



Talking

sexual health

NATIONAL FRAMEWORK FOR EDUCATION
ABOUT STIs, HIV/AIDS AND BLOOD-BORNE
VIRUSES IN SECONDARY SCHOOLS



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Acknowledgments

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EXECUTIVE SUMMARY

Fairness, respect for others, trust and responsibility as values learnt in the family, social and school environment, are important for young people forming personal relationships. Such values also influence and inform decisions about sexual relationships. However, young people must also have accurate and practical information to protect themselves from sexually transmissible infections (STIs), HIV/AIDS and blood-borne viruses (BBVs) in a rapidly changing world.

Australia has an international reputation for innovation in dealing with the complex issues of HIV/AIDS and related diseases in relation to the diverse needs of its population. The *National HIV/AIDS Strategy 1996–97 to 1998–99* identified young people as a priority for education and prevention interventions, and schools as most likely to provide a comprehensive and effective means of educating for long-term change.¹ It concluded that education and prevention programs should place HIV/AIDS in the context of sexual health, hepatitis C and injecting drug use where appropriate.

Recent research has indicated a cultural shift towards safe sexual practices amongst young people and has shown that they display a greater knowledge about the transmission of HIV/AIDS. However, knowledge of other STIs and BBVs is poor. It is important that young people understand the differences between the hepatitis and transmission routes because the infection rate from hepatitis C far exceeds that of HIV/AIDS in Australia. The research also indicates that a substantial number of young people are still engaging in high-risk sexual practices such as unprotected sexual intercourse with casual partners.

To understand some of the reasons for this, the complexity of the social world in which young people make decisions about their sexual health needs to be acknowledged. This acknowledgment should consider the role of alcohol and other substance use and abuse in their social lives. In addition, recent research shows that the 8–11 per cent of students who do not identify as exclusively heterosexual are not having their sexual health needs met by school programs, and that many young people of culturally and linguistically diverse backgrounds are reliant on school programs for all their sexual health information. School programs, which in the past may have focused narrowly on disease prevention, must be expanded to accommodate these issues and needs.

With these concerns in mind, the then Commonwealth Department of Health and Family Services convened a national forum of representatives of government and non-government education authorities, health authorities,

parents and key related organisations in all States and Territories in March 1998. Recommendations made at that forum led to the Australian Research Centre in Sex, Health and Society (ARCSHS), La Trobe University, Victoria being commissioned to develop *Talking Sexual Health: National Framework for Education about STIs HIV/AIDS and BBVs in Secondary Schools*.

The purpose of the Framework is to inform and support education authorities and whole school communities to implement education that reflects the complexity of issues related to STIs, HIV/AIDS and BBVs. The Framework has five key components for the development and delivery of a comprehensive education that focuses on STIs, HIV/AIDS and BBVs, which are based on the most current national and international research. These include:

- Taking a whole school approach – developing partnerships
- Acknowledging young people as sexual beings
- Acknowledging and catering for the diversity of all students
- Providing an appropriate and comprehensive curriculum context
- Acknowledging the professional development needs of the school community.

Each key component is supported by strategic advice, which will help in the reviewing and development of policies, and will help to guide the development and evaluation of curriculum, resources and professional development programs. The Framework will also assist in the development of approaches to support and include the experiences of all students. The Framework is designed to give educational institutions flexibility to treat sensitive issues in a manner that reflects their own ethos.

The study of STIs, HIV/AIDS and BBVs fits firmly into a broad health education curriculum with a particular focus on sexual health. Although all other aspects of health need to be integrated into a comprehensive approach, drug-related issues are an important element when addressing issues of sexual safety and hepatitis C infection. In general all States and Territories place sexuality and related drug education within the learning area of Health and Physical Education. Some States and Territories have used *A Statement on Health and Physical Education for Australian Schools* and *Health and Physical Education – A Curriculum Profile for Australian Schools* to guide curriculum development, or as a basis for their own guidelines.^{2, 3} The Statement and Profile provide an important and relevant curriculum context for the implementation of the Framework. They do so because the Health and Physical Education learning area focuses on the significance of personal decisions and behaviours, and community structures and practices in promoting health, including sexual health. Emphasis is placed on the importance of recognising the influence that personal actions, beliefs, attitudes and values held by families, cultural groups and the wider community and public policies have on health.

Some of the aims of this Framework are clearly articulated in a number of the learning goals in the Statement. The Statement also provides commonly agreed-upon key principles and values that are critical to the study of STIs, HIV/AIDS and BBVs within a health education context. These key principles cover diversity, social justice and the provision of supportive environments. School-based programs need to be culturally sensitive and aware of the range of different cultural norms and the implications of these for teaching and learning practices for all groups, but in particular for Indigenous Australian young people.

Schools can make an important contribution to education and prevention initiatives relating to STIs, HIV/AIDS and BBVs. It is important to remember that schools are part of a broader community response to improve the health of young people in Australia. A number of national strategies and frameworks provide a policy and guidelines' context that recognises schools as one partner in this process. These include:

- *National HIV/AIDS Strategy 1996–97 to 1998–99* ¹
- *The Second National Mental Health Plan 1998* ⁴
- *Gender Equity: A framework for Australian schools* ⁵
- *National Indigenous Australians' Sexual Health Strategy 1996–97 to 1998–99* ⁶
- *National Drug Strategic Framework 1998–99 to 2002–03*, including the *National School Drug Education Strategy* ^{7, 8}
- *National Strategy for Health Promoting Schools in Australia 1998–2001* ⁹.

Each document supports a broad health context for education about STIs, HIV/AIDS and BBVs and the promotion of sexual health in an integrated way that recognises the social context. Australian schools have legal obligations to comply with in their provision of these programs. These include legal and moral responsibilities for the 'duty of care' of students under both State and Commonwealth legislation, and anti-discrimination legislation at both state and federal levels which is relevant to the creation and maintenance of safe and supportive learning environments free from harassment and discrimination for all students.

The Framework is designed to assist in the provision of education for secondary school students. However, as health and sexuality education does not suddenly begin in secondary school, it is appropriate and desirable for those involved in the provision of primary education to be familiar with the research and the theoretical understandings presented in this document and adapt it to their needs.

Addressing the key components and developing an understanding of the most current research and the implications for young people will ensure an inclusive and comprehensive school-based approach to education about STIs, HIV/AIDS and BBVs within a broad education context.

SECTION 1: OVERVIEW

1.1 Purpose

The purpose of the Framework is to inform and support education authorities and whole school communities to implement education that reflects the complexity of issues related to sexually transmissible infections (STIs), HIV/AIDS and blood-borne viruses (BBVs). It is designed to assist them in responding to the implications of current research and in providing young people with comprehensive education within safe and supportive school environments. In doing so, the Framework will assist those working in this area to incorporate issues around STIs, HIV/AIDS and BBVs into education addressing the social context in which young people live and make decisions about their health.

The Framework is based on key components for the development and delivery of effective health education focusing on STIs, HIV/AIDS and BBVs. The key components are supported by strategic advice, which will specifically help in:

- reviewing and developing policies
- guiding curriculum and resource development
- planning, implementing and evaluating professional development
- assisting education authorities and schools in planning, developing, implementing and evaluating programs
- developing strategies to support and include all students.

It is recognised that individual schools, education authorities and agencies have their own particular values, needs and requirements. This Framework is not designed to replace these but rather to provide a review of current approaches in the context of what is known about young people and strategies that aim to improve their health. The Framework is designed to give education authorities the flexibility to treat sensitive issues in a manner which reflects their own ethos. It can also support school communities to meet the identified needs of young people in their community.

1.2 How to use the Framework

The Framework is divided into three sections. Section 1 describes the Framework's general purpose and gives suggestions for its use. Section 2 sets the context by providing a summary of relevant research, clarifying key concepts and placing issues of STIs, HIV/AIDS and BBVs in the appropriate curriculum, school-based and policy context, and describes the underlying principles. Section 3 provides strategic advice by outlining the following five interrelated and equally important key components.

1. Taking a whole school approach – developing partnerships
2. Acknowledging young people as sexual beings
3. Acknowledging and catering for the diversity of all students
4. Providing an appropriate and comprehensive curriculum context
5. Acknowledging the professional development needs of the school community.

Each key component is presented with a comprehensive discussion of current research, policies and school-based practice. Each key component is supplemented by strategic advice. The strategic advice, based on current research and practice, can be used by education authorities, school communities and agencies to review, develop and implement effective school-based education programs about STIs, HIV/AIDS and BBVs.

The suggested activities have been grouped into five areas of the whole school environment. These areas are:

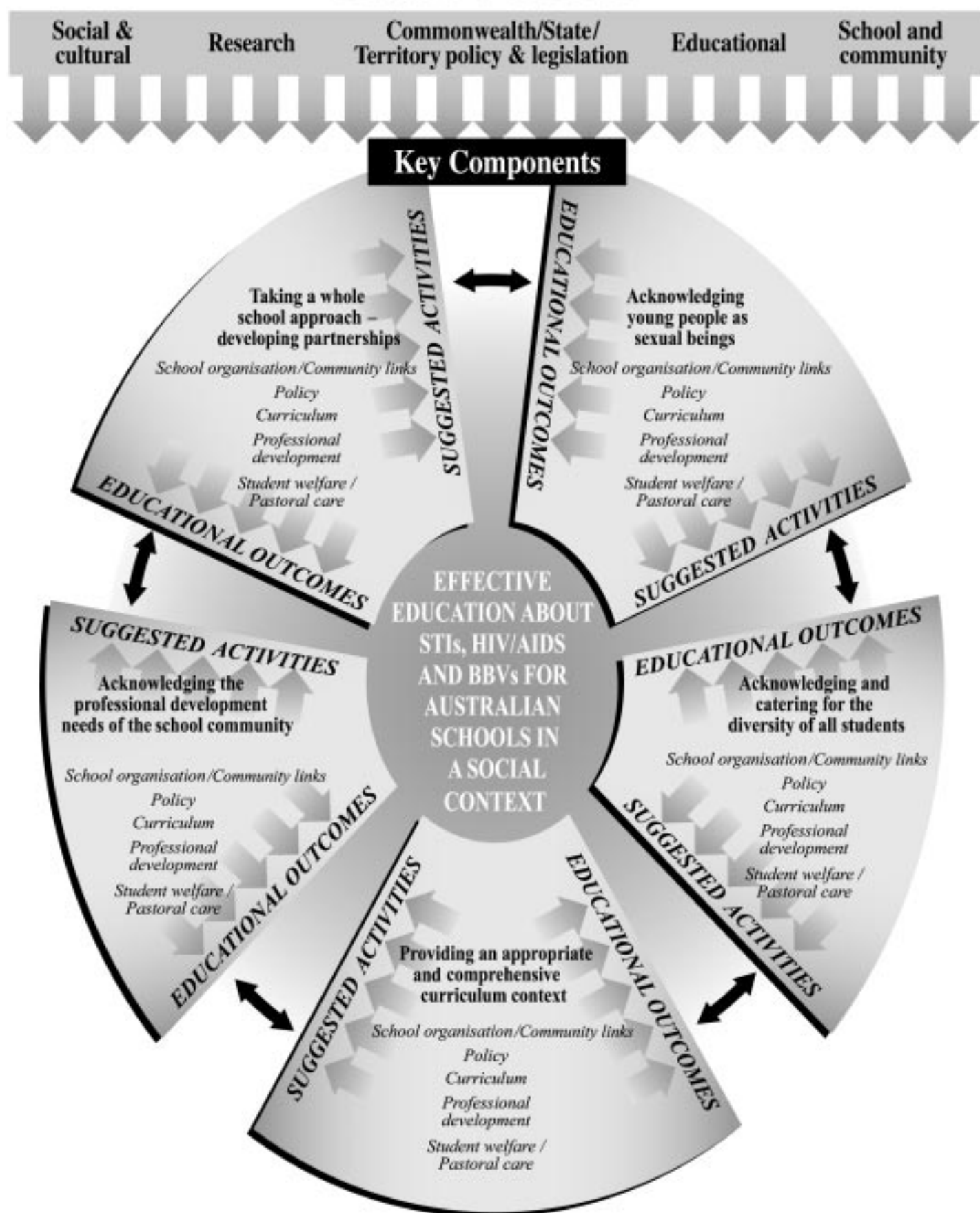
- school organisation
- policy and guidelines
- curriculum
- professional development
- student welfare/pastoral care.

