GDHR Impact Evaluation:
A Desktop Literature Review Identifying 'Best Practice' in School-based Relationships and Sexuality Education

John Scougall Consulting Services

Table of Contents

List of Tables

1. Introduction

This literature review forms part of a broader evaluation of the Growing and Developing Healthy Relationships (GDHR) resource used by teachers. GDHR provides online relationships and sexuality (RSE) curriculum support for educators working in WA schools. The initiative contributes to ensuring students receive quality relationships and sexual health education at school. This review discusses aspects of the literature related to the 'best practice' of RSE.

The reason for identifying best practice is to establish benchmarks against which the characteristic features of GDHR might be assessed in subsequent work, thereby identifying potential areas for improvement. Knowing best practice opens up the possibility of transforming initiatives so that increasingly they reflect the leading edge of innovation and success as standard practice. Comparing the GDHR against recognised best practice criteria is a way in which to identify areas where there is scope to strengthen, modify or add value. The notion that initiatives can be purposely designed and re-designed in this way has deep roots in the literature of policy evaluation, management and organisational theory (Owen & Rogers, 1999; Taylor, 2001, 2003).

The literature related to RSE is vast, enabling this review to draw from multiple sources that include books, journal articles, conference papers, policy documents, and websites. Authors include academics, government agencies and practitioners. The methodologies they have employed include case studies, surveys, reviews, evaluations, expert opinions, community consultations, descriptions of processes of material resource development, practical experience and randomised control trials.

The 'snowball' technique was used to identify relevant literature. Sources identified in the GDHR resource materials led to other pertinent literature, which in turn led to more. Information collected in this way provides the bulk of material included in this review. The extensive bibliography is the end product of this process.

Literature beyond that which is specific to school-based RSE has also been explored so as to enable the evaluator to include findings on what makes for effective capacity-building more generally. Due to time constraints two primary sources have been relied upon: 'Good Practices and Pitfalls in Community-based Capacity Building and Early Intervention Projects' (Cooper et al. 2005), and 'Using Training to Build Capacity for Development: An Evaluation of the World Bank's Project-Based and WBI Training' (IEG, 2008), available online at https://openknowledge.worldbank.org/handle/10986/6312.

Searches for school-based relationships and sexuality education on the web were undertaken to identify initiatives similar to GDHR operating in Australia and Canada (which may be considered a comparable context). Examination of these and other health promotion resources used in schools makes it possible to explore similarities and differences between these resources and GDHR. The World Health Organization's (WHO) Ottawa Charter (WHO, 1986) describes health promotion as "the process of enabling people to increase control over, and to improve, their health". It is noted that a key aspect of

recognised best practice is to create opportunities for local communities to become involved and potentially lead initiatives, with diminishing reliance on external resources over time.

It is important to note that not every initiative is written up, and consequently not all evidence of best practice can be accessed in written form (Willis et al. 2005). As Greenhalgh et al. (2003) point out: "Evidence in education should include not only formal, research-derived knowledge but also tacit knowledge (informal knowledge, practical wisdom, and shared representations of practice)." In the instance of this GDHR evaluation, fresh localised evidence has been collected using an online survey, interviews, a workshop and case studies.

The format of this literature review is to firstly establish the general case for investment in school-based RSE, secondly to define what might be understood as best practice, and thirdly to identify practices emerging from the literature review that might be posited as best practice and explain why each might be considered to be such.

2. The Case for School-based RSE

The case for school-based RSE as a form of sound public investment is firmly established in the literature (WHO, 2015). Indeed, it may be the most effective means of delivering RSE to school-aged children.

Education and health are inextricably linked. Health status impacts on school performance because healthy students tend to be better learners. Those students with relationship and unresolved sexuality issues tend towards poorer academic achievement and social functioning. Furthermore, it has been demonstrated that school-based intervention can be effective in maintaining positive health behaviours and reducing risk-taking behaviour amongst students over the life course (WHO, 2015).

There is a high level of need for RSE amongst Australian youth. The Fifth National Survey of Secondary Students and Sexual Health (Mitchell et al. 2014) collected data from over 2000 Year 10–12 students attending public, catholic and independent schools. Half of the Year 12 students had experienced sexual intercourse. A quarter of students reported an experience of unwanted sex. The practice of exchanging explicit text messages was routine. Most boys watched pornography. The concern at this stage is that students may not be developmentally ready to process what they view and may therefore be at greater risk of engaging in high-risk practices without first establishing a healthy and respectful sexual identity. Young people may have limited perception of the potential consequences of sexually related risk-taking behaviour and the possible impact on family and friends.

The rationale for including RSE in schools is strong. Firstly, the risks for young people are greater than for others. These include unplanned pregnancy, abortion, sexually transmitted infections (STIs), infertility and psychological damage. It is known that teenagers have higher and increasing rates of STIs and blood-borne viruses (BBVs) than other age groups (Commonwealth of Australia, 2014). There are also other risk factors. The incidence of students being abused, bullied or assaulted because of their sexual orientation is high (Dyson, 2008; Hillier et al. 2005). There are high rates of child abuse and there are some children exposed to sexualised behaviour at a very young age.

Secondly, it is known that youth are receptive to school-based RSE because they generally tend to regard it as relevant, trustworthy, confidential, safe and non-judgemental. In their survey, Mitchell et al. (2014) found that Australian secondary students generally see schools as a reliable source of information. It indicates there is a pre-existing foundation of trust upon which RSE can build. For many students school is a primary source of such education.

Thirdly, there is evidence that RSE can give young people the tools they need to help protect themselves from harm where the focus is on students accepting responsibility, recognising consequences and knowing what action they can take to optimise their personal health and safety. International research suggests that the impact of school-based programs can be profound, and that sexuality education, well implemented, can lay the foundation for a safe and fulfilling passage to adulthood (UNFPA et al. 2015).

Known benefits of RSE can include:

a. providing valued opportunities for young people to learn factual information and discuss relationships and sexual health issues outside their homes;

b. increasing the confidence and ability of adolescents to make informed decisions;

c. delaying the age at which sexual activity commences;

d. decreasing the frequency of sexual intercourse;

e. reducing risk-taking behaviours;

f. increasing the use of contraception;

g. reducing the incidence of sexually transmitted infections;

h. reducing teenage pregnancy rates, a factor associated with lifelong health, social, and education disparities; and

i. having a positive impact on attitudes and values associated with evening out power dynamics in intimate relationships, thus contributing to the prevention of abuse and fostering mutually respectful and consensual partnerships (WHO, 2015; UNFPA, 2015).

In 2016 the Royal Australasian College of Physicians (RACP) added its voice through its Sexual and Reproductive Healthcare for Young People Position Statement (RACP 2015) by advocating, in the interests of the healthy sexual development of young people, for evidence-based relationships and sexuality education curricula in Australian schools.

3. Defining Best Practice

'Best practice' is the process of drawing from a range of credible and relevant evidence and appropriately adapting it to a particular context, in this instance RSE education and training. According to Willis et al. (2005) it is an approach, activity or strategy found, on the basis of evaluation and research evidence, to produce outstanding results and which can be adapted to improve effectiveness, efficiency, outcomes, and innovation.

Interest in best practice is driven by public interest in ensuring sound public investments, backed by reliable and robust data. A best practice approach matters to the extent it contributes to identifying 'what works'.

The term 'best practice' is open to critique on the grounds it implies a universal standard of what is 'best' and a rigid rule-based process for determining it. In fact, all initiatives are context-bound (Rogers et al. 2008). For this reason some writers prefer to use terminology such as 'models of good practice', 'evidence-informed practice' (Nutley et al. 2007) or 'evidence-led' practice (Gray, Plath & Webb, 2009). The use of such alternative language correctly places emphasis on the need to learn from the evidence and then apply and adapt it to a particular context.

A best practice approach seeks to discover 'What works for whom and in what circumstances?' There is simply is no one right way in every situation. What is 'best' always depends on the fit between a particular action, people and place. RSE is a dynamic process involving interaction between different educators, different agencies and different communities at different points in history. Inevitably it produces variable outcomes.

It is also important to remain open to the possibility there may be several good ways of doing things, reflecting that various stakeholders and audiences may have different needs. An effective health-promotion initiative is necessarily tailored to meet the needs of a particular target group. What works with students and teachers in Nedlands may be different from what works in Halls Creek. Patton (2001) writes:

> "In a world that values diversity, many paths exist for reaching some destination; some may be more difficult and some more costly, but those are criteria that take us beyond just getting there and reveal the importance of asking, 'best' from whose perspective using what criteria?"

Not all information, evaluation and research are of sufficient quality to serve as a reliable guide to practice. The quality of any body of evidence is always variable. Identifying RSE best practice is rendered difficult by a lack of methodological rigour and the existence of gaps in the evidence base. Willis et al. (2005) write:

> "Although we identified a large number of interesting and important studies, most studies that we reviewed did not even reach the threshold level of methodological quality. Many of the studies were descriptive, and reported on consultation processes and program design, but not on the outcomes of the intervention …"

For the purposes of this review, best practice is understood to be an aspect of a practice that satisfies the following criteria:

a. **Trusted source**: The information relied upon is known to have originated from a source with recognised expertise and reputation. A trusted source may include a peer-reviewed publication or professional journal or validation by a reputable body or group. It may also encompass the 'practice-based evidence' of recognised expert leaders and experienced practitioners in the field.

b. **Plausibility**: The relationship between variables can only be said to be strong if it is underpinned by some plausible theoretical explanation for what is going on (Miles & Huberman, 1994). A good fit between the theoretical knowledge about what works and the practice knowledge of what works provides plausibility. By itself, a mere association between action and positive outcome is not sufficient to prove causation, nor is it a basis on which to conclude best practice. Theories and models of behaviour that purport to explain the mechanisms of how and why an intervention may work are also required.

c. **Relevance/Embedded**: All knowledge needs to be sieved for context relevance before it is applied. The evidence of what works needs to be derived from sources close to the particular context of the initiative being examined. Evidence about what works drawn from the actual experience of RSE in Australian schools has a higher level of local validity than other evidence. This is because it is derived from 'what happened' in a similar social and cultural context. Such data is especially useful because it can impart an understanding of the circumstances under which an intervention might be expected to work. Thus, evidence drawn from Australian schools should be accorded greater weight than, say, an evaluation conducted in Africa.

There are some practices that may meet some, but not all, of the criteria of best practice outlined. These have been included in this review because they are 'promising practice'. Potentially, such practices may come to be regarded as best practice over time, after more evidence is gathered. The credibility, reliability, veracity, relevance and appropriateness of all evidence must be weighed. Some evidence is stronger than other evidence (Willis et al. 2005). Willis et al. (2005) outline a hierarchy of methodological quality. They favour analytical case studies and randomised control trials as providing 'higher order' evidence.

In the process of seeking to identify best practice, it is important to acknowledge there will always be uncertainty and disagreement about what constitutes it. Judgement is based on both facts and values. Furthermore, evidence is always incomplete and the search for more goes on infinitely. As a result, views about what constitutes best practice may morph and change over time.

There is scope to improve the quality of the evidence underpinning the best practices identified in this review. Doing so would increase confidence that the practices identified are indeed best. As things stand, much of the available evidence is towards the low end of methodological quality, highlighting the need for more systematic evaluation and research.

4. Best Practice RSE

This section of this synthesis posits seven best practices for school-based RSE drawn from the evidence available to the evaluator in the literature examined, as summarised in Table 1 below. These practices have been identified by the evaluator based on a review of the available evidence from those written sources that have been accessed. During the process of developing this set of principles, the evaluator also obtained input from those who attended a GDHR Program Logic Workshop and from the GDHR Evaluation Reference Group.

Table 1: Criteria of sexual health education best practice

Best Practice	Trusted Source	Plausible	Embedded
Comprehensive Content	Yes	Yes	Yes
Age appropriate	Yes	Yes	Yes
Delivered by educators trained in RSE	Yes	Yes	Yes
Informed by independent expertise	Yes	Yes	Yes
Commitment to continuous improvement	Yes	Yes	Yes
Whole-school context	Yes	Yes	Yes
Inclusive of community	Yes	Yes	Yes

Those practices identified as best practice satisfy triple criteria, namely they derive from a 'trusted source', they are 'plausible' and they are 'embedded'. The term 'trusted source' refers to the practice of drawing on the expertise of respected researchers, evaluators and practitioners. In this context the term 'plausible' means consistency with theoretical knowledge and sequential logic. And the description of a practice as 'embedded' indicates that it is routinely used and recognised as effective in a similar context.

Previous evaluation work undertaken in Western Australia by the Information Access Group (IAG, 2012) identified best practice pedagogy in relation to GDHR. An Evaluation Reference Group established by SHBBVP to work with the Information Access Group subsequently endorsed the recommended pedagogical approach. The principles identified by the IAG (2012) have informed, are consistent with, and have been subsumed into this review of best practice. Key factors identified by the IAG (2012) include:

a. clearly defined learning outcomes for students;
b. recognition of a range of learning needs and styles;
c. use of ICT tools and activities that engage students and develop skills;
d. student assessment in-built as an integral element of a teaching-learning resource;
e. established curriculum standards;
f. adoption of a strength-based approach that does not 'pathologise' or 'medicalise' sexuality;
g. a whole-school health promotion model; and

h. student inquiry-based learning.

The seven best practice principles identified in this evaluation are set out in the first row of Table 2 (below). Each column lists a series of six points describing the best practice criteria. These are in effect summaries of the range of available evidence that warrant the naming of any particular practice as best practice. The GDHR initiative has been benchmarked against each of these points later in this evaluation.

Table 2: Seven principles of best practice in school-based RSE

1. CONTENT IS COMPREHENSIVE	2. AGE APPROPRIATE	3. DELIVERED BY EDUCATORS TRAINED IN RSE	4. INFORMED BY EXPERTISE	5. COMMITMENT TO CONTINUOUS IMPROVEMENT	6. WHOLE-SCHOOL APPROACH	7. INCLUSIVE OF COMMUNITY
1.1 Resource imparts both factual and values content in areas such as reproduction, the characteristics of respectful relationships and diversity.	2.1 Content is provided across all years of schooling with materials appropriately and logically sequenced from early childhood to adolescence.	3.1 Delivered by male and female educators such as qualified teachers, school nurses, counsellors and community educators with specialised expertise in RSE.	4.1 Informed by behavioural theory.	5.1 Process of systematic data collection to enable judgments to be made about how well the resource is working.	6.1 Online curriculum resource is located within a broader 'health promoting schools' framework.	7.1 The development of the RSE resource follows a partnership model in which agencies work together.
1.2 Resource provides a varied range of pedagogically sound instruction methods and tools to teach RSE.	2.2 Resource materials align with curriculum standards and are demonstrably evidence-based.	3.2 Teaching-learning materials are freely and easily accessible to educators.	4.2 Resource draws on RSE research and evaluation literature.	5.2 Benchmark comparisons made with other RSE online curriculum resources used in schools.	6.2 School leadership is actively supportive of RSE and have RSE policies and procedures in place.	7.2 The resource is non-judgemental, non-discriminatory and respectful of diversity and difference in gender, sexual orientation, faith, culture and values.
1.3 Resource encompasses the teaching of protective behaviours and promotes harm minimisation.	2.3 Clear learning objectives are established for each year.	3.3 RSE capacity-building initiatives are informed by training needs analysis.	4.3 Resource is informed by curriculum expertise.	5.3 Opportunities to learn from, and share ideas with, similar initiatives operating elsewhere.	6.3 Schools work to ensure adequate space for RSE in a crowded curriculum, and explore opportunities to teach RSE in learning areas beyond the Health and Physical Education curriculum.	7.3 There are opportunities for educators to enhance their cultural competence.

1. CONTENT IS COMPREHENSIVE	2. AGE APPROPRIATE	3. DELIVERED BY EDUCATORS TRAINED IN RSE	4. INFORMED BY EXPERTISE	5. COMMITMENT TO CONTINUOUS IMPROVEMENT	6. WHOLE-SCHOOL APPROACH	7. INCLUSIVE OF COMMUNITY
1.4 Resource includes activities that enable students to make informed personal and interpersonal decisions and choices.	2.4 Informed by current curriculum expertise and pedagogy, and current recommended models of curriculum support for school-based RSE educators.	3.4 Educators have opportunities to access RSE training and PD in which adult learning principles are upheld.	4.4 Resource is informed by information and communication technology and state-of-the-art website design and graphics.	5.4 Periodic independent audit, review and evaluation of the resource.	6.4 Schools actively promote use of the GDHR resource by teachers.	7.4 Information about RSE resource content is freely available to parents/carers.
1.5 Resource is relevant to current issues in RSE.	2.5 Educators are resourced with a set of guiding educational principles, not just content.	3.5 The resource supports educators to feel both competent and comfortable when teaching RSE.	4.5 Experienced school-based RSE educational practitioners have opportunities to input into resource development.	5.5 Curriculum resource is responsive to technological and value changes in the social context over time.	6.5 Schools provide incentives to motivate educators to teach RSE.	7.5 Parents/carers have access to RSE resources that compliment and support them in their educational role with their children.
1.6 Resource promotes access to relevant community services.	2.6 There are opportunities for high school students to engage in inquiry-led learning and have input into RSE content and process.	3.6 Sustained support is available to RSE educators in the form of coaching and mentoring.	4.6 There are checks for compliance with government policy and legal requirements.	5.6 Input of parents and carers into school-based RSE is openly encouraged, demonstrating adaptation and responsiveness to local community needs.	6.6 School-based RSE educators have opportunities to network with each other as part of a community of practice.	7.6 Local communities are encouraged to take responsibility for RSE issues.

5. Best Practice 1: Comprehensive Content

An online RSE curriculum resource needs to have comprehensive content. Credibility for the resource demands that it be clear, accurate, unambiguous, engaging and authoritative. Educators using the resource also need to be informed and equipped with relevant knowledge and skills to provide students with the factual information and social skills necessary to make informed personal and interpersonal choices.

The aim is that students be able to:

   a.   reflect upon and understand their own personal values and beliefs relating to RSE;
   b.   make sound relationship decisions and have the confidence to stand up for them;
   c.   recognise potentially risky situations and deal assertively with them;
   d.   access help and support from reliable sources; and
   e.   negotiate safe-sex practices.

The World Health Organization (WHO) promotes a model of 'socially determined' health (WHO, 2008), and understands it to be a function of the living conditions in which people are born, grow, live, work and age. WHO (2008, 2015) defines sexual health as a state of well-being achieved when people possess:

   a.   a level of personal knowledge and skills sufficient to enable them to make healthy life choices;
   b.   the ability to enjoy and control sexual behaviour based on personal and social values;
   c.   freedom from fear, shame, guilt and violation which erodes self-esteem and harms individuals, communities and relationships;
   d.   freedom from disease and the absence of unplanned and unwanted pregnancy; and
   e.   the freedom and right to choose positive expressions of sexuality.

