Factors For Success in Conducting Effective Sexual Health and Relationships Education with Young People in Schools: a Literature Review

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Conducting Effective Sexual Health and Relationships Education with Young People in Schools - Factors for Success
A Literature Review

In recent years one of the major challenges facing educators has been providing education programs to assist young people to gain the knowledge, skills and understanding they need to optimise their sexual health. For many years 'sex education' focused on the human reproductive system and urged sexual abstinence on young people. In recent years the concepts of sexual health and sexual health promotion has started to replace this kind of program, and in Australia and many other western countries, schools have become the primary site for programs to promote sexual health for young people.

Sexual health is defined by the World Health Organization as

> "the integration of the physical, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love . . . every person has a right to receive sexual information and to consider accepting sexual relationships for pleasure as well as for procreation" (World Health Organisation 1975).

The Olin Health Centre at the University of Michigan takes this definition further and suggests that:

> The development of sexual health is a lifelong process of acquiring information and forming values, beliefs and attitudes about identity, relationships, and intimacy. It encompasses sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image and gender roles. Sexual health encompasses the biological, sociocultural, psychological, and spiritual dimensions of sexuality from the cognitive domain, the affective domain, and the behavioural domain, including the skills to communicate effectively and make responsible decisions (Olin Health Centre 2001).

The aim of the SHine Sexual Health and Relationships (SHARE) project is to "improve the sexual health, safety and well-being of young South Australians by

running sexual health and relationships education programs over a three year period with young people in years 8, 9 and 10 in selected secondary schools". To inform the SHARE program, this literature review will focus on two questions:

1. What are the critical factors for success that have been identified for effective sexual health and relationships education with young people in schools?

2. Is there any evidence that a whole schools approach to relationships and sexual health has a positive impact on issues such as teenage pregnancy, STIs, homophobic harassment and sexual coercion/assault?

CRITICAL FACTORS FOR SUCCESS

A number of authors have attempted to identify the factors that are critical to success in sex education programs. A 1996 project to develop a strategic plan for HIV, sexually transmitted infections (STI) and blood borne virus (BBV) prevention education in secondary schools in Australia included an extensive review of literature, as well as a nation-wide consultation with experts in the field. Ollis (1996) suggests a framework for the development of a comprehensive program in STI prevention education with five key elements:

- Taking a whole school approach and developing partnerships;
- Acknowledging that young people are sexual beings;
- Acknowledging and catering for the diversity of all students;
- Providing an appropriate and comprehensive curriculum context;
- Acknowledging the professional development and training needs of the school community (Ollis 1996).

Ollis' five elements are supported by Gourlay (1996), who sought to identify and document the critical factors for successful sex-education programs and suggests ten interconnected features for planned and effective outcomes:

- Showing an acceptance of adolescent sexuality.
- Adopting a multi-dimensional approach to sexuality and sexuality education.
- Avoiding making generalisations about adolescents.
- Adopting a developmental-based approach to curricula.

- Ensuring programs are gender inclusive.
- Incorporating peer education strategies.
- Introducing sexuality education early.
- Involving parents and the community.
- Providing sexuality educators with adequate training and support.
- Working at a systems level as well as an individual level (Gourlay 1996).

This review will focus on the elements for success in teaching sexual health identified by Ollis and Gourlay, and explore relevant Australian and international literature that addresses the critical factors for success in teaching sexual health, including curriculum content, personnel and the efficacy of the whole school approach to sexual health education.

Young people are sexual beings

Gourlay (1994) argued that it is essential for educators to realistically acknowledge that young people are sexual beings, and that their sexuality will inevitably find expression, not only in how they act, but also in how they think and feel. Ample evidence exists to demonstrate that young people are sexual beings from a very early age, and that increasingly they are becoming sexually active from early in their adolescence. In a national survey of Australian secondary school students, by year 10, the majority were found to be sexually active in some way. Eighty percent participated in deep kissing, 67% had genital contact, 45.5% gave or received oral sex and 25% had experienced vaginal intercourse. By year 12, just over half had experienced vaginal intercourse (Smith, Agius et al., 2003). In the United Kingdom a population based survey found that 30% of young men and 26% of young women aged 16 to 19 reported their first heterosexual intercourse occurring before age 16 (Starkman 2002).

A 2001 study in New Zealand explored the gap between what young people aged 17 – 19 learned in sexuality education and what they do in practice. This study reported that the participants gained information about sexuality in two ways, from sexuality education, and from personal sexual experience. The types of sexual knowledge

young people were most interested in, and which they identified as lacking in sexuality education, centred on a 'discourse of erotics' (Allen 2001). Thus a critical factor for the success of any program promoting sexual health is to acknowledge that young people are sexual beings, and that the majority of them will be sexually active in some way; to ensure that the content of any program is appropriate to the needs and interests of the entire group, including those who are, and those who are not sexually active. Ollis (1996) and Gourlay (1996) both identify the importance of any program taking a positive and accepting approach to the sexuality of young people.

Teaching Sexual Health

The Learning Environment

While the content of school-based sexual health education is vitally important, the context in which such education is delivered is equally important. Sexual health curriculum content is vastly different from other school subjects and both the environment and the approach of those teaching sexual health programs need special preparation and attention. Buston, Wight et al. (2002) suggest that teachers need to be approachable, that students should be able to ask explicit questions, including those about the physical aspects of sex. Furthermore, students should be able to make comments that are not dismissed by the teacher. Wight (1993) identified four interrelated processes that work to reduce students' discomfort in the classroom setting. These include the teacher as protector and friend, that there should be a climate of trust fostered between students and that the program should be seen as fun.

