

Impact of HIV and sexual health education on the sexual behaviour of young people:

a review update



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Impact of HIV

and sexual health education

on the sexual behaviour

of young people:

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This document is an update by Anne Grunseit of the review by Grunseit & Kippax entitled *Effects of sex education on young people's sexual behaviour*, WHO/GPA, Geneva, 1993, and a publication arising out of that review (Grunseit, Kippax, Aggleton, Baldo & Slutkin, in press).

UNAIDS/97.4

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Abstract

*T*o assess the effects of HIV/AIDS and sexual health education on young people's sexual behaviour, a comprehensive literature review was commissioned by the Department of Policy, Strategy, and Research of UNAIDS, 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 attendant rates of pregnancy and STDs. Twenty-two reported that HIV 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. The interpretative value of this research was somewhat compromised, however, because of inadequacies in study design, analytic techniques, outcome indicators, and reporting of statistics. Future education programmes need to incorporate the features that have been associated with successful interventions in the past, as well as mechanisms by which their impact can be evaluated. Programme evaluation should be grounded in solid study design, and valid and appropriate statistical techniques. Gender and developmental stage of students are issues for the educator and researcher at both the design and the evaluation stages of sexual health/HIV education development.

Acknowledgements

The author thanks Dr Mariella Baldo of UNAIDS for her contribution to this review, in particular her draft of the section on the implications of programme planners.

Introduction

Sexual health education for children and young adults is one of the most hotly debated and emotional issues facing policy makers, national AIDS programme planners, and educators today. Arguments have raged over how explicit education material should be, how much there should be, how often it should be given, and at what age to initiate education. Indeed, the question has been asked: Why educate adolescents about sex, sexual health and sexually transmissible diseases (STDs) at all?

Sexual debut for most young people occurs during their teenage years. Sexual experience among young people has been estimated in a number of countries: At age 15 years, 53% of young people in Greenland, 38% of young people in Denmark (Werdelin, Misfeldt, Melbye & Olsen, 1992), and 69% of young people in Sweden (Klanger, Tyden, & Ruusuvaara, 1993) have experienced intercourse. By age 18/19 years, the percentage that are sexually active has been reported as 54.1% in the United States, 31% in the Dominican Republic (Westhoff, McDermott & Holcomb, 1996), 66.5% in New Zealand (Paul *et al.*, 1995), and 51.6% in Australia (Rodden, Crawford, Kippax & French, 1996). Age of debut has been estimated at a median of 17 years in England (Wellings *et al.*, 1995) and a mean of 15.95 years in the United States (Zelnik & Shah, 1983), and 16.8 years in Sweden (Schwartz, 1993). Therefore, the majority of young people have begun to have sexual intercourse before they leave their teens, and at least half by the age of 16. Use of contraception and STD prevention has been reported to vary across adolescence according to the age at which initiation occurs. Condoms (Kraft, Rise & Træen, 1990) and contraception (Faulkenberry, Vincent, James & Johnson, 1987; Mosher & Bachrach, 1987; Zelnik & Shah, 1983) are more likely to be used the later sex is initiated. Education on these topics has been found to modify that pattern (see Tables 1 to 4), and appears to be more effective if given prior to first intercourse (see, for example, Howard & McCabe, 1990), that is, in adolescence or pre-adolescence.

Partner turnover rate is greater during adolescence and the early twenties than in later years (Billy, Tanfer, Grady & Klepinger, 1993; Paul *et al.*, 1995). This is true not only for numbers of casual partners, but also for those relationships perceived as being regular and monogamous (Rosenthal, Moore & Brumen, 1990). Although these serially monogamous pairings may be of short duration, their regular status, in the minds of many of the young people in them, confers safety with respect to STD transmission (Rosenthal *et al.*, 1990). Unprotected sex is viewed as not risky because the partner is a regular partner as opposed to a casual one. Thus unprotected sex occurs with multiple partners, but the cumulative risk is rendered invisible by the apparent monogamy and commitment of each discrete relationship.

The risk posed by unprotected sex in young people is reflected in disproportionately high rates of STD infection (Braverman & Strasburger, 1994; Maxwell, Bastani & Yan, 1995; Rosenthal & Reichler, 1994) and unwanted pregnancy. Higher rates of STD infection have been associated, in at least one study, with earlier initiation of sexual intercourse (Rosenthal, Biro, Succop, Cohen & Stanberry, 1994). Educating adolescents on contraception, HIV, and STD prevention has been shown to be effective in reducing these unintended consequences (Daures, Chaix-Durand, Maurin, Viala & Gremy, 1989; Nafsted, 1992; National Committee on Health Education, 1978; Vincent, Clearie & Schluchter, 1987). Unfortunately, parents, although keen to help their children, still do not communicate adequately with them about sex (Geasler, Dannison & Edlund, 1995; Postrado & Nicholson, 1992). Many parents feel inadequate to the task (Geasler *et al.*, 1995). Further, children are often reluctant or too embarrassed to approach parents with the topic (Goldman & Goldman, 1981), and therefore have turned, particularly in more recent times, to more formal sources of sexual health education such as school-based lessons (Wellings *et al.*, 1995).

Thus, we have a period in which people are beginning their sexual lives, and have a reasonable turnover of partners once they do; there is a demonstrated risk in terms of unwanted outcomes (pregnancy and STD infection); parents are concerned but unprepared for intervention; and there is evidence that education prior to initiation is most efficacious in achieving programme aims. The need for formalized provision of education about sexual health and its potential consequences for young people is therefore apparent.

Formal sexual health education for adolescents in developed countries has had a long and chequered history, its fortunes waxing and waning with the changing of governments and the tide of public opinion (Holmstedt, 1974; Mellanby, Phelps & Tripp, 1992; Nazario, 1992; Scales, 1981; Siedlecky, 1979; Thomson, 1994; Wallace & Vienonen, 1989). Those changes are reflected in the content and ideologies that underpin school sexual health education curricula and the public controversy they often engender. As a consequence, sexual health education is far from being a homogeneous or unitary concept: it encompasses a wide range of curricula that differ with respect to their aims, scope, implementation, and content (Jorgensen, Potts & Camp, 1993; Nazario, 1992). The variety of approaches is reflected in the range of nomenclature used to describe what otherwise is broadly termed *sexual health education*. For example, programmes have been labelled variously as family life education, sexual health, personal development, values clarification, “just say no”, sex respect, and human sexual health. The descriptions of the interventions to be covered in this review also attest to the variety of approaches to sexual health education.

The degree of success these approaches have achieved is varied. Kirby *et al.* (1994) investigated factors that contributed to the efficacy of school-based sexual health education programmes in reducing unwanted outcomes of adolescent sexual activity (Jones *et al.*, 1985; Nafsted, 1992; Wallace & Vienonen, 1989). But attempts to refine programme efficacy inevitably encounter the philosophical concern of legitimizing sexual activity in adolescence (Thomson, 1994).

The advent of the HIV/AIDS pandemic has further inflamed the debate. The necessarily frank treatment in education programmes of historically taboo sexual practices (e.g., anal sex, homosexual sexual practice) has rekindled fears as to how young people will respond to the information presented to them. Whereas HIV education and sexual health education for young people clearly have fundamental points at which they diverge (Gillies, 1994), both have been subject to the same criticism, namely, that the discussion of sexual health for purposes other than the promotion of abstinence is an incitement and enticement to precocious sexual involvement (Allgeier & Allgeier, 1988; Nazario, 1992; Scales, 1981; Thomson, 1994; Vincent *et al.*, 1994; Whatley & Trudell, 1993). It is clear that such criticism has had, and will continue to have, a significant effect on the extent and nature of HIV and sexual health education (Scales, 1981; Udry, 1993; Vincent *et al.*, 1994). For this reason a thorough examination of the validity of that contention is essential.

The aim of the current review is not to assess the relative merits of HIV and sexual health education programmes, nor is it to theorize about why some approaches appear more successful than others in reducing the unintended consequences of adolescent sexual activity. Both of those issues have been addressed comprehensively elsewhere; the findings are summarized in the discussion section of this review (Kirby, 1992; Kirby *et al.*, 1994; Kirby, 1995; Mellanby *et al.*, 1992; Oakley, Fullerton & Holland, 1995; Visser & van Bilsen, 1994; Christopher, 1994). This report will complement and extend the previous work by bringing together data collected within and outside the United States, and will go beyond the scope of previous reviews that are restricted to school-based interventions (Kirby, 1995; Kirby, 1992; Kirby *et al.*, 1994; Stout & Rivara, 1989), covering interventions conveyed in tertiary education institutions (e.g., Marcotte & Logan, 1977), clinical settings (e.g., Mansfield, Conroy, Emans & Woods, 1993), by mail distribution (e.g., Kirby, Harvey, Claussenius & Novar, 1989), and through public campaigns (e.g., Herlitz, 1993) and community groups (e.g., Postrado & Nicholson, 1992). The primary intention is to inform policy makers, programme planners, and educators about the impact of HIV and sexual health education on the sexual behaviour of young people as described in the published literature. The review includes:

- a presentation of studies, summarized in Tables 1 to 4;
- a discussion of key findings under each study type (see Methodology for the way the studies were classified);
- conclusions, drawn from the data, about the impact of HIV and sexual health education on the sexual behaviour of young people;
- a general discussion of the methodological problems that have compromised the assessment of this body of literature;
- a discussion of broader issues in education with respect to gender and social context;
- a listing of features of successful programmes;

- a look at questions arising from the social context in which education takes place; and
- implications arising from this review and other research in this area.

This review seeks to encompass the majority of the works available in the peer-reviewed literature, which may well mean that studies with flawed methodologies will be included. Their inclusion here is justified however, as these works, despite their shortcomings, are part of the body of available information contributing to the debate over the impact of HIV and sexual health education. Details of study design and inadequate evaluation will be provided so that readers may make their own comparisons, with those inadequacies in mind. This approach will also allow for the findings to be grounded in, and therefore generalized to, a wide range or programmes, contexts of interventions, and intervention media.

It should be noted that because this review was designed to answer a specific question related to the *outcome* of HIV/sexual health education, issues around evaluation will be necessarily also be focused on outcome. However, this does not constitute a position that evaluation of outcomes is the only level at which interventions have something to teach us. This paper extends and develops work initiated in two reviews earlier commissioned by the World Health Organization's Global Programme on AIDS (Ford, Fort-D'Auriol, Ankomah, Davies & Mathie, 1992; Allgeier, 1993). Further, it is an update of a review commissioned by the World Health Organization's Global Programme on AIDS in 1993 (Grunseit & Kippax, 1993), and a publication arising from that review (Grunseit, Kippax, Aggleton, Baldo & Slutkin, in press). The request for this update by the Department of Policy, Strategy, and Research of UNAIDS, the Joint United Nations Programme on HIV/AIDS, was made subsequent to the acceptance of the latter paper for publication. Hence it contains 16 additional papers, as well as extended discussion of some of the broader issues around HIV/sexual health education for young people.

Methodology

*T*hirteen literature databases were searched and international experts in the field were consulted to obtain relevant material¹. Where possible, articles were translated into English. The articles cited in this review are representative rather than exhaustive.