For further information go to: http://www.who.int/topics/sexual_health/en/.

RSE curriculum content ought to be about more than basic information (Harrison & Ollis, 2015). RSE health promotion work long ago moved beyond the dissemination of the 'facts of life'. According to Dyson (2008): "Whether sexuality education occurs in school or in the context of the family, it should be more comprehensive than the simple provision of information." Equally, RSE ought to be about attitudinal and values content in areas such as enacting respectful relationships from an early age. A foundation of respectful relationships is necessary to improve young people's ability to have rewarding relationships and to negotiate safe sex. The process involves the development of positive values and patterns of behaviour from the beginning of schooling until the end (WHO, 2015).

The most effective RSE initiatives examine the character of positive relationships, teach social and life skills such as assertiveness, and also discuss human emotions and values such as affection, intimacy, love, jealousy and anger (Bunker et al. 2002). A five-year research project sponsored by the W. T. Grant Foundation in the US sought to identify factors crucial

to the success of effective RSE initiatives. A key factor is self-awareness, such as the ability to read social and emotional cues and understand what is and is not acceptable behaviour. Also, a developed capacity to identify and express feelings and control impulses was found to enable young people to make better, more informed, decisions and choices. The findings lend support to the development of interpersonal skills that enable students to express their thoughts and emotions, know their boundaries and resist negative influences.

A recurring theme in the literature is that young people who experience comprehensive RSE are better able to protect themselves because they are more likely to be assertive and speak up (Goleman, 2005). It is therefore critically important for a curriculum resource to encompass the teaching of protective behaviours and harm-minimisation strategies (Goleman, 2005). Children need to be able to distinguish between situations that feel right and wrong, and between good and bad touching. Goleman (2005) writes:

> "No single kind of intervention, including one targeting emotions, can claim to do the whole job. But to the degree emotional deficits add to a child's risk – and we have seen that they add a great deal – attention must be paid to emotional remedies, not to the exclusion of other answers, but along with them."

A state-of-the-art RSE curriculum resource that seeks to uphold WHO (2008, 2015) standards necessarily needs to be broad in scope. Typically, such a resource would need to encompass information about:

    a. the reproductive system;
    b. sexuality;
    c. student health literacy, resilience and personal capability;
    d. communication strategies;
    e. respectful relationships and what constitutes healthy and abusive relationships;
    f. consent;
    g. protective behaviours;
    h. emotional intelligence, including skills of empathy, communication, managing stressful situations and assertiveness;
    i. pregnancy;
    j. contraception;
    k. relevant aspects of women's and men's health;
    l. parenting;
    m. harm- and risk-minimisation;
    n. safe sex;
    o. peer influence;
    p. gender and diversity;
    q. stereotypes and how to challenge them;
    r. contemporary issues such as pornography, sexting and cyber-bullying; and
    s. access to support services.

The evidence is that those RSE resources that only provide basic factual information don't work very well. Goleman (2005) argues such interventions leave children vulnerable:

> "A national [US] survey of two thousand children found that … basic training was little better than nothing – or actually worse than nothing – in helping children do something to prevent being victimized, whether by a school bully or a potential child molester. Worse, the children who had only such basic programs and who had subsequently become victims of sexual assault were actually half as likely to report it afterward than were children who had had no program at all."

Teachers and students are only likely to make use of a curriculum resource if it demonstrates contemporary relevance, a point reinforced repeatedly throughout the entire evaluation. Changes in the context are always in progress, placing ongoing demands on the capacity of staff and governments to respond. There are pedagogical changes afoot to the ways in which schools teach. The teacher remains a definite role model and influential adult communicator, and potentially a powerful and positive influence on students. However, the post-modern student tends to be more independent and self-directed than in previous generations. The critical point of student engagement in learning is becoming less teacher-centric, with students directly engaging with resources. The trend has implications for the future design of curriculum resources and the assumptions about how students learn that underpin them.

A comprehensive RSE resource is one that seeks to normalise sexuality and respectful relationships, and reduce any misplaced sense of shame. Getting young people to use support services has long been problematic due to feelings such as fear and guilt. Therefore a fundamental aspect of any effective RSE initiative is the promotion of access to confidential, relevant and high-quality service providers (Miller & Torzillo, 1998). RSE resources ought to promote awareness and access to appropriate RSE health services for adolescents so that they know where to turn if they do need help.

Beyond the teaching of RSE in the classroom, schools can provide a support system for individual students in need. Effective initiatives teach young people that they have a network of support. This may start with parents, carers and teachers, but it may also extend outwards to others. The resources and services about which school students are made aware do, however, need to be carefully screened to ensure social, cultural and political acceptance. Failure to do so is a risk factor for every RSE initiative.

6. Best Practice 2: Age Appropriate

The use of age-appropriate materials accords with current recommended models of curriculum support (Mazin, 2014). Ideally, students experience RSE as a staged process in which they come to understand, in age-appropriate ways, how sex fits into their world. Age-appropriate RSE curriculum content is purposely designed for delivery across all years of schooling, from early childhood through to adolescence. In the early years the focus is on educating children about sex differences, reproduction and puberty, with content shifting over time to talking with older students about sexuality more broadly (Dyson, 2008). Lessons are taught in a structured sequence as students progressively move from one level to another.

Early commencement of RSE is generally regarded as critical (WHO, 2015). It makes it possible to place discussion of sexuality within a broader healthy lifestyle context, laying the foundations for enduring relationship and sexual health (Dyson, 2008). RSE may be conceptualised as an integral, lifelong process of acquiring information and forming attitudes, beliefs, and values about relationships, personal identity and intimacy (SIECUS). Ideally, it begins long before people become sexually active. According to Dyson (2008): "There is general agreement among 'experts' in child rearing that sexuality education should start early, be age-appropriate, and be dealt with in an open, natural way." The evidence is that learning delivered over the whole course of the school years, building to ever higher levels over time, lays the foundation for open discussions about sexuality later in adolescence (Dyson, 2008; Goleman 2005).

Effective RSE is an ongoing social process that transforms what may formerly have been considered a 'taboo' topic into everyday discourse. A reason to start RSE early is that the subject matter comes to be regarded by both teachers and students as routine. This contributes towards an orderly environment devoid of the embarrassment and disruptive behaviour that can be associated with some RSE classes. Fear of speaking up and feeling shy, shamed or intimidated are all common barriers to RSE teaching and learning.

Effective class management is foundational to effective teaching and learning (Freiberg, 1999). It allows a teacher to facilitate an RSE class, comfortable in the knowledge that this group has, in a sense, been prepared for the lesson over their entire schooling. They have had prior foundational RSE learning, built incrementally since kindergarten. Beyond this the classroom behavioural dynamics that contribute to mutually respectful relationships are ingrained. There may be already embedded within the group a valuing of standards of acceptable behaviour, cooperation and mutual respect. In such an environment student learning about RSE has a chance. Conversely, a failure to build a strong foundation makes the job of the teacher more confronting and challenging than it might otherwise need to be, for all concerned.

The planned delivery of RSE throughout the whole of schooling has been found to work better than the delivery of ad hoc classes (Goleman, 2005). There was a time when RSE might not have started until around Year 8 or 9, if indeed it was taught at all. Indeed, a survey conducted in 2011 into sexual education in Australian secondary schools still found it

was often the case that sexuality education is mostly concentrated in years 9-10 (Smith et al. 2011).

The evidence is that RSE is less effective when confined to the latter years of schooling or taught as a one-off series of classes. In the Netherlands, for example, age appropriate RSE is embedded in the school curriculum, and the country has achieved one of the lowest teenage pregnancy and abortion rates in the world (Wiefferink et al. 2005; Ferguson et al. 2008; Van Keulen et al. 2015; De Graaf et al. 2011; Bachus et al. 2010). In Australia there is debate around whether too little RSE might be taught in schools (Milburn, 2006).

The literature suggests that teachers want curriculum resources that equip them by providing the guidance of clear learning outcomes for every year level, specifying the knowledge, skills, and values to be learnt. It therefore needs to be abundantly clear that any RSE resources they might consider using are aligned with national and state curriculum standards for Health and Physical Education. A sound curriculum resource must, by definition, follow the scope and sequence of the curriculum which teachers are obliged to teach.

A key reason for the substantial investment in the development of GDHR by WA Health in recent years has been to ensure the resource is consistent with new curriculum standards coming into force in WA schools. School curriculum identifies achievement standards for students. GDHR needs to be clearly aligned with the curriculum if it is to be delivered. Health promotion work can only occur in schools if it is first shaped to fit an education agenda, one primarily determined by education authorities, and not the health sector. The Australian Curriculum Assessment and Reporting Authority (ACARA) carries responsibility for implementation of the national curriculum. The School Curriculum and Standards Authority (SCSA) is responsible for the Health and Physical Education syllabus in WA. Whereas historically it was largely left up to individual schools and teachers to determine what RSE was taught and when, now RSE has an established place in the curriculum.

In September 2015 federal and all state and territory ministers for education endorsed a new national Australian Health and Physical Education school curriculum. Aims include the development of student knowledge, skills and understandings to equip students to:

a. access, synthesise and evaluate information;
b. take positive action to protect, enhance and advocate for their own and other's health, well-being and safety;
c. develop and use personal, interpersonal, behavioural, social and cognitive skills and strategies;
d. promote a sense of personal identity and well-being;
e. build and maintain positive relationships; and
f. analyse how varied and changing personal and contextual factors shape understanding of, and opportunities for, health and physical activity locally, regionally and globally.

A sound curriculum resource is also one that explicitly aligns with the current practice of pedagogy and specifies its philosophical origins. The theoretical roots of the age-appropriate approach to RSE are found in the work of Bloom et al. (1956). Essentially, Bloom provides a framework for categorising educational goals using taxonomy of remembering, understanding, applying, analysing, evaluating and creating.

A comprehensive resource ought to offer educators a varied range of sound instruction methods, activities and tools with which to teach RSE. This includes the use of current terminology, and recognition of a range of learning styles to engage, explore, explain and elaborate RSE. Teaching also needs to be sufficiently flexible to accommodate different levels of student development, achievement and diverse learning styles (visual-spatial, auditory-linguistic-musical, tactile, bodily kinaesthetic, interpersonal, intrapersonal, linguistic, logical-mathematical, theoretical, pragmatic and reflective (Fleming, 1995).

The materials used in a school-based RSE should be evidence-based, which is to say they have been routinely found to work well in school environments. The teaching-learning also ought to vary over the schooling cycle. By way of illustration, some of the techniques routinely used in RSE classes include:

- body-parts brainstorm;
- true-false statements;
- listing advantages and disadvantages to inform decision-making;
- creating a safe-space activity;
- weighing costs and benefits of alternate courses of action;
- identifying the characteristics of STIs and viruses;
- discussion of issues such as media representation and body image;
- listing information sources;
- identifying stereotypes, facts and myths;
- student group work;
- homework research (sometimes requiring parental involvement);
- class presentations;
- role-plays and scenarios;
- use of checklists;
- classroom demonstrations;
- use of concrete and visual aids;
- independent, student-led inquiry;
- debate;
- framed discussion;
- interactive online activities such as a blog or wiki;
- risk continuum;
- values continuum;
- card clusters;
- mind mapping;

- graffiti walk;
- circle talk;
- jigsaws;
- videos;
- demonstrating an emotion;
- classification;
- planning;
- statement responses (agree/disagree);
- risk-assessment scenarios and minimisation strategy; and
- independent research.

Work by IAG (2012) identified opportunities for GDHR to more closely align with contemporary Australian pedagogical practice by adopting a student inquiry approach that recognises their analytical capacity and that they are not merely passive recipients of knowledge. IAG (2012) suggested that teaching-learning resources like GHDR recognise students as stakeholders, able to contribute their own knowledge and understanding of their own physical, social and emotional health issues.

Engaging the voice of young people in the development of a curriculum helps ensure relevancy and demonstrates a valuing of student experience (Gleeson et al. 2015). An educator should therefore seek to engender an atmosphere of trust. They must be seen to respond with empathy and compassion to what students say. It is only through the maintenance of good relationships that a teacher can hope to influence learning outcomes and values. Learning may be regarded as most effective when it involves two-way processes in which both teachers and students have some influence over content. Students expect opportunities to have some input into what is taught.

An example of student-centred learning is where a group undertakes a research project. WebQuests are one way in which students might build their investigative skills and become self-reliant learners. A WebQuest is an inquiry-led lesson format where learners seek out the information they need on the web. A WebQuest is created using links to websites and is illustrated on the Canadian Sex and U website www.sexandu.ca/.

The Health and Physical Education learning area of the Australian Curriculum seeks to foster a student inquiry approach, also known as a student-led or inquiry-based investigation. A stakeholder survey conducted by the IAG on behalf of SHBBVP in respect of GDHR found that inquiry-based learning is regarded as an important aspect of sound pedagogy (Thomas et al. 2012). It is older students in middle high school who have opportunities to engage in inquiry-led learning. Student inquiry involves the development of more advanced analytical skills suitable in high school, but it is not generally considered relevant to primary school.

An effective RSE resource may seek to equip older students with the knowledge and skills to analyse current issues. For example, pornography may come to be understood as a product made for commercial rather than educational reasons. It may sometimes depict unsafe

practices. It may also contribute to the normalisation of violence and partner abuse. These are leading preventable causes of illness, injury and death for Australian women aged 15-44 (Department of Human Services, 2012; COAG 2012; & VicHealth 2004).

The literature stresses the value of those who are sufficiently responsive to be able to recognise opportunities wherever and whenever they might arise in an increasingly frenetic world (Goldsworthy, 2005). The critical factor is no longer what the teacher knows but rather how quickly they can adapt to what is happening around them. The post-modern teacher is expected to modify and adjust group and individual student learning experiences to ensure relevance, tailoring lessons to different developmental needs and starting points. Rather than being a primary source of information, the teacher facilitates and guides self-directed learners to sources of information that respond to their particular needs and interests. No longer is the teacher positioned as the one with the answers. Instead, they reflect student questions back to the class to draw out knowledge and experience.

A flexible educator is one who is alert to their environment. The onus is on them to be able to adapt to opportunities and demands in a variety of ways. Variable contexts demand different teaching and learning styles. An educator competent with a group in a particular situation may be less so in another. Change the topic and/or the environment and the learning outcomes may be different. The best teachers are responsive, adapting sessions and materials to the diverse learning needs of particular classes at particular times. Education is not a simple process of preparing one lesson that is appropriate for all because students do not always react in the same way to the same presentation.

The idea that teachers need to be flexible has theoretical support. 'Chaos Theory' posits that structures, systems, policies, procedures, initiatives, organisations, communities and technologies are always in a state of non-equilibrium (Devaney, 1986). Instability and dynamic human interactions are the norm. Seen from this perspective, RSE, teachers and school curriculum are understood as always operating in a state of dynamic and unpredictable flux. The most effective educators in such an environment are those who can adapt resources to situations. Not only do they accept the inevitability of change, they openly embrace it as a potential source of new teaching-learning opportunities.

The Youth Development Assets Approach is one emergent, promising way of working with students by developing a sense of connection to school (Aspy et al. 2012). Students receive positive acclamation and empathetic social support in order to encourage a sense of belonging that is likely to reduce engagement in high-risk behaviour. According to Aspy et al. (2012):

> "School is very much a part of the lives of youth and therefore the relationship they have with their school experience is important and may influence their involvement in risk behaviours. Feeling connected to school is a positive asset that can protect youth from such risky behaviours as sexual initiation and alcohol consumption."

7. Best Practice 3: Delivered by Educators Trained in RSE

RSE that is delivered by educators who have been trained in RSE is best practice. While a generalist teacher may be a sound teacher of RSE, the evidence is that access to quality curriculum resources and specialised professional development (PD) generally makes for better delivery of RSE.

Having the general skills of a trained teacher is one thing; filling the niche of an RSE teacher may be another. At issue is whether general teacher training is sufficient to be effective in what can be, arguably, one of the most difficult of all specialised teaching tasks. Teachers may appear to be well placed to deliver RSE by virtue of their pre-service training, qualifications and subsequent professional development. However, Australian research indicates teachers of Year 9 and 10 students tend to have little confidence in their capacity to teach RSE and feel they would benefit from opportunities for more specialised in-service PD (Ollis, 2013). It is also noted that there are no specific pre-requisites to teach RSE in schools, and there is no quality control system to oversee delivery.

There is now a broad national curriculum in place, but it is still up to each teacher and school to determine how they implement it. Having a national curriculum does not change the fact that teaching RSE requires considerable judgment on the part of the educator to discern what is appropriate for a particular group in a particular situation in a particular community. A barrier for teachers of RSE is the fear of inadvertently overstepping content and social-value boundaries.

The available evidence suggests that educators involved in the delivery of RSE ideally ought to have opportunities to access professional development. Curtin University has been contracted by the WA Health to deliver RSE in-service training to Western Australian teachers. Pre-service teacher-training courses generally involve some learning about RSE, but it is not always extensive. Curtin University is an exception, offering elective undergraduate units in sexology and opportunities for postgraduate study. Nevertheless, it is understood that few trainee teachers choose these options.

No prior training is mandated to deliver the GDHR resource in the classroom. By way of comparison 'Keys for Life' is a pre-driver education initiative for schools in WA designed to develop positive driver attitudes and skills. It is delivered by SDERA. Like GDHR, the Keys for Life initiative seeks to provide young people with the knowledge, skills and attitudes that enable informed and responsible decisions about safety and looking after others in challenging situations. More than 100,000 school students in WA have completed the program. Teachers involved in the delivery of SDERA's Keys for Life program are required to attend a professional learning workshop teaching in order to become a registered Keys for Life educator. Only then are they emailed a user name and password which enables access to a suite of classroom learning resources.

Any initiative designed to raise the capacity of educators needs to uphold adult learning principles. Such principles have an established place in educational theory and practice (IEG,

2008; Knowles, 1980; Kolb, 1984; Baumgartner & Merrian, 2000). Key principles include the following:

- Adults learn best when they perceive the subject matter as interesting and relevant. Establishing a clear link between the objectives of any resource and the needs of participants is crucial in developing a sense of ownership (Chambers, 2002).

- Resources need to be practical. The use of participatory exercises, discussions, scenarios and games are some of the ways to foster an environment in which knowledge and experience can be shared.

- The literature suggests people learn better and remember more when they are actively engaged in experiential learning. There needs to be opportunities to apply the acquired knowledge and skills.

- Participants ought to receive feedback on their workplace performance. Doing so can build confidence and provide a sense of progress towards objectives.

- The teaching-learning strategies employed ought to be flexible and responsive, rather than adhering too rigidly to any predetermined pathway.

