other members of staff. Participants were asked their level of agreement with the following statements on a five-point scale where one is strongly disagree and five is strongly agree. The agree/strongly agree and strongly disagree/disagree data has been combined and presented for each question in the graph below

- 16% of respondents disagreed and 15% strongly disagreed with the statement *as a result of me attending the course, other teachers at my school(s) are using the GDHR Curriculum Support Materials resource*. 25% were neutral, 31% agreed and 13% strongly agreed (n=166).
- 31% agreed and 4% strongly agreed that *it is possible to effectively use the GDHR resource material without going to the training*. 41% were neutral, 17% disagreed and 7% strongly disagreed (n=180).
- 38% of respondents agreed and 19% strongly agreed with the statement *I have been able to help other teachers use the GDHR resource material as a result of my attending the course*. 12% disagreed and 12% strongly disagreed and 19% were neutral (n=177).
- 40% agreed and 19% strongly agreed that *other staff members were very interested in hearing about the training I attended*. 21% were neutral, 14% disagreed and 6% strongly disagreed (n=176).
- 29% of respondents agreed and 21% strongly agreed with the statement *I shared and continue to share information gained through the course with other members of staff*. 30% were neutral, 12% disagreed and 8% strongly disagreed. (n=178)
- 32% of respondents agreed and 11% strongly agreed with the statement *I have been able to influence the teaching staff to utilise the GDHR resource materials*. 28% were neutral, 17% disagreed and 12% strongly disagreed (n=171).

- 34% of respondents strongly disagreed and 20% disagreed with the statement *I have facilitated relationship and sexual health education training in my school to my peers*. 12% were neutral, 24% agreed and 10% strongly disagreed (n=180).



The majority of respondents felt that they had been able to help other teachers to use the GDHR resource material, however when asked if they were able to influence teaching staff to utilise the GDHR, significantly fewer participants agreed. The explanation for this somewhat contradictory finding can be found in high agreement levels to the statement that *other staff members were interested in hearing about the training* and the lower agreement levels with the statement that *other teachers are using the material*. It appears that where teacher colleagues are interested in and/or already using the GDHR resource material participants were able to assist, however where teachers were reluctant to use the material participants had very little influence.

The majority of respondents were unsure if it was possible to use the material without attending the course and the majority said they had not facilitated relationship and sexual health training in their school.

Further analysis⁵

Analysis was undertaken to determine if differences existed between the groups who had undertaken the professional development course. For the purpose of this analysis groups were defined as teachers (primary and secondary), school health nurses (school health nurses with a single school and school health nurses with more than one school) and non-teaching professionals.

Significant differences were found between the groups for the statements:

- It is possible to effectively use the GDHR material without going to the training;
- I have been able to help other teachers use the GDHR resource material as a result of my attending the course; and
- I have facilitated relationship and sexual health education training in my school to my peers.

⁵ For further details see Appendix 5

The school health nurse with a single school and teachers were more likely to agree that it is possible to use the GDHR resource material without attending the training, than school health nurses with more than one school and non-teaching professionals. Comments suggest that teachers are more used to working from such resource material and are therefore relatively comfortable with the idea of being able to use the material without attending a training course. Comments from school health nurses suggested that they were comfortable with the content of sexual health education and therefore found the activities in the resource easy to understand and incorporate without the aid of training. For those further away from teaching sexual health in a classroom the need for the course became more pronounced. However, even though there was a statistical difference between groups, it must be noted that only 35% agreed or strongly agreed that the material could be used without the training; the majority were neutral. Analysis of the comments for those who gave a neutral score suggest that they believed that it was possible to use the material without training but it would not be as effective as the material and the training.

Teachers and non-teaching professionals were more likely to agree that they have been able to help other teachers use the material and facilitate sexual health education training in the school than either of the school health nursing groups. However comments from school health nurses suggested that they were discussing the course with other school health nurses and had been able to help other colleagues use the material.

Question: Please comment on any experiences or issues, positive or negative, you have had regarding influencing other teachers to use the GDHR Curriculum Support Materials resource or on any other information you received from the course

One hundred and nineteen participants took the opportunity to comment. Some respondents covered more than one issue in their comments. The comments were themed and are presented in the table below.

Please comment on any experiences or issues, positive or negative, you have had regarding influencing other teachers to use the GDHR Curriculum Support Materials resource or on any other information you received from the course	Frequency	Percentage
Able to spread the use of the material	35	20.5
It is an easy resource to use/no problems	26	15.2
The feedback very positive	18	10.5
Most teachers do not use the material	11	6.4
Teachers with fixed ideas not interested	11	6.4
Able to be a resource to others	10	5.8
Made teachers more comfortable using the material/teaching the subject	9	5.3
Teachers still resistant to the subject	9	5.3
Problems getting staff together – no time	9	5.3
Very positive use of cooperative learning – useful for teachers in the system	5	2.9
Conducted staff meetings	4	2.3
Health teachers interested but professional development limited	4	2.3

Teachers are still not comfortable	3	1.8
Teachers attitudes need to change	3	1.8
Getting teachers to want to use it is the key (and the problem)	2	1.2
Have influenced teachers to do the course	2	1.2
No problems passing on information	2	1.2
Many would benefit from the course	2	1.2
Have had no real impact	2	1.2
Only issue is with same-sex material	2	1.2
Some teachers were vocally opposed to the material	2	1.2
Total	171	100

Participants related a variety of positive and negative experiences regarding their experiences in influencing other teachers. Some had been able to pass on information easily; they are seen as a resource in the use of the material and have influenced others to undertake the course. Others talked about the negative experiences of having been verbally abused by teachers who were not comfortable with the subject matter.

Question: What would you say has been the greatest impact on your professional practice, teaching and general work with students from attending this course?

One hundred and seventy-four participants took the opportunity to comment. Some respondents covered more than one issue in their comments; these comments were themed and are presented in the table below.

What would you say has been the greatest impact on your professional practice, teaching and general work with students from attending this course?	Frequency	Percentage
New strategies – making learning fun	54	21.5
More confidence to tackle the subject	49	19.5
Strengthening knowledge base	30	12.0
Awareness of materials	22	8.8
Increased enthusiasm for the subject	19	7.6
More awareness of students' needs/issues	18	7.2
Awareness of the importance of the topic	13	5.2
Nothing	12	4.8
More able to answer students' questions	11	4.4
More awareness of the teacher–student relationship	8	3.2
Awareness of own and other values	5	2.0
Increased interaction with colleagues	5	2.0
Increased presentation skills	5	2.0
Total	251	100

The impact of the professional development in raising awareness of the materials, of students' needs, the importance of the topic, the teacher–student relationship and their own beliefs were highlighted

as impacts. New strategies for making learning fun and increased enthusiasm for the topic and a strengthened knowledge base were also discussed.

3.13 Participants' general observations about how to attain better teacher professional development in this field

The final two questions were open-ended and asked participants their views on how to overcome obstacles for getting more teachers to the training and how to improve relationship and sexual health education for students.

Question: What are the major obstacles to getting more teachers to the training? And how could this be overcome?

One hundred and sixty-four participants took the opportunity to comment. Some respondents covered more than one issue in their comments; these comments were themed and are presented in the table below.

What are the major obstacles to getting more teachers to the training and how could this be overcome?	Frequency	Percentage
Shortage of relief teachers	87	26.9
Lack of time to undertake training	43	13.3
Competing demands for scarce professional development time/lack of time for professional development	35	10.8
Schools need to give priority to the area and to the professional development	33	10.2
Funding for professional development	27	8.4
Send the material out to the schools/advertise more widely	23	7.1
Get to the remote and regional areas	21	6.5
Paid relief	15	4.6
Many teachers are not comfortable with the subject	15	4.6
Training in the area should be compulsory for all teachers	9	2.8
Get the trainers to the school to run the course to all the staff	8	2.5
Don't make teachers teach the material if they don't want to	4	1.2
Prioritise the schools with no health/sexual health specialist teachers	3	0.9
Total	323	100

Shortage of relief teachers, a lack of time to undertake professional development and competing demands for scarce professional development time were perceived as the main obstacles to the uptake of the GDHR professional development.

Question: How would you improve education about relationships and sexual health for students?

One hundred and seventy-five participants took the opportunity to comment. Some respondents covered more than one issue in their comments; these comments were themed and are presented in the table below.

How would you improve education about relationships and sexual health for students?	Frequency	Percentage
Health education/sexual health education needs to be a priority teaching area	47	18.3
Taught throughout the school curriculum	41	16.0
More time needs to be devoted to the subject in the timetable	33	12.8
There is a need for ongoing in-service training in the area	25	9.7
There needs to be a greater involvement of parents	22	8.6
Up-skill staff – more info to staff	17	6.6
There needs to be more specialist teachers	15	5.8
Teaching aids and materials needs to be updated. Particularly the audio-visual materials used when teaching the topic	15	5.8
The needs of the students with regard to relationships and sexual health education should be given a high priority at the school and within the department	13	5.1
Need to take the taboo out of the subject	10	3.9
The actual details of what should be taught to what age group need to be spelt out in the curriculum. (more specific info)	9	3.5
Mandatory part of teacher training	8	3.1
Ongoing in school training	2	0.8
Total	257	100

Respondents felt that sexual health education should be given a higher priority within schools, given more time in the timetable and taught throughout the curriculum. They felt that there should be ongoing training in the area and that teachers may need to be up-skilled with both pre-service and in-service training.

3.14 Comparison between Concord and Estill surveys

The common questions contained in each of the surveys were analysed to determine the long-term effect of the gains made during the professional development course. The data collected by Concord at the conclusion of each training course and the current survey were analysed using independent samples t-tests (for more details see Appendix 6).

The mean score for the statement *sexuality education is an important part of health education* was found to be 4.9 for both studies. This suggests no diminution in the perception of the importance of sexuality education over the time from completing the course to the present survey.

The mean scores for the statement *health trained teachers working in partnership with parents and the wider community is the ideal way to educate young people about sexual health* were found to be significantly different at the 0.05 level. The mean score obtained in the current survey (4.4) was found to be significantly lower than that obtained at the completion of the course (4.7). Similarly the means for the statements:

- *I understand how my own values around sexuality affect my work with young people and my peers;*
- *The majority of parents support sexuality education in schools; and*
- *The GDHR Curriculum Support Materials are extremely useful*

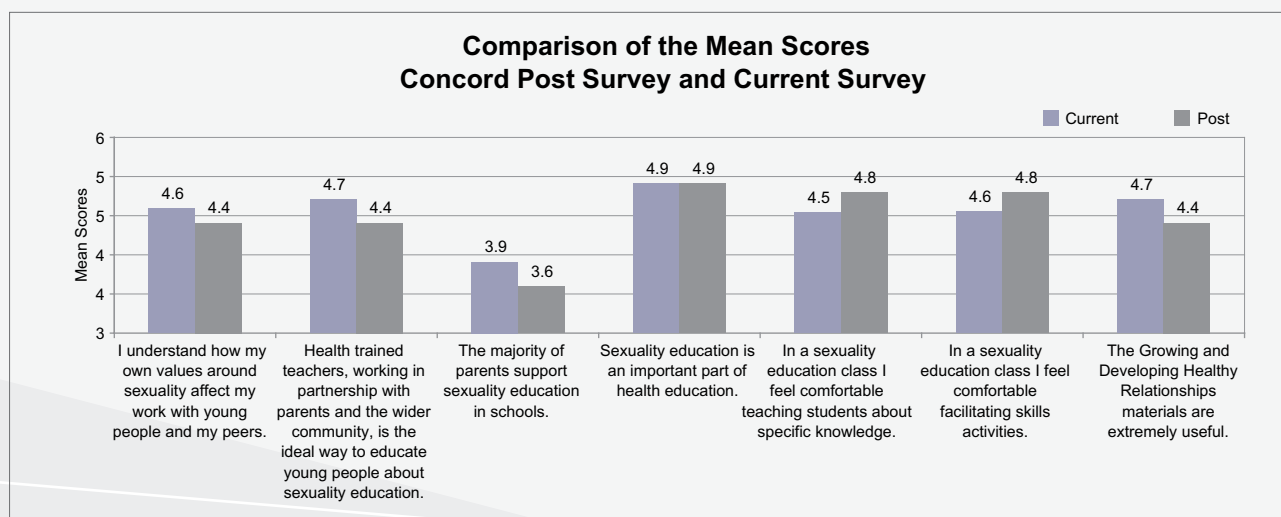
were found to be significantly lower in the present evaluation study than at the completion of the course but the mean scores were high suggesting that the course was perceived to be of high quality. The lower scores are likely to reflect the heightened emotional state at the completion of the course and this is a well-known phenomenon and is the reason for suspicion of evaluation studies that only use end-of-course data and not long-term data.

