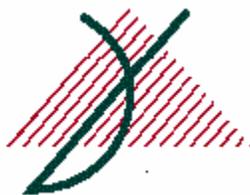


***An Evaluation of the
Sexual Health and Relationships
Education (Share) Project***

2003 – 2005

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Australian Research Centre In Sex, Health and Society

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Commissioned by Shine SA



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Summary of Key Findings

The Project

La Trobe University was commissioned in 2002 to evaluate the Sexual Health and Relationships Education (Share) Program, to be introduced by Shine SA into fifteen schools in South Australia, in 2003. The goal of the Share program, over three years, was to improve the sexual health, safety and well-being of young South Australians. The targets for the intervention were fourfold: students, parents and families, teachers and school staff and school ethos/ environment. A mixture of quantitative and qualitative methods was employed to carry out the evaluation.

Young people

Indicators of change in knowledge, attitudes and behaviour are notoriously difficult to measure in the complex, social domain represented by sexuality, and surveying the students before and after the intervention was fraught with difficulty. Therefore results in relation to young people must be viewed with caution.

In relation to the objective to increase knowledge and understanding about sex and sexual health, and to practise safety in all aspects of sexual relationships, we observed only small changes after the Share intervention. Students were able to name correctly a greater range of STIs and showed a slight improvement in confidence that they would not be infected with an STI. They appeared overall to have a slightly improved understanding of STI prevention and to be slightly more confident that they could say no to unwanted sex. There was no change in the small number of students who were the “risk takers” having casual sex, often under the influence of drugs and alcohol. These relatively small gains should not be discounted and are more likely to indicate unrealistic expectations rather than a fault with the program. For the two thirds of students who were not sexually active STI knowledge may appear as of no relevance at the time it is being taught. This does not

mean that the information is of no use as lessons relating to STIs also teach skills enabling them to find this information in the future when it does become necessary. The importance of current relevance to students is born out by the much greater knowledge (improved after exposure to the Share Program) that students had about puberty which is an issue highly relevant to them all. Despite the fact that increased knowledge was not observed in all areas it is still considered worthwhile to teach across all domains which the program currently covers.

The ability to know where and how to access the information when it is needed, as well as skills in critical thinking and decision making and values clarification (as opposed to teaching specific values) are vital components of any sexual health and relationships program. These are skills covered in the Share program. Those students who do not need the information when it is taught may benefit from it in the future. While most students use their peers as a common source of sexual health information, well over half the students nominated school programs as having value in this area.

In responding to such questions as “what does sex mean to you?” references made to such values and qualities as love, respect, communication and consent demonstrates that many students have positive attitudes towards sex and to each other. More disturbing was the fact that many of these responses were strongly gendered and this improved only marginally after exposure to the program. Thus there remains ongoing evidence of the need to teach about gender and power in relation to sexual health as the Share program does.

It is encouraging to note that while actual parent/ child communication had not changed dramatically as a result of the program, students indicated a greater degree of confidence that they could talk with their parents about sex and relationships if the need arose. Parent/ child communication will not change by only addressing one side of the equation. The student’s responses to questions in the survey about communicating with parents and who initiates the communication, demonstrates that work with parents in this area is much needed.

A clear finding from the results of the surveys is that the predictions of those who opposed the implementation of the program have not been borne out. Those who felt that exposure to an intervention such as the Share Program would lead to greater sexual activity, less responsible behaviour and taking sexual matters out of the hands of parents were proven wrong. This did not occur. Indeed, many students' responses indicate thoughtful consideration and an understanding about sex and love as an area in which responsibility and respect are important, and in which parents have a role as educators and advisors.

School Staff

Key informant interviews were carried out with staff in both Share and non-Share schools. In general, the staff involved in teaching and supporting the Share program in schools indicated that they had been well supported by Shine SA, and an increase in comfort and confidence was observable as the project progressed. This was not only in the classroom, but in attempts to make the school environment safer and more accessible for all. Increased visibility for sexual health matters in Share schools was observed with creative approaches such as "health rooms" and "information points" for all students being tried. Early in the program, some staff expressed uncertainty concerning their capacity to teach sex-education; it was apparent that the Shine SA training made a difference to this, and was valued by school staff. It is also apparent from some of the teachers' comments that the controversy that surrounded the implementation of the Share program impacted on their confidence to teach, as well as on them personally.

Overall, in relation to the stated aims of the project in relation to school staff, some gains can be seen. Key elements identified by the co-ordinators for the success of the program in schools include: leadership from the school administration, faculty support for the program, and the presence of a committed key teacher who drives the program and supports other staff as they deliver it. The co-ordinators observed that in schools where any of these elements were lacking, the program was less successful.

School Environment

To assess progress in changing the school environment to a more supportive one, data were gathered from school staff, Share Co-ordinators and from students via the survey.

Almost no change was noted in the students' responses to questions about school environment between the 2003 and 2005 surveys. However, from the key informant interviews and the co-ordinator workshops, it is apparent that a great deal was done in schools to address the project objectives concerning the school environment. While the survey did not demonstrate that the work done to change the school environment had reached a large proportion of the students, it may be of no particular significance. For example, some students may not be aware of the existence of school counsellors, or the services they offer, because they have no need for them. Their greater visibility will undoubtedly be of value if and when they are required.

Interviews indicated that between 2003 and 2005, schools were making real efforts across the board to address issues of diversity, including their incorporation in the wider curriculum. Schools organised health days for year 12 groups, implemented peer education initiatives and ran parent information nights.

It is clear that the Share co-ordinators played a critical role in driving and supporting these initiatives. Sexual health and relationships education is an area that has been fraught for many years, with a wide variety of community attitudes about what is right, what should be taught and by whom. Schools rightly approach it with caution. The provision of well-resourced, sympathetic 'experts' available to support, guide and advise, was a valuable resource which schools strongly appreciated.

Parents/ Families

No direct contact was made with families for the evaluation. Data concerning these issues were collected in the Co-ordinator workshops and the student surveys. Students reported increased confidence to talk with their parents following exposure to the Share program,

despite the fact that no increase was seen in the frequency with which they actually talked with them in the survey period. This can be seen as a promising finding for the future.

Attempts to involve parents in health and wellbeing committees were largely unsuccessful. A number of problems arose with school timetables that made parent involvement difficult, and parent availability conflicted with student availability in some cases. Parent attendance at information evenings was high during the 2003 controversy but dropped off as the program progressed. This fact combined with the high numbers of parents who consented to their children attending the program can be seen as indicating confidence in the school run appropriate programs.

Recommendation

The Share program has demonstrably not harmed the students who participated in it and appears to have offered them some benefits. The long term value of such benefits cannot be adequately assessed by an evaluation which is as time-limited as this one. There have been clear benefits to the schools and teachers as a result of the Share training and the support of Share coordinators. There remain strong indications in the student data for the need to continue with education in those areas such as safe and respectful sexual behaviour, gender and power and accepting diversity, all of which are covered by the Share program. It is therefore recommended that the program be continued and expanded to allow all secondary schools in South Australia to have access to these benefits.

1. Introduction

Project Aims

La Trobe University was commissioned in 2002 to evaluate the Sexual Health and Relationships Education (Share) Program, to be introduced by SHine SA into fifteen schools in South Australia, in 2003. The goal of the Share program, over three years, was to improve the sexual health, safety and well-being of young South Australians. The targets for the intervention were fourfold: students, parents and families, teachers and school staff and school ethos/ environment. The stated objectives of the project focused on these four domains, and included:

For young people to:

- have increased knowledge and understanding about relationships, sex and sexual health;
- have increased understanding of, and the ability to practice safety in all aspects of sexual relationships with confidence;
- know about and feel comfortable accessing a range of services and people for support;
- have increased skills to enable them to establish and maintain respectful positive relationships;
- develop positive attitudes and behaviour relating to sexual health, relationships (including sexual, cultural and physical diversity).

For parents and families to:

- have increased knowledge and understanding concerning relationships, sex and sexual health;
- increase communication about sexual health issues between young people and their families.

For school staff to:

- have increase knowledge and understanding about young people's relationships, sex and sexual health;

- have increased competence and confidence to deliver the Share program;
- develop partnerships with the community in order to improve links with, and access for young people to youth health and general health services;
- develop positive attitudes and behaviour relating to sexual health, relationships.

School Environment

- To ensure that schools have a commitment to addressing relationships and sexual health issues in the whole school environment;
- To develop positive attitudes and behaviour that are inclusive and respectful of diversity.

The goal of the evaluation was to develop a deeper understanding about the relevance and impact of the Share Program, and to identify the extent to which the Program achieved its stated objectives in the four domains identified in the project plans.

Methodology

In designing the research methods for this evaluation, a number of different approaches were used, with a view to approaching the object in a creative and innovative manner. The Share program was introduced in fifteen schools in South Australia. However this evaluation initially focused on three schools where the program was being taught (*intervention schools*) and three comparable schools where no Share Program was introduced (*control schools*). This represented one intervention and one control school from each of the three regions where the Share Program was introduced. Because of the nature of the project, and the complexity of the object being evaluated, both qualitative and quantitative methodologies were used. The effect of the Share curriculum with students was evaluated using a questionnaire-based survey, and those areas of the project that addressed school ethos and staff changes were evaluated through interviews with key informants in schools. As the role of the project co-ordinators was critical to the overall implementation of the project, their observations of the processes involved in planning and implementing the project were elicited in a series of three annual workshops.

Qualitative Methods

Key Informant Interviews

Key informant interviews with key school staff sought to establish a richer understanding about the ways in which the project supported teachers, influenced the school environment, and encouraged the development of linkages between schools and relevant community agencies and services. The key informants were identified from three intervention schools and three control schools by the SHine SA co-ordinators, in consultation with the school staff. An interview schedule was developed by the La Trobe University evaluation team, and semi-structured interviews were then carried out over the telephone. A copy of the interview schedule is appended to this report. The intention was to interview key informants prior to the implementation of the program, in the middle and at the end. This proved somewhat problematic. Due to delays in implementing the project, by the time key informant interviews commenced it was late in the school year and some difficulty was experienced in contacting the key informants for interviews. As a result, in 2003/ 2004, in the three intervention schools, a total of ten interviews were achieved of a potential 26 who consented to be interviewed. The problems experienced in contacting school staff for key informant interviews did not change in the next round of interviews. In 2005 five interviews were achieved from a potential nine key informants who were still at the intervention schools and willing to be interviewed a second time.

Co-ordinator Workshops

Prior to the commencement of the project, the Share Project co-ordinators, the Project Manager and the SHine SA Coordinator of Teacher Education attended a one day workshop to map the project objectives and activities and to identify performance indicators and measures for the evaluation. This was followed by three further one day workshops with the project co-ordinators and the project evaluator, which were held early in 2004, 2005 and 2006. The objective for these workshops was to discuss the project co-ordinators experiences and observations in the past year, against the stated project objectives, indicators and measures identified at the first workshop late in 2002.

Quantitative methods

Questionnaires

As the Share curriculum was the main direct intervention with students, a questionnaire was developed to gauge any change in knowledge, understanding, behaviour, or attitudes. It was administered at the baseline, and again after the curriculum had been delivered three times. It involved students who were in the year 8, 9 and in 2003, and in years 10 and 11 in 2005.

Administering the survey proved problematic. The SA Department of Education & Children's Services required active parental consent, both for student participation in the Share classes, and for the evaluation questionnaire. Active parental consent is not normally required for health education classes in schools, which regularly include sexual health information. Student participation in the survey was somewhat limited as a result: many of the consent forms that were sent home with students were not returned. It is impossible to ascertain whether this was because parents did not see them, or they were reluctant to sign, or whether the signed consent forms were not returned by students. A number of students returned questionnaires containing too little information to be included (for example just their name) and these were rejected on the basis that there was too little information to make them useful. It may be that some students experienced survey fatigue, as they appear to have been asked to complete a number of different surveys during the year. This kind of evaluation requires exam like conditions, teacher supervision and a time commitment from both students and staff. This can be problematic in an environment that carries out many surveys.

The original intention had been to administer the questionnaires prior to the implementation of the Share Project to establish baseline data, and then to administer it again at the end of the second and third years of the project. Given a number of difficulties experienced in the first administration of survey, it was decided that the year 8 and 9 students would be surveyed once more at the end of the third year of the project in 2005, when they would be in years 10 and 11. The students who were in year 10 in 2003 were only surveyed once. Problems emerged with the administration of the questionnaire

in control schools in the second round, when very small numbers of completed questionnaires were returned. Therefore in the final analysis, the control school data were not used.

Two questionnaires were utilised, one for the junior group in years 8 and 9, and a slightly different one for the senior students in year 10. In this report we present a ‘snapshot’ of the students’ knowledge, behaviour and attitudes in 2003, before they were exposed to the Share Program. We then compare this with the students who were exposed to 2 or 3 years of the Share program. Most of the data from the student questionnaires will be discussed under the headings Knowledge, Behaviour and Attitudes (Chapter 2). The section of the students’ questionnaire that applied to the school ethos/environment will be discussed under that heading (Chapter 4.2), and the one that applied to parents and family, will be discussed in Chapter 5.