- Adult learners generally learn best when materials are designed to focus their attention on key messages.

- Adults appreciate having opportunities to check their understandings by asking questions, listening to group discussions and using techniques and terminology known to the group.

Ideally, educators need to feel both capable and comfortable. A teacher about to commence a lesson may have an easy confidence drawn from opportunities to practise their delivery stemming back to their pre-service training and extended in subsequent PD. Furthermore, the teacher may have a capacity for critical self-reflection on their own performance, imbued from their training. Alternatively, none of these things may be true as the teacher nervously faces their first RSE class with only generalist foundational knowledge upon which to draw.

Ultimately, RSE is something teachers do in the classroom, not something they read about. Mastery requires the application in the real world. It involves learning by doing. The available evidence is that the application of new understandings, skills and capacities at work is most effective when practised over time. It is critical to provide opportunities to apply skills (IEG, 2008). Work commissioned by the World Bank found that the most effective capacity building is that which is matched to the way in which people actually do their jobs (IEG, 2008). Sound initiatives devote attention to practical exercises and activities and, as a consequence, they are directly relevant to key work functions.

> "The use of practical learning techniques is recognized in the literature as fundamental to the sustainable acquisition of skills … Research on adult learning indicates that tasks learned through practice are more likely to be remembered, particularly where more complex skills are involved." (IEG, 2008)

Capacity building is a long-term investment (IEG, 2008). Equipping educators to teach RSE is likely to require intensive and sustained support. A common shortcoming is that investment

is too short (IEG, 2008). A study for the World Bank (IEG, 2008) found that in some instances, investment only provided a beginning for what needed to be a much longer process of ongoing follow-up (IEG, 2008).

Learning is more likely to be retained when it is reinforced by follow-up support in the workplace. In the absence of close-at-hand support, initial enthusiasm is easily dashed on hard workplace realities. According to a report prepared for the World Bank (IEG, 2008), impact "depends not only on learning but also on participants' ability to implement learning in the workplace and on the relevance of that learning" (IEG, 2008).

The report for the World Bank (IEG, 2008) found that initiatives benefit from access to sources of ongoing advice and support: "Where follow-up support is not given, short-term learning gains often do not translate into sustainable behavioural change, due to participant uncertainty about how to apply the learning or lack of positive reinforcement in the workplace for learning application". A recurring problem is that those who acquire new knowledge experience difficulties applying it at work (IEG, 2008).

Coaching and mentoring are ways in which knowledge and skills might be sustained in the workplace (Goleman, 2005). Mentoring is the process of using the expertise, skills, experience, support and influence of another person to assist personal or professional development. It is a way in which people with greater experience assist those in the same field with less experience. Coaching is a 'close cousin' to mentoring, but it differs in that the focus is on the acquisition of specific skills. The coach is responsible for developing particular competencies. Coaching relationships thus tend to be short term, not enduring beyond the transfer of any particular skill. The significance of mentoring and coaching in the context of RSE is that these are techniques that focus attention on the intangible aspects of teaching and learning such as emotions, attitudes and beliefs. They are strategic in circumstances where the transfer of acquired knowledge to the workplace cannot be automatically assumed. Mentoring and coaching relationships foster a two-way exchange. These can be contrasted with a skill-and-knowledge-deficit approach to workforce development that focuses on what an individual may lack.

Mentoring is especially relevant to circumstances where:

    a. a sense of professional isolation is experienced in the workplace;
    b. close and non-threatening forms of support are required; and
    c. the achievement of outcomes requires the ongoing application of acquired skills demonstrated over the medium to long term.

The focus of mentoring is on how to improve the work of the mentee. Essentially, it is a support system that can help identify situations and circumstances that have the potential to affect individual performance. One-on-one mentoring, unlike the development of a curriculum resource or participation in PD, is an unstructured process that provides opportunities to talk freely and confidentially about any aspect the mentee chooses. The process enables the less experienced to draw on the knowledge and wisdom of the more

experienced. Building a mentoring relationship is a way to contribute to a collegiate work environment grounded in effective communication and trust.

The aim is to develop each mentee to their full potential. One-on-one meetings provide opportunities to talk freely and confidentially about any aspect of work that the mentee chooses. The focus is on how to develop and improve the work performance of the mentee. The mentor not only passes on knowledge but also wisdom gained from experience in the field. A mentor may also connect the mentee to other resources and sources of support. The literature suggests there are numerous potential benefits for the mentee:

a. opportunities to debrief;
b. feedback on work performance;
c. enhanced self-belief;
d. increased self-awareness;
e. greater capacity to self-assess work performance;
f. raised morale and job satisfaction;
g. acceptance of greater responsibility for personal and professional development; and
h. enhanced commitment to lifelong learning.

Depending on the particular needs of the mentee, a mentor may be a sounding board, trusted advisor, confidant, counsellor, protector, role model, network builder, knowledge resource, expert and advocate (Thomas et al. 2012). There are several dimensions to the role of a mentor:

a. emotional support (listening, debriefing and shared concern);
b. appraisal support (affirmation and feedback);
c. informational support (strategic advice and guidance);
d. instrumental support (resources); and
e. cultural support (cultural identity and cultural security).

A mentor may not necessarily be physically present, perhaps just someone offering guidance on the Internet. They may be internally or externally sourced.

The content of a mentoring session may involve:

a. engaging the mentee in assessing their own learning needs and planning their own actions;
b. setting priorities for action;
c. sharing information about experiences;
d. discussing how the mentee feels about the role; and
e. constructive feedback on classroom performance.

Mentoring needs to function as a two-way process of intensive feedback and critical reflection. Some mentoring relationships work better than others. Not all turn out well.

Both participants need to be receptive to ideas about how to improve performance, and to accept that they have strengths and weaknesses.

The literature identifies certain practices that can strengthen the effectiveness of a mentoring relationship:

a. careful matching of mentor and mentee;

b. formalisation of the mentoring relationship;

c. recognition that trust provides the foundation for every constructive mentoring relationship;

d. allowing sufficient time for each mentoring relationship to develop and produce results;

e. orientating both mentor and mentee to their role to ensure they understand what is expected of them; and

f. ensuring the mentoring process is planned and organised, and the process has a clear strategic purpose and agreed objectives.

The concept of mentoring finds theoretical support in the literature. It is based on the assumption that people seeking to contribute to the achievement of substantive behavioural changes may need intensive personal support in order to do so effectively.

Bandura's (1977) 'Social Learning Theory' views behaviour as the end result of dynamic interaction between personal, environmental and other factors (Willis et al. 2005). People are understood as being influenced by those with whom they share common identity in terms of key social and personal characteristics (McDonald et al. 2003).

> "There is evidence to suggest that information influence is strongest when the messenger is an in-group member. Messages conveyed by in-group members are more likely to more strongly engage the listener's attention, who, in turn, is likely to spend greater effort processing and considering the information." (McDonald et al. 2003).

'Social Comparison Theory' also infers that mentoring has value. According to McDonald et al.(2003), "People form beliefs about their own abilities and opinions primarily by comparing themselves with others who are similar in relation to relevant characteristics."

'Innovation Theory' (Rogers and Hough, 1995) lends further support to the mentoring model. It suggests innovations are communicated and spread through social networks by those respected as 'opinion leaders' or 'champions' in the field. The implication is that people with the power to influence are best placed to communicate messages through their social network. McDonald et al. (2003) write:

> "Strategies that may successfully enhance diffusion of preventative innovations include those that use opinion leaders as champions to promote preventative innovations, use peer support to change norms within the social network, use entertainment to present educational ideas, and activate peer networks to diffuse preventative innovations."

Coaching is a way of instructing a person or group to do a specific task or develop certain skills (Bennis, 1999). It involves demonstration of a skill, followed by close monitoring. The

cycle may be performed multiple times until competence is demonstrated. A set of core competencies has been developed by the International Coach Federation and is available at: www.icfaustralasia.com/.

Coaching is popular in the corporate sector, especially the '360-degree feedback' technique (Lepsinger & Lucia, 1997). This is a structured process that provides comprehensive feedback on performance in the workplace from a range of different sources and perspectives (Lepsinger & Lucia, 1997). The purpose is to identify knowledge and skill gaps, and areas requiring further development. The process can be supported by online software.

RSE work requires educators able to demonstrate emotional intelligence (Goleman, 2005; Boyatzis & McKee; 2005). This is a practice capability that can be coached, not something purely innate. Emotional intelligence encompasses:

a. empathic and connective listening, and the ability to hear and understand another's point of view and take new ideas on board in a process of shared, open communication;

b. social skills, including the capacity to relate to others non-judgementally;

c. a capacity to gain trust and develop mutual respect;

d. self-control and the ability to think things through before reacting;

e. self-awareness and the ability to understand one's own strengths and weaknesses, accept constructive criticism and reflect on one's own practice; and

f. mindfulness, understood as the capacity to distil meaning through a process of conscious, deep reflection (Goldsworthy, 2005).

Professional coaching activities can support the development of emotional intelligence by building fundamental competencies such as interpersonal communication, social skills as well as intrapersonal competencies such as self-awareness, self-motivation and self-regulation. Those who are effectively coached may be better able to display emotional strength and sensitivity, demonstrate their compassion for others, offer support and understanding, and critically reflect on their own practice with their head, hands and heart. Skills and knowledge alone are not sufficient in areas like RSE. As Weick and Sutcliffe (2001) observe, coaching may "encourage people to be self-conscious about the validity of their beliefs and to question them, re-affirm them, update them, replace them, and learn from all these activities".

School can be a challenging implementation environment for even the most committed RSE practitioner. Where ongoing sustained support is absent, the hard realities of organisational life can frustrate the initial enthusiasm of the educator. Literature on capacity-building suggests that, beyond curriculum resourcing and professional development, it is important to also offer sustained follow-up support to assist teachers in putting knowledge into practice. The evidence is that the use of knowledge, skills and understanding at work is more likely where colleagues are available to advise and support each other when problems are experienced (IEG, 2008).

Technology has revolutionised the delivery of curriculum resources. The era of 'e-learning' has provided free and accessible new tools for distance learning (Avolio, 2005). Placing materials online has the advantage of transcending barriers of cost and remoteness. It has reduced reliance on resource-intensive, difficult-to-organise, time-consuming and costly face-to-face contact and PD workshops.

RSE curriculum resources are now freely accessible to educators online. One way in which an online curriculum resource adds value is by placing a set of materials and practical tools conveniently in one place. Thomas et al. (2012) write:

> "Classroom teachers do not have the time, skills or knowledge to design their own ICT tools, so often look online in order to track down resources that can help them deliver teaching content in a dynamic and engaging format with which students can interact. Educational websites need to offer teachers these tools and make them accessible. Offering teachers a 'one-stop shop' for all of their curriculum needs can be advantageous."

Beyond being a means for the dissemination of curriculum resources, the Internet also has potential to provide peer support so that teachers can share ideas, concerns and success stories about RSE. Potentially, the technology extends to supporting online mentoring, coaching, listserv networks and self-directed chat groups.

While e-learning opens up new possibilities, it nevertheless has one significant limitation. There is little evidence to suggest that e-learning is suited to developing the emotional intelligence capacity critical to effective RSE (Bunker et al. 2002). Goldsworthy (2005) observes that: "Inspiring followers in a face-to-face situation is one thing – doing the same thing via e-mail or a video-conference, with the possible loss of facial expressions, body language, group responses, and the atmosphere of a physical meeting is quite another."

Capacity-building initiatives may be most effective when informed by an initial training needs analysis (IEG, 2008). A report for the World Bank (IEG, 2008) found that where initiatives fail to improve workplace performance, it is often attributable to inadequate initial targeting and alignment with the needs of the workforce. Where there is no training needs analysis, what is delivered may not be well matched to needs (IEG, 2008). Such analysis is a means of prior diagnosis (Leading Insight, 2000; IEG, 2008). It addresses analytical questions such as: 'What is present workforce capacity?' and 'What kind of initiative is needed to address existing capacity gaps?' It informs the process of setting clear, concrete and measurable objectives, and helps identify the appropriate target group and content of any intervention. A training needs analysis also clarifies what kind of capacity is to be built and how it is best done. Should there be greater investment in pre-service training? Should there be increased emphasis on in-service professional development? Or does the investment need to focus on further development of curriculum resource materials?

Curriculum resource support is a way to address certain capacity constraints, but it is not the answer to every kind of capacity constraint. Ideally, a decision to pursue a curriculum resource development strategy would be based on a prior training needs assessment. The choice to go with a curriculum resource support strategy is predicated on teachers already

being skilled at classroom delivery. It assumes they know how to educate students in the classroom. Where this is not the case, a form of strategic intervention other than development of a curriculum resource may be preferable.

Not all teachers have the same needs when it comes to developing their RSE capacity. Users of a curriculum resource are likely to have a range of different starting levels. There are several ways in which needs might be identified (Owen and Rogers, 1999; McDonald et al. 2003):

    a. 'felt need' (what staff say they need);

    b. 'normative need' (expert opinion about what is required);

    c. 'expressed need' (observed); and

    d. 'comparative need' (what one group has or lacks relative to another).

Finally, RSE does not have to entirely depend on the knowledge, skills and understandings of the teacher alone. An educator facilitating the delivery of RSE in a school in WA does need to be a qualified teacher. However, they may also enjoy the support of other staff, such as school nurses, counsellors and more experienced peers. There are also specialised sexuality educators working in the community services sector who can assist schools.

8. Best Practice 4: Informed by Expertise

School-based RSE seeks not only to inform students, but also to influence attitudes and behaviour. The literature suggests the most effective health promotion interventions are those founded on solid theoretical foundations that can explain the mechanisms at work that 'fire-up' desired behavioural change (McDonald et al. 2003). There are several established theories relevant to RSE.

The 'Stages of Change Model' (also known as the 'Trans-Theoretical Model of Change'), conceptualises the process of behavioural change occurring in five stages:

1. **Pre-contemplation** – Failing to recognise there is a problem and not seeking to change behaviour;
2. **Contemplation** – Awareness there is problem, but wondering how to change behaviour;
3. **Preparation** – Planning to take positive steps to change behaviour;
4. **Action** – Implementing changed behaviour; and
5. **Maintenance** – Making efforts to sustain the behavioural change and not relapsing (Prochaska & DiClemente, 1982; Prochaska et al. 1992).

'Stages of Change' theory contributes to understanding that knowledge of risk by itself is not sufficient to change behaviour and may, at best, only move people from Stage 1 to Stage 2. Furthermore, it explains why effective initiatives need to support and reinforce the process of ongoing behavioural change at every step. An implication of the Stages of Change Model is that there is no logical reason to expect positive societal level change to occur as a result of short-term intervention. According to Taylor (2001): "The changing of behavioural patterns is a long-term undertaking which, to be successful, needs to be continually monitored and reinforced." The process of behavioural change may not be a smooth and orderly progression through each stage (McDonald et al. 2003). 'Backsliding' may occur if an intervention is not sustained.

The 'Health Belief Model' (Rosenstock 1974; Willis et al. 2005) is concerned with understanding why people choose, or choose not, to take preventative action. The theory is that an individual will weigh up their perceived susceptibility, the likely costs and benefits, and the prospects of a favourable outcome before taking preventative action (McDonald et al. 2003). Accordingly, individuals factor in their own weighing of both positive and negative impacts relating to the adoption of healthy behaviours. A fear of rejection by one's peers may be an influential negative factor in their calculation. So, too, might be their self-assessment of whether or not they feel they are able to change a particular behaviour successfully. The Health Belief Model carries implications for the design of curriculum resources, suggesting it is necessary to do more than simply point to effective patterns of behaviour.

The 'Theory of Planned Behaviour' (Ajzen, 1985) focuses on the level of self-control an individual may feel able to exercise in relation to their own behaviour. The theory is concerned with the connection between individual beliefs and consequences. If, for

example, an individual believes that bad outcomes are primarily the result of fate or bad luck, as distinct from personal decisions, they are less likely to take personal responsibility and change their behaviour. The implication for RSE is that educators need to convince students they do have choices and to motivate them to decide and act (McDonald et al. 2003).

'Cognitive Dissonance Theory' (McDonald et al. 2003) refers to the state of mind that exists when an individual receives information that is inconsistent with their existing understandings, values, attitudes, beliefs or self-image. Feelings of conflict, guilt, depression, lowered self-esteem and decreased self-efficacy are symptomatic of cognitive dissonance. Key lessons to be drawn from this theory are:

a. sound foundational understandings of community attitudes and beliefs are critical to the development of effective interventions;
b. information is more likely to be accepted where it, and any examples used, are consistent, relevant and similar to the context and experience of the recipients;
c. presentation of a balanced perspective increases the credibility of both the message and the messenger, whereas one-sided or alarmist views are more likely to be rejected; and
d. educators are most effective when they are non-judgemental (McDonald et al. 2003).

This discussion of relevant theories is indicative but not comprehensive. There are other theories referred to in the RSE literature, such as Glasser's (1980) 'Reality Therapy/Control Therapy'.

Beyond having explicit theoretical foundations, a best practice RSE curriculum resource ought also to be informed by the body of research and knowledge of scholars and the experience of practitioners with renowned professional expertise in the field. A study for the World Bank (IEG, 2008) found the most effective capacity building initiatives are informed by expert professional advice that helps to ensure sound practice remains 'top of the mind'. In the instance of RSE, the challenge is that a crafted resource necessarily needs to be informed by a broad range of practitioner, academic and other independent advice across multiple areas:

a. sexual health;
b. pedagogically sound instruction methods, teaching tools and curriculum materials;
c. information technology, website design and graphics;
d. project management, legal advice in areas such as copyright, policy and evaluation; and
e. behavioural theory related to health promotion and relationships.

The available research and evaluation work done in the area of RSE lends support to the adoption of a 'strength-based' approach in schools, with relationships and sexuality presented as positive aspects of human life (WHO, 2015; Ollis, 2013). The focus ought to be on enhancing student understandings and the promotion of positive relational values such

as love and intimacy. A strength-based teaching model emphasises the development of knowledge, self-awareness and a range of competencies consistent with a Health Promoting Schools Framework. Work carried out by the Information Access Group (2012) on behalf of SHBBVP found that a strength-based perspective attracts support from core RSE stakeholders in WA.

The evaluation evidence is that negative scare campaigns and 'abstinence only' approaches that focus on the risks of disease and pregnancy are not effective (Santelli et al. 2006). Youth introduced to such initiatives are just as likely to have unprotected sex as before being introduced to them. In Australia there is evidence suggesting that abstinence can be promoted as one option amongst others, but only when placed within a broader context that includes information about contraception (Family Planning Victoria, Royal Women's Hospital and Centre for Adolescent Health, 2006). However, there is no evidence that abstinence only initiatives reduce sexual risk-taking behaviour (Dyson, 2008). The approach is commonplace in the US, however research and evaluation has found it does not contribute to safer or reduced sexual behaviour (Aspy, 2011; Thomas et al. 2012). Further details can be accessed from the Sexuality Information and Education Council of the United States of America website www.siecus.org/.

