SEXUALITY EDUCATION AND LIFE-SKILLS ACQUISITION IN SECONDARY SCHOOLS: GUIDELINES FOR THE ESTABLISHMENT OF HEALTH PROMOTING SCHOOLS

Beverley Buckley-Willemse

B.A., H.O.D., B.A.(Hons.)

Dissertation presented for the degree Magister Educationis in Educational Psychology at the Postgraduate School for Education (Faculty of Educational Sciences, North West-University)

Supervisor: Dr Charles Viljoen

Potchefstroom
2005

ACKNOWLEDGEMENTS

1. My husband, Ian for your motivation and support. Thank you for believing in me.
2. Bevan and Shaun-Ryan: I hope one day you will understand the urge one has to start and finish projects like this – thank you for coming second sometimes.
3. My mother, Naomi, for her support and helping with my boys.
4. My father, Brian, for proofreading and editing.
5. Wikus – it was you that motivated me to start this dream and have helped me to keep the ball rolling. Thank you for all your support and for sharing this dream!
6 Maria – without you my dreams would not be possible! You are an amazing friend/housekeeper and you raise my children like your own.
7. Marlene Wiggel from the Ferdinand Postma library for her exceptional help with the literature study.
8. Dr Suria Ellis with the statistical data and technical explanations that I really didn't understand in the beginning.
9. Dr Charles Viljoen – thank you for your help and support. You have a passion for your work and I admire that in people.
10. My Heavenly Father that gave me strength, insight and perseverance.

SUMMARY

Keywords:

Adolescents. Behaviour patterns. Decision-making skills. Factual knowledge. Health Promoting Schools. Life-skills. Risk behaviour. Sexuality education.

Sexuality education has been introduced into the South African syllabus, on a very elementary level, in the Life Orientation learning area of Outcomes-Based Education widely known as Curriculum 2005. Unfortunately outcomes-based education ends in Grade 9, leaving learners from Grade 10 -12 with the old syllabus that includes academic subjects only. Very few schools follow a sexuality education programme in Grades 10 – 12 on their own initiative, because it is not compulsory in these grades.

The Health Promoting Schools' policies do not include a comprehensive sexuality education programme outline as yet, but when the life-skills approach that is taught in Life Orientation is considered, many similarities in these approaches are identified. Therefore, sexuality education should not be purely factual, but should be taught in conjunction with important life-skills. The two skills investigated in this study are the ability for adolescents to identify and avoid risk behaviour and to be able to make more responsible decisions.

Two schools in the Bronkhorstspruit area were identified to take part in this project. School A has implemented a comprehensive sexuality education programme for all its learners and School B has not. The results of the data collected from the questionnaire completed by 100 respondents from the two schools indicated that those from School A had a significantly higher level of knowledge regarding sexuality and appeared to have far better life-skills than the respondents from School B. There was, however, no indication that that this knowledge affected their behaviour in any way. This doesn't mean, though, that the programme has been unsuccessful because the programme doesn't only teach abstinence, but also various methods of precaution.

The long-term effect of comprehensive sexuality education has not yet been established because there are so few schools implementing it the way it

should be and it is currently not implemented at a young enough age. Unhealthy behaviour patterns, reinforced by years of traditions and taboos, as well as the contradicting information given through the media, cannot be changed overnight. The process of intensive comprehensive sexuality education has only started in South Africa and, with time, a change in the behaviour patterns of adolescents and adults is anticipated.

OPSOMMING

Sleutelwoorde:

Adolessente. Besluitnemingsvaardighede. Feitelike kennis. Gedragspatrone. Gesondheidsbevorderende skole. Lewensvaardighede. Riskante gedrag. Seksualiteitsopvoeding.

Met die aanvang van uitkomsgebaseerde onderwys, meer bekend in Suid-Afrika as Kurrikulum 2005, is seksualiteitsopvoeding op 'n baie eenvoudige vlak, in die Lewensoriënteringsleerarea aangebied. Omdat uitkomsgebaseerde onderwys slegs strek tot aan die einde van Graad 9, ontvang Graad 10 – 12 leerders slegs onderrig in akademiese eksamenvakke. Weinig skole bied vir Graad 10 –12 enigsins seksualiteitsopvoeding aan, omdat dit nie verpligtend is nie.

Tans sluit die algemene beleid van Gesondheidsbevorderende Skole nie seksualiteitsopvoeding in nie. Die onderliggende filosofie van uitkomsgebaseerde onderwys is dat die fondament van alle onderrig, in elke leerarea, die aanleer van lewensvaardighede moet insluit. Hierdie benadering stem nou ooreen met die algemene beleid van Gesondheidsbevorderende Skole. Dus, wanneer seksualiteitsopvoeding aangebied word, moet dit gepaard gaan met die aanleer van die belangrike lewensvaardighede. Die twee vaardighede wat in hierdie projek bestudeer is, is die vaardigheid om verantwoordelike besluite te neem en die vermoë om situasies wat kan lei tot riskante gedrag, te kan identifiseer en vermy.

Twee skole in die Bronkhorstspruit gebied is geïdentifiseer om deel te neem aan hierdie navorsingsprojek. Skool A het 'n volledige seksualiteitsopvoedingsprogram vir al die leerders in die skool geïmplementeer en Skool B beskik nie oor so 'n program nie. 'n Vraelys is deur 100 respondente van albei skole voltooi en soos dit blyk uit die resultate wat verkry is uit die versamelde data, beskik die leerders van Skool A oor 'n beduidende hoër vlak van feitelike kennis. Dit het ook voorgekom dat dié respondente se lewensvaardighede ook heelwat beter ontwikkel is as die ander s'n. Daar was, nietemin, geen bewys dat hierdie kennis en vaardighede op enige wyse hulle gedrag beïnvloed het nie. Dit beteken

hoegenaamd nie dat die seksualiteitsopvoedingsprogram onsuksesvol is nie, omdat die program nie slegs onthouding van seksuele aktiwiteite bevorder nie, maar wel ook fokus op veilige seksuele gedrag.

Die langtermyn invloed van hierdie volledige seksualiteitsopvoedingsprogram is nog nie vasgestel nie, omdat daar baie min skole is wat dit tans korrek aanbied en indien dit aangebied word, word dit op 'n laat ouderdom begin. Ongesonde gedragspatrone wat versterk is deur jare se tradisies, asook die invloed van die teenstrydige inligting wat van die media verkry word, kan nie oornag verander word nie. Intensiewe seksualiteitsopvoeding is baie nuut in Suid-Afrika en mettertyd sal die sukses van hierdie programme 'n invloed kan hê op die gedrag van adolessente en volwassenes.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

APPENDIX

CHAPTER 1

INTRODUCTION, ORIENTATION, PROBLEM STATEMENT, AND METHODOLOGY

1.1 INTRODUCTION AND ORIENTATION

"There have been strong demands for greater inter-sectoral co-operation and a united approach towards making schools more health promoting in South Africa" (Williams & Reddy, 1998:33). Schools have been identified as central parts of communities that can provide access to a very large proportion of children and youth at critical developmental stages (Flisher & Reddy, 1995:629) and students can become disseminators of information, skills and attitudes back to their families, communities and others (Fraser-Moleketi, 1996).

According to the Ottawa Charter for Health Promotion (WHO,1986), "(general) health promotion is the process of enabling people to increase control over and improve health." The Charter also states that in order for individuals to make healthy choices there is a need to have access to information and life-skills.

Based on the above definition of general health-promotion, a new approach to education has been implemented in most Australian schools (Anon., 1998b:3) and is currently being piloted into some South African schools. A school in the process of becoming a Health Promoting School should aim to display, "in everything they say and do, support for and commitment to enhancing the emotional, social, physical and moral well-being of all members of the school community" (Anon., 1998b:2).

Donald, Lazarus and Lolwana (1997:83-84) define a Health-Promoting School as a school "aiming at achieving healthy lifestyles for the school population by developing supportive environments conducive to the promotion of health. It offers opportunities for, and requires commitments to, the provision of a safe and health-enhancing social and physical environment." Only this type of

education could really alter behaviour and improve health (Dept. of Health, 1999).

A review of World Health Organisation (WHO) documents (WHO, 1996a, 2000) and a document published by the South African Department of Health as a guideline document (1999), reveal that no mention is made of sexuality education of any kind while 'sex education' is mentioned only once in WHO (2000) as part of a pilot study done in a Bulgarian Health Promoting School. HIV/AIDS and unintended pregnancy are briefly mentioned in the lists of problems identified in schools alongside tree-planting and tuck-shop menus.

According to Mukoma (2001:57) the "health promotion approach provides a framework within which there is *potential* to address these adolescent health issues (like unwanted pregnancy and STDs including HIV/AIDS) holistically rather than in isolation" (own italics and parenthesis). To this 'sexual well-being' could well be added. Thus, if any education policy advocates a holistic approach, it should include sexuality education that aims to change the current behaviour patterns of adolescents. Including sexuality education without a clear sexuality education policy, though, would be disastrous.

In 1997 UNAIDS did a survey regarding the impact of HIV and sexual health education on the sexual behaviour of young people. This research was commissioned by the Joint United Nations Programme on HIV/Aids. Sixty-eight reports were reviewed. Of 53 studies that evaluated specific interventions, 27 reported that HIV/Aids and sexual health education neither increased nor decreased sexual activity and rates of pregnancy and sexually transmitted diseases (STDs). A total of 22 reported that HIV/Aids and/or sexual health education either delayed the onset of sexual activity, reduced the number of sexual partners or reduced unplanned pregnancy and STD rates. Only three studies found increases in sexual behaviour associated with sexual health education. "Hence, little evidence was found to support the contention that sexual health and HIV education promote promiscuity" (UNAIDS, 1997).

Education programmes alone cannot eradicate irresponsible behaviour, but empowering learners with knowledge and teaching them life-skills can have a

positive influence on behaviour. If schools aim to improve the health of the learners, they have to start somewhere and try something.

South Africa has taken a step in the right direction by introducing sexuality education into the Life-Skills syllabus as part of the South African Outcomes-Based Education Programme - Curriculum 2005. The question is, if this is sufficient, because sexuality education not only consists of providing factual information, but should also include the physical, social, emotional and spiritual aspects of being a sexual entity (Kelly, 1998:2; Anon., 1995:37; Coleman & Roker, 1998:2).

It has also become evident by looking at the curriculum material, (Greathead, Devenish & Funnel, 1998; Louw, De Villiers, Amorim, Roos & Delagey, 2001; Anderson, Brouard, Brooke & Wilkinson, 2001) that even more important than teaching information, is the teaching of skills. Putting information into action is what will bring about the changes in adolescent behaviour that is currently preventing individuals from developing into healthy individuals.

Although the majority of South African schools are not Health Promoting Schools *per se*, health promotion is becoming increasingly important. In a speech made by the Minister of Education (Asmal, 2000) reference was made to an infrastructure survey done in 2000 to access progress in schools in the period 1996 to 2000. The percentage of students without access to proper toilet facilities has declined from 55% in 1996 to 16% in 2000. A staggering 40% of schools are still without running water compared to 34% in 1996.

In the same speech made by the minister of Education introducing the debate on the education budget, it was said that "it is imperative that we mobilise our communities around HIV/AIDS [because] education is central to counteract HIV/AIDS" (Asmal, 2000:6). It was also stated that most children enter the education system HIV-negative but that an unacceptable number leave school HIV-positive, and many more become infected shortly after leaving school. It would be ideal of the education system were able to influence children's ideas about sex and relationships even before they are formed. If this were possible, "we would play the key role in changing the course of the epidemic. We have no other option" (Asmal, 2000:6).

The following outcomes of comprehensive sexuality education are based on the curriculum material (Greathead, *et al.*, 1998; Louw, *et al.*, 2001; Anderson, *et al.*, 2001). The learners' health is promoted when they are taught to

- feel comfortable with the changes brought about by the onset of adolescence;
- have personal skills to know how to behave in different circumstances;
- respect others' requests as well as people with different orientations;
- accept own sexual identity; and
- have correct factual information and know how to use it to make healthy decisions.

Theorists Coleman & Roker (1998:12) include these five points in their definition of sexual health. Sexual health is, therefore, much more than avoiding harm of pregnancy or STDs. Mukoma (2001:56) includes under sexual health "knowledge of HIV/AIDS transmission and prevention, attitudes to HIV, sexual attitudes, behaviours and practices."

An analysis of Coleman & Roker's (1998) and Mukoma's (2001) views reveals that they share the view that factual knowledge as well as the acquisition of life-skills is important to be able to make responsible decisions and ensure sexual health. Life-skills are the skills necessary to "perform the tasks for a given age and sex in the different areas of human development. These are all the skills people need to enable them to handle their life situations adequately and live meaningful lives" (Olivier, Greyling & Venter, 1997:25).

When sexuality education is combined with the acquisition of life-skills, education in secondary schools will have moved even closer to "enabling people to increase control over and improve health" (WHO, 1986). By means of a preliminary analysis of the contents of a selection of textbooks/study guides/ guidelines (Anderson *et al.*, 2001; Greathead *et al.*, 1998; Louw *et al.*, 2001; Van der Walt, 2001) currently used by some secondary schools in Gauteng in the sexuality education curricula, the following life-skills have been identified as essential skills that will enable adolescents to be more sexually responsible and healthy:

- Responsible decision-making
- Refusing, negotiating and communicating skills
- Finding and applying knowledge
- Identifying and avoiding risk behaviour

According to an editorial in the *South African Medical Journal* by Flisher and Reddy (1995:629), high risk behaviour is one of the major causes of the high drop-out rate in South African schools. Risk-taking behaviours include alcohol use/abuse, drug abuse, interpersonal violence, risky road usage, suicidal behaviour and *sexual misbehaviour.* It doesn't take much insight to see that these types of behaviour are often interconnected and cause or precipitate each other.

Although "(k)nowledge is a pre-requisite for safe behaviour," (Coleman & Roker 1998:22) it seems as if something is still lacking. Mukoma (2001:55) reports some shocking evidence that supports the view that mere knowledge is insufficient to ensure effective sexuality education. By 1998, South Africa was reported to have among the highest HIV infection rates world wide and those that are most affected are between 15 and 24, which represents the most productive segment of the population.

Eaton and Flisher (2001) state that South African adolescents have a high level of awareness and knowledge regarding this disease and how it is contracted, but "this knowledge has not translated into safer sexual behaviour." This means that knowledge taught without the acquisition of skills is not effective in changing behaviour.

Against the background described above, it can be stated that the establishment of Health Promoting Schools has the potential to change the behaviour patterns of the school population. It can be further deduced that there is an urgent need to address the issue of sexuality in schools. Children are being misinformed by the media, friends and even parents. Sexuality education is not a topic that centres around the physical facts only, as each group, race and culture or sub-group/culture have different values, ideals, beliefs and taboos attached to these facts, as well as their own opinions and attitudes regarding their own sexuality (Coleman & Roker, 1998; Snyman, 2001:88; Mokgalabone, 1999:55; Van Niekerk & Louw, 1996: 40).

The problem in South Africa is complex. Due to many different reasons, sexuality education is not being implemented in schools the way it should be. Teachers aren't always qualified, willing or suitable; poor examples are set by teachers (especially considering the high number of South African teachers living with HIV/AIDS); sexuality education is started in grade 6 which is far too late; and there is a lack of government funding. Thus, dealing with health issues related to lifestyle will inevitably affect learning outcomes negatively (Sanders, 2001: 42; Mukoma, 2001:57; Mokgalabone, 1999:55).

1.2 PROBLEM STATEMENT

Based on the discussion above, the central research problems this study focused on were:

Do adolescents who have been exposed to comprehensive sexuality education

- display better developed basic life-skills?
- know how to use the information and knowledge they have to identify and avoid risk behaviour? and
- make responsible decisions more successfully than those who have not?

1.3 AIMS OF THE RESEARCH

The aims of the research were to:

- investigate the skills a learner needs to be sexually 'healthy';
- inspect whether a combination of knowledge and life-skills enables adolescents to identify and avoid unhealthy risk behaviour more effectively and make more responsible decisions; and
- highlight the necessity for comprehensive sexuality education in Health-Promoting Schools.

1.4 METHODOLOGY

1.4.1 Literature Study

An overview study of the available sexuality textbooks and guidelines currently prescribed for the secondary schools in Gauteng (Anderson *et al,* 2001; Greathead *et al,* 1998; Louw *et al,* 2001; Van der Walt, 2001) was done to determine what learners should be taught in a comprehensive sexuality education program. The World Health Organization's reports regarding Health Promoting Education were also researched.

A further literature review regarding the following topics was done:

- the current situation in South African schools;
- the problems and paranoia around sexuality education in general;
- the different types of sexuality education offered world wide; and
- sexuality education and life-skills.

1.4.2 Empirical research

1.4.2.1 The aim of the empirical research

The aim of the empirical research is to determine the necessity for Health Promoting Schools to implement a comprehensive sexuality education programme that provides adolescents with the life-skills needed to identify and avoid risk behaviour and to make responsible decisions.

1.4.2.2 Population

A sample was selected from two secondary schools in a rural area in eastern Gauteng. School A has a comprehensive sexuality education programme and policy in place for Grade 8 - 12, and School B does not have above-mentioned programme. The sample from School B was the entire Grade 11 group from that school and 50 Grade 11 subjects at School A were chosen by the teachers of that school. The mean age was 17 years.

The size of the sample was 100: 50 subjects from each school. The sample included 50 male and 50 female subjects although this was coincidental.

1.4.2.3 Ethical measures

The subjects were selected by teachers at the school and they were informed of the aim of the study as well as given the opportunity to withdraw from the group if they so wished. Their anonymity was ensured and the confidentiality of the questionnaires explained.

1.4.2.4 Procedure

Interviews with the principals and teachers concerned were carried out to obtain permission and to discuss the nature and purpose of the study with regard to the current curricula followed at the school. A detailed outline of the study at hand was also communicated with these role players.

In this study, the independent variable was the presence/absence of a comprehensive sexuality education programme and the dependent variables the presence/absence of (a) factual knowledge; and (b) life-skills.

