
Sex education: teachers' and future teachers' conceptions and social representations; what relevance for teachers' training?

Education à la sexualité : représentations sociales, conceptions des enseignants et futurs enseignants, quelle incidence en formation ?

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Abstract

School-based education programmes are particularly good at providing information and opportunities for skills development and attitude clarification in more formal ways, through lessons within a curriculum. To public health, school sex education is nowadays an important public health issue as it concerns not only youth AIDS prevention (and other sexually transmitted infections) and adolescent pregnancy prevention but also interpersonal relationships and psychosocial issues. So it's very important to well know the obstacles to sexuality education's implementation. Therefore school sex education contributes to promote better citizenship. Various researches show the importance of social representations on teachers' individual conceptions and practices. In this communication we analyse teachers' and future teachers' conceptions about sex education by using a questionnaire from 12 countries of Europe, Africa and Middle East, focusing on differences in conceptions related to controlled parameters (e.g. social context, religion, gender). It was applied to 5189 teachers and future teachers and we used standard statistical multivariate methods to investigate the structure of this complex dataset. The results show that teachers' conceptions and future teachers' conceptions clearly correlate to social representations linked to the countries' culture, to religion, and in individual conceptions, especially to the level of belief in God and the level of religious practices. It was also found that the level of teaching (primary versus secondary school) and the training level correlate to individual conceptions on sex education. Detailed results will be presented and discussed at the meeting and we will conclude on their incidence on teacher's training program.

Acknowledgements

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This study is included in the Biohead-Citizen research project « Biology, Health and Environmental Education for better Citizenship » (FP6, CIT2-CT2004-506015, Carvalho et al. 2004). One of its two axes aims to analyse in service teachers or pre-service teachers' conceptions. We will present here the first results coming from 12 countries on the reproductive health education /sexuality education [RHE/SE].

Our objective is firstly to identify the teachers' conception variation, in each country and between countries. Are these conceptions linked with knowledge, with believes, philosophical or/and political issues? What is the role of local and social practices in each country? How are the interactions between “knowledge”, “values” and “social practices” (Clément, 2004)? In fine, what are the in service teachers or pre-service teachers' conceptions on RHE/SE and on the impact of RHE/SE would be promote better citizenship.

We aim to build training programmes on teachers' knowledge of and attitude towards reproductive health education /sexuality education [RHE/SE].

1. Scientific background

Sex education, sometimes called sexuality education or sex and relationships education, is the process of acquiring information and forming attitudes and beliefs about sex, sexual identity, relationships and intimacy. It is also about developing young people's skills so that they make informed choices about their behaviour, and feel confident and competent about acting on these choices. It is widely accepted that young people have a right to sex education, partly because it is a means by which they are helped to protect themselves against abuse, exploitation, unintended pregnancies, sexually transmitted diseases and HIV/AIDS.

Human sexuality is not enclosing in the life transmission and includes four important dimensions:

- Anatomy and biology with sex physiology, procreation and survival mankind
- Social dimension with cultural influence, social norms and rules and theirs political, juridical and religious incidences
- Psychological dimension with gender issue, the personality's construction and self esteem.
- Affective and relational dimension with feelings (love, desire), points of vue and emotions...

Sexuality presents a multidimensional aspect and concern deeply humans in the interweaving between sexuality, social influences, cognitive and affective development. So sexuality can be reduce in a dichotomy biology/psychology and involve in same time psycho-affective and biological maturation and social learning.

Sexuality education seeks both to reduce the risks of potentially negative outcomes from sexual behaviour like unwanted or unplanned pregnancies and infection with sexually transmitted diseases, and to enhance the quality of relationships. It is also about developing young people's ability to make decisions over their entire lifetime. Sex education that works, by which we mean that it is effective is sexuality education that contributes to this overall aim.

Although most interventions on Sex education concern teenagers (see ref in Kirby, 2002) or young adults (Ergene and al., 2005), the WHO texts insist on the necessity for implementing early sexuality education, particularly in primary schools (WHO, 1999;

2004a). Many authors underline the importance of the educational dimension of this: “the action must be integrated into a global life-education strategy; the way it is spoken of must be adapted to the situation, the parents’ involvement, as they are the first resource for the children, must be as great as possible, and the educators must come from different fields” (AFLS, 1993).

It is necessary, in order to go beyond a prescriptive approach, and adopt a decidedly educational perspective, to implement a learner-centred approach (Develay, 1993), taking into account the children’s peculiarities, expectations, needs, and also their own conceptions (Fischer, 2001). In this way, taking into account pupils’ conceptions is an important part of the learning process. The interest of taking them into account in an HIV/AIDS or sex education programme for children under twelve has already been underlined (Fassler and al., 1989; Ferron and al., 1989; Thomas, 1991; Sly and al., 1992; Schaalma, Kok and Peters, 1993; Shonfeld and al., 1993; Kelly, 1995; WHO, 1999 ; 2004a ; 2004b).

The model on which these propositions was based assumes that learners build knowledge from their own lives. They learn through social representations, which depend on each person’s social culture and experience, and build individual conceptions. Learning is a highly active mental process which works in an integrative mode in the conflict between what the learner has in his mind and what he can find and understand through his conceptions about his environment. When a learner makes a new model, his mental models must be rebuilt in an interaction between the pre-existent conception and outside information (Giordan, 2000). Sex education requires the teacher to take into account the pupils’ conceptions and to help them build other more relevant ones. Moreover, the child’s environment must be taken into account in the programme as children’s conceptions are not only based on what they learn at school, but also on all the other aspects of a child’s life (Downie, Tannahill and Tannahill, 1996) and including culture and social representations .