As these areas are of equal importance, education authorities and school communities can choose the starting point which best suits their situation. For example, in some school communities classroom-based programs may be in operation with schools and communities looking for suggestions about supporting these programs with appropriate student welfare/pastoral care structures. In other circumstances, education authorities may have formulated or reviewed policy around education about STIs, HIV/AIDS and BBVs and are looking for suggestions about appropriate professional development policies and programs to support policy. Although the starting point and priorities may differ between and among education communities, it is important that all areas of the school environment are considered for the provision of effective education.

Each key component includes a broad education outcome under each of the above areas of the whole school environment and a number of suggested activities for its achievement. The activities presented do not generally recommend specific curricula or outline specific teaching strategies as these can be found in other resources.

NATIONAL FRAMEWORK FOR EDUCATION ABOUT STIs, HIV/AIDS AND BBVs IN SECONDARY SCHOOLS

BROAD CONTEXT



Although each key component and suggested activities have been presented separately, effective education requires consideration of all the components (refer to the diagram). At a practical level this requires users to cross refer to strategies in each of the other key components. For example, in a review of curriculum programs, as well as considering the suggested activities in key component 3.4 'Providing an appropriate and comprehensive curriculum context', it will be useful to refer to the curriculum outcomes and suggested activities in the other four key components.

A simple checklist has been included at the end of Section 3. It provides a list of key questions to be considered in the evaluation of resources and programs and a summary of key issues from all five components.

SECTION 2: CONTEXT

2.1 Background

Australia has an international reputation for innovation in dealing with the complex issues of HIV/AIDS. A key platform of Australia's approach has been the continuing education programs developed to cater for the diverse needs of the Australian population. The *National HIV/AIDS Strategy 1996–97 to 1998–99* identified young people as a priority for education and prevention interventions.¹ It indicated that such education interventions should place HIV/AIDS in the context of sexual health, hepatitis C and injecting drug use where appropriate. The Strategy also identified school-based education programs as a priority area for further development because education about STIs, HIV/AIDS and BBVs in schools was most likely to provide a comprehensive and effective means of educating for long-term change.

In 1997 the Centre for the Study of Sexually Transmissible Diseases, La Trobe University, Victoria was commissioned to conduct a survey of secondary students in years 10 and 12 in Australian government schools. This survey, *Secondary Students, HIV/AIDS and Sexual Health*, documented their knowledge, attitudes and practices concerning sexuality issues, STIs, HIV/AIDS and related infections.¹⁰ This survey was a follow-up to a survey conducted by the National Centre in HIV Social Research in 1992, *National HIV/AIDS Evaluation 1992 HIV Risk and Sexual Behaviour Survey in Australian Secondary Schools Final Report*.¹¹ As such, the 1997 survey documented changes in the knowledge, attitudes and practices of young people at the national level over a period of five years.

The findings of the 1997 survey indicate that school-based sexuality education has had an impact on the knowledge, attitudes and practices of young people. The comparison of 1997 findings with those of the 1992 survey showed that there had been a cultural shift towards safe sexual practices among the young people surveyed and that young people displayed a greater knowledge about the transmission of HIV/AIDS. However, there were still many significant gaps in young people's knowledge of other STIs and BBVs and a substantial number of young people were still engaging in high-risk sexual practices such as unprotected sexual intercourse with casual partners.

The results of the 1997 survey are consistent with a number of other recent Australian and international studies. While it appears that school-based health education programs have been successful in increasing young people's knowledge about the transmission of HIV/AIDS, it is still apparent that there is a knowledge–action gap.¹² In other words, although young people have developed knowledge of transmission, they are still engaging in risk behaviours.

To understand some of the reasons for this, the complexity of the social world in which young people make decisions about their health needs to be considered. The structure and content of many existing school-based programs and resources also needs to be examined. To date many of these programs have ignored the broader social context in which STIs, HIV/AIDS, BBVs and sexuality education is situated and narrowly focus on disease prevention instead of health enhancing behaviours. It has been well documented that education on these issues cannot be carried out successfully in schools unless students have the opportunity to examine broader issues such as the social construction of sexuality, gender and power relations, homophobia and other forms of discrimination.

The challenge to develop and implement comprehensive and effective education programs around STIs, HIV/AIDS and BBVs and sexuality is crucial in order to improve the sexual health of Australian young people.

In March 1998 the Commonwealth Department of Health and Family Services hosted a meeting of State and Territory government and non-government representatives from educational authorities and related agencies to consider the implications of the 1997 national survey and to set directions for future action. *Talking Sexual Health: National Framework for Education about STIs HIV/AIDS and BBVs in Secondary Schools* has been developed as a result of the recommendations arising from that meeting.

The consultation and review process through all stages of the Framework development included:

- a survey of key stakeholders in each State and Territory to assess what policies, programs and practices had been developed and implemented in the area
- development and distribution of a discussion paper and proposed Framework for consultation
- conducting a consultation meeting in each State and Territory on the discussion paper and proposed Framework
- distribution of the revised Framework to all those involved in the consultation process for final comments.

The outcome of this process is a Framework that can be used to guide the development of effective education programs about STIs, HIV/AIDS and BBVs in all school communities.

2.2 Research

The findings from a number of national research projects clearly demonstrate a continuing need to address education about STIs, HIV/AIDS and BBVs in schools. Further detail can be found in Section 3.

- Most students have a good knowledge of HIV and AIDS; although many do not know that HIV cannot be transmitted by mosquitoes, that a pregnant woman with HIV can infect her baby, or that a person who looks healthy could pass on HIV.
- Knowledge of STIs and the different types of hepatitis is poor.
- 48 per cent of year 12 students are sexually active with either serial monogamy or a high turnover of sexual partners being the norm.
- 22 per cent of sexually active students have three or more partners in one year.
- Between 8 and 11 per cent of year 10 and year 12 students do not identify as exclusively heterosexual.
- 53.6 per cent of young men in years 10 and 12 and 27.7 per cent of young women in years 10 and 12 used condoms on every occasion they had penetrative sex.
- Alcohol and drug use are major predictors of unsafe sexual practices.
- Of the sexually active young people in years 10 and 12, 13 per cent binge drink once a week or more, have sexual intercourse with casual partners and use condoms inconsistently or not at all.
- Students are still relying on trust and monogamy as a safe-sex practices.
- Students are ignorant of safe sexual practices other than condoms to prevent HIV/AIDS.
- Attitudes towards condom use are more positive than negative, but use is inconsistent and usually for contraception.
- 18 per cent of young women in year 12 rely on withdrawal as a contraceptive method.
- For many students of culturally and linguistically diverse backgrounds school-based sexuality education programs are the only way they can get information about sexual health issues.
- Discrimination in terms of gender and homophobia are key issues for schools.
- Many students believed there were 'deserving' and 'undeserving' people with HIV.
- Teachers find it difficult to challenge homophobic attitudes.
- 46 per cent same-sex attracted young people have been abused, with 70 per cent of the abuse occurring in school by other students and 3 per cent by teachers.
- Parents, teachers and school-based programs are major sources of information used and trusted by young people.^{13, 14, 15, 10}

2.3 Clarifying sexuality, sexual health, blood-borne viruses and the links to drug education

Sexuality and sexual health

Issues related to education about STIs, HIV/AIDS and BBVs are overwhelmingly related to human sexuality and, in the case of hepatitis C, injecting drug use. The terms 'sexuality' and 'sexual health' are key concepts in the Framework and set the broad parameters for school-based education around STIs, HIV/AIDS and BBVs. The Framework has drawn on the World Health Organization (WHO) definitions which have been widely accepted throughout Australia.

Sexuality is an integral part of the personality of everyone: man, woman and child. It is a basic need and aspect of being human that cannot be separated from other aspects of life ... [It] influences thoughts, feelings, actions and interactions and thereby our mental and physical health. Since health is a fundamental human right, so must sexual health be a basic human right.

Sexual health is the integration of the physical, emotional, intellectual and social aspects of sexual beings, in ways that are positively enriching and that enhance personality, communication and love.

[It involves] a capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic. It involves freedom from shame, fear, guilt, false beliefs and other psychological factors inhibiting sexual response and impairing sexual relationships ... [and the] freedom from organic disorders, diseases and deficiencies that interfere with sexual and reproductive function.¹⁶

Blood-borne viruses (BBVs) and drug education

An issue in need of clarification is that of blood-borne viruses and their inclusion in a framework predominantly addressing infections contracted through sexual activity. Simply, 'a blood-borne virus is a virus that can be transmitted from an infected person to another infected person by blood to blood contact, including through the sharing of injecting equipment.'¹⁷

There is a great deal of confusion around the group of viruses known as hepatitis. Young people understand that HIV is a blood-borne virus and that it can be contracted from blood to blood contact, such as from the sharing of injecting equipment.¹⁰ However, their knowledge of hepatitis A and the blood-borne viruses, hepatitis B and C, is extremely poor.¹⁰

The 1997 survey, *Secondary Students, HIV/AIDS and Sexual Health*, shows that school-based programs have had difficulty in effectively covering issues related to hepatitis with young people. This may be because many education authorities and schools separate sexuality education from drug education. Such separation can result in a lack of clarity as to who is responsible for the development and implementation of school-based programs. For practical reasons, the blood-borne hepatides are often covered under the umbrella of STIs as part of programs looking at HIV/AIDS, rather than through the much stronger links to injecting drug use.

It is not the intention of this Framework to be all encompassing of drug education principles and practices. Issues related to drug use need to be considered in any framework that is aiming to provide a comprehensive approach to education about STIs, HIV/AIDS and BBVs particularly because of the link between hepatitis C infection and injecting drug use. More detail on the links with drug education can be found in Section 3.

It is important that young people understand the differences between the hepatides because of the high infection rate from hepatitis C in Australia. Hepatitis C is overwhelmingly contracted through the sharing of injecting equipment, although there is a small possibility of it being sexually transmitted. It is estimated that approximately 80 per cent of injecting drug users are hepatitis C-positive and that about 13 per cent of uninfected users become infected each year.¹⁸ Hepatitis B can be contracted through sexual activity as well as blood to blood contact, such as injecting drug use. While there is a vaccine available to prevent hepatitis B infection, there is no such vaccine for hepatitis C.

Such confusion indicates the need to ensure that education about STIs, HIV/AIDS and BBVs is dealt with in the broad context of an integrated health education curriculum. To do so means examining and integrating issues around physical, mental, emotional and social health for young people. Accurate information about how infections are contracted, detected and where to go for help, as well as how they can be avoided, is crucial to education about STIs, HIV/AIDS and BBVs. Young people who have a positive sense of themselves, who understand their social world and its competing demands, and who are able to communicate and solve personal problems are more likely to make health-enhancing decisions.

2.4 Curriculum context

The provision of education about STIs, HIV/AIDS and BBVs fits firmly into a broad health curriculum. States and Territories vary in curriculum guidelines, syllabus provision and mandated time spent on health education. Even so, all States and Territories place sexuality and drug education within the learning area of Health and Physical Education.

Some States and Territories have used *A Statement on Health and Physical Education for Australian Schools* and *Health and Physical Education – A Curriculum Profile for Australian Schools* to guide curriculum development, or as a basis for their own guidelines.^{2, 3}

The development process of the Statement involved national collaboration with all education authorities and facilitated the integration of issues around gender, cultural and linguistic diversity, Indigenous Australians and disability into the main body of the documents rather than in separate and isolated sections. The Statement provides an important and relevant curriculum context for the implementation of the Framework. The learning area focuses on the significance of personal decisions and behaviours and community structures and practices in promoting health, including sexual health. Moreover, it emphasises the importance of recognising the influence that personal actions, beliefs, attitudes and values held by families, cultural groups and the wider community and public policies have on health. According to the Statement ‘an understanding of the beliefs, practices and policies in the area of health allows people to play an informed part in public debate and take individual and collective action necessary for emotional, mental, physical, social and spiritual well-being, both personal and social’.¹⁹

The Framework draws on similar theoretical understandings about young people and health. In particular, a number of the learning goals in the the Statement clearly articulate some of the aims of the Framework.

