Examining how major stakeholders within one school district in British Columbia are implementing the sexual health curriculum

by

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B.A., Redeemer University, 2009
B.Ed., Redeemer University, 2009

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Abstract

Sexual health education (SHE) in Canadian schools is a controversial subject. Thirty years have passed since the government mandated that SHE be taught in Canadian schools, yet the subject still struggles to secure its place in education as curriculum design remains stagnated. In British Columbia, the 2016 - 2018 curriculum update relocated health topics, specifically SHE, to physical education (PE), the subject now known as physical and health education (PHE). To date, little research is available on the implementation of SHE curriculum within Canadian schools. This qualitative case study examined how major stakeholders (district, administration, and teachers) are implementing SHE in one school district within British Columbia. Data collection methods included interviews with district staff, administrative staff and teachers as well as district documentation analysis. Data were analyzed using content comparison. Three resulting themes explicated how the school district utilized components of a top-down implementation approach, identified deficiencies in the sustainability of SHE and factors that supported and hindered the implementation of SHE. Comments from all three stakeholders highlighted the value of SHE delivery in schools but where and how to best intergrade this topic remains unclear.

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Acknowledgments

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Dedication

I dedicate this thesis to my family and friends who supported me in various ways throughout my time as a graduate student. Most importantly, Brigitte. I am beyond grateful for your encouragement and support. Finally, I want to dedicate this to the man I call my dad, Roger Wright. Thank you for truly demonstrating unconditional love and inspiring me to strive for the things I never thought possible.

Chapter 1: Introduction

Why is Sexual Health Education Important?

Sexual Health Education (SHE) is a fundamental right for the health and well-being of all young people. The Sex Information and Education Council of Canada (2019) states that SHE can have a positive impact on adolescents' physical, emotional, and social well-being. Students who receive sexual health education engage in sexual intercourse at a later age, increase their use of contraception, as well as experience fewer unplanned pregnancies and sexually transmitted infections (Bourke et al., 2014; Mueller et al., 2008). Moreover, when sexual health programs included information about gender and power, sexual risk reduction studies have found that this approach demonstrated significant positive effects on girls' sexual health outcomes (Haberland & Rogow, 2015; Rottach et al., 2009). The benefits of incorporating SHE goes beyond pregnancy reduction and STI prevention; it also supports interrelational skills and mental wellness. When youth learn about sexual assault and personal boundaries, that awareness equips them with the necessary tools to not only make more informed decisions, but also protects them from dangerous relationships and exploitation (Louie, 2018; McKibbin, 2017). Furthermore, evidence has indicated that lesbian, gay, bisexual, transgendered and questioning (LGBTQ) youth are at a higher risk of suicide. While researchers have isolated several contributing factors, in-school victimization is one of them (Bontempo & D'Augelli, 2002; Maticka-Tyndale, 2008). Sexual health education has been proven to mitigate bullying about sexuality, as the content broadens adolescent understanding of, and respect towards, gender, sexual orientation and expression. This promotes a more

inclusive environment and provides an opportunity for LGBTQ youth to develop a healthier mental well-being (Baams et al., 2017; Eisenberg & Resnick, 2006; Pingel et al., 2013). Given the significant personal and social impact, the quality of SHE is paramount. The evidence pertaining to health prevention programs within educational institutions shows that student outcomes are highly correlated with the quality of implementation (Domitrovich et al., 2008; Durlak & DuPre, 2008; Han & Weiss, 2005).

The History of Sexual Health Education in Canada

Despite the diverse benefits that youth experience from SHE, the implementation of this subject within the school system has been a lengthy ordeal for Canadian classrooms. Since the late 1960s, Canadian SHE has been replete with controversy amongst parental groups, religious organizations, politicians and other interested parties, all vying for influence over what would be taught to youth (Barrett, 1994). This once very taboo subject now demanded open discussion and academic institutions had to engage.

The 1960s saw a dramatic shift in traditional values related to sex; attitudes towards women and sexuality, homosexuality, and freedom of sexual expression shifted greatly. As Adams (1995) notes, within two years of the New York City Stonewall Riots of 1969 there was a series of spontaneous and violent protests against police by members of the gay community. There were gay rights groups in every major American city as well as in Canada, Australia and Western Europe. Further, in Canada. supporting this cultural shift were the televised words of the Prime Minister, Pierre Trudeau, in December 1967: “There is no place for the state in the bedrooms of the nation,” making an appeal for the decriminalization of homosexuality in Canada (“CBC Archives,” n.d.).

Two years later, not only was homosexuality legal, but also birth control - the highly publicized historical event was a pivotal moment in Canadian history for gender equality ("CBC Archives," n.d.). During a very public sexual revolution there was growing concern for the safety and education of our country's adolescents.

As Hansman (2015) indicated, at this time the British Columbia Teachers Federation (BCTF) supported the idea of schools implementing Family Life (FL) education. Sexual Health Education was an 'integral' component of the FL curriculum and while it was reported that a 'handful' of BC's schools may have already been providing a version of sexuality education since the 1950s, the BCTF's motion for implementation did not bring about change within the province (Hansman, 2015).

In 1975, a country-wide survey found that one-third of Canadian schools included FL education (Rathus et al., 2016). However, with little consensus and strong opposing positions, stakeholders remained at a standstill for nearly ten years. While BCTF continued to strive for change and published a *Family Life Handbook* in 1986, a change in government, along with divergent views of the text, hindered the development and implementation of SHE at that time (Hansman, 2015). This changed drastically in the 1980s when the AIDS crisis contributed to growing fear amongst Canadians (Rathus et al., 2016). This global epidemic, along with increased awareness about child abuse, sexually transmitted infections (STIs) and teen pregnancy, put the public debate on SHE on display. Contentious debates amongst various groups on sexual education within the schools continued. However, there was now agreement that SHE was needed. (Barrett, 1994; Hutchinson Grondin, 2016). The challenge was how to teach this content in schools and how this change should be implemented (Hansman, 2015). As a result of

these very public health concerns, the government stepped in to protect and educate its citizens. By the early 1990s, governments within every province and territory in Canada had mandated some form of sexual health education in their school system (Barrett, 1994; Hansman, 2015; Rathus et al., 2016).

In British Columbia, BCTF and the Ministry of Education revised the Family Life Education curriculum that was being taught to grades 7 to 12 (Hansman, 2015). By 1994, Barrett (1994) indicated that there was a structure in place and the new Personal Planning curriculum educated students from kindergarten to grade 10. The curriculum included: family life education, personal health, safety and injury prevention and child abuse. Although these developments looked promising on paper, the message delivered to students was clear: sex is for marriage and family, outside of that context it could result in unwanted pregnancy or disease. Additionally, the BCTF acknowledged significant gaps for both teachers and students; there were inconsistencies with teachers' professional development and questions of fidelity in the delivery of the curriculum (Hansman, 2015). Also, according to Hansman (2015), students across the province did not have equal access to SHE and as a result, they did not receive all the curriculum.

In 2004 and up to 2007, a new curriculum that included SHE was implemented in BC schools. This new curriculum would be utilized until June 2016 for kindergarten to grade 7 students and until 2018 for students grades 8 to 12. Unlike previous years, a significant amount of time and detail went into designing Health and Career Education 8 & 9 (2005) as well as Planning 10 (2007) curriculums. Fifteen school districts from across the province contributed towards the writing and resource editing or served as pilot sites. These thorough curriculum documents identified the overarching learning

elements, prescribed learning outcomes, achievement indicators (including suggestions for assessment) and recommended 36 to 38 hours specifically on health to cover the required material. The prescribed learning outcomes focused on healthy living, healthy relationships and healthy decisions. Sexuality was one of the subtopics addressed in this unit. Additionally, within each of the grade levels there were several suggested achievement indicators outlining how students could identify factors that influence healthy sexual decision-making and demonstrate an understanding of the consequences of contracting STIs, including HIV/AIDS (two of the prescribed learning outcomes). While much of the structure remained the same in the 2007 revisions, content such as media and technology, social and environmental influence, and respect towards gender and orientation were added (BC Ministry of Education, 2005, 2007).

Sexual health topics that were not included in the curriculum throughout this time included:

- sexuality without reproduction, sex for sex and not family planning
- homosexual relationships (dating and family)
- sexual self-pleasure as it relates to self-efficacy and sexual readiness

Between 2016 and 2018 the province of BC launched a new curriculum with significant structural changes which phased out the 2004-2007 curriculum. Emphasis was no longer placed on prescribed outcomes and achievements but rather a more flexible learner-focused approach through the Know-Do-Understand curriculum model (BC Ministry of Education, 2019). Through this approach teachers will "combine these three elements in ways they see fit to personalize their classrooms" (BC Ministry of Education, 2019, p.2). There has also been one significant structural change at the

secondary level (grades 8 through 10) between Career Life and Physical Education. Health, including sexual health, was no longer taught as a part of the Career Life Education curriculum, but rather, effective September 2018, it began its transition to Physical Education, now known as Physical and Health Education (BC Ministry of Education, n.d.). Additionally, in comparison to the 2004-2007 Career Life curriculum, the 2018 SHE curriculum documents provided a condensed summary of the content to be covered, omitting the prescribed outcomes and omitting the list of suggested achievements.

In the past 30 years, the combination of topics and government mandate has resulted in the implementation of health as a subject which has rapidly evolved to better serve British Columbia's youth. Schools are an important vehicle for this knowledge transmission and curriculum provides a map to guide the process. With young people spending most of their time in the school setting, this environment is the ideal setting for SHE to reach most adolescents. Although Haberland and Rogow (2015) indicate that the global evidence on the effectiveness of sexuality education has been promising, there is a continued need for improvement, and this is certainly the case for the province of BC as demonstrated by concerning sexual health statistics.

What are the Sexual Health Trends among BC Adolescents?

In Smith et al., (2018) provincial adolescent health survey, data collected amongst the youth who have had intercourse found that nearly half are not making safe sex choices. Forty-six per cent of the youth indicated that they used the withdrawal method to prevent pregnancy, a rate which has doubled since 2008. Additionally, there was a decline in condom use from 64% in 2008 to 58% in 2018. While there was no change

between 2013 and 2018 in the rate of giving oral sex within each of the age categories, the study findings revealed that the rate of oral sex increased as youth grew older, and that the number of female youths giving oral sex was proportionately higher than that of male youth.

Over the past 18 years, studies have shown that the rate of sexually transmitted infections has increased among youth aged 15 to 19 in British Columbia. Provincial reports showed that chlamydia and extra-genital chlamydia cases have consistently increased, and females are infected at an alarmingly higher rate, four times higher than males (BC Centre for Disease Control, 2018; C. Lencar, personal communication, July 31, 2019; Office of the Provincial Health Officer, 2016). Similarly, the rates of gonorrhea and extra-genital gonorrhea have progressively been on the rise since the early 2000s and while males are typically infected at double the rate of females, adolescent females are the one exception as they are infected at a rate two times greater than males (BC Centre for Disease Control, 2018; C. Lencar, personal communication, 2019). Since the mid 2000s there has been a number of syphilis outbreaks affecting predominantly men across the province in all age brackets. In the last four years, reported incidences of males 15 to 19 years have been at an all-time high (BC Centre for Disease Control, 2018; C. Lencar, personal communication, 2019).

In the first national climate survey on homophobia, biphobia, and transphobia in Canadian schools, Taylor et al. (2011) reported a high prevalence of verbal, physical and sexual harassment directed towards LGBTQ students, with over half of the transgender and female sexual minority students and 42% of the male sexual minority students reporting that they were verbally harassed about their perceived gender or sexual

orientation. While physical harassment or assault was experienced by 21% of the LGBTQ students, 33% to 49% experienced sexual harassment in their school. The most notable of the study's findings was that over 60% of the LGBTQ students and students with LGBTQ parents indicated that they did not feel safe while at school (Taylor et al. 2011). Most alarming, Indigenous girls are at greater risk of sexual violence, including human trafficking. Indigenous girls are overrepresented in victim reports of sexual exploitation in Western Canada. According to Louie (2018), this phenomenon is overlooked in education and academia.

Research has proven that providing SHE can positively impact youth; data also recognizes that quality curriculum delivery has a greater impact on skill acquisition, behaviours and sexual well-being (Mevissen et al., 2018; Schutte et al., 2014; Weaver et al., 2005). However, in BC, there appears to be a disconnect which suggests that the program in place is not being implemented to its full potential.

Implementation Matters - How is SHE Being Implemented?

Sexual health education has had a turbulent journey in the process of becoming curriculum within BC and while it has become provincially mandated, its sense of place is still being determined. In the past thirty years, significant advances have been made to include various topics of SHE in every school district throughout the province. Similarly, there has been increased interest within academia to examine adolescent sexuality, research exploring the trends in adolescents' sexual behaviours (Lindberg & Maddow-Zimet, 2012; Mueller et al., 2008; Shoveller et al., 2010), the attitudes towards SHE (Cairns et al., 1994; Frappier et al., 2008; Sears et al., 2003) and adolescent sexual health in relation to health care (Boyce et al., 2006; D'Augelli et al., 2001; Sedgh et al., 2015).

Coming to a consensus on what to teach is only a part of the equation; it is also critical that we examine and evaluate SHE implementation to guide informed practice, achieve program objectives and improve adolescent sexual health behaviours. To date, very little has been documented about how SHE curriculum has been implemented within the Canadian school system.

Research is replete with evidence supporting the need to examine a program's implementation process in order to understand its effectiveness as well as why the program succeeds in obtaining the learning outcomes or why it fails (Foster-Fishman & Watson, 2012; Han & Weiss, 2005; Mevissen et al., 2018; Meyers et al., 2012; Schutte et al., 2014). In their review of literature, Han and Weiss (2005) identify numerous factors that are associated with teacher-level implementation and the sustainability of school-based health programs. Next, they allocate the factors into one of three categories within the implementation process:

- contextual factors
- teacher-specific factors (which are comprised of school- and teacher-factors as well as program-specific factors)
- implementation sustainability factors

Utilizing this data, they constructed a sustainability process model. Han and Weiss (2005) postulate that if teachers are provided with intensive training and have implemented the program correctly, they will see the desired objectives and positive student behaviours. This subsequently increases their belief in the program's effectiveness and will motivate teachers to continue to deliver the program. The three categories identified by Han and Wiess (2005) will serve as the framework for this study. Their

research provides an overview of the major stakeholders' impact on teacher-implemented classroom programs. The focus of this study will be to examine the process for curriculum implementation, identify teacher-level factors associated with implementation and highlight existing SHE implementation research.

Given this significant change in the BC Ministry of Education curricular content and structure of SHE, and given the emerging evidence supporting the need to assess implementation processes, the methods utilized, as well as the teacher-level factors affecting school districts, an examination of SHE implementation processes is warranted. Within BC, curriculum change is currently underway, and this presents an opportunity to study and capture what has not been addressed adequately in the past. This is the ideal time to investigate how SHE is being implemented in a particular time and place.

To investigate the implementation model being utilized for the SHE curriculum, this study employed a case study research design. A case study design allows the researcher to observe the implementation of SHE in its natural setting. As well, using multiple data collection methods such as participant interviews, the collection of program materials, and observational field notes, the researcher can provide a rich description of the setting, participants, and program under investigation (Creswell, 2013).

Purpose Statement

The purpose of this study was to examine how major stakeholders within one school district were implementing the sexual health curriculum in British Columbia. This research examined the implementation process utilized by the district staff, administrators, and teachers in order to gain insight into how one school district chose to implement the new sexual health curriculum for secondary students grade 8 through 10.

Research Questions

1. What methods are utilized at the school district level to implement and disseminate the sexual health curriculum?
2. What methods are employed by high school principals to implement the sexual health curriculum and policies within their schools?
3. What methods are employed by teachers within their schools to implement the sexual health curriculum?
4. What factors at the district (district staff), school (principals), and class (teachers) level support or hinder implementation of the sexual health curriculum?

Assumptions

1. The participants (district office staff, principals and teachers) responded truthfully during the interviews.
2. The participants were able to accurately recall their implementation experiences.
3. The participants were able to verbally express and reflect authentically on their personal experiences and actions.
4. The researcher's previous experiences became part of the research process.

Limitations

1. The study will investigate one school district resulting in a small sample size, potentially limiting the transferability of the results.
2. The outcome of the study may be limited by focusing on grades 8 – 10.

3. The researcher might have biased the results or influenced the interpretation of the responses.

Delimitations

1. The study was limited to interviews with district administrators, school principals and teachers from one school district.