Representations are to be taken as coherent models used by learners and teachers to reason when faced with a problematic situation (Jodelet, 1991; Farr, 1997). The building of these is rather complex and depends on values and beliefs shared by a social group and which give rise to a common outlook manifest during social interactions. As these representations are linked to the subject’s emotional responses, the cultural and social group he belongs to, and constitute a decisive element in his relationship with the world, they are resistant to change. Representations are closely linked to behaviour (Abric, 1997) and they could be considered as being a good target, as it is well known that knowledge is easy to change, but behaviours are much more challenging. Thus if a study aiming at impacting these representations is to be relevant, it has not only to target the transmission of knowledge, but also to take into account the social and cultural aspects of the children’s and teacher’s daily environment (Doise and Mugny, 1997).

Most researches are quasi-experimental designs. This method is of great evidentiary value but, due to its peculiarities, sex education also needs other designs (Victoria and al. 2004). In our context using the controlled randomized trial as a method for assessing the effects of the social representations is really difficult. The impact of representations means that using a control group is delusive, and that randomisation is tricky (Tones and Tilford, 2001). This is mainly because causal chains in public health interventions are very complex. Although such an approach has its limits, several authors conclude that they are in favour of new research on teachers’ conceptions being set up, aiming at determining exactly what content and what tools would be most suitable (Darroch J. and Silverman J.

1989 ; Heymans, 1993). Associating multidisciplinary partners in the drawing up and the implementation of the researches' programmes makes it possible to better understand the interactions between teachers' conceptions and social issues (beliefs, knowledge and practices) (Martinand, 2003; Clément, 2005). If these interactions were not considered, they would be confounding factors.

2. Methodology

Between the 19 countries of the Biohead-Citizen project, 12 give us data on sex education. Four are outside Europe and widely (Tunisia, Morocco, Senegal) or in large part (Lebanon) muslim. Height countries are Europeans members (Portugal, France, Italy, Finland, Cyprus, Estonia, Hungry and Romania) and resent different characteristics: north and south, east and west Europe, catholic, protestant or orthodox culture.

In each country, we have data coming from pre (PRE) and in (IN) service teachers in primary school (P) and in secondary schools in biology (B) and national language (L) in 6 balanced data groups.

The corpus include responses from 5189 questionnaires: Cyprus (CY, 322), Estonia (ES, 183), Finland (FI, 306), France (FR, 732), Hungry (HU, 334), Italy (IT, 559), Lebanon (LB, 722), Morocco (MA, 330), Portugal (PT, 351), Romania (RO, 273), Senegal (SN, 324), Tunisia (TN, 753).

2.0. Questionnaire and coding

The questionnaire was elaborated in the Biohead-Citizen Project in a common work with all the research teams and translated in national language (validate by retro-translation). It was pre-tested before implementation in each country.

Our work concerns only Sexuality education (cf. annex) and 35 questions (A2, A9, A21, A 30, A31, A36, A41, A 46, A57 to A60, A65, A85 to A90, B3, B5, B11, B13, B17 to B19, B24, B30 to B32, and B37 to B41).

Responses are coding with a number scale. Questions A2, A9, A21, A 30, A31, A36, A41, B1 to B3, B5, B6, B9, B12, B13, B15 to B19, B21 to B27 are coding from 1 to 4 from « agree to totally disagree”.

Few questions are on values (e.g. A41: “Homosexual couples should have the same rights as heterosexual couples”), on biological knowledge (e.g. « B17: After ovulation, the follicle changes into corpus luteum which produces high levels of progesterone and estrogens”). More are on teaching practices, values and knowledge (e.g. B19: Psychological and social aspects of sex education should be taught primarily by biology teachers). Questions A57 to A59 and A65 are about abortion. Responses are coding from 1 “In this case, abortion is morally acceptable” to 4 ”In this case, abortion is morally unacceptable” and in A 65 “Abortion is acceptable” , from 1 “never” to 5 “ at any moment”.

Question A 60: “There are several behaviours that can help to decrease the spreading of AIDS world-wide. In your view, what is the behaviour you find most relevant to be considered in school sexual education? “, is coded from 1 “To have sex only within a stable relationship (not have several sexual partners)” to 4 “To have safer sex, for instance by using a condom in sexual intercourse”.

The questions A85 to A90 and B37 to B41 are on the age teachers think the following topics should be first introduced at school by teachers and/or external specialists. Responses are coded from 1 “less than 6 years old” to 5 “never in school”.

2.1. Responses' Analysis

Our hypothesis is that teachers' personal values influence their conceptions on sex education. These conceptions may be linked to the school disciplinary (biology or national language), to the teaching level (primary or secondary level), to the training (in service or pre service). But the variables linked to country's context, religion or gender, are determining. What may most differentiate the conceptions of individuals with varying religions, specialities or any other feature? In fact, how to highlight the link between conceptions related to scientific knowledge or educative system in one hand and the teacher's personal, social and cultural background on the other hand?

