

A Review of the International Literature on the Role of Outside Facilitators in the Delivery of School-based Sex Education

*Jan de Vries, Paula Mayock, Agnes Higgins,
Leslie Sherlock, Louise Doyle, Lorraine Andrews, Greg Sheaf*

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Dr. Jan de Vries (PI), Dr. Paula Mayock, Prof. Agnes Higgins, Leslie Sherlock, Louise Doyle,
Lorraine Andrews, Greg Sheaf

About the Authors

Dr. Jan de Vries (PI) is Senior Researcher, Psychology Lecturer, and Subject Leader at the School of Nursing and Midwifery, Trinity College Dublin.

Dr. Paula Mayock is Senior Researcher and Lecturer in Youth Research at the School of Social Work and Social Policy and Children's Research Centre, Trinity College Dublin.

Prof. Agnes Higgins is Associate Professor, Assistant Head of School, and Senior Researcher and Lecturer in Mental Health at the School of Nursing and Midwifery, Trinity College Dublin.

Leslie Sherlock is a PhD student in the Children's Research Centre, Trinity College Dublin.

Louise Doyle is Lecturer in Mental Health Nursing and PhD student at the School of Nursing and Midwifery, Trinity College Dublin.

Lorraine Andrews is Lecturer in Midwifery and PhD student at the School of Nursing and Midwifery, Trinity College Dublin.

Greg Sheaf is Librarian and Lecturer in Research Skills in Trinity College Dublin.

Foreword

It gives me great pleasure to introduce this publication. The report provides a review of the international literature in relation to sex education delivered by organisations or individuals other than the school teacher in the post-primary school settings.

The rationale for this research is a previous study commissioned by the Department of Education and Science (DES) and the Crisis Pregnancy Agency (CPA) which indicated that approximately 40% of post-primary schools use outside facilitators or 'visitors' to the classroom to teach aspects of Relationships and Sexuality Education (RSE) in the context of Social, Personal and Health Education (SPHE) and almost 80% of schools felt having more outside facilitators in schools would enhance the future implementation and delivery of RSE.

This literature review was commissioned to examine the effectiveness of sex education delivered by 'visitors' to the classroom, evidenced in the international literature. The area of 'visitors' supporting the delivery of sex education is a very specialised one. The authors have commented on the dearth of literature with this specific focus and have therefore included in their review studies in the international literature that would inform the general area of enquiry. Despite exhaustive searches the authors found that the literature in the field did not always make a distinction between programmes delivered in schools by teachers and programmes delivered by external school visitors. As a result the review focuses on what appear to be the most effective or well received programmes. The result is a useful and interesting report, one that we hope will be of particular benefit to those providing services and devising policy in relation to supporting sex education in schools. This literature review will inform a broader area of work being undertaken by the DES and the CPA on the use of outside 'visitors' to support the delivery of RSE/SPHE. As mentioned above, 'visitors' to schools have been identified by previous research as an important component of RSE/SPHE for many schools; understanding the impact of such interventions, as evidenced in the literature, will help inform the process of further developments in this area for Irish schools.

I would like to thank the researchers for their work in reviewing the literature and in compiling the report, in particular Dr. Jan de Vries, who led the research team. The Agency is confident that the report will be of practical benefit to its own work in the area of supporting Relationships and Sex Education in the context of Social, Personal and Health Education in Ireland, and to others who share this interest.

Caroline Spillane
Director
Crisis Pregnancy Agency

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1.0 Background and Introduction

Schools are one of the main sites where knowledge can be imparted on sexuality and relationships. There is widespread parental support in the Irish context for the provision of school-based sex education (Morgan, 2000; North Western Health Board, 2004; Mayock, Kitching and Morgan, 2007), and recent research also suggests that young people strongly favour classes that deal with relationships, sexuality and sexual health (Hyde and Howlett, 2004; Mayock and Byrne, 2004). However, school-based sex education is a challenging area of curricular provision and one with which many schools continue to struggle. Different approaches to provision and delivery exist: for example, relationships and sexuality education can be delivered by teachers, peers and/or outside agencies, health professionals, and some models incorporate all three modes of delivery (Young, 2004). The practice of involving outside agencies/professionals in the delivery of school-based RSE is a relatively common practice in Ireland (Mayock et al., 2007), yet there are gaps in knowledge and understanding of the potential role these professionals play in supporting schools and teachers in the delivery of sex education. This introductory section provides a background and context for an international literature review of external supports for school-based sex education, with specific reference to Relationships and Sexuality Education (RSE) in Ireland. The section begins by briefly outlining the main features of RSE policy and comments on the place of outside facilitators within this policy (Section 1.1). Attention is then drawn to dimensions of RSE policy (and existing policy guidelines) that have potential implications for schools' use of outside facilitators (Section 1.2). Section 1.3 reviews the current state of knowledge about outside facilitators to RSE in the Irish context. The final section outlines the scope and method of this international review of literature on external supports for school-based sex education.

1.1 RSE Policy and Outside Facilitators

The *Report of the Expert Advisory Group on Relationships and Sexuality Education* (Department of Education, 1995a) was the first official government document in Ireland to make a case for the introduction of Relationships and Sexuality Education (RSE). Concluding that sex education was 'generally uneven, uncoordinated and sometimes lacking', it recommended that RSE should be 'a required part of the curriculum of each primary and post-primary school, starting at junior primary level' (Department of Education, 1995a:18). The aim of Relationship and Sexuality Education is, according to the policy guidelines subsequently issued by the Department of Education (Department of Education, 1997:4), to help children to 'acquire a knowledge and understanding of human relationships and sexuality through processes which will enable them to form values and establish behaviours within a moral, spiritual and social framework'. The Department of Education announced the introduction of Relationships and Sexuality Education in 1995 (Department of Education, 1995b) and the programme commenced in schools in the autumn of 1997.

From the outset, the teaching of RSE was located within a broader programme of Social, Personal and Health Education (SPHE), although it was not until 2000 that schools were advised of the introduction of SPHE into the Junior Cycle (Department of Education and Science, 2000a) when the Department of Education and Science issued curriculum guidelines (Department of Education and Science, 2000b). Importantly, the *Report of the*

Expert Advisory Group on Relationships and Sexuality Education (Department of Education, 1995a) recommended that RSE be introduced into schools alongside the development of a school policy for SPHE/RSE. According to the Department of Education (1995a:11):

This policy, which should reflect the core values and ethos of the school, is a written statement of the aims of the programme, its organisation within the school and how it will meet the needs of students, parents and teachers.

A key recommendation of the Expert Advisory Group was that school policy statements be devised in consultation with teachers, parents, students and the Board of Management. In addition to reflecting the broader philosophy or ethos of the school, the school policy statement on RSE should, according to the Expert Advisory Group, address the management of the programme, discuss implications for training, and a plan for the review and evaluation of the programme. The policy guidelines subsequently issued by the Department of Education (Department of Education, 1997:5) outlined six steps to be taken by schools in formulating and reaching consensus on an RSE policy. The first two steps in this process advise schools to study and review relevant RSE documents and current RSE provision within their schools. In describing Step 2 – the process of reviewing of current provision of RSE – the guidelines do not mention schools' use of outside speakers or facilitators, although they do instruct schools to consider and include specific programmes (e.g. Stay Safe), special initiatives (e.g. transition year programmes), and the teaching of elements of SPHE/RSE within or across a range of existing school subjects in their review of current provision. This would not, of course, preclude schools from including the work of outside facilitators in the review. When outlining Step 3 – the drafting of an RSE policy statement – the Guidelines do give specific, albeit brief, mention to outside speakers in the context of deciding how the National Council for Curriculum and Assessment (NCCA) curriculum and guidelines are to be implemented:

In this context, issues such as confidentiality, parents' rights and responsibilities, including the withdrawal of pupils, visiting speakers, sensitive issues, class groupings and multi-class situations may arise (Department of Education, 1997:10).

On November 13th, 2007 the then Minister for Education and Science, Mary Hanafin, T.D., announced the publication of three new policy templates, one pertaining to Relationships and Sexuality Education, to support the planning process in second-level schools. The RSE template issued (www.education.ie) largely reiterates and re-affirms the steps recommended for policy formulation as outlined in the original 1997 document (Department of Education, 1997). It also suggests a number of steps (eight in total) to enable schools to revise or update RSE policy. In March, 2008, Circular 0027/2008 was issued to all second-level schools. The purpose of this Circular was to remind schools of their obligations to: (a) develop a school policy in regard to Relationships and Sexuality Education and (b) to implement a programme in this area as an element of Social Personal and Health Education at junior cycle, and as an RSE programme in senior cycle.

Specific directives on schools' use of outside facilitators are contained in the SPHE handbook issued in 2003 (Department of Education and Science, 2003: Section 7), which contains guidelines on 'The Visitor to the SPHE Class'. These guidelines start by

acknowledging that schools have traditionally looked to outside agencies for support in delivering various aspects of the curriculum. However, whilst acknowledging that ‘visitors’ can be an invaluable asset to SPHE delivery, the guidelines state firmly that ‘the delivery of the programme remains the responsibility of the teacher’ and that, even when outside agencies are engaged, the SPHE teacher needs to be ‘actively involved and present at all stages, i.e. preparation, presentation, facilitation and follow-up’ (p. 62). Specific reference is also made to approaches to engaging outside facilitators deemed to be *ineffective*, including 1) One-off talks or short programmes in reaction to a crisis; 2) One-off talks or short programmes where there is no preparation/opportunity for reflection or evaluation; 3) Scare tactics, sensationalism and/or preaching. The guidelines then set out a quite specific approach to scheduling and engaging outsiders to the school community, emphasising that when a visitor is enlisted to assist with SPHE delivery, this visit ‘represents a meeting with the school community’. This means that ‘the ethos, interests and needs of the wider school community, as outlined in the school policy on visitors, be respected’ (p. 63). The planning process is therefore strongly emphasised, suggesting that it is seen as a vital step to assuring that outside facilitation is effective.

Apart from increasing students’ knowledge on a particular aspect of the SPHE curriculum, the guidelines also refer to broader benefits of engaging ‘visitors’ or outside facilitators:

The visitor to the classroom also provides an opportunity for the teacher to network and forge working relationships with the local community and other agencies. It can provide the possibility of learning new approaches and methodologies, updating information and research, and identifying current available resources. Outside agencies can be a useful source of help and support regarding appropriate referral and providing contacts for further information. All this can assist in fostering an appreciation of the complexity and richness of the local, national, and global communities (Department of Education and Science, 2000:63).

The guidelines go on to specifically highlight the role of student evaluation of the work of ‘visitors’ to the school environment, which can be used to give feedback to the facilitator(s) and also ‘to enable the school to decide whether or not this method and/or this visitor is appropriate in future’ (p. 64). This strongly implies that the role of outside facilitators to SPHE needs to be monitored and regularly assessed by the school. The handbook also includes a number of handouts (e.g. ‘Preparing for the SPHE Visitor’, ‘Sample Letter to Parents’, ‘Student Evaluation Form’) to assist schools and teachers to effectively engage outside facilitators.

1.2 RSE Policy Guidelines: Some Implications for Schools’ Use of Outside Facilitators

In addition to the guidelines provided to schools on engaging ‘visitors’ to assist with the delivery of SPHE (Department of Education and Science, 2000), there are a number of dimensions of recommended practice in the implementation and delivery of the RSE programme that have direct implications for schools’ use of outside facilitators. These include the emphasis placed within the existing RSE policy guidelines on a ‘whole school approach’ and on ‘experiential learning approaches’ to RSE. The use of outside facilitators also merits full consideration in schools’ approach to the formulation and revision of RSE policy.

1.2.1 Whole School approach

From the outset, a commitment to the notion of a supportive school environment was central to RSE, as it was to SPHE, with the earliest documents issued by the Department of Education on the RSE curriculum (NCCA, 1997a,b) emphasising the importance of pursuing a whole school approach. For example, the 1997 RSE interim curriculum and guidelines for post-primary schools (NCCA, 1997b:7-8) stated that '(e)very teacher and staff member, every class and extra-curricular activity can offer opportunities for enhancing the personal and social development of the student' and went further to suggest that a 'supportive school environment is essential if SPHE and therefore RSE is to be effective'. Likewise, the guidelines issued subsequently by the Department of Education and Science (2000a) on the SPHE programme emphasised the central role of a supportive school environment, laying the responsibility for SPHE firmly on 'the whole school community' (Department of Education and Science, 2000a:5). There is an implicit assumption, therefore, that efforts to promote and develop the social, personal and health education of each pupil is carried out *across* the curriculum and that all teachers are in effect SPHE teachers (Department of Education and Science, 2000a:6). Accordingly, the subject should be appropriately linked with material covered in subjects apart from SPHE, including the Science curriculum (reproduction, nutrition) and English (communication skills), among other areas. Although there is (usually) at least one teacher assigned specifically to SPHE who has a distinct co-ordination and leadership role, ideally, the SPHE Co-ordinator works in collaboration with the entire staff to establish and maintain the status of SPHE within the school and to achieve balanced coverage of topics and modules. This organisational structure and, in particular, the notion of a 'whole school approach' or 'supportive school environment' (terms which are used interchangeably throughout the published curriculum guidelines and resource materials for SPHE and RSE) would require visitors or facilitators who contribute to the delivery of RSE to blend appropriately with the school's overall approach to the delivery of programme. In other words, the lessons delivered by these outside facilitators should not be viewed in isolation of other aspects of the RSE programme. This would imply that teachers need to know the content of facilitators' lessons and that facilitators also need to be aware of the coverage and content of RSE instruction by teachers within SPHE and across the curriculum.

1.2.2 Teacher as facilitator of learning

SPHE and RSE explicitly require teachers to make a distinctive shift in teaching methods from that of the teacher as instructor to teacher as facilitator of learning. This approach is emphasised and reiterated in practically all of RSE/SPHE policy and curricular guidelines issued by the Department of Education and Science. According to the 1997 *Interim Curriculum and Guidelines for Post-primary Schools* (NCCA, 1997:11), 'Teaching methods in RSE, as in all of SPHE, are concerned with the acquisition of knowledge, attitudes and skills which have implications for behaviour. An open and facilitative teaching style and participative and experiential methodologies are essential'. The learning environment therefore requires consideration, as does the overall learning experience. From a teacher standpoint, then, teaching RSE requires a high level of commitment, competencies in facilitating and promoting discussion, and the ability to address complex and sensitive issues and topics related to the lives and experiences of young people. From a pupil perspective, learning is experiential and enabling, since the environment engenders

trust and respect and confers positive regard to student views and needs. In keeping with this approach, outside facilitators would be expected to create an enabling learning environment and to use experiential learning approaches in their work within schools.

1.2.3 RSE policy development/revision within schools

As stated earlier, the *Report of the Expert Advisory Group on Relationships and Sexuality Education* (Department of Education, 1995a) recommended that education on sexuality and relationships be introduced into schools alongside the development of a school policy for RSE. The procedures to which schools are expected to adhere in developing an RSE policy are quite specific. The Department of Education (1995) recommended that each school establish a committee comprising two teachers, two members of the school's management board and two nominated parents. The task of this committee is to examine the relevant documents (e.g. the NCCA curriculum guidelines) and to engage in a wider consultation with parents, teachers and the school authorities. Only then is the committee to draw up a policy which is submitted for approval to the school's board of management and then disseminated to parents. In keeping with the overall orientation of the RSE policy-making approach within schools, it would seem important that all parties – principal, teachers, parents and pupils – are fully aware of the content of outside facilitator input. Schools would therefore be expected to discuss and agree the content of outside facilitator contributions to RSE delivery prior to the commencement of their work in the school.

1.3 The Current Role of Outside Facilitators in the Delivery of RSE: An Incomplete Picture

To date, no dedicated national 'audit' of the extent to which schools avail of outsiders or visitors to assist with the delivery of RSE has been conducted, nor has the work of such facilitators been subject to review or appraisal. Consequently, a precise statement on the extent or nature of the contribution of these professionals to the work of schools is not possible. The most relevant information available can be found in a recent study of the implementation of RSE in second-level schools published by the Crisis Pregnancy Agency and Department of Education and Science in 2007 (Mayock et al., 2007). This mixed-methods study examined the extent of RSE implementation in post-primary schools and aimed to identify the factors and processes that impact on RSE implementation and delivery. A quantitative survey was administered to a representative sample of post-primary schools to ascertain the level of implementation of RSE nationally. Qualitative data collection methods were then used to investigate the policies, processes and activities that impact on RSE delivery and involved conducting interviews with professionals at government, national and regional levels. In addition, case studies were undertaken in nine schools, carefully selected from the survey sample to reflect differing levels of implementation and delivery of RSE. While the study did not incorporate a detailed or in-depth investigation of the role of outside facilitators, *per se*, it did include a small number of interviews with outside facilitators. In addition, information on schools' use of outside facilitators was available from the survey data. The findings of this study strongly suggest that the use of outside facilitators by schools and teachers to assist with the delivery of RSE and/or other components of the SPHE programme is a relatively common practice at present, with 40% of the schools surveyed indicating that they drew on the expertise of outside facilitators to assist with the delivery of RSE. Furthermore, 80% of schools felt

that having more outside facilitators would help 'a lot' or 'somewhat' in enhancing the future implementation and delivery of RSE (Mayock et al., 2007). Although this study did not investigate the precise nature or content of outside facilitator input to RSE across the schools surveyed, the qualitative components of the study raised a number of significant issues in relation to schools' use of outside facilitators to assist with the delivery of RSE. For example, there was widespread support among government-, national- and regional-level respondents (i.e., government department officials/individuals with responsibility for RSE and SPHE management at national level; SPHE support service teams; health board personnel) for schools' availing of the expertise of outside facilitators. Indeed, a considerable number of government-level respondents felt that these outside agencies should play a greater role in RSE instruction. Interviews with teachers, SPHE co-ordinators, school principals and a small number of outside facilitators also revealed generally positive endorsement of the use of 'outsiders' to the school community in assisting with the delivery of the RSE programme. However, concern was also expressed by teachers and SPHE co-ordinators about the precise *role* of outside facilitators. Questions were raised, for example, about the need for schools to achieve and maintain a balance between teacher and outside facilitator input to RSE delivery and concerns were also expressed about the content of outside facilitator input. These findings, which were generated in the main from the study's case-study data, are perhaps unsurprising since the nine schools studied in-depth for the purpose of the research varied in the extent to which they drew on the expertise of outside facilitators. At one end of the spectrum, some schools did not avail of the services of outside facilitators, while, at the other, there were schools where facilitators of RSE covered the vast majority of the programme. Five of the nine case-study schools identified outside agencies/facilitators as an important resource, although only one of these schools reported using outside facilitators to complement an existing comprehensive in-school approach to RSE teaching. The authors of the research drew the following conclusion, based on the study's findings: 'It seems, therefore, that where RSE is poorly developed and teachers feel uncomfortable with the subject matter of RSE, schools may develop an over-reliance on outside facilitators and consequently assign all RSE teaching to outside agencies' (Mayock et al., 2007:232).

Although firm conclusions cannot be drawn about schools' use of outside facilitators – or, indeed, about the nature or content of the input of these professionals – based on this study's limited investigation of how schools draw on the resources of external agencies, the study nonetheless highlights clear inconsistencies in the manner in which schools use the skills of sexual health professionals to enhance, supplement or, alternatively, to largely deliver RSE.

1.4 Review of the International Literature on the Role of Outside Supports to School-based Sex Education: Scope and Methods

RSE is an important component of the SPHE curriculum and one with which many schools continue to struggle in terms of its implementation and delivery (Mayock et al., 2007). Clearly, outside facilitators have a potential role to play in assisting and/or complementing teacher-led RSE and in improving and enhancing the level and quality of RSE teaching within Irish schools. It is therefore important to ascertain how best schools and teachers might be supported to engage and use outside agencies and facilitators in their efforts to enhance the teaching of RSE. An international literature review of external support of

school-based sexuality and relationships education provides a useful starting point and is timely. Such a review has the potential to generate an evidence base of the type and role of outside facilitators used in supporting RSE delivery and to inform evidence-based guidelines for schools on how best to develop and advance RSE delivery in collaboration with outside facilitators.

This document reviews the available research literature on the use of outside facilitators or 'visitors' by schools to support the delivery of sex education programmes, with particular attention to the development of an evidence base of the range, type, and role of outside facilitators to sex education programmes. Materials on teacher characteristics in general which inform but do not specifically address the role of outside facilitators are included in Appendix I. Appendix II addresses considerations for pupils with special educational needs (see also Section 1.5).

The review process adhered, in a broad sense, to the following recommended principles (Slavin, 1986; Evans and Benefield, 2001):

- Systematic searching for studies
- Clear criteria for including and excluding studies
- Assessments of the methodological quality of studies
- A synthesis of quantitative and qualitative evidence

1.4.1 Systematic and exhaustive searching for studies

The main sources initially used for searching for studies on the role of outside facilitators consisted of several electronic databases, in order to ensure comprehensiveness. These included: ERIC (Educational Resources Information Centre); BEI (British Education Index); PsycLIT, the American Psychological Society's international database of the literature in psychology and related disciplines; MEDLINE, the major medical database; CINAHL (Cumulative Index to Nursing and Applied Health Literature); Social Science Citation Index; Sage Journals Online; Science Direct; British Medical Journals Online; Academic Search Premier; PsychArticles; and the Cochrane Library. The search emphasised sources in the English language, but here and there sources in other languages were also included. Materials on sex education from sources around the globe were consulted.

The key terms and combinations thereof used initially for the purpose of these searches included:

- Sexuality education/sex education
- School-based sex education
- Outside facilitators and sex education
- External facilitators of sex education
- SRE (Sexual and Relationship Education)
- RSE (Relationship and Sexual Education)
- Whole school approach to sex education
- Health Promoting Schools
- Peer-led school based sex education
- Nurse-led school based sex education
- Sexual health promotion
- HIV prevention

- AIDS prevention
- Abstinence – only
- Abstinence – plus
- Teenage pregnancy
- Adolescent sexual health
- Adolescent sexual behaviour
- Adolescent knowledge of sexual health
- Adolescent attitudes to sexual behaviour
- Sex education and vulnerable groups, truancy, intellectual disabilities, learning disabilities, physical disabilities (various types), immigrants, various religious groups

As we began to categorise literature during the search process (see later section), new terminology was included in accordance with emerging evidence of specific approaches to outside facilitation of school-based sex education. For example, specific 'types' of facilitators were identifiable (e.g. nurses, medical professionals, gay and lesbian agencies, etc.) and we therefore included additional and more specific search criteria to locate all available literature documenting evidence on the role of these individuals/agencies in the delivery of school-based sex education (examples include 'drama sex education', 'lesbian, gay, bisexual and transgender (LGBT) sex education', 'gay-inclusive. sex education' and 'medical led sex education').