Wight (1993) argues that students should receive sex education in familiar class groupings, that the teacher should, ideally, attempt to minimise disruptions, and that they should work towards eliminating hurtful humour while maintaining an approachable manner.

Personal qualities and staff selection

Those involved in teaching sexual health programs need to have a number of personal qualities if they are able to work effectively in this area. (Bowden 2003) argue that the most important element in a successful human sexuality program may not be the material, but the classroom teacher. Teachers' attitudes are identified as influential in the success of any program they present, however these authors argue that evaluations of specific curricula tend to concentrate not on teacher qualities but on the program components, reliability, validity and outcomes. They assert that teacher characteristics, attitudes, conceptions of self, and intellectual and interpersonal dispositions can influence both the explicit and the hidden curriculum in the classroom.

According to (Hillier 1996)) young people lack positive, realistic and candid models that they are able to draw from as they begin to develop their own sexual identities. Wight (1993) argues that when schools decide who should deliver sex education it is more important to select teachers who feel comfortable with sex education, and have the requisite skills to deliver it, than selecting who will teach in the subject based on 'timetable' provisions or other constraints; teachers who are uncomfortable with discussing sexuality with students convey this attitude to their students. Given Hillier's assertion that young people need role models who are positive, realistic and candid, teaching about an area that creates personal discomfort is clearly inappropriate.

Peer education and peer support

Benefit has been demonstrated in sexuality education programs that involve adolescent 'peer leaders'. The authors of a study that investigated the efficacy of peer leaders suggest that they should be drawn from the school community and exercise an ability to influence the behaviour of others 'irrespective of adult wishes or norms'. Providing that the peer leaders chosen are those approved of by teachers and school administrators, this study indicates that they can play an important role in influencing how other students respond to health-related curricula (Carter 1999).

In the United Kingdom researchers found that if education programs are to do more than merely inform they must be resourced to include peer led interventions and skills training (Bellingham and Gillies 1993). (Mellanby, Phelps et al. 1995) also advocate peer led interventions as part of an effective HIV/AIDS education program. Their study examined an intervention that included medical and peer led training in various Devon (UK) secondary schools. They concluded that school sex education that includes specific targeted methods with the direct use of peers can produce behavioural changes that lead to health benefits.

Curriculum

(McGrane 1993) argues that in order to empower young people to be responsible for their own sexual health, sexuality and relationship education programs are needed. This author recommends that such programs focus on providing a forum for discussion of ideas about sexuality, promote respect for differences and the views and values of others, as well as promote a positive view of one's own body and sexuality. This view of sex education as a forum where respect and positive views are promoted is at variance with the traditional sex education class, which has mainly focused on providing information about reproduction and disease transmission and a number of authors posit that information alone is not sufficient to ensure safe and responsible sexual behaviour. (Smith, Kippax et al. 2000) argue that that school-based programs and activities need to go beyond infection transmission and knowledge about reproduction to focus on sexual health in its social context. They suggest that this may include such areas as assertiveness development, values clarification and negotiation skills. Furthermore, programs must be appropriate and comprehensive and cater to the diversity of students. This suggests that teachers should be aware that not all students will be heterosexual, that some will already be sexually active and others will have decided to delay becoming sexually active, that a range of cultural backgrounds will be represented and that sexuality is constructed differently for young women and young men.

Inclusive Curricula

Sexual health programs must be delivered in a manner that is culturally and socially relevant to the lives of all the young people for whom it is intended. This means that

program content must be planned with an awareness of diversity. Accordingly all plans and language should be inclusive of gender, cultural and racial diversity and disability, regardless of the make up of the group, as some groups may be invisible, or prefer not to disclose their presence because of fear of prejudice or discrimination (Flick, 2002).

Gender

Young people's knowledge, attitudes and behaviour about sexuality is strongly gendered, with different understandings, beliefs and behaviours being ascribed as 'appropriate' for young women and young men. The report *Secondary Students and Sexual Health 2002* highlights this and calls for some sexual health education to be gender specific to ensure that young women and men have the knowledge and understanding necessary to ensure that they can make sound decisions and minimise risk (Smith et al. 2003). Because of this gendering, relations between young men and young women can present challenges in the classroom context when teaching about sexual health. Many young people experience discomfort when asked to discuss sexual matters, and this may be particularly so in a mixed gender environment, where they may be reluctant to ask questions or participate actively in lessons (Wight 1993). Buston, Wight et al. (2002) suggest that teachers should try to minimise factors such as gender dynamics which lead to student discomfort and inhibit open discussion.

Teachers and others involved in sexual health education with young people must have a sound understanding about gender issues, and be comfortable about approaching these issues in the classroom context. This understanding will provide the best possible ground work for ensuring that gender issues are addressed in both mixed and single gender groups.

