Government of **Western Australia**
Department of **Health**

GDHR Impact Evaluation: Interview Report

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1. Introduction

This is a report on eight in-depth interviews conducted as part of the GDHR Impact Evaluation. The report is structured around four key areas of interest identified in the Terms of Reference: perceived quality of the resource, understanding how the resource might add value, suggested improvements and future aspirations.

The individuals interviewed were selected on the advice of the Evaluation Reference Group. There was one exception, where the Chair of the Evaluation Reference Group chose one interviewee following consultation with the evaluator after others previously selected by the Group were not available.

All of those interviewed had relevant expertise that was able to inform the evaluation. The nature of their experience varied. Most interviewees had been aware of the GDHR resource for many years, in two instances since it first became available. Five were in the education sector and experienced with the delivery of RSE in a classroom and/or teacher training institution. Interviewees included a primary teacher, two secondary teachers, a school nurse and two teacher trainers. Those interviewed can be broadly categorised by occupation:

- school staff (3);
- tertiary institution (2); and
- public sector program management (3).

Six interviewees based in Perth were met face-to-face. However, two of the interviewees were based in regional locations and interviews with them were conducted by telephone. One of the eight interviewees was male.

The interviewees were:

- Michael Wills, Teacher, Bassendean Primary School;
- Shirley Reynolds, Secondary Teacher, Mount Barker College;
- Marian Hulatt, School Nurse and Crystal Nullmeyers, HPE teacher, Ashdale Secondary College (joint interview);
- Joan Strikwerda-Brown, Senior Lecturer, School of Education, Bunbury Campus, Edith Cowan University;
- Janeen Thomsett, Lecturer School of Education, Faculty of Education and Arts, Mount Lawley Campus, Edith Cowan University;
- Anne Miller, Acting Manager, School Drug Education and Road Aware (SDERA);
- Lisa Bastian, Program Manager, Sexual Health and Blood-borne Virus Program (SHBBVP), Health Department WA;
- Siobhán Cadogan, Acting Health Promotion Coordinator, School-Aged Portfolio, Practice Implementation, Practice Support Unit, Child and Adolescent Community Health (CACH).

The interviews were semi-structured. The interviewer worked from a pre-prepared schedule of broad points (see Appendix 1). Essentially it served as a checklist to ensure that areas of

key content were covered by the line of questioning in each interview. The interviews resembled a free-flowing discussion, with interviewees raising any matter they thought relevant.

The evaluator took notes during the interviews. They were not recorded. Notes were subsequently written up as a record of interview that was emailed back to each person interviewed. Interviewees were then able to make amendments or clarifications. Most interviewees chose to make minor changes using the 'track changes' feature in the Microsoft Word program. These amendments were accepted and emailed back as a final agreed record of key points.

The interview data does not lend itself to quantitative analysis for several reasons. Only eight in-depth interviews were conducted. Meaningful significant statistical analysis is not possible with such a small sample.

Interviewees were selected on the basis of informing different, not similar, aspects of the evaluation. Some interviewees were school educators, some were teacher trainers and some were program administrators. All had relevant expertise, but it was relevant in different areas. Interviewees were not selected on the basis that they constituted a representative sample.

The interviews were free flowing semi-structured discussions. Those interviewed were free to raise whatever themes they wanted. Themes raised reflect their interests more so than those of the interviewer. Depending on professional background and experience people raised different issues, or had different emphases. Interviewees also differed markedly in respect of their degree of familiarity with the GDHR teaching-learning resource. For example, one felt entirely unable to comment on the quality of resource content.

Table 1 below categorises responses from the interviewees. No assumptions should be made about the views of a participant where they did not express an opinion or chose not to raise an issue.

The qualitative data collected at interview was validated with participants. Detailed summaries were written as a record of interview. These were emailed back to each interviewee, who was then free to amend the record as they saw fit. Five of the eight interviewees choose to make some minor amendments to the record. Data collected was only included in this report after each interviewee agreed it was an accurate account.

Table 1: Thematic analysis of interview data

Theme	No. of interviewees	Specific matters identified by interviewees (no.)	Explanatory notes and other comments
Quality of GDHR **c**ontent/**f**eatures What do they regard as good?	7 NB: One interviewee felt they had insufficient exposure to GDHR to comment on content.	Aligned with curriculum requirements (6). Resource reminds teachers of curriculum requirements (4). Age appropriate sequencing (6). Seen as a credible information source and/or evidence-based (4). Based on sound pedagogy (6). Offers a range of teaching-learning strategies (4). Website has certain valued features (4): • Capacity to search by topic and year • Background notes • Links to other resources.	Expert content review needs to be an ongoing process (2). Consideration could be given to adding domestic violence and sexual abuse as GDHR topics (2)
Adding value to RSE How does GDHR contribute?	8	Builds RSE capacity of teachers (6) by: • providing good entry point for inexperienced RSE teachers • easy to use, convenient and time saving. Building new partnerships in RSE field with multiple agencies such as SCSA, AISWA, Curtin University and CACHS (5). Contributes to student health and well-being (5): • where RSE is approached as a whole-school experience • where students are provided with foundational RSE language terms • where sexuality is taught in the context of respectful attitudes • where students learn critical life skills of communication, resilience and assertiveness • where the curriculum and schools allocate sufficient time. • where classes are interactive and participatory • where parents reinforce RSE at home.	Responsibility for RSE delivery too often falls to the least experienced educators (2). Ideally, there is a pre-existing secure student-teacher relationship (2). The development of RSE teaching capacity can be self-directed (1). Confidence to teach RSE is linked to experience (3). Health education tends to work best when accompanied by PD for educators (5). Barriers to RSE partnership include philosophical, political and faith-based differences and sensitivities (3). Careful management is required to build and sustain strategic relationships around RSE (2).

Theme	No. of interviewees	Specific matters identified by interviewees (no.)	Explanatory notes and other comments
Suggested improvements What would make GDHR better?	8	Invest in more marketing and promotion activities (7): • raising awareness of GDHR amongst pre-service teachers • distributing practical hard copy RSE resources • e-newsletter • social media • targeting niche marketing. Invest in performance monitoring to measure progress towards measurable objectives and desired outcomes (2) Enhance website (4): • add student assessment tools • reduce risk of content overload by recognizing that different audiences have different resource needs • locate video links in text • produce videos of teachers delivering GDHR. Connect GDHR more closely with other health-education and safety resources in WA (3). Better connect GDHR resource and school nurses (3). Modify GDHR resources to better engage Aboriginal students (1).	It is challenging to get any health-education message into a school environment, with many initiatives competing for scarce classroom time (5). There are no KPIs for GDHR (1).
Future aspirations for GDHR/RSE Where might GDHR go in the future?	8	Health and well-being, including RSE, is recognised as a core priority in all schools (6): • demonstrated commitment to enacting a HPS framework inclusive of RSE • RSE is recognised as a set of critical life skills that helps provide a sound foundation for learning in all areas • RSE is integrated into school curriculum beyond HPE • support for an emergent community of mutually supportive school-based RSE practitioners • incentives for schools to deliver RSE.	There is a perception that insufficient time is dedicated to delivering significant health-education content at some schools (6). There is still considerable social stigma and stereotyping in relation to issues of gender and sexuality (2). The quality of relationships, including issues of family violence and abuse, is a significant social issue.
Total no. **of i**nterviewees	8		

2. Perspective on Quality of Content

2.1 Overview

Interviewees were asked for their thoughts on the quality of the GDHR resource. All found GDHR to be a useful resource making a valuable contribution to RSE through WA schools. One interviewee described GDHR as reflecting aspects of 'best practice' in school-based RSE delivery. Another described GDHR as "easy to use" and a resource that did a good job of "guiding them around". Other favourable comments about the GDHR resource included "really helpful" and "great tool".

2.2 Website features

Interviewees identified features of the GDHR online curriculum resource that they particularly liked.

- year level (age-appropriate) organisation of materials;
- capacity to locate material/content organised by topic;
- Background Notes;
- links from the GDHR website to other useful RSE resources;
- the focus on developing student life skills rather than just knowledge transition;
- emphasis placed on ensuring students have the language terms to describe body parts; and
- range of teaching-learning strategies.

2.3 Curriculum alignment

The teaching of RSE is now mandated by the HPE Curriculum. Interviewees thought the GDHR resource is valued by teachers in WA schools because it is aligned with curriculum requirements. The interviews reinforced the view that it is important that the GDHR resource is age- (year level) appropriate with national and state curriculum requirements.

Part of the challenge for a teacher often lies in knowing the right age and appropriate time to teach particular RSE topics. There is reassurance in being able to search the resource by school year. It is one thing to have teaching-learning resources, but another to know how to sequence them.