Ethical Considerations

Ethics approval for the Share Project has involved two separate bodies, La Trobe University and the Department of Education and Children’s Services in South Australia. After formal ethics approval was obtained, consent was sought from schools as well as from the parents to survey the students, and finally from the students themselves. For the key informant interviews, consent was first obtained from the school, and then from the staff who were identified as key informants by the Project Co-ordinators. The project co-ordinators were signed on as external researchers, which authorised them to obtain informed consent from the school staff in the key informant interviews. Signed informed consent forms were then passed on to the evaluation team at La Trobe University. As there was the potential for key informants to be identifiable by their role, this was made clear to all involved prior to interviews being carried out. As far as possible every attempt was made to ensure that the anonymity of key informants has been protected, and those who consented to contribute were offered the opportunity to withdraw at any time.

Reading this report

The findings of this evaluation are arranged according to the target groups identified by SHine SA in their project plans: Young People, School Staff, School Ethos and

Environment and Parents and Families. Each section specifies the objectives identified for the target group, presents the available evidence and identifies and discusses the main issues emerging.

2. Findings: Young People

Through the introduction of the Share curriculum, over a three year period, the project set out to bring about the following changes in students:

- increased knowledge and understanding about relationships, sex and sexual knowledge
- greater understanding about the social supports and services in the community available to them and how to use them.
- ability to practice safety in all aspects of sexual relationships with confidence,
- increased skills in establishing and maintaining respectful and positive relationships
- development of positive attitudes and behaviour regarding sexual health and relationships (including sexual, cultural and physical diversity).

The Sexual Health and Relationships Education Curriculum in yrs 8, 9 and 10 were expected to involve a minimum of fifteen lesson modules each year, for three years. All staff teaching the Share program were required to have undertaken training run by SHINE SA. A curriculum guide was provided to all Share schools. However each school was able to decide on the distribution and spacing of lessons, which was determined by the school's overall timetabling structure and the availability of trained teachers.

Demographics

In 2003, 375 questionnaires were completed by 168 male and 207 female students in years 8 and 9. Of these, 94.5% indicated they were born in Australia, 4.3% were of Australian Indigenous origin and 2.5% spoke a language other than English at home. In 2003, 159 questionnaires were returned from 71 male and 88 female year 10 students. Almost all (97%) of these were born in Australia, including 2.5% of Indigenous origin, while 2% spoke a language other than English at home.

In 2005, 273 questionnaires were returned from year 10 and 11 students. Of these, 48% (n=131) were male and 52% female (n=142). All participants were aged 15 or 16 years, with 97% were born in Australia (5.9% were of Indigenous origin) and 3.4% spoke a language other than English at home.

2.1 Knowledge

Objectives

For young people:

- To have increased knowledge and understanding about relationships, sex and sexual health;
- To have increased understanding of, and the ability to practice safety in all aspects of sexual relationships with confidence;

2.1.1 Knowledge about Sexually Transmitted Infections (STIs)

Summary

No significant change was observed in knowledge about STIs, and some misinformation was still apparent after exposure to the Share Program.

Knowledge Before the Share Program

In 2003, it was clear that young people were aware of STIs, however a number of misunderstandings and misinformation were also apparent. For example while around 80% were aware that HIV could be sexually transmitted from a man to a woman during sex, only 63% thought it could be transmitted from a woman to a man. Forty-four percent of the junior students thought some STIs could lead to infertility. Only 32% of junior students understood how emergency contraception worked, and 29% of junior students thought withdrawal was effective to prevent pregnancy. Patterns of response to this question were similar in the senior survey, although answers to questions indicated slightly higher levels of knowledge about each item. For example 92% knew HIV was sexually transmitted from a man to a woman, and 80% knew it could be sexually transmitted from a woman to a man. Sixty-one percent knew STIs could lead to

infertility, 44% understood how emergency contraception works, and 16% thought withdrawal was a way to prevent pregnancy.

In relation to the likelihood of ever being infected with an STI, in 2003, 71% of the junior students and 81% of the senior students thought they would never, or be unlikely to be infected with an STI. These students were asked to select from a number of potential reasons why they believed they would not be infected with an STI. In the junior group, 76% said they would always use a condom, 66% that they would never inject drugs, 54% that they would not have sex with people who 'sleep around', 53% that they would only have sex with 'clean people', 49% said they would trust their partner and 42% said they would keep away from someone they thought might have an STI. Only 2.6% thought they would have only one partner and 9% thought they would wait until they were married to have sex.

Among the senior group, the pattern of answers was similar. Fewer (70%) thought they would always wear a condom, and that they would have sex with only one partner (15%). Fewer also thought they would only have sex with one partner (15%) and that they would wait until after marriage (2.5%).

Two questions were asked of the senior group concerning specific knowledge about STIs. In 2003 16.6% of students thought that all STIs (other than HIV) can be cured if they are treated, and 33.8% of students indicated that they assumed they would know if they had an STI because they would have symptoms. In response to the statement 'people who always use condoms are always safe from all STIs', 30% of both groups thought that this was true. In 2003, 17.7% of the junior group, and 14.6% of the senior groups agreed/strongly agreed that it is 'better to wait for marriage for sex'.

After Exposure to the Share Program

Knowledge levels concerning HIV and STIs after the Share Program were very similar to those prior to its introduction. Students were asked to name any STIs they knew of other than HIV. In 2005 approximately one third of those completing questionnaires answered this question. Answers listed included gonorrhoea, genital herpes, Chlamydia, Syphilis, hepatitis, crabs and genital warts. They were then asked the question, 'How likely do you think you are to get a sexually transmitted infection'? Responses indicate that students were slightly more confident that they would never be, or were unlikely to be, infected with an STI than they had been in 2003 (71% vs. 80%). Students who indicated that they would never, very unlikely or unlikely to get an STI were invited to choose from a number of potential reasons. The number of students who answered this section of the questionnaire were too small to report. Thirty percent of the total sample (n=81) responded that they 'would never inject drugs', 19.4% said they had never had sex (n=53), 21.6% that they would trust their partner (n=59), 34% that they would always use a condom (n=93), 21% said that they would only have sex with 'clean people' (n=58), and 22.7% that they would not have sex with people who 'sleep around' (n=62).

It is of note that before the Share program, no students responded to the statement, 'I would only have sex with clean people'. However, after undertaking the program, 62 students stated this as the reason why they would not get an STI. Similarly, more students in 2005 agreed that they would not have sex until they were married. A small number of students (25) reported that they would only have sex with one partner.

In response to the question 'all STIs (other than HIV) can be cured if they are treated', almost half of the group (n = 83, 46%) were unsure, and 38.8% (n = 69) correctly answered no. A large proportion of the group were also uncertain about whether they would know they had an STI because of the symptoms, 36% were unsure, and 35.4% answered yes to this question. Students were asked to write the name of two sexual activities that they believed to be unsafe in terms of either pregnancy or STIs. In 2005 the answers focused more on wearing protection, communication and having STI checks, although some confusion and misinformation was still apparent. Students were then

asked to write two activities they believed to be safe in terms of pregnancy and STIs, and safe-sex, sex with a condom and not sleeping around were mentioned. Oral sex and digital sex were commonly listed as safe, although some added 'with a new condom' to oral sex. There was less apparent confusion in responses to this question than were seen in 2003.

2.1.2 Knowledge about Puberty

Summary

Not surprisingly, students generally had good knowledge about the anatomy and physiology of puberty. An increase in knowledge was observed after exposure to the Share Program.

Before the Share Program

Both junior and senior students were asked what puberty means, and in 2003, most did not answer this question. Students who did answer referred to growing up, body changes, maturing, developing and changing. When asked to list five changes that happen at puberty to girls and to boys, they demonstrated extensive knowledge about changes for both sexes. Boys who listed changes for girls emphasised the body shape changes, particularly the development of breasts and widening hips. Girls listed body changes for boys including growing taller, broader shoulders, development of muscles, expansion of the chest, and growth of the penis. Acne, body odour and hair growth was also commonly listed by girls and boys, about boys. Girls and boys both made reference to changes in boys' voices and the development of the 'Adam's apple'. Both boys and girls included mood changes as an aspect of the female experience of puberty. Some girls talked about boys 'thinking differently', starting to take an interest in girls, and wanting sex. Girls and boys described the reproductive changes that occur for each other and themselves. Specifically, girls wrote about the development of ova, menstruation and boys' production of sperm. Boys wrote about the 'release of eggs' and that girls are 'able to have kids' after they begin menstruation. Most girls included 'wet dreams', and erections as a component of changes experienced by boys at puberty. Sexual attraction was

mentioned as a change for both sexes and was exclusively expressed in terms of attraction to the opposite sex.

There did appear to be some confusion: for example, some boys and girls thought that boys 'balls dropped' at puberty, and that girls began to produce breast milk. The latter may be confused with the development of breasts that have the capacity to produce milk, but this is not clear from the answers. Students in the senior groups answered this question in detail and with considerable accuracy.

After Exposure to the Share Program

While in 2003 few students had answered the question 'what does puberty mean', in 2005 it was answered by most students. Physical changes referred to both external and internal body changes, such as pubic and body hair growth, hormone activity, breasts and genitals changing, periods, emissions, and fertility. References to puberty as a transitional life stage were also apparent in answers:

When one transitions from a child to an adult, becoming mature, physical and mental development (female student 2005).

A stage that everyone goes through to become a man or a woman involving physical changes and behaviour (female student 2005).

the stage that every person goes through when he grows up (male student 2005).

its the transition between being a child and a teenager - becoming sexually able, development of body and maturity (female student 2005).

a time in your life when your body begins to change, when you develop into an adult (male student 2005).

when you hit the age of a teenager and you start to grow and develop things you wouldn't normally have as a child (male student 2005).

2.1.3 Knowledge/views about sexual issues

Summary

A small but significant level of confusion existed regarding the effectiveness of condoms in relation to STIs, and attitudes and laws relating to homosexuality. There appeared to be a slight rise in confusion after the Share program, suggesting a need for further clarity in future education programs on such issues.

Before the Share Program

In 2003, around 80% of students viewed masturbation as normal for both males and females. In the junior and senior groups, 56% said that same sex attraction is a normal part of human sexuality. Of concern is the finding that 21% believed there are laws against homosexuality. In the past laws making homosexuality illegal have existed, and age of consent laws still apply to homosexual relations. However, consensual homosexual acts are not illegal in any state or territory in Australia.

Most students in both groups did not think they would know straight away if they were pregnant. The majority also did not think that it was OK for a boy to push a girl to have sex unless she actually said no.

After Exposure to the Share Program

Again, responses to this question were remarkably similar to answers in the pre-test. Slightly more saw masturbation as normal for females and males (85%), same sex attraction was still seen as a normal part of human sexuality by just over half of the students, slightly more thought that there are laws against homosexuality (25.4%). Just over half of the students thought that sexual diversity should be supported because we can learn from the experiences of others. Most said that they would not know straight away if they were pregnant, and that it was unacceptable to push a girl to have sex, regardless of whether or not she has said no. What is of more concern in relation to these questions, is the number who responded 'don't know' to some of the questions. Slightly more (25.4%) thought there were laws making homosexuality illegal after the Share Program than before, with 20.8% unsure about whether same-sex attraction is a normal

part of human sexuality, and 20.7% unsure whether people who use condoms are safe from all STIs.

2.2. Behaviour

Objectives

- Young people will develop an understanding and the ability to practise safety in all aspects of sexual relationships, and
- Young people will know about, and feel comfortable, accessing a range of services and people for support.

2.2.1 Relationships

Summary

Students' self reported behaviour and beliefs about behaviour were strongly gendered. Girls tended to respond to questions in terms of emotions, while boys' answers were more focussed on the physical aspect of sex. Little difference was observed in this area before and after the Share program.

Before the Share Program

Students were asked 'What does sex mean to you?' In 2003 the most common response from the junior group was 'sexual intercourse', and many specified between a man and a woman. Boys tended to describe more physical aspects of intercourse than girls, but in both groups some referred to an emotional component to sex. This was characteristically described as a physical expression of emotions. Girls were more likely than boys to describe sex as an expression of love between two people. Some boys and many girls referred to the reproductive function of sex. For these students sex was not separate from the potential to produce a child. Some girls interpreted the question as asking what meaning sex had for them in the context of their experience of it. Answers related to this interpretation included views that sex was fun; that it symbolised love between two people; and that it was 'the thing to do to take the relationship to another level' of

maturity and intimacy. Senior students tended to describe what sex meant to them in terms of anatomy and physiology, for example 'sexual intercourse' or 'penis in vagina'.

They were also asked 'When do you think a person is ready for sex with another person, and why'. For boys the latter issue appeared to revolve around several milestones which they saw as critical: for some, legal age of consent was equated with 'readiness', while others identified 18 as the age at which adulthood was reached.

The age you should have sex is 18, because they will be mature enough to understand the consequences (male student 2003).