Any sexual health program which ignores the gendered sexual positioning of men and women puts both young men and young women at a disadvantage. Hillier et al. (1999) has stressed the importance of challenging the notion that female sexuality is passive and male sexuality active (for example men penetrate, women are penetrated) in sex education. She argues that such gendered constructions are deeply

embedded in culture and delimit the sexual choices that many women feel are open to them, and if young women are to control and enjoy their own sexuality, they need to be presented with active representations of female sexuality. This representation of female sexuality as passive has resulted in a silence surrounding the female body, and according to Hillier, many young women (particularly those from rural areas) lack a sense of embodied sexuality. This silence has ramifications for sexual health, because in order to practise autonomy and agency in sexual encounters, women need to feel connected to their own bodies and have access to language to express their needs. More generally, she argues that young women need to be given permission to use language to describe their sexuality and pleasure. This will start to redress the dominance of male descriptions of embodied sexual pleasure that proliferate in discourse and culture (Hillier 1999). Other authors have argued that sex education programs should counter the prevailing norm of passive female sexuality, which may prevent women from being "trained into positions of victimization" (Wight 1993). Mitchell, Peart et al. (1996) examined the gendered assumptions behind programs aimed at helping young women to say "no" to sex and suggested that including a positive discourse of desire for young women will help to counterbalance discourses which construct women as victims and focus on how girls can please men.

Research has demonstrated that 'trust' or 'faith' in sexual partners may have become equated with offering a precaution against STIs or pregnancy for young women, which conflicts with the safe sex messages in education programs. It is therefore critical that the discourse of trust, love and romance is included in sex education programs to help students appreciate that students that these concepts are not protective (Hillier 1998).

While a great deal of stress has been placed on young women in the literature, it is becoming increasingly evident that young men are also disadvantaged by the gendered nature of sexuality. Smith et al. (2003) reported that young men in year 10 were more likely than young women to have multiple sexual partners, to participate in casual sex and be drunk or high at their last sexual experience (although this gap appears to be closing). McGrane (1993) posited that young men need to be given permission to experience and express their normal human need for intimacy and

emotional expression without fear of being seen as weak or lacking in masculinity. There is increasing recognition that the social construction of sexuality has harmful outcomes for both young women and young men. In a comparative study in the UK and New Zealand, young people in year 12 were found to invoke a discourse of gender differences to explain male and female sexuality. Young women were found to take the role of gate keepers of heterosexual relations, and to have to negotiate complex and contradictory discourses that cast them as either 'sluts' or 'angels'. Their desire is defined by its absence. Young men saw themselves as unlikely to use protection against pregnancy or STIs because in sexual encounters, their 'hormones' and 'emotions' take over. Young men in both countries were found to believe that they must be vigilant in establishing and maintaining their distinction from homosexuals, mainly accomplished by the pursuit of women. (Hird 2001)

Culture

A number of researchers have explored the relevance of sexual and social cultures to the provision of education. Rosenthal and Moore (1991:25) conducted research into the relationship between knowledge, intentions and behaviours in regard to HIV and adolescents. They concluded that education needs to take place within a framework to which young people feel culturally connected. They suggest that young people may have multiple cultural identities (e.g. the 'student', the 'middle-class conservative adolescent', the 'homeless teenager', the 'disco/club attendee' and the 'church minded youth'), and that all of these groups have an unspoken but persuasive climate of beliefs, attitudes and values which direct their sexual behaviour. They argue that it is the task of the educator to understand these cultures and develop HIV/AIDS education programs which are targeted appropriately. Buzwell, Rosenthal et al. (1992) similarly argue that to provide effective HIV/AIDS education, it is important to first understand that adolescent sexuality is constructed by a range of social factors. For example, constructions and understandings of young people's understanding of such notions as 'virginity', 'fidelity', 'infidelity' and 'faithfulness' need to be unpacked in order to understand what these terms mean and how they affect the ways in which adolescents behave and interact on a sexual level. For example, one area where youth culture and commonly accepted understandings about terminology differ is illustrated by Smith et al. (2002) who

report that while 45.5% of young people surveyed in 2002 engaged in giving or receiving oral sex, they do not consider it to be 'sex'.

Smith (2000) argued that educators must recognise the importance of cultural differences as determined by regions or localities (for example rural and urban students may require differently constructed health messages). These views are summarised by Hillier (1998:28) who conclude that safe-sex education must address the range of young people's sexual concerns, while at the same time providing them with more ways of being safe.

Awareness in of young people from culturally and linguistically diverse backgrounds has also been recognised as significant, although has been the subject of remarkably little research. Rosenthal, Moore et al. (1990) studied adolescents from Anglo-Celtic, Greek, Italian and Chinese backgrounds and emphasize the need for educators to take ethnic and cultural differences into account when planning HIV/AIDS prevention programs. These differences are seen as important so that such young people do not feel that the lessons and messages they receive are not applicable to their culture and, therefore, their lives.

Sexual orientation

Sexuality education curricula must make room for the discussion of sexualities other heterosexuality, because in discourse about sex homosexuality is frequently vilified, demonised or missing, which leaves nowhere for lesbian, gay or bisexual youth to situate themselves other than as absent or abhorrent. This represents a serious concern for sex educators, as such silences and omissions contribute to problems of low self esteem, self loathing and vulnerability to self harming behaviours. Hillier et al. (1999) argued that by ensuring that human sexuality is presented as fluid and multiple, same-sex attraction is kept 'visible' and relevant in the educational program, and lesbian and gay youth will be less likely to disengage from lessons. In a study with rural young people, the authors noted that young people tended to assume heterosexuality as the norm, and penis-vagina sexual intercourse as the pivotal activity in sex. Effective sex education can disrupt these assumptions and

expose students to the diversity of human sexual practices and their concomitant risks in relation to HIV and STIs.