2. The study was limited to secondary curriculum focusing on grades 8 through 10.

Operational Definitions

Abstinence-based sexual health education: Health curriculum that recommends refraining from engaging in sexual activity until marriage or adulthood due to the associated health (psychological, social and physical) risks (SIECCAN, 2019).

Adolescence: Adolescence is the transitional period between puberty and adulthood that is characterized by many physiological, cognitive, psychosocial, and sexual changes. This study focuses on middle adolescence ages 14-16 years (Allan & Waterman, 2019).

Comprehensive sexual health education: Endorses safe sex teaching through the promotion of condoms and birth control (SIECCAN, 2019).

LGBTQ: A frequently used acronym for individuals identifying as lesbian, gay, bisexual, transgender and queer

Sexual Health Education: Grade 8-10 Physical and Health Education: A mandatory school subject in the province of British Columbia which allows students to acquire the knowledge, skills and attitudes to enhance their quality of life through active living and healthy decision-making.

SOGI: Sexual Orientation and Gender Identity. A term used in the province of British Columbia to support inclusion and increase awareness about issues that impact the

LGBTQ community. In order to create an environment of respect, SOGI education aims to promote understanding and acceptance (Government of British Columbia, 2019).

Chapter 2: Review of Literature

The purpose of this literature review is to summarize pertinent research associated with curriculum implementation frameworks and sexual health education. The review is organized into the following sections: (a) outlining the approach taken by the BC Ministry of Education to implement sexual health education curriculum; (b) defining implementation; (c) specifying the implementation process models utilized in education; (d) identifying teacher-level factors affecting implementation, and (e) identifying studies that have examined the implementation of sexual health education. The content of this literature review provides both a rationale for and a guide to understanding curriculum implementation of sexual health education.

The Approach of the BC Ministry of Education to Implement Sexual Health Education Curriculum

In order to achieve a better academic understanding of what sexual health education (SHE) looks like in British Columbia, it is beneficial to establish a definition that is recognized globally. To understand SHE in BC, it is helpful to understand goals, practices, and outcomes in other jurisdictions. To aid comparisons, a common definition of sexual health is presented. According to the World Health Organization, sexual health is defined as:

> the state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual

> experiences, free of coercion, discrimination and violence (*WHO | Defining Sexual Health,* n.d.).

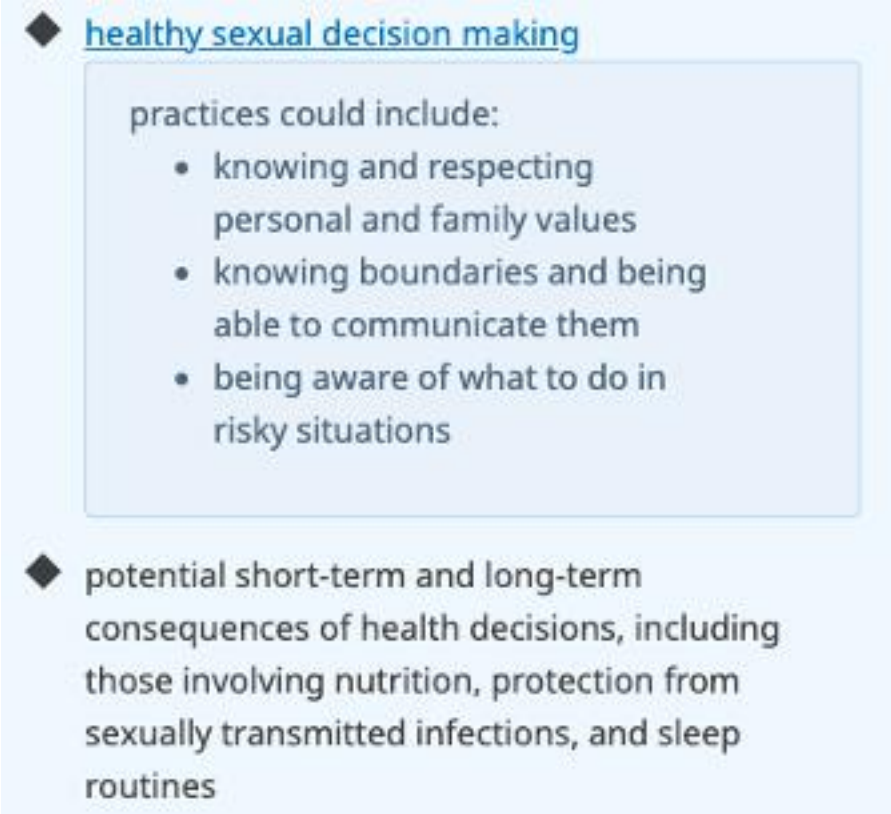
The preceding definition was utilized by the Sex Information and Education Council of Canada (SEICAN) in their publication Canadian Guidelines for Sexual Health Education (2019). Educating youth on such a complex topic can be challenging. Within Canada, and British Columbia specifically, the school system is the ideal setting to influence and promote the sexual health of students. Education focusing on human sexuality differs from other subjects' curriculum; the content and objectives contrast those of core subjects which focus on knowledge acquisition to enable students to become proficient in their future academic pursuits and careers while SHE is intended to inform and support behaviours that help students understand healthy decisions and lifestyle choices. Accordingly, sexual health awareness and information can empower and influence youth in life-altering ways.

In 2018, the Ministry of Education (MOE) in British Columbia began transitioning towards new curriculum at the secondary education level. This included the removal of SHE from the Career Life Education curriculum and the restructuring of Physical Education to Physical and Health Education (PHE) to encompass SHE. The goal of the new PHE curriculum is to empower students by "developing educated citizens who have the knowledge, skills, and understandings they need to be respectful, safe, active, and healthy citizens throughout their lives" (BC Ministry of Education, n.d.-a). In order to help facilitate this goal, the BC Ministry of Education (2019) updated the PHE curriculum documents. The general competencies identified within PHE specifically allow school districts and teachers complete autonomy to address the content in ways that

supports each school district's objectives. Figure 1 includes an example of grade-by-grade break down for grade 8 students with elaboration:

Figure 1

Physical and Health Education 8



Note. The image was adapted from the BC Ministry of Education grade 8 curriculum document. (https://curriculum.gov.bc.ca/curriculum/physical-health-education/8/core). Copyright 2021 by the Province of British Columbia.

The grade-by-grade breakdown is identical for students in grade, 8, 9 and 10, apart from the elaboration which suggests what 'practices could' be included was omitted for the two later grades. The short length and lack of detail reveals the direction provided by the MOE is in this subject area. The material is very generalized and does not differentiate

between what students within each grade are expected to know. This content is much less prescriptive when compared to the 2004-2007 curriculum and demonstrates how the MOE has shifted away from detailed and prescribed content. Further, when reading the detail provided in other sub-topics within PHE itself, such as 'healthy active living,' 'social and community health' and 'mental well-being,' it is clear that, by comparison, there is a progression of higher-level critical thinking evolving as students move up in grade level in these areas. No such progressions are listed for SHE whereas thorough and concrete learning outcomes are communicated in other sub-topics.

When the Ministry of Education introduced the new PHE curriculum documents, there was a consensus that educators teaching SHE required support in the area of curriculum content. As a result, the Ministry of Education, in collaboration with teachers, produced two guides, one for the elementary level and for the secondary level: Supporting Student Health, Key Topics and Ideas for Instruction (BC Ministry of Education, n.d.-b). These documents were not intended to be a standardized tool for teachers to follow with fidelity, but rather, provide educators with an overview of topics to include when teaching about sexual health, as well as suggestions for navigating potentially difficult situations (BC Ministry of Education, n.d.-c). In an attempt to provide additional support to teachers, the British Columbia Teachers Federation (BCTF) published their Guidelines for the Implementation of Sexual Health in 2019. The intent of this document is to (a) address variables that teachers should consider to ensure the content is appropriate for a diverse demographic, (b) suggest inclusive topics that are presented accurately, (c) address conditions within the classroom environment such as rules and how to respond student questions; considerations when including guest

speakers, and (d) draw attention to ways that school districts can support teaching staff (BCTF, 2019, p. 42). In addition to providing their own guidelines, the BCTF also endorses the SIECCAN (2019) guidelines for sexual health education. The three primary objectives for the SIECCAN (2019) guidelines are to "(a) guide the development, implementation and evaluation of SHE in order to support educators' ability to maximize positive sexual health behaviours and well-being, (b) deliver a framework to evaluate both past and present Canadian SHE curriculum, policies and services, and (c) provide major stakeholders with well-defined goals, details and background for the delivery of quality SHE" (p. 6). These guidelines provide a list of sexual health online resources (including available organizations and services within the province) and are all accessible through the BCTF website. These documents, the BC Ministry of Education PHE curriculum documents, Supporting Student Health publication, BCTF Guidelines for Implementing Sexual Health Education and SEICAN's Canadian Guidelines for Sexual Health Education, appear to be the only sources of information specifically endorsed at the provincial level. This limited amount of reference materials suggests that the learning of SHE is primarily an outcome that is controlled and influenced by the district and educator. It is the educator's responsibility to develop and facilitate SHE curriculum content for BC students.

Implementation Defined

This section highlights the data extracted from research to support clarity and direction of this study. Research shows that, when established and implemented correctly, health programs can bring about behaviour change in youth (Domitrovich et al., 2008). Copious amounts of research that have focused on school health intervention

and promotion programs have demonstrated that the quality of implementation is highly correlated with student outcomes (Domitrovich et al., 2008; Durlak & DuPre, 2008; Meyers et al., 2012). However, researchers recognize that when considering the numerous variables and factors that are present during the stages of implementation the data is still in its infancy and additional research is necessary (Durlak & DuPre, 2008; Fixsen et al., 2005; Han & Weiss, 2005). A significant outcome of these findings has been directed towards obtaining a thorough understanding of the concept of implementation (Domitrovich et al., 2008; Durlak & DuPre, 2008; Fixsen et al., 2005; Han & Weiss, 2005). If implementation research had lexical unanimity as well as standards for processes and procedures, researchers and practitioners could better identify shortcomings, as well as improve dissemination and outcomes.

To date, there has been a considerable amount of research that has examined program implementation. Han and Weiss (2005) define implementation as the execution of procedures to successfully accomplish the goals of a program. A successful implementation process provides plans, goals and objectives. These should be coupled with resources such as stakeholders, policies and theories which then contribute to the adoption of a program (Fertman et al., 2016). Additionally, Han and Weiss (2005) state that implementation is an interconnected and dynamic process comprised of three predominant phases, pre-implementation, implementation and sustainability. These three phases have also been referred to in different ways by various researchers. For instance, both Schutte et al. (2014) and Rogers (2003) refer to these phases as adoption, implementation and continuation, however, for the purpose of this paper, the terminology utilized by Han and Weiss (2005) will be employed.

Durlak and Dupree's (2008) research also focuses on school-based health prevention and promotion programs. Their data expands upon Han and Weiss' (2005) definition by providing a practical understanding in an educational setting. In their review of 500 studies from 1976-2006, Durlak and Dupree (2008) investigated factors affecting the implementation process as well as the influence that implementation has on program outcomes. From these data they extracted specific factors that affected the implementation process. These factors occur at three levels. The community level focused on school district policies and fiscal allocation for professional trainers and professional development. The provider level draws attention to the perceptions about the program importance and the value held at the district, school and teacher level. The innovation level is further divided into two systems (a) the prevention delivery system, which discusses the importance of leadership, the value of stakeholders' input in decision-making and stewardship, and (b) the prevention support system, which involves factors such as training delivery and technical assistance. The authors also outline the importance of preparing providers in delivery, mastery, expectations, motivation and self-efficacy. This training should include modeling, role play, and performance feedback in a supportive environment, in order to positively impact the implementation process. Durlak and Dupree (2008) elaborate further by addressing program content as a critical element to understanding the concept of implementation. Again, due to the lack of consensus in the vocabulary and operational language, they specify that the definition of implementation must consider what a program is comprised of when it is disseminated in a specific environment. Durlak and Dupree (2008) enumerate eight sources of influence that consistently affect program outcomes. Of most interest for the purpose of this study,

the following are discussed: fidelity (the degree to which program implementers deliver the program as intended); dosage (the quantity of the original program content being delivered); quality (the content delivered correctly) and the participants' responsiveness (the interest and engagement of the students). The authors postulated that these influences should be assessed and evaluated in order to determine if and how the program was conducted.

The difficulties with quality implementation are not limited to health prevention and health promotion research within the grade school settings; challenges of implementation have been recognized in public health, crime prevention, manufacturing sector and within management at the corporate level (Fixsen et al., 2005). In their monograph of 377 studies Fixsen et al., (2005) suggested that loosely defined terms created an arduous and confusing challenge when compiling the research. For example, the term ‘implementers’ means either the ones teaching, or the ones being taught, depending on the context and authorship (Fixsen et al., 2005). They provide a definition of implementation to allow outside observers to detect its existence through measurement. The authors documented commonalities and concluded that implementation should be described in adequate detail for outside observers to be able to see it. According to Fixsen et al. (2005), “implementation processes are purposeful and are described in sufficient detail such that impendent observers can detect the presence and strength of the specific set of activities related to implementation” (p.5). This means that implementation processes can be categorized by strength, purpose and outcomes in three ways. First, paper implementation is merely implementation documented through changes in policies and procedures with no actual evidence of practical implementation.

Second, process implementation equates to putting new procedures in place, changing reporting processes and supervision without any assessment of the impact of this innovation within the culture. Third, performance implementation means applying the previous two degrees in a way that successfully produces desired outcomes. These three ways of defining implementation in everyday settings provide a practical interpretation that complements the framework outlined by Han and Weiss (2005). Han and Weiss (2005), Durlak and Dupree (2008), and Fixsen et al. (2008) along with several other researchers have examined and defined implementation. They have outlined a working definition that contributes to the success of curriculum implementation and identified influencing factors and processes that are essential to program success.

It is important to note that a great proportion of the research on implementation has examined curriculum that was presented as a fully developed and structured program (Dale et al., 2013; Han & Weiss 2005; Meyers et al., 2012; van Lieshout et al., 2017). As Durlak (1998) explains, fully developed programs have the advantage of being more easily measured, evaluated and replicated.

> We cannot make confident connections between programs and outcomes (internal validity), expect to replicate interventions in other settings (external validity), or determine how or why a program works (construct validity) without knowing how well the proposed program was actually conducted. (p. 6)

Researchers specified that their study is based on evidence-based programs, and the term program is used interchangeably with intervention, health prevention or health promotion program (Domitrovich et al., 2008; Durlak & DuPre, 2008; Han & Weiss, 2005). Han and Weiss's (2005) research reviews the factors related to teacher implementation of the program Reaching Educators, Children and Parents (B. Weiss, personal communication,

2021). The evidence-based program includes a teacher manual, a scripted number of lesson plans, a list of objectives and materials, consultations to provide classroom specific options as well as classroom materials (Murphy, n.d.). Accordingly, a specific and detailed framework has allowed researchers to measure the effectiveness of both the curriculum and the implementation process. In order to support measurability further, researchers have identified quantifiable aspects to implementation. The consensus amongst Han and Weiss (2005), Durlak and Dupree (2008), and Fixsen et al. (2008) specifically, are: (a) curriculum fidelity, was the specific material taught as intended or adapted; (b) quantity, how much of the specific program was delivered; and (c) quality, how well the program was delivered. In contrast, the SHE curriculum presented to BC teachers is more of an unstructured skeleton framework with no prescribed curriculum to follow. This has left teachers with significant autonomy in determining their daily lesson plans and activities. As such, the concepts *fidelity* and *quantity* do not exactly apply as they have been defined in the literature as there is no set program or dosage which teachers are expected to adhere to. As noted earlier, while some may argue that there are learning standards prescribed by the BC Ministry of Education which students are expected to achieve in each grade, these are quite vague; specific content criteria are not given. One could argue this learning standard could be achieved via abstinence only curriculum or via curriculum that emphasizes contemporary concepts such as consent, contraceptive behaviour skills, and healthy relationships.

Implementation Process Frameworks Utilized in Education

As seen in the previous section, understanding the definition of implementation and establishing agreed upon language is just a beginning. This section describes some of

the implementation frameworks found in the literature. Frameworks serve as blueprints that orient stakeholders through the process of implementation.

Meyers et al. (2012) analyzed data from 25 studies which focused on implementation frameworks over a twenty-year time period (1989 - 2011). The authors extracted commonalities within these varying frameworks and highlighted the critical steps to achieve quality implementation. Meyers et al. (2012) explain the "how-to" of implementation by defining an implementation framework as guidelines describing the prerequisite actions required for the preparation or execution of implementation efforts, as well as missteps that should be avoided. They formulated a process model comprised of four phases: (a) initial considerations regarding the host setting, (b) creation of a structure for implementation, (c) ongoing structure once the implementation begins, and (d) improvements to future applications. These four phases provide structure for both research and practice by noting the importance of delivering ongoing assistance and training to practitioners and identifying strengths and weaknesses of the process through feedback such as retrospective investigation and self-reflection (Meyers et al., 2012).