Relatively quickly it became apparent that database searches were yielding only a limited number of articles on the substantive issue under review, and a number of measures were then taken in an effort to ensure that an exhaustive body of literature on the substantive topic was located. The searching for additional studies began with the scanning of reference lists of relevant articles found through database searches, a strategy which helped to identify further studies for consideration. A number of key journals in the field (e.g. Sex Education; Gender and Education; Educational Studies) were then hand searched to identify articles that had been missed in the database searches. Other types of literature included in the search included grey or fugitive literature (materials that often do not appear on conventional databases and may only be available through specialised channels).

Grey literature can consist of documents such as technical reports, research reports, discussion papers, theses, and conference proceedings. Internet searches and reference lists were used to locate both grey literature and all relevant policy documents containing specific reference to the use of outside facilitators in the delivery of school-based sex education. The internet was also used to access websites of Non-Governmental Organisations (NGOs) and other international organisations involved in the delivery of sex education (for example, SIECUS in the USA (<http://www.siecus.org>) and Rutgers-Nisso group in the Netherlands (<http://www.rutgersnissogroep.nl/English>) that might contain information pertaining to the use of external agencies or professionals by schools and teachers to assist with sex education.

The search of this type of literature sometimes met with disappointing results. For instance, the consultation of the Irish Index of Theses, which lists theses from all universities in the Republic of Ireland and Northern Ireland as well as the main Institutes

of Technology and equivalents, yielded no relevant sources. In other cases, unexpectedly rich sources were traced. In particular, the internet provided a wealth of information.

1.4.2 Criteria for including and excluding studies

Due in large part to the dearth of literature on the role of outside facilitators in the delivery of school-based sex education, we did not apply the type of inclusion/exclusion criteria often associated with systematic reviews of literature (e.g. that the evaluation of a programme has an equivalent control or comparison group; it reports pre- and post-intervention data for all individuals/groups). Neither did we exclude commentaries/opinion pieces on the substantive topic under review, which is another characteristic of many approaches to systematic reviews. Nonetheless, the overall methodological approach and rigour of relevant studies was assessed throughout the review process and, where relevant, details of the methodological approach adopted are documented. The following issues were considered in assessing the methodological rigour of all available empirical studies: study design, sample, measurement tools, data analysis methods and outcome data.

1.4.3 A synthesis of quantitative and qualitative evidence

The review included the following study types: quantitative studies (based on survey data/questionnaires); qualitative studies; in-depth case studies; policy reviews/analysis; commentaries; conference proceedings; and research reports. In keeping with Evans and Benefield's (2001) approach to 'data extraction', the following criteria were considered in an attempt to categorise the available evidence:

- *How the study can be identified* (citation details, language, the search strategy that identified it, whether it is published or unpublished)
- *Type of study* (whether it is a process or outcome evaluation [or both] and whether it is a prospective or retrospective study)
- *A description of the intervention* (including country where it was carried out, the content of the intervention, the aims, dates when it was carried out, the theoretical model underpinning it, the intervention site, its length, the type of intervention and the medium of delivery, and who was providing it)
- *A description of the study population* (age, sex, social class, ethnicity etc.) and how they were recruited into the study
- *Planning and process measures* (how the intervention was developed and by whom, how the evaluation was designed and by whom)

Studies were analysed based on relevance, applicability, quality, and other criteria emerging from the available research evidence, and a synthesis of the findings was then embarked upon using thematic techniques. The organisation of this literature review in accordance with a number of specific types of outside facilitation – including, peer-led approaches, school nurses, medical professionals, LGBT-led approaches, the use of drama, computer programmes and the internet – reflects the dominant models of facilitation evident in the literature.

1.4.4 Challenges and limitations

We are aware that a common criticism of reviews of literature is that ‘they are often unable to provide specific guidance on effective (or even ineffective) interventions; instead, they often conclude that little evidence exists to allow the question to be answered’ (Petticrew, 2003:756). Nonetheless, the lack of systematic research attention to the role of outside facilitators and agencies in the delivery of school-based sex education was a key challenge associated with this review. Additionally and importantly, it was not possible to identify much of the literature relevant to this review through the use of conventional database searches using combinations of key words and terms. This in part reflects the scarcity of dedicated evaluative research on the contribution of outside facilitators to school-based sex education but also the range of approaches and terminology used to describe or frame the contribution of these individuals and agencies. The fact that a proportion of the literature identified had not been published in peer reviewed research output also presented challenges and, to overcome these, a range of techniques were used to ensure that the search strategies yielded a comprehensive database of literature relevant to the topic under consideration. This involved broadening the search and looking for relevant literature in related and specific fields.

Sex education is not an area of research with a broad evidence base rooted in randomised control trials. However, rather than exclude relevant texts that might not meet the rigorous scientific standards associated with systematic reviews, we included and reported on relevant grey literature, qualitative studies, commentaries and policy documents that contained direct or indirect reference to outside facilitators. Thus, following Hammersley’s (2001) critique of the arguments advanced by advocates of the ‘systematic’ review as a tool for making research evidence available in usable form to policy makers and practitioners, we subscribe to the view that, particularly when complex areas of practice are under consideration, all possible sources of information need to be exploited in order to thoroughly review and appraise the available evidence on the topic under study.

1.5 Special Educational Needs and RSE

The involvement of outside facilitators can also be envisioned in relation to the provision of RSE adapted to adolescents with special educational needs. This includes physical, sensory, intellectual and learning disabilities, or any other condition that may require a different approach to teaching and learning. Present-day national and international policies aim to include these students in mainstream education rather than set them apart in special schools (Department of Science and Education Inspectorate, 2007:12). In line with the ‘whole school’ philosophy, mainstream schools in Ireland now have the obligation to make ‘reasonable’ adaptations to accommodate these groups while also ensuring that their inclusion in mainstream classroom activities is maximized. The Irish Inspectorate policy guidelines stipulate that:

Students with special educational needs should be included in mainstream classes to the greatest extent possible. Such students should be withdrawn for individual or small-group teaching only when it is clearly in their interest or at times when it is not possible to provide appropriate education in the mainstream class for them. (Department of Science and Education Inspectorate, 2007:38).

As with other classes, RSE provision to pupils with special needs is subject to this policy. Realistically, the resources available in (and to) the schools determine whether and how the individual needs for special provisions can be balanced successfully against the inclusion principle. Although solutions to this problem are outside of the scope of this report, the specificity of the accommodations that may need to be made to provide effective and meaningful RSE for these divergent groups of pupils may be an argument to call upon outside expertise. This can be in the form of support and training for mainstream teaching staff or through the introduction of qualified external facilitators to assist the special educational needs pupils (when possible within the classroom with the other pupils).

The commissioners of this literature review specified that focused considerations be made of the issues involved in the RSE provision for pupils with special educational needs and other 'vulnerable' or non-standard groups. Unfortunately, efforts to locate such literature with special reference to outside facilitators providing RSE adapted to these groups in mainstream schools yielded no publications. Broadening the scope including all teachers made little difference. This need not surprise us, because the development towards 'mainstreaming' of special needs education is of a recent date. Therefore, in order to provide at least some meaningful considerations for these pioneering efforts, the focus was expanded even further to include all literature on RSE for adolescents with special educational needs or otherwise vulnerable teenagers. The yield of this effort provided some insight into the main issues dominating the field, even though empirical publications were scarce and many of the publications were anecdotal, experiential, theoretical, or rooted in advocacy. Notwithstanding these limitations, an overview of the main findings is presented in this report. Since its scope is somewhat removed from the focus of the main text of this report, the authors thought it best to present these findings and the considerations based on them outside of the main text body (see Appendix II).

2.0 Involving Outside Facilitators or Supports in the Delivery of School-based Sex Education

Worldwide, education curricula and programmes vary according to their theoretical and methodological underpinnings. Frequently, government mandates inform their structure and content, but factors such as school ethos, culture, location and staff interest can further influence who is chosen to deliver sex education lessons, and which types of lessons are deemed acceptable. Although curriculum content varies, programmes usually discuss biological aspects of puberty and often focus their efforts on sexually transmitted infection (STI) and pregnancy prevention via abstinence or abstinence-plus models. In Ireland, standard curriculum guidelines for RSE were introduced by the Department of Education in 1997 (Mayock et al., 2007). In contrast to the widespread academic discussion and debate about theoretically-based 'abstinence-only', 'abstinence-plus' and more progressive models of sex education curricula, very little research and literature has comprehensively addressed the issue of who is facilitating or delivering such sex education lessons. While a number of systematic reviews of research on the impact of a variety of programme types are available (Suellentrop, 2009; Lopez, Tolley, Grimes and Chen-Mok, 2009; Underhill, Montgomery and Operario, 2008; Underhill, Operario and Montgomery, 2007; Kirby, Laris and Roller, 2007; Kirby, Short, Collins, Rugg, Kolbe et al., 1994; Hauser, 2004; DiCenso, Guyatt, Willan and Griffith, 2002; Silva, 2002; Corcoran, O'Dell Miller and Bultman, 1997; Kirby and Coyle, 1997), none such endeavours have been traced which address the role and impact of facilitators.

This is not surprising because, in reality, sex education is a holistic effort provided by an amalgam of different 'facilitators', whether in an official or unofficial capacity. A comprehensive approach to effective sexuality education acknowledges the role and responsibility of parents, teachers, peers, health and social care practitioners. The Canadian guidelines for Sexual Health Education emphasise that 'effective sexual health education requires collaboration between the Department of Education and Health and other relevant agencies ... in order to help coordinate the development, implementation and evaluation of sexual health curricula in schools' (Minister of Public Works and Government Services: Canada 2003). Likewise, a notable innovation of the SPHE programme in Ireland is the direct link its introduction established between schools and local Health Boards (now Health Service Executive (HSE) areas). This partnership recognises 'the way in which SPHE is embedded not just into the school but also into its social, economic and spatial and Health Board region' (Mayock et al., 2007:30). Health board specialists and others in the community are often involved in the provision of in-service support to teachers or are invited to speak to pupils in schools about a particular aspect of sex and relationships.

While the notion of school-based sex education often implies or assumes that teachers will be the sole deliverers of sex education lessons, the practice of engaging outside 'experts' or facilitators to deliver all or part of the sex education programme is a common practice in Ireland and elsewhere. The rationale for this practice is, in many cases, founded on teacher discomfort with the subject matter and content of sex education programmes and the associated belief that other professionals and/or agencies are better positioned to address specific (or, sometimes, all) aspects of the curriculum because they have a higher level of expertise on the topics of sex and relationships.

In a review of sex education in schools in England, the Office for Standards in Education (OFSTED (2005)) noted that schools generally make good use of supports from a range of individuals and agencies, including nurses, general practitioners, health promotion units, LEA (Local Education Authority) staff, theatre-in-education teams, youth workers and peer education teams. In Ireland, but also elsewhere, the role of outside supports to the schools often takes the form of the agencies providing either a small or large portion of the sex education curriculum and most often visiting the schools to do so.

Although the paucity of research focusing expressly on the 'outside facilitator' aspect of sex education delivery has already been mentioned, the particular absence of research on this common type of school-agency collaboration is noteworthy. Therefore, research located for the purpose of this review focuses more on specific or specialty *types* of external facilitation rather than on the work of agencies. For example, much has been written on the delivery of sex education by peer educators. Whilst not always viewed as 'outside' facilitation, *per se*, the use of young people as educators is an alternative to (or may be integrated with) traditional 'teacher led' models and, most often, peer educators are given instruction by 'outside agencies'. Schools' use of individuals with specific areas of expertise is also explored. Though an uncommon practice in Ireland, a limited number of studies have examined the use of medical professionals, including school nurses and medical students, as facilitators of sex education. Additionally, members of the LGBT (Lesbian, Gay, Bisexual and Transgender) community may be engaged for all or part of sex education lessons – again, often in connection with an outside agency – with the aim of addressing or combating homophobia. Furthermore, alternative models of instruction such as drama and theatrical approaches, computerised methods and internet programmes are explored in this literature review. These different models of facilitation are, again, often also provided by an outside agency or organisation and presented as an alternative, or supplement, to teacher-led sex education provision. Peer-led and teacher-led facilitation are contrasted in section 2.1.3 and a separate section on characteristics of effective RSE teaching is provided in Appendix I. Finally, the review also includes special considerations to be made for the effective inclusion of pupils with special educational needs. In light of recent policy developments towards the mainstreaming of special education, these considerations are of interest to the further development of RSE in Irish post-primary education and may have particular implications for the role of outside facilitators (see Appendix II). Relevant empirical literature on RSE for pupils with special needs was scarce, but experiential and anecdotal evidence provided important insights.

While variations in the models of outside facilitation used to complement, supplement or replace school-based sex education make it difficult to draw conclusive assertions about their effectiveness, threads of commonality can nonetheless be gleaned from the available research findings. These are discussed in detail in the concluding section of the review.

2.1 Peer-led Approaches

Internationally, peer-led approaches to sex education have increased in popularity since the mid-1980s when they were perceived as one way of mobilising efforts to design and implement HIV/AIDS prevention programmes. Consequently, a significantly larger and more in-depth body of literature exists on this, compared to other forms of 'external support' (e.g. facilitation by school nurses, medical professionals) to school-based sex

education. Strong advocates of peer-led approaches base their enthusiastic support on the assumption that sex education lessons delivered by peers are more accessible and exciting than those delivered by teachers (Forrest and Lynch, 2002). Peer-led approaches are also claimed to be more likely to be perceived as credible, trustworthy and less threatening when source-audience similarity is perceived (Pinkleton et al., 2008). Students have been found to relate well to peer facilitators, to feel better understood by them than by teachers, and to experience the lessons as fun (Forrest and Lynch, 2002). These external facilitators/visitors are often perceived to provide greater confidentiality, with slightly older peer-educators sometimes preferred because of their lack of prior and continuing contact with recipients of peer-led programmes (Forrest, Strange and Oakley, 2002).

Wight (2008) has assessed the theoretical bases for teacher and peer-led sexual health promotion, pointing out that although most peer-led programmes aspire to the concepts of self-esteem and empowerment, peer education is essentially a collection of methods without a clear theoretical basis and without much empirical support for their success. Indeed, the lack of a clear theoretical basis for peer education has been one major criticism of the approach (Turner and Shepherd, 1999).

2.1.1 Advantages of peer-led facilitation

Wight (2008) asserts that peer-education's theoretical underpinnings imply that peer educators already exist as opinion leaders within the community prior to intervention and can thus provide credible role models. This theory, of course, only applies when the peer intervention is truly comprised of 'outreach peer leaders' (those same-age peer educators coming directly from the class which they educate) rather than 'older peers' brought in to conduct formal tutoring.

Advantages of peer-led lessons are claimed to include the peer leaders' ability to educate in ways that adults cannot, their provision of positive role models, potential to re-engage students who are otherwise marginalised or excluded, propensity to increase client uptake of local services, maintenance of clear and realistic expectations, and their provision of better opportunities for discussion amongst young people (Forrest and Lynch, 2002; Pinkleton et al., 2008; Forrest et al., 2002; Mellanby et al., 2001).

Pinkleton et al. (2008) researched a peer-led abstinence-focused media literacy curriculum in Washington State in the United States which focused on sexual portrayals in the media. This study found that, compared to a control group, participants in the trial were more likely to perceive they possessed the ability to delay first sex, less likely to expect to benefit socially from sexual activity, and more aware of myths surrounding sex. Participants in the trial were further demonstrated to perceive media sexual imagery as less desirable (Pinkleton, Austin, Cohen, Chen and Fitzgerald, 2008).

The RIPPLE (Randomised Intervention of Pupil Peer Led Sex Education) Study Team (Forrest et al., 2002) conducted a qualitative analysis of a randomised controlled trial of peer-led sex education in English secondary schools in 1998/99 by comparing pupils' views on teacher- versus peer-led sex education. The peer-led portion of the trial was an introduction of the RIPPLE programme, which trains co-educational, voluntarily recruited peer educators from year 12 (age 16-17 years old) to deliver three lessons to year 9 (age

13-14 years old) students. RIPPLE peers received a standard active learning training package to work in mixed-sex teams of three having received classroom management and delivery skills in using interactive classroom strategies to cover topics of relationships, sexually transmitted diseases (STDs) and contraception (Forrest et al., 2002). Teacher controls received no additional support or training. Fifty-two focus groups were conducted in 19 schools, and questionnaires were administered to 7770 pupils. RIPPLE researchers concluded that peer-led interventions increased student satisfaction and acceptability over teacher-led programmes (Forrest et al., 2002). This trial was conducted following the UK Governmental recommendations of the Social Exclusion Unit in 1999 and the Department for Education and Employment in 2000 that schools consider incorporating peer-led sexual health interventions. The RIPPLE trial involved a total of 27 co-ed secondary schools and allocated 14 such schools to peer-led intervention, while the remaining 13 schools acted as controls by continuing with teacher-led provisions (Forrest et al., 2002). Peer educators tended to have higher than average grades and were more often female and 'white', thus not proportionately representative of the pupils taught. Despite some debate about the methodological imperfections of this and similar studies (Kim and Free, 2008), the qualitative findings provide insight into the advantages and disadvantages to peer-led approaches (Forrest et al., 2002).

The RIPPLE study's findings suggest that peer-led programmes have distinct characteristics that contribute to student satisfaction and acceptability (Forrest et al., 2002). For example, students appreciated that peer-led sessions were conducted using active teaching methods, while most teacher-led lessons were delivered in lecture style. The results also indicate that significantly more students received sex education lessons if taught by peer educators, potentially an effect of the particular effort invested in the intervention programme. Students perceived the content of lessons delivered by peer-educators to be significantly more relevant to their lives and reported more student participation in discussions and questioning of the sex educator. Peer-educators were perceived to be enthusiastic, imaginative, allowing of laughter and joking, and seen as respectful by speaking to students as equals. Students expressed the desire for more explicit, timely, relevant and practical information, and were more satisfied that they had received this from the peer-educators and were also more likely to report that they had learned something new (Forrest et al., 2002). A greater proportion of respondents perceived peer educators to be experts, perceiving them to be sexually experienced and as such reliable educators because they provided realistic information based upon their own experiences (Forrest et al., 2002).

A study conducted by Mellanby, Phelps, Newcombe, Rees and Tripp et al. (2001) involved both quantitative and qualitative comparison between the delivery to 13/14 year olds of the UK 'A PAUSE' programme (Adding Power And Understanding in Sex Education) by 16-17 year-old peer educators versus adults. The A PAUSE programme involves ten specific lessons, six delivered by an adult team involving both a teacher and a healthcare worker and possibly a doctor and/or school nurse and additional teachers, and four lessons led by peer educators. This study solely evaluated the peer-led lessons by using pre- and post-intervention questionnaires, with the control group having identical lessons delivered by adults. Peers and adults attended the same training sessions. Participation included 1061 students in peer-led groups and 624 students in adult-led groups (Mellanby et al.,

2001). The peer-led schools had been receiving A PAUSE sex education delivered by the research team for the three years prior to the study, whereas A PAUSE was a new element for the teacher-led schools. There were other differences between the schools prior to intervention and, in keeping with these discrepancies, the researchers acknowledged that the study was not a randomised control trial and furthermore involved the loss of a data set (Mellanby et al., 2001). The findings indicated that students led by adults were more likely to answer that they considered sexual intercourse as appropriate for 13/14 year olds than did their peer-led counterparts. However, they also indicated that peer-led programmes may be no more effective than teacher-led when it comes to transmitting factual health information. Nonetheless, peer-led approaches tended to be more successful in dealing with teenage relationships and in setting conservative norms (Mellanby et al., 2001). Specifically, the 'norm' in this intervention referred to the belief that most teenagers have not had sexual intercourse before age 16. The peer educators were found to be significantly more effective in establishing this norm as truth than were the adult teacher facilitators. This finding is confirmation of the underlying theories promoting peers as educators for their influential value (Mellanby et al., 2001).

2.1.2 Disadvantages of peer-led facilitation

Disadvantages to peer-led lessons are claimed to include their extensive organisation and management requirements, fluxes in student commitment to programme, value system and classroom management tensions between peer educators and teachers/supporting adults, and the difficulties associated with attracting sustainable funding (Forrest and Lynch, 2002; Kim and Free, 2008). Additionally, despite being peers of recipients of sex education, in most cases, peer educators deliver content based on adult-led agendas. Harden, Oakley and Oliver (2001) came to this conclusion on the basis of a review of the international literature on peer-led health promotion. Ochieng (2003) studied the discourse enforced by peer educators in the context of a sex education programme in the UK and found a tendency among the educators to focus on sexually healthy lifestyles as a uni-dimensional choice rather than on the multi-faceted complex relationship between variables which may prevent 'choice'. Influential and dynamic psychosocial and demographic variables such as beliefs, socioeconomic status, gender, violence and the media were not discussed by peer educators in relation to the suggestion that students have 'choices' around health-related behaviour (Ochieng, 2003). Finally, as with teacher-led approaches, formal peer-led education has the limitation that it takes place in schools and therefore does not reach pupils outside of the classroom (Wight, 2008).

Research on peer-led approaches is often limited in that it tends to emphasise the personality and characteristics of the sex educator rather than contextual factors. RIPPLE peer-educators were less judged on their levels of knowledge, though they were criticised for weaknesses in communication effectiveness (Forrest et al., 2002). Moralistic views were generally disliked by students in the RIPPLE trials regardless of the educator in question, although such moralistic views were more often disliked when they came from peers (Forrest et al., 2002). Additionally, a significantly greater proportion of students receiving peer-led approaches felt that some students were not included in lessons (Forrest et al., 2002). Factors contributing to students' exclusion in peer-led approaches included the disruptive and aggressively sexist and heterosexist behaviour of boys, which discouraged active participation from girls, though boys often felt excluded from provision

when it came to topics around menstruation, for example. It is possible that the more enjoyable atmosphere created by peer educators led to some students' comfort in invoking intimidating behaviour, thus causing other students to feel vulnerable. Students noted that some individuals simply chose not to participate, an option which was more often allowed in peer-led sessions (Forrest et al., 2002).