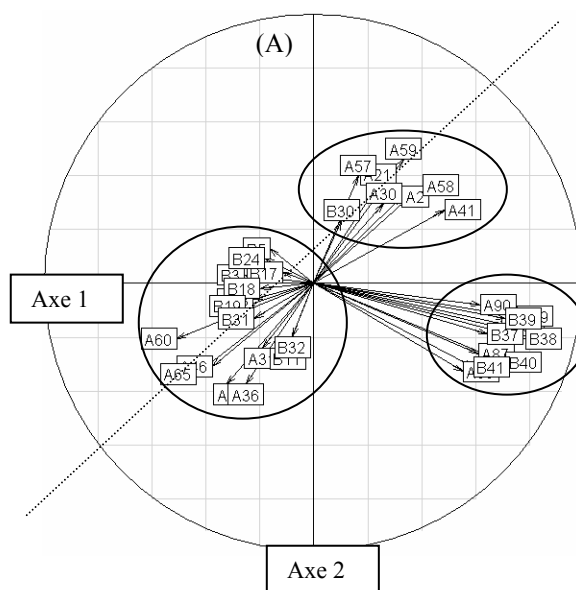
Multivariate analysis allows representing the more structuring components of individuals. These components state better individual's variance. Statistical multivariate analysis has become a standard to investigate complex data featuring the behaviour of many individuals, according to many variables (Lebart et al., 1995). Here variables are questions in a questionnaire for which we gathered answers. To analyse the HRE/ SE and teaching practices data, we use principal component analysis (PCA, Lebart et al., 1995). Variables are coding as numbers. We have done a discriminating analysis (Between group analysis, Dolédec & Chessel, 1987) in complement of PCA to show differences between groups' conceptions (country context, religion, faith and gender). We use instrumental variables in responses' structures as disciplinary (P, B, L), training (In or Pre service) and countries.

3. Results and analysis

In this results' presentation, we have chosen to don't show calculation, just graphics which are more explicit. We present the first results and just few variables. We don't propose an exhaustive study, just a skimming over to explore the new research field founded by Biohead-Citizen Project.

3.0. Global approach

Figure 1: Principal component analysis (PCA), global correlation circle



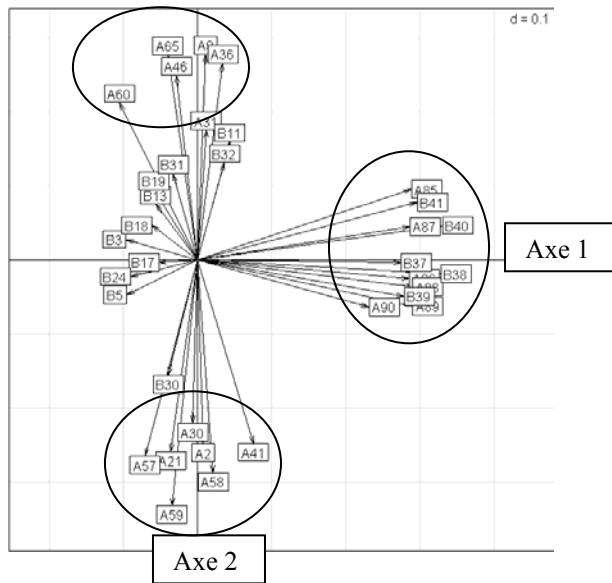
The schema shows us three distinct groups of variables. The group of questions (A) contributes strongly to axe 1 and illustrate that teachers think it is not possible to teach the social components of sexuality education to young pupils. Moreover they don't agree to teach in school before 15 years old contents as homosexuality, paedophilia, pleasure organs, abortion, incest and sex violence, orgasm and pleasure, eroticism and pornography (A85 to A90 and B37 to B41). Netherless, pupils found all these topics in their daily life with their peers, in the streets or in the media (press, radio, TV...).

There is another interesting correlation. We found a group (B) composed by questions about possibility of abortion (A57 to 59); the respondents who don't agree with abortion think also that women have not the same rights then men (A2), that it's not important to have same number women deputies than men (A30) and that women, biologically, have not same intelligence than men (A21). For them, Homosexual couples must not have the same rights then other couples... And they think also, it's the hazard who determines the sex of a baby (B30).

The group (C) of questions is defining the same oblique axis as the group (B), with just opposite positions: it's possible to try to choose baby sex by specific diet or medically assisted techniques (B31, B32) and who agree with the idea that abortion would be acceptable at any time (A65); a man can be as sensitive and emotional as women (A46) and there is no biological reason which would justify inequality between men and women (A6, A36, A46). Finally the question related to safer sex (as behaviour most relevant to be considered in school sexuality education) is included in this group (C) of questions.

Using the Varimax processes, the 3 groups of questions are clearly correlated the first orthogonal first axes (Figure 2). There are two groups of variables who contribute to the first axe and are determining in the teachers' conceptions. In one hand we found a group (A85 to A90 and B37 to B41) who concern the contents of sexuality education. Clearly, to the teachers, these contents do not be taught in primary school never in the first years of secondary school. In other hand, on the same axe, they think that teachers avoid to teach SE because it's private.

