

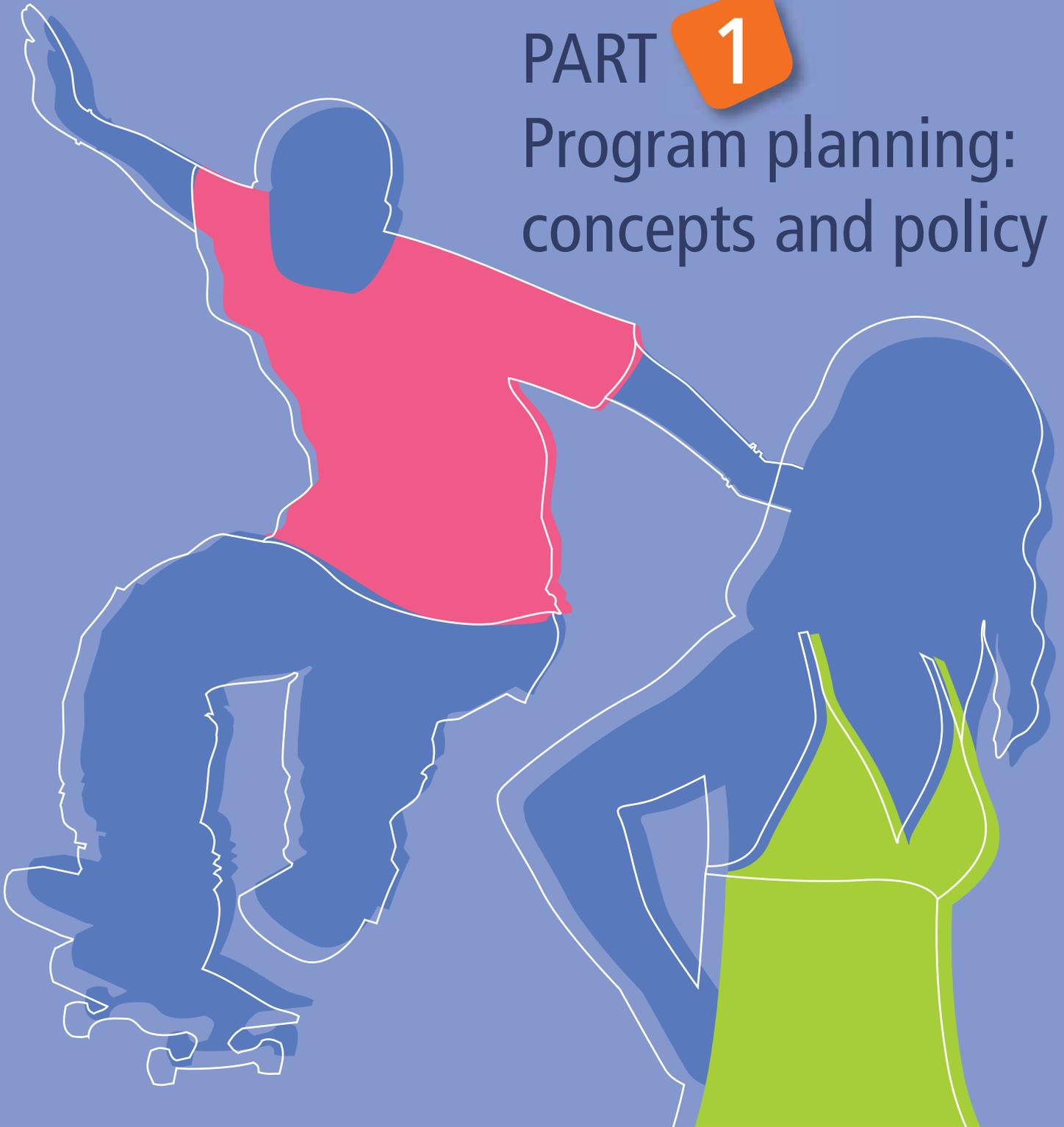
# Catching On *Everywhere*

Sexuality education program development  
for Victorian schools

PART

1

Program planning:  
concepts and policy



*Catching On-line*

[www.education.vic.gov.au/studentlearning/teachingresources/health/sexuality](http://www.education.vic.gov.au/studentlearning/teachingresources/health/sexuality)



# Catching On *Everywhere*

Sexuality education program development  
for Victorian schools

## PART 1

Program planning:  
concepts and policy

Published by the Student Learning Programs Division Office for Government School Education,  
Department of Education and Early Childhood Development,  
Melbourne, April 2008.

© State of Victoria 2008

The copyright in this document is owned by the State of Victoria or in the case of some materials, by third parties (third party materials). No part may be reproduced by any process except in accordance with the provisions of the *Copyright Act 1968*, NEALS (see below) or with permission.



An educational institution situated in Australia which is not conducted for profit, or a body responsible for administering such an institution, may copy and communicate the materials, other than third-party materials, for the educational purposes of the institution.

ISBN 978-0-7594-0499-1.

Authorised by the Department of Education and Early Childhood Development,  
2 Treasury Place, East Melbourne, Victoria 3002.

Also published on:

<[www.education.vic.gov.au/studentlearning/teachingresources/health/sexuality](http://www.education.vic.gov.au/studentlearning/teachingresources/health/sexuality)>.

# Contents

Acknowledgements	v
About This Resource	vii
<b>1</b> The Whole-school Sexuality Education Project	1
About the Whole-school Sexuality Education Project	3
Evaluation of the schools' programs	5
<b>2</b> Literature review – Whole-school Approaches in Sexuality Education	9
<b>3</b> The Policy Environment	27
<b>4</b> References	35

## Acknowledgements

This resource has been developed through the Whole-school Sexuality Education Project.

The Whole-school Sexuality Education Project and the production of this program development resource have been made possible through the partnership of the Department of Education and Early Childhood Development and the Department of Human Services.

- Principal author: Dr Sue Dyson, Australian Research Centre in Sex, Health and Society, La Trobe University.
- Curriculum Audit Tool and curriculum advice: Nerida Matthews, Victorian Curriculum Assessment Authority.
- Policy, additional material and editing: Steven O'Connor, Targeted Initiatives Unit, Department of Education and Early Childhood Development.
- Project assistance: Associate Professor Anne Mitchell, Dr Lynne Hillier and Dr Catherine Barrett, Australian Research Centre in Sex, Health and Society, La Trobe University.
- Design: Polar Design Pty Ltd.

### **Department of Education and Early Childhood Development**

- Project leadership: Steven O'Connor, Targeted Initiatives Unit.
- Management: Dennis Torpy, Targeted Initiatives Unit, Student Learning Programs Division.
- Office support: Belinda Burns, Targeted Initiatives Unit, Student Learning Programs Division.
- Project support: Jude Quinn, Targeted Initiatives Unit, Student Learning Programs Division.
- Regional support: Deborah Maher, Southern Region.
- Regional support: Kristen Douglas, Eastern Region.
- Innovations and Excellence Educator: Carol Hankinson.

### **Department of Human Services**

- Philip Clift, Manager, BBV/STI Section, Communicable Diseases Prevention and Control Unit, Public Health.
- Roger Nixon, Senior Policy Officer, BBV/STI Program, Communicable Diseases Prevention and Control Unit, Public Health.

### **Association of Independent Schools of Victoria**

- Deborah Maher, Health Education Officer.

### **Leading project schools**

- Berendale School, Coordinator: Maree McCutcheon.
- Camperdown College, Coordinator: Sue Maskell.
- Carey Baptist Grammar School, Coordinator: Kay Rogers.
- Catholic Education Office Wangaratta, Coordinators: Clare Grogan and Trish Merlo.

- Catholic Education Office Warragul, Coordinators: Pam Mathieson and Sue Collis.
- Catholic Ladies College (Eltham), Coordinators: Anne Young and Christopher Dalton.
- Cobden Technical School, Coordinator: Nicole Rock.
- Corio Bay Senior College; Flinders Peake Secondary College and Norlane High School, Coordinator: Raelene Laver.
- Daylesford Secondary College, Coordinator: Anthony Avotins.
- Eumemmerring College, Coordinator: Maxine Foster.
- Gilmore College for Girls, Coordinators: Allison Webb and Karen Marsh.
- Haileybury (Senior School, Keysborough), Coordinator: Carmel Stafford.
- Healesville High School, Coordinator: Richard Flanagan.
- Ivanhoe Grammar School, Coordinator: Judy Hewett.
- Kalianna Special School, Coordinator: Alison Byron.
- Noble Park Secondary College, Coordinator: Claire Lynch.
- Our Lady of the Sacred Heart College (Bentleigh), Coordinator: Maureen Malone.
- Portland South Primary School, Coordinator: Margaret Millard.
- Shelford Girls' Grammar, Coordinator: Ili Pelletier.
- Spensley Street Primary School, Coordinators: Anne Nelson and Maureen Douglas.
- St Brigid's Secondary College, Coordinator: Tarn Mclachlan and Jacky Hateley.
- St Charles Borromeo Primary School, Coordinators: Sue Cahill (Student Wellbeing Coordinator) and Kate Wilde (Youth Worker).
- Wellington Secondary College, Coordinator: Peter O'Bree.
- Western Port Secondary College, Coordinator: Robyn Minty.

#### **Leading community agencies supporting the schools**

- Australian Research Centre in Sex, Health and Society.
- Centre for Developmental Disability Health Victoria.
- City of Greater Geelong.
- Cobden Health Services.
- Connections (Same Sex Attracted Worker).
- Family Planning Victoria.
- Hepburn Health Service.
- Jean Hailes Institute.
- Manifold Place.
- North East Support & Action for Youth Inc.
- Peninsula Community Health Service.
- Portland District Health.
- Primary Mental Health - North East Division.
- Rainbow Network.
- Respect Protect Connect programs at Women's Health in the South East (WHISE) and South Eastern Centre Against Sexual Assault (SECASA).
- Upper Hume Community Health Service.
- Western Region Health Centre.
- Yarra Valley Community Health Service.