When to introduce sexual health promotion programs

The age at which sexual health education should be delivered to young people remains a controversial matter. Ollis (1996) asserts that sexuality and health promotion programs should be introduced early, prior to students becoming sexually active, ideally in late primary or at the beginning of secondary school and be designed at an age appropriate level for the students. The content of such programs should focus not only on the physiology of sex, but on such notions as intimacy and desire as well.

In Victoria, sex education was mandated for primary school students in 1998. The curriculum for upper primary (9 – 12 year old) students focuses on the biological aspects of reproduction, when it is generally accepted that they may be able to grasp the material at a cognitive level. However, in a study with primary school aged children who were recipients of the Victorian curriculum, (Hay 2001) found that not all students who received this program did grasp the information adequately. According to Hay, this is not a problem with the timing of the introduction of a sexual health curriculum, but a matter that could easily be rectified by changes in pedagogical practices. She argues that unless programs provide a means by which children can conceptualise the dynamic and integrated nature of reproductive biology, they will fail the students.

Given that many students will not receive any sexual health teaching until middle secondary school, that a significant number do not clearly understand the program delivered in primary school and that a considerable proportion of students are sexually active by middle secondary school (Smith et al. 2003), leaving young people inadequately informed between the ages of 12 and 15 may for some have grievous results, and do a serious disservice to others at a time when they most need not only information but a venue in which to explore values and learn skills in communication, assertiveness and negotiation.

A Multi-dimensional approach

It is critical to the success of sexual health programs that the curriculum is multi-dimensional, focusing the domains of knowledge, attitudes and behaviour (Gourlay, 1996; Hillier et al., 1998). This review will examine the literature on each of these domains and argue that sexual health programs that do not address all three are incomplete.

Information/ Knowledge

Gourlay (1996) stresses that 'knowledge alone does not change behaviour'(p. 42) and that behaviour will not be changed by the mere acquisition of knowledge. Hillier et al (1998) argued that beyond the provision of information, consideration needs to be given to the social and gendered meanings that young people attribute to sexuality and sexual behaviour, and how these factors impact upon the rational choices they make. She further suggests that successful sexual health promotion strategies must address the social context in which young people live their lives, including the broad spectrum of concerns facing young people when they become sexually active. Smith (2000) further argued that if HIV/AIDS education is confined within a subject such as science or biology, that the links between HIV/AIDS and broader social concerns are likely to be left unexplored. Indeed where HIV/AIDS is positioned as a 'question' for science, any useful discussion of interpersonal sexual relations may be systematically downplayed. Hillier et al. (1998) suggested that programs which focus exclusively on HIV prevention run the risk of being perceived as irrelevant if they do not acknowledge other perhaps more immediate concerns in the lives of young people.

Sexuality education remains a controversial topic with vigorous debate about whether or not it is appropriate for young people by both its many detractors and supporters. Those opposing sexuality education have accused it of undermining family values, and promoting inappropriate sexual behaviour, and argue that young people should be taught that celibacy is preferable until after marriage (noted in Gourlay, 1995), as a result some programs have promoted abstinence. While abstinence is a certain way of preventing pregnancy and the transmission of infections, it has not been demonstrated to be an effective strategy for many young

people. DiClemete (1998) reported from a US study that after a 17 month follow up, that young people who received an abstinence curriculum were as likely as the control group, who received safer sex education, to become sexually active, and report similar rates of pregnancy and STIs. The young people in this study who received the safer sex program reported less frequent sexual intercourse, which contradicts the belief that sex education increases sexual activity. Christopher (1990) evaluated another teenage pregnancy prevention program, based on abstinence, called 'Just Say No' and discovered that after being exposed to six program sessions espousing abstinence and the need to confine sex to marriage, the only change shown by the 191 participants was an increase in precoital sexual activity. Smith, Kippax and Aggleton (2000) argued against the promotion of abstinence as a valid option to avoid contracting diseases. They pointed out that, morality issues aside, no credible evidence suggests that such an approach works. The casualties of such an approach are the young people who are denied information about how to prevent HIV and STIs in the likely event that a number of them become sexually active.

Attitudes

Attitudes and values are identified by a number of authors as critical to the success of any sexual health program, both in terms of content and the approach of those involved in running programs. This applies equally to the personal attitudes of those teaching the program, their understanding of the values clarification process and their skills as they work with young people to assist them to clarify their own values in relation to sexuality. Ollis (1996) argues that programs should involve values clarification and be taught by skilled, confident teachers with assistance from local health professionals who understand and can complement this conceptual framework.

Harrison et al. (1996) posited that attempts by teachers to adopt a value-neutral stance are doomed to failure. They argued that that teacher values and attitudes are invariably imparted to students through spoken languages as well as through silences, body language, and role modelling (p. 69). According to Harrison et al. values transmitted through the curriculum hinge as much on what is written and said, as what is not written and not said. The authors propose that teachers should 'work

to create a safe environment for their students and themselves …. one in which they can talk about not only what is safe, but what is pleasurable/desirable for all their students' (p. 81). Fine (1988) argues that to promote the development of sexual responsibility among young people, anti-sex rhetoric should be avoided. She suggests that young people are entitled to a discussion of desire rather than being exposed to anti-sex rhetoric, which may be remote from their own feelings and may alienate them from what is being taught. Hillier, Harrison et al. (1998) also take this position, arguing that in the curriculum, sex for pleasure should to sit alongside sex for reproduction as a valid reason for engaging in sex.