Interviewees noted that the GDHR resource has been amended in response to a spate of curriculum changes. Knowing what is okay to teach and when can get confusing when curriculum changes are frequent, especially if teachers don't regularly teach the subject matter. One interviewee made the point that RSE is not a foremost consideration for most teachers. Consequently, they are likely to refer back to materials like GDHR each time they need to use them to remind themselves of curriculum requirements. While GDHR is linked to system requirements, one interviewee suggested there might be scope for teaching-learning activities to be more explicitly linked to the curriculum codes.

SHBBVP is not alone in recognising the necessity of curriculum alignment for school resources. One interviewee noted that the health promotion resources developed for use in

WA schools by SDERA are also mapped to the curriculum. SDERA originally evolved out of what was initially known as the School Drug Education Project. The range of government-funded health promotion resources and services it offers has subsequently expanded considerably. The role of SDERA now includes road safety and alcohol and drug education programs delivered through schools, early childhood services and community agencies.

While the teaching of RSE is mandated by the HPE curriculum, different schools can, nevertheless, still exercise discretion, independence and flexibility in their choice as to when to deliver RSE across terms and different year levels. For example, one secondary college condenses RSE content into Years 7-9 because the school does not offer HPE as an option for its Year 10 students.

It is noted that SHBBVP has in recent years developed a solid working relationship with SCSA that is critical to the ability to ensure GDHR remains curriculum aligned. The value of this relationship is discussed in a separate case study that forms part of this evaluation.

2.4 Credible information source

One interviewee observed that the available research indicates that students want authentic and credible information about RSE. Significantly, they generally regard teachers as a reliable source. Students may still continue to use multiple sources of information that include their peers, parents and the internet, but the evidence is that they also value the RSE delivered in school. This is affirming for a GDHR model that assumes teachers provide a strategic conduit to students.

GDHR is an initiative of government. One interviewee felt that it is precisely because it is resourced by the State that it has credibility. However, another interviewee felt the involvement of government could be a disadvantage, placing some limitations on the material considered appropriate to include in school curriculum. It was noted that in other jurisdictions contracted non-government agencies are sometimes involved in the delivery of RSE in schools.

Discussions with interviewees suggest the credibility of a resource is an important consideration. Teachers want reassurance that a resource is consistent with current RSE literature, research, recognised best practice and trends. A strategy for ensuring independent content oversight is the proposed new GDHR Governance Council that will comprise people with external expertise in RSE. Two interviewees stated that a resource like GDHR needs to be seen to have a process of regular review and content update in order to ensure accuracy, keep pace and retain relevance and credibility in the eyes of teachers.

2.5 Pedagogy

The general trend is for schooling to become less teacher directed and more student centred. The role of the teacher is being reconceptualised as a facilitator of learning rather than its source. Teacher training institutions and schools also encourage responsive practice with educators, continually reflecting on what they might do better or differently.

Interviewees were conscious of shared philosophical and pedagogical threads that run through the resource development work of agencies such as SCSA, teacher training institutions, SDERA, CACH and SHBBVP. All share a pedagogical approach which teaches 'What? how? and why?'

According to interviewees, early career teachers often start out with a 'cookbook' or 'cookie cutter' approach with respect to RSE. They tend to look for 'off the shelf' resources like GDHR that they can use in the classroom with minimal preparation.

As their confidence and teaching capacity grows, however, they are likely to develop greater flexibility and responsiveness. A good teacher recognises learning opportunities that present in the moment. For example, one interviewee regarded incidents such as stereotyping, peer pressure, bullying and other poor behaviour at school as presenting opportunities to discuss relational issues. They are openings that permit teaching with immediate relevance. One interviewee felt that taking the time to address relational issues early eventually saves a lot of time in addressing entrenched behavioural problems in later years of schooling when they might be entrenched behaviour.

Interviewees agreed that it is critical that students have the opportunity to learn relationship competencies and how to cope with life's challenges. Health promotion activities in schools seek to achieve more than knowledge transfer. They seek to impart relational skills. Building social capacity in areas such as decision-making and resilience is at the core of GDHR, as it also is in the case of other health promotion initiatives. Locating the sexuality aspects of RSE within a broader relational framework has been an important development.

A frustration is that RSE does not always get allocated sufficient time. The topic is part of mandated HPE Curriculum, but beyond meeting curriculum requirements it remains the case that most schools offer limited opportunities to teach RSE content to their students. The amount of health-promotion-related content that might be covered in schools is daunting. A great many issues compete for attention. These include social and emotional well-being (mental health), nutrition, bullying, alcohol and drugs, road safety, driver education, sun safety and RSE. There are just so many issues demanding attention that schools and teacher training institutions cannot reasonably be expected to cover everything. There will never be sufficient classroom time to adequately cover content in depth. RSE is "underdone", but according to one interviewee so, too, are some of other areas like social and emotional well-being relating to issues such as youth suicide and self-harm. Competition for scarce classroom time is a major issue in HPE.

3. How GDHR Adds Value

3.1 Overview

The interviewees had differing levels of exposure to GDHR, but all regarded it as a resource that adds value to RSE in WA schools. Those interviewed were asked about *how* GDHR adds value. The predominant view is that it primarily does so by contributing to the capacity of teachers to deliver lessons in the classroom.

3.2 Building capacity

GDHR as entry point

It is especially in the case of inexperienced teachers that the GDHR resource is seen as providing an entry point into RSE. The convenience of using GDHR is its main attraction: "A new teacher can run with GDHR." It makes life easier. It can be time consuming for teachers to find appropriate teaching-learning resources online. GDHR saves time by providing ready access.

One interviewee described GDHR as providing a "really good excellent starting point". GDHR provides the initial platform. Interviewees see it as providing inexperienced teachers of RSE with readily accessible and practical and downloadable teaching-learning materials they can use in the classroom with minimal prior preparation.

Interviewees distinguished between how a less experienced and more experienced teacher might make use of the GDHR resource. GDHR works well as a source of initial ideas and classroom activities for those new to teaching the subject matter. Less experienced educators are more inclined to simply follow the template.

More experienced teachers, on the other hand, might use the GDHR resource as a way to check and perhaps modify what they are already doing, periodically ensuring they are up to date with current trends. More experienced RSE educators are able to adapt the GDHR resource to meet particular class needs and circumstance. An instance was where one interviewee chose to pace a particular GDHR lesson over two lessons, when one was suggested in the resource. Their view was that for some groups it is better to "leave stuff out" rather than rush RSE classes.

There is no substitute for classroom experience. One interviewee observed: "It takes practice to be good at teaching RSE." Another felt it was the more experienced educators who tended to be better at making their classes interactive. RSE works well when students are kept "active and busy". The ideal is that teachers provide opportunities for movement about the classroom, rather than 'lecturing' students.

Confidence to teach RSE

Interviewees regard having confidence to teach RSE as a critical aspect of teaching capacity. Lack of confidence to teach RSE tends to be an issue for early career teachers. There is a 'fear factor' involved that is simply not there with 'safe topics' such as nutrition or road safety. One interviewee stated that a barrier to becoming engaged in teaching RSE is that "some teachers are scared" by aspects of the subject matter. The view of several

interviewees is that confidence to teach RSE is best accomplished through actual classroom practice. While confidence to deliver is not likely to be built by a resource such as GDHR, an inexperienced teacher is likely to rely heavily on such a resource until their confidence does build.

Pre-service training

Interviewees agreed that a resource like GDHR ought to be supported by opportunities for teachers to engage in professional development.

It was noted that in their pre-service training teachers receive little, if any, exposure to RSE. Furthermore, time constraints make it unrealistic to think that RSE content might ever become a substantial training component. What may be possible, however, is to ensure that graduating teachers are at least aware of the existence of GDHR. One training institution asks pre-service teachers to develop an annotated bibliography of available HPE resources that they then share within their group. These lists are intended to inform future practice and may include RSE resources.

The evaluation was also informed that upon commencing Semester 2 2016 pre-service primary school teachers now, for the first time, have the option of undertaking a specialised health unit at ECU. The unit includes training related to the use of some GDHR materials.

Pre-service teachers are also offered a hands-on PD session by SDERA during their training, both in an elective and in the teaching community. One interviewee felt this strategy tends to spark continuing interest in the subject matter flowing on into subsequent teaching practice. SHBBVP already contracts Curtin University to provide a 12-week undergraduate pre-service unit for students within the School of Education and has also established a post-graduate unit for teachers.

In-service professional development

Those interviewed think it important that teachers have in-service opportunities to be trained in the delivery of RSE. Currently there are RSE PD opportunities offered through Curtin University and other training providers. The Curtin course is funded by SHBBVP. One interviewee recalled that SHBBVP had in the past assisted the Department of Education (DoE) to develop an online RSE PD module for teachers. This course is not publicly available, but it is understood that it is accessible to teachers with an HE number.