In their analysis, Meyers et al. (2012) identified 14 critical steps, of which they noted that over 90% of the studies recognized the importance of on-going monitoring as well as developing buy-in and creating a supportive organizational climate. Also of note, the vast majority of these frameworks emphasized the need for providing on-going support for front-line providers.

The Meyers et al. (2012) study takes the concept of implementation to a practical and applicable level by indicating the necessity of a framework to achieve quality implementation. The four phases of implementation discussed by Meyers et al. (2012)

were established through general observations of many studies over many years. This process-driven approach does little to specify what actors should be responsible for what actions. For further insight into these roles and responsibilities, we turn to Domitrovich et al. (2008) for their discussion of implementation interventions and support systems. The authors devised a multi-level model which focuses on contextual factors in order to measure the quality of implementation once a school has adopted a program. They make a distinction between the intervention program itself and the support system surrounding it. Domitrovich et al. (2008) suggest that "the purpose of a support system is to reduce variability in the quality of program implementation by providing the means and establishing the context for the delivery of interventions through elements such as training implementers and providing the infrastructure necessary to coordinate the deployment of the intervention" (p.7). The authors emphasize the need for standardization not only of the intervention itself, but as importantly, they recommend the standardization of how the program is delivered to the implementers through replication, training and policies and procedures across all sites. To help drive standardization, as well as identify intervention strengths and weaknesses, the authors highlight the importance of support systems for ongoing monitoring as well as reflective analysis throughout the entire process.

Domitrovich et al. (2008) delineate the contextual factors that impact implementation in their multi-level framework. This framework is described at several levels of influence. At the macro-level they note that school district policies, government funds and/or monies received through grants and partnerships, fiscal allocation for professional trainers, the allotment of professional development and materials available

across all sites, as well as leadership stability within the school district are significant influences on implementation. At the school-level, they focus on the application of policies and processes within the individual school and school climate and call attention to a very interesting contextual factor: the characteristics of the classroom and classroom management. Finally, the individual-level contextual factors address psychological characteristics of the teachers delivering the material. The authors recognize that lack of experience and comfort level with the subject can increase anxiety when delivering material. One of the strengths of this framework is that the stakeholders or persons responsible for the intervention are clearly identified at every level.

Bartholomew et al. (2016) provide an elaborate summary of their Intervention Mapping (IM) framework in their book *Planning health promotion programs: An intervention mapping approach.* This resource outlines a system of steps, theories, and procedures that help promote effective health education programs.

The IM process prioritizes the need for forming a group of key stakeholders, including experts, community members, potential implementers, and members of the intended audience (these players will be referred to as the IM committee), to plan a theory- and evidence-based health promotion program and action the plan through a systematic and step-by-step approach. Recognizing the complexity of designing behaviour change interventions, the authors emphasize the need for the IM committee to identify theories of behaviour change in order to understand and predict desired behaviour change, as well as design an intervention that will support a diverse audience.

Bartholomew et al. (2016) list the six steps of IM that serve as tools to work through. First, the IM committee conducts a needs assessment to grasp the current status

and future health risks in order to conceptualize one that is more desirable. In the second step, the IM committee develops matrices of behavioural change objectives for the program. The outcome of this step will result in clear awareness of what the program will accomplish, specifically, will achieve health promotion behaviours or risk reduction behaviours. In the third step, the IM committee identifies theory-based methods that facilitate meeting the objectives set out in step two. The fourth step discusses the production of program components and support materials that will best operationalize the intervention. Step five shifts the focus towards the individuals who adopt the program, those who will be the stewards of the program and maintain it into the organization's future: here the IM committee plans for program adoption, implementation, and sustainability. In step six, the implementors plan for ongoing evaluations in the previous steps as well as a summative evaluation: was it effective in the real world, were the appropriate delivery materials used, was the theory flawed or was it applicable? Once the details of each step have been planned the program is ready to be executed.

The IM framework is popular in health prevention programs (Bartholomew et al., 1998; Dalum et al., 2012). Within education this framework has been utilized extensively by the Dutch in the execution of their Long Live Love sexual health curriculums (Mevissen et al., 2018; Schutte et al., 2014; Wiefferink et al., 2005).

The results of the studies highlighted in this section have shown the effectiveness of establishing an implementation framework. These findings strengthen the notion that a specifically designed framework can lead to improved implementation and increase the level of achievement of program objectives.

Prior to a curriculum initiation in the classroom, significant steps must take place. Meyers and Durlak (2012) indicated that there are 14 steps to achieve quality implementation, 10 of which occur even before implementation begins. Many researchers note that it is essential for key stakeholders to form a curriculum development group in order to establish an implementation framework (Bartholomew & Eldredge, 2016; Fixsen et al., 2005; WHO & BZgA, 2013). This framework guides them through every step of the process: this includes producing and conducting a needs assessment (Bartholomew & Eldredge, 2016; Fixsen et al., 2005) as well as establishing a curriculum that is theory- and evidence-based (Action Canada for Sexual Health & Rights, 2020; Bartholomew & Eldredge, 2016; Nilsen, 2015; SIECCAN, 2019; Wight & Abraham, 2000). Without a needs-assessment, the stakeholder group will be limited in its ability to identify curriculum goals and objectives and will have no means to measure and evaluate the success of the established curriculum (Bartholomew et al., 1998; Domitrovich et al., 2008; Durlak & DuPre, 2008; Fixsen et al., 2005; Meyers et al., 2012; WHO & BZgA, 2013). Additionally, while researchers have proven the effectiveness of theory- and evidence-based curriculums (Bartholomew et al., 1998; Mevissen et al., 2018; Schutte et al., 2014; Wiefferink et al., 2005; Wight & Abraham, 2000) there are other factors that impede or support curriculum implementation. The following section will address other critical factors.

Teacher-level Factors Affecting Implementation

As discussed in the previous section, utilizing a framework can serve as a blueprint to guide an entire organization through the implementation process, establish a cohesive approach in procedures and delivery, and determine necessary supports. The

research is clear: implementation is a multifaceted and complex process (Domitrovich et al., 2008; Fixsen et al., 2005; Han & Weiss, 2005; Meyers et al., 2012)**,** however, more data is required to understand (Domitrovich et al., 2008; Fixsen et al., 2005; Han & Weiss 2005; Meyers et al., 2012) the reasons why a curriculum may succeed in achieving the learning outcomes or why it may fail. Many teacher-level and school-level factors can affect the achievement of learning outcomes during implementation (Fixsen et al., 2005; Haldre et al., 2012; Nilsen, 2015; Wiefferink et al., 2005; Wight & Abraham, 2000). As Han and Weiss (2005) state, delivering the curriculum is ultimately the teacher's responsibility; teachers are the key contributors to program delivery. This section further elaborates upon teacher-level factors that influence implementation. Quality curriculum delivery requires quality teacher training. Researchers agree, teacher training, especially SHE-specific training, is not effective when delivered through one-off facilitator lectures as commonly seen with professional development days (Han & Weiss, 2005; Hanley et al., 2009; Lachausse et al., 2014; Leach & Conto, 1999). Providing teachers with pre-service training and refresher sessions can help them learn new material, reflect upon their own views and experiences regarding sexuality, and address hypothetical student questions with their cohort. This will promote more effective communication about sexuality (Domitrovich et al., 2008; Leach & Conto 1999; UNESCO 2016; WHO & BZgA 2013)**.** SHE may be considered a sensitive subject that causes discomfort for some teachers (Herbert et al., 2014). Teachers need to feel that they are competent enough to teach all the topics in order to have a positive impact on their students (Woo et al., 2011).

In their review of literature, Han and Weiss (2005) identify teacher training as well as 11 other factors that are associated with teacher-level implementation and the

sustainability of school-based health programs. The other factors Han and Weiss (2005) include have been apportioned into three main categories: (a) school- and teacher-specific; (b) program-specific; and (c) sustainability. Under school- and teacher-specific, factors identified include administration support, teacher self-efficacy, professional burnout and program acceptability. In the program-specific category, factors include teacher training and performance feedback. And, included in the sustainability category, factors include acceptable to teachers, flexible and adaptable, feasible and program effectiveness (Han & Weiss 2005). Buston et al. (2002) expand on the topic of teacher training in addition to teacher- and school-specific factors, and further remark that interventions only achieve their intended goals when the intervention is standardized. Standardization builds consistency in the training approach, develops teachers theoretical understanding and increases measurability across all schools in a district. Buston et al. (2002) examined the factors that facilitated or hindered the implementation of SHE programs through introduction of randomized trials in 13 Scottish schools. The degree to which a program was implemented depended on several factors, including staff absence and high turnover rates, level of commitment to the curriculum, the nature of adoption, and the theoretical understanding of the program. To encourage fidelity to the program and its implementation, Scottish teachers were supported by senior management and received intensive multi-day training sessions prior to program initiation. They also received on-going support over the school year and were given a follow- up session before the beginning of year two.

Using a mixed method approach, Buston et al. (2002) collected data from the teachers and learned that competition for time to cover the curriculum, inadequate

attention to the program from senior management, especially in allocating it in the timetable, and the lessons' brevity, were among the impediments to the implementation of the program. It is apparent that when schools lack a school-wide implementation strategy, educators may focus on core subjects and ignore those such as SHE (Fertman et al., 2016; Hanley et al., 2009). School-level challenges to teacher-level implementation are evident. There is emerging research exploring additional sources of support and unorthodox approaches for teacher delivery of SHE, yet more research in this area would be beneficial.

Pound et al. (2017) discussed two such approaches. They investigated factors influencing the acceptability, sustainability and capability of implementing sex and relationship education (SRE) programs in schools in England. They analyzed the findings from the following sources: a case study investigation, telephone interviews with English practitioners, the National Survey of Sexual Attitudes and Lifestyles, and a review of systematic reviews of SHE and alcohol interventions. The researchers also consulted with a group of 55 youth and a group of 19 professionals within the field to obtain their feedback as to where research fell short. Pound et al. (2017) provide recommendations and discuss best practices in SHE. One notable recommendation is that school-based SRE be linked to sexual health services within schools as this can play a significant role in improving the students' sexual health. A collaboration such as this has been successfully documented in Estonia's SHE development (Haldre et al., 2012) and is endorsed by UNESCO's 2018 International Technical Guidance on Sexuality education report. Pound et al. (2017) reported that improvements in students' sexual health can also be supported when they are presented in an age-appropriate, interactive and safe format. Their

investigation found agreement between professionals and young people in that both do not support the abstinence approach, but instead identify the need for including a discussion of risks. However, there was a difference of opinion between professionals and students in their position on the preferred SRE provider: While professionals were in support of teachers delivering SRE, the students would rather have an individual other than their own teacher provide this curriculum. Stakeholder consultations suggests that schools should appoint an internal teacher devoted to SHE delivery. Employing a specific teacher exclusive to SHE promotes continuity, provides a safe and confidential environment for students, and allows key messages to be consistently emphasized. Although there is little data to support this internal teacher approach, it may be a worthwhile method to explore.

Curriculum implementation is not simply regurgitating material in the classroom. As the research has shown, implementation is a dynamic and complex process where, as Han and Weiss (2005) emphasize, teacher-level factors are present throughout. As demonstrated in the following studies, psychological, emotional and social factors play a prominent role in how teachers deliver curriculum.

In the Beets et al. (2008) study on implementation they believed that teachers- and school-level factors impact the implementation of school-based prevention and social character development (SACD) programs. The researchers focused on elementary-level teachers across 20 public schools and utilized a multi-year randomized trial of the SACD program. They studied the relationship between the teachers' beliefs and attitudes towards a SACD program and examined how the school's administration plays a role in teacher assimilation and delivery of a program. In the article, implementation refers to the

programs' curriculum delivered and the use of materials unique to a specific program in the classroom. Beets et al. (2008) recognized that while their cross-sectional study does not infer causality, it does provide considerable evidence speaking to direct and indirect relationships among teacher perceptions of the school climate on teacher beliefs about the significance of program concepts, and teacher attitudes concerning the usefulness of the program itself.

Education processes are continuously evolving. Throughout a teacher's career, a teacher is inundated with new data on district mandated curriculum changes, best practices in teaching and student learning, student behaviours, assessment, school procedures, etc. Teachers must be able to process and assimilate these changes in order to maintain best practices and avoid professional burnout (Byrne, 1994; Shen et al., 2015; Skaalvik & Skaalvik 2010). Evidence suggests that teacher acceptability of new data can be identified through their attitudes (Brezicha et al., 2015; Elliott, 2017; Han & Weiss 2005; Hanley et al., 2009; Kealey et al., 2000). More importantly, the examination by Beets et al. (2008) specifies that teachers' attitudes are malleable and that their positive attitudes are positively correlated to the amount of the program's curriculum delivered. Which, the authors concluded, could be associated with greater program utilization, both in the classroom and school wide. One interesting approach the authors suggested in response to the implications of these findings was teacher attitude assessments; early implementation assessments could identify low-level implementers and provide those individuals with additional evidence on the program's effectiveness in an attempt to increase acceptance.

Beets et al. (2008) postulate that program developers and administrators should address curriculum adaptability during the pre-implementation phase in order to agree on acceptable modifications while maintaining the message. Otherwise, if teachers perceive the curriculum as incompatible or that it restricts classroom adaptations during implementation, it may negatively impact level of delivery (Beets et al., 2008; Brezicha et al., 2015; Han & Weiss, 2005). In summary, school climate is a significant factor directly related to teachers' attitudes. Therefore, Beets et al. (2008) suggest that school leadership should cultivate a united vision between the administration and teachers, one that values the new curriculum and encourages teacher participation and support in implementing the programs.

Expanding on teacher beliefs, Schutte et al. (2014) address teacher-level implementation and sustainability. In their research on the Netherlands Long Live Love (LLL) SHE programs, they examine the factors that impact the implementation and sustainability stages of the diffusion process in the school setting. The authors draw attention to the misconception that adoption at the organization level inevitably leads to adoption and implementation at the teacher level. In their study, 130 teachers completed survey questions. From their responses, the scholars concluded that the beliefs the teachers held on the SHE curriculums affect every stage of the diffusion process in different ways. For instance, if teachers believed that the content was socially acceptable, they were more likely to adopt and confidently implement the program. Additionally, Schutte et al. (2014) found that the teachers' training and support primarily influenced their beliefs about SHE curriculum and these beliefs consequently influenced their implementation in terms of content fidelity and continued use of these programs. This is

in contrast to other research that report that self-efficacy predominantly predicted teachers' curriculum adoption (Schutte et al., 2014).

Modifying programs to suit the audiences, omitting lessons, and making amendments because of intuition rather than a theory- and evidence-based design, can have deleterious consequences (Wight & Abraham 2000), not to mention a waste of funding and resources (Mevissen et al., 2018). When teachers delivered the program correctly and witnessed how effective the curriculum was at changing student behaviours in their classroom, they were more likely to continue to utilize the program (Schutte et al., 2014).

Echoing the previous studies, Wiefferink et al. (2005) sought to understand how systematically designed innovation strategies influence the teachers' decisions to implement sex education curriculums. In this quasi-experimental group design, all teachers involved in the study were asked to complete questionnaires and were interviewed on the factors that determined their implementation of the curriculum. Additionally, teachers in the experimental groups journaled the activities used in class. Among the determinants measured were the teachers' beliefs in the LLL curriculums, the characteristics of the innovation strategies, and the characteristics of the interactive context, such as school policy for providing SHE.

Wiefferink et al. (2005) found a well-structured program for teachers and their students to work through to be promising for positive implementation. The researchers noted that SHE teachers commonly neglected interactive skill-based learning activities, giving preference towards a more passive approach, such as lecturing and reading handouts, suggesting that they may find it difficult to address hilarity and challenges

caused by role-play. Teachers valued the opportunity to engage in situational practice during teacher training, and they indicated that providing teachers with a manual that addresses responses to student reactions and behaviours was well-received.

The most significant finding that Wiefferink et al. (2005) reported was the impact of utilizing an innovation strategy. Through the support of external health services, specifically, regional health professionals, the two-step innovation process focused on teacher adoption and implementation. First, health services recruited teachers and informed them about the efficacy of the program. The group of teachers interested in adopting this program became the experimental group. The second part consisted of this experimental group receiving training and support to implement the program. Wiefferink et al. (2005) discovered that the innovation strategy impacted classroom-based SHE practices positively, and that teachers' belief in the curriculum was a direct determinant of the use of the curriculum. This data draws attention to the need for further examination of teacher-level factors affecting SHE implementation in British Columbia.

