

# *Reaching Teenagers Where They Are: Best Practices for Girls' Sexual Health Education*

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*It is well established that girls face an ever-growing list of sexual health challenges. There is a paucity of available literature on ways to reach and teach adolescent girls about sexual health issues and use of health promoting strategies. This article focuses on suggestions for teachers and health care practitioners on developing knowledge competencies, or health literacies, in the area of adolescent girls' sexual health. We suggest a number of health education practices such as the application of literacy strategies and gender sensitive, developmentally appropriate lesson plans. Instructors, both teachers and health care providers, need also to consider the school or community's context, curriculum factors and the learning environment. Effective instructional frameworks for lesson planning can help school teachers and health care providers deliver effective sexual health education.*

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There can be no doubt that adolescent girls face a number of serious sexual health issues. Among adolescents more generally, the major causes of morbidity are related to health risk behaviours, such as unprotected sexual activity and substance use (The McCreary Centre Society, 1999). In the US, The Centers for Disease Control and Prevention (CDC) (2004) identified risky sexual behaviour as one of six health behaviours most associated with mortality, morbidity and social problems among youth. For example, early sexual intercourse increases the risk of sexually transmitted infection and cervical cancer (Stone et al., 1995) and has been associated with depression and suicide (Hallfors et al., 2004). Furthermore, intimate violence is a leading cause of injuries among young people. Reported rates of dating violence in high school students range from 9% to 45% (Downey, Bonica & Ricon, 1999), with significant numbers continuing such relationships despite the abuse. Abusive experiences associated with adolescent dating disrupt normal developmental processes such as the development of a stable self-concept and integrated body image during adolescence (Ackard, Neumark-Sztainer & Hannan, 2003), and may lead to impairments in behaviours, thoughts and feelings (Grasley, Wolfe, & Wekerle, 1999). Problematic romantic relationships can have multiple negative effects, for example, on adolescents' self-esteem (Ackard, Neumark-Sztainer & Hannan, 2003) and emotional health (Compián, Gowan, & Hayward, 2004).

Adolescent girls specifically face a number of serious health issues related to sexuality and relationships. Unplanned pregnancy,

HIV/AIDS and sexually transmitted diseases (STD's) are a major public health concern (Health Canada, 2002). Furthermore, dating violence has been associated with STD/HIV among sexually active adolescent girls. Decker, Silverman and Raj (2005) report that more than half (51.6%) of girls diagnosed with STD/HIV reported experiencing dating violence. Compared with non-abused girls, girls who experienced both sexual and physical dating violence were 2.6 times more likely to report a STD diagnosis (Decker, Silverman & Raj, 2005). Conflicting social pressures continue to affect girls' abilities to make decisions about contraceptive use and safe sex and contribute to risk-taking behaviours in heterosexual intimate relationships. For example, Hutchinson (1998) found that for 59% of young women, sexual risk history was not discussed with their partners prior to having sexual relations for the first time.

Gender role socialization influences girls' dating relationship norms and expectations. A variety of gender-based determinants influence girls' sexual health. Denton, Prus and Walters discovered that "[t]he impact of childhood/ life events, chronic stressors and psychological resources play an important role in determining health, but their effects are generally stronger for women than men" (p. 2598). Messages about gender expectations are deeply entrenched through direct and indirect communication and can be difficult to monitor (Bronstein, 2006). Girls compared with boys are likely to report greater concerns about their appearance and behaviour and lower self esteem and career aspirations. They are also less likely to assert their needs (Bronstein, 2006). The link between gender and dating violence continues to be an area which is in need of further theoretical and practical development: "Violence against women is a highly politicized area of social inquiry" (DeKeseredy, 2000, p. 739).