# About This Resource

The program development materials in this resource are designed for school leaders, teachers and other school staff when developing, delivering and evaluating sexuality education programs in their schools. The materials are designed to assist primary, secondary and special schools across all year levels. They have been developed through the key learnings from the Whole-school Sexuality Education Project (2006-2008).

The resource supports the important role schools play in the sexuality education of young people, a responsibility shared with parents and local health organisations.

It is compulsory for government schools to deliver sexuality education within the Health and Physical Education domain of the Victorian Essential Learning Standards (VELS). Sexuality education is most effective when it is delivered across curriculum and with a whole-school learning approach. A *whole-school learning approach* to sexuality education aims for maximum student learning in the classroom, in the school environment and in the school's community partnerships.

This resource will assist schools in the consideration of the many complexities of the area. The case studies illustrate the variety of processes and creative solutions schools can undertake to tackle these complexities, all through a whole-school learning approach. The resource provides a tool for auditing curriculum, developed through the Victorian Curriculum Assessment Authority. Finally, the resource proposes a three-year program development plan based on the learning experiences of the many schools involved in the Whole-school Sexuality Education Project.

The resource is in two parts.

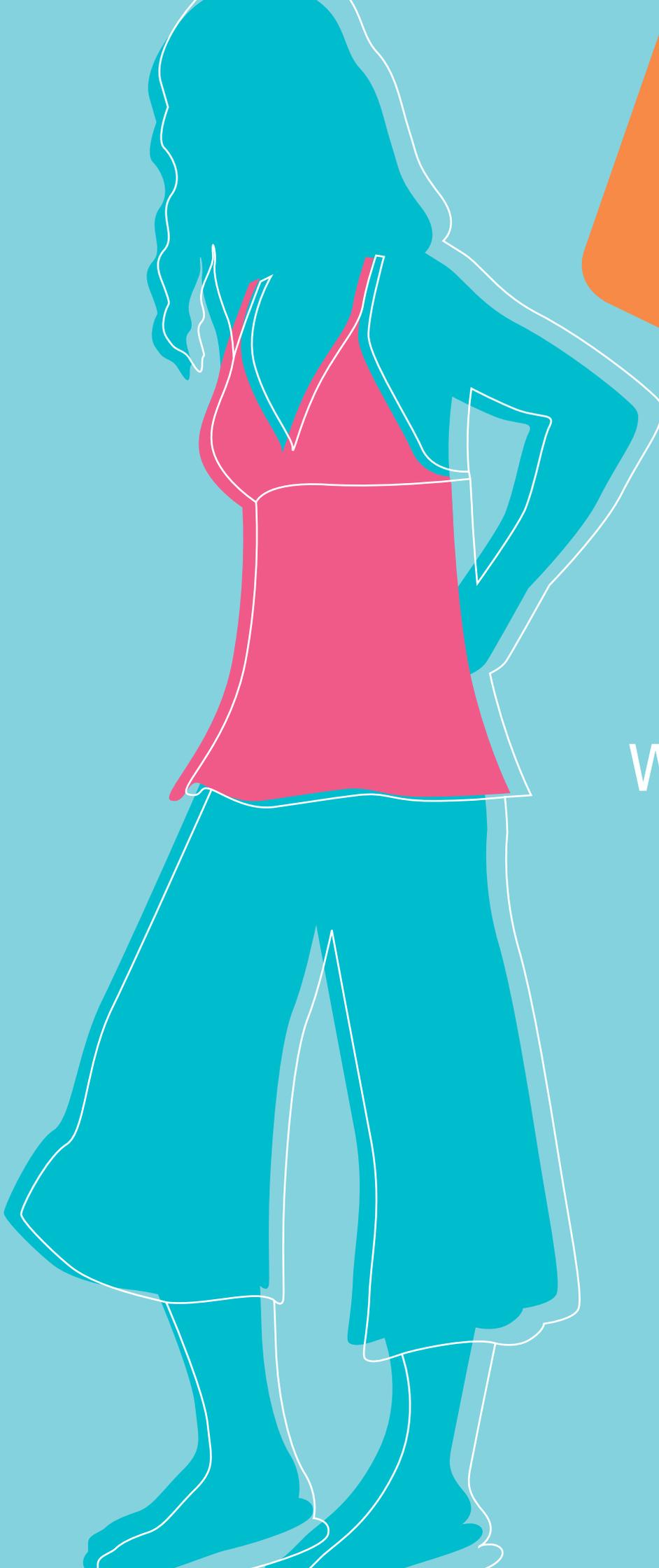
## **Part 1 – Program planning: concepts and policy**

Part 1 of this resource provides a background to the Project, a literature review and an outline of the sexuality education policy environment.

## **Part 2 – School practice in sexuality education**

Part 2 of this resource provides the Model for Whole-school Learning in Sexuality Education, five school practice examples, a three-year plan for program development and a sexuality education curriculum audit tool.





The  
Whole-school  
Sexuality  
Education  
Project



# About the Whole-school Sexuality Education Project

The Whole-school Sexuality Education Project was an initiative of the Victorian Department of Education and Early Childhood Development (DEECD) in partnership with the Department of Human Services (DHS).

The Project involved individual schools and groups of schools planning, delivering and evaluating sexuality education programs at the local level. Funded programs included government secondary and primary schools, clusters of schools, special schools, Catholic and independent schools and two Catholic education offices.

Twenty-three programs were completed; however, the reach of the Project was far wider than the funded programs. Because the networks, clusters and Catholic Education Offices worked across multiple sites, in all 50 schools were directly involved, including 13 government secondary schools, one government P-12 school, 12 government primary schools, three special schools, six independent secondary colleges, two Catholic primary schools and 13 Catholic secondary colleges. Urban, suburban and rural schools were involved.

The Department commissioned La Trobe University's Australian Research Centre in Sex, Health and Society (ARCSHS) to evaluate the Project. This involved facilitating schools to develop implementation plans at the beginning of the Project that included individual evaluation measures for each school to apply to their own programs. The ARCSHS evaluation involved carrying out interviews with stakeholders from a selection of participating programs and evaluating the data received from the school programs against the criteria for a whole-school learning approach to sexuality education.

In September 2005, the Department announced the Whole-school Sexuality Education Project and applications for funding were sought from all Victorian schools. Schools were invited to propose sexuality education programs that reflected:

- the Model for Whole-school Learning in Sexuality Education (an overview of the model is provided on page 30, a more detailed version is provided in Part 2 of this resource)
- Sexuality Education – Section 3.17.2, *Victorian Government Schools Reference Guide* (2005)
- *Talking Sexual Health – The National Framework for Education about STIs, HIV/AIDS and Blood-borne Viruses* (2001) (see page 33).

Successful schools were required to implement and trial a whole-school learning approach to sexuality education based on the Department's model and the Victorian Essential Learning Standards; work in partnership with parents and the community; develop and implement a program plan; attend a series of professional learning and briefing activities provided by the Department and fulfil reporting requirements.

Criteria for selection to participate and receive funding for the programs were a commitment to work towards using a whole-school learning approach; a clearly articulated program plan; and a leadership team. Programs were also expected to identify a specific need that the program would address; describe their community links and demonstrate support from their local health agency. Commitment to continue work on the program beyond the funding was also expected of participating schools.

## Evaluation of the schools' programs

While a whole-school approach is commonly seen as a strategy of health promoting schools, a review of current literature revealed scant information about this approach being used in the delivery of sexuality education in schools (the full literature review is provided on page 9). A *whole-school approach* as a strategy of health promoting schools has the support of the World Health Organisation. This approach has been described as making 'a positive and tangible contribution' to young people's health with 'corresponding benefits for the whole-school community' (Healy, 1998, p. 23).

Sexuality education has often been constructed as a response to a problem with consequences such as pregnancy and sexually transmissible infections (STIs) that need to be prevented. The primary aim of many sexuality education programs is to delay first sex for younger students and to ensure that older students practise safer sex and contraception (Aarons 2000).

Evaluation of sexuality education programs has tended to focus on outcomes, and evaluation has been approached as if the area is a stable, objective science, rather than a complex, social domain which is constantly subject to shifts and changes. This Project represented a change from problem-focused sexuality education towards involving the total school community in a learning and teaching process and calling on the skills and expertise of community services, sometimes outside of the school's geographic boundaries. The aim of this approach was to improve the sexual health and wellbeing of young people while still addressing potential problem areas.

The evaluation criteria for the meta-evaluation were the criteria for a whole-school approach, which are school organisation, ethos and environment; community links and partnerships (including parents); and curriculum, teaching and learning.

*School organisation, ethos and environment* encompasses social justice, safety, school-based policies such as codes of conduct, sexual harassment, homophobia and bullying and student welfare policies; staff profile and support, support for young parents, student input, display of materials and physical environment, access to school nurse and student welfare coordinator in private space, and professional learning for school staff.

*Community links and partnerships* relates to partnerships with parents and carers, links with local health, counselling and youth services, and other relevant community groups.

This Project represented a change from problem-focused sexuality education towards involving the whole-school community in a learning and teaching process.

*Curriculum, learning and teaching* includes age appropriate sexual and reproductive health education for students from prep to year 12, inclusive of issues relating to family, puberty and healthy development, the reproductive cycle, safer sex and STI prevention, pregnancy prevention and fertility protection. It also includes interpersonal relationships, gender, decision-making, same-sex attraction, sexual safety and values education. The focus of this area is two-fold, on teachers and students.

## School organisation, ethos and environment

Schools approached the school ethos and environment in a number of innovative and creative ways. Some schools focused on cultural diversity, other schools attempted to bring about culture change to make the school environment safe and inclusive. Policy review and development, and administrative and student welfare processes were areas in which schools worked to develop a supportive culture.

Many found that policies were either nonexistent or outdated and some found accessing these policies to be difficult or impossible. Long-term culture change in schools ensures that the environment is safe for all members of the school community. Schools that reported effective culture change reported that they used a planned approach with long-term goals, but at a pace that acknowledged that not everyone was in the same place. For example, not encouraging same-sex attracted students to disclose when there is a risk involved that there may be an adverse reaction. They also reported that training for all members of the school community assisted with these changes.

