Background

This study was commissioned by NHS Health Scotland to review the approaches, activities and resources currently in use to support the delivery of sex and relationships education (SRE) in primary schools in Scotland.

Changing context

In Scotland, *Respect and Responsibility* (Scottish Executive, 2005) is a key policy driver for sexual health and wellbeing based on principles of self-respect, respect for others, and strong relationships. It sets out clear actions for schools, emphasising the importance of a stable family life in a child’s development and places the values of respect and responsibility at the centre of sexual health and relationships education.

However, promoting health within the school setting is not a new initiative within Scottish schools. The ministerial target that all schools would be health promoting by December 2007 had already made a significant impact, and has seen an increase in activity at both school and local authority level.

During the course of this research, further legislative and policy changes in relation to local authorities and schools, and their responsibilities for health, were in development. While these did not impact directly on existing practice, they would go on to have a significant impact.

The Schools (Health Promotion and Nutrition) (Scotland) Act 2007 (Scottish Government, 2007) came into force from January 2008. This builds on *Hungry for Success* (2002) and introduces nutritional standards for schools and, importantly, it also places an obligation on local authorities to ensure all schools are health promoting; putting health promotion at the heart of school life.

In tandem with this, *Curriculum for Excellence* (Scottish Executive, 2004), Health and Wellbeing: Experiences and Outcomes were launched in April 2009. This places health and wellbeing alongside literacy and numeracy as the responsibility of all. Within these experiences and outcomes, a framework for ‘relationships, sexual health and parenthood’ is provided.
Research aims, objectives and methodology

The research reviewed the approaches, activities and resources used to support the delivery of SRE in Scottish primary schools by:

• conducting a literature review of the effectiveness of SRE programmes and activity relating to outcomes within primary schools worldwide

• mapping and appraising existing SRE programmes within primary schools in Scotland

• synthesising the evidence from the literature review and relating this to SRE activity within Scottish primary schools.

The literature review identified a range of qualitative and quantitative evidence, covering both process and outcomes. The mapping consisted of two questionnaire studies and six case studies which illustrate innovative approaches to SRE.
Findings

1. The case for SRE in primary schools

The literature firmly makes the case for introducing SRE in primary schools on the grounds that puberty, for many children, occurs before their transfer to secondary school. Equally important is the need to support children to make informed choices which will help them to avoid difficulties in their teenage years.

There was some evidence of fears about perceived opposition from pressure groups, which often resulted in a cautious approach to SRE activity at both local authority and school levels. Questionnaire responses from schools indicated that while the teaching of SRE was widespread (less than 5% – 13/299 primary schools did not formally offer SRE), it was not universal or consistent – a conclusion similarly reached in the review of secondary schools.

2. Guidance for primary schools in teaching SRE

The majority of local authority participants were aware of a formal written local authority policy, but a substantial minority did not think such a document existed. However, the absence of formal policy did not necessarily indicate an absence of support for schools, as some of these local authorities provided evidence of extensive guidance.

The extent of the guidance offered by local authorities varied, with some detailing what should be taught (and when, and how) as well as providing teaching resources. Others offered less prescriptive guidelines, while some simply referred schools to national guidelines, leaving the responsibility for curriculum planning to each school.

There was little evidence of guidance towards an understanding of the diverse needs of different groups of pupils.

Denominational schools, while bound by national guidelines, looked to, for example, the Scottish Catholic Education Service (SCES) for guidance and, in some cases, the local diocese was also active in producing guidance. This led to a consistency of approach on content.

By contrast, non-denominational schools sought guidance from a range of sources in addition to their local authority including, most commonly, the Scottish Government, and Learning and Teaching Scotland. Schools appeared to welcome and actively seek guidance on SRE.
3. Training and support of staff

Eighteen local authority representatives (out of 31 who responded) made reference to low levels of teacher confidence in delivering SRE and cited the subject matter as an area of difficulty, indicating a widespread need for staff training. However, the availability of SRE training for primary school staff was patchy across the country, with some local authorities more active than others. In some cases training had reduced in recent years. Local authority questionnaire responses indicated widespread problems with the provision of training, mainly associated with logistics such as: cost, time, availability of staff, issues of staff cover, distance of travel (cited by rural local authorities), and competing curricular priorities. Some also mentioned the reluctance of teachers to engage with the topic – the introduction of the health and wellbeing outcomes through Curriculum for Excellence should help address this latter issue.

Equally the school responses indicated a variable level of training, with 42% reporting some level of staff training (although perhaps only one or two members from the school complement), one quarter (24%) had no SRE trained staff, and in 52% of schools the staff currently responsible for SRE delivery were not trained.

In the case studies, where staff had received training, they reported a positive impact on their understanding of the issues facing young people and an increased confidence in their ability to deliver SRE.

4. Partnership with parents/carers

At a strategic level, only two local authorities reported parental input to policymaking. The majority encouraged schools to provide parents/carers with written information about the SRE curriculum and/or input at parents/carers evenings. It was less common to encourage parents/carers to take an active role in curriculum planning.

In keeping with this approach, the school questionnaire indicated that 79% of schools sent information to parents/carers, 69% invited them to contact the school if they wished to discuss SRE, and half (51%) hosted SRE events for parents/carers.

However, the case studies demonstrated that engaging with parents/carers on this topic is not straightforward as meetings with parents/carers were often poorly attended. Hence it was not easy to gauge parental opinion, and schools remained wary of potential/perceived difficulties. In reality, parental complaint was rare and, where parents were involved, their initial fears went unrealised.