These include assisting young people to:

- develop the knowledge and skills to make informed decisions, plan strategies and implement and evaluate actions that promote growth and development, effective relationships and safety and health of individuals and groups
- take an active part in creating environments that support health and contribute to community debate and discussion on these issues
- accept themselves as they grow and change, and promote their own and others’ worth, dignity and rights as individuals and as members of groups
- evaluate the influence of diverse values, attitudes and beliefs on personal and group decisions and behaviour related to health
- develop an understanding of how individuals and communities can act to redress disadvantage and inequities in health and access to health care and resources
- use and evaluate services, products and facilities that promote well-being.²⁰

2.5 Key principles and values

Any area that examines issues related to social life will involve individual and community decision-making. In making decisions and taking action, community, family and individual values are important considerations. Issues around STIs, HIV/AIDS and BBVs are no exception to this. Not only do these issues reside in the area of health but their very nature means that issues around the social context of sexuality and drug use will need to be examined. This process of examination brings with it many differing value positions because 'people's values underlie the judgments they make in everyday life. This means that valuing is an important process, relevant to decision-making, that needs to be taught.'²¹

According to Lemin et al. (1994), 'values are determined by the beliefs we hold. They are ideas about what someone or a group thinks is important to life and they play a very important part in our decision-making.'²² Even though our values are central to who we are and how we act it 'is not uncommon for people to find it difficult to identify and state what their values are'.²³

Learning strategies underpinned by a values approach can help students understand this process and make choices and take actions to support values important to themselves, their family, their school, and the broader community. It also assists young people to understand that community values can be an important dimension of the social, cultural and spiritual identity of a person.

Often there is confusion between teaching valuing as a process and teaching for particular values or for a certain value position. Consideration of the teaching of particular values is a sensitive issue and requires clarification and agreement by the whole school community. School communities need to have the opportunity to clarify their own values as they relate to young people and their sexual safety as these will impact on policy and program development and implementation.

In the discussion about values it is understood that some values are generally approved of as appropriate guiding principles, sometimes called 'procedural values'. Other values, which differ from person to person, are sometimes called 'substantive values'.

In education about STIs, HIV/AIDS and BBVs many of these can relate to issues around sexuality, drug use, gender, relationships, discrimination, illness and death. Examining personal and community values is an important process in this area as it enables young people to understand their own values, those of others and the impact these have on personal and community decision-making. The process of valuing and teaching young people these skills can require careful and sensitive treatment at school and in classrooms and require skilled health education teachers.

The Statement and Profile are relevant because they provide a commonly agreed-upon set of key principles and values important to the study of STIs, HIV/AIDS and BBVs within a sexuality education context.^{2, 3} The inherent principles and procedural values in the Statement and Profile have been used to guide the development of this Framework. The key principles of diversity, social justice and the provision of supportive environments inform the Framework and guide the identification of knowledge, skills, processes and values in those strategies recommended to improve the 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 well-being when making decisions.

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 (for example 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 well-being.

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 and care-givers in the development of 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 students' own well-being and that of others.²⁴

2.6 Policy, guidelines and legislation

Schools can make an important contribution to education and prevention initiatives relating to STIs, HIV/AIDS and BBVs. It is important to remember that schools are part of a broader community response to improve the health of young people in Australia. A number of national strategies and frameworks provide a policy and guidelines' context that recognises schools as one partner in this process. They have been used in the development of this Framework to ensure that education authorities, agencies and schools are provided with a consistent and complementary approach to improving the sexual health of Australia's young people.

Of particular relevance are:

- *National HIV/AIDS Strategy 1996–97 to 1998–99*¹
- *The Second National Mental Health Plan 1998*⁴
- *Gender Equity: A framework for Australian schools*⁵
- *National Indigenous Australians' Sexual Health Strategy 1996–97 to 1998–99*⁶
- *National Drug Strategic Framework 1998–99 to 2002–03 and the National School Drug Education Strategy*^{7, 8}
- *National Strategy for Health Promoting Schools 1998–2001*⁹.

Australian schools have legal obligations to comply with in their provision of safe and supportive environments for students. Effective provision of education about STIs, HIV/AIDS and BBVs involves the examination of legal as well as moral and ethical issues around sexuality, so it is likely that issues such as discrimination may arise and they need to be addressed.

Schools are both providers of services and are employers, and have legal and moral responsibilities for the 'duty of care' of students under both State/Territory and Commonwealth legislation. Anti-discrimination legislation at both State/Territory and federal levels is a relevant framework for creating and maintaining safe and supportive learning environments free from harassment and discrimination for all students.

Of particular relevance are:

- *Commonwealth Racial Discrimination Act 1975*
- *Commonwealth Sex Discrimination Act 1984*
- *Commonwealth Human Rights and Equal Opportunity Act 1986*
- *Commonwealth Disability Discrimination Act 1992.*

Schools also need to be aware of relevant anti-discrimination and equal opportunity legislation in each State and Territory and incorporate them into school-based policies and practices.

2.7 The primary and secondary school divide

This Framework is designed to assist in the provision of education for secondary school students. However, the division between primary and secondary education is often arbitrary. For example, States and Territories have different levels for the beginning of secondary education: in some States and Territories it is year 7; in others it is year 8, and there are other school structures with no divide, for example first year of school to year 12 colleges.

Sexuality education does not suddenly begin in secondary school. The role of primary school programs cannot be underestimated as they form the basis for secondary school programs. So it is appropriate and desirable for those involved in the provision of primary education to be familiar with the research and the theoretical framework presented here. Content may differ for primary and secondary classrooms but the principles, issues and skills development being promoted to assist young people to make health-enhancing decisions about their sexuality will remain constant.

Education programs and practices should not treat all primary school students as a homogeneous group. Issues around socio-economic conditions, gender, geographic isolation, culture, disability and differing ages of maturation and puberty make it impossible to develop an all-purpose education that begins at age 12. In some schools, where large numbers of students leave at the age of 15, programs will need to begin early to ensure that the young people have access to a comprehensive, sequential program that has given them the opportunity to develop the knowledge and skills necessary to maintain or improve their sexual health.

SECTION 3: KEY COMPONENTS

This section provides a detailed discussion of the current research relevant to the provision of effective education about STIs, HIV/AIDS and BBVs for Australian secondary school students. It provides suggested activities related to achievable outcomes to assist education authorities and school communities to implement effective education in this area.

The Section is divided into five interrelated and equally important components designed to provide the necessary guidance to review, plan, develop, implement and evaluate effective educational strategies.

These include:

1. Taking a whole school approach – developing partnerships
2. Acknowledging young people as sexual beings
3. Acknowledging and catering for the diversity of all students
4. Providing an appropriate and comprehensive curriculum context
5. Acknowledging the professional development needs of the school community.

Each component is presented with a comprehensive discussion of current research, policies and school-based practice and is supplemented by strategic advice. The strategic advice have been grouped into five areas of the whole school environment. Each of the five areas of the whole school environment includes a broad education outcome and a number of suggested activities for its achievement.

3.1 Taking a whole school approach – developing partnerships

Discussion

Strategies designed to improve the sexual health of adolescents have been shown to be more successful if they are delivered in the context of a whole school approach. This means developing, implementing and reviewing policy and guidelines; consulting and working in partnership with parents, elders and the school community; accessing community resources and involving students.^{25, 26, 27, 13, 28, 29}

A whole school approach

A whole school approach means more than the implementation of the formal curriculum. It means ensuring that the messages students learn through the informal curriculum are supported by policy, guidelines and practices in the student welfare and pastoral care areas. For example, it is of limited use for students to examine the implications of discrimination on the basis of sexual orientation if in the playground or during sport they observe no response to or support for a student who is harassed for this reason. Similarly, there needs to be an integration of formal programs within a comprehensive student welfare and support structure so that linking students to community health agencies complements education programs.

Whole school approaches to education about STIs, HIV/AIDS and BBVs vary depending on the specific needs and values of the school community. Sexual health education programs and policies developed to reflect attitudes, values, skills and philosophy of each respective community will assist students to understand and act in their own social environment when making informed and healthy lifestyle decisions.

The importance of policy/guidelines

Strong policy and guidelines development may partially explain the success of school-based programs in HIV/AIDS education. All States and Territories have central policies related to HIV/AIDS. Many schools develop their own policies, consistent with these central guidelines and advice, to match the needs of their specific communities. These policies have been generated in response to State and Territory responsibility in relation to ongoing national HIV/AIDS strategies and in recognition of the importance of a pro-active approach to education for young people. The focus of the educational policies varies enormously. Some States and Territories focus purely on infection control around HIV alone; others include BBVs. Several use a more comprehensive approach that includes infection control issues and guidelines on curriculum and student

welfare issues, such as discrimination and harassment. The importance of a policy/guidelines for accountability cannot be underestimated. Many of the current documents need revision in order to more clearly integrate education into a framework addressing all aspects of education about STIs, HIV/AIDS and BBVs in a whole school approach.

Health promoting schools – linking with partners

Education and health authorities have developed several models of successful whole school approaches to health issues. The Health Promoting Schools model, endorsed by the World Health Organization (WHO), is the one most universally recognised by States and Territories. This model, built on the idea of sustainable partnerships, is centred on the interrelationships of three areas of the school community: curriculum and teaching; school organisation, ethos and environment; and community links and partnerships. In this model, a school promoting sexual health as a goal for all students would develop and maintain a supportive learning environment. This would be achieved by catering for the diverse needs of students and staff, by providing information and services and developing and maintaining an environment built on respect and empowerment. It would also develop and support policy and guidelines designed to provide staff and students with clear codes of ethics, provide information and resources that promote safe sexual practices and ensure sexual health issues are linked to student welfare. This model would also develop the personal skills of staff and students in relation to sexual health and consequent decision-making.

A key to this approach is the development of ongoing and sustainable partnerships within the whole school community. Health services would be reorientated to ensure effective partnerships between health and education authorities, agencies and organisations. Such a school would strengthen community action by involving parents and outside agencies in the school.

Students

A significant component of a whole school approach is student involvement in resource development, planning and program delivery, and also in their role as peer educators. Programs have been found to be effective if peer education is conducted to complement school based approaches.³⁰

Gourlay (1996) argues that messages from peers are inherently more likely to be relevant and contextualised and to use appropriate and familiar language and concepts. He also points to the valuable learning experience for young people through involvement in the design and implementation of programs and resources. By involving peers, schools can 'capitalise on the

recognition that the sexual attitudes and behaviours of young people are strongly related to their perceptions of sexual behaviour of their peers'.³¹

Parents/care-givers/elders

Schools working in partnership with parents acknowledge the role of parents/care-givers and elders as primary educators of sexuality. Studies show that partnerships with parents and the community help to integrate 'consistent and relevant health messages into the home and the community', improve student health, and enable a greater awareness of health issues by students and their families.³²

Programs implemented and initiated in consultation with parents are more successful and also empower parents.¹² Parents often have difficulty discussing issues concerning sexuality with their children.^{33, 34, 35} Yet young people see parents as the most trusted and preferred source of information around sexuality issues, with mothers being used by 70 per cent of young people.^{36, 15, 10} Very few same-sex attracted young people, although they would prefer to get information from parents, have easy and/or comfortable access to this trusted source.¹⁴

Schools can support parents as primary sexuality educators by providing them with current information about a wide range of sexuality issues. Schools working in partnerships with parents alleviate some of the anxiety parents experience from an expectation that sexuality education is their sole responsibility. Furthermore, such programs have the potential to provide parents with skills and knowledge to initiate and carry out informed discussion with their children.