Two main barriers to the implementation of a whole-school learning approach to sexuality education were identified repeatedly in project reports: school leadership and staff attitudes. Programs that enjoyed the full support and involvement of their principals were demonstrably more successful than those who lacked overt support. Where leadership was inconsistent, staff were less likely to be released to attend professional learning. Leadership support is essential for the successful implementation of the kind of culture change required for a whole-school learning approach. A steering committee or reference group is an effective way of ensuring this, particularly if it has among its members the principal, or principal's representative, staff members, parents and students.

Programs that enjoyed the full support and involvement of their principals were demonstrably more successful than those who lacked overt support.

## Community links and partnerships (including parents)

Despite attempts to involve parents, no projects demonstrated unqualified success in their efforts. Some schools held information nights for parents on curriculum choices, school ethos or codes of conduct, and invited parents to become more involved. Primary schools and special schools were more successful at involving parents than secondary schools.

This is an area that needs more work – not only to find ways to involve parents, but to establish what parents want and why they appear reluctant to become involved.

The contribution of community agencies in school programs adds value to sexuality education. There appears to be a lack of common understanding about language and contexts between schools, which report to Department of Education and Early Childhood Development, and community agencies, which in the main report to the Department of Human Services. This was problematic for some programs. It is important that these differences be clarified and resolved to ensure effective partnerships.

School and community partnerships must work to complement each other.

Furthermore, teachers have pedagogical and curriculum development skills not necessarily possessed by health and community workers. School and community partnerships must work to complement each other rather than be the exclusive domain of one or the other.

## Curriculum, learning and teaching

A number of schools carried out curriculum reviews and designed new curricula using the results. The main finding in this area related to teacher comfort in teaching sexuality education. While most teachers with primary responsibility for sexuality education were relatively comfortable, many reported that beyond these domains, many teachers were uncomfortable and reluctant to address sexuality issues should they arise.

Effective sexuality education provides not only knowledge but also opportunities for individuals to explore attitudes, feelings, values and customs that may influence their choices. Educators must have the ability to connect sexuality education with the social context in which young people come into contact with sex. To do this work, they need to be comfortable to discuss sexuality with young people. This requires a clarification of their own values and attitudes and an affirmation of their desire and comfort to work in this area.

Teachers with training were able to address the issues with ease.

Those schools that worked across curriculum areas and undertook team teaching found that when issues relating to sex or relationships arose in classes such as English or Art, teachers with training were able to address the issues with ease.

One-off events did not stand alone as effective sexuality education. Events such as guest speakers and excursions with students were an important adjunct to an overall program. It was apparent that the one-off events that worked best in this project were the ones supported by a comprehensive curriculum approach.

## Conclusions

Based on the literature review and the findings of the evaluation of the school programs, it is clear that a number of key elements are important to ensure effective school-based sexuality education.

## **The role of school leaders**

It is crucial that principals and others in leadership roles in schools demonstrate their support for a whole-school learning approach to sexuality education, for example, through their ongoing and active involvement in the planning and management of sexuality education programs.

In recognition of sexuality education as a shared responsibility, principals are in the best position to actively forge appropriate links and partnerships with the wider school community, including parents/carers and local community services.

## **Professional learning**

Ongoing and regionally-based professional learning opportunities for schools is important. This will ensure a critical mass of staff across different curriculum areas possesses the necessary skills to teach sexuality education.

## **Partnerships**

Partnerships at a government level (such as currently exists between the Department of Education and Early Childhood Development and the Department of Human Services) as well as between community agencies and schools are essential to ensuring an effective shared responsibility.

Schools and community agencies work in very different contexts. In the Project, effective collaboration was affected by such issues as lack of common language, departmental timelines, funding, and different lines of reporting. Community agencies and schools need to understand each other's differing demands to help them form common objectives and effective partnerships. Effective partnerships can also lead to sharing of information and training opportunities, and ensures mutual understanding and consistent goals.

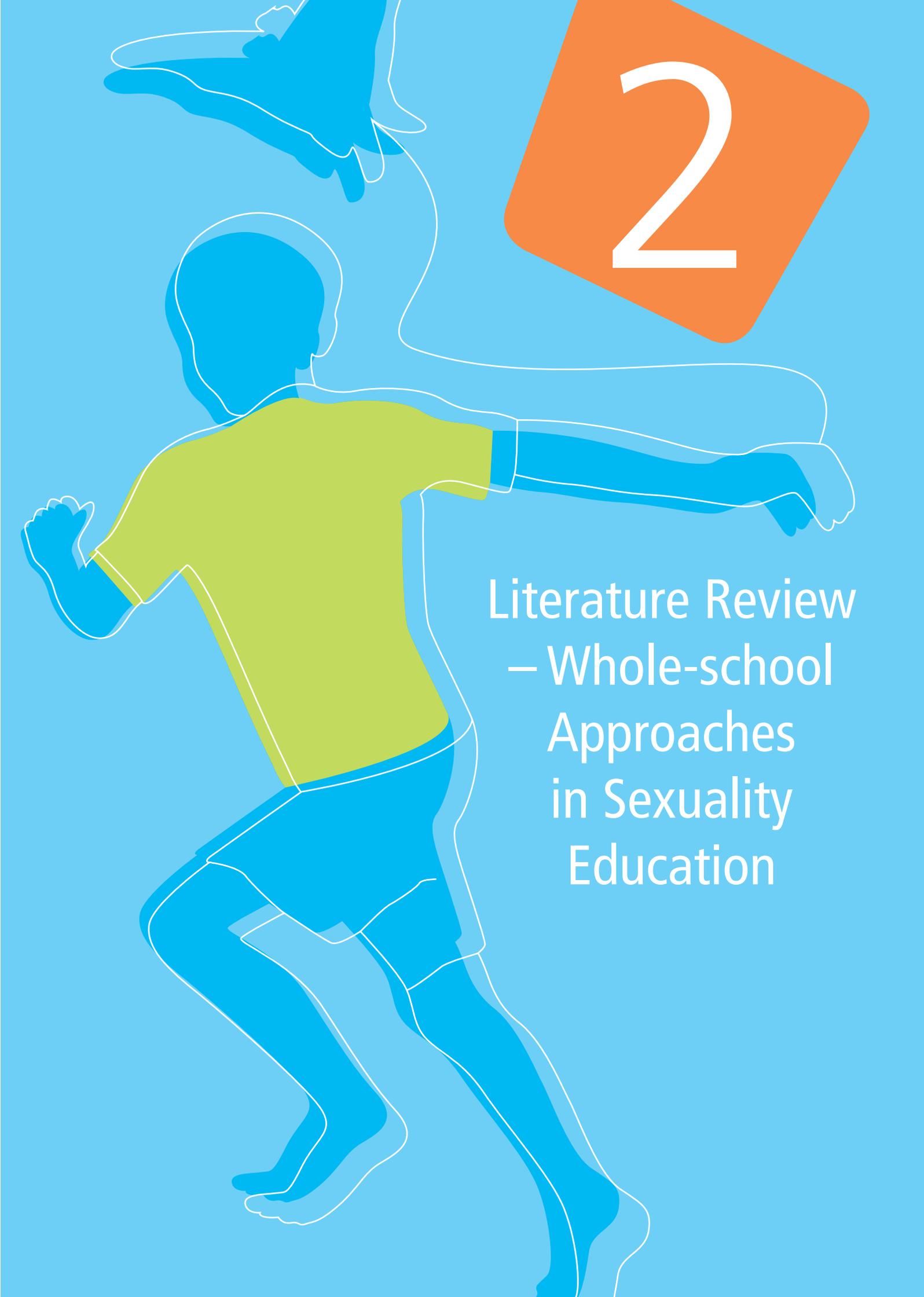
Parent engagement is also crucial. Parent engagement in secondary schools remains problematic when it comes to the kind of partnership sought for a whole-school learning approach to sexuality education. More research could assist to understand this phenomenon and find ways to engage parents in a meaningful way.

## **Use of external providers and external resources**

While there are many resources available for schools, it is important for schools to identify what constitutes an effective resource to support their programs. There is a paucity of research in this area.

## **Special schools have special needs**

Three special schools participated in the Project and it is apparent that while they shared many of the same difficulties as other schools, they are unique in other ways. Further investigation into the specific sexuality education curriculum needs in special school settings would assist in this area.



2

Literature Review  
– Whole-school  
Approaches  
in Sexuality  
Education



A review of current literature concerning sexuality education using a whole-school approach was carried out. The review was developed around the following questions:

- What definitions have been used for a whole-school approach to sexuality education? What models and applications have been used in different settings?
- In what ways does the school ethos and environment influence students? In what ways have schools addressed these issues?
- In what ways can parent/community links be established? What are the barriers and facilitators to these links functioning effectively?
- What issues emerge concerning the evaluation of sexuality education programs, and in what ways are they relevant to the current Project?

## Using a whole-school approach for sexuality education

In Victoria, sexuality education (which is also commonly known as sex education or sexual health education) is part of the health and physical education curriculum. The United Nations defined sexual health as ‘a state of physical, emotional, mental and social wellbeing related to sexuality, including the absence of disease, dysfunction or infirmity, a positive and respectful approach to sexuality and sexual relationships, the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence, and respect for the sexual rights of all persons’ (World Health Organisation [WHO] 2002). It has been argued that sexual health promotion should be evidence based, needs driven, evaluated and ecological in perspective (Schaalma, Abraham et al., 2004).

A whole-school approach is often discussed in the literature as a strategy of health promotion, particularly in relation to mental health promotion, and WHO has encouraged a whole-school approach to the promotion of mental health and wellbeing in schools (Konu, 2006). It has been advocated and practised in a wide variety of other education settings to address social issues, such as violence and bullying; literacy, pastoral care and citizenship. Surprisingly few references were found to a whole-school approach to sexuality (or sex, sexual health) education, although web searches did capture a number of sites about the use of a whole-school approach that incorporated sexuality education, particularly from Europe and the United Kingdom.