In 2017, the BCTF conducted a survey on kindergarten to grade 9 teachers to evaluate their experiences with the curriculum change that launched in September 2016. One specific area the survey focused on was teachers' attitudes and experiences towards the new physical health education (which then included sexual health). The report stated that, of the teachers currently teaching physical education and/or careers, 70% felt ready and prepared to teach health-related topics, while 25% of these teachers disagreed and believed that they were not ready or prepared. What is not indicated is the specific health-related topics they feel ready and prepared to teach or what were their attitudes

towards the SHE specifically. Additionally, it would be helpful to understand how or why the 25% felt they were not ready and unprepared.

Moreover, approximately half of the teachers felt they did not have enough access to materials on health-related topics and 62% of the teachers indicated that they did not have sufficient access to in-service training, (BCTF, 2017). While kindergarten to grade nine teachers completed this survey, there are more in-depth curriculum concepts covered in the higher-grade levels. It would be informative to see if there are variations in between grades in terms of comfort level with the subject matter.

Research indicates that SHE evokes varied negative attitudes and beliefs and is significantly influenced by teachers' values (Action Canada for Sexual Health & Rights, 2020; Herbert et al., 2014; Moore & Rienzo, 2000; Woo et al., 2011)**.** All these major determinants impact teacher-level delivery, curriculum objectives, as well as student behaviours and health. That said, it is critical to understand how SHE is being implemented within BC and to examine what curriculum teachers are delivering as there is no Canadian data to date (Action Canada for Sexual Health & Rights, 2020). Therefore, it is advantageous to examine SHE that is implemented outside of Canada.

Research on the Implementation of SHE

To date, there has been limited research examining Canadian SHE curriculum within the K-12 school system. There is little to no data on what SHE youth are learning, on what is included in the curriculum, on what assistance educators are receiving with implementation, on clearly defined objectives or on how this varies province to province. Understanding SHE implementation is problematic due to this lack of information

(Action Canada for Sexual Health & Rights, 2020). What has helped or hindered the implementation of SHE is unclear, and there is little research on what works in SHE implementation in Canada. As such, this section will discuss three programs and SHE curriculums which have been implemented outside Canada and have been selected based on the structured program in place.

In Scotland, the SHE curriculum, Sexual Health and Relationships Education (SHARE) is an evidence- and theory-based curriculum designed through the collaborative efforts of researchers, sexual health experts and educators. First implemented in the mid-90s (Dale et al., 2013), SHARE is intended for students ages 13 to 15 years. The program is comprised of 22 lessons and is supported by a variety of materials for replicability and sustainability in the classroom (Dale et al., 2013).

In their research paper on SHARE, Wight and Abraham (2000) focused on the pre-implementation phase, examining the development of this theoretically based SHE program to draw attention to the challenges associated with turning theory-based SHE into practice in a classroom setting. The authors recognized that minor improvements in youth sexual health behaviours may have stemmed from the curriculum, but they also note the increased availability of birth control and contraceptives.

Most notably, the results from their study elaborate on the evidence that the implications of research and rigorous evaluations strongly conflict with orthodox health pedagogy and principles. Wight and Abraham (2000) argue that the country's educational authorities utilize an ill-informed approach. More specifically, the Scottish educational policies emphasize on guiding and empowering students in order to support the students' own learning agenda. A pedogeological approach that they believe builds

self-esteem and increases the likelihood of making informed healthy decisions (Wight & Abraham, 2000). However, the authors note that adopting methodology that aims to build self-esteem allows students to set the curriculum agenda, does not prescribe specific behaviours, and is in direct contrast with behaviour change research. The authors state that this voluntarist methodology opposes the data which, on the contrary, emphasizes the positive outcomes from standardized behaviour-specific instruction.

Other prevalent challenges Wight and Abraham (2000) associated with putting theory into practice in the classroom setting include: the gender construction of sexuality and classroom dynamics, sexual inexperience, practice in negotiating sexual encounters and practice in getting and using condoms. The authors conclude that if a program is to achieve its objectives and be sustainable beyond the research phase, it must be designed to overcome such problems while remaining theoretically informed. By the year 2000, this prototype gained interest from educators, and spread through the country (NHS Scotland, 2014; Wight & Abraham 2000). The SHARE curriculum had also garnered the attention from academia (Buston, 2002; Kirby, 2008). Despite this, the 2010 Scottish sexual health information report stated that the country had the highest teenage pregnancy rates in Western Europe and increased incidence of STIs (NHS Scotland, 2014). This suggests that the curriculum was perhaps outdated and required revision. This could also further validate Wight and Abraham's (2000) criticism that employing long-standing and deeply entrenched practices of involving youth in driving the curriculum may not have been effective. These health rates suggest that the SHARE implementation was unable to overcome the challenges of putting theory into practice in the classroom.

According to the WHO Regional Office for Europe/BZgA (2018) overview on sexuality education in Europe and Central Asia (2018), Estonia's curriculum is age-appropriate with a strong emphasis on the development of attitudes and behaviour skills in the later years. Their curriculum model was influenced by the Dutch and Scandinavian sexuality education. With the organizational support from these countries, the Estonian curriculum expanded and was implemented across the country (WHO Regional Office for Europe/BZgA., 2018). Additionally, the overview clearly identified curriculum goals for each grade and the number of lessons (for example grade 2s received two lessons per week for the duration of the school year whereas students in grades 5 to 8 received 35 lessons annually). At the secondary level, students were required to complete one final compulsory class and have the option to complete a related elective class (WHO Regional Office for Europe/BZgA., 2018).

Through their exploration of Estonia's SHE, Haldre et al. (2012) documented the development of the SHE curriculum and youth health services between 1990 and 2009 and examined the concurrent trends of youth sexual health. The authors report that SHE was legally mandated in Estonia in 1996 and its gradual implementation was predominantly in line with UNESCO's evidence-informed recommendations. Occurring simultaneously through to 2010, 20 youth counseling centres were erected across the country. These counseling centres work in close collaboration with teachers and students.

Haldre et al. (2012) analyzed 12 population-based surveys, Medical Birth Registries, Estonian Abortion Registry and data from the Estonian Medical Statistical Bureau between 1990 and 2007 to track the changes in sexuality-related knowledge and behaviour as well as relevant sexual health indicators before implementation and during.

Their analysis found that from the 1990s onward, condom use had increased greatly: from less than 25% to 75% by 2005. This likely caused the reduction of STIs and HIV infections. Also, teenage abortion and birth rates improved even though the age of young women's first sexual contact had decreased. Their research indicates that the national implementation of SHE in collaboration with youth sexual health clinics had contributed to an increase in positive sexual health behaviours.

The Netherlands is known as a sex-positive country, recognizing that young people not only want to know about sex and explore their sexuality but that they also have a right to be educated in order to make informed, healthy decisions (Ferguson et al., 2008). Mandated by the Dutch government, SHE has been included in nearly all the secondary schools and approximately half of the elementary schools since the early 1990s (Weaver et al., 2005). The country has gained international attention, as researchers have recognized in comparative studies that young adults (ages 13 to 19) in the Netherlands rank amongst the lowest in sexually transmitted infections, as well as teen pregnancy and abortion rates (Feijoo, 2009; Sedgh et al., 2015; Singh & Darroch, 2000). Studies suggest that this can be partially attributed to the progressive and comprehensive sexual health curriculum taught within the country (Ferguson et al., 2008; Schutte et al., 2014; Weaver et al., 2005).

Although Dutch youth are known for their favorable sexual health status as Mevissen et al. (2018) state, there are still opportunities for enhancement. To understand this anomaly further, the researchers examined the Dutch curriculum, Long Live Love (LLL) as it is the most widely-used SHE curriculum in the Netherlands. Since 2012, LLL expanded to reach a larger student demographic. Mevissen et al. (2018) describe the

development of the more recent version, LLL+ which targets students aged 15 and up through the use of the IM approach. They elaborate on the effectiveness of the six-step IM approach in comparison to other designs utilized in the field. "IM helps provide a better understanding of the complexity of a behaviour by delineating behaviours in terms of performance objectives and underlying change objectives. This in turn helps to define SMART intervention objectives and to ensure that important factors influencing the ultimate behavioural outcome are outlined" (Mevissen et al., 2018, p.64). The LLL+ program was designed to apply theory and evidence at each step of the implementation process. The authors indicated that the program had four main objectives and that it delivered lessons both online and offline. These were "(a) have healthy, happy (sexual) relationships, free of coercion; (b) prevent pregnancies; (c) prevent STIs, and (d) that students 'are not prejudiced towards sexual minorities' was also included but is separately described in a different article" (p. 64). Additionally, this version of LLL provided a teacher manual with suggestions for modifications to suit various classroom needs, which was a concern stressed by other researchers. Mevissen et al. (2018) concluded that teacher involvement throughout the development proved to be an asset; however, contrary to other reports, students did not have clear opinions to contribute to the curriculum.

Chapter 3: Methodology

The purpose of this study was to explore how major stakeholders are implementing the sexual health education (SHE) curriculum in a school district within the province of British Columbia. This chapter outlines the methodology that was used to address the research questions at hand. A description of the study design, the participants, the recruitment methods, the data collection and the analysis processes are provided. This chapter closes with a discussion of the trustworthiness, and the background of the researcher.

Design

This study utilized a case study design. A case study design is defined by Yin (2014) as an empirical inquiry where researchers examine a contemporary phenomenon within its real-life context. According to Yin (2014), this method allows the researcher to focus on the perspectives of the participants in order to glean a broader and deeper understanding of the phenomenon. Moreover, an embedded case study approach was applied, as it enabled the researcher to give attention to the subunits within this single case (Yin, 2014). Accordingly, this design was selected to provide insight into how major stakeholders are implementing SHE in one school district.

Case Description

The case for this study was a publicly funded school district comprised of multiple secondary schools implementing SHE, which was mandated by the BC Ministry of Education in the PHE curriculum. As of 2018, the PHE curriculum began to include the content of SHE, which used to be included in Health and Careers 8/9 and Planning

10. Of particular interest were the strategies the district used to help prepare PHE teachers to deliver SHE, a content area that was new to many of them. The school district has been selected because of proximity to the researcher. The study took place during the summer semester beginning in May 2021.

Description of the Subject

The subject of focus in this study was PHE for secondary students in grades 8 to 10. As a part of the BC curriculum, PHE is a requirement for secondary students up to grade 10. More specifically, this study concentrated on the topic of SHE as guided by the PHE curriculum Learning Standards (British Columbia Ministry of Education, 2019).

Participants

The following district personnel were invited to participate in this study: head office staff, the Deputy Superintendent of Learning, secondary school administrators from each school and secondary school teachers currently delivering PHE to grade 8-10 students in the 2020-2021 school year.

Participant Recruitment

Prior to contacting the potential participants, approval from the University of Victoria Human Research Ethics Board was obtained (see Appendix A), followed by the approval from the school district (not included for anonymity). Once the approval was received, the researcher hand delivered invitation letters (see Appendix B) to all high school administrators and teachers known to be teaching PHE. Five administrative staff (a vice-principal or principal) and nine secondary level PHE teachers (teaching grades 8-10) were recruited. The researcher then provided the district staff with an electronic copy

of the invitation letter which resulted in the recruitment of one district level staff member. All interested participants were then emailed a consent form to complete (see Appendix C) as well as a proposed online interview date.

Data Collection

As Yin (2009) explains, using multiple methods of data collection will enhance the trustworthiness of the evidence and quality of the case study. This approach has been defined as triangulation (Cohen et al., 2000; Stake, 1995). In this study, data collection methods included interviews of district personnel and an analysis of documents including district policies.

Interviews

This study utilized semi-structured open-ended interviews and asked the same questions at each level in order to facilitate the organization and examination of the material (Cohen et al., 2000). Employees consenting to be participants in this study included: one staff member from the district; administrative staff from five different high schools; and nine teachers currently teaching PHE from the district's secondary schools. The interviews allowed the researcher to obtain a greater understanding of the perspectives and the related implementation processes occurring at each level within the school district. To achieve this, a series of semi-structured interview questions, directed by the research questions under examination, were generated to guide the interviews. Questions focused primarily on the methods participants have utilized to implement SHE within the district; with a specific focus on factors that supported or hindered the implementation process.

In compliance with COVID safety policy, all interviews were conducted one-on-one using an online video conferencing platform. Additionally, to increase participant comfort and to obtain higher quality data, interview questions were provided to the district staff (see Appendix D), administrators (see Appendix E) and teachers (see Appendix F) before the interview. With permission from the participants, interviews were recorded through the online conferencing platform and the researcher took notes to support the recorded data. Each interview was approximately 40 minutes in length and a copy of the transcribed interview was presented to the individuals to verify that the data accurately reflected the interview. Participants were also given the opportunity to have any comments made excluded from the transcript.

Implementation Documents

Alongside interviews, data collection in this study included analysis of documents associated with the implementation process. Documents were collected from the Ministry of Education curriculum documents as well as supporting reports, and district-level documents such as policies and procedures.

Data Analysis

In qualitative research, it is common practice to begin analyzing data at the onset of data collection (Schutt, 2012; Thorne, 2000). As such, the collection, organization, and examination of all the data was initiated at the start of this study. Thematic analysis was the strategy utilized to interpret the interview data in this study. This approach helped organize and interpret the data as well as identify themes within the data (Crowe et al., 2015). As Crowe et al. (2015) explain, a thematic analysis can be achieved chronologically through the following six steps: (a) data familiarization; (b) creation of

codes; (c) search of the data for themes; (d) review of themes; (e) definition and naming of themes, and (f) demonstration of the themes referencing transcripts. During step one, data familiarization, the researcher immersed herself in the interviews and documentation by watching the interview video recordings and reading the district policies. Interviews were transcribed using Microsoft Word. This allowed the researcher to examine the data further. The transcriptions were analyzed and summarized into categories (e.g., staff position) and preliminary themes were generated based on the research questions. In the second step, the researcher uploaded the qualitative data into the management software, NVivo, and created codes. To complete this step, all statements from the interview questions were read and allocated to at least one specific code (e.g., some of the codes included 'district barrier', 'teacher comfort' and 'administration plan for sustainability'). If a statement was not suitable for a preexisting code it was assigned a new code (e.g., 'teacher risk avoidance'). To search for themes in step three, the researcher first reviewed notes made in step one, re-familiarized herself with the purpose of the study and the research questions to ensure that she only highlighted information relevant to answering the research questions, and then the researcher grouped the codes into preliminary themes. Three predominant themes emerged inductively form the data. For the fourth step the research supervisor reviewed the findings to ensure that themes were sound and that the data sections were organized accurately according to theme. During step five, definition and naming of themes took place took place based on input from the research supervisor. In the final step, step six, common themes were tabulated for delineation in chapter four.

Establishing Trustworthiness

To provide significant evidence of the overall trustworthiness, Elo et al. (2014) emphasize that it is "important to scrutinize the trustworthiness of every phase of the analysis process, including the preparation, organization, and reporting of results." Additionally, Lincoln and Guba (1985) posit that trustworthiness can be manifested through credibility, dependability, conformability, and transferability. Strategies within the following five concepts were implemented to establish trustworthiness.

Credibility

To endorse credibility within the study, the researcher used the following techniques as outlined by Thomas et al. (2005):

- A rich, thick description: the setting, participants and context were described in detail to increase the reader's understanding and determine whether the study is transferable to their own research.
- Triangulation: multiple methods of data collection (interviews with organizational employees from multiple levels as well as data collection, such as district plans, administration processes for each school) were used to support findings and conclusions across the study.
- Member checking: after transcription of the interviews, the researcher verified the accuracy by providing the participants with copies of their comments. This provided them with the opportunity to add, alter or remove any information they felt necessary.
- Peer debriefing: the research supervisor reviewed the findings to ensure the conclusions were sound.

Transferability

In order to increase transferability, research techniques and results were described in detail and recommendations for future research and implications of the study at hand were discussed following data analysis.

Dependability

Dependability refers to the requirement for the researcher to be flexible when collecting data during interviews and document the changes in the methodology accordingly (Thomas et al., 2015). To ensure that dependability was high, the interview format in this study was semi-structured and open-ended.