There is also some indication in the comments of teachers that they do not feel fully supported by parents and are not using the materials; this could also account for the drop in scores.

With regard the two most important statements, that measure most nearly the aims of the PD, namely:

- *In a relationship and sexuality education class I feel confident and comfortable teaching students about specific sexual health knowledge; and*
- *In a relationship and sexuality education class I feel comfortable facilitating age appropriate skills development activities with students (for example condom use demonstration with older adolescents),*

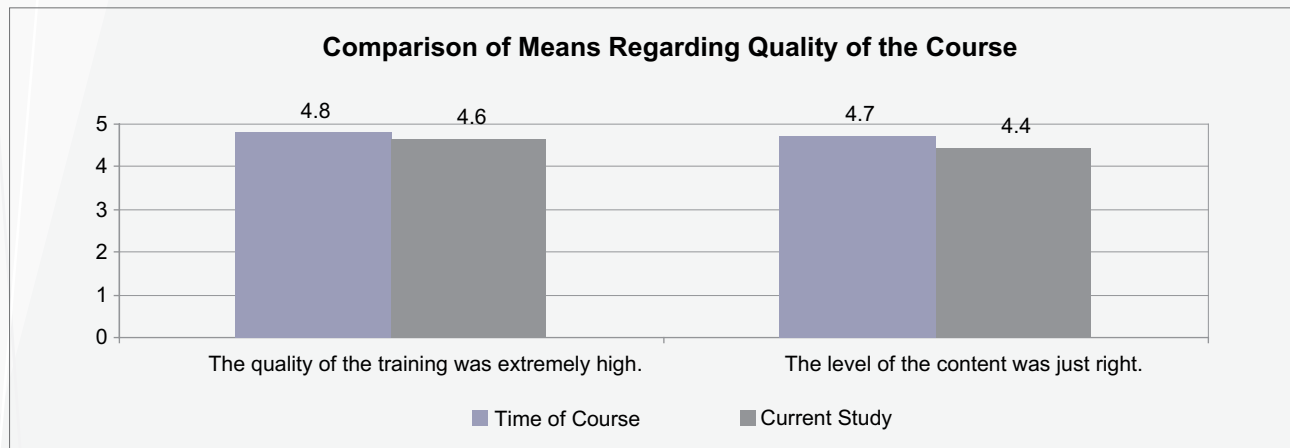
the mean scores were found to be statistically equivalent between the two surveys; that is there had been no increase or decrease in the mean scores. It should be noted that these questions were modified in the current impact evaluation survey; though the intent of the questions were equivalent they contained extra definitional qualities and as such direct comparisons should be made with caution. However comments from participants suggest that the major ongoing effect of the course was to increase confidence in teaching sexual health to students; it is therefore likely that the result represents ongoing gains due to the training course.



Both surveys asked two questions relating to the quality of the course. When asked to agree with the statement *the quality of the training was extremely high*, the mean score obtained at the conclusion of the course was found to be 4.7; the mean obtained with the current survey was found to be 4.6. An independent samples t-test found this to be significantly different at the 0.05 level.

When asked to agree or disagree with the statement *the level of content was just right* the obtained mean at the conclusion of the course was found to be 4.7; the mean obtained with the current survey was found to be 4.4. An independent samples t-test found this to be significant at the 0.05 level.

Although the means obtained in the current study were found to be significantly lower than those obtained at the conclusion of the course it must be noted that the mean for the current study is still high, indicating that respondents found the quality of the professional development to be extremely high and the content was thought to be 'just right'.



3.15 Key findings: what impact did the professional development course have?

Personal and professional views about sexual health education

The majority of respondents believe that sexuality education is an important part of health education (97.9%), that health trained teachers working in partnership with parents and the wider community is the ideal way to educate young people (89.4%), that teachers' attitudes to sexuality affect the way they teach sexual health education (72.2%), that they understand the impact of their own values (87.7%) and that the GDHR Curriculum Support Materials are extremely useful (86.5%).

There is a perception among participants that the majority of teachers are not comfortable teaching sexual health education (75%). There were somewhat mixed views about the role of the specialist teacher for sexual health education: 51.8% said there should be, 31% were neutral and 17% disagreed. Comments suggest that the interpretation of what is a specialist was one of the reasons for the mixed results; many were not prepared to agree that a teaching specialist, such as a maths specialist or English specialist was required, but even those who disagreed with this level felt that some form of training such as that offered by Concord would be needed to teach the subject.

Secondary teachers were significantly more likely to agree that sexual health education should be taught by a specialist teacher and primary school teachers were the least likely to agree. This finding is consistent with different pedagogical structures and roles in primary and secondary education.

Non-teaching professionals and school health nurses with a single school were significantly more likely to agree than teachers that a teacher's personal attitude to sexuality affects the way they teach sexual health education.

The school health nurse (with a single school) and secondary teachers were more likely to agree than primary school teachers and school health nurses servicing more than one school that the majority of parents support sexuality education in schools. This may reflect the age divide of the students represented by these two groups: parents may be more likely to support sexuality education in secondary school than in primary school. As such the result may reflect a perception of the nature of sexual health education; it may be that the definition is narrowly defined as sex education. If this is the case, work may be needed to educate parents on the content of sexual health education.

Participation in the professional development course run by Concord and the Department of Health

There was overwhelming support for all aspects of the course; it was thought the course would benefit all teachers, with high quality training, good content, a useful way to better understand and use the GDHR Curriculum Support Materials and which gave them the confidence to design their own sexual health education programs. Although some of the school health nurses commented that the course had been too short and that they would like to have attended the two-day teachers' course, there was no support for the course being too short generally.

Aspects of the training considered useful included:

- the teaching strategies/activities;
- the introduction to the GDHR Curriculum Support Materials; and
- the talks and information provided by experts/agencies.

The majority of respondents (70%) could not recall an aspect of the course that had not been of some benefit. Comments received suggest that courses they had attended previously made elements of the course repetitive and that some of the information was not needed for some of the teachers (i.e. too much information on STIs for primary teachers) and a few participants did not enjoy the role-playing games.

School(s) environment including policies related to relationship and sexual health education

There was strong agreement that principals fully supported relationship and sexual health education programs; however participants felt that their schools did not have a developed sexual health policy or that the school had implemented information sessions for parents.

However there were mixed responses to the other statements. It appears from comments received that determining if a school provides a relevant sexual health relationship education component within its curriculum; makes sexual health and relationship education and/or information programs available to parents; and provides sufficient time for health education depends on the particular school. The program varies between schools, with some schools less supportive of the program than others.

Respondents' views suggest that the short answer to *where does relationship and sexual health education fit within the overall curriculum at your school?* is that *it varies from school to school*. For the majority of respondents it fits within health education or health and physical education and is taught in years 8, 9 and 10. Comments from school health nurses servicing more than one school stressed this question was difficult to answer as their schools were not consistent. Secondary teachers were likely to point out the lack of programs in years 11 and 12, but some of the more disturbing comments were from primary school teachers, who said that it depended on the individual teacher, not the school policy. One primary school teacher was particularly distressed that in their school it was left up to individual teachers and that if a teacher did not want to teach even such basics as menstruation it was not taught. Comments from other teachers that they had offered help, or had offered to teach topics that they felt to be important at the year 5 and year 7 level, and had been rejected, suggests that this may not be an isolated incident.

15% of respondents felt that all the sexual health policies within the school were working well. 18% felt that there needs to be more teacher training or more trained teachers (as teachers don't like teaching sexual health education). 15% said there was no policy and that there needed to be a policy in place at the school. Primary school teachers in particular were concerned that not all children have an equal education when it comes to sexual health education and many comments suggested that there is a need for sexual health to be a priority both at the departmental and school level and that, at the school level, sexual health education should be given a higher priority within the curriculum and timetabling.

The effect and impact of the course on teaching

The majority of participants felt that the impact of the professional development course on their teaching had been positive. They agreed that the GDHR resource is appropriate for their classroom, that they have had an opportunity to implement the skills and knowledge they gained through the course and that the course increased confidence and helped to make them feel comfortable teaching skills and specific sexual health knowledge.

The most common time allocation for teaching sexual health classes was one hour a week for one term per year, followed by teaching more than one class one hour a week for one or two terms. 14.2% (mainly school health nurses) said they were utilised whenever needed and 12% of respondents do not teach at all. 3.6% (primary school teachers) said that it was taught as a component of all areas.

- 59% of respondents felt that the time spent teaching sexual health now was the same as that prior to undertaking the course. 33% felt that they spend more time and 7% said they spent less time teaching the subject than prior to the course.
- 64% of participants felt that their teaching practices had changed since undertaking the course. They felt that they had been able to incorporate the activities and strategies learned in the course, that they were more confident or more relaxed when teaching and that their teaching practices were more student-centred.

The majority of respondents felt that the greatest impact on their professional practice had been that the new teaching strategies and activities learned on the course had helped them to make learning fun for the students. Participants reported that they had more confidence to tackle the subject and that the course had strengthened their knowledge base.

Flow-on effect (or impact) on colleagues and other members of staff

The majority of respondents felt that they had been able to help other teachers to use the GDHR resource, however when asked if they were able to influence teaching staff to utilise the GDHR significantly fewer participants agreed. The explanation for this somewhat contradictory finding can be found in high agreement levels to the statement *other staff members were interested in hearing about the training* and the lower agreement levels with the statement *other teachers are using the materials*. It appears that where teacher colleagues are interested in and/or already using the GDHR resource participants were able to assist, however where teachers were reluctant to use the material participants had very little influence.

The school health nurse with a single school and teachers were more likely to agree that it is possible to use the GDHR resource without attending the training than those school health nurses servicing more than one school and non-teaching professionals.

Teachers and non-teaching professionals were more likely to agree that they have been able to help other teachers use the GDHR resource and facilitate sexual health education training in the school than were the school health nurses with a single school.

With regard to influencing their peers the responses were mixed; for some there had been no particular issues influencing others as it is an easy resource to use. They felt they had been able to spread the use of the GDHR resource and that the feedback had been very positive. Some participants saw themselves as a resource to others and had been able to make teachers more comfortable using the GDHR materials or teaching sexual health. A few had been able to influence teachers to undertake the course.

Problems reported with influencing their peers centred on the resistance of teachers. Teachers with fixed ideas were not interested in the GDHR material; it was felt by some respondents that teachers' attitudes toward sexual health education need to change, so that they will want to use the GDHR material or teach the subject. Some respondents felt that teachers are still not comfortable teaching sexual health and there was a suggestion by some that most teachers do not use the GDHR material. Some felt they have had no real impact in influencing their peers.

General observations about how to attain better teacher professional development in this field

The major obstacles in attracting more teachers to participate in the professional development program were seen to be the shortage of relief teachers, the lack of time for teachers to undertake training, competing demands for scarce professional development time and the lack of priority given to sexual health and sexual health-related professional development and the lack of funding allocated for this professional development.

Many of the comments concerning better teacher PD in this field were related to the broader political climate in that respondents felt that health education/sexual health education needs to be a priority teaching area to improve the relationships and sexual health education for students. It should be taught throughout the school curriculum and allocated more time in the timetable.

3.16 Part A: Recommendations and conclusions

From the review of current research literature undertaken for this study (see Part B) it is clear that the design, structure and implementation of the professional development training course implemented in WA is in keeping with best practice standards described in the literature (see Kirby 1994, 2001, 2005, 2007).

It is also clear that the results obtained from those surveyed in this study (Part A) indicate that the training and professional development course is perceived to be a very valuable contribution to the professional development of the participants. It was seen to be of high quality and the information provided in the course was easy to translate into actions in the classroom. Importantly the gains in confidence reported at the conclusion of the course have been maintained over time, with teachers/school health nurses suggesting that they felt as confident with their skills to teach sexual health over time as they did at the completion of the course. As this increase in confidence has been related to teachers' successful implementation of sexual health programs, the importance of this finding should not be overlooked. The stated aim of the course was to increase confidence and this has been achieved.

Beyond this there was also a general sense that the information presented during the training inspired teachers to change their teaching behaviours in other areas of the curriculum, adopting a more student-centred teaching style that they found personally satisfying and more motivating for the students. These gains cannot be understated; they are an important impact of the professional development training course.