The work of Mitchell, Ollis et al. (2000) in developing a national framework for sexual health promotion in secondary schools in Australia defined a whole-school approach as being more than the implementation of a formal curriculum. It calls for consultation and working in partnership with parents, elders and the school community; accessing community resources and involving students. They also argued that this is insufficient, if policy and guidelines do not support practice.

Surprisingly few references were found to a whole-school approach to sexuality (or sex, sexual health) education.

For example, antidiscrimination practices should not only be taught, but policies put into practice throughout the school; and programs should be integrated within a formal student welfare support structure so that, for example, education programs can be complemented by linking young people with relevant community agencies for support or assistance should it be needed.

The concept of health promoting schools is relevant to any discussion of a whole-school approach, particularly in the context of sexuality education. 'Health promoting schools' is defined by the World Health Organisation, as displaying in everything that is said and done in schools, as well as providing support for, and commitment to, enhancing the emotional, social, physical and moral wellbeing of all members of their school community. Moon and Mullee (1999) described the concept of the health promoting schools as embodying a holistic, whole-school approach to personal and community health promotion.

A health promoting schools approach has been widely adopted at a policy level by Governments, and in practice in many school communities.

In Australia, a health promoting schools approach has been widely adopted at a policy level by governments, and in practice in many school communities. The Health Promoting Schools Framework has been depicted as having overlapping and interconnected domains: curriculum, teaching and learning; school organisation, ethos and environment; and community services and parent partnerships – in other words, using a whole-school approach.

Curriculum, teaching and learning includes cognitive domains, content, pedagogy, resources and student outcomes. School organisation, ethos and environment focuses on social domains such as school culture and ensuring a safe environment, as well as on attitudes, values, policies and practices, extracurricular activities and the social and physical environment. Partnerships and services is concerned with the relationships between school, home and the community. The Curriculum Framework should also recognise the value of this holistic approach to education (Magill, 2000).

Marshall, Sheeman et al. (2000) have written extensively about the health promoting schools (HPS) movement and explain its connection to a whole-school approach. They stress that any HPS project must develop a whole-school approach to be successful. In this, a whole-school approach can be seen as a strategy that is central to creating a health-promoting environment in schools. Simply providing curriculum 'that might or might not be supported by broader policies and practices within the school' will not guarantee success (Marshall et al. p.252).

A whole-school approach ... is central to creating a health-promoting environment in schools.

However they warn that multiple interpretations of HPS are problematic because broad and flexible approaches could lead to justification of any health-related activity as being health promoting even if 'it failed to adopt a holistic, whole-school approach' (p. 252). In conclusion, they argued that there is a need to provide training for teachers around the concepts of the HPS, that curriculum documents and topic-specific projects need to be embedded in a whole-school approach, and that greater cooperation is necessary between the health and education sectors at a national, state and local community level.

Greater cooperation is necessary between the health and education sectors.

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

Some factors that have been identified as important to achieve positive outcomes using a whole-school approach for health promoting schools are that:

- all teachers use a common language to describe ‘personal and social development’ learning within a school
- learning outcomes are agreed upon from the outset
- these are mapped across the whole school
- strengths and areas for further development are established
- minimum teaching expectations are agreed upon for all teaching staff
- school policies specify intentions and approach and that these are embedded in all policies, schemes of work and lesson plans. (Gloucestershire County Council, 2003).

## School ethos and environment

The school ethos has been described as that set of values, attitudes and behaviour which are characteristic of the school as a whole (Rutter, Maughan et al., 1979). Ethos should not be seen as an independent entity of itself, it can change over time as staff and leadership changes and new ideas gain precedence (Buston, Wight et al., 2001).

The roles of individuals in shaping the school ethos are important and must be guided by principles and policies that provide direction. Flentje (2005) raised the issue of school ethos in relation to sexuality education. She argued that schools may be giving mixed messages with regard to relationships and sexual health issues and that this may not be seen as being reflected in the school ethos. According to Flentje, there is little point in advocating respect and celebration of sexual diversity within a classroom if incidents of bullying and homophobia go unchecked outside the classroom, or of encouraging young people to feel comfortable about the changes of puberty, if girls are not able to deal with menstruation with dignity and privacy.

Schools may be giving mixed messages with regard to relationships and sexual health issues ... there is little point in advocating respect and celebration of sexual diversity within a classroom if incidents of bullying and homophobia go unchecked outside the classroom.

In relation to homophobia in schools, Pallotta-Chiaroli (2000) identified that many students 'wish to see schools supporting student initiatives in policy, curriculum and school culture that challenge homophobia and heterosexism in ways that are meaningful for students' (p. 38). A three-tiered approach that encompasses policy, curriculum and school culture clearly matches the philosophy of a 'whole-school' model. Pallotta-Chiaroli argued that a common mistake that schools often make is that they deal with the issue of homophobia as 'an issue about students' (p. 38), without actually involving the students themselves.

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

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

Whilst Nickson (1996) does not specifically use the term 'whole-school approach' in her article which proposes strategies to combat homophobia, it is clear that such an approach underpins the strategies that she details. She asserts that a holistic and proactive approach is the only effective way for school communities to tackle homophobia, and that as a microcosm of society, schools must stop reinforcing a dominant heterosexist norm and begin to both teach and practise acceptance of sexual and cultural difference.

Nickson advocated that change needs to be addressed at the institutional, classroom and curriculum levels. She provided detailed and comprehensive suggestions for each of these three 'streams'. These emphasise confronting the existence of

homophobia, providing all school members not only with strategies to challenge it, but permission to do so, and acknowledging that it is the insidious culture of denying, silencing and ignoring the existence of homophobia that allows it to flourish. Many of the interventions proposed by Nickson are aligned with simple concepts such as the imperative not to assume heterosexuality and the need to affirm sexual diversity.

In busy schools, where there are many competing priorities, it is important for a person or group of people to have responsibility for driving the project to keep it on track.

In South Australia, the Sexual Health and Relationships (Share) project introduced sexuality education into 15 schools over a three-year period (2002–2005) using a whole-school approach. The evaluation reported that while schools did considerable work on auditing and developing policies to address issues of ethos and environment, few students were aware of these changes.

The evaluation also noted that in busy schools, where there are many competing priorities, it is important for a person or group of people to have responsibility for driving the project to keep it on track. The project supported schools by employing coordinators for each region to assist them to implement a whole-school approach, and their existence was described as the 'glue' that kept the projects on track (Dyson and Fox, 2006).

To ensure that the school ethos and environment provides a safe and supportive setting for all students, staff and community members, systemic change is needed. This will 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. Processes and policies are needed to ensure that the environment and ethos is maintained.

## Community/parent links

While family and school have been viewed as having the greatest influence on young people, recently communities have received attention for their role in influencing young people's development. Epstein (1987) proposed a theory of overlapping spheres of influence that emphasises that schools, families and communities are major institutions that socialise and educate children. A central principle of the theory is that certain goals, such as student academic success, are of interest to each of these institutions and are best achieved through their cooperative action and support.

Changing family demographics, demands of the professional workplace and growing diversity among students have been identified as some reasons why schools and families alone cannot provide sufficient resources to ensure that all children receive the experiences and support needed to succeed in the larger society (Heath & McLaughlin, 1987). School/family/community collaborations have been described as a way to provide a caring component in today's often large, overburdened schools (Toffler & Toffler, 1995).

School/community links have been described as a way of schools being part of a total system of interactive forces that include individuals, institutions, goals and expectations that are inextricably linked together (Waddock, 1995).

School/family/community collaborations have been described as a way to provide a caring component in today's often large, overburdened schools.

School-community partnerships can be defined as the connections between schools and community individuals, organisations, and businesses that work together to promote students' social, emotional, physical, and intellectual development. Within this definition of school-community partnership, community is not necessarily constrained by the geographic boundaries of neighbourhoods, but is more about the social interactions that can occur within local boundaries (Sanders, 2001).

The principle of including parent and community links in the whole-school approach acknowledges that outside the school, young people's experiences within their homes and communities influence their health and education experiences (Denman, 1999). Furthermore, the cooperation of parents and their involvement in their children's education can enhance the academic achievement of schools (Brighouse & Tomlinson, 1991).

The cooperation of parents and their involvement in their children's education can enhance the academic achievement of schools.

In a health promotion study about nutrition in schools, the active involvement of parents was shown to reduce risk factors (Nader, Sallis et al., 1989). This study reported that as a sole strategy, information sent to parents by schools was unlikely to impinge on health to any great extent.

Sexuality education is a more contested and complex field than nutrition. Perceptions of parental support for sexuality education in schools can be influenced by a number of factors. For example, those who oppose sexuality education in schools may be highly vocal and persistent in promoting their point of view, thereby giving the impression that they represent a large proportion of community opinion.

In one Canadian survey of parents' attitudes towards the provision of sexuality education in schools, the vast majority of the almost 7,000 parents surveyed agreed or strongly agreed that sexuality education belongs in schools (McKay, Pietrusiak et al., 1998).

In South Australia, the report of a three-year sexuality education intervention in 15 schools found that prior to the introduction of the program, many parents were uncertain or concerned about the program content (Dyson and Fox, 2006). This was alleviated by attendance at public information sessions that were provided in all schools, which appeared to increase parents' understanding and acceptance of the program. This project also reported that despite efforts to involve parents in school health and wellbeing committees to oversee the project, there was little success. They recommended that further research was required to establish why parents did not get involved.

The South Australian Share project's information evenings – which focused on the content and process of the Share program – were very well attended by parents. There was public opposition to the program, which may explain the high levels of parent attendance (Dyson and Fox, 2006).

Those who oppose sexuality education in schools may be highly vocal and persistent ... thereby giving the impression that they represent a large proportion of community opinion.

A British study reported that many parents feel they do not know enough about what is being taught to their children in health education programs (Denman, 1998). In this study, only 35 per cent of secondary students' parents felt they knew enough, and less than 11 per cent said they had been given the opportunity to express their views about the program. The high level of attendance at the Share information evenings, while assumed to be due to a controversy, may also reflect a desire on the part of parents to be better informed.