Behaviour

Perhaps the most controversial area of sex health education is that of behaviour. A persistent fear that is voiced about sexual health promotion suggests that providing young people with knowledge about sexuality will lead to increased sexual behaviour, unplanned pregnancy and exposure to disease. An evaluation of a sexual health and relationships education program in Scotland found that while there were no differences in sexual activity or sexual risk taking between the intervention group and the control group by the age of 16, those in the intervention group reported less regret at first and most recent intercourse. Students evaluated the intervention program more positively and their knowledge of sexual health improved (Wight 2002). Another study that investigated sex education programs that included promotion and distribution of condoms as a major component of the curriculum, found that this did not lead to an increase in sexual activity among adolescents (Sellers, McGraw et al. 1994).

One of the major concerns expressed about discussing sexual behaviour and acknowledging that some students are sexually active, is that of increased risk. Many adolescents perceive themselves as invulnerable to the threat of HIV/AIDS and continue to engage in unsafe sexual practices Moore and Rosenthal (1991a). These authors suggest that it is critical for educational programs to discuss issues related to risk taking behaviour and perceptions of safety. For example, students should be made aware that risk taking behaviours expose people to the possibility of HIV infection, not sexual identity. Misconceptions and myths about HIV/ AIDS only

affecting people they view as different to them must be challenged (1991a: 178). In a follow up study, (Moore and Rosenthal 1991b) stress that education programs and interventions often under-estimate young people's ability to make realistic judgements about risk, and consequently overstate the dangers of behaviours considered undesirable. The danger is that such tactics can lead to young people rejecting the total content of the message, instead of engaging in the rational decision making process of deciding which parts of the message have greatest personal relevance.

Sex education programs are more likely to influence behaviour if they are narrowly focused on behaviours, have a clear behavioural message and develop student's negotiation skills (Wight, Raab et al. 2002). Kirby and Alter (1980) concluded that sex-education programs are different from other high-school courses because, in addition to imparting knowledge, they seek to change behaviours. They argue that it is: 'vital to the effectiveness of school-based education that teachers adopt strategies which allow knowledge and skills to be generalized to appropriate human relations' situations'.

Sexuality education programs must also address interpersonal and communication skills. This will empower students to negotiate sexual intimacy more effectively and Wight (1993) argues that this will help young women avoid and resist unwanted sexual experiences. Sikkema, Winett et al. (1995) also emphasise the importance of imparting assertiveness skills to young women. They devised an AIDS education and prevention education strategy that focused on sexual assertiveness skills and the reduction of risk related behaviours, which was designed and evaluated in comparison with an 'education-only' program. They found that skills training participants compared to education-only participants, scored higher on sexual assertiveness skills.

A WHOLE SCHOOL APPROACH

A whole school approach has been advocated for wide variety of educational applications, and practiced in a wide variety of education programs to address social

issues, including anti-bullying and anti-violence programs, health promotion and mental health promotion strategies in schools. In spite of this there appear to be surprisingly few references that refer to the whole school approach for sexual health programs. When referring to the whole school approach definitions are either absent or unclear, and each reference appears to define the concept differently, although many share the same principles. A web search for programs using a whole school approach revealed the following definitions

> The whole school approach is … the involvement of all teachers with the potential to deliver sexual health education (Health Education Board of Scotland 2002).

> Whole-school approaches seek to engage all key learning areas, all year levels and the wider community. They include many aspects of school life, such as curriculum, culture, teaching practices, policies and procedures (Queensland Government 2003).

A search of the AUSTROM (Education) data base showed 137 records relating to a whole school approach, however only one related to sexuality education. It is apparent from both the data base and web search that in general, the term whole school approach refers to cross curricula integration of a subject within a school. Some of the layers which can be identified in a whole school approach include the policy domain; curriculum and pedagogical practices; professional development; staff-student relationships; student-student relationships; parent-staff and school community relationships' (Magill 2000). Carter (1999) also argued that for sexual health strategies to be effective, the wider school community needs to be involved, particularly the school parent body; community based strategies optimise the likelihood of successful health education outcomes.

The work of Mitchell, Ollis et al. (2000) in developing a national framework for sexual health promotion in secondary schools in Australia builds on and extends these concepts and defines a whole school approach as being more than the implementation of a formal curriculum. It calls for policy and guidelines to be

developed, implemented and reviewed; consultation and working in partnership with parents, elders and the school community; accessing community resources and involving students. They argue that this is insufficient if policy and guidelines do not support practice. For example anti-discrimination policies should not only be taught, but put into practice throughout the school; programs should be integrated within a formal student welfare support structure so that linking students to community agencies complements education programs.

In attempting to examine the efficacy of the whole school approach to specific social issues such as teenage pregnancy, STIs, homophobic harassment and sexual coercion it is possible to learn both from the experience of using this approach in other related areas such as health promotion and behaviour change programs, as well as from the (limited) literature pertaining to the issues specifically identified. The concept of health promoting schools is relevant to any discussion of a whole school approach, particularly in the context of sexual health promotion.