Confirmability

Confirmability focuses on the necessity for readers to have faith that the results of the study are authentic to the participants' narrative, rather than potential researcher biases and that the researcher will endeavour to attain the confirmability by providing evidence that is transparent and from multiple sources (Thomas et al., 2005). In accordance with Thomas et al. (2005), I have provided the following researcher background to adequately address my potential bias.

Background of Researcher

In 2009, I obtained my Bachelor of Education in the province of Ontario. As a part of the degree requirement, I concentrated on grades 4 to 12 and my teachable subjects were physical and health education (PHE) and social studies. SHE was a subtopic included in PHE at that time. The material I was instructed on during my education studies was outdated. My teaching experience in Ontario was solely teaching

on-call and I did not have an opportunity to teach PHE. I am currently employed as an on-call teacher in BC. In 2019, due to my interest in SHE, I completed a course entitled Sexuality, Society and Culture at the University of Amsterdam to fulfil an elective course requirement for my graduate studies. This course broadened my understanding, values and beliefs towards SHE. The Dutch endorse the United Nations position on SHE, asserting that SHE is a fundamental human right; it is not merely an optional subject that some teachers select and teach. This motivated me to better understand how we are serving students in BC and Canada. While I am not currently teaching PHE or SHE, I was very intrigued to learn how this province is implementing SHE.

Chapter 4: Findings

The purpose of this research study was to gain a deeper understanding of how major stakeholders within one school district are implementing the sexual health education (SHE) in British Columbia through examining the implementation process utilized by the district staff, administrators, and teachers.

This chapter presents the findings drawn from the interviews and documentation provided. Three themes resulted from data sources. These themes are described in detail using notes and comments from the data sources to illuminate the context and provide further insight into the experiences and perspectives of district staff, as well as secondary school administrators and teachers. The data sources included one district staff interview (DS), five administrative staff interviews (AS), nine teaching staff interviews (TS) and district documentation (DD). The supporting details are identified by a data source and a participant coded name. To illustrate, as "AS01," the first two represent the data source, so "AS" means the data is from an administrative staff interview. The succeeding numbers, "01" represent a participant name code. Patterns, categories, and themes were derived through the constant comparative method of qualitative data analysis, in which one data set was compared to the next. The three recurring themes are summarized in Table 1. The titles of each theme were decided by identifying major ideas from data sources.

Table 1

Reoccurring Themes from the Qualitative Data Analysis

Theme 1	Top-down District Implementation Framework

Theme 2	Sustainability Deficiencies in the Sexual Health Education Curriculum
Theme 3	Factors that Support and Hinder the Implementation of Sexual Health Education

Theme 1 – Top-down District Implementation Framework

Theme 1 describes the intricate nature of an implementation framework within a school district and explains how district staff, administrators and teachers disseminated the sexual health education curriculum. The findings from the district, administration, and teacher interview responses, as well as district documentation (e.g., elucidate that this was a top-down implementation approach). Additionally, based on the interview responses, it is not clear if a needs analysis was conducted at the district level. It should be noted that an implementation committee was not formed at the district level.

District-Level Responses

In 2016, when the province of BC launched the curriculum changes, the school district focused on in this study adopted two new policies: The Sexual Orientation and Gender Identity (SOGI) and the Inclusion Policy. The impetus of these policies was to foster a more inclusive environment in the schools within the district. In 2018, to support these policies, the district hired a health coordinator (HC). The goals of this position, as determined and enumerated by the district, were to focus on teachers to improve the quality of SHE.

> *The goal was to ensure all students were receiving equitable sexual health education across the district by first focusing on training teachers, and to help support educators with the new curriculum...by focusing on teachers/educators as*

> *our goal, we were able to hopefully have a positive impact trickle down [to students]. (DS01)*
>
> *[The district wanted] ...to build teaching capacity of educators so that SHE was happening in the classrooms and delivered more from classroom teachers than outside sources, to build comfort through education, in service, and make resources for educators. (DS01)*

During the HC's three-year term, they focused on providing comprehensive SHE resources and mentorship to support the delivery of SHE by educated teachers rather than utilizing external facilitators for the delivery of SHE. The succeeding statements from the HC describe these details.

> *There initially was the mindset from staff and admin that I would just come in and teach for teachers like outside agencies had done. But I was instructed by the district not to do that at all, and I had to take a more coaching approach. (DS01)*
>
> *...I was directed to build up resources like the website, then I had to work with teachers, mostly modelling lessons, and Pro D [professional development] ...which was mandatory for grade 8-10 teachers to attend...I also provided regular professional development workshops focussing on different grades...and open to all staff. (DS01)*
>
> *I bought and distributed the Kids in the Know Program for each school and trained staff. (DS01)*

Administrative-Level Responses

According to the respondents, as a part of the early phases of the SHE rollout, the district notified secondary school administrative staff that they would align their curriculum with the province's plan to move health topics from Career Life 8/9 and Planning 10 to Physical Education, which would become Physical and Health Education (PHE). The district coordinator was to prepare the PHE teachers for this transition. The following administrative comments explain such processes.

> *My assistant superintendent would have let us know that that we were having our PE teachers take on the change of curriculum. PE teachers were going to be changing to physical and health education. (AS01)*

> *The assistant superintendent called in PE teachers, probably at least one maybe two from each of the secondary schools, an administrator went with them. (AS01)*

> *...Four or five years ago I guess is when we kind of made the switch from Planning a lot of the things being imbedded in Planning 10 to being embedded in PHE. (AS05)*

> *The coordinator working with the other district staff began to develop resources but also do the in-service and then things kinda rolled out gradually like that. (AS05)*

Teacher-Level Responses

Teaching staff were informed about the PE to PHE change and directed by their school's administration to participate in the SHE training provided by the HC. Full-time PE teachers whose teaching portfolio was comprised of at least fifty percent PE instructional time participated in the SHE training.

> *Initially, we were informed by, I believe it was administration. I'm gonna say around the changes of the whole curriculum in Phys Ed changing from physical activity to physical education to physical and health education. And then we were introduced to our health coordinator and they gave in-services. (TS02)*

> *So, they allocated some resources and some money to actually getting a district coordinator and they made all PHE teachers that had, I think, .5 or more of PE in their teaching job, they gave us mandatory training, so I think it was about four half days throughout the year. (TS06)*

Seven of the nine teachers interviewed in this study were among the group of employees teaching fifty percent or more and were included in the training. It is worth noting that one respondent indicated that this PHE training was not exclusive to SHE and that it included other health-related content transitioning out of Career Life 8/9 and Planning 10.

> *...The district did provide a fair bit of funding to pull us out of class, I think it was over 4 sessions over 4 morning sessions or over a term or a semester I think it was. Although I got to say not all of that time was used for not all of it was used for sexual health some of it started to get into some other areas that was sort of*

> *mental health and then we got into a little bit of the time was on other curriculums so I would say probably two-thirds to three-quarters of that time was on sexual health. (TS08)*

Theme 2 – Sustainability insufficiencies in the Sexual Health Education Curriculum

This theme explains the sustainability of a curriculum implementation framework as discussed during the research interviews. This section is also divided into three parts: the district level, administration level, and teacher level.

District Level

Based on the answers provided by the respondents, the implementation framework utilized in this district did not plan for sustainability. The following inhibiting factors as listed by the HC draws attention to the most critical.

> *Factors that impact the sustainability of the sexual health education was it lacked*
> *-a dedicated role to address changing needs of youth, staff and health education*
> *-ability to connect with admin*
> *-funded, long range plans to provide training to teachers*
> *-a tool to ensure accountability curriculum is being taught*
> *- a team approach: district coordination, school point persons.*
> *-tie in more of the mental and physical health curriculum to the SHE*
> *-more fine tuning and update of resources that link to the curriculum and have assessment developed to go with them. (DS01)*

Further to this lengthy list of concerns, there had also been extensive district staff turnover.

> *The senior administration in the level above me has also changed during that time, so there's been quite a turnover for sure. (AS02)*

The district HC was no longer permitted to provide formal training as the 3-year term, which started in 2018 ended in June 2020

> *Unfortunately, the role [health coordinator] ended with little notice and no exit strategy from the district leaders. (DS01)*

The HC elaborates further on gaps in teacher training and how it impacts sustainability.

> *This is the obstacle I ran into time and time again: the accountability piece on teachers. There is so much work still to be done with training new teachers, transient teachers... This is an area that needs to be addressed. At this point teachers are expected to be delivering this curriculum. I wanted to create a way to ensure accountability it is being delivered but again it was idea that got shot down. Teachers now have the resources on the website, but no one is updating it, but comfort and capacity take time to evolve and with the flow of new staff and transience in educators there is always a need to support them around this essential curriculum. (DS01)*

Beyond the district's internal training gaps, district respondents identified lack of training in university for new teachers as a major sustainability barrier.

> *Accountability of the teachers teaching – new teachers are not being trained in their university courses... (DS01)*

Administration Level

One overwhelming factor that has impacted, and will continue to inhibit sustainability, is the high level of turnover at the administration level. The administration level was identified as the most integral; the prime responsibility for continuance of this curriculum rests with them.

> *We've had quite a turnover in admin, right. So, at least half the administrators in secondary schools have not had formal training or been aware of the district roll out of it. (AS02)*

There is a clear lack of capability pertaining to monitoring and measuring the district goals at the administration level. The respondents made powerful statements regarding their lack of confidence and competence in this area. The administrative staff need support, training, and tools to better monitor and measure both the implementation of the SHE curriculum and the level of student achievement, just as they would any other curriculum. One respondent indicated that they relied on anecdotal evidence, others

expressed that they are struggling and finding it difficult to monitor and measure, while some are simply not aware that this is their responsibility.

> *So, it might be more anecdotal but having those conversations with our student support staff, our counselors, with our PHE teacher and having those discussions at our department head table to set some goals...So do we have data? You know probably not, we don't keep track of how... I mean I think a lot of it you know when you're in a building you kinda know right ... so we don't have the data, formal data but it would be more anecdotal. (AS05)*

> *Well, now that's an interesting one because you know, as I said, sexual-health, being one content area across thousands of contents that you can talk about cross-curricular, it isn't always brought in the forefront. So, you know it's not something I would say track how well kids understand their sexual health, or are comfortable talking about it or know boundaries, but ways of measuring can also be anecdotal you know like stories kids tell ... (AS04)*

> *Specific to this topic, it's difficult to monitor and measure the sort of the efficacy of the delivery because it is such a personal piece to the student and how they respond... (AS03)*

> *That is the responsibility primarily of our physical health and education teachers. So, they are assessing as they go through those units... (AS01)*

As illustrated in previous themes, the administration values this curriculum; however, there is a noticeable lack of planning for how to sustain it to ensure that all students receive equitable SHE and that all educators are delivering the new curriculum as specified in the district goals. To demonstrate this point, one administrator makes this comment:

> *That's a really good question and you know I guess it's one that I would address if I saw in my future that I wasn't going to have sustainability in my building, in any teacher, I mean a lot of it is teacher responsibility. To go and become an expert and professional in your teaching area. (AS01)*

This previous comment demonstrates that there does not appear to be any contingency planning. Further, the following respondents suggest that there is a lot of reliance on the department head to be the steward of this curriculum.

> *Yeah, we don't have a plan. I think that's a discussion for department head, probably. And thankfully we haven't had a ton of turnover in our PHE department, which has probably saved us in this aspect for sure. (AS02)*

> *The nature of the department head and the and the sort of the formal leadership roles is that there's a considerable amount of sustainability from one year to the next. Even if we do see changes in teaching assignments and new people coming in, the department head positions are really helpful and making sure that we have consistency across years. (AS03)*

It is worth noting that according to this district's policy, the department head position is a two-year term. Multiple respondents commented that they would be in support of bringing in external facilitators to better support delivery, consistency and sustainability, which, ironically would be returning to the pre-2018 curriculum dissemination method.

> *I think that we need to, let's go back to that idea of bringing someone back into the building that is a trusted expert. Ok. I see a lot of value in bringing in a sexual health educator into the school. (AS01)*

> *And so, I am supportive of outside agencies coming in when it's challenging to address the really important pieces about protection and STDs and STIs, and things like that. (TS04)*

Teacher Level

Many of the teacher-level influences around sustainability have been discussed in the previous themes. One teacher-specific barrier to the sustainability of the SHE implementation that has not been previously noted is that a significant number of PHE teachers were not trained on the new SHE curriculum due to the allocated PHE teaching time in their contract (less than the 50% or more threshold for participation in training).

> *... A number of teaching staff that are transient teachers those coming in with smaller PHE assignments never having had the mandatory training. (DS01)*

> *...We found it interesting that only teachers [required to go to that training] were half time or more. Like when we were semesters right, if the teacher only taught one block, then they weren't required to go to the training. (TS02)*

Another factor impacting the sustainability at the teacher level is their ability to measure their goals and objectives. A major indicator of this is through the assessment of student learning. The district staff recognized the need for evaluating student learning and that this was a missed opportunity. There was little direction provided in this area and according to the respondents, methods of assessment included conversations, level of student participation and engagement, evaluation of completed assignments, and in some cases, teachers expressed that they did not know what measurement methods to use.

> *There is so much work still to be done with ... making assessment tools where teachers can use. That was another goal I had... I do feel this was a missed opportunity to do a final assessment. (DS01)*
>
> *I would say that's completely subjective, so for me, how I monitor and measure, you know, with different pieces of I guess assessment. The conversations that I can have with the students around it. (TS01)*
>
> *Well, it really depends on the activity that they're doing in, how they engage and through. I do some reflective work, or it could be their group work. (TS02)*
>
> *We do group discussions, big group discussions, small group discussions, handwritten stuff. (TS03)*
>
> *I tend to more just do assessment of what I see during conversation and go from there. (TS04)*
>
> *I have no way of knowing really. They do assignments to show they understand the info, but that's about it. (TS07)*

Theme 3 - Factors that Hinder or Support Implementation of Sexual Health Education

This theme explains the complexities involved with implementation which affected employees' ability to disseminate the curriculum at each level. All the respondents in this study identified factors which supported as well as hindered their ability to deliver quality SHE.

District-level Responses

The district-level respondents indicated that one factor supporting SHE implementation was the policy language and documents to help everyone at all levels get on the same page and feel supported.

> *A district procedure was implemented around the same time: the SOGI Procedure and then the Inclusion policy. Together those documents worked to support schools and staff to create inclusive environments using more diverse resources, especially around gender and sexual orientation and language. These documents work also to ensure staff know they are supported at the district level and are referred to when there is pushback from some parents at times. (DS01)*

Additionally, the policy specifically highlights the value and responsibilities of educators in the classroom. To illustrate, the following excerpt from district policy elaborates on this detail.

> *Educators have an important role to play in teaching and modeling respect for gender diversity. It is expected that teachers will create classrooms where students can see a commitment to creating a safe, caring and discrimination-free environment. Students need to see that teachers are striving to change the notions of only two genders. (DD)*

Funding that was to be utilized during this three-year term was allocated toward the purchase of resources to better support teachers, and this further supported the district's implementation process.

> *The first year I had a budget to create In Service which was mandatory for teachers grade 8-10 to attend was in year 2, then year 3 I focused on grade 7 for In Service which cost approximately 10-15 thousand dollars per year.*

The information from the district interview also details factors that significantly hindered the implementation of SHE. The following statement exposes that, although the HC was directed to train and support the administration and teachers, front-line did not have the opportunity to influence the implementation with their input.

> *District buy in from the top like DPAC [District Parent Advisory Council] and superintendents etc... I soon found out the stakeholders, like parents have some of the largest say in what gets accomplished or not. It's not teachers. (DS01)*

When asked during the interview if there were a committee or team dedicated to implementation of this curriculum, the HC stated that, in retrospect, the district should have had a committee to better support them and improve the dissemination of SHE.

> *At the District level, no, unfortunately, which I feel was the biggest regret looking back. It was a factor that hindered. A team approach. (DS01)*

Elaborating further on the importance of a team approach, the HC indicated that it was challenging to support multiple schools and staff within numerous facilities. It was recognized that the administration plays a vital role in ensuring that a competent group of educators are prepared to deliver the material.

> *It is really up to administrators to ensure this SHE is being delivered: working with admin was another group of people who need support too as they also are unaware or trained in this curriculum. (DS01)*

District staff remarks made during the interview emphasized that changes in the communication process hindered the dissemination process further when communication from coordinators with administration was restricted.

> *Another barrier was the district changed the way we were allowed to contact administration and we weren't allowed to email them, unless certain circumstances, and instead had to post updates on a newsletter which I felt really affected my way of connecting with staff unfortunately. (DS01)*

Administrative-level Responses

According to the responses from the administrative staff, notable factors supported the implementation process of SHE. Findings across all respondents were unanimously positive regarding the importance of implementing this curriculum. Administration expressed that students should have access to this knowledge. To

illustrate, the succeeding responses from the administrative staff highlight their supportive beliefs about the SHE curriculum.