Respondents to a survey by the Information Access Group stressed the importance of information and communications technology (ICT) tools as a core element in contemporary Australian pedagogy. The use of current ICT tools and activities is necessary to engage users of a curriculum resource. Students need to be engaged before they can learn. To be widely used, an RSE resource needs to be perceived as user friendly, relevant, interesting and fun. An example of a site with eye-catching attention to graphic design is www.yoursexhealth.org.

Design of the website home page is a critical consideration. A succinct overview of the site is required to enable users to quickly access what they want. Materials like background notes and activities also need to be easily downloadable. The teaching-learning activities on offer might also incorporate the use of interactive whiteboards and OneNote lessons. Standard content features might include a glossary, FAQs, links to other relevant websites and a list of reference materials. According to Thomas et al. (2012):

> "Classroom practices have shifted away from the use of worksheets as independent tasks and towards more open-ended tasks involving training skills, creativity and concrete materials. The integration and use of ICT has been a significant part of this shift."

Curriculum resources also need to be supported by practical ideas and teaching-learning materials that have been demonstrated to work in classroom settings. Not all expertise resides in the academy. Best practice can be found in many places. It may emerge from the work of researchers and evaluators and then be passed 'down' to schools, but equally it may be discovered in the course of classroom practice and passed 'around' to other teachers. Those experienced in the practice of RSE in schools need to be recognised for their expertise, and should have opportunities for input into shaping curriculum resource development.

Finally, professional policy and legal expertise may be required. It is best practice in RSE curriculum development to check for compliance with government policy and for the satisfaction of legal requirements. Government policy sets the broad framework of principles upon which a curriculum resource must necessarily be founded. There are also legal issues relating to content such as the mandatory reporting of abuse, age of consent, privacy and copyright.

9. Best Practice 5: Commitment to Continuous Improvement

Effective capacity-building initiatives are embedded in a culture of continuous improvement, always striving to improve performance over time to ensure the resource remains up to date, relevant, useful and in line with current recommended models of curriculum support for school-based RSE educators. Continuous improvement means engaging in activities that guide informed judgements about how well an initiative is working. These activities might include planned and systematic data collection to monitor impact, benchmark comparisons with other online curriculum resources used in schools, independent audit and evaluation, and professional legal and policy advice to ensure compliance. It is about establishing a feedback loop in which the past is allowed to inform the future (Hawe et al. 2000; Commonwealth Department of Health and Aged Care, Health Services Division, 2001).

Those initiatives considered to be operating on the leading edge of good practice are those that have developed a systematic monitoring framework that draws on a foundation of reliable data serving as a solid evidence-base (Willis et al. 2005; Owen & Rogers, 1999; Shadish et al. 1991). The process demands systematic data collection to enable informed judgments to be made about how well a resource is working. The ideal is where the collection of relevant data is planned for and implemented from the very beginning of an initiative. This can take numerous forms, including statistical data, document review, benchmarking, surveys, interviews, workshops and case studies.

Kirkpatrick (1959) conceptualised data collection to gauge the effectiveness of education and training initiatives as ideally occurring on four levels:

- Level 1 – measurement of short-term learning outputs such as participant satisfaction captured in feedback;
- Level 2 – measurement of identifiable changes in skills, knowledge and attitudes;
- Level 3 – measurement of the extent to which learning translates into behavioural change; and
- Level 4 – measurement of the long-term impact at a community and societal level.

The framework has proven to be robust and enduring, notwithstanding extensive discussion in the literature, and some subsequent methodological advances, additions and critiques (Holton, 1996; Kaufman et al. 1995; Bushnell, 1990; Tamkin et al. 2002; Loos et al. 1999; Alliger & Janak, 1989; Bramley, 1996; Bramley & Newby, 1984; Arthur et al. 1998; WBIEG, 2007; Axtell et al. 1996 and Fitz-Enz, 1994).

Few measures ever extend beyond Level 1 (Keller, 1996). It is standard practice to harvest immediate feedback from participants on their perceptions of the quality of learning (Lee & Pershing, 2002). However, satisfaction measured at Level 1 is a necessary, but not a sufficient, indicator of ultimate medium and longer-term impact (Lee & Pershing, 2002; Bramley & Newby, 1984). Participant feedback collected immediately following completion of an activity does not measure actual change in work performance and does not provide

proof of long-term impacts (IEG, 2008). While immediate feedback has value, it is an inadequate guide to any actual application of knowledge, skills and understandings.

The methodological challenge is to measure what happens beyond Level 1. Ultimately, only intervention which leads to substantial positive behavioural change is effective. This is difficult to gauge, however, when many things are occurring simultaneously. In a school, for example, there might be new models of governance, new facilities, administrative changes, numerous programs and curriculum changes all occurring at once. It is therefore difficult to disentangle the impact of one initiative from that of another, a problem known as the 'challenge of attribution' (IEG, 2008).

Ideally, there should be opportunities for those involved in the delivery of RSE in one jurisdiction to learn from and share ideas with similar initiatives operating elsewhere. The making of benchmark comparisons with other curriculum resources used in schools is a hallmark of best practice. Continuous improvement should not be thought of as a one-way process of adopting what others are doing, it should be embedded in a process where there are opportunities to learn from and share ideas with similar initiatives operating elsewhere. This may extend to include resources used in other comparable countries.

GDHR is one of several online health-promotion resources used in Australian schools. Examination of comparable resources may potentially be a source of affirmation and new ideas. Cited examples of best practice in the field of online curriculum resources designed for school-based health promotion include the following:

a. The See Me website is a media literacy resource focused on issues of body image and media advertising to young people. Strong features identified include curriculum links, graphics and layout, a clear statement of principles and a glossary. The review found it contained "excellent" materials with "many strong features that GDHR can draw from" (Thomas et al. 2012). www.seeme.org.au/.

b. School Drug Education and Road Aware (SDERA) is concerned with drug and alcohol education and driver safety training in WA. The website was found to set a benchmark for the provision of inquiry-based student centred learning activities (Thomas et al. 2012). It was also found to be sufficiently flexible to respond to a range of learning needs www.det.wa.edu.au/sdera.

c. Mind Matters is a social and emotional well-being initiative of the Australian Government Department of Health and Aging. A strong feature is the manner in which this resource maps curriculum requirements. www.mindmatters.edu.au/.

There is scope to learn more about what is happening internationally, and how this differs from what is occurring in Australia. Such work mostly lies beyond the limited scope of this best practice synthesis. It is, however, important to note that the contextual relevance of programs operating elsewhere always needs to be weighed. Caution is necessary before assuming the transferability of strategies from one place to another and from one culture to another. The starting point needs to be an understanding of contextual similarities and differences. Tools and activities that work well in one setting may not do so in another.

The following Canadian online RSE curriculum resources are widely used as benchmarks in Australia:

a. Teaching Sexual Health www.teachingsexualhealth.ca/
b. Sex & U http://www.sexandu.ca/

Examination of school-based RSE websites in Australia undertaken for this review reached the following summative findings:

a. several states have made significant investment in the development of RSE resources;
b. although there is now a national school curriculum, there is no uniform national approach to RSE curriculum resource development;
c. a range of different agencies including mainstream not-for-profit organisations, government bodies and universities are involved;
d. a cross-agency partnership approach is the norm;
e. some organisations have been active in the RSE field for many years and have a wealth of experience;
f. organisations involved in the delivery of RSE may also provide related clinical, counselling and professional development activities;
g. all initiatives share a commitment to a culturally appropriate, accessible and inclusive approach;
h. most initiatives are reliant on government funding, although a couple of community services do generate some revenue through fee for service arrangements;
i. all initiatives recognise the value of involving both male and female educators;
j. RSE is a field in which innovative approaches to engagement are encouraged often incorporating activities such as art, music, dance, camps, competitions, games and sport;
k. RSE service providers vary in the extent to which they are involved in active 'face-to-face' outreach work in schools; and
l. initiatives that are designed to work through better resourcing of school-based educators are commonplace in Australia.

A best practice curriculum resource is subject to periodic audit, review and evaluation to identify those aspects that are working well and those where there is scope for improvement (IEG, 2008). These are common practices in the RSE field as evidenced by the work of Dyson and Fox (2006), Johnson (2006), Powell (2007) and Rychetnik & Frommer (2000). One review recommended that evaluation become a standard contractual requirement in funding agreements (Willis et al. 2005). Yet evaluation is only ever likely to be adopted as standard practice where it is appreciated as an aid to improvement (Patton, 2001; Goff, 2001).

It is, however, still uncommon for evaluations of health promotion initiatives to attempt an assessment above Level 1, mainly because of the methodological challenges inherent in doing so (IEG, 2008). Most evaluations say little about ultimate impact, falling back on initial

feedback from participants and descriptions of processes, resource design, content and implementation. Willis et al. (2005) judge that: "Australia is generally poorly served with examples of evaluated projects that aim to change sexual behaviour, either by increasing condom use, decreasing the rate of partner change, or improving the quality of sexual relationships."

Finally, the changing nature social values mean that the content of an on-line curriculum resource cannot stay stable for long. The context within which RSE is located is dynamic and responsive to changes in information and communication technology. The information sources people rely upon have shifted towards mobile phones and the World Wide Web. These are pervasive influences demanding on-going changes and curriculum resources may struggle to keep pace.

10. Best Practice 6: Whole-School Approach

Effective health promotion initiatives are embedded within a supportive whole-school culture. It is best practice for curriculum resources to be part of a broader 'health promoting schools' framework, also known as the 'whole-school approach'.

The approach is about creating a safe milieu and strengthening the capacity of a school as a healthy setting in which to learn, work and interact. The focus is on the broader institutional environment: school leadership and ethos, supporting policies and procedures, management and action-planning (Nutbeam, 1992). Health Promoting Schools make clear statements about the inclusive values they stand for. One challenge is to get schools thinking more holistically about the links between education and health.

The Health Promoting Schools framework is based on the principles set out in the World Health Organization's Ottawa Charter for Health Promotion (WHO, 1986). Essentially, it is a socio-ecological perspective that understands health outcomes as a function of individual, social and political considerations (WHO, 1986). This broad social conceptualisation of health and well-being encompasses physical, social and emotional needs. The framework can be read in full at http://www.iuphe.org/index.html?page=50&lang=en.

The evidence-base in support of a Health Promoting Schools framework is strong (Ridge et al. 2002; Ledger & Nutbeam, 2000; Lister-Sharp et al. 1999). Education is rendered more effective when accompanied by initiatives that address organisational and institutional constraints (IEG, 2008; Taschereau, 1998). Developing a sense of school ownership of health issues contributes to educational goals. According to one RSE curriculum resource:

> "The most effective school-based sexuality education programs take a whole-school approach to learning. A whole-school learning approach recognises that the young person's whole experience of attending school is one of continuous learning. Hence, a whole-school learning approach to sexuality education means teaching sexuality education in the classroom, in the school environment, in the way the school routinely runs itself, and in various ways the school connects with parents and the surrounding community."
> http://www.education.vic.gov.au/school/teachers/teachingresources/social/physed.

Numerous online health promotion resources in Australia cite a philosophical commitment to a whole-school approach. These include the Sexual Health in Schools (NSW), True (Queensland), Catching On (Victoria) and Mind Matters (national) websites. In the US the approach is known as the 'Coordinated School Health' initiative (Tones, 1996). Gleeson et al. (2015) argue that the "single most important criterion for best practice … is the adoption of a whole school approach … providing students with multiple exposure to key messages across the curriculum".

The capacity-building literature generally suggests that the best results are likely to be achieved where attention is paid to issues of organisational capacity, not just knowledge transfer. At the core of a Health Promoting Schools framework is the idea that the knowledge and skill of the teacher is more likely to be applied where it is linked to institutional capacity (IEG, 2008). Improved workplace performance is the result of

committed organisational leadership, school policies and procedures, clear priorities, incentives, and managerial practices that enable staff to utilise their knowledge (IEG, 2008; McDonald et al. 2003).

A report for the World Bank found that capacity-building initiatives generally pay insufficient attention to issues of organisational context (IEG, 2008). Building organisational capacity requires work beyond the provision of quality teaching-learning materials (IEG, 2008). Curriculum resources and the work of dedicated teachers may not be enough to achieve RSE outcomes. Positive change can only be expected where there is the organisational wherewithal to support the application of learning.

A Health Promoting School works to ensure adequate space for RSE in a crowded curriculum (Ridge et al. 2002). RSE is only likely to be taught to the extent it fits with the school philosophy and the expectations placed on teachers. Schools tend not to sustain initiatives perceived as not fitting with their core business of education. A resource like GDHR is likely to gain traction if perceived as discrete and externally driven (Ridge et al. 2002). The promotion of health and well-being at school is not only the responsibility of the health sector, but also shared by those in the education sector.

One of the challenges is that teachers typically have multiple expectations and demands on their time. RSE competes with road safety, drug education, nutrition, social and emotional well-being, and a raft of other priorities. RSE is but one component of the multifaceted health role teachers are expected to play, and therefore may not be allocated the real time required.

Those schools that do value RSE may look for creative opportunities to embed it in areas beyond the Physical Education and Health curriculum. The Melbourne Declaration on Educational Goals for Young Australians (MCEETYA, 2008) identified a need to promote RSE as a cross-curriculum priority. It can be creatively integrated into many curriculum areas. The fiction novel set for English might explore relationship issues and the statistics exercise might involve calculating the incidence of STI, and so on. An online curriculum resource might usefully assist by providing examples of how this can be done in other subject areas such as Civics and Citizenship, Humanities, Legal Studies and History. It is all part and parcel of 'normalising' RSE by approaching the topic as an essential set of life skills required to produce well-rounded citizens (Ollis, 2013).

A Health Promoting School is one that encourages and motivates educators to teach RSE. The general capacity-building literature stresses the value of rewards to encourage the development of a well-trained and effective workforce. Where incentives are weak, recruitment difficulties can be expected. An especially problematic area is the engagement of male teachers in RSE. The vast majority of sexual health teachers in Australia are female HPE teachers aged 20 to 39 (Smith et al. 2011). In WA there is a dearth of male teachers willing and able to teach RSE. Ideally, RSE will utilise the potential contribution of both male and female teachers.

Incentives can take various forms. The vocational education and training sector long ago endorsed accredited core competency-based standards (ANTA, 1999). Accreditation provides an incentive in the form of formal recognition. It is noted that currently there is little accreditation available to educators trained and skilled in the delivery of RSE. However, it is not clear that accreditation would necessarily amount to best practice because:

a. there is no one prescribed pathway for learning how to teach RSE;
b. the prospect of formal assessment might be perceived as threatening by some educators, thereby eroding enthusiasm to teach the topic; and
c. accreditation has cost implications because it does require the use of assessors.

While accreditation may not be the answer, the question of how to get sufficient numbers of educators involved in RSE remains.

One way in which the work of RSE educators in schools might be supported is by creating opportunities for teachers to network with each other as part of a supportive community of practice. Beyond having access to online curriculum resources, teachers of RSE may also benefit from being better connected to each other so they can share classroom experiences, materials and pedagogical foundations. The unresolved issue is how to foster a dialogue between school staff involved in RSE so that experiential learning can contribute to improved practice.

The capacity-building literature lays emphasis on the power of fostering horizontal, free, transparent and open flows of information. Such 'sideways learning' enables stakeholders to learn from each other, disseminating and reinforcing good practice. There are various tried and proven strategies that are used to build and maintain networks. These include symposiums, conferences, membership of a peak body or professional society, journal publications, an accessible database, a register of current courses, regular Internet chat contact and the provision of outreach support by visiting school consultants. All these forums and approaches could potentially be used to share and disseminate knowledge about best practice between educators.

11. Best Practice 7: Inclusive of Community

The development of an RSE online curriculum support resource ought to follow a partnership model in which key agencies work together with schools. RSE is a culturally, socially and politically sensitive subject matter taught within schools. Public investment in resources such as GDHR can quickly become exposed and vulnerable if the initiative is perceived as not inclusive of community. The continuity of every initiative is contingent on community support.

Partnership is recognised as an element of best practice in health promotion, as in many areas of health service delivery (Voyle & Simmons, 1999; WBI, 2007b). Ridge et al. (2002) write: "It is concluded that in any effective health promotion activity in schools, the agenda needs to be driven primarily by an education sector that has demonstrated it can embrace holistic approaches to health, with the health sector acting as partner and facilitator."

In Victoria, for example, partners involved include Family Planning Victoria, the Royal Women's Hospital, and the Centre for Adolescent Health. The Melbourne Sexual Health Centre provides support via online resources, as well as offering onsite education and training opportunities: http://www.mshc.org.au/.

The task of RSE in schools lies beyond the capacity of any one organisation or group working in isolation. Reductions in teen pregnancies (31% reduction) in Milwaukee were achieved by a partnership led by the United Way of Greater Milwaukee (a not-for-profit organisation) https://www.unitedwaygmwc.org/Teen-Pregnancy-Prevention. Previously, the city had one of the highest teenage birth rates in the US. A 31% reduction was achieved through the collaborative structure of the city's Teen Pregnancy Prevention Oversight Committee. This was achieved in the challenging context of increasing local poverty rates due to recession and steady national rates of teenage pregnancy in other jurisdictions.

Partnership can strengthen an initiative by furnishing multiple sources of resource support, as well as access to a wider network of skills, advice, experience and expertise. The explicit support of government can provide status and credibility for an initiative. However, community service agencies and universities are able to engage in public advocacy in ways government cannot. An advantage of a partnership model is that it makes possible endorsements from reputable organisations. A feature of many of the curriculum resources viewed online is the use of endorsements to establish trust and confidence.

Acceptance of a partnership model has implications for governance arrangements. The effectiveness of school-based RSE requires a joint approach by teachers, education workers, school nurse, school authorities, students, parents, community services, curriculum and funding bodies. The process of building connections is often slow and intensive work, as education and health organisations may not have worked closely together before. Partnership can be time consuming, and may take resources away from more immediate strategic priorities. It is never cost free.