This study has found the GDHR resource and the supporting PD course have been developed consistent with world best practice. In particular this research has shown that over the last five-plus years this professional development course has had positive impacts on the teaching practices of those who have undertaken this training. The positive impact of the course on the confidence of teachers to teach about sexual health and in age appropriate development stages was maintained over time. What is also exciting about this finding is that participants indicated that the professional development had impacted positively on other areas of their teaching style, reinvigorating them to become more student-centred in their educational methodology.

Recommendations

1. Continue to provide the face to face workshop course as an available teacher PD option
2. Continue to use Concord Training Services to conduct the PD program
3. Continue the provision of the follow-up workshops
4. Continue the provision of teachers being able to have ongoing contact with the PD facilitators and the dissemination of information and updates to teachers by the same facilitators.

Conclusions

It is clear that the major issue then is not the quality of the GDHR resource or the professional development to promote the use of the materials, but rather the slow progress of ensuring the majority of relationship and sexual health education teachers have access to the professional development. Therefore a **key future task** is to ensure that as many as possible current and potential teachers of health and relationship education have access to the professional development. The difficulties of face-to-face professional delivery have been long identified (see, for example, Department of Education 2001) and alternative and complementary methods of delivering the GDHR professional development should now be investigated.

Teachers commented on the major obstacles in attracting more teachers to participate in this PD and not surprisingly the reasons given were shortage of relief teachers, the lack of time to undertake training, competing demands for scarce time for professional development and the lack of priority and funding allocated to sexual health education and related professional development.

Many of the comments concerning better teacher PD in this field were related to the broader political climate in that respondents felt that health education/sexual health education needs to be a priority teaching area to improve the relationships and sexual health education for students. It should be taught throughout the school curriculum and allocated more time in the timetable.

Similarly, a general observation also worthwhile highlighting is the concern expressed particularly by primary school teachers in the telephone interview survey that not all children have an equal education when it comes to sexual health. Many comments suggested that there is a need for sexual health to be a priority both at the departmental and school level and that at the school level sexual health education should be given a higher priority within the curriculum and timetabling.

Further specific recommendations arising from the research literature component of this study (see Part B) provide a vision for future professional development programs to include a menu of flexible delivery modes, which will enable teachers to access professional development experiences in a variety of ways appropriate to their needs and thus increase the appeal to more teachers. Specific options described include the face-to-face workshops, an online computer based course and peer mentoring approaches.

4. Part B: Preferred models of teacher professional development and training in sexual health education

A Snapshot overview of the findings of Part B

Comparison of other PD models with the Concord model

Based on the models of PD for sexual health education found in the literature review and the evaluation of the PD conducted by Concord the following strengths of the Concord model were identified:

- The participants in the Concord PD valued their experience in the course, consistently rating it as positive and rewarding. The results showed that the participants found the PD had impacted positively on their teaching practice;
- The follow-up workshop was rated highly; and
- Teachers derived benefit from the access to ongoing contact with the PD facilitators and the dissemination of information and updates provided by the same facilitators.

Findings from the literature review of other PD models and evaluation of the Concord PD suggest the following practices could improve future PD programs:

- Run two separate PD courses, one for primary and one for secondary school teachers, or alternatively combine the first half of the PD course for both groups then divide into two separate groups in second half according to content needs. This has been an effective approach within the PD model used by the Calgary Health Region (Canada);
- Provide teachers with continual opportunities to upgrade their skills and update their knowledge; and
- Use a combination of different 'best fit' models of PD to achieve a broader reach to more teachers in WA, namely:
 - face-to-face workshops/courses;
 - online or computer-based courses; and
 - a system of mentoring, collegial support/discussion groups.

4.1 The Desktop literature review

Definition of 'sexual health'

Sexual health has been defined as a state of physical, emotional, mental, and social wellbeing related to sexuality: (1) the absence of disease, dysfunction, or infirmity; (2) a positive and respectful approach to sexuality and sexual relationships; (3) the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence; and (4) respect for the sexual rights of all persons (World Health Organization 2002).

Sexuality education

Families are the primary source of education about sexuality and health and ideally should be engaged in promoting sexual health – supported by local services for young people if necessary. However school-based sex education, delivered before the minimum school-leaving age, remains the most effective way of universally, comprehensively and uniformly targeting adolescent populations (Abraham & Wight 1996).

Evidence for the benefits of comprehensive skills-based education

There is good evidence that implementation of a comprehensive skills-based school health education program can reduce sexual risk-taking behaviour as well as many other problem behaviours such as drug use. More specifically, relationship education programs have been found to:

- Increase adolescents' confidence and ability to make informed decisions (Baldo et al. 1993, Kirby et al. 1994);
- Delay onset of sexual activity (Baldo et al. 1993, Kirby et al. 1994);
- Decrease the frequency of sexual activity (Baldo et al. 1993, Kirby et al. 1994);
- Increase the use of contraceptives in those adolescents who have decided to be sexually active (Baldo et al. 1993, Kirby et al. 1994); and
- Decrease teenage pregnancy and sexually transmitted infections among young people (Baldo et al. 1993, Kirby et al. 1994).

Teachers' views, values and morality

Teachers' sexual experiences or moral views about teenage sexuality may make it difficult for them to facilitate the development of skills relevant to safer sex negotiation. Teachers may also need to be sensitive to different levels of experience, values and sexualities among their students if they are to avoid alienating members of the class.

Consequently, although the prerequisite social skills may overlap with other areas of health promotion and education, and although the same methods may be used to facilitate their development, those who deliver sexual health and safer sex programs may require special training (Kirby 2001, Kirby et al. 1994, 2005, 2007).

Teachers' views, values and morality are crucial determinants of the implementation of sexual health promotion in the classroom. Paulussen et al. (1994) found that the extent to which teachers used recommended sex education curricula and the way in which they used them were determined by:

- teachers' views of the feasibility of classroom procedures;
- their expectations of students' responses to program activities (interest, enthusiasm); and
- their confidence in their ability to deliver the curriculum and their moral beliefs regarding sexual behaviour.

For example, the more conservative the moral beliefs of the teachers, the less willing they were to adopt the curriculum ($r = -0.24$) and the lower their confidence in their ability to deliver the curriculum ($r = -0.30$). Such teachers are sometimes forced to adopt a sex education curriculum and may be less successful using it effectively. These findings underline the importance of teacher training for all sexual health promotion and education in schools.

Knowledge, skills and comfort

Teachers need the knowledge, skills and comfort required for teaching about human sexuality in a developmentally and culturally appropriate manner (McKay & Barrett 1999). Institutional support from both the health and education systems is important and sexual health education training opportunities are a key feature of such support (Health Canada 2003). The ongoing updating of skills when in practice is also important. As stated in the *Canadian Guidelines for Sexual Health Education* (Health Canada 2003), '[e]ffective sexual health education requires in-service training and continuing education that gives educators the opportunity to upgrade their skills on a regular basis' (p. 27).

Scotland example

An example of a program that was designed to give teachers the confidence and skills as well as the specific sexual health program content was conducted in Scotland. The SHARE program collaborated with a respected sex education expert known to teachers in Scotland who became the first author on the finished program (Abraham et al. 2002). In addition, all teachers who delivered SHARE were provided with a five-day course on how to deliver the program. During this course part-time relief teachers (paid for as part of the cost of program implementation) covered the teaching duties of participants. Teachers' evaluation of this training was overwhelmingly positive and the course was particularly successful at boosting the confidence of teachers who felt uncertain about their abilities at the outset (Buston et al. 2002). Nevertheless, despite apparently successful training, some teachers remained reluctant to deliver key aspects of the program. For example, although the importance of student participation and the development of student self-efficacy had been emphasised, some teachers substituted a teacher demonstration of how to use a condom for the hands-on student practice prescribed by the program. Many teachers also remained uncertain about managing role-play exercises in the classroom (Buston et al. 2002). This mirrors observations in the Netherlands (Paulussen et al. 1994) suggesting that key activities, such as condom demonstrations and role-play exercises on sexual issues, are especially challenging for classroom teachers, probably because of a fear of losing control over their students.

Evidence of effectiveness of teacher training

Training and support for teachers is critical to the success of school-based sexual health education programming. In a survey of elementary and middle school teachers in New Brunswick, Canada, Cohen et al. (2004) asked respondents to rate their comfort, knowledge and willingness to teach a variety of sexual health topics (e.g. puberty, personal safety, STIs and HIV, contraception, masturbation, sexual diversity). Overall, the teachers' responses indicated that they were somewhat comfortable, knowledgeable and willing to teach the various sexual health topics. Those who had participated in sexual health education training were significantly more comfortable, knowledgeable and willing to teach the various topics compared to their untrained counterparts (Cohen et al. 2004). The authors concluded that teachers' comfort and knowledge levels related to teaching human sexuality were likely to affect both their willingness to teach this subject and their effectiveness in doing so (Cohen et al. 2004).

In-service training of teachers to foster such knowledge and comfort is known to build capacity to teach sexual health education. Levenson-Gingiss and Hamilton (1989) showed that in-service training increased comfort and knowledge related to sexuality education curriculum content. Their research also showed that teachers who felt well equipped to teach human sexuality were more comfortable in presenting sexual health information and in facilitating classroom discussions (Hamilton & Levenson-Gingiss 1993). Such teachers also had the most influence on their students in terms of sexual attitudes, knowledge and anticipated behaviours.

The design of teacher PD: Some tips

The sexual health education literature provides guidance in terms of the skills, abilities and attributes that should be acquired through sexual health education in-service training. Lokanc-Diluzio et al. (2007) summarised this research and concluded that in-service training programs should:

- Assist teachers in obtaining a broad understanding of human sexuality and various sexual health topics;
- Assist teachers in developing feelings of comfort and capability in terms of teaching the curriculum;
- Provide teachers with up-to-date, grade-appropriate resources;
- Provide teachers with information on issues pertaining to sexual diversity;
- Provide teachers with the opportunity to network with others teaching human sexuality; and
- Provide teachers with varied instructional methods (e.g. demonstrations, group discussion, role-play) for implementing the human sexuality curriculum.

4.2 Models of professional development delivery in sexual health education

The research literature on professional development for teachers within the health promotion field (particularly sexual health) has revealed a great deal about designing and implementing specific preventative interventions (see, for example, Gourlay 1995, Kirby et al. 2007) and the effectiveness of these programs on the teacher and student behaviours; **however no systematic evaluation of the effectiveness of different delivery models of professional development was found in the literature review for this study.**

Five predominant methods used in teacher PD

Professional development can be delivered to teachers using a variety of methods. In examination of various presentation formats for professional development five predominant approaches were identified in the literature related to health education:

1. **Face-to-face:** Learning facilitated by personal contact, such as workshops;
2. **Video-facilitated learning:** Video training can be used as an alternative method of professional development to workshops, particularly when behavioural rehearsal and modelling of skills and experiential learning are objectives of the training. (Basen-Engquist et al. 1994);
3. **Peer based:** Collegial support groups, including mentoring;

- 4. Action research:** Participants undertake action research to improve their practices and their understanding of their practices. Action research is problem-centred and action-oriented. It involves teachers in a diagnostic, action-learning, problem-finding and problem-solving process. Data gathered is used as a change agent, identifying and ranking specific problems and in developing plans for coping with them realistically and practically. Action research models of professional development are becoming more prevalent in implementation in the Australian school context (Department of Education 2001) allowing an emphasis on school-based professional development. However recent evidence from Calgary, Canada, suggests that linking this model of professional development to performance and accountability may be counter-productive (Judah & Richardson 2006); and
- 5. On-line learning:** The development and implementation of online courses for formal courses of study in Australia is growing but it appears that the provision of online professional development for teachers is yet to be extensively implemented (Jackson 2004).

Five categories identified by Hill for the Australian teacher

Hill et al. (1998) examined the breadth of professional development experiences of Australian teachers and described five categories for the methodologies reported by the teachers. These are summarised below:

1. Traditional training and development activities

- Seminars and workshops
- Guest lecturers/speakers on topical issues
- Formal training programs/short courses
- Professional conferences/conventions

2. Technology-assisted and self-directed learning

- Self-directed reading
- Internet (for accessing information)
- Self-paced and open learning programs
- Computer-based training
- E-mail (to communicate with other educators)
- Teleconferencing
- Presentations via satellite link or videotape

3. Formal teacher education

- Full- or part-time academic study

4. Learning from work roles and relationships

- Critical reflection on personal experience
- School-based action research
- Visits to other schools/work sites
- Relieving/acting in higher positions
- Working on committees/taskforces
- Participation in school's development planning
- Participation in curriculum development
- Exchange teaching
- Industry work placements
- Involvement in professional associations
- Opportunities to shadow colleagues
- Mentoring: being mentored/acting as a mentor
- Collegial support/discussion groups
- Informal networking with colleagues

5. Other

- Assessment centres
- Access to examples of good practice
- Information on requirements of various roles

Traditional professional development has focused on methods incorporating some form of face-to-face delivery method and this method has been used predominantly in teachers' professional development in sexual health education (Ross et al. 1991). Professional development in sexual health education is often conducted to introduce teachers to a specific prevention program carefully designed to produce a change in children's risk-taking behaviour. These prevention programs usually employ such activities as discussion groups, planning exercises, scenario rehearsals, video modelling and role-play with students; all methods that have proven to be effective for the development of social skills required to prevent health-risk behaviours (e.g. Abraham et al. 2002, Jemmott et al. 1992).