Figure 2: global approach, Varimax technique



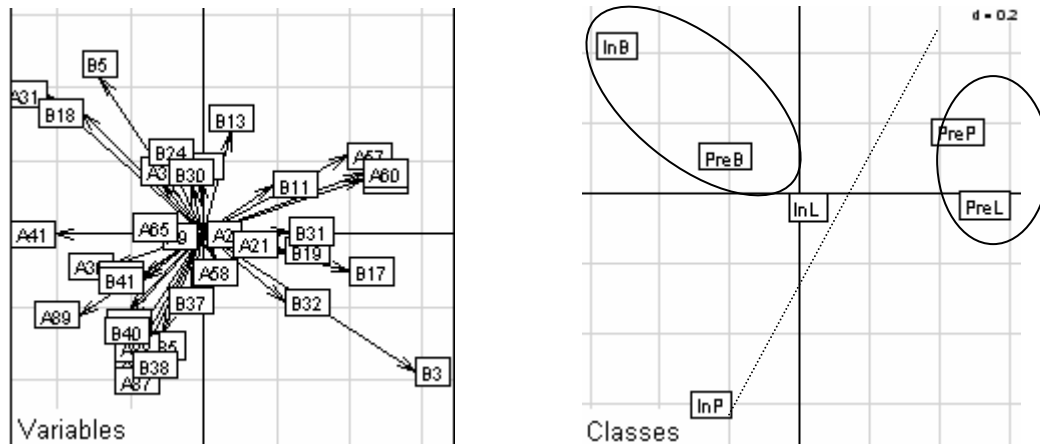
The varimax technique is interesting because it increases the differences between the variables and allows a better chart's interpretation. In the second axe (men/women equality and abortion) we found 2 groups who contribute. The first group include those who are opposed to abortion (A57, A58, and A59). It's interesting to observe that this group agree also with the thesis of inequality between men and women (A 21, A2, A30) and are opposed to homosexual rights. In the diametrically opposite we found clearly people who agree with safer sex, homosexual rights, abortion at any time and to the equality

between men and women (they don't agree with A9, A36 and A46). The values appear clearly. We have now to try to identify the controlled parameters linked to each group of values.

3.1. Training issue

The analysis (figure 2) shows us a difference between training. A PCA has been done to differentiate the six "groups of teaching" controlled in our sampling design (pre or in service, primary or secondary level, biology or letters). In fact Biology teachers (in service or pre service) have conceptions more based on knowledge and on the conviction that they can teach the whole dimensions of sexuality education (Q A31, B5, B18 B17, B22, B3 B24, B30). They think that they have to teach biological aspects of sexuality (human reproduction and ISD) and say that they are able o speak with their pupils about emotion, feelings, pleasure but they have the same difficulties as the others with safer sex (A60) and homosexual rights (A41).

Figure 3: teachers' statute variable



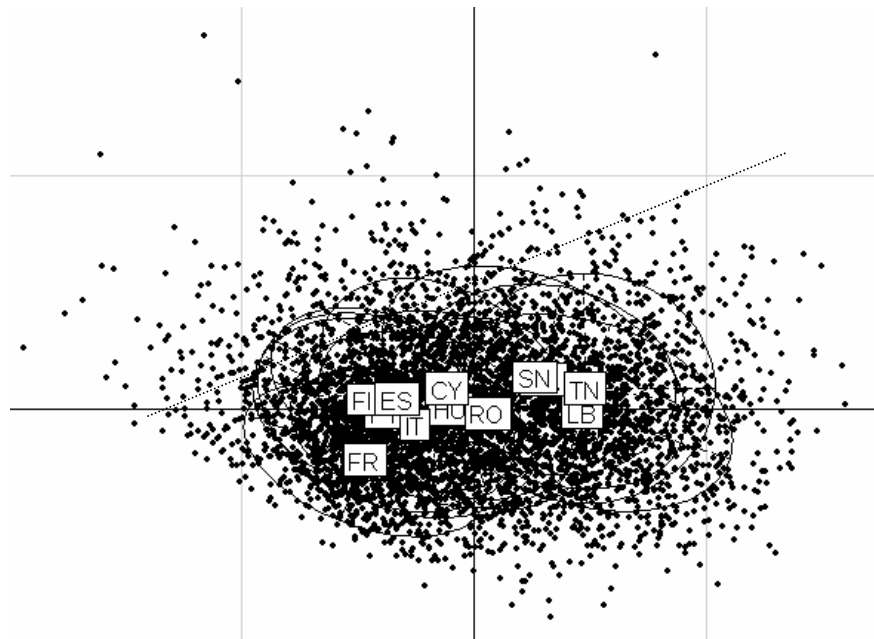
In relation with the others groups, we found a clear difference between in service and pre service teachers in particular for primary teachers. The in service primary teachers are in difficulty in front of the content of sexuality education especially with social and affective issues like homosexuality, abortion, contraception, pleasure organs, paedophilia, safer sex (Questions : A 85 to A90, A 60) for example their conception is based on a false knowledge about the homosexuality origin (Question: B11).

The pre service primary teachers are in opposition with in service primary teachers and agree with safer sex, abortion, homosexual rights... and prefer teach these contents early in the curriculum.

There is an effect of age in the teachers' conceptions. Inside the three thematic groups (primary, secondary biology and secondary letters), older teachers (in service; mean age = 40 years old) are always on the upper part of the axis 2 and the younger teachers (pre service; mean age = 23 years old) are in the lower position (figure 3).