In a survey that aimed to gauge the nature and extent of the involvement of external agencies in school health programs in the UK, schools and community health agencies were found to have different agendas. Community agencies expressed concern about being invited into a school to run a one-off session without any prior collaborative planning between the school and the agency to establish where the session fit in the curriculum, or a profile of the students and their expectations (Sidebottom, 1995).

This *ad hoc* approach can lead to patchy and variable provision. Furthermore, schools were reported to be generally unaware of the range of agencies operating in their area and to be likely to rely on 'incidental contact through the community' (p.21). Because some schools had ill-defined health promotion programs within their curriculum, a fragmentation of the subject was observed, which lowered its status and undermined delivery. Schools that gave priority to nurturing self-esteem and providing a supportive pastoral care system were identified as those where a 'meeting of the minds' between education and health occurred, 'even though the language we use may be different' (Sidebottom, 1995, p.22).

Cushing (1997) identified three barriers to school/community collaborations: schools' fear of public scrutiny; staff burnout; and personal attitudes and perceptions of school leaders and staff.

The UK policy on school health promotion has been criticised because, while it highlights the importance of establishing links with the community, it does not advise schools what kind of community they should be looking for, the purpose of the endeavour and what the role of the school should be (Denman, 1999).

Two different perspectives on the role of schools have been described. One places schools in the central role of planning and coordinating resources in health promotion. In this model, schools take responsibility for linking young people with the services they need, and any environmental changes made within the school must be mirrored by corresponding changes in the community (DeGraw, 1994).

Community agencies expressed concern about being invited into a school to run a one-off session ... This ad hoc approach can lead to patchy and variable provision.

Schools were reported to be generally unaware of the range of agencies operating in their area and to be likely to rely on 'incidental contact'.

The other model places schools as one component of a broad-based community program of health promotion. In this model the school health curriculum would be an extension of community health programs across a range of settings (Farley, 1991).

Denman (1999) notes that both approaches require careful management, coordination, collaboration and integrated design, but that the latter approach places the school in a contributing role rather than a leadership role.

It is important for schools to understand the role required of them if they are expected to collaborate with community agencies, and for some clarity about the nature and type of agencies they are expected to liaise with to be provided from a Departmental level.

## Curriculum, teaching and learning

### Teaching

While this area is often seen as being focused on students, it is not only about students and curriculum content but also about teachers' skills, attitudes, values and knowledge.

Teaching sexuality education does not require the same skills as teaching academic subjects; it requires skills for working with groups and the ability to combine formal and informal learning approaches. Effective sexuality education provides not only knowledge, but opportunities for individuals to explore attitudes, feelings, values and customs that may influence their choices (*Health Canada*, 2003). Furthermore, teachers/educators must have the ability to connect sexuality education with the social context in which young people come into contact with sex (Rogow and Haberland, 2005).

A two-year sex education intervention in 25 schools in Scotland was evaluated using a randomised control trial (RCT). The obstacles and facilitators to teacher-delivered sex education were evaluated as part of this, using qualitative and quantitative measures. Buston, Wight et al. (2002) reported on the reasons why teachers did not fully implement the program. Effective, teacher-delivered classroom sex education was aided by teacher training and senior management support. It was hindered by competition for curriculum time, brevity of lessons, and sex education being accorded a low priority by school management, particularly in relation to timetabling, teachers' limited experience and ability to use techniques such as role-play.

For many teachers sexuality education is an uncomfortable area. Sexuality, the sexual knowledge, beliefs, feelings, attitudes, values, intentions and behaviours of individuals (Sexuality Information and Education Council of the United States [SEICUS]), is a 'contested and problematic area' (Weeks, 1989). In one British study, teachers talked about sexuality education as 'difficult', and the requirement to discuss sexual issues in front of a number of adolescents while upholding the pedagogical relationship may seem an impossible practice for some (Epstein & Johnson, 1998).

Teaching sexuality education ... requires skills for working with groups and the ability to combine formal and informal learning approaches.

In relation to teaching, Schlaama (2004) argued that those who deliver sexuality education programs require special training. Citing the Sexual Health and Relationships Education (SHARE) intervention in Scotland, Schlaama refers to the outcomes of the five-day training that all SHARE teachers were required to attend. The teacher evaluations were overwhelmingly positive, and after the training, teachers who were lacking in confidence about their abilities prior to the training, were more confident to deliver the program. However, some teachers remained reluctant to deliver some 'key aspects' of the program.

Those who deliver sexuality education programs require special training.

The authors argue that there is ample evidence from studies of the implementation of sex education programs to highlight the need for teachers to be provided with not only the training required to develop skills for the delivery of participatory programs such as those required for sexuality education, but also with clearly documented exercises that have been piloted and found to work well in classrooms (Schlaama, Abraham et al., 2004).

Schlaama's (2004) findings echo those of Walker, Green and Tilford (2003), who evaluated team teaching training for sex educators from 11 schools in the UK. They found that following the specially designed training, teachers were able to make a positive contribution to both program and policy development in their schools. Teachers were better able to build their school's capacity to be responsive to young people's needs, and other areas such as team building, building greater collaboration between the school and local health services, and improved links between the school, parents and students.

It has been argued that the absence of statutory training and limited opportunities to attend courses on the delivery of sexuality education means that teachers who do feel uncomfortable teaching about sex and related issues have little chance to gain skills or confidence (Buston, Wight et al., 2001).

Walker (2002) identified the location of teacher training as an issue. Taking teachers out of school for five-day training places great pressure on schools, while training provided after school hours or on weekends eats into teachers' personal time. The willingness of schools to release teachers for team training has been described as being indicative of the level of priority they attach to [sexuality] education (Walker, Green et al., 2002). Team training has been recommended, as it avoids isolating individuals within schools and builds a critical mass of teachers willing to take an initiative forward.

Parents were more satisfied with the program when they knew about it, and welcomed communication with the school.

If sexuality education is to be embedded in the curriculum, then cross-curricular representation is essential, as is the involvement of the school nurse (Walker, Green et al., 2002). Teacher training in the SHARE (Scotland) project resulted in better relations with parents and increased consultation with parents. Furthermore, parents were more satisfied with the program when they knew about it, and welcomed communication with the school. The inclusion of senior management in team training also helped to secure support for the program (Walker, Green et al., 2002).

Buston and Wight (2001) reported from their research that there are several, interrelated factors that are important in understanding the provision of sex education in the classroom. These include the priorities of the leadership team within a school, the cohesiveness of the teachers delivering the program, and the personal characteristics of the classroom teachers. In their study, where the guidance team was weak, this was reflected in the outcomes of the program.

The inclusion of senior management in team training also helped to secure support.

## Curriculum and learning

Reducing the incidence of teenage pregnancy has been the target of many sexual health programs around the world.

An evaluation of programs that provided sexual health education for young people was carried out by UNAIDS in 1997. Of the 53 studies that evaluated specific interventions, 27 reported that HIV/ AIDS and sexual health education neither increased or decreased sexual activity, 22 reported a delay in the onset of sexual activity and only three found an increase in sexual behaviour associated with sexual health education (Grunseit, 1997).

In the USA, which has extremely high teenage pregnancy rates with four in ten teenage girls becoming pregnant while in their teens, there has been a consistent decline in these rates over the past decade.

While [sexuality education] programs cannot solve the problem of teenage pregnancy, they are an important part of the answer.

While the reasons for this decline is not entirely understood, a number of sexuality education (and other) programs aimed at reducing these rates were evaluated in 1997, with a follow up in 2001. The author of the study examined the various approaches to reducing teenage pregnancy and concluded that while these programs cannot solve the problem of teenage pregnancy, they are an important part of the answer.

In the USA, almost every teenager in the country receives some form of sex education, which can be divided into two broad categories: *abstinence only*, and *sex or HIV education* (also known as *abstinence plus*, or *comprehensive sex education*). (Kirby, 2001.)

Abstinence-only programs teach delaying sexual activity until after marriage, abstinence-plus programs include information about safer sex and contraception, as well as stressing the benefits of abstinence. The federal government in the USA promotes and funds abstinence-only sex education (DiCenso, Guyatt et al., 2002). One study claims that this has influenced teacher attitudes to the provision of sex education away from what would be best for the students to what best suits adult beliefs (Fisher, 2002).

Studies that have evaluated both kinds of programs have shown mixed results, but overall, abstinence does not do any better in delaying sexual debut or preventing pregnancy than programs that include information about contraceptives.

One study that reviewed 26 randomised control trials that evaluated sex education programs reported that while none of the interventions delayed initiation of sexual intercourse, four abstinence programs and one abstinence-plus program were associated with an increase in the number of pregnancies.

There were also fewer pregnancies among the young women who received multifaceted programs (DiCenso, Guyatt et al., 2002).

Another study that looked at STI transmission found that young people who received a safer sex intervention reported less frequent sexual intercourse, contradicting the belief that sex education increases sexual activity (DiClemente, 1998). Furthermore, there is little evidence that abstinence-only programs are successful in encouraging teenagers to delay sexual activity until marriage, and consequently, avoiding pregnancy, STI or HIV infection.

Comprehensive sex education, which emphasises the benefits of abstinence while also teaching about contraception and STI prevention, has been proven to reduce rates of teen pregnancy and STI infection. These findings suggest

There is little evidence that abstinence-only programs are successful in encouraging teenagers to delay sexual activity until marriage.

that abstinence-based programs do not necessarily result in improved sexual health outcomes for young people, or that comprehensive programs encourage more sexual activity. Furthermore, comprehensive programs may serve to better equip young people with skills that promote sexual health (Mckay, 2000).

A large body of evaluation research demonstrates clearly that sex education and HIV programs delay sexual activity for some students and increase responsible sexual behaviour among those who do become sexually active (Kirby, 2001).