Best practice RSE involves the promotion of values of cultural inclusion, equal opportunity and anti-discrimination (WHO, 2015). Content should recognise, acknowledge and demonstrate respect for diversity and difference in gender, sexual orientation, faith and values (Mazin 2014; Formby et al. 2010; Allen 2011; Ferguson et al. 2008; Ollis, 2013; Family Planning Victoria, 2006). In the past, an ethnocentric bias and cultural blindness has pervaded education discourse (Lau & Roffey, 2002). Historically, most resources and materials have emanated from North America and Europe, feeding a tendency to write and speak about topics such as RSE as if it were a generic universal practice. The problem is that initiatives predicated on western worldviews may not create safe learning spaces for minority groups (UNESCO, 2009). There may, for example, be a failure to consider the values and practices of Indigenous peoples (Hallinger & Leithwood, 1998; Foster & Goddard, 2003; Dimmock & Walker, 2005). Learning only occurs in a culturally secure setting where those being educated feel comfortable.

Increasingly, a capacity to educate across cultures is seen as an essential tool for teachers (Trujillo-Ball, 2003; Dimmock & Walker, 2005; Stewart, 2006; Fitzgerald, 2004). In the age of globalisation, greater emphasis is being placed on enhancing the capacity of educators to work across cultures (Wenger, 1998; Keller, 1996). Increasingly, school communities are economically, socially and culturally diverse. Educators now live and work with students from diverse backgrounds.

A requirement for cultural competence adds a new dimension to the desired skill set of an educator, namely the capacity to communicate across value differences. According to the National Center for Cultural Competence, it is about valuing and managing the dynamics of difference and acquiring the institutional knowledge to adapt to diversity http://nccc.georgetown.edu/. A commitment to cultural competence means striving for more culturally sensitive ways of working that acknowledge diverse beliefs, practices and life experiences.

Cultural awareness training may help to equip educators with an understanding of the complex issues and challenges students from different cultures face at school. When students are subjected to disrespect at school, their teachers need to know how to respectfully challenge such attitudes. There are theoretical frameworks available specifically relating to the process of cross-cultural learning in the health field (Rasmussen, 2001).

The challenge for those who design curriculum resources for general use in schools is to ensure they are appropriate for a population displaying a broad range of beliefs and attitudes. Cultural factors influence the way in which students respond to different styles of teaching and learning. Some cultures are more individualistic and some more family oriented. Some place greater emphasis on autonomous learning, some have different expectations about how teachers should engage, and some have views about the appropriateness of males and females learning together. Some students may have particular curriculum support needs on account of factors such as:

a. cultural identity;
b. religion;

    c.   sexual and gender identity;

    d.   English as their second language;

    e.   non-English speaking background;

    f.   remoteness and isolation;

    g.   socio-economic background; and

    h.   disability.

Teachers face the challenge of teaching RSE across cultural differences associated with different behavioural and social expectations. There may be great variation in cultural values and norms related to adolescence and sexuality, such as views on identity and independence. This may conflict with cultures where a competent adolescent is understood as someone who meets family obligations. Some cultures regard adolescence as a time of strengthening family bonds and taking on new responsibilities within the family. Rather than expressing independence, adolescents from such cultures may feel more restricted. In particular, girls may be subject to strict monitoring where their families feel threatened by exposure to the values of the new culture.

Students from multicultural backgrounds who seek to fit in may be torn between the expectations of family and the values of their peers. They may suffer emotional stress and may be subject to bullying.

Cultural differences range from clothing choices to major lifestyle decisions, and can leave many teens bewildered as to how to reconcile family culture with the more permissive attitudes of peers. Parental opinions weigh heavily at home but many may be abandoned when teens are with friends. Relational and educational problems at schools may be the end result of a clash between teen and family culture. Teens may be subject to cultural aggression due to skin colour, religion and sexual orientation.

The lifestyle choices made by teens can have a far-reaching effect on families that have different traditions. A healthy family relationship requires open conversations within a supportive family. But ultimately, teenagers have to make their own decisions when their cultural beliefs differ from those of their peers. School counsellors and mental health professionals can assist teachers to support those students for whom tensions related to cultural difference are an issue. But the first requirement is a teacher with the cultural competence and awareness to recognise such issues.

The opportunity is for a broader range of values, knowledge, skills and understandings to be brought to bear on the process of RSE, with people from different backgrounds engaged and learning from each other. Thus the process of capacity building becomes a form of cross-cultural education where people learn from their disparate experiences.

To date there has been limited research and evaluation work around what are effective forms of RSE practice when working with people from marginalised or diverse backgrounds (Dyson 2008). The work of Larkins et al. (2007) with Aboriginal and Torres Strait Islander (ATSI) youth in North Queensland stands as an exception. There are also specialised

resources such as *Yarning On* developed by SHine SA specifically designed to meet the RSE learning needs of Aboriginal students www.healthinfonet.ecu.edu.au/key-resources/programs-projects?pid=1051.

The best practice of school-based RSE openly encourages the involvement of parents and carers. Parents and carers may be a significant source of advice and support for children and adolescents. The evidence is that RSE is more effective when parents and carers reinforce classroom information and discussion at home.

Ideally, online curriculum resources support RSE information being made freely available to the home, and explain ways in which parents and carers might be engaged as partners in reinforcing school RSE messages. Dyson (2008) writes: "The most effective approach to young people's sexual health education is achieved when a supportive partnership exists between parents and – the other vital component – the school." She recommends that schools provide written communication to parents about what is covered in RSE and that they remain open to meeting to discuss any concerns (Dyson, 2008). Where schools and parents regard themselves as partners in RSE, it is easier to engage children at home about what they have learnt at school.

Parents and carers generally want RSE taught in schools, provided they know that what is being taught does not compromise their values, that it is reassuringly age appropriate, that it does not contribute to the early sexualisation of their children, that it does not promote promiscuity, and that the teachers are competent (Dyson, 2008). It is rare for parents to withdraw their children from school-based RSE, the implication being that most approve (Dyson, 2008). Nevertheless, there is still work to be done on developing and sustaining trust between parents and schools. According to Dyson (2008): "Parents want to be assured that those educators who will be teaching their children sexual health education have the skills and qualifications to do their job well, while remaining sensitive to the diversity of values among their students and their families."

Parents and carers can make a significant contribution to the development of informed and confident young people (Dyson, 2008). According to Dyson (2008): "Those families in which sexuality has been discussed from the beginning of the children's lives as an ongoing conversation, in an easy, relaxed manner, seemed less likely to face conflict with their adolescent children." Australian research suggests that adolescents in communication with their parents about relationships and sexuality are more likely to delay commencement of sexual activity (Moore & Rosenthal, 2006; Marie Stopes International, 2008).

The evidence is that parents and carers often feel ill prepared for the responsibility of engaging with their children about issues to do with relationships. Many could benefit from access to resources and support (Dyson, 2008; Marie Stopes International, 2008; Sorenson et al. 2007). Parents can feel embarrassed talking with their children about relationships and sexuality (Moore & Rosenthal, 2006). The subject matter may also raise sensitive cultural issues for some (Dyson, 2008). Feeling more comfortable comes with more frequent communication. According to Dyson (2008):

> "Some parents struggle to fulfil their role of raising sexually healthy children and expressed the need for support and assistance. Some had negative experiences of their own childhood sex education, others felt they were not well prepared and lacked both the knowledge and self-confidence needed for the task."

A gender gap exists when it comes to talking about sexuality at home (Dyson, 2008). More females engage in discussions about relationships and sexuality than males (Dyson, 2008). Fathers tend to be more reticent communicators and reluctant to become involved (Dyson, 2008). Boys are more likely to be influenced by their peers than their fathers (Dyson, 2008). Another barrier for parents and carers in the workforce is limited time to engage with their children as they juggle life's priorities (Dyson, 2008).

The extent to which parents and carers are able to exercise influence over their adolescent children is variable. Young people may be seeking to create their own personal space and identity, struggling to separate emotionally. Parents and carers who try to raise the topic risk being seen as intrusive (Dyson, 2008; Smith et al. 2003). Dyson (2008) writes that the most effective strategy is to start the conversations early.

> "Most parents had not discussed sexuality with their children unless they thought their child was in a relationship that might lead to sex. This might already be too late to prevent risky sexual behaviour. The authors advocate encouraging parents to begin open conversations with their children when they [the children] are young – well before they might be in a relationship that could lead to sex."

The evidence is that parents and carers value resources and support that enable them to talk with their children. Parents and carers may benefit from access to RSE resources that support them in fulfilling their role with their children, enabling communication about RSE to extend beyond the classroom. For example, they may benefit from guidance on conversation starters and opening lines (Dyson, 2008). The Triple P (Positive Parenting Program) is popular with parents and carers in WA. A feature of PPP is that it can be pitched at different levels tailored to the needs of particular groups. Parents and carers may also appreciate practical advice on how to supervise their children's Internet usage and install filters on devices such as smartphones, iPods, iPads and home computers.

RSE outcomes are more likely to succeed where there are strategies that engage parents and community to complement classroom teaching and learning. Unfortunately, one of the least successful aspects of RSE is attaining the involvement of parents and carers (Dyson 2008). Few schools engage parents and carers in RSE planning and implementation (Dyson, 2008).

RSE may now be widely accepted as an integral part of the education curriculum (Dyson, 2008). Nevertheless, the wider social, political, cultural and economic milieu still make it a challenge to deliver since:

a. many parents and carers are uncomfortable discussing sexuality which can conjure feelings of embarrassment, controversy, guilt and inadequacy (Moore & Rosenthal, 2006);

b. sexuality is a contested flashpoint where progressive and conservative views can conflict;

c. there can be divergent values about RSE, even within families;

d. there are sensitive boundary issues for the state, schools, parents and communities to negotiate (Dyson, 2008); and

e. gendered assumptions are socially ingrained.

These are contextual issues that cannot be overcome by a curriculum resource alone and which ideally require a sound foundational understanding of local community attitudes and beliefs to take account of the local social environment. For example, early parenthood is an issue in some communities more so than in others. It is also the case that some communities reflect particular faith-based values and beliefs. It is noted that historically little sexuality education has occurred in some faith-based schools, limiting the reach of resources such as GDHR. Not all students have the same information and support needs. Cultural diversity, language differences, competing values, attitudinal divides and gender divisions are all factors that will continue to pose challenges in some schools.

The influential 'Stages of Lifestyle Change' theory focuses on understanding change processes at a community and societal level (Prochaska et al. 2002). Investment in getting community involved is seen as the key to achieving sustainable outcomes. The approach reflects general broader trends in capacity-building evident in areas such as international aid and development (Ausaid 2004, 2006; Horton et al. 2003). The aim is to strengthen the collective capacity of people interacting socially. From this perspective the most effective initiatives are early intervention and prevention measures that foster community participation, thereby enabling people to take greater ownership and respond to health issues (Willis et al. 2005). However, there are limits on the capacity of time-poor educators. A teacher pressed for time is likely to be looking for a good resource to use in a hurry. The extent to which they can participate in devising responsive tailor-made solutions adapted to local community needs and demographic characteristics is limited.

12. Best Practice 8: Aligning GDHR with Best Practice Principles

This GDHR literature review has identified principles of best practice in RSE. These principles were discussed and refined in consultation with the Evaluation Reference Group.

The extent to which GDHR might be considered to align with the principles was also discussed. The results are summarised in Table 3 below. This process assisted the evaluator to identify the strengths of the GDHR resource and to highlight areas for possible improvement.

In most respects the evaluation found that the GDHR online curriculum resource aligns with the principles. Changes which may provide scope to further enhance the resource could include:

a. greater attention to promoting positive student values;
b. more varied use of pedagogically sound teaching-learning techniques;
c. greater opportunities for students to engage in inquiry-led learning;
d. use of incentives to engage more teachers and a broader range of school staff with the GDHR resource;
e. provision of sustained support for RSE educators such as networking, mentoring and coaching;
f. greater use of ICT and graphics in the online resource and in the classroom;
g. systematic monitoring of usage of the GDHR resource by teachers;
h. engaging with other health-education resources to promote a cross-fertilisation of ideas;
i. encouragement of parental and community input into the future development of the resource; and
j. greater support for GDHR implementation from school leadership.

Table 3: Supporting evidence of GDHR best practice

1. CONTENT IS COMPREHENSIVE	2. AGE APPROPRIATE	3. DELIVERED BY EDUCATORS TRAINED IN RSE	4. INFORMED BY EXPERTISE	5. COMMITMENT TO CONTINUOUS IMPROVEMENT	6. WHOLE-SCHOOL APPROACH	7. INCLUSIVE OF COMMUNITY
ME Resource imparts both factual and values content in areas such as reproduction, the characteristics of respectful relationships and diversity.	**MR** Content is provided across all years of schooling, with materials appropriately and logically sequenced from early childhood to adolescence.	**ME** Delivered by male and female educators/school staff such as qualified teachers, school nurses, counsellors and community educators with specialised experience and/or expertise in RSE.	**MR** Informed by behavioural theory.	**MR** Process of systematic data collection and monitoring to enable judgments to be made about how well the resource is working.	**MR** Online curriculum resource is located within a broader 'Health Promoting Schools' policy framework.	**ME** The development of the resource follows a partnership model in which agencies work together.
ME Resource provides a varied range of pedagogically sound instruction methods and tools to teach RSE.	**ME** Resource aligns with curriculum standards and is demonstrably evidence-based.	**MR** Teaching-learning materials contained in the resource are readily available to educators without barriers to access.	**MR** Resource draws on RSE research and evaluation literature.	**MR** Benchmark comparisons made with other RSE and health promoting online curriculum resources used in schools.	**ME** School leadership is actively supportive of RSE and has RSE policies and procedures in place.	**MR** The online curriculum resource is non-judgemental, non-discriminatory and respectful of diversity and difference in gender, sexual orientation, faith, culture and values.

1. CONTENT IS COMPREHENSIVE	2. AGE APPROPRIATE	3. DELIVERED BY EDUCATORS WITH EXPERTISE IN RSE	4. INFORMED BY EXPERTISE	5. COMMITMENT TO CONTINUOUS IMPROVEMENT	6. HEALTH PROMOTING SCHOOLS APPROACH	7. INCLUSIVE OF COMMUNITY
ME Resource encompasses the teaching of protective behaviours and promotes harm minimisation.	**MR** Clear learning objectives are established for each year.	**ME** RSE capacity-building initiatives are informed by training needs analysis.	**MR** Resource is informed by curriculum expertise.	**MR** Opportunities to learn from and share ideas with similar initiatives operating elsewhere.	**LE** Schools work to ensure adequate space for RSE in a crowded curriculum and take opportunities to teach RSE in learning areas beyond the Health and Physical Education curriculum.	**MR** There are opportunities for educators to enhance their cultural competence.
MR Resource includes activities that enable students to make informed personal and interpersonal decisions and choices.	**ME** Informed by current curriculum expertise and pedagogy and current recommended models of curriculum resource support for school-based RSE educators.	**MR** Educators have opportunities to access RSE training and PD in which adult learning principles are upheld.	**ME** Resource is informed by information and communication technology and state-of-the-art website design and graphics.	**MR** Periodic independent audit, review and evaluation of the resource.	**LE** Schools actively promote use of the GDHR resource to and by teachers.	**LE** Information about resource content is made readily available to parents/carers.

1. CONTENT IS COMPREHENSIVE	2. AGE APPROPRIATE	3. DELIVERED BY EDUCATORS WITH EXPERTISE IN RSE	4. INFORMED BY EXPERTISE	5. COMMITMENT TO CONTINUOUS IMPROVEMENT	6. HEALTH PROMOTING SCHOOLS APPROACH	7. INCLUSIVE OF COMMUNITY
ME Resource is relevant to current issues in RSE.	**MR** Educators are resourced with a set of guiding educational principles, not just content.	**MR** The resource supports educators to feel both competent and comfortable when teaching RSE.	**MR** Experienced school-based RSE educational practitioners have opportunities to input into resource development.	**MR** Resource is responsive to technological and value changes in the social context over time.	**LE** Schools provide incentives to motivate educators to teach RSE.	**MR** Parents/carers have access to resources that support them in their RSE role with their children.
MR Resource promotes access to relevant community services.	**LE** There are opportunities for high school students to engage in inquiry-led learning and have input into RSE content and process.	**LE** Sustained support is available to RSE educators in the form of networks, coaching and mentoring.	**MR** Checks for compliance with government policy and legal requirements.	**MR** Input into school-based RSE from parents and carers is openly encouraged and responsively adapts to local community needs.	**ME** School-based RSE educators have opportunities to network with each other as part of a community of practice.	**LE** Local communities are encouraged to take responsibility for RSE issues.

Key: **MR**   Meeting requirement

                 ME   Mixed evidence/partially meeting requirement/room for improvement

                 LE   Little evidence of substantially meeting the requirement.

13. Conclusion

This report has posited seven criteria as best practice in school-based RSE, based on lessons learnt from the literature.

13.1 Comprehensive Resource
The content of a curriculum resource needs to be comprehensive. There are several aspects to this: the inclusion of both factual and values content; utilising a varied range of pedagogically sound instruction methods and tools; ensuring the resource retains engaging contemporary relevance over time; locating learning about sexuality in a broader context of values and healthy relationships; teaching protective behaviours and harm minimisation; including activities that enable students to make informed personal and interpersonal decisions; and promoting access to other relevant resources and community services.

13.2 Age Appropriate
The curriculum standards in place should be age appropriate (UNESCO, 2009; Mazin, 2014), with lessons logically sequenced from early childhood to adolescence, with learning objectives by year. There also ought to be a set of clear guiding principles, not just content. If a resource is to be used in schools, it is critically important that the materials it contains explicitly align with current recommended models of curriculum support. Current curriculum expertise and pedagogy should guide what is taught and when. Older children, for instance, may want to be more self-directed and inquiry led (Allen, 2005; Harrison & Ollis, 2015).

13.3 Access to PD
Educators delivering RSE should ideally receive some specialised professional development in the field. To achieve this educators need accessible teaching-learning resources that are freely available to them. In addition to curriculum resourcing, some educators benefit from opportunities to access training in RSE. This would ideally be confirmed by prior training needs analysis to ensure the right teachers are being reached. Being a qualified teacher and having a curriculum resource may not always be sufficient to enable educators to feel both competent and comfortable with RSE delivery.

13.4 Informed by Expertise
A sound curriculum resource needs to be informed by independent expertise in a range of relevant areas, including sexual health, behavioural theory, pedagogy, policy and evaluation, project management and information and communications technology. Such expertise can be found in the academy, within government and in external jurisdictions. It can also be sourced amongst school-based practitioners, some of whom are highly experienced in the delivery of RSE.

13.5 Continuous Improvement
A curriculum resource ought to be grounded in a culture of continuous improvement. Where this is the case there will be a trail of evidence in the form of audit, review or evaluation. Such work needs to be founded on systematic data collection to enable judgments to be made about how well the resource is working. Opportunities to learn from,

and share ideas with, similar health promotion initiatives operating in schools in other jurisdictions also need to be taken up. Doing so enables benchmark comparisons to be made. A further aspect of quality control is checking to ensure any resource is compliant with policy and legal requirements. Where the characteristic features of a resource align with current approaches, in Australia and internationally, then this may be taken as a source of reassurance. By itself, however, it does not provide sufficient basis upon which to assume quality in all respects.