Community health agencies and services

A whole school model is useful because it stresses the important and complementary role that community health agencies have in improving the health of students. Young people trust the information they get from these services although they do not readily access them.^{10, 15, 14} Schools and agencies working in partnership can make this trusted source of information more accessible. Students feel more comfortable about using community health agencies if schools have linked these agencies into school-based programs.¹³ There are many gains to be made from involving community health agencies in school-based programs as long as clear roles and responsibilities are negotiated between schools and community health agencies. These include increased people resources to schools, accurate information to students and teachers, and connecting young people to their local health services.^{30, 13}

Appropriate work in schools by community agencies could include assistance in program, policy and guidelines' planning; advice on resources; referral services; professional development for teachers and parents; and conducting, as appropriate, sessions for students to support existing school-based programs. Community health agencies should not be used in one-off sessions; they should be used as part of a continuing program.

Taking a whole school approach – developing partnerships. Strategic advice

WHOLE SCHOOL	OUTCOMES
School organisation, School – community links	Appropriate strategic partnerships developed to support a whole school approach to education about STIs, HIV/AIDS and BBVs.
Policy/guidelines	Policies on STIs, HIV/AIDS and BBVs cover whole school issues such as curriculum; student welfare and support; professional development; partnerships with community health agencies working with schools and infection control procedures.
Curriculum	Formal curriculum on STIs, HIV/AIDS and BBVs is supported by policy and guidelines, as well as ethos and practices across the whole school environment.
Professional development	Professional development for the education community focused on the development and maintenance of a whole school approach to education about STIs, HIV/AIDS and BBVs.
Student welfare/ pastoral care	Student welfare and pastoral care structures and procedures recognise the breadth and interrelationship of issues related to education about STIs, HIV/AIDS and BBVs.

SUGGESTED ACTIVITIES

- Coordinate activities, such as interdepartmental reference groups and working parties of education and health departments at central, regional/district and local levels.
 - Provide advice and resources to assist schools in developing appropriate whole school approaches that fit within existing State and Territory policies and frameworks.
 - Encourage parents to play a complementary role in the sexuality education of students, preferably in interaction with teachers, students, community leaders and community agencies. This could include parent information sessions, use of parent knowledge and experience in dealing with issues of cultural and linguistic diversity.
 - Provide information about a range of sexuality issues to parents to support and encourage school-based programs.
 - Coordinate the work of schools and community agencies in the promotion of sexual health in schools with clearly defined individual roles and responsibilities. Appropriate work in schools by community agencies could include assistance in program and policy and guidelines' planning; advice on resources; referral services; professional development for teachers and parents; and conduct, as appropriate, sessions for students to support existing school-based programs. Community agencies should not be used in one-off sessions; they should be used as part of a continuing program.
 - Develop partnerships with key community groups which impact on school programs; these could be cultural, religious and ethnic groups.
-
- Review policies and guidelines to ensure that education about STIs, HIV/AIDS and BBVs corresponds to the school ethos and includes advice around student welfare issues; curriculum; partnerships with parents, elders, care-givers, community leaders and community health agencies; and infection control issues.
-
- Ensure that program development and review (curriculum design and delivery) has input from the whole school community.
 - Include education about STIs, HIV/AIDS and BBVs as part of existing or newly developed peer education programs and/or work in schools.
 - Ensure that program development and review is based on current research and existing evidence.
-
- Provide professional development activities for the whole school community to assist in developing an understanding of and the need for a whole school approach to education about STIs, HIV/AIDS and BBVs.
-
- Develop, implement and review policies, guidelines and procedures to deal with harassment of students on the basis of disability, positive status, gender and real or perceived sexual orientation.

3.2 Acknowledging young people as sexual beings

Discussion

The first step in effective education about STIs, HIV/AIDS and BBVs is to help all young people accept that they are sexual and that their sexual feelings and desires are normal. School-based policies, guidelines and programs should support young people in making informed choices about engaging or not engaging in sexual activity. This means for some young people delaying intercourse until they are emotionally, socially and developmentally ready or as it accords with the values of the communities in which they live. For others, it will mean helping them to accept their sexual feelings and activity and to develop skills to protect themselves.³⁷ Research indicates that if young people are involved in comprehensive sexuality programs they are far more likely to delay the onset of sexual activity and, if already sexually active, to increase safe-sex behaviours.³⁸ It is also important to recognise a percentage of students are choosing not to be sexually active.

Young people's ability to participate in safe-sex behaviours, including the decision not to have sexual intercourse, needs to be supported by a climate that affirms their sexuality as a significant component of their identity.

Inclusivity

School-based programs and policies that recognise the sexuality of all students are more likely to succeed. For example, school-based programs rarely include the experiences of the 8–11 per cent of secondary students who are attracted to members of their own sex.¹⁰ Students with disabilities are another group of students whose sexuality is rarely acknowledged.

Sexual experience

The level of sexual activity amongst adolescents has remained fairly stable over the past decade.^{39, 37, 11, 10} The 1997 survey, *Secondary Students, HIV/AIDS and Sexual Health*, found that 20 per cent of year 10 students and 48 per cent of year 12 students have had sexual intercourse. Other research has found that the level of sexual activity increases with age. The 1992 survey of year 7–12 students, found that approximately one in every four is sexually active by year 9, around one in four had had penetrative sex by year 10 and one in every nine say they have had penetrative sex before the end of year 8.¹¹ The Centre for Adolescent Health (1992) found that 8 per cent of boys and 2 per cent of girls in year 7 have had sexual intercourse.⁴⁰ If the definition of sexual activity is broadened, then the level is much higher. The 1997 survey found that 77 per cent of year 10 and 88 per cent of year 12 students had experienced passionate kissing and that 60 per cent of year 10 and 79 per cent of year 12 students had experienced sexual touching.¹⁰

Sexual activity in adolescence may also include sexual activity amongst same-sex attracted youth. Research indicates that 5 per cent of 13- to 18- year-olds have participated in some type of same-sex experience.³⁷ Hillier et al. (1998) found that 60 per cent of the young people (aged 15 to 18) identifying as same-sex attracted indicated they were sexually active.¹⁴

Risk practices and safe sexual practices

The findings of the 1997 survey confirm what many other researchers have recognised about adolescents; namely, that young people put themselves at risk of contracting a STI or related infection not because of their level of sexual activity or because they belong to a risk group, but because of their own risk behaviours, most notably the decision to have sexual intercourse without a condom. It appears that the sexual lifestyles of adolescents, such as serial monogamy (short-term sequential relationships which are monogamous) casual partnering and engaging in sexual activity under the influence of alcohol and other drugs are keys to understanding why adolescents are at risk of a sexually transmissible infection.^{41 11, 10}

Between the 1992 and the 1997 surveys there has been a shift towards young people having fewer sexual partners. In 1997, 16 per cent of sexually active young people in years 10 and 12 had three or more sexual partners in the previous year in comparison with 22 per cent in 1992.^{10, 11} In 1992 and 1997 young men in years 10 and 12 were more likely than young women in years 10 and 12 to have had sexual intercourse with casual partners.^{10, 11} The 1997 survey showed that more year 10 (78 per cent) than year 12 (57 per cent) young people had had sexual intercourse with casual partners.¹⁰

The number of students, particularly young men, having sexual intercourse with casual partners is a concern. According to the 1997 survey young men have more partners than young women so they may be having sexual intercourse with both steady and casual partners.¹⁰ The 1998 study of same-sex attracted youth showed that 27 per cent of young women and 39 per cent of young men were having sexual intercourse with both young men and young women.¹⁴

Condom use

The above findings alone do not demonstrate that adolescents are at risk of contracting a STI or related infection. The crucial factor is whether they engage in safe sexual practices and, importantly, whether they consistently use condoms during penetrative sex. Australian research indicates a confusing picture of condom use among young people. The 1997 survey found that condom use among sexually active students in years 10 and 12 had increased considerably since 1992.¹⁰ In 1997, 54 per cent of sexually active students always used condoms and 37 per

cent used them sometimes compared to 1992 data where 43 per cent always used condoms and 42 per cent used them sometimes.^{10, 11} However, closer scrutiny shows a more complex and inconsistent picture of condom use amongst secondary students. In both 1992 and 1997, young men were more likely than young women to report that a condom was always used.^{10, 11} Specifically, in 1992, 60 per cent of young men in year 10 and 52 per cent in year 12 reported that a condom was always used compared to 41 per cent of young women in year 10 and 28 per cent of year 12.^{10, 11} In 1997, 73 per cent of year 10 and 56 per cent of year 12 young men compared to 41 per cent of year 10 and 44 per cent of year 12 young women reported that a condom was always used.¹⁰ Although the percentage of students who never used a condom has decreased significantly in the last five years, 4 per cent of year 10 and 7 per cent of year 12 young men, and 5 per cent of year 10 and 9 per cent of year 12 young women never used a condom during penetrative sex.^{10, 11}

The research literature suggests a number of complex and interrelated reasons, which appear to explain the inconsistency in condom use. These must be considered when developing school-based policies, guidelines and programs. First, it appears that for a significant number of secondary students the motivation for condom use is to prevent pregnancy rather than infection. The 1997 survey found that, although condoms were the most commonly used form of contraception, fewer than one-third of students in years 10 and 12 talked about using condoms to avoid STIs or HIV/AIDS.¹⁰ The 1997 survey indicated that students felt there was no need to use condoms because the contraceptive pill was being used.¹⁰ The 1997 survey highlighted the concern about the 18 per cent of year 12 young women relying on withdrawal as a means of contraception.¹⁰ These findings seem to confirm the observation, made by a number of researchers, that adolescents are behaving in response to the constant threat of pregnancy rather than the threat of infection with new or multiple partners.^{42, 11}

Moreover, many young people appear to justify their non-use of condoms in the belief that condoms are unnecessary as their current relationship is monogamous and promises to be long term.^{42, 11, 43, 10} Moore and Rosenthal (1993) call this the 'trust to love' myth and argue that trust is a significant element in making decisions about condom use.⁴³ The 1997 survey found that having a steady partner was a major reason for young people not using a condom.¹⁰ This gives rise to additional concern when it is recognised that adolescents change their partners at about three to six monthly intervals and fail to take into consideration their partner's other current sexual behaviour and activity or their partner's sexual history.

Related to this, some young people feel that asking their partner to use condoms, or insisting on using condoms, is a sign of 'mistrust, tantamount to implying that the partner may be infected or, at least, sexually promiscuous. Such an implicit lack of trust does nothing for the idealised attitudes of sexuality which many teenagers, especially girls, still hold'.⁴⁴

In addition, students still do not see themselves as being at risk of contracting a STI, particularly HIV/AIDS. The 1997 survey found that students see themselves less at risk now than they did five years ago.¹⁰ Moore and Rosenthal (1993) call this the 'not me myth' and argue that not only do adolescents fail to see STIs and HIV/AIDS as a threat, but that the threat of infection has little to do with their decision to have sexual intercourse.⁴³

Alcohol consumption, drug use and sexual behaviour

Between the 1992 and the 1997 surveys there has been a small but statistically significant increase in the number of students reporting not using condoms because they were too drunk or 'high'.^{10, 11} The 1997 survey also found that 12 per cent of young women in years 10 and 12 and 14 per cent of young men in years 10 and 12 had engaged in three or more binge drinking episodes in the previous fortnight.¹⁰ This is significant because they also found that binge drinkers were more likely to be sexually active. Of this group, 61 per cent of young women and 64 per cent of young men had had sexual intercourse compared to 18 per cent of young women and 19 per cent of young men who did not binge drink.¹⁰

In addition, approximately one-third of year 10 students and one-fifth of year 12 students had had sexual intercourse when they didn't want to because they were drunk or 'high'.¹⁰ In 1997, 20 per cent of sexually active students had not used a condom, even though one was available, because they were drunk or 'high'. The 1997 survey showed a small but significant proportion of sexually active students was involved in 'a potentially risky combination of drinking and sex'.¹⁰ In 1997, 13 per cent of sexually active students in years 10 and 12 were binge drinking once a week or more, were having sexual intercourse with casual partners and using condoms inconsistently if at all.¹⁰

National surveys have shown that between 1 and 2 per cent of 14- to 19-year-olds have injected drugs.^{7, 10} In comparison, the drug use patterns of same-sex attracted young people are of concern with 11 per cent of the 14- to 21-year-olds surveyed injecting drugs (of these 12 per cent injected more than three times a week).⁷ Many of the young people in this study were using other drugs on a weekly basis. For example, 23 per

cent were using marijuana, 5 per cent 'party drugs' such as ecstasy and 7 per cent heroin on a weekly basis. Statistics in the *National Drug Strategic Framework 1998–99 to 2002–03* show 34 per cent of 14- to 19-year-olds were using marijuana.⁷

There was also a significant gender difference in drug use patterns; with the exception of alcohol, young women used more drugs than young men and more regularly.