Some boys identified earlier ages between 12 and 14 and described this as a period as when interest in sex and sexual attraction is due to changes in hormones. However, not all thought about readiness in terms of age, many described a need to feel comfortable physically and emotionally. These responses often included reference to the relationship with a partner and the need to feel comfortable with each other.

[You need to] really like each other because 'it' might not go very well and will be less embarrassing if you know each other really well (male student 2003).

When they truly know they are in love with one another, for it is not good if you have sex with someone you don't surely know you love (male student 2003).

Most boys who responded in terms of love and relationships indicated that readiness for sex would not be until a couple had been together for between six months and two years, although a small number felt that less time was necessary. They also emphasised that the decision needed to be mutual between partners

Two people are ready to have sex when they both love one another and both agree to have sex (male student 2003) .

Some felt it was up to the girl to communicate readiness.

When a girl wants to come over to your house and she knows no-one else is home then she is interested (male student 2003).

When a girl seduces you, you know that she is ready for sex' (male student 2003).

The depth of the relationship, the level of commitment and the length of time in relationship were important themes for girls. Words such as ‘taking it to the next level’ or ‘taking the big step’ were used by some girls. ‘Loving each other’ was another criterion for readiness. ‘Feeling comfortable’ and ‘trusting each other’ were words used frequently by girls to describe when they thought a person would be ready to have sex with another person. While boys emphasised the need for mutual agreement, girls emphasised the need not to be pressured or forced into sex. One girl wrote:

It’s when you feel ready, not when you look ready that counts (female student 2003).

The year 10 students’ responses in 2003 were less gendered, focused more on the relationship and were less specific than the junior students about age or stage of readiness.

After Exposure to the Share Program

In the second survey, in response to the question, ‘What does sex mean to you?’, both physical and emotional aspects of sex were mentioned, although a strong gender difference was still observed. Among the girls, some responses were given in physical terms, for example ‘having intercourse with someone’; ‘sexual intercourse between a male and female’; ‘intercourse, when the penis is inserted into the vagina’. The responses that focused more on intimacy included: ‘sexually showing affection for someone you love’; ‘sex means to me that if you do that with someone you think that person means a lot to you. Its an act of love’; ‘sex means to me that your comfortable and want to show affection with your partner’; ‘I think sex is a big thing and I think its more making love because it brings couples closer together’; ‘having sexual intimacy with your partner, its the physical side of a relationship. It could also be when a couple are trying to have kids’. There was also some mention of pleasure and fun: ‘something that feels good and exciting’; ‘something that feels good for the guys’; ‘sex is either something fun or something you do because you really like or love the person’ (year ten girls, 2005).

Among the boys the answers were more in the vernacular. They were given permission to use slang and not worry about spelling in the questionnaire, and many of the boys took

the opportunity to express themselves. Physical aspects of what sex means to them included ‘sticking the willie in the vagina’; ‘the act of sexual intercourse’; ‘when you have intercourse with someone/making love’; ‘sticking your willy into somebody vagina or bum’. Reproductive aspects were also mentioned by boys in 2005: ‘to create life or have a bit of fun’; ‘fun and having babies’. Some boys also mentioned emotional meanings of sex: ‘sex is a act between two people when they are at most trust with each other’; ‘trust, fun if your careful’; ‘It means loving and sharing something fun with your partner’; ‘a way to say that you love them’; ‘The union of two people in an intimate setting’. References to pleasure were also apparent: ‘pleasure, having a root’; ‘trust, fun if your careful’; ‘a fun, enjoyable thing that you do when you love someone’ (year 10 boys, 2005).

Overall, little change was observed in this area after the Share Program. Among the senior students in the pre-test, there was already some knowledge demonstrated about the physical aspects of sexual intercourse, and some showed an understanding that this was an act that is intimate, and requires trust and love. Given their age and levels of embarrassment about sex among some students it is not surprising that joking responses were also given to this section of the questionnaire. However, the emotional content tended to be more limited to the girls’ responses, while the joking responses were more likely to come from the boys.

2.2.2 Safe-sex Behaviour

Summary

Some positive signs were observed in relation to safe-sex behaviour. After exposure to the Share program students demonstrated increased understanding and more were aware of the multiple meanings of safe-sex.

Before the Share Program

Students were asked what ‘safe-sex’ means to them. The junior students tended to focus on preventing pregnancy. Some boys’ interpreted safe-sex to mean knowing the person

you are having sex with is healthy. For one boy this meant knowing someone 'long enough to know they don't have AIDS'. Others interpreted the question differently and explained that 'safe-sex' meant that the environment in which you have sex is safe and secure. Sex with people you don't know, or with more than one person was described as 'unsafe'. Approximately half the students mentioned using condoms as their definition of 'safe-sex'. Many thought safe-sex was for those who wanted to have sex but did not 'want to start a family'. STI prevention was a secondary concern to preventing pregnancy, when discussing safer sex.

Among the senior group in 2003, safe-sex was described in three main ways. Some girls thought of safe-sex as contraception, but ideas varied about what kind of contraception was safe. Some girls simply wrote 'protection' or 'condoms'. Others thought of safe-sex as a combination of condom and pill. The third group wrote 'contraception'. The group that thought in terms of contraception were unclear about methods. Some suggested that any one of a range of devices or products would be sufficient.

When asked what safe-sex means to them, the year 10 boys wrote about safe-sex predominantly in terms of the use of condoms or what they called 'other forms of protection' or 'precautions'. Not all thought that condom use was necessary for safe-sex. For the Year 10 boys, safe-sex was interpreted in terms of contraception, with just under a quarter believing the contraceptive pill was an alternative to condom use. Some year 10 boys thought about safe-sex in terms of having sex in safe environment and making sure they knew the sexual history of the girl. They described needing to 'know the girl well'; 'knowing the girl's STI history'; 'feeling safe'; and 'not having sex in public places such as toilets'.

In response to being asked to name STIs other than HIV, in 2003 both boys and girls had trouble providing the names of four STIs, even in slang terms. The most commonly mentioned STI was herpes. Genital warts and pubic lice were also commonly listed. Approximately six students listed AIDS as an STI, only two included hepatitis. Gonorrhoea, Chlamydia and Syphilis were also mentioned by a few students (less than

one quarter). More than half the students did not provided any answer at all to this question.

After Exposure to the Share Program

In the 2005 survey, the boys were less likely to mention personal responsibility as a meaning for safe-sex. Most boys simply listed some version of ‘condom’, ‘contraception’ or ‘protection’. A very small number mentioned protection/ prevention of STI transmission or pregnancy, and some mentioned ‘cleanliness’, for example: ‘wear a condom wash your hands’, ‘that the 2 people are both clean and both want to have sex’ (year 10 boys, 2005).

It was common for girls to indicate that safe-sex involved the prevention of both pregnancy and STIs. A few girls listed a number of contraceptive methods other than the condom: ‘using a condom or using other forms of contraception’; ‘Safe-sex is to use a condom so the woman cannot get pregnant’; ‘using protection when having sex so you do not become pregnant or catch an STI’. There were a few girls who found emotional meaning in the term, writing about general safety, respect and understanding: ‘Having sex with a condom and being sure that you take all the right measures to be free of STIs and pregnancy’; ‘safe-sex means wearing a condom and being aware of the infections you can get from sex’.

In response to being asked to name STIs other than HIV, in 2005 many more answered this question, and could name a good range of STIs, including thrush, syphilis, herpes, hepatitis, crabs, warts, Gonorrhoea, Chlamydia, and lymphogranuloma venereum (one student). Infertility was also mentioned. However only 14 students could name three or more STIs.

2.2.3 Sexual Behaviour

Summary

One third of students in years 10 and 11 were sexually active and some demonstrated high levels of risk taking behaviour. There is still a small, but concerning minority of students who are not confident of their ability to say no to unwanted sex.

Both prior to and after the Share Intervention, the students surveyed were slightly more sexually active than the national average and this did not change as a result of the Share intervention.

Before the Share Program

In 2003, most students (around 80%) in years 8, 9 and 10 reported having, or having had a steady boy/ girl friend. In the first administration of the survey, the junior questionnaire (years 8 and 9) omitted a number of questions about sexual behaviour. Here we report on the senior group's responses prior to the Share Program.

One third of the senior student in 2003 reported that they had ever had sex (n=76). Of these, 9 had not had sex in the past year. They were asked how often in the past year they had sex while under the influence of alcohol or other drugs. Seventy two students responded. Of these, 48.6% reported never, 33% occasionally, and 18% often or always. Twenty six students (13%) reported that they have sex with casual partners.

The year 10 students who reported that they were sexually active were asked to think back to the last time they had sex, and whether they had talked to their partner about avoiding pregnancy. Approximately 42% (41.5%) indicated that they had, 29.6% indicated that they had discussed avoiding HIV, 30% had discussed avoiding other STIs, 42.5% had discussed how to get pleasure without having intercourse and 76.5% had discussed using a condom.

Two thirds of Year 8 and 9 students were confident of their own ability to say no to sex in an imagined future situation, and a similar proportion were confident that they could respect a partner's wish to say no in the future. Most year 10 students (80%) were confident they could say no to sex, and 86% were confident that they would be able to respect their partner's wish to say no. In both groups, students were confident that they would be able to talk with a prospective partner about using and obtaining condoms.

After Exposure to the Share Program

In 2005, 93% of students reported that they had a steady boy/ girlfriend or had had one in the past, although only 24.4% currently had a steady boy or girlfriend. One third (36.2%) of the total group reported that they had sex in the past year. Around 18% reported having sex with one person, and 16% (n=28) reported having had sex with two or more people in the past year. Sixteen percent of the group (n=38) reported that they had sex with casual partners, 21% (n=51) reported that they had occasionally, often or always had sex while under the influence of alcohol or other drugs, and 9.5% reported that they had sex when they did not want to because they were drunk or high at the time (n=23). The proportion of students having sex, casual sex, mixing alcohol and drugs with sex, remained remarkably similar after the Share intervention.

Students were asked a series of questions about communicating with partners about sexual matters. Only 8% responded that they had discussed avoiding pregnancy, and 5% reported that they had discussed avoiding HIV. Only 5.5% reported that they had discussed the prevention of other STIs, 23% had discussed using a condom, and 8% had discussed how to get pleasure without having intercourse.

Also in 2005, 72% indicated that they felt 'confident' to 'very confident' about saying no to unwanted sex, and 86% said that they would be confident/ very confident to respect a prospective sexual partner's wish to say no. Students were asked how confident they would be to talk to a prospective partner about using a condom: 90% reported themselves to be confident/ very confident that they would be able to talk to a partner about using a condom, and 80% were confident/ very confident that they would be able to get condoms

if they needed them. A slight increase can be seen in the students' confidence to say no to unwanted sex, but in all other areas there was no significant change.

2.2.4 Access to services and support

Summary

Young people showed increased ability to use peers for information about sexual health and relationships.

Before the Share Program

Students were asked how often they had made use of a number of sources of information about relationships and sexual health. The junior group reported they had used their mother or female guardian most often (74%), followed by books and magazines (68%), female friends (65%), television (57%), male friends (56%), boyfriend/ girlfriend (55%) and health education at school (54%). The senior group reported a very similar pattern in that the top seven sources remained the same, but their ranking order changed. Senior students were using female friends (76.6%), books and magazines (72%), television (64%), male friends (64%), mother/female guardian (63%), health education at school (62.6%), and boyfriend/ girlfriend (61%).

After Exposure to the Share Program

Students were more likely to have sometimes or often used female friends (79.6%), male friends (74%), boyfriend/ girlfriend (68.4%), mother/ female guardian (68.8%), books and magazines (63.2%) and health education at school (54%). All other sources were used less than half of the time. It is of note that the year 10 and 11 students in 2005 were more likely to be talking to their friends about these matters. Only 39% of students said they talked with their father sometimes or often, and 36.7% talked to teachers or a school nurse.

2.3. Attitudes

Objectives

- For young people to have increased skills to establish and maintain respectful, positive relationships, and
- To develop positive attitudes relating to sexual health, relationships (including sexual, cultural and physical diversity).

2.3.1 Sexuality and relationships

Summary

A small change was observed in attitudes towards sex and relationships that was gendered in nature. More students after the Share program agreed that relationships should be based on equality and that boys were able to give their girlfriend pleasure. However more students thought girls were better able to control their sexual urges and that boys should make the first moves.

Before the Share Program

In 2003, in response to a series of statements about sexuality, relationships, responsibility and trust, students indicated their attitudes about these matters. There was little difference in responses between the junior and senior groups prior to the Share intervention.

Overall, most students agreed that a healthy relationship is one where both people feel equal, and around half thought that girls could control their sexual urges better than boys. In both groups 46% agreed or strongly agreed that ‘most guys know how to give their girlfriends sexual pleasure’. In the senior group, slightly more (50%) thought that the best thing about sex is the physical pleasure, compared with 42% in the junior group, and the senior students were more likely than the junior students to think that ‘guys should make the moves when they have sex with girls’ (seniors 32%, juniors 24%). Around 20% in both groups thought a girl could be called a slut if she knows a lot about sex. In the junior groups, 14% agreed it would be better to wait until marriage to have sex, and among the senior students this had dropped to 9%.