For girls, the serious nature of their sexual health issues seems to indicate that we need more effective approaches to reach these teenagers 'where they are', in terms of their physical and emotional health. Adolescents have identified the importance of having accurate sexual health information available to them (DiCenso et al., 2001) and opportunities to talk about their sexual health (Ackard & Neumark-Sztainer, 2001). In a study of adolescents' views on preventing teen pregnancy, participants in grade 10 and 11 acknowledged the need for information on pregnancy and birth control, dating relationship dynamics, parental communication and education about the realities of parenting (Hacker et al., 2000). The school is viewed by many adolescents as a main source of information about human sexuality, birth control and HIV/AIDS (Boyce et al., 2003). However, barriers to effective sexual health education, such as insufficient classroom time devoted to the subject, is the norm in most schools (McKay, Fischer, Maticka-Tyndale, & Barrett, 2001). An analysis of research on adolescent sexual health education revealed that "sexual health education in Canadian schools is less than optimal" (McKay, 2001, p. 133). The available research reports

some success for sexual health education stress areas such as high quality teacher training (Schaalma et al., 2004), the employment of theoretical models, consistent reinforcement through a clear message about abstaining from sexual activity and/or using condoms or other forms of contraception (Kirby, 2001), and the use of sexual health interventions that are well designed (Bennett & Assefi, 2005; Kirby, 2001).

Youth are reticent to initiate conversations about issues such as sex and need health educators who are willing to broach sensitive topics in a gender sensitive, direct, non-judgmental and open manner. Health educators need access to sexual health strategies that are well documented and piloted for their effectiveness in classrooms; they also need the skills to deliver the strategies as designed (Schaalma et al., 2004). There is a paucity of available literature on ways to reach and teach adolescent girls about sexual health issues and use of health promoting strategies (Health Canada, 2003). This article therefore focuses on suggestions for practitioners—teachers and health care providers—on developing knowledge competencies, or health literacies, in the area of adolescent girls' sexual health. For teachers, this article will provide a review of teaching approaches specifically applied to sexual health topics. For health care providers, we describe an innovative approach to the implementation of health education. To address both contexts, we refer to 'learner/students.'

### *Literacy Strategies for Teaching Health Education*

Traditionally, health education has been offered primarily in the schools. Schools are the only formal institution with which most young people have contact and offer an ideal context for delivering health information and related skills to young people (Health Canada, 2003). The hours spent in health education however are often minimal. In terms of sexual health education, limited classroom time for program delivery, lack of resources and lack of consistent implementation of programs across Canada have been identified as some of the barriers to program effectiveness (Health Canada, 2003). In addition, sexual health information programs seem to lack approaches which might lead to the reduction of health risk behaviours among adolescents (Begoray & Banister, 2005). In this paper, we argue that one important missing part of these programs is a focus on literacy. Our premise is that literacy strategies allow adolescents to become more able to find, use, evaluate and communicate health information. These strategies can be taught. While the school system has traditionally kept the teaching of literacy strategies within the English/language arts classroom, there is well established literature on the importance of literacy for learning in a variety of disciplinary contexts (Begoray, 2002).

Literacy worldwide is recognized as serving the purposes of both the individual and the community. International and national groups define the term in similar ways. For example, literacy is:

- *possession by an individual of the essential knowledge and skills which enable him or her to engage in all those activities required for effective functioning in his or her group and community (United Nations Educational, Scientific & Cultural Organization, 1978)*
- *an individual's ability to read, write, speak in English compute and solve problems at levels of proficiency necessary to function on the job and in society, to achieve one's goals and develop one's knowledge and potential (United States Congress, 1991)*
- *fundamentally about participation and being able to take an active part in society (Canadian Education Association, 2006)*