One RSE educator had received no formal training yet nevertheless felt confident about their capacity to deliver. They had developed their capacity from classroom experience and self-directed searches of RSE resources, including GDHR alone.

Another interviewee described their personal journey of having completed “heaps” of RSE related PD over many years, most recently the Curtin course which they described as “brilliant”. In the past they had also attended the ‘Opening the Closet’ workshop and the ‘Nuts and Bolts’ course facilitated by Sexual Health Quarters. Another interviewee identified the 2015 Curtin GDHR Symposium, funded by SHBBVP, as an excellent event that also contributed to the overall task of building teacher capacity.

The critical point here is that it is possible to deliver a sound class in RSE just with general teacher qualifications and the assistance of the GDHR online curriculum support resource. Some teachers are able to develop their capacity to teach RSE without specialist training or support. A good teacher with curriculum support resources is a positive first step. Nevertheless, the general view is that it is preferable that teachers of RSE do have access to quality PD opportunities.

One interviewee commented that RSE capacity needs to extend beyond the classroom. For example, it was noted that it is important they are made aware of what is appropriate to do when a child makes a disclosure or, if they witness, sexualised child behaviour.

The experience of interviewees is that health promotion generally works best in schools when accompanied by face-to-face PD. As a point of comparison, it was noted that SDERA invests in training school staff involved in the delivery of its health promotion programs. Participants in full-day workshops are able to develop transportable skills they carry with them from school to school, the expectation being that they will be relocated several times throughout their careers.

However, the professional development of teachers comes with a substantial price tag. Providing relief currently costs about $580 per day. SDERA is in the fortunate position of being able to contribute about $350 per day, offsetting the cost borne by schools. This is a significant financial incentive that enables participation by school staff. Similarly, SHBBVP funds Curtin University to cover the cost of teacher relief as well as travel and accommodation costs for teachers from regional schools who attend an annual two-day teacher PD workshop held at the University.

RSE as knowledge source

GDHR does have value as a source of RSE knowledge, although interviewees generally tended not to see this as its main value. After all, there are multiple sources of RSE information readily available to teachers. GDHR is one resource amongst many. One interviewee took the view that, as an RSE educator "you can't have too many resources".

Most of the interviewees had past experience using online curriculum resources other than GDHR. Such exposure and experience – both internationally and in Australia – provided useful comparative points of reference when assessing the value of GDHR. Where other resources are used these are often accessed through the GDHR website. For instance, one interviewee followed a useful link to a Queensland Government online resource. Other resources routinely used by some interviewees include:

1) *Boys and Puberty*, *Girls and Puberty* and *Relationships, Sex and other Stuff* hardcopy booklets produced by the Department of Health WA and distributed through SHBBVP on request;
2) 'Me, Myself and I' (a Year 7 sexual health teaching toolkit package designed and developed by Child and Adolescent Community Health, Department of Health WA, 2011 for school nurses to assist them with their presentations in schools ;

3) *Human Bodies* (a series of videos); and http://video.nationalgeographic.com.au/video/101-videos/human-body-sci
4) *Where Did I Come From?* video https://vimeo.com/65880384

Teachers are free to use whatever RSE teaching-learning materials they want. They are not required to utilise GDHR. SCSA does not recommend or mandate resources for teachers. More experienced teachers of RSE tend to be 'bower birds', creatively assembling their own personal collection of RSE teaching-learning materials over time. For instance, one interviewee described using the movie *Grease* as a tool to engage classes in relationship discussions.

3.3 Partnership

Politics of health education

Interviewees were conscious that GDHR operates within a social and organisational milieu inhabited by sensitivities and moral perspectives about RSE. One interviewee noted that inter-agency sensitivities arise in respect of RSE that are entirely absent in other areas of school-based health promotion such as driver education, nutrition or mental health. One interviewee reflected on how different moral perspectives related to RSE delivery in school communities can be a source of tension that impacts on the take-up of RSE, especially in some faith-based schools.

One of the challenges for any school-based health education initiative, at least according to one interviewee, is a philosophical tension between the "language of health" and the "language of education". While both fields recognise the importance of enhancing the relational and sexual health of young people, links between the health and education sectors are not always seamless.

The challenges inherent in building and sustaining partnerships extend beyond philosophical differences. Originally, the Departments of Health and Education worked together on the development of GDHR. However, there were very real practical, organisational and systematic difficulties associated with trying to efficiently administer a process whereby two agencies were expected to jointly sign off at the most senior levels on matters such as content and contractual arrangements. There may also have been a more risk-averse approach within DoE, according to one source from within the Department.

One interviewee reflected on the historical trajectory that has led to the present configuration of RSE policy and practice. In WA the development of the GDHR resource has been driven by SHBBVP located within the Department of Health WA. The original catalyst for GDHR development was as part of a raft of broader health responses to the rates of sexually transmitted infections in young people and the implications of HIV. Although the initiative is resourced by the Department of Health, one interviewee observed that GDHR has evolved into a more "educationally based" school intervention.

The fluid service configuration in the RSE field typically involves government, not-for-profit organisations, commercial business and the university sectors. There is scope to contest

appropriate roles and the distribution of responsibilities within the sector. As with any health education initiatives, there is room to debate whether any particular initiative belongs under the auspice of the Department of Health, the Department of Education, a health promotion authority, an academic institution or a community service agency.

At one stage the tendency was to locate the management of health education initiatives like GDHR outside of government in the community. Subsequently, the trend has been back towards more direct service delivery by government. The ever-evolving issue of determining appropriate service delivery arrangements in respect of RSE is bound up with the sometimes intense politics of sexual health. This can make for challenging inter-agency relations. It may also influence the flow of resources in areas such as:

- extent of school engagement;
- support from school leadership;
- value attached to RSE relative to other school priorities; and
- available funding and human resources.

Careful management of the sensitivities inevitably associated with RSE needs to be a primary preoccupation for those leading the roll-out of GDHR in schools. A teacher may just want the convenience of quick access to a resource they can use in the classroom. However, broader social tensions continue to whirl around RSE. One interviewee observed that a range of interests seek to put their own philosophical stamp on RSE by "hitching their wagon" to it. Depending on values and perspectives, GDHR can be envisioned and packaged as variously being primarily about better quality relationships, knowledge that improves physical health, the enhancement of social and emotional well-being, life-skilling, educational learning outcomes, a broader human rights agenda, an element of any anti-bullying campaign, or an STI-related public health strategy.

New governance arrangements

SHBBVP is currently planning to adopt a multi-agency management model to guide the future direction of GDHR development, involving people with relevant expertise and experience from various agencies. It is envisaged the proposed GDHR Advisory Council meet twice annually and include representation from recognised experienced practitioners and experts in the field, including some drawn from outside government and even from interstate. One interviewee saw this kind of governance structure as providing "healthy" transparency, public accountability, and enabling the kind of deep interrogation of practice required to ensure the quality of content.

It was noted that SDERA is a somewhat similar program which already adopts a collaborative approach to the development of its health promotion resources in schools inclusive of communities, curriculum authorities, parents and not-for-profit services. Due to the nature of SDERA's governance and funding structure, it is served by a management committee with multi-agency representation that signs off on the use of resources in schools. Their practice is also to pilot new materials with school staff and students ahead of use. Subsequently the Department of Education, AISWA and Catholic Education WA must also approve the use of teaching-learning materials in their schools throughout the State.

However, comparisons between the health-education work of SDERA and SHBBVP can be taken too far. One of the big differences is that the programs that SDERA delivers are in non-controversial areas such as driver education. Another fundamental difference is that SDERA has access to significant revenue sources not available to GDHR. Substantial external funding is derived from well-resourced alcohol and other drugs program funding, in turn derived from both the State and the Commonwealth. In addition SDERA benefits from an impost on the funds generated from state breathalyser infringements. Substantial funding enables it to provide outreach services in support of its resources. Unlike SHBBVP, which is a program of the WA Department of Health (WA Health) and reliant on WA Health funding and budget cycles, SDERA is a quasi-government agency managed by a cross-sector board. By virtue of this status, SDERA has a greater in-built capacity for cross-sector coordination and independence.

Building links to parents

Interviewees reflected on the involvement of parents and carers in RSE. The general view is that classroom delivery at school works best when it is also reinforced at home. One interviewee commented: "You can tell that the ones that talk with their parents are most engaged."