13.6 Health Promoting Schools Framework

The literature suggests that delivery of effective school-based RSE may require more than curriculum resources and a lesson plan. Health promotion initiatives appear to work better when located within a broader health promoting schools framework. This requires local school leadership actively supportive of RSE, the promotion of curriculum resources to teachers, incentives that motivate educators to teach RSE, the creation of adequate time and space for RSE lessons, the adoption of whole-school RSE policies and procedures, and exploring opportunities to embed RSE beyond the Physical Health and Education curriculum. It also means a shift towards greater self-development, with interested educators encouraged to network more with each other around RSE as part of an emergent community of practice.

13.7 Inclusive of Community

A curriculum resource ought to strive to be inclusive of community. It requires a non-judgmental and non-discriminatory stance respectful of diversity and difference in gender, sexual orientation, faith, culture and values (Harrison & Ollis, 2015). Initiatives may reflect a partnership model with key stakeholders working together across organisational boundaries. The involvement of parents, carers and the community service in the RSE sector is to be encouraged. These stakeholders in turn can benefit from better access to RSE resources specifically designed to support their capacity to engage their children about relationships and sexuality. A policy systems view might see a resource like GDHR occupying a place alongside other initiatives that together work on a platform of agreed outcomes and shared responsibilities.

Bibliography

Abraham, C & Wright D (1996), 'Developing HIV-preventative Behavioural Interventions for Young People in Scotland', *International Journal of STD and AIDS,* 7 (supplement 2), pp. 39-42.

Ajzen, I (1985), 'From Intentions to Actions: A Theory of Planned Behavior', in J Kuhl & J Beckmann (eds), *Action-control: From Cognition to Behavior*, Springer, Heidelberg, Germany, pp. 1-39.

Allen, L (2011), *Young People and Sexuality Education: Rethinking Key Debates*. Palgrave Macmillan, Houndmills, UK.

Allen, L (2005), 'Say Everything: Exploring Young People's Suggestions for Improving Sexuality Education', *Sex Education*, 5(4), pp. 389-404.

Allensworth, D (1995), *The comprehensive social health programme: Essential element,* World, Geneva.

Alliger, G & Janak, E (1989), 'Kirkpatrick's levels of training criteria: Thirty years later', *Personnel Psychology*, 42 (2), pp. 331–42.

Altman, D (1992), 'AIDS and the discourses of sexuality', in Connell, R W and Dowsett, G (eds) *Rethinking Sex: Social Theory and Sexuality Research*, Melbourne University Press, Melbourne.

Anderson, L W, Krathwohl, D R & Bloom B S (eds) (2001), *A taxonomy for learning, teaching, and assessing: A revision of Bloom's taxonomy of educational objectives*.

ANTA see: Australian National Training Authority.

Arnot, M & Reay, D (2007), 'A sociology of pedagogic voice: power, inequality and pupil consultation', *Discourse: Studies in the Cultural Politics of Education,* 28 (3), pp. 311-325.

Arthur, W, Bennett, W, Stanush, P & McNelly, T (1998), 'Factors that influence skill decay and retention: A quantitative review and analysis', *Human Performance*, 11, pp. 57–101.

Ashton, M & Varga, L (n.d.), *101 Games for Groups,* Hyde Park Press, Adelaide.

Aspy, C B, Vesely, S K, Oman, R F, Tolma, E, Rodine, S, Marshall, L & Fluhr, J (2012), 'School-related assets and youth risk behaviour: alcohol consumption and sexual activity', *Journal of School Health*, 82(1), pp. 3-10.

AusAID (2004), *Capacity development principles and practices,* AusAID, Canberra.

AusAID (2006), *A staged approach to assess, plan, and monitor capacity building,* AusAID, Canberra.

Australian Communications and Media Authority (2009), *Click and Connect: Young Australians' Use of Online Social Media*.

Australian Indigenous Health Info Net (2003), *Infectious diseases – STIs*. Online, Australian Indigenous Health Info Net, Edith Cowan University.

Australian National Training Authority (1999), *Providing Life-long Skill Training Through an Integrated Education and Training System: The Australian Experience,* Australian National Training Authority, Brisbane.

Avolio, B J (2005), *Leadership development in balance: Made/born*, Lawrence Earlbaum Associates, New jersey.

Axtell, C, Maitlis, S, & Yearta, S (1996), 'Predicting immediate and longer-term transfer of training', *Personnel Review*, 26 (3), pp. 201–13.

Azzam, T & Szanyi, M (2011), 'Designing evaluations: A study examining preferred evaluation designs of educational evaluators', *Studies in Educational Evaluation,* 37(2–3), pp. 134–143.

Bachus, L, Martens, M & van der Sluis, M (2010), 'An impact and process evaluation of two Dutch sexuality education programmes for 10–12 year olds in primary school', *Relationships and Sexuality* and *Comfortable in your skin,* Rescon, Amsterdam.

Backett-Milburn, K, & Wilson, S (2000), 'Understanding peer education: insights from a process evaluation', *Health Education Research: Theory and Practice*, 15 (1), pp. 85-96.

Badura, A, Millard, M, Peluso, E, & Ortman, N (2000), 'Effects of peer education training on peer educators: Leadership, self-esteem, health knowledge, and health behaviours', *Journal of College Student Development*, 41 (5), pp. 471-478.

Baldo M, Aggleton P, & Slutkin G (1993), 'Does sex education lead to earlier or increased sexual activity in youth?' in: *IXth International Conference on AIDS*, Berlin. World Health Organization, Geneva.

Baldwin, T, & Ford, J (1988), 'Transfer of Training: A Review and Directions for Future Research', *Personnel Psychology,* 41 (1), pp. 63–105.

Bamberger, M, & Kirk, A (2009), 'Making Smart Policy: Using Impact Evaluation for Policy Making - Case Studies on Evaluations that Influenced Policy', *Doing Impact Evaluation*, vol. 14.

Bament, D (2001), *Peer education literature review,* South Australian Community Health Research Unit, Adelaide.

Bandura, A (1977), *Social learning theory,* Prentice Hall, New Jersey.

Baumgartner, L & Merriam, S M (2000), *Adult Learning and Development: Multicultural Stories*, Krieger, Malabar, Florida.

Beasley, C (2005), *Gender and Sexuality: Critical Theories, Critical Thinkers,* Sage, London.

Beasley, C (2012), 'Problematizing contemporary Men/Masculinities theorizing: the contribution of Raewyn Connell and conceptual-terminological tensions today', *British Journal of Sociology,* 63(4), pp. 747-765.

Beauvoir, S (1972), *The Second Sex,* (trans H. M. Parshley), Jonathan Cape, London.

Bennis, W (1999), *Old Dogs, New Tricks: On Creativity and Collaboration,* Executive Excellence Publishing, Provo, Utah.

Benson, J (1997), *Working More Creatively with Groups (2nd ed)*, Routledge, London.

Bloom, B, Engelhart, M D, Furst, E J, Hill, W H & Krathwohol D R (1956), *Taxonomy of educational objectives: The classification of educational goals. Handbook I: Cognitive domain,* David McKay Company, New York.

Bloor, M, Frankland J, Langdon, N, Robinson, M, Allerston, S, Catherine, A, Cooper, L, Gibbs, L, Gibbs, N, Hamilton-Kirkwood, L, Jones E, Smith R & Spragg, B (1999), 'A controlled evaluation of an intensive, peer-led, schools-based anti-smoking programme', *Health Education Journal*, 58, pp. 17-25.

Boyatzis, R & McKee, A (2005), *Resonant Leadership*, Harvard Business School Press, Boston, Massachusetts.

Brady, M (1991), *The health of young Aborigines: A report on the health of Aborigines aged 12-25 Years*, prepared for the National Youth Affairs Research Scheme, Australian Institute of Aboriginal and Torres Strait Islander Studies, Canberra.

Bragg, S (2007), '"Student Voice" and governmentality: the production of enterprising subjects?', *Discourse: Studies in the Cultural Politics of Education,* 28(3), pp. 343-358.

Bramley, P (1996), *Evaluating training effectiveness,* McGraw-Hill, London.

Bramley, P, & Newby, A (1984), 'The evaluation of training, part 1: Clarifying the concept', *Journal of European Industrial Training*, 8 (6), pp. 10–16.

Brellocks, C (1995), *Ingredients for success: Comprehensive school-based health centers,* School Health Policy Initiative, New York.

Brew, R (1996), *Word is Out! A resource booklet on peer education for workers with young people and funding provider*, Family Planning South Australia, Adelaide.

Briggs, G, & Naylor, J (1962), 'The relative efficiency of several training methods as a function of transfer task complexity', *Journal of Experimental Psychology*, 64, pp. 505–512.

Brinkerhoff, R (1987), *Achieving results from training,* Jossey-Bass, San Francisco.

Bunker, K, Kram, K & Ting, S (2002), 'The young and the clueless', *Harvard Business Review*, 80(12).

Bush, C, Radcliffe, J, Ward, R, Scott, M & Parsons, M (n.d.), *All of Us Health and Physical Education Resource Understanding Gender Diversity, Sexual Diversity and Intersex Topics for Years 7 & 8,* Safe Schools Coalition, Victoria.

Bushnell, D (1990), 'Input, process, output: A model for evaluating training', *Training and Development Journal*, 44 (3), pp. 41–43.

Buston, K, Wright, D, Hart, G & Scott, S (2002), 'Implementation of a teacher-delivered sex education programme: obstacles and facilitating factors', *Health Education Research: Theory and Practice,* 17(1), pp. 59-72.

Butler, J (1999), *Gender Trouble: Feminism and the Subversion of Identity,* Routledge, New York.

Calamidas, E (1990), 'Aids and STD education: what's really happening in our schools?', *Journal of Sex Education Therapy,* 16(1), pp. 54-63.

Carey, R, Donaghue, N & Broderick, P (2013), 'Peer Culture and Body Image Concern Among Australian Adolescent Girls: A Hierarchical Linear Modelling Analysis', *Sex Roles*, 69, pp. 250-263.

Carmody, M (2009), *Sex & Ethics: Young People and Ethical Sex*, Palgrave Macmillan, Melbourne. http://www.sexualethics.org.au/Reports/Sex_and_ethics_flyer.pdf

Carmody, M & Willis, K (2006), *Developing Ethical Sexual Lives: Young People, Sex and Sexual Assault Prevention*, University of Western Sydney, Sydney.

Catalyse (2006), *Growing and Developing Healthy Relationships: Audit of the Uptake of the Curriculum Support Materials in WA Schools,* Report prepared for the Department of Health, Government of Western Australia, Perth.

Catholic Education Office (n.d), *The Teaching of Human Sexuality,* Catholic Education Office of Western Australia, Western Australia.

Chambers, R (2002), *Participatory workshops: A sourcebook of 21 sets of ideas and activities*. Earthscan, London.

Check J (1995), 'Teenage Training: The Effects of Pornography on Adolescent Males' in LJ Lederer & R Delgado (eds), *The Price We Pay: The Case Against Racist Speech, Hate Propaganda, and Pornography,* Hill and Wang, New York.

Chewning, B, Douglas, J, Kokotailo, P, LaCourt, J, Clair, D & Wilson, D (2001), 'Protective factors associated with American Indian adolescents' safer sexual patterns, *Maternal & Child Health Journal,* 5, pp. 273-280.

Christie, C (2003), 'What guides evaluation? A study of how evaluation practice maps onto evaluation theory', *New Directions for Evaluation*, 97, pp. 7–35.

COAG see: Council of Australian Governments

Coalition for Evidence-Based Policy (2015), *What Works in Social Policy? Findings From Well-Conducted Randomized Controlled Trials, Coalition for Evidence-Based Policy.* Retrieved from http://evidencebasedprograms.org.

Coetzee, E & Schnell, A (2013), *Turning children's rights into children's realities,* Policy brief. http://internationalbudget.org/wp-content/uploads/Policy-brief-BT4CR-final.pdf

Cohen, J N, Byers, E S, Sears, H A & Weaver A D (2004), 'Sexual health education: attitudes, knowledge and comfort of teachers in New Brunswick schools', *The Canadian Journal of Human Sexuality,* 13, pp. 1-5.

Cole, B (2001), *Hair in Funny Places*, Red Fox, London.

Commonwealth Department of Health and Aged Care Health Services Division (2001), *Evaluation: A guide for good practice,* Commonwealth Department of Health and Aged Care, Canberra. www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-resources-evaluation

Commonwealth of Australia (1999), *Talking Sexual Health National Framework,* Australian Research Centre in Sex, Health and Society, Melbourne.

Commonwealth of Australia (2014), *Third National Sexually Transmissible Infections Strategy 2014-2017.*

Connell, R W (1987), *Gender & Power,* Polity Press, Cambridge and Oxford.

Connell, R W (2005), *Masculinities* (2nd ed), Allen & Unwin, NSW.

Connell, R W (2009), *Gender: In World Perspective* (2nd ed), Polity Press, Cambridge.

Cooper, L, Verity, F & Bull, M (2005), *Good practices and pitfalls in community-based capacity building and early intervention projects: A toolkit,* Commonwealth of Australia, Canberra.

Council of Australian Governments (2012), *National plan to reduce violence against women and their children,* COAG, Canberra. https://www.dss.gov.au/sites/default/files/documents/05_2012/national_plan.pdf

Craig, S (1995), *Making partnership work,* Combat Poverty Agency, Dublin.

Craig, S & McKeown, K (1994), *Progress through partnership*, Combat Poverty Agency, Dublin.

Cuijpers, P (2002), 'Effective ingredients of school-based drug prevention programs: A systematic review', *Addictive Behaviours*, 27, pp. 1009-1023.

Cuijpers, P (2002), 'Peer-led and adult-led school drug prevention: a meta-analytic comparison'*, Journal of Drug Education*, 32(2), pp. 107-119.

Curriculum Materials Information Services (2007), Health Studies WACE Course Resource List, Department of Education and Training, Perth.

Davies, B (2003), *Frogs and Snails and Feminist Tales: Preschool Children and Gender,* Hampton Press, Cresskill, New Jersey.

De Graaf, H, Kruijer, H, van Acker, J, & Meijer, S (2011), *Sex under the age of 25. A population study of Dutch adolescent's sexual health*, Rutgers, Utrecht. http://www.rutgerswpf.org/how-we-work/research/sex-under-age-25

Department of Education and Child Development (2014), *Involve me: an introduction to effective youth participation,* Department of Education and Child Development, Adelaide.

Department of Education and Early Childhood Development (2004), *Catching On,* Student Learning Programs Division Office for Government School Education, Melbourne.

Department of Education and Early Childhood Development (2008a), *Catching on everywhere - Part 1 Program planning: concepts and policy,* Student Learning Programs Division Office for Government School Education, Melbourne.

Department of Education and Early Childhood Development (2008b), *Catching On everywhere - Part 2: School practice in sexuality education,* Student Learning Programs Division Office for Government School Education, Melbourne.

Department of Education and Early Childhood Development (2011), *Catching on Early: Sexuality education program for Victorian primary schools,* Student Learning Programs Division, Office for Government School Education, Melbourne.

Department of Education (2007), *Student voice: a historical perspective and new directions*, Paper no. 10, April, Department of Education, Melbourne.

Department of Health (2007), *Boys and Puberty: Almost Everything Boys Will Ever Need to Know About Body changes and Other stuff!,* Government of Western Australia, Perth.

Department of Health (2007), *Girls and Puberty: Almost Everything Girls Will Ever Need to Know About Body changes and Other stuff!* Government of Western Australia, Perth.

Department of Health (2009), Impact Evaluation Study on the professional development course for teachers in sexual health education and the use of the *'Growing and Developing Healthy Relationships Curriculum Support Materials' and preferred models of teacher professional development in sexual health education,* Government of Western Australia, Perth.

Department of Human Services (2012), Family and domestic violence strategy, Australian Government, Canberra. http://www.humanservices.gov.au/corporate/ publications-and-resources/family-and-domestic-violence-strategy

Devaney, R (1986), *An Introduction to Chaotic Dynamical Systems*, Benjamin/Cummings, Boston.

Dimmock, C. & Walker, A. (2005), *Educational Leadership Culture and Diversity*, Sage, London.

Donovan, P (1998), 'School-based sexuality education: the issues and challenges', *Family Planning Perspective,* 30, pp. 188-193.

Dyson, S (2008), 'A Whole School Approach to Sexuality Education: is it any different?*', Sexologies: European Journal of Sexual Health*, 15(S1), p. 39.

Dyson, S & Fox, C (2006), '*An evaluation of the Sexual Health and Relationships Education (Share) project 2003 – 2005',* Australian Research Centre in Sex, Health and Society, SHine SA.

Ellis, S, & Grey, A (2004), *Prevention of STIs: a review of reviews into the effectiveness of non-clinical interventions,* Health Development Agency, London.

Eriksen, J, Reddy, S & Muir, J (2012), 'Human rights and gender equality in evaluation' *in M Segone M (Ed.), Evaluation for equitable development results*. http://www.capacity.org/capacity/export/sites/capacity/documents/topic-readings/Evaluation_for_equitable_results_web.pdf

Evans, D, Coad, J, Cottrell, K, Dalrymple, J, Davies, R, Donald, C, Laterza, V, Long, A, Longley, A, Moule, P, Pollard, K, Powell, J, Puddicombe, A, Rice, C & Sayers, R (2014), 'Public involvement in research: assessing impact through a realist evaluation', *Health Services and Delivery Research*, 2, p. 36.

Family Planning Victoria, Royal Women's Hospital and Centre for Adolescent Health (2006), *The Sexual and Reproductive Health of Young Victorians,* Women's Health Victoria, Melbourne.

Farrelly, C, O'Brien, M & Prain, V (2007), 'The discourses of sexuality in curriculum documents on sexuality education: an Australian case study', *Sex Education*, 7(1), pp. 63-80.

Fast Forward (1997), *The Crunch. Negotiating the agenda with young people. A peer education training manual,* Health Education Board for Scotland, Edinburgh.

Ferguson, R, Vanwesenbeeck, I & Knijn, T (2008), 'A matter of facts… and more: an exploratory analysis of the content of sexuality education in The Netherlands', *Sex Education*, 8(1), pp. 93-106.

Fielding, M (2001), Students as radical agents of change, *Journal of Educational Change*, 2(2), pp. 123-141.

Fielding, M (2004), '"New Wave" student voice and the renewal of civic society', *London Review of Education*, 2(3), pp. 197-217.

Fielding, M (2007), 'Beyond "voice": new roles, relations, and contexts in researching with young people, *Discourse: studies in the cultural politics of education*, 28(3), pp. 301-310.