Literacy teachers in schools now acknowledge that learners need a variety of approaches to comprehend new knowledge. For example, there are now six accepted forms of literacy: Reading, writing, listening, speaking, viewing and representing (Governments of Alberta, British Columbia, Manitoba, Northwest Territories, Saskatchewan & Yukon Territory, 1998). Traditionally, reading and writing of print texts (i.e., words on a page) have been the primary methods of conveying and delivering learning material. These approaches, while still important in schools and in society in general, are no longer considered to be sufficient for all learners or indeed for all learning situations (Begoray, 2002). Oral language skills, what literacy educators would call listening and speaking abilities, are now an accepted part of the curriculum. The most recent additions to the list of 'literacies' are viewing and representing (International Reading Association & National Council of Teachers of English, 1996) or working with visual 'texts'. Viewing might include analyzing diagrams or models of the reproductive system, looking at colored condoms in a sexual education class, or watching a role play on approaches to deal with sexual harassment. Representing could be drawing pictures of stereotypical male and female behaviour, creating a web site on adolescent dating violence or making Aboriginal 'dream catchers' to show the attainment of healthy living goals (Banister & Begoray, 2006).

Many researchers now acknowledge that people must have multiple literacies in order to succeed in a variety of groups and communities. For example, a 15 year old learner/student might be literate in a number of oral, written and visual sign systems and use all of these abilities each day. Imagine Maria finding two web sites on unwanted pregnancy. Each one has illustrations and print to view and read. She takes this information with her when she goes to her neighbourhood clinic and speaks with a nurse. There she learns that she has misunderstood some of the information and trusted other information which was not from a credible source. Later, she e-mails her friend Pat and writes about her new understanding. Multiple literacies thus include abilities in speaking and listening (oral literacy used in her conversation with the nurse), reading and writing (print literacy used

when she reads the web site and writes to her friend) and viewing and representing (visual literacy used when she looks at the illustrations on the web site). Integrating a number of different literacies as Maria has strengthens the ability of a range of learners/students to comprehend new information. For example, researchers (Sadoski & Paivio, 2001) have proven that information obtained simultaneously through both visual and verbal channels, called 'dual coding' is more easily understood initially and is better retained for future use.

Health literacy—"[t]he degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions" (Ratzan & Parker, 2000 as cited in Nielsen-Bohlman, Panzer & Kindig, 2004, p. 32)—involves the use of multiple literacies in health contexts. As described above, Maria obtains information about unwanted pregnancy by conducting a web search and talking to a health professional. Her reading, viewing and listening may be limited by her ability to understand the written or visual information. Or, she may be lacking in evaluation skills because she chose a misleading web site. Nevertheless, Maria checks her understanding with a professional. She also communicates her understanding to a friend. In the future she may act on her knowledge by deciding to avoid an unwanted pregnancy. Decision making is an important part of health education skills leading to greater health literacy.

If health literacy is placed in the forefront of our teaching strategies, more effective health education may result (Institute of Medicine, 2004). Influential journals such as the *Lancet* comment that "A great deal could be accomplished if doctors and other health professionals took time... to make sure the patient had understood" (Taking health literacy seriously, 2005). We believe that the same criteria need to be applied to other health education contexts such as those in the schools.

### *Strategies to Support Adolescent Developmental Readiness*

Besides the inclusion of literacy strategies in the health education context, we propose also that such teaching be augmented with an application of knowledge concerning developmental readiness. Concepts from educational psychology concerning the developmental stages of children and adolescents help to guide educators' choice of appropriate teaching approaches, always realizing that context also influences behaviour.

Decisions on developmental appropriateness are based on adolescents' biological changes, cognitive processes and social development and their associated capacities at each age level. Lessons should match the developmentally appropriate level (Somers & Surmann, 2005). Literacy strategies chosen on the basis of clients' developmental stage, for example using concrete visuals especially for early adolescents, will strengthen traditional health education programs. In this way, lessons

learned from both health and education can be brought to bear on the sexual health issues of adolescents.

Cognitive processes undergo significant changes during adolescence. Two primary developmental scholars are Piaget (1971) and Vygotsky (1986). They use this conceptual framework to suggest ways to involve learners/students in their own learning.