The focus of the review is on research that studied the behavioural impact of HIV/AIDS and sexual health education on young people. Research that dealt solely with knowledge and attitudes about sex has been excluded, because of the poor association between attitudes and knowledge on the one hand, and behaviour on the other (Kirby, 1985b). This also means that only the behavioural outcomes of multifaceted studies are reported. Similarly, studies describing only policy and services, with no behavioural impact analysis, have been excluded. Behavioural outcome is most commonly assessed by comparing people who did or did not receive HIV/AIDS or sexual health education in terms of adolescent pregnancy, abortion and birth rates, STD infection rates, and self-reported sexual activity.

Included in this report are data dating from the mid-1970s, even though some of the research was conducted before the advent of HIV/AIDS. Although the content of sexual health education has changed in the last 20 years, the basic findings from early studies are still relevant with respect to the relationship of sexual health education to sexual behaviour.

The studies considered in this review were classified into four types: controlled intervention studies; other intervention studies; cross-sectional surveys; and national and international comparison studies. The general findings arising from research under these headings will be described, with key studies discussed in detail. Three additional studies whose findings conflict with those of the general corpus of research will be discussed outside that framework.

¹ The databases were: PSYCLIT; SOCIOFILE; APAIS; AUSTROM; MEDLINE; FAMILY RESOURCES; EMBASE; MENTAL HEALTH ABSTRACTS; PASCAL; SOCIAL SCISEARCH; PAIS INTERNATIONAL; DISSERTATION ABSTRACTS ONLINE; CURRENT CONTENTS.

Findings

Controlled intervention studies

Experimental designs were employed in 15 studies, all of which were conducted in the United States. Those studies randomly assigned individual participants or groups (e.g., school classes) to either treatment (e.g., sexual health education or HIV/AIDS education) or control conditions. They were conducted primarily with school-age or college students, most involving mixed gender groups, although some were single gender studies (Danielson, Marcy, Plunkett, Wiest & Greenlick, 1990; Kirby, Harvey, Clausenius & Novar, 1989; Vincent, Clearie & Schluter, 1987; Williams, Achilles & Norton, 1985). Intervention impact was assessed by pretest and post-test measures of self-reported sexual activity and/or indicators of unprotected sexual activity² such as pregnancy, abortion, and birth rates.

The findings of those studies (see Table 1) were remarkably consistent despite variations in sample size, course composition, course duration, country of origin, and year of publication (1985 through 1996). Six of the sexual health education programmes were associated with delayed initiation of intercourse (Jorgensen *et al.*, 1993; Kirby, Barth, Leland & Fetro, 1991; Zabin, Hirsch, Smith, Streett & Hardy, 1986), and/or reduced sexual frequency (Smith, 1994), pregnancy, abortion, or birthrates, for instruction recipients (Vincent *et al.*, 1987; Williams *et al.*, 1985). Following an AIDS prevention curriculum, one study found greater monogamy and more consistent condom use (Walter & Vaughan, 1993), and another reported fewer sexual partners in the previous two months for education recipients compared to controls (Main *et al.*, 1994). Six studies reported no relation between sexual health education and sexual activity (Bellingham & Gillies, 1993; Danielson *et al.*, 1990; Kirby *et al.*, 1989; Kvaalem, Sundet, Rivo, Eilertsen & Bakketeig, 1996; Levy *et al.*, 1995; Miller *et al.*, 1993). However, changes or differences in rates of sexual activity in the Miller *et al.* study would have been difficult to detect given the overall low rates of sexual intercourse (between 3% and 5%).

Despite varying success in achieving programme aims, 14 of the 15 studies did not indicate that sexual health education leads to earlier initiation or greater sexual activity. The exception to the trend was reported by Christopher & Roosa (1990); that study will be described in a later section (see Exceptions).

² The term “unprotected” with reference to intercourse as used here means intercourse without the use of contraception, in contrast with HIV/AIDS discourse, where unprotected intercourse generally refers to vaginal or anal intercourse without the use of condoms.

Vincent *et al.* (1987), for example, demonstrated the potential for a dramatic decrease in rates of adolescent pregnancy through the provision of sexual health education and family planning services. The programme was instituted within a portion of a county in South Carolina (USA), with the remainder of the county and three other counties serving as control areas. The intervention involved education for adult leaders, such as community agency professionals, religious leaders, and parents. There were also school-based sexual health education for students from grades K through 12, broadcasting of programme initiatives and messages through the media, and integration of sexual issues into mainstream health promotion. After two to three years of programme implementation, the area in which the intervention was conducted experienced a 35.5/1000 reduction in the estimated pregnancy rate for females 14 through 17 years of age, as compared with 14.4/1000 in the non-intervention area of the target county, and increases of 5.5 ($P < 0.002$), 16.4 ($P < 0.001$) and 13.9/1000 ($P < 0.0001$) in the control counties. The study demonstrated that the effects of sexual health education initiatives may be observed on a scale larger than that of a single school or college class, or institution.

The randomized and controlled design of those intervention studies permits an accurate assessment of the impact of particular sexual health education programmes. Tight control over programme content and the study sample allows valid comparison with the absence of intervention conditions, although one study that reported comparative reductions in birth rates in the treatment group failed to state the statistical significance of the findings (Williams *et al.*, 1985). From those studies it would appear that sexual health education does not lead to greater sexual activity but may lead to safer and more responsible choices for young people.

Other intervention studies

The bulk of the studies of the relation of HIV and sexual health education to sexual activity were non-experimental designs. A total of 38 studies (see Table 2) are grouped in this category. Because of this large number, the text describing study outcomes has been divided into sections on sexual activity and the markers of pregnancy, abortion and births; contraceptive use; and condom use, while the table summarizing the findings has been divided by programme type.

Sexual activity, pregnancy, abortion, and births

Fourteen studies reported reductions in sexual activity, pregnancies, births, or abortions (Dycus & Costner, 1990; Daures *et al.*, 1989; Edwards, Steinman, Arnold & Hakanson, 1980; Howard & McCabe, 1990; Mansfield, Conroy, Emans & Woods, 1993; Mellanby, Phelps, Crichton & Tripp, 1995; Nafsted, 1992; National Committee on Health Education, 1978; St. Pierre, Mark, Kaltreider & Aiken, 1995; Schinke, Blyth, Gilchrist & Burt, 1981; Sellers, McGraw & McKinlay, 1994; Slap, Plotkin, Khalid, Michelman & Forke, 1991;

Turner, Korpita, Mohn & Hill, 1993; Young, Core-Gebhardt & Marx, 1992). However, note that the findings of Edwards *et al.* have been re-examined using newer methods of birthrate calculation; results indicate that the provision of clinical services had no effect on birthrates (Kirby *et al.*, 1993). Twenty-one showed no impact of sexual health education on levels of coital activity (Baldwin, Whitely & Baldwin, 1990; Berger *et al.*, 1987; Bernard & Schwartz, 1977; Blanchard, Narring, Michaud & Dubois-Arber, 1993; Davidson & Darling, 1986; de Fine Olivarius, Worm, Petersen, Kroon & Lynge, 1992; Dignan, Denson, Anspaugh & C'mich, 1985; Eisen & Zellman, 1987; Goertzel & Bluebond-Langner, 1991; Herlitz, 1993; Jemmott, Jemmott & Fong, 1992; Kipke, Boyer & Hein, 1993; Kirby, 1985a; Postrado & Nicholson, 1992; Rees & Zimmerman, 1974; Rotherum-Borus, Koopman, Haignere & Davies, 1991; Sakondhvat, Leungtongkum, Kanato & Kuchaisit, 1988; Siegal, DiClemente, Dubin, Krasovsky & Saliba, 1995; Weis, Ranbinowitz & Ruckstuhl, 1992; Wielandt & Jeune, 1992; Yarber & Anno, 1981). One study of school-based clinics reported mixed effects on students' sexual and contraceptive practice across school sites and varying with the priorities of the programmes (Kirby, Waszak & Ziegler, 1991). Marcotte & Logan (1977) described what seems to have been an increase in the percentage of medical students reporting regular sexual intercourse from 70.9% to 75.6%, and frequency of intercourse from 9.4 to 9.7 times per month pretest to post-test. The questions were about regular sexual intercourse and frequency in the last month following a course of only three days' duration, and therefore the increase may have reflected a greater rate of admission of sexual activity due to the intervention rather than an increase in activity *per se*. Moreover, interpretation is difficult, as the statistical significance was not reported. Zuckerman, Tushup & Finner (1976) reported statistically significant increases for male students attending a sexual health course in homosexual experiences and numbers of partners at post-test (see Exceptions).

The Howard & McCabe (1990) study provided an example of the apparently successful use of the *social inoculation* theory of health education, based on the premise that it is possible to "immunize" people against the social and peer pressures that encourage negative health behaviours. That programme targeted 13- and 14-year-old boys and girls, and consisted of five periods of instruction (given by slightly older peers) in combination with a five-period programme on reproduction, family planning, and sexually transmitted diseases. The curriculum focused on identifying and resisting social and peer pressures that might motivate early coital activity. In those schools in which the programme had been implemented, there were lower proportions of male and female students beginning sex than in schools that did not take part in the programme: in the eighth grade 4% as compared to 20% ($P < 0.01$), and in the ninth grade 24% compared to 36% ($P < 0.01$) had become sexually active. Contraceptive use was higher among those sexually active students who had been the recipients of sexual health education. Pregnancy rates for the female students in the programme were also lower; a result both of greater utilization of effective contraception and of less sexual activity. This highlights the importance of reaching both those young people who are, and those who are not, sexually active.

Contraceptive use

A number of studies have demonstrated increased use of contraception among the sexually active following sexual health education (Berger *et al.*, 1987; Blanchard *et al.*, 1993; Eisen & Zellman, 1987; Herlitz, 1993; Howard & McCabe, 1990; Wielandt & Jeune, 1992; Sakondhavat *et al.*, 1988). Other studies have indicated that although sexual health education does not generally produce an increase in coital activity, such education may lead to increases in alternative and safer practices (in terms of pregnancy or HIV transmission) such as masturbation or oral sex (Dignan *et al.*, 1985; Yarber & Anno, 1981; Zuckerman *et al.*, 1976).

Condom use

Eight recently published studies evaluated education campaigns that focused on HIV/AIDS issues and the promotion of condom use (Blanchard *et al.*, 1993; Goertzel & Bluebond-Langner, 1991; Herlitz, 1993; Kipke *et al.*, 1993; Rotherum-Borus *et al.*, 1991; Siegal *et al.*, 1995; Turner *et al.*, 1993; Wielandt & Jeune, 1992). Four of those reported no change in condom use post-test (Goertzel & Bluebond-Langner, 1991; Kipke *et al.*, 1993; Siegal *et al.*, 1995; Turner *et al.*, 1993), but six (the remaining four plus Jemmott *et al.*, 1992; and Mansfield *et al.*, 1993) reported post-intervention increases in condom use with no accompanying increase in sexual activity or lowering of age of first intercourse. For example, in Switzerland, Blanchard *et al.* (1993) serially surveyed first- through fourth-year apprentices in the Swiss canton of Vaud in 1987, 1990, and 1992 regarding their sexual behaviour, knowledge, and attitudes. Over that five-year period, the young people had been exposed to the Swiss Stop-AIDS campaign, which promoted safer, rather than reduced, sexual activity. From 1987 through 1992 there were dramatic increases in regular condom use, and no lowering of age of first intercourse. Slap *et al.* (1991) reported a decrease from 30% to 24% in condom use among the sexually active from baseline to post-intervention. This was due to the fact that seven baseline condom users were not sexually active at follow-up.