3.2. Country variable

Figure 4: (PCA) between analysis to differentiate countries



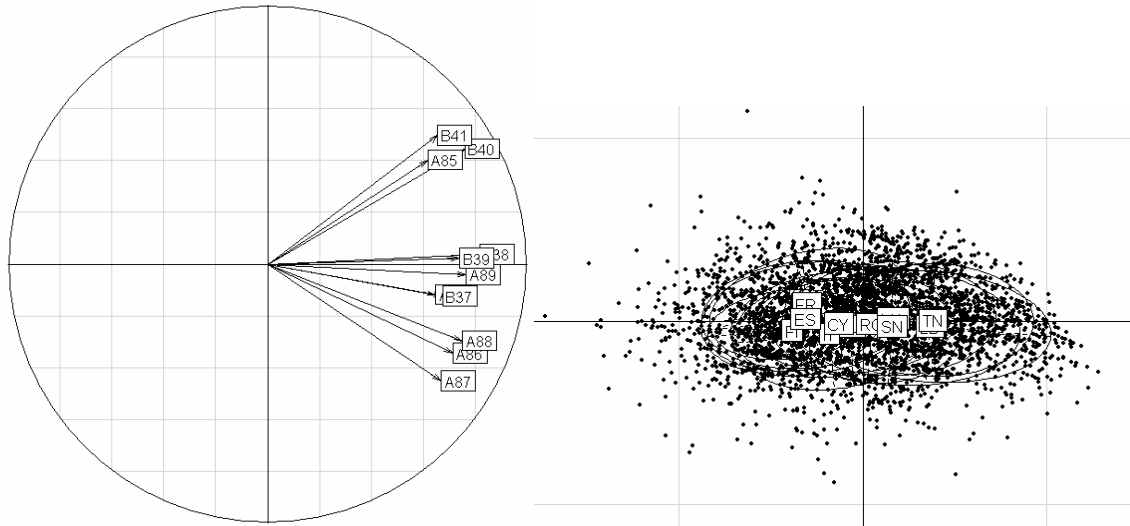
When we link the data (fig 1) with countries variables, the schema indicate clearly the incidence of a cultural effect. We have on the first axe the distribution of the countries between two poles. At one end we have Lebanon, Tunisia, Morocco and Senegal at the other end France, Finland, Portugal, Estonia and Italy, in the middle, Hungary, Romania and Cyprus. Crossing this graphic with the figure 1, we can see that there is a correlation between countries and conceptions.

The charts are linked by axes' superposition. It seems that European countries have different point of view and conceptions than south countries. News entrants in Europe are in middle position. According to figure 1, we can see that south countries have conceptions founded on inequality between men and women and about their rights and same thing about homosexual rights. They have conservative conceptions about abortion, safer sex and sexuality education. They do not agree to teach sexuality topics in primary school or in

first years in secondary school before 15 years. In opposition around France (Fr), we can see the correlation with open view about abortion, equality between men and women and homosexual rights.

But we have to nuance this analysis. The opposition is also in teaching practices about topics like homosexuality, paedophilia, pleasure organs, contraception, abortion, sexual diseases (A85 to A90). France, Finland, Estonia, Portugal and Italy agree more to teach these contents.

Figure 5: Principal component analysis (PCA) questions A85 to A90 and B37 to B41



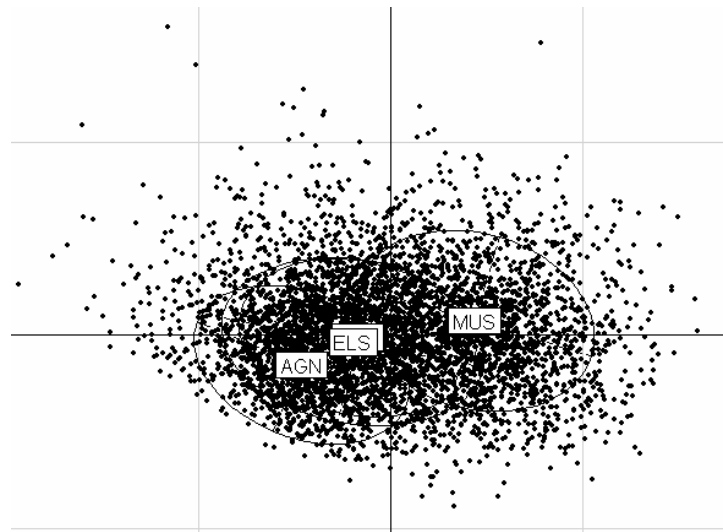
The charts are explicit on these issues. We see on the left chart the distribution of these questions on the correlation circle. Their scores are superior to 3 or 4. It seems that teachers think that the following topics should be first introduced at school by teachers not before 15 years old. The vectors show us where these conceptions are strongly implanted. The right chart indicates the countries concerned.

The questions about social aspect of sexuality (B37 to B41; pregnancy and birth, sexual intercourses, incest and sexual violence, orgasm and sexual pleasure, eroticism and pornography) have scores near 5. The teachers clearly think that it's not their job to teach these contents. The scores are powered by south countries.

On the right charts we can see two poles. One is constituted by south countries (Tunisia, Lebanon, Morocco, and beneath Senegal) and the other one by European countries (France, Estonia, Finland, Portugal, Italy, and beneath Cyprus). New entrant's countries are in the middle (Romania, Hungary). In the right chart we can see also the large distribution of the answers reveal the conceptions' diversities.

3.3. *The religious impact*

Figure 6: religion distribution (MCA)