> *It's a topic that needs to be talked about and students need to be able to, especially around consent, have practice, have this topic talked about. I'm an advocate for teaching sexual health awareness. (AS01)*

> *We have all these curricular areas right and so for me it's one of the most important parts 'cause it's the this is the life piece. (AS05)*

> *Yeah, I think that more information for kids is better and you know they're so focused on their bodies changing right now. Really, you could run that curricular content really interests kids, and so you know you could run an English class that was all focused on that kind of stuff. Yeah, I just think more information is better and more exposures to it or better. Yeah, I think that the more we can destigmatize and demystify. (AS02)*

> *I think that it needs to be implemented every year, and there needs to be a level of at the level of comfort in addressing the material so that it becomes more normalized, talking about sexual health and mental health and it becomes more normalized in our practice and kids know that if they're feeling uncomfortable about something that the adults in the building are available to them to answer questions or to direct them to the right resources. No shaming, I think that's really important. (AS03)*

> *My personal attitudes… I run with the idea that whatever is best for kids to help them be healthy adults that's my goal and so however we get there can sometimes be a little messy but that's the ultimate goal. (AS04)*

The administration supports the implementation process through a number of contextual factors. For instance, they support training requests, facility allocation and school-wide support.

> *We're scheduling our um our facilities for next year we're going to try to keep a room that's down by the gym kind of as an open room and that'll be bookable by those teachers so that's their spot they can go to do and it just becomes part of their routine. (AS05)*

> *You know what any kind of workshop activities people sell me stuff constantly all the time you know anytime I can pass off a resource or if they ask me for anything. I never say no I always figure out a way to pay for it if they initiate some sort of idea around anything even just around sexual-health. (AS04)*

Administrative staff confirmed that the community was in support of this curriculum being delivered in the schools and have not had experiences with parents looking to excuse their child from the curriculum. To illustrate, comments from the administrative staff highlight their experiences.

> *I think the parents are really supportive and want this talked about in schools. (AS02)*

> *You know quite honestly, it's pretty rare that you'll get a parent who will opt out of the student having that content. It's part of the curriculum we don't often send a letter home saying we're going to talk about sexual health are you okay with that, we stopped doing that we don't do that anymore so we used to kind of give people that opportunity because we want it to be it's part of the curriculum. (AS04)*

As noted previously, the administrators are responsible for ensuring curriculum fidelity through its delivery. The administrators describe in their responses the supportive steps they take to ensure the delivery of this curriculum.

> *We do course outlines at the beginning of each quarter so they're usually part of the course outline. (AS04)*

> *I sit in on class every now and then and help them out, so to kind of take a look at the quality and the fidelity of what's going on. (AS01)*

> *I attended all the[training]sessions with the staff. Right, so then, we would have discussion around it...So, the Admin and I provide a level of support in how to present material. Also, you know, just encouragement right. (AS01)*

> *Again, we're trying take barriers away... not everybody has kind of a home base so for when we're scheduling our facilities for next year, we're going to try to keep a room that's down by the gym. (AS05)*

One factor that hinders curriculum implementation is an apparent breakdown in who is ultimately responsible for ensuring delivery. Some administrators are making the assumption that this curriculum is being delivered, and some may not recognize that it is their responsibility, and are not taking the steps to verify for themselves.

> *You know. I know that the teachers who are delivering it went through the big training with a district coordinator and are aware of the resources. But in terms of what's actually really happening in classrooms, I don't know right now. (AS02)*

> *Last year I was new to the school so I was building relationships with teachers. I have incredible confidence in the in the professional conduct of our staff and the department head who is responsible for our physical health education department. (AS03)*

> *One of our learning leaders that is their role, to you know, it's a PHE learning leader so obviously there is the phys-ed part but there's also the health... so we do have that learning leader piece who would coordinate with those teachers. (AS05)*

Complicating matters further is the COVID-19 pandemic. As indicated by one administrator, this has presented challenges to support staff and we need to ensure curriculum is being delivered.

> *I haven't been able to really supervise that aspect of what's happening in the school right now given the circumstances [pandemic]. But like I said, I have an incredible amount of confidence in the professionals who are in the department. (AS03)*

One important hindering factor is that more than half of the administrators were not trained on the SHE implemented in the district.

> *I was not specifically prepared by the district although aware that a lot of work was done when the redesigned curriculum was rolled out. (AS03)*

> *To say specifically that we've done workshops or anything around sexual health education content wise it's just not our focus. We do more generalized conversations around curriculum if that makes sense... So, if anything more formal was done here, I certainly wasn't aware of it. (AS04)*

> *I haven't been in the district for an extensive amount of time. And although I'm aware of people like the learning coordinator as a district resource person and that there are resources available on district web site, as a school leader, um, we haven't been part of the sexual health rollout. I think that that happened before I came here. (AS02)*

Teacher-level Responses

The interview responses revealed that teachers believed that there were multiple factors that supported curriculum delivery. All teacher respondents commented on establishing a consensus on language and classroom behaviours with students as it set up a supportive classroom environment for curriculum delivery, as illustrated in the following three responses.

> *I think it's setting the ground rules and like well, I've been in this business now for many years so really setting the ground rules, establishing boundaries before delivering content is absolutely crucial and letting them know who is driving the ship and then you can veer off it a little more and you get that respect from the students which is really important. But they respond really well when you set those boundaries. (TS02)*

> *We start each class with a reminder that it's a sensitive topic. That everyone has different comfort levels and that we need to try to stay professional about it. When we talk, we use proper terminology rather than slang. I like to ask a lot of questions and have class conversations but I monitor them closely to make sure no one is offended and that everyone is being respectful. (TS07)*

> *I insist on the use of anatomical names and respect in the class, when dealing with this curriculum. (TS05)*

All the teachers had a positive attitude towards the curriculum and there was a consensus among the teaching staff; they believe that it is valuable curriculum that students should learn in school.

> *It is excellent and relevant information that kids should be informed about and educated on. (TS02)*

> *We all think it's important, so we do it to the best of our abilities... (TS07)*

> *I believe it's important that we deliver this material to students, as many of them are not getting it from home and many are learning from other areas of the Internet and social media. We should care on how we support our students and make sure that they're getting the right information and education they need to be healthy citizens. (TS09)*

However, many believe that physical education is not the most suitable area of study for this content to be included. The teachers expressed their reluctance and

questioned how time spent on this topic took away from time originally devoted to physical activity, as noted here.

> *My reaction was, well it was all over the shop, because I felt like we were cheating the kids out of their physical activity with the health portion being put into the physical education piece...Taking away physical activity time. There is resentment around that. (TS02)*

> *I don't like that it takes away time for kids to be active. Um, but I really like that it is in the curriculum, somewhere. So, I am kind of torn. (TS04)*

> *I don't think it should be taught in PHE. I think we should go back to PE and put teaching about relationships in a class like…SOCIAL studies, and I teach Socials. (TS07)*

> *I think it's super, super important, but for 31 years I taught another course, PE, that I thought was super, super important too and I'm not so sure they did the right thing by just plunking it into a course and say you guys go for it now, do the best you can. (TS03)*

One of the most notable factors that hindered implementation was expressed by both administration and teachers: respondents stated that there was a certain level of discomfort in delivering this material depending on the level of preparation. One administrator was skeptical of the quality of information provided.

> *I think there was some initial hesitancy. I think it's just a comfort level thing early on like why is this getting put into PE ... but I think that the pendulum has kind of shifted now when it's kind of the new normal they feel comfortable feel supported you know that the education piece and I think that's helped with a lot of that too. (AS05)*

> *I think that teachers who are not trained in delivering this curriculum find a level of discomfort in delivering the curriculum because it is, it is something that is sensitive material... and if teachers get embarrassed because they said something or a kid laughs and it's you know it's, it's still a very sensitive topic. (AS04)*

> *Teachers, I think, initially were a little bit uncomfortable, but found their own way through it. I think it's really positive, but again, that being said, you know some teachers like to dive deeper into it, and some just kind of go. OK, well like we talked about these things, tick tick tick right. (AS02)*

However, there was a discrepancy between administration and teaching staff responses on the level of comfort in the delivery of this material. The level of discomfort alluded to by administration was of a lesser degree than expressed by that of the teachers. This is made clear by the following statements made by teachers.

> *Some also feel quite anxious around concept based on their own experiences with students, and some things have not worked out very well in the student's maturity levels, so it becomes uncomfortable situation. So, I would say right now it's mixed on excitement and dread. Uh, in basically in in the sexual intercourse and contraception part. (TS01)*

> *You can also have the headspace where, this is fantastic we have some great supports, but I would not say that that was the case for the majority of my colleagues. (TS02)*

> *I just have this one person in mind like they're mad that they have to teach it, so they're just going to do the bare minimum. Right, they're not going to give it a fair shot, it's just frustrating. (TS06)*

> *It needs to be planned, prepared like you care about it, and that you think it's important 'cause kids can tell. If you give a 15-minute lesson on puberty and call it done and there's no clarification and no discussion is just throwing information on it for 10 minutes, they're going to see that as not worthy, and they're not going to take it seriously, and they're not going to learn anything. Um, so I know that there are reluctant colleagues out there, and it is just super hard and frustrating when you see it. (TS06)*

> *I have to be honest there are several teachers in the district who do not have the same attitude in regard to delivering this material and their attitudes are much different than others...we still have a long way to go. There are a couple of my peers who are not comfortable and I can understand and have supported them as best I can. (TS09)*

> *I'm not different from many people. I mean I think they're here and they're prepared to do a job. Their level of comfort with this stuff isn't maybe what they would like it to be. I think some are keen about it... but I think I think the majority of people certainly have concerns about teaching it. (TS08)*

Additionally, teacher gender can be a factor that hinders teacher-level comfort in delivery.

> *The male PE teachers, not as comfortable with it, for sure, so that if there's anything to work on it would be that. (AS04)*

> *I think as a male teacher I think that those things [risks] probably come to mind a little quicker maybe as well and you have female students like you're definitely very conscious of how you introduce the topics, what language you use, things like that. (TS08)*

The following section represents the mixed views regarding the online and printed curriculum resources provided to teachers. Some PE departments were more organized and cohesive than others.

> *There was a lot that the district coordinator showed us [in the mandatory training]. The district coordinator got us into the district web page and showed us exactly where to go for educators when they needed help and assistance as she had started like the slideshow presentations, the where to get accurate good information. I found that useful. (TS06)*

> *I only started teaching this because we got our act together as a staff here and we came together as a department and we started to build our repertoire of all the activities and took a really hard look at what the district coordinator had given us and spent some PLC time as a department working on those.... So, my colleague and I majority sat down and put together slideshow presentations. Um, for each grade in each lesson because we want it to be an extension in each year as just repeating or regurgitating or overlapping the same assignments they did the year before. (TS06)*

Some teachers found the resources helpful, while others found that too much information was provided, yet others were uncertain about what to include in their presentation of the material.

> *There are also pamphlets like a booklet style for those that aren't comfortable with interactive lesson plans that want to directly teach where it's called Kids In the Know... that I've seen people use to kind of understand sexual health. (TS01)*

> *I think, on behalf of our department, there are many, many great resources that were put forth on the [web] site, but it's also daunting and overwhelming. (TS02)*

> *There is so much material and there's no rule or decision about everyone, here are these things here's what we're going to talk about in grade 8. It's not really done that way so. I teach in grade 8 and I teach in grade 9 and grade 10 and I have little booklets that were handed to us. (TS03)*

Teachers identified inconsistencies in what content students were receiving as a hindrance. The succeeding responses from multiple teachers, a department head and administrative staff have indicated that it would be preferable, and they would find it helpful to have more specific and structured tools or materials to use, such as a web-based learning portal or a colourful booklet-style workbook.

> *The ability to have the resources at the district level and using community resources would help, but also to make sure that we are delivering the same curriculum and the same messages. I'm finding that it has been difficult to make sure as Department head that even my own staff are able to deliver the same scope and sequence so that we're all on the same page. (TS09)*

> *There was a huge push from people in the department to have unit lessons prepared for us and make them activities we could send the students off to the computers to complete. (TS05)*

> *I'm following a little specific book [Kids in the Know] ... I don't think that if I went through the school that we would see that people were on the same wavelength or consistent at all. (TS03)*

> *...If you were to focus in on that sexual health piece, I think you know a prescript nature you know or yeah kind of some key… are some strategies to make sure that all students are getting this in a in a good way. (AS05)*

Teachers were not directed to employ any particular content within this curriculum. They were offered a large amount of information to choose from, but no content was specifically required. The district recommended 7 hours for instructional time, but precise content taught in each class was left to the discretion of the teacher.

> *So, when it comes to implementation, we do have guidance. But again, with it comes to teacher autonomy. It also goes to what fits who you're teaching and how you feel about it. (TS01)*

> *We were given basically a list of resources, put together by the district, that fit the new curriculum and we were advised to pick and choose, use it, don't use it. (TS04)*

> *The health coordinator said probably around 7 hours or so. You know, I don't know where the 7 hours came from, what that really meant.... It's just number that's thrown out there, an arbitrary number, rather than reasonable content. (TS03)*

> *I just feel that it's doing a disservice to it because there's so much honestly to talk about, that whole spectrum of mental and sexual health, it's that you just have to pick and choose whatever you think individually, unless you decide this school what it is going to be. (TS03)*

One administrator disclosed that perhaps the curriculum is not being delivered as noted in the district policies, and that the practice of teaching a more traditional content persists.

> *I don't know how, how broad we are in our curriculum delivery because of that, so it's more of a traditional like a traditional model of delivery around traditional sexual norms and values...I think it's more along the lines of heterosexual norms and maybe not looking at the broader LGBTQ plus community...So that's yeah, and the 2 spirited peoples in the indigenous culture and those are things that don't come up in traditional sexual health education and I don't know if the level of comfort that people have in discussing that, right. (AS03)*

Chapter Four provided a description of the findings from the interviews with district personnel, administrators, and teachers. Data provided by the major stakeholders illustrate details about the implementation framework utilized, its sustainability and the factors that supported or hindered curriculum implementation. The following chapter will comment on these findings in the context of previous literature and provide future considerations for research and recommendations.

Chapter 5: Discussion

The primary purpose of this study was to increase our understanding of how major stakeholders within one school district in British Columbia have implemented the sexual health education (SHE) curriculum for secondary students grade 8 through 10. This case study included responses from interview questions as well as district documentation. This has provided valuable details on how sexual health education (SHE) was being implemented and the factors that supported or hindered implementation of SHE. These details are described and explained in three themes that were identified from analysis of data. Theme 1 demonstrated that the school district involved in this study utilized a top-down approach and applied components of an implementation framework to disseminate the SHE curriculum. Theme 2 showed that there have been and are significant deficiencies to the sustainability of the SHE implemented by the district. Theme 3 detailed the factors identified by the stakeholders as either supporting or hindering the implementation of SHE. Discussion of these three themes connects with literature reviewed in Chapter 2 to answer the research questions. Theme 1 and 2 address research questions one through three. This section explains the implementation methods utilized by the district, the administration, and the teachers of this district. Theme 3 addresses the factors that supported and hindered stakeholders' ability to implement SHE. This chapter concludes with practical implications for educational implementers at all levels involved, and considerations for future research.

Theme 1 – Top-down Implementation Framework

The results of this study corroborated and, in some instances, expanded on what previous studies of implementation have found. Researchers specify that implementation

is a process comprised of three predominant phases: pre-implementation, implementation, and sustainability (Han & Weiss, 2005; Rogers, 2003; Schutt, 2012). Moreover, within these phases there is a framework. As noted by Meyers et al. (2012), an implementation framework is the how-to guide describing the prerequisite steps necessary for the execution of implementation efforts. They enumerated four phases: (a) initial considerations regarding the host setting, (b) creation of a structure for implementation, (c) maintaining an ongoing structure once the implementation begins, and (d) planning on improving future applications.

The implementation framework utilized by the school district surfaced from participants' responses to interview questions, as well as district documentation. The findings show that the SHE curriculum was implemented through a top-down approach. The initial considerations for the curriculum changes were rooted in a decision made at the provincial level by the Ministry of Education (MOE). In 2016-2018 the MOE launched curriculum changes among which included moving health topics, including SHE, from Careers 8/9 and Planning 10 to Physical Education (PE), renaming it to Physical and Health Education (PHE). With this shift, a structure for this required implementation was needed. To this end, the district adopted an inclusion policy, a sexual orientation gender and identity (SOGI) policy, and followed the provincial Ministry of Education (MOE) 2016-2018 curriculum update. Next, the district contracted a health coordinator (HC) for a 3-year term. The responsibility of the HC was to guide this implementation by supporting teaching staff in the delivery of this newly acquired content. Through training and resource support, this coordinator was mandated to apply a

teacher-focused implementation approach, to fulfil the district's primary goal ensuring all students in the district were receiving equitable SHE.