These findings from non-experimental studies demonstrated that education can lead to increases in the extent to which safer sex is practiced but does not necessarily result in more sexual activity. Interpretation of the findings of six studies remains speculative, as details of statistical significance were not provided for observed differences (Dycus & Costner, 1990; Edwards *et al.*, 1980; Marcotte & Logan, 1977; National Committee on Health Education, 1978; Sakondhavat *et al.*, 1988; Schinke *et al.*, 1981).

Cross-sectional surveys

In the nine cross-sectional surveys reviewed, study participants were not assigned randomly to treatment and control conditions, nor were interventions manipulated by the investigators. Rather, respondents were surveyed as to whether they had or had not received sexual health and/or contraceptive education and then

compared with respect to subsequent sexual behaviour. With one exception (Marsiglio & Mott, 1986; see Exceptions), survey investigations did not report any increase in sexual behaviour (either lower age of onset or greater number of partners) associated with receiving sexual health education (Anderson *et al.*, 1990; Dawson, 1986; Furstenberg, Moore & Peterson 1985; Pick-de-Weiss, Diaz-Loving, Andrade-Palos & David, 1990; Ku, Sonenstein & Pleck, 1992; Moreau-Gruet, Ferron, Jeannin & Dubois-Arber, 1996; Philliber & Tatum, 1982; Spanier, 1978; Wellings *et al.*, 1995). Three studies reported greater contraceptive use among those respondents who had received sexual health education (Ku *et al.*, 1992; Dawson, 1986; Marsiglio & Mott, 1986) (see Table 3).

A large-scale study by Ku *et al.* (1992) surveyed over 1800 males 15 through 19 years of age and found that most of them had received formal education on HIV/AIDS, birth control, and resisting sexual activity. The analysis revealed an association between education and decreased numbers of sexual partners, lower frequency of intercourse, and increased condom use. The effects were found to be significant even after potentially confounding variables such as age, ethnicity, and religion were controlled for. The development of skills for resisting intercourse was found to be particularly important in reducing levels of sexual activity. The authors concluded: "In many communities, concerned parents or community members have feared that education about sex or AIDS may increase sexual activity by condoning contraception; this analysis does not indicate such an association." (Ku *et al.*, 1992, p. 105).

Overall, the evidence from cross-sectional surveys has failed to find an association between sexual health education and greater sexual involvement, irrespective of whether the recipient was or was not sexually experienced. A major drawback of this type of study design is that interpreting changes in sexual practices as an outcome of course participation is always limited by the self-selecting nature of the groups to be compared. Perhaps those students enrolling in a sexual health course are more amenable to adopting new sexual practices than those who do not choose such a course. Without randomization, such confounding factors remain uncontrolled for.

International or national comparison studies

Another source of information examined was the cross-national and intranational comparative literature. Those studies (see Table 4) detail the impact of sexual health education on sexual activity and its outcomes, while taking into account reproductive and sexual health policy and services in differing countries, states, or cultures (Siedlecky, 1987; Edelman & Pittman, 1986; Singh, 1986; Jones *et al.*, 1985; Kroger & Wiesner, 1981). Such reviews provide an interesting and valuable background against which the findings of more narrowly focused investigations can be interpreted.

All five of the comparison studies indicated that when and where there was open and liberal policy as well as the provision of sexual health education and related services (e.g., family planning) there were lower pregnancy, birth, abortion, and STD rates. For example, Jones *et al.* (1985) used a 37-country comparison of patterns of adolescent pregnancy to examine the impact of, *inter alia*, government education policy, financial support for abortion and single parents, religiosity, openness about sexual health, ethnicity, and marriage laws, on adolescent pregnancy and sexual activity. Findings from that study indicated that those countries that rated higher on openness about sex were also those that experienced the lowest birthrates; teaching of birth control in schools was associated with low adolescent fertility; and low birth rates were associated with low abortion rates. In a detailed analysis comparing the United States with Canada, England and Wales, Sweden, the Netherlands, and France, the United States was found to have by far the highest rates of adolescent pregnancy, birth, and abortion. Differences in amount of financial support for unmarried mothers, minority issues, and adolescent unemployment did not account for the discrepant birth rates. If discouraging the discussion of sex and access to family planning services in an effort to deter or shield adolescents from sex were effective policies, the United States would have been expected to have one of the lowest adolescent pregnancy rates. Instead, for 1980, 15- through 19-year-olds in the United States had a pregnancy rate of 96/1000 females, over double that of the countries ranked second (England and Wales: 45/1000) and nearly seven times that of the sexually liberal Netherlands (14/1000). Countries that address young people's sexual health in a frank, open, and supportive manner experienced fewer of the negative consequences of sexual activity, yet did not see greater sexual involvement. Jones *et al.* conclude that "increasing the legitimacy and availability of contraception and sexual health education (in its broadest sense) is likely to result in declining adolescent pregnancy rates" (1985, p. 61).

A complementary review by Singh (1986) examined, on a state-by-state basis within the United States, factors linked to variations in adolescent pregnancy. With regard to education about sex, state policy and its implementation varied widely within and between states. Sexual health education was quantified by documenting the proportions of adolescents receiving sexual health education in junior and senior high schools, the amount of class time devoted to that instruction, whether parental consent was required, and the openness of each state's policy towards permitting sexual health education. The only statistically significant finding was an inverse relationship between the proportion of senior high school students receiving sexual health education and pregnancy rates. Unfortunately, this study did not gather direct measures of levels of sexual activity, only pregnancy rates. Therefore, it is not clear whether lower pregnancy rates were due to less sexual activity or more effective contraceptive use.

There is an interesting contrast between the Singh (1986) analysis and the aforementioned analysis by Jones *et al.* (1985). Within the United States a higher abortion rate was correlated inversely with birth rates. The international study, however, found a positive correlation between birth and abortion rates: that

is, those countries with low birth rates also experienced low abortion rates, and vice versa. By way of explanation, it is possible that in the United States the pregnancy rate already was high, and birth rates were offset only by the number of young people deciding on abortion. In other countries, adolescent pregnancy rates were low overall, as were birth and abortion rates, because of effective contraception (given levels of sexual activity that were essentially comparable). This interpretation is, of course, speculative.

International and intranational comparison studies of this type reinforce the findings noted in the previous sections, and indicate that sexual health education either does not have an adverse effect on unprotected sex and adolescent pregnancy, or may even promote more appropriate choices around sexual health. Furthermore, there is evidence that policy, service provision, and prevailing attitudes may interact differently from one socio-cultural context to another.

Exceptions

Three studies appear as anomalies with respect to the general trends described here. The first compared students taking psychology in college and those enrolled in a sexual health course (Zuckerman *et al.*, 1976). There were no differences between experimental and control female students in sexual behaviour from pretest to post-test. For male students, however, those in the experimental group reported greater numbers of masturbatory and orgasmic experiences at post-test than did controls (controlling for pretest measures). Although there were no increases in the number of heterosexual partners, there were significant increases among males in the experimental group, but not the control group, in number of homosexual partners and homosexual sexual experiences at post-test. The authors speculate that the increase may represent coming-out behaviour coincidental to the course, or perhaps a greater willingness to admit to homosexual activity stemming from the frank treatment of the subject during the course. Either way, the findings were confounded by the potential relation between treatment group sampling (i.e., self-selected enrolment) and study outcome measures.

Christopher & Roosa (1990) evaluated an abstinence-only programme, through a quasi-experimental study design, which included 320 male and female students. The programme viewed abstinence as the most desirable way of preventing adolescent pregnancy, and educators and students were dissuaded from discussing birth control. An increase in mean level of non-coital sexual activity (such as breast touching) from pretest to post-test for male programme recipients, but not controls, was the only statistically significant finding. Coital activity remained stable over time for both groups. A non-independent replication of this study (Roosa & Christopher, 1990) revealed the same trends. The four other abstinence-based programmes included in this review (Jorgensen *et al.*, 1993; Miller *et al.*, 1993; St. Pierre *et al.*, 1995; Young *et al.*, 1992) failed to confirm those findings. The Christopher & Roosa analyses challenge the assertion that only

those approaches that advocate abstinence will achieve decreases in sexual involvement or guard against promiscuity. Whatley & Trudell (1993) questioned the validity of two abstinence programmes as comprehensive sexual health education. Criticisms included: insufficient and inaccurate information; reliance on scare tactics; ignoring the realities of adolescents' lives; reinforcing gender stereotypes; lack of respect for economic and cultural diversity; presenting only one side of controversial issues; and inadequate evaluation of programme outcomes. An abstinence-only approach ignores the developmental diversity in young people's sexual health, and marginalizes, and possibly alienates, those who, for whatever reason, do not adopt the "no sex" option. Further, a programme that precludes the discussion of prophylactic measures so as to not undermine the abstinence message misses the opportunity to educate students who will become sexually active in the future.

The third study that reported an association between sexual health education and increased sexual activity was by Marsiglio & Mott (1986). In their sample of 14- through 22-year-olds followed over a five-year period, prior exposure to a sexual health education course was associated positively and significantly with the initiation of sexual intercourse at 15 and 16 years of age, but not at 17 or 18 years of age. As with any other statistical data, correlation does not imply causality, but this result should not be overlooked. The effect of sexual health education, however, was less important (according to the statistical model proposed by the authors) than infrequent church attendance, parental education of less than 12 years, and ethnicity. The authors concluded that "it is unlikely that sexual health education courses will substantially alter teenage [sexual] behaviour" (Marsiglio & Mott, 1986, p. 161).

Discussion

The overwhelming majority of reports reviewed here, regardless of variations in methodology, countries under investigation, and year of publication, found little support for the contention that sexual health education encourages experimentation or increased sexual activity. The impact, if any, of education strategies is in the direction of postponed initiation of sexual intercourse and safer practices, such as the effective use of contraceptives. Only three studies out of 68 reported a relation between sexual health education and increased sexual interaction. What light those three studies can shed on the debate may be compromised variously because of inadequate study design (non-randomized allocation of subjects to experimental and control conditions; Zuckerman *et al.*, 1976), marginal effect in the context of other variables (Marsiglio & Mott, 1986), and reliance on an abstinence-only approach (Christopher & Roosa, 1990).