The extent to which RSE is, in fact, discussed at home has an impact on student classroom learning. While it is rare for parents or carers to remove their children from RSE classes, anecdotal evidence suggests that the level of RSE support provided at home is highly variable. With some students there is a sense that no RSE conversations are occurring with family. In these cases students are uncomfortable in class with the language of RSE and tend not to contribute. Use of the 'Question Box' technique works well in the classroom as a way of enabling tentative students with little RSE knowledge to enquire in a safe learning environment.

Interviewees raised the pervasive impact of pornography on children. Children may be exposed to the Internet at an early age. One interviewee observed that it is one thing to organise age-appropriate, sequenced curriculum around child developmental stages, however ease of access to the internet at an early age undermines this. There is, in fact, often little control over what students see at any particular age. One interviewee hoped that in an ideal future, society may fathom more effective means of controlling access by children. Meanwhile, it is important that teachers and parents know how to open up and effectively manage discussions about pornography with their children and youth.

According to interviewees, it is not only teachers who need to be resourced in the RSE field. Many parents also want to know how they can contribute to informing their kids with respect to RSE. Two interviewees stressed the importance of providing relevant support to parents so that they do feel able to talk with their children about emerging issues, such as sexting and pornography. Like teachers, they too are in need of resources that will help them carry out their role in a dynamic environment.

It appears that most schools and teachers do not seek to resource parents in the RSE area. However, two interviewees described how they take it upon themselves to distribute RSE

information to parents to not only make them aware of what their children are learning, but to also encourage them to contribute at home. They seek to connect with parents and carers and keep them aware and engaged with school-based RSE. Specifically, they distribute the *Talk Soon. Talk Often* booklet, a resource produced by WA Health to assist parents to talk with their children about RSE issues. One interviewee described it as a "fantastic" addition to the total package of RSE resources. Another noted that in the roughly five years that the *Talk Soon. Talk Often* resource has been available as a support for parents, production has not been able to keep pace with demand.

It was noted by one interviewee that SDERA maintains close relations with bodies representing parents and carers. It has links with the Western Australian Council of State School Organisations (WACSSO), the peak body for parents and citizens committees operating in state government schools. It also has a relationship with the Parents and Friends Federation of Western Australia, a statewide parent organisation in the Catholic education sector. Similarly, it also has a relationship with parents in the independent schools sector developed through AISWA.

Interviewees regard the parent-child interface as critically important, not only in enabling families to feel comfortable about the nature of RSE content at school, but also to encourage reinforcement at home.

3.4 Student health and well-being

Social and emotional well-being

The general view is that GDHR can make a significant contribution to the health and well-being of school students in WA. When taught as a whole-school experience, it is seen as not only contributing to physical health by enhancing student knowledge in areas such as STIs, but also in areas like social and emotional well-being.

Those interviewed see value in an approach to RSE that provides foundational whole-of-school learning for students about safe and respectful relationships. GDHR is consistent with this kind of relational approach, where the teaching of sexuality is embedded within a broader relational context. The prevailing view of interviewees is that relational skills ought to be taught from an early age to lay a foundation for school learning in all areas.

There is a sense amongst those interviewed that RSE in schools is "getting better", having improved significantly in recent years. One interviewee observed that in the past the focus was on "facts, facts, facts". Now RSE in schools is trending away from a narrow anatomical and physiological focus towards locating lessons about sexuality within a broader relational frame. There is more emphasis placed on enabling students to identify and understand their emotional responses.

Not only does GDHR increase knowledge and skills, it also enables students to display more respectful attitudes. According to one interviewee, social exclusion of students by their peers can be a significant relational issue. They gave the example of "cattiness" amongst some students around Years 5 and 6. Vulnerable students can be "baited". It was suggested that it is not enough to work on the behaviour of perpetrators. There is also scope to teach

students protective behaviours that will enable them to cope better. Friendship is now perceived as a skill that can be taught. Relational skills developed may be as basic as learning how to be respectful towards others. They may also permit students to develop a better understanding of situations in which they may be vulnerable or at risk.

Interviewees regard GDHR as an initiative that helps build a society that better respects women and the LGBTI community. The main mechanism via which interviewees understand the resource contributes is that it helps develop the life skills of students in areas such as communication and assertiveness. Interviewees hope to see evidence of societal-level change occurring in the longer term, as students come to better understand the nature of quality relationships, free from coercion. It is important that students learn that they can make choices and have opportunities to practise life skills, such as refusal. One interviewee observed that in some cases boys don't have any positive male role models in their lives. This experiential gap can feed disrespectful attitudes towards females in some cases. While resources such as GDHR are seen as potentially contributing to a reduction in the incidence of abusive relationships, it was noted that domestic violence is a topic not currently addressed in the GDHR resource.

An environment in which differences based on gender and sexuality are normalised is less threatening. A relational approach to education is seen as reducing the stigma and stereotyping associated with issues of sexuality, and contributing towards a reduction in homophobic attitudes.

Teacher-class relationship

One interviewee reflected that effective delivery of RSE requires a teacher in a developed pre-existing trusting relationship with their class. Generally, students relate well to relevant stories about relationships from someone they know. It is also useful to use facts and figures in the classroom, so students know there is evidence to back up what is being taught. The interviewee stressed the importance of the message that sex is a normal and healthy part of life, adding: "I talk to them like I would talk to my grandkids."

Students are interested in learning about sex, so engaging them around the topic is usually not problematic for a teacher. What is problematic, according to one interviewee, is that the responsibility too often falls to the least experienced educators, despite the fact that aspects of RSE can be one of the more challenging topics to teach.

Monitoring progress

SHBBVP is yet to develop KPIs for the GDHR initiative. Two interviewees stated they would like to see reliable performance measures developed for GDHR. They emphasised the importance of an evidence-led approach to school-based RSE driven by data about need, and not by other considerations.

Interviewees were conscious that the success of an RSE initiative can be gauged in several different ways, depending on values and desired outcomes. In the case of the GDHR resource, success can be envisioned as:

- better educational (knowledge and skill) outcomes;

- enhanced social and emotional well-being;
- improved quality relationships; and
- positive population health change.

Being able to demonstrate that an initiative like GDHR makes a contribution to broader societal-level change is a challenge for health promotion. Such initiatives seek to educate in order to influence values, attitudes and behavioural outcomes over the life course. The difficulty is that they are rarely resourced well enough to carry out the kind of longitudinal research necessary to measure changes in health and well-being over time. Interviewees noted this is the case for GDHR and other initiatives, such as those of SDERA.

One interviewee observed that policymakers and funding bodies often have different ideas about what success looks like. For instance, the Mental Health Commission and the Road Safety Commission, both funders of SDERA, have quite different functional priorities.

Participant numbers, or "bums on seats", is the main KPI output measure used by SDERA, according to one interviewee. It has been challenging for SDERA to derive reliable estimates of how many school staff are being reached by its resources. The exception is the Keys for Life driver education initiative. In this instance it is relatively easy to count the number of trained and registered teachers equipped to deliver the resource. The initiative is delivered under an agreement between SDERA and the Department of Transport (DOT). Teachers are only eligible to use this resource and assist young people to sit the Learners Permit test if they have first completed prescribed training and have signed up to a Code of Conduct.

A critical output measure for GDHR might be the number of teachers in WA that utilise the resource. Currently this is not used as a performance indicator, nor is it necessary for anyone to register in order to access the GDHR website. The view of SHBBVP is that an online resource like GDHR should be freely available to anyone. The downside of this position is that it makes it more difficult to demonstrate evidence that the resource is reaching its target audience of current and prospective RSE teachers in WA. Finding a reliable way of estimating the number of teachers involved with the classroom delivery of GDHR is not straightforward.

It is also noted that SDERA monitors the number of requests it receives for hardcopy resources. For instance, it is known that in excess of 13,000 young people in WA have used the *Student Driver Education Workbook*. This statistic is a measure of the breadth of engagement. In respect of GDHR, one interviewee noted that some school staff already take the option of ordering "puberty books" online.

4. Suggested Improvements to GDHR

4.1 Overview

Interview participants were asked how the GDHR resource might be improved in order to more effectively build the capacity of teachers and enhance the effectiveness of the resource. They identified practical ways in which it might be strengthened through:

- greater emphasis placed on marketing and promotion;
- enhancements to website content;
- closer alignment between the GDHR resource and other school-based RSE resources;
- adaptation of the resource to engage with Aboriginal students; and
- better utilisation of the knowledge, skills and understandings of school nurses.

4.2 Marketing and promotion

Interviewees raised the issue of better marketing and promotion of GDHR. The impression of interviewees is that currently most teachers are not involved with RSE. Available RSE teaching resources are thinly spread, with a handful taking most of the RSE classes in most schools. At present it appears that many teachers in WA are not aware of the GDHR resource. One interviewee described their own experience of "tripping over" GDHR when doing a search for RSE teaching-learning resources online.