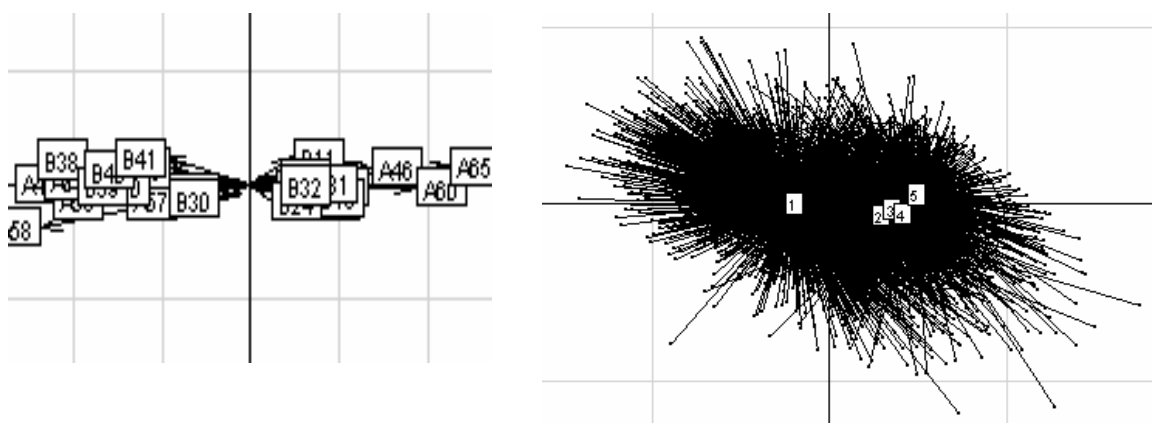
The four categories (AGN, agnostic, atheist, without religion; MUS, Moslem [Sunnite, Chiite, Druze and Alevi]; ELS, other religions or believes [Jewish, Hindus, Animist...]; CHR, [Catholic, Protestant and Orthodox]). We have two poles on an axe with in one hand Moslem and in the other hand Agnostic. In the middle part, we found others religions and Christians. With a similar process; we have crossed religion and teachers' conceptions (cf. fig1).

There is a strong correlation between religion and teachers' conceptions. Agnostics and atheists agree with the idea that abortion would be acceptable at any time (A65). They think also that a man can be as sensitive and emotional as women (A46) and there is no biological reason to inequality between men and women (A6, A36, A46).

For them, safer sex is the behaviour they find most relevant to be considered in school sexuality education. They agree with rights' equality between men and women and homosexual couples. At the opposite we find Moslem. This statement needs to be qualified. So, we crossed this data with God believing levels.

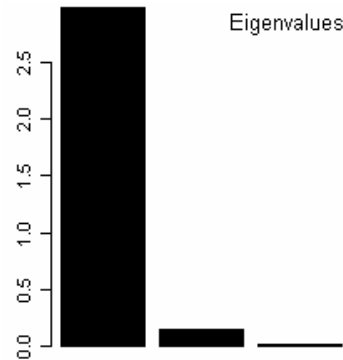
3.4. *Crossing the data with God believing levels.*

Figure7: between groups analysis, faith's distribution (1= high level to 5=no faith)



In question P12, The responses are coded from 1 “most important” to 5 “I don’t believe in God”. To do that, we use a PCA which illustrate that the level of faith is an important variable more than religion’s membership.

Figure 8: relative contribution of main factors (faith’s level)



The variable “faith” contributes heavily to axe 1 as also shown by this graph.

There is a great difference between those who have a high level in faith (1) and all the others (2, 3, 4 and 5). We note a small scale progression between 2 to 5 along axe 1.

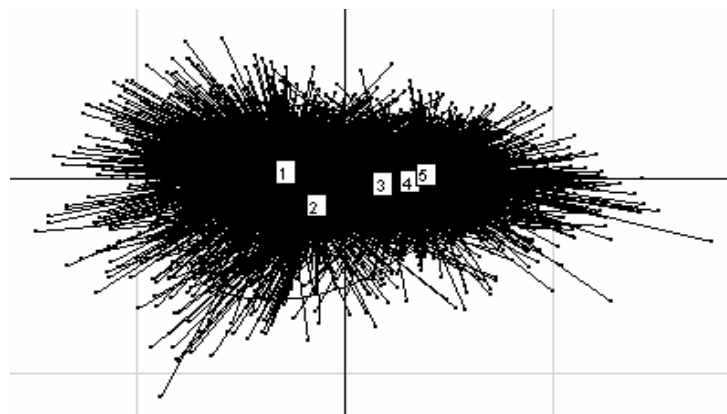
All the data are clearly oriented in two blocks. Those who believe deeply in God are positioned on conservative point of view about men and women equality about women rights and homosexual rights. They don’t agree with abortion and they think that it is not to school to teach social content in sexuality education.

In the opposite, more the teachers don’t believe in more they agree with social contents of SE and think that men and women are equal, more they agree with women rights and homosexual rights. They think also it’s possible to teach social contents as paedophilia, homosexuality, incest and violence, sexual intercourses... pregnancy and birth and they agree abortion at any moment.

It is also interesting to cross these data (faith level) with religion. In fact the results show us that faith’ level is the most important factor which impact on teachers’ conceptions. Christians with high faith’s level have same kind of responses to the questionnaires than Moslem with same level.

3.5. *Crossing the data with religious practices*

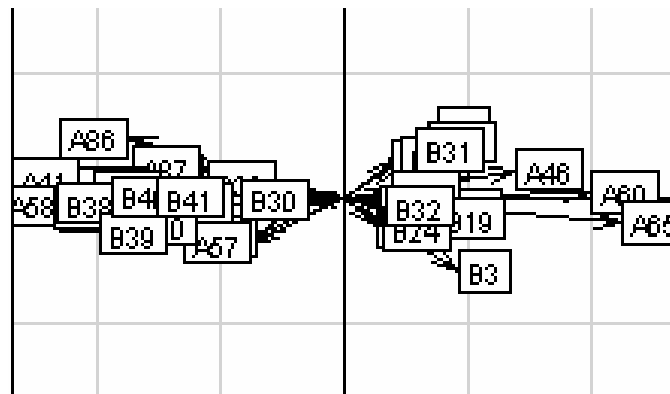
Figure 9: Between groups analysis, religious practices (1=high level to 5 =no practices)



This schema shows us the evaluation of religious practices' level. The responses are coded from 1 "I practice a religion" to 5 "I don't practice a religion". The distribution near axe 1 indicate that the religious practices' factor is also relevant

In coherence with the faith level we can observe two groups. The first composed by those who declare practising a religion (1 and 2) and the other characterised by low practices or no practice. These groups are also linked with the teachers' conceptions. We found the same orientations about teaching practices in social components of sexuality education abortion and men and women equality and rights.