'Health promoting schools' is defined by the World Health Organisation, as displaying in everything that is said and done in schools providing support for and commitment to enhancing the emotional, social, physical and moral well-being of all members of their school community. In Australia the health promoting schools approach has been widely adopted at a policy level by Governments, and in practice in many school communities. The Health Promoting School framework has been depicted as having overlapping and interconnected domains,

- Curriculum, teaching and learning. This domain includes content, pedagogy, resources and outcomes;
- School organisation, ethos and environment. This domain focuses on school culture, attitudes and values, policies and practices, extracurricular activities and the social and physical environment; and
- Partnerships and services. This domain is concerned with the relationships between school, home and the community.
- The Curriculum Framework recognises the value of this holistic approach to education (Magill 2000)

Marshall, Sheeman et al. (2000) have written extensively about the 'health promoting schools' (HPS) movement and explain its connection to a whole school approach. They stress that any HPS project must develop a whole school approach if it is to be successful. Simply providing curriculum 'that might or might not be supported by broader policies and practices within the school' will not guarantee success (p. 252). However they warn that multiple interpretations of HPS are problematic because broad and flexible approaches could lead to justification of any health-related activity as being health promoting even if 'it failed to adopt a holistic, whole school approach' (p. 252). In concluding their findings, they argued that there is a need to provide training for teachers around the concepts of the HPS, that curriculum documents and topic-specific projects need to be embedded in a whole-school approach, and that greater cooperation is necessary between the health and education sectors, at a national, state and local community level.

In an extensive evaluation of the impact of a co-ordinated whole school approach to health education in 16 pilot and 32 reference schools in Europe, Healy (1998) concluded that such an approach can make 'a positive and tangible contribution' to young people's health. He particularly emphasised that the contribution of welfare staff may greatly enhance the health promotion message, with 'corresponding benefits for the whole school community' (p. 23). The schools in question used the whole school approach to address issues relating to healthy eating, substance misuse, bereavement and grief, and various sex education provisions, although the article does not elaborate on the details of these programs.

Using a whole school approach to combating prejudice and discrimination
Pallotta-Chiaroli (2000) has identified that many students: 'wish to see schools supporting student initiatives in policy, curriculum and school culture that challenge homophobia and heterosexism in ways that are meaningful for students' (p. 38). A three tiered approach encompassing policy, curriculum and school culture clearly adheres to the philosophy of 'whole school' model. Pallotta-Chiarolli argues that a common mistake that schools often make is that they deal with the issue of homophobia, 'an issue about students', without actually involving the students themselves (p. 38). Her research reveals that it is critical to involve students by

soliciting their opinions, given that they are the people affected by homophobic discrimination within the school and wider schools environment. She asserts that many students want to be effective leaders and take on challenges in regard to homophobia and that it is therefore imperative that students be consulted to gauge what their role should be in a whole school approach to homophobia and hetero-normativity. Owens (1999) concurs with this idea, arguing that schools need to encourage and support 'grassroots student tactics'.

The whole-school approach is suggested as a model for addressing discrimination, harassment and vilification in NSW schools. This model involves using a unified approach; the provision of policies and mechanisms to address complaints; including the necessity of dealing with homophobia sensitively; the need to implement programs which assist gay and lesbian students to feel comfortable within the school community; and the need to provide professional development resources to ensure staff fully understand the consequences of homophobic harassment (Gardner 1996).

Whilst Nickson (1996) does not specifically use the term 'whole-school approach' in her article which proposes strategies to combat homophobia, it is clear that such an approach underpins the strategies that she details. She asserts that a holistic and proactive approach is the only effective way for school communities to tackle homophobia, and that as a microcosm of society, schools must stop reinforcing a dominant heterosexist norm and begin to both teach and practice acceptance of sexual and cultural difference. Nickson advocates that change needs to be addressed at an institutional, classroom and curriculum level. She provides detailed and comprehensive suggestions for each of these three 'streams'. The emphasis is that of confronting the existence of homophobia and providing all school members not only with strategies to challenge it, but permission to do so, acknowledging that it is the insidious culture of denying, silencing and ignoring the existence of homophobia that allows it to flourish. Many of the interventions proposed are aligned with simple concepts such as the imperative not to assume heterosexuality and the need to affirm sexual diversity.

Other sources support the benefits of utilising a whole school approach to racist, cultural and homophobic bullying. For example, the Manchester City Council News (2002) reported that an anti-bullying conference held in the city would provide the backdrop for the launch of a new information pack for teachers which provided guidelines for developing anti bullying policies and practices in schools based on a whole school approach.

Hinson (1996) proposes that if schools are to successfully address the problem of physical, verbal, visual or sexual forms of homophobic violence directed against individuals or groups, on the basis of their perceived sexual orientation, then a concerted approach is required across the entire school to effect a cultural change. Hinson stresses that the key to addressing heterosexist harassment is to seek to change specific local, contextual, violence-maintaining practices with the school environment. These include certain kinds of blame attribution, silencing and oppressive constructions of gender and sexuality. These factors typically include the things that people 'do, say and think' which maintain and sanction heterosexist violence. These actions, statements and thoughts which contribute to victim blaming, offender defending and silencing need to be addressed across the school, to disrupt those embedded practices which reflect and reinforce dominant power-relations in class rooms, schools and departments. Hinson also advocates that violence-maintaining practices need to become a central consideration when reforming related policy, guidelines, procedures, behaviour management, curricula, professional development.