### *Early Adolescence*

During early adolescence (ages 12-14), according to Piaget, cognitive development is at a pre-operational or concrete level. Adolescents at this stage may see themselves as invulnerable. They lack the ability to question the consequences of their health risk behaviours and may have difficulty asking and answering the question 'What if?' Nevertheless, they are capable of building knowledge for themselves and are starting to examine their own sexual feelings. Some are becoming sexually active (Lieberman et al., 2000). Vygotsky (1986), a developmental theorist, also advocated social constructivism. Social constructivism maintains that knowledge is co-constructed between learners. Vygotsky argues that children and adolescents can be led from one developmental stage to the next with the assistance of a more sophisticated learner. Learning can take place in adolescents' 'zone of proximal development'—what an adolescent can learn on his or her own while under the guidance of adults or more capable peers (Vygotsky, 1978). For example, a mentor can help a younger adolescent to engage in more abstract reasoning about the consequences of unsafe sex by supporting their learning during discussion.

One way to activate abstract reasoning, so important for decision making in the often emotionally laden context of sexual relationships, is to make learning interactive and concrete. Early adolescents need to be physically active and like to work with their peers. Instructors can use strategies such as role-playing to involve adolescents in discovering effective health communication approaches and developing social skills needed to prevent health-risk behaviours (Schaalma et al., 2004). Literacy behaviours engaged would be listening and speaking as the instructor encourages discussion before, after and during the role play; Viewing and representing as learners/students watch the role play of others and are engaged in their creating their own role play; Reading and writing when learners/students compose journal entries responding to the role play experience.

### *Middle Adolescence*

During middle adolescence, ages 15-17, adolescents are more capable of abstract reasoning. They are able to reflect on the consequences of their actions and able to consider the social context of their behaviours (Haffner, 1995). However, they may revert to concrete thinking when in stressful or confusing situations (Ehrman & Matson, 2002). Middle

adolescents are more likely than early adolescents to be involved in risky sexual behaviours such as not using a condom and continue to be influenced by suggestions of their peers (Health Canada, 2002). At this developmental stage instructors must be prepared to work intensively with activities which encourage more sophisticated thinking concerning the long term consequences of sexual behaviours. For example, middle adolescents can be informed about gender role behaviour and how gender socialization and identify begins at an early age through everyday interaction within the family environment (Bronstein, 2006).

Role playing experiences for middle adolescents can incorporate more abstract thinking activities but should still be based in concrete experiences. Girls can be invited to rehearse specific situations which can be generated during discussion before the actual role playing activity takes place. For example, girls can be asked what they would do in a situation where they were being asked to engage in sexual intercourse but were reticent to have sex. Different ways of responding can be brainstormed first and then a selection of responses can be rehearsed. In this way, girls can develop their abstract thinking in ways that may be difficult to do by themselves (Metcalf-Wilson, 2002). The oral and visual literacy strategy used here helps to develop assertive communication ability. Rehearsal in a safe environment makes it more likely that girls will be able to transfer their new skills to a higher risk, emotionally laden dating situation. At the same time, girls need the opportunity to examine how gender role expectations may create barriers to transferring such skills. A brainstorming activity can be used to respond to questions such as: 'How might cultural messages about girls' worth influence their ability to use such skills?'

Peer education is another effective method to inform adolescents about sexual health issues (Ochieng, 2001; Phelps, Mellanby & Crichton, 1994). For example, information about obtaining condoms and their use and the consequences of having unprotected sex can be delivered in the classroom by an adolescent mother. Listening and speaking are health literacy strategies leading to better health education. Using peers to convey sexual health information may help adolescents acquire decision making skills such as those related to condom use. (A detailed lesson plan for middle adolescents is described below.)

### *Late Adolescence*

During late adolescence, ages 18-21, teenagers will have more sophisticated abstract reasoning abilities (Piaget, 1971). They have their personal values more clearly defined. Girls at this stage often have mature, long term and committed relationships with their sexual partners. Thus, they may be less vulnerable for risky experimentation and exploitation by a sexual partner. These adolescents can make a clear link between actions and long term consequences in matters of sexual health. Nevertheless, they continue to need information and guidance from

adults. They can consider advice more reasonably, reflecting critically to evaluate the appropriateness of the advice. For example, it is easier for them to listen to and discuss with health instructors unhealthy living habits and strategies for enhancing health (Ehrman & Matson, 1998) than it is for early and middle adolescents.