Face-to-face workshop courses

The most commonly used method to train teachers in the skills to use these educational activities in the classroom and therefore implement the preventative program has been the workshop or short course conducted by a trained facilitator. Courses may be conducted by government agencies, quasi-government agencies or specialised private training organisations. They often have a component of 'training the trainer' included, so that the initial recipients of the professional development can act as trainers themselves and pass on the information and skills to other teachers.

The majority of professional development in Australia has concentrated on face-to-face methods such as workshops and short courses. Although some Australian teachers have indicated that they find ongoing professional development more effective, 'one-off' events are most commonly conducted because they more easily accommodate busy teaching schedules (Department of Education 2001).

The Findings of both the research and evaluation sections of this study support the retention of the face-to-face method of providing professional development as part of an arsenal of methods offered along with other alternative PD programs. Participants in the impact evaluation study greatly valued their experience in the PD course, consistently rating their experience as positive and rewarding and gaining long term positive impact on their teaching practice.

Technology-assisted and self-directed learning methodology

When the objective of a professional development program is to provide training to a large number of teachers dispersed across a wide area, face-to-face delivery may not be the most cost-effective or feasible model. Equal access to professional development for all teachers, regardless of geographical location, years of teaching experience, or type of school, is also an important consideration for planning professional development programs. Face-to-face professional development may not be always suitable to serve the needs of all teachers. Alternative methods of professional development addressing the specific needs of rural and remote teachers and/or those with time constraints, which affect attendance at professional development, should be explored (McRae 2001).

Costs both monetary and personal for the education system and for the individual teachers are an important consideration in the uptake of PD. Rural and remote teachers are particularly burdened by attending face-to-face PD as travel and accommodation costs are significant, and increased time away may pose difficulty with family commitments (Hill et al. 1998). One solution is to offer the professional development in an online format. The DoH is currently developing an online interactive version of the GDHR resource to both complement the existing hard copy material and difficulties in attending face-to-face PD.

It is notable that a study conducted by Hill et al. (1998) asked respondents to identify strategies to overcome professional development access problems in rural/remote areas. Respondents to this survey did not consider that technology-based professional development formats were appropriate alternatives. They indicated equitable access would be best achieved by providing more funding to allow teachers to travel to large centres for training (Hill et al. 1998).

The telephone interview survey component of this impact evaluation study report also details results from similar questions put to teachers about ways to improve their uptake of PD. Participants in this survey also did not suggest using technology as a means of making PD courses more widely available. These participants however had already undertaken the course in face-to-face mode and this is likely to be their favoured mode of PD. An online course would likely attract a different demographic; teachers who are more used to the methodology, perhaps younger teachers who are more technologically aware, or regional and remote teachers who have to rely on technology to overcome professional isolation and lack of physical resources.

The online methodology would address some of the recommendations made about the face-to-face professional development methodology. In particular it overcomes the need for paid relief teachers to take over teacher responsibilities while attending the workshop. As the online professional development is undertaken in teachers' own time the need to reduce the course to one day is not necessary. The online program can be easily set up to cater for the separate needs of primary and secondary schools and can easily accommodate further content modules.

Similar to the out-of-hours face-to-face workshop, there may be a need to offer some form of incentive, either financial or time compensation, if teachers are expected to complete professional development in their own time.

Methodology based on communicating with colleagues

Networking opportunities with colleagues

Teachers consistently identify a need to communicate and network with other teachers (Department of Education 2001). Participants in the current study felt that the ability to discuss their concerns with other teachers and to share their fears and successful strategies with others allowed them to gain confidence and to feel part of a community of like-minded professionals. This was seen as a very important component of the workshop. Isolating teachers by providing professional development via the technology-based methodologies of professional development may make it more difficult to address this need of teachers.

E-networking

Online discussion groups and forums are another way to create a social dimension to the professional development following on from attendance at the face-to-face course. These methods can be initiated at set times to allow the facilitator to participate in the discussion group and can also be accessed at times convenient to the individual teacher.

Teachers attending the WA course are provided with a version of this through access to ongoing contact with the PD facilitators and the dissemination of information and updates to teachers by those same facilitators

Mentoring

Better utilisation of peer-based learning can be supported by instigation of a mentoring system. Over 390 teachers and school health nurses have undertaken the Concord PD and some these former participants could be recruited to act as mentors to teachers undertaking the course for the first time. Mentoring can be an effective method of professional development and can offer an effective learning environment for both the teacher being offered mentoring and the teacher who is the mentor (Klinger 2004).

E-mentoring

E-mentoring (electronic mentoring) is mentoring carried out using some form of electronic communication and is variously referred to as tele-mentoring, online mentoring, virtual-mentoring or cyber-mentoring. Asynchronous mentoring is usually carried out by email but other synchronous methods may also be utilised; for example, messaging, online voice-to-voice networks such as 'Skype' and video conferencing. More recently a number of social software tools such as blogs and wikis provide communication channels to support the mentoring relationship (Stewart & McLoughlin 2007).

Recommendation: Encourage and support the participation of more than one teacher from any one school in the PD to secure ongoing peer support and contact with immediate colleagues.

Recommendation: Build mentoring approaches into future PD including within technology based methodology.

4.3 A framework for professional development delivery models

The flexible learning model

An examination of alternative methods of professional development in the literature identified that a flexible learning model might be the most useful model because it can address the specific needs of rural and remote teachers and the time constraints affecting teachers' attendance at professional development. Flexible learning also appears to be an appropriate method of professional development delivery with many teachers previously using flexible learning approaches to upgrade their own undergraduate and postgraduate qualifications (Jackson 2004). In the literature the term 'flexible learning' has almost become a euphemism for online teaching/learning; this limited definition is not the one proposed here.

Flexible learning and delivery for teacher professional development is:

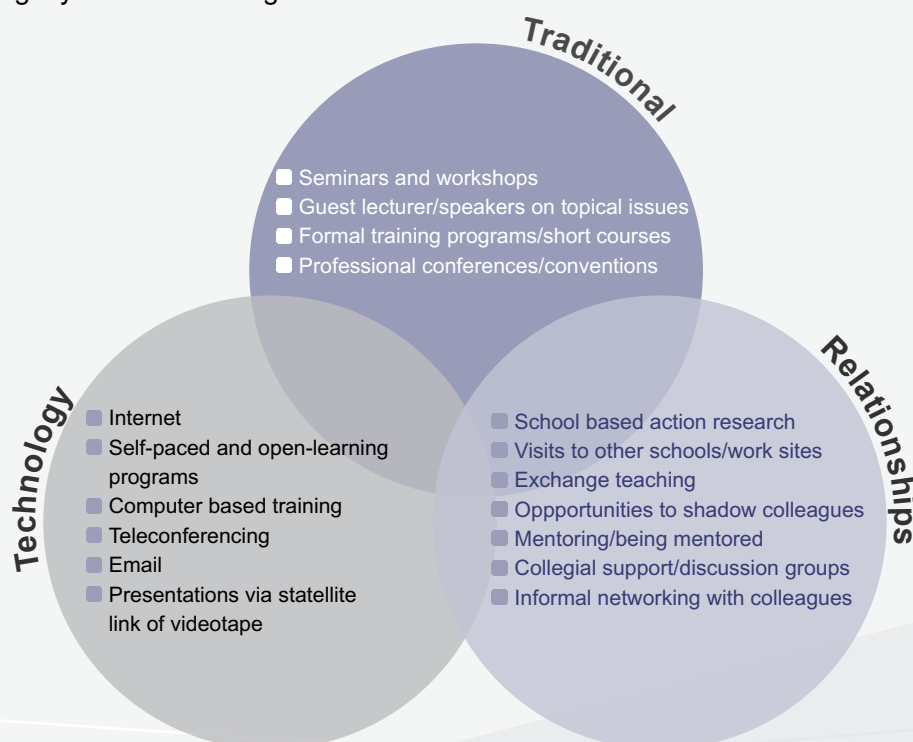
Providing a teaching and learning environment that supports a range of access and delivery methods and different learning modes to optimise the opportunities of teachers to participate in and benefit from professional development.

It is useful to distinguish between the two components:

- flexible delivery modes, which mean that teachers can access professional development experiences in variety of ways; and
- a variety of teaching/learning modes, which are responsive to different *learning styles* and which strive to maximise what teachers learn from their professional development.

Flexible learning for professional development in sexual health

Using the three categories of Hill et al. (1998) it is possible to generate a flexible professional development model that would incorporate flexible delivery and a variety of modes that would allow for different learning styles. These categories can be seen below.



The use of the Venn diagram is appropriate as overlap between modes should be encouraged. For example, although mentoring is usually associated with face-to-face contact, the advent of new technology allows for variations of mentoring, collectively referred to as e-mentoring. Technology can also be used to deliver seminars and workshops in real time to multiple locations and face-to-face workshops can include discussion groups and informal discussions with colleagues.

Feedback from respondents in this evaluation suggests that face-to-face workshops, online or computer based courses and mentoring (collegial support and discussion groups) methods seem to best fit with the aims of the PD in sexual health education:

Recommendation: Utilise a combination of three of the flexible learning PD categories, traditional (face-to-face workshops), technology (online or computer-based courses) and collegial relationships and work roles (mentoring support/discussion groups) in planning for future PD.

This report concentrates on these methodologies but also proposes that further consideration should be given to other complementary methods or variations of these methods.

4.4 Internationally found professional development courses in sexual health education

**Note the summary below is not fully comprehensive, other programs are known to operate particularly in the United Kingdom and the Netherlands but details were not able to be obtained prior to publication of this report.*

1. Scotland: The SHARE program

Model used:	Designed to give teachers the confidence and skills as well as the specific sexual health program content.
Duration:	Teachers intending to using the SHARE program provided with a five-day course on how to deliver it.
Cost:	£900 (Part-time relief teachers paid for as part of cost of program implementation, costs covered relief teaching.)
Evaluation:	Teachers' evaluation was positive and the course was particularly successful at boosting the confidence of those who felt uncertain about their abilities. Despite apparently successful training, some teachers still remained reluctant to deliver key aspects of the programme. For example, although the importance of student participation and the development of student self-efficacy was emphasised, some teachers substituted a teacher demonstration of how to use a condom instead of the hands-on student practice prescribed by the program. Many teachers also remained uncertain about managing role-play exercises in the classroom (Buston et al. 2002). Note: this mirrors observations in the Netherlands (Paulussen et al. 1994). A study published in the BMJ in 2002 found that when compared to conventional sex education, the SHARE program did not significantly reduce sexual risk taking in adolescents. (BMJ 2002;324:1430 (15 June)
Contact:	share@health.scot.nhs.uk

2. Vancouver, Canada: Options for Sexual Health certification course

- Model used:** The OPT Certification Program for Sexual Health Educators is a competency, knowledge and performance-based training program comprising the following elements:
- Course component consists of a series of three to four day workshops on specific related topics using evidence-based methodology to provide participants with sound theory and opportunities for observation, demonstration, presentation, facilitation and evaluation;
 - Practicum component consists of 60 hours of direct instruction and ten hours of supervised instruction, followed by recommendations for certification which are reviewed by the Certification Advisory Committee; and
 - Continuing education component involves periodic knowledge updates and skill guiding workshops. Certified educators are required to complete a minimum number of these sessions to maintain their certification.
- Cost:** \$2500–3000 CN (covered by the participant)
- Duration:** N/A
- Evaluation:** N/A
- (Source: Options for Sexual Health website)

3. Calgary Health Region (Canada): Teaching Human Sexuality Course

- Model used:** Offers a number of six-hour, division specific continuing education in-services geared to the individual needs of elementary, junior high school, senior high school and Catholic education teachers. Facilitated by a sexual & reproductive health educator and school board representative. A variety of teaching methods are utilised such as small group discussion, facilitator led discussion, question and answer periods, group work, didactic instruction, Powerpoint presentation, demonstrations, video, and resource presentation. Since 2007 an online version of the course has been offered based on the teacher resource www.teachingsexualhealth.ca and the existing in-service course.
- Number trained:** From February 2006 to March 2007, 11 in-services offered to teachers (eight in-services offered to elementary teachers and three to junior high school teachers); 6–16 participants per in-service. Total of 127 elementary and junior high school teachers participated in the in-services. Most of the participants taught in elementary schools (81%) and were female (79%).
- Duration:** Six hours
- Cost:** Covered by the Calgary Health Region and the schools cover the cost of the substitute teachers (Loanc-Diluzio et al. 2007).
- Evaluation:** Course has been evaluated, see 'Building capacity to talk, teach, and tackle sexual health'. (Sieccan Newsletter)(Report), *The Canadian Journal of Human Sexuality* 22 Sept 07, Authors: Lokanc-Diluzio, W.; Cobb, H.; Harrison, R.; Nelson, A.