Methodological limitations

However, there are a number of methodological problems that limit the usefulness of the findings of many of the studies reviewed here. First, nine studies did not include levels of significance for reported increases and decreases in outcome measures (Blanchard *et al.*, 1993; Dycus & Costner, 1990; Edwards *et al.*, 1980; Herlitz, 1993; Marcotte & Logan, 1977; National Committee on Health Education, 1978; Rees & Zimmerman, 1974; Schinke *et al.*, 1981; Williams *et al.*, 1985). Significance levels are essential for differentiating those alterations in behaviour to be expected by pure chance from those associated with an intervention. In addition, most studies failed to report exact *P*-values associated with non-significant results and whether a statistical test was one-tailed or two-tailed. A non-significant two-tailed result at the standard 0.05 error level may become significant if submitted to a one-tailed test (see Yarber & Anno, 1981, and Zuckerman *et al.*, 1976, for example). The risk of inflated Type II error cannot be evaluated if exact test statistic details are not given for non-significant results³.

Second, five of the 21 intervention studies, using control groups and comparisons of pretest and post-test data, failed to assess the interactive effect of time and intervention (Bellingham & Gillies, 1993; Davidson & Darling, 1986;

³ If analyses are testing for effects in only one direction, it must be noted that it is only those effects that are being assessed, and that changes in the other direction remain untested. Further, if two-tailed tests are used with a standard error rate of 0.05, this will mean that the risk of Type II error (accepting the null hypothesis of no difference when it should be rejected) is actually 0.1. Hence the error rate should be halved to 0.025 for two-tailed tests to maintain an overall Type II error rate of 0.05.

Goertzel & Bluebond-Langner, 1991; Kipke *et al.*, 1993; Yarber & Anno, 1981). One of the five made only between-group comparisons at pretest and post-test (Bellingham & Gillies, 1993). It is possible for a significant group-by-time interaction to occur without between-group differences at either pretest or post-test. The other four studies evaluated within-group pretest to post-test differences separately for experimental and control groups. Again, important information regarding the interactive effect of time and intervention is lost with such a design. The remaining 16 studies used repeated measures analysis including a group-by-time interaction term, between-group differences in change scores from pretest to post-test, and/or analysis of covariance adjusted for pretest measurements.

Third, drawing conclusions from some studies was difficult because post-test measurements were made so close to programme completion. This is particularly so for courses of short duration (Bellingham & Gillies, 1993; Christopher & Roosa, 1990; Marcotte & Logan, 1977). Post-test measures of behaviour may overlap the time period in which baseline measures were taken, particularly if measures are monthly or yearly averages. At best this masks change and at worst it confounds results. Longer follow-up time allows for sufficient numbers to accumulate that statistical analysis of change may be validly undertaken (Stout & Kirby, 1993). Delayed post-test measurements will also yield information on the durability of change, and assist in the identification of correlates of sustained change.

Fourth, in evaluations that take an experimental approach, the non-randomization of subjects to control and experimental conditions means that results will always be subject to self-selection bias, unless the sampling procedure takes account of this potential confounder (see sampling procedure of Bernard & Schwartz, 1977). Yet the largest group of studies in this review employed non-experimental designs. Oakley *et al.* (1995), in a critical review of the HIV/AIDS prevention literature, questioned the ability of non-randomized-controlled studies to address adequately biases introduced in the sample selection process⁴.

Finally, when comparing experimental and control groups, researchers should be mindful of the heterogeneity in sexual development of the students that comprise these groups. Evaluation should include some assessment of interactive effects of sexual developmental stage and the intervention. Differences between entire groups only reveal aggregate change, which may veil important differential change in a developmentally diverse group. As far as numbers will allow, comparisons should be made between developmentally comparable subjects from the control and experimental groups.

⁴ This review should not be read as endorsing randomized controlled designs or any other experimental design over other, non-experimental approaches to evaluation of health promotion interventions. It merely notes that in an experimental approach certain hazards are likely to be encountered depending on the techniques employed. In an area as complex as health promotion, where behaviour and social practices are informed by a variety of information sources and understood within particular discourses, it would be unwise to limit research to any one particular paradigm or to claim that there is only one way to evaluate results.

To summarize, inadequate attention has been paid to evaluation of sexual health education and therefore programmes have not benefited from lessons learned in the past. Rigorous evaluation should include valid sampling and methods of analysis, appropriate comparison groups, and sufficient follow-up periods. Intervention evaluation should also contain sufficient detail regarding the interplay between the developmental stage of subjects and the intervention strategy used.

HIV, sexual health, and pregnancy

There are difficulties in evaluating the impact of HIV/STD prevention in the context of sexual health education when historically this type of education has been directed at reducing unintended pregnancy; many of the studies cited here used unplanned pregnancy as the behavioural outcome for programme evaluation. As it is possible to be protected against pregnancy while remaining vulnerable to STD transmission (e.g., by the use of oral contraceptives), unintended pregnancy is an incomplete evaluative tool for HIV/sexual health education. Sexual health education needs to address in its design and evaluation the attendant problem of transmission of HIV and other STDs.

Generalizability of findings

There is comparatively little accessible, peer-reviewed data from countries outside the United States. This raises a question as to whether intervention principles generated primarily within one cultural context can be generalized to other situations. It would be instructive to compare the sexual health education policy, content, and practices within countries with low adolescent pregnancy rates (e.g., Sweden and Denmark) or vastly different cultural and economic circumstances (e.g., developing countries) with those of North America. However, there is a comparative dearth of information available from Europe (Visser & van Bilsen, 1994) and evaluations from the developing world are almost entirely lacking. Perhaps due to limited economic resources, sexual health and HIV programme evaluations may be deemed too costly and secondary in importance to the provision of basic needs. Programming in these countries may therefore have to rely upon models formulated elsewhere.

Broader education issues

Realistic expectations of HIV/sexual health education

At a broader level, there is much more to HIV and sexual health education than taking individuals and exposing them to information designed to protect and promote well-being. For example, individual teacher competence has been shown to interact with programme content, influencing achievement of the

aims of the programme to an appreciable degree (de Gaston, Jensen, Weed & Tanas, 1994). There is also a diversity of sources of information about sex to which young people either deliberately or inadvertently are exposed. It cannot be assumed that what is taught will be translated directly into behaviour, hence the weak association between sexual knowledge, attitudes, and behaviours.

The question is not whether children will get sexual health education, but how and what kind they will receive. It is impossible to hide children from sexual influences. Adult role models, television, advertisements and parents bombard young children with them ... silence and evasiveness are just as powerful teachers as a discussion of the facts (McNab, 1981, p. 22).

Kirby (1985b) asserted that although the accusation that sexual health education incites sexual activity is unfounded, it is unrealistic and overly optimistic to construe sexual health education as the panacea for unacceptably high rates of adolescent STDs and unintended pregnancy. Sexual health education represents a valuable resource that informs young people's sexual contact but often it is not the most influential, thus the potential of education in the development of behavioural patterns must be assessed in the context of other influences on the sexual health of young people (Goldman & Goldman, 1981; Spanier, 1976; Stout & Rivara, 1989).

Features of successful programmes

Although it may be premature to state that education programmes and provision of clinical services unequivocally reduce STD and unintended pregnancy rates, the evidence here for reductions in their antecedents suggests that such interventions have the potential to achieve those outcomes. This raises the question as to which features of past interventions are associated with reductions in sexual intercourse and in unprotected sexual intercourse. Several researchers have turned their attention to this question, most notably Douglas Kirby and his associates (Kirby, 1992; Kirby *et al.*, 1994; Kirby, 1995). The findings of these three reviews have given rise to a number of identifiable features associated with successful outcomes, which will be briefly described here. The nine features identified in his 1995 review of 50 studies of interventions with young people below the age of 19 years are summarized below, as these support and reflect his earlier findings.

Kirby (1995) found that the following features were common characteristics of programmes that successfully achieved delays in first intercourse, and/or increased the use of contraception or condoms:

1. Social Influence Theory, Social Learning Theory or Cognitive-Behavioural theories of behaviour underpinned the interventions;
2. the programmes were focused on the specific aims of delayed intercourse and protected intercourse;

3. the interventions were at least 14 hours in length or there was work in small groups to optimize the use of time in shorter programmes (Vincent, Geiger & Willis, 1994 also flagged the limited effectiveness of single, isolated interventions);
4. a range of interactive activities such as role-playing, discussion, and brainstorming were employed such that participants personalized the risks and were actively involved in the process of developing strategies;
5. clear statements were given about the outcomes of unprotected sex and how those outcomes could be avoided;
6. the social influences of peers and media to have sex or unprotected sex were identified, and strategies to respond to and deal with such pressures were generated;
7. there was clear reinforcement of values supporting the aims of the programmes and development of group norms against unprotected sex relevant to the age and experiences of the participants;
8. programmes included activities that allowed participants to observe in others, and rehearse themselves, communication and negotiation skills, yielding greater effectiveness in achieving delays in initiation of intercourse or protected sex; and
9. there was effective training for those leading interventions.

Additional issues raised in Kirby's reviews and by other researchers (Christopher, 1995; Kelly, 1995; Schaalma *et al.*, 1996; Schaalma, Kok & Peters, 1993) were timing of education, the placement of school education within a broader context reinforcing and supporting the aims of classroom activities, and skills training. First, education programmes appear to have greater impact if they are given prior to the onset of sexual activity. It has been suggested that it may be easier to establish the desired patterns of behaviour from the beginning of sexual involvement, rather than trying to change pre-existing habits (Kelly, 1995; Schaalma *et al.*, 1993). Second, although Kirby (1995) recommends that education be narrowly focused, this refers to the number of topics to be covered rather than the number of levels on which the same message is conveyed. Since most education takes place in the school context, a supportive environment beyond the classroom is desirable. This could mean having school-wide activities, making connections with sexual health centres located near the school, or incorporating sexual health messages in community activities. That is, the broader context of young people's social environment could be engaged to reinforce the teachings made in the classroom. Third, the inclusion of skills rehearsal has proved pivotal to the success of sexual health/HIV programmes in improving young people's confidence with, and acquittal of, sexual negotiation and communication (see, for example, Ku *et al.*, 1992).

The social context: gender

The social context of human sexual health has recently been receiving greater attention, particularly in the HIV/AIDS literature (Kippax, Crawford, Waldby & Benton, 1990; Kirby, 1985b; Moore & Rosenthal, 1990; Thomson, 1994). Choosing to have or not to have sex or to use condoms has social meanings, consequences, and implications for public and private identity (Hollway, 1984). In the British *Women, Risk and AIDS Project* (Thomson & Scott, 1991), which studied 500 young women 16 through 21 years of age, the authors examined the perceived appropriateness of the sexual health education the women had received.

By far the most common criticism of sexual health education at school was that it had little or no relationship to the real choices and pressures around sexual health that affected the young women in question... the concentration upon the biology of human reproduction was consistently criticised for taking no account of the context in which sexual behaviour takes place nor the personal and social consequences of such behaviour (Thomson & Scott, 1991, p. 6).