Fixsen et al. (2005) describes this as paper implementation, which is implementation documented through changes in policies and procedures with no actual evidence of practical implementation. To the district's credit, they effectively created the policy backdrop for sound implementation, which was observable through this study. Unfortunately, this was not followed up with what Fixsen et al. (2005) would have considered necessary in a process implementation; one where new procedures were put into place, changing reporting and supervision processes. As will be detailed further in subsequent themes, evidence of practical implementation appears to have been limited to the duration of the HC's contracted term.

Progressing through the how-to-implementation-guide, Meyers et al. (2012) states that it is necessary to have an ongoing structure once the implementation begins, however it is evident that at this stage the implementation studied here started to fall short. Further, regarding the final point in Meyers et al. (2012) formula, there remains little indication that the district is building a process that would improve future applications. These points will be discussed in further detail in the next theme.

According to Han and Weiss (2005), implementation is defined as the execution of procedures to successfully accomplish the goals of a program. Additionally, implementation research has been largely based on program implementation disseminated in a specific environment (Bartholomew & Eldredge, 2016; Domitrovich et al., 2008; Durlak & DuPre, 2008; Han & Weiss, 2005; Meyers et al., 2012; Schutte et al., 2014). Programs examined within the research were evidence-based and would serve as

an intervention, health prevention or health promotion program. Han and Weiss' (2005) research is an example that illustrates this. Their examination of implementation is based on the program, Reaching Educators Children and Parents (B. Weiss, personal communication, August 13, 2021). It focuses on the social emotional development of children in school. This program has content that is structured, provides scripted materials that teachers are required to follow, and it delivers training support for classroom-specific modifications (Murphy, n.d).

A good example of a SHE-specific program is from the Netherlands' Long Live Love (LLL). This school-based program trains educators both online and in-person allowing for teachers to work through a teachers' LLL guide and practice hypothetical student situations. Students receive a corresponding LLL workbook which teachers systematically instruct them through. The workbook is comprised of six lessons which are an hour in duration (Mevissen et al., 2018; Schutt, 2012; Wiefferink et al., 2005). LLL was created in the 1990s and "produced desirable student outcomes" (Schutt, 2012). LLL is a good example of internal and external validity as it was revised three times since its inception. Due to its success, this program model was used in other countries (WHO Regional Office for Europe/BZgA., 2018). The above examples and other implementation research were assessing fully developed and structured programs (Dale et al., 2013; Dalum et al., 2012; Meyers et al., 2012; van Lieshout et al., 2017; Wight & Abraham, 2000). Consensus amongst the researchers identified quantifiable aspects to implementation as: (a) curriculum fidelity, was the specific material taught as intended or adapted; (b) quantity, which indicates how much of the specific program was delivered;

and (c) quality, which refers to the delivery process specific to the program (Domitrovich et al., 2008; Durlak & DuPre, 2008; Meyers et al., 2012).

It was evident from this study that the district executed several procedures initially to achieve their goal, but contrary to what is seen in the breadth of research on implementation, what the district under study attempted cannot be considered a program. Although the district stated that teachers were expected to be delivering this content, it was evident in the findings that many teachers believed the resources provided and number of lessons required for delivery was merely a recommendation left to the teacher's discretion. The district lacked the direction that could be obtained from an evidence-based program: a consistent structure of a scripted program where all teachers are required to deliver the same specified content for a specified number of lessons would better support the district's ability to achieve its goal of equitable SHE for all.

The district's plan lacks the structure seen in other implementations schemes. This, in part, can be traced back to the MOE curriculum changes; as seen in chapter 1, there was a degradation of detail from the 2004-2016 to the 2016- 2018 curriculum. By comparison, the previous curriculum had provided some structure and requirements on content and time required to deliver the curriculum while the MOE changes moved away from prescriptive curriculum documents towards a more flexible approach.

According to Hanley et al. (2009) the more adaptable the curriculum, the less likely a teacher will follow it. Adherence to a structured program renders better outcomes in students and "fidelity of implementation of school-based curricula has been repeatedly associated with achieving expected outcomes" (Hanley et al., 2009, p.40). The MOE has left it up to the discretion of the districts to address the SHE learning standards, and in the

case of the district studied, they provided training and resources in support of these learning standards. This permitted teachers to largely adopt the SHE content of their choice. The outcome we see in the findings is a wide variety of mixed methods, potentially reducing the material delivered to an ad hoc curriculum where teachers have a great deal of flexibility and autonomy. This is problematic in two ways: first, it makes assessment of implementation difficult as there is no consistent material to study in terms of fidelity, dosage, or quality. Second, this approach is so open and versatile that there is no teacher accountability to the district goal of "ensuring all students were receiving equitable sexual health education across the district" (DS01).

Theme 2 Sustainability Challenges in the Sexual Health Education Curriculum

To understand sustainability of SHE in this district, this theme continues through Meyers et al.'s (2012) how-to-guide of implementation and will discuss the ongoing structure once the implementation begins, and what attempts were made to improve future applications. As defined by Durlak and Dupree (2008), sustainability is when a program is maintained over time. It was clear in the responses to the questions posed in this study that multiple staff from all levels stated that they did not plan for sustainability. At the district level there appears to be no plan for continuation, and this was punctuated when district staff's recommendation for sustainability and methods to support were not well received; the district was not receptive to these recommendations, and they were not adopted. At the administrative level, there was an overreliance on the professional competence of senior staff who have been in the department for a long time to ensure the job got done. Several indicated that they would address this when it became an issue, not recognizing that it already was.

Researchers stress the essential need and importance of a team-based approach to establish an implementation framework (Bartholomew & Eldredge, 2016; Fixsen et al., 2005; WHO & BZgA., 2013). As opposed to a top-down approach, this inclusive approach better supports implementation and sustainability. As noted by one respondent, the "trickle-down approach" was limited in its capacity and in order for the district's SHE to be sustainable "it needed a team." Additionally, students, teachers and administration had little input, as one participant stated, the senior administration and the district parental advisory committee heavily influenced what was accomplished. Buston (2002) argues that staff turnover, among other factors, can impact the degree to which a program is implemented. In accordance with Buston (2002), respondents indicated that major contributors at the district level were no longer with the organization, superintendent and senior administration who spearheaded the organization of SHE for the district had moved on, the HC role ended in 2020, more than half of the administration are new to the district, and teachers with smaller PHE teaching assignments are quite transient within this teaching subject.

Complicating matters further, the education being provided to future teaching professionals coming into the district is also a sustainability barrier. "There is a disconnect between what SHE is expected to be taught by teachers, and what is being taught in the PHE training within BC universities the ED students were really looking for more learning opportunities" (DS01). As a result, staff turnover has presented recognizable challenges for the sustainability of SHE in this district.

Another factor affecting the sustainability of the district's implementation framework are the differing opinions regarding who should deliver the SHE curriculum.

Respondents indicated that with the hiring of a HC, the district intended teachers to ultimately deliver SHE, and in contrast, some administrator and teacher respondents in this study did not agree and would prefer to see SHE taught by an external partner in whole or at least in part. It is worth noting that according to the findings, less than one year after the HC role was discontinued, administration and teachers have begun to bring in external experts to support the delivery of SHE in varying capacities.

Further, although this research did not address student preferences on who would deliver SHE, one study (Pound et al., 2017) did note that students would rather have an individual other than their own teacher provide this curriculum. It would seem that there was a lack of buy-in for creating a self-sustaining system in which teachers are assigned to exclusively deliver SHE. The reasons why teachers did prefer not to deliver SHE are multifaceted and is explained further in theme 3.

Wiefferink et al. (2005) found a well-structured program for teachers and their students to work through that is promising for positive implementation. Teaching a structured curriculum provides a common language. Doing so not only ensures the material is provided in an equitable fashion for all students, but it also enables monitoring, a facet of implementation which could be improved within the district studied. Researchers emphasize the need for monitoring and measurement to see if a program exhibits appropriate fidelity, quantity and quality. Further, not only is it important to prove a program's effectiveness but also monitoring and measuring the implementation framework utilized is of critical importance. (Bartholomew & Eldredge, 2016; Domitrovich et al., 2008; Fixsen et al., 2005a; WHO and BZgA, 2013). Implementation framework is a continuous process with many active parts that need

ongoing monitoring in order to evaluate and adjust accordingly so you can maximize quality of overall implementation (Domitrovich et al., 2008; Durlak & DuPre, 2008; Han & Weiss, 2005; Meyers et al., 2012).

The district studied here is not currently engaged in any monitoring of its framework: the curriculum resources are no longer being updated because the HC role no longer exists, and several administrators are not familiar with what was being delivered or if it was being delivered at all. As discussed in the findings, the assessment of student learning has been identified by the district as a major need, yet the curriculum effectiveness is not being assessed at this school district.

Beets et al. (2008) postulated that program developers and administrators should address curriculum adaptability during the pre-implementation phase to agree on acceptable modifications while maintaining the message, considerations that were not made in the district studied here. Several teachers did note that if they had something to follow with some minor adaptations here and there, they would achieve more consistency, continuity and more importantly, comfort in delivering curriculum that teachers at times find awkward. As stated by Han and Weiss (2005), curriculum that is flexible and adaptable, feasible and effective to teachers, will support sustainability. The district did provide staff with the opportunity to be flexible in their approach, trusting their professional judgement; however, without having a common language as a foundation, this was a challenge identified by administration and teaching staff. This is discussed in greater detail in the final theme.

Theme 3 Factors that Support and Hinder Implementation of Sexual Health Education

Researchers have identified the need to obtain a better understanding of why a curriculum may succeed in achieving the learning outcomes or why it may fail (Domitrovich et al., 2008; Han & Weiss, 2005; Meyers et al., 2012; van Lieshout et al., 2017; Wight & Abraham, 2000). Theme 3 provided insight into the factors affecting SHE implementation within the school district studied. The responses to questions during the district-, administration- and teacher-level interviews identified that there were factors which either supported or hindered the implementation at each level.

As Domitrovitch (2008) posited, factors which can support implementation include establishing school district policies, fiscal allocation for professional trainers, and the allotment of professional development and materials. Rather than leaving this subject for their teaching staff to take on and figure out, this district devoted attention to this curriculum. As noted earlier, the district adopted a SOGI Policy and Inclusion Policy which provided common language around sexual orientation, gender identity and maintaining a safe, inclusive learning environment to support students' diverse backgrounds. Additionally, a budget was established specifically for SHE. Funding was allocated toward the HC position, the purchase of resources and training for staff. Most notably, there were two supporting factors which were prominent throughout interview responses. Firstly, all respondents' comments about SHE indicated that it is very important for students to receive this content. Secondly, every teacher answered that establishing classroom management was essential for ensuring a safe space. They all noted that instituting ground rules and boundaries were key to maintaining a safe learning

environment. They also shared common strategies, such as using anatomically correct terminology, highlighting that it could be a sensitive topic with varying comfort levels amongst the students. This is echoed in the research, as Domitrovitch (2008) explained, the characteristics of the classroom and classroom management can support teacher-level implementation.

Multiple factors nonetheless hindered the implementation of SHE within this district. The most notable conclusion extracted from the answers to the interview questions was that there was a discrepancy between what the district and administration thought was being done and the omissions admitted by the teachers. The administration was trusting that the teachers were delivering fulsome lessons on SHE whereas teachers reported that their colleagues had discomforts and were omitting portions of SHE. For example, one administrator noted that the approach to SHE employed by their teachers was heteronormative and was comprised of traditional SHE topics, questioning the extent of discussions about homosexuality. As we have seen in the findings there is no mechanism to monitor or measure fidelity of SHE, or whether the teachers are adhering to the spirit of district policies, which are inclusive to LGBTQ2+ issues. The level to which teachers are utilizing inclusive language, if they place an LGBTQ2+ lens on teaching 'healthy sexual relationships' and whether they are adhering to the teaching required in the policy regarding LGBTQ2+ remains unknown. Worse, provincial curriculum learning standards do not specify including these topics and LGBTQ2+ terminology is excluded. Here again the district falls short of delivering an equitable and inclusive SHE.

As seen in the review of literature, modifying content based on intuition rather than a theory- and evidence-based design, can be detrimental to comprehensive implementation (Wight & Abraham, 2000). In accordance with Fertman et al. (2016) and Hanley et al. (2009), when schools lack a school-wide implementation approach, educators may focus on core subjects and ignore those such as SHE. Further, teachers interviewed in this study expressed resentful feelings of the loss of PE time. For the above-noted reasons, it is clear, based on this study, that students are not receiving equitable SHE in this district.

One important fact that has not been discussed in previous SHE research did surface in this study: administration and teaching staff drew attention to teacher gender as it appears to affect both teacher attitudes toward teaching SHE and may also influence the content delivered. Some male respondents admitted to delivering a watered-down content to avoid uncomfortable topics and language. They expressed interest in having external partners such as nurses come in to deliver the more sensitive material. Most notably, one teacher was concerned about the risks of possibly saying the wrong thing.

Domitrovich (2008) stressed the importance of standardization in the dissemination process through replication training, policies, and procedures. He emphasized the need for a cohesive and consistent formula for dissemination across all levels and schools. Buston et al. (2002) suggested that standardization of training supported uniformity and improved measurability across all schools. The importance of standardization in training cannot be overstated. The lack of a structured and standardized approach, one mandated at the district level, was a factor that hindered the implementation of SHE in this district. Major stakeholders identified inconsistencies in

training as a factor hindering the implementation of SHE. The findings of Domitrovich et al. (2008) and of Buston et al. (2002) are consistent with needs identified in this study; the majority of administration staff were not trained or even aware of any SHE-specific district curriculum content, some teaching staff did participate in the mandatory training, while some received partial training through occasional in-service workshops, but were mostly left to devise curriculum content on their own, and conversely, others did not receive training. Additionally, as seen in the research, one-off in-service sessions fall short in providing the necessary staff development. Researchers agree that the most effective approach in professional development in the achievement of teacher mastery and comfort is practice and in-class teacher performance feedback (Han & Weiss, 2005; Hanley et al., 2009; Lachausse et al., 2014; Leach & Conto, 1999). This is not to say that the mandatory training on SHE was not beneficial, multiple teaching respondents commented positively on the delivery of training through modeling. This is consistent with what researchers say is an effective approach in SHE-specific training (Han & Weiss, 2005; Hanley et al., 2009; Leach & Conto, 1999).

A reoccurring topic throughout the responses in this research was the need for a program. Respondents expressed that not having concise content was a factor that hindered the implementation of SHE. The resources provided to teachers in this district were overwhelming; many respondents stated that they did not know which parts to select, and teacher respondents and one administrator specifically indicated the need and desire to follow a structured program. They expressed that this was not only important in improving ease of delivery but would also improving teachers' confidence that they were delivering the correct and consistent messages.

Conclusions and Future Considerations

The findings of this case study demonstrated how major stakeholders in one school district have implemented sexual health education in British Columbia. This study also presented the factors which have either supported or hindered the implementation. A qualitative data analysis of district-, administration-, and teacher-level responses to interview questions highlighted that some components of an implementation framework were utilized. Han and Weiss (2005) identify three categories within the teacher-level sustainability and implementation process: contextual factors, teacher-specific factors, implementation sustainability factors. This study examined the current status of SHE which this district implemented in 2016-2018. Through this lens, findings indicated that there were factors that both facilitated and impeded implementation. Ultimately, this study concluded that the district's implementation is incomplete and unsustainable.

Educational practices are constantly evolving. Over the course of a teacher's career, teaching strategies, curriculum content, and assessment methods are in a continuous state of change. Teachers are constantly inundated with modifications in district mandated curriculum, alterations in best practices in teaching and student learning, student behaviours, school procedures, etc. Teachers must be adaptable and able to process and assimilate these changes to continue to be effective at their profession.

Limitations of this study included the inability for the researcher to observe teachers delivering SHE in a classroom setting due to a pandemic. Another consideration that could have enhanced this study was to have student input on their experiences of SHE. Next steps in the research on SHE might be to examine teacher gender and SHE delivery, specifically comfort level as it relates to fidelity, quantity, and quality. It would

be informative to conduct a provincial-level survey on SHE topics being delivered by grade 8-10 PHE teachers. It would also be revealing to conduct exit interviews with high school graduates on their knowledge about SHE topics covered in class and to identify what content they would like to receive.