1.4.2.5 Questionnaire

The purpose of the questionnaire was threefold:

- Firstly, biographical information was collected on a nominal level (questions which require the subject to mark one of the possible options, e.g. gender).
- Secondly, there were questions that set out to determine the level of factual knowledge of the subjects regarding sexuality. These questions covered physical development, reproduction, contraception, HIV/Aids and other sexually transmitted diseases , etc.
- Thirdly, there were questions that were designed to determine whether the subjects had developed decision-making skills and whether they could identify and avoid risk behaviour.

The responses to open-ended questions had to be coded with numbers and all subjects that answered in the same vein, would be assigned the same number.

For example, if an answer to a question was "I was afraid", a (1) is assigned to the response. "I was angry", a (2); "I was so scared", a (1), etc. It is

laborious in that all the responses have to be paraphrased, but a great deal of valuable information is collected in this way.

Even though the questionnaire was slightly complex because of the inclusion of abstract and factual questions, care was taken to ensure that the language level was simple because of the age and home languages of the participants. There is also a danger that answers can be normative because of the sensitivity of the topic. This could be minimized if the researcher is anonymous and supervises the answering of the questionnaire alone in the absence of the class teacher. This will also ensure that the questionnaires will all be collected.

1.5 THE LIMITATIONS OF THE RESEARCH

As in all research, there were problems and limitations, mostly unexpected and some foreseen. It is impossible to control all the variables that could possibly affect the hypotheses. The following limitations were experienced:

- It would have been ideal to include more schools in the research project, but it would have increased other variables such as different cultural backgrounds and home languages.
- Even though the language of instruction at these schools is English, the subjects do not have English as a home language. Care was taken to ensure that the level of language was as simple as possible and that the terms referred to were explained where necessary.
- The mean age of the subjects was 17 years, but there were a few subjects who were between 20 and 23 years of age. As age increases so does the likelihood of sexual activity and this could have had an effect on those subjects' responses.
- The questionnaire was compiled to investigate sexuality issues that are sensitive and personal. However, the questionnaire and the study in general, were based on the assumption that the subjects were heterosexual. Care was taken to refer to 'partners' in general or to a 'boyfriend/girlfriend', but no provision was made for subjects who are homosexually oriented.

- Although the incidence of abuse, rape and incest is much higher than researchers anticipate, this was also not addressed in the questionnaire. Of course this will affect the subjects' perceptions and opinions but it was not investigated at all.
- Initially it seemed that unanswered items could affect the reliability of the items, but when the results were scrutinized, the unanswered items were a strong indication of a lack of knowledge to be able to answer the question. Subjects from School A, for example, left very few questions unanswered because the questions were familiar to them, whereas the subjects from School B had never been confronted with questions of that nature and therefore did not know how to respond. This lack of information was very useful.

1.6 THE STRUCTURE OF THE RESEARCH REPORT

The research report consists of four chapters.

Chapter 1: An orientation, statement of the problem and a discussion of the research methodology followed

Chapter 2: (Article 1) An overview article that aims to explore the development necessary in the establishing of Health-Promoting Schools. The focus of the article is on the importance of teaching life-skills in conjunction with comprehensive sexuality education.

Chapter 3: (Article 2) A discussion of the data collected during the empirical research as well as the practical significance of the results obtained.

Chapter 4: An outline of the findings, conclusions and the recommendations for possible further research.

CHAPTER 2

TOWARDS THE HEALTH PROMOTING SCHOOL: SEXUALITY EDUCATION THROUGH LIFE-SKILLS – AN OVERVIEW

2.1 INTRODUCTION AND ORIENTATION

Ideally education should have wider goals than teaching reading, writing and arithmetic; it should be an instrument of teaching the skills and art of living healthy, successful lives. Many curricula in educational systems worldwide tend to focus on preparing individuals to be successful employees (Bailey, 1976:43). The average number of hours actually spent at work only comprises approximately 20% of an average life-span. The holistic approach of Health Promoting Schools aims at redefining education and incorporating the social, emotional, spiritual, psychological and ethical dimensions for individual and community well-being throughout life (Anon., 1998b:2; Lazarus & Reddy, 1994: 6).

Donald, Lazarus and Lolwana (1997:83-84) define a Health-Promoting School as a school "aiming at achieving healthy lifestyles for the school population by developing supportive environments conducive to the promotion of health. It offers opportunities for, and requires commitments to, the provision of a safe and health-enhancing social and physical environment". This is the type of education that could really alter behaviour and improve health (Department of Health, 1999).

"The health promotion approach provides a framework within which there is *potential* to address these adolescent health issues (like unwanted pregnancy and sexually transmitted diseases [STDs], including HIV/AIDS) holistically rather than in isolation" [own italics and parenthesis] (Mukoma, 2001:57). "Sexual well-being" should be added to school curricula in the pursuit of promoting holistic well-being.

The new curriculum currently implemented in South African schools is an Outcomes-Based curriculum, commonly referred to as Curriculum 2005, which also has the aim of preparing individuals for life by teaching life-skills (Pretorius, 1998:v). An increasing number of studies have produced strong

evidence "that skills-based health education applied in an appropriate context, changes behaviour – including behaviour in sensitive and difficult areas where knowledge based health education has failed" (Anon., s.a.; Rice, 2000; UNESCO, 2004; UNICEF, 2001). This curriculum and what it aims to achieve, reinforces the Health-Promoting Schools' policies. It is about changing the focus in the system.

"Essentially, the Health Promoting School framework, in its most basic guise, is really just a different way of thinking about and *doing better,* the things that we already do in schools, the things that we have to do, need to do and want to do, to create optimal conditions for learning and working with school communities" [own emphasis] (Anon., 1998b:6). Bailey (1976:16) aptly stated that one of the most effective ways of improving the life chances of children is to implement curricular changes in schools. This, then, could trigger a chain of events moving out from the classroom curriculum to the families and communities. In this way education starts promoting health on the macro-levels of the society.

"There have been strong demands for greater inter-sectoral co-operation and a united approach towards making schools more health promoting in South Africa" (Williams & Reddy, 1998:33). Schools have been identified as central parts of communities that can provide access to a very large proportion of children and youth at critical developmental stages (Flisher & Reddy, 1995:629) and students can become disseminators of information, skills and attitudes back to their families, communities and others (Fraser-Moleketi, 1996).

O'Byrne, Jones, Sen-Hai and Macdonald (1996:5) idealistically state that a Health Promoting School should be "constantly strengthening its capacity as a healthy setting for living, learning and working." McMurray (1999:301) shares this ideal by saying that schools should be the 'hub of health promotion' where every sector of the society comes together to maximise the health, education and development needs of young people, yet he maintains that the most significant problems of today's society are greatly caused by the types of behaviour patterns established during adolescence. This seems ironic as this

is the time when the young people leave the 'hub of health promotion' – not ready to face adulthood.

In 1986 in Canada the World Health Organisation (WHO, 1986) compiled the Ottawa Charter for general Health Promotion which has served as a blueprint for future health promotion on each level of society. The fundamental conditions and resources that are important for community health as identified in the Charter (WHO, 1986) have been adapted to design effective comprehensive health programs in schools as well as other organizations. These interactive components are: health services; psychological, counselling and social services; health education; physical education and other physical activities; the psychosocial and biophysical environment; health programs for faculty and staff; and integrated efforts of schools, families and communities to improve the health of students and staff (McMurray, 1999:303).

These components should be integrated so that the school could become a healthy organisation in a healthy community with the full participation of all the involved parties: students, teachers, parents, non-government organisations (NGOs) and other members and organisations of the community. Besides the involvement of these parties, there are changes that must take place on a curricular level which is, after all, the main tool that can be used to achieve these ideals. Essentially, the content of the curriculum would be aimed at the changing of behaviour of adolescents (Mackie & Oickle, 1997:1302; Nutbeam, 1997:400). The goal of education should be to prevent unsafe behaviour patterns from being started, and to change the patterns that have already formed. The goal should be to promote health in such a way that it is a "process of enabling people to increase control over and improve health" (WHO, 1986).

Ironically, a review of World Health Organisation documents (WHO, 1996, 2000) and a document published by the South African Department of Health as a guideline document for Health Promoting Schools (1999), reveal that no mention is made of *sexuality education* of any kind and 'sex education' is mentioned briefly once in WHO (2000) as part of a pilot study done in a Bulgarian Health Promoting School. The absence of information regarding sexuality education in Health-Promoting Schools is as disturbing as the lack of

reference to sexuality education by the WHO. This doesn't weigh up to the major problems caused worldwide as a result of teenage pregnancies and HIV/Aids. There is a need to rethink and address this topic comprehensively even on the macro-levels.

A paradigm shift is necessary to change the perceptions around schools and about curricula. The society is constantly changing and yet there seems to be stagnation around the way children are taught to be ready to live healthy, balanced lives in that society. The "facts of life" have never changed - but the way it is approached by adolescents, the media, parents, the church and schools, has. Goldman (2000:1) reports that "compared to pre-millennial teenagers, today's youth have experienced the highest level of sexualisation" and yet it is very clear that "sex is still a taboo subject to many communities" in South Africa (Lifhiga, 2003:12). Even a first world country like the United States of America (USA) doesn't seem to be much further ahead of South Africa because an analysis of USA textbooks used in the sexuality education classes showed that the same material had been implemented from 1956 to 1993 (Kelly, 1998:223). Only when HIV/Aids gripped the world did the content of sexuality education start to change and very slowly at that.

No matter how ambitious a change in a programme or how challenging the implementation of a new programme, or how well-intentioned or well-designed the training intervention is, it will not "take root in a school setting where existing ideologies and practices were not likely to nurture it" (Kenyon, Heywood & Conway, 2002:166). To accommodate the changes taking place in society, schools should consider a more holistic approach to prepare adolescents to be responsible, well-informed adults in this ever-changing world. In the Life Orientation program currently implemented in South Africa from grades 1 – 9 (Pretorius, 1998), the aim is to transform individuals and then through the individuals, the society.

This article aims to explore the development necessary in the establishing of Health Promoting Schools. The particular focus is on the importance of teaching life-skills in conjunction with comprehensive sexuality education. The questions directing this study are as follows: What is the current scenario in South African schools? What are the problems around sexuality education?

What is the role of life-skills in sexuality education? How can these insights be utilised to enhance existing approaches towards the establishment of the Health Promoting Schools?

The study is based on a literature review. International trends and the South African situation are reviewed.

2.2 THE SOUTH AFRICAN SCHOOLS' CONTEXT

Adolescents worldwide deal with the same types of problems even though their immediate contexts differ. Developing a self-image, dealing with blossoming sexuality, handling peer pressure and being exposed to high-risk behaviour are just a few of the universal issues adolescents deal with. The media and peer pressure play an important role whether the adolescent is South African or North American.

An Australian study researching healthy behaviour of adolescents found that the most effective way to reach adolescents is by combining the media exposure and school-based education. (McMurray, 1999:125). The research done was aimed at reducing the number of adolescents that smoke cigarettes. If however, contradictory messages are being brought across by these sources, it will have little effect. For adolescents watching 27 or more hours of TV per week where sexual activity occurs or is referred to a few times an hour, there is no link between what they are taught, what they see and what is actually happening (Van Niekerk & Louw, 1996:51).

It would be ideal if education, schools and teachers could have similar influence in the forming of healthy adolescents. However, children and adolescents are ***not*** being taught the facts by educators and health workers, but rather by their friends, politicians and the media. Mokgalabone (1999:56) found that "teenagers influenced by peers have a higher level of premarital pregnancy." Children and adolescents are forming their own set of values and morals and follow role models.

Adolescents may not even be aware that they attach so much importance to their peers and the media. As Samantha Bartlett reported in the *The Star* (2002:9): "South African teenagers rank *education* as their top priority and

HIV/Aids as their biggest concern, but most believe their chances of getting the disease are low to non-existent." [The subjects that took part in the survey done by LoveLife (South Africa's national HIV prevention programme for youth) represented a cross-section of the country's population]. Learners don't seem to be receiving the education they need from reliable sources.

According to Louw, *et al.* (2001:2) research done by UNAIDS has shown that 60% of all new HIV infections are among 15 - 24 year olds and that currently in South Africa, approximately 1 500 people are being infected *daily.* Many people enter the education system HIV/Aids negative, but leave it infected or become HIV/Aids-positive shortly after leaving. In order to curb the spread of HIV/Aids, other sexually transmitted diseases (STDs) and unwanted pregnancy, adolescents have to be the target group because they have a right to timely information and the right to the means to protect themselves.

Fourteen years ago, in 1991 (Anon., 1991:15), it was said that "children constitute the most hopeful group in the community and should at all cost remain uninfected." They are on the brink of making important decisions about life-style, including sexual behaviour, and therefore they should be educated to adopt and retain healthy behaviour patterns that will lessen the risk of becoming HIV infected or having an unwanted pregnancy.

What has been done to educate this 'hopeful group' in the community? The Department of Education started research on an appropriate Aids and Life-style education programme so that it could be implemented in schools as from 1992 (Anon., 1991:15). The interim syllabi were only implemented in 1996 and there was no form of sexuality education included in the interim syllabi. In fact, subjects like religious instruction, guidance, physical education and youth preparedness were all phased out of the school timetable due to a low education budget. Only in 2001 the outcomes-based education programme with life-skills education was implemented in secondary schools and then only up to grades 8 and 9. In effect, "in South Africa, until late in 1999 the Department of Education had no policy on HIV/Aids" (Anon., s.a.).

According to the Department of Education in the Western Cape, curriculum-compliant learning support material for grades 8 and 9 was to be distributed during the teacher-training phase in early 2003 and that there was still no material available from grades 10 – 12 (Department of Education: 2003).

Education is accepted throughout the world as the most important strategy to combat AIDS and other negative consequences such as unwanted pregnancy and other STDs. The World Health Organisation (WHO:1996b) has identified schools as the ideal setting to reach millions of students most cost effectively. If Life-Skills is taught effectively before adolescents become sexually active, it can delay the age at which first intercourse takes place and risk behaviour can be identified and avoided. It is also the best age to target because they are still developing behaviour patterns and can adopt safer sexual practises before it is too late.

The sexuality education included into the Grade 8 and 9 Life-skills syllabus is not very comprehensive either. Unfortunately, this is where most sexuality education has stopped as no curriculum has been implemented in the senior secondary phase as yet (Department of Education, 2003). Since the government started researching an appropriate programme until now, millions of people from the 'hopeful group of the community' have been infected and affected by the virus, most of whom would have benefited from immediate reactions from the Department of Education.

The South African Department of Health (1999:14) has also identified the lack of intervention in the schools and has published a strategic plan regarding HIV/Aids and STDs. It identifies four priority areas and 14 goals that need to be met. Interestingly, Priority Area 1 is prevention and the first goal is to "promote safe and healthy sexual behaviour." The suggested strategy will be to implement life skills education in all primary and secondary schools. This is the type of commitment needed on government level for a comprehensive sexuality education programme. In spite of this, the "[i]mplementation of the programme [sexuality education by guidance teachers] did not happen as envisaged" (Department of Education, 1999:5) and unfortunately due to the undermining of teachers over the last number of years and the restructuring

and redeployment that has taken place, there is a shortage of teachers and so guidance/life-skills cannot be taught properly (Terre Blanche, 1999).

Sexuality education in South Africa is most often HIV/Aids awareness and focuses on the problems and the negative aspect of sexuality. Thus, the current situation of sexuality education in South Africa is tenuous and rife with problems and paranoia.

2.3 PROBLEMS AND PARANOIA AROUND SEXUALITY EDUCATION

For years many adult groups have strongly opposed sex education in schools because they are afraid that it will either encourage children to experiment with sex at an earlier age, or it will be introduced to children too young to really understand, and in some way corrupt children's minds and will lower the "moral tone of the community" (Anon., 1998a:38). But it has also been proved that "[t]eens who are most sexually active usually are the least well-informed about sexual behaviour" (Anon., 1995:20). Kirby, *et al.* (1994:342) reported evidence a decade ago that well implemented skills-based programmes, conducted in an atmosphere of free discussion of all issues, is likely to lead to young people delaying the initiation of intercourse and reducing the frequency of intercourse and number of sexual partners.

Kosunen, Rimpela and Rimpela (1996:30) discuss successful education policies that have been implemented in Health Promoting Schools in Scandanavia. In Finland it has been proved that having healthy public policy reorienting health services, has had a distinct effect on teenage pregnancies and abortions. Since school sex education was incorporated into all curricula in all Finnish schools, the national rates of teenage pregnancy and abortion have dropped by almost 50%. In the Netherlands the abortion rates have dropped to the lowest in the Western world since they have implemented their programmes. These statements do not mean, however, that teenagers in these countries are less sexually active, but it does indicate that they have started making more responsible decisions based on the knowledge they have been given.

Ironically, according to research done by Kunio and Sono (1996:27), earlier experimentation with sexual activities is due to poor role models in parents

and teachers, parental control has decreased and adult society is more lenient toward previously unacceptable sexual behaviour. Research has proved that teenagers who talk openly with their parents about sex and who have been exposed to sex education classes are more likely to postpone sexual activity and to use contraception more responsibly when they do (Anon., 1995:20; Coleman & Roker, 1998:40; Anon., 1998a:39). This is a movement in the right direction because it shows that patterns of behaviour can change with education. The aim should be, then, to maximise this change by implementing programmes that will result in an even greater behaviour change.

Another problem is that, no matter how comprehensive the syllabus is, many schools are not teaching it the way it should be. In fact, South Africa has one of the most far-sighted policies in the world but these policies have not been successfully implemented (Greathead, *et al.*, 1998; Kenyon *et al.*, 2002:161). Studies done by Bartlett (2002:9), Mokgalabone (1999:5) and Van Dyk (2001:154) reveal that together with sweeping statements made by politicians and/or the media and the lack of efficiently implemented comprehensive sexuality education, adolescents are not equipped with the knowledge they should have to avoid risk and danger, or the skills to communicate a refusal or to negotiate an alternate sexual behaviour.

The statistics recorded by Kenyon, Heywood and Conway (2002:165) reiterate the fact that sexuality education is not taking place efficiently even though most schools sent two teachers to be trained to teach sexuality education (with specific reference to HIV/Aids) as early as 1997. There are serious inadequacies in the implementation of the plan. In the Limpopo Province, for example, 8% of youth still do not believe in the existence of HIV/Aids, whilst 61% assume that AIDS is not on the increase.