This also highlights the relevance of gender in the delivery of education regarding HIV and sexual health. Male-to-female transmission of HIV, for example, was estimated in one study of sero-discordant couples to be 23% (Padian *et al.*, 1987). In the Masaka district in Uganda, prevalence of HIV in girls aged between 13 and 19 years old is 20 times that of boys in the same age group (The status and trends of the global HIV/AIDS pandemic, 1996). Increased risk arises out of not only a physical vulnerability, but also a social one. Often responsibility for contraception and STD protection is located with females. This is so even in the case of condom use, despite their being a male controlled prophylactic. Messages to that effect make use of the stereotype that women are responsible for their own sexual conduct and that of their actual or potential male partners. Women are implicitly asked to step out of their other gender stereotype of passivity and guide the sexual encounter to safety with respect to disease transmission. There is an inherent contradiction in asking women to ensure the use of condoms or discouraging penetrative practices, when their culturally legitimized role in most cultures is one of passivity (Waldby, Kippax & Crawford, 1993). That is, the meanings and assumptions that currently define and inform young women's and young men's sexual lives are often at odds with the strategies proffered by education campaigns (Kippax *et al.*, 1990; Lever, 1995; Thomson & Scott, 1991). This is most notable in steady or regular relationships where, in comparison to casual encounters, condoms are much less likely to be used consistently (Plitcha, Weisman, Nathanson, Ensminger & Robinson, 1992; Rodden *et al.*, 1996).

The importance of gender considerations in formulating and delivering HIV and sexual health education can be found in other studies focusing on practice. The average age difference between females and their first male partners has been estimated at 1.8 years in the United States and 2.3 years in Sweden (Schwartz, 1993); in Norway 83.7% of girls but only 28.4% of boys reported an older partner

at first intercourse (Træen, Lewin & Sundet, 1992). Females are also more likely to state that their first partner was a regular boyfriend (Træen *et al.*, 1992; Faulkenberry *et al.*, 1987). In a study examining the correlates of early coitus, the partner's insistence was the single most important reason for engaging in their first sexual intercourse for 5% of boys, but 33% of girls (Faulkenberry *et al.*, 1987). In a study by Maxwell, Bastani & Yan (1995), in sex with a regular or steady partner only 11.8% of male respondents but 40.9% of female respondents reported that the partner made the decision not to use condoms. Further, not only are condoms less likely to be used in a steady relationship, but condom use also decreases as sexual experience increases (Kraft, Rise & Træen, 1990; Dunne *et al.*, 1994; Moreau-Gruet *et al.*, 1996; Leland & Barth, 1992).

It could therefore be argued that women are called upon to demand protected intercourse precisely when the odds appear to be against their success: that is, they are in a (regular) relationship they may believe does not require them to use condoms; they are with an older partner who is less likely to be using condoms as he is more experienced and is often in charge of the decision-making about condom use; and they are operating in a culturally determined model that assigns women a passive role in the sexual encounter. It is not that it is impossible, nor is it unreasonable to want women to ask for means by which they can protect themselves from unwanted outcomes of sexual intercourse (see, for example, the description of the development of "Girl Talk" in Guthrie *et al.*, 1996). But it is the gender system with which education must engage, not just women (du Guerny & Sjöberg, 1993): the negotiation of safe sexual practice challenges the culturally constructed notions of femininity and masculinity. Therefore seeking to change female behaviour without taking into account its relationship to male behaviour limits the viability of such strategies. Managing the vulnerability of young women in sexual health and HIV education may also mean addressing young men and the notions of gender and sexual identity through which they understand their experiences.

Implications for programme planners

*D*esigning high quality programmes is a major challenge for educationalists and policy makers (BMA Foundation for AIDS, 1997), often overwhelmed by the array of data and by pressures from public opinion. This review provides a foundation for policy makers to argue for the continued development of programmes on life skills, HIV and STD, sexual health, and reproductive health. The major points raised are these:

- education on sexual health and/or HIV does not encourage increased sexual activity;
- good quality programmes help delay first intercourse, and protect sexually-active youth from STD, including HIV, and from pregnancy;
- responsible and safe behaviour can be learned;
- sexual health education is best started before the onset of sexual activity;
- education has to be gender sensitive for both boys and girls;
- young people's sexual health is informed by a wide range of sources;
- young people are a developmentally heterogeneous group and not all can be reached by the same techniques.

In addition, studies show that effective education programmes:

- are grounded in Social Learning Theory;
- have focused curricula, giving clear statements about behavioural aims, and feature clear delineation of the risks of unprotected sex and methods to avoid it;
- focus on activities that address social influences;
- teach and allow for practice in communication and negotiation skills;
- encourage openness in communicating about sex;
- equip young people with skills for decoding media messages and their underlying assumptions and ideologies.

The challenge for those who plan for the provision of HIV/sexual health education is to take the discoveries made by researchers and apply them in practice. Programme developers need to resist the temptation to design on the basis of convention and current epidemiological data, and rely rather on evaluated best practice and trend analysis. Grounding HIV/sexual health education in lessons

learned from past research can provide much-needed direction for programme formulation. Experience has shown that writing learning materials and curricula without a policy framework that has foundations in research can mean that planners for Ministries of Education never get beyond the debate over whether to teach HIV/sexual health, who should teach it, and at what grade (Ministry of Education, Barbados, 1993; Ministry of Education and Culture & UNICEF, Zimbabwe, 1993). Previous programmes and their evaluations are tools by which planners can fine tune their approaches and also address the concerns of interested parties. Curriculum experimentation (small scale programmes with evaluation), policy development, and macro-planning can be achieved in a timely fashion provided that those concerned are consulted and informed. It should be made clear to those people what the overall aims of planned interventions are. If aims are clearly stated, evaluation and outcome measures can be formulated in terms of the achievement of those aims. For example, for school AIDS education the aim could be “to increase towards full coverage the percentage of young people attending school, who learn how to ... reduce the risk of infection” (UNAIDS, 1997, p. 2). The impact of subsequent HIV/AIDS interventions can easily be framed within these goals.

Unfortunately, while many programmes are innovative and well received, their effects remain unmeasured. Any advances made are, therefore, unlikely to be carried into future programmes. Policy makers with concerns about public reaction have no evaluation data to support their policies. However, guidelines (NIGZ Netherlands Institute for Health Promotion and Disease Prevention, 1995; WHO & UNESCO, 1994; National Association of State Boards of Education, 1996), examples of policies and programmes (Ministry of Education, Barbados, 1993; Ministry of Education and Culture & UNICEF, Zimbabwe, 1993), quality standards (UNAIDS, 1997), and assessment and evaluation instruments (WHO & UNESCO, 1994; Division of Adolescent and School Health, 1995) are currently available for developers to use in policy and curriculum planning, implementation, and evaluation. Further, demographic analysis, the evolution of technology, and trends in the financing of education (World Bank, 1995) can help point to the most cost-effective strategies. Hence, there are resources available to help with effective evaluation. Although the impact on the education system of an innovation such as HIV education can take some years to be estimated (Shaeffer, 1994), policies should allow for an evaluation component in programme planning to facilitate this process. Increased investment in evaluation, in its broadest sense, is needed to give solid direction to new curricula and to demonstrate that the effort made benefits both the participants and the wider society.

Conclusion

*I*nfluences on young people's sexual lives are not restricted to explicit messages about sex. In pursuit of an appropriate and effective way to promote healthy, positive sexual behaviour, engagement with those influences is vital. It is important that policy makers, programme managers, and teachers be aware that the evidence indicates that safer sexual practice among young people may be achieved through education. Future education programmes need to incorporate the features that have been associated with successful interventions in the past, as well as including their own evaluation procedures. Programme evaluation should be grounded in solid study design and valid and appropriate statistical techniques. The gender and developmental stage of the student are issues for the educator and researcher at both the design and evaluation stages of sexual health/HIV education development. Failing to provide appropriate and timely information and services to young people for fear of condoning and encouraging sexual activity is not a viable option.

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Tables

Table 1: Controlled intervention studies

Table 2: Other intervention studies

Table 3: Cross-sectional surveys

Table 4: International or national comparison studies

Table 1: Controlled Intervention Studies: Summary of Study Design, Type of Intervention, and Key Findings *

| Study | Intervention | Sample | Key findings for impact on sexual behaviour |
|---|--|---|--|
| Bellingham & Gillies 1993, USA | Discussion & role play based around a peer produced comic play dealing with HIV, safer sex, values, attitudes re: people with HIV over 2 weeks | N = 164 cont. & 173 exp. M & F youth centre trainees aged 16 through 19 years | <ul style="list-style-type: none"> • No differences between experimental & control groups at pretest or immediate post-test in percentage sexually active in the last year (no <i>P</i>-value), or in number of partners ($\chi^2 = 0.15$, <i>df</i> = 2: NS) • No impact on condom use |
| Kirby <i>et al.</i> 1991, USA | 15 x 1 period skills-based lessons focusing on contraception & postponing sexual intercourse | N = 329 cont. & 429 exp. M & F aged 15 through 18 years | <ul style="list-style-type: none"> • For pretest virgins 29% of experimental & 38% of control subjects became sexually active by 18 months follow-up (<i>P</i> < 0.05) • Significant reduction in proportion initiating unprotected sex after 18 months (experimental: 7% compared to control: 13%; <i>P</i> < 0.05) |
| Kvale <i>et al.</i> 1996, Norway | 10-14 hours in 2 days peer education on STDs, pregnancy, barriers to safe sex, decision-making & implementation, through discussion | N = 1065 cont., 360 in intervention M & F aged 16 through 20 years | <ul style="list-style-type: none"> • No difference between pretest virgins in intervention (30%) and controls (28%) on initiation of intercourse at 12 months follow-up (no <i>P</i>-value given) |
| Levy <i>et al.</i> 1995, USA | 15 sessions from 7th to 8th grade on STD/HIV prevention, pregnancy, resistance & negotiating skills by lecture, discussion & videos | N = 124 cont. & 186 exp. M & F in 7th grade | <ul style="list-style-type: none"> • No difference between newly sexually active students from treatment and control conditions on number of sexual partners in last 12 months (<i>P</i> > 0.1) • Treatment group marginally more abstinent in last 30 days (73.7%) compared to controls (65.3%; <i>P</i> < 0.1) |