Using a whole school approach to prevent bullying and harassment
'The whole school approach emerges strongly through the literature as primary good practice, addressing multiple layers of intervention' (Magill 2000). Magill stresses that it is evident that the success of the whole school approach is based on collaborative contributions from a range of individuals. Furthermore, he argues that to effectively challenge violent cultures, attention must be paid to the whole school climate, and suggests that 'it is very clear in this arena that 'the medium is the message' (p. 140). The whole school approach should be focused on reducing the

inequality gaps in outcomes for students because it addresses the fact that the production of inequality in schools functions a system of violence in its own right.

A whole school based preventative strategy to bullying and harassment was effectively implemented in a Canberra school for students with mild intellectual disabilities. This involved formulating anti-harassment policy initiatives, soliciting parent support, and involving the entire school community in what was termed 'anti-harassment lessons'. Furthermore, the entire school community adopted and enforced school rules designed to create a safe school environment. The perpetrators of harassment and bullying were offered support and counselling rather than be subjected to punishment. Parents were called upon to assist in changing anti-social behaviours (Driscoll 1998). Whilst this paper did not use 'rigorous measures of research', it asserts that: 'anecdotal results of the program suggest that a whole school preventative approach with all students involved in learning about harassment was most worthwhile'. It was also notes that harassment incidents declined after the program was implemented. The authors note that 'commitment to a whole school approach of anti-harassment based on a protective behaviours program is a significant step forward in teaching students about safety and respect for themselves and community members' (p. 10).

The text 'Bullying: A Whole-School Approach' has a practical approach to this issue. The authors set out a clearly defined approach to developing a whole-school approach, providing practical intervention and prevention studies. They provide guidelines for formalising grievance procedures; and developing and implementing an anti-bully policy and suggest ways of putting these approaches into practice. Fifteen lessons that teachers can adapt to their particular school environment are provided (Suckling and Temple 2001).

Using a whole school approach to combat gender-based violence
Based on extensive reviews of the research, and consultation in Australia a comprehensive 'whole of school' approach to the problem of gender-based violence against girls was developed by Ollis and Tomaszewski (1993). These authors advocate that schools need to develop management practices and organisational

structures to promote a culture where any form of violence against women is unacceptable. They detail strategies that intervene at the level of the school, the individual student and teachers. Whilst no empirical data is supplied to substantiate the relative success of such interventions, it is argued that the adoption of whole school approach is imperative if the culture of violence is to be interrupted and diminished. In regard to specific educational approaches, at a whole school level they advocate educating staff and students about the criminal nature of violence and drawing out links between sex-based harassment and violence against girls and women.

A gender and violence project advocated by the Australian Council of State School Organisations (ACSSO) argues that a whole school approach is required to deal with the problem of gender-based violence within schools. The 'No Fear' kit for use by students (in conjunction with a 'parent pack'), is designed to help create a non-violent school community. The benefits of a whole school approach are promoted in his kit, which suggests that 'productive partnerships are an important ingredient in the whole school approach and in groups working together on sensitive and controversial issues' (Beckett, Bode et al. 1995). Partnership strategies include inviting key parent representatives to work on a school 'anti violence' team. This ensures that parents are able to contribute their knowledge, life experiences and insights into violence. The authors stress that such input is 'relevant to the task of teaching and learning' and should not be omitted in attending to a whole school approach to the problem of violence (p. 150).

An analysis of sexual harassment in schools provides some understanding of the levels of resistance to gender reform in schools. In order to bring about gender reform in schools, it is important to think strategically about how to introduce policies in ways which address the investment that both boys and girls have in existing constructions of masculinity and femininity. Unless these power relations are addressed in ways which do not merely redress individual grievances (as sexual harassment policies tend to do), there is little chance to make cultural shifts or provide new subject positions and discourses of masculinity and femininity which will produce significant change. This research suggests that programs which merely

react to specific harassment grievances will not adequately remedy the underlying systemic culture that sees acts of harassment go unchallenged in the school environment on a daily basis (Blackmore, Kenway et al. 1996).

In a US study a whole school approach is advocated by investigators who researched strategies prevent sexual harassment in the classroom and the wider school environment. Several elements are proposed First, plans must be made for 'teachable moments' through the curriculum. Lessons messages 'must travel into the mainstream discourse and into the public arena of the classroom'. Secondly, the entire school community (teachers, administrators, cafeteria workers etc) need staff development to ensure that includes case studies detailing what constitutes harassment and how best to respond to it. Thirdly not punitive, but compassionate responses must be offered to students involved in harassing or abusive interpersonal relationships (Stein 1996).

Using a whole school approach to educate students about STIs.
In a Netherlands study into HIV/STD education, with ninth and tenth grade students at vocational secondary schools, a program based on 'co-operation with students, teachers and gatekeepers within the school' was found to be likely to improve the implementation of the program. The findings from this study suggest that involving the whole-school community in the process of developing curriculum is a desirable objective (Schaalma, Kok et al. 1994). Another study that assessed HIV/AIDS health education programs in Scotland, advocated that schools need to develop policies to achieve good school-parent links in relation to sex education by adhering to a 'whole-school approach' model (Wight 1993). In a later study Wight, Raab et al. (2002) indicated that recent finding from the USA suggest that 'school wide events' and parent education can reduce sexual risk taking.