'Outreach' peer education (coming from within direct same-age peer group) can be informal and can serve to reinforce learning through ongoing social contact rather than just in the classroom (Wight, 2008). Wight asserts that empowerment can only be realised with this mode of delivery since educators apart from the true peer group would serve as outsiders attempting to influence change on the group's behaviour, violating a key principle of the notion of empowerment. Despite this, unless the peer educators themselves define the goals of the intervention, they are ultimately putting across adult messages to the students. Theoretically, Wight (2008) asserts, this infers that true empowerment is less important to sex education discourse than is the achievement of compliance by young people with healthy behaviours. When peer educators are recruited from the community being educated, it is likely they will share some of the values and understandings that the intervention aims to change, and any personal conflicts they might have with the message they are asked to communicate will serve to undermine the programme (Wight, 2008).

Formal tutoring by older peers can position them as 'proxy role models' (Wight, 2008). Wight (2008) points out that while peer educators are relatively easy to recruit, and young people often look up to those just a few years older, the greatest disadvantage with this method is the presumption that pupils are more homogenous than they actually are. Year groups have segregated friendship groups which can dictate, for example, that being 'cool' in one group is the same as being 'geekish' in another. Older peer educators are rarely recruited for their high standings with the most vulnerable young people. This concept is crucial in the consideration of older peer educators as role models because those chosen may not be seen as the types of 'role models' admired by the greatest risk takers (Wight, 2008). Perhaps even more so with older peer educators than outreach peer education, this method uses young people to transmit adult messages. Older peers maintain the propensity to perpetuate undesirable norms, though perhaps less so than outreach peer educators (Wight, 2008).

2.1.3 Comparisons of peer-led with teacher-led

Most peer-led approaches are researched in relation to teacher-led approaches. Some research has highlighted teachers' perceived lack of confidentiality, lack of confidence around sensitive issues, the low priority they attach to sex education in general, as well as their lack of comfort with active teaching methods (Forrest et al., 2002). Both peer leaders and teachers in the Morgan, Robbins and Tripp (2004) study described challenges associated with power struggles during programme provision, with some teachers complaining of their reluctance to 'hand over' to the peers and peers reporting teachers as 'taking over' their portion of the lessons.

Wight (2008) is the only author in this review to point out that the theoretical rationale for teacher-delivered sex education has yet to be explored, and is often unquestioned since it is the norm (Wight et al., 2002). Despite this, he highlights several demonstrated benefits

of teacher-led interventions. Teachers are more likely than peer educators to maintain consistency with behavioural messages and are in a better position to challenge dominant norms of the group simply because of their non-peer status (Wight, 2008; Wight et al., 2002). Teachers are more likely to control the class and avoid disruption, they tend to have fewer issues with motivation (it is part of their job anyway), and are cost-effective since they are on site (and usually trained), while new peer leader groups often must be trained annually. Wight also suggests that students may still learn the material, even if they are unenthusiastic. On the negative side, teachers are unlikely to be regarded as credible role models and can be reluctant to adopt new resources or theoretical approaches. Importantly, teachers are not able to reach young people outside of the school setting, particularly non-attendees and street children (Wight, 2008).

Students in the RIPPLE study generally felt that teachers promoted sexual abstinence and overemphasised the risks of STIs and unplanned conceptions, whereas peer educators were perceived to promote 'being careful' over abstinence (Forrest et al., 2002). Some students found that teachers adopted a patronising and disrespectful tone and were perceived as suspicious of interactive activities due to their potential for digression and subversion (Forrest et al., 2002). Students' concerns with teacher-led approaches were associated with a perceived lack of confidentiality, either due to previous confidentiality breaches in other capacities, or due to ongoing and continued engagement with teachers outside of the sex education classroom. Significantly more students led by teachers felt the classroom sessions were well controlled, though both approaches gleaned similar results in relation to the number of students misbehaving in sessions and statements of preference for someone else to have taken the lessons (Forrest et al., 2002).

2.1.4 The peer educator's experience

The peer educator experience itself has been shown to have clear benefits for boosting efficacy, empowerment and self-esteem among the educators themselves (Wight, 2008). Although largely deemed beneficial, however, peer educators often report they are asked to deliver a message which is not consistent with their personal behaviour or beliefs (Ebreo, Feist-Price, Siewe and Zimmerman, 2002).

A qualitative study by Ochieng (2003) of peer educators in a sexual health programme in 1998 reported that their experiences, although complex, were largely beneficial. The outcomes showed that one of the benefits of peer education to the peer educators was their exposure to various modes of content delivery, due to the types of formal training peer educators are likely to receive from outside agencies. Personal, self-motivated interest in being a peer leader was found to be a crucial factor for the positive experience of the peer educator. The process of peer leadership was demonstrated to have a ripple effect of visibly influencing healthy behaviours in other realms (i.e. smoking and drug use) (Ochieng, 2003).

Ebreo et al.'s (2002) study set out to examine the effect of peer education on peer educators themselves in the US by comparing the outcomes experienced by peer educators with those of other students in the classroom. The study looked separately and specifically at same-age or 'outreach' peer educators chosen according to their level of risk (sensation-seeking tendencies based on survey questions around a number of

variables) (Ebreo et al., 2002). Findings from this study indicate that peer educators were more interested in their health class, found it more fun, daydreamed less during class, took their tasks seriously and enjoyed the peer education programme more compared to their peers. As a result of the pilot programme, peer educators were found to have more positive results in relation to alcohol consumption than their peers, yet the sole sex-related statistically significant result was in the negative direction for peer educators. A noteworthy conclusion arising from this study was that peer educators are only effective role models to the extent that their peers believe they 'do as they say' (Ebreo et al., 2002:420).

In the UK, Kidger's (2005) research explored the role of teenage mothers as sex educators, implemented in order to allow teenage mothers to recount their experiences in an effort to educate pupils about making 'informed choices' about pregnancy. The study looked at four projects, three of which recruited peer educators out of young mother support groups. A trained youth worker coordinated the projects, which arose out of discussions between health staff and young mothers about the inadequate information the young mothers themselves had received prior to pregnancy. The project approached schools to deliver a portion of the Sex and Relationship Education (SRE in the UK) lessons in a way that was 'empowering' as opposed to 'moralistic'. It was anticipated that the young mothers would also benefit from this scenario, though this was not a principle aim. Interviews were conducted with the 14 young mother peer-educators, and delivery of 17 sex education lessons was observed.

Internal conflict arose for the young educators when they realised that the stories which would benefit them as young mothers might differ from the kinds of stories which would provide pupils with 'informed choice'. Much sex education discourse focuses heavily on the prevention of pregnancy and infection, and this study's data suggests that 'most of the young mothers in fact reproduce these dominant accounts in order to improve their own moral positioning' (Kidger, 2005:482). The young women initially aspired to seizing the opportunity of becoming a peer educator in order to challenge myths and to provide an alternative to traditional scare tactics. Aims stated at pre-lesson interviews of 'telling you what it's really like', that there are 'good bits and bad bits' and a rationale that 'I don't think it's to prevent them from having children' or 'it's not about not having sex' were quickly lost when the young mothers entered the classroom setting (Kidger, 2005:487). Classroom observation accounts displayed stories which had been changed, shaped and now contained omissions and primarily negativity narratives in line with dominant young pregnancy discourse such as, 'my life went downhill from there' (Kidger, 2005:489). In this setting, young mothers admitted that, 'I say that I don't go out at weekends but I do', and 'I don't tell them the good bits as well', framing pregnancy to be much more difficult than they had in the initial interviews (Kidger, 2005:488).

Despite the fictionalising of their narratives, the young mothers ultimately did find the peer-education project beneficial for the opportunities it provided to enable them to distance themselves from their problematic identities. Interview data articulated how the opportunity helped young mothers to 'know I've done something good', to 'go and feel like we're doing our bit for the community' and 'gives me a bit of respect' (Kidger, 2005:489-90). Participation helped them to recreate their narratives to fit dominant expectations,

aligning with a position of regret, and 'redeem' themselves by reproducing the 'danger' discourse to slightly younger pupils, who – interestingly – they viewed not as peers but as analogous to their own young children (Kidger, 2005).

2.1.5 Recommendations for peer-led approaches

Many of the studies reviewed in previous sections have made recommendations for good practice based on their research findings. A number of authors, for example, have emphasised that effective peer-led approaches require networking with outside agencies and a distinct school-wide commitment to programme delivery, and are best delivered in the context of a wider socio-cultural health promotion strategy (Forrest and Lynch, 2002; Kim and Free, 2008). In terms of cost, any use of peer educators will continue to require frequent recruitment and training (Wight, 2008). Wight concludes that the delivery of sex education interventions should be theoretically informed, but this is not enough; a programme must be feasible and appropriate to the specific setting, target group and curriculum deliverer, otherwise it will not succeed.

Notably, the RIPPLE results suggest that neither peer-led nor teacher-led sex education interventions met the needs of a substantial number of the young people surveyed (Forrest et al., 2002). Some trials identified problems with school uptake of peer education due to financial and logistical concerns, since they are far more labour intensive than other methods and involve the training of new cohorts of peers every year or two (Ross, 2008). Ebreo et al. (2002) assert that some studies have shown that students prefer to receive factual information, for example, around HIV/AIDS specifically, from health care professionals rather than peer educators – and will actively seek additional information from healthcare professionals even if taught by peer educators on the topic. Students in all of the RIPPLE groups sampled agreed that good sex educators should have expertise on the subject, be confident and caring, and good at working with youth (Forrest et al., 2002).

Based on the findings of their comparative study of peer- and adult-led school sex education, Mellanby et al. (2001) suggest that young people cannot be expected to deliver all aspects of sex education since they are most often students themselves, therefore rendering it inefficient and inappropriate to train such teenagers as experts in all of the topics requiring attention or, indeed, to deliver sex education to all students at all levels. Mellanby et al.'s (2001) conclusions did, however, indicate that peer-led sex education should be looked to as an integral part of mainstream curricula, since it may be more effective in assisting young people to develop their own skills and standards of behaviour than is instruction from adults.

Monitoring and assessment of any sex education programme is clearly critical, and scope exists for monitoring by other peer educators if sessions are co-facilitated (Wight, 2008). In 2004, Morgan et al. undertook research on a pilot peer leader assessment process for the A PAUSE programme. Feedback for peer leaders was deemed advantageous and necessary in supporting the peers, and the assessment itself was reported to enhance peer leaders' focus in the classroom. Teachers were mostly amenable to completing the assessment and several felt that it helped raise the profile of the sex education curriculum within their school. Researchers discussed how, with appropriate training and support, the sex education programme assessment process itself was found to aid in development

of the 'community' aspect and approach of the programme as well as facilitating 'whole school' investment in sex education (Morgan et al., 2004).

Peer education programmes were also found by Ochieng (2003) to be more beneficial when the schools acknowledged the role of the programme by creating proper time allowances for the activity within the curriculum. Family and peer support for the peer educator's roles were also recommended for best outcomes (Ochieng, 2003). Ebreo et al.'s (2002) survey concluded that only students interested in the role of peer educator should be selected, that their motivations are most effective if altruistic, and recommended that consideration be given to a peer nomination process. This survey and anecdotal reports suggest to the researchers that selection of 'at-risk' students as peer educators may not be successful due to potential incredibility, inability to work with teachers and low level involvement (Ebreo et al., 2002).

Family Health International (Svenson and Burke, 2005) sought to evaluate peer education effectiveness in the US by producing research on peer education programme productivity and sustainability, examining such programmes in a variety of contexts and locales, by collecting data on costs, activities, outputs and peer educator questionnaires. Despite considerable variation across the programmes reviewed, universal conclusions for best practice in relation to peer-education included that youth involvement in such programmes is crucial for retention, motivation and productivity (Svenson and Burke, 2005). Community participation and support, including parental support and successful youth-adult partnerships, were also deemed critical to programme success, and it was suggested that programmes required sound technical frameworks, including adequate supervision and training. The research found trained youth to contribute significantly to civil society but that this resource is potentially 'wasted' once they 'age out' due to lack of follow-on structure and policy (Svenson and Burke, 2005).

2.1.6 Evidence of peer-led programme effectiveness

In a more outcome-oriented evaluation, the RIPPLE study conducted longitudinal follow-ups with students at age 20 in an effort to compare the effectiveness of the two approaches in reducing rates of abortion, unprotected sexual intercourse, and improving the quality of sexual relationships (Stephenson, Strange, Forrest, Oakley, Copas et al., 2004; Stephenson, Strange, Allen, Copas, Johnson et al., 2008). Abortion was chosen as a clear indicator of unintended pregnancy but was acknowledged not to reflect all unintended pregnancies, and data on live births were also obtained. This study is the only one of its kind to have included both questionnaire data on self-reported pregnancies and abortion in addition to blinded health service register data on live births and statutory abortion notification. Results were weighted to account for missing data (Stephenson et al., 2008). Analysis demonstrated significantly fewer self-reported pregnancies among girls in the peer-led groups by the age of 18. Girls, but not boys, in the peer-led groups were found to be more likely to report the use of contraception at last sex, although this difference did not remain when data was weighted. The proportion of abortions was the same for both groups. Most significantly, the proportion of girls with one or more live births was 7.5% for peer-led, compared with 10.6% for teacher-led (Stephenson et al., 2008). There were no significant differences found between peer-led intervention and teacher-led control groups for girls and boys in unprotected first sex, regretted or pressured sex,

quality of relationship with current partner, STDs, knowledge of emergency contraceptive pill, or ability to identify sexual health services locally. However, where small differences occurred they tended to favour the peer-led groups. Data on matched live births and reported pregnancy were more consistently lower in the peer-led groups, leading the authors to suggest that the reduction of live births for students experiencing peer-led sex education is 'real' rather than just a chance finding (Stephenson et al., 2008). Interim study results suggest that the RIPPLE peer-led approach was popular with students and may have resulted in fewer teenage births. This led to the programme's inclusion on a short list of sex education programmes aimed at accelerating progress through the UK's Teenage Pregnancy Strategy. This initiative was launched to tackle the UK's teenage pregnancy rates, which are the highest in Western Europe.

Despite the promising results of, and widespread enthusiasm for, peer-led approaches, two significant broad-based research documents have found that the evidence for effectiveness of such sex education programme delivery remains decidedly unclear. Kim and Free (2008) did not find convincing evidence that peer-led approaches improved sexual outcomes amongst adolescents in their assessment of all controlled trials published from 1998 to 2005. Harden et al. (2001) found similarly in their 1998-99 review of 210 evaluations of peer-led interventions. Only 64 evaluations met their inclusion criteria and, from those, only 12 were deemed methodologically sound (those deemed unacceptable often lacked clear descriptions of methods used). Both Kim and Free (2008) and Harden et al. (2001) deemed the methodological quality of numerous studies assessed to be poor and insufficient for inclusion. Overall, the Kim and Free (2008) review found no difference in uptake of condom use or a reduction in the number of sexual partners or incidence of pregnancy when peer- and teacher-led approaches were compared. One study was found to report a statistically significant reduction in the incidence of Chlamydia and another showed an increase in the odds that female participants never had sex when taught by peer leaders. Most studies revealed positive effects on measures of knowledge, attitudes and intentions (Kim and Free, 2008). Harden et al. (2001) found more evaluations to deem peer-led interventions more effective than ineffective; yet, of the 12 included studies, only seven found peer-led methods to be effective for one or more behavioural outcome. Five of Harden et al.'s (2001) evaluated studies directly compared peer-led methods to teacher-led methods and achieved somewhat contradictory results – two found peers to be more effective than teachers, two showed no difference in effectiveness, and one demonstrated that neither leadership style was effective.

Major differences exist amongst programmes in terms of the age and methods of choosing peer leaders, and little research has examined the context under which the peer interventions are introduced (Harden et al., 2001). Despite the ambiguous support for peer-led interventions, Kim and Free (2008) argue that such approaches should not be abandoned but rather improved upon since they hold such promise. They fault the quality of the research for the ambiguity rather than the interventions, and ascertain that rarely was enough emphasis placed on design details and evaluation procedures.

2.2 School Nurses as Facilitators

School nurses are another group of 'outside facilitators' who provide sexual health education, although they rarely do so in Ireland. Government strategy in the UK identifies school nurses as playing a key role in the delivery of sex education because of their access to the school-based populations (Department of Health (UK), 2001). In 2002, an OFSTED review listed nurses as one of the groups who made a contribution to school-based sex education (OFSTED, 2002). Hayter, Piercy, Massey and Gregory et al. (2008) suggests that the school nurse is valued as an 'outsider', capable of providing specialist knowledge on a sensitive subject. School nurses can, according to Halstead and Reiss (2003:180), complement the role of teachers; make valuable links between the school and other relevant professionals and services, such as general practitioners and family planning clinics; tell pupils about health services available in the area; provide confidential support and advice; and provide expert knowledge about sexual health.

Following a detailed search of the literature, no studies were located that expressly evaluated the effectiveness of school nurse input. However, three small studies were identified: two explored school nurses' educational preparation and knowledge to assume the role (Westwood and Mullan, 2006; McFadyen, 2004) and one explored nurses' perceptions of themselves as sex educators (Alldred and David, 2007). It is easy to assume that by virtue of their health professional role, school nurses are well-educated in the field of sexual and reproductive health. However, both studies suggest that school nurses are generally inadequately prepared and lack the confidence to teach sex education. The majority of school nurses in McFadyen's (2004) Scottish study perceived sex education to be part of their role and 75% (n=126) were actively involved in teaching sex education to school students; however, only 39% (n=65) reported receiving any specific sex education training and, consequently, many reported a lack of confidence in this area of practice.

In the UK, Westwood and Mullan (2006) reported a similar lack of confidence and comfort among the 24 school nurses in their study. In a qualitative study of 16 school nurses in a single geographic area in England, Hayter et al. (2008) found that school nurses felt under 'covert surveillance' by the teaching staff and restricted in the type of education they could provide. Practices such as teachers attending the class and looking at materials/session content prior to delivery were perceived by the nurses in this study as a form of negative surveillance and control, perhaps due to power and hierarchical dynamics within the school and amongst colleagues. Interestingly, these 'surveillance' practices are common in the use of any type of outside facilitator and are considered by OFSTED as examples of good practice and in keeping with the school's social responsibility to the children (OFSTED, 2002).

These findings contrast sharply with the more positive outcomes of a study conducted by Alldred and David (2007). They interviewed 15 school nurses in the UK, all women, who served the 17 secondary schools in their wider sex education study. These school nurses saw themselves as key players in the delivery of the SRE curriculum and distinguished themselves from teachers in that they were 'sexual health experts' (Alldred and David, 2007:104). All of the school nurses surveyed had recently taken training on SRE delivery and the researchers felt that the culture of, and commitment to, continuing professional development among these school nurses was 'striking' (Alldred and David, 2007:104).

All of the 15 school nurses felt that they were the ideal candidates for SRE delivery and wished that their professional expertise was better recognised and more fully utilised in the execution of the SRE curriculum (Alldred and David, 2007). It is possible that these nurses' training made them so confident and so different from the ones that participated in Westwood and Mullan (2006) and Hayter et al.'s (2008) studies.

Rather than contribute to SRE by way of classroom instruction, many of the school nurses in this study had set up 'drop-in' clinics as a source of information about sexual health. They felt that they had a different pedagogical style and type of rapport with students, as evidenced by one respondent who felt:

They can ask me absolutely anything and I won't be fazed by it ... They can't do that with the teachers: at the end of the day that's a power relationship. The teacher has the power; they don't, whereas I think in my class the power is far more evenly distributed (Alldred and David, 2007:105).

The researchers concluded that school nurses, by and large, saw themselves as having up-to-date medical information and the ability to empower students by treating them as clients, whereas dominant educational discourse would more likely see parents as the clients of the school, rather than the young people themselves.

Finally, the evaluation of a study on 'health workers' who provided a sexual health programme set up by the Health Board in an underprivileged area in Glasgow echoes the positive findings reported so far. Pupils in the school felt that the health workers had provided them with accurate information, were more suitable than their teachers and that 'their knowledge and an ability to make decisions in the area had been enhanced' (Lowden and Powney, 1994:22). It is a pity that the study does not provide information on the training of the 'health workers', but they were all employed by the local Health Board.

2.3 Physicians as Facilitators

Physicians and other medical professionals are sometimes used as facilitators in sex education programmes, again, due to their perceived status as experts (Twine, Robbe, Forrest and Davies et al., 2005). Clarke, Brey and Banter (2003:389) suggest that a physician can be 'an important member of the school health team', and can add credibility to sexual health promotion messages. They suggest that physicians should take a more active role in the sex education of adolescents by initiating discussions on sexual matters, and by becoming involved in school education. However, literature on the subject acknowledges that time constraints and lack of reimbursements for services create barriers to physicians' involvement (Twine et al., 2005; Clarke et al., 2003).

Research on the involvement of physicians/doctors as educators within schools is limited. Only a handful of publications could be located. Twine et al. (2005) conducted a study on young peoples' sexual health knowledge and attitudes in South Wales as a needs assessment for proposing a medical student-led education programme. The research team administered questionnaire-based cross-sectional oral surveys to 423 year 10 pupils (14-15 year olds) in relation to sexual health knowledge containing both quantitative and qualitative elements. Twine et al. (2005) claim that the results obtained by students in this

study provided justification for the development and implementation of a sex education programme facilitated by medical students. The rationale advanced by the authors was that the approach was 'quasi-peer' education and could tackle embarrassment, which students noted around the use of GPs, and yet avail of the positive effects of GP participation in young peoples' sexual health. As such, it seems to be an interesting effort to marry two aspects supported by research addressed elsewhere in this report: the importance of trust in the expertise of the facilitators and the advantage of a smaller age gap.

Medical student input may be implemented as part of a larger, multi-faceted facilitation approach to sex education. Mellanby, Phelps, Crichton and Tripp et al. (1995) compared sex education programmes between an intervention group which received a combination of medical and peer-led lessons and a control group which received their regular teacher-led sessions. The research comprised 25-30 one-hour experimental lessons to youth in years 9-11 (13-16 year olds) in Britain; these lessons were evaluated by 'examination' questionnaires given to students in order to determine the effectiveness of the programme. The study identified changes in attitude, increases in knowledge and a relative decrease in sexual activity in the medical/peer-led group based on their survey responses in comparison to the control groups (Mellanby et al., 1995). The researchers speculated that 'attitude changes', which included measures of 'tolerance' about sexual activity and girls' reputations, resulted from the lack of proscription in teaching by the intervention group. The study found that the presence of a medical professional aided in accuracy of information delivery, even at points when teachers or peers controlled the lessons. It also found a low level of student withdrawal from the intervention group, perceived to be due to the reassurance provided to parents and schools by medical professionals' commitment to the programme. Regular teachers in the intervention group remarked that the up-to-date knowledge of medical professionals was beneficial, since teachers are unable to keep up with medical advancements and research (Mellanby et al., 1995).