There must be a problem behind this inefficient implementation of the program. Goldman (2000), Yarber and Torabi (1997) and Louw *et al.* (2001) have very clear specifications for the ideal sexuality education teacher and one cannot help wondering how many educators actually fit the description. Having the 'wrong' person doing the job could very well be the problem. These educators should be knowledgeable and understand his/her own

sexuality; live according to the set of values and principles he/she wishes to instil in the learners; be trustworthy and honourable; have suitable qualifications and the personality to present the programme efficiently; strive to be value-fair in acknowledging social diversity; and be motivated and enthusiastic about the programme.

Unfortunately many educators think that by using ultimatums, lectures, sermons and frightening stories about illness and pregnancy they have done their job, but this will only cause the adolescents to avoid talking about sexual matters, it will not alter behaviour or form healthier patterns of behaviour. It is essential that the educator fosters a child's opinion and therefore also builds a self-esteem which is most crucial when making responsible decisions about sex (Anon., 1995:22). The educator must be open-minded enough to be objective and also have a healthy self-esteem so as to guide adolescents with confidence.

Another problem around suitable educators is that they do not necessarily practise what they preach. A shocking statistic published by the World Bank is that more than 40 000 of South Africa's 350 000 teachers have HIV/Aids (Steyn & Louw, 2002:1). Teachers are dying faster than they can be trained. Currently the situation in South Africa is not a very positive one. "Educators are increasingly dying from Aids" (Grey, 2001:13). She also states that sick leave due to Aids-related illnesses is on the increase among those working for provincial education departments. "[T]eacher deaths [have] escalated to more than 40% due to HIV/Aids" (Venter, 2001:6). Govender (2001:1) reported that the Education Department is currently dealing with the issue whether a four-year teaching degree is practical when teachers are dying so young. The government is spending so much money subsidising universities and tertiary institutions, but these teachers die before they can spend a single day in a classroom.

Regardless of the fact that the educators are trained to teach life-skills and to promote health and wellness, many are involved with irresponsible, deplorable behaviour that makes them poor role-models. The South African Medical Research Council reported late in 2000 that one half of all schoolgirls had been forced to have sex against their will – one third of them by teachers

(Maree & Ebersöhn, 2002:240). The former Minister of Education, Mr Kader Asmal, stated that he *anticipated a decline* in the number of new cases of sexual abuse by educators. He also stated that 45 educators had been dismissed from eight provinces for sexual abuse [own italics](Asmal, 2002). Ironically, in February 2004, two years later, *The Citizen* printed a report with the heading *"Government is 'ignoring school abuse"* in which an alleged 55 cases of teachers abusing school children were reported in KwaZulu-Natal alone of which only two were investigated. In Gauteng the report adds that no action was taken following the 18 cases reported (Msimang, 2004:1).

Some of the problems and perceptions around sexuality education are unfounded and biased. Some seem insurmountable and impossible to tackle, but there is no choice, the lives of many young people depend on it.

2.4 SEXUALITY EDUCATION

Sexuality education should not only supply biological facts, but also life-skills that will enable behaviour change. Since the democratic election in 1994 many changes have taken place in South African education. Outcomes-Based Education (OBE) has been implemented and one of the new learning areas is a Life-Orientation programme which includes sexuality education and HIV/Aids awareness, even though to a very limited degree.

There are currently three basic approaches that are implemented in different schools throughout the world. The abstinence-only approach and the abstinence-plus approach are very rigid and conservative, while the ideal and most successful curriculum – the comprehensive sexuality education programme - is based on a life-skills approach. It is encouraging that the majority of the learner material published and used in South African schools is based on the skills-based comprehensive approach.

2.4.1 The Abstinence-only Curricula

The Congressional Act of 1996 defines the abstinence-only approach as the "teaching of benefits of abstinence in terms of social, psychological and health gains, as well as the potential harmful consequences of sexual activity and childbearing outside of the context of marriage" (Thomas, 2000:6). The focus

is on the *negative* effects of sexual behaviour and the dangers of becoming sexually involved. The only option for adolescents, according to this approach, is abstinence. There also seems to be no proof that this approach has the desired effect in delaying or reducing sexual intercourse or encouraging more effective use of contraceptives (Kirby, 2000:73; Parker, 2001:3; Wiley, 2002:166). Wiley (2002:165) goes as far as to say that implementing this abstinence-only approach is unethical because it is misleading and withholds information necessary to make informed, responsible choices.

2.4.2 Abstinence-Plus Approach

This approach still emphasises that abstinence is the only safe way of avoiding sexually transmitted diseases, unwanted pregnancy and HIV/Aids, but that the use of condoms is safer than unprotected sex (Kirby, 2000:73; Wiley, 2002:164).

The abstinence-only approach is often religion-based and focuses on moral values. The abstinence-plus model of sex education tries to "convey relevant comprehensive knowledge in a value-free and non-judgemental manner" where "sex information is sex education" (Holmshaw, 1992).

2.4.3 Comprehensive Sexuality Education

Comprehensive sexuality education may be defined as a "lifelong process of acquiring information and forming attitudes, beliefs, and values about identity, relationships and intimacy" (Goldman, 2000:2). This approach revolves around sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image and gender roles. It addresses the biological, socio-cultural, psychological and spiritual dimensions of sexuality from different perspectives: the cognitive, affective and the behavioural domains. It also includes the skills to communicate effectively and make responsible decisions. Comprehensive sexuality education is also about social change and helping to create a world where all people have the information and the rights to make responsible sexual choices based on that information (Gourlay, 1996; Earles, Fraser & Sumpter, 1992; Parker, 2001). This approach which also advocates that abstinence is the safest way to avoid unwanted

pregnancy, sexually transmitted diseases and HIV/Aids, focuses on the positive aspects of sexuality as well as teaching essential life-skills to be able to avoid risk behaviour and negative consequences.

After the comprehensive program, adolescents should be prepared for (Coleman & Roker, 1998; Anon., 1998b; Greathead *et al*, 1998):

- emotional risks such as betrayal, disappointment, unrequited love, deception, etc.
- social risks or peer rejection and pressure from both peers and superiors
- spiritual/moral risks of living with guilt and shame, and
- physical risks such as pregnancy or sexually transmitted diseases.

Goldman (2000:2) and Coleman and Roker (1998:11) suggest that successful comprehensive sexuality education should:

- provide accurate information about human sexuality;
- provide an opportunity for young people to develop and understand their values, attitudes and beliefs about sexuality;
- help young people develop relationships and interpersonal skills;
- help young people exercise responsibility regarding sexual relationships;
- allow young people to feel comfortable and assured about the changes of puberty;
- teach young people to have the confidence to resist the pressure to have sexual relationships before feeling ready;
- teach that having respect for the needs and views of others is important; and
- encourage feeling happy and supported in a sexual identity.

Parker (2001:3) states that it is not realistic or advisable to deny that adolescents are sexually active and thereby fail to provide the scientifically validated curricula. Instead he suggests that schools should respond "proactively by providing students with the comprehensive sexuality education curricula they need to prevent the detrimental outcomes of their sexual behaviour."

2.5 SEXUALITY EDUCATION AND LIFE-SKILLS

Having defined the context of Health Promoting Schools and the problems and short-comings of sexuality education in South Africa, it is time to consider a possible solution to the problem. Life-skills education seems to be the most holistic approach currently available to teach comprehensive sexuality education.

2.5.1 What is the life-skills approach?

In traditional pre-1994 education structures, the accent of education fell on academic content and not on acquiring skills (Pretorius, 1998:viii). The Curriculum 2005 programme is an Outcome-Based programme. Spady (1994:18) defines outcomes as "high-quality, culminating demonstrations of significant learning in context." UNICEF (2001:1) defines the life-skills approach as the "interactive process of teaching and learning which focuses on acquiring knowledge, attitudes and skills which support behaviours that enable us to take greater responsibility for our own lives; by making healthy life choices, gaining greater resistance to negative pressures, and minimising harmful behaviours".

The skills-based approach focuses on student centred and participatory methods giving the learners the opportunity to "explore and acquire health promoting knowledge, attitudes and values and to practice the skills they need to avoid risky and unhealthy situations and adopt and sustain healthier life styles" (Anon., s.a.). The previous Minister of Education, Mr Kader Asmal in a report to President Thabo Mbeki (2000) stated that "only learners who are following Curriculum C2005 receive life-skills training. There is very little or no life skills training offered in the Grades still following the old curriculum" and continues to say that "these learners therefore remain exposed, especially considering that they fall within the age group which is already sexually active."

2.5.2 What are life-skills?

Macnamara (1995:1) defines life-skills as skills which enable people to function as happily and independently as possible in their own environment.

These are social skills, coping skills, independent living skills, daily living skills and survival skills.

A number of authors compiling study material for the Life Orientation program have identified the following as some of the important life-skills: self-awareness; critical thinking; problem-solving; communication; finding information; creative thinking; conflict resolution; refusal skills; positive self-esteem; goal setting; decision-making; handling emotions; self-discipline; assertiveness; negotiation and the ability to foresee consequences of behaviour (Anderson *et al.*, 2001; Greathead *et al.*, 1998; Louw *et al.*, 2001; Maree & Ebersöhn, 2002; Olivier *et al.*, 1997).

The following three core skills are integral when maintaining sexual health and wellness. These skills are also taught extensively in outcomes-based education curricula. Some of the life-skills are included with all three core skills which is indicative of how the life-skills integrate to eventually develop a well-equipped, healthy individual as holistically as possible.

These life-skills can be categorised into three core skills, i.e.

ABILITY TO IDENTIFY RISK/SAFETY BEHAVIOUR
* assertiveness skills
• critical thinking skills
• refusal skills
* self-awareness
• self-discipline
* ability to foresee consequences
* conflict resolution skills

DECISION-MAKING SKILLS
• finding information skills
• ability to foresee consequences
* critical thinking skills
* creative thinking skills
• self-discipline

* conflict resolution skills
* problem-solving skills
* assertiveness skills

COMMUNICATION SKILLS
• positive self-esteem
* refusal skills
• negotiation skills
• assertiveness

If these skills are learned, the following critical [basic] outcomes, which have been identified in the statement on the National Curriculum for Grades R(1) – 9, will be achieved (Pretorius, 1998:29):

Learners will be able to:

- identify and solve problems by making responsible decisions;
- work effectively with others as a member of a team/group;
- organise themselves and their activities;
- collect, analyse, organise and critically evaluate information;
- communicate effectively; and
- demonstrate an understanding of the world as a set of related systems.

This is the axis of the Curriculum 2005 education system around which outcomes-based education takes place. No matter the learning area, whether the learner is being taught numeracy, communication or technology, he/she should be learning the above skills. Macnamara (1995:3) says a skill is "something that is learned with practise". Nobody can learn to swim by reading how it is done or listening to an explanation. The same applies to learning life-skills. Life-skills are learned through practice. Developing personal skills in the teenage years is the "pivot point for the development of personal skills for adult survival" (McMurray, 1999:129).

Maree and Ebersöhn (2002:223) refer to life-skills as a survival kit. It teaches the ability to "process, challenge and act in multiple ways, to know what to do, how to do it and when it is appropriate to do it". The question to have or not to have sex usually starts at puberty and continues throughout one's life, but it is most difficult during adolescence because of the imbalance of hormones, lack of decision-making skills, traditional risk-taking behaviour, bombardment by the media and the misconception that adulthood starts when sexual activity has started (Greathead *et al*, 1998:95).

2.5.3 Safety-risk behaviour

"There is a high level of sexual activity among learners. Nationally, two thirds of thirteen year-olds in SA are estimated to have already experienced their sexual debut. [I]n grades 10 – 12, about 75% of learners were sexually active, about 30% of learners have more than one current partner and learners had an average of 3 partners and 9 sexual encounters in the past year" (Terre Blanche, 1999).

Dr Elna McKintosh often goes around to schools in the Gauteng province and counsels young people to practise safer sex. She says that it is shocking how many high school learners are sexually active and "[t]here is definitely a lack of sexual knowledge when it comes to safer sex" (Coetzer: 2004, 30). The headmaster of Northcliff High School, Walter Essex-Clarke, says that he feels strongly that alcohol and drug use is the most serious problem facing teenagers at his school – and it has a direct relationship to sex (Coetzer: 2004, 29). "Research evidence indicates associations between unsafe sexual behaviour and other unhealthy and risky behaviour amongst adolescents" (Flisher *et al.*, 1996:1094).

In Mr Kader Asmal's (2000:11) report regarding outcomes-based education he states that the learners in Grades 5, 8, 9, 10, 11 and 12 in 2000 had had virtually no life-skills training at school level and that these learners, who fall within the age group which is already sexually active, are exposed. They have not had sex education in the classroom and thus depend on other information outside the classroom (2000:11).

All life-skills material currently focuses mainly on the effects of alcohol and drugs. Beside the fact that they want to emphasise that these are unhealthy lifestyles, the affect these stimulants have on the person's behaviour is also dealt with carefully. Anecdotes are told about girls who were raped while under the influence and that one has far less control over one's actions while intoxicated. Louw, *et al.* (2001), for example, dedicates a whole chapter to the story of the Soweto teenager and taxi queen, Busi Zulu and how she contracted HIV/Aids and fell pregnant at 15. Learners have to identify the risk behaviour, suggest prevention methods, criticise and improve her communication styles, etc.

Another facet of teaching adolescents to discern between safety and risk behaviour is to look at the messages that the advertisers are aiming at them. More than at any other age, adolescents are eager to feel accepted by their peers. Many times the pressure has been to have a drink or smoke a joint and then the individual has lost his/her inhibitions and ability to discern. This leads to sexual activity that, under normal circumstances, would not have taken place.

2.5.4 Responsible decision-making

Responsible decision-making is making a choice based on the facts, knowledge and understanding about the topic (Louw, *et al.,* 2001:118). Making responsible decisions and solving problems go hand in hand. Sensible decisions lead to solutions and poor decisions create new problems. Making decisions about sex is linked to knowing 'who you are' and 'what you believe in'. This influences how you behave (Greathead, *et al.,* 1998:95).

Louw *et al.* (2001:106) identifies the aims of teaching the decision-making skills regarding sexuality are to:

- facilitate an understanding of sexual awakening in puberty that results in the increased awareness of and interest in sex.
- explore reasons adolescents become sexually active
- facilitate the exploration of differences between love and sex
- examine reasons for and consequences of casual sex

- assist in their exploration and choice of values and beliefs
- assist in developing skills in making informed decisions regarding sexual relationships.

The decision-making process involves the following steps:

- Identifying the problem
- Gather information related to the problem
- List possible ways to solve the problem
- List possible outcomes for each possible decision
- Apply your values
- Choose your best decision
- List the steps you'll take in carrying out your decision
- Do what is necessary

Making informed decisions requires help and guidance. "Most adolescents make decisions about sex in the absence of accurate information and access to support and services" (Maree & Ebersöhn, 2002:240). Teenagers who have been placed in front of these issues, even in a simulated situation, are much better prepared that those who have not. Anderson *et al.* (2001), Greathead *et al.* (1998), Louw *et al.* (2001) and Olivier *et al.* (1997) have all included some method of tabulating, for example, the problem, the possible solutions, the negative and positive consequences of any problematic situation. This means that an individual has already worked through the steps and have learned to predict the outcomes of their actions.

2.5.5 Communication skills

There are a number of communication skills that need to be mastered. Communication with parents and adults is also vital but the programme focuses mainly on communication between peers and partners.

Assertiveness communication relies on a feeling of self-worth and confidence. There also has to be no doubt in the individual's mind as to what his/her rights are. A great deal of role-play is used to teach this type of assertiveness. A situation is sketched and then a group has to suggest effective ways of handling the situation assertively. This is then practised in front of a class.

Thus they have already verbalised the answers in simulated situations, making it easier to repeat at a later stage. For example:

James: *I love you and I need you to show me how much you love me by sleeping with me.*

Jane: (Jane would then give a response practising one of the skills)

A list of possible answers is then compiled and each individual has the opportunity to verbalise one in an assertive manner. The scenarios given in the learner workbooks that require assertive communication range from sexual behaviour, alcohol and drug use, rape, incest and sexual abuse. (Anderson *et al.*, 2001; Greathead *et al.*, 1998; Louw *et al.*, 2001; Olivier *et al*,1997).

Refusal skills rely heavily on assertiveness. A 'NO' has to be confident and strong and leave no doubt. There should be no question in the tone of voice or body language as to what is meant. The most difficult aspect of the refusal is that it means resisting peer pressure. Assertive refusal is "something that is learned with practise" (Macnamara, 1995: 3). The different ways of saying 'no' are given to the children to verbalise – E.g. No, I don't want to. No, it's my right to refuse, etc.

They are also taught how to give positive options. E.g. I would rather go home. I would appreciate it if we could take a walk and talk.
What happens when assertive refusal has failed? What happens when someone is already involved in a sexual relationship by the time they are exposed to life-skills?

Negotiation skills are essential tactics to know but they take practice and insight. An individual will only be able to negotiate successfully if he can anticipate a solution that is advantageous to both parties. This is not as easy as it sounds – especially when hormones are talking louder than words. Young people lack confidence and the skill to negotiate sexual issues, contraception and the prevention of infection" (Maree & Ebersöhn, 2002:240). Everyone should be able to talk about the conditions under which they are willing to do something. If an individual has practised assertive negotiation

skills he will know, at least, how to buy some time and allow a potentially 'dangerous' situation to diffuse.

2.6 CONCLUSION

Sexuality education is not only teaching adolescents how to make responsible decisions about sex, it is providing information and developing individuals to be able to function optimally in the society. The problems currently encountered around sexuality education in South Africa, as in the rest of the world, don't seem valid if the advantages of teaching life-skills are considered. Sexuality education is no longer about the 'facts of life' but about the 'skills of life'. Thus, in a nutshell, equipping children with life-skills is the education they need to promote health in their own lives, the lives of their children, as well as in the community at large.

The holistic and developmental perspectives have to focus on the individual, the family and the environment. It has to include primary prevention *and* early intervention. There has to be treatment and rehabilitation facilities in the school, community and home environment (McMurray, 1999:304). These are the basic precepts of Health Promoting Schools.