Sources of advice

It appears that young people, in particular young men, are reluctant to seek advice around sexuality issues. The 1997 survey found that those who are sexually active are more likely to seek advice than those who are not.¹⁰ Around 48 per cent of young men in years 10 and 12 and 36 per cent of young women in years 10 and 12 had never sought any advice about HIV/AIDS or other STIs.¹⁰ A similar picture exists in regards to seeking advice about contraception, with the exception of young women in year 12. Just over 70 per cent of these young women had sought contraceptive advice. This can also be seen as an indication that young women take more responsibility for contraception than young men do.¹⁰

Both the 1992 and the 1997 surveys show that overwhelmingly students seek information from parents and teachers. For many students school-based programs may be the only reliable and trusted source of information around HIV/AIDS, STIs and other sexuality issues, particularly for students from culturally and linguistically diverse backgrounds.¹³ Hillier et al. (1996) also found that students use the media for information about sexuality issues although they did not trust the information they gained.^{15, 10} They also found that, with the exception of mothers, students often did not use the information sources they trusted such as teachers, fathers, doctors and sexual health clinics.

The issue is more complex for same-sex attracted young people. Hillier et al. (1998) found school and the media were the major sources of information around STIs, HIV/AIDS and safe-sex issues for them.¹⁴ Approximately 36 per cent of the sample had received information from school and a further 36 per cent from the media. Only 10 per cent of these young people used their parents as a source of information compared to about 30 per cent of year 10 students and 40 per cent of year 12 students in the 1997 survey.^{14, 10} Unlike the heterosexual young people, same-sex attracted young people do not have easy/comfortable access to their most trusted sources of information.

Communication

One of the encouraging findings from the 1997 survey was the increased level of confidence exhibited by students in talking about their sexual health needs.¹⁰ The majority of students were confident that they could

say no to unwanted sexual intercourse and persuade a partner to use a condom. Young men felt less confident than young women in saying no to unwanted sexual intercourse. The 1997 survey reflects changes over the last five years showing that more young people used condoms more regularly than they did in 1992.^{10, 11}

Even so, there is a need for caution in making the assumption that young people have developed the necessary skills for effective sexual communication and that they then use them consistently. The 1997 survey confirmed the findings of a number of other studies describing an increase in condom use when young people feel comfortable and able to communicate their feelings about sex. They also found that confidence was gained from being in a steady relationship.^{45, 46, 11} However, as Moore and Rosenthal (1993) indicate, such communication is not always straightforward. It can be undermined by 'embarrassment, defensiveness, fear of rejection, the desire to exploit or simply misunderstanding one's partner'.⁴⁷ They argue that research reveals many adolescents fail to discuss these important issues during a sexual encounter.

Broadening safe-sex definitions

Although the use of condoms greatly reduces the risk of contracting a STI during penetrative sex, it is not the only option for safe sexual practice. Safe sexual practice appears to be equated with condom use. A number of studies indicate that young people have poor knowledge of the term 'safe sex', or its alternative 'safer sex', and that few young people equate non-penetrative sex with safe sex.^{48, 49, 50} It can be considered unrealistic to expect young people to use condoms at all times: 'Educators should continue to emphasise the concept of safe sexual practice beyond sexual intercourse with condoms to include other acceptable and realistic options for young people of both sexes.'⁵¹ By doing this, school-based programs will also affirm the experiences of many young people who are not engaging in penetrative sex as well as those students choosing to delay sexual activity.

Acknowledging young people as sexual beings. Strategic advice

WHOLE SCHOOL	OUTCOMES
School organisation, School – community links	Effective partnerships with the whole school community built on a common understanding and acceptance of young people as sexual beings.
Policy/guidelines	Policy and guidelines' formulation in education about STIs, HIV/AIDS and BBVs articulate the links between promotion of sexual health and the current research on young people.
Curriculum	Program and resource development and delivery reflects the current research on young people and sexuality.

SUGGESTED ACTIVITIES

- Develop partnerships at all appropriate levels to improve the sexual health of young people in schools.
 - Work with parents, care-givers, elders and community leaders to include development of a shared understanding of young people as sexual beings and the importance of parents and teachers as trusted sources of information for young people.
 - Develop partnerships with local community health agencies and services that enable young people to be aware of and access services to promote their sexual health.
 - Review policies and guidelines to ensure that education about STIs, HIV/AIDS and BBVs corresponds to the school ethos and includes advice around student welfare issues; curriculum; partnerships with parents, elders, care-givers, community leaders and community health agencies; and infection control issues.
-
- Review policies and guidelines to ensure they acknowledge and reflect the realities and documented research about young people's sexual activity and experiences.
 - Review and update drug education policies to ensure that the links to STIs, HIV/AIDS and BBVs are clearly articulated with appropriate implementation strategies.
-
- Review programs and resources so that they reflect and develop in young people a broad understanding of sexuality as part of human relationships.
 - Develop new resources and curricula for education about STIs, HIV/AIDS and BBVs, which should reflect current research on young people and sexuality.
 - Ensure that future development of resources and programs broaden the definition of safe sexual practices to include information about the range of sexual practices, from penetrative to non-penetrative to delaying sexual activity.
 - Develop a curriculum that enables young people to explore the connection between drug use, sexuality and STIs, HIV/AIDS and BBVs.
 - Ensure that information provided for students around sexuality and safe sexual practices also includes information that caters for the needs of those groups of students who are often ignored, such as same-sex attracted young people and young people with disabilities.

Acknowledging young people as sexual beings. Strategic advice (cont.)

WHOLE SCHOOL	OUTCOMES
Professional development	Professional development in STIs, HIV/AIDS and BBVs includes an acknowledgment that young people are sexual beings.
Student welfare/pastoral care	Student welfare structures and procedures reflect the research on young people and their sexual health.

SUGGESTED ACTIVITIES

- Provide professional development for the whole school community focusing on the sexual health of young people.
 - Provide teachers with professional development which broadens their understanding of adolescent sexuality based on research evidence.
 - Offer culturally appropriate programs to parents to focus on young people's sexual health and the importance of their role as primary sexuality educators.
-
- Encourage student welfare staff to take a health promotion approach in addressing welfare aspects of sexual health, such as display of posters that support all sexualities, having material readily available for all students and working with the classroom teachers in the delivery of programs.

3.3 Acknowledging and catering for the diversity of all students

Discussion

Acknowledging diversity among students is crucial to ensuring that school-based programs are relevant to all students. Diversity refers to the broad range of differences amongst students and their communities and includes aspects related to gender, drug use, race, geographic location, culture, socio-economic background, age, disability, religion and sexuality. Education programs that affirm this diversity, taking into account its implications on young people's social worlds, have greater potential to reach a wider audience of students. Programs should acknowledge that students differ in their personal, social and political experiences and environments, and are not a homogeneous group.

Effective education about STIs, HIV/AIDS and BBVs enhances sexual health within the context of an individual's values, moral beliefs, cultural and religious background, ability, sexuality and gender. Recognition and understanding of different cultural or religious traditions and established values about sexual practices and relationships helps identify specific sexual health education needs. In other words, educational messages will be heard and understood differently by different groups. 'Sometimes it will be gender that filters the message, sometimes it will be our stage of cognitive development, and sometimes it will be our experiences and relationships with the world as influenced by such factors as our culture, ethnicity and the socio-economic milieu.'⁵²

Gender

It is impossible to generalise about the gendered experience of sexuality and the implications for safe behaviours because, 'gender differences depend, at least in part, on the particular experience under scrutiny'.⁵³ However, if successful programs are to be developed for use in schools, gender must be acknowledged and taken into account. Gifford and Jones (1994) argue for an understanding of the effect of gender expectations on relationships, sexuality and safe sexual practices.⁵⁴ For example, there is a clear need to challenge beliefs that males cannot control their sexual urges and consequently cannot be expected to take responsibility for contraception. The 1992 survey deplored the possibility that innovative school-based education programs could address the 'very strong but inequitable attitude that females should take primary responsibility in suggesting the use of condoms'.⁵⁵ It is evident from the 1997 survey findings that this is still in need of redress.¹⁰

Research shows that there are many gender issues for young men that need to be considered. Their reluctance to communicate about personal feelings and to take responsibility for contraception and other safe sexual practices limits their possibilities of developing equal, respectful

and supportive relationships. The 1997 survey found that young men expose themselves to high risks of infection from a range of STIs, HIV/AIDS and BBVs.¹⁰ Challenging their perceptions of masculinity and their perceptions of traditional femininity is a critical stage in their education, especially in the context of health and sexuality education. Their education should also include, from a range of curriculum perspectives, the development of critical understandings of gender and power in relationships and the concepts of the construction of gender.⁵⁶

Differing positions of power characteristic of gender relations are central to adolescent sexual behaviour and understanding the inconsistent and variable use of condoms. According to Woodruff (1994), education messages aimed at women which do not examine issues of power inequality and which rely solely on advocating condoms to prevent STIs, HIV/AIDS and BBVs in sexual encounters are doomed to failure.⁵⁷ For, as Woodruff points out, 'power relations in heterosexual relationships are central to the possibilities for heterosexual transmission'.⁵⁷

For Szirom (1988) programs need to examine the underlying attitudes that discriminate against women who make their own choices, such as the choice to be sexually active, and they need to 'equip men to become full and equal partners in this important aspect of women's lives'.⁵⁸ Thus, we should not assume that assertiveness, for example, is purely a skill to assist young women to say no to unwanted sexual advances. 'It might mean that, but it may also mean that a young woman can say yes, I want, I feel, I know this about myself.'⁵⁹

It appears that for some adolescents there are gendered motivations for sexual intercourse which affect their use of condoms. Nielsen (1991) suggests that young men are more likely to see intercourse as a way of establishing their maturity and achieving social status, whereas most young women see intercourse as a way of expressing their love or of achieving greater intimacy.⁶⁰ She argues that, as a consequence, young men are more likely to have sex with someone who is a relative stranger, to have a number of sexual partners and to divorce sex from love. Shaw (1992) argues that cultural norms of romantic love are important determinants of how women (and men) communicate and behave in intimate relationships.⁴² Related to this is the greater level of trust that young women place in relationships. Moore and Rosenthal (1993) argue that because young women take the view that sex is about romance and love, they operate through rose-coloured glasses and on notions of trust.⁴³ Given young men's attitudes to sexual relationships described above, relying on trust is considered an unsafe strategy.

Students from culturally and linguistically diverse backgrounds, including Indigenous Australian students

The literature review and consultation feedback indicates that students from culturally and linguistically diverse and Indigenous Australian backgrounds need specific consideration in the planning and delivery of sexuality programs to reduce adolescent risk-taking in relation to STIs, HIV/AIDS and BBVs' infection in mainstream schools. This diversity needs to be acknowledged before schools can develop and implement appropriate intervention strategies. Schools also need to consider the consolidating impact of gender and socio-economic conditions on the experiences and needs of these students.