Some research has also reviewed experimental, multi-method interventions led by medical students. Cora-Bramble, Bradshaw and Sklarew (1992) described an innovative sex education practicum developed as a community collaborative effort, where medical students provided a programme of sex education to elementary schools in DC in the US, over a four to six week period. The programme consisted of showing the students a series of films, developed specifically for the initiative, which addressed topics such as menstruation, reproduction and STDs. Following the films, the medical students facilitated group discussion among a small number of students, answering questions and correcting information. Although the long-term impact on behaviour was not assessed, feedback from the medical students, teachers and student evaluations were very positive. Cora-Bramble et al. (1992) also suggest that the programme offered a cost-effective model of increasing elementary students' knowledge of sexual issues, while simultaneously enhancing medical students' communication skills.

Often medical student involvement consists of facilitation of a few specific lessons, rather than being a comprehensive part of the wider social, political and health education curriculum. Jobanputra, Clack, Cheeseman, Glazier and Riley (1999) carried out a similar pilot study to determine the feasibility of medical students being involved in sex education in secondary schools in Edinburgh, Scotland. Medical students following a special training

programme delivered by health professionals from various Edinburgh services acted as small-group facilitators for three sessions of the SRE course. Each medical student worked with six to eight pupils. Findings from the evaluations suggest that teachers were overwhelmingly in favour of medical student involvement and felt that the facility to break students into small groups provided excellent learning opportunities. They perceived that the age of the medical students conferred additional advantage in building rapport with the pupils, enabling a more relaxed discussion, especially in areas such as homosexuality and relationships. Teachers identified the following as advantages of utilising medical student facilitation: age (77%), outsider status (46%) and lack of inhibitions (27%); however, 15% expressed concerns about their lack of teaching experience. Ninety-four percent of teachers and 93% of students were in favour of medical student involvement in sex education in schools (Jobanputra et al., 1999). Feedback from students identified teacher embarrassment as a barrier to communication, and students reported feeling more relaxed talking to the medical students and enjoying the lessons more than usual. Although the authors of the report indicated that the medical students' lack of teaching experience and, specifically, their skills in group work did not lead to problems in the classroom, they did stress that training programmes needed to place more emphasis on such skills (Jobanputra et al., 1999).

The use of medical students as facilitators of sex education appears to be a novel idea, which may spread in response to the need for new and affordable external facilitation. Inspired by the Jobanputra et al. (1999) study, Pasquier, Poirson, Charlin and Mellier (2006) wrote a letter to the Editor of *Medical Teacher* to report on their evaluation of a similar initiative in France. Findings from their study of 423 adolescents aged 14.7 years suggest that a single education session by fourth year medical students improved students' knowledge and was associated with greater satisfaction when compared with an education session delivered by other health professionals.

2.4 LGBT-led Approaches

Commentators on the content of school-based sex education across several jurisdictions, including Ireland, have drawn attention to the heteronormative assumptions underpinning the content of these programmes (and the curriculum more generally), their failure to address diversity, and their exclusion of lesbian, gay, bisexual and transgender (LGBT) sexual identity (Epstein, 1994, 1996; Ingles, 1998; Kiely, 2005; Mac an Ghaill, 1991; Sumara and Davis, 1999). More broadly, it is claimed that LGBT youth are a hidden minority in schools and that many school climates foster norms, values and belief systems that communicate rejection and intolerance to LGBT students (Epstein and Johnson, 1998; Mac an Ghaill, 1991, 1994; Nicholas, 1999). Such claims provide an important backdrop to understanding the potential role of LGBT-led facilitation of aspects of school-based sex education. Furthermore, and as will be demonstrated later in this section of the review, LGBT facilitators are often engaged by schools because of teachers' lack of confidence in dealing with the topic of 'sexual orientation'. First, however, it is useful to document research evidence from Ireland and elsewhere that provides a case for LGBT-inclusive curricular interventions.

Schools can be unsafe places for those pupils who identify as gay, lesbian, bisexual or transgender. Homophobic bullying within the school setting is now regarded as a

significant problem in the US, the UK and in other European countries, including Ireland (Ellis and High, 2004; Warwick, Chase and Aggleton, 2004; Kosciw, 2004; Norman and Galvin, 2004; Norman, Galvin and McNamara, 2006; Norman, Dahl, O'Moore and Tuck, 2008; Mayock, Bryan, Carr and Kitching, 2009; Minton, Dahl, O'Moore and Tuck, 2008). Irish research on homophobia in second-level schools indicates that as many as 79% of teachers were aware of verbal or physical bullying that was homophobic in nature but that only thirty-eight percent of the teachers surveyed reported that their school policy on RSE included information on gay and lesbian issues (Norman and Galvin, 2004; Norman et al., 2006). A more recent Irish study of homophobic bullying among a self-selected purposive sample of 123 LGBT pupils ranging in age between 15 and 31 years found that half had been bullied in the last three months and over 30% reported that they had been bullied during the last five school days (Minton et al., 2008). On the basis of these and other indicators of the extent of homophobic bullying, the authors concluded that 'it seems likely from the present findings that LGBT people are much more likely to be bullied at school than are their heterosexual peers' (Minton et al. 2008:185). Finally, a recently published study of the mental health and well-being of lesbian, gay, bisexual and transgender people in Ireland has identified the school setting as an especially stressful environment for LGBT people (Mayock et al., 2009). This mixed methods study, based on the administration of an on-line survey and the conduct of forty in-depth interviews with LGBT people of all ages, found that 58% of the overall survey sample and half of all current school-goers reported the existence of homophobic bullying in their schools. Two-fifths of on-line survey participants indicated that they had been verbally threatened by fellow students because they were, or were thought to be, LGBT, while 4% of the sample had been verbally threatened by staff. This study also revealed that 70% of on-line respondents felt that it was hard for them to be accepted at school. At least three-quarters of all respondents reported that they would have felt uncomfortable talking to their teachers or school principal about LGBT issues, raising or responding to LGBT issues in class, taking a date of the same sex to a school event such as the 'Debs', or setting up or being part of a club addressing LGBT issues. Qualitative findings (both from in-depth interviews with LGBT people and accounts offered by on-line participants) indicated that feelings of isolation, self-loathing and distress were common consequences of negative school experiences. Overall, the findings on the school experiences of this study's relatively large, albeit non-random, sample of LGBT people of all ages indicate that 'schools were perceived and/or experienced as unsupportive and hostile places for those who identify as LGBT' (Mayock et al. 2009:65).

While there is little systematic research examining what young LGBT people think about school-based sex education, available UK-based studies strongly suggest that provision is inadequate (Buston, 2004; Mac an Ghaill, 1991; Rogers, 1994). Research has demonstrated that young LGBT people perceive sex education as focusing exclusively on heterosexual relationships, thereby excluding their need for information around safety in the context of LGBT sexual relationships (Forrest, Biddle and Clift, 1997; Kubicek, Carpineto, McDavitt, Weiss, Iverson et al., 2008). Research conducted by Buston and Hart (2001), involving the observation of sex education lessons delivered by 40 teachers in Scotland, found that while some teachers were LGBT-inclusive others rendered LGBT sexuality invisible and, in some instances, contained utterances of explicit homophobia. In the Irish context, Mayock et al.'s (2009) study found that less than 5% of their overall survey sample of LGBT people

(n=1110), and less than 8% of current school-goers, were aware of coverage of LGBT-specific content in the Relationships and Sexuality Education (RSE) curriculum.

Several studies indicate that, for a host of reasons, teachers may lack confidence in delivering lessons that include specific reference to, or discussion of, LGBT sexuality. For example, one Scottish study found teachers reported feeling less confident about discussing homosexuality than about dealing with the more traditional aims of sex education (Buston and Hart, 2001). In the UK, Alldred and David (2007) report that teachers experience pressures surrounding the delivery of Sexuality and Relationships Education – including feelings of uncertainty about professional boundaries and values, as well as constraints from school rules – which lead to discomfort with many of the topics within the programme. In the Irish context, Mayock et al.'s (2007) study of RSE implementation in second-level schools revealed discomfort among teachers as a significant barrier to RSE delivery generally, with the topic of 'sexual orientation' perceived as particularly challenging. Research also suggests that teachers are frequently aware of the existence of homophobic bullying but are often confused about or unable or unwilling to address the needs of gay and lesbian youth (Ferfolja, 2007; Warwick, Aggleton and Douglas, 2001). Norman et al.'s (2006) research in Irish second-level schools similarly found that teachers frequently did not directly address or challenge homophobic taunts that they witnessed in their schools or classrooms, while 41% of teachers who had encountered verbal or physical bullying of a homophobic nature stated that they found it more difficult to deal with this than other types of bullying in their school. Teachers also feared the possible reaction of parents, other staff or students if they were seen to take the side of a student who was perceived to be gay or lesbian.

It has been suggested that in order to serve all young people in the school context educators and practitioners need first to understand their own prejudices and biases 'by asking themselves why it is so important to maintain a heterosexist environment' (Little, 2001:106). Indeed, it is claimed that approaches to sex education in school are bound up with issues of biography, identity and experience, with instructors' (including both teachers' and school nurses') approaches to teaching and learning being 'shaped by their past experiences as pupils and as gendered sexual subjects' (Kehily, 2002:229). Recent research in the US, based on the autoethnographies¹ of trainee teachers, found that despite these teacher candidates' desire and intention to create open and safe classrooms in which respectful dialogue could be fostered and developed, less than half depicted themselves as capable of empathic behaviour in relation to students' struggles in understanding sexuality and gender identity, with many expressing explicit fear about responding to such issues in the classroom context. Engagement with this autoethnographical exercise did, however, help the cohort of future teachers who participated in the study 'to feel more comfortable and confident about facing rather than ignoring the pain young people can experience' (Vavrus, 2009:389). Teacher candidates, according to Vavrus (2009:390), 'need instruction in conducting discussions related to gender identity and sexuality as well as strategies to respond appropriately and directly to homophobic and sexist discourse'.

¹The autoethnography assignment was one aspect of a teacher education curriculum 'infused with a critical pedagogy on multicultural topics presented through seminars on critical texts, workshop/lectures, and guided autoethnographic explorations' (Vavrus, 2009:385)

While recent research has begun to identify teachers' own biographies, including their personal experience of schooling and society, as influencing their approach and perceived ability to address LGBT sexuality, studies have equally identified other dimensions of school organisation and culture as impacting on the delivery of LGBT-sensitive instruction in the context of sex education. The absence of clear policy directives on the inclusion of LGBT issues, lack of clarity on the school's position on the delivery of LGBT-specific instruction, fear about parents' responses and the possible repercussions, both for individual teachers and the school as a whole, of including lessons that seek to acknowledge and address the needs of LGBT students appear to play a powerful role in deterring LGBT-specific instruction, both in Ireland and elsewhere (Norman and Galvin, 2004; Hilton, 2003; Norman et al., 2006; Mayock et al., 2007).

Nonetheless, there is a burgeoning literature which suggests that sex education lessons that contain specific reference to LGBT sexuality are both necessary and beneficial (Blake, Ledsy, Lehman, Goodenow, Sawyer and Hack, 2001; Goodenow, Szalacha, Robin and Westheimer, 2008; Woodiel, Angermeier-Howard and Hobson, 2003; Woods, Samples, Melchiono, Keenan, Fox et al., 2000). Blake et al. (2001) examined the self-reported risk behaviours of heterosexual and LGBT adolescents, and then compared the risk behaviours reported by LGBT students receiving sex education with and without gay-sensitive instruction. The study was the first of its kind to assess youth behaviour according to both self-declared sexual orientation as well as sexual behaviour and used the '1995 Massachusetts Standard Youth Risk Behaviour Survey' items for the purpose of data collection. The survey randomly sampled three to five classes in 63 schools during the 1994-1995 school year, yielding 4159 student and 226 teacher completed surveys. On the basis of the findings, the authors concluded that 'in schools where gay-sensitive HIV instruction was provided, GLB youths reported lower sexual risk behaviours' (Blake et al., 2001:944). Furthermore, where teachers were provided with a gay-sensitive curriculum and supporting materials, they expressed greater confidence in meeting the needs of their LGBT students. Those LGBT students in schools that did not provide gay-sensitive instruction reported 'greater risk than all other youths for HIV infection, pregnancy, suicide and victimization' (Blake et al., 2001:944). Perhaps significantly, the authors noted that most 'gay-sensitive' instruction took place in areas with higher median family incomes. For Blake et al. (2001), properly LGBT-inclusive interventions contained aspects of 'inclusive instruction, adequate support services, acknowledgement of diversity, and a non-discriminatory school climate [which] addresses self-management and social skills relevant to GLB youths. [Such] HIV prevention programs might be gender-neutral or address the full range of sexual partner relationships that exist' (Blake et al., 2001:940).

In a more recent study, Goodenow et al. (2008) examined the relationship between adolescent females' sexual orientation and HIV infection in a 4-wave, population-based survey of 3973 Massachusetts students between 1995 and 2001. Investigating the association between students' sexual identity, sex of partners and HIV-related behaviour, the study findings indicated that 'adolescent females with same-sex partners are less likely than are heterosexual peers to report receiving [AIDS education] instruction' (Goodenow et al., 2008:1057). Attention was also drawn by the authors of this study to the widespread misconception that LGBT females are not at risk of disease, and further speculated this population's tendency to skip such instruction courses due to fear of negative responses or repercussions. They concluded from their findings that, '[s]chool AIDS education that is sensitive to the needs of lesbian, gay and bisexual adolescents and adolescents with same-sex partners may exert a positive influence on their behaviour, but political constraints in many school districts may make open discussion of sexual orientation or same-sex behaviour difficult' (Goodenow et al., 2008:1057).

It is claimed that the vulnerability of young gay men to HIV infection may be increased due to the lack of references to, and positive role models for, gay relationships and safe sex within school-based sex education (Forrest et al., 1997). Paradoxically, many heterosexual youth erroneously conclude that gay men are the only source of HIV infection and the only group affected by HIV/AIDS (Forrest et al., 1997). Indeed, a common criticism of many LGBT-specific interventions, whether delivered in the community or within schools, is that they are aimed primarily at reducing HIV/AIDS risk among gay and bisexual males in particular (Blake et al., 2001). When the topic of LGBT identification is dealt with within the school curriculum, it is often associated with the 'risk' of HIV/AIDS and facilitated by representatives from LGBT agencies (Abel and Fitzgerald, 2006). 'Gay inclusive' sex education is, in fact, frequently delivered by 'outsiders' because of teachers' lack of expertise and/or comfort with the topic of sexual orientation. This partitioning of LGBT and HIV/AIDS topics from the rest of the curriculum is claimed to be strongly associated with the dominant themes and messages within sex education generally and their association with the belief that 'sex should occur in a monogamous, heterosexual, 'committed relationship' and that sexual initiation should be delayed until this ideal relationship was achieved' (Abel and Fitzgerald, 2006). This can sometimes lead students to distance themselves from the risk of HIV/AIDS – feeling that such information has little relevance to their situations and that they are invulnerable – since they associate HIV risk solely with the gay community who often provide such training. The following is an account from one respondent in Abel and Fitzgerald's (2006:110) mixed-methods study of pupils' views on the school-based sex education which incorporated sessions led by outside facilitators from the LGBT community:

We had two like ... two guys come in and they were gay and... not together... but um they were like ... one of them had ... one of them was HIV positive and the other one was just ... the other one was alright ... and they were just talking to us about AIDS and you know ... homosexuals and stuff like that ... so we had a bit talk about that ... and we were asking questions and stuff about, you know, their lives and stuff
(Richard).

This account demonstrates some of the possible undesirable consequences of engaging LGBT individuals in the school context, particularly if the content (in this case, information about HIV/AIDS risk) is delivered only by facilitators and with limited or no attention to broader aspects of LGBT lives. For students in this study '[t]he topic of homosexuality was covered very briefly within the syllabus ... within a 'risk' discourse of HIV/AIDS' (Abel and Fitzgerald, 2006:110).

More positive findings have, however, been documented on the input of outside facilitators to the provision of educational activities to address sexual orientation and identity in schools. A study by Douglas, Kemp, Aggleton and Warwick (2001) specifically interrogated the role of a 'Young Gay and Bisexual Men's Development Worker' in providing instruction on elements of sexual orientation as part of the wider SRE curriculum. The project involved the delivery of 19 workshops to youth aged 16-18 in four London secondary schools between 1996 and 1999. The workshops sought to address homophobia, to provide resources and information for teaching staff, and to encourage a supportive environment for LGBT students as part of the wider SRE curriculum aims. This relatively small-scale study found that 93% of participants enjoyed the learning arising from the lessons. Students also reported a heightened awareness of homophobia and reported that they felt empowered to challenge such behaviour, with 73% citing an increase in understanding of the issues affecting gay and lesbian people. In terms of the operationalisation of this outside facilitation, it is perhaps noteworthy that the research found that teachers initially acted as gatekeepers and particularly feared receiving negative media attention around their provision of instruction on this specific topic. In order to be effective, the development worker (that is, outside facilitator) built relationships with the schools throughout the year and was involved in other health promotion activities which were not LGBT-specific. The study further noted comments from teachers on development workers' personal attributes which contributed to the interventions' success and appeal with the youth, including:

Humour; openness and open mindedness; sensitivity and empathy; the use of non-didactic approach; the provision of opportunities to talk about issues not commonly discussed, especially at home; being listened to; being offered constructive criticism; being provided with interesting, relevant information; and being facilitated by an external project worker as opposed to a teachers ... the provision of opportunities to access further support and advice about sexual orientation and identity issues (Douglas et al., 2001:156-157).

The development worker and manager interviewed for the purpose of this study stressed the importance of a sensitive and non-confrontational approach, delivered in a manner that is not perceived as seeking only to promote a specific political agenda which, they believed, can be off-putting for teachers, students and their parents. They also noted that this type of work could potentially be more damaging than beneficial, particularly to LGBT students, if not delivered appropriately. Significantly, a majority of students (78%) felt that the sessions should have been delivered in an earlier school year, recommending age 14-16 as most appropriate. An external audit of this programme recommended that it be revised to include more instruction around positive aspects of being lesbian, gay or bisexual in addition to addressing prejudice and discrimination (Douglas et al., 2001). The programme evaluated by Douglas et al. (2001) is noteworthy in that the project

worker or facilitator had previously developed relationships with the schools, a factor described as 'crucial' by the authors. Furthermore, the sessions delivered were embedded with the broader Personal, Social, Health Education (PSHE) programme, a factor also deemed to be important 'not only in enabling follow-up of the work by teachers but also in 'normalising' the topic as one subject among a range of others to be considered' (Douglas et al., 2001:157). The approach, therefore, did not rely on the delivery of 'one-off' sessions by an 'outsider' who lacked familiarity with the broader sex education curriculum. Recent years have, in fact, seen the emergence of critiques of the provision of discrete or one-off educational workshops to address homophobia facilitated by 'outsiders' who are most often lesbian or gay. One critique of this type of LGBT-led instruction is the disproportionate emphasis it can place on the need for LGBT youth to 'tell stories' and, in effect, educate the 'normative' majority (Srivastava and Francis, 2006). This requirement is associated with peer-led approaches more generally and with 'gay-inclusive' instruction specifically since LGBT students are often asked to facilitate the LGBT portion of the curriculum.

Srivastava and Francis (2006) evaluated the TEACH programme (Teens Educating and Confronting Homophobia) in Toronto from 1992-1995, which is a peer-education anti-homophobia programme facilitated by LGBT youth. TEACH workshops focussed on a range of areas related to sexuality, 'from inquiries about sexually transmitted infections, to masturbation, and menstruation' (Srivastava and Francis, 2006:294). Findings from this research revealed the paradox that repercussions exist for youth who speak out and reveal their identity, yet refusal to 'come out' in these contexts can prove equally dangerous for young people once they are 'found out'. The disproportionate tokenistic burden placed on LGBT youth to educate their peers about their experiences often translated to opportunities of benefit for the 'majority' at the expense of those doing the teaching since inequitable relations and hierarchies were in effect reinforced. The practice of storytelling by youth facilitators was, therefore, marked by profound contradictions, whereby:

Audiences can more easily assume that "being gay" is just "someone else's story," which might have nothing to do with "us" – the presumed straight majority of the class (Srivastava and Francis, 2006:294).

The demand for LGBT youth to educate their peers was further found to be seen as a demand on such young people to provide 'appropriate stories', not necessarily concentrating on what their experience is 'really like', but rather reconstructing stereotypes of their identities. Those facilitators who presented differing, fluid or 'non-normative' accounts sometimes found themselves attacked by students and teachers alike, for presenting 'opposite' identities and confusing the workshop participants – leaving the LGBT peer educators to feel that if they did not reproduce stereotypes or present fixed identities they would be seen as non credible or would be punished. Although this study found TEACH peer presentations to be valuable for their interruption of the everyday hierarchies that exist within school contexts, and in breaking the taboo that youth should not speak publicly to other youth about sex or sexual orientation, it concluded that an implicit goal of the programme was to 'sidestep or erase, rather than explore, the existing knowledge of racism and heterosexism that already pervades all our social institutions' (Srivastava and Francis, 2006:291-292). One significant problem with the input of TEACH facilitators was that it was inevitably limited to one-time events, an approach that can

serve to isolate the issues raised and further aggravate the general lack of support for LGBT students. It is perhaps interesting to note in light of this finding – which suggests that LGBT gender identity and sexual orientation should be infused throughout the curriculum – that the authors of this study later explained that professional development training and classroom resources were provided for teachers by equity staff at the Toronto District School Board during the mid-1990s to help them to integrate an analysis of homophobia into the curriculum. However, teachers preferred to engage ‘outside experts’ rather than to engage with the topics of sexual orientation or homophobia:

Teachers voiced a high level of discomfort at the prospect of initiating discussion about these topics themselves. Interviews with equity staff indicate that even when teachers have attended special extracurricular courses designed to assist them in integrating this topic into their existing class schedule and curriculum, their preferred method for dealing with the area was to instead ask for “outside” speakers to address the issue. In short, they prefer to sponsor anti-homophobic workshops as special events by “outside experts” (Srivastava and Francis, 2006:299-300).