Sexuality education will have to be comprehensive, holistic and take into consideration the developmental stage of children and adolescents. Prevention and intervention can only take place if knowledge is translated into behaviour. Dr Olive Shisana, the previous Director-General of Health, states the following: "The major problems facing the youth are tobacco, alcohol and drug abuse, teenage pregnancy and the threat of HIV/Aids. South Africa has the highest rates of teenage pregnancy in the world" (quoted in Lazarus & Reddy, 1994:6). Responsible sexual behaviour will mean fewer unwanted pregnancies and more disease-free adolescents and adults. This will automatically impact positively on families, nuclear and extended, as well as the community at large.

The development of personal skills should be an integral aspect of the health promoting school ethos, curriculum and environment and it will extend beyond the school domain (Mukoma, 2001:58). A "Health Promoting School provides a comprehensive approach in which to address [problems] in totality, focusing

on both prevention and promotion". It is not only their sexual health, but how adolescents feel about themselves or think about their present or future that can influence whether or not they will practise healthy behaviour (Mukoma, 2001:64).

Below are the overall goals of health promotion as listed in the executive summary of the health promoting schools conference held in Cape Town in July 1994 (Lazarus & Reddy, 1994). When these goals of health promotion are carefully considered in the context of Health Promoting Schools' policies, sexuality education and skills-based education, it is clear how interlinked these aspects are.

The goals are to:

- develop settings and structures that promote and sustain health;
- improve the physical environments within which children live, work and play;
- improve children's capacity to become and stay healthy;
- reduce the number of children who are affected by learning difficulties;
- reduce the number of children who are at risk of illness, injury or premature mortality; and
- improve the health and quality of life of children who experience learning difficulties, disease, injury or disability.

These goals are challenges for Health Promoting Schools and these goals can be attained through the successful teaching of comprehensive sexuality education and life-skills education.

Not only are schools and education policies being challenged like never before. "The challenges facing young people today have changed significantly from those affecting previous generations; some simply did not exist before, and others have intensified or become more complex – for example HIV/Aids and other sexually transmitted diseases, alcohol, tobacco and other drug use, war and political instability, also unemployment, sexual and other forms of exploitation, and discrimination in its many forms. The causes of these problems are complex and multifaceted, and so they are unlikely to be solved

quickly or simply. A life-skills approach may help to contribute to a reduction in the harm associated with these issues, and to maintaining and promoting healthy lifestyles" (UNICEF, 2001:1).

BIBLIOGRAPHY

ANDERSON, S., BROUARD, A., BROOKE, L. & WILKINSON, L. 2001. Soul City Life-skills: Grade 9. Johannesburg : Institute for Health and Development Communication. 145 p.

ANON. 1991. AIDS - Everybody's problem. *SALUS*, 14(2):14-15, April.

ANON. 1995. Talk to your teen about sex: a guide for parents. *SALUS,* 18(1):20-23, May.

ANON. 1998a. Education for protection. *Agenda,* 27:37-41.

ANON. 1998b. Health-promoting schools (AHPSA). *Primary Educator,* 4(5):1-4.

ANON., s.a. Core Intervention 3: Skills Based Education. *School health at a glance.* [Web:] http:/wbln0018.worldbank.org/HE.../14a963942b43268a85256a4e0064fcb4? OpenDocumen [Date of access: 26 June 2003].

ASMAL, K. 2000. *Part One: Key themes that emerged from the analysis of the state of education.* [Web:] http://pwv.gov.za/content/documents/303.pdf [Date of access: 26 June 2003].

ASMAL,K. 2002. Asmal expects fall in cases of sexual abuse. *Dispatch Online.* [Web:] http://www.dispatch.co.za/2002/11/01/southafrica/SEX.HTM [Date of access: 26 June 2003].

BAILEY, S.K. 1976. The purposes of education. Indiana : *Phi Delta Kappa.* 142 p.

BARTLETT,S. 2002. Survey - Most teens believe chances of getting AIDS are slim. *The Star.* 9, July 17.

COLEMAN, J. & ROKER, D. (Eds). 1998. Teenage Sexuality: Health, Risk and Education. Australia : Harwood Academic Publishers. 205 p.

COETZER, D. 2004. From the mouths of babes. *Fair Lady,* 807:28-32. April.

DEPARTMENT OF EDUCATION, North West Province. 1999. Business Plan: HIV/Aids Life skills Education; Secondary Schools. December. [Web:] http://www.population.org.za/SAPLER/Pioneers/Proposal/Project.../ProjectIdentification.html [Date of access: 26 June 2003].

DEPARTMENT OF EDUCATION, Western Cape. 2003. WCED HIV/Aids Life skills programme. [Web:] http://wced.wcape.gov.za/planning&devel/support/special_ed/hiv_aids/info_2003.html [Date of access: 26 June 2003].

DONALD, D., LAZARUS, S. & LOLWANA, P. 1997. Educational Psychology in social context. Challenges of development, social issues, and special need in Southern Africa. Cape Town : Oxford University Press.

EARLES, R.F., FRASER, J. & SUMPTER, B. 1992. An analysis of legislative, state agency, and local change arenas in sexuality and the curriculum: the practices of sexuality education, J.T. Sears (Ed.), Teachers College Press, New York.

FLISHER, A.J. & REDDY, P. 1995. Towards Health-Promoting Schools in South Africa: editorial. *South African Medical Journal*, 85(7):7, July.

FLISHER A.J., ZIERVOGEL C.F., CHALTON, DO., LEGER, PH., & ROBERTSON, B.A. 1996. Risk-taking behaviour of Cape Peninsula high school student. Part X: Multi-variate relationships among behaviours. *South African Medical Journal,* 86, 1094-1098.

FRASER-MOLEKETI, G. 1996. Opening speech for the inaugural Health Promoting Schools Conference, University of Western Cape, Cape Town.

GOLDMAN, J. 2000. Sexuality education for teenagers in the new millennium. *Youth Studies Australia,* 19(4):1-13, Dec.

GOURLAY, P. 1996. If you think sexuality education is dangerous, try ignorance! Sexuality Education: critical factors for success, Family Planning Victoria, Box Hill.

GOVENDER, P. 2001. Aids wipes out SA's teachers. *The Sunday Times*: 1, Nov.4.

GREATHEAD, E., DEVENISH, C. & FUNNEL, G. 1998. Responsible Teenage Sexuality: PPASA. 2nd ed. Pretoria : Van Schaik. 311p.

GREY, J. 2001. HIV/Aids on the increase among educators? *The Teacher:* 13, Dec. 13.

HOLMSHAW, M. 1992. Aids prevention in South Africa. Vigssimposium, WNNR, Pretoria.

KELLY, G.F. 1998. Sexuality Today: The Human Perspective. 6th ed. Boston, Mass. : McGraw Hill. 580 p.

KENYON, C., HEYWOOD, M. & CONWAY, S. 2002. Mainstreaming HIV/Aids progress and challenges in South Africa's HIV/Aids campaign. [Web:] www.afronets.org/archive/200203/msg00052.php [Date of access: 17 October 2004].

KIRBY, D. 2000. What does the research say about sexuality education. *Educational Leadership*: 72-76, October.

KIRBY, D., SHORT, L., COLLINS, J., RUGG, E. *et al.* 1994. School-based programs to reduce sexual risk behaviours: a review of effectiveness. *Public Health Reports,* 109(3):339-361.

KOSUNEN, E., RIMPELA, A. & RIMPELA, M. 1996. From control policy to comprehensive family planning: success stories from Finland. *International Journal of Health Promotion and Education,* 3(2): 28-32, Sept.

KUNIO, K. & SONO, A. 1996. Study on the promotion of unwanted teenage pregnancies: Perspectives drawn from the international survey. JFPA.

LAZARUS, S. & REDDY, P. 1994. Executive Summary: Health Promoting Schools in South Africa – Challenges for the 21st century. Cape Town. July.

LIFHIGA, M. 2003. Is sex still a taboo subject in primary schools? *The Teacher: Your Guide to Education.* 5(4) April.

LOUW, O., DE VILLIERS, V., AMORIM, C., ROOS, A. & DELAGEY,S. 2001. Life-skills and HIV/Aids Education: An Educator's Guide: Grade 9. South Africa: Department of Health. 142p.

MACKIE, J. & OICKLE, P. 1997. School-based health promotion: the physician as advocate. *Canadian Medical Association Journal,* 156(9):1301-1305.

MACNAMARA, M. 1995. Life-skills: A positive approach. London : Souvenir Press. p.240.

MAREE, J.G.& EBERSÖHN, L. 2002. Life-skills and career counselling. Sandown : Heinemann. 307p.

McMURRAY, A. 1999. Community health and wellness: A socio-ecological approach. Sydney : Harcourt Mosby Publishers. 408p.

MOKGALABONE, M.B. 1999. Socio-cultural conditions, teenage pregnancy and schooling disruption: themes from teachers and teenage mothers in "poor rural school. *South African Journal of Education,* 19(1).

MSIMANG, T. 2004. Government is 'ignoring school abuse'. *The Citizen.* 1, February 3.

MUKOMA, W. 2001. Rethinking School-Based HIV/AIDS interventions in South Africa. *South African Journal of Child and Adolescent Mental Health,* 13(1):55-62.

NUTBEAM, D. 1997. Promoting health and preventing disease: and international perspective on youth health promotion. *Journal of Adolescent Health.* 20:396-402.

O'BYRNE, D., JONES, J., SEN-HAI, Y. & MACDONALD, H. 1996. WHO's global school health initiative. *World Health,* 4:5-6, Jul.-Aug.

OLIVIER, M.A.J., GREYLING, S. & VENTER, D.J.L. 1997. Life skills in a changing society, with specific reference to the adolescent. *South African Journal of Education,* 17(1):24 -28.

PARKER,J.T. 2001. School-based sex education: a new millennium update. [Web:] http://www.ed.gov/databases/ERIC_Digests/ed460130.html [Date of access: 17 October 2002].

PRETORIUS, F. 1998. Outcomes-based Education in South Africa. Randburg: Hodder and Stoughton Educational. 129p.

RICE, M. 2000. Medicine meets Millennium – Adolescent sexual and reproductive health. [Web:] http://www.mh.hannover.de/aktuelles/projekte/mmm/englishversion/fs_prog.../Rice_V.htm [Date of access: 6 September 2004].

SANDERS, F.N. 2001. Spread the word, not the virus: an innovative HIV youth education project. *Archimedes,* 43(2):42, August.

SNYMAN, M. 2001. My kind seksueel aktief? *Rooi Rose,* 59(2):88 -90, February.

SOUTH AFRICA. Department of Health. 1999. Second Draft: Health Promoting Schools Policy Guidelines. August. [Web:] http://web.uct.ac.za/depts/chu/projects.htm [Date of access: 26 June 2003].

SPADY, W.G. 1994. Choosing outcomes of significance. *Educational Leadership,* 51(6): 18-22.

STEYN, P. & LOUW, B. 2002. Meer as 40 000 onderwysers in Suid-Afrika het vigs, sê Wêreldbank. *Die Burger:* 1, May 9.

TERRE BLANCHE, M. 1999. The SHARP programme (Sensible, Healthy and Responsible People).[Web:] http://www.population.org.za/SAPLER/Pioneers/Proposal/Project.../ProjectIdentification.html [Date of access: 26 June 2003].

THOMAS, M.H. 2000. Abstinence-based programs for prevention of adolescent pregnancy: a review. *Journal of Adolescent Health,* 26(1):5-17.

UNAIDS, 1997. Impact of HIV and sexual health education on the sexual behaviour of young people: a review. [Web:] www.unaids.org/html/pub/publications/irc-pub01/jc010-impactyoung people_en_pdf.pdf- [Date of access: 21 October 2004]

UNESCO, 2004. Education for all – Global co-ordination. [Web:] www.unesco.org/education/efa/global_co/working_group/pres8_sheldon_sha effer.shtml [Date of access: 6 September 2004]

UNICEF. 2001. Teachers talking: What is the life skills approach? [Web:] http://www.unicef.org/teachers/teacher/lifeskil.htm [Date of access: 6 September 2004].

VAN DYK, A. 2001. HIV/Aids care and counselling: A multidisciplinary Approach. 2nd ed. Cape Town : Pearson Education South Africa. 442 p.

VAN NIEKERK, P.A. & LOUW, C.D. 1996. Die invloed van televisie op die geslagsopvoeding van die vroeë adolessent. *Pedagogiekjoernaal,* 17:1, p.40 - 58.

VENTER, L. 2001. Caution over HIV/Aids stats. *The Citizen:* 6, Nov 5.

WILEY, D.C. 2002. The ethics of abstinence-only and abstinence-plus sexuality education. *Journal of school health,* 72(4):164-167, April.

WILLIAMS, P. & REDDY, P. 1998. Improving child and adolescent health through schools: learning from Australia. *Southern African Journal of Child and Adolescent Mental Health,* 10(1):32-42.

WORLD HEALTH ORGANISATION. 1986. Ottawa Charter for Health Promotion. *Canadian Journal of Public Health,* 77(12):425-430.

WORLD HEALTH ORGANISATION. 1996a. Improving School Health Programmes: Barriers and Strategies. WHO/HPR/HEP/96.1.

WORLD HEALTH ORGANISATION. 1996b. Research to improve implementation and effectiveness of school health programmes. WHO/HPR/HEP/96.3, Geneva.

WORLD HEALTH ORGANISATION. 2000. Local Action: Creating Health Promoting Schools. Education Development Centre, Inc. WHO/SCHOOL/00.3. Geneva.

YARBER, W.L. & TORABI, M.R. 1997. Comprehensive sexuality education in Indiana secondary schools: instructional topics, importance ratings and correlates with teacher traits. *American Journal of Health Studies,* 13(2) 65.

CHAPTER 3

PROMOTING HEALTH IN SCHOOLS THROUGH COMPREHENSIVE SEXUALITY EDUCATION AND LIFE-SKILLS

3.1 INTRODUCTION

Many methods of sexuality education have been tried and tested and most methods have failed to satisfy parents or teachers and have not had the desired effect on the learners. One of the shortcomings in previous curricula, which advocated strict abstinence and focused mainly on reproduction and contraception, is that sexuality was not approached holistically. Health Promoting Schools aim to develop each facet of a learner holistically rather than in isolation.

The philosophy around Health Promoting Schools is based on the definition of general health as cited in the Ottawa Charter for Health Promotion (WHO, 1986): "(general) health promotion is the process of enabling people to increase control over and improve health." The Charter also states that in order for individuals to make healthy choices there is a need to have access to information and to develop life-skills. The holistic approach of Health Promoting Schools aims at redefining education and focusing on issues that incorporate the social, emotional and ethical dimensions for individual and community well-being (Anon., 1998:2).

"Essentially, the Health Promoting Schools framework, in its most basic guise, is really just a different way of thinking about and doing better, the things that we already do in schools, the things that we have to do, need to do and want to do, to create optimal conditions for learning and working with school communities" (Anon., 1998:6). Spady (1994:18) defines optimal learning as outcomes-based learning where outcomes are "high-quality, culminating demonstrations of significant learning in context." Optimal learning, therefore, takes place when learners have been taught how to apply the factual content through the various skills so that the necessary outcomes can be achieved.

Coleman and Roker (1998) and Mukoma (2001) agree that they share the view that factual knowledge, together with the acquisition of life-skills, is important to be able to make responsible decisions and ensure sexual health.

According to Haffner (quoted by Goldman, 2000:2), and in agreement with Kelly (1998:2), Coleman and Roker (1998:2) and Grazioli (1997:149), sexuality education is defined as a "lifelong process of acquiring information and forming attitudes, beliefs, and values about identity, relationships and intimacy. It encompasses sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image and gender roles. Sexuality education addresses the biological, socio-cultural, psychological and spiritual dimensions of sexuality from 1) the cognitive domain, 2) the affective domain and 3) the behavioural domain, including the skills to communicate effectively and make responsible decisions." This is a very comprehensive definition of sexuality education that emphasizes all the most important aspects of this study, i.e. factual knowledge will affect the behaviour patterns of the learners if it is taught by means of these life-skills. "Sexuality education is about social change – about helping to create a world where all people have the information and the rights to make responsible sexual choices" (Goldman, 2000:2).

Eaton and Flisher (2001:55) state that although South African adolescents generally have a high level of awareness and knowledge regarding the contracting of HIV/Aids and other STDs, "this knowledge has not translated into safer sexual behaviour." This could imply that knowledge taught together with the acquisition of skills, is likely to be more effective. In a National Adolescent Sexual Health Initiative survey, 90% of South Africans are aware of HIV/Aids and the means of transmission and prevention, but only about 15% of South Africans are prepared to change their sexual behaviour to prevent contracting or spreading HIV/Aids (Maart, 2000:2).

For comprehensive sexuality education to be successful, curricula should be "futures-oriented for lifelong-learning and skills" (Goldman, 2000:5). It has also become evident by looking at the curriculum material, (Greathead, *et al.,* 1998; Louw, *et al.,* 2001; Anderson, *et al.,* 2001) that teaching life-skills is the only aspect of education that lasts a lifetime. Information is important, but what to do with that information and how to do it is far more valuable. Putting information into action is what will bring about the changes in adolescent

behaviour that is currently preventing individuals from developing into healthy individuals. The challenge is to turn awareness into behaviour change.

Perhaps one of the reasons why behaviour changes are not taking place as they should be, is that there is not enough focus on sexuality education and life-skills education on policy-making levels. A review of World Health Organisation (WHO) documents (WHO, 1996, 2000) and a document published by the South African Department of Health as a guideline document (1999), reveals that no mention is made of sexuality education of any kind while 'sex education' is mentioned only once in WHO (2000) as part of a pilot study done in a Bulgarian Health Promoting School. HIV/AIDS and unintended pregnancy are only briefly mentioned.

According to a selection of textbooks/study guides/guidelines (Anderson *et al.*, 2001; Greathead *et al.*, 1998; Louw *et al.*, 2001; Van der Walt, 2001) currently used by some secondary schools in Gauteng in the sexuality education curricula, there are many life-skills to master in order to function optimally. However, in this study, only two life-skills were included in the study because of their relevance to the hypotheses, i.e. responsible decision-making skills and the ability to identify and avoid risk behaviour.