Figure 10: between group analyse, variables' distribution (practices)



This chart linked with the previous one, indicates that issues about abortion (A65) and safer sex (A60) and homosexual couple's rights (A41) and about the biological aspect of sensitivity and emotion (A46) are the most relevant.

Teacher's who have a religious practice don't agree with abortion, homosexual couple's rights and safer sex, they don't agree also with the social contents of sexuality education (A 85-90 and B37-41). To the teaching practices, they think that psychological and social aspects of sexuality education should be taught by health professionals.

4. Conclusion

The implementation of early educational actions on health risk behaviours (e.g. nutrition, drugs abuse and sexually transmitted infections) can answer more effectively to the strong social demand, which has also been taken constantly by the political sector for many years in order to answer to major societal needs (WHO, 2001). Since the efficacy of the preventive policies is largely dependent of the citizens' adhesion to them, Health Education and Sexuality education turned out to be a rather important social issue. Although being a school mission, health authorities have reinforced the idea that Sexuality Education should be carried out in partnership with other social organisations involved in Health Education, in particular local organisms of the Health sector (WHO, 2006).

To study the effects of the context components and to identify the elements that interact with the sexuality learning domain has been a rather difficult task due to the lack of adequate instruments of research. It is in this field of educational determinants of the person's construction (especially his/her self-esteem) and his/her ability to communicate, that educational actions must be taken, contributing in particular to the development of the

psychosocial competencies. This involves moving beyond practices that rely mainly on classroom-based sexuality education models, to a more comprehensive, integrated approach that focuses both on child-youth attitudes and behaviours, and their environment. Sexuality is regarded as an important determinant of the personal development and wellbeing.

These first results must be considered with prudence. Deep analysis must be done to highlight precisely the variances between groups and their links with social representations and individuals' conceptions.

Forever, we have found that individuals' conceptions have a great incidence on teachers' social representations and on their practices. Recent publications (St Léger, 1998; Lister-Sharp et al. 1999; INSERM, 2001; WHO 2006) have shown that certain pedagogical activities have some positive effect, others no effect at all and yet other ones have a negative effect. This negative impact can be due not only to the quantitative increase of pupils' risk behaviours but also to the intensification of pupils' uneasy feeling or of their perception of a tension between their social/family life experience and the school prescriptions. So the teacher's conceptions are really important especially in prevention to promote health and sexual health. Sexuality Education is determined directly by both the teaching pedagogical practices and the social context (Allensworth and Kolbe, 1987; Gold, 1994) especially in skills developments.

To be effective, sexuality education needs to include opportunities for young people to develop skills, only having information is not sufficient. The kinds of skills young people develop as part of sexuality education are linked to more general life-skills. Being able to communicate, listen, negotiate, ask for and identify sources of help and advice, are useful life-skills and can be applied in terms of sexual relationships. Effective sexuality education develops young people's skills in negotiation, decision-making, assertion and listening. Other important skills include being able to recognise pressures from other people and to resist them, deal with and challenge prejudice, seek help from adults - including parents, carers and professionals - through the families, community and health services. Sexuality education also helps young people to be able to differentiate between accurate and inaccurate information, discuss a range of moral and social issues and perspectives on sex and sexuality, including different cultural attitudes and sensitive issues like sexuality, abortion and contraception.

The first prevention level is to be in capacities to access to information (WHO). Sexual health education involves a combination of educational experiences that allows individuals to do the following:

- to acquire knowledge that is relevant to their specific sexual health issues;
- to develop the motivation and personal insight that they will need to act on the knowledge;
- to acquire the skills necessary to enhance sexual health and avoid negative sexual health outcomes;
- and to help create an environment that is conducive to sexual health.

Research consistently shows that positive sexual health outcomes are most likely to occur when sexual health education integrates knowledge, motivation and skill-building opportunities and occurs in an environment conducive to sexual health.

School-based sexuality education is an important and effective way of enhancing young people's knowledge, attitudes and behaviour (Kirby, 2001, 1992). There is

widespread agreement that formal education should include sexuality education and what works has been well-researched. Evidence researches suggest that effective school programmes will include the following elements:

- A focus on scientific information about human reproduction , providing accurate information about contraception and birth control;
- A basis in theories which explain what influences people's sexual choices and behaviour and gender issue
- A clear, and continuously reinforced message about sexual behaviour and risk reduction;
- Working on psychosocial abilities, self esteem, dealing with peer and other social pressures on young people; providing opportunities to practise communication, negotiation and assertion skills;
- Uses a variety of approaches to teaching and learning that involve and engage young people and help them to personalise the information;
- Uses approaches to teaching and learning which are appropriate to young people's age, experience and cultural background;

Formal programmes with these elements have been shown to increase young people's levels of knowledge about sex and sexuality, decrease risk when they do have sex. All the elements are important and inter-related, and sexuality education needs to be supported by links to sexual health services, otherwise it is not going to be so effective. It also takes into account the messages about sexual values and behaviour young people get from other sources, like friends and the media. It is also responsive to the needs of the young people themselves - whether they are girls or boys, on their own or in a single sex or mixed sex group, and what they know already, their age and experiences.