Other authors have argued for sexuality education to take a broader approach, for example, Rogow (2005) suggested that sexuality education is often disconnected from the social context in which sex takes place for young people. In an article that argues for sexuality education to take a social studies approach, Rogow argued that students need to develop 'critical thinking skills that enable them to reflect meaningfully on the ways that gender directly and indirectly shapes their sexual lives and relationships, and begin to transcend these deeply entrenched roles' (p. 335).

Short-term curricula have no measurable impact on the behaviour of young people.

Echoing this call for a broader approach, in an evaluation of sex education programs, Kirby (2001) argued that short-term curricula have no measurable impact on the behaviour of young people and suggests that effective sexuality education programs share the following characteristics. They:

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

- provide basic, accurate information about the risks of teen sexual activity and about ways to avoid intercourse or use methods of protection against pregnancy and STIs
- include activities that address social pressures that influence social behaviour
- provide examples of, and practice with, communication, negotiation and refusal skills
- employ teaching methods designed to involve participants and have them personalise the information
- incorporate behaviour goals, teaching methods and materials that are appropriate to age, sexual experience and culture of the students
- last a sufficient length of time (that is, more than a few hours)
- select teachers or peer leaders who believe in the program and then provide them with adequate training.

Kirby's evaluation focused on more than curricula approaches to sex education, including programs for parents and families, clinic-based programs to provide reproductive health care, community-wide initiatives that address the social factors that lead to teenage pregnancy including early childhood, and youth development programs.

However, he does not mention using a whole-school approach that includes involving students, teachers, parents and the wider community in the planning, delivery and support of sexuality education programs. Indeed, there appears to be a paucity of literature that evaluates a whole-school approach for sexuality education programs.

There appears to be a paucity of literature that evaluates a whole-school approach for sexuality education programs.

Web searches identified specific school districts that stated they utilised 'a whole-school approach' to teenage pregnancy. Such programs appear to have been adopted in California (USA), Alberta (Canada), Middlesbrough (UK), Essex (UK), and Aberdeen (Scotland). All of these sources merely noted that a 'whole-school approach' was being implemented.

There was no evidence of any evaluation of these programs or of their specific content. Nevertheless, given that these programs are reported as having been implemented in the years 2000 to 2001, it would appear that a whole-school approach to teenage pregnancy is being widely used across national boundaries.

Few references were found to the use of classroom resources such as video, computer/CD-ROM, written resources and classroom guest speakers, and no literature on the evaluation of these resources was identified, even though educators put a high priority on using resources in sexuality education programs.

One resource that has gained a considerable amount of attention in recent years is the infant simulator, or 'virtual babies'. The theory of cognitive development put forward by Inhelder and Piaget in 1958 hypothesised that children and adolescents may not think about sexual activity, pregnancy and child rearing in the same way as adults (Barnett and Hurst, 2004).

In recent decades, this theory has underpinned some attempts to prevent unintended pregnancy and attempts have been made to simulate the experience of caring for infants in a variety of ways, so that young people will understand the complexity and difficulty involved in parenting.

Early programs involved young people caring for eggs and other fragile objects as substitutes for babies, but more recent technology has improved on these methods. Infant simulators are constructed to be the size, weight and appearance of real infants. They are computerised to mimic the unpredictable nature of infant behaviour and require adolescents to care for them for varying lengths of time. Some even differ in their temperaments and the length of time they cry (Barnett & Hurst, 2004).

One program using the infant simulator that has been extensively evaluated is Baby Think It Over (BTIO). BTIO has been found to be popular with health teachers (Kralweski, Stevens-Simon, 2000) and the parents of students who participated in the experience (Price, Robinson, Thompson and Schmalzried, 1999). However, a USA survey of students in grades six and eight who participated in a BTIO program found that adolescents continued to overlook the negative aspects of parents after the program (Kralweski et al., 2000). In this study, only 29 per cent of 109 students who participated in BTIO thought that real infant care would be anything like simulated infant care, or that the infant simulator had any effect on their intent to become teen parents.

Based on self-reported data from the students, Barnett and Hurst (2004) reported that BTIO appeared to have a slightly more positive impact on students in grade eight and 10 than those reported by Kralewski et al. (2002) with students in grades six and eight. However, Barnett et al. further cautioned that once adolescents are sexually active, that the message to 'wait' may be ineffective and that self-reported data, such as that gathered in their study, should always be interpreted cautiously.

A more recent evaluation of BTIO by Barnett (2006) reported even less positively than the earlier evaluations. This study evaluated a state mandated, abstinence-only sex education program in two schools in Missouri that used BTIO with 49 students. They found no evidence that BTIO had any benefits for the students and that it is expensive to purchase and maintain. They recommend that before spending scarce school resources on infant simulators, evidence of their efficacy, which is currently lacking, is necessary.

In summary, while infant simulators are popular with teachers, nurses and parents, they have been shown to have little effect on the attitudes of young people towards parenting, sexual or contraceptive behaviours (Somers and Fahlman, 2001).

They found no evidence that BTIO [and the use of infant simulators] had any benefits for the students and that it is expensive to purchase and maintain.

## Evaluating sexuality education programs

Evaluation is the process by which we judge the worth or value of something (Suchman, 1967). It is a field of applied science that seeks to understand how a successful social program may be designed, implemented, assessed and sustained (Ostrom, et. al., 1995). Another way of defining evaluation is as a continuous process of asking questions, reflecting on the answers and reviewing ongoing strategy and actions (National Mental Health Promotion and Prevention Working Party, 2001).

Sexuality education is often constructed narrowly as a response to a problem, with consequences such as pregnancy and sexually transmissible infections (STIs) that need to be prevented. In this construction, the primary aim of programs is to delay first sex for younger students and to ensure that safer sex and contraception are practised by older students (Aarons 2000).

Evaluation of sexuality education programs has tended to focus on outcomes, and evaluation has been approached as if the area is a stable, objective science, rather than a complex, social domain which is constantly subject to shifts and changes.

Indicators of change in knowledge, attitudes and behaviour are notoriously difficult to measure in the complex, social domain represented by sexuality, and, in the literature, sexuality education programs have not evaluated well. For example, in a meta analysis of sex education programs that used randomised control trials (RCT), DiCenso (2002) concluded that prevention strategies did not delay first sexual intercourse, improve the use of birth control or reduce unintended pregnancies among young people. McKay (2001) questioned the methodology of the study as well as the conclusions drawn by DiCenso, and argued that by only including the randomised control trials [RCTs], other methodologies that might have been more theoretically advanced and behaviourally effective were likely to have been excluded.

Data in the form of numbers, indicators or other measures do not necessarily represent 'facts' about sexuality education interventions.

Effective sexuality education must address not only the knowledge domain but also the social domains of emotions and behaviours. According to Kippax (2005):

... effective sex and relationship education provides people with opportunities to socially transform their worlds. In other words, it posits that the desired outcomes of educational interventions, such as reducing HIV or sexually transmitted infection transmission, or reducing the frequency of unsafe sexual behaviours, are difficult if not impossible to achieve unless the educational messages of the interventions are actively taken up, adopted and acted upon by populations or subgroups; in this case, young people (p. 360).

Kippax and Stephenson assert that, to be effective, the messages of the educational programs must be 'negotiated, questioned, adapted to suit and appropriated. Unlike medicines, they cannot be thought of as absorbed passively into the body of the recipient' (p. 360).

Effective evaluation must address what the program is trying to achieve. In the case of sexuality education, this is a change in sexual practice and reducing risk taking behaviours, which themselves are fluid, embedded in specific social formations, and involves the negotiation of meaning (Kippax and Stephenson, 2005). Sexual practice is complex, rooted in social conditions and the discourses which construct it.

Thus, sexual practice is constructed by the ways in which people relate to each other, as well as by education interventions, which shift according to time and culture. The object of this kind of research is social, and the participants are agents in their own lives. Recognition of agency is therefore essential in the evaluation of sexuality education programs and must be addressed in evaluation design that is rigorous, transparent, and attempts to approach the object being studied from 'useful and illuminating' angles (Kippax and Stephenson, 2005).

Data in the form of numbers, indicators or other measures do not necessarily represent 'facts' about sexuality education interventions. Therefore, evaluation must be a creative process, and the interpretation of the patterning of data is required to develop an understanding about what is going on. For example, knowing that a certain percentage of responses said one thing or another, may not tell a story about whether an intervention is effective, had the desired effect, or whether the effect was practised and maintained by those who received it.

Three principal sets of criteria inform good research and evaluation to develop a deeper understanding of outcomes. First, careful consideration of the object being researched; second, sound method and innovative design; and third, interpretation of the patterning of the data at a number of levels.

When planning to evaluate social programs such as sexuality education, it is important to remember that evaluation is a critical component of every effective program and an integral part of the planning process. Evaluation represents one step of an ongoing process of planning, implementation and review. It enables a program to remain relevant, appropriate and dynamic and provides a way of checking that it is delivering the results that it set out to achieve (PADV, 2000).

Effective evaluation processes build relationships between stakeholders, clarifies and articulates the purpose and desired outcomes of an intervention and ensures accountability. It also continually improves strategies and actions to achieve better results, increases organisational and personal capacity to develop, implement, track progress and assess outcomes, and promotes an understanding of the issues and progresses knowledge about the outcomes (*Evaluation, A Guide for Good Practice*, Commonwealth of Australia, 2000).

Evaluation of sexuality education programs has tended to focus on outcomes, and evaluation has been approached as if the area is a stable, objective science.

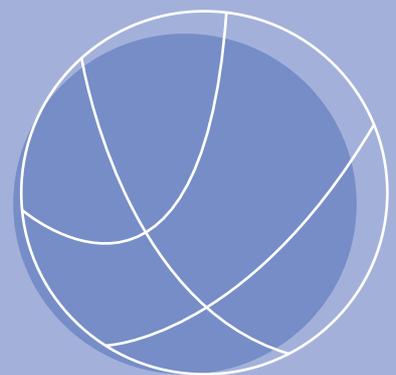
To be effective, evaluation should focus on formative (process), summative (outcome) and impact levels, if it is to describe not only changes in knowledge and attitudes immediately after the intervention, but also to understand shifts in meaning, as demonstrated by maintenance of knowledge, attitude change, and behaviour in the medium and longer term. Furthermore, these changes may not be predictable, so measures of success and effectiveness need to allow for unforeseen and unpredictable outcomes. Changes can take place at many different levels: the individual, group and organisation.