* See end for explanation of abbreviations

| Study | Intervention | Sample | Key findings for impact on sexual behaviour |
|--|---|--|---|
| Main <i>et al.</i> 1994, USA | 15 sessions over 1 semester HIV prevention using social cognitive theory on risk behaviour norms, factual knowledge & skills development | N = 419 cont. & 560 exp. M & F in 9th through 12th grade | <ul style="list-style-type: none"> • At 6-month follow-up no difference in initiation of coitus in experimentals (16%) compared to controls (17%: $P = 0.98$), or frequency of intercourse in those active at pretest ($P = 0.533$) • Of those sexually active at pretest, experimental group reported fewer sexual partners in past 2 months compared to controls at post-test ($P = 0.046$) |
| Smith, 1994, USA | 8 sessions incl. self-esteem, STDs communication, decision-making, sexuality in workshops plus sessions using role-playing for skills & negotiation rehearsal | N = 60 cont. & 60 exp. M & F, mean age = 15.1 years | <ul style="list-style-type: none"> • Greater reduction from baseline to immediate follow-up in frequency of intercourse in the last 2 months for experimentals (3.5/month to 1.19/month) than controls (3.95/month to 2.74/month) $P < 0.05$ • Significant increase from baseline to immediate follow-up in contraceptive use due to intervention ($P < 0.005$) |
| Walter & Vaughan, 1993, USA | 6 x 1 period over 2 days AIDS prevention curriculum using health belief, social cognitive & social influence models incl. condom use negotiation & refusal of sex | N = 577 cont. & 739 exp. M & F in 9th & 11th grade | <ul style="list-style-type: none"> • At 3-month follow-up, significant reduction in experimental group compared to controls in sexual intercourse with partners who used drugs intravenously ($P < 0.05$) • Greater monogamy ($P < 0.05$) and consistent condom use ($P < 0.05$) in experimental group compared to controls • No significant difference in changes to rates of abstinence from pretest to post-test ($P = 0.6$) |

| Study | Intervention | Sample | Key findings for impact on sexual behaviour |
|--|--|--|--|
| Zabin <i>et al.</i> 1986, USA | 3-year sex education & counselling programme; contraceptives available at clinic nearby | <i>N</i> = 1749 cont. & 1201 exp. M & F aged 13 through 18 years | <ul style="list-style-type: none"> • Delayed initiation of intercourse for those who took part in the 3-year programme (particularly for those age < 16) e.g., first coitus at age 15 at pretest approx. 57% compared to 3 years post-test approx. 43% (no <i>P</i>-value available) • Pregnancy rate declined in education recipients by 30.1%, but increased by 57.6% in controls from baseline to 28-month follow-up (no <i>P</i>-value given) |
| NON-SCHOOL-BASED | | | |
| Danielson <i>et al.</i> 1990, USA | 1 hour counselling session incl. sexually explicit presentation on biology, reproduction, contraception, STDs, AIDS, condom use & abstinence | <i>N</i> = 971 M, age 15 through 18 years | <ul style="list-style-type: none"> • No significant difference between experimental (30%) and control (34%) pretest virgins who became sexually active by 12-month follow-up (no <i>P</i>-value given) • Greater contraceptive use at last intercourse by those in experimental group compared to controls who became sexually active during programme (OR: 2.53; <i>P</i> < 0.01) |
| Kirby <i>et al.</i> 1989, USA | Direct mailing of pamphlet on contraception, STDs, AIDS & order form for free condoms | <i>N</i> = 1033 cont. & 984 exp. M aged 15 through 18 years | <ul style="list-style-type: none"> • No difference between those reading pamphlet (57%) and controls (54%) on whether ever had intercourse (<i>P</i> > 0.05) at 5 weeks post-test • Those reading pamphlet had experienced significantly less acts of intercourse ever (mean 13.5) than controls (15.5; <i>P</i> < 0.05) |

| Study | Intervention | Sample | Key findings for impact on sexual behaviour |
|--|--|---|--|
| ABSTINENCE PROGRAMS | | | |
| Christopher & Roosa 1990, USA | 6 sessions incl. sex refusal skills, self-esteem, consequences of sex, life goals & family values | <i>N</i> = 129 cont. & 191 exp. M & F aged 12 through 13 years | <ul style="list-style-type: none"> • At immediate post-test there was a significant increase in mean lifetime sexual interaction for those taking the programme ($P < 0.02$), but not for controls • No significant differences in coital behaviour (no <i>P</i>-value given) |
| Jorgensen <i>et al.</i> 1993, USA | 6 week abstinence-based pregnancy prevention programme incl. self development, family values, pregnancy & STDs | <i>N</i> = 52 cont. & 39 exp. M & F 7th grade | <ul style="list-style-type: none"> • At 6-month follow-up, for pre-programme virgins there was a marginal difference in initiation of sexual activity in recipients of education (23%) compared to controls (50%) $P = 0.051$ |
| Miller <i>et al.</i>, 1993, USA | Home-based 6 x 20 min. sex education videos discussing puberty, abstinence, gender equality, sexual anatomy, decision-making and refusal-of-sex skills | <i>N</i> = 290 cont. & 258 exp. with 7th & 8th grade M & F children in culturally Mormon area | <ul style="list-style-type: none"> • Follow-up measures taken at 3 and 12 months • Low rates of sexual intercourse overall (3-5%) • Significant increase in sexual interaction over time ($P < 0.001$) for both groups, but no group by time interaction ($P = 0.662$) |

| Study | Intervention | Sample | Key findings for impact on sexual behaviour |
|---|---|--|---|
| PUBLIC CAMPAIGNS | | | |
| Vincent <i>et al.</i> 1987, USA | Public education (children, parents, teachers, community leaders) on reproduction, contraception, decision making, communication; sex education from K-12 | Estimated pregnancy rates for F aged 14 through 17 years | <ul style="list-style-type: none"> • From baseline to between 2 & 3-year follow-up birthrate per 1000 females in target area of intervention county dropped from 60.6 to 25.1 compared to control area (66.8 to 52.4: $P < 0.01$) • In 3 non-intervention counties the comparable rates were 52.9 to 58.3 ($P < 0.01$), 34.8 to 51.2 ($P < 0.01$), and 38.7 to 52.6 ($P < 0.01$) per 1000 females |
| Williams <i>et al.</i> 1985, USA | At least 1 x 50-minute education including contraception, STDs, decision-making skills & values; provision of contraceptive services | Birth rates of $N = 4,278$ F 11 through 18 years of age | <ul style="list-style-type: none"> • At 2 years follow-up, birth rates per 1000 females declined from 24.3 to 19.7 in target counties compared to an increase of 24.7 to 26.1 in control counties (no P-value given) • Relative risk of a female becoming pregnant in control county compared to target county: 1.32. |

M = males, F = females, cont. = control subjects, exp. = experimental subjects

Table 2: Other Intervention Studies: Summary of Study Design, Type of Intervention, and Key Findings *

| Study | Intervention | Sample | Key findings for impact on sexual behaviour |
|--|--|--|--|
| HUMAN SEXUALITY COURSES | | | |
| Baldwin <i>et al.</i> 1990, USA | 10 week human sexuality course on STDs/AIDS, contraception through lectures & readings | N = 107 cont. & 141 exp. M & F freshman to senior sexually active students | <ul style="list-style-type: none"> • At immediate post-test, no significant differences in number of vaginal or oral partners for experimental or control groups since the course began ($P > 0.05$) • No significant changes in condom use during vaginal or oral sex for experimental or controls pre- to post-test ($P > 0.05$) |
| Dignan <i>et al.</i> 1985, USA | 3 hours x 15 week human sexuality course (no course content details given) | N = 103 cont. & 101 exp. M & F sophomore year students | <ul style="list-style-type: none"> • Significant difference at pretest in levels of premarital intercourse for exp. (67%) compared to control subjects (43%; $P < 0.05$), but no significant changes by immediate post-test • Increase in oral sex in experimental group ($P < 0.05$) |
| Dycus & Costner 1990, USA | 9-week human sexuality curriculum involving parents & school counsellors on HIV, STDs, & decision-making | N = 364 M & F aged 12 through 15 years | <ul style="list-style-type: none"> • A drop in the pregnancy rate from 30 (at pre-program) to 8 for girls age between 12 & 15 years of age in the first year of the pilot programme (no P-value given) |
| Rees & Zimmerman 1974, USA | Human sexuality on homo-sexuality, family planning, VD, contraception & abortion | N = 230 M & F college students | <ul style="list-style-type: none"> • No increases in percentage sexually active (M at pretest = 79%, at immediate post-test 73%, no P-value given; F at pretest 61%, at immediate post-test 62%, no P-value given) |

* See end for explanation of abbreviations

| Study | Intervention | Sample | Key findings for impact on sexual behaviour |
|--|--|---|---|
| Weis <i>et al.</i> 1992, USA | Human sexuality course (no details on course content given) | $N = 172$ M & F mean age = 20.8 years | <ul style="list-style-type: none"> No significant change in the group's age at first coitus ($P = 0.67$), ever had coitus ($P = 0.95$), or number of premarital partners ($P = 0.62$) from pretest to immediate post-test |
| Yarber & Anno 1981, USA | 16 x 90 minutes twice a week human sexuality course on cognitive aspects of sexuality lectures & small group discussion self-understanding through values & attitudes | $N = 80$ cont. & 70 exp. M & F mainly between 18 and 23 years | <ul style="list-style-type: none"> No increase in coital activity in past 4 weeks from pretest to immediate post-test Significant increase in masturbation in F (mean frequency in past month: cont.: 0.12 to 0.38; $P < 0.05$; exp.: 1.25 to 1.79 ($P < 0.05$)) More oral-genital contact in exp. M (mean frequency in past month: 1.5 pretest, 2.41 post-test; $P < 0.05$) |
| Zuckerman <i>et al.</i> 1976, USA | 15-week human sexuality course using explicit movies, slides, and small discussion group work on personal experiences | $N = 97$ cont. & 137 exp. M & F mean age = 20.3 years | <ul style="list-style-type: none"> No significant behavioural changes for F at immediate post-test Significant increase in exp. M in homosexual experience ($P < 0.05$), & number of homosexual partners ($P < 0.05$) Marginal increase in experimental males in heterosexual experience ($P = 0.1$), but no increase in number of partners |

| Study | Intervention | Sample | Key findings for impact on sexual behaviour |
|--|--|--|---|
| PUBLIC CAMPAIGNS | | | |
| Blanchard <i>et al.</i> 1993, Switzerland | Public "Stop AIDS" information campaign carried out in schools, youth centres at social & sporting events over 5 years | N = 2911 M & F 16 through 19 years of age | <ul style="list-style-type: none"> • No significant trends in proportion sexually active over 5 years • Of those sexually active, no increase in number of partners over 5 years (no <i>P</i>-value given) • Large increase in regular condom use from 1987 to 1992 (M approximately 22% to 42%; F approximately 10% to 32%.; Statistically significant but no <i>P</i>-value specified) |
| de Fine Olivarius <i>et al.</i> 1992, Denmark | Effect of 1985 public campaign promoting barrier methods of contraception and limiting numbers of partners from 1984 to 1988 | N = 2365 F aged attending VD clinic, mean age = 25.2 years | <ul style="list-style-type: none"> • No change in total numbers of sexual partners, frequency of intercourse, births, pregnancies, abortions, chlamydia, herpes, and cervical dysplasia (<i>P</i> > 0.05) • Over 4-year period, decrease in gonorrhoea from 22% to 6% (<i>P</i> < 0.01), but increase in genital warts from 4% to 10% (<i>P</i> < 0.05) |
| Herlitz 1993, Sweden | Effect of 1987 nationwide campaign on AIDS from 1986 to 1989 | N = 11025 M & F aged between 16 & 44 years | <ul style="list-style-type: none"> • No statistically significant changes in percentage reporting coital activity or number of sexual partners (no <i>P</i>-value given) • Increase in use of condoms among singles with no regular partner (1986: 24% compared to 1989: 35%, no <i>P</i>-value given) |