Available research sheds little light on the sexual experiences of young people of culturally and linguistically diverse backgrounds. Wyn (1993) found that, in one small study, young women of culturally and linguistically diverse backgrounds reported low levels of safe sexual practices.⁶¹ Pedic (1990) reported similar findings, concluding that these young people were more likely than the general community to have negative attitudes towards those people living with AIDS.⁶² She also found that they were less knowledgeable about HIV/AIDS and STIs and engaged in more high-risk behaviours. Rosenthal et al. (1990) found lower levels of knowledge among adolescents of culturally and linguistically diverse backgrounds, with young women being even less well informed about HIV/AIDS and safe sexual practices.⁶³

This research does not tell us whether the needs of students of culturally and linguistically diverse backgrounds should be met in separate programs. This may be because, as Rosenthal and Reichler (1994) conclude, there are in fact more similarities than differences in the sexual practices and attitudes of young people of culturally and linguistically diverse backgrounds.⁴⁸ They caution, however, that findings may under-represent differences because the studies of young people of culturally and linguistically diverse backgrounds groups capture those who 'have succeeded in the predominantly Anglo-Celtic educational system'.⁶⁴ Harrison and Hay (1996) found that young men of culturally and linguistically diverse backgrounds were more likely, for example, to display more openly homophobic attitudes.¹³

This lack of research findings and indications has implications for school-based programs. Schools adopt inclusive programs based on raising the self-esteem of students of culturally and linguistically diverse backgrounds through celebration of elements of their culture. Cope and Kalantzis (1988) maintain that this approach rests on an assumption that 'traditionalism and cultural conservation is a good thing'.⁶⁵ They find this problematic because it is based on a stereotypical view of culture which sees culture and young people of culturally and linguistically

diverse backgrounds as one-dimensional. Harrison and Dempsey (1998) found students resistant to activities that required them to single out issues that were culturally defined because they did not want to be seen as different.²⁹

However, celebrating cultural difference, in the same way as in mainstream curriculum, is not straightforward for teachers in health education. A number of practices either real or perceived, particularly in relation to young women (for instance female genital mutilation) do not sit comfortably with the aims of many health education programs. This is not necessarily a bad thing as Cope and Kalantzis (1988) maintain:

Cultural differences are not innocent, colourful and simply worthy of celebration. They also embody relations of inequality (p. 153) ... Culture is dynamic as much as it is founded in tradition, and moving away from some aspects of traditionalism (such as racism and sexism) is in all probability a good thing (p. 156).⁶⁵

This problem is often one of perception in which teachers make assumptions about the practices and values of particular cultural groups.¹³ Cope and Kalantzis (1988) suggest an approach based on a pedagogical commonsense: 'that students learn what they want to learn and that what they want to learn is very much defined by what is relevant to their own particular cultural context'.⁶⁶

School-based programs need to be culturally sensitive and aware of the range of different cultural norms and the implications of these for teaching and learning practices for all cultural groups, but in particular for Indigenous Australian young people. In many Indigenous Australian communities cultural norms require sexuality education to be conducted in single-sex groups. In some communities single-sex classes may need to be taught by a teacher of the same sex. Such program delivery acknowledges varying traditions amongst different Indigenous Australian groups which can include strict laws for men and women so that 'women's business' and 'men's business' must be discussed separately. Moreover, the *National Indigenous Australians' Sexual Health Strategy 1996–97 to 1998–99* points out that little research has been done into how behaviour is influenced and changed in these communities.⁶ However, the strategy makes it clear that sexuality is a 'sensitive' and 'intimate' issue for Indigenous Australian people and often brings a good deal of 'shame' with it. This makes common classroom strategies such as discussion and role-plays 'awkward and uncomfortable' for these young people.⁶⁷

To cater for the diversity of Indigenous Australian young people 'programs should be designed and developed within a local community context, using local concepts and learning strategies'.⁶⁷ According to the

strategy it is 'only possible if local Indigenous people are involved in all stages of program development and delivery'. The strategy also reinforces the importance of 'retaining existing systems and mechanisms that are recognised by community members and strongly embedded in cultural structures and communication networks'.⁶⁷

Education authorities need to establish and maintain procedures for extensive consultation with the appropriate communities, agencies, service providers and health professionals and workers when developing programs specifically targeted at inclusion of the experiences, traditions and values, of not only Indigenous Australian communities, but other cultural groups in their schools.

Religious diversity

The diverse views of religious groups needs to be acknowledged and catered for when developing school-based policies, programs and practices. Often the issues of diverse religious values are ignored because of the perceived difficulty in talking about or acknowledging young people's sexual behaviour when it could be in conflict with religious teaching. This does not mean that young people with strong religious beliefs should not have relevant teaching about health and safety, especially in sexual health.

A key belief across a number of religious traditions is that sexual intercourse is the most intimate expression of love between two people and is only morally and ethically acceptable when it takes place within marriage. Schools catering specifically for young people of a particular religion may base their programs on this belief. It is also important to acknowledge the research that shows a significant number of secondary students are sexually active and have had sexual intercourse.

While it is appropriate for school-based sexuality education programs to take into account the needs and values which the school serves, consideration must also be given to the sexual health education needs of all students. The experience in some State and Territories would suggest that the time spent in community consultation and the negotiation of appropriate school-based programs can lead to innovative local practice. Strong support for programs dealing with the challenge of sensitive issues is often forthcoming from a wide range of community groups. There is an additional benefit in that parents and families and community members become better informed about important health issues, including sexual health, issues.

Developmentally, adolescents are seeking to formulate their own moral and ethical positions on a range of issues that impact upon their lives. Religious teachings will have a significant role to play in this process for

many students. Learning to respect the range of views that people hold in complex areas such as sexuality is an important aspect of education for all students.

Fostering the importance of the partnership of home and school in developing approaches to sexuality education is likely to provide the soundest approach to catering for and acknowledging a range of religious beliefs within a school community.

Students with disabilities

Community attitudes, including attitudes of teachers in schools, mean that many adolescents with disabilities encounter obstacles to the expression of their sexuality.⁶⁸ Students with disabilities are often excluded or not catered for in school-based programs because of false assumptions about their sexual health education needs. Sexuality education programs incorporating information and skills development about issues to do with conception, contraception, safe sexual practice, sexual health and prevention of sexual infections and relationships are as important to the lives, aspirations and sense of self for students with disabilities as for those without disabilities. Education authorities need to acknowledge that young people with disabilities have sexual identities and sexual feelings and need accurate information and skills' development just as young people without disabilities.

Bramley et al. (1990) found that a failure to recognise adolescents with disabilities as sexual beings has led to programs which do not reflect their specific needs.⁶⁹ They found that, apart from young people with intellectual disabilities for whom there were specific courses, young women with spina bifida, cerebral palsy, or hearing or visual impairment had no information related to their particular disability.

In addition, Grbrich and Sykes (1989) maintain that parents of adolescents with disabilities are over-protective, denying their daughters' and sons' need for sexual health education.⁷⁰ They also allude to additional communication difficulties among this group that may hinder the negotiation of safe sexual practices.

Same-sex attracted young people

The majority of existing programs fail to acknowledge the sexual diversity of students. As with heterosexual young people, there is a need to recognise that many gay, lesbian and bi-sexual young people are sexually active. The 1997 survey found that a significant minority, 8 per cent of year 10 students and 9 per cent of year 12 students, was not exclusively heterosexual in their feelings of attraction towards others, and that discrimination and a lack of recognition and affirmation complicated their safe sexual practices.¹⁰

Dunne et al. (1993) maintained that the one obvious omission from the 1992 study was not including questions about sexual orientation. The report concludes that:

Clearly, we will not be able to properly evaluate the effectiveness of HIV/AIDS education until researchers, education authorities and school communities can acknowledge homosexuality among young people and, with careful and sensitive planning, carry out studies of social, psychological and educational factors which promote safe behaviours among young gay men who have sex with men.⁷¹

Hillier et al. (1998) found that same-sex attracted young people between 14 and 21 years are sexually active, with 73 per cent of the sample saying they had had sexual intercourse.¹⁴ This study found that this group was engaging in a number of high-risk behaviours. A particular concern related to the transmission of STIs was the 27 per cent of same-sex attracted women and 39 per cent of same-sex attracted men who were having unprotected sexual intercourse with both males and females.¹⁴

For these young people, their behaviour indicates they are vulnerable to infection and they are often alienated, harassed, violated, discriminated against or invisible in schools. There also appears to be some evidence that they are at risk of suicide. Gibson (1989) estimates that young gay and lesbian people account for as many as 30 per cent of completed youth suicides a year.⁷² The US Task Force on Youth Suicide suggests rates of attempted suicide amongst same-sex attracted young people are six times higher than that of the general community.

Researchers have argued that the problem is caused by a society that stigmatises homosexuality and fails to recognise that there are substantial numbers of gay and lesbian young people.^{72, 73} *Suicide Prevention: Victorian Task Force Report July 1997* maintains adolescence is a risk period for same-sex attracted young people because 'at the same time as acknowledging their sexual orientation they can also be subject to community violence, loss of friendship or family rejection'.²⁸

Hillier et al. (1998) found that 46 per cent of same-sex attracted young people had been verbally abused and 13 per cent had been physically abused. Nearly 70 per cent of the abuse had happened at school, 60 per cent by other students, 10 per cent by friends and 3 per cent by teachers. In addition, 40 per cent of the young people did not feel good about their sexual orientation, 18 per cent had never spoken to anyone about their feelings and, of those who had, one-third had experienced rejection of some type. It is not surprising, then, that only 26 per cent of

same-sex attracted young people felt very safe at school, with 14 per cent feeling unsafe or very unsafe at school.¹⁴

Australian schools are clearly not achieving their goal of providing a safe and supportive learning environment for all students. For gay and lesbian young people it is not only the overt harassment and violence they experience but also their invisibility in mainstream programs. Griffin (1992) argues that the focus on biology and heterosexuality in mainstream literature has meant that the social construction of sexuality has largely been ignored and the reality of gay and lesbian youth denied.⁷⁴ Hillier et al. (1998) confirmed this in a study of sexuality education programs in secondary schools which found that schools had great difficulty altering programs to include the experiences of gay and lesbian young people in any holistic way.¹³

According to Willie (1994), 'the debate about including sexual orientation in health education is all about difference, expressing difference and fear of difference. Our society is so simplistic about sexuality and the complexities of sexual orientation and gender orientation and sex-role fit'.⁷⁵ Gourlay (1996) maintains that programs assume heterosexuality as the norm with the majority of programs and resources dominated by references to male–female relationships, heterosexual intercourse and contraception.¹² He maintains: 'this may not only reinforce the sense of isolation and difference for young gay men and lesbians, but also deny the rest of the class the opportunity to challenge their own assumptions about sexuality. Heterosexism and homophobia are assaults and constraints that impact on the whole community no matter what our sexual orientation.'⁷⁶

Studies have found that while the process of engaging students with issues around sexual identity was new, students engaged well in such activities, often demonstrating a sophisticated understanding of issues.^{13, 29} According to one of the young men in the study, 'I reckon I learned heaps about sexual stereotypes ... how people are expected to be heterosexual ... anyone who isn't is sort of you know like an outcast' (year 10 boy).⁷⁷

Acknowledging and catering for the diversity of all students. Strategic advice

WHOLE SCHOOL	OUTCOMES
School organisation, School – community links	Effective partnerships developed with the whole school community to ensure programs, policies and practices in schools reflect the needs of diverse groups and communities.
Policy/guidelines	Formulation and review of policy and guidelines on STIs, HIV/AIDS and BBVs which acknowledges the need to cater for diversity in implementation strategies for educational institutions.
Curriculum	School-based education programs about STIs, HIV/AIDS and BBVs acknowledge and cater for the needs of all students.