Physical and emotional health facts can still be directly taught by the instructor to late adolescents. The complexities of health issues, such as the control of HIV/AIDS can be more easily discussed. In addition, these more mature adolescents can see the whole picture of health issues, including contradictory viewpoints and reach their own conclusions. For example, a great number of adolescents believe that HIV/AIDS has been cured (Health Canada, 2002). The real picture of partial control but continuing loss of life takes more abstract thinking to fully comprehend. Late adolescence is a stage where such topics are more easily considered.

In summary, adolescents at every stage are experiencing many developmental changes which have an impact upon their sexual health. They ask themselves questions such as: 'Do I fit in to this group?' 'Is my body like other girls?' 'What will my parents say if I get pregnant?' Such questions address the adolescent's need for peer acceptance, which is of course sometimes in conflict with parental approval and their growing need for autonomy. They are also navigating the sometimes difficult transition between concrete thinking focused on the present and the ability to engage in abstract, future oriented thinking. Adolescents are developmentally ready to become aware of and to evaluate their understanding. Therefore, in order to be actively involved in their education rather than passively receiving information, they will benefit if lessons specifically involve them in actively acquiring knowledge.

Delivering health education is thus more successful with the application of knowledge about developmentally appropriate practices. In addition, lessons will be influenced by school context and classroom environment.

### *School Context*

When planning sexual health curriculum, the school context must be taken into account. Schools are political sites where many issues in society at large are played out. Right wing, conservative and more liberal, left wing government philosophies influence both curriculum documents and classroom implementation. For example, more conservative districts might prefer a 'just say no' type of lesson rather than the presentation of choices with positive and negative consequences. More liberal health education approaches such as providing condoms on demand, which may be easily implemented in a clinical or hospital setting where patients can choose to seek help, need to be carefully reconsidered for use in a public classroom setting with an underage population which does not have the same choice. The political climate around sexual health information especially may create additional barriers or sensitivities to



full implementation of candid, explicit and detailed information.

Schools are also designed primarily for the education of learners/students in larger class groups. There is, therefore, less possibility for one-on-one tutoring or discussions related to sensitive issues such as those related to sexual health. While many teachers now use grouping procedures to encourage interaction, even small groups of four to six become challenging to monitor because a single teacher/facilitator cannot be with each group continually.

Finally, schools have as their primary mandate the delivery of academic subjects such as mathematics, science and English. While the list of mandated curricula is growing to include other subjects, it is rare to find teachers of health education who are as knowledgeable as health professionals. Buston et al., (2002) found that many teachers are unsure about overseeing role playing exercises that focus on sexual health concerns. Courses such as Planning 10 (British Columbia, 2004) for all the province's grade 10 students contain health education as only one module along with a variety of other topics such as career planning, all taught by one teacher. Nevertheless, the school is now the only institution which touches the lives of almost all adolescents. Here is where they congregate, socialize and are accessible for receiving sexual health education interventions. Both informal information exchange in the hallways and washrooms and more formal health education occurs at school. The school in its role as educational setting, community centre and social setting is clearly an ideal environment for offering sexual health education.

