

# APPLYING THE S – IVAC METHODOLOGY IN SCHOOLS TO EXPLORE STUDENTS' CREATIVITY TO SOLVE SEXUAL HEALTH PROBLEMS

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## ABSTRACT

*A research to evaluate the development of participatory and action-oriented sexuality education projects in schools (7<sup>th</sup> to 12<sup>th</sup> grades) (n=16), with the use of ICT will be described with the following objectives: i) to discuss the creativity of students' visions regarding how the world and their lives could be, and how society and the environment could be improved in relationship to their particular sexual concerns; and ii) to characterize the type of actions carried out to solve their sexual problems. Participant observation, group interviews and materials put online by students were selected as research techniques for the triangulation of data. The principal results showed that these students thought creatively to formulate visions and develop, individually or collectively, reflexive actions which lead to positive changes in their lifestyles and/or living conditions which improve their sexuality.*

Key Words: Sexuality education; action-oriented knowledge; visions; actions; action competence.

## 1. Introduction

### **The Portuguese Context of Sexuality Education in the school community**

The approach to sexuality education adopted in Portugal has been focused on the sexual health aspects associated with the acquisition of health results that are generally seen as positive (e.g. respect for oneself and for others, self-esteem, compensating human relationships, pleasurable sexual relationships and a desired maternity/paternity), and the avoidance of negative results (e.g. unwanted pregnancy, sexually transmitted diseases/ HIV infections, sexual coercion). The current Portuguese legislative framework advocates the compulsory inclusion of sexuality education in primary, preparatory and secondary schools, within a programme aimed at health promotion and human sexuality, in which suitable information will be provided on human sexuality, the reproductive system and the physiology of reproduction, AIDS and other sexually transmitted diseases, contraceptive methods and family planning, interpersonal relationships, the sharing of responsibilities and gender equity. This global student training area should be integrated in the Class Project. The dominant curricular model proclaimed is transdisciplinary which could be developed through integration in

curricular subjects and in the interdisciplinary form in the Project and Civic Training Areas (non-subject areas). The normative framework reinforces the role of the family in sexuality education in the school community, the role of teachers in the development of school projects and in the development of co-partnerships, and the role of students as genuine actors and active participants in the selection of problems and in the resolution of individual and collective problems related to sexual and reproductive health.

In August 2009, the Assembly of the Portuguese Republic published the final law regarding sexuality education in the school community (Lei n.º 60/2009 de 6 de Agosto), which established how to apply compulsory sexuality education in the school community in the next school year (2009/2010). The Government demanded the integration of sexuality education in the ambit of Health Education in the non-subject curricular area in primary and preparatory schools (from six to fourteen years of age) and in the subject and non-subject curricular areas in secondary schools (from fifteen to seventeen years of age) in a pre-determined way (article 3), and with curricular content guidelines (article 4) that will be defined by the Portuguese Government in the near future. A minimum of six hours to develop sexuality education from the 1<sup>st</sup> to 6<sup>th</sup> grades (from six to eleven years of age) and a minimum of twelve hours from the 7<sup>th</sup> to 12<sup>th</sup> grades, distributed in a balanced way between the three periods of the school year (article 5) was defined.

This law also stated that sexuality education will be compulsory in the Educative Project of the School, as planned by the General Council, after Student Association, Parent Association and teachers had been heard (article 6), and in the Class Project where the contents and themes which will be developed by the class as well as the carrying out of initiatives and visits, and the external organizations, technicians and experts involved in the Project will be defined (article 7). The necessary training of the teacher coordinator of health and sexuality education, the teacher responsible for the Health and Sexuality Education Class Project and other teachers involved was also established by the Ministry of Education (article 8). Simultaneously, according to article 10, until the beginning of the school year 2010-2011, a Support and Information Office for Students in the ambit of health and sexuality education will function at least one morning or afternoon per week with professionals trained in these areas. This Office should articulate its activities with the local Health Centre or other State organizations, namely The Portuguese Youth Institute, and should guarantee an Internet space that provides student information and rapid answers to their questions and doubts. This

Office should be organized with student participation, guarantee student confidentiality, be integrated in the educative projects involving students in the establishment of its aims and, with the collaboration of the Health Centre, to provide students with adequate access to contraceptive methods.