4. New Jersey, USA: Answer's Sexuality ABCs and STD Basics

- Model used:** Online professional development workshops (launched July 2009) will provide educators and youth-serving professionals the opportunity to participate in an active learning community online. Includes video, podcasts and discussion forums used across the education spectrum – K–12, higher education, continuing education, home schooling as well as professional development.
- Number trained:** 140 participants to date have signed up for Sexuality ABCs.
- Duration:** Self-paced
- Cost:** \$125 US per person. Groups from the same school/agency receive discount.
- Evaluation:** Pre planning research has consistently shown that online professional development can provide an educational experience comparable to – or better than – learning in the classroom. Results from the 2007–2008 evaluation of the Sexuality Education Training Initiative supports what has been observed in practice that such courses do provide participants with “valuable and lasting learning experiences that substantially increase knowledge and confidence in the key skill areas of importance to teachers of sexuality education.” The report also finds that the gains in confidence and knowledge do not disappear following the training, but are sustained after participants return to their classrooms (Answer, Rutgers University, 2008).
- Contact** tslawsky@rci.rutgers.edu or <http://answer.rutgers.edu>

5. Connecticut, USA: Training Institute in Sexual Health Education (TISHE)

- Model used:** Intensive residential, skills-based summer institute
- Number trained:** 32 participants per year since 2001
- Duration:** 40 hours over 5 days
- Cost:** \$1200 (lodging, meals, resources) subsidised by the Educational Foundation of American and the Mary Owen Borden Foundation.
- Evaluation:** An evaluation consultant has been commissioned to inform them more about the impact of this program and whether the course is achieving the sustained changes in their “end users”. TISHE will be using the evaluation plan and survey tools developed by the consultant to comprehensively measure the courses impact on all participants.
- Contact:** norag@rci.rutgers.edu or <http://answer.rutgers.edu>

4.5 The Australian context

4.5.1 The foundation: a curriculum in sexual health education

Within Australia there is a growing recognition that if school-based sexual health education programs are to be effective in promoting sexual health, they must examine the whole social and cultural context in which young people make decisions relating to their sexual health. However there is not a national policy or national curriculum for the promotion of sexual health within schools.

SHine SA (Sexual Health information networking and education, South Australia) is the state's leading sexual health agency and commended a Senate Committee call for comprehensive relationships and sexual health education programs in all Australian schools (SHine 2008).

Recommendation: Join with other appropriate intra and inter state organizations eg SHine SA to advocate for a national policy or national curriculum for the promotion of sexual health within schools.

National resource: 'Talking Sexual Health'

Although the national resource *Talking Sexual Health* was designed primarily for use with students in years 9 and 10, it is also suitable for students in years 11 and 12 and many of the activities can be modified to use with students in years 7 and 8. 'Talking Sexual Health' assists teachers to focus on issues related to education about STIs, HIV/AIDS and other blood-borne viruses (BBVs) however it relies to some extent on other aspects of sexuality being covered in earlier year levels (Ollis et al, 2000). This resource is available throughout Australia and is generally supplemented within each state by a resource specific to the state's requirements.

State specific sexuality education

Various agencies in all Australian states have attempted to develop comprehensive, whole-school sexuality education programs which provide consistent and accurate information to all students from an early age, is respectful of diversity, and which can contribute to positive behaviour change. These education programs are based on the understanding that young people can make good decisions about their sexual health if education policies, programs and services are available to help them and take a shared partnership approach between schools, parents and the local community.

The most common approach to student health and wellbeing issues in schools are mostly addressed through the context of the health and physical education areas. It is also acknowledged that other aspects of curriculum, school policies and procedures, and community partnerships, contribute to and enhance student health and wellbeing in the school setting. Schools' programs use a skills-based approach highlighting the links between health issues and student health and wellbeing through the development of the personal and interpersonal skills, including decision-making, communication, assertiveness and self-esteem, that underpin health behaviours in a range of settings.

4.5.2 The Western Australian situation

Though it is recognised that relationship education is primarily the responsibility of children's parents and caregivers, it is important that the school also supports young people to make positive choices about their relationships and sexual health. Research shows that, to be effective, school health education needs to include a developmentally and culturally appropriate health curriculum that is delivered by trained teachers and supported by school policy, curriculum resources and the school community, including parents. Discrimination in terms of gender and homophobia are also key issues for schools to address.

The policy framework advocated by the DoH and the DET for the implementation of relationships education in WA schools is based on three key principles:⁶

- Promoting abstinence and postponement of sexual activity for young people;
- Supporting sexual activity in the context of respect, intimacy, readiness and love; and
- Encouraging harm reduction strategies for those young people who are sexually active.

The WA resource: *Growing and Developing Healthy Relationships Curriculum Support Materials (GDHR)*

In July 2002, the Department of Health published the GDHR materials to promote the above key principles. This was the product of over three years' work by a reference group of school and sexual health education experts including the Department of Education and Training, Curriculum Council of WA, Family Planning WA, Association of Independent Schools and, importantly, practising teachers and experts in the field.

The GDHR resource consists of three separate developmentally targeted books aimed at:

- Early childhood;
- Middle childhood; and
- Early adolescence.

The materials are available in hard copy versions and electronically on the DoH and DET websites. Currently the DoH is upgrading this resource into an interactive website.

4.5.3 Other issues affecting the delivery of professional development in WA

Teacher relief

In order for teachers to leave the classroom to attend PD they must have their teaching duties covered and this is usually done by a replacement or relief teacher.

The two major problems with provision of relief teaching are:

- Financial: provision of a relief teacher is an extra cost to the school. The school must be convinced of the value of the professional development in the context of budgetary constraints. It is imperative that paid relief staff be made available to enable teachers to participate in PD.

⁶ See Department of Health (2002) *Growing and Developing Healthy Relationships: Curriculum Support Material*

- Lack of replacement teachers: this is particularly difficult remote areas of WA, with the scarcity of relief teachers. There may be funds within the school budget for PD but if no-one is available to take on this role this adds to the difficulty of teachers being able to attend face-to-face PD. It is therefore important to be flexible about when and where PD is offered such as enabling teachers to access professional development on weekends or during school holidays.

Recommendation: Investigate the possibility of offering PD courses outside teaching hours (e.g. school holidays or weekends).

Health education low on the list of priorities

One of the major themes apparent in the results of the current study was the perceived lack of importance attached to health education (particularly sexual health education) by the school, the district and the DET. Without the support of the structures surrounding teachers, training will have little impact on the spread of quality sexual health education offered in schools.

Anecdotal evidence⁷ supports the perception that the subject and therefore this course was not given a high priority. For example, 13 senior staff (deputies and principals) were withdrawn from a sexual health professional development course conducted in a rural region in which they had enrolled, to be given professional development courses in other subjects at the request of the District, because these were considered a higher priority. The attendance of senior staff at professional development in this area is an important and influential mechanism for disseminating information about the course. Therefore implementing the course within individual schools would be a good strategy because deputies and principals are key gatekeepers and role models. There was evidence from respondents in this study that principals were supportive of sexual health education thus suggesting a possible correlation between staff attending the Concord PD and principals' positive attitudes toward sexual health education.

Recommendation: Work with Education sectors and appropriate professional bodies to target school principals with information about the importance of sexual health education, the GDHR resource and the need for supporting PD.

Recommendation: Work to increase the priority given to health education (particularly sexual health education) in schools.

Advertisement of the course

Regardless of the method of professional development utilised some planning issues related to effective professional development need to be highlighted. One of the keys to successfully engaging more teachers is effective advertising about the professional development course. The evaluation study has noted that problems can arise from limiting advertising to **only** the school level and not to the individual teacher.

⁷ Based on interviews with Concord Trainers.

A survey into the DET Regional Development Centre, which was established to assist professional development in regional WA, reported the need to advertise professional development initiatives directly to teachers as only one in three were aware of the Centre. Administrative gatekeepers in schools may set priorities for school professional development with little regard for individual teachers being able to choose their own PD. Advertisements may fail to be circulated to all staff members (Department of Education 2001).

Recommendation: **Work with the Education sectors to:**

- find ways to extend teacher access to this training
- arrange for PD promotion and advertising material to be sent to individual teachers as well as to school administrators/principals.

Pre-service teacher training

Further enhancement of the capacity of the education system to offer quality school sexual health programs would be better supported by inclusion of this content area in pre-service teacher education and as a compulsory component of the training of primary school teachers.

In secondary education where there is more specialisation this should be compulsory content for those who will be teaching health education. Currently the health education area sits under the umbrella of physical education; a compulsory component should be part of the tertiary education and training course for physical education teachers.

Recommendation: **Undertake negotiations with those universities that provide pre-service teacher education to include a compulsory component of relationship, sexuality and sexual health education into this training;**

4.6. Professional development courses in sexual health education for Australian teachers and schools

1. Perth, WA Department of Health/Concord Training Services

- Model used:** Conducted by Concord Training Services since 2002, this uses a partial 'train-the-trainer' model to encourage transfer of information and skills to school colleagues and peers. The originally planned PD model was for an initial three-day period with a one-day follow-up session. Aimed to recruit a couple of people from the same school to attend together (e.g. teachers and/or other school support staff – school nurse or counsellor). The PD model was ultimately reduced to two consecutive days for teachers.
- Number trained:** At January 2008 training had been delivered to over 390 teachers, 60 school health nurses, and others. The course usually has between 20 and 25 participants.
- Duration:** Two days for teachers, one day for nurses and a follow-up day for both.
- Cost:** The courses have been funded by Department of Health Western Australia, Sexual Health and Blood-born Virus Program. Schools cover teacher relief.
- Evaluation:** Impact evaluation conducted by Estill (this report).

2. South Australia: SHine SA -Focus Schools Relationship and Sexual Health Education Program

- Model used:** Developed in 2003 in partnership with South Australian Education and Health Departments. Face-to-face workshop-based course conducted by SHine SA.
- Duration:** Two days
- Number trained:** Since 2003, 1500 teachers have undergone training. It is expected that by the end of 2008, 60% of state secondary schools (years 8, 9 & 10) will be or have been involved.
- Cost:** Ongoing annual budget of \$505,000, a state Health Department funded dedicated team of six full-time trainers that are available to run teacher professional development courses for the focus schools. Participants do not pay for training.
- Evaluation:** La Trobe University conducted an evaluation of the program in 2002 which found that educators who had expressed uncertainty concerning their capacity to teach sex-education improved their comfort and confidence through participating in training.