Fine, M & McClelland, S (2006), 'Sexuality education and desire: still missing after all these years', *Harvard Educational Review*, 76(3), pp. 297-338.

Fink, A & Kosecoff, J (1998), *How to conduct surveys - A step by step guide* (2nd ed.), Sage Publications, Beverly Hills.

First International Conference on Health Promotion Ottawa (1986), http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf.

FIT (Foundation for International Training) (1983), *Training of trainers,* Markham, Canada.

Fitz-Enz, J (1994), 'Yes, you can weigh trainers' value', *Training*, 31 (7), pp. 54–58.

Fitzgerald, T (2004) 'Powerful Voices and Powerful Stories: Reflections on the Challenges and Dynamics of Intercultural Research'. *Journal of Intercultural Studies* 25(3): 233-245.

Fleming N D (1995), 'I'm different; not dumb. Modes of presentation (VARK) in the tertiary classroom', in *Research and Development in Higher Education*, edited by A. Zelmer.

Flood, M & Hamilton, C (2003), *Youth and Pornography in Australia: Evidence on the Extent of Exposure and Likely Effects,* Discussion Paper No. 52, Australia Institute.

Formby, E, Hirst, J, Owen, J, Hayter, M, and Stapleton, H (2010), Selling it as a holistic health provision and not just about condoms … Sexual health services in school settings: current models and their relationship with SRE policy and provision', *Sex Education: Sexuality, Society and Learning.* 10(4).

Foster, R & Goddard, T (2003), 'Leadership and culture in schools in northern British Columbia: Bridge building and/or re-balancing act?', *Canadian Journal of Educational Administration and Policy*, 27.

Foucault, M (1972), *The Archaeology of Knowledge* (translated A. M. Sheridan Smith), Tavistock, London.

FPWA (2008), *The Mooditj Manual: A sexual health and life skills program for Aboriginal youth*, 3rd edition, Family Planning Association of WA, Western Australia.

Frances, B (1998), *Community based Health Promotion – Evaluation and Development,* SA Community Health Research Unit, South Australia.

Freiberg, H J (Ed) (1999), Beyond behaviorism: Changing the classroom management paradigm. Boston: Allyn and Bacon.

Funnell, S & Rogers, P (2011), *Purposeful Program Theory: Effective Use of Theories of Change and Logic Models,* John Wiley & Sons, Queensland.

Gellard, K & Gellard D (2006), *Counselling Adolescents: The proactive approach*, 2nd Edition, Sage, London.

Gillies, S, Dimitrijevich, S & Lambert, M (2011), *What is a Health Promoting School?* WA Health Education Services, Western Australia.

Gingiss, P (1992), 'Enhancing program implementation and maintenance through a multiphase approach to peer-based staff development', *Journal of School Health,* 62(5), pp. 161-166.

Glasser W (1980), *Stations of the Mind: New Directions for Reality Therapy*, Harper Collins, New York.

Gleeson, C, Kearney, S, Leung L & Brislane, J (2015), *Respectful Relationships: Education in Schools*. Our Watch, Australia.

Goff, S (2001), *Participatory evaluation manual. Professional Development Network for the NSW Department of Education*, Ryde, NSW.

Goldsworthy, A (2005), *The heart and soul of leadership*. Retrieved from http://www.aim.com.au/publications/bkchapters/heart_ch8.html

Goleman, D (1998), *What Makes a Leader?,* Harvard Business Review, Harvard.

Goleman, D (2005), *Emotional Intelligence: Why It Can Matter More than IQ,* Bantam Books.

Gorman, D M (1998), 'The irrelevance of evidence in the development of school-based drug prevention policy', *Evaluation Review*, 22, pp. 118-146.

Gourlay, P (1995), 'Sexuality education', *Family Matters,* (41), pp. 39-42.

Gray, M, Plath, D, & Webb, S (2009), *Evidence-based Social Work: A Critical Stance*, Routledge, London.

Greenhalgh T, Toon P, Russell J, Wong G, Plumb L & Macfarlane F (2003), 'Transferability of principles of evidence based medicine to improve educational quality: systematic review and case study of an online course in primary health care', *British Medical Journal*, 326.

Grunseit, A & Kippax, S (1993), *Effects of sex education on young people's sexual behaviour,* World Health Organization, Geneva.

Hallinger, P & Leithwood, K (1998), 'Unseen forces: The impact of social culture on leadership', *Peabody Journal of Education*, 73(2), pp. 126-151.

Harris, R (1994), *Let's Talk About sex: Growing Up, Changing Bodies, Sex and Sexual Health,* Walker Books.

Harrison, L & Ollis, D (2015), 'Stepping out of our comfort zones: pre-service teachers responses to a critical analysis of gender/power relations in sexuality education', *Sex Education: Sexuality, Society and Learning,* 15(3), pp. 318-331.

Hawe, P, Degeling, D & Hall, J (2000), *Evaluating health promotion: A health worker's guide* MacLennan and Petty, Sydney.

Health Canada (2003), *Canadian guidelines for sexual health education,* Ministry of Health (Community Acquired Infection Division, Centre for Infectious Disease Prevention and Control Population and Public Health Branch), Canada.

Hillier, L, Jones, T, Monagle, M, Overton, N, Gahan N, Blackman, J & Mitchell, A (2010), *Writing Themselves in 3: The third national study on the sexual health and well-being of same sex attracted and gender questioning young people*, Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne.

Hillier, L, Turner, A & Mitchell, A (2005), *Writing themselves in again – 6 years old. The second national report on the sexual health and wellbeing of same-sex attracted young people in Australia*, Australian Research Centre in Sex, Health and Society, La Trobe University, Victoria.

Holmes, M (2007), *What is Gender? Sociological Approaches,* Sage, London.

Holton, E (1996), 'The flawed four-level evaluation model', *Human Resource Development Quarterly*, 7 (1), pp. 5–21.

Horton, D, Alexaki, A, Bennett-Lartey, S, Brice, KN, Campilan, D, Carden, F, de Souza Silva, J, Duong, LT, Khadar, I, Boza, AM, Muniruzzaman, IK, Perez, J, Chang, MS, Vernooy, R & Watts, J (2003), *Evaluating Capacity Development: Experiences from Research and Development Organisations around the World*. International Service for National Agricultural Research (ISNAR).

Human Rights Council (2014), *Towards better investment in the rights of the child [Agenda items 2 and 3 of the Annual report of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commissioner and the Secretary-General's 28th session [A/HRC/28/33]*. http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session28/Pages/ListReports.aspx.

Hunter, D & Nielsen, S B (2013), 'Performance management and evaluation: Exploring complementarities', *New Directions for Evaluation*, 137, pp. 7–17.

Impact Evaluation Working Group (2012), *Dare to measure*, Retrieved from http://www.cpb.nl/en/article/daremeasure-evaluation-designs-industrial-policy-netherlands.

IEG see: Independent Evaluation Group.

Inchley, J, Currie, C & Young, I (2000), 'Evaluating the health promoting school: A case study approach', *Health Education*, 100, pp. 200-206.

Independent Evaluation Group (2008), *Using Training to Build Capacity for Development An Evaluation of the World Bank's Project Based and WBI Training*, The World Bank, Washington DC.

Information Access Group (2012), *Benchmark report,* unpublished, Sexual Health and Blood-borne Virus Program, Western Australian Department of Health, Perth.

Johnson, B (2006), *Final research report: An evaluation of the trial implementation of the Sexual Health and Relationships Education (SHARE) program 2003-2006,* University of South Australia, Adelaide.

Jones, T (2011), 'A Sexuality Education Discourses Framework: Conservative, Liberal, Critical, and Postmodern', *American Journal of Sexuality Education*, 6(2), pp. 133- 175.

Kalnins, I, Ballanryne, P, Quataro, G, Love, R, Sturis, G & Pollack, P (1994), 'School based community development as a health promotion strategy for children', *Health Promotion International,* 9, pp. 269-279.

Kaufman, R, Keller, J, & Watkins R (1995), 'What works and what doesn't: Evaluation beyond Kirkpatrick', *Performance and Instruction*, 35 (2), pp. 8–12.

Keller, J (1996), *Evaluating diversity training: 17 ready-to-use tools*, Pfeiffe, San Diego.

Kim, C & Free, C (2008), 'Recent evaluations of the peer-led approach in adolescent sexual health education: A systematic review', *International Family Planning Perspectives Journal*, 34 (2), pp. 89 – 96.

King County Sexual Assault Resource Center (2009), *Reducing the Risk for Children in Our Care*, King County Sexual Assault Resource Centre, Washington.

Kirby, D (2001), *Emerging answers: research findings on programs to reduce teen pregnancy,* National Campaign to Prevent Teen Pregnancy, Washington DC.

Kirby, D (1999), 'Reflections on two decades of research on teen sexual behaviour and pregnancy', *Journal of School Health*, 69, pp. 89-94.

Kirby, D (2001), *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy*, National Campaign to Prevent Teen Pregnancy, Washington DC.

Kirby, D & Rolleri L (2005), *Impact of sex and HIV education programs on sexual behaviours of youth in developing and developed countries,* Family Health International, North Carolina.

Kirby, D, Short, L, Collins, J, Rugg, D, Kolbe, L, Howard, M, Miller, B, Sonenstein F & Zabin L (1994), 'School-based programs to reduce sexual risk behaviors: a review of effectiveness', *Public Health Reports,* 10, pp. 339-360.

Kirkpatrick, D (1959), 'Techniques for evaluating training programmes', *Journal of the American Society of Training Directors*, 13 (11), pp. 3–9.

Kirkpatrick, D (1998), *Evaluating training programs: The four levels* (2nd ed.), Berrett-Koehler Publishers, San Francisco.

Knowles, M (1980), *The modern practice of adult education: From pedagogy to andragogy,* Cambridge Adult Educator, Englewood Cliffs.

Kolb, D (1984), *Experiential learning,* Prentice-Hall, New Jersey.

Konrad, C (2001), 'The adolescent and interactive mentor program', *Health in Schools Journal*, 8 (2).

Kurtz, G & Snowden, D (2003), 'The new dynamics of strategy: Sense-making in a complex and complicated world', *IBM Systems Journal*, 42, no. 3, pp. 462- 483.

Labin, S N, Duffy, J L, Meyers, D C, Wandersman, A & Lesesne, C A (2012), 'A research synthesis of the evaluation capacity building literature', *American Journal of Evaluation*, 33(3), pp. 307–338.

Larkins, S, Page, P, Panaretto, K, Scott, R, Mitchell, M, Alberts, V, Veitch P & McGinty S (2007), 'Attitudes and behaviours of young Indigenous people in Townsville concerning relationships, sex and contraception: the "U Mob Yarn Up" project', *Medical Journal of Australia,* 186 (10), pp. 513-518.

Lau, A & Roffey, B (2002), 'Management education and development in China: A research note', *Labour and Management in Development Journal*, 2, no. 10, pp. 3-10.

Larson, A, Mitchell, E & Gilles, M (2001*), Looking, listening and learning about young Aboriginal people's views of sexual health in Carnarvon, Western Australia.* Combined Universities Centre for Rural Health, Western Australia.

Leading Insight Pty Ltd (2000), *An analysis of the training needs of people working in the area of sexual health promotion in Western Australia,* Health Department of Western Australia and FPWA, Western Australia.

Leahy, D & McCuaig, L (2013), 'Supporting teachers to teach relationships and sexuality', *Learning*, 10 (2), pp. 217-230.

Lee, S & Pershing, J (2002), 'Dimensions and design criteria for developing training reaction evaluations', *Human Resource Development International*, 5 (2), pp. 175-97.

Leger, L & Nutbeam, D (2000), 'A model for mapping linkages between health and education agencies to improve school health', *Journal of School Health*, 70, pp. 45–50.

Lepsinger, R & Lucia, A (1997), *The Art and Science of 360 Degree Feedback*, Jossey-Bass, San Francisco, California..

Levenson-Gingiss, P & Hamilton, R (1989), 'Evaluation of training effects on teacher attitudes and concerns to implementing a human sexuality education program', *Journal of School health,* 59: pp. 156-160.

Lezin, N (n.d), *With a Little Help From My Friends: Peer Education in Teen Pregnancy Prevention,* Resource Centre for Adolescent Pregnancy Prevention. www.etr.org/recapp/theories/peereducation/index.htm

Lister-Sharp, D, Chapman, S, Stewart-Brown, S & Sowden, A (1999), 'Health promoting schools and health promotion in schools: two systematic reviews', *Health Technology Assessment*, 3(22), pp.1-207.

Lodge, C (2005), 'From hearing voices to engaging in dialogue: problematizing student participation in school improvement', *Journal of Educational Change*, 6(2), pp. 125-146.

Lokanic-Diluzio, W, Cobb, H, Harrison, R & Nelson A (2007), 'Building capacity to talk, teach, and tackle sexual health' (Report), *The Canadian Journal of Human Sexuality* 16(4), pp. 135-145.

Loos, G & Fowler, T (1999), *A model for research on training effectiveness,* NIOSH, Cincinnati.

Macbeth, A, Weerakoon, P & Sitharthan, G (2009), 'Pilot study of Australian school-based sexual health education: parents' views', *Sexual Heath,* 6, pp. 328-333.

Maiano, C, Ninot, G & Bilard, J (2004), 'Age and gender effects on global self-esteem and physical self-perception in adolescents', *European Physical Education Review,* 10(1), pp. 53-69.

Mannison, M (1999), *Interactive teaching strategies adolescent sexuality,* Nice Business Publications, Queensland.

Marie Stopes International (2008), *SEX — Telling it like it is: A parent and teen insight*. www.mariestopes.com.au/research.

Martinez, A & Cooper, V (2006), *Laying the foundations: sex and relationships education in primary schools,* National Children's Bureau, United Kingdom.

Maslow, A (1943), 'A theory of human motivation', *Psychological Review, 50*, pp. 370-396. Retrieved June 2001, from http://psychclassics.yorku.ca/Maslow/motivation.htm.

Mazin, R (2014), Introduction Health + Equality + School Engagement: Scenarios USA reinvents Sex Education, 'Quality/Calidad/Qualite Population Council', 21: pp. 1-3.

McDonald, J, Roche, A, Durbridge, M & Skinner, N (2003), *Peer education: From evidence to practice: An alcohol and other drugs primer,* National Centre for Education and Training on Addiction, Finders University of South Australia, Adelaide.

McKay, A & Barrett, M (1999), 'Pre-service sexual health education of elementary, secondary, and physical education teachers in Canadian faculties of education', *The Canadian Journal of Human Sexuality* 8, pp. 91-102.

McLaughlin, C & Swartz, S (2015), 'Inviting Backchat: How schools and communities in Ghana, Swaziland and Kenya support children to contextualize knowledge and create agency through sexuality education', *International Journal of Educational Development*, 41, pp. 208-216.

McLaughlin, C, Swartz, S, Kiragu, S, Walli, S & Muhamed, M (2012), *Old Enough To Know: Consulting Children on African Sexualities,* Human Sciences Research Council Press, Cape Town, South Africa.

MCEETYA see: Ministerial Council on Education, Employment, Training and Youth Affairs.

Mikhailovich, K & Arabena, K (2005), 'Evaluating an Indigenous sexual health peer education project', *Health Promotion Journal of Australia*, 16 (3), pp. 189-93.

Milat, A, Newson, R, King, L, Rissel C, Wolfenden, L, Bauman, A, Redman, S & Giffen, M (2016), 'A guide to scaling up population health interventions', *Public Health Research and* Practice, 26(1).

Milburn, C (29 May, 2006), Think sex, *The Age,* Retrieved from www.theage.com.au.

Miles, B & Huberman, A (1994), *Qualitative data analysis: An expanded sourcebook*. Sage, Thousand Oaks.

Miller, P & Torzillo, PJ (1998), 'Private business: The uptake of confidential HIV testing in remote Aboriginal communities on the Anangu Pitjanjatjaru Lands', *Australian and New Zealand Journal of Public Health*, 22(6), pp. 700-703.

Mitchell A, Patrick K, Heywood W, Blackman P & Pitts M (2014), *5th National Survey of Australian Secondary Students and Sexual Health 2013*, (ARCSHS Monograph Series No. 97), Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, Australia.

Mitchell, E & McMahon, S (1999), 'Girlpower and P.A.S.H. (Promoting Adolescent Sexual Health) - Aboriginal health programs', *Eleventh National Health Promotion Conference: Building Social Capital in the 21st Century*, Hyatt Regency Hotel, Perth, Western Australia.

Ministerial Council on Education, Employment, Training and Youth Affairs (2008), *Melbourne Declaration on Educational Goals for Young Australians*, Melbourne.

Mkumbo, K, A K (2013), 'Old enough to know: consulting children about sex and AIDS education in Africa', *Sex Education: Sexuality, Society and Learning*, 13(4), pp. 478-480.

Moore, S & Rosenthal, D (2006), *Sexuality in adolescence*: *current trends* in Furlong, A (Ed.) *Handbook of youth and young adulthood*, Routledge, London.

Nielsen, S B, Lemire, S & Skov, M (2011), 'Measuring evaluation capacity - results and implications of a Danish study' *American Journal of Evaluation*, 32(3), pp. 324–344

Nutbeam, D (1992), 'The Health promoting school: Closing the gap between theory and practice', *Health Promotion International*, 7, pp. 151-153.

Nutbeam, D (2000), 'Health literacy as a public health goal: A challenge for contemporary health education and communication strategies into the 21st century', *Health Promotion International,* 15, pp. 259-268.

Nutbeam, D (2004), *Theory in a nutshell: a practical guide to health promotion theories,* McGraw-Hill, Sydney.

Nutley, S, Walter, I & Davies, H (2007), *Using evidence: How research can inform public services*, University of Bristol, Bristol.

O'Connor, M & Parker, E (2001), *Health promotion: principles and practice in the Australian context,* Allen & Unwin, Crows Nest, NSW.

Oakley, A (1972), *Sex, Gender and Society,* Sage, London.

Oakley, A, & Fullerton, D (1994), *Reviews of effectiveness: HIV prevention and sexual health education interventions,* University of London Institute of Education, London.

Ollis, D (2013), Position Paper No. 1*:* Comprehensive Sexuality Education, *The Engaging Young People in Sexuality Education Project (EYPSEP)*, Deakin University.

Ollis, D (2011), 'A Respectful Relationships Approach: Could it be the answer to preventing gender-based violence?' *Redress: Journal of the Association of Women Educators*, 20 (2), pp. 19-26.

Ollis, D & Tomaszewski, I (1993), *Gender and Violence Project: Position Paper*, Australian Government Publishing Service, Canberra.

Owen, J & Rogers, P (1999), *Program evaluation: Forms and approaches* (2nd ed.), Allen & Unwin, St Leonards.