After Exposure to the Share Program

In the 2005 survey 90% of students agreed/ strongly agreed that an equal relationship is one where both people feel equal, a slight increase from before the Share Program. A slightly smaller proportion of students in 2005 agreed/ strongly agreed that girls could control their sexual urges better than boys (40%), that ‘most guys know how to give their girlfriends sexual pleasure’ (44%), and that the best thing about sex is the physical pleasure (44%). Many more agreed/ strongly agreed in this survey that ‘guys should make the moves when they have sex with girls’ (67% compared with 32% of year 10 students in 2003). Similar responses were seen to the statement ‘a girl could be called a slut if she knows a lot about sex’, with around 19% agreeing or strongly agreeing. In this group a smaller proportion of students (6.6%) indicated that they would wait until they are married to have sex.

2.3.2 Attitudes to Sexual Diversity

Summary

In general, the students demonstrated a degree of tolerance to sexual diversity. However the nature of this was strongly gendered, and males displayed higher levels of intolerance towards gay friends than females.

Before the Share Program

In 2003, 46% of the junior group, and 61% of the senior group, said it was true that it is ‘important that we support sexual diversity because we can learn from the experiences of others’. Most students in both groups said they would not stop being friends with someone if they found out they were gay or lesbian.

However, when these data were further broken down by gender, a disparity between males and females was apparent. In 2003, 26.4% of the year 8 and 9 male students, and

32.5% of the year 10 male students agreed or strongly agreed that they would stop being friends with someone if they found out he was gay, while only 6.3% of the year 8 and 9 and 5.8% of the year 10 male students, would stop being friends with someone if they found out she was a lesbian. In the girls' responses, 2.6% of the year 8 and 9 girls and none of the year 10 girls said they would stop being friends with someone they found out was gay, while 5.3% of the year 8 and 9 and 0.9% of the year 10 girls would stop being friends with someone they found out was lesbian.

Around a quarter of the junior students agreed that non-traditional families such as lesbian families, should be recognised and supported by the school community in the junior group, and in the senior group this increased to a third.

After Exposure to the Share Program

There was little change in these attitudes after the program. Responses to the statement 'I would stop being friends with someone if I found out he was gay' continued to demonstrate a strong gender difference. Among the boys, around a third said they would stop being friends, a third they would stay friends and a third was not sure. Among the girls, no girls indicated they would stop being friends with someone if they found out he was gay, and only 2.3% were unsure, the remainder (98%) disagreed or strongly disagreed with the statement. However, in response to the statement, 'I would stop being friends with someone if I found out she was a lesbian, only 4.5% of the boys agreed, and 83.5% disagreed or strongly disagreed, while 1.6% of the girls agreed or strongly agreed, 14.5% were not sure and 83.9% disagreed or strongly disagreed.

2.4 Discussion: Young people

The results of these surveys must be viewed with caution. Indicators of change in knowledge, attitudes and behaviour are notoriously difficult to measure, in the complex, social domain represented by sexuality. However, there is no evidence that exposure to an intervention such as the Share Program leads to greater sexual activity, less responsible sexual behaviour or reduced parental involvement in such areas of their

children's lives. Indeed, many students' responses indicate thoughtful consideration and an understanding about sex and love as being an area in which responsibility and respect are important. The results of these surveys must not be viewed in isolation, but taken in conjunction with the qualitative components of this evaluation.

In relation to the objective to increase knowledge and understanding about sex and sexual health, and to practise safety in all aspects of sexual relationships, we observed little changes after the Share intervention. This may not be a problem with the Program, but with the objective. One third of students reported that they are sexually active, and for many students knowledge about STIs is of no relevance at the time it is being taught. This is not to say that the information is of no use, as students are likely to have some understanding of this territory which they can use to explore it more fully when it does become necessary. That increased knowledge was not observed does not mean that it is not worthwhile teaching about STIs.

From the data that are available, it is difficult to comment on changes in the student's knowledge and understanding about sex and sexual health as a result of their participation in the Share Program. Because sex is social, information that is not of interest or needed at the time it is taught is unlikely to be retained by all students. While teaching about sex is important, as some will need the information at the time it is taught, skills development is at least of equal importance. The ability to know where and how to access the information when it is needed, as well as critical thinking and decision making skills and values clarification (as opposed to teaching specific values) are vital components of any sexual health and relationships program. These are the skills that will stand those students who do not need the information when it is taught in good stead in the future, when they do need it.

The references made to such values and qualities as love, respect, communication and consent by many of the students, demonstrates that many students have positive attitudes towards sex and each other. There remains a small number of young people who are involved in risk-taking behaviours, such as multiple and casual sex partners, unsafe-sex

practices, and being under the influence of alcohol or other drugs when they have sex. Programs targeting this group of students who engage in risk taking activities must be developed.

It is also encouraging to note that, while parent/ child communication has not changed dramatically as a result of the program, students indicated a greater degree of confidence that they could talk with their parents about sex and relationships, if the need arose. Parent/ child communication will not change by only addressing one side of the equation. The student's responses to questions in the survey about communicating with parents and who initiates the communication, demonstrates that work with parents in this area is much needed.

3. Findings: School Staff

Objectives:

For School Staff to:

- have increased knowledge and understanding about young people's relationships, sex and sexual health;
- have increased competence and confidence to deliver the Share program;
- develop partnerships with the community in order to improve links with, and access for young people to youth health and general health services;
- develop positive attitudes and behaviour relating to sexual health, relationships.

Data concerning these objectives were collected via key informant interviews with school staff, and from the annual co-ordinators workshops.

3.1 Staff competence and confidence

Key informant interviews took place in late 2003/ early 2004 and again late in 2005, to elicit information about staff experience of the Share curriculum within the school environment. Interviews were carried out with school staff in three schools that had the Share Program, and three control schools. Interviews focused on the confidence and competence of teachers to teach sexual health and relationships education, the development of community connections, addressing sexuality and relationships issues across the curriculum and in policies, and addressing diversity issues within the school community. The themes and prompt questions for these interviews can be found in Appendix 2.

The staff interviewed as key informants included both Share and non-Share teachers, administrators and school counsellors. They were identified by the Share Co-ordinators, in conjunction with the school staff. Due to the delays experienced in implementing the program, the first round of key informant interviews were not completed until early 2004. Some of the key informants had experience teaching sex and relationships programs prior to their participation in the Share program. Among those interviewed in schools participating in the Share Program, not all had participated in the SHine SA training

when the initial interviews were carried out, and key informants included non-Share teachers who were not trained, in both the control and Share schools. To maintain the confidentiality of the key informants quoted here, they are only identified as Share and non-Share teachers.

Of those key informants who had been trained, all expressed a greater degree of comfort with teaching Share, while those who had not been trained (and were not teaching the curriculum) harboured some reservations.

I didn't want to be trained in the area, in early 2003 I didn't see it as anything that I need to teach (non Share teacher, 2003).

If [sexuality or relationships] came up in a science class where it's more biological, I would take the kid aside rather than talk about it to the whole class (non Share teacher, 2003) .

I wouldn't feel uncomfortable [now that I have seen the program but] I would need to develop more skills in that area [before I was prepared to teach it] (non Share teacher, 2003).

The attitude of Share staff to teaching the program was more mixed in the first round of interviews:

[Teaching the] emotive stuff can be a bit tricky, [for example] homosexuality. When that became a focus I was a little uncomfortable because it was a outside of the norm for myself. It took [me] a little while to sort out the boundaries of what you teach. Accepting diversity. [But I'm] quite comfortable now (Share teacher, 2003).

Within the nature of what I do I feel highly valued working in that area. It's a terrific relationship tool, to teach [the students] something that's so relevant to them. I am fundamentally and philosophically in agreement with this work being done (Share teacher, 2003).

In the second round of interviews late in 2005, it was clear that the Share training provided by SHine SA was valued by the teachers:

I think the training has been excellent as a support. And I think we have been quite lucky in that we have had quite experienced teachers anyway. The courses and training was another backup for them which means that they are quite comfortable in delivery (Share teacher, 2005).

Some respondents in 2005 indicated that they had seen positive results from the introduction of the Share curriculum.

The main good things were that everyone gave positive reviews and respected each other opinions. Some of the things, the older students maybe, body changes things like that, they were reluctant to talk about I guess, because of embarrassment and things like that. If you can have a bit of a laugh about things along the way the group becomes comfortable (Share teacher, 2005).

They loved a lot of the games and activities. Because they don't see that in other subjects. Role plays, putting them in groups, scenario situations. All the surveys they did they filled out with some type of meaning (Share teacher, 2005).

However some doubts were also expressed about the relevance of some of the content to some students:

The year nines, they didn't find any relevance in some of the sexually transmitted infections and things. But they had no idea about it and they thought it was bit of a joke, that it was never going to happen to them (Share teacher, 2005).

At least one teacher's attitude shifted from being opposed to any involvement in the project, to expressing an interest in being trained as the Program progressed.

Now I wouldn't mind doing the training. I didn't want to be forced to teach that 14/15 age group and mixed groups (Non-Share Teacher 2004).

It appears that differences between the level of comfort and feelings of competence among Share teachers and non-Share teachers can be attributed to training and experience. A number had already participated in other training prior to the introduction of the Share program. Those who had participated in both Share and other sex education training indicated that they felt relaxed and comfortable with the program, while those

who had not been trained expressed reservations and concerns. It is of note that those who expressed reservations during the interviews, also expressed the opinion that this could change if they were able to develop more skills and knowledge.

In 2003 the Share Project Co-ordinators reported that many teachers were anxious about teaching the Share program, largely because of the controversy that had surrounded it. By the second year of the project, observable shifts had been noted in school staff attitudes, and the co-ordinators reported that key teachers appeared to be more comfortable with the Share program than they had been earlier in the year. By the end of the project there appeared to be less anxiety about teaching the curriculum and teachers were more confident. It was of some concern to the co-ordinators that some school staff had adapted sections of the program. This involved passive teaching, using videos or providing the students with worksheets, which was not within the spirit of the Share program. The co-ordinators were philosophical about these changes, however, commenting that ‘these things happen in the reality of school life’.

3.2 Community Connections

The development of community connections differed from school to school. While it did not emerge strongly from the key informant interviews, a more complete picture of the disparity of community connections between schools was apparent. One of the outer suburban Share schools appears to have had extensive connections with a number of local and central agencies. In the key informant interviews, the school counsellor from this school described how some local services came to the school and ran sessions for students, and also how some students had been taken out from the school in groups or individually, to visit local services. However, this information was not known by all the key informants interviewed at this school, and appeared to have intentionally remained the domain of the school counsellor. One of the other key informants from the same school said:

[Community agencies] do come to school but see the counsellor. [We try to] keep it centralised so that three teachers don't ring up regarding the same student (2003 key informant).

At a rural school, the key informants interviewed indicated that there were ‘not a lot’ of community support services available to them. This informant then went on to nominate quite a few services, such as family and youth services (including emergency housing), the local hospital, a community nurse at the local hospital, psychiatric support services, the youth sector network which provides activities for young people, telephone hotlines for young people, local GPs, religious groups who provide counselling, Department of Education social workers and psychologists, Central Mission, Centrelink, parenting groups for teenage mothers, and Second Story for same sex attracted youth issues. However many of these services were based in the next large town, about one hour away from the school, which created access issues for the students. A number of issues were identified by teachers with some of these services:

...family and youth service will act on referrals only and only come out for extreme cases of high risk (2003).

Locally [there is] very little; lots of help lines for kids, Central Mission, Centrelink. There is a parenting group - if a kid is pregnant or has a baby they run groups. The GP is never the same and often doesn’t speak English very well. We refer on to Second Storey in Adelaide) for same-sex attracted issues; will do pregnancy tests for students and refer them on to the pregnancy advisory centre if necessary. We supply condoms [but] condom distribution isn’t as effective as we’d like. (2003).

Despite the number of agencies named, there were no formal processes in place at this school for connections between any of the agencies and the school, and referrals were made on an ‘as needed’ basis, generally through the school counsellor or the principal. It appears that contact is made on an ad hoc basis, rather than within a preventative or health promoting framework. Two of the interviewees raised student confidentiality as a barrier to closer ties between the school and community based agencies. Knowledge about how to contact these agencies also remains the domain of the school counsellor:

The school counsellor would have which [agencies] and their numbers. [There are] youth groups, anger management, not sure if they deal with sexual health. The school [knows] but I’m not sure what they are (2003).

In contrast to this patchy knowledge about assistance with sexual health and relationships issues, all of the staff interviewed had good knowledge about mental health (MIND Matters) and drug prevention programs.