An evaluation of an anti-homophobia education programme in Germany by Rieske (2009) has revealed a number of findings that are similar to those documented by Srivastava and Francis (2006). This German ‘queer ed team’, founded in 1990, is based on the idea that LGBT activists have experienced discrimination directly and are thus more capable of conducting the ‘anti-homophobia’ element of sex education than most teachers. Consequently, the facilitation of an encounter with an LGBT person (by way of their external facilitation of a portion of sex education) should lead to appreciation of sexual and gender diversity. Rieske (2009) found the ‘queer ed team’ to conceal instabilities and multiplicities from their narratives in providing lessons, with many of the educators finding omissions and fabrications to be helpful in this context. As one educator interviewed for the purpose of the study noted:

‘[I] present myself as a pure lesbian, and I consciously leave out any episodes in which I was together with men because I kind of, so to say, don’t want to cause any confusion ... I resort to this falling-in-love narrative really strongly. And I do not mention that ... I had a terrible crush on a boy, and made out with him for the first time, and this was really wonderful. So I aim at all the crushes that I have had for girls in the course of my coming out’ (‘queer ed team’ educator) (Rieske, 2009:5).

On the basis of these findings, Rieske (2009) articulated the limitations of using a peer educator element *specifically* for LGBT topics, noting that the pool of youth who may be potentially used for such purposes is inherently limited and that the content of the programmes is usually prescribed by adults. Rieske (2009) nonetheless concluded that the personal narratives and LGBT youth-led approaches can be valuable to the extent that ‘confusing’ narratives are allowed and encouraged, and that ‘adults’ – be they teachers or LGBT agency representatives – are positioned and presented as collaborators to the young people’s experiences, rather than as experts.

In a 2007 special edition of *Educational Studies* dedicated to ‘examining the role of sexuality and sexual diversity in schooling, investigating how homophobia and heterosexism

operate in school settings and structure the schooling experiences of all students and teachers' (Spickard Prettyman, 2007:5), two scholars, who themselves participated in 'outside facilitation' or teaching offered their critical reflections on the effectiveness of this pedagogical approach. In the first of these, MacIntosh (2007:33), who provided one-off or single-class anti-homophobic lectures and workshops to student teachers, typically on the day allocated to 'gay and lesbian issues', described how she came to 'recognize the dangers of this method and, more broadly, the hazards of partially integrated curricula'. MacIntosh (2007:35) is particularly critical of the reliance of Schools of Education on curricula that focus solely on anti-bullying or anti-homophobia and safe-space initiatives and which do not 'foster a framework for engaging with systemic change or elicit critical interrogations of local or institutional contexts'. Describing the one-off lecture format delivered by LGBT facilitators variously as an 'add-and-stir' or 'band-aid' approach, which attempts to offer 'tidy solutions' to the inequities of gender and sexuality, MacIntosh (2007:40) asserts that approaches to addressing the marginalisation of minority sexuality youth need to be infused throughout the curriculum, 'not "Balkanised" into one-off lectures and single-course foci'.

In a separate contribution to this special edition, Gust (2007) writes specifically about his experience of teaching as a gay man in an autoethnographic exploration of his use of *The Laramie Project*² as a teaching and learning tool. One of the key messages arising from his account is that such teaching and learning can be both dangerous and empowering. Gust's (2007) personal reflections on his experience as an 'out' gay man attempting to encourage thoughtful and critical reflection among students again highlights some of the dangers of assuming that this kind of curricular input necessarily achieves positive responses from the recipients of such instruction; it may also be a challenging experience for those individuals delivering such lessons or, as expressed by Gust (2007:59), 'risky in the paradoxical way that "coming out" is always dangerous'.

LGBT-led approaches are a relatively new development and appear not to be widely used by schools in the context of delivering sex education. Neither have they been systematically evaluated in terms of their outcomes or contribution to the broader sex education curriculum. One of the studies located for the purpose of this review (Douglas et al., 2001) documents clear successes arising from the use of this approach to address sexual orientation and identity issues in secondary schools in the UK. This study is significant for a number of reasons, but most notably because the project worker or facilitator was familiar with the broader aims and approach to sex education within the schools and was also relatively well integrated into the educational settings under study. In other words, this LGBT-led approach did not rely on 'one-off' sessions or lectures, a format or model that has recently been scrutinised and critiqued because of the undesirable messages it can impart to all students and the negative repercussions it may have for those individuals delivering such programmes (Gust, 2007; MacIntosh, 2007; Srivastava and Francis, 2006).

²In October 1998 Matthew Shepard was kidnapped, severely beaten and left to die, tied to a fence on the outskirts of Laramie, Wyoming. The murder was generally perceived as a hate crime motivated by homophobia. Five weeks later, Moisés Kaufman and fellow members of the Tectonic Theatre Project went to Laramie and, over the course of the following year, conducted more than 200 interviews with people of the town. From these interviews they wrote the play *The Laramie Project*, a chronicle of the life of the town of Laramie in the year after the murder. *The Laramie Project* is one of the most performed plays in the US today. Tectonic Theatre collaborated with HBO to make a film based on the play which was first screened in 2002.

2.5 Using Drama and Theatre to Facilitate Sex Education Delivery

Drama is regularly used in schools and in the classroom as a means of educating pupils on a variety of topics. Drama-based methods can be participatory approaches, involving pupils as actors/actresses in their own learning, or they can be implemented by a drama group performance engaged by the school to educate pupils about a specific portion of the curriculum. These two approaches to the use of drama can be seen as variations on peer-led approaches and approaches which use outside facilitators, or both. In recent years, drama-based education has become increasingly popular as a means of delivering health education in general, and sex education in particular (Swaney, Sykes, Keene, Swinden and McCormack, 2003).

Theatre in Education (TIE) is a widely used method in the UK, said to have originated in the 1960s at the Belgrade Theatre Company in Coventry, which aims to engage young people with issues in a stimulating way (Swaney et al., 2003). TIE is an 'umbrella term' which uses scripted, live drama in conjunction with workshops to reinforce learning and contains elements of performance such as role-playing and 'hot-seating'. It is increasingly taking place in UK schools within the context of Personal, Social, Health Education (PSHE) and, more specifically, within SRE. Swaney et al.'s (2003) review of published and unpublished literature concluded that there is sufficient evidence to support the use of theatre in education (TIE) as an effective method in delivering sex and relationship education to school-going children. This research team subsequently used results of their review to develop a good-practice guide for the use of TIE.

The Swaney et al. (2003) review found consensus in the literature around a set of key points, asserting that TIE works best and most efficiently when:

- The programme is an integrated part of a wider SRE curriculum.
- The staff is aware of and committed to the considerable organisation and planning involved in TIE, and is in close liaison with theatre/drama group.
- There is a long lead-in time for the programme (up to a year), yet planning and implementation of the programme takes place within the same year.
- Staff members are given training and resources to adequately prepare for TIE and also to conduct follow-on activities.
- Small, discussion-based workshops take place after the TIE intervention and are run by appropriately trained staff.
- Actors are portrayed as credible, have similar accents and use language relevant to young people, and also reflect relevance to current issues and local places.
- The actors and facilitators are trained and supported in SRE educational issues such as behaviour management and child protection.
- The role of staff is carefully considered, discussed with the theatre company and decided upon in advance.
- The programme addresses specific misconceptions held by the audience.
- The programme is evaluated as part of the wider SRE curriculum.
- Information about local health services is provided to the young people as follow-up.

The Swaney et al. (2003) research located a number of reports that explored the effectiveness of TIE, the results of which overwhelmingly conclude that students find TIE to be interesting, engaging, enjoyable, and effective for generating discussion around

sensitive issues; students also appreciated and enjoyed the participatory nature of the lessons. Studies examining teacher perspectives found that teachers also feel that TIE is an effective learning tool and valuable aid in SRE, and furthermore that few parents express concern over use of this method of facilitation (Swaney et al., 2003). Agreement among the studies they evaluated did not exist in relation to the method's impact on the knowledge levels of participants, and while some studies displayed positive influences in attitudes as a result of TIE, there was little conclusive evidence displaying any impact on behaviour as a result of the programme. No rigorous studies evaluated cost effectiveness, although one study concluded TIE to be expensive compared to other interventions, and several studies cite school administration feedback that the programme is financially unsustainable (Swaney et al., 2003). Many jurisdictions had made efforts to collaborate with local funding agencies in an attempt to make the programmes more affordable and therefore sustainable. The authors recommended that the issue of sustainability be addressed during the early stages, that working relationships between the school, theatre and commissioners be developed and nurtured over time, and that commissioners and schools or youth services decide in advance whether 'one-off' performances are useful in the event that the programme cannot be continued (Swaney et al., 2003). One evaluation felt that the most significant impact of TIE was the shift in attitude and culture towards SRE in general that its use provided by way of the deliberate planning required in implementing the programme (Swaney et al., 2003:5/6). Young peoples' responses to the TIE programmes were overwhelmingly positive, with most respondents feeling that their 'eyes had been opened' by viewing engaging, emotive and realistic-seeming scenarios in a way that facilitated ease and comfort. The programme was also supported by parents and fostered effective workshop discussion afterwards. Swaney et al.'s (2003) good practice guide is comprehensive in that it further outlines guidance around key issues for consideration in developing and commissioning TIE projects, including commissioners' responsibilities, guidelines on implementing and managing the projects, and recommendations for TIE programme evaluation.

A systematic review of the literature, published from 1994-2004, on the effects of using performing arts for youth health issues was conducted by Daykin, Orme, Evans and Salmon (2008). This review focused on studies, including interventions with young people aged 11 to 18 within mainstream education and community settings, which incorporated drama, dance and music (Daykin et al., 2008). Initial database searches yielded 3670 studies, which were narrowed down to 85 full text papers to be scrutinized, with only 14 papers to be included in the review after rigorous application of inclusion criteria. All of the 14 studies examined focused on drama interventions, with the intervention's target population being the audience in some cases and the performers themselves in others. Some focused more selectively on 'at risk' youth, whereas others focused more generally on school students or community youth groups. Key findings from the review emerged in the distinct areas of peer interaction, social skills and empowerment; knowledge, attitude and risk in relation to HIV/AIDS; sexual health; and alcohol, tobacco and illegal drug use (Daykin et al., 2008). Overall, the review concluded that evidence of positive outcomes from the use of drama interventions existed, and the strongest of these outcomes fell under the classification of impact on peer interaction and social skills. In relation to HIV/AIDS awareness, increases in condom use were reported in two of the studies evaluated, although evidence of increased knowledge on the subject of HIV/AIDS

was mixed amongst the surveys examined. More broadly, several studies demonstrated improved sexual knowledge as well as changes in attitudes concerning availability and access to contraception. Student-participatory drama was also found to be useful for communicating the sexual health needs of the client group to service providers (Daykin et al., 2008).

In 2004, a specific TIE project entitled 'Icebreaker' was commissioned in Liverpool and delivered to approximately 3000 pupils aged 12-15 years. It was subsequently independently evaluated by John Moore's University (Peerbhoy and Bourke, 2007). The intervention provided an emotive, nuanced and engaging scenario for the young viewers, and facilitated interactive audience participation as a method of learning. Mixed quantitative and qualitative evaluation was conducted on 14 performances and 9 schools by way of observation, teacher/student questionnaires (adapted from Swaney et al.'s (2003) guidelines), actor feedback and a director interview (Peerbhoy and Bourke, 2007). Believing that short-term success leads to long-term positive outcomes, the aims of the intervention were more focused on influencing short-term gains in changing attitudes and increasing awareness and, possibly, the behaviour of young people rather than achieving statistical outcomes such as reduced teenage pregnancy and STI rates (Peerbhoy and Bourke, 2007). The use of standardised evaluation methods were found by Peerbhoy and Bourke (2007) to be overly quantitative and insufficient – a result which they found consistent with previous research – and rendered poor rates of return. Input from actors was disregarded as they were not paid to take time to evaluate the programme. The evaluation found conflicting responses among teachers as to the type of content deemed necessary and appropriate. All of the teachers believed that a performance by strangers had a greater impact on younger people than class discussion about sexual health issues. One notable success of 'Icebreaker' was that the intervention portrayed boys' experiences in ways they could relate to (Peerbhoy and Bourke, 2007). A key objective of the project was to link the intervention with local sexual health services by implementing a speech by a service representative at the end of the play. However, many students failed to make a connection between the play and the talk by the service representative (Peerbhoy and Bourke, 2007). Another significant finding from the evaluation related to time constraints, with adequate time required for reflection on sexual health as a result of the drama intervention. Despite the TIE aim of promoting active participation and discussion via workshops, less than a quarter of the observed sessions allowed time to complete a follow-up workshop. Finally, teacher follow-up was found to be non-existent in many of the schools, often due in part to teachers not receiving the Teacher Guidebook due to logistical difficulties. This finding is particularly telling in the context of the previous one demonstrating lack of time for post-intervention workshop discussion.

An earlier study evaluated a London TIE project entitled 'Vital Youth', which involved 19 African/African-Caribbean young people from an inner-city borough experiencing significant social and economic deprivation (Douglas, Warwick, Whitty and Aggleton, 2000). The project consisted of 17 three-hour workshop sessions, addressing health and sexual health topics. The overall time investment and cost of the project was significant, totalling £48,836, most of which was accounted for by staffing costs. Benefit from investment was intended to be recuperated by developing the production into a peer-led intervention for local schools, but funding was terminated before this aim could be realised. The aims

of the drama intervention included providing young people with skills in drama, music, script-writing, art, knowledge of sexual health issues relevant to their lives, social skills, self-esteem, confidence, understanding of their identities and a role in the performance production (Douglas et al., 2000). Although topics such as sexual health were expressly addressed, the primary aim was to raise the self-esteem and confidence of participants. External evaluation of the programme was commissioned by the provider trust in order to examine effectiveness and aid further programme development. Traditional research methods were deemed inappropriate for this creative endeavour, and a qualitative case-study approach was implemented by means of evaluation workshops. This methodology involved the young people in the conduct of the evaluation and included brainstorming, 'round-robin' exercises and 'film-star' peer-interviews of drama participants (Douglas et al., 2000). The majority of the objectives initially set out for the project were met due to the intervention's effectiveness in providing young people with relevant experiences. In terms of the objective around sexual health knowledge, small group brainstorming suggested project success in raising numerous related topics such as: puberty, sex, relationships, STDs, condoms, pregnancy, sexual health, AIDS, homophobia, impotency, 'horniness', ejaculation, hormones, sexual language and sexual promiscuity (Douglas et al., 2000). The manner in which the intervention fostered the organic development of relevant themes around sexual health that were pertinent to the young people via their active involvement in the process suggests that 'Vital Youth' was well-received and dealt effectively with multiple relevant facets of sexual health. The evaluation concluded that this type of intervention required committed, multi-skilled staff teams who are unlikely to be low-cost. However, it was also suggested that greater impact and benefit may be achieved when such a project is facilitated to develop a peer-education model within schools as originally envisaged by this project (Douglas et al., 2000).

The A PAUSE peer-led sex education programme in the UK (mentioned in Section 2.2.1) has been subject to rigorous evaluations to demonstrate changes in knowledge, beliefs and attitudes as a result of its intervention. In response to its failure to significantly change teenagers' beliefs in their ability to negotiate sexual relationships (Evans, Rees, Okagbue and Tripp, 1998), these authors piloted a peer-led theatre-based adaptation of the A PAUSE programme, designed to aid participants in identifying the need for negotiating skills and to practise them using role-play. The theoretical underpinnings for this pilot programme and other theatre-based interventions include 'social learning theory' (Bandura, 1977), which holds that human behaviour is acquired via prior modelling, memory through symbolic representation, rehearsing the behaviour and, finally, performing the behaviour (Evans et al., 1998). In the classroom, the authors assert that this theoretical approach - in conjunction with social inoculation and social norms theories - translates into practices which avoid traditional teacher-pupil power dynamics, emphasise non-didactic teaching and learning methods, use small group activities and discussion and incorporate role-playing activities (Evans et al., 1998). The A PAUSE programme asserts that knowledge acquisition and changes in attitudes and beliefs alone will not result in significant behavioural change; however, symbolic enactment of knowledge, attitudes and beliefs through performance and role-play may provide visual and experimental examples for alternatives in behaviour (Evans et al., 1998). Thus, development of a theatre-based A PAUSE intervention was carried out by a commissioned theatre company and evaluated by questionnaire.

The target population in the Evans et al. (1998) study comprised of four Year 11 (15-16 year olds') drama classes from two Exeter schools, yielding 55 participants in this pilot intervention. Findings indicated that the involvement of peer educators in such a theatre-based process aided in the emergence of concerns relevant to the young people themselves, rather than reproducing the priorities of medical and educational professionals. The researchers concluded that best practice for such a model requires using peers less than two years older than the recipient group to model desirable attitudes and beliefs, transfer power away from teacher to pupil, build collaborative processes between all involved, generate dialogue between the sexes and develop alternative 'scripts' which differ from traditional 'risk-taking' narratives. The researchers also acknowledge the importance of the slightly-older peers as 'proxy role models' (Evans et al., 1998). Notably, the intervention was formulated and executed using the assumption that the majority of participants would be involved in heterosexual relationships, therefore leaving the responsibility to raise any topics related to LGBT identities to young people themselves. The aims of the programme to be achieved through role-play were articulated as: promoting stable relationships with better communication, providing understandings of sexual behaviour and sexual feelings which do not involve 'full sexual intercourse', encouragement around negotiating alternative sexual expression within their relationships (including mutual masturbation), and postponement of sexual intercourse until such a time as all parties are able to negotiate contraception (Evans et al., 1998:237).

While the Evans et al. (1998) sample was too small to provide statistically significant results, all statements around perceived self-efficacy in sexual relationship negotiation displayed positive shifts following the intervention. Increased accuracy outcomes around perceptions of societal norms in relation to sex provided an unexpected outcome. Gender differences were distinct, and males were found to place more importance on peer group norms, to consider it acceptable to apply pressure in relation to having sex, and to have difficulty considering negotiation of physical aspects of relationships. The most prevalent comment around the intervention was that 'it was fun'; 90% reported enjoying the sessions, 96% had made contributions to group discussions, 80% took part in role-plays and 62% felt the experience had helped them in their own relationships. Teachers also reported being impressed by high levels of student involvement and commitment to the programme (Evans et al., 1998). The researchers noted that outcomes of 'delaying first sex' would require longitudinal research and further concluded that, in order to remain part of the A PAUSE framework or the framework of any other publicly funded initiative, the intervention would need to operate a three-way relationship which fosters dialogue between young people, educators and health professionals (Evans et al., 1998). The researchers also concluded that large-scale implementation of such a drama-based programme would inherently involve a reduction in the autonomy of the peer-educators and their own personal involvement in programme content. Large-scale implementation might also tempt practitioners to codify a 'script' in exchange for a more fluid and organically developing model, yet this would be antithetical to the aims of theatre-based peer interventions. Long-running theatre-based programmes must, according to Evans et al. (1998) ensure that teachers and practitioners are adequately trained by theatrical professionals. Facilitators could be permanent staff such as school nurses or teachers. Finally, the authors commented on the rehearsal process itself, noting that it is a prime opportunity for generating dialogue which could identify the relevant obstacles preventing the specific target group from achieving effective sexual health (Evans et al., 1998).

In addition to these UK-based studies, a study in the Netherlands compared the impact of attending a theatre performance specifically designed to promote condom use in teenagers with a folder containing information with the same purpose (Van den Bogaard and Janssens, 2004). The researchers concluded that the intention to use a condom was not increased by the folder information or theatre intervention compared with a control group who received no intervention. Although knowledge and attitudes towards condom use had been positively affected by the theatre performance, the researchers concluded that the cost of the theatre production could not be justified by its impact (Van den Bogaard and Janssens, 2004).

Consistent among a number of the studies located on the use of drama in facilitating sex education is the finding that these 'involving' interventions have the potential to change attitudes and behaviours, and increase the knowledge of young people. All of these studies recommend that drama-based sex education needs to be part of a wider, ongoing and holistic sex education curriculum which requires intervention, follow-up and school collaboration with theatre groups and commissioners, both prior to and after the performances.

2.6 The Use of Computer, Internet and Multimedia Methods to Facilitate the Delivery of Sex Education

As technology becomes more versatile and interactive, and adolescents are becoming more computer literate at an earlier age, computer programmes and internet applications have become increasingly relevant as facilitators of sex education. Use of computers can help make sex education curricula come alive in ways not otherwise possible. Computers also have the potential to aid in standardising the delivery of essential aspects of the curriculum, to individually tailor outputs to the programme user, and to provide a cost-effective, yet innovative, method of facilitation that can be used both in and out of the classroom. User flexibility with many of these programmes is a key benefit, as they can essentially provide a 'sex educator' to the pupil whenever they need one. Some computerised sex education methods are interactive in nature, implementing elements of chat room or peer-to-peer discussion, while others are provided on-line via various internet websites. Computer-based programmes have also been used in the training of teachers in traditional teacher-led sex education programmes (Lokanc-Diluzio, Cobb, Harrison and Nelson, 2007; Goldman, 2009). Research available on computerised delivery of sex education is limited and primarily US-based.

Computerised facilitation has been looked to for decades as a low-cost, accessible, standardised, yet user-tailored, option in sex education. An overview of evaluations of a number of computer applications for adolescent health assessments including sexual health (Paperny, 1997) suggests that retention of the information was higher and that participants felt more comfortable interacting with the computer when assessing sexual health issues than with a health care professional. These applications were used in schools, but also in clinics, detention centres and health fairs. Around the same time Thomas, Cahill and Santilli (1997) evaluated an interactive computer programme - 'Life Challenge' - which was developed by the New York State Department of Health to improve adolescents' self-efficacy in HIV/AIDS prevention programmes. They found that users of the computer kiosk provided for the purpose and placed in 13 different sites engaged in a

serious way with it. The authors also registered significant learning gains and increases in self-efficacy in the participants. An even earlier study by Kann (1987) used computer-assisted instruction to teach skills around responsible sexuality. The programme was not very sophisticated and in no way representative of the computer facilitated sex education on offer today. Nonetheless, it was demonstrated that the computer simulations used were superior to regular classes or a control group on measures of knowledge, human interaction and decision-making tendencies in regard to responsible sexual behaviour.