Palmer, P J & Palmer, P (1998), *The Courage to Teach*, University of Michigan, Michigan.

Parenthood Publications (2008), *The facts of life: A guide for teens & families*. www.ppfastore.org/publications.html.

Parker, I (2014), *Young people, sex and relationships: the new norms*. http://www.ippr.org/publications/young-people-sex-and-relationships-the-new-norms.

Parkin, S & McKegney, N (2000), 'The rise and rise of peer education approaches', *Drugs: Education, Prevention and Policy*, 793, pp. 293-310.

Patterson, K, Grenny, J, Maxfield, D, McMillan, R & Swirtzler, A (2008), *Influencer: The power to change anything*, MacGraw-Hill, New York.

Patton, M (2001), *Qualitative research & evaluation methods*, Sage, St Paul, Minneapolis.

Patton, M (2008), *Utilization-focused evaluation* (4th ed.), Sage, Thousand Oaks, California.

Peppard, J L (2008), 'Culture Wars in South Australia: the sex education debates', *Australian Journal of Social Issues*, 43(3) pp. 499-516.

Phillips, R, McNaught, C & Kennedy, G (2012), *Evaluating e-learning: Guiding research and practice*, Routledge, New York.

Population Council International Sexuality and HIV Curriculum Working Group (2009), *It's all one curriculum. Guidelines and activities for a unified approach to sexuality, gender, HIV and human rights education,* Population Council, New York.

Porn exposure a growing problem (2012), *The West Australian.* November 9, 2012.

Powell, A (2007), 'Youth at risk: Young people, sexual health and consent', *Youth Studies Australia*, 26(4), pp 21-28.

Preskill, H & Boyle, S (2008), 'A multidisciplinary model of evaluation capacity building', *American Journal of Evaluation*, 29(4), pp. 443–459.

Prochaska, J & DiClemente, C (1982) *Psychotherapy: Theory, Research & Practice*, Vol 19(3): 276-288.

Prochaska J, DiClemente C, & Norcross J (1992), 'In search of how people change. Applications to addictive behaviors', *American Psychologist*, 47(9), pp. 1002-1114.

Prochaska, J O, Redding, C & Evers, K (2002), 'The Transtheoretical Model and stages of change'. In K. Glanz, F.M. Lewis and B.K. Rimer (Eds.), *Health Behavior and Health Education: Theory, Research and Practice* (3rd Edition). New York: Jossey-Bass Publications.

RACP see: Royal Australasian College of Physicians.

Rasmussen, L (2001), *Towards Reconciliation in Aboriginal Health: Initiatives for Teaching Medical Students about Aboriginal Issues*, University of Melbourne, Melbourne.

Ray, C & Jolly, J (2002), *Forum Factsheet: Sex and Relationships Education for Primary Age Children*, Sex Education Matters, London.

Reynold, E & Ringrose, J (2008), 'Regulation and rupture: Mapping tween and teenage girls' resistance to the heterosexual matrix', *Feminist Theory,* 9(3), pp. 313-338.

Richardson, J & Schuster, M (2003), *Everything you never wanted your kids to know about sex (but were afraid they'd ask): The secrets to surviving your child's sexual development from birth to the teens*, New York.

Ridge, D, Marshal, B, Northfield, J, Maher, S, Leger, L, Sheehan, M & Elisha, D (2000), *Health Promoting Schools in action: An evaluation*, Deakin University, Melbourne.

Ridge, D, Northfield, J, Leger, L, Marshall, B, & Sheehan, M (2002), 'Finding a place for health in schooling process: A challenge for education', *Australian Journal of Education*. 46(1), pp. 19-33.

Robinson, C & Taylor, C (2007), 'Theorizing student voice: values and perspectives', *Improving Schools*, 10(5), pp. 5-17.

Rog, D J (2012), 'When background becomes foreground: Toward context-sensitive evaluation practice', *New Directions for Evaluation*, 135, pp. 25–40.

Rogers, P J (2000a), 'Program theory: Not whether programs work but how they work'. In Stufflebeam, D L, Madaus, G F & Kellaghan, T (Eds.) *Evaluation models: Viewpoints on educational and human services evaluation* (2nd ed.), Boston: Kluwer: pp. 209–232.

Rogers, P J (2000b), 'Causal models in program theory evaluation'. In Rogers, Petrosino, Hacsi, & Huebner (eds.). *Program theory evaluation: Challenges and opportunities*, Jossey-Bass, San Francisco.

Rogers, P J (2001), 'The whole world is evaluating half-full glasses', *American Journal of Evaluation*, 22(3), pp. 431-435.

Rogers, P J (2003), 'Reflections on learning about Australasian evaluation theory and practice', *Evaluation Journal of Australasia*, 2, pp. 30-34.

Rogers, P J (2007), 'Theory-based evaluation: Reflection ten years on. Enduring issues in evaluation: The 20th anniversary of the collaboration between NDE and AEA', *New directions for evaluation*, 114: pp. 63-67.

Rogers, P J (2008), 'Using programme theory for complicated and complex programmes, *The International Journal of Theory, Research and Practice*, 14 (1), pp. 29-48.

Rogers, P J (2009), 'Learning from the evidence about evidence-based policy', in Productivity Commission (ed.), *Strengthening Evidence-Based Policy in the Australian Federation,* Productivity Commission, Melbourne.

Rogers, P J (2009), 'Matching impact evaluation design to the nature of the intervention and the purpose of the evaluation', *Journal of Development Effectiveness*, 1 (3), pp. 217-226.

Rogers, P J & Hough, G (1995), 'Improving the effectiveness of evaluations: Making the link to organisational theory', *Evaluation and Program Planning*, 18 (4), pp. 321-332.

Rogers, P J & Williams, B (2006), *Evaluation for practice improvement and organizational learning*, Sage, London.

Rogers, P J, Petrosino, A J, Hacsi, T & Huebner, T A (2000), 'Program theory evaluation: practice, promise and problems'. In Rogers, Petrosino, Hacsi & Huebner (ed.). *Program theory evaluation: Challenges and opportunities, New Directions in Evaluation series*, Jossey-Bass, San Francisco.

Rogers, P, Stevens, K & Boymal, J (2008), 'Qualitative cost-benefit evaluation of complex, emergent programs', *Evaluation and Program Planning*, 32 (1), pp. 83-90.

Rosenfield, R, Bachrach, l, Chernausek, S, Gertner, J, Gottschalk, M, Hardin, D, Ross, J, Luepker, R, Nelson, G, Sgavedra, P & Hubbard B (1991), 'Teenage health teaching modules: impact of teacher training implementation and student outcomes', *Journal of Health,* 61(1), pp. 31-34.

Rosenstock I M (1974), 'Historical origins of the health belief model', *Health Education Monograph*, 2, pp. 328-335.

The Royal Australasian College of Physicians (2015), *Position Statement: Sexual and Reproductive Health Care for Young People.*

Rudduck, J (2006), 'The past, the papers and the project', *Educational Review*, 58(2), pp. 131-143.

Rudduck, J & Fielding, M (2006), 'Student voice and the perils of popularity', *Educational Review*, 58(2), pp. 219-231.

Rychetnik, L & Frommer, M (2000), *A proposed schema for evaluating public health interventions: A discussion paper prepared for the National Public Health Partnership*, NPHP, Melbourne.

Saenger, P (2000), 'Current Age of Onset of Puberty', *Pediatrics*, 106, pp. 622–23.

Santelli J S, Ott M A, Lyon M, Rogers J, Summers D (2006), 'Abstinence-only education policies and programs: A position paper of the Society for Adolescent Medicine', *Journal of Adolescent Health,* 38, pp. 83–87.

Save the Children (2014), *A toolkit for monitoring and evaluating children's participation - booklet 1*, Save the Children, London.

Savin-Williams, R (2005), *The New Gay Teenager,* Harvard University Press, Harvard, Massachusetts.

School Drug Education & Road Aware (2014), *Keys for Life*, SDERA, Western Australia.

Scougall, J (2011), *An evaluation of the Aboriginal Educators Programme*. Report prepared on behalf of The Family Planning Association of WA Inc., unpublished, Perth.

Sette, C. (n.d.), *Participatory evaluation*. http://betterevaluation.org/plan/approach/participatory_evaluation.

Shadish, W, Cook, T & Levington, L (1991), *Foundations of program evaluation*, Sage, Newbury Park.

SHine SA (2006), *Teach it like it is*, Sexual Health Information Networking and education SA Inc., Woodville, South Australia.

SHine SA (2011), *Teach it like it is 2*, Sexual Health Information Networking and Education SA Inc., Woodville, South Australia.

Shiner, M (2000), *Doing it for themselves: An evaluation of peer approaches to drug prevention*. Public Policy Research Unit, Goldsmith College, University of London, London.

Siecus (1998), *Right from the start: Guidelines for sexuality issues, birth to five years*, Siecus, New York.

Smith, A, Agius, P, Dyson, S, Mitchell, A & Pitts, M (2002), *Secondary Students and Sexual Health*, Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne.

Smith, A. Agius, P, Dyson, S, Mitchell, A & Pitts, M (2003), *Secondary Students and Sexual Health 2002: Report of the findings from the 3rd National Survey of Australian Secondary Students, HIV/AIDS and Sexual Health,* La Trobe University, Melbourne.

Smith, A, Agius, P, Mitchell, A, Barrett, C & Pitts, M (2009), *Secondary Students and Sexual Health 2008: Results of the 4th National Survey of Australian Secondary Students,* Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne.

Smith, A, Schlichthorst, M, Mitchell, A, Walsh J, Lyons A, Blackman, P & Pitts, M (2011), *Sexuality Education Results of the 1st National Survey of Australian Secondary Teachers of Sexuality Education 2010*, Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne.

Smith, E, Jones, T, Ward, R, Dixon, J, Mitchell, A & Hillier, L (2014), *From Blues to Rainbows: The mental health and well-being of gender diverse and transgender young people in*

Australia, Australian Research Centre in Sex, Health and Society (ARCSHS), La Trobe University, Melbourne.

Sorenson, A & Brown, G (2007), Sexual health education and young people in WA: A youth consultation. Perth: Department of Health.

Stake, R E (2000), 'The case study method in social inquiry'. In R. Gomm, M. Hammersley & P. Foster (Ed.), *Case study method: Key issues, key texts*, SAGE, London.

Stein, M, Smith, M & Silver, E (1999), 'The development of professional developers: learning to assist teachers in new settings in new ways', *Harvard Educational Review* 109(3), pp. 237-269.

Stern, E (2015), *Impact Evaluation: A Guide for Commissioners and Managers*, Report prepared for the Big Lottery Fund, Bond, Comic Relief and the Department for International Development, Bond, London.

Stewart, S (2006), *Cultural Competence in Health Care,* Diversity Health Institute, Position Paper.

Stewart, S & McLoughlin, C (2007), *Design features of an e-mentoring system for the health professions: choosing to learn in partnership.* in Proceedings ASCILITE 2007 ICT: Providing Choices for Learners and Learning.

Stoller, R J (1968), *Sex and Gender: The development of masculinity and femininity*, Karnac, London.

Tamkin, P, Yarnall, J & Kerrin, M (2002), *Kirkpatrick and beyond: A review of models of training evaluation*, Institute of Employment Studies, United Kingdom.

Taschereau, S (1998), *Evaluating the impact of training and institutional development: A collaborative approach*, World Bank, Washington DC.

Taylor, C & Robinson, C (2009), 'Student voice: theorising power and participation', *Pedagogy, Culture & Society*, vol 17(2), pp. 161-175.

Taylor, P (2001), *Ten key stages towards effective participatory curriculum development*, Helvetas, Zurich.

Taylor, P (2003), *How to design a training course*, Continuum, London.

Thomas, L, Grage-Moore, S & Thomas, I (Information Access Group) (2012), *Growing and Developing Healthy Relationships Website Content Review, Survey of Key Stakeholders and Opinion Leaders,* SHBBVP (unpublished), Perth.

Thomas, L, Grage-Moore, S & Thomas, I (Information Access Group) (2012), *Initial Report - Early Observations, Growing and Developing Healthy Relationships, Website Content Review*, SHBBVP (unpublished), Perth.

Thomas, L, Grage-Moore, S & Thomas, I (Information Access Group) (2012), *Recommendations, Growing and Developing Healthy Relationships Website Content Review,* SHBBVP (unpublished), Perth.

Tiggemann, M (2005), 'Television and adolescent body image: The role of program content and viewing motivation', *Journal of Social and Clinical Psychology,* 24, pp. 193-213.

Trujillo-Ball, LA (2003), *Mexican American female principles and their chameleon identity: working against s socially constructed identity in a predominantly white school district*, University of Texas, Houston.

Turner, G & Shepherd, J (1999), 'A method in search of a theory: Peer education and health promotion', *Health Education Resource*, 14 (2), pp. 235 – 247.

UNESCO see: United Nations Educational, Scientific and Cultural Organization.

UNFPA see: United Nations Population Fund.

UNFPA, WHO and Federal Centre for Health Education (2015), *Sexuality Education. Policy Brief No. 2*, BZgA (WHO), Germany.

United Nations Educational, Scientific and Cultural Organization (2009), *International technical guidance on sexuality education: An evidence-informed approach for schools, teachers and health educators*, (UNESCO, Paris, France p.2).

United Nations Educational, Scientific and Cultural Organization (2009), *International Technical Guidance on Sexuality Education,* UNESCO, France.

University of Western Australia (2014), *Sport Science, Exercise and Health - Health Promotion in Schools, Diploma of Education Resource Handbook,* UWA, Perth.

University of Western Australia (2014), *Health Education SSEH5491*, Unit guide, Semester 1, Sport Science, Exercise & Health Graduate Diploma in Education, UWA, Perth.

Van Keulen, H M, Hofstetter, H, Peters, L W H, Meijer, S, Schutte, L & Van Empelen, P (2015), *Effectiveness of the Long Live Love 4 program for 13 and 14-year-old secondary school students in the Netherlands: a quasi experimental design*, Netherlands Organization for Applied Scientific Research (TNO), Delft.

Vella, J (1989), *Learning to teach: Training of trainers for community development*, Save the Children, Washington DC.

VicHealth (2004), *The health costs of violence. Measuring the burden of disease caused by intimate partner violence. A summary of findings*, Victorian Health Promotion Foundation, Melbourne.

Voyle, J A & Simmons, D (1999), Community development through partnership: promoting health in an urban indigenous community in New Zealand. *Social Science & Medicine. 49*(8): 1035-1050.

Walsh, J (2004), *Partnership theory and practice. In Partnerships for effective local development*, Creadel Publication, Universite Libre de Bruxelles.

Walsh, J (2011), *Talk soon. Talk often: a guide for parents talking to their kids about sex.* Retrieved from http://www.apo.org.au/node/25355. Australian Research Centre in Sex, Health & Society at La Trobe University, Melbourne, and Western Australian Department of Health, Perth.

WBI see: World Bank Institute

WBIEG see: World Bank Institute Evaluation Group.

Webster, R, Hunter, M, Keats, J (2002), 'Evaluating the effects of a peer support program on adolescents' knowledge, attitudes and use of alcohol and tobacco', *Drug and Alcohol Review*, 21, pp. 7-16.

Weick, K E & Sutcliffe, KM (2001), *Managing the Unexpected - Assuring High Performance in an Age of Complexity*, Jossey-Bass, San Francisco, California.

Weiss, C H (1998), *Methods for studying programs and policies*, Prentice Hall, New Jersey.

Wellings, K, Wadsworth, J & Johnson, A (1995), 'Provision of sex education and early sexual experience: the relation examined', *British Medical Journal*. 311, pp. 417-420.

Wenger, E (1998), *Communities of practice: Learning, meaning, and identity,* Cambridge University Press, Cambridge UK.

West, C & Zimmerman, D H (2009), 'Accounting for Doing Gender', *Gender and Society*, 23(1), pp. 112-122.

White, D & Pitts, M (1997), *Health promotion with young people for the prevention of substance misuse,* Health Education Authority, London.

White, H & Phillips, D (2012), *Addressing attribution of cause and effect in small impact evaluations, International Initiative for Impact Evaluation*. http://www.3ieimpact.org/media/filer_public/2012/06/29/working_paper_15.pdf.

WHO see: World Health Organization.

Wiefferink, C H, Poelman, J, Linthorst, M, Vanwesenbeeck, I, van Wijngaarden, J C M & Paulussen, T G W (2005), 'Outcomes of a systematically designed strategy for the implementation of sex education in Dutch secondary schools', *Health Education Research*, 20, pp. 323-333.

Willis J, Anderson I & Morris K (2005), *Sexual health promotion for Aboriginal and Torres Strait Islander people: a community guide to evidence-based best practice in social and behavioural interventions,* Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne. Viewed 12 February 2012, <http://www.health.gov.au/internet/main/publishing.nsf/Content/3B4FA8ECFB8823 6ACA25732B00390E8B/$File/Sexual Health Promotion for ATSI People - A Community Guide to Best Practice.pdf>.

Wilson, D (1996), 'Sexual health education: a one-stop shop', *Aboriginal and Islander Health Work Journal*, 20 (3), pp. 26-33.

Wilson, J (1995), *Mapping a winning training approach*, Kogan Page Ltd, LOndon.

World Bank Institute (2007), *Principles for considering partnership arrangements*, World Bank, Washington DC. Retrieved from: http://siteresources.worldbank.org/WBI/Resources/Partnerships/Partnership_Princi ples_ext.pdf.

World Bank Institute Evaluation Group (2007b), *Are there new approaches to the evaluation of learning programs?,* World Bank, Washington DC.

World Health Organization (1986), *Ottawa Charter for Health Promotion*, World Health Organization, Geneva.

World Health Organization (2002), *Gender and reproductive rights: sexual health,* World Health Organization, Geneva.

World Health Organization (2008), *Commission on social determinants of health (CSDH) – final report*, World Health Organization, Geneva. http://www.who.int/social_determinants/thecommission/finalreport/en/index.html

World Health Organization Regional Office for Europe and BZgA (2010), *Standards for Sexuality Education in Europe: A framework for policy makers, education and health authorities and specialists*, BZgA, Cologne.

World Health Organization (2014), *Sexual and reproductive health: Defining sexual health*, www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/>

World Health Organization (2015), *Sexuality Education Policy Brief No.2. Sexuality Education: What Is Its Impact?*, Federal Centre for Health Education, Cologne.

Yin, R K (2009), *Case study research design and methods*, Sage, Thousand Oaks, California.

Zillmann, D (2000), 'Influence of Unrestrained Access to Erotica on Adolescents' and Young Adults' Dispositions Toward Sexuality', *Journal of Adolescent Health*, 27(2), pp. 41–44.