In the co-ordinator workshops, some identified examples of innovative approaches to productive engagement with the local community and services in schools:

- Health displays in common areas within the school, that are accessible to all students and allow them to retain their anonymity and privacy.
- Health and well being days were also held in a number of schools.
- Because the Share curriculum was only taught in years 8, 9 and 10, one school developed a health day for year 12 students.
- Health days and displays often linked with other well-being programs, for example Beyond Blue, the Drug Strategy and other service providers.
- Another school held a ‘health expo’ which focussed on relationships and sexual health. The school principal endorsed the Share program, the SHine co-ordinator spoke and students were able to ask questions.
- Fortnightly attendance by a local general practitioner from a local clinic in one rural school to allow students to have easy access to medical services.
- Setting up a local intranet counselling service online for students which allows them anonymous contact, provides them with information about where to go for help and links them with the school counsellor to ask questions.

3.3 Addressing Relationships and sexual health in policy and curriculum

In the 2003 interviews, there was patchy knowledge about policies concerning relationships and sexual health. In 2005, nothing was added to the comments made in 2003. Only senior school staff and counsellors seemed to have a good knowledge of their school’s policies and were able to nominate bullying and harassment, drug policies and strategies and other matters such as mandatory reporting. At Share schools, most non-Share teachers were unclear about whether sexual health was addressed in the broader curriculum.

Bullying gets addressed in English through texts etc sometimes.

Mainly in health and PE, they don't really get addressed elsewhere. In science students get information on STIs; how you get them and how to avoid them.

Not a great deal ... The school has had guest speakers in the past where whole year [groups] have gone and missed their classes and that was okay.

Unlike their non-Share counterparts in these schools, key informants who were involved in the health curriculum were of the opinion that there was a good degree of visibility for health and sexuality matters in the school.

There are posters in the student counsellor's windows and in some class rooms. And students know where to go for information, to the student counsellor. Some things are kept inside the office but [whether it is accessed] depends on how much students want others to know what they are doing. I'm not sure if there are things in the library, but I am sure that there are teacher resources (2004).

During this section of the interviews, the discussion shifted away from visibility in the school to the controversy that arose over the Share Project as a result of objections by groups and individuals who are opposed to sex education in schools. This issue will not be discussed in this report, but is being addressed in another evaluation carried out separately. The controversy created very high visibility for the project as a whole and the schools bore the brunt of community concerns. Despite, or perhaps because, of the controversy, staff at the Share schools indicated they felt very supported by SHine SA and the co-ordinators. Concerns raised by a few parents appear to have been generalised to all parents by the staff interviewed here:

I realised how segregated [we are from] the values of the parents. Issues relating to homosexuality was what most parents were concerned and alarmed about, not all but a lot. Concerned that we'd turn [their children] into homosexuals and how to do it all. They just couldn't get that we were teaching acceptance of difference (2004).

It was made clear that the activities [in the Share program] were suited for ages 12/13 and up, but some parents thought that the content was too explicit... Homosexuality was the issue (2003).

All of the teachers interviewed also felt very supported by the school administration and policies, and they appeared philosophical about the controversy.

A small number - very supportive, a small number - very anti, and a large number apathetic. That's the nature of this community – you would get the same with other issues although not as many anti. A large number of parents don't care what we do; as long as we baby-sit their kids it's fine (Share school, 2004).

One non Share teacher discussed the effect that the attack had on her family in the small rural community where she lived.

I was not personally on the receiving end of the 'backlash' against the program ...but I don't want to be put under pressure. Some opponents of the program were loud and aggressive and made it uncomfortable for the teachers. Most were glad they didn't have to [teach Share], teaching is already stressful enough and without community support it can be difficult. The DECS district office supported the program but were not at the school dealing with the community. My husband heard conversations at work that were not supportive or positive about the program. I am also concerned about these subjects being taught at school. My son is in primary school and I think he has more information than he needs at his age. I would rather have taught him about these things myself.

Programs like Share often take away parent's rights to introduce things and teach them to their own children when they think it is time. I actually have concerns about the age at which it is introduced (non-Share teacher, 2004).

3.4 Barriers and challenges

In the 2005 interviews, school staff were asked to identify barriers and challenges they saw with the implementation of the Share Program in their schools. One of the major issues staff raised was the requirement for students to obtain written parental consent to participate in the program. Normal school policy does not require parental consent for students to participate in sexual health programs; however consent was required for the Share program by the Department of Education. According to one teacher:

Our biggest disadvantage is that we still required written consent. Phone consent would make our life easier. But because of the political climate around SHine [SA] we can't do that until we get out of the SHine program. The parents are failing to return the consent form. We've tried posting, we've tried ringing. The ringing works well because they'll

actually tell us on the phone. But we aren't allowed to use that while we're in the study. So we have to work around it (Share teacher, 2005).

Despite almost all the teachers teaching Share being trained, staff turnover in some schools meant a few teachers who had not done the actual two day course were assigned to teaching health classes. This problem was noted by the Share regional coordinators who usually met with staff before they began teaching to assist in familiarising them with the program. At least one school overcame the requirement for teachers to be trained to run the Share program by team teaching:

We had a trained person who went in with them and went in with their classes (Share teacher, 2005).

Another challenge for the Share Program was its competition for time with other subjects. At least one teacher felt that the seven weeks needed for Share made the timetable 'a bit crowded'. As ever, there was pressure of time on the curriculum to fit in all the subjects, and sexual health was not seen as a top priority by all teachers, or schools. At least one school decided to make the course an elective for year 10 students in future.

3.5 Discussion: School Staff

In general, the staff involved in teaching and supporting the Share program in schools indicated that they had been well supported by SHine SA, and an increase in comfort and confidence was observable as the project progressed. This was not only in the classroom, but in attempts to make the school environment more safe and accessible for all. Early in the program, some staff expressed uncertainty concerning their capacity to teach sex-education, and it was apparent that the SHine SA training made a difference to this, and was valued by school staff. It is also apparent from some of the teachers' comments, that the controversy that surrounded the implementation of the Share program impacted on their confidence to teach, as well as on them personally. This was raised in both the key informant interviews, and in the co-ordinator workshops.

Despite a number of creative approaches to engagement with local services and agencies, linkages between schools and their local community were inconsistent. Some schools

already had well functioning connections with local and central youth and health services upon which they built, while others were less well connected and made less progress towards developing these links.

Overall, in relation to the stated aims of the project in relation to school staff, some gains can be seen. Key elements identified by the co-ordinators for the success of the program in schools include: administrative and management leadership, faculty support for the program, and the presence of a committed key teacher to drive the program and support other staff as they deliver it. The co-ordinators observed that in schools where any of these elements were lacking, the program was less successful.

4. Findings: School Environment

Objectives:

- To ensure that schools have a commitment to addressing relationships and sexual health issues in the whole school environment;
- To develop positive attitudes and behaviour that are inclusive and respectful of diversity.

To assess progress against these objectives, data were gathered from staff interviews, at the Co-ordinator's workshops and from students via the questionnaire. Issues concerning a whole school approach have previously been discussed in detail in a review of literature (Dyson, Mitchell *et al.*, 2003).

4.1 A whole school approach to relationships and sexual health

This area produced quite a bit of comment from the key informant interviews. One teacher reported:

There is an unwritten school policy that we deal with students who need help. The school is clear on what we do with, say, unwanted pregnancies. We support the individual to do what they want and link them and their families with agencies. This is a confidential service. Teenage mothers are supported by the whole school community and currently [we have] teenage mothers in Years 12 and 10.

Counselling and welfare support were seen to be accessible and speedily dealt with, and interviewees indicated that, in general, they felt supported by the school's policies, the administration and the parents to teach about sexual health. There was some criticism of the existing policies however:

Policies. Things can improve in terms of a specific policy on sexuality. We are looking at surveying to identify what we think are the gaps. It may come to light that we need specific policies. For example, there is no policy on young parents, and if a staff member challenges what we do we then perhaps we may need to have a specific policy that says that this is the school's policy. Maybe with sexuality we need to flesh out the Harassment and Bullying Policy.

At one of the Share schools same sex attraction remained controversial, as one teacher reported:

Not everyone is happy with all aspects of the Share program. There are aspects that they think are not necessary... [they think that] heterosexual and homosexual are too explicit for some age groups.

However at another Share school this was not the case, as one of the interviewees related that:

In 2002 a lesbian girl ... went to her Year 12 formal with her female partner and the boss was okay with that. They both wore suits instead of dresses. The other kids were quite supportive, but it was a combined formal and some of the kids from other schools didn't cope. She was good at music which probably helped – she had a strong personality. In the beginning of 2002 kids were harassing her ... and calling her names. Nothing too serious physically but they were suspended for bullying and picking on her ... it takes time to see tolerance building, but the bullies are learning that it's not acceptable. It would be naïve to think that it will never happen again ...but at least there are steps are in place now to deal with it.

At another of the intervention schools, diversity was addressed across the whole curriculum:

... [we] look at all areas of diversity, race, culture. For example in life skills students study how people are different: homosexuals, speech impairment, glasses, fat people. All of these groups of people can be minimised and stigmatised, singled out. All diversity, not just homosexuality, is addressed. This is done in English, Social Science, Pastoral Care and Life Skills – but not science.

However other school staff felt that the curriculum was already too full, and that social issues such as health and sexuality placed pressure already stretched resources.

You barely have time to introduce anything new, I have left [health and sexuality] to the health team. There needs to be additional money to involve more people. Responsibility rests on too few shoulders and with too few people. We need to be getting the community on side before the program starts and it shouldn't be the teachers who take responsibility for this.

In the 2005 interviews, a whole school approach to diversity was more apparent than it had been in the first round of interviews. Some schools had decided to start to adapt the sex and relationships program, so that diversity issues could be addressed across the curriculum.

A couple of our more experienced teachers said that they would vary it a little bit more than they had. They've just said that some of the stereotyping work has been confronting for students and so there is a lot of debate whether that should continue to that level of confrontation and whether we should spread it out some more across the curriculum. Spread it across the English, etc. The kids find it confronting and so that is something that needs to be worked with. We need to make sure that that is a bit more cross-curricular. So not just in the Share program but also in English and Social studies and a few other areas so it is not seen as sexual health exclusively but more mainstream.

Teachers appear to be aware of homophobia and regard it as a problem. There were some comments about the gendered nature of homophobia, with male students being singled out as being more intolerant and homophobic.

Our biggest problem at that year level is the 18 and 19 year old, intolerant young men. They are very unaccepting and intolerant of anyone grappling with their sexuality.

Not an incredible homophobia wave, but they seem to have difficulties coping at a certain age.

But some change was observed:

There is still a problem with homophobia...but it is better than it was a couple of years ago so that is moving forward.

Negativity about diversity was seen by at least one teacher as not being limited to the students, particularly in country schools.

Being a country school there is a certain amount of insulation and isolation which tend to promote those intolerant views.

The Project co-ordinator workshops identified a number of SHine SA activities for bringing about changes in the school ethos. These included regular Share related articles in school newsletters; ensuring ongoing visibility of issues related to sexual health and relationships; and facilitating reviews of school policies to ensure that all members of the school community were included and are treated with respect. While these changes were the domain of the schools, the Share co-ordinators maintained contact with their schools to support them as they worked on these changes.

Schools used a variety of different and at times creative approaches to address these issues. Some provided 'health rooms' where students were able to get information about services and access leaflets and printed materials; others provided 'information points' in their school, so that students could obtain printed information without having to go through school staff. One home economics teacher complemented the Share lessons in her fabrics class by having students create fabric squares that expressed their values about relationships. These were then assembled into a quilt and displayed at the school.

In another school, a needs analysis (that was provided to all Share schools by SHine SA separately from this evaluation) was used to raise parent awareness about bullying and privacy issues in the school. The results of the needs analysis were then used to implement policy changes within the school. Another school demonstrated their commitment to the program by providing teachers with 'non-contact time', to administer and manage the Share program, in addition to their time teaching the program. At this school, the principal also participated in the teacher training and is a member of the health and well being team. At other schools there have been more difficulties. Issues such as high turnover of staff and intense lobbying from opponents of the program took a toll. In spite of these setbacks, schools have continued their commitment to the program. One of these schools has committed all health related teaching time to the Share program for the next two years.

It was planned that parents would participate as members of the student health and well being teams. However this was often affected by the timing of the meetings, and some

schools were more successful than others. Co-ordinators also noted that there appeared to be a greater level of parent involvement in rural schools than in city schools. Although it is possible to speculate on this, the reasons are not clear and this may be an area for future research to establish what makes this possible.

In the last two years of the project, a number of the Share schools used innovative and creative ways of promoting sexual health and relationships education within the school environment. One school reported in the SHine SA newsletter that a health and well being forum involving 70% of year 12 students had been very successful, and that parent information evenings had not only alleviated parent concerns, but won their strong support for the Share Program. Another rural school reported that senior students who were to become peer leaders as well as the entire school staff had participated in the *Safety In Our Schools* training which aims to eliminate homophobia within the school environment. The training identified that not all staff or students felt safe within the school environment, and policy change was being considered to address these concerns at the end of 2005. These are just a few examples of creative ways the schools have responded to environment change, and more can be found in the Share newsletter published by SHine SA.