This study is one of the few studies to examine how SHE is being implemented in BC. The findings of this study produced several implications for major stakeholders (school district, administration, and teachers), universities and the Ministry of Education pertaining to SHE curriculum and its implementation.

Thirty years ago, the government stepped in and mandated that schools deliver SHE. When looking back on the SHE history in this province, it was noted that the 1990s SHE delivery faced difficulties in professional development and inconsistencies in delivery throughout the province. In the 2000s, while there was improved structure, SHE struggled due to controversies regarding content (Hansman, 2015). All these issues continue to plague SHE. The recent relocation of the content from Career Life/Planning 10 to PHE is a continuation of the historic neglect this subject matter has endured. Further, there currently is less formal provincial guidance on the topic. All school subjects are not given equal treatment; students must pass tests on core subjects: if a student fails a component of math, say a trigonometry test, the student could potentially fail the entire subject and may not even graduate. All students will go on to have sexual experiences throughout their entire lives yet, in terms of curriculum, we do not place the same importance on this topic. One could argue that if SHE teachings are not properly conveyed to all students, these students could potentially engage in risky behaviours, yet little is done to enhance learning in this important subject matter. Further, most subject

matters are not laden with issues that can vary based on culture, religious views, values and beliefs and few teachers will express discomfort in the delivery of other curriculums due to these reasons. Teachers have extreme variations in their knowledge and comfort level with SHE and many feel they take actual personal risk in the delivery of SHE. Leaders at the provincial level owe it to teachers to provide them with a clear, easy to use, year-by-year structured curriculum to follow for SHE.

Currently, the acronym LGBTQ2+ is not found in the curriculum documents for students in grade 8-10. A move away from heteronormative language must occur and LGBTQ2+ topics must be normalized to truly represent the diversity of Canadian youth. This opportunity should not be missed: the provincial curriculum documents currently published are lacking and vague on SHE in general, and queer topics are excluded entirely. Additionally, the supporting student health resource for secondary students provided by the MOE does not reference LGBTQ2+ in the sexual health examples, this term is only used a single time in the entire document. Common language in curriculum mandated to be taught by the MOE would support district staff and administration when addressing content coverage and when monitoring delivery. This would make teachers accountable to effectively provide this material to students.

Rather than staying in the comfort of the status quo, BC needs to look beyond the examples demonstrated in other provinces and territories in Canada. If BC were to take a lead in providing a comprehensive SHE curriculum, university-level teaching programs would benefit. As seen in the findings, there is some concerns that SHE is not covered adequately at the university level. Future teaching professionals need a foundation of

quality SHE, regardless of the district these new teachers go to work for within this province: all will be equally prepared.

As the research on implementation emphasized, a team approach is needed at the district level to fully support implementation. Also, students should be a part of that team: BC curriculum is learner-centered and seeks to "better emerge students in their own learning." Creating a team and involving students will foster a bottom-up approach as opposed to the current top-down only strategy. This team would alleviate the lack of clarity around who is ultimately responsible for the delivery and would also ease long term sustainability issues created by the high teacher and administration turnover rate.

There are many reasons to place more emphasis on SHE and much more must be done to provide sound SHE to youth. Utilising an implementation framework with a team approach, offering a clear developed and rigorous program including written materials as aids, and planning for sustainability would greatly improve outcomes for students. The value of implementing an evidence-based SHE curriculum within BC schools cannot be overstated.

I plan to disseminate the findings of this study in the following ways:

- Provide an executive summary of this thesis to the participating entities.
- Publish findings in a related academic journal such as the *Journal of Sex Education, the Journal of Heath Education Research and the Canadian Journal of Human Sexuality.*
- Approaching the BCTF as well other Canadian agencies, including SIECCAN, PHE Canada and SOGI with short informative articles on the outcomes of the research.

- To present key findings to other education faculty within BC universities.

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Appendices

Appendix A: Certificate of Ethics Approval

University of Victoria
Office of Research Services | Human Research Ethics Board
Michael Williams Building Rm 6232 PO Box 1700 STN CSC Victoria BC V8W 2Y2 Canada
T 250-472-4545 | F 250-721-8960 | uvic.ca/research | ethics@uvic.ca

Certificate of Approval

PRINCIPAL INVESTIGATOR	**Sandra Gibbons** (Supervisor)	**ETHICS PROTOCOL NUMBER** Expedited review - delegated	**21-0043**
PRINCIPAL APPLICANT	**Tara Wright** **Master's student**	ORIGINAL APPROVAL DATE	25-Mar-2021
		APPROVED ON	25-Mar-2021
UVIC DEPARTMENT	**Exercise Science, Physical and Health Education EPHE**	APPROVAL EXPIRY DATE	24-Mar-2022

PROJECT TITLE **Examining how major stakeholders within one school district in British Columbia are implementing the sexual health curriculum**

RESEARCH TEAM MEMBERS
Tara Wright - ,

DECLARED PROJECT FUNDING **None**

DOCUMENTS INCLUDED IN THIS APPROVAL
tcps2_core_certificate.pdf - 06-Feb-2021
Appendix 4.docx - 17-Feb-2021
Appendix 6.docx - 17-Feb-2021
Appendix 3.pdf - 17-Feb-2021
Appendix 2.doc - 17-Feb-2021
Appendix 5.docx - 17-Feb-2021
Appendix 1.docx - 21-Feb-2021
Appendix 7.doc - 24-Mar-2021

CONDITIONS OF APPROVAL

This Certificate of Approval is valid for the above term provided there is no change in the protocol.

Modifications
To make any changes to the approved research procedures in your study, please submit a "Request for Modification" form. You must receive ethics approval before proceeding with your modified protocol.

Renewals
Your ethics approval must be current for the period during which you are recruiting participants or collecting data. To renew your protocol, please submit a "Request for Renewal" form before the expiry date on your certificate. You will be sent an emailed reminder prompting you to renew your protocol about six weeks before your expiry date.

Project Closures
When you have completed all data collection activities and will have no further contact with participants, please notify the Human Research Ethics Board by submitting a "Notice of Project Completion" form.

Certification

This certifies that the UVic Human Research Ethics Board has examined this research protocol and concluded that, in all respects, the proposed research meets the appropriate standards of ethics as outlines by the University of Victoria Research Regulations Involving Human Participants.

Rachael Scarth

Dr. Rachael Scarth
Associate VP Research Operations

Certificate Issued On: 25-Mar-2021

Appendix B – Invitation Letter

University of Victoria

Invitation Letter

You are being invited to participate in a study entitled *Examining how major stakeholders within one school district in British Columbia are implementing sexual health education curriculum* that is being conducted by Tara Wright, a graduate student in the School of Exercise Science and Physical Health Education (EPHE) at the University of Victoria. Tara's supervisor at the University of Victoria is Dr. Sandra Gibbons, a faculty member in the School of EPHE. Dr. Gibbons can be contacted at sgibbons@uvic.ca.

Purpose and Objectives

The purpose of this research project is to examine how major stakeholders in one school district are implementing the sexual health education curriculum in the province of British Columbia. The goal is to increase understanding of the implementation process utilized by the district staff, administrators, and teachers to gain insight into how one school district is choosing to implement sexual health curriculum for secondary students grade 8 through 10.

Importance of this Research

To date, there has been minimal research examining Canadian sexuality education curriculum within the K-12 school system. There is little to no data on what youth are learning, on what is included in the curriculum or what assistance educators are receiving with implementation. Research of this type is important because sexual health education can have a positive impact on adolescents' physical, emotional, and social well-being. It can increase their use of contraception, as well as reduce unplanned pregnancies and sexually transmitted infections. Sexual health education has also been proven to mitigate bullying about sexuality, as the content broadens adolescent understanding of, and respect towards, gender, sexual orientation and expression.

Participants Selection and Involvement

You are being asked to participate in this study because of your staff position within the school district. If you consent to voluntarily participate in this research, your participation will include a 60-minute web-based interview on Microsoft Teams, which will take place on at an agreed upon date/time. You will also be asked if you would like to provide documentation that you believe is pertinent to your role in the implementation process.

If you are interested in taking part in this study, please contact me via return email and I will send you a consent form with further information about the study.

If you have any questions about the study, or if you would like additional information to assist you in reaching a decision, please feel free to contact me by phone [647-746-2977] or email [t.wright07@yahoo.com]. Thank you in advance for your interest and support of

this project.

Sincerely,
Tara Wright

Appendix C: Participant consent form

University of Victoria

Participant Consent Form

Project Title: Examining how major stakeholders within one school district in British Columbia are implementing the sexual health curriculum.

Researcher: Tara Wright, Graduate Student, School of Exercise Science, Physical and Health Education (EPHE), University of Victoria, Phone: 647-746-2977, email: t.wright07@yahoo.com.
I am conducting this research for my master's thesis.

Supervisor: Dr. Sandra Gibbons, School of Exercise Science, Physical and Health Education (EPHE), Phone: 250-721-8383, Email: sgibbons@uvic.ca

Purpose(s) and Objective(s) of the Research:

The purpose of this study is to examine how major stakeholders are implementing the sexual health education curriculum in a publicly funded school district in the province of British Columbia. The goal is to increase understanding of the implementation process utilized by the district staff, administrators, and teachers to gain insight into how one school district is choosing to implement the new sexual health curriculum for secondary students grade 8 through 10.

This Research is Important Because:

Sexual health education has been proven to have a positive impact on adolescents' physical, emotional, and social well-being. It can increase their use of contraception, as well as reduce unplanned pregnancies and sexually transmitted infections. Sexual health education has also been proven to mitigate bullying about sexuality, as the content broadens adolescent understanding of, and respect towards, gender, sexual orientation and expression.

Participation:

- You are being asked to participate in this study because of your staff position within the school district.
- Participation in this project is entirely voluntary.
- Whether you choose to participate or not will have no effect on your position [e.g., employment] or how you will be treated.

Procedures:

- Participants will take part in a 60-minute interview. The interview will take place at an agreed upon date and time. The researcher will provide the questions in advance to facilitate the interview. The interview will be conducted on the district managed Microsoft Teams account. This account stores and contains data within the school district OneDrive account, which remains in Canada.

- The session will be audio recorded and I will be taking notes.
- Participants will be asked if they would like to provide any implementation or sexual health education documentation (e.g. workshop materials, policy documents, lesson plans) related to their position at this time.
- Once the interview is completed, participants will be provided with the opportunity to review the interview transcripts.
- **Duration:** 60 minutes
- **Location:** Remote
- **Inconvenience:** Time dedicated for interview.

Benefits:

- Benefit to participants: This research provides an opportunity to discuss and reflect on the school districts dissemination process, perceived challenges, and benefits of teaching sexual health education as well as the opportunity to provide suggestions on how future practices might be improved.
- Benefit to the state of knowledge: Increased understanding of what and how district staff, principals and teachers are implementing sexual health curriculum and whether such strategies are effective.

Risks:

- There are no known or anticipated risks to you by participating in this research.

Withdrawal of Participation and Review of Interview Transcripts:

- You may withdraw at any time without explanation or consequence.
- Should you withdraw, your information will be removed from analyses.
- You will have the opportunity to review transcripts of your interview.

Anonymity and Confidentiality:

- Due to the nature of the video conference interviews, you will not be anonymous in the data gathering phase of research. However, your anonymity will be protected during the dissemination of the results using pseudonyms and de-identified data.
- There will be limits to protection of participant confidentiality due to the small and target sample in the school district. To protect participant confidentiality as much as possible, the following steps will be taken – Participants will be assigned a pseudonym, which, will be used for data collection, transcripts, and reporting findings. Participants will be asked not to use identifying information, and transcripts will not contain identifying information, such as names of individuals, schools etc. Only the researchers will have access to the data. Audio files and transcribed interviews will be kept in a locked filing cabinet. Interviews will be transcribed by Tara Wright. The interview files, transcribed data, and any notes taken during the interview will be destroyed after five years.

Research Results May be Used/Disseminated in the Following Ways:

- Directly to school district (copy of completed thesis); thesis posted on UVicSpace, presentations at scholarly meetings; published article.

Disposal of Data:

- Data from this study will be disposed of after five years. Audio tape from interview and transcriptions will be erased, and paper copies will be shredded.

Questions or Concerns:

- Contact the researcher using the information at the top of page 1.
- Contact the Human Research Ethics Office, University of Victoria, (250) 472-4545 ethics@uvic.ca

Consent:

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher, and that you consent to participate in this research project.

_____	_____	_____
Name of Participant	*Signature*	*Date*

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix D: District staff interview questions

University of Victoria

Interview Questions: District Staff

District staff – Interview Questions

1. With respect to the new provincial SHE implemented in 2018, were there any local amendments you made to make this curriculum more efficacious for your school district?

2. What is the district's overall approach to SHE? Risk avoidance? Comprehensive? (attitudes and beliefs)

3. What were the primary goals you had that were specific to your district? Were there particular goals that were highest in priority? (what was the end target)

    a. Did you conduct a needs analysis when identifying these goals and objectives? (measurable?)

    b. Was there a committee or team dedicated to this curriculum?

    c. How did you decide on the approach for your school district and how did you disseminate to the schools, secondary schools in particular? (imp. Framework).

4. How has the district evaluated and measured if the goals and objectives have been achieved? (measurable)

5. How does the district plan for sustainability of this plan?

6. What factors support or hinder your ability to implement and/or sustain and/or modify/improve over time the curriculum to the secondary schools across the district?

Appendix E: Administration interview questions

University of Victoria

Interview Questions: Administration

Secondary School Administration - Interview Questions

1. How were you informed and prepared by the district to disseminate this curriculum to your school? (implementation framework)

2. What are your goals and objectives with SHE for your staff and students? (what is the end target?)

    a. How do you monitor and measure if you are achieving your goals and objectives? (measurability/fidelity/quantity/quality)

    b. What is the schools' overall approach to SHE? Risk avoidance? Comprehensive? (attitudes and beliefs)

    c. How do you ensure teachers are delivering a message that supports the district and schools' values?

3. Given the districts stated goal to promote healthy sexual decision making, how has this been impacted by local beliefs or constraints?

    a. Please comment on your opinion about how effective local implementation has been in fulfilling this directive.

4. If you have observed levels of discomfort in the teachers required to deliver this material, how have you addressed this? (teacher level support & attitudes)

5. What forms of support do you provide for your staff? (admin attitudes and support)

    a. Are there specific, incremental resources are available for SHE?

6. What are your personal attitudes towards the goals and objectives we discussed in question number 2? (admin attitude school climate)

    a. How do these relate to what you believe are the norms of your particular school

7. How does the school plan for sustainability? Especially when considering staff turnover?

8. What factors support or hinder your ability to implement the curriculum within your school?

    a. Incremental funding, specific training for teachers

Appendix F: Teacher interview questions

University of Victoria

Interview Questions: Teachers

Group 1 Interview Questions

1. How were you informed and trained to deliver this curriculum to your students? (implementation framework)
2. Are you aware of the district/school goals are for SHE?
3. What are your goals and objectives with SHE for your students? (what is the end target?)
    a. What is your overall approach to SHE? Risk avoidance? Comprehensive? (attitudes and beliefs)
    b. How do you monitor and measure if you are achieving your goals and objectives? (measurability/fidelity/quantity/quality)
4. How do you deliver SHE? (e.g. typical teaching strategies/lesson design)
    a. What strategies are in place to ensure a safe space for all students?
5. What support and resources were made available to deliver SHE? Are they practical and applicable to your students? (admin attitudes and support)
    a. Were you ready and prepared to deliver SHE specifically?

    Probe: What areas did you feel more prepared? Less prepared?
6. What do you believe are the teacher level difficulties in delivering SHE?

   a. Are there particular components that you are uncomfortable delivering? Why? Or Why not? (teacher level support, attitudes, classroom management)

7. What are your attitudes and beliefs towards your responsibility to deliver this material?

   a. Do you believe you can positively impact student behaviour? (teacher attitude school climate)

   b. Have you observed changes in student behaviours from this curriculum? Do you think it is effective?

8. What do you believe are the norms, attitudes of your peers towards the SHE curriculum? (admin attitude school climate)

9. The learning standard content states that students are expected to know 'Healthy sexual decision making' – how do you interpret this? What is included? How many lessons are required to deliver this? (fidelity, quality, quantity)

10. Have you had any experiences with classroom management when delivering SHE? (classroom management impacts delivery and teacher self-efficacy)

11. What factors support or hinder your ability to implement the curriculum to the secondary schools across the district?