Mastering these life-skills is also important for success on many other levels of life. Thus, the importance of teaching life-skills should not be limited to sexuality education, but seen as part of the holistic development of the learners. It is a pity, though, that life-skills education is seldom part of school curricula and the "'real' recognition of the importance of life-skills education is still only on paper" (Maree & Ebersöhn, 2002:233).

3.2 AIMS AND OBJECTIVES OF THE STUDY

The purpose of this research was, firstly, to determine whether the learners who have been exposed to comprehensive sexuality education programmes are in any way advantaged compared to those who have had no sexuality education at school. Secondly, the research set out to determine whether the teaching of life-skills better prepared learners to make responsible decisions and identify and avoid risk behaviour.

3.3 PROBLEM STATEMENT

The research set out to investigate whether adolescents who have been exposed to comprehensive sexuality education

- know how to use the information and knowledge they have to identify and avoid risk behaviour and
- make more responsible decisions than those who have not.

3.4 RESEARCH DESIGN AND METHOD

A quantitative research design, including descriptive items, was used in the study. The primary aim was to investigate whether the learners who have been exposed to the comprehensive sexuality education programme, are better informed and skilled to behave in a more sexually responsible way.

3.4.1 Subjects

Two schools from a rural district in eastern Gauteng were identified as suitable for the study because the learners come from basically the same feeder area, speak the same languages and have similar cultural backgrounds. The teachers from both these schools are residents of the same town. School A has been teaching comprehensive sexuality education, using a life-skills approach, for quite a few years, whereas School B has no structured sexuality education programme. Fifty grade 11 subjects were selected at random by the teachers from each school. Some biographical information is summarized in Table 1. This sample included 50 male subjects and 50 female subjects with a mean age of 17.

Table 1 – Biographical information

	SCHOOL A n=50	***SCHOOL B n=50***
Male/Female	20/30	30/20
Mean age	16.9	18.3
Average no. of rooms in their house	9.4	4.5
Average no. of people living in the house	4.6	5.9
Percentage that receive pocket money	90%	46%
Average amount of pocket money monthly	R147	R75

The majority of the subjects live with their own parents. The subjects from School A have more divorced families, but the subjects from School B have had more parents dying and this could also be the reason that there are more subjects living with their grandparents. The percentages are given in Table 2.

Table 2 – With whom the subjects live

With whom the subjects live	***SCHOOL A n=50 %***	***SCHOOL B n=50 %***
Live with both parents	56	43
One parent deceased, living with other parent	10	22
Parents divorced	22	17
Live with grandparents	2	12
Live with other family members	6	6
Live with friends	2	0
Other	2	0

Appointments were made with the principals of the two schools and both groups were addressed and briefed about the project and the process to be followed. The subjects were ensured of their anonymity and the confidentiality of the information. They were also informed that their participation was voluntary. It appears that the learners from School A are from a slightly higher socio-economic bracket (See Table 1).

3.4.2 Measures

Data were collected from the subjects using a questionnaire constructed with the help of the Department of Statistics at the North West-University. The questionnaire was divided into four sections with different types of questions in each section, including qualitative and quantitative questions in each of the following four sections.

Section 1 - biographical information
Section 2 - factual knowledge
Section 3 – whether the subjects could identify and avoid risk behaviour
Section 4 – whether the subjects had mastered decision-making skills

This questionnaire was compiled based on the content of the curriculum material (Greathead, *et al,* 1998; Louw, *et al,* 2001; Anderson, *et al,* 2001; Van der Walt, 2001). Multiple choice questions, true and false questions and matrix questions made up the majority of the questionnaire, but open-ended questions were added to try and prevent the subjects from giving normative replies.

All the descriptive, open-ended answers were transcribed by highlighting thoughts, words, phrases and actual quotes that reflected possible themes.

3.5 RESULTS

Data were analysed by calculating percentages and effect sizes. Three formulae were used: a) where *d* is the difference in means;

b) where *d* is the difference in proportions; and

c) where *w* indicates the relationship between the two variables.

a) *The effect sizes for means*

This formula was used in paragraph 3.4.1 (see p. 46) to determine the difference between the means of the level of knowledge of School A and School B.

The effect size (d) that indicates whether there is a significant difference between the means of the two groups, is calculated with the use of the following formula:

$$d = \frac{\left|\bar{x}_1 - \bar{x}_2\right|}{s_{\max}}$$

where d ≈ 0.2 indicates no practical significant difference;

d ≈ 0.5 indicates a medium significant difference; and

d ≈ 0.8 indicates a significant difference between the two groups.

(SAS Institute Inc., 1999).

b) *The differences in proportions*

This formula was used throughout to determine whether the difference between two proportions (percentages) is significant in practice. The cut-off points here are the same as in the above formula.

$$d = \frac{|p_1 - p_2|}{\sqrt{p(1-p)}}$$

c) *The relationship between two variables*

"In many cases it is important to know whether a relationship between two variables is practically significant. For random samples, the statistical significance of such relationships are determined with Chi-square tests, but actually one wants to know whether the relationship is large enough to be important" (Ellis & Steyn, 2003). Using the following formula (Cohen:1988)

$$w = \sqrt{\frac{X^2}{n}},$$

where w = 0.1 indicates a small effect – no practical significance;

w = 0.3 indicates a medium effect – might be practically significant;

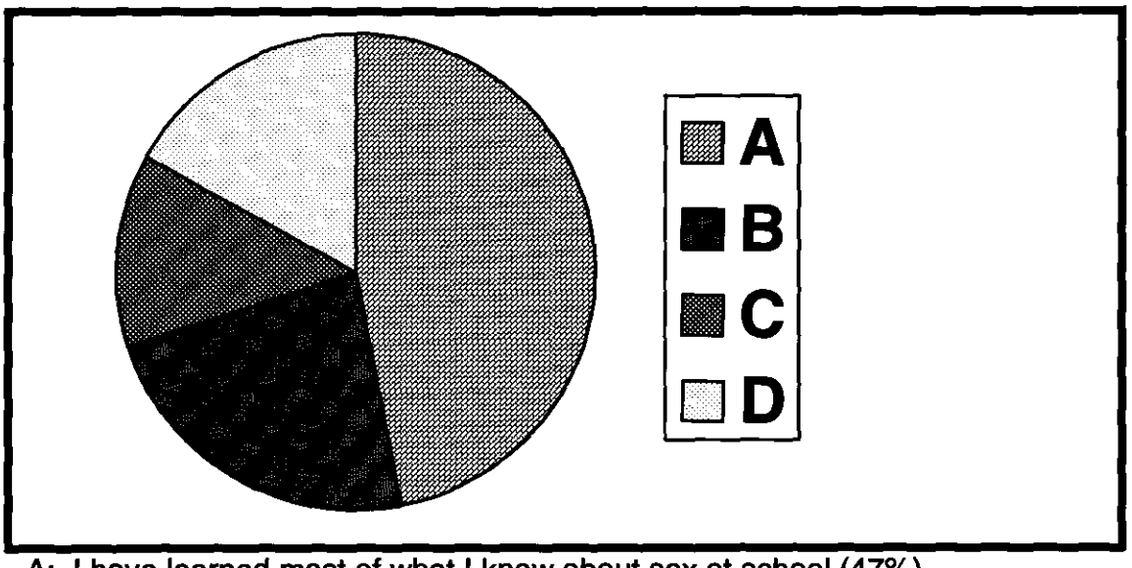
w = 0.5 indicates a large effect – considered practically significant.

Throughout the discussion of the results, comparisons are made between the two schools to determine whether the comprehensive sexuality education programme has resulted in any practically significant difference between the two schools. The results are discussed as follows:

- the difference in the level of factual knowledge;
- the difference between the groups' ability to identify and avoid risk behaviour; and
- whether their decision-making skills differed in any way.

Because School A is the only school that has received comprehensive sexuality education, they were asked to indicate whether they had benefited from the programme at their school. Figure 1 indicates their responses.

Figure 1 – How beneficial was the comprehensive sexuality education programme?



A: I have learned most of what I know about sex at school (47%)
B: I have learned more about sex at school than at home (23%)
C: I feel more prepared for a sexual relationship because of the classes(13%)
D: I have learned nothing new about sex at school (17%)

83% of the subjects felt that the comprehensive sexuality education programme had been beneficial (A+B+C).

3.5.1 Factual Knowledge

Research quoted by Hyde and DeLamater (1997:583) states that "sexual experience and behaviour typically precede knowledge and understanding, at least among younger children. The fact that children engage in sexual behaviour before they have a clear understanding of what it is all about places them at high risk for a variety of adverse experiences which can impact negatively on their development".

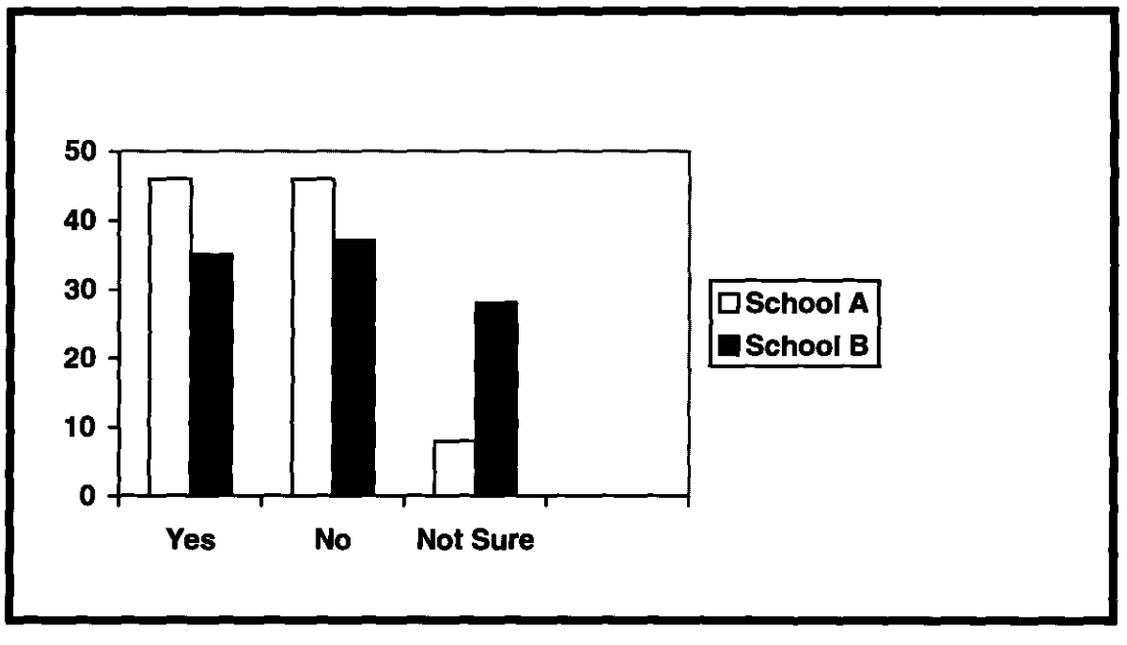
All the interrelated items that were designed to test the level of the knowledge of the subjects were "summed to obtain an overall score for each participant. Chronbach's alpha estimates the reliability of this type of scale by determining the internal consistency of the test or average of items within the test" (SAS Institute Inc., 1999). When comparing the two sample groups' average knowledge, the effect size is used to determine whether the difference in average knowledge is large enough to be important in practice. Cronbach's alpha = 0.51 which is indicative that this measuring instrument may be

reliable. If Cronbach's alpha was lower than 0.5, the reliability coefficients would be inadequate and then the individual items, and not the overall score would be used. In this case, when the overall score of the data collected from the questions testing the knowledge of the subjects was analysed, d=0.82 which indicates a practically significant difference in knowledge between School A's and School B's subjects.

It was hypothesized that learners who had been exposed to a comprehensive sexuality education programme would have a better knowledge about sexuality and the implications of a sexual relationship. The questions testing factual knowledge about sexuality, were not questions that could be answered purely with general knowledge. (Examples of the type of questions asked can be seen in Figure 3).

When the subjects were asked whether they had been in a sexual relationship, the results were as follows:

Figure 2 – Percentage of subjects who have had sexual relationships



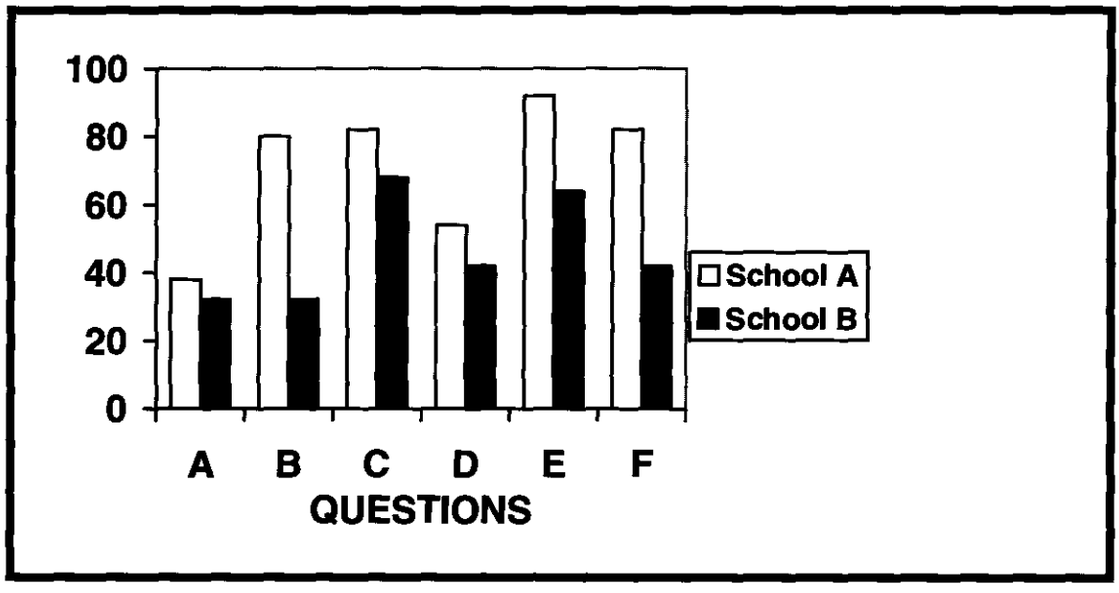
40,8% of the total population (n=100) said that they had been in a sexual relationship, 41,8% said that they had not and a disconcerting 17.4% said that they were *not sure* whether or not they had been in a sexual relationship. 76.5% of the group that was unsure about whether or not they had been sexually involved, were from School B and 23.5% from School A (d=0.502).

A total of 13 questions tested the knowledge that the subjects should have if a comprehensive sexuality education program had been taught. A percentage of the subjects that answered the questions correctly was recorded and six of the questions' results were plotted on the graph in Figure 3. (These questions were selected because they are also directly related to the skills discussed in 3.4.2 and 3.4.3). From these six questions it is evident that the subjects from School A had significantly more correct answers than the subjects from School B.

The questions posed to the subjects were:

A: If you had unprotected sex with someone tonight, you could go for an HIV/Aids test tomorrow to see if you have been infected. (d=0.125)
B: A condom is 100% safe for preventing pregnancy. (d=0.968)
C: You can fall pregnant when you have sex for the first time. (d=0.326)
D: Masturbation is harmful. (d=0.240)
E: It is possible that some of my classmates are HIV positive. (d=0.676)
F: Condoms are 100% safe to prevent getting HIV/Aids. (d=0.825)

Figure 3 – Percentage of correctly answered questions



It is evident that the subjects from School A have a higher level of knowledge than the subjects in School B.

3.5.2 Identifying and avoiding risk behaviour

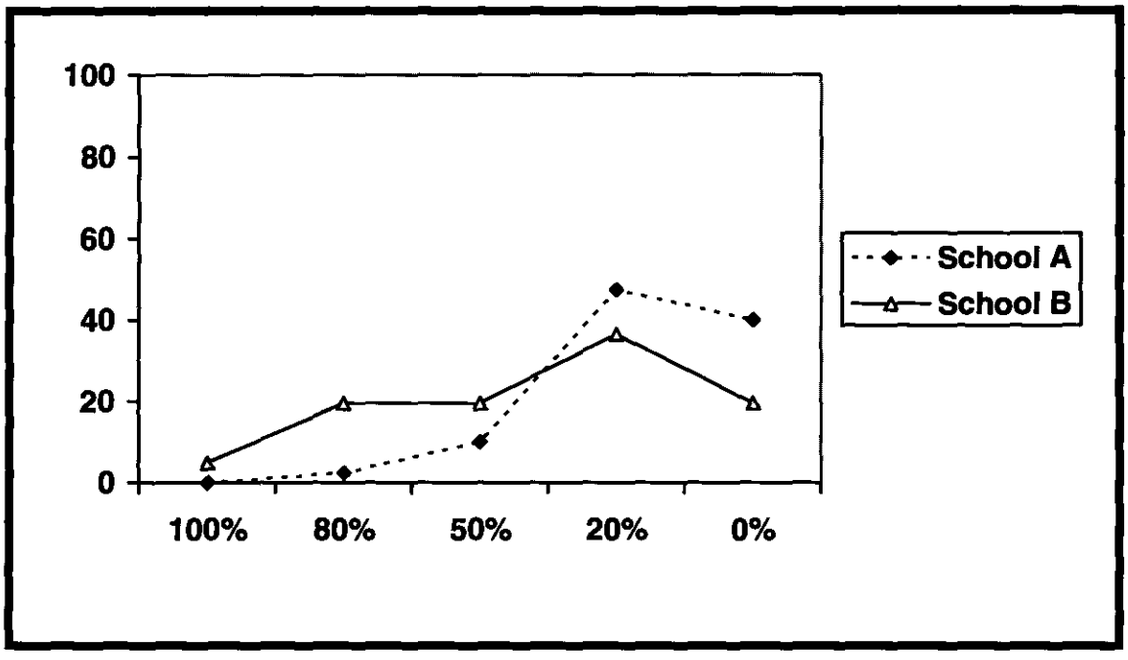
Terre Blanche (1999:1) quotes some statistics from a survey done in South Africa that illustrates the exceptional risks adolescents are taking:

- 66% of 13-year olds in South Africa are estimated to have experienced their sexual debut;
- 75% of learners in grades 10-12 are sexually active;
- 30% of learners have more than one current partner, and have had an average of 3 partners and 9 sexual encounters in the past year.