Parents, students and the representatives of the local community should have an active role in the development of these projects and should be informed about all curricular and non-curricular activities carried out in the sexuality education area (article 11). The Ministry of Health guarantees the necessary conditions for the Health Units to cooperate with schools, and their establishment of protocols with recognized Non-Governmental Organizations specialized in sexuality education in order to develop specific projects in a format that will be defined by the Government (article 9). The Ministry of Education should also guarantee the evaluation of these school projects and the elaboration of report evaluations (article 13).

The above-mentioned law was preceded by a very participative public debate between some organized social groups. At that time, a lot of contradictory opinions emerged in the public opinion, for example through the radio:

The Executive-Director of The Planned Parenthood Association (...) considers that “it is important to facilitate as much as possible, access to contraceptive methods for youths who are sexually active”. On the other hand (...) the President of the [National] Parents’ Confederation (...) [defends that parents] “understand that the availability of condoms must be carried out using a different logic. Until the age of 14, all problems related with sexual education must deeply involve families (...) [and] only from the age of 16, could schools guide students to Health Centres (...) [because condoms] must not be available in schools, as if they were any other type of urgent consumer goods” (...). The Coordinator of the National Commission Against HIV – AIDS said; “the presence of condoms is at least providing the possibility to minimize the risks. We know that a large proportion of children have sexual relationships before the age of 15 (...) and we have a high unacceptable level of adolescent pregnancy (...) [and] the distribution of condoms is not an incentive to sexuality or promiscuity, but a guarantee that a way to prevent [sexually transmitted] infections exists”. (TSF, 2009-05-18)

The President of The Portuguese Episcopal Conference (...) considers that this is a sensitive subject that was legislated in a precipitated way. (...) [He] defends Sexual Education, but with more closed rules because, in his opinion, the law only invites youths to carry out determined experiences: “What matters is the humanization of sexuality, which is integrated not only in informative education, which can act as an invitation to [sexual] proposals, but in a more global education”. (TSF, 2009-05-14).

This public debate continues until now. The cornerstones of this discussion are essentially: the roles of the family and the school in youth sexuality education; the availability or not of contraceptive methods, namely condoms, contraceptive pills and the day after pill in schools; the ethical referential for sexuality education in the school community of the Non-Governmental Organisations of which schools could adopt as

co-partners in their educative projects; and the lack or deficient scientific, pedagogic and ethical preparation of teachers and other school staff. Part of this discussion of not accepting sexuality education as previewed in the national policies is probably connected with the lack of knowledge related to the recent reforms (Lei de Bases do Sistema Educativo, Lei nº 49/2005, de 30 de Agosto), namely the constitution and the role of the School Board (artigo 48º, nº4), or a perceived vulnerability of the local community to implement this recent and new management model in a participatory and democratic way.

### **Action oriented knowledge, creativity, communication and participation**

Current health problems are a great challenge for the educational environment. If the solution possibilities for these problems are being developed, a fundamental rupture with the present ways of thinking in health is required. In the educational world, this means knowing if the questions regarding what constitutes the central learning contents should have a more central position than the questions of a methodological nature. An important consequence is that health education must deal with an interdisciplinary context oriented at the problems. Natural Sciences can describe the extension of the health problem; the Humanities can be planned within the work, considering the desirable changes in the future society and Social Sciences can be used in connection with the elucidation of the entire spectrum of action possibilities (collective and individual) that can be found in a democratic society (Jensen, 1994; 1995; 2000).

Action oriented teaching, within the democratic perspective, involves working in a broad field of knowledge, which includes knowledge, not only regarding the consequences of health problems, but also, of their causes, their visions regarding the future and the knowledge regarding the strategies in order to find solutions. In other words, action oriented knowledge is a complex interdisciplinary understanding built on a shared process of critical dialogue, reflection, development of visions, planning and action included in the teaching and learning process (Jensen, 2000; Simovska & Jensen, 2003; Vilaça & Jensen, 2009). The S – IVAC methodology (Selection of the Problem – Investigation, Vision, Action & Change) has been developed as a practical instrument that can be used in schools in order to structure health promoting activities and make student participation easier, with the objective of constructing their own action-oriented

knowledge and to promote the development of actions in order to increase action competence. This instrument assumes the perspectives above referred to that can be dealt with in a project or teaching methodology within health and sexuality education (Jensen, 1997; Simovska & Jensen, 2003; Vilaça, 2006; 2007; 2008). Therefore, with this model, it is possible to clarify what type of insights teachers and teaching materials should attempt to provide. Given that knowledge between people integrates scientific, social and historical elements, and that students attain these insights better, if they are allowed to gain experience on their own with the questions when working on projects, the role of teachers consists of, to a great extent, being a consulter to the students' action-oriented projects, rather than only overwhelming them with heavy scientific facts.