Evaluation represents one step of an ongoing process of planning, implementation and review.

At the organisational level, an understanding of the process of change is best gained through formative evaluation. Quantitative evaluation methods are limited by the dynamic nature of schools (Denman, 1999). The evaluation of school health programs should include cognitive and social outcomes, including young people's experience of their school, its organisation, teachers and classmates. (Konu, 2006.)



# The Policy Environment





Sexuality education in Victorian schools is guided by a number of government policies. They include the Victorian Essential Learning Standards, the *Victorian Government Schools Reference Guide*, the Department of Human Services' related health policies, the *Equal Opportunity Act 1995*, *Talking Sexual Health – The National Framework for Education about STIs, HIV/AIDS and Blood-borne Viruses in Secondary Schools*, and the National Safe Schools Framework.

## Catching On-line – sexuality education website

The Department of Education and Early Childhood Development's sexuality education website, *Catching On-line*, includes a detailed overview of government policy in sexuality education. The policy support documents and strategies noted in this section are all available through this website.

The website also provides a range of sexuality education learning and teaching resources, links to external resources and professional learning opportunities, and includes specific pages for principals and parents.

The website is located at:

<[www.education.vic.gov.au/studentlearning/teachingresources/health/sexuality](http://www.education.vic.gov.au/studentlearning/teachingresources/health/sexuality)>.

## Victorian sexuality education policy

Section 3.17.2 of the Health Education section of the *Victorian Government Schools Reference Guide* (updated 2007) provides an outline of sexuality education policy for government schools. The section notes that the inclusion of sexuality education in the Victorian Essential Learning Standards makes it compulsory for government schools to provide sexuality education in their learning and teaching programs.

This government policy emphasises the whole-school learning approach as the most effective learning strategy. Page 30 of this resource provides an overview of whole-school learning in sexuality education. (A more detailed version of the model is provided in Part 2 of this resource.) School programs must be evidence-based, inclusive and comprehensive, including a focus on abstinence, safer sex, love and relationships.

The policy also emphasises the shared responsibility nature of sexuality education, which includes the important roles played by parents and local health organisations. The shared responsibility for the sexuality education of Victoria's young people must be present at every level, from government initiatives and peak bodies, to local community groups, stakeholders at the coalface and parents and carers. The partnership between two government departments that led to the development of this resource reflects this shared responsibility.

It is important that schools maintain an open dialogue with parents (for example, through the school council agenda, newsletter and parent evening) regarding the school's sexuality education program. Parental roles in sexuality education include providing the child with the family perspective, providing opportunistic education at home and supporting the child's level of comfort in discussing sexuality-related issues.

## Whole-school learning in sexuality education (overview)

### Curriculum, learning and teaching

- Comprehensive sexuality education (e.g. abstinence, relationships, identity and safer sex).
- Compulsory in H&PE domain and included across curriculum.
- Student achievement assessed and reported against the Victorian Essential Learning Standards.
- Use of government and policy-appropriate external resources to support learning and teaching programs.
- Education materials readily available.
- Respectful of diversity.

### Community links, partnerships and services

- School promotes a shared responsibility approach with the local community and parents.
- The use of external providers complements the comprehensive, whole-school learning approach.
- School networks with other schools for teacher support and resource sharing.

### School organisation, ethos and environment

- Policy, responses to critical incidents and student discipline procedures reflected in learning and teaching.
- Compliance with relevant legislation (e.g. Equal Opportunity) and policy (e.g. government health policy) reflected in student learning.
- Student wellbeing support and prevention programs inform student learning and teaching.
- Staff role-modelling supports learning.
- Displayed materials support learning.
- Professional learning is available for school staff.
- Student input has been sought.

Sexuality education should be developmentally appropriate and be present in primary, secondary and special school curricula. Schools are the principal drivers of school-based sexuality education programs and teachers are responsible for the assessment of student achievement. Refer to Section 3.17.2 for more detail.

## Victorian student health and student care policies

While the student health and student care sections (4.5 and 4.6) of the *Victorian Government Schools Reference Guide* do not specifically focus on sexuality education, they contain student health intervention, prevention and care information that is sex related. For example, they outline policy related to sexual assault, homophobic bullying and the school engagement of pregnant and parenting students.

A whole-school learning approach to sexuality education will ensure that sexuality education activities (education to ensure a student's sexually healthy adult life) support health and wellbeing activities (issues-related prevention and wellbeing support).

There are opportunities in student health and wellbeing activities for powerful learning in sexuality education, for example, through a student-focused examination of an aspect of a school's wellbeing policy or health procedures.

The occurrence of sex-related critical incidents such as sexual assault and homophobic bullying can also indicate a need to re-evaluate the curriculum and student learning needs in a school's sexuality education program.

## Victorian curriculum policy

Sexuality education is compulsory within the Health and Physical Education domain of the Victorian Essential Learning Standards. Schools are expected to report on sexuality education achievement as with Mathematics, English, Science and so on, reflecting student learning against the VELS framework. While schools develop their own individual learning and teaching programs, all curriculum planned and taught across Victorian schools is assessed against these standards.

Specific reference to content relevant to sexuality starts at level four. Sexuality education at an earlier level relates to knowledge areas such as protective behaviours, understanding your body and family systems. Essential learning standards related to sexuality education are also present in other domains.

## Supporting Victorian health policy

The following three health strategies of the Department of Human Services support a comprehensive, whole-school learning approach to sexuality education:

- Victorian Sexually Transmissible Infections Strategy 2006–2009, available at: <[www.health.vic.gov.au/ideas/diseases/sti\\_strategy](http://www.health.vic.gov.au/ideas/diseases/sti_strategy)>.
- Victorian HIV/AIDS Strategy 2002–2004 and Addendum 2005–2009, available at: <[www.health.vic.gov.au/ideas/diseases/hiv\\_strategy](http://www.health.vic.gov.au/ideas/diseases/hiv_strategy)>.
- Victorian Hepatitis C Strategy 2002–2004 and Addendum 2005–2009, available at: <[www.health.vic.gov.au/ideas/diseases/hepc\\_strategy](http://www.health.vic.gov.au/ideas/diseases/hepc_strategy)>.

The whole-school learning approach is recognised as one of three key methods with the potential to significantly reduce the prevalence and impacts of STIs in the Victorian community.

## Victorian equal opportunity legislation

*The Victorian Equal Opportunity Act 1995* makes it unlawful to discriminate or sexually harass in education. 'Education' covers schools, colleges, universities and other institutions where training and education is provided. It also includes people or bodies that run educational institutions.

Schools are covered by the *Equal Opportunity Act* because they educate children, employ people (e.g. teachers, office staff and aides) and provide goods and services (e.g. canteen, parent interviews and after-school programs).

School leaders, teachers and support staff have a responsibility to put effective strategies in place to provide positive and safe environments and real learning outcomes for all students.

## Talking Sexual Health

*Talking Sexual Health – The National Framework for Education about STIs, HIV/AIDS and Blood-borne Viruses in Secondary Schools* focuses on the key principles of diversity, social justice and promoting a supportive environment. The framework was developed on behalf of the Australian National Council on AIDS, Hepatitis C and Related Diseases in 2001. Page 33 provides an overview of these key principles.

The complete *Talking Sexual Health* package includes a national framework resource, a curriculum resource and a parents' guide. They are available on the Catching On-line website: <[www.education.vic.gov.au/studentlearning/teachingresources/health/sexuality](http://www.education.vic.gov.au/studentlearning/teachingresources/health/sexuality)>.

## National Framework for Education about STIs, HIV/AIDS & Blood-borne Viruses

The key principles of diversity, social justice and the provision of supportive environments guide the knowledge, skills, processes and values important to the improvement of the sexual health of young people.

### Diversity

Understanding diversity involves:

- recognising the cultural and social diversity of society and examining and evaluating diverse values, beliefs and attitudes
- recognising the contribution of social, cultural, economic and biological factors to individual values, attitudes and behaviours
- exploring different views about issues such as gender roles, physical activity, peer-group relationships, sexuality, cultural beliefs and what constitutes a healthy environment
- exploring conflicting values, morals, and ethics for wellbeing when making decisions.

### Supportive environments

Establishing supportive environments involves:

- recognising the home, school and community as settings for promoting health
- consultation, interaction and cooperation between the home, school and community and participation of parents in school programs and approaches to teaching and learning
- sensitivity to personal and cultural beliefs in dealing with some issues in the Health and Physical Education area
- recognising the crucial role that supportive physical and social environments play in enhancing personal growth and development, physical activity, effective relationships and safety
- understanding the responsibilities of communities in caring for the natural environment
- creating physical and social conditions which support the wellbeing of students and others.

### Social justice

Promoting social justice involves:

- concern for the welfare, rights and dignity of all people
- understanding how structures and practices affect equity at personal, local and international levels
- recognising the disadvantages experienced by some individuals or groups (e.g. remote communities or people with disabilities) and actions to redress them
- understanding how decisions are made and priorities established, and how these affect individual, group and community wellbeing.

## National Safe Schools Framework

The Ministerial Council on Education, Employment, Training and Youth Affairs developed the National Safe Schools Framework in 2003. It provides a national approach to help schools and their communities address issues of bullying, harassment, violence, and child abuse and neglect.

The Framework's guiding principles for the provision of a safe and supportive school environment includes a recognition that schools 'have a responsibility to provide opportunities for students to learn through the formal curriculum, the knowledge, skills and dispositions needed for positive relationships'.

The key elements identified in the Framework parallel a whole-school learning approach in relation to school organisation, ethos and environment; curriculum, learning and teaching; and links with parents and local health and welfare services.