Although the subjects from School A have a practically significant higher level of knowledge in comparison to School B's subjects, it doesn't necessarily seem as if that knowledge is preventing them from taking sexual risks. 46% of the subjects from School A are in, or have been in sexual relationships compared to 35.5% from School B (d=0.244). However, the aim of the programme is not to teach abstinence only, but to be more responsible when being involved in a sexual relationship.

In one of the questions, which relates to the abovementioned discussion, subjects were asked to indicate approximately how many of their friends were still virgins. It is not surprising, then, that those from the group that has a higher number of sexually active subjects, also have more friends that are sexually active. Figure 4 illustrates the difference between the number of friends that are still virgins from the two samples. This also indicates a possible profile of the groups' sexual activity. The subjects from School A seem to be more promiscuous than those of School B (w = 0.3971). The relationship between these variables can, therefore, be said to have a medium effect size which might indicate a practically significant difference between the variables.

Figure 4 – Percentage of subjects' friends still virgins



According to Kelly (1998:173) sexual experimentation between males and females is an important step in the development of many adolescents and this heterosexual contact seems to proceed through stages of progressive intimacy. How rapidly these stages are passed through depend on many factors like "patterns of family socialization, stage of biological development and the ability to exercise social control". Social control is taught in comprehensive sexuality education programmes as socially appropriate behaviour. Determining what is socially appropriate is also one of the life-skills taught.

One of the items ranked 11 physical/sexual activities from slightly intimate, a goodbye kiss and ending with ultimate intimacy, sexual intercourse. The subjects were asked to indicate at which point they would 'draw the line', with regards to intimacy with their boyfriend or girlfriend. In Table 3 the difference between the two groups of subjects is clear. The effect size between the variables is w = 0.5327, which is an indication of a significant difference between the groups' sexual risk-taking behaviour.

Table 3 - The stage of intimacy at which subjects would stop sexual activity

Stages of sexual activities	***School A n=50 %***	***School B n = 50 %***	***d***
Quick goodbye kiss	10.4	12.2	0.07
Holding hands	8.3	12.2	0.13
Hugging	***0***	***34.8***	***0.92***
French kissing	8.3	6.1	0.08
Touching above clothes	2.0	0	0.22
Touching under clothes above waist	4.2	0	0.29
Touching under clothes below waist	10.4	6.1	0.15
Petting semi-naked	2.0	2.0	0
Both naked	***25.0***	***6.3***	***0.51***
Mutual masturbation	21.1	12.2	0.35
Intercourse	8.3	8.1	0.01

Surprisingly, the highest percentage of responses from School A's subjects placed their limits at being naked and at mutual masturbation, whereas the highest percentage of responses from School B's subjects placed their limits at hugging and less. (See bold rows). When considering this result, it seems as if the subjects with the higher level of knowledge are not necessarily avoiding risk behaviour.

Alcohol seems to play an important role in risk behaviour among adolescents. Parties seem to equate to alcohol and no supervision. When asked whether they would avoid parties if they knew there would be no adult supervision, 70% from School A's subjects say that they would not avoid an unsupervised party, compared to 40% from School B. The effect size is w = 0.3015 which could indicate a practically significant difference between their tendency to take risks. In the same vein, the subjects were asked to give reasons why it is safer to avoid alcohol. 60% of School A's subjects and 40% of School B's subjects say that it causes people to lose control of themselves and do wrong things. It seems as if parties on weekends are definitely cause for concern. 60.23% of all the subjects identified parties as the opportunity that most teenagers use to have sex. Perhaps a further study could investigate the relationship between sexual activity and alcohol abuse which are both high risk behaviours.

In the learner support material available, many scenarios aimed at helping learners to identify risk behaviour are given to learners and they have to discuss possible ways of reacting in those particular circumstances. Often role play is done in order for the learners to actually verbalise such responses.

One of the exercises suggested by Louw, *et al.* (2001:110) to help learners identify and avoid risk behaviour is:
"*What will your response be if you are invited to play 'spin the bottle' and you don't want to and your friends call you a 'chicken'?* ('Spin the bottle' is a game where a group of people sit in a circle and the bottle is spun in the middle and the one to whom the bottle points when it stands still, must drink alcohol and then do whatever the others in the group request them to do). This was an open-ended question. Only 52% of the subjects from School B attempted to answer the question, compared to 80% of the subjects from School A. The effect size for the differences in percentages of responses is d = 0.60 which is an indication that there is a significant difference between these two groups in practice.

For adolescents to avoid risk behaviour there has to be an alternative choice of activities. The subjects were asked to write down three things that they would classify as 'good, clean fun'. Only 36% of the subjects from School B attempted to answer compared to 84% of the subjects from School A. The effect size for the differences in percentages in this question, d=0.96.

There is an indication that the subjects from School A have more knowledge and know how to answer the questions. Although abstinence is taught to be the most responsible option for adolescents, it is not possible to say that those who are sexually active are taking irresponsible risks. Only once the rate of unwanted pregnancies and HIV/Aids and other STD infection has been lowered, will one be able to say the comprehensive sexuality education programmes has been successful in changing behaviour. However, the subjects in School A are undoubtedly taking more sexual risks than the subjects in School B.

3.5.3 Sexual decision-making

To have sex or not to have sex is a question that starts at puberty but continues throughout people's lives. "The process is more difficult during adolescence owing to factors like the imbalance of hormones, lack of decision-making skills, traditional risk-taking behaviour and bombardment by sexual images in the media. Making decisions about sex is linked to knowing 'who you are' and 'what you believe in'. This influences 'how you behave'" (Greathead *et al*, 1998:95). It is wrong to try and teach a teenager to make responsible decisions by indoctrinating them with fear about the negative consequences of sexual activity. The point of comprehensive sexuality education is to assist teenagers to make informed choices.

Often sexuality education is reduced to facts about reproduction and contraception, but to teach responsible sexual decision-making skills, far more than facts is needed. For example, what is the difference between love and sex, what are the reasons adolescents become involved in casual sex, what are the emotional demands of a sexual relationship and what to do when an individual needs help of any kind.

Sexuality Information and Education Council of the United States (SIECUS) identified key concepts in a holistic sexuality education program and values, communication, assertiveness, negotiation, forgiveness and how to find help were all included in sexual decision-making skills (Grazioli, 1997:149; Hyde & DeLamater, 1997:582). Decision-making relies on communication skills. A decision is not worth much if it is not assertively and clearly communicated. A few of the items in the questionnaire sketched a scenario and then required the subjects to give a projected response communicating a decision.

When subjects confronted with the question: "*How would you respond if your partner asked you: 'Why don't you make love to me? All my other partners have!*", 92% School A's subjects answered, whereas only 66% from School B even attempted to answer the question (d = 0.638). The responses given by the subjects from School A were 'textbook' answers like: "I'm different from the others and that's why you're attracted to me" or "If the others were so willing, why did you leave them?" or "Sex isn't love". The subjects from School

B gave more general, almost irrelevant answers that didn't convey a decision, like: "Are you sure you're HIV/Aids negative?" or "You're using me!"

Below, Table 4 illustrates the different questions asked to determine whether the subjects had enough information to make responsible decisions. The questions were answered with either TRUE or FALSE and the percentages have been recorded below. All the percentages in bold italics are the correct answers and when the percentages are compared, School A's subjects seem, once again, to have considerably higher percentages of correct answers.

Table 4 – Analysis of number of correct answers to decision-making questions

	School A (n=50)		***School B (n=50)***		***Effect size (d)***
	TRUE	FALSE	TRUE	FALSE	
Carrying a condom with you all the time is consent to have sex	24%	***76%***	42%	***58%***	0.38
I would rather lose my partner than have sex just to please him/her	***70%***	30%	***48%***	52%	0.45
I say NO to sex so that I don't disappoint my parents	42%	***58%***	68%	***32%***	0.57
Having sex is a normal part of growing up	38%	***62%***	70%	***30%***	0.64
I feel it is my responsibility to please my partner sexually	28%	***72%***	44%	***56%***	0.33
I have decided to wait until I am married to have sex	***48%***	52%	***84%***	16%	0.78

The subjects from School A had more correct answers to all the statements except the last one. The fact that 84% of the subjects from School B say they have decided to wait until they are married to have sex, doesn't correspond to the percentage of subjects that are already sexually active. (See Figure 2). If their general attitude towards marriage, according to Table 7 and 8, is taken

into consideration, it is possible that this question was answered idealistically and not realistically.

Nobody is immune to making mistakes and learners are encouraged to speak to a trusted person when an irresponsible decision has been made. It is also naïve to think that all risky sexual behaviour is due to poor decision-making. Maree and Ebersöhn (2002:239) states that there is extensive sexual violence in which children and young people are forced to have sex, young women live in fear of harassment or rape and a great deal of fear affects sexual relationships between young people. This, however, is a study on its own.

So much can go wrong in adolescent sexual relationships. HIV/Aids and other sexually transmitted diseases are everyone's nightmare, unplanned pregnancy alters lives instantly and psychological, emotional and physical trauma abounds when rape or abuse has occurred.

The subjects were asked who they would decide to approach for help if they thought they were in trouble because of unprotected sex. The results are given in Table 5.

Table 5 – Who would subjects go to if they needed help due to unprotected sex?

To whom would they go for help?	***School A***	***School B***	***d***
Parents	16%	22%	0.15
Teachers	10%	6.5%	0.13
Older sibling	10%	6.5%	0.13
Uncle/Aunt	8%	2%	0.20
Friends	22%	9%	0.36
Health worker at clinic	26%	47%	0.44
Other	8%	7%	0.04

As stated in an article written by Strachan (1999:7) "parents in black societies don't talk to their children about what is happening to their bodies or about sex." She reports that 11 or 12 years old daughters are taken to the clinic by their mothers asking for contraception for them without ever discussing the issue of sex. Once she is menstruating she will fall pregnant and nothing is

said about what happens in between. The subjects from School B trust the health workers more than any other.

The subjects from School A are less likely to go to health workers or parents, but more likely to go to friends. The reason that the subjects from School A are not hesitant to go to friends could be that they are more comfortable discussing sexual matters with peers because of the encouragement learners get in comprehensive sexuality education classes to be open and candid. They practise responses to scenarios with their friends and therefore they feel at ease with their friends. Friends who are uninformed cannot be trusted, whereas friends who have shared in the comprehensive sexuality education programme can be supportive.

It is a point of concern that such a low percentage of subjects from both schools chose to approach to their teachers. This is probably because they are not assured of confidentiality and anonymity.

When faced with an unwanted pregnancy, very few people can possibly make a spur-of-the-moment decision. This is really a decision that requires the best decision-making skills an individual has. Information and guidance is needed. It is not surprising then, that the subjects from School B opted for marriage where the subjects from School A said they would consider abortion. (See Table 6). An ethical, moral discussion of abortion is not appropriate in this research report, but it is merely an indication that the subjects from School A have been informed of the possible options. The percentages of those who decided to opt for marriage correlates with the data in Table 7. It is clear that the two groups of subjects do not have the same views regarding marriage. The subjects from School B only have their traditional values and points of view on which to base their answers, whereas the subjects from School A have been exposed to different options.

Table 6 – What would be considered in the case of an unwanted pregnancy

What would you consider doing when faced with an unwanted pregnancy?	***School A (%)***	***School B (%)***	***d***
Get married	***2***	***24***	***0.66***
Abortion	***30***	***4***	***0.68***
Keep baby – grandmother looks after	56	48	0.16
Keep baby – raise it myself	4	8	0.17
Suicide	2	0	0.22
Adoption	8	2	0.27
Other	6	4	0.04

Having a child out of wedlock is no longer the social disgrace it used to be. It is interesting to note that the majority of the subjects from both schools decided that having the baby would be the best option.

The dynamics of relationships, self-esteem and independence are dealt with in detail in comprehensive sexuality education programmes. When the subjects were asked whether they wanted to marry some day, only 65% of the subjects from School A answered Yes compared to an 80% Yes answer from School B's subjects. But what was insightful, was the second part of the question where the subjects were asked to give a reason for their decision. The percentages of the subjects' reasons for marriage are tabulated in Table 7. Notice the significant difference between the two schools' percentages and d-values in the first two responses. Traditionally seen, marriage is a functional unit in which one raises a family and this is the reason given by most of the subjects from School B. The subjects from School A, on the other hand, focus on relationships, companionship and love – these relationship dynamics are discussed at length in the comprehensive sexuality education programme. (Only the reasons with the highest percentages were included in Table 7).

Table 7 – Most frequent reasons for wanting to get married.

Reasons for marriage	***School A***	***School B***	***d***
Have a home/children	22%	49%	0.562
Love and friendship	24%	4.6%	0.554
Guilt-free & disease-free sex	10%	11%	0.032
It's the right thing to do	6%	14%	0.267
Everyone wants to marry	2%	7%	0.241

Almost double the percentage of subjects from School A indicated that they did not want to marry (34%) compared to the subjects from School B (18%) (d=0.36). In Table 8 the reasons for not marrying are given. An equal percentage of this group of subjects from both schools, don't have faith in marriage or in partners. This is almost certainly due to the poor examples revealed in the high divorce rates, domestic violence and the media. Another large percentage from both schools don't want to lose their freedom. But the actual difference between the groups is evident when considering the other two reasons. These are directly related to the comprehensive sexuality education programme.

Table 8 – Most frequent reasons for not wanting to marry.

Reasons for not marrying	***School A***	***School B***	***d***
Don't have faith in marriage or partners	40%	40%	0.0
Don't want to lose my freedom	41%	38%	0.04
I want to develop a career	6%	0%	0.352
Afraid my partner will die of HIV/Aids	13%	0%	0.526

The comprehensive sexuality education programme tries to broaden the learners' view of adult life and that there is more to life than marriage and having children. Although marriage is taught to be a very special relationship in which love and companionship is shared, learners are also encouraged not to see marriage as the alpha and omega of success.

The fact that the 13.3% of the subjects from School A are not keen to marry, because they are afraid that their partners will die of HIV/Aids indicates that these subjects are far more aware of the dangers and realities of HIV/Aids to the extent that it affects their decisions to marry or not. When the subjects had to indicate whether they thought any of their classmates *could* be HIV-positive, only 8% from School A say that they don't think any of their classmates can be HIV-positive compared to 36% from School B (d=0.683). In Table 8 it is also evident that the subjects from School A are more aware of the realities around HIV/Aids than those of School B.

3.6 Conclusion

As is evident in the research, there is still something missing. Neither information, nor the acquisition of skills seems to be enough to change the sexual behaviour of adolescents. "It is not enough that skills are known; they must become part of an internalised system of competencies that enables individuals to assimilate and use what they experience, know or learn, and what they think, feel and believe. Young people must be given opportunities to experiment with, succeed in and fail in life lessons" (Maree & Ebersöhn, 2002:225).

The comprehensive sexuality education programmes does not teach abstinence only. Abstinence is taught as the safest way to avoid unwanted pregnancy and HIV/Aids as well as other sexually transmitted diseases, but other methods of responsible sexual behaviour are also discussed.

The first aim of the study was to determine whether the subjects that had been exposed to a comprehensive sexuality education programme had higher factual knowledge than those who had not. This proved to be true. The second aim of the study was to determine whether better life-skills had been developed due to the comprehensive sexuality education programme. The subjects from School A knew what the correct answers were and how certain situations should be handled responsibly, but there is no indication of whether these skills have been used to translate knowledge into a change in behaviour.

A true assessment of whether the comprehensive sexuality education programme has been successful or not is whether, in the long run, there are fewer unwanted pregnancies, a lowered rate of HIV/Aids infection and an increase in well-balanced, optimally functioning adults. Responsible decision-making and identifying risk behaviour should not equate solely to abstinence.

On the basis of the research findings and literature study, a few recommendations can be made for comprehensive sexuality education programmes in Health Promoting Schools.

- First and foremost, sexuality education has to be taught holistically, aiming at improving not only sexual, but emotional, physical and psychological health.
- The following characteristics of a successful comprehensive sexuality education programme (cf. Kirby in Parker, 2001) can play a major role the promoting health in schools:
    - have a basis of theoretical approaches that have been demonstrated to be effective in influencing other health-risk behaviours as well;
    - integrate behavioural goals, teaching methods and materials that are appropriate to the age, sexual experience and culture of the students;
    - provide basic factual information about the risks of adolescent sexual behaviour and about methods of avoiding intercourse or using protection against pregnancy and STDs;
    - focus on reducing one or more sexual behaviours that lead to unplanned pregnancy and HIV/Aids/STD infection;
    - include activities that address social pressures and peer pressure that then also influence sexual behaviour:
    - provide role play and practice with communication, negotiation, refusal and decision-making skills;

- give clear messages about sexual activity and condom/contraceptive use and continually reinforce that message;
- use a variety of teaching methods designed to involve the participants and have them personalize the information;
- continue long enough to complete important stages and important activities properly; and
- choose teachers who believe in the programme they are implementing and then provide them with training.

With the implementation of a very elementary sexuality education segment in the life orientation curriculum as recently as 2001, it is not yet possible to ascertain any real effects in the general behaviour of adolescents. Many subjects had their sexual debut in primary school where no sexuality education was taking place. Sexuality education started too late for both these groups of grade 11 learners. The evidence of knowledge is there, the skills are understood and practised, but the behaviour patterns have formed and, for this age group, it is too late.

BIBLIOGRAPHY

ANDERSON, S., BROUARD, A., BROOKE, L. & WILKINSON, L. 2001. Soul City Lifeskills: Grade 9. Johannesburg : Institute for Health and Development Communication. 145 p.

ANON. 1998. Health-promoting schools (AHPSA). *Primary Educator*, 4(5):1-4.

COHEN, J. 1988. Statistical power analysis for behavioural sciences. Second edition. Hillsdale, NJ: Erlbaum.

COLEMAN, J. & ROKER, D., *eds.* 1998. Teenage Sexuality: Health, Risk and Education. Australia : Harwood Academic Publishers. 205 p.

EATON, L. & FLISHER, A.J. 2001. Why do young people engage in unsafe sex? : editorial. *South African Medical Journal.* Supplement. *South African journal of psychiatry,* 17:3, 55-58, Sep.