There were several suggestions about how to market and promote use of the GDHR resource in schools. Marketing in this context needs to adopt an 'opportunistic' approach. Other health promotion initiatives operating in schools may provide a source of ideas.

Pre-service teacher training presents an opportunity to make future educators aware of GDHR before they graduate. One interviewee recalled receiving no RSE content whatsoever in their own pre-service teacher training. However, closer engagement between SHBBVP and teacher training institutions may provide an avenue to raise awareness of the resource.

Interviewees noted that the 'crowded' nature of teacher training leaves few opportunities to train teachers specifically in the delivery of RSE. However, one teacher training institution in WA asks pre-service teachers to do an exercise in which they are required to develop a list of health promotion resources. Some choose RSE, and their lists are shared amongst the class. Ensuring that teachers complete their training with knowledge of the existence of the GDHR resource is a realistic objective.

Two interviewees stated that teachers would appreciate receiving a complementary kit of practical RSE resources. Sending out materials is seen as a way of keeping RSE front and centre of mind in schools. Examples of hands-on practical resources routinely used in the classroom include 'Barbie and Ken' dolls, and the Magno-mate Reproductive Kit used to illustrate male and female reproductive organs. One interviewee had seen other useful items for sale at the 2015 Curtin University GDHR Symposium.

One interviewee noted that SDERA's strategy is to send every school in WA a free set of hardcopy materials. Initially, the practice was to send these to the principal, but it was

discovered that they did not always find their way into the school resource centre. Hardcopy resources are now sent directly to the resource coordinator through the principal.

One interviewee suggested that a multifaceted approach to the marketing and promotion of GDHR should also encompass e-newsletters that illustrate how school staff (including school nurses) are using the GDHR resource. It is understood that *SDERA News* is distributed to every school in WA once each term via an email distribution list developed by the organisation. Hard copies are also sent addressed to the principal, the health and physical education coordinator and the Parents and Citizens (P&C)/Parents and Friends (P&F) groups.

SDERA utilises social media, including Facebook and Twitter, and the number of its followers is increasing. However, the experience has been that maintaining a social media presence is resource intensive and time consuming, requiring dedicated monitoring of campaigns.

One interviewee thought it particularly important for SHBBVP to directly target school principals by packaging key informative messages about GDHR for delivery at events such as conferences and meetings. It was also noted that SDERA promotes its programs and resources at relevant events such as the WA Primary Principals Conference, through the Australian Council for Health, Physical Education and Recreation *(*ACHPER*),* Alcohol and Other Drugs Conferences, the Australian College of Road Safety and via parent conferences. Other opportunities to promote resources include trade displays and maintaining a presence at early childhood events such as Toddlerfest and Scitech.

One of the marketing and promotion challenges for GDHR is to explore ways to encourage more male teachers to become involved in the delivery of RSE. The interviews suggest that male teachers of RSE are in especially short supply.

It is a school workforce characteristic that female teachers greatly outnumber their male counterparts. As a consequence, women deliver most RSE classes. The evaluator was informed about a primary school where only one male teacher is involved with RSE classes.

There is a general under-representation of men in the teaching profession. One interviewee estimated that about 90% of those currently enrolled in one pre-service primary teacher training course were women. However, it was also noted that males are not under-represented in every area of the teaching profession. For instance, the evaluator was informed that men probably comprise a slight majority of secondary HPE pre-service trainee teachers currently enrolled at one institution. Overall, however, males are under-represented in the teaching profession, and hence in the ranks of RSE teachers.

While there is a shortage of male RSE teachers, the experience of one interviewee is that it is often female teachers who feel “more embarrassed” about teaching aspects of RSE. It is also an open question as to whether or not male students are necessarily disadvantaged if male teachers are not involved with their RSE.

4.3 Website enhancements

Interviewees generally found the GDHR website easy to navigate. The latest version of the resource is seen as easier to navigate than earlier iterations. One interviewee felt that "too many clicks" were required to navigate the website. Two interviewees had experienced difficulties in the past finding what they were looking for. It was noted that a resource like GDHR assumes an IT-literate workforce. For some older school staff, IT skills do not always come as easily as they do for later generations. The less IT-savvy may still find aspects of GDHR frustrating to navigate when looking for specific content. An example provided by one interviewee was the difficulty they experienced in trying to find a lesson plan on contraception that was suitable for Year 7 students. The general impression is, however, that growing familiarity with the website over time reduces navigation difficulties. A suggested improvement was a more straightforward process for downloading and printing materials.

A criticism of the GDHR resource was that it tends to be "a bit wordy", especially for visual learners. Two interviewees suggested that educators new to RSE delivery may feel a sense of overload with the sheer amount of material available on the website.

Interviewees identified the potential to build student assessment tools into GDHR. One suggested these might possibly be developed in collaboration with SCSA. One stated that if assessment tools were made available, GDHR would likely have more appeal to teachers.

There was a suggestion that the website would be improved through use of direct in-text links to video resources, rather than locating them at the bottom of the page, as at present. It was also further suggested the resource would be enhanced by investing in the production of videos illustrating GDHR lessons being facilitated by teachers in the classroom. One interviewee commented that it is one thing to read about teaching-learning strategies, but quite another to actually be able to see them in action.

One interviewee made the observation that not all teachers use an online teaching and learning resource in the same way. Teachers may have a range of different resource requirements and expectations, with generalist and specialist HPE teachers likely to have different pre-existing capabilities and expectations in respect of RSE. Users of a resource like GDHR can also be envisaged as variously strung along a continuum. At one end are the 'time-poor' teachers. It is not unusual for mathematics and science teachers, for example, to be called upon to take an HPE class where they deliver RSE curriculum. These teachers want an online resource that provides quick and easy access to lesson plans and teaching tools. Too much choice can be overwhelming for this group. Their attitude towards any teaching and learning resource might be: 'You tell me what's best.' They are unlikely to look for resources beyond GDHR. At the other end of the continuum are specialist HPE teachers in secondary schools who may routinely take RSE classes. This group is more likely to want choice around what they teach and how. One interviewee felt that it was possible for the GDHR resource to explicitly cater for both groups by offering generic teaching-learning activities recommended by the resource developer ("our advice"') as well as links to "add-

ons" for those more specialised teachers who are explicitly seeking more choice and options in relation to classroom activities.

4.4 Alignment with other resources

Interviewees noted that other health resources used in schools can provide some useful points of comparison with the GDHR resource. In particular, it was noted that other health promotion initiatives, such as those offered through SDERA, may be better resourced.

SDERA has a regional network of state-funded consultants who conduct school visits and meet face to face with teachers to assist with the delivery of health promotion programs. Eleven consultants are located in regional and remote areas of WA, including centres such as Broome, Kalgoorlie and Karratha. This enables SDERA to have program reach into places such as the Goldfields, Pilbara and Kimberley. Invitations for SDERA to work with schools may come from the school principal. The role of a consultant involves extensive contact, communication and rapport with schools, so it is critical that they have the credibility necessary to sustain these relationships. The experience of SDERA is that it is crucial that consultants operating in this space have a teaching background. According to one interviewee, the use of consultants has "really impacted" positively on the effectiveness of initiatives in areas such as road safety, alcohol and drug education. Being regionally based enables consultants to understand local health and safety concerns, community priorities, and other programs that may complement its own programs and services. By contrast, GDHR is purely an online resource. One interviewee thought that the confidence of some teachers to become involved in the delivery of RSE in the classroom might be raised if there was visiting health education 'support officer' role facilitating familiarity with the GDHR online curriculum support resource.

Over many years SDERA has developed its own style guide, with consistent use of colours and a similar look and feel to its resources. One interviewee felt it bred a sense of familiarity amongst teachers. In the future it may be open to SHBBVP to participate in discussions with others agencies involved in school health promotion to possibly agree on a common resource format for use in WA schools.

Another point of comparison with SDERA's approach could be made with a resource like Mind Matters, a social and emotional well-being initiative www.mindmatters.edu.au. One interviewee understood that the Mind Matters initiative is, like GDHR, only supported as an online resource and, furthermore, that it had been impacted by staff cuts. It would be interesting to know how this model of school-based health promotion is faring, given that there appear to be some similarities with how delivery of the GDHR resource is structured.

4.5 Engagement with Aboriginal students

One interviewee felt more might be done to extend GDHR to "hard-to-reach" Aboriginal students. Certain factors make RSE especially pertinent in regional areas of WA, where many Aboriginal people live. Their issues include the high burden of disease, and concerns about the incidence of unwanted and unplanned sex.