Those parents/carers who were interviewed as part of the case studies reported a variety of views about the school’s role and their own role in SRE, and about the type of information that should be covered. Some looked to the school to take the main responsibility for SRE, some felt it was their own role, while others viewed it as a shared undertaking.
5. Interagency working

Collaboration with health boards was the most common form of interagency working. At a strategic level, health boards had a role in the drafting of policy in all local authorities where a policy existed.

The delivery of SRE in the upper stages of primary school was widely supported by an input from the school nurse (although not universally). The case studies revealed a high level of trust in the school nurses among teachers, pupils and parents/carers. The school nurses interviewed placed a high value on SRE.

Staffing shortages in the NHS, coupled with competing demands for school nurse time, e.g. immunisation programmes, meant that existing staff were thinly spread and there was no cover for absent school nurses.

6. Teaching and learning

Although some local authorities provided SRE materials and curricular guidance, there was little direct pedagogical advice, other than the occasional mention of discussion. The literature review offered some insights into ‘what works’, albeit in secondary school children.

Current approaches to general teaching and learning in primary schools in Scotland have an emphasis on pupils as active contributors and a leaning towards project-based group work. However, SRE knowledge is bound by what is deemed ‘stage appropriate’ and much teaching is designed to protect pupils from too much knowledge at too early an age – which can be problematic when there are different experiences and levels of knowledge within the class.
7. What should be included in the primary school curriculum?

The school questionnaire responses consistently supported the inclusion of factual information about personal hygiene, puberty and reproduction within the primary school curriculum. The need to locate the topic within respectful and trusting relationships, and self-respect, was emphasised. It was widely acknowledged that young people should enter adolescence with sufficient information to be able to keep them safe while, at the same time, enabling them to make informed choices. However, the responses to questions about topics such as contraception, sexually transmitted infections (STIs), gender stereotypes and discrimination elicited a wide variation in opinions from school staff as to whether they should or should not be included, and whether they should be discussed in class if raised by the children. Notably, denominational schools predominantly expressed views that contraception should not be discussed even if raised by pupils (76%), and 70.6% were unwilling to discuss STIs – both of these are considered by the ‘Called to Love’ programme developed for use in denominational schools.

Overall, the questionnaires and the case studies agree with the literature that teachers were more likely to discuss factual questions but were less comfortable with questions which (a) required a value judgment or (b) the curriculum did not deem ‘age/stage appropriate’.
8. Children’s perspective

In common with the findings in the literature, the study of young people’s perspectives generally evoked responses that were largely around the sex education classes of the upper stages. When prompted, the children could remember other aspects of SRE, such as health promotion and anti-bullying events, but had little understanding of the role of the informal curriculum in developing positive relationships.

The children had experienced a range of teaching methods and identified the value of different approaches. For example, an opportunity to raise questions privately in class (e.g. through individual written work or anonymous question boxes) was seen to be important, alongside more public whole-class approaches.

Pupils valued open and honest discussions around SRE and needed to be confident that their comments and questions would be treated sensitively.

A repeating theme raised by girls was the desire for some time spent in female-only groups to discuss their developing bodies without the presence of male participants. A small number of boys raised the issue that they received their education from female teachers or school nurses. While they respected their knowledge base, they doubted whether they really understood how boys felt about SRE issues.
Conclusion

The review of SRE in primary schools highlighted many common issues. Despite a firm case being made by the literature for introducing SRE in primary schools, there was some evidence of fears about perceived opposition from pressure groups. Although SRE teaching was widespread, it was not universal or consistent. The majority of local authority participants were aware of a formal written local authority policy – the absence of a policy did not necessarily mean there was no guidance. The extent of the guidance offered varied greatly, with some local authorities providing detailed guidance and others leaving responsibility with the school. There is a definite need for training to be provided to staff delivering SRE to enable them to do this effectively and with confidence. In order for staff to feel confident in the delivery of SRE, partnership working with parents/carers needs to improve. Case studies showed that schools initial fears about parental complaint went unrealised. The most common form of interagency working was collaboration with health boards, however, staffing shortages in the NHS, coupled with competing demands for school nurse time meant that existing staff were thinly spread and there was insufficient cover available. SRE knowledge is bound by what is deemed ‘stage appropriate’ and much teaching is designed to protect pupils from too much knowledge at too early an age, which can be problematic. When prompted, children could remember aspects of SRE such as health promotion and anti-bullying, but had little understanding of the role of the informal curriculum in developing positive relationships. Pupils valued open and honest discussions around SRE, but needed to be confident that their comments and questions would be treated sensitively.

Find out more

Supporting children and young people’s learning about sex and relationships is available at www.healthscotland.com

NHS Health Scotland’s Education Programme supports and facilitates health and wellbeing in Scottish schools. It produces resources and training programmes, commissions research, and works in partnership with a wide range of agencies to strategically link policy, evidence and practice. Visit www.healthscotland.com

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NHS Health Scotland is Scotland’s national health improvement agency. It works with organisations and individuals to take action to improve the health and wellbeing of everyone living in Scotland and to reduce health inequalities. It works with a wide range of partners in the public and private sectors, nationally and internationally.
Next steps

In disseminating the findings of this research, NHS Health Scotland anticipates that it will contribute to the ongoing debate around the key components of effective sex and relationships education in the school context. In particular, it will inform the ongoing implementation of national policy such as Respect and Responsibility, the Early Years Framework and the achievement of the health and wellbeing experiences and outcomes of Curriculum for Excellence.

The full report is available to download from: www.healthscotland.com

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