ELLIS, S.M. & STEYN, H.S. 2003. Practical significance (effect sizes) versus or in combination with statistical significance (p-values), *Management Dynamics,* 12(4):51-53.

GOLDMAN, J. 2000. Sexuality education for teenagers in the new millennium. *Youth Studies Australia,* 19(4):1-13, Dec.

GRAZIOLI, A. 1997. Effective sexuality education for youth. *The South African Baptist Journal of Theology,* 6:147-153.

GREATHEAD, E., DEVENISH, C. & FUNNEL, G. 1998. Responsible Teenage Sexuality:PPASA. 2nd ed. Pretoria : Van Schaik. 311 p.

HYDE, J.S. & DELAMATER, J. 1997. Understanding Human Sexuality. Boston : McGrawhill. 685p.

KELLY, G.F. 1998. Sexuality Today: The Human Perspective. 6th ed. Boston, Mass. : McGraw Hill. 580 p.

LOUW, O., DE VILIIERS, V., AMORIM, C., ROOS, A. & DELAGEY,S. 2001. Life-skills and HIV/Aids Education: An Educator's Guide: Grade 9. South Africa : Department of Health. 142 p.

MAART, B. 2000. http://www.interfund.org.org.za/pdffiles/vol3_two/health.pdf [Date of access: 21 October 2004].

MAREE, J.G.& EBERSÖHN, L. 2002. Life-skills and career counselling. Sandown : Heinemann. 307p.

MUKOMA, W. 2001. Rethinking School-Based HIV/AIDS interventions in South Africa. *South African Journal of Child and Adolescent Mental Health,* 13(1):55-62.

PARKER,J.T. 2001. School-based sex education: a new millennium update. [Web:] http://www.ed.gov/databases/ERIC_Digests/ed460130.html [Date of access: 17 October 2002].

SAS Institute Inc., 1999. SAS Institute Inc., SAS OnlineDoc®, Version 8, Cary, NC.

SCALES, P. 1999. Reducing risks and building developmental assets: essential actions for promoting adolescent health. *Journal of School Health,* 69(3):113-119, March.

SOUTH AFRICA. Department of health. 1999. Second Draft: Health Promoting Schools Policy Guidelines. August. [Web:] http://web.uct.ac.za/depts/chu/projects.htm [Date of access: 26 June 2003].

SPADY, W.G. 1994. Choosing outcomes of significance. Educational Leadership, 51(6): 18-22.

STRACHAN, K. 1999. Policy in Progress: What is it like to be a young person living in South Africa? *HST Update,* 44:7-10. July.

TERRE BLANCHE, M. 1999. The SHARP programme (Sensible, Healthy and Responsible People).[Web:] http://www.population.org.za/SAPLER/Pioneers/Proposal/Project.../ProjectIdentification.html [Date of access: 26 June 2003].

VAN DER WALT, J. 2001. Skills for Life - Learner's book 9. Braamfontein: Nolwazi Educational Publishers. 242 p.

VAN NIEKERK, P.A. & LOUW, C.D. 1996. Die invloed van televisie op die geslagsopvoeding van die vroeë adolessent. *Pedagogiekjoernaal,* 7(1):40 - 58.

WORLD HEALTH ORGANISATION. 1986. Ottawa Charter for Health Promotion. *Canadian Journal of Public Health,* 77(12):425-430.

WHO. 1996. Improving School Health Programmes: Barriers and Strategies. WHO/HPR/HEP/96.1.

WHO. 2000. Local Action: Creating Health Promoting Schools. Education Development Center, Inc. WHO/SCHOOL/00.3. Geneva.

CHAPTER 4

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

In this chapter the research is being concluded by a presentation of the findings, the drawing of conclusions on the basis of the findings, and finally, the formulations of recommendations for future research.

4.2 FINDINGS

4.2.1 Findings in the literature overview – Towards the Health-Promoting School: Sexuality Education through life-skills

- The Health-Promoting School's policies focus on a holistic approach in education, including social, emotional, spiritual, psychological and ethical dimensions of health (cf. paragraph 2.1).
- The sexual dimension has been neglected and a noticeable gap exists in the literature regarding sexuality education in Health-Promoting Schools. This gap is also evident in the health and educations policies of the World Health Organisation (cf. paragraph 2.1).
- One of the main aims of Health-Promoting Schools, is to change unhealthy behaviour patterns in children and thus disseminate what they have learned into the larger community (cf. paragraph 2.1 & 2.4).
- Research shows that the only way to change behaviour patterns, is to teach basic life-skills in which learners apply the knowledge they have gained (cf. paragraph 2.1, 2.2 & 2.5).
- The media is playing a very important role in the forming of adolescents (cf. paragraph 2.2).
- The new South African outcomes-based education programme with life-skills education was implemented in secondary schools in 2001 and currently ends at the end of Grade 9 (cf. paragraph 2.1, 2.2 & 2.5).

- This curriculum includes Life Orientation that has an elementary sexuality education component that focuses mainly on HIV/Aids and how to avoid contracting the virus (cf. paragraph 2.1 & 2.2).
- There is, as yet, no compulsory sexuality education or life-skills education for learners in grades 10 – 12 (paragraph 2.2 & 2.5).
- Many problems and erroneous perceptions still exist regarding sexuality education (cf. paragraph 2.3).
- Research has shown that sexuality education does *not promote* promiscuous behaviour (cf. paragraph 2.3).
- Many schools are not teaching sexuality education the way it should be taught. Often educators do not regard it as important because it is not formally examined and often any teachers that have open periods on the time-table are filled with Life Orientation/sexuality education classes (cf. paragraph 2.3).
- The teachers are not trained or motivated to implement the program. Educators also don't set good examples to the learners regarding sexuality because such high numbers of educators are HIV/Aids positive (cf. paragraph 2.3).
- Some teachers are guilty of abusing learners sexually (cf. paragraph 2.3).
- Three main models of sexuality education programmes were examined: the abstinence only programme, the abstinence-plus approach and then, comprehensive sexuality education programme, which proves to be the most suitable to implement in Health-Promoting Schools, because the approach is based on teaching life-skills and focuses on holistic development. It is not at all ideal to teach that abstinence is the only healthy option (cf. paragraph 2.1, 2.4 & 2.5).
- Life-skills education is a process of acquiring knowledge, attitudes and skills that allow learners to make responsible choices that will promote healthy behaviour patterns (cf. paragraph. 2.4, 2.5).

- The life-skills essential to healthy sexual behaviour are the ability to identify and avoid risk behaviour, responsible decision–making skills and communication skills (cf. paragraph 2.3 & 2.5).

4.2.2 Findings in the research investigation that health is promoted in schools through comprehensive sexuality education and life-skills

- The subjects from School A have been exposed to approximately four years of comprehensive sexuality education (cf. paragraph 3.3.1).
- The subjects from School A indicated that they had found the comprehensive sexuality education programme to be beneficial (cf. paragraph 3.4).
- The subjects from School A's level of factual knowledge significantly supersedes the level of knowledge in the subjects from School B (cf. paragraph 3.4.1)
- When the questions regarding risk behaviour were analysed, it seems that the subjects from School A know how to identify risk behaviour and even know, theoretically, how to avoid such situations (cf. paragraph 3.4.2 & 3.4.3).
- There seems to be an indication that these subjects are not applying their theoretical knowledge or their skills to change their behaviour patterns (cf. paragraph 3.4.1, 3.4.2 & 3.4.3).
- The subjects from School B did not know how to respond to many of the questions, whereas those from School A knew exactly what to say (cf. paragraph 3.4.2 & 3.4.3).
- Those who had been exposed to the comprehensive sexuality education programme, knew how to answer the questions regarding decision-making skills, correctly, but did not prove that they were actually employing the skills to ensure responsible sexual behaviour (cf. paragraph 3.4.2 & 3.4.3).
- Abstaining from sexual activity is not the only indication of safer, more responsible sexual behaviour (cf. paragraph 3.4).

- Subjects from School B have more traditional opinions regarding marriage and unplanned pregnancy than subjects from School A (cf. paragraph 3.4.3).

- Other variables also influence the ability of the subjects to identify and avoid risk behaviour as well as make responsible decisions. These include alcohol abuse, sexual abuse and rape, as well as the media (cf. paragraph 3.4.2 & 3.4.3).

4.3 CONCLUSIONS

4.3.1 Conclusions from the literature overview – Towards the Health-Promoting School: Sexuality Education through life-skills

- A comprehensive health education policy which incorporates social, emotional, spiritual, psychological dimensions should be included in Health-Promoting School's policy. The World Health Organisation's policies, as well as Health-Promoting Schools policies should not approach sexuality education purely as an HIV/Aids awareness programme, but incorporate it holistically and comprehensively using the life-skills approach.

- Teaching comprehensive sexuality education with life-skills is the only way in which any kind of behaviour change can take place, but it will take time to alter behaviour patterns that have formed through centuries. Only in 2001 the new outcomes-based curriculum introducing life-skills education was implemented in South Africa. Therefore learners currently in Grade 11 (the age of the subjects in this research project) were only exposed to life-skills education in Grades 8 and 9. In most schools all forms of sexuality education ends in Grade 9. Two years of very elementary sexuality education, aimed mainly at the prevention of contracting HIV/Aids, is not sufficient. The experimental group from School A has been exposed to more comprehensive sexuality education for a longer period of time than most learners in Grade 11, but beginning this programme in Grade 8 is already too late as many have already experienced their sexual debut by that age. This explains, too, the fact that although the subjects from

School A have more knowledge and better life-skills, it did not prevent them from sexual activities.

- The conclusion cannot be made based on studies such as this, that the comprehensive sexuality education doesn't have the desired effect. As the comprehensive sexuality education programme is introduced at the correct levels of development and taught consistently throughout the 12 years of formal education, changes will become evident.
- Comprehensive sexuality education should be compulsory from the junior phase through to Grade 12. Schools should be compelled by legislation to implement the programmes and train educators and by so doing, alter the perception that sexuality education is inferior to other more important examinations subjects such as the sciences and languages.
- The problems encountered around sexuality education seem to be coming from the 'top'. Firstly, the policies are not comprehensive. Secondly, the subject is treated as an inferior subject that can be taught if there is time or educators available. Thirdly, it is possible to conclude that many of the problems are due to the sensitive nature of the content and that educators experience personal uneasiness teaching sexuality education. It is interesting that other learning areas like Mathematics, Science, Geography and English have never experienced any implementation problems.
- The focus should never be teaching abstinence only. This approach condemns sexual activity outside of marriage and doesn't equip learners with the necessary skills to be able to make decisions, communicate their decisions or to identify and avoid risk behaviour.

4.3.2 Conclusions from the research investigation that health is promoted in schools through comprehensive sexuality education and life-skills

- The fact that the subjects who had been exposed to the comprehensive sexuality education programme had a higher level of knowledge can be directly attributed to the education they received. This is also illustrated in Figure 1 of Chapter 3. However, the

difference could've been higher if the programme had been implemented earlier. If the statistics from previous research are true, many of the subjects would already have been sexually active by the time there were first exposed to the programme in Grade 8.

- A few conclusions can be made based on the findings regarding the presence or absence of these life-skills:

  - *The programme teaches learners the skills they need and how they should behave.*

  The subjects from School A had been taught various skills and they knew how to formulate answers far batter than the subjects from School B. Although, testing a life-skill in a written answer can only indicate whether the subject understands what he/she should do. It is not possible to determine what they actually do when in the real situation.

  - *The programme exposes learners to more responsible sexual behaviour and is not teaching abstinence only.*

  The subjects from School A seem to be more sexually active than those from School B but are also more aware of precaution and alternative sexual activities. The real difference will be seen in a few years' time if the number of unplanned pregnancies and sexually transmitted diseases has decreased.

  - *The comprehensive sexuality education programme at School A is not flawless*

  School A has implemented a comprehensive sexuality education programme for Grades 8 – 12 for the past few years. They have been doing so on their own initiative, but Grades 10 – 12 are still less exposed than would be ideal. Although their approach is correct and their educators are positive, the learners are aware that the classes are informal and not examinable at the end of their matriculation year. Therefore, the learners do not approach the comprehensive sexuality education programme with the seriousness that they should.

➢ *Comprehensive sexuality education programmes broaden the general views of the learners.*

There is nothing wrong with teaching traditional values like the importance of marriage, but it is important that the programme also informs learners that there are other options, even though it means teaching alternative choices like abortion.

➢ *Other variables are also playing an important role on behaviour patterns.*

Only if learners were solely exposed to the comprehensive sexuality education programme for sexual information, can the programme be solely accepted or rejected as successful. Currently, and probably even more so in future, the media brings across conflicting messages of sexually acceptable behaviour to learners. The role of alcohol and drugs cannot be underestimated in the high level of sexual activity among adolescents.

4.4 Recommendations for further research

On account of the preceding findings and conclusions, the following recommendations are being made:

- that a comprehensive sexuality education programme be designed from Grade 1 – 12 as soon as possible. Research should be done regarding age specific information, cultural differences and traditions, as well as adult education;
- that future researchers explore the use of a different, more applicable method of collecting data regarding the presence or absence of life-skills;
- that the effect of alcohol and drug abuse on risk behaviour, especially sexual risk behaviour be investigated; and
- that the role of coercive sexual activities be considered when researching adolescent sexuality education. When learners have been exposed to abuse, especially by school teachers, rape and incest, a whole different approach should be considered.

4.5 CLOSE

The research report is closed in this chapter by the presentation of the findings, the drawing of conclusions on the basis of the findings, and finally, the formulation of recommendations for future research.

BIBLIOGRAPHY

ANDERSON, S., BROUARD, A., BROOKE, L. & WILKINSON, L. 2001. Soul City Life-skills: Grade 9. Johannesburg : Institute for Health and Development Communication. 145 p.

ANON. 1991. AIDS - Everybody's problem. *SALUS,* 14(2):14-15, April.

ANON. 1995. Talk to your teen about sex: a guide for parents. *SALUS,* 18(1):20-23, May.

ANON. 1998a. Education for protection. *Agenda,* 27(1):37-41.

ANON. 1998b. Health-promoting schools (AHPSA). *Primary Educator,* 4(5):1-4.

ANON., s.a. Core Intervention 3: Skills Based Education. *School health at a glance.* [Web:] http:/wbln0018.worldbank.org/HE.../14a963942b43268a85256a4e0064fcb4? OpenDocumen [Date of access: 26 June 2003].

ASMAL, K. 2000. *Part One: Key themes that emerged from the analysis of the state of education.* [Web:] pwv.gov.za/content/documents/303. [Date of access: 26 June 2003].

ASMAL, K. 2002. Asmal expects fall in cases of sexual abuse. *Dispatch Online.* [Web:] http://www.dispatch.co.za/2002/11/01/southafrica/SEX.HTM [Date of access: 26 June 2003]

BAILEY, S.K. 1976. The purposes of education. Indiana : Phi Delta Kappa. 142 p.

BARTLETT, S. 2002. Survey: Most teens believe chances of getting AIDS are slim. *The Star*:9, July 17.

COETZER, D. 2004. From the mouths of babes. *Fair Lady,* 807:28-32. April.

COHEN, J. 1988. Statistical power analysis for behavioural sciences. Second edition. Hillsdale, NJ: Erlbaum.

COLEMAN, J. & ROKER, D., *eds.* 1998. Teenage Sexuality: Health, Risk and Education. Australia : Harwood Academic Publishers. 205 p.

DEPARTMENT OF EDUCATION, North West Province. 1999. Business Plan: HIV/Aids Life skills Education; Secondary Schools. December. [Web:] http://www.population.org.za/SAPLER/Pioneers/Proposal/Project.../ProjectIdentification.html [Date of access: 26 June 2003].

DEPARTMENT OF EDUCATION, Western Cape. 2003. WCED HIV/Aids Life skills programme. [Web:] http://wced.wcape.gov.za/planning&devel/support/special_ed/hiv_aids/info_2003.html [Date of access: 26 June 2003].

DONALD, D., LAZARUS, S. & LOLWANA, P. 1997. Educational Psychology in social context. Challenges of development, social issues, and special need in Southern Africa. Cape Town : Oxford University Press.

EARLES, R.F., FRASER, J. & SUMPTER, B. 1992. An analysis of legislative, state agency and local change arenas in sexuality and the curriculum: The practices of sexuality education. Teachers College Press: New York.

EATON, L. & FLISHER, A.J. 2001. Why do young people engage in unsafe sex? : editorial. *South African Medical Journal.* Supplement. *South African journal of psychiatry,* 17:3, 55-58, Sep.

ELLIS, S.M. & STEYN, H.S. 2003. Practical significance (effect sizes) versus or in combination with statistical significance (p-values), *Management Dynamics,* 12(4):51-53.

FLISHER, A.J., CRUZ, C., EATON, L., MUKOMA, W. & PILLAY, Y. 1999. Review of Research Involving Health of South African Youth. Report submitted to the Youth Development Trust. Cape Town, Department of Psychiatry, University of Cape Town. [Web:] http://population.pwv.gov.za/ConSemEvents/Documents/Development%2520and%2520validation%2520of%2520a%2520CD-ROM%2520information%2520package%2520.doc

FLISHER, A.J. & REDDY, P. 1995. Towards Health-Promoting Schools in South Africa: editorial. *South African Medical Journal,* 85(7):Jul.7.

FLISHER, A.J., ZIERVOGEL, C.F., CHALTON, DO. LEGER, PH., & ROBERTSON, B.A. 1996. Risk-taking behaviour of Cape Peninsula high school student. Part X: Multi-variate relationships among behaviours. *South African Medical Journal,* 86, 1094-1098.

FRASER-MOLEKETI, G. 1996. Health Promoting Schools. (paper delivered at the inaugural Health-Promoting Schools Conference at the University of Western Cape 1996.) Cape Town. (unpublished.)

GOLDMAN, J. 2000. Sexuality education for teenagers in the new millennium. *Youth Studies Australia,* 19(4):1-13, Dec.

GOURLAY, P. 1996. If you think sexuality education is dangerous, try ignorance! Sexuality Education: critical factors for success, Family Planning Victoria, Box Hill.

GOVENDER, P. 2001. Aids wipes out SA's teachers. *The Sunday Times*: 1, Nov.4.