SUGGESTED ACTIVITIES

- Develop productive partnerships with those sectors and community agencies relevant to the cultural groups in the school.
 - Establish and maintain procedures for extensive consultation with the appropriate communities, agencies, health professionals, health workers and service providers when developing programs to ensure they are inclusive of or specifically targeted at the experiences, traditions, values etc. of particular groups in their schools.
 - Work in partnership with the appropriate state or territory Aboriginal education workers to connect schools with appropriate people in their communities. These could be community organisation chairpersons, community managers, environmental health workers, Aboriginal health workers and community nurses. Two critical groups within Indigenous communities are those of the mainstream structure of local community/Aboriginal and Torres Strait Islander Council and the Indigenous cultural structure.
-
- Review policies/guidelines, programs and procedures to ensure the information and strategies are inclusive of the needs of all students. Appropriate consultation with cultural, ethnic and religious groups in the communities will enhance the review process.
-
- Ensure programs are age appropriate, culturally sensitive, respectful of individual choices and include information about the range of sexual practices, from penetrative to non-penetrative to delaying sexual activity.
 - Review health education programs and resources to include an examination of the construction of gender and to ensure they are inclusive of same-sex attracted young people and students with disabilities.
 - Use available research on young people and sexuality to assist in developing and implementing programs in those schools catering for diverse religious beliefs and practices.
 - Ensure teaching and learning strategies are culturally sensitive. For example, discussion may not be the most appropriate for Indigenous young people because of the 'shame' attached to issues about sexuality.
 - Ensure programs for students with disabilities and indeed all students:

Acknowledging and catering for the diversity of all students. Strategic advice (cont.)

WHOLE SCHOOL	OUTCOMES	
Curriculum (cont.)	School-based education programs about STIs, HIV/AIDS and BBVs acknowledge and cater for the needs of all students.	
Professional development	Professional development in STIs, HIV/AIDS and BBVs enables the education community to understand and develop strategies to cater for the diversity of the student population.	
Student welfare/pastoral care	Student welfare and pastoral care structures and procedures acknowledge and implement strategies to cater for the diversity of student needs in relation to sexual health promotion.	

SUGGESTED ACTIVITIES

- are relevant to their physical, intellectual and social/emotional needs
 - anticipate the students' future needs
 - are part of the continuum of learning for life
 - offer opportunities, challenges and choices
 - encourage independence while recognising the interdependence of members of the community
 - value individual learning styles and preferred learning styles
 - provide for different rates of learning
 - enhance the student's self-esteem, worth, identity and dignity
 - provide for a range of opportunities for individualised and groups learning of skills, knowledge and attitudes
 - provide a broad range of experience, processes and approaches
 - are realistic, achievable and have clearly stated goals.
-
- Provide professional development that encourages school staff to critically reflect on their own assumptions and beliefs about young people with disabilities, from culturally and linguistically diverse backgrounds, of Aboriginal and Torres Strait Islander background and diverse religious traditions. They also need to do this in regard to issues of gender and sexuality and towards same-sex attracted young people.
 - Provide professional development opportunities around a range of sexuality issues for parents, families and care-givers of young people with disabilities.
-
- Student welfare personnel work with classroom teachers to develop programs that reflect not only curriculum but build on the welfare issues related to catering for diversity in sexual health.
 - Review student welfare and pastoral care procedures and strategies to ensure that they comply with State/Territory and Commonwealth anti-discrimination legislation, with particular reference to the attribute of sexual identity.

3.4 Providing an appropriate and comprehensive curriculum context

Discussion

Education in schools about STIs, HIV/AIDS and BBVs should be consistent with recognised and stated public health goals. This means ensuring that provision of information about infections and viruses is not divorced from the social context in which they occur and in which young people make decisions about both their sexual health and broader health.

It means integrating education about STIs, HIV/AIDS and BBVs into a broad health framework that examines other health issues, such as alcohol and other drug use, instead of only presenting knowledge in a topic-based approach examining STIs as one more negative consequence of sexual behaviour.

Health promotion is the combination of educational and environmental supports for actions and conditions of living conducive for health. A context that is health promoting will 'provide individuals with the knowledge, skills and critical awareness that enables them to make voluntary and informed choices concerning personal and social changes to enhance their health'.⁷⁸

Effective programs

According to Kirby (1992), it is difficult to evaluate those school-based programs which are expected to change personal behaviour.

Changing behaviour outside the classroom – and especially changing adolescent behaviour with all of the physical and emotional needs that affect it – is clearly a more ambitious and different challenge than improving knowledge and skills. Furthermore, it requires different types of evaluation criteria. Notably, few other classes or programs in schools evaluate effectiveness by observing changing behaviour outside the school.⁷⁹

Research into effective education about STIs, HIV/AIDS and BBVs in schools is fraught because of the controversial nature of its subject matter, sexuality, and the near impossibility of measuring its outcomes. Moore and Rosenthal (1993) maintain that, although there is a policy of providing HIV/AIDS-relevant education in Australian schools, the controversial nature of the topic with 'its unique set of social, economic, political and legal problems makes it difficult to implement any type of program, let alone effective ones'.⁸⁰

Studies show that there is an increase in student knowledge about sexuality and sexuality-related issues following formal programs.⁸¹ Nevertheless, the impact of these programs on attitudes, skills and behaviours is more difficult to ascertain. Kirby (1992–93) maintains that many early HIV/AIDS education curricula relied heavily upon group discussions and passing on information about HIV/AIDS, with little attempt to improve communication skills or to change behaviour.²⁵ They were based upon the assumption that dispelling myths about HIV/AIDS would change behaviour. Evaluation of these programs, according to Kirby, indicates that they increased young people's knowledge, made them more sensitive to HIV-positive people and reduced unnecessary fears about transmission. However, they had little impact on adolescent relationships and sexual practices.

Researchers agree that programs based on a model that contextualises issues and provides students with situational skills is far more likely to be effective than the provision of information alone. Studies show that students not only enjoy this approach but feel they retain more knowledge from those discussions and activities requiring them to reflect on their own and others' feelings and attitudes. Using activities which approximate those situations, students could easily encounter in their daily lives facilitates understanding of difficult conceptual content.^{25, 13, 29}

Education programs about STIs, HIV/AIDS and BBVs need to be based on a conceptual framework that:

- develops sequentially in young people the ability to be able to make informed personal choices based on accurate information, their own values' structure and an awareness of what feels comfortable and appropriate, as well as an appreciation of how this can impact upon themselves and others ⁸²
- places decision-making and values' clarification activities in a relevant social context
- draws on experiential learning, inquiry, goal-setting, modelling and role-play ^{12, 13, 29, 27}
- has a dynamic and compelling curriculum ^{12, 13, 29}
- has skilled teachers who are qualified, comfortable, sensitive and trusted by students ⁴³
- recognises the complementary role that parents can play ^{32, 36}
- provides a classroom climate which enables students to feel confident and comfortable that their views will be respected and confidentiality will be maintained ^{27, 13}.

Increasing knowledge

The findings of the two national surveys in 1992 and 1997 are consistent with other available research. They tell us that students, in general, are very well informed about HIV/AIDS and its transmission with few

differences in knowledge based on gender and age differences.^{10, 11} The 1997 survey found the range of understandings included that the virus could be transmitted sexually or through the shared use of needles or syringes in injecting drug use and that condoms provided protection from HIV during penetrative sex. As the level of knowledge had increased over the five-year period, the 1997 survey maintains that school-based education programs can make a difference.¹⁰

Even so, the 1997 survey showed there were several areas where student knowledge was poor. These included the fact that students believed that HIV could be transmitted by mosquitoes, that HIV could not be transmitted from mother to baby during pregnancy and that a healthy looking person could not pass on the HIV virus.¹⁰

The finding that student knowledge about specific STIs, in particular chlamydia, was poor is of great concern as chlamydia is one of the most common STIs.¹⁰ Fewer than 12 per cent of students knew that chlamydia affects both women and men, and fewer than one-third of young people in year 10 or the young men in year 12 knew that it could lead to sterility in women.¹⁰ While most students knew that people can have STIs without obvious symptoms and that condom use does not provide protection against all STIs, their knowledge of specific STIs was lacking. Young people's lack of knowledge of other STIs (except HIV/AIDS) and hepatitis must be addressed in school-based programs.

This information is not new to researchers, many of whom have found similar results over the last decade. It would appear from these findings that school-based programs have concentrated on HIV/AIDS at the expense of education about other STIs.^{83, 84, 85, 11, 43, 86, 15, 13, 29} The other major area of concern arising from the 1997 survey was the very low level of knowledge about the different forms of hepatitis, how they were transmitted, their consequences and for which of the viruses there was a vaccine. The only area that students appeared to have some knowledge of was the link between injecting drug use and hepatitis C.

Drug education

Many State and Territory education authorities have separate approaches to education about drugs and education about STIs, HIV/AIDS and BBVs. Although there are good reasons for this, it does little to assist young people make the social connections between drug use, infection, sexual safety and the realities of their social lives. For many young people, drugs are involved in many sexual encounters. As the 1997 survey found, one-third of year 10 students had had sexual intercourse when they didn't want to because they were drunk or 'high' and 13 per cent were binge drinking once a week or more, were having sexual intercourse with casual partners and using condoms inconsistently if at all.¹⁰ Hillier et al. (1998)

found much higher rates of drug use amongst their sample of same-sex attracted young people, particularly among young women.¹⁴

Moreover, artificially separating issues of sexuality and drug education raises the question of responsibility for the development and delivery of resources and programs, particularly those focusing on hepatitis. Although hepatitis B can be contracted through both sexual contact and the sharing of injecting equipment, hepatitis C is overwhelmingly contracted through the sharing of needles and equipment. If education is to bridge the gap in young people's knowledge of hepatitis and assist them to explore the broader social context in which decisions about drug use and sexuality are enmeshed, programs must take a more holistic approach.

Attitudes towards people living with HIV/AIDS

The 1997 survey showed that most students held unprejudiced attitudes towards people living with HIV/AIDS, although on all measures of attitudes young women expressed slightly more tolerant views.¹⁰ The survey found students had developed more tolerant attitudes towards the possibility of a friend and/or schoolmate having HIV. However, students were less tolerant towards HIV positive people working with young people. They displayed intolerant, if not ambivalent, attitudes to the question "People with HIV only have themselves to blame".¹⁰ Hillier et al. (1996) found similar attitudes in their sample of rural students but were concerned by the 43 per cent of students who agreed with or were unsure about the statement 'people with HIV have only themselves to blame'.¹⁵

It is crucial that students have the opportunity to explore values, attitudes and myths associated with HIV transmission and the implications for those living with the virus. This indicates the need to ensure that school-based programs do not isolate knowledge from the broader social context around HIV/AIDS. It is increasingly important that schools not only address issues of living with HIV/AIDS but also those associated with other blood-borne viruses such as hepatitis C.

Providing an appropriate and comprehensive curriculum context. Strategic advice

WHOLE SCHOOL	OUTCOMES	
School organisation, School – community links	Effective partnerships across the whole school community support a comprehensive health promotion approach to education about STIs, HIV/AIDS and BBVs.	
Policy/guidelines	Formulation of policy and guidelines on STIs, HIV/AIDS and BBVs which clearly articulate a rationale and strategies for the provision of formal education within a comprehensive health education curriculum.	
Curriculum	Curriculum reform in education about STIs, HIV/AIDS and BBVs provided in the context of comprehensive health education.	

SUGGESTED ACTIVITIES

- Establish committees, working parties and reference groups between health and education authorities at all levels to plan, review and implement curriculum.
 - Encourage students, parents, care-givers, elders and community leaders to participate in program development at the school level.
 - Provide structural support for Aboriginal health workers and other ethnic health workers to assist schools in providing culturally appropriate health education.
 - Provide support to enable the provision of appropriate spaces and classroom organisation to facilitate discussion of sensitive issues.
-
- Review existing policies to ensure that STIs/BBVs form part of HIV and AIDS policy/guidelines.
 - Review existing policies to ensure that policy and guidelines on STIs, HIV/AIDS and BBVs include information on curriculum provision in schools.
-
- Provide opportunities for all students to be educated about STIs, HIV/AIDS and BBVs within the context of comprehensive health education.
 - Develop opportunities for cross-curricula work to enrich programs in health education; for example through liaison and cooperative work with drama, English and science learning areas.
 - Review existing curriculum and resources to ensure issues around STIs, HIV/AIDS and BBVs are presented in the context of health education advocating a health promotion approach. This would still incorporate teaching about risks to sexual health and would also be explicit about varieties of sexual behaviours, safe sexual practices, sexual orientation and other topics considered to be controversial.
 - Develop a curriculum on STIs, HIV/AIDS and BBVs in the context of health education curriculum ensuring that links are made between other health-related behaviours, such as drug education, depression and sexuality, in a broad social context. Particular emphasis to be placed on safe-sex issues and drug use, HIV/AIDS-related discrimination and gender-related discrimination with specific attention given to strategies examining the construction of masculinity.
 - Review and, if necessary, develop programs and resources that include current information on STIs, HIV/AIDS and BBVs, particularly hepatitis.