An interdisciplinary perspective can be referred to as a precondition in the development of action competence. The health education approach, here delimited, implies that it cannot be treated merely within the subject of Natural Sciences. If only the scientific aspects are applied, the focus will be to describe – and illustrate – the effects that serious problems present and as a result the teaching outcomes will be the concern of students and their lack of power to solve the problem. If that lack of power is to be transformed or qualified into the real ability to act, classes must place the action perspective in the centre and involve the social perspectives in the discussion of the solutions for their health problems (Jensen, 1995; Simovska & Jensen, 2003). Based on the experience of a great number of study groups – within the Health Promoting Schools project and other connections regarding the environmental education area – the eight perspectives mentioned below can be dealt with in the projects within the area of health (figure 1).

1. Which subject should be worked on?
2. Which problem within the subject in question should we work with?
3. What are the causes of this problem?
4. Why did it become a problem?
5. What alternatives can one imagine?
6. What action plans exist to obtain these alternatives?
7. What barriers will be brought to light through these actions?
8. What actions will be started?

Figure 1. The perspectives within the health education projects (Jensen, 1994, p. 83)

These perspectives do not necessarily represent steps that should be worked on following a certain order, but issues that must be dealt with during the learning process. Dealing with these perspectives means creating some important preconditions in order

to develop action competence in health (and sexuality) education (Jensen, 1994). Jensen (2000) argues that the main objective of health (and sexuality) education should be the development of students' ability to act and change, therefore, it is possible to conclude that knowledge and insights should be, in essence, action-oriented. This starting point has great consequences on the type of knowledge that will be the focus of the planning, implementation and evaluation of the teaching and learning process (Vilaça, 2006).

This type of knowledge, especially when it is the only knowledge dimension that students possess, does not promote actions and, consequently, does not promote student empowerment and action competence. It is necessary to insist on the inclusion of causal analysis and in the ways to produce changes within health and sexuality education (Jensen, 2000).

The above-mentioned theoretical framework was applied in a participatory and action-oriented sexuality education project, using information and communication technology (ICT). The results of this Project will be described with the following objectives: i) to discuss the creativity of students' visions regarding how, in general, the world and their lives could be and how society and the environment could be improved in relation to their particular sexual concerns; and ii) to characterize the type of actions carried out to solve their sexual problems.

## **2. Methodology**

### **2.1. Sample**

Eight hundred and seventeen students from the 7<sup>th</sup> to the 12<sup>th</sup> grades, of sixteen schools of the Braga District in the North of Portugal, were involved in this sexuality education project and constituted the online population of this research. Each school year in preparatory education had approximately the same number of students in the project (27,2%, 27,3% and 26,2% from the 7<sup>th</sup>, 8<sup>th</sup> and 9<sup>th</sup> grades respectively). The same does not occur in secondary education (10,0% and 9,3% in the 10<sup>th</sup> and 11<sup>th</sup> grades respectively). In all school years, female participation was predominant, except in the 7<sup>th</sup> grade.

In order to allow an in-depth comprehension of the implementation of the project, six schools involving three hundred and fifty students of this project were selected from the

initial population, in order to investigate how sexuality education methodology was implemented in the Project Area in secondary education (10<sup>th</sup> to 12<sup>th</sup> grades) and in the Project Area and/or Civic Training in preparatory education (7<sup>th</sup> to 9<sup>th</sup> grades).

## **2.2. Methods and techniques of collecting and analysing data**

In the research techniques, participatory observation, semi-structured group interviews, materials of the project put online by students, online class diaries and e-forum discussions were included. The students, with the teachers' collaboration, agreed on the investigation method focussed on them. A triangulation of those techniques and the inferences or conclusions between the researcher and the participants were carried out.

This study was developed in two phases. During the first school year, approximately during five months, the students created the online infrastructure to participate in the project's website, debated the concept of sexuality and sexuality education and selected the themes/problems that they would like to see discussed. In the second phase, which occurred in the following school year, the students developed one or two themes/problems that they would like to see discussed in the ambit of the project's methodology.