### *Curriculum Implementation*

Given that the school is the ideal setting for adolescent health education, there are a number of implementation approaches that can be used for developing curriculum to make information more accessible and comprehensible. School curricula are based on the development of *knowledge*, *skills* and *attitudes* such as those found in the Common Curriculum Frameworks from the Western Canadian Protocol for Collaboration in Basic Education (Governments of Alberta, British Columbia, Northwest Territories, Manitoba, Saskatchewan & Yukon Territories, 1998). The Planning 10 curriculum (British Columbia, 2004) calls for learners/students to have *knowledge* of the factors affecting health and characteristics of safe and caring schools. *Skills* include how to work with information. For example, learners/students need to know how to access and analyze health information. *Attitudes* include the emotional mindset to consider the information acquired. For example, persistence is important in the consideration of conflicting information on best health practices and tolerance is crucial in a multi-cultural community with a variety of understandings about healthy behaviours. Sexual health education instructors who want learners/students to learn about condoms would have *knowledge* outcomes such as how safe condoms are

in protecting the user from STD/STIs or unplanned pregnancy. A related *skill* outcome might be the ability to put a condom on a wooden penis in the dark. An *attitude* outcome could be the acceptance of the necessity of using a condom every time they have sex.

In order to achieve the development of knowledge, skills and attitudes, educators must consider learners/students' prior understanding in each area. There are various ways to determine learners/students' background knowledge. A writing activity, for instance, will quickly reveal the range of understanding, misunderstanding and curiosity related to the topic. For example, learners/students can be told the topic of an upcoming class on 'Condom Use' and asked to write anonymously for three minutes about what they know about condom use. Such an approach can be assigned at the end of the class previous to the planned lesson so the instructor has time to review the material and plan accordingly. Such an approach has the additional benefit of alerting learners/students to upcoming lessons and reinforces positive classroom atmosphere because it shows learners/students that their input is valued.

### *Classroom Environment*

Adolescents are best reached within an approach which is learner centered. Learner centered instruction acknowledges the primacy of the learner's background, understanding and receptivity to learning situation. Following the previously discussed premise of social constructivism, groups of learners work collaboratively to build knowledge and understanding of new ideas. In order to facilitate the likelihood of productive outcomes, relationships within groups become salient characteristics of such groups. Meaningful relationships established between and among peers and adults can provide a supportive environment for dialogue on sensitive issues leading to co-construction of knowledge. Young women especially build understanding best in cooperative groups which are congruent with the ways young women have been socialized to understand, communicate and construct meaning (Belenky et al., 1986).

Group approaches to obtaining information and problem solving, common to schools, can be adopted by health professionals in other contexts as well. Therefore, educators are advised to enter an educational site with an openness to accept and work with adolescent learner' needs. Supportive relationships as discussed above make it more likely that adolescents will attend to instruction.

### *Instructional Framework for Lessons*

Once the school context and the outcomes mandated by the curriculum are considered, the instructor is ready to plan a specific lesson, considering principles of effective teaching while formulating their lesson approaches (Begoray & Banister, 2005). The lesson below also infuses the

six literacy strategies. Readers will find reading, writing, listening, speaking, viewing and representing contained in brackets within the lesson plan.

Instructors should first consider providing clear lesson outcomes. For example, a lesson outcome might be: *Learners/Students will be able to orally differentiate between passive, assertive and aggressive behaviours and visually represent each one.* Passive behaviour means that individuals merely agree to the wishes of others without asserting their own needs. People engaged in aggressive behaviour are attempting to dominate others through verbal and or physical intimidation. They force others to acquiesce to their point of view. Assertive behaviour shows respect for others while expressing one's needs and desires. Second, instructors can choose appropriate strategies to assist adolescents to reach the desired outcome, for instance by discussing definitions of passive, assertive and aggressive behaviours, then performing a role play in which they represent such behaviours, ending with writing a journal entry where they reflect on the personal meaning of the behaviours.

Pre-planning a lesson helps the instructor to put into practice the principles outlined above with regards to developmentally appropriate learning strategies and using a variety of literacies to reach all learners. An efficient heuristic to organize a lesson plan is the Instructional Framework (Vacca, Vacca & Begoray, 2004). Instructors can think of the lesson in three parts:

**Opening, Body, Closing:** The Opening section may include such elements as explaining the purpose of the lesson or outcome to the learners, discovering what background knowledge or experience learners bring to the lesson, engaging learners' interest in the topic to be addressed and providing any directions that learners will need in order to participate fully in the learning experience. The Body of the lesson is the major part. Having set up the learners for maximum success in the opening, the instructor must then engage their attention in the material to be learned. Finally, each lesson needs to be completed with activities that extend learning to other contexts beyond the classroom. Realistically, single lessons cannot be expected to change behaviours which have been developed over periods of time. Repetition should be a part of further lessons to reinforce new knowledge, skills and attitudes.