Using a whole school approach to prevent teenage pregnancy
Reducing the rate of teenage pregnancy has been the target of many sexual health programs around the world. An evaluation of programs that provided sexual health education for young people was carried out by UNAIDS in 1997. Of the 53 studies that evaluated specific interventions, 27 reported that HIV/ AIDS and sexual health

education neither increased or decreased sexual activity, 22 reported a delay in the onset of sexual activity and only 3 found an increase in sexual behaviour associated with sexual health education (Grunseit 1997) In the USA, which has extremely high teenage pregnancy rates, with four in ten teenage girls becoming pregnant while in their teens, there has been a consistent decline in these rates over the past decade. While the reasons for this decline is not entirely understood, a number of sexuality education (and other) programs aimed at reducing these rates were evaluated in 1997, with a follow up in 2001. The author of the study examined the various approaches to reducing teenage pregnancy and concluded that while these programs cannot solve the problem of teenage pregnancy, they are an important part of the answer. In the USA, almost every teenager in the country receives some form of sex education, which can be divided into two broad categories, abstinence only and sex or HIV education. A large body of evaluation research demonstrates clearly that sex education and HIV programs delay sexual activity for some students, and increase responsible sexual behaviour among those who do become sexually active (Kirby 2001).

In his evaluation of sex education programs, Kirby identified that short term curricula do not have a measurable impact on the behaviour of young people, and suggests that effective sexual health education programs share the following characteristics. They:

1. Focus on the behaviours that lead to unintended pregnancy or HIV/ STI infection;
2. Are based on theoretical approaches that have been demonstrated to influence other health related behaviour and identify specific important sexual antecedents to be targeted;
3. Deliver and consistently reinforce a clear message about abstaining from sexual activity/ and or using condoms or other forms of contraception. This appears to be one of the most important characteristics that distinguishes effective from ineffective programs;

4. Provide basic, accurate information about the risks of teen sexual activity and about ways to avoid intercourse or use methods of protection against pregnancy and STIs;

5. Include activities that address social pressures that influence social behaviour;

6. Provide examples of and practice with communication, negotiation and refusal skills;

7. Employ teaching methods designed to involve participants and have them personalise the information;

8. Incorporate behaviour goals, teaching methods and materials that are appropriate to age, sexual experience and culture of the students;

9. Last sufficient length of time (i.e. More than a few hours);

10. Select teachers or peer leaders who believe in the program and then provide them with adequate training.

Kirby's evaluation focuses on more than curricula approaches to sex education, including programs for parents and families, clinic based programs to provide reproductive health care, community wide initiatives that address the social factors that lead to teenage pregnancy including early childhood and youth development programs. However there is no mention of a whole school approach that includes involving students, teachers, parents and the wider community in the planning, delivery and support of sexual health programs.

Indeed, there appears to be a paucity of literature that evaluates a whole school approach for sexual health programs. Web searches identified specific school districts that stated that they utilised 'a whole school approach' to teenage pregnancy. Such programs appear to have been adopted in California (USA), Alberta (Canada), Middlesbrough (UK), Essex (UK), and Aberdeen (Scotland). All of these sources merely noted that a 'whole school approach' was being implemented. There was no evidence of any evaluation of these programs or of their specific content. Nevertheless, given that these programs are reported as having been implemented in the years 2000 to 2001, it would appear that a whole school approach to teenage pregnancy is being widely used across national boundaries.

In spite of the many applications of the whole school approach to a wide variety of education programs there appear to have been few evaluations of the approach. Curtin University evaluated a schools drug education project in Western Australia that used three levels of teacher training in schools implementing the program. Some schools elected to participate in a whole school approach, some in a train the trainer program and others in a regional school drug education network. When this evaluation compared each of the interventions, it found that while schools that received the train the trainer intervention did well on all measures, the schools which received the whole school intervention were more likely to be actively involved in regional drug networks, teachers were significantly more likely to be aware of harm reduction and have higher drug related knowledge than the other groups. In addition the whole school approach schools were more likely to have implemented a school drug related policy and see it as a priority, and to be more successful in involving parents and community in planning and other awareness raising, as well as teaching and learning activities (Cross 2000). However, on outcome measures evaluation of a whole school approach appears to be less successful. Schonfeld (1995) evaluated a whole school anti-smoking strategy and found that program failed to improve smoking behaviour over 2 years. The program was successful in improving smoking knowledge, but not attitudes. Gourlay (1995) argues that it is a mistake to evaluate only the measurable outcomes of sexuality education, and that education can have effects and intrinsic worth beyond its measurable outcomes. He suggests that when young people report positive effects from sexuality education they refer to more diverse outcomes than the obviously measurable behavioural changes. For example self esteem, body awareness, confidence, hope and understanding.

While there is insufficient formal evidence to be able to definitively answer the question seeking evidence that a whole school approach to relationships and sexual health has a positive impact on issues such as teenage pregnancy, STIs, homophobic harassment and sexual coercion/assault, it is clear from anecdotal information and the limited evaluation data that such an approach has a great deal to offer. Clearly there is a need for more programs to be evaluated, particularly programs that aim to promote improved sexual health and behaviour change. It is also apparent that it is

not enough to use rhetoric about a whole school approach without providing understandable definitions to all those who will be involved and training and ongoing support to the staff who will have primary responsibility for the program.

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