In the treatment of data that will be later presented and discussed, the entire school was used as a unit of analysis.

## **3. Results and discussion**

### ***Creative visions as a prerequisite for the desire and ability to initiate changes***

Students from the fifteen schools that carried out action-oriented sexuality education projects developed ideas, dreams and perceptions regarding their future lives and the society in which they will grow up in relationship to the following problems chosen by the students in order to carry out their projects: the prevention of adolescent pregnancy and contraceptive methods (73,3% of the 15 schools); prevention of sexually transmitted infections (60,0%); the first sexual relationship (46,7%); sexual behaviour (40,0%); dating (40,0%); dialogue with parents concerning adolescent sexuality (40,0%); puberty/ awakening of sexual maturity (33,3%); homosexuality (20,0%);

interpersonal relationships and friendships (13,3%); the Youth Consultation at the Health Centre (13,3%); the morning-after pill (13,3%); human fertility (6,7%), abortion (6,7%); love, intimacy and communication between romantic partners (6,7%); paedophilia (6,7%) and other paraphilias (6,7%); adult sexuality (6,7%); and sexual dysfunctions (6,7%).

The students worked on a broad and positive dimension of sexual problems in the following visions which they developed in their action-oriented projects.

The visions developed 'to improve the dialogue with parents regarding sexuality' were, in the students' voices the following: "we should have more courage and initiative to talk with our parents"; "we must start talking with our parents about contraceptives and unwanted pregnancies"; "we need to open one's heart with parents in order not to feel so down"; "parents should have a more open mentality so that the initiative of talking about these themes would come from them"; "society should accept each person's sexual options". These visions were presented as a consequence of their desire to change the causes of the problems identified in themselves (e.g., "why do we feel ashamed to expose such [sexual] issues, even to our parents?"; "why do we fear that our parents will censor us?"); in their parents (e.g., "why do many [parents] act aggressively and even violently?"; "why do they think they are acting in the best way by not saying anything?"; "they should talk with us, because parents are older and they received an education different from ours, they had a more closed education regarding this issue, therefore, do not understand us") and in society (e.g., "because we live in a preconceived society and there are still many taboos, society reveals itself as very modern and receptive regarding sexuality, but we all feel that in fact it isn't").

The visions developed 'to educate older colleagues regarding sexuality' included: to promote debates; carry out discussions; distribute informative leaflets in pharmacies, streets and at school; parents talk more at ease with their children regarding the theme; to promote meetings with the people in charge of the students education regarding the theme; and there should be more information in the mass media. These visions were aimed at the causes of the problems identified in their own students (e.g., "shame people feel when they approach this theme"; "shame in asking and talking about certain things with parents, due to their reactions"; "lack of communication with parents and older friends") and in society (e.g., "why didn't they have the same information in some schools and at home?"; "why is there lack of sexual education information at school?", "why weren't there debates regarding this [sexual] themes?"; "why is there so much



sexual censorship?"). In the visions developed to educate older colleagues, the main concern was to teach the older ones to improve their own living conditions and wellbeing and, only in second place, collaborate in the promotion of the older colleagues' sexual and reproductive health.

The students' visions developed 'to educate themselves and their colleagues of the same age so as to solve the problem regarding the lack of knowledge about how to obtain and use contraceptives were: increase their knowledge regarding the use of contraceptives and their effectiveness; improve personal and social abilities to prevent an undesired/unintended pregnancy; find alternatives to vaginal sex; improve access to condoms and the pill; and improve the dialogue about these issues with parents and teachers. Their intention was to act in order to eliminate the causes of the problems identified in themselves and in their colleagues of the same age (e.g., "why don't they inform themselves, most of the times they don't even know what is family planning"; "they are irresponsible for not using contraceptives"; "they do not know how to use contraceptives"; "when it is the first time, many people don't know which are the methods and how to use a contraceptive"; "they do not know the methods well and do not know how to use them"; "with the anxiety of practicing sex they forget everything and also the contraceptives"; "they think that by using condoms they will feel less pleasure"; "they think they do not run risks") and the social causes of the problem (e.g., "girls are pressured and in order not to lose their boyfriends they have sexual relationships"; "they quite often go to discos, drink and then do not know what they do and boys take advantage of them"; "due to the influence of bad company, because they feel inferior to their older colleagues that have already had sexual relationships"; "the freedom that most of our parents give us makes us commit many mistakes").