One international review (Delgado and Austin, 2007) of the literature was located. This review evaluated media, internet, and interactive computer interventions promoting responsible sexual behaviour. Although only a handful of studies in the review addressed interactive computer interventions directly, the authors offer the cautious conclusion that computerized and multi-media interventions have the capacity to impact sexual knowledge, attitudes, and behaviours and are worthy of consideration by policy makers (Delgado and Austin, 2007:405). They also suggest, however, that longitudinal research is required to assess if short-term multi-media intervention successes, such as improvements in knowledge, attitudes and behaviour, can be maintained in the long term. A more elaborate systematic review for the Cochrane Library (Bailey, Murray, Rait, Mercer, Morris Richard et al., 2008) is underway, but was not completed at the time of the writing of this report.

Much research on computer-based interventions focuses to a greater extent on programme content development than on the impact of such methods on users. Goold, Bustard, Ferguson, Carlin, Neal and Bowman's (2006) UK study reported on their use of two small focus groups with adolescents in Nottingham for the development and design of an Interactive Multimedia Learning Environment (IMLE). Nottingham is characterised by particularly high rates of teenage pregnancy and STIs among young people, and designers wanted the IMLE to be easily incorporated into school-based sex education while remaining accessible at other sites in order to access young people who have been excluded from school (Goold et al., 2006). This study pointed to the opportunities available for pupils to formulate their own virtual characters through their unique input. However, most students appeared to incorporate stereotypes and perceived or real societal norms such as associating drugs and alcohol with sexual activity. Personalised character selection enabled students to choose characters of their same ethnic makeup. Disconnects were found in focus group participants' knowledge base in that the programme resulted in extensive awareness of STIs, yet few participants had knowledge of actual local STI clinics, should they require access to one (Goold et al., 2006). One finding suggested that 'framing' of information within the programme to emphasise gains or positives may be more effective than focusing on negative aspects of sex (Goold et al., 2006). The authors are using their findings to aid in the development of the described IMLE. The implementation may have taken place but its evaluation has to yet been published.

Another recent development was documented by Ito, Kalyanarama, Ford, Brown and Miller (2008). They conducted a pilot study on a CD-ROM aimed at preventing STIs in female adolescents. Study participants included 47 female patients aged 15-19 years visiting a North Carolina adolescent family planning clinic as new patients between January and

May 2005 (Ito et al., 2008). The CD-ROM included prevention information and sexual negotiation skills around abstinence and condom use, and provided users with a choice of culturally appropriate virtual facilitators to navigate the CD-ROM. The study compared a control group receiving only an educator-led didactic session with the intervention group receiving the didactic session along with the CD-ROM. The authors noted that CD-ROMs have the advantage of not requiring additional trained facilitators or staff, of being easily reproduced and distributed, and of being able to be used in a number of settings (Ito et al., 2008). Interactive technology is further thought to increase content retention due to the active and participatory nature of the programmes and has the ability to incorporate a variety of learning styles in presenting information through audio, text, graphics and video (Ito et al., 2008). This has the added benefit of boosting computer literacy. Additionally, content can be individualised based on user characteristics and responses. As with most computerised interventions, results were measured purely quantitatively. The intervention was found to be highly acceptable and feasible among the predominantly African American and Hispanic female adolescent clientele of the clinic (Ito et al., 2008). HIV/STI knowledge increased significantly as a result of the intervention and nearly all adolescents reported the intent to use condoms at next intercourse after viewing the CD-ROM. However, such positive outcomes did not differ significantly between the intervention and control groups (Ito et al., 2008).

Several computer-based interventions are specifically targeting adolescent girls. Di Noia, Schinke, Pena and Schwinn (2004) evaluated the 'Keeping it Safe' CD-ROM with an ethnically diverse sample of 205 adolescent girls aged 11 through 14 in New York City. The intervention provides a 30-minute interactive game in which girls identify facts and myths about HIV/AIDS, view video footage of a young woman who contracted HIV, and use scenarios and simulations of assertiveness responses, intended to help manage personal behaviours and reduce HIV risk (Di Noia et al., 2004). The aims of the programme were to increase HIV/AIDS knowledge and to enhance protective attitudes (including peer and partner 'norms' and attitudes towards sexual activity) and risk-reduction self-efficacy amongst the adolescent girl participants. The intervention was compared with a control group exposed to a regular programme already on offer at the social service sites (Di Noia et al., 2004). The evaluation, which was solely based on self-reported responses, demonstrated significantly more progress from pre- to post-test stage in HIV/AIDS related knowledge and risk reduction self-efficacy in the intervention group than in the control group programme.

The use of computer-based interventions to educate college-age students on sexual health seems to be a growing trend in the US. Studies by Evans, Edmundson-Drane and Harris (2000) and Kiene and Barta (2006) demonstrated the effectiveness of computerised HIV/AIDS risk-reduction programmes to 157 college students. However, it would seem that the age of participants may not matter much, as a similar intervention for high-school-age adolescents yielded comparable results. Downs, Murray, de Bruin, Penrose, Palmgren et al. (2004) evaluated an interactive video intervention entitled 'What could you do?' The intervention focuses on STI-related knowledge, sexual behaviours and STI acquisition. The randomised controlled trial testing the results of the intervention included 300 sexually active female adolescents between the ages of 14 and 18, recruited from urban Pittsburgh health care clinics (Downs et al., 2004). This specific video intervention depicted scenarios

for female adolescents in which male characters prompt sexual situations from females which could either be risky or healthy. Other sections of the intervention contained information on condom efficacy and STI awareness, with additional 'optional' sections which users could browse through at their discretion (Downs et al., 2004). While the intervention group accessed this CD content, two control groups were exposed to either a 127-page book with the same dialogue and images from the video or commercially available brochures which closely matched the video content (Downs et al., 2004). The interventions occurred at one, three and six months, with STI tests self-administered at 6 months. While there was no significant difference in Chlamydia infection rates between the intervention and control groups, the intervention group was found to be significantly less likely at follow-up to report condom failures or having been diagnosed with an STI (Downs et al., 2004).

The internet offers adolescents unique access to information on a range of sex and health-related topics in a manner that is convenient and confidential and it also provides links with services. These benefits are crucial in the context of adolescents feeling embarrassed about initiating discussion with health providers about sensitive topics and the fear they have about their confidentiality being breached. Adolescents as a demographic are major users of the internet. Therefore Gray and Klein (2006) set out to review recently published literature relating to adolescents' access to sexual health information online. In their review period, few empirical studies addressing adolescents' use of the internet for health-related information were located and still fewer reviews addressed sexuality issues specifically (Gray and Klein, 2006). Health-related studies were often more general in nature, and typically found that convenience, rather than concerns about privacy or embarrassment, was cited as the most relevant reason for adolescents' use of the internet for health information. Several studies concluded that health literacy skills would improve on-line experiences, particularly in terms of being a critical information consumer and learning who to trust for information, products and services. Gray and Klein (2006) referenced one study, by Cameron et al., which found 14- to 17-year-old participants reported high levels of exposure to sexually explicit websites. Young peoples' accessing of pornography or sexually explicit material is a central concern in debates around internet usage within the context of sexual health education. Despite the fact that 40% of parents report the use of filtering or monitoring software, such software often also eliminates web sites which provide crucial information for young people (Gray and Klein, 2006). For example, words such as 'breast' or 'rape' would likely trigger the filter and block access to the related site. Furthermore, adolescents from economically deprived backgrounds are likely to rely on computers that are available in schools or libraries, and these often contain very restrictive filters, thus magnifying the 'digital divide' which prevails and exacerbates the marginalisation of poverty for young people (Gray and Klein, 2006). One on-line survey located by Gray and Klein (2006), and conducted by Gilbert et al., found frequent topics of interest for adolescents to include sexual expression, teen sexuality, virginity, relationships, contraception and STD information; thus displaying the widespread use of the internet to obtain information on sex education-related topics. Gray and Klein's (2006) review also found evidence that the internet is particularly important for same-sex attracted youth in coming to terms with, and finding language to describe, their experiences, and also for 'rehearsing' their 'coming-out' on-line while confiding in others who have similar experiences (Gray and Klein, 2006). This is, of course, in the context of the vast majority not having access or exposure to information on LGBT identities through mainstream school-based sex education programmes.

So far, this section has focused on how computerized interventions can be used directly with the students or pupils. However, there is also some evidence that such methods can be used effectively in training RSE facilitators. Canadian elementary and secondary school teachers who took part in Web-based sexual health training (www.teachingsexualhealth.ca) to prepare them to deliver RSE classes (Lokanc-Diluzio et al. 2007) reported that they had become more comfortable in the delivery of such classes. They also reported increases in knowledge, comfort, and ability to present accurate information. Increases in comfort levels were also found in health care students who learned about sex education in a web based interactive module (Weerakoon, Sitharthan and Skowronski, 2008). Goldman and Torrisi-Steele (2005) developed an interactive multimedia module using a CD-ROM to instruct student teachers in the delivery of a Sexuality and Human Relations module for primary school children. No evaluation of its use has been published yet but the author summarizes her impressions as follows: 'The student-teachers told me that they enjoyed learning by CD-ROM only for a 13-week course. They most liked that they could do it at any time of the day or night - that is 24/7. This is because most of them work part-time. They said that they enjoyed this type of learning as it was a change from "boring lectures"! They also said that they enjoyed the variety of pedagogies included in the CD-ROM. They also liked the way the content was cut into "Bite-sized" pieces, which was manageable. They found the instructions clear and easy-to-understand. One student said that it was much easier to carry around a little lightweight CD-ROM rather than a great big expensive textbook' (Goldman, 2009).

In sum, these results demonstrate the promise of the use of computer-mediated learning in teaching a variety of aspects of RSE. Considering their presence on the internet, it is evident that this potential is already widely recognised by organisations promoting sexual health in many countries. The challenge for schools would be to harness this potential while effectively navigating the risk factors.

3.0 Conclusion

As stated in the methods section of this review, there is a dearth of dedicated, systematic investigation of the role of outside facilitators in the provision of school-based sex education, a strategy that is currently being used both in Ireland and elsewhere. This situation severely constrains the analytic power of an international literature review on the topic and limits the ability to draw clear-cut or reliable conclusions from the existing research evidence. This does not render the effort futile, as some valuable studies have been uncovered; furthermore, this exercise has demonstrated the urgent need for more research into approaches to effectively engage 'outsiders' to the school community in the delivery of sex education.

To conclude this review, we consider the available evidence on the effectiveness of the contributions of outside facilitators to school-based sex education. Negative aspects of outside facilitation are identified, as are the characteristics of successful outside facilitation, based on a synthesis of findings arising from the review. The final section considers the extent of professional support for and official endorsement of outside facilitation of school-based sex education, an area that is particularly salient to policy makers and practitioners.

3.1 The Effectiveness of Outside Facilitators to School-based Sex Education

Evidence on the effectiveness of outside facilitation of school-based sex education is inconclusive. This is not surprising given the paucity of systematic evaluation of school-based sex education programmes in general and, more specifically, of those that draw on the expertise of individuals and/or agencies from outside of the school community. Some approaches to outside facilitation (e.g. peer-led approaches) have received far more research attention than others (e.g. school nurses), making it difficult to compare the outcomes of different approaches to facilitation. In any case, variations in the methodological approach to assessing or evaluating the effectiveness of individual programmes rules out direct comparison of the available findings. Nonetheless, it is possible to comment in a broad sense on what can be reasonably concluded about the effectiveness of outside facilitation to the delivery of sex education within schools on the basis of the literature reviewed in the previous section. Here we address effectiveness in terms of the impact of sex education programmes facilitated by outsiders on behaviour, attitudes and knowledge. We further discuss a number of other areas of effectiveness, particularly those pertaining to the responses of pupils and teachers. Some findings related to the impact of outside facilitation on broader aspects of sex education delivery within schools are also noted.

Research evidence concerned with the behavioural impact of school-based sex education programmes in general is uncertain (Kirby et al., 1994, 1997; Kirby, 2007; Underhill, Operario and Montgomery, 2007, Underhill et al., 2008). Likewise, the research located for the purpose of this review of school-based programmes facilitated by outside professionals or agencies has produced ambiguous findings on the behavioural impact of these initiatives, with different outcomes demonstrated, in some cases, for the *same type* of facilitated programme, as well as across the whole range of facilitators who support school-based sex education.

Stephenson et al.'s (2008) longitudinal study found that the proportion of girls having had one or more live births was 3.1% lower for peer- than teacher-led students. However, other evidence of differences in behavioural outcomes for peer- versus teacher-led programmes remains unclear, with some studies having found those led by peers to be more effective, others demonstrating similar or identical results for those led by peers and teachers and yet others concluding that neither method demonstrated a behavioural impact (Harden et al., 2001; Kim and Free, 2008). Kim and Free's (2008) review found no difference in the uptake of condom use and identified no reduction in the number of sexual partners or the incidence of pregnancy when peer- and teacher-led approaches were compared. LGBT-led instruction is a relatively new school-based innovation, and most evaluations of these programmes have concentrated on attitudinal outcomes rather than behavioural change. However, the findings of two studies have demonstrated that programmes which included LGBT-sensitive sex education produced reports of reduced sexual risk behaviour among LGBT youth (Blake et al., 2001; Goodenow et al., 2008). Drama and computer-led interventions/instruction have also been shown to produce a positive behavioural impact, with an increase in reported condom use found in two evaluations of drama-led methods (Daykin et al., 2008). Finally, one study of a computer-led intervention found the method to bring about a significant increase in self-reported risk-reduction behaviour generally and condom use specifically (Kiene and Barta, 2006). Another evaluation of a computer-based method found the intervention group to be less likely to report condom failures or having been diagnosed with an STI after a six-month follow-up, in comparison with the control group (Downs et al., 2004).

There is more evidence of increases in knowledge and in positive attitudinal change among recipients of sex education delivered by outside facilitators. For example, knowledge and attitudes towards condom use were found to be positively affected by a theatre-based intervention (Van de Bogaard and Janssens, 2004). Evaluations of drama-led approaches have also demonstrated a positive impact on sexual knowledge as well as changes in attitudes concerning availability of and access to contraception (Daykin et al., 2008). Likewise, computer-based methods have been found to increase pupils' STI and HIV knowledge (Ito et al., 2008; Di Noia et al., 2004), as well as intent to use condoms (Ito et al., 2008) and risk-reduction self-efficacy (Di Noia et al., 2004). Computer-based interventions have been found to be superior to traditional methods in measures of student knowledge and decision-making tendencies related to responsible sexual behaviour (Kann, 1987). Another mixed-method outside-facilitation approach delivered by medical professionals and peer educators found changes in attitude, increases in knowledge and a relative decrease in sexual activity when compared to teacher-led control groups (Mellanby et al., 1995). Finally, Douglas et al.'s (2001) investigation of the role of a Young Gay and Bisexual Men's Development Worker in providing instruction on elements of sexual orientation as part of the wider SRE programme found that students reported a heightened awareness of homophobia and reported that they felt empowered to challenge such behaviour; the majority also reported an increase in understanding of the issues affecting gay and lesbian people.

Looking, then, to indicators other than those associated with knowledge, attitudes and beliefs, there is considerable evidence that students respond positively to outside facilitators and that they enjoy their input to sex and relationships education. Students

who were recipients of 'peer-led' or 'proxy-peer-led' methods, for example, viewed facilitators as role models who were credible, trustworthy, expert, and less threatening than teachers (Wight, 2008). Furthermore, peer approaches have been demonstrated to be effective in re-engaging students who are otherwise marginalised or excluded; they have the propensity to increase client uptake in local services, maintain clear and realistic expectations, and provide better opportunities for discussion among young people (Pinkleton et al., 2008; Forrest et al., 2002; Forrest and Lynch, 2002; Mellanby et al., 2001). There is also evidence that some students prefer to receive factual information from people who they perceive to be 'experts' (meaning not peer educators or teachers) (Ebreo et al., 2002). The fact that facilitators are not always on-site appears to confer a level of confidence among students. For example, students viewed school nurses as 'outsiders' and as therefore capable of providing specialist knowledge (Hayter et al., 2008).

Theatre-led methods have been demonstrated to be most effective when actors are knowledgeable of the local area, when they address specific misconceptions held by the audience, discuss current issues, appear credible, and have similar accents and language use to the young people (Swaney et al., 2003). Computer and internet methods of sex education are perceived by students as confidential and are often appreciated by users for their convenience (Gray and Klein, 2006). Internet sources have been found to be particularly widely used by LGBT pupils because they enable them to confide in others who are experiencing similar marginalisation and to come to terms with their experiences (Gray and Klein, 2006). Also, the peer educator experience itself has been shown to have clear benefits of boosting efficacy, empowerment and self-esteem amongst them (Wight, 2008), and drama-led interventions have been found to have strong positive outcomes in the areas of peer interaction and social skills (Daykin et al., 2008).

There is also evidence that students like 'outside facilitators' simply because they are not teachers. For example, teachers are sometimes perceived by students as being unable to maintain confidentiality due to their ongoing contact with them or because of perceptions of previous breaches of confidence (Forrest et al., 2002). Furthermore, teachers may not be perceived as credible role models (Wight, 2008). Finally, teachers have been found, in some studies, not to acknowledge or address sexual diversity. Many teachers appeared not to include lessons on sexual orientation and in some instances presented sex education that contained utterances of explicit homophobia (Buston and Hart, 2001).

There is some evidence that specific interventions (e.g. computers) and the work of outside facilitators can have a positive impact on broader aspects of sex education delivery within schools. It is, in fact, claimed that sex education lessons are more likely to occur when outside facilitators are engaged by schools (Forrest et al., 2002). One Theatre in Education (TIE) evaluation found that the programme's most significant impact was the shift in attitude and culture towards sex education that it provided within the school, possibly because of the deliberate and dedicated planning required in implementing the programme (Swaney et al., 2003: 39). Many outside-educator methods also have additional benefits that would not occur with traditional teacher-led methods. Computerised methods can, for example, have the added value of teaching pupils media literacy skills (Ito et al., 2008).

3.2 Negative Aspects of Outside Facilitation

A number of the studies reviewed have highlighted aspects of outside facilitation that can produce negative results, not because they impact in a negative way on student knowledge, attitudes or behaviour, but rather because there may be unintended consequences arising from schools' efforts to implement such initiatives. Such negative consequences are important, since they draw attention to potential challenges associated with effectively organising and implementing outside facilitation of sex education.

There is some evidence to suggest that there are aspects of outside facilitated sex education that may be disliked by some teachers. For example, Forrest et al. (2002) found that some teachers were suspicious of the interactive pedagogical approaches used by facilitators, due to their potential for digression and possible 'subversion' of the pupils. Indeed, teachers have been demonstrated to be more likely to control the class and to avoid disruption (Wight, 2008; Forrest et al., 2002), and some complain about having to relinquish 'control' of their classrooms to 'outsiders' (Morgan et al., 2004). Teachers have also been found to express concern about medical students' lack of teaching experience (Jobanputra et al., 1999. (See section 3.3 for a discussion of how these issues can, in fact, be resolved.))

Despite being peers of the recipients of sex education, most peer educators deliver content based on adult-led agendas (Harden et al., 2001). The work of peer educators has been characterised as ultimately communicating adult messages to students (Wight, 2008), and it is significant that peer educators often complain that they are asked to deliver messages that are inconsistent with their personal behaviour and beliefs (Ebreo et al., 2002). Alldred and David (2007:101) suggest that the way in which schools and educational projects hear what children and young people say requires close scrutiny. These authors claim that, compared to the health arena, the educational sector lacks a tradition of taking account of the perspectives of children and young people:

Listening to children and young people's views is now recognised as good practice across services, but the discourse of the consumer of health services was established earlier than in education ... school represented the last bastion of authoritarian paternalism of the 'do as I say because I know what's best for you' variety. (Alldred and David, 2007)

The construction of morality and values by outside facilitators is another issue that emerges in the literature. The presentation of moralistic viewpoints, whether by teachers or 'outsiders', is disliked by young people, and is particularly disliked when such viewpoints come from their peers (Forrest et al., 2002). Ebreo et al. (2002) found peer educators only to be effective role models to the extent that they 'do as they say'. The approach and content of a programme involving young mothers as peer educators was explored in one study and the findings suggested that, despite the aim of empowering pupils, young mothers in fact fictionalised their narratives, thus reproducing dominant moralistic accounts (Kidger, 2005).

In a somewhat similar vein, confusing, fluid and 'non-normative' accounts were found to be suppressed by LGBT facilitators because they were thought to be unacceptable in the classroom. Thus, LGBT facilitators were often found to reconstruct stereotypes of

their sexual identity experiences and to conceal instabilities and multiplicities rather than communicating the truthful, 'messy' narratives of their sexuality stories (Srivastava and Francis, 2006; Rieske, 2009). LGBT-led methods have been found to be more successful when 'adults' (whether LGBT representatives or teachers) position themselves as collaborators in young peoples' experiences rather than as 'experts' (Rieske, 2009). Notable also is that Evans et al. (1998) found drama-based approaches to be more effective when they developed alternative 'scripts' that differed from traditional 'risk-taking' narratives.