GDHR materials may need to be adapted for use with Aboriginal school students. Regional and remote communities are diverse, meaning that 'one-size-fits-all' responses tend not to work across a range of different contexts. Increasing the efficacy of GDHR with Aboriginal students requires work to match the teaching-learning resource to local needs. Creating space in the syllabus for RSE poses a particular challenge in schools faced with multiple competing priorities that range from literacy and numeracy through to nutrition.

SHBBVP has been examining how the RSE needs of Aboriginal school children in WA might be better met. Nationally significant research work, such as that led by James Ward et al (2013) documented in the 'Goanna Study', is seen as providing valuable foundational insights that can inform this task. Goanna is the first national survey of Aboriginal and Torres Strait Islander people aged 16–29 to explore their knowledge, risk behaviours and pattern of service utilisation.

In August 2016 SHBBVP released the online resource 'Let's Yarn!' https://letsyarn.health.wa.gov.au/. It has also recently published a new background note about teaching RSE to Aboriginal students. Strategically, SHBBVP seeks to engage with Aboriginal and Islander Education Officers (AIEOs) in regards to enabling them to become significant partners in supporting the delivery of RSE to Aboriginal students. SHBBVP is also looking at ways to strengthen the relationship between the GDHR and 'Let's Yarn' resources, and also map opportunities for cross-promotion.

4.6 School nurses as an RSE resource

It is a requirement that a qualified teacher always be present to teach in the school classroom. School nurses do not have formal teaching qualifications, so cannot teach RSE classes at school alone. It has, nevertheless, been demonstrated that they can provide significant assistance to a teacher in class. According to one interviewee the "gold-star standard" is for a teacher and nurse to work in conjunction, and complement each other in the planning and co-facilitation of RSE classes.

Interviewees see school nurses as having the potential to play a key support role in RSE classes. Some nurses already have substantial knowledge and experience in this area across the breadth of the RSE curriculum, not just in anatomical and physiological aspects. For example, the author of this evaluation became aware of one nurse assisting in facilitating classroom discussions in areas such as 'respectful relationships' and 'sex and the law'. One interviewee observed that school nurses were often accustomed to making clinical decisions, and appeared well placed to contribute professional judgements about matters such as when it is age appropriate for students to receive particular information.

Most of the work of a school nurse occurs outside the classroom, often in one-on-one interactions with students. A nurse may be aware of RSE issues that need to be addressed beyond what happens in the classroom. Nurses do work confidentially one on one with students in respect of RSE-related issues. The role encompasses health consultations, assessments and referrals. Some schools face prominent RSE issues, and school nurses can be positioned as effective health promotion advocates within the broader school and

community environment. They can also recommend suitable resources to parents that encourage them to play a role in the RSE of their children.

Interviewees stated that several factors impact on the level of involvement of school nurses in RSE classes, including nurses' personal values and beliefs, level of training, abilities and confidence as well as the views of school leadership. The RSE contribution of nurses in the classroom also depends on the experience and confidence of the teacher. Where these are limited, nurses are more likely to be called upon to assist. Because of such factors, there is considerable variation in the extent to which school nurses are involved in RSE delivery. They may or may not take a particular interest in RSE, and therefore may or may not choose to play a substantial support role alongside qualified teachers in the classroom. They may or may not regard a classroom role as lying within the scope of their position. They may not be invited to contribute in the classroom by the principal or teacher, and they may or may not have the time to contribute to RSE classes. Some nurses are very experienced, and feel comfortable and competent with RSE resources. Others don't.

Every school needs to consider who in their ranks is well placed to effectively deliver RSE. School leaders have a range of views about RSE curriculum and the appropriate role of school nurses in relation to it. Sometimes a principal wants the nurse involved, but this is not always the case. It is also the case that some teachers are happy to have school nurses alongside in the classroom, while others are happy to work alone. School nurses too have varying levels of confidence in this area.

CACH supports school-nurse participation in a classroom facilitation role in respect of RSE. It seeks to equip them with general principles, key messages and access to resources that will enable their involvement in both session-planning and delivery. One interviewee stated that GDHR is "put highly" amongst the resources recommended to school-based community health nurses. They are also known to access a range of other RSE resources. 'Me, Myself and I' is an example of one designed by CACH specifically for use with students in Years 5-7. School nurses also may have attended professional development courses such as 'Birds and the Bees', and SHQ's 'Tools of the Trade' and 'Nuts and Bolts'.

One interviewee noted that before a school nurse and teacher can work together well in class, they first need to be familiar with the same teaching-learning materials. By virtue of their training, teachers are accustomed to developing lesson plans and activities. A school nurse, on the other hand, is likely to appreciate having access to a resource that sets out clear steps and provides them with 'pre-developed' materials, such as those available through GDHR.

CACH is currently reviewing its Me, Myself and I resource for school nurses with assistance from SHBBVP. A suggestion has been made to ensure resource alignment with GDHR. Potentially, this work will also encourage more nurses to play a role in RSE delivery. One interviewee suggested that greater attention might also be paid to providing school nurses with better access to RSE PD opportunities.

The general perception is that school nurses are a resource that can be better utilised in school-based RSE work. Interviewees tended to regard school nurses as an underutilised resource. It is wasteful not to utilise their expertise, especially in circumstances where a teacher may be lacking the confidence to teach RSE.

5. Future Aspirations

5.1 Overview

This section is about how, in an ideal world, GDHR might be rendered better or different. Interviewees were asked to identify areas where they hope to see positive change in respect of RSE, and to describe their aspirations for GDHR. In the future, interviewees hope to see GDHR, and RSE more generally, given greater priority in schools, for it to become embedded as part of a broader Health Promoting Schools (HPS) framework, for it to be integrated into school teaching and learning beyond the confines of HPE curriculum, and for 'communities of practice' to emerge around RSE in schools.

5.2 RSE becomes a priority

Interviewees want to see RSE accorded greater priority in schools. The vision is that every child should have the opportunity to be engaged in comprehensive RSE throughout their schooling, inclusive of opportunities to both "know and understand". Interviewees are conscious that at present RSE competes for scarce classroom time, not only with other health education topics such as alcohol and other drugs, nutrition, lifestyle illnesses, road safety, and social and emotional well-being, but sometimes also with non-core activities such as work experience and resume writing.

One interviewee observed that at present RSE is "not done enough" in schools, despite being "so relevant to students today and child health." Typically, a high school student might receive an hour of HPE tuition each week. At most, one semester of classes might be devoted to HPE, perhaps totalling 8-10 hours of tuition, but considerably less in some cases. They stated it would be good to see schools making more extensive use of resources like GDHR. It is possible is to equip students with strategies that develop critical life skills that can be more generally applied beyond RSE.

One interviewee hopes for a future in which RSE is widely recognised as a critical aspect of life education. Not only would schools devote more time to the subject, but resources like GDHR would be recognised as core educational tools, not as peripheral to education. There would also be ongoing investment to further develop and improve the resource.

5.3 Health Promoting Schools framework (HPS) philosophy adopted

SHBBVP, SDERA, CACH and numerous schools in WA have committed to a comprehensive 'Health Promoting Schools Framework'. The intent is better health and well-being outcomes for school communities. The framework supports the healthy growth and development of students by promoting action across three domains: education, partnership and environment. The partnership and environmental domains require more attention in the future than they currently receive according to one interviewee.

Familiarity with the HPS concept is highly variable amongst those interviewed, ranging from extensive knowledge to no previously knowledge of the notion. One interviewee noted favourably that the GDHR website includes a "very useful summary" of the HPS framework. Some were aware of research findings suggesting that an environment in which schools,

parents and communities act together is likely to produce better RSE outcomes. The support of school governance, principals, teachers, administration staff, parents and communities is critical.

Interviewees were conscious of how school leadership, policies and practices impact on RSE. Schools can pose a tough implementation environment for a health promotion initiative like GDHR. Primary pressures in schools are towards maintaining academic standards. Literacy, numeracy and NAPLAN scores tend to take precedence, whereas health and well-being are not necessarily prioritised. There are also hard-to-reach student cohorts with poor attendance records. To work, an HPS philosophy needs to be driven by the school leadership, from the board and principal down, if it is to become embedded in the school ethos.

SDERA's Changing Health Acting Together (CHAT) initiative utilises a system of bronze, silver and gold targets to incentivise school participation in an HPS framework. One participant felt considerable progress was now being made, with increasing numbers of schools subscribing to the philosophy. Examples of relevant school activities cited in the interviews included a 'friendship bench', a 'no-hat-no-play' policy, permitting healthy food and drink to be consumed in classrooms, and participation in the Global Health Challenge. Health promotion stories in the school newsletter were also seen as helping to set the right tone.

CHAT seeks to promote a HPS philosophy in schools: www.sdera.wa.edu.au/programs/chat/. It is the end result of a three-year development process informed by research undertaken as part of the Health Promoting Schools Project 2009 and the findings of the KIT-Plus Research Project 2008-2010 (a collaboration between SDERA and the Child Health Promotion Research Centre.