(Source: SHine SA website)

3. Victoria: Family Planning Victoria

- Model Used:** Offers a variety of professional development courses for teachers of special needs populations and primary and secondary school teachers.
- Number trained:** N/A
- Duration:** Offers a variety of 1-2 day courses.
- Cost:** \$187 GST Inclusive for 1 day or \$287 for a 2 day course
- Contact** ceu@fpv.org.au

4. New South Wales: Family Planning NSW

- Model Used:** Teaching Sexual Health is for secondary school teachers and covers challenging subjects such as sexual safety, homophobia and sexual identity. FPNSW delivers this course in partnership with NSW Department of Education and Training and NSW Health. The use of technology and on-line teaching is part of the future of education at FPNSW and in 2008 an important step was taken in this direction by employing a project officer who is responsible for producing high quality audio-visual resources to support educational activities.
- Number trained:** In 2007-08, 267 teachers participated in this course.
- Duration:** –
- Cost:** –
- Evaluation:** –
- Contact** education@fpnsw.org.au

5. NSW Education Department: Sexual Health in Schools Project

- Model Used:** During 2007 and 2008 the NSW Department of Education partnered with NSW Health to develop and deliver professional learning for teachers. The professional learning was developed in consultation with Family Planning NSW. The NSW Sexual Health in Schools Project supported the implementation of sexual health programs and related health issues in schools with a particular focus on sexually transmitted infection. Workshops were presented by Department of Education and Training Curriculum Advisers, Area Health Service officers and Family Planning NSW representatives.
- Number trained:** In 2007 213 teachers from 162 schools attended Phase 1 Teaching Sexual Health workshops across NSW. In 2008, 63 teachers from 50 schools attended Phase 1 and 61 teachers from 51 schools attended the Phase 2 Affirming Diversity workshops.
- Duration:** Phase 1: 5 hours (one-day workshop). Phase 2 workshops accredited by the NSW Institute of Teachers. Resource materials and website information continues to be developed to support schools. Further course to be offered in 2009.
- Cost:** Phase 1 workshops free to participants, individual schools providing funds for casual relief from their global professional development funds. Phase 2 workshops, participants paid \$110 and individual schools providing funds for casual relief from their global professional development funds.
- Evaluation:** Each participant completed an evaluation form at the end of the workshop. Evaluation report developed by the Department of Education and Training.
- Contact:** allan.booth@det.nsw.edu.au

6. Tasmania: Family Planning Tasmania

- Model Used:** Primary and Secondary Tool Box - Sexuality & Relationships Education
- Number trained:** N/A
- Duration:** K-6 is a 2 day course. The Secondary course 7–12 is a 2 days.
- Cost:** \$260/hour
- Evaluation:** –

7. Queensland: Family Planning Queensland

- Model Used:** Needs based- FPQ offers teachers professional development in the area of sexuality and sexual health. Most of this training is done based on the specific needs of the school that has requested the services. This training is tailored and there is not a set training course available to date.
- Contact:** Vonda McDougall [vmcdougall@fpq.com.au]

4.7 Recommendations arising from reviewed national and international models of PD and the impact evaluation study of the WA program.

The evaluation study survey and the research literature have identified several issues for consideration in the design of effective future PD programs in WA:

- course duration;
- teacher relief;
- the different needs of primary and high school teachers;
- ongoing updates and training;
- quality facilitators;
- accreditation/reward;
- interpersonal communication; and
- peer support /mentoring support.

The current WA professional development course funded by the DoH and conducted by Concord attempts to cover the whole curriculum material (K–10) and participants' comments in the survey suggest that some of the material is not appropriate to the student age level they teach. This was particularly true for some primary school teachers who felt that they did not need some of content covered. It would therefore be appropriate to streamline the course to suit the needs of the different groups by running separate courses for high school and primary school teachers/school health nurses. This approach has been effective within the PD model conducted by the Calgary Health Region.

Recommendation: Run two separate PD courses, one for primary schools and one for secondary schools, or alternatively have a combined first half for both groups then divide the PD into two separate groups in second half according to content needs.

Primary schools require a more whole-of-school approach to the material than high schools. The conduct of workshops at individual primary schools would assist all teachers at the school being educated and updated about the GDHR materials and how they can be incorporated into their lessons. A three-hour face-to-face workshop may be all that is needed.

Recommendation: Run PD workshops at individual primary or secondary schools, to promote and enable a whole-of-school uptake of the GDHR materials and develop teacher expertise in sexual health education.

The provision of follow-up after participating in professional development has been identified as a significant factor in achieving positive outcomes (Calamidas 1990, Guskey 1994). Respondents to McRae et al. (2001) indicated that individual activities (usually workshops) were thought to have less impact than those that were sequential or followed up in some way. As outlined in Part A, the current model of professional development in WA employed a follow-up day, six months after the initial training. This was seen as valuable by the participants and has been recommended to be continued. Participants were also supported by newsletters and emails from the Concord training facilitators and participants felt that this ongoing support was beneficial.

Recommendation: Continue the provision of the follow-up workshop (as per Part A).

Recommendation: Continue the provision of teacher access to and ongoing contact with the PD facilitators and the dissemination of information and updates to teachers by the facilitators (as per Part A).

Participants felt that ongoing training, possibly half-day courses dedicated to specialist content knowledge of sexual health, would be useful. For example, a half-day course discussing puberty, date rape, or a number of other topics within the field would allow participants to further develop their skills and strategies. This approach is the same used by the School Drug and Road Aware program (SDERA) that offers specific topics as a supplement to the general program.

Recommendation: Provide teachers with continual opportunities to upgrade their skills and update knowledge and offer other forms of ongoing training such as half-day courses in specialist content knowledge, e.g. puberty, date rape, hypersexualisation in the media, etc.

Rewarding teachers who participate in professional development programs is now becoming an accepted feature of in-service training (Department of Education 2001). These rewards can take a number of forms including:

- A stipend for time taken to participate;
- Employer recognition and career opportunities; or
- Academic credit (Crowther & Gaffney 1994).

This could be an effective and important component motivating teachers to attend a professional development outside official work hours. For example, if, rather than paying a relief teacher, the money is paid as a stipend to the teacher for using their personal time, teachers may be more inclined to participate in professional development in their own time. Several participants in Jackson's 2004 study considered that if teachers were expected to complete professional development in their own time, some form of incentive, either financial or time compensation, should be given. Both the courses described previously run by Rutgers University in the USA offer professional recognition for graduating from their course.

Recommendation: Investigate means of rewarding those teachers who participate in PD in this field.

4.8 Ongoing structural implementation considerations

As well as determining the best models of PD to be delivered consideration needs to be given to the structures that will support the delivery methods. As described in Part A, the current WA PD course is conducted by Concord Training, a private training company specialising in teacher professional development, and is funded by the DoH. The success of this professional development program (for a relatively small financial outlay) shown in this evaluation, suggests this method of outsourcing professional development can be cost-effective. Concord Training have clearly demonstrated their competence and this report has recommended the DoH continue to engage their services. Incorporation of other new delivery methodologies would also logically continue to increase the number of teachers completing this PD, while retaining the benefits and the cost-effectiveness shown within this

evaluation. A change in future circumstances or the results of ongoing course evaluation may require the consideration of other options.

The incorporation of systematic evaluation should therefore continue to assess both the effects of future PD programs and to guide the implementation of any further proposed programs. If any alternative models of PD are ever implemented researchers will have good tools to examine the effects of different modes of PD delivery on teaching practices and possibly student outcomes, both areas that have little coverage in the current research literature.

Recommendation: **Incorporate ongoing systematic evaluation into all PD to enable assessment of the effects and continue to guide program implementation**

Other potential options for future investigation

Not-for-profit sector. If the DoH and the DET consider it helpful to conduct an examination of other alternatives to the current conduct of the PD by private consultants, consideration could be given to advantages gained by, for example, the non-profit sector conducting this program. The FPWA Sexual Health Services (FPWA) have extensive experience in facilitating courses on various aspects of sexuality to many occupational and agency groups in WA and have also developed a specialist Aboriginal sexual health education course conducting training sessions for teachers and other professionals who work with Aboriginal youth. With an increase in staff and greater funding, FPWA might be well placed to take on the conduct of sexual health education PD for WA teachers and school health nurses. Such a model would be similar to the SHine SA approach described earlier and the Options for Sexual Health model used in Vancouver, Canada, also previously referred to. It is critical to note however that the SHine SA program is highly successful because of the well resourced commitment of the SA Education Department.

In-house. In-house options for delivering the professional development should also be examined. A training unit could be established within the DET or shared between the DoH and the DET⁸. This would require full-time dedicated staff who could plan and conduct short courses at primary schools, face-to-face workshops, and facilitate online learning and discussion sessions. Having a full-time team would allow teachers who have undertaken or will be undertaking the professional development to have full-time support for enquiries. This model is also the one adopted by the Calgary Health Region, which has devoted staff for such training. A WA team could be located in the Perth metropolitan region with consideration given to placing a team member in each of the district offices. Placing a team member in each district would enable workshops to be conducted in regional and remote WA, and enable each district to have a facilitator within easy access of teachers. Having a team member in the districts would also make it possible to conduct in-class training. This model would be similar to the School Drug Education and Road Aware program (SDERA).

Merge with SDERA. Another possibility would be to include sexual health education in the SDERA program, thereby acknowledging the natural connection between sex, alcohol and other drugs (so-called intoxicated sex) as well as the fact that both have very similar educational and curriculum content.

⁸ Funding arrangements for the program are outside the scope of this report. Discussions on funding should include the cost-effectiveness of the program and might include a business case study to determine the best outcome for the allocated cost.

University involvement. A fourth option that could be considered for the future delivery of PD is the conduct by a tertiary institution. Universities are responsible for pre-service teacher training and there may be scope for them to increase involvement with in-service training in this area. WA Universities have experience in distance education and have support structures that allow the suggested flexible delivery and learning methodologies. There is an example of this approach in Canada where the Calgary Health Region formed a partnership with the University of Calgary and the Alberta Society for the Promotion of Sexual Health to deliver their online PD program.

In conclusion

The scope of this report was not to map the ramifications of the recommendations made about the teaching and support infrastructure, nor to cost, or fully detail, all the possibilities and suggested changes noted. What is offered is a *vision* – to enhance the current paradigm for professional development, indicate other possible methodologies and approaches used elsewhere and suggest additional elements to consider incorporating in future teacher PD in this area.

4.9 Part B Preferred models of PD: summary of recommendations for future programmes

Findings from the research literature together with the impact evaluation study have been used to recommend specific actions to be incorporated into the development of the future PD. Other successful models of PD used elsewhere were examined and could be of potential use to the WA education environment. It was also concluded that there is potential for different approaches to be utilised for example using a more in-house collaborative model with the drug education sector. This and other possibilities could be considered by the DoH and the DET for their prospective applicability and future benefit.

The following is a summary of the Recommendations made for the conduct of future courses:

- 5. Utilise a combination of three of the flexible learning PD categories, traditional (face-to-face workshops), technology (online or computer-based courses) and collegial relationships and work roles (mentoring support/discussion groups) in planning for future PD.**
- 6. Encourage and support the participation of more than one teacher from a school in the PD to secure ongoing peer support and contact with immediate colleagues.**
- 7. Investigate the possibility of offering PD courses outside teaching hours (e.g. school holidays or weekends).**
- 8. Build mentoring approaches into future PD including within technology based methodology.**
- 9. Run two separate PD courses, one for primary and one for secondary school teachers, or alternatively combine the first half of the PD course for both groups then divide into two separate groups according to content needs in second half.**
- 10. Run PD workshops at individual primary or secondary schools, to promote and enable a whole-of-school uptake of the GDHR materials.**
- 11. Work with the Education sectors and appropriate professional bodies to target school principals with information about the importance of sexual health education, the GDHR resources and the need for supporting PD.**

12. **Work with the Education sectors to:**
 - find ways to extend teacher access to this training
 - arrange for PD promotion and advertising material to be sent to individual teachers as well as to school administrators/principals.
13. **Provide teachers with continual opportunities to upgrade their skills and knowledge and offer other forms of ongoing training such as half-day courses in specialist content knowledge e.g. puberty, date rape, body image, hypersexualisation and the media etc.;**
14. **Investigate means of rewarding those teachers who participate in PD in this field;**
15. **Incorporate ongoing systematic evaluation into all PD to enable assessment of the effects and continue to guide program implementation.**
16. **Undertake negotiations with those universities that provide pre-service teacher education to include a compulsory component of relationship, sexuality and sexual health education in this training.**
17. **Work to increase the priority given to health education (particularly sexual health education) in schools.**
18. **Join with other appropriate intra and inter-state organizations e.g.; SHine SA to advocate for a national policy or national curriculum for the promotion of sexual health education in schools.**

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Appendix 1.

Letter

Dear Diane,

GROWING & DEVELOPING HEALTHY RELATIONSHIPS PROFESSIONAL DEVELOPMENT IMPACT EVALUATION

In July 2002 the Department of Health distributed *Growing & Developing Healthy Relationships Curriculum Support Materials (GDHR)* to health education teachers in all public and independent schools in WA. Professional development for teachers and school health nurses was a key component of the implementation and quality of this educational innovation.

The Department of Health, with support from the Department of Education and Training, has commissioned Estill & Associates to undertake a formal, independent survey and evaluation of the use of *GDHR* materials and professional development conducted by Concord. This evaluation will examine the impact that these initiatives have had on the practice of school teachers and nurses regarding sexual health education.

Having completed the professional development course your feedback is an important component in this evaluation. Your participation will allow us to assess the impact of this training and make recommendations about practical and best practice model(s) of professional development in sexual health education for WA teachers. Neither you nor your school will be identified in the evaluation report.

You will be contacted shortly by Estill & Associates to discuss convenient times and dates for you to undertake a short phone interview.