#### *A Sample Lesson Plan on Safe Sex*

This lesson is made up of two, one hour consecutive interactive sessions on sexual health with 25 female learners/students in middle adolescence who are participating in a family life class in a high school. The lesson facilitator could be a school nurse or teacher. In the planning, she concentrates on concrete activities, suited to the developmental level of the girls and applies six strategies of literacy teaching.

The lesson assumes a previously established, adolescent friendly classroom environment. Such an environment might include comfortable

chairs, colorful posters about the topic placed on the walls, privacy for class conversations, a well-established rapport between the girls and the facilitator and among the girls. Many family life courses include opportunities for participants to place questions anonymously in a small box (similar to a suggestion box in an office or business setting). The questions can be used to guide lesson planning and discussion in various lessons.

The first sexual health session in this example included an introduction to the topic. The facilitator had read the questions on this topic from the box and used some as topics for the lesson. The questions were referred to throughout the session to acknowledge the girls' concerns and focus on their own understanding about their needs. The facilitator developed links between those questions and delivered basic information about safe sex. She also addressed the consequences of having unprotected sex. At the end of this first one hour session, the girls were invited to create a scenario related to safe sex with an intimate partner for a role play performance in the next session described below.

### *Opening*

1. *Explaining the purpose of the lesson to the learners.* The facilitator explained that the purpose was to provide the girls with some concrete experience about discussing safe sex with an intimate partner (listening).
2. *Discovering what background knowledge or experience learners bring to the lesson.* The facilitator then engaged them in brief review of the previous class on safe sex and consequences of having unprotected sex (listening, speaking).
3. *Engaging learners' interest in the topic to be addressed.* The facilitator reminded them that their questions were used to create the lessons and guide the plan for the day (listening).
4. *Providing any directions that learners will need in order to participate fully in the learning experience.* The facilitator then addressed the role play experience by providing some basic rules. For example, the audience is instructed to avoid interrupting the actors. Each role play has two participants with the audience sitting in a semi-circle surrounding the actors. It is the role players' job to act out the scenario. The audience is directed to focus on specific aspects of the role play during successive observations. For example, observers can be watching the body language of each participant as the pair negotiates whether or not to use a condom. In addition, the audience could focus on the actors' words. Observers can write their observations on a notepad during the role play. Writing will encourage learners to connect individually with the scenario rather than following the opinions of the group. Role plays in this learning situation are most effective when kept

short (three to five minutes). The opening is kept to ten minutes (listening).

### *Body of the Session*

Having set up the learners for success in the Opening, the facilitator can now engage learners through the role plays. This section of the lesson is kept to 40 minutes.

1. *Introducing the topic of assertive behaviour.* The facilitator describes the difference between passive, aggressive and assertive behaviour and how each may contribute to sexual health enhancing or compromising experiences. Each behaviour can be represented by drawing 'stick people' on a chalk board or flip chart. This section of the session takes approximately five minutes (listening).
2. *Providing concrete examples of passive, aggressive & assertive behaviour.* The facilitator demonstrates each behaviour in sequence by speaking to an imaginary 'boyfriend' about having safe sex. Learners are invited to ask questions about the examples in order to clarify the points being made (listening, speaking).
3. *Recapping the main points in the scenario about safe sex created in the previous session.* This helps the learners recall the details and anticipate how the role play might unfold. The facilitator then asks for two volunteers for the role play (listening, speaking).
4. *Facilitating the role play.* Spontaneity is encouraged to help actors feel comfortable in their roles. The pair will partake in three brief role plays demonstrating each behaviour. In the first role play the girlfriend uses passive behaviour in negotiating safe sex with her boyfriend. After two minutes the facilitator asks the actors to stop the interaction and poses questions to the group to help them think about verbal and nonverbal cues. 'What did you notice?' 'What stood out?' Following a brief discussion the same procedures are used for role playing aggressive and assertive behaviour. Such rehearsal of social interaction can increase learners' awareness of social cues and help them in assessing future risky situations (Schaalma et al., 2004). It also facilitates the practicing of verbal skills important in all communication situations (viewing, representing, speaking, listening).
5. *Debriefing with the group.* The actors are invited to share their perception of being in their roles. Observers are then asked to share their observations of the role plays and key features of each. Group discussion facilitates learners' perspective sharing and helps them consider alternative ways of behaving in social situations where risky behaviours may occur (listening, speaking).