CHAT provides a framework of core concepts and values that guide school-level planning, implementation and review of health promoting policies and practices. In addition to an online resource, the following kinds of support are also offered to schools as part of the CHAT initiative:

- accessible resources, such as templates, action plans and surveys;
- professional development opportunities;
- consultancy advice; and
- financial assistance.

One interviewee felt that in the last three years significant progress had been made towards embedding a whole-school health promotion ethos in WA. There is anecdotal evidence that the message is spreading through participating schools and benefits of the approach are becoming evident. One interviewee said some schools involved with CHAT were doing "amazing things". Over 100 WA schools currently choose to participate in the scheme.

5.4 Integrated curriculum

Rather than regarding school-based health promotion as the prerogative of HPE curriculum, the adoption of a broader cross-curriculum perspective is seen as one "clever" strategy for

the future by some interviewees. The hope is that RSE might eventually be integrated across the whole school curriculum. Should it ever be realised, it would mean that areas other than HPE would include RSE-related material. The novel set for English might, for example, explore relationship issues. One interviewee felt that integration of RSE into other learning areas such as science, mathematics and English, might enhance relevance and interest for students. Several stated they would like to see schools exploring opportunities to employ such a strategy because, as things stood, opportunities to teach RSE content were too limited.

The notion of an integrated curriculum may have most relevance to primary school education, where a teacher mostly works with a single class and is familiar with their whole learning experience, and is usually more able to incorporate cross-curriculum learning opportunities. Arguably, an integrated curriculum strategy has less scope at secondary level, where learning is organised around subjects rather than year levels. No single teacher is completely familiar with the whole learning experience across the totality of secondary student learning experience.

5.5 Community of practice

A resource yet to be harnessed is the reservoir of knowledge, skills and understandings about RSE that already exists in school and community networks. The opportunity is for less experienced staff to make use of the more experienced as a resource. There is untapped capacity for teachers, nurses and others to learn from each other. An aspiration of one interviewee is to see a “community of practitioners” emerge around RSE issues. Their hope is that, in time, RSE might come to be recognised as a “sub-speciality” for educators within the teaching profession.

Any vision of establishing a network of RSE teachers is, however, a long way from being realised. Generally, only a handful are involved with the delivery of RSE in most schools. The common experience is that of a teacher delivering RSE content directly to a class alone with minimal collegial support, mentoring or coaching. As yet there is little evidence of mutual support networks developing amongst school staff interested in RSE issues. While links amongst teachers sharing RSE classroom experiences and resources may be desirable, such networks are likely difficult to prove difficult to sustain because RSE is not a core activity for anyone, and few are likely to have the time.

Nevertheless, two interviewees described having developed their own RSE support networks that included others in government, the not-for-profit community services sector and academic institutions. One felt that those who teach RSE in schools are not as professionally isolated as they once might have been. Increasingly, teachers do talk to each other about the delivery of RSE: “I do it this way, you do it that way.”

In one secondary college the HPE coordinator encourages HPE teachers to access more experienced staff as a resource. Collaboration is actively encouraged. The school currently has seven HPE teachers involved with the delivery of RSE, and another five who normally teach in other subject areas. At this college two staff are highly experienced with RSE and

serve as a resource for others. One interviewee said that sometimes teachers come into an RSE class to watch delivery in order to learn how they might do it themselves.

Mutually supportive links between educators can form as a consequence of engagement with others in face-to-face PD. One interviewee saw potential for a school PD day to be framed around getting those who teach RSE together to discuss and learn from each other. This process might occur both within and across schools so that educators learn how other schools go about the delivery of RSE.

6. Conclusion

This final section reflects on possible implications of the interviews for the GDHR resource. The general view of interviewees is that the contribution of GDHR ideally needs to be understood and progressed as one part of a broader integrated health education strategy that encompasses related initiatives for groups such as Aboriginal students, students with special needs, and culturally and linguistically diverse (CALD) students. Furthermore, the delivery of key RSE messages needs to extend beyond teachers to include school nurses and parents.

The interviews suggest the GDHR website has several valued features that support the teaching of RSE in WA schools. It is curriculum aligned, appropriately sequenced and based on sound pedagogy. Furthermore, the fact that it is an initiative supported by government adds a layer of credibility. These are the factors that underpin perceptions of quality, and which therefore need to be sustained. These findings provide clear key messages that might be reinforced in marketing and promoting GDHR to teachers.

Interviewees specifically elaborated on how the GDHR resource adds value to RSE in WA schools. First and foremost, it provides a convenient starting point for teachers new to RSE, quickly equipping them to deliver a class. It is important to note that most teachers do not have the opportunity to practise the delivery of RSE in their training, underlining the strategic importance of SHBBVP continuing to work with teacher training institutions to ensure that all graduates leave at least being aware that GDHR exists as an RSE teaching-learning resource.

While GDHR contributes to building teacher capacity, by itself it does not resolve all capacity constraints. A teacher can become a competent RSE educator equipped only with a general teacher qualification and the GDHR resource. However, generally supplementary short pre-service courses, exposure to the classroom practice of other educators and years of experience actually teaching RSE also add value. Indeed, the more experienced an RSE teacher is, the less likely they are to need to rely on a resource like GDHR. Nevertheless, the interviews suggest GDHR continues to be a useful reference and source of new ideas even for experienced teachers, enabling them to check that their practice aligns with current trends in this field.

The GDHR resource also adds value by contributing to the social and emotional well-being of students by teaching life skills in areas such as assertiveness. The focus of RSE has changed. Once ‘sex education’ was confined to a couple of high school lessons. Now RSE commences in the early years and is approached as a whole-school experience. Once, the emphasis was on imparting factual information. Now RSE seeks to influence attitudes, values and behaviours. GDHR is consistent with these new directions.

One of the challenges for health-education initiatives in schools is being able to demonstrate that they are evidence-led and do make a difference for students. It is important to establish a monitoring framework that can show that the GDHR initiative is indeed effective. Key performance indicators founded on monitoring the achievement of

SMART objectives are the necessary starting point. One critical measure required is a reliable estimate of the number of RSE teachers in WA schools who regularly utilise the GDHR resource. SHBBVP do monitor and have longitudinal Google Analytics data for GDHR, but there is scope to better analyse the data.

One interviewee drew attention to the various ways in which the content and delivery methods of health-education resources used in schools might be kept consistent with current best practice. Best practice is guided by multiple sources of information:

- feedback from practice;
- staying up to date with relevant journals, research and evaluation;
- following the work of key organisations in the sector;
- accessing expert advice located in universities; and
- attendance at conferences.

Key principles of best practice in health education were understood to include:

- whole-school approach;
- resources embedded within an age-appropriate curriculum framework;
- ensuring the support of school management;
- active engagement of students that enables them to develop practical skills through student centred interactive activities that encompass risk scenarios; and
- establishing and maintaining collaborative links with community services so that resource materials reflect shared expertise and experience.

The terms of reference for the evaluation require examination as to how collaboration and partnership add value to GDHR. Sensitivities and different value perspectives associated with the delivery of RSE in schools can make for a challenging implementation environment. It is also a field in which community services, government, academic institutions and parent organisations are all active, and in which there is there is a heightened level of media, religious and political interest. Management of any initiative operating in such a charged social and organisational milieu necessarily requires active and sensitive engagement with other interests.

Attention might be given to the formulation of an engagement strategy purposely designed to build and sustain critical key relationships. One of the key relationships is with parents so that they too come to see value in school-based RSE and lend their support to initiatives such as GDHR.

It is noted that other agencies involved in health and safety education in schools invest in building and sustaining interagency relationships at both a governance and operational level. SHBBVP is currently in the process of developing its own model of inter-agency governance arrangements to guide the future development of the GDHR resource.

In the course of the interviews, potential ways of enhancing the GDHR website were canvassed. One concern was to ensure the resource does not become too content laden.

Other specific suggestions were to maintain the present focus on enhancing ease of navigation around the website, the addition of assessment tasks, providing a straightforward means of downloading and printing materials, use of in-text video links, and the production of videos illustrating delivery of GDHR lessons. A useful distinction might also be made between the different resource needs of generalist and specialist teachers.

Interviewees commented on the need to better market and promote the GDHR resource. The perception is that many teachers still don't know about it. Suggested strategies to effectively market and promote GDHR were to:

- strengthen links to teacher training institutions to ensure pre-service teachers are at least aware of the resource;
- seek opportunities to promote GDHR at existing principal, teacher and parent forums;
- produce and distribute a regular newsletter;
- develop a social media strategy;
- resource schools with practical resources that promote GDHR; and
- target male teachers.