We encourage you to take part in this important study. For further information please contact Lesley Brain at Estill & Associates on 9355 0300.

Yours sincerely



Dr Paul Van Buynder
Director
Communicable Disease Control



Andrew Thompson
Director
Syllabus Development and Resources Directorate

16 June 2008
LB:YC

Appendix 2.

Telephone Survey questions

What is your teaching specialty/role at your current school?					
Were you in the same position at the time of training? (if not, what has changed?)					
How long have you been a teacher? (if nurse, how long have you been involved with education?)					
The next few questions are related to your personal and professional views about sexual health education. Using a five-point scale where 1 is strongly disagree and 5 is strongly agree please rate your level of agreement to the following statements:					
Sexuality education is an important part of health education.	1	2	3	4	5
Sexual health education should be taught by a specialist teacher.	1	2	3	4	5
Health trained teachers, working in partnership with parents and the wider community, is the ideal way to educate young people about sexuality education.	1	2	3	4	5
Teachers' personal attitudes to sexuality affect the way they teach sexual health education.	1	2	3	4	5
The majority of teachers are comfortable teaching sexual health education.	1	2	3	4	5
I understand how my own values around sexuality affect my work with young people and my peers.	1	2	3	4	5
The majority of parents support sexuality education in schools.	1	2	3	4	5
The Growing and Developing Healthy Relationships Curriculum Support Materials are extremely useful.	1	2	3	4	5
The next few questions relate to your participation in the professional development course run by Concord and the Department of Health.					
When did you undertake the training course?					
How long was the course?					
Using the same five point scale would you agree or disagree with the following statements:					
Most teachers would benefit from undertaking the course.	1	2	3	4	5
The quality of the training was extremely high.	1	2	3	4	5
The level of the content was just right.	1	2	3	4	5
The course helped me to better use the Growing and Developing Healthy Relationships Curriculum Support Materials.	1	2	3	4	5
The course gave me the confidence to design my own relationships and sexual health education programs.	1	2	3	4	5
The course was too short.	1	2	3	4	5
My personal values and attitudes towards sexuality were valued by the course instructor.	1	2	3	4	5
What aspect of the training did you find most useful? Why?					
What aspects were the least useful for you?					
How could the training be improved?					

The next few questions are about your school(s) environment including policies related to relationship and sexual health education. Using the same five-point scale would you agree or disagree with the following statements:					
The school provides a relevant sexual health and relationship education component in the school curriculum for all year levels.	1	2	3	4	5
The school has developed a school sexual health policy.	1	2	3	4	5
The school makes effective use of student health services.	1	2	3	4	5
The school makes sexual health and relationship education and/or information programs or other strategies available to parents and caregivers.	1	2	3	4	5
The school has implemented information sessions and/or other strategies for parents related to use of the Growing and Developing Healthy Relationships Curriculum Resource Materials.	1	2	3	4	5
The school has sufficient time allocated for health education.	1	2	3	4	5
The principal fully supports relationship and sexual health education programs.	1	2	3	4	5
Where does relationship and sexual health education fit within the overall curriculum at your school?					
What aspects of the schools sexual health policies and procedures are working well, could they be improved and how?					
The next few questions relate to the effect and impact of the course on your teaching. Using the same five-point scale would you agree or disagree with the following statements:					
The material presented in the Growing and Developing Healthy Relationships resource is appropriate for my classroom.	1	2	3	4	5
I have had the opportunity to implement the skills and knowledge I gained in the training course in my educational role including in the classroom.	1	2	3	4	5
The course increased my confidence to teach relationship and sexual health education with my class and students.	1	2	3	4	5
The course introduced new teaching methods that I have been able to use in the classroom.	1	2	3	4	5
In a relationship and sexuality education class I feel confident and comfortable teaching students about specific sexual health knowledge.	1	2	3	4	5
In a relationship and sexuality education class I feel comfortable facilitating age appropriate skills development activities with students (for example condom use demonstration with older adolescents).	1	2	3	4	5
On average how much time do you spend on relationship and sexual health education per week, per month, per term or per year?					
Is this more or less time than you would have given to this subject area than before undertaking the course?					
Have your teaching practices changed since undertaking the course and if so, how?					
The following questions concern your participation in the course and any flow-on effect or impact on colleagues and other members of staff. Using the same five-point scale, would you agree or disagree with the following statements:					

As a result of me attending the course, other teachers at my school(s) are using the Growing and Developing Healthy Relationships Curriculum Support Materials resource.	1	2	3	4	5
Is this more or less time than you would have given to this subject area than before undertaking the course?					
Have your teaching practices changed since undertaking the course and if so, how?					
The following questions concern your participation in the course and any flow-on effect or impact on colleagues and other members of staff. Using the same five-point scale, would you agree or disagree with the following statements:					
As a result of me attending the course, other teachers at my school(s) are using the Growing and Developing Healthy Relationships Curriculum Support Materials resource.	1	2	3	4	5
It is possible to effectively use the Growing and Developing Healthy Relationships resource material without going to the training.	1	2	3	4	5
I have been able to help other teachers use the Growing and Developing Healthy Relationships resource material as a result of my attending the course.	1	2	3	4	5
Other staff members were very interested in hearing about the training I attended.	1	2	3	4	5
I shared and continue to share information gained through the course with other members of staff.	1	2	3	4	5
I have been able to influence the teaching staff to utilise the Growing and Developing Healthy Relationships resource materials.	1	2	3	4	5
I have facilitated relationship and sexual health education training in my school to my peers.	1	2	3	4	5
Please comment on any experiences or issues, positive or negative you have had regarding influencing other teachers to use the Growing and Developing Healthy Relationship Curriculum Support Materials resource or on any other information you received from the course.					
What would you say has been the greatest impact on your professional practice, teaching and general work with students from attending this course?					
The final questions ask for your general observations about how to attain better teacher professional development in this field.					
What are the major obstacles to getting more teachers to the training, and how could this be overcome?					
How would you improve education about relationships and sexual health for students?					
<p>That is the end of the survey.</p> <p>Thank you very much for participating, your comments have been very valuable and we appreciate your support for this research.</p>					

Appendix 3:

T-Test results: Concord pre- and post-test data

Paired Samples Statistics					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Pre: Children learn about their sexuality from the time they are born.	4.270047	212	0.85806	0.058932
	Post: Children learn about their sexuality from the time they are born.	4.834906	212	0.433883	0.029799
Pair 2	Pre: I understand how my own values around sexuality affect my work with young people and my peers.	4.004762	210	0.856987	0.059138
	Post: I understand how my own values around sexuality affect my work with young people and my peers.	4.733333	210	0.5133	0.035421
Pair 3	Pre: Health trained teachers, working in partnership with parents and the wider community, is the ideal way to educate young people about sexuality education.	4.388498	213	0.755216	0.051747
	Post: Health trained teachers, working in partnership with parents and the wider community, is the ideal way to educate young people about sexuality education.	4.842723	213	0.369735	0.025334
Pair 4	Pre: The majority of parents support sexuality education in schools.	3.561321	212	0.868629	0.059658
	Post: The majority of parents support sexuality education in schools.	3.811321	212	0.799742	0.054926
Pair 5	Pre: Sexuality education is an important part of health education.	4.661972	213	0.631941	0.0433
	Post: Sexuality education is an important part of health education.	4.95892	213	0.171055	0.01172
Pair 6	Pre: In a sexuality education class I feel comfortable teaching students about specific knowledge.	4.184211	209	0.833949	0.057685
	Post: In a sexuality education class I feel comfortable teaching students about specific knowledge.	4.523923	209	0.621646	0.043
Pair 7	Pre: In a sexuality education class I feel comfortable teaching students about attitudes and values.	4.184211	209	0.833949	0.057685
	Post: In a sexuality education class I feel comfortable teaching students about attitudes and values.	4.576555	209	0.570826	0.039485
Pair 8	Pre: In a sexuality education class I feel comfortable facilitating skills activities.	4.124402	209	0.881884	0.061001
	Post: In a sexuality education class I feel comfortable facilitating skills activities.	4.552632	209	0.552186	0.038195
Pair 9	Pre: The Growing and Developing Healthy Relationships materials are extremely useful.	3.772989	174	1.206397	0.091457
	Post: The Growing and Developing Healthy Relationships materials are extremely useful.	4.744253	174	0.44572	0.03379
Pair 10	Pre: As a train-the-trainer, I feel confident facilitating sexual health education training in my school to my peers.	3.472772	202	1.177315	0.082836
	Post: As a train-the-trainer, I feel confident facilitating sexual health education training in my school to my peers.	4.455446	202	0.569101	0.040042

Paired Samples Test

	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference		t	df	Sig. (2-tailed)
Pair 1	-0.56486	0.959292	0.065884	-0.69473	-0.43498	-8.57348	211	2.15E-15
Pair 2	-0.72857	0.920341	0.06351	-0.85377	-0.60337	-11.4718	209	6.02E-24
Pair 3	-0.45423	0.832325	0.05703	-0.56664	-0.34181	-7.96468	212	1E-13
Pair 4	-0.25	1.037793	0.071276	-0.3905	-0.1095	-3.5075	211	0.000553
Pair 5	-0.29695	0.666873	0.045693	-0.38702	-0.20688	-6.49872	212	5.69E-10
Pair 6	-0.33971	1.072785	0.074206	-0.48601	-0.19342	-4.57797	208	8.07E-06
Pair 7	-0.39234	1.004384	0.069475	-0.52931	-0.25538	-5.6473	208	5.31E-08
Pair 8	-0.42823	1.046798	0.072409	-0.57098	-0.28548	-5.91408	208	1.35E-08
Pair 9	-0.97126	1.284312	0.097363	-1.16344	-0.77909	-9.97565	173	8.45E-19
Pair 10	-0.98267	1.326517	0.093333	-1.16671	-0.79863	-10.5286	201	6.31E-21

Appendix 4. Frequency table

	Frequency										Percentage				
	SD	D	N	A	SA	Valid	Don't know/No	Total	SD	D	N	A	SA	Don't know/No	Total
Sexuality education is an important part of health education.	0	0	4	15	171	190	12	202	0.0	0.0	2.0	7.4	84.7	5.9	100.0
Sexual health education should be taught by a specialist teacher.	13	21	60	53	48	195	7	202	6.4	10.4	29.7	26.2	23.8	3.5	100.0
Health trained teachers, working in partnership with parents and the wider community, is the ideal way to educate young people about sexuality education.	1	4	15	69	100	189	13	202	0.5	2.0	7.4	34.2	49.5	6.4	100.0
Teachers' personal attitudes to sexuality affect the way they teach sexual health education.	5	18	29	62	73	187	15	202	2.5	8.9	14.4	30.7	36.1	7.4	100.0
The majority of teachers are comfortable teaching sexual health education.	36	99	31	13	1	180	22	202	17.8	49.0	15.3	6.4	0.5	10.9	100.0
I understand how my own values around sexuality affect my work with young people and my peers.	3	8	12	62	102	187	15	202	1.5	4.0	5.9	30.7	50.5	7.4	100.0
The majority of parents support sexuality education in schools.	4	11	75	69	23	182	20	202	2.0	5.4	37.1	34.2	11.4	9.9	100.0
The Growing and Developing Healthy Relationships Curriculum Support Materials are extremely useful.		4	22	71	96	193	9	202		2.0	10.9	35.1	47.5	4.5	100.0
Most teachers would benefit from undertaking the course.	2	6	17	63	109	197	5	202	1.0	3.0	8.4	31.2	54.0	2.5	100.0
The quality of the training was extremely high.		1	12	58	125	196	6	202		0.5	5.9	28.7	61.9	3.0	100.0
The level of the content was just right.		4	20	76	95	195	7	202		2.0	9.9	37.6	47.0	3.5	100.0
The course helped me to better use the Growing and Developing Healthy Relationships Curriculum Support Materials.	1	4	22	61	93	181	21	202	0.5	2.0	10.9	30.2	46.0	10.4	100.0
The course gave me the confidence to design my own relationships and sexual health education programs.	4	17	35	81	55	192	10	202	2.0	8.4	17.3	40.1	27.2	5.0	100.0
The course was too short.	43	55	46	29	9	182	20	202	21.3	27.2	22.8	14.4	4.5	9.9	100.0