3.3 Characteristics of Effective Outside Facilitation

A key issue arising from this review relates to the in-school organisation of outside facilitation. Irrespective of the type of facilitation in question – whether involving peers, school nurses, medical professionals, LGBT individuals or organisations or theatre- or drama-based methods – the degree to which the work of these facilitators is embedded in, rather than separate or removed from, the school's broader sex education programme appears to play a crucial role in determining the effectiveness of the contribution (Douglas et al., 2001; Swaney et al., 2003). Professionals, organisations and peers who worked in collaboration with the school's teachers, and with comprehensive knowledge of the content of the broader sex education programme, appeared to achieve better and more effective outcomes. There is also evidence to suggest that teachers and facilitators need to consider and agree the programme content well in advance of outside speakers engaging with students. Again, this appears to be important in terms of ensuring that teacher and facilitator programmes are complementary but also in terms of alleviating or removing distrust on the part of teachers towards facilitators and vice versa. As stated earlier, some teachers can be resistant to the presence of 'outsiders' in their classrooms. Both peer leaders and teachers in Morgan et al.'s (2004) study described challenges associated with power struggles during programme provision, with some teachers complaining of their reluctance to 'hand over' to the peers and peers reporting teachers as 'taking over' their portion of the lessons. There is also evidence of school nurses feeling under 'covert surveillance' by teaching staff and restricted in the type of education they can provide (Hayter et al., 2008). Douglas et al.'s (2001) evaluation of the role LGBT-led outside facilitation of education about sexual orientation documented teachers' tendency to initially act as gatekeepers, particularly fearing negative media attention for providing instruction on the topic of sexual orientation. This programme was evaluated positively, and crucial to its success was that the development worker (facilitator) was involved in other health promotion activities which were not LGBT-specific and also built relationships with schools throughout the year. Familiarity on the part of the development worker with working with schools was deemed to be another important factor in ensuring the programme's success. Possibly the most noteworthy feature of this facilitated programme was its considered approach to building partnerships with schools and working with young people (Douglas et al., 2001). Drama-based methods have similarly been found to be most effective when integrated as simply one part of a wider sex education curriculum, including staff involvement in the planning of drama interventions, close liaison between teachers and the drama groups, and follow-up activities conducted by staff (Swaney et al., 2003; Evans et al., 1998). As stated in the introduction, there is heavy emphasis within the RSE policy guidelines in Ireland on the need for schools to adopt a whole school approach to the delivery of relationships and sexuality education. These findings highlight

the crucial importance of integrating and embedding the work of facilitators into the broader sex education curriculum. They also demonstrate that teacher suspicion (where it may exist) of the work of outside facilitators can be effectively addressed and eradicated if their input is negotiated and discussed in advance and embedded in the larger sex education programme. A whole school approach to outside facilitation would also rule out the model of providing 'one-off' lectures to students on one or a number of topics. Such input on issues such as sexual-orientation has in fact been heavily critiqued (Srivastava and Francis, 2006). As with other sex education content, approaches to addressing LGBT identities need to be infused throughout the curriculum (MacIntosh, 2007).

The personal and professional characteristics of facilitators feature repeatedly throughout the literature and appear to play a significant role in how facilitated interventions are judged or appraised by both the recipients of programmes and by teachers. This is perhaps unsurprising since there is a sizeable body of research literature on the characteristics of effective sex education *teachers*, with research highlighting characteristics such as openness and the ability to foster discussion, trustworthiness, and having an awareness of the realities of young people's lives, as important in fostering an environment where students can engage with the subject matter and learn (Allen, 2009). Students also feel that those who deliver sex education, whether a teacher or guest speaker, must be comfortable with the subject area and able to create a climate of openness (Hilton, 2003).³ Some of the findings on the characteristics of 'good' or effective facilitators are similar to those related to teachers. For example, students in all of the RIPPLE (peer-led) groups agreed that good sex educators should have expertise on the subject, be confident and caring, and good at working with youth (Forrest et al., 2002). This study also revealed that students held positive views of peer educators, who they perceived as enthusiastic, imaginative, accepting of laughter and joking, and respectful of students. As a result, students reported being more interested in the peer-led sex education than in other classes, took it more seriously and day-dreamed less (Ebreo et al., 2002; Forrest and Lynch, 2003). Likewise, Douglas et al.'s (2001) evaluation of LGBT-led facilitation drew attention to the personal characteristics of the facilitator of an LGBT-led school-based programme, stating that teachers valued the facilitator's humour, openness, sensitivity, empathy and use of a non-didactic approach and viewed these characteristics as appealing to students.

While it is possible to identify specific personal characteristics that appeal to students, the pedagogical approach of outside facilitators is a factor noted in a number of studies as influencing the success of programmes. For example, the use of active or participatory teaching methods was commended by recipients of peer-led sessions (Forrest et al., 2002). Students who participated in sex education lessons which integrated drama and theatre reported having fun and felt that the experience helped them in their own relationships, a perspective that appears to be linked to their level of active participation through role play and the contributions they felt they made to group discussions (Evans et al., 1998). These findings are noteworthy since experiential learning approaches are endorsed within the RSE and SPHE guidelines in Ireland and are regarded as the most appropriate and effective teaching methods for the delivery of school-based relationships and sexuality education (Department of Education and Science, 1998a).

³Appendix 1 includes a review of the characteristics of effective teachers in the area of sexuality and sexual health. Many of these have relevance to outside facilitators since they adopt the role of 'educator' within school settings.

Confidence on the part of facilitators in delivering sex education is critical, and it cannot be assumed that all outside facilitators have the skills to convey confidence to students, even if their professional training appears relevant. For example, a number of studies on school nurses' contribution to sex education indicate that many report a lack of confidence in this area of practice (Westwood and Mullan, 2006; McFadyen, 2004). Likewise, experience and confidence in managing classrooms and working with young people are important and contribute to the success of programmes facilitated by outsiders (Douglas et al., 2001). Indeed, one of the difficulties with peers as facilitators is that they can be perceived as lacking in disciplinary skill, which can lead to disruptive student behaviour (Forrest et al., 2002; Wight, 2008). Jobanputra et al. (1999) also stressed that more emphasis needed to be placed on the teaching and group-facilitation skills required by medical students to enable them to deliver sex education effectively in the school context. Perhaps significant in terms of teaching and classroom management is that the project development worker in the LGBT-led programme evaluated positively by Douglas et al. (2001) had familiarity with working with schools and the demands and challenges of being a teacher.

The feasibility and appropriateness of particular lessons and interventions delivered by individuals who are not members of the teaching staff also merits consideration, since it can impact on programme efficiency and effectiveness. In relation to peer-led programmes, Wight (2008) emphasises that these programmes must be feasible and appropriate to the specific setting, target group and curriculum deliverer. Indeed, some of the disadvantages of peer-led programmes include their extensive organisation and management requirements, the need to re-train peer leaders at regular intervals, and the difficulties associated with attracting sustainable funding (Forrest and Lynch, 2002; Kim and Free, 2008; Wight, 2008). Likewise, Theatre in Education (TIE) has been judged to be expensive compared to other interventions, and questions have therefore been asked about the financial sustainability of such programmes (Swaney et al., 2003). It should be added, though, that low-cost in-class drama may provide similar benefits without the high expense. The cost of bringing in physicians can also be high and create a barrier to their involvement (Twine et al., 2005; Clarke et al., 2003). On the other hand, Cora-Bramble et al. (1992) suggest that a sex education programme provided by medical students offered a cost-effective model of increasing elementary students' knowledge of sexual issues, while simultaneously enhancing medical students' communication skills. It has also been noted that CD-ROMs do not require additional trained facilitators or staff, can be easily reproduced and distributed, and are feasible for use in a range of settings (Ito et al., 2008).

Finally, monitoring and assessment of any sex education programme is clearly critical. The assessment process described by Morgan et al. (2004) for the A PAUSE programme is a good example of how such an undertaking can positively impact on programme effectiveness. Feedback for peer leaders was deemed advantageous and necessary in supporting the peers, and the assessment itself was considered to enhance peer leaders' focus in the classroom. Teachers were almost always amenable to completing the assessment and several felt that it helped raise the profile of the sex education curriculum within their school. Researchers discussed how, with appropriate training and support, the sex education programme assessment process itself was found to aid the development of the 'community' aspect and approach of the programme. As well as facilitating 'whole school' investment in sex education, the assessment process itself lent

credibility to, and increased the status of, sex education (Morgan et al., 2004). In terms of planning assessment and evaluation that is appropriate, it is perhaps important to note that traditional or standardised evaluation methods have been deemed overly quantitative and insufficient in rating the success of creative methods of facilitation such as drama (Douglas et al., 2000; Peerbhoy and Bourke, 2007).

3.4 Professional Support for and Official Endorsement of Outside Facilitation of School-based Sex Education

There appears to be very considerable support among educators and policy makers, both in Ireland and internationally, for using 'outsiders' to assist with the delivery of sex education. As highlighted in the introduction, the use of outside facilitators by schools and teachers to assist with the delivery of RSE and/or other components of the SPHE programme in Ireland is a relatively common practice, with 40% of second-level schools currently drawing on the expertise of outside facilitators to assist with the delivery of RSE (Mayock et al., 2007). Eighty percent of schools expressed support for greater use of outside facilitators, and felt that they would help 'a lot' or 'somewhat' in enhancing the future implementation and delivery of RSE. Furthermore, several of the study's key informants at Government, national and regional levels endorsed the contribution of outside facilitators to school-based RSE and expressed support for the expansion of this form of support. Likewise, Westwood and Mullan's (2007) assessment of the sexual health knowledge of teachers who contribute to secondary school sexual health education in the UK revealed strong support among teachers for engaging 'outsiders' to the school community in the delivery of sexual health programmes. This study found that only 6% of teachers agreed or strongly agreed that teachers should teach all SRE; 28% were not sure and 66% either disagreed or strongly disagreed. Eighty-three percent of teachers felt that SRE should be taught by a combination of teachers, healthcare professionals and other outside agencies. This literature review has also documented support among teachers for LGBT-led facilitation (Douglas et al. 2001), peer-led approaches (Morgan et al., 2004), facilitation by medical professionals (Jobanputra et al., 1999), and the use of theatre and drama methods to facilitate the delivery of sex education (Swaney et al., 2003).

As outlined in the Introduction, guidelines were issued by the Department of Education and Science (2003) to assist schools and teachers in the planning and evaluation of the work of outside facilitators to the SPHE programme. Nonetheless, compared to the UK, there is less explicit policy discussion of the use of external agencies to assist with the delivery of the sex education component of the larger SPHE programme. For example, in a review of sex education in schools in England, the Office for Standards in Education (OFSTED) (2002) notes that schools generally made good use of supports from a range of individuals and agencies. Nurses, general practitioners, health promotion units, LEA staff, theatre-in-education teams, youth workers and peer education teams are all considered to make significant contributions. The involvement of these external agencies was viewed very positively by OFSTED and judged to provide students with 'access to a wealth of experience and expertise, new resources and different approaches to learning' (OFSTED, 2002:17).

This report specifically draws attention to the value placed by Year 6 girls on the talks they received on personal hygiene from a 'visitor or a school nurse'. Year 12 students (16-17 years old) had a doctor talk to them about STIs, and the report also referenced the local

networks available to support students. It also noted that a significant number of schools engaged in peer-education programmes in which young people, who were trained and supervised by external agency professionals, provided information to students. OFSTED (2002:18) identified a number of characteristics associated with the successful use of outside agencies or facilitators. These can be summarised in terms of schools having adhered to the following procedures:

- Made explicit reference in curricula to the involvement of external agencies and how external agencies were to contribute.
- Arranged a preliminary meeting with the visiting educator where they made the person aware of the nature of the SRE programme, and what part they were being asked to play in it.
- Gave the visiting educator an opportunity and time to consider if they could meet the brief set by the school.
- Familiarised the outside educator and themselves with objectives and any ground rules concerning sexuality.
- Provided visiting educators with enough time to plan their programme/lesson and share their plans with the school.
- When a visitor came to teach, the school teacher remained in the class, so that subsequent work could build on the visitor's input.
- Evaluated the sessions and sought students' views to help both parties evaluate the session.
- Shared evaluations with each other as a useful way of determining future co-operation.

In 2008, the Department for Children, Schools and Families published a review of the delivery of Sex and Relationships Education (SRE) in the UK. The recommendations of this report fell broadly into six headings, one of which was dedicated to encouraging greater use of external professionals and agencies to support schools' delivery of SRE (Department for Children, Schools and Families, 2008a):⁴

Whilst we have some reservations about the use of external professionals and agencies: their qualifications and/or appropriateness; the extent to which they were involved in the overall planning of the programme; and the danger that some schools might use external contributors as a way of abdicating responsibility, overall we conclude that external contributors can add expertise and experience of talking to young people in an open, honest and unembarrassed way, that could benefit schools. External contributors could also play a vital role in linking young people to sexual health services and other support systems based in the local community (Department for Children, Schools and Families, 2008a:para 34).

The report also recommended that new SRE guidelines should provide examples of good practice in relation to the involvement of a wide range of external partners and it made specific reference to the development of directories and protocols for engaging external facilitators:

⁴ Other recommendations included: those designed to improve the skills and confidence of those who deliver SRE — the key delivery challenge; those that address the need for more guidance and support on how best to deliver SRE; those designed to increase young people's opportunities to influence the design of their SRE programmes; those aimed at maximising the impact of wider Government programmes on the quality and consistency of SRE; those designed to improve leadership on SRE, in terms of both school leadership teams and strategic oversight by local authorities and PCTs. The report also considered how best to ensure that schools and parents could work in partnership to educate children and young people about sex and relationships.

Local PSHE/Healthy Schools leads should develop local directories of voluntary and community sector organisations that could offer support to schools on SRE delivery. Schools should develop protocols with external providers so that there is clarity about the content of their input and how it fits into schools' broader SRE programme (Department for Children, Schools and Families, 2008a:para 36).

A subsequent Government response to this report (Department for Children, Schools and Families, 2008b) accepted these recommendations on the role and expansion of external professionals and agencies, stating:

We agree that well-planned input from external individuals and organisations can enhance schools' delivery of SRE. The development of new SRE guidance ... will provide an opportunity to set out the variety of ways in which schools can draw on expertise from external individuals, both from partner organisations – for example, school nurses, health promotion staff and youth workers – and voluntary and community sector organisations (Department for Children, Schools and Families, 2008b:8).

The provision of school-based sex education is recognised as a challenging area of curricular provision and it is therefore critical to explore models that may enhance programme delivery and effectiveness. The use of outside facilitators certainly appears to have promise and also appears to be supported by policy makers, schools and teachers. Certainly, 'schools are increasingly seeing the benefits of delivering sex education in partnership with others, including parents, health promotion specialists, school health services, youth drop-in centres, churches and family planning agencies' (Young, 2004:185).

3.5 Concluding Remarks

Although this review cannot draw firm conclusions about the effectiveness of outside facilitator input to school-based sex education delivery, it nonetheless provides a valuable evidence base on the work of such facilitators. The review has identified several types of outside facilitation, including peer-led approaches, the input of school nurses and physicians, LGBT-led approaches, drama- and theatre-led initiatives, and the use of computer, internet and multi-media approaches to facilitate the delivery of sex education. The available research on the delivery of sex education through all of these approaches has been assessed. On this basis it has been possible to identify negative aspects of outside facilitation as well as characteristics of effective facilitation. The review therefore helpfully provides an evidence base and foundation to inform future research on this topic and also provides policy-relevant guidance on the delivery of school-based sex education by individuals and professionals from outside the school community. Additional materials on characteristics of RSE facilitators and effective delivery methods are presented in Appendix I, while considerations for the provision of RSE to pupils with special educational needs and other non-standard or vulnerable groups are discussed in Appendix II.

Appendix I: Characteristics of Effective Teachers in the Area of Sexuality and Sexual Health

‘Comprehensive school-based sexuality education acts as a building block for Sexual Health across the lifespan and therefore requires particular attention’ (Pan American Health Organisation/World Health Organisation 2000:25). Effective sexual health education integrates four key components: acquisition of knowledge; development of motivation and critical insight; development of skills; and creation of an environment conducive to sexual health (Minister of Public Works and Government Services: Canada 2003). In other words, quality sexual health education and training requires a holistic person-centred approach, encompassing all aspects of people’s well-being (Department of Health: England and Wales 2005). Within the Irish RSE curriculum sexuality is viewed holistically, with a focus on facilitating students to develop the knowledge, attitudes, values and personal skills necessary to communicate effectively about feelings and relationships, as well as developing frameworks to guide decisions and behaviour.

Teaching sexuality is a challenging and complex endeavour for educators, as it involves both the students’ and the educators’ personal, family, religious, and social values in understanding and making decisions about sexuality and sexual behaviour. It demands that an educator provides accurate, current information, using teaching methods that engage students and that address the context of students’ lives (Bickerton and deRoche 2005). The Report of the Expert Advisory Group (Department of Education 1995:17) states that ‘in organising the learning environment the teacher should be careful to create an atmosphere in the classroom which respects the privacy of each individual student and to treat all with due sensitivity and care’.

Employing well-qualified educators is an important prerequisite for effective school-based sexuality education programmes, irrespective of whether educators are drawn from within the school or invited in from the wider community. However, having the requisite qualifications to deliver quality sexuality and relationship education necessitates more than merely having knowledge in the subject area. While competence in relation to knowledge of sexuality is expected, sexuality educators are required to do more than impart information about anatomy, physiology and reproduction in a didactic manner. Indeed, traditional, rationalistic, information-giving approaches to sexuality education, or what Hilton (2003:35) calls the ‘scientific objective approach to the subject’, are now considered inadequate, since they pay insufficient attention to the social contexts in which meaning is constructed and sexual practices enacted, and do not affect behavioural change. Kippax and Stephenson (2005:360) claim that effective sex and relationship education must provide recipients with:

Opportunities to socially transform their worlds ... opportunities for agency ... To be effective messages of the educational programmes must be negotiated, questioned, adapted to suit and appropriated ... they cannot be thought of as absorbed passively into the body of the recipient.

In addition, according to Milton, Berne, Peppard, Patton, Hunt and Wright (2001:183-184):

Teachers must provide opportunities and learning experiences that shape students' attitudes, intentions and social norms towards responsible behaviors and positive sexual health. Students need skills and practice in making decisions, analysing risks and solving problems. Learning these skills requires student-centered, participatory strategies which have been shown to affect change in attitudes and behaviour. Creating a climate that encourages students to participate and to express their views and feelings requires a teacher with well developed facilitation skills and knowledge of experiential pedagogical approaches, as well as familiarity with developmental psychology and age-appropriate teaching strategies and the ability to tailor information in an age appropriate manner.

As stated in the introduction, experiential learning approaches are recommended within the RSE and SPHE guidelines in Ireland and are regarded as the most appropriate and effective teaching methods for the delivery of school-based relationships and sexuality education. The resource materials for RSE at junior cycle (Department of Education and Science, 1998a:7) clearly outline the role of teacher as facilitator:

A key factor in the role of the teacher in RSE is the facilitation of experiential learning. 'Teacher talk', although at times necessary, should be kept to a minimum ... Wherever possible, participatory methods are suggested so that students can creatively interact with material, thus learning is ultimately more real and relevant to the students' present and future lives.

However, the requirement that teachers adopt a facilitating role emerged as a source of anxiety for teachers in a recent study of RSE implementation in second-level schools; this approach to teaching was adopted in only one of the nine schools studied in-depth for the purpose of the research (Mayock et al., 2007). Some teachers were resistant to this pedagogical style, fearing that they would lose 'control' in the classroom if they adopted experiential learning approaches, while others highlighted a range of practical barriers, most notably class size, with large numbers of pupils perceived not to be conducive to this approach to teaching. This anxiety and discomfort is reflected in a variety of publications. Alldred, David and Smith (2003) studied 17 secondary schools in an inner city area of England which had a large teenage pregnancy rate. They found that the role of the teacher in SRE is very contentious, as teachers report considerable anxieties about SRE as a subject and its low status in the school curriculum.

In addition to skills and knowledge of experiential pedagogical approaches, several ideal characteristics of effective educators are identified within the literature. They include an acceptance of sexual thoughts and desires as natural; an awareness of one's own sexuality, a comfort with sexuality issues, a sense of humour; a tolerance of ambiguity; an expressed desire to teach sexuality; awareness of personal limitations, and a non-judgmental and non-moralistic attitude (Minister of Public Works and Government Services: Canada, 2003). The socially constructed nature of sexuality as 'private', 'sensitive' and 'dangerous' requires educators to be comfortable with their own sexual identity, and have the confidence to discuss sexuality issues in an open and relaxed manner (Allen, 2009). Facilitators lacking such comfort and confidence are likely to

demonstrate their discomfort with various sexual topics and transmit feelings of guilt, shame and/or embarrassment to students (Department of Health: England and Wales, 2005). In fact, a recent study, in which 20 biology and home economics teachers who taught sex education in the Netherlands were interviewed, showed that they perceived the success of their teaching strategies and representations of the subject matter was secondary to their ability to respond effectively to specific student learning difficulties and their knowledge of young people's life styles and even their use of media (Timmerman, 2009). Commenting on sex education for boys, Biddle and Forrest (1997) list many of the above attributes and highlight the importance of teachers being familiar with research into masculinity and the media portrayals of what it is to be male. Without this awareness they are of the view that educators may inadvertently perpetuate 'old-style masculinity' views.

What characteristics make for the best sexuality educators is a key question. A small number of research papers exist that address the question of the 'qualities' that best sexuality educators display, as opposed to focusing on the status or identity of these educators. In a recent study in New Zealand, Allen (2009) explored, through the use of questionnaires (n=1180) and focus groups (n=78), students' (16-18 years) views on the qualities of best sexuality educators, challenging the idea that a certain type of educator, such as peer, nurse, school counsellor, family planning expert, make the best educators, or that the age and sex of the educator has significant implications. Although student responses to the questionnaire ranked the best sexuality educators in the following order: peer educators (47%), teachers (37%), public health nurses (35%), specialist organisations (18%), and counsellors (13%), findings from the focus group interviews suggest that the relationship between teacher identity and effectiveness is not so neatly aligned, and may be more arbitrary. Within the focus groups, students attributed the same best qualities to all types of educators. Being knowledgeable, approachable, comfortable, and able to relate to young people were qualities that transcended the role of identity and age. The ability to relate to young people required the educator to be trustworthy, aware of the realities of young people lives, and able to foster open discussion. Educators who could talk of personal experiences and were perceived as 'experienced' in dealing with sexuality issues were regarded by some students as more credible. In addition, students identified the need for educators to be skilled in challenging 'heteronormative' or other assumptions made by students within the class. Findings also suggest that the students had no marked preference for either an anonymous, unknown external educator or an internal known teacher. Known teachers were not considered problematic if they displayed the qualities above.