Therefore the great challenge we have done with this study, is to identify better not only the nature of the teaching practices but also the teachers' conceptions, especially in sexuality education and their links with the practices. When teacher's have a high level in believes in God, they don't agree to men and women equality, homosexual rights, abortion and safer sex. They don't agree to teach social component of sexuality education before 15 years old. Or, the early access to information is the best way to prevent sexual violence, sexual transmitted diseases, and to promote sexual health and more largely health education. Providing effective sexuality education can seem daunting because it means tackling potentially sensitive issues. However, because sex education comprises many individual activities, which take place across a wide range of settings and periods of time, there are lots of opportunities to contribute. School-based education programmes are particularly good at providing information and opportunities for skills development and attitude clarification in more formal ways, through lessons within a curriculum. So it's very important to Public Health, especially to prevent AIDS and sexual transmitted diseases and sexual violence to well know the obstacles to sexuality education's implementation.

5. References

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6. Appendix

Questions about HRSE

- A2. In a modern society, men and women should have equal rights.
- A9. Women are less intelligent than men are because their brains are smaller than men's brains are.
- A21. Biologically, women can be as intelligent as men.
- A30. It is important that there are as many women as men in parliaments.
- A31. When a couple has already had two girls, the chances that their third child be a boy are higher.
- A36. Men might be more able to think logically than women, because men might have different brain bilateral symmetry.
- A37. Religion and politics should be separated.
- A41. Homosexual couples should have the same rights as heterosexual couples.
- A46. Biologically, men cannot be as sensitive and emotional as women.

Here are stories of couples, or women, who are considering the necessity of having an abortion. If you were in these situations, would you too consider the possibility of abortion? (Tick only ONE of the four boxes for EACH situation):

A57. A couple already has one child, and the mother is at risk of dying from a complication during her pregnancy.

In this case, abortion is morally acceptable In this case, abortion is morally unacceptable

A58. A young couple in severe economic difficulty.

In this case, abortion is morally acceptable In this case, abortion is morally unacceptable

A59. A woman who has been informed of the high probability of giving birth to a severely handicapped child.

In this case, abortion is morally acceptable In this case, abortion is morally unacceptable

A60. There are several behaviours that can help to decrease the spreading of AIDS world-wide. In your view, what is the behaviour you find most relevant to be considered in school sexual education? (Tick only ONE of the four boxes)

To have sex only within a stable relationship (not have several sexual partners) To have safer sex, for instance by using a condom in sexual intercourse

Here are stories of couples, or women, who are considering the necessity of having an abortion. If you were in these situations, would you too consider the possibility of abortion? (Tick only ONE of the four boxes for EACH situation):

A57. A couple already has one child, and the mother is at risk of dying from a complication during her pregnancy.

A58. A young couple in severe economic difficulty.

A59. A woman who has been informed of the high probability of giving birth to a severely handicapped child.

A60. There are several behaviours that can help to decrease the spreading of AIDS world-wide. In your view, what is the behaviour you find most relevant to be considered in school sexual education? (Tick only ONE of the four boxes)

To have sex only within a stable relationship (not have several sexual partners) To have safer sex, for instance by using a condom in sexual intercourse

A65. Abortion is acceptable (tick only ONE answer):

- Never
- Up to 2 weeks after conception (*i.e.* before implantation in uterus)
- Up to 12 weeks after conception (the legal period in countries where abortion is authorized).
- Up to 6 months (before the foetus can survive outside the uterus)
- At any moment

At what age do you think the following topics should be first introduced at school by teachers and/or external specialists? (Tick only one box in EACH line):

| Topic | | Less than 6 years old | Between 6 and 11 years old | Between 12 and 15 years old | More than 15 years old | Never in school |
|-------|--|-----------------------|----------------------------|-----------------------------|------------------------|-----------------|
| A85. | Organs of pleasure: clitoris, penis... | | | | | |
| A86. | Contraception and birth control | | | | | |
| A87. | Sexually transmitted diseases | | | | | |
| A88. | Abortion | | | | | |
| A89. | Homosexuality | | | | | |
| A90. | Paedophilia | | | | | |

- B3. Sexually transmitted diseases should be taught primarily by biology teachers.
- B5. Sexually transmitted diseases should be taught primarily by health professionals (doctor, nurse).
- B11. There are genetic factors in parents that predispose their children to become homosexual.
- B13. When women stop taking the contraceptive pill, menstruation occurs, due to the absence of progesterone and estrogens hormones.
- B17. After ovulation, the follicle changes into corpus luteum which produces high levels of progesterone and estrogens.
- B18. Teachers avoid teaching sex education because these topics are private.
- B19. Psychological and social aspects of sex education should be taught primarily by biology teachers.
- B24. Psychological and social aspects of sex education should be taught primarily by health professionals (doctor, nurse).

Admitting that you don't have any children and that you wish to have only one child, would you do the following?

- B30. Let chance determine the sex (as usual)
- B31. Try to choose the sex of your child by a specific diet
- B32. Try to choose your child's sex by spermatozoa selection (or by other medically assisted techniques)

When do you think the following topics should be first introduced at school by teachers and/or external specialists? (tick only ONE box per line):

| Topic | | Less than 6 years old | Between 6 and 11 years old | Between 12 and 15 years old | More than 15 years old | Never inschool |
|--------------|-------------------------------|--------------------------------------|---|--|-----------------------------------|---------------------------|
| B37. | Pregnancy and birth | | | | | |
| B38. | Sexual intercourse | | | | | |
| B39. | Incest and sexual abuse | | | | | |
| B40. | Orgasm and sexual pleasure | | | | | |
| B41. | Eroticism and pornography | | | | | |