| Study | Intervention | Sample | Key findings for impact on sexual behaviour |
|--|---|---|--|
| Nafsted 1992, Norway | Campaign in Stovner district 1988-1990 incl. free adolescent- health service, education at school & youth clubs on contraception | Abortion rate of F between 15 & 19 years of age | <ul style="list-style-type: none"> Abortion rate was significantly reduced from 35 per 1000 to 15 per 1000 females aged between 15 & 19 years ($P < 0.01$) in campaign district, whereas the rate for all of Norway remained constant (1988: 22/1000 & 1990: 20/1000: NS) |
| National Committee on Health Education 1978, Sweden | 3-year public information campaign | Pregnancy rate in F aged 14 through 19 years | <ul style="list-style-type: none"> In third year of programme, dramatic drop in youth abortions & number of adolescent pregnancies (104 in previous year to 78) Reduced rate of gonorrhoea per 100,000 inhabitants in area receiving programme (258 in previous year to 181), compared to national total: (296 in previous year to 320, no P-value given) |
| Sellers <i>et al.</i> 1994, USA | 18 month city-wide HIV programme using school & community group workshops & events, posters, public announcements, condom promotion & distribution | $N = 536$ Latino M & F 14 through 20 years | <ul style="list-style-type: none"> No greater frequency of sex in last 6 months in exp. M & F than among subjects in control city (M, $\beta = 0.21$, 95% CI: -0.2 to 0.62; F, $\beta = -0.11$, 95% CI: -1.74 to 4.26) at 18 months post-test Pretest virgin M in exp. city less likely to initiate intercourse than those in control city (OR: 0.08, $P < 0.05$; F NS, $P = 0.692$) F in exp. city less likely to have 2+ partners in last 6 months than F in control city (OR: 0.06, $P < 0.005$; M NS, $P = 0.79$) |

| Study | Intervention | Sample | Key findings for impact on sexual behaviour |
|---|---|--|--|
| Wielandt & Jeune 1992, Denmark | Pretest prior to 1985 public information of HIV/AIDS from 1984 to 1989 | N = 1381 M & F aged 16-20 years | <ul style="list-style-type: none"> • No difference in age profiles for first coitus in 1984 & 1989 (median age F: 1984 = 16.7 years, 1989 = 16.8 years; M = 16.9 years in both 1984 & 1989) • From 1984 to 1989 more condoms used for first coitus: M = 36.5% to 61% ($P < 0.001$); F = 42.1% to 62% ($P < 0.001$) |
| ABSTINENCE PROGRAMS | | | |
| St. Pierre <i>et al.</i> 1995, USA | 12 sessions over 3 months, booster programme at 1 & 2 years (for only half of experimental group), on resistance, skills, peer pressure, abstinence promotion using role-playing & advertisement analysis | N = 53 cont. & 99 exp. M & F, mean age = 13.6 years | <ul style="list-style-type: none"> • No significant differences in exp. & cont. pretest virgins in initiation of intercourse, or subsequent frequency & time since last intercourse at immediate, 1 year & 2 years post-test • Reduction in pre-programme non-virgins in frequency & time since last sexual intercourse at 1 year ($P < 0.1$), & 2 years ($P < 0.05$) post-test compared to cont. & exp. subjects who also completed booster programme |
| Young <i>et al.</i> 1992 USA | 24 sessions on self-esteem, puberty, sexual decision-making, parent-child communication, abstinence promotion | N = 66 cont. & 60 exp. M & F junior high school students (N.A.S) | <ul style="list-style-type: none"> • At 1 week post-test, 6 exp. & 3 cont. who had had intercourse in last month at baseline, had not had intercourse in last month, and 0 exp. & 3 cont. who had not had intercourse at baseline in the last month, had had intercourse in the last month ($P < 0.001$) |

| Study | Intervention | Sample | Key findings for impact on sexual behaviour |
|--|--|--|--|
| OTHER EDUCATION | | | |
| Berger <i>et al.</i> 1987, USA | At least 1 session at family planning clinic on abstinence, non-coital practices, refusal of sex, contraception, pregnancy & STDs | <i>N</i> = 383 M & F clinic attendees aged 16 through 25 years | <ul style="list-style-type: none"> • After 12-month study period, no significant increase in number sexually active (pretest: 35%, post-test: 38%; NS, no <i>P</i>-value given) • For those sexually active at pretest, contraception use at last intercourse was 27% at pretest, & 76% at study close (<i>P</i> < 0.001) |
| Bernard & Schwartz 1977, USA | 12 weeks x 3 sessions sex education course on birth, pregnancy, abortion, psychosexual development, contraception by lectures & discussion | <i>N</i> = 141 cont. & 275 exp. M & F college students | <ul style="list-style-type: none"> • Students in the course did not show statistically significant increases or decreases in sexual activity from pretest to immediate post-test compared to controls |
| Davidson & Darling, 1986, USA | 16-week functional marriage & family course incl. premarital sex, sexual arousal, family planning & autoeroticism | <i>N</i> = 88 cont. & 85 exp. M & F junior & senior college students | <ul style="list-style-type: none"> • Acquisition of knowledge of human sexuality did not result in statistically significant (<i>P</i> > 0.05) increased participation in sexual intercourse • Ever had or frequency from baseline to immediate post-test |
| Eisen & Zellman 1987, USA | 15-hour health-based education programme incl. reproductive biology, VD (not HIV) & contraception | <i>N</i> = 120 M & F aged 13 through 18 years | <ul style="list-style-type: none"> • Adolescents who reported at least 1 hour of tuition prior to intervention were no more likely to be coitally active (36%) than those who reported none (31%; <i>P</i> = 0.44) • Those in the programme showed no greater coital participation at 3 & 6-month follow-up compared to pretest (<i>P</i> = 0.598) |

| Study | Intervention | Sample | Key findings for impact on sexual behaviour |
|--|--|---|---|
| Daures <i>et al.</i> 1989, France | Individualized information programme on abortion, pregnancy & STDs | N = 64 cont. & 190 exp. M & F aged 15-18 years | <ul style="list-style-type: none"> • At 3-year follow-up, a significant reduction in pregnancy in the informed group (2%) compared to controls (20%; $P < 0.05$) • Reduced STDs among boys in informed group (4.3%) compared to male controls (11.5%; $P < 0.05$) • Girls who received information were 2.3 times less likely than controls to have intercourse without contraception ($P < 0.05$) |
| Howard & McCabe 1990, USA | 10-period peer-led instruction on resistance, reproduction, STD (no HIV) & family planning | N = 141 cont. & 395 exp. M & F aged 13 through 14 years | <ul style="list-style-type: none"> • At 2-year follow-up, delayed initiation of sexual intercourse for those in programme (e.g., at end of 8th grade $F = 4\%$ compared to controls $F = 20\%$; $P < 0.01$) • A potential one-third reduction in number of pregnancies for those in course compared to controls |
| Kirby 1985a, USA | Meta-analysis of 14 courses ranging from 1 day to 2 semesters | | <ul style="list-style-type: none"> • Meta-analysis of programme outcomes grouped by course duration showed no statistically significant impact of education on having sex ever or in the last month, frequency of sex, or birth control use |

| Study | Intervention | Sample | Key findings for impact on sexual behaviour |
|---|--|--|---|
| Marcotte & Logan 1977, USA | 3-day medical sex education course incl. sex role socialization, physiology, cross-cultural comparison of sexuality & sexual health | <i>N</i> = 41 M & F medical students mean age = 24.9 years | <ul style="list-style-type: none"> • 70.9% at pretest and 75.6% at immediate post-test had sexual intercourse regularly (no <i>P</i>-value given) • Frequency of intercourse: 9.4/month at pretest and 9.7/month at post-test (no <i>P</i>-value given) |
| Melanby <i>et al.</i> 1995, UK | 25-30 x 1 hour education by doctors, teachers & peers on puberty, reproduction, contraception, relationships, assertiveness training through role play & group work | <i>N</i> = 5398 cont. & 1175 exp. M & F, 15 through 16 years | <ul style="list-style-type: none"> • After approximately one year post-intervention, controls were 1.45 (95% CI: 1.13 – 1.87) times more likely than programme students to be sexually active at 15.5 to 16.5 years of age |
| Postrado & Nicholson 1992, USA | I) 6 x 2 hours on pregnancy prevention, peer pressure, resistance skills, assertiveness by discussion & films, & II) 5 x 2 hours with parent on parent-child communication about sex | <i>N</i> = 117 cont. & 295 exp. F, 12 through 14 years | <ul style="list-style-type: none"> • At 1-year follow-up, pretest virgins doing component I just as likely to initiate sex as non-participants (OR: 1.0, <i>P</i> = 0.974) • For component II, at 1-year follow-up pretest virgin non-participants marginally more likely to initiate intercourse than participants (OR: 2.6, <i>P</i> = 0.054) |
| Sakondhavat <i>et al.</i> 1988, Thailand | Sex education including abortion, contraceptive information, STDs | <i>N</i> = 520 M & F attending vocational school, mean age = 20.6 years | <ul style="list-style-type: none"> • After 1 year, no increase in sexual activity (no <i>P</i>-value given) • Increase in contraceptive use (no <i>P</i>-value given) |

| Study | Intervention | Sample | Key findings for impact on sexual behaviour |
|--|---|---|---|
| Schinke <i>et al.</i> 1981, USA | Cognitive behavioural prevention with social worker on reproduction, contraception, problem solving, decision making & interpersonal skills (no information on course length) | N = 49 cont. & 44 exp. M & F adolescents (no age specified) | <ul style="list-style-type: none"> • Reduction in intercourse without contraception in treatment compared to controls at 6-month follow-up (Group 1: 5% versus 23%, Group 2: 7% versus 31%), at 9-month follow-up (Group 1: 8% versus 26%, Group 2: 11% versus 42%) & at 12 months follow-up (Group 1: 6% versus 30%, Group 2: 11% versus 41%) (no <i>P</i>-values reported) |
| Siegel <i>et al.</i> 1995, USA | 12 sessions in 3 weeks on HIV, skills to refuse sex, decision-making, sex education | N = 123 cont. & 434 exp. M & F 7th, 8th & 9th grade | <ul style="list-style-type: none"> • No significant difference in changes in sexual risk-taking (i.e., number of partners, frequency of sex, & condom use) from pretest to 3-month follow-up post-test between experimental and control groups (no <i>P</i>-value given) |
| Turner <i>et al.</i> 1993, USA | 3 to 5 week college seminars on STDs, safer sex, values, decision-making & assertiveness skills | N = 227 cont. & 341 exp. M & F mean age = 18.3 years | <ul style="list-style-type: none"> • At 3-month follow-up, greater abstinence in experimental males at post-test (42%) compared to pretest (25%; <i>P</i> < 0.05) and compared to control group at post-test (29%; <i>P</i> < 0.05), but not for females • No significant differences in number of partners between pretest & post-test, or between experimental & control groups |