Providing an appropriate and comprehensive curriculum context. Strategic advice (cont.)

WHOLE SCHOOL	OUTCOMES
Curriculum (cont.)	Curriculum reform in education about STIs, HIV/AIDS and BBVs provided in the context of comprehensive health education.
Professional development	Professional development on STIs, HIV/AIDS and BBVs enables curriculum writers, planners, and those delivering programs to locate education about STIs, HIV/AIDS and BBVs in a comprehensive health education framework.
Student welfare/pastoral care	Student welfare and pastoral care policy/guidelines and procedures support and complement a comprehensive health education curriculum.

SUGGESTED ACTIVITIES

- Review and, if necessary, develop programs and resources that include current information on STIs, HIV/AIDS and BBVs, particularly hepatitis.
 - Review programs to ensure that they enable students to develop a broad context of sexuality issues. This should include aspects such as communication, sexual and emotional intimacy, friendship, companionship, love, shared activities, interests and hopes, independence and personal space, sexual intimacy, respect and learning that the balance of these aspects varies between people and across time and is influenced by community and personal values.
 - Encourage and support teachers to use a range of teaching and learning strategies (such as role-plays, case studies and problem-solving exercises) that cater for the diversity of student experiences with emphasis on the need to acknowledge and understand personal and community values and attitudes.
-
- Provide professional development for those education personnel responsible for the development and delivery of curriculum to enable them to understand a health promoting framework for education about STIs, HIV/AIDS and BBVs.
 - Provide professional development for teachers enabling them to develop skills in establishing supportive classroom climates, activity-based learning, decision-making activities, role-play and to understand the need to place these in relevant social contexts.
-
- Provide opportunities for student welfare staff to be involved in the development and delivery of classroom programs.
 - Review student welfare and pastoral care policy and guidelines and procedures to ensure that the curriculum is understood as being linked to those student welfare policies and procedures in place to deal with issues arising as a result of material covered in classroom programs.

3.5 Acknowledging the professional development needs of the school community

Discussion

Successful delivery of effective school-based programs requires skilled teachers who are qualified, sensitive and trusted by students. According to Harrison and Dempsey (1998) students were clear about the attributes required of a good health educator. These include tolerance, understanding, being knowledgeable and supporting an interactive classroom environment.²⁹ Teachers need to be secure in their understanding of sexuality and able to cope with discussion of a wide range of views they do not necessarily share. Teachers themselves emphasised the need for health educators to be well trained and empathic, given the complex and sensitive nature of the curriculum.^{29, 6}

The effective implementation of a framework for STIs, HIV/AIDS and BBVs for Australian schools needs teachers who have had comprehensive professional development in a broad range of issues related to health and sexuality education. Professional development was clearly identified by all States and Territories, through the consultative process, as a key issue in need of support. At present, provision of professional development varies in its approach and its content. Generally, all States and Territories provide some central professional development, often in conjunction with community agencies. These agencies include Family Planning Associations, Community Health Centres, Departments of Health and Community Services and universities, some of which offer accredited courses for participating teachers.

Some States and Territories provide professional development at a school-based level within central guidelines. Central professional development is generally planned and delivered around knowledge and awareness of specific infectious disease protocols. Several States and Territories provide a broader approach focused on STIs and HIV/AIDS in the context of sexuality which is compatible with central resources used by teachers in the classroom. Funding ranges from central provision to determination at school level from overall budgets. However, the amount of central funding has diminished in line with devolution and the increasing responsibility and autonomy being given to individual schools. In the non-government sector professional development may be offered in the context of Catholic and/or Christian and/or other religious or philosophical values.

It appears that most of the professional development programs being offered nationally centre on knowledge of HIV/AIDS and BBVs and infection control issues. Research indicates that effective education in this area requires teachers also to have an understanding of the broad context of health and sexuality. Therefore, teachers need more comprehensive

education, not just knowledge of infections. Few teachers have any specialist training in STIs, HIV/AIDS and BBVs education. A curriculum audit carried out in Victoria and Queensland in 1995 found sexuality education to be a major area of discipline renewal requested by teachers.^{87, 88}

Gourlay (1996) points out that sexuality education overwhelmingly relies on volunteers and conscripts who are largely expected to train themselves. It could justifiably be argued that sexuality education, 'the most loosely defined and disparate of curriculum areas, is being taught by teachers who invariably feel under-trained, under-resourced and under siege'.⁸⁹

Educators in this area face additional difficulties because of the moral and ethical dimensions of sexuality education and a concern that teachers will influence students' values and attitudes. According to Gourlay (1996) we cannot ignore that sexuality educators do hold positions that are reflected in their programs, for example promotion of social justice and opposition to discrimination and violence. However, he maintains that, educators in this area cannot be value-free but should strive to be value-fair, offering a balanced perspective and acknowledging diversity.¹²

It is unrealistic to expect teachers to change their teaching approaches to assist young people to examine the broader social context of issues around STIs, HIV/AIDS and BBVs without adequate and comprehensive professional development. A number of researchers have pointed to the difficulty for teachers in effectively facilitating this with students.^{27, 13, 29}

Harrison and Dempsey (1998) recommended that professional development programs should not only focus on improving the knowledge base of teachers, but on developing skills to build an appropriate classroom climate, to recognise and cater for the diversity of students, and to link at-risk students to appropriate services.²⁹ States and Territories also identified the need for updated knowledge and skills in working with students and parents on a broad range of sexuality issues, skills in policy and guidelines development and formulation, the development of materials and resources and focusing on education in this area under a health promotion banner.

Acknowledging the professional development needs of the school community. Strategic advice

WHOLE SCHOOL	OUTCOMES
School organisation, School – community links	Partnerships developed across the education, health and wider community to ensure effective and appropriate professional development in education about STIs, HIV/AIDS and BBVs.
Policy/guidelines	Review and formulation of policy and guidelines in education about STIs, HIV/AIDS and BBVs including a rationale and guidelines for the provision and delivery of appropriate professional development.
Curriculum	Development and delivery of appropriate professional development includes a key component related to the development and implementation of comprehensive curricula.
Professional development	Appropriate and ongoing professional development in STIs, HIV/AIDS and BBVs provided to all members of the school community.

SUGGESTED ACTIVITIES

- Provide professional development for the whole school community to effectively develop and implement a whole school approach to education about STIs, HIV/AIDS and BBVs.
 - Education authorities work in partnership with other agencies/institutions such as universities and community health organisations to develop professional development programs for the school community in STIs, HIV/AIDS and BBVs.
 - Central education authorities to develop and review and provide to schools a list of accredited providers of professional development in education about STIs, HIV/AIDS and BBVs. For Aboriginal and Torres Strait Islander communities education authorities should develop local networks of trainers and educators and create a register of trainers, speakers and support personnel that might be used to develop local or regional programs (*National Indigenous Australians' Sexual Health Strategy 1996–97 to 1998–99*, p. 8).
 - Liaise with teacher training institutions, including universities, to encourage the inclusion of training in education about STIs, HIV/AIDS and BBVs.
 - Education authorities support the development and use of parent resources for schools to use.
 - Alternative or extra provision of and access to professional development to be made available for teachers working in remote and isolated school/community settings.
- Work in partnership at all appropriate levels to ensure policy and guidelines include a complementary component on professional development.
 - Ensure policy in STIs, HIV/AIDS and BBVs enables the provision of and support for professional development to enable all teaching staff access to the knowledge of and skills needed to develop a cross-curriculum approach.
- Education authorities should ensure that professional development in education about STIs, HIV/AIDS and BBVs is linked to other health-promoting initiatives and programs, such as drug education, suicide prevention, mental health promotion, body image issues etc.
 - Provide continuing professional development for teachers to upgrade their knowledge and skills related to the development and maintenance of supportive classroom climates.
- Provide professional development for the groups that make up a whole school community which enables them to acquire most of the following:
 - access to current research on young people and sexuality
 - those pedagogical skills to implement sexuality education programs focusing on education about STIs, HIV/AIDS and BBVs for same-sex attracted young people
 - the ability to provide students with accurate information, with opportunities to understand personal attitudes, values and behaviours and to develop skills in decision-making around sexual health issues

Acknowledging the professional development needs of the school community. Strategic advice (cont.)

WHOLE SCHOOL	OUTCOMES
Professional development (cont.)	Appropriate and ongoing professional development in STIs, HIV/AIDS and BBVs provided to all members of the school community.
Student welfare/pastoral care	Student welfare and support personnel provided with appropriate professional development.

SUGGESTED ACTIVITIES

- an ability to foster comfort levels, to create rapport with students from diverse backgrounds and experiences, and a capacity to respond confidently and respectfully to the sexual health needs identified by specific groups
 - the capacity to communicate in a positive and sensitive manner and to affirm that sexual feelings are a natural part of life
 - an ability to identify and understand the beliefs and values of individual students which involves sensitivity to the cultural norms, beliefs, attitudes and goals of various racial, ethnic, socio-economic, gender and religious groups
 - specific understanding of issues around sexual orientation and skills in providing effective education in that area
 - sensitivity to gender-related issues
 - insight and skills in helping young people to reflect upon, and evaluate the various ways the media depicts/represents sexuality issues
 - an awareness of and ability to refer students to appropriate community health organisations and/or welfare and support services
 - an ability to work in partnership with other health agencies.
(Several points modified from *Canadian Guidelines for Sexual Health Education* 1994)
 - Schools should ensure that professional development provided by outside agencies is delivered through accredited providers. Most States and Territories have a list of such providers. If not, schools need to ensure that guest speakers, both for staff and students, complement existing school-based programs and priorities.
-
- Provide appropriate levels of professional development for central, regional and school-based student welfare and support personnel in student welfare issues related to STIs, HIV/AIDS and BBVs.
 - Provide professional development for school-based student welfare and pastoral care personnel to enable them to acquire knowledge of and skills in all aspects of education about STIs, HIV/AIDS and BBVs so they can more effectively work with and support the whole school community.

KEY QUESTIONS: A CHECKLIST

This checklist has been designed as a useful guide for program and resource development and evaluation. It summarises an inclusive and comprehensive school-based approach.

It would be impossible for any one program, activity or resource to fulfil all of the following criteria. However, this checklist can be used to assess and review available resources and programs for their inclusivity and comprehensiveness.

- Does the resource/program acknowledge that students are sexual beings?
- Does the resource/program place STIs, HIV/AIDS and BBVs in the context of sexuality?
- Is the resource/program easily understood by the intended audience?
- Is the resource/program culturally sensitive to the intended audience?
- Does the resource/program include activities that improve knowledge of STIs and other BBVs, as well as addressing the lack of knowledge identified around HIV transmission and perceived risk?
- Does the resource/program form part of a whole school approach to addressing issues of STIs, HIV/AIDS and BBVs and sexuality in schools?
- Does the resource/program use a health promotion approach?
- Does the resource/program address a value position as an integral step in developing sexual health attitudes, decisions and behaviours?
- Does the resource/program include the experiences of a range of students; in particular are same-sex attracted youth included in a holistic way rather than only in relation to infection risk?
- Does the resource/program address issues around homophobia and discrimination?
- Does the resource/program examine the construction of masculinity and femininity and the power dynamics in sexual relations?
- Does the resource/program present a range of safe-sex options?
- Does the resource/program integrate other issues, such as drug use, safe sexual practice and relationships?
- Does the resource/program include strategies to encourage discussion with parents?
- Does the resource/program enable students to examine the sources of information they use and those they trust?
- Does the resource/program enable students to make links to health services?
- Does the resource/program complement the ethos of the school?

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