Attempts to implement health and wellbeing teams in schools, were not entirely successful, and policy change can be a lengthy process in schools. However, many schools found creative ways to make links with their local community and work towards creating safer space for the entire school community. In the course of the project the SHine SA Share co-ordinators realised that a prescriptive approach was not workable, and this particularly applies to environment change. As well as addressing these matters locally within schools, systemic change is needed to ensure that sexism and homophobia are unacceptable, that young mothers are welcomed and supported in the school environment, and that students who are in the minority (because of race, ethnicity, culture, disability, sexuality, gender identity or other factors) are included and celebrated.

4.2 Student Perceptions of the School Environment

Before the Share Intervention

Students were asked a range of questions about what it was like for them at school. In 2003, 35% of junior students reported that their school had resources available that dealt with relationships, sexual diversity and sexual health in a positive light, and 17% indicated that teachers used and referred to these resources in class. Only 7% of students thought their school had a code of conduct making homophobia unacceptable.

Approximately 70% of students thought there were staff members especially available to provide counselling and support for students with personal problems, however only 36% thought that all students knew about these staff members and how to access them.

Students were asked what would happen at their school for a number of scenarios. In 2003, just under half of the students said that if a girl at their school were pregnant and continuing with her education, she would be supported and treated with respect, however 38% were not sure. Three quarters were confident that a teacher would intervene if they heard a student calling another student a 'dirty faggot', however far fewer (27%) thought that a teacher would intervene if they heard a student say another student's shirt was 'gay'. Two thirds of the students responding to these questions said that boys and girls were equally encouraged to participate in classes and sports, including in areas traditionally for one gender.

Among the year 10 students, responses were similar. In relation to whether their school had resources available that dealt with relationships, sexual diversity and sexual health in a positive light, 2003, 33.5% that they had, but 61.4% said they did not know. In addition, 77% of students thought there were staff members especially available to provide counselling and support for students with personal problems, however 40% thought that all students knew about these staff members and how to access them. Over half (65.6%) said that students thought that the counselling areas in the school provided confidentiality and privacy for students seeking support.

After the Share Intervention

In 2005, students were asked whether their school had resources in the library that dealt with sexual health and relationships in a positive way: 34% responded yes, and 59% responded that they did not know. They were asked if teachers use and refer to these resources in class: 31% answered no, and 51% that they did not know. In relation to whether their school had a code of conduct that made homophobia unacceptable, 35% said no, and 60% that they did not know. Asked whether there are staff members especially available to provide counselling and support students, 79% answered yes, and 17% did not know. Forty four percent thought that all students know about these staff members and how to access them. They were asked whether counselling areas in the school provided confidentiality and privacy for students seeking assistance: 63% answered yes, and 31.6% did not know. Only 46% said that they would feel comfortable seeking support should the need arise, approximately 27% responded no to this question, and a further 27% that they did not know.

Again they were asked to indicate comment on a number of possible scenarios in their school. If a girl were pregnant and continuing her education, 46% said they would 'often' or 'always' be treated with respect and supported, and 42% were 'not sure'. In response to the statement, 'If a teacher heard a student call another student a dirty faggot, the teacher would intervene', 67% thought this would happen often/ always, and 18% were not sure. However, they were less certain about how a teacher would intervene if they heard a student show disapproval of another boy's shirt by calling it 'gay': 27% thought always/ often, 41% thought rarely/ never, and 32% were not sure. In response to the statement, 'If a teacher heard a boy call a girl a "slut" they would be more likely to intervene than if they heard a girl call another girl the same name', 46.6% thought it would always or often happen, and 37% were not sure. They were asked about whether they thought gender equity was addressed at their school. In response to the statement, 'At my school, girls and boys are equally encouraged to participate in all classes and sporting opportunities, including those traditionally seen as being for one sex only', 60% thought this happened often/ always, 31% were not sure. Only 9% responded never/ rarely to this statement

4.3 Discussion: School Environment

It is clear that the Share co-ordinators were the glue that made this project possible, and kept it on track. Sexual health and relationships education is an area that has been fraught for many years. There is a wide variety of community attitudes about what is right, what should be taught and by whom, and schools rightly approach it with caution. Having well resourced, sympathetic 'experts' available to support, guide and advise, provided a valuable resource, the value of which cannot be underestimated.

Almost no change was noted in the students' responses to questions about school environment between the 2003 and 2005 surveys. From the key informant interviews and the co-ordinator workshops, it is apparent that a great deal was done in schools to address the project objectives concerning the school environment. While the questionnaire did not demonstrate that the work done to change the school environment had reached a large proportion of the students, this may be explained by the time taken for such changes to be observed within the student body. For example, some students may not be aware of the existence of school counsellors, or the services they offer, because they have had no need for them.

5. Findings: Parents/ Families

Objectives:

For parents and families to have:

- Increased knowledge and understanding concerning relationships, sex and sexual health, and to
- Increase communication about sexual health issues between young people and their families.

No direct contact was made with families for the evaluation, and data concerning these objectives were collected in the Co-ordinator workshops and the student surveys.

Students reported increased confidence to talk with their parents, but no increase was seen in the frequency with which they actually talked with them.

5.1 Knowledge and Understanding about Relationships and Sexual Health

Share project co-ordinators reported that a number of schools had taken an innovative approach in an attempt to involve and inform parents. This appears to have been more successful in some schools than others. In some schools, parent involvement was low because parents were happy to trust the school to run appropriate programs, evidenced by the high level of return of consent forms for students to participate in these schools. In one school only four parents attended the information session, but a high rate of return of consent forms was noted. It was also speculated that some parents were fearful about having their own low levels of knowledge exposed.

In 2003 the project was receiving high levels of controversial or negative media attention, and parents were being lobbied by those who opposed the program, Share Program information evenings were very well attended by parents and other members of the public. However a drop in parent participation after the first year of the project was noted. One school had 100 parents attending an information evening in 2003, and only 27 in 2004. Overall, the co-ordinators noted that information sessions were not well attended

by parents, even though all Share Project schools offered at least one information (or similar session) each year.

In 2005 the Share Project attempted to survey parents directly. While parent feedback surveys that went directly back to schools have been a successful evaluation strategy in the past, the strategy of directing them to SHine was not successful. Six thousand surveys were sent out with the Share newsletter - participating schools were asked to send them home with students, to be returned by mail to SHine SA. Only nine returns were received out of the 6000 printed. This may well indicate that parents were happy to leave the work to schools and did not feel the need to have a say once the initial controversy had settled. The co-ordinators also noted that some of the parents who came into the project in 2004/5 had no knowledge of the controversy that had occurred in 2003. The project aimed to establish student health and well being committees to drive community connections and develop a whole school approach in each school. Overall these committees did not work well as it was difficult to co-ordinate student, family and teacher involvement at a time that worked for all.

5.2 Communication Between Young People and Parents

Summary

While young people indicated some confidence to talk with their parents about sexual health and relationships, far fewer reported actually initiating, or having their parents initiating communication.

Before the Share Program

Students were asked about their confidence to talk with parents and carers about sexual health and relationships. Around 45% of students in the 2003 junior group reported that they were confident/ very confident to talk with their parents about STIs and sex, more than half felt the same about relationship problems, and 39% about contraception and pregnancy. A similar pattern was observed among the year 10 students in 2003, with a little over 40% of students reporting they would be confident to talk with their parents

about STIs, contraception and pregnancy and sex, and more than half about relationship problems.

They were also asked whether they had ever spoken to a family member about these issues. In 2003, in both the junior and senior groups, around half answered that they had spoken to a family member. Of those who had answered 'yes' to this question, an overwhelming number indicated that they had done this rarely or seldom. A small number of students responded that they do talk to family members when they need to, or when they have a problem or question they need help with. A further question asked 'who initiates the conversation?', to which those who had answered that they had talked with family member/s, were roughly evenly divided between the student and the family member/s small number answered that the conversation could be initiated by either or both family member and/ or student. Those who responded that they had not talked to a family member were asked why this was, to which they replied that they were either too embarrassed or had no current need. Some explained that they were too shy, or did not feel close to their parents. Others indicated that it was too personal to discuss with their family, or that they feared their parent's disapproval.

After Exposure to the Share Program

A slight increase in confidence to talk with parents was observed after exposure to the Share Program, with 76% reporting that they would be confident or very confident to discuss STIs with their parents, 77% about contraception and pregnancy, 71% about sex, and 87% about relationship problems.

Almost half (49%) of the students in 2005 reported that they had spoken with a family member about relationships and sexual health issues. It is of note that students reported being much more confident to talk to their parents about these matters than had actually talked with them.

Of those students who had spoken with their parents, most had done so only occasionally or rarely, while a very small number had done so frequently or regularly. In relation to

who initiates the conversation, this remained roughly evenly divided between the young person and the family member/s. A small number answered that the conversation could be initiated by either or both family member and/ or student both in 2005. Embarrassment continued to feature in some students' reasons for not speaking with parents, while some explained that they were too shy, or did not feel close to their parents. Others indicated that it was too personal to discuss with their family, or that they had no current need to talk with family about sexual health and relationships. Little change was observed between 2003 and 2005 in this area.

5.3 Discussion: Parents and Family

Attempts to involve parents in health and wellbeing committees were unsuccessful. A number of problems arose with school timetables that made parent involvement difficult, and parent availability conflicted with student availability in some cases. Most families work during the day when students are in school, and there may be reluctance to attend evening sessions. Future research with parents may establish the ways in which they are more able and willing to be involved in participating in such activities. This is an area for more concentrated work.

After exposure to the Share Program young people appear to be much more confident to talk with their parents about sexual health and relationship matters. However this has not translated into increased communication. More work is required to establish what it means to young people to 'need' to communicate with their parents. Similar work with parents could establish ways of keeping communication about sexual health and relationships open with their children across different ages.

6. Conclusion

6.1 Young People

Little change was noted in the students questionnaire after the Share intervention. The negative predictions of those who opposed the implementation of the program have certainly not been borne out. These results indicate that exposure to an intervention such as the Share Program does not lead to greater sexual activity, or less responsible behaviour, or negative interference in the parent/child communication process.

Indicators of change in knowledge, attitudes and behaviour are notoriously difficult to measure in the complex, social domain represented by sexuality, and these results illustrate this. The expectation of increased knowledge in domains such as sex and relationships, may be unrealistic. Information about STIs and contraception are likely to be of little interest to the two thirds of the students surveyed who were not sexually active. For many of these students, knowledge about STIs is of no relevance at the time it is being taught. It is interesting to contrast the high levels of knowledge demonstrated about puberty, which is likely to have been of current, or recent interest to all of the students' surveyed, with the low levels of knowledge about STIs. This is not to say that information about STIs is of no use, as it may be available for recall in the future when it does become necessary.

Teaching about sex is important, as some will need the information at the time it is taught, however, the development skills is at least of equal importance. The ability to know where and how to access the information when it is needed, as well as critical thinking and decision making skills and values clarification (as opposed to teaching specific values) are vital components of any sexual health and relationships program. These are the skills that will stand students in good stead in the future, even if they do not need the information now.

The references made by a number of students, to love, respect, communication and mutual consent, demonstrate that many have positive attitudes towards sex and each

other. There remains however, a small number of young people who are involved in risk-taking behaviours, such as multiple and casual sex partners, unsafe-sex practices, and being under the influence of alcohol or other drugs when they have sex. It was apparent in the survey that some students were sexually active and were not communicating about safe sex practices with their partners prior to having sex. It is important that the needs of this group are addressed in sex-education programs.

Others students indicated that they felt embarrassed or shy about communicating with their parents about these matters. This suggests that sexual health and relationships education programs should acknowledge and deal with young people's embarrassment. They could assist them to develop the vocabulary and understanding to discuss intimate matters with their parents, health care workers and each other.

Another issue that emerged were the gendered responses to a number of questions, particularly male students' attitudes to homosexuality, and responses to questions about puberty. This was also apparent in male ideas about sex, which was described as something that boys do to feel good, and that girls do for love. This reinforces the need for programs such as Share which address issues of gender and power, constructions of masculinity and femininity, and dispel of gender biased myths.

6.2 A whole school approach

Through the Share Project, Shine SA introduced a program intended address issues across the whole school environment. This included young people, school staff, the school environment or ethos, parents and families, and relevant local community services and agencies. In recent years a considerable amount of work has gone into developing models for a whole school approach to a range of social issues within school systems. Part of the Share Project was a literature review about a whole school approach, but the project did not claim to use a model, rather to ensure all parts of the school community were involved, towards the overall goal of improving the health and wellbeing of young people in South Australia.

The support to schools from Shine SA, in implementing the Share program, and in providing training, the Share curriculum and ongoing support, were invaluable to school staff. Over the period spanning the project, teachers became more relaxed and comfortable with the program, and with their own ability to teach it. Those staff who were not involved in the Share Program were less well informed about it, and many students were not aware of attempts to change the school environment. In future, greater efforts to communicate with the entire school community about the program, and about policy changes, may improve attempts to change the school environment.

It is encouraging that the young people expressed greater confidence in discussing sexual health and relationships with their parents, but disappointing that there was no increase in actual communication. For some students, embarrassment and shyness remain barriers to communication with their parents about matters concerning sex, and many parents do not appear to initiate discussions with their adolescent children about sex. It is important that school counsellors, chaplains and others charged with discussing personal matters with young people are well equipped to discuss sexual health and relationships, or to refer students to other appropriate sources, and that young people are aware of, and feel comfortable with, approaching these people.