Another way of strengthening GDHR is to possibly pursue a closer alignment with the approach adopted by other health education and safety initiatives that operate in WA schools. The roll-out of health and safety education resources developed by SDERA receives supplementary support by a network of regionally based consultants who work directly with schools. By contrast, GDHR exists only as an online resource and does not have the resources to provide face-to-face back-up to teachers on location in their workplace. There may also be scope for inter-agency discussions around ensuring consistency of resource formatting and approaches to performance monitoring.

Other improvements to GDHR include enabling broader involvement of school nurses in the classroom delivery of lessons acting in support of teachers, as well as more strenuous efforts to ensure GDHR resources reach social groups most in need of them, especially Aboriginal students in regional and remote areas. It is noted that SHBBVP planning processes have already prioritised both of these tasks.

Finally, the interviews canvassed the aspirations of participants for the future of GDHR in particular, and RSE in general. The hope is that these will be accorded greater priority in schools in future. To achieve this it may be necessary to transcend a widespread binary perception of RSE, whereby the resource is perceived as competing for limited classroom time with other content. An alternative perspective is that RSE constructs critical life skills, such as resilience and values such as respect, that enable learning to occur in all areas of schooling by furnishing a necessary foundation of social and emotional well-being.

Learning requires a safe environment. Interviewees regard the quality of relationships as a fundamental social concern that school-based RSE can help to address. One strategy is the potential to demonstrate the use of integrated curriculum in practice in schools. There may be opportunities for the GDHR website to furnish examples.

There is a growing commitment by WA schools to a HPS philosophy, albeit off a low base. There may be opportunities to explore how GDHR can more effectively 'hitch its wagon' to this movement to ensure it is inclusive of RSE. Such an approach would require commitment to a range of policies and actions in schools beyond the resourcing of teachers.

Some interviewees would eventually like to see a 'community of practice' evolve in schools around RSE issues. Over time this can be conceptualised as a movement away from externally resourcing teachers towards processes in which they increasingly come to resource each other through mutual support. Teachers are generally time poor, and RSE is not their core business, so strategies such as online chat groups are unlikely to be sustained. However, there are other ways in which school staff can, and already may, lend practical support to each other that could be promoted by resources such as GDHR.

Appendix 1: GDHR Interview Guides

Guide used with teachers

1. Overview the purpose of interview and evaluation objectives:

- to assess **how well** the GDHR online curriculum resource is working;
- to identify **practical ways** in which the GDHR resource might be strengthened.

2. Overall, what do you find **most useful and valuable** about GDHR, if you find it valuable and useful?

3. What training and support is made available to yourself and other teachers of school-based relationships and sexuality education (RSE)?

- Have you received any **training or PD** to support your use of GDHR or delivery of RSE?
  - Pre-service
  - In-service
  - Self-directed learning
  - Peer support from colleagues.
- Do you think it is important to receive training in RSE, or is a general teaching qualification and access to an online resource sufficient?
- In your school/organisation how many others teach RSE and what training and support is available?
- More generally, and in your experience, are there enough teachers of RSE in schools, and do they receive sufficient training and support?

4. **Your use** of the GDHR resource.

- How and when do you remember first becoming aware of the GDHR website?
  - Online
  - Work colleagues
  - During your pre-service training
  - From family or friends
  - At a PD or other event
  - Other (please specify).
- How often do you estimate that you visit the GDHR website and why?
- Would you have visited the GDHR website in the last year since the website was updated?
- What areas of the website do you spend most time on when online?
  - Are there particular **year level** materials you utilise more than others?
  - Are there particular **themed topics** that you utilise more than others?

- Staying Safe
- Growing Bodies
- Emotional Well-being
- Respectful Relationships
- Diversity
- Health Literacy.

5. In your experience, how (in what ways and why) does GDHR **add value (**if you think it does)?

- What contribution does GDHR make to building **teacher and school capacity** (if any):
  - providing educators with a ready to use set of teaching tools?
  - saving time by providing ready access to downloadable resources?
  - knowledge building?
  - classroom competence building?
  - confidence building?
- Building partnerships/collaborative relationships.
  i. Do you feel there is collaborative partnership between stakeholders involved in GDHR?
  ii. How well are the health and school sectors linked together around RSE issues?
  iii. Are there key stakeholders that need to be linked in?
  iv. Are community services involved?
  v. Are there opportunities for parents and carers to be involved?

Making a significant contribution to the **health and well-being** of young people (K-10).

i. Correcting myths and eroding stereotypes?
ii. Building communication, assertiveness and other social skills?
iii. School environment supportive of healthy growth and development?
iv. Influencing positive values of students?
  - Any examples?
  - Data?
  - Reporting?

6. What is your perception of the **quality of the content** of the GDHR resource?

- Is it engaging?
- How easy is it to navigate?
- Is anything missing?
- Do you make use of other RSE resources and, if so, what do you see as the advantages and disadvantages of other resources relative to GDHR?
- How important is it for you to know the GDHR resource is age- (year level) appropriate and aligned with Australian and state curriculum requirements?

- How could the GDHR resource be improved to better build the capacity of educators?
    i. Does it share/disseminate useful state-of-the-art information about RSE?
    ii. Does it give credibility to RSE as an important area of health education?
    iii. Does it help with student assessment?
    iv. What would happen in the absence of GDHR content?

7. What are **practical ways** in which the GDHR online curriculum support resource might be further strengthened or improved (if it can be)?

- Appropriateness?
- Catering for 'post-modern' students/greater attention to inquiry-led activities?
- What environmental challenges does GDHR face that you think might impact on its effectiveness?
    i. Resources (funding, human)
    ii. Technological change
    iii. Diverse needs of different stakeholders
    iv. Level of support from school leadership or administration
    v. Finding space within a crowded curriculum
    vi. Health education undervalued in the curriculum
    vii. Sensitive and controversial nature of some topics (differences in value systems)
    viii. Getting male teachers involved
    ix. Overall standard of teaching competency.

8. What might you hope to see in the future (done better or differently) in relation to RSE in general or GDHR in particular?

- What are the potential benefits you hope to see from RSE in the medium to long-term?
- What does success look like in this area?
- What might need to change, and what is required to make it happen?
    i. Health Promoting Schools framework
    ii. RSE taught across the whole curriculum
    iii. Network of support amongst RSE teachers

9. For whom and in what circumstances do you think GDHR works best, when it does work well?

10. Is there anything else you would like to say about GDHR?

Modified interview guide used with non-teachers

1. Overall, how useful and valuable an initiative do you believe GDHR to be?

2. What does success look like in this area?

3. What are the environmental challenges that you think might impact on effectiveness?

4. Training and support

5. Number of teachers reached

- Are there enough teachers of RSE in schools?

Marketing

6. In your experience, how (in what ways and why) does GDHR add value (if you think it does).

- What contribution does GDHR make to building teacher and school capacity (if any):
    i. providing educators with a ready to use set of teaching tools?
    ii. saving time by providing ready access to downloadable resources?
    iii. knowledge building?
    iv. classroom competence building?
    v. confidence building?
- Building partnerships/collaborative relationships
    i. Proposed new governance structure and why it is being established?
    ii. Do you feel there is collaborative partnership between stakeholders involved in GDHR?
    iii. How well are the health and school sectors linked together around RSE issues?
    iv. Are there key stakeholders that need to be linked in?
    v. Are community services involved?
    vi. Are there opportunities for parents and carers to be involved?
- Making a significant contribution to the health and well-being of young people (K-10)
    i. Correcting myths and eroding stereotypes?
    ii. Building communication, assertiveness and other social skills?
    iii. School environment supportive of healthy growth and development?
    iv. Influencing positive values of students?
        - Any examples?
        - Data?
        - Reporting?
        - Monitoring

8. What is your perception of the quality of the content of the GDHR resource? What feedback do you receive?

- Is it engaging?
- How easy is it to navigate?
- Is anything missing?
- It is keeping up to date
- Age- (year level) appropriate and aligned with Australian and state curriculum requirements?
- Shares/disseminates useful state-of-the-art information about RSE?
- Give credibility to RSE as an important area of health education?

9. What are practical ways in which the GDHR online curriculum support resource might be further strengthened or improved (if it can be)?

10. What might you hope to see in the future (done better or differently) in relation to RSE in general or GDHR in particular?

- What are the potential benefits you hope to see from RSE in the medium to long-term?
- What might need to change and what is required to make it happen?
  i. Health Promoting Schools framework?
  ii. RSE taught across the whole curriculum?
  iii. Network of support amongst RSE teachers?

11. For whom and in what circumstances do you think GDHR works best, when it does work well?

12. Is there anything else you would like to say about GDHR?