Hilton (2003) conducted focus groups with 16- to 17-year-old school boys in the UK to ascertain their views on the type of teacher they would like to teach them about sex and relationship issues. The most important qualities the 24 boys identified were: teachers who could be trusted to maintain confidentiality, teachers who could create a safe and relaxing environment and allow students to discuss personal and difficult subjects, teachers who did not get embarrassed or used humour or sarcasm to cope with embarrassing questions, and teachers who were well informed and knew 'their stuff' (Hilton, 2003:39). Interestingly, classroom management was also an issue for the boys in this study as they wanted a teacher who could maintain control and discipline in the class and not allow students to 'muck about' or 'act stupid'. This was a particular issue in relation to visiting/outside specialists, who although viewed as experts in their

subject, were perceived by the boys as lacking classroom management skills and were often unable to maintain discipline with the class. In relation to the age and sex of the teacher, the boys considered the ability to be empathetic and talk openly about any aspect of sexuality and relationships without embarrassment as more important than the age or sex of the teacher. All groups were of the view that a combination of male and female teachers should share the delivery of the curriculum so that they would benefit from both perspectives. Strange, Oakley and Forrest (2003), in the UK, reported that the 13- to 16-year-old boys and girls in their study perceived the personal characteristics of the educator to be more important than the person's gender. Both the girls and boys spoke of the importance of having a knowledgeable 'expert' who was comfortable, confident and unembarrassed. Students in this study also expressed a preference for educators who used interactive pedagogies, such as group discussion. Similar views were expressed by American students in Eisenberg, Wagenaar and Neumark-Sztainer's (1997) study. Participants in this study expressed the view that an educator, whether a guest or regular teacher, must be comfortable with the subject area, and able to create a climate of openness for questions and discussion. Educators who displayed a visible discomfort inhibited students asking legitimate questions for fear of engendering further embarrassment. Guest speakers who had 'real experience', such as people living with HIV and teen-age parents, were evaluated as 'interesting' and 'compelling' educators. In light of the emphasis placed in the international literature on the importance of teacher comfort with teaching and discussing sex and sexuality in the classroom, it is significant that Mayock et al.'s (2007) study of the implementation of RSE in post-primary education found teacher discomfort with the subject matter of RSE to be one of the major barriers to the delivery of the programme. Interviews conducted within the nine case-study schools revealed various levels of discomfort on the part of teachers, with a considerable number stating openly that they felt ill-equipped or unable to teach the subject; others felt inadequately qualified or prepared to deal with many aspects of the RSE programme. Pupils, on the other hand, were highly sensitive to teacher discomfort with the subject matter of RSE and many attributed 'bad' RSE to teachers being 'too close', 'embarrassed' or 'not able to handle the class.' In keeping with the findings of much of the international literature, 'good' sexuality education took place, according to these pupils, when educators were open, candid and comfortable talking about sex and sexuality. There was less agreement on the importance of other characteristics such as the age of the teacher, with some expressing a preference for a teacher who was younger or closer to their age and others stating that the teacher's ability to maintain discipline and 'order' during RSE classes was more important.

A study of Irish post-primary school students' perspectives on sexuality and sex education similarly found that students held mixed views on the impact of the age of the teacher. While the vast majority suggested that a younger person would be more appropriate, a small number of students, especially those who had experienced an older, but relaxed and competent, teacher felt that being at ease and comfortable with the subject was a more important characteristic. The issue of classroom management was also raised by the students in this study, with some commenting on the difficulty teachers encounter around the problematic behaviour of some students, which, if poorly handled, disrupts the learning environment for all students and may result in the sex education classes being abandoned altogether (Hyde and Howlett, 2004).

Women participating in the WiSE UP Sexuality Education programme in Ireland, many who had left school at an early age, felt that the success of their education programme was due in no small part to the skills of the facilitator, who was not only very knowledgeable about the area of sex and sexuality and the support services available, but who also had the skills: to deliver the programme in a respectful, sensitive and non-judgmental climate; to create an educational space where opinions were addressed in safety, and in the context of boundaries and working agreements/ground-rules which were negotiated and made explicit from the outset (Murphy-Lawless et al., 2008).

Studies that have explored teachers' views of instructor qualities support many of the above findings. A study involving focus group interviews with teachers from 19 high schools from across five Australian states found that the educator qualities most consistently reported and valued by teachers involved in sexuality education were being non-judgmental, respecting students' views, being trusted by students to respect confidentiality, being flexible and willing to respond in an open and honest manner to students' questions, as well as being honest about any knowledge deficit on the teacher's part (Milton et al., 2001). Teachers also valued being comfortable with one's own sexuality, having a sense of humour, and a willingness to respect students' right to make their own decisions, while taking the responsibility to help students to learn to make good decisions and have confidence in their decision-making skills. Some teachers reported that having the skills to challenge students when they expressed opinions that violated the principles of justice and equity for others was also important. In a similar study, teachers of primary school children in Sydney expressed the view that, in addition to being knowledgeable and comfortable with the subject area, they needed to be approachable, honest, open-minded, respectful of students' views and confidentiality, and, again, have a sense of humour (Milton, 2001). Teachers in Bickerton and deRoche's (2005) Canadian study (n=14) believed that the teacher's personality, comfort level, and commitment, were key qualities, with the sex of the teacher having little influence on the teaching environment. Teachers emphasised the importance of creating 'a warm and welcoming classroom environment with a certain level of seriousness and trust, along with the need to establish good rapport with students before approaching the sexuality portion of the course' (Bickerton and deRoche, 2005:3). Teachers also felt that the teacher's personal view of sexuality not only affects the choice of topics discussed in the classroom, but also impacts on the emphasis or 'slant' put on particular issues or topics. In a recent study, involving interviews with twenty biology and home economics teachers in eight schools in the Netherlands, teachers emphasised the importance of 'communicative competence', 'the ability to care', 'a safe atmosphere', and 'empathy'. These teachers also highlighted the challenges teachers face in structuring lessons in a way that corresponds to the development stage of students, and emphasised the need for teachers to be aware of each student's stage of development, so that information is presented and discussed in an emotionally-, age-, and time-appropriate manner (Timmerman, 2009:504).

The importance of teacher qualities and skills was highlighted in the UK Government's Office for Standards in Education report (OFSTED, 2002), commissioned to evaluate good practice in relation to the Sex and Relationship programme in schools. The authors of this report noted that the most effective teaching was provided by teachers who had a particular interest and background in the content and methods of teaching sexuality.

In schools where teaching was weak one of the most common problems was the inability of teachers to create a climate in which students were given the opportunity to debate their own views and explore disagreements with others and contradictions in their arguments, as opposed to teachers telling students what they considered was the right attitude. Other common problems were: the lack of teacher skill to explore issues 'seriously and openly' and handle their own and students' embarrassment in a constructive manner; the lack of teacher skill to challenge students' attitudes, particularly homophobic attitudes; and poor management of class discussion, with a small number of students being allowed to dominate. The key features of good teaching in SRE (Sexuality and Relationships Education) seen by the reviewers included: teachers having broad and detailed understanding of the aspects of SRE they were teaching; a clear focus for lesson planning; expectations of pupils that were appropriate to their different levels of maturity and understanding; the ability to create a climate that encouraged pupils to express their views and feelings and that respected the views of others, with clearly established boundaries for both courtesy and confidentiality; the use of a variety of teaching methods, including giving students opportunities to reflect on and assimilate their learning and the assessment of pupils' knowledge, understanding and development of their values, attitudes and personal skills (OFSTED, 2002:23). In a more recent report, OFSTED (2005:7) identified the following characteristics of good teaching in PSHE, whether by specialist teachers or by experienced and appropriately trained tutors. Effective teachers used a well-structured lesson with clear, realistic learning objectives; they used lesson activities that were matched to the lesson aims; had high expectations of the pupils, taking due note of their prior experiences; had good subject knowledge, manifested in the high quality of teacher exposition; made effective use of a range of strategies, including group work, role play and whole-class discussion; created a climate that allowed and encouraged pupils to express their views on their feelings; and promoted respect for the views of others.

Appendix II: Considerations for the Delivery of Relationship and Sexuality Education (RSE) to Adolescents with Special Educational Needs and other Non-Standard or Vulnerable Groups

There is a wide variety of approaches to RSE worldwide (Mufane, 2008; Bennet, 2007; Cok and Gray, 2007; Oshi and Nakalema, 2005; Che, 2005; Weaver, Smith and Kippax, 2005). The majority of these approaches to RSE are aimed at addressing the needs of 'most' pupils within a given context, and it is then expected that this will also provide a more or less accepted and meaningful contribution to the sex education of non-standard and vulnerable groups, in particular those with special educational needs. Although this expectation may often be justified, there is also considerable concern that the needs of adolescents who deviate from the norm are not met. The legal requirement in Ireland is that schools provide adaptations in their teaching approaches to accommodate pupils with special educational needs (Department of Education and Science Inspectorate, 2007). In light of this requirement and mindful of the mentioned concern, this appendix aims to present considerations for the provision of RSE to these groups (see also Section 1.5 for further rationale).

The content of this appendix deviates from the main body of this report in that it does not focus on the role of outside facilitators in the delivery of RSE to pupils with special educational needs or other vulnerable adolescents within mainstream schools. The absence of research with this particular focus prevented us from providing a review that fits within the scope of this report. There is however a body of publications that identifies the problems and needs of these groups and the particular provisions that can be made for them. Since these findings may have implications for the role and focus of outside facilitation it was decided to provide a brief review of this literature and present it separately in this appendix. Highlighted here are: (1) Truancy and early school leaving; (2) Intellectual or learning disabilities; (3) Physical disabilities; (4) Visual impairment; and (5) Immigrant children and/or those from an ethnically and culturally different background. Section 2.4 in the main text addresses the issues around lesbian, gay, bisexual and transgendered (LGBT) students. These will therefore not be revisited here.

II.1 Truancy and/or Early School Leaving

Typically, children who frequently miss school due to truancy are vulnerable in society. This vulnerability is often the culmination of poor school attendance, school-leaving or weak exam results, which may lead to diminished job opportunities and lack of economic stability. Teenage pregnancies and sexual risk-taking are also more common in this group, which may exacerbate the issues. Remedial interventions in response to the problems resulting from this tend to be costly and – more importantly – may be ineffective (Lall, 2007). The limited peer-reviewed literature that explored the relationship between truancy and RSE addressed the issue in relation to the prevention of teenage pregnancy (Lall, 2007; Forsyth, 2006) and sexual risk-taking in young offenders (Mistler, Kirkwood, Potter and Cashin, 2008). These authors convey a common message that there may be a need for modified sex and relationship education provided outside of the schools to include at-risk youth. The literature also describes the need for collaboration between schools, social services, parents, and other stakeholders to facilitate such efforts. In addition to

formal schemes, alternative and creative initiatives could possibly play a role in reaching adolescents who are slipping through the cracks. Such efforts, which made use of the internet or other interactive media, have already been discussed in Section 2.6.

II.2 Intellectual or Learning Disabilities

The education of children with learning difficulties, learning disabilities, intellectual disability, developmental disabilities, cognitive disability, mental retardation, special needs – a variety of terms have been in vogue in recent history - is a field in its own right. Research in these areas uses different terminology dependent on the country and the period in which publication took place. Today, the terms intellectual disabilities (ID) and learning disabilities (LD) are most common. NAMHI (2003) defines ID as 'a greater than average difficulty in learning. A person is considered to have an intellectual disability when the following factors are present: general intellectual functioning is significantly below average; significant deficits exist in adaptive skills and the condition is present from childhood [eighteen years or less]' (NAHMI, 2003:3). The literature on RSE and ID or LD is much more extensive than that related to truancy and within a different context would justify a much more elaborate review. In Ireland the terms learning disability, developmental disability and intellectual disability are by and large used interchangeably, such as on the Psychological Society of Ireland (PSI) Learning Disability Special Interest Group webpage (2006). An exception is that the terms learning disabilities or difficulties are also sometimes used to indicate problems like dyslexia or ADHD (Attention Deficit Hyperactivity Disorder), which are not considered intellectual disabilities. These students may require special provisions during RSE classes, but since these are also necessary for their education in general they need not be discussed specifically here.

Adolescents with ID often do not receive sexual and relationship education (Wheeler and Jenkins, 2004). According to Smith, Wheeler, Pilecki and Parker (1995:59) this is a problem because they are just as interested in sex as other adolescents, but have difficulty learning about sex, developing sexual competencies, and lack opportunities to express their sexuality appropriately. Consequently, inappropriate or challenging sexual behaviour (Wheeler and Jenkins, 2004; Koller, 2000), sexual offending (Brown and Thompson, 1997) and abuse (Grieveo, McLaren and Lindsey, 2006; Doyle, 2008; Martorella and Portugues, 1998) are more likely among them, and they are also at a higher risk of STIs (Rohleder and Schwartz, 2009; Cambridge and Mellan, 2000). Each of these issues could conceivably be addressed through ensuring that appropriate sex and relationship education is provided.

In special education and residential care, customised approaches for adolescents with learning disabilities (Doyle, 2008; Koller, 2000) have been developed. A literature search in this field yielded significant sources (Doyle, 2008; Sheppard, 2006; Nursing Standard, 2006; Gresham, Sugai and Horner, 2001; Koller, 2000; Martorella and Portugues, 1998; Rothenberg, Franzblau and Geer, 1979), which provide models for adaptations for adolescents with different types and degrees of ID. Each of these publications contains considerations for the delivery of RSE to this group that may also be relevant to mainstream educators. Their recommendations include the use of stories, games, imitation and role play, visual means, simple and concrete language, and avoidance of double meanings and figurative or symbolic language. Also, the instruction should address real-life settings and be brief and repeated frequently. The creation of a safe

atmosphere is probably even more important for children with ID than it is for non-disabled pupils (Martorella and Portugues, 1998). Most authors also highlight the importance of the inclusion of parents.

Just like in the mainstream approaches to RSE discussed in this report, many authors suggest that sexual education for adolescents with ID should be taught as part of a programme addressing relationships, health, love and a variety of related social and life skills (Doyle, 2008; Sheppard, 2006; Haight and Fachting, 1986; Rothenberg et al., 1979). This emphasises that to a large extent the needs of intellectually disabled adolescents are similar to those of non-disabled pupils, and suggests that to address these needs within mainstream education, the method of RSE presentation may need to be adapted, but not the core content.

11.3 Physical Disabilities

The emerging literature on sexuality, sexual education and physical disabilities provides a litany of problems that physically disabled adolescents are confronted with. Berman, Harris, Enright, Gilpin, Cathers and Bukovy's (1999) review of the literature highlights frequent exclusion from sex education, evidence that the physically disabled are uninformed or misinformed about sex, and the myth that they are not interested in sex. McCabe (1999) speculated that the lack of knowledge has its roots in ineffective formal sex education. Among the reasons for this mentioned in the literature are lack of political will and funding (Fiduccia, 2000), complexity and specificity of the needs (Mantsun and Udry, 2002, and overprotective parents (Nosek, Howland, Rintala, Young and Chanpong, 2001; Guest, 2000). Apart from the impact this may have on their quality of life, there is evidence to suggest that this puts the physically disabled in jeopardy. Just like the intellectually disabled, this group experiences more sexual abuse, and it is suggested that sexual education and assertiveness are important factors in the effort to reduce this risk (Van Berlo and Van der Put, 2003:114). A number of scholars have argued for sex education for adolescents with physical disabilities which takes their disability into account (Guest, 2000; Fiduccia, 2000; Davies, 2000). However, an overview of the literature after 1990 mainly demonstrates a lack of such specific adaptations in schools internationally (Van Berlo and Van der Put, 2003). The accounts in the literature of programmes and training opportunities to remedy this situation suggest that a (partly) peer-led approach may help provide a solution (Jacobson, 2000; Davies, 2000).

The outcomes of the two empirical studies located, one in a health care setting (Gill and Hough, 2007), the other in mainstream education (Mantsun and Udry, 2003), suggest that sexual issues that set adolescents with physical disabilities apart mostly apply to those with severe disabilities. Nonetheless, there is also evidence to suggest that there is a need for additional or special RSE support to provide protective and other specific knowledge even for those with mild physical disabilities. Introducing such special provisions should probably keep in mind McCabe's (1999:168) conclusion that 'most importantly, sexuality needs to be normalized among people with disability.' Mainstreaming of education for physically disabled could (under the right circumstances) help contribute to this.

11.4 Visual Impairment

A specific search for literature on RSE and visually impaired adolescents in academic databases yielded only two relevant empirical studies and a few anecdotal sources. That this was no flaw in our search methods was confirmed in the reviews provided in the accessed articles, which each included comments on the paucity of research. White (2003:134) adds to this that the lack of blind commentators on the issue limits the value of the publications he reviewed. He argues that in particular the absence of the perspective of the congenitally blind (blind from birth) obstructs the development of the field. Because the congenitally blind have no visual representation of body image, it is surmised that their processing of information on anatomy, but also sexual excitement and attraction, may be radically different from sighted people, even to the extent that sexual identity and orientation may be affected (White, 2003). In contrast, those who lost their eyesight later or have partial vision may not be so dissimilar from the sighted population in how they experience sexuality. A fundamental aspect that affects all types of severe visual impairment is that the use of eye contact and visual cues to establish sexual rapport are absent in their lives (Kef and Bos, 2006). This suggests that the issues blind adolescents encounter in their sexual development may include social-sexual elements.

Kef and Bos (2006) examined blind adolescents in the Netherlands for sexual knowledge, psychological adjustment and sexual behaviour and found that only in regard to the last variable were the participants different from non-disabled youth. The study also highlighted that vulnerability of blind children leads to parental protection, which sometimes inhibits sexual development. This finding confirms what was concluded by other authors (White, 2003; Duh, 2000). The findings of the other empirical study located contrasted in a vital way with Kef and Bos's findings. Duh (2000) surveyed and compared sexual knowledge of Taiwanese adolescents with and without visual impairment and found that the visually impaired were less knowledgeable, with the congenitally blind showing the lowest scores on the test they received. It was not possible to identify the source of this difference between the studies without insight into possible differences in the adjustment of RSE teaching methods to the blind in Holland and Taiwan. Notwithstanding this contrast, Duh's findings partly emulated those of Kef and Bos (2006) in that social factors also seemed to impact the Taiwanese visually impaired: those that reported having friends of the opposite sex outscored those who did not on sexual knowledge.

An account of the kind of teaching and learning approaches available for blind students (White, 2003) highlights the use of recorded tapes and tactile models. However, the author underscores that plastic anatomical models are poor substitutes for the real thing and that the use of live human models is subject to ethical and legal concerns most schools will be most reluctant to face (White, 2003:142). A detailed discussion of a programme for deaf-blind youths developed at the Helen Keller National Center (HKNC) in New York (Ingraham, Vernon, Clemente and Olney, 2000) emphasises the importance of physical boundaries, especially in light of the vulnerability of these groups to abuse. Although the Centre can not avail of materials designed specifically for deaf-blind youth, the authors express satisfaction with the educational tools available, including the anatomical models. They also stress that it is very important to include the parents or caregivers as much as possible in RSE. They find that 'students who share the new information they have acquired with their parents and other family members will develop confidence, body

awareness and an understanding of interpersonal relationships' (Ingraham et al., 2000:2). The mention of these elements resonates with research on other vulnerable groups in which the role of parents and the development of self-esteem is emphasised (Koller, 2000).

II.5 Immigrant Adolescents and/or those from an Ethnically and Culturally Different Background

The phenomenon of RSE lessons contradicting cultural and religious aspects of the education students receive at home is a worldwide problem, which involves a variety of ethnic and religious differences in how sexual education should be provided. Research has identified that children whose ethnic or cultural background is at variance with the prevailing culture may need special consideration if relationship and sexuality education is to be effective for them.

Research efforts in the Netherlands have established the vulnerability of immigrant groups to sexual abuse, STIs, and unwanted teenage pregnancies (Van Berlo, Wijsen and Vanwesenbeeck, 2005; De Haas, De Graaf, Kuyper and Bakker, 2008; Garssen, 2008). The causes of this are related, among other factors, to the lack of an appropriate sexual education or non-attendance at RSE classes (Van Lee, Marjanovic, Wijsen and Mouthaan, 2005; Mouthaan, De Neef and Rademakers, 1999). These findings reflect similar research efforts elsewhere in the Western world.

An example of how the 'one size fits all' approach to relationships and sexuality education might not be appropriate for adolescents from ethnically and culturally different backgrounds is given in the literature examining how sex education is delivered to Muslim young people in Western nations (Soundvision, 2009; Coleman, 2008; Fernandez, Chapman and Estcourt, 2008; Bartz, 2007; Bennett, 2007; Mouthaan and De Neef, 2006; Orgocka, 2004; Halstead and Lewicka, 1998). These authors identify elements of relationships and sexuality education that may conflict with Islamic teaching.

A number of authors have suggested ways in which the content and mode of delivery of sex education, as well as materials used for sex education should be culturally sensitive. In the literature that discusses sex education for Muslim young people researchers describe the provision of a 'culturally sensitive' sex education, based on community consultation (Fernandez et al., 2008; Coleman, 2008; Bennett, 2007). Coleman (2008) and Bennett (2007) provided some insight in how this cultural sensitivity might be achieved in practice. In Coleman's study the majority of respondents suggested that the credibility of the person delivering sex education was most important and emphasised the need for this person to be able to identify with their religious beliefs. Bennett (2007:380-383) describes how using teaching strategies and materials that are respectful of students' values – in this case replacing photographs or sexually explicit video material with medical drawings and images to respect the Islamic notion of modesty – can overcome some of the barriers to delivering an effective sex education to young people from different cultural or religious backgrounds.

In general, it would seem that sensitivity is required in the provision of RSE, and awareness of possible cultural and religious clashes may need to be raised. Immigrant populations may be an obvious source for such clashes, but it should be kept in mind that different types of programmes offered within Europe and the USA, and elsewhere

in the world (abstinence-only, abstinence-plus, comprehensive sex education) are also subject to heated internal debate rooted in differences in perspectives on sexuality, religion and relationships within the host nations. In Mayock et al.'s 2007 research on RSE implementation in Ireland the issue of how elements of the RSE curriculum might clash with the values or beliefs of pupils or parents - or with the religious ethos of the school itself - was raised (Mayock et al., 2007). In some countries issues around sex education are still debated vociferously (Peppard, 2008; Sears, 1992) while in others it has crystallised in a more or less generally accepted approach to RSE. The influx of immigrants is bound to affect these debates or may even lead to reopening them.

II.6 In Sum

This appendix to the report has presented a variety of considerations for the provision of RSE to vulnerable groups of adolescents. Although not an exhaustive review, it has been the intention to highlight significant publications and key issues. The majority of publications found were published in scholarly journals, but many of them were anecdotal, experiential, theoretical, or based on advocacy. Empirical research was scarce in most areas. The drawing of conclusions is therefore unwarranted. It needs also be stated that general statements based on the different issues of the vulnerable groups described here cannot do justice to the complexity and diversity encountered. Nonetheless, it is safe to say that the call for special provisions in the delivery of RSE to adolescents with special educational needs or other non-standard or vulnerable groups, has found overwhelming support in the publications reviewed here.

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Crisis Pregnancy Agency
4th Floor
89 - 94 Capel Street
Dublin 1

tel: 353 1 814 6292
fax: 353 1 814 6282
email: info@crisispregnancy.ie
web: www.crisispregnancy.ie

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