Attempts to involve parents in school activities and decision making were not notably successful. Overall, this is the area that requires the most work in the future if parent/child communication remains an objective, and consultation directly with parents may establish ways of increasing parent involvement.

Despite a number of creative approaches to engagement with local services and agencies, linkages between schools and their local community were inconsistent. Some schools had already well functioning connections with local and central youth and health services, which they built on, while others were less well connected and made less progress towards developing these links. To address the disparities between schools, greater support for those schools with less well established community connections may be required.

Appendix 1. Student Questionnaire

**Note that questions F1 to F6 in this questionnaire were not included in the 2003 survey for year 8 and 9 students.*

SHARE PROJECT SURVEY

Instructions to Students

We are a group of researchers from La Trobe University who are looking at relationship and sexual health issues for young people. Our survey asks you questions about your knowledge, thoughts, and feelings concerning relationships, sexuality and safer sex.

Please don't talk to anyone about the questionnaire until you have finished because we want your own personal thoughts and ideas. You will have the opportunity at the end to ask us questions and for us to give you information.

This survey will take about 50 minutes to complete. Please do not write your name anywhere as the answers you give will be anonymous. Please answer the questions as honestly as possible; if you do not want to answer a question, just leave it blank. When you have finished, someone will collect your survey.

This information will be used to help us learn about the special sexual health needs of young people. Any publications which are written about the information collected from the project will refer to young people as a group and not to any individuals.

SECTION A. DEMOGRAPHICS

This section asks you questions about yourself, your family and where you were born.

- A1. Are you? Male 1
Female 2
- A2. How old are you? _____ years old
- A3. Which year are you in at school? Year 8 1
Year 9 2
Year 10 3
- A4. Were you born in Australia? Yes 1
No 2

If you were not born in Australia, please specify where?

- A5. If you were not born in Australia, how long have you lived here? _____ years
- A6. Are you of Aboriginal or Torres Strait Islander origin? No 1
Yes, Aboriginal 2
Yes, Torres Strait Islander 3
Yes, both Aboriginal and Torres Strait Islander 4

- A7. In which country was your mother born?
- A8. In which country was your father born?
- A9. Is English the main language spoken at home? Yes 1 No 2

If NO, please specify the main language spoken at home

SECTION B. ROLES AND RELATIONSHIPS

This section asks you questions about relationships, sexuality and the roles that men and women should/do play in our society.

- B1. Do you have a steady girlfriend or boyfriend at the moment?
(please \surd one box only)
- 1 yes

2 no

B2. Have you had a steady boyfriend or girlfriend in the past?

(please \surd one box only)

1 yes

2 no

B3. How long would you need to go out with a girl/boy before you would say they were your steady/regular girlfriend/boyfriend?

B.4 When do you think a person is ready to have sex with another person? Why?

B.5 What does 'sex' mean to you?

B.6. What does 'safe-sex' mean to you?

B7. Please show whether you agree or disagree about the following statements about sexuality. (please circle a number for every item)

		Strongly disagree	Disagree	Not sure	Agree	Strongly agree
A	Girls can control their sexual urges better than guys.	1	2	3	4	5
B	Most guys know how to give their girlfriends sexual pleasure.	1	2	3	4	5
C	It is bad for a girl's reputation to supply a condom for sex.	1	2	3	4	5
D	The <u>best</u> thing about sex is the physical pleasure you get	1	2	3	4	5
E	Guys should make the moves when they have sex with girls.	1	2	3	4	5
F	Guys should be more responsible					

	than girls for safe-sex.	1	2	3	4	5
G	If you trust your partner you don't need to worry about STIs	1	2	3	4	5
H	A girl could be called a slut if she knows a lot about sex.	1	2	3	4	5
I	The <u>most</u> important reason to have sex is to feel close to someone	1	2	3	4	5
J	A guy can get a bad reputation if he supplies a condom for sex	1	2	3	4	5
K	A healthy relationship is one where both people feel equal	1	2	3	4	5

SECTION C. SEX AND SEXUAL HEALTH

This section asks you questions on what you know about sex and sexual health, including contraception and sexually transmittable infections (STIs)

Please ✓ one box for each question.

- | | Yes | No | I'm not sure |
|--------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| C1. Could a woman be infected with HIV (the virus that causes AIDS) through having sex with a man? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C2. Does the pill (birth control) protect a woman from HIV infection? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C3. Could a man be infected with HIV through having sex with a woman? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C4. Is a person completely safe from the sexual transmission of HIV if they have sex only with one steady partner? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C5. Some STIs can lead to infertility | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

(you can't have children).

C6. 'Pulling out' before you 'cum' (withdrawal) 1 2 3

protects you from pregnancy.

C7. The emergency contraceptive pill stops a girl getting pregnant only if she takes
the pill the morning after having unprotected sex. 1 2 3

C8. If you forget to take the pill on only one day, you still won't get pregnant
. 1 2 3

C9 (a) Do you know the names of any STIs, other than HIV?

(please ✓ one box only)

1 yes 2 no

C9 (b). If you said YES, please write down the names (slang is okay) and symptoms of as
many STIs as you can (don't worry about the spelling).

C10 (a) How likely do you think you are to get a sexually transmitted infection?

(please ✓ one box only)

1 never

2 very unlikely

3 unlikely

4 likely

5 very likely

C10 (b) If you answered 'never', 'very unlikely' or 'unlikely', why do you think so?

(please ✓ as many boxes that you think apply)

a the STI problem is not as bad as some people think

b I would only have one sexual partner

c I would keep away from people who I think might have an STI

d I am too young to get an STI

e I would not inject drugs

f I have never had sex

g I would trust my partner

h I would always use a condom when having sex

- i* I would only have sex with clean people
- j* I would not have sex with people who sleep around
- k* I would not have penetration during sex
- l* Young people don't get STIs
- m* I'm not going to have sex until I'm married
- n* I would only have sex with my boyfriend/girlfriend
- o* You can tell if someone is clean.
- p* other (please write)

C11. All STIs (other than HIV) can be cured if they are treated. (*please* ✓ one box only)

- 1 yes
- 2 no
- 3 unsure

C12. You'd know if you had an STI because you'd have symptoms. (*please* ✓ one box only)

- 1 yes
- 2 no
- 3 unsure

C13. Write two sexual activities that you believe are NOT safe in terms of pregnancy or sexually transmitted infections (STIs).

C14. Write two sexual activities, which you believe are safe in terms of pregnancy or sexually transmitted infections (STIs).

C15. What does puberty mean?

C16. List five changes that happen to girls at puberty

C17. List five changes that happen to boys at puberty.

SECTION D. YOUR OPINIONS

This section asks you questions about your opinions on beliefs and myths about sex and sexual health. Please answer what you think.

D1. Please ✓ a box for each question to show whether you think the statement is true or false

	True	False	Don't know
a. People who always use condoms are safe from all STIs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b. Masturbating is a normal activity for sexual pleasure for both females and males	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
c. I will know straight away if I am pregnant.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
d. Same sex attraction is a normal part of human sexuality.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
e. Unless a girl actually says no, it's OK for a boy to push her to have sex.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
f. It is important that we support sexual diversity because we can learn from the experiences of others.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
g. There are laws that say homosexuality is illegal	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Here are some statements. Please tell us what you think about them. Please show whether you agree or disagree about the following statements (*please circle a number for every item*)

	Strongly disagree	Disagree	Not sure	Agree	Strongly agree
D2. I would stop being friends with someone if I found out he was gay.	1	2	3	4	5
D3. I would stop being friends with someone if I found out she was a lesbian.	1	2	3	4	5
D4. Non traditional families (such as lesbian parents) should be recognised and appreciated by the school community.	1	2	3	4	5
D5. It's better to wait until you're married to have sex.	1	2	3	4	5

SECTION E. SERVICES AND SUPPORT

This section will ask you questions about your access to services and support regarding sex, sexual health and relationships.

E 1. How often have you **used** the following sources of information about relationships and sexual health (including HIV/AIDS and STIs)? (please **circle** a number for **every** item). If you don't have access to any sources of information for any reason, please cross those ones out.

	<i>never</i>	<i>sometimes</i>	<i>often</i>
<i>a</i> Mother/female guardian	1	2	3
<i>b</i> Father/male guardian	1	2	3
<i>c</i> Brother/s	1	2	3
<i>d</i> Sister/s	1	2	3
<i>e</i> Boyfriend/girlfriend	1	2	3
<i>f</i> Male friend/s	1	2	3
<i>g</i> Female friend/s	1	2	3
<i>h</i> Teachers at school/school nurse	1	2	3
<i>i</i> Health education at school	1	2	3
<i>j</i> Health care worker	1	2	3
<i>k</i> Doctor	1	2	3
<i>l</i> Minister/priest/chaplain	1	2	3
<i>m</i> A friend's parent/s	1	2	3
<i>n</i> Counsellor/youth worker	1	2	3
<i>o</i> Sexual health clinic/SHine SA clinic	1	2	3
<i>p</i> Telephone information service	1	2	3
<i>q</i> TV	1	2	3
<i>r</i> Radio	1	2	3
<i>s</i> Special pamphlets/posters	1	2	3
<i>t</i> Books/magazines	1	2	3

<i>u</i>	Community health centre	1	2	3
<i>v</i>	The internet	1	2	3
<i>w</i>	Other source (please write)	1	2	3

E2. How confident are you that you could talk to one of your parents, or an adult who looks after you, about sexually transmitted infections?

- Very confident 1
- Confident 2
- A little confident 3
- Not very confident 4
- Not at all confident 5

E3. How confident are you that you could talk to one of your parents, or an adult who looks after you, about decisions concerning contraception and pregnancy?

- Very confident 1
- Confident 2
- A little confident 3
- Not very confident 4
- Not at all confident 5

E4. How confident are you that you could talk to one of your parents, or an adult who looks after you, about sex

- Very confident 1
- Confident 2
- A little confident 3
- Not very confident 4
- Not at all confident 5

E5. How confident are you that you could talk to one of your parents, or an adult who looks after you, about relationship problems?

- Very confident 1

- Confident 2
- A little confident 3
- Not very confident 4
- Not at all confident 5

SECTION F. YOUR OWN PERSONAL EXPERIENCE

This section will ask you questions about your own sexual behaviour and feelings.

F1. How many people have you had sex with in the **past year**?

*(please √ **one** box only)*

- 1 I have never had sex
- 2 I have not had sex in the past year
- 3 1 person
- 4 2 people
- 5 3 people
- 6 more than 3 people

If more than 3 people please state how many _____

If you have not had sex please go to Question F8.

F2. How often do you have sex with your regular/steady girlfriend/boyfriend? *(please*

*√ **one** box only)*

- 1 I have never had sex
- 2 I don't have sex with my boyfriend/girlfriend
- 3 more than once a week
- 4 more than once every two weeks
- 5 more than once a month

F3. How often do you have sex with casual partners? *(please √ **one** box only)*

- 1 I have never had sex
- 2 I don't have sex with casual partners
- 3 more than once a week
- 4 more than once every two weeks
- 5 more than once a month

F4. In the **past year** when you had sex, how often were you under the influence of alcohol or other drugs? (please √ **one** box only)

- 1 I have never had sex
- 2 never
- 3 occasionally
- 4 often
- 5 always

F5. Have you **ever** had sex when you didn't want to because you were too drunk or too high at the time? (please √ **one** box only)

- 1 I have never had sex
- 2 yes
- 3 no

F6. Think back to the **last** time you had sex. BEFORE you had sex, did you talk to this person about.....

- a) Avoiding pregnancy? Yes 1 No 2
- b) Avoiding HIV? Yes 1 No 2\
- c) Avoiding other sexually transmissible infections? Yes 1 No 2
- d) How to get sexual pleasure without intercourse? Yes 1 No 2
- e) Using a condom? Yes 1 No 2

F7. Which of these statements best describes your sexual feelings at the moment? (please √ **one** box only)

- 1 I am attracted only to people of my own sex
- 2 I am attracted only to people of the opposite sex
- 3 I am attracted to people of both sexes
- 4 Not sure

The following questions are about how confident you think you would feel at some time in the future in the following situations. Please √ **one** box for each question.

F8. Imagine in the future that you are going out with someone. They want to have sex but you don't want to. How confident are you that you could say no? *(please ✓ one box only)*

- 1 I would never be in this situation
- 2 very confident
- 3 confident
- 4 a little confident
- 5 not very confident
- 6 not at all confident

F9. Imagine in the future that you are going out with someone. You desperately want to have sex with them but they don't want to. How confident are you that you would respect their wishes? *(please ✓ one box only)*

- 1 I would never be in this situation
- 2 very confident
- 3 confident
- 4 a little confident
- 5 not very confident
- 6 not at all confident

F10. Imagine in the future that you and your partner have decided to have sex. How confident are you that you could talk to your partner about using a condom? *(please ✓ one box only)*

- 1 I would never be in this situation
- 2 very confident
- 3 confident
- 4 a little confident
- 5 not very confident
- 6 not at all confident

F11. Imagine in the future that you and your partner have decided to have sex. How confident are you that you could get the condoms you needed? *(please ✓ one box only)*

- 1 I would never be in this situation

- 2 very confident
- 3 confident
- 4 a little confident
- 5 not very confident
- 6 not at all confident

F12. Have you spoken to family members about relationships and sexual health issues.
(please √ one box only)

- 1 Yes
- 2 No

If yes how often?