	Frequency										Percentage					
	SD	D	N	A	SA	Valid	Don't know/No	Total	SD	D	N	A	SA	Don't know/No	Total	
My personal values and attitudes towards sexuality were valued by the course instructor.	1	10	26	62	72	171	31	202	0.5	5.0	12.9	30.7	35.6	15.3	100.0	
The school provides a relevant sexual health and relationship education component in the school curriculum for all year levels.	17	32	58	32	19	158	44	202	8.4	15.8	28.7	15.8	9.4	21.8	100.0	
The school has developed a school sexual health policy.	49	33	24	13	15	134	68	202	24.3	16.3	11.9	6.4	7.4	33.7	100.0	
The school makes effective use of student health services.	7	16	51	52	29	155	47	202	3.5	7.9	25.2	25.7	14.4	23.3	100.0	
The school makes sexual health and relationship education and/or information programs or other strategies available to parents and caregivers.	24	33	39	36	17	149	53	202	11.9	16.3	19.3	17.8	8.4	26.2	100.0	
The school has implemented information sessions and/or other strategies for parents related to use of the Growing and Developing Healthy Relationships Curriculum Resource Materials.	56	45	22	16	8	147	55	202	27.7	22.3	10.9	7.9	4.0	27.2	100.0	
The school has sufficient time allocated for health education.	25	34	34	32	30	155	47	202	12.4	16.8	16.8	15.8	14.9	23.3	100.0	
The principal fully supports relationship and sexual health education programs.	2	7	29	50	61	149	53	202	1.0	3.5	14.4	24.8	30.2	26.2	100.0	
The material presented in the Growing and Developing Healthy Relationships resource is appropriate for my classroom.	4	4	16	73	74	171	31	202	2.0	2.0	7.9	36.1	36.6	15.3	100.0	
I have had the opportunity to implement the skills and knowledge I gained in the training course in my educational role including in the classroom.	10	11	22	71	71	185	17	202	5.0	5.4	10.9	35.1	35.1	8.4	100.0	
The course increased my confidence to teach relationship and sexual health education with my class and students.	2	8	23	71	72	176	26	202	1.0	4.0	11.4	35.1	35.6	12.9	100.0	
The course introduced new teaching methods that I have been able to use in the classroom	6	3	38	64	63	174	28	202	3.0	1.5	18.8	31.7	31.2	13.9	100.0	
In a relationship and sexuality education class I feel confident and comfortable teaching students about specific sexual health knowledge.	1	2	10	38	125	176	26	202	0.5	1.0	5.0	18.8	61.9	12.9	100.0	

	Frequency								Percentage						
	SD	D	N	A	SA	Valid	Don't know/No	Total	SD	D	N	A	SA	Don't know/No	Total
In a relationship and sexuality education class I feel comfortable facilitating age appropriate skills development activities with students (for example, condom use demonstration with older adolescents).	2		11	40	117	170	32	202	1.0		5.4	19.8	57.9	15.8	100.0
As a result of me attending the course, other teachers at my school(s) are using the Growing and Developing Healthy Relationships Curriculum Support Materials resource.	24	27	41	52	22	166	36	202	11.9	13.4	20.3	25.7	10.9	17.8	100.0
It is possible to effectively use the Growing and Developing Healthy Relationships resource material without going to the training.	13	32	72	56	7	180	22	202	6.4	15.8	35.6	27.7	3.5	10.9	100.0
I have been able to help other teachers use the Growing and Developing Healthy Relationships resource material as a result of my attending the course.	21	21	33	67	35	177	25	202	10.4	10.4	16.3	33.2	17.3	12.4	100.0
Other staff members were very interested in hearing about the training I attended.	11	24	38	70	33	176	26	202	5.4	11.9	18.8	34.7	16.3	12.9	100.0
I shared and continue to share information gained through the course with other members of staff.	14	22	54	51	37	178	24	202	6.9	10.9	26.7	25.2	18.3	11.9	100.0
I have been able to influence the teaching staff to utilise the Growing and Developing Healthy Relationships resource materials.	21	30	46	55	19	171	31	202	10.4	14.9	22.8	27.2	9.4	15.3	100.0
I have facilitated relationship and sexual health education training in my school to my peers.	61	36	21	43	19	180	22	202	30.2	17.8	10.4	21.3	9.4	10.9	100.0

Appendix 5.

ANOVA Results for Differences Between groups

		Descriptive						
		N	Mean	Standard Deviation	Standard Error	95% Confidence interval for mean		Maximum upper bound
						Lower bound	Upper bound	
Sexual health education should be taught by a specialist teacher.	Primary teachers	47.00	2.96	1.18	0.17	2.61	3.30	5.00
	Secondary teachers	38.00	4.21	0.91	0.15	3.91	4.51	5.00
	School nurse	39.00	3.64	0.99	0.16	3.32	3.96	5.00
	Nurse more than one school	22.00	3.77	1.15	0.25	3.26	4.28	5.00
	Non-teaching	48.00	3.29	1.18	0.17	2.95	3.64	5.00
	Total		194.00	3.52	1.17	0.08	3.35	3.68
Teachers' personal attitudes to sexuality affect the way they teach sexual health education.	Primary teachers	46.00	3.72	1.07	0.16	3.40	4.03	5.00
	Secondary teachers	38.00	3.71	1.31	0.21	3.28	4.14	5.00
	School nurse	38.00	4.08	1.02	0.17	3.74	4.42	5.00
	Nurse more than one school	19.00	3.79	1.13	0.26	3.24	4.34	5.00
	Non-teaching	45.00	4.38	0.78	0.12	4.14	4.61	5.00
	Total		186.00	3.96	1.08	0.08	3.80	4.11
The majority of parents support sexuality education in schools.	Primary teachers	46.00	3.35	0.77	0.11	3.12	3.58	5.00
	Secondary teachers	36.00	3.61	0.84	0.14	3.33	3.89	5.00
	School nurse	37.00	3.89	0.81	0.13	3.62	4.16	5.00
	Nurse more than one school	20.00	3.30	0.92	0.21	2.87	3.73	5.00
	Non-teaching	42.00	3.43	0.97	0.15	3.13	3.73	5.00
	Total		181.00	3.52	0.87	0.06	3.40	3.65
It is possible to effectively use the Growing and Developing Healthy Relationships resource material without going to the training.	Primary teachers	45.00	3.00	0.95	0.14	2.71	3.29	5.00
	Secondary teachers	38.00	3.21	0.91	0.15	2.91	3.51	5.00
	School nurse	35.00	3.40	0.91	0.15	3.09	3.71	5.00
	Nurse more than one school	19.00	2.63	1.12	0.26	2.09	3.17	4.00
	Non-teaching	42.00	2.90	0.93	0.14	2.61	3.20	5.00
	Total		179.00	3.06	0.97	0.07	2.92	3.20

Descriptive									
		N	Mean	Standard Deviation	Standard Error	95% Confidence interval for mean		Maximum upper bound	
						Lower bound	Upper bound		
I have been able to help other teachers use the Growing and Developing Healthy Relationships resource material as a result of my attending the course.	Primary teachers	45.00	3.53	1.27	0.19	3.15	3.92	5.00	
	Secondary teachers	37.00	3.81	1.00	0.16	3.48	4.14	5.00	
	School nurse	36.00	2.89	1.24	0.21	2.47	3.31	5.00	
	Nurse more than one school	19.00	3.00	1.37	0.32	2.34	3.66	5.00	
	Non-teaching	39.00	3.56	1.29	0.21	3.14	3.98	5.00	
	Total	176.00	3.41	1.26	0.10	3.22	3.60	5.00	
			48.00	2.96	1.43	0.21	2.54	3.37	5.00
I have facilitated relationship and sexual health education training in my school to my peers.	Secondary teachers	37.00	2.76	1.34	0.22	2.31	3.20	5.00	
	School nurse	35.00	1.89	1.13	0.19	1.50	2.27	5.00	
	Nurse more than one school	19.00	2.26	1.45	0.33	1.57	2.96	5.00	
	Non-teaching	40.00	2.70	1.57	0.25	2.20	3.20	5.00	
	Total	179.00	2.58	1.43	0.11	2.36	2.79	5.00	

ANOVA						
		Sum of Squares	df	Mean Square	F	Sig.
Sexual health education should be taught by a specialist teacher.	Between groups	37.47	4.00	9.37	7.87	0.00
	Within groups	224.99	189.00	1.19		
	Total	262.45	193.00			
Teachers' personal attitudes to sexuality affect the way they teach sexual health education.	Between groups	14.02	4.00	3.50	3.11	0.02
	Within groups	203.64	181.00	1.13		
	Total	217.66	185.00			
The majority of parents support sexuality education in schools.	Between groups	8.09	4.00	2.02	2.76	0.03
	Within groups	129.04	176.00	0.73		
	Total	137.14	180.00			
It is possible to effectively use the Growing and Developing Healthy Relationships resource material without going to the training.	Between groups	9.57	4.00	2.39	2.66	0.03
	Within groups	156.76	174.00	0.90		
	Total	166.32	178.00			
I have been able to help other teachers use the Growing and Developing Healthy Relationships resource material as a result of my attending the course.	Between groups	20.52	4.00	5.13	3.40	0.01
	Within groups	258.02	171.00	1.51		
	Total	278.55	175.00			
I have facilitated relationship and sexual health education training in my school to my peers.	Between groups	27.38	4.00	6.84	3.52	0.01
	Within groups	338.35	174.00	1.94		
	Total	365.73	178.00			

Appendix 6.

Comparison T-Test

	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
						Upper	Lower
Sexuality education is an important part of health education.	-1.179	511	.239	-.037	.031	-.098	.024
	-1.114	331.638	.266	-.037	.033	-.101	.028
Health trained teachers, working in partnership with parents and the wider community, is the ideal way to educate young people about sexuality education.	-5.581	509	.000	-.323	.058	-.436	-.209
	-5.096	295.955	.000	-.323	.063	-.447	-.198
I understand how my own values around sexuality affect my work with young people and my peers.	-3.401	509	.001	-.240	.070	-.378	-.101
	-3.154	309.170	.002	-.240	.076	-.389	-.090
The majority of parents support sexuality education in schools.	-3.765	508	.000	-.291	.077	-.443	-.139
	-3.548	324.759	.000	-.291	.082	-.453	-.130
The <i>Growing and Developing Healthy Relationships Curriculum Support Materials</i> are extremely useful.	-4.201	517	.000	-.258	.061	-.379	-.137
	-3.929	332.476	.000	-.258	.066	-.387	-.129
The quality of the training was extremely high.	-3.114	519	.002	-.156	.050	-.254	-.058
	-2.920	335.635	.004	-.156	.053	-.261	-.051
The level of the content was just right.	-5.364	516	.000	-.305	.057	-.416	-.193
	-4.921	311.049	.000	-.305	.062	-.427	-.183
In a relationship and sexuality education class I feel confident and comfortable teaching students about specific sexual health knowledge.	1.482	450	.139	.092	.062	-.030	.215
	1.434	334.541	.153	.092	.064	-.034	.219
In a relationship and sexuality education class I feel comfortable facilitating age appropriate skills development activities with students (for example, condom use demonstration with older adolescents).	.979	385	.328	.064	.066	-.065	.194
	.951	312.508	.342	.064	.068	-.069	.197

	Survey	N	Mean	Std. Deviation	Std. Error Mean
Sexuality education is an important part of health education.	Estill	190	4.88	.386	.028
	Concord Post Test	323	4.92	.310	.017
Health trained teachers, working in partnership with parents and the wider community, is the ideal way to educate young people about sexuality education.	Estill	189	4.39	.768	.056
	Concord Post Test	322	4.71	.535	.030
I understand how my own values around sexuality affect my work with young people and my peers.	Estill	188	4.36	.905	.066
	Concord Post Test	323	4.60	.676	.038
The majority of parents support sexuality education in schools.	Estill	188	3.61	.961	.070
	Concord Post Test	322	3.90	.765	.043
The <i>Growing and Developing Healthy Relationships Curriculum Support Materials</i> are extremely useful.	Estill	198	4.38	.796	.057
	Concord Post Test	321	4.64	.596	.033
The quality of the training was extremely high.	Estill	198	4.58	.646	.046
	Concord Post Test	323	4.74	.491	.027
The level of the content was just right.	Estill	198	4.37	.768	.055
	Concord Post Test	320	4.67	.524	.029
In a relationship and sexuality education class I feel confident and comfortable teaching students about specific sexual health knowledge.	Estill	177	4.62	.706	.053
	Concord Post Test	275	4.53	.606	.037
In a relationship and sexuality education class I feel comfortable facilitating age appropriate skills development activities with students (for example, condom use demonstration with older adolescents).	Estill	174	4.62	.741	.056
	Concord Post Test	213	4.56	.551	.038

(Footnotes)

¹ A response rate of 48% was obtained on the complete data set supplied from Concord and equates to a sampling error of ± 4.88 .

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