The visions developed 'to educate themselves and their colleagues of the same age in the resolution of problems in interpersonal relationships included: "knowing how to make decisions without being influenced"; "knowing how to chose friends, resisting negative habits which friends teach without losing their friendship"; and "manage a counsellor to help solve the problems among friends". They were thinking of how to eliminate the causes of the individual problems, e.g.: "it is difficult to say no to the negative habits, it is difficult to say no because we feel threatened by these classmates"; "we do not refuse vices because we are afraid of losing a friend and we are pressured and mocked at").

These projects created a bridge between education and sexual health because what the students wish is aimed at interpersonal communication, affection, pleasure, health and fertilization and the sexuality education practices at school work on such positive and broad visions of sexuality. These practices are aimed at not only their sexual lifestyles, but also their living conditions, in a perspective of wellbeing and absence of illness.

### **Action & Change**

The students as change catalysers of their parents' conceptions and practices regarding youth sexuality occurred with two types of actions: interviews and roundtables with students or students and specialists invited by students (figure 2).



Figure 2. Actions should always be part of teaching: Roundtable for parents coordinated by students and specialists

In the roundtables, the students of the secondary schools explained to their parents the day-to-day problems which they identified as being real problems in their age related to sexuality, the reasons why they had considered them as priority problems to help them to solve their lack of ease to talk with parents about sexuality, why it was important for

them to talk comfortably with parents about sexuality, why they didn't talk comfortably with parents regarding these issues and which are the consequences both in the short and long run for them and for society if such problems are not solved. They also explained what they would like to see happen in the future, plan the action within these visions and present some attitudes and behaviours to youths and parents in order to be discussed and after assumed by all as a contract to be followed in the future. When specialists were invited, they were asked by students to intervene in this debate adding more information regarding youth sexuality. In the preparatory schools, in these roundtables, the students only presented the project to the parents and prepared with them an afternoon tea and asked the specialists to talk about adolescent sexuality. In all school levels, the debate between students, parents and specialists was well participated by all, always generating new visions for the future.

Peer education from the same school level, from a lower or higher school level, was carried out in action-oriented projects with different characteristics: education of colleagues orienting the sessions regarding the topics of sexual health as 'monitor teachers'; conception and presentation of posters, stickers and news items for newspapers; writing, rehearsal and presentation of plays or films and change catalysers in the colleagues through conducted interviews.

All the actions in which the students acted collectively as change catalysers of their parents, in peer education (of older colleagues or colleagues of the same age) or in their own education, worked on the dimensions of a Health Promoting School because: (1) the dimensions of sexual health worked on by these students showed a broad and positive holistic vision of health and were created from their personal experiences and from their ideas (re) constructed in a bottom-up and broad learning contextual organisation; (2) the students were active partners in the dialogue with their parents, teachers and invited specialists in all the situations and phases of these action-oriented projects; (3) their actions revealed learning results categorised in a critical level of literacy of health education with the application of knowledge acquired in the four action-oriented areas defined by Jensen, revealing positive evidences in the several constituent elements regarding the operationalization of the concept of action competence: insight and knowledge, commitment, visions and action experiences.

#### **4. Conclusions and implications**

In these participatory and action-oriented sexuality education projects, the students thought creatively to find solutions for changing their lifestyles and life conditions. They manifested the desire to increase their competences to talk with their partner and parents about sexuality, resist the pressures of others and gain access to the pill, the day-after pill and the condom. They also manifested the desire to change the location of the Youth Consultation Office in the Health Centre and change the habit of drinking alcohol in discos. Their visions, as in the previous action-oriented knowledge investigated, continued to work on a positive and broad concept of sexuality; in all of the schools the students place great emphasis on the concept of wellbeing and quality of life, even when the concern focus was to avoid negative health conditions such as an unintended/undesired pregnancy and pressure from friends to acquire unhealthy behaviours.

These teachers and students assumed, as a starting point for their work, that the sexual health problems were structurally anchored in our society and in our way of living and recognised that sexual health is influenced both by lifestyles (attitudes, values and behaviours) and living conditions (social and physical environments and cultural and economic networks that affect people's lives). On one hand, they experienced that living conditions and society affect our immediate action possibilities and, on the other hand, they became aware that they can act to help change the social network. According to this, their projects contributed to their empowerment and development of action competence, just as it is established by the European Network of Health Promoting Schools, and more recently by the Schools for Health in Europe.

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