| Study | Intervention | Sample | Key findings for impact on sexual behaviour |
|--|---|---|---|
| HIV PREVENTION | | | |
| Goertzel & Bluebond-Langner 1991, USA | 1 semester interdisciplinary AIDS course on legal, social, personal, medical aspects of AIDS in lectures, readings, & discussion group | <i>N</i> = 76 cont. & 79 exp. M & F, 80% aged between 18 & 20 years | <ul style="list-style-type: none"> • At immediate post-test, no statistically significant changes from baseline for experimental or control groups in number of partners, condom use for vaginal, anal or oral sex in last 3 months (no <i>P</i>-value given) |
| Jemmott <i>et al.</i> 1992, USA | 5 hour, 1-day programme on risks of drug & sexual practices, condom use, & prevention strategy implementation using videos & role playing | <i>N</i> = 72 cont. & 85 exp. M, mean age = 14.6 years | <ul style="list-style-type: none"> • At 3-month follow-up, no difference in abstinence in the last 3 months between programme (<i>P</i> > 0.1) • Exp. group had significantly fewer coital partners & days when they had coitus, & more frequent condom use than controls (all <i>P</i> < 0.05) |
| Kipke <i>et al.</i> 1993, USA | 3 x 90-minute sessions in 5 weeks on HIV transmission, prevention, condom use & access, pressure resistance, decision-making, assertiveness through role-playing & group discussion | <i>N</i> = 46 cont. & 41 exp. African-American & Latino M & F, aged 13 through 18 years | <ul style="list-style-type: none"> • At 4 weeks post-test, no significant differences between groups in number of sexual encounters or number of partners or condom use in last month (no <i>P</i>-value given) |

| Study | Intervention | Sample | Key findings for impact on sexual behaviour |
|---|--|---|--|
| Mansfield <i>et al.</i> 1993, USA | Physician intervention: Cont.: standard HIV counselling on risk assessment, condom use & supply of free condoms; extra intervention incl. 20 minutes discussion on HIV infection susceptibility, prevention, HIV testing | N = 43 standard & 47 extra intervention M & F, mean age = 17.6 years | <ul style="list-style-type: none"> • At 2 month follow-up, no significant differences between standard & extra intervention groups in sexual behaviour or condom use • From baseline to 2-month follow-up, 0.4 reduction in number of partners in last month ($P < 0.0001$), and increase in condom use always from 13% to 23% ($P < 0.001$) for both intervention groups combined |
| Rotherum-Borus <i>et al.</i> 1991, USA | 3-30 x 90-120 minutes on HIV knowledge, coping in risk situations, skills identification through videos & discussion | N = 67 cont. & 78 exp. M & F runaways aged 11 through 18 years | <ul style="list-style-type: none"> • Rates of abstinence in past 3 months was the same for experimental & control groups at 3-month & 6-month follow-ups • As number of sessions increased, so did consistent condom use at 3-month ($\beta = 0.3, P < 0.06$) & 6-month follow-up ($\beta = 0.25, P < 0.06$) |
| Slap <i>et al.</i> 1991, USA | 1 peer-counselling session (5-30 minutes) on HIV transmission, condom use, risk behaviours, abstinence, HIV testing & contraception | N = 241 F at adolescent clinic aged 12 through 19 years | <ul style="list-style-type: none"> • Significant decrease in reporting of sexual intercourse in last 2 weeks from pretest (21.3%) to 2-6 week follow-up (13.7%: $P < 0.05$) • Decline in condom use always from pretest (30%) to post-test (24%: $P < 0.05$) |

| Study | Intervention | Sample | Key findings for impact on sexual behaviour |
|--|--|--|---|
| CLINICAL SERVICES | | | |
| Edwards <i>et al.</i> 1980, USA | School family planning clinics giving counselling, education & physical examinations | Birthrate for F 13 through 19 years of age at 3 schools over 6 years | <ul style="list-style-type: none"> • Birth rate for school population fell in the junior-senior high school project from 79/1000 to 35/1000, and from 60/1000 to 40/1000 in the two senior high school projects after 3 years of programme implementation (no <i>P</i>-value given) |
| Kirby, Waszak & Ziegler 1991, USA | Analysis of 6 school-based clinics providing a range of general medical & counselling services with much variability in provision of sex education and contraception. Matched control schools with no clinic | <i>N</i> ranged from 824 to 1360 M & F 9th to 12th grade | <ul style="list-style-type: none"> • No difference between clinic and non-clinic schools in age of first intercourse in pretest virgins or frequency of sex in the sexually active • Mixed findings in percentage sexually active when comparing clinic to non-clinic schools (no pretest measures) • No association between presence of clinical services and pregnancy rates |

M = males, F = Females, cont. = control subjects, exp. = experimental subjects

Table 3: Cross-Sectional Surveys: Summary of Study Design, Type of Survey, and Key Findings *

| Study | Intervention | Sample | Key findings for impact on sexual behaviour |
|--|--|--|--|
| Anderson <i>et al.</i> 1990, USA | Survey about HIV/AIDS education in schools | <i>N</i> = 8098 M & F between 9th and 12th grade | <ul style="list-style-type: none"> Once HIV/AIDS knowledge, gender, race & age were taken into account, HIV/AIDS education had no effect on having ≥ 2 sexual partners over lifetime and/or in last year, or on always using condoms ($P < 0.05$) |
| Dawson 1986, USA | Retrospective survey on receiving education on menstruation, VD, birth control, reproduction, & sexual behaviour | <i>N</i> = 1888 F aged 15 through 19 years | <ul style="list-style-type: none"> No effect on probability of initiation of sexual activity (no <i>P</i>-value given) Education recipients more likely to use contraception: Ever: ($P < 0.05$) & at first intercourse (if education is given prior to initiation) ($P < 0.05$) |
| Furstenberg <i>et al.</i> 1985, USA | Retrospective survey of sex education & sexual behaviour | <i>N</i> = 469 M & F 15 through 16 years of age | <ul style="list-style-type: none"> Prevalence of intercourse significantly higher in those who did not have sex education (25.5%) compared to those who did (16.5%: $P < 0.05$) |
| Ku <i>et al.</i> 1992, USA | Evaluated formal education in AIDS, birth control, STDs & resisting sexual activity | <i>N</i> = 1,880 M 15 through 19 years of age | <ul style="list-style-type: none"> HIV/AIDS education was associated with a marginal increase in the number of those who had no partners in the past year (4%: $P < 0.1$), & 9% increase in proportion using a condom 100% of the time ($P < 0.01$) |

| Study | Intervention | Sample | Key findings for impact on sexual behaviour |
|---|---|--|--|
| Marsiglio & Mott 1986, USA | Retrospective 5-year longitudinal study of relationship between attending sex education course in school & subsequent sexual behaviour | <i>N</i> = 12069 M & F 14 through 22 years of age | <ul style="list-style-type: none"> • Prior exposure to a sex education course was positively & significantly associated with initiation of sexual activity at 15 & 16 ($P < 0.01$), but not at 17 & 18 years of age ($P > 0.05$) • Those who had taken a sex education course were more likely to use effective contraception (73%) compared to controls (64%: $P < 0.01$) |
| Moreau-Gruet <i>et al.</i> 1996, Switzerland | Retrospective national survey on receiving sex education & sexual experience (1992/1993) | <i>N</i> = 9286 M & F aged 15 through 20 years | <ul style="list-style-type: none"> • Having had sex education was not significantly related to having begun sexual intercourse before 15 years of age ($P > 0.5$) |
| Pick-de-Weiss <i>et al.</i> 1990, Mexico | Retrospective survey on attendance at formal sex education course and sexual behaviour | <i>N</i> = 392 F aged 16 through 17 years | <ul style="list-style-type: none"> • Having attended a sex education course did not affect initiation or continuation of sexual behaviour ($\chi^2 = 0.1$: NS) or contraceptive behaviour (no <i>P</i>-value given) |
| Philliber & Tatum 1982, USA | Retrospective survey of students who had and had not taken a Life Science course that incl. discussion on contraception, sexuality, genetics & reproduction | <i>N</i> = 78 cont. & 190 exp. M & F 10th, 11th, & 12th graders | <ul style="list-style-type: none"> • At up to 3 years post-course, no support for the notion that sex education encouraged or discouraged sexual activities once academic achievement and class level are taken into account (no <i>P</i>-values given) |

| Study | Intervention | Sample | Key findings for impact on sexual behaviour |
|--|---|--|---|
| Spanier 1978, USA | Retrospective survey on attendance at a sex education course at either junior or senior high school, & sexual behaviour | N = 1177 M & F college students | <ul style="list-style-type: none"> • No relationship between attending a sex education course in junior or senior high and subsequent premarital sex behaviour ($\chi^2 = 6.3$, $df = 4$: NS) • No relationship of birth control instruction to subsequent premarital sexual behaviour (F: $\chi^2 = 2.2$, $df = 4$:NS; M: $\chi^2 = 4.4$, $df = 4$:NS) |
| Wellings <i>et al.</i> 1995, UK | Retrospective national survey of sexual attitudes & lifestyles | N = 18876 M & F aged 16 through 59 years | <ul style="list-style-type: none"> • M whose main source of sex education was school-based were significantly more likely to be virgins at 16 years compared to those whose main source was friends ($P < 0.05$). This relationship was non-significant for F ($P > 0.05$) • M & F significantly more likely to use contraception ($P < 0.05$) & F more likely to use condom at first intercourse ($P < 0.05$; M: NS, $P > 0.05$) if school was main source of sexuality information compared to friends as main source |

M = males, F = females, cont. = control subjects, exp. = experimental subjects

Table 4: International or National Comparison Studies: Summary of Study Design, Type of Article, and Key Findings

| Study | Type of Article | Sample | Key findings for impact on sexual behaviour |
|--|---|--------------|--|
| Edelman & Pittman 1986, International | Comparison of the United States with other Western industrialized nations on education, sexual behaviour, adolescent pregnancy & abortion | | <ul style="list-style-type: none"> • Withholding sex education & family planning services has not led to less adolescent sex activity in the United States • The provision of information & services in Europe & Canada has not resulted in increased sexual activity; it has heightened sexual responsibility |
| Jones <i>et al.</i> 1985, International | 37-country analysis of adolescent pregnancy | F ≥ 19 years | <ul style="list-style-type: none"> • Adolescent pregnancy rates are lower in countries that have a greater availability of contraceptive services & sex education • Levels of sexual activity in the USA are not very different from those in countries with much lower adolescent pregnancy rates |
| Kroger & Wiesner 1981, USA | Review of STD literature | | <ul style="list-style-type: none"> • STD rates soared following legislation that restricted classroom education on human sexuality, & decreased following reintroduction of STD education |

| Study | Type of article | Sample | Key findings for impact on sexual behaviour |
|------------------------------|---|---------------------------------|---|
| Siedlecky 1987, Australia | Commentary on issues for young people's sexuality | | <ul style="list-style-type: none"> • Even though there has been an increase in the number of school programmes on sexuality education there has not been a concomitant increase in adolescent pregnancies & births |
| Singh 1986, USA | Interstate comparison within the United States of sex education, abortion, pregnancy & birth rates | F 15 through 19 years of age | <ul style="list-style-type: none"> • A higher proportion of white senior high school students receiving sex education was associated highly with lower pregnancy rates in white but not black females (standardised $\beta = -0.98$; $P < 0.01$) • No significant relationship between sex education & abortion rates ($P > 0.05$) |