GRAZIOLI, A. 1997. Effective sexuality education for youth. *The South African Baptist Journal of theology,* 6:147-153.

GREATHEAD, E., DEVENISH, C. & FUNNEL, G. 1998. Responsible Teenage Sexuality: PPASA. 2nd ed. Pretoria : Van Schaik. 311p.

GREY, J. 2001. HIV/Aids on the increase among educators? *The teacher:* 13, Dec. 13.

HOLMSHAW, M. 1992. Aids prevention in South Africa. Vigssimposium, WNNR, Pretoria.

HYDE, J.S. & DELAMATER, J. 1997. Understanding Human Sexuality. Boston : McGrawhill. 685p.

KELLY, G.F. 1998. Sexuality Today: The Human Perspective. 6th ed. Boston, Mass. : McGraw Hill. 580 p.

KENYON, C., HEYWOOD, M. & CONWAY, S. 2002. Mainstreaming HIV/Aids progress and challenges in South Africa's HIV/Aids campaign. [Web:] www.afronets.org/archive/200203/msg00052.php [Date of Access: 24 October 2004].

KIRBY, D. 2000. What does the research say about sexuality education. *Educational leadership*: 72-76, October.

KIRBY, D., SHORT, L., COLLINS, J., RUGG, E. *et al.* 1994. School-based programs to reduce sexual risk behaviours: a review of effectiveness. *Public Health Reports,* 109(3):339-361.

KOSUNEN, E., RIMPELA, A. & RIMPELA, M. 1996. From control policy to comprehensive family planning: success stories from Finland. *International Journal of Health Promotion and Education,* 3(2): 28-32, Sept.

KUNIO, K. & SONO, A. 1996. Study on the promotion of unwanted teenage pregnancies: Perspectives drawn from the international survey. JFPA.

LAZARUS, S. & REDDY, P. 1994. Executive Summary: Health Promoting Schools in South Africa – Challenges for the 21st century. Cape Town. July.

LIFHIGA, M. 2003. Is sex still a taboo subject in primary schools? *The Teacher: Your Guide to Education.* 5(4) April.

LOUW, O., DE VILLIERS, V., AMORIM, C., ROOS, A. & DELAGEY,S. 2001. Life-skills and HIV/Aids Education: An Educator's Guide: Grade 9. South Africa: Department of Health. 142p

MAART, B. 2000. Risky business: Issues affecting adolescent sexual health in South Africa. [Web:] http://www.interfund.org.za/pdffiles/vol3_two/health.pdf [Date of access: 21 October 2004].

MACKIE, J. & OICKLE, P. 1997. School-based health promotion: the physician as advocate. *Canadian Medical Association Journal,* 156(9):1301-1305.

MACNAMARA, M. 1995. Life-skills: A positive approach. London : Souvenir Press. p.240.

MAREE, J.G.& EBERSÖHN, L. 2002. Lifeskills and career counselling. Sandown : Heinemann. 307p.

McMURRAY, A. 1999. Community health and wellness: A socio-ecological approach. Sydney : Harcourt Mosby Publishers. 408p.

MOKGALABONE, M.B. 1999. Socio-cultural conditions, teenage pregnancy and schooling disruption: themes from teachers and teenage mothers in "poor rural school. *South African Journal of Education,* 19(1).

MSIMANG, T. 2004. Government is 'ignoring school abuse'. *The Citizen.* 1, February 3.

MUKOMA, W. 2001. Rethinking School-Based HIV/AIDS interventions in South Africa. *South African Journal of Child and Adolescent Mental Health,* 13(1):55-62.

NUTBEAM, D. 1997. Promoting health and preventing disease: and international perspective on youth health promotion. *Journal of Adolescent Health.* 20:396-402.

O'BYRNE,D., JONES, J., SEN-HAI, Y. & MACDONALD, H. 1996. WHO's global school health initiative. *World Health,* 4:5-6, Jul.-Aug.

OLIVIER, M.A.J. 1996. Adolescent's perceptions of sexuality. *South African Journal of Education,* 16(1):6-8, February.

OLIVIER,M.A.J., GREYLING, S. & VENTER, D.J.L. 1997. Life skills in a changing society, with specific reference to the adolescent. *South African Journal of Education,* 17(1):24 -28.

PARKER,J.T. 2001. School-based sex education: a new millennium update. [Web:] http://www.ed.gov/databases/ERIC_Digests/ed460130.html [Date of access: 17 October 2002].

PERLMAN, H. 1997. Bodywise: Sex Education, Health and Advice for South African Youth. PPASA. Rev. Ed. Cape Town: Maskew-Miller Longman. 96p.

PRETORIUS, F. 1998. Outcomes-based Education in South Africa. Randburg: Hodder and Stoughton Educational. 129p.

RICE, M. 2000. Medicine meets Millennium – Adolescent sexual and reproductive health. [Web:] http://www.mh.hannover.de/aktuelles/projekte/mmm/englishversion/fs_prog.../Rice_V.htm [Date of access: 6 September 2004].

SANDERS, F.N. 2001. Spread the word, not the virus: an innovative HIV youth education project. *Archimedes,* 43(2):42, August.

SAS Institute Inc., 1999. SAS Institute Inc., SAS OnlineDoc®, Version 8, Cary, NC

SCALES, P. 1999. Reducing risks and building developmental assets: essential actions for promoting adolescent health. *Journal of School Health,* 69(3):113-119, March.

SNYMAN, M. 2001. My kind seksueel aktief? *Rooi Rose,* 59(2):88 -90, February.

SOUTH AFRICA. Department of Health. 1999. Second Draft: Health Promoting Schools Policy Guidelines. August. [Web:] http://web.uct.ac.za/depts/chu/projects.htm [Date of access: 6 September 2004].

SPADY, W.G. 1994. Choosing outcomes of significance. Educational Leadership, 51(6): 18-22.

STEYN, P. & LOUW, B. 2002. Meer as 40 000 onderwysers in Suid-Afrika het vigs, sê Wêreldbank. *Die Burger:* 1, May 9.

STRACHAN, K. 1999. Policy in Progress: What is it like to be a young person living in South Africa? *HST Update,* 44:7-10. July.

TERRE BLANCHE, M. 1999. The SHARP programme (Sensible, Healthy and Responsible People).[Web:] http://www.population.org.za/SAPLER/Pioneers/Proposal/Project.../ProjectIdentification.html [Date of access: 26 June 2003].

THOMAS, M.H. 2000. Abstinence-based programs for prevention of adolescent pregnancy: a review. *Journal of adolescent health,* 26(1):5-17.

UNAIDS, 1997. Impact of HIV and sexual health education on the sexual behaviour of young people: a review. [Web:]

www.unaids.org/html/pub/publications/irc-pub01/jc010-impactyoung people_en_pdf.pdf- [Date of access: 21 October 2004].

UNESCO, 2004. Education for all – Global co-ordination. [Web:] www.unesco.org/education/efa/global_co/working_group/pres8_sheldon_sha effer.shtml [Date of access: 6 September 2004].

UNICEF. 2001. Teachers talking: What is the life skills approach? [Web:] http://www.unicef.org/teachers/teacher/lifeskil.htm [Date of access: 6 September 2004].

VAN DER WALT, J. 2001. Skills for Life - Learner's book 9. Braamfontein: Nolwazi Educational Publishers. 242 p.

VAN DYK, A. 2001. HIV/Aids care and counselling: A multidisciplinary Approach. 2nd ed. Cape Town : Pearson Education South Africa. 442 p.

VAN NIEKERK, P.A. & LOUW, C.D. 1996. Die invloed van televisie op die geslagsopvoeding van die vroeë adolessent. *Pedagogiekjoernaal,* 17:1, p.40 - 58.

VENTER, L. 2001. Caution over HIV/Aids stats. *The Citizen:* 6, Nov 5.

WILEY, D.C. 2002. The ethics of abstinence-only and abstinence-plus sexuality education. *Journal of school health,* 72(4):164-167, April.

WILLIAMS, P. & REDDY, P. 1998. Improving child and adolescent health through schools: learning from Australia. *Southern African Journal of Child and Adolescent Mental Health,* 10(1):32-42.

WORLD HEALTH ORGANISATION. 1986. Ottawa Charter for Health Promotion. *Canadian Journal of public health,* 77(12):425-430.

WORLD HEALTH ORGANISATION. 1996a. Improving School Health Programmes: Barriers and Strategies. WHO/HPR/HEP/96.1.

WORLD HEALTH ORGANISATION. 1996b. Research to improve implementation and effectiveness of school health programmes. WHO/HPR/HEP/96.3, Geneva.

WORLD HEALTH ORGANISATION. 2000. Local Action: Creating Health Promoting Schools. Education Development Centre, Inc. WHO/SCHOOL/00.3. Geneva.

YARBER, W.L. & TORABI, M.R. 1997. Comprehensive sexuality education in Indiana secondary schools: instructional topics, importance ratings and correlates with teacher traits. *American Journal of Health Studies,* 13(2) 65.

APPENDIX: QUESTIONNAIRE

BIOGRAPHICAL INFORMATION

Tick the appropriate block or write a short answer where necessary.

1. Gender

Male	
Female	

2. Age

15	
16	
17	
18	
19	

3. With whom have you lived the greatest part of your life?

a. I live with my own father and mother.	1
b. One of my parents has died and I live with my remaining parent.	2
c. My parents are divorced/separated and I live with one parent.	3
d. I live with my grandparent/s.	4
e. I live with another family member, e.g. sister, aunt, etc.	5
f. I live with friends	6
g. In a hostel	7
h. Not one of these. Write down an explanation. _____	

4. How many rooms (including kitchen and bathroom/s) are in the house that you live in?

5. How many people live in the home where you live?

6. Do you get pocket money?

Yes	1
No	2

7. If you answered ***Yes*** in question 6, how much do you get MONTHLY? Fill in the amount you receive each month in the block provided. E.g. R50.00

8. Does your school have any sex education classes?

Yes	1
No	2

9. If you said YES in question 8, what would you say about it? Tick the appropriate block.

a. I have learned most of what I know about sex at school.	1
b. I have learned more about sex at school than at home.	2
c. I feel more prepared for a sexual relationship because of the classes.	3
d. I have learned nothing new about sex at school.	4

10. I have been in a sexual relationship.

Yes	1
No	2
Not sure	3

11. Write down the two subjects that you get the best marks for?

_____

_____

STATE WHETHER THE FOLLOWING STATEMENTS ARE ***TRUE*** OR ***FALSE*** BY MAKING A CROSS IN THE APPROPRIATE BLOCK.

		True	False
12.	If you had unprotected sex with someone tonight, you could go for an HIV/Aids test tomorrow to see if you have been infected.	1	2
13.	If you want to keep your boyfriend or girlfriend happy, you will have sex with him/her.	1	2
14.	It's harder to avoid sexual activities when you have been drinking alcohol at a party.	1	2
15.	A condom is 100% safe for preventing pregnancy.	1	2
16.	Carrying a condom with you all the time means you are willing to have sex.	1	2
17.	Drinking alcohol is safer than taking drugs.	1	2
18.	You can fall pregnant when you have sex for the first time.	1	2
19.	I would rather lose my boyfriend/girlfriend than have sex.	1	2
20.	I avoid parties when I know there will be no adults or parents.	1	2
21.	Masturbation is harmful.	1	2

READ THE FOLLOWING STATEMENTS AND THEN CROSS THE BLOCK WITH THE NUMBER THAT BEST DESCRIBES HOW YOU FEEL. BELOW ARE THE NUMBERS AND WHAT EACH NUMBER REPRESENTS.

1 – STRONGLY DISAGREE
2 – DISAGREE
3 – AGREE
4 – STRONGLY AGREE

E.g. You must have an education to achieve success.

1	2	3	4

22. You must make up your mind how far you are willing to go on a physical level with your date before you go out with them.

1	2	3	4

23. When a girl of 14 agrees to have sex with a boy of 18 her parents can have him arrested for rape.

1	2	3	4

24. If you and your partner both go for an HIV/Aids test and the results are negative, you are completely safe to start a sexual relationship.

1	2	3	4

25. My reason for saying NO to sex is that I don't want to disappoint my parents.

1	2	3	4

26. Having sex is a normal part of growing-up.

1	2	3	4

27. Girls who are raped, are raped by strangers.

1	2	3	4

28. I feel it is my responsibility to please my partner sexually.

1	2	3	4

29. It is possible that some of my classmates are HIV positive.

1	2	3	4

30. Love and sex is the same thing.

1	2	3	4

31 I feel comfortable discussing sexual matters with my partner.

1	2	3	4

32. Couples should use condoms when practising oral sex.

1	2	3	4

33. A condom is 100% safe to prevent getting HIV/Aids.

1	2	3	4

34. I have decided to wait until I am married to have sex.

1	2	3	4

35. If a boy takes a girl on an expensive date, or buys her expensive gifts she has to repay him by giving him sex if he asks for it.

1	2	3	4

READ THE STATEMENTS/QUESTIONS CAREFULLY AND THEN MAKE A CROSS IN THE BLOCK THAT YOU THINK IS RIGHT.

36. A girl can fall pregnant any time after she

A	turns 13 years old
B	develops breasts
C	starts having a monthly period
D	has started enjoying sex

37. HIV/Aids is the most important reason most teenagers should not have sex. What do you think is the next most important reason why you would not have sex while you are a teenager?

A	If a girl/boy are going to have a baby it will destroy their future education and plans.
B	It will make me feel guilty because it is against my beliefs.
C	I am not old enough to be in a committed relationship.
D	Nobody will want to marry me one day.

38. Think of 10 of your friends – boys and girls. Approximately how many of them are STILL virgins?

A	10 (all of them – 100%)
B	7 – 9 (most of them – 80%)
C	4 – 6 (about half of them – 50%)
D	1 – 3 (few of them – 20%)
E	0 (none of them – 0%)

39. Which one of these statements about condoms is FALSE?

A.	There is a new condom for women.
B.	Leaving a sealed condom in a hot car for long periods of time.
C.	Condoms without date stamps could be too old to use.
D.	Using Vaseline or baby oil with a condom will cause it to break
E.	There are no condoms available for safe oral sex.

40. What do you think you would consider doing if you found out you (your girlfriend) were pregnant?

A	Get married
B	Keep it to yourselves and decide on an abortion.
C	Tell your parents and then go through with it and ask your mother/grandmother to look after the child.
D	Have the baby, give it up for adoption and carry on with your lives.
E	Keep it hidden for as long as possible
F	Commit suicide
G	Another option: _____

41 When do you think teenagers have the most opportunity to have sex?

A	After school because both parents are still at work.
B	At parties on weekends
C	In a motor car parked somewhere in the dark or out of sight
D	On holiday
	Another possibility_____

42. Why do you think teenagers have sex? Write down a ***1*** in the block next to the ***MOST IMPORTANT REASON***, then a ***2*** next to the ***SECOND MOST IMPORTANT*** reason and then a ***3*** next to the one you think is used ***THIRD MOST*** often.

A		To show true love in a special love relationship.
B		To be 'in' with their friends who have done it.
C		Because they are curious about what it feels like.
D		Because they are usually drunk and can't control themselves.
E		To prevent a boyfriend or girlfriend form leaving them.
F		Because everyone is doing it.
G		To prove they are grown-up.
H		It's natural for the human race to have sex.

43. Read all these activities carefully and then put down a tick next to the ***FIRST*** one that you feel uncomfortable with when you are alone with a boyfriend/girlfriend. (Where you would like to draw the line)

a quick goodbye kiss	
Holding hands	
hugging	
French (open-mouth) kissing	
touching my body ABOVE my clothes	
touching my body UNDER my clothes, ABOVE my waist	
touching me UNDER my clothes, BELOW my waist.	
holding each other with some clothes off	
Both of us naked	
playing with each other's sex organs	
intercourse (sex – all the way)	

44. If you were on a first date with a boy/girl, which of these activities are acceptable? Put a tick in the appropriate block.

a quick goodbye kiss	
holding hands	
hugging	
French (open-mouth) kissing	
touching my body ABOVE my clothes	
touching my body UNDER my clothes, ABOVE my waist	
touching me UNDER my clothes, BELOW my waist.	
holding each other with some clothes off	
both of us naked	
playing with each other's sex organs	
intercourse (sex – all the way)	

Answer the following questions in a short sentence using your own ideas and words. Remember to be honest – ***your name is not on this questionnaire.***

45. Where or to whom would you go for help if you thought you were in trouble because of unprotected sex? Why?

46. Your boyfriend/girlfriend wants to have sex and you don't feel ready. He/she says to you: "Having sex will make our love grow into something very special." How would you respond?

47. You are invited to play 'spin the bottle' (when someone spins a bottle around and if the bottle points at a person, that person is supposed to do anything the others want him/her to do without refusing). You don't want to and then one of your friends asks: "Are you a chicken or are you your mommy's baby?"

48. Write down the four most common ways in which the HIV/Aids virus is spread.

49. Why do you think it is difficult to say NO, mean it and stick to it?

50. Write down THREE things that teenagers can do to have "good, clean fun".

51. Write down THREE places where you could get hold of condoms if you needed them.

52. Would you like to get married one day? Why or why not?

53. Both girls and boys are in danger of being raped. How can a person avoid being raped?

54. There are many other physical ways of expressing sexual feelings and attraction without having sex. Write down ***THREE*** other things that can be done to show someone physical love. (Don't be shy when you answer – be honest)

55. What would you say to a boy/girlfriend if they say: "Why don't you make love to me? All my other girlfriends have done it with me."

56. Why is it safer to avoid alcohol?

57. Where did you learn ***most*** of what you know about sex? Put a tick next to the appropriate answer.

My parents
Teachers
Magazines and love stories
Movies
Friends
Older brothers/sisters
A book about the facts of life

58. If you have already had sex, how did you feel about the ***first time*** you had sex? Read all the possible answers and then tick all those that describe the way you felt.

It was the most wonderful experience I have ever had.	
It was okay.	
I felt abused because I was forced.	
I didn't know what was happening.	
I felt so disappointed because I didn't enjoy it at all.	
It was very painful	
I didn't understand why everyone said it was so great.	
It happened so quickly that I can't remember much.	
I was too drunk to remember much.	