### *Closing*

This final section of the lesson helps learners integrate new knowledge and encourages them to anticipate future learning in the area. This section is kept to 10 minutes.

1. *Encouraging reflection, critical analysis & discussion of knowledge or skills that learners acquired from the lesson.* The facilitator can pose questions such as: 'What was the main thing you learned?' 'How did you learn it?' asking for oral or written response (listening, speaking, writing).
2. *Engaging learners to consider ways that the learning may be transferred to other contexts.* "How might you apply some of the learning?" "What is the first step?" (listening, speaking)
3. *Generating learners' ideas about what to include in future sexual health information sessions.* 'What do we need to do next?' Inviting learners' input into future lesson plans can facilitate forward thinking and learning that is relevant to learners'/students' lives (listening, speaking).
4. *Assessment of the lesson's effectiveness must be based on an evaluation of the learner/student's ability to meet the stated outcome.* In this case, instructors might observe and make brief notes on each participant's ability to verbally and visually engage with knowledge about passive, assertive and aggressive behaviour. Such assessment is termed 'authentic' as it involves an actual application of knowledge. This lesson integrates all six literacy forms (speaking, listening, reading, writing, viewing, representing) and provides a concrete activity leading to more abstract thinking.

### *Final Words*

Adolescent girls' serious health issues are often not properly acknowledged in health promoting programs especially within the schools. Gender-based determinants influencing such relationships are generally overlooked. In addition, adolescents are not well informed about their sexual health which may lead to risky sexual behaviours. For example, many adolescents believe that STD prevention is not necessary in monogamous relationships (Health Canada, 1998). This is important given that decisions about sexual behaviour during adolescence can have lifelong consequences (Health Canada, 2002). While acknowledging the highly politicized nature of sexual health (DeKeseredy, 2000) our program seeks to provide psychological resources including community support and information (Denton, Prus & Walters, 2004) to assist girls in forming healthy dating relationships before they become adults.

It is a challenging job to make informed decisions in a world where health information abounds—and decision making can have very real consequences. A curriculum such as for example British Columbia's

Planning 10 (2004) mandates just 36 hours to teach a variety of health issues, including sexual decision making, HIV/AIDS, substance use and misuse and road safety. Careful approaches to teaching health education in all contexts are important. Knowledge, skills and attitudes which are transferable to new situations are the most valuable. The literacy learning strategies of reading, writing, listening, speaking, viewing and representing are useful in a variety of contexts. Teachers come and go, knowledge explodes, information changes and adolescents grow up. Peers cannot always be relied upon to provide accurate information. Individuals must be given the tools and time to reach their own decisions.

If we are to reach adolescent girls where they are, we need to prepare educators to deliver sexual health information using a variety of effective well informed approaches which are sensitively implemented (Schaalma et al, 2004). Such education needs to be based on literacy strategies and developmental appropriateness and awareness of gender-based determinants. Lessons need to be delivered in positive, nurturing classrooms, taking into account the local school context, government mandated curriculum and established instructional frameworks. Education and health promotion experts can work together to address adolescent girls' sexual health education needs.

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