Who initiates the conversation?

If no why not?

SECTION G. SCHOOL ENVIRONMENT

This section asks you questions about what it is like at your school

G1. Does your school library have resources (books, posters, videos) available that deal with relationships, sexual diversity and sexual health in a positive light?

- 1 Yes
- 2 No
- 3 Don't know

G2. Do teachers use and refer to these resources in class?

- 1 Yes
- 2 No
- 3 Don't know

G3. Does your school have a code of conduct that makes homophobia unacceptable?

- 1 Yes
- 2 No
- 3 Don't know

G4. Are there staff members especially available to provide counselling and support to students with personal problems?

- 1 Yes
- 2 No
- 3 Don't know

G5 Do all students know about these staff members and how to access them?

- 1 Yes
- 2 No
- 3 Don't know

G6. Do counselling areas in the school provide confidentiality and privacy for students seeking support?

- 1 Yes 2 No 3 Don't know

G7. Would you feel comfortable about seeking support from the school counsellor should the need arise?

- 1 Yes 2 No 3 Don't know

G8. Please read the following and tell us what you think happens at your school?

(Please circle a number for each statement.)

	<i>Never</i>	<i>Rarely</i>	<i>Not sure</i>	<i>Often</i>	<i>Always</i>
If a girl at your school was pregnant and continuing with her education she would be supported and treated with respect.	1	2	3	4	5
If a teacher heard a student call another student a 'dirty faggot' the teacher would intervene.	1	2	3	4	5
If a teacher heard a boy call a girl a 'slut' they would be more likely to intervene than if they heard a girl call another girl the same name.	1	2	3	4	5
If a teacher heard a student show disapproval of another boy's shirt by calling it 'gay' they would intervene.	1	2	3	4	5
At my school, girls and boys are equally encouraged to participate in all classes and sporting opportunities, including those traditionally seen as being for one sex only.	1	2	3	4	5

Thank you for completing this questionnaire

Appendix 2. Key informant interview schedule

Themes and prompt questions:

- How do teachers feel about:
- their levels of knowledge
- Comfort levels to teach various subjects

Discussion points:

- Has there been any sexuality or relationships program in your school before now?
- Who has been involved? Did you work together as a team?
- Have you ever done any training to help you run sexuality programs in the school? Have others in the school been involved? Have you used a team approach?
- To what extent do you feel comfortable/ and or confident teaching about sexual health and relationships?
- Are there any areas you feel less comfortable/ confident with?

3.4. Develop positive attitudes and behaviour relating to sexual health, relationships (including sexual, cultural and physical diversity).

Discussion points

- Can you tell me which services and agencies in your area provide support or assistance to young people?
- Do you have connections with services or agencies in the wider community? How do you use them? Do any of them come into the school? Does the school go to any of them?

4.1. To ensure that schools have a commitment to addressing relationships and sexual health issues in the whole school environment.

- What do you know about policies?
- What do you know about curriculum?
- Is the curriculum generally inclusive?

- What kind of visibility is there around the school about sexuality issues?
- How supported do you feel in dealing with sexual issues?

Discussion points:

- What policies does your school have that support sexual health and relationships education?
- In the broader curriculum, do sexual health issues get addressed?
- What kind of visibility is there around the school about sexuality issues?
- How supported do you feel in dealing with sexual issues with students?
- Are there designated student welfare counsellors easily available for young people in the school? Are they regularly used?

4.2 To develop positive attitudes and behaviour to be more inclusive and respectful of diversity

- Teachers feel supported in dealing with sexual health issues by the whole community

Discussion Points

- Do you feel you are supported in the school community to teach about sexual health issues? By school policies? Administration? Other teachers? Parents? The wider community?
- Have you implemented steps to make the curriculum more inclusive and respectful of diversity? How/ what?
- To what extent have the regular Share updates helped you to feel supported in doing this?

Appendix 3. Approaches to Evaluation

There are many different approaches to, and understandings of evaluation. Ostrom et al. (1995) defined evaluation of social programs as:

... a field of applied science which seeks to understand how a successful social program may be designed, implemented, assessed and sustained

The National Mental Health Promotion and Prevention Working Party (2001) described it as:

...a continuous process of asking questions, reflecting on the answers to these questions and reviewing your ongoing strategy and action.

The Program Against Domestic Violence (2000) also argue that:

Evaluation is a critical component of every effective program. It is one step of an ongoing process of planning, implementation and review which allows a program or project to remain relevant, appropriate and dynamic. It is a way of checking that a program is delivering the results that it set out to achieve

Evaluation also occurs at different levels. **Formative evaluation** is a method of judging the worth of a program while the program activities are forming or happening. Formative evaluation focuses on the process (Bhola 1990). **Process Evaluation** is the examination of procedures and tasks involved in implementing a program and can include examination of both the administrative and organizational aspects of a program.

Summative (or outcome) evaluation is used to obtain descriptive data on a project and to document short-term results, it is task focused and the results describe the output of the project. **Impact Evaluation** is an in depth, comprehensive evaluation that focuses on the long-range results of a program. The results often cannot be directly related to the effects of an activity or program because of other (external) influences on the target audience that occur over time. These evaluations can be carried out internally by the project workers, or externally by an evaluator. The internal evaluation can be seen as less rigorous than the external evaluation, but external evaluation can be beyond the means of most community based organisations.

Consultative Evaluation

The team at ARCSHS have developed an approach to community based evaluations that involves both formative, process, summative and impact evaluation, and which involves the participation of the (internal) project workers and external evaluators working together in a consultative manner to achieve a rigorous and affordable evaluation outcome. This approach has been termed “consultative evaluation”.

The consultative evaluation model uses the skills and knowledge of the project workers as well as the expertise and rigour of the researchers at ARCSHS. Unlike traditional external or internal evaluation models, the workers and the evaluation team work together to develop the evaluation measures and tools, and much of the data collection is carried out by the project workers. The data is then passed on to the evaluator for analysis and the evaluation report is then usually incorporated into the larger report of the project.

The Share Project team met with the ARCSHS evaluation team in late 2002 for a one day workshop at which the goals of the project were worked through in detail to clarify objectives and related project activities, as well as to identify key performance indicators and performance measures, which has formed the basis of the evaluation strategy. The strategy includes surveying students, key informant interviews and workshops with the three SHine Project co-ordinators. Thus formative and process evaluation was carried out through key informant interviews with school staff and SHine SA project co-ordinator workshops. Summative evaluation was carried out via the survey of students who participated in Share. Impact evaluation was not part of the brief for this evaluation, but a number of external factors impinged on the implementation of the project, and will be addressed elsewhere. A further area that has not been addressed in this evaluation, and is rarely (if ever) addressed in sex and relationships education, which include the implications of life events, sexual timetables, age effects and maturity for young people who have been exposed to such interventions. As Kippax and Stephenson (2005) have argued, ‘things are not as simple as they seem’ in relation to sex and relationships education, and evaluating such programs is not the same as evaluating more stable, ‘objective’ areas.

Appendix 4. Student Survey: Tables

Roles and relationships

Table 1.

	Agree/ strongly agree Statement	2003	2003	2005
		Jnr %	Snr %	%
A	Girls can control their sexual urges better than guys	51.7	56.3	44.4
B	Most guys know how to give their girlfriends sexual pleasure	46.0	46.5	40.2
C	It is bad for a girl's reputation to supply a condom for sex	6.0	9.7	5.6
D	The best thing about sex is the physical pleasure you get	42.3	50.3	44.2
E	Guys should make the moves when they have sex with girls	24.4	20.4	67.2
F	Guys should be more responsible than girls for safe sex	42.6	31.9	26.2
G	If you trust your partner you don't need to worry about STIs	12.0	11.6	6.2
H	A girl could be called a slut if she knows a lot about sex	15.2	22.4	18.6
I	The most important reason to have sex is to feel close to someone	45.7	45.2	38.2
J	A guy can get a bad reputation if he supplied a condom for sex	3.0	1.9	3.4
K	A healthy relationship is one where both people feel equal	91.7	93.1	90.0

Table 2

	Question	2003 Jnr Yes %	2003 Snr Yes %	2005 Yes %
C1.	Could a woman be infected with HIV (the virus that causes AIDS) through having sex with a man?	81.1	91.8	82.7
C2.	Does the pill (birth control) protect a woman from HIV infection?	1.8	3.1	1.1
C3.	Could a man be infected with HIV through having sex with a woman?	66.8	80.4	73.7
C4.	Is a person completely safe from the sexual transmission of HIV if they have sex only with one steady partner?	10.6	7.0	8.4
C5.	Some STIs can lead to infertility (you can't have children).	44.1	60.9	61
C6.	'Pulling out' before you 'cum' (withdrawal) protects you from pregnancy.	29	15.8	10.6
C7.	The emergency contraceptive pill stops a girl getting pregnant only if she takes the pill the morning after having unprotected sex.	32.4	44.0	47.2
C8.	If you forget to take the pill on only one day, you still won't get pregnant.	11.4	8.9	11.7

Table 3.*Question D1 a. to g.*

True	2003 Jnr %	2003 Snr %	2005 %
People who always use condoms are safe from all STIs	30.2	29.6	29.1
Masturbating is a normal activity for sexual pleasure for both females and males	81.4	84.1	84.9
I will know straight away if I am pregnant.	7.3	10.1	9.0
Same sex attraction is a normal part of human sexuality.	55.6	56.4	56.7
Unless a girl actually says no, it's OK for a boy to push her to have sex.	1.2	3.2	2.8
It is important that we support sexual diversity because we can learn from the experiences of others.	45.9	60.9	53.4
There are laws that say homosexuality is illegal	15.6	20.9	25.4

Table 4.*Questions D2 – D5*

Statement agree/strongly agree	2003 Jnr %	2003 Snr %	2005 %
I would stop being friends with someone if I found out he was gay.	12	12.6	11.8
I would stop being friends with someone if I found out she was a lesbian.	5.1	3.7	4.5
Non traditional families (such as lesbian parents) should be recognised and appreciated by the school community.	27.3	31.7	42.1
It's better to wait until you're married to have sex.	13.9	8.9	16.3

Table 5. *Question E1. How Often Have you used the following sources of information about relationships and sexual health (including HIV and STIs)?*

Sometimes/ Often	2003 Jnr %	2003 Snr %	2005 %
Female friend/s	65.3	76.6	79.6
Male friend/s	56.3	63.9	74.0
Mother/female guardian	73.8	63.4	68.8
Boyfriend/girlfriend	54.9	60.8	68.4
Books/magazines	68.2	71.8	63.2
TV	56.8	64.1	57.4
Health education at school	53.8	62.6	54.0
The internet	35.4	40.7	39.4
Father/male guardian	38.9	41.3	39.1
Special pamphlets/posters	41.4	44.3	37.6
Teachers at school/school nurse	25.7	32.3	36.4
Sister/s	32.6	32.1	35.2
Radio	36.9	41.4	34.6
A friend's parent/s	17.8	27.5	30.8
Brother/s	22.8	25.5	25.4
Doctor	35.4	32.3	24.4
Sexual health clinic/SHine SA clinic	21.5	16.5	20.2
Counsellor/youth worker	14.6	10.5	15.0
Health care worker	17.4	11.6	14.5
Community health centre	12.1	8.6	10.7
Telephone information service	11.8	7.8	8.4
Minister/ priest/ chaplain		5.5	6.1

Questions E2. to E 5.

Table 6.

How confident are you that you could talk to a parent, or an adult who looks after you, about:

Confident/ very confident	2003 JNR %	2003 SNR %	2005 %
STIs	45.5	43.3	75.9
Contraception and Pregnancy	38.8	45.2	76.9
Sex	43.8	42.7	70.9
Relationship problems	57.9	53.5	87.1

Table 7.

G. 8 Please tell us what you think happens at your school?

Always/ often		2003 JNR %	2003 SNR %	2005 %
A	If a girl at your school was pregnant and continuing with her education she would be treated with respect and supported.	49.4	43.6	45.7
B	If a teacher heard a student call another student a 'dirty faggot' the teacher would intervene.	66.9	74.7	66.7
C	If a teacher heard a boy call a girl a "slut" they would be more likely to intervene than if a girl called a girl the same name.	36.7	43.6	46.6
D	If a teacher heard a student show disapproval of another boy's shirt by calling it "gay" they would intervene.	32.8	27.3	27.0
E	At my school girls and boys at the school are equally encouraged to participate in all classes and sports opportunities, including those traditionally for one sex	57.9	63.5	53.8

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