4

References



- Barnett, JE & Hurst, C (2004), 'Do Adolescents Take "Baby Think It Over" Seriously?', *Adolescence* 39, (153).
- Barnett, JE (2006), 'Evaluating "Baby Think It Over" Infant Simulators: A Comparison Group Study', *Adolescence* 41 (161).
- Brighthouse, T & Tomlinson, J (1991), *Successful Schools – Education and training paper 4*, London: Institute for Public Policy Research.
- Buston, K, Wight, D, & Scott, S (2001), 'Difficulty and Diversity: the context and practice of sex education' *British Journal of Sociology of Education*, 22 (3), 353.
- Buston, K, Wight, D, Hart, G & Scott, S (2002), 'Implementation of teacher-delivered sex education programme: obstacles and facilitating factors', *Health Education Research*, 17 (1), 59-72.
- Cushing, E & Kohl, E (1997), *Allies for education – Community involvement in school change: A two year exploration*, San Francisco: San Francisco School Volunteers and the William and Flora Hewlett Foundation.
- DeGraw, C (1994), 'A community based school health system: parameters for developing a comprehensive student health promotion program', *Journal of School Health*, 64 (5), 192-195.
- Denman, S (1998), 'The health-promoting school: reflections on school-parent links', *Health Education* (2), 55-58.
- Denman, S (1999), 'Health promoting schools in England – a way forward in development', *Journal of Public Health*, 21 (2), 215-220.
- Department of Education and Early Childhood Development (2005, updated 2007), 'Sexuality Education', *Victorian Government Schools Reference Guide*, Victoria, Australia.
- Department of Education and Early Childhood Development (2005), *Victorian Essential Learning Standards*, Victoria, Australia.
- Department of Education & Training (2004), *Catching On for Years 9 & 10*, Victoria, Australia.
- DiCenso, A, Guyatt, G, Willan, A, Griffith, L (2002), 'Interventions to reduce unintended pregnancies among adolescents: Systemic review of randomised controlled trials', *British Medical Journal* (international edition), 324 (7351): 1426-1431.
- DiClemete, R J (1998), 'Preventing Sexually Transmitted Infections Among Adolescents', *Journal of the American Medical Association*, 279: 1574-75.
- Dyson, S & Fox, C (2006), *Evaluation of the SHine SA Sexual Health and Relationships (Share) Project – 2003-2006*, Melbourne: La Trobe University, The Australian Research Centre in Sex, Health and Society.
- Epstein, D & Johnson, R, (1998) *Schooling Sexualities*, Buckingham: Open University Press.
- Epstein, JL (1987) 'Toward a theory of family-school connections: Teacher practices and parent involvement' in Hurrelmann, K, Kaufmann, E & Losel, E (eds.), *Social intervention: Potential and constraints* (pp. 121-136), New York: De Gruyter.

- Farley, P (1991) 'From School to Community a case study from the UK' in Nutbeam, D, Haglund, B & Farley, P (eds.), *Youth Health Promotion – from theory to practice in school and community*, London: Pluto.
- Fisher, JL (2002), 'The Controversy between Abstinence-only and Abstinence-plus Approaches to Sexuality Education', *Health Education Monograph Series: Student Monograph* 19 (2): 22-26.
- Flentje, J (2005), 'Young Peoples' Relationships and Sexual Health: A Model of Health Promotion that Advocates, Enables and Mediates', *15th National Health Promotion Conference*, Canberra: Australian Health Promotion Association.
- Gardner, K (1996), 'Strategies to Address Discrimination, Harassment and Vilification in NSW Schools' in Laskey, L & Beavis, C (eds.), *Schooling and Sexualities: Teaching for a positive sexuality*: Deakin University.
- Gloucestershire County Council (2003), 'Developing a whole-school approach', retrieved March 9, 2006, from <<http://www.gloucestershire.gov.uk/index.cfm?articleid=3569>>.
- Grunseit, A (1997), 'Effects of Sex Education on Young People's Sexual Behaviour', Geneva: UNAIDS.
- Health Canada (2003), Canadian Guidelines for sexual health education.
- Healy, C (1998), 'Health promoting schools: learning from the European project', *Health Education*, 98 (1), 21-26.
- Heath, SB, & McLaughlin, MW (1987), 'A child resource policy: Moving beyond dependence on school and family', *Phi Delta Kappan*, 68, 576-580.
- Hillier L, Dempsey D et al. (1999) *Writing Themselves In: A national report on the sexuality, health and well-being of same sex attracted young people*, La Trobe University, Australian Research Centre in Sex, Health and Society, Melbourne.
- Hillier, L, Turner, A et al. (2005) *Writing Themselves In Again*, The Australian Research Centre in Sex, Health and Society, Melbourne.
- Inhelder, B & Piaget, J (1958), *The Growth of Logical Thinking from Childhood to Adolescence*, New York, Basic Books.
- Kippax, S & Stephenson, N (2005) 'Meaningful evaluation of sex and relationship education', *Sex Education: Sexuality, Society and Learning*, 5 (4) 359-373.
- Kirby, D (2001), *Emerging Answers: Research Findings on Programs to Reduce Teenage Pregnancy*, Washington DC: National Campaign to Reduce Teenage Pregnancy.
- Konu, AI, Lintonen, TP & Rimpelä MK (2002), 'Factors associated with schoolchildren's general subjective well-being', *Health Education Research*, 17 (2) 155-165.
- Kralweski, J & Stevens-Simon (2000), 'Does mothering a doll change teens thoughts about pregnancy?' *Journal of Pediatrics*, 105 (3), 1-5.
- Magill, R (2000) 'Good Practice in Schools', paper presented at The Way Forward – Children, Young People and Domestic Violence National Forum, Barton ACT.

- Marshall, BJ, Sheeman, MM, Northfield, JR, Maher, S, Carlisle, R & St Leger, LH (2000), 'School-based Health Promotion across Australia', *Journal of School Health*, 70 (6), 251.
- McKay, A, Pietrusiak, MA, & Holowaty, P (1998), 'Parents opinions and attitudes towards sexuality education in schools', *The Canadian Journal of Human Sexuality*, 7 (2), 139.
- McKay, A (2000), 'Postponing sexual Intercourse among urban junior high school students – a randomized controlled evaluation', *The Canadian Journal of Human Sexuality* 9 (2).
- Mitchell, A, Ollis, D, Watson, J (1999), *Talking Sexual Health – The National Framework for Education about STIs, HIV/AIDS and Blood-borne Viruses in Secondary Schools*.
- Moon, AM, Mullee, MA, Rogers, L, Thompson, RL, Speller, V, & Roderick, P (1999), 'Helping schools to become health-promoting environments – an evaluation of the Wessex Healthy Schools Award', *Health Promotion International*, 14 (2), 111-122.
- Morris, R (2005), 'Research and evaluation in sexuality education: an allegorical exploration of complexities and possibilities' *Sex Education*, 5, 405-422.
- Nader, PR, Sallis, JF & Patterson TL, (1989) 'A family approach to cardiovascular risk reduction: results form the San Diego family health project' *Health Education Quarterly*, 16 (2), 229-244.
- Nickson, A (1996), 'Keeping a Straight Face: schools, students, and homosexuality' in Laskey, L & Beavis, C (eds.) *Schooling and Sexualities: Teaching for a positive sexuality*, Deakin University.
- Norden, P (2006), *Not So Straight – A national study examining how Catholic schools can best respond to the needs of same-sex attracted students*, Melbourne, Jesuit Social Services.
- Owens, RE, (1999), *Queer Kids: The challenges and promises for lesbian, gay and bisexual youth*, New York: Harrington Park.
- Paiva, V (2005), 'Analysing sexual experiences through scenes: a framework for sexuality education and evaluation', *Sex Education*, 5, 345-358.
- Pallotta-Chiaroli, M (2000), 'What do they think? Queerly raised and queer friendly', *Youth Studies Australia*, 19 (4), 34-40.
- Price, JH, Robinson, LK, Thompson, C & Schmalzried, H (1999), 'Rural parents perceptions of the Baby Think It Over program – a pilot study', *American Journal of Health Studies* 15 (3), 149-155.
- Rogow, D, & Haberland, N (2005), Sexuality and relationships education: towards a social studies approach, *Sex Education: Sexuality, Society and Learning*, 5 (4), 333-344.
- Rutter, M, Maughan, B, Mortimore, P, & Ouston, J (1979), *Fifteen thousand hours: secondary schools and their effects on children*, London: Open Books.

- Sanders, MG (2001), 'The Role of "Community" in Comprehensive School, Family and Community Partnership Programs', *The Elementary School Journal*, 102 (1), 19-34.
- Schlaama, H, Abraham, C, Gillmore, M & Kok, G (2004), 'Sex Education as Health Promotion: What Does It Take?' *Archives of Sexual Behavior*, 33 (3), 259.
- Sidebottom, D (1995), 'School health education: do too many cooks spoil the broth?' *Health Education*, 6 (November), 17-23.
- Sommers, CL, Fahlman, MM (2001). 'Effectiveness of "Baby Think It Over" teen pregnancy prevention program', *School Health*, 71 (5), 188-95.
- Student Learning and Support Services Taskforce of the Ministerial Council on Education, Employment, Training and Youth Affairs (2003), *National Safe Schools Framework*, Australian Government.
- Suchman, EA (1964), *Evaluative research*. New York, Russell Sage Foundation.
- Toffler, A, & Toffler, H (1995), 'Getting set for the coming millennium', *The Futurist*, 29 (2) 10-15.
- Waddock, SA (1995), *Not by schools alone: Sharing responsibility for America's education reform*, Westport, CT: Praeger.
- Walker, J, Green, J, & Tilford, S (2002), An evaluation of school sex education team training, *Health Education*, 103 (6), 320-329.
- Weeks, J (1989), *Sex, politics and society: the regulation of sexuality since 1800*, London: Longman.
- Wight, D (1999), Limits to empowerment-based sex education, *Health Education*, 6 (November), 233-243.



Catching On *Everywhere*

