The programme originated in the early 1990s and is now being implemented in schools across Scotland largely due to its positive reception by pupils and teachers and the rigorous evaluation of processes.

Daniel Wight and Hilary Dixon
SHARE - Sexual Health And Relationships: Safe, Happy And Responsible

SHARE is a sexual health and relationships programme for 13 to 15 year olds. It was developed and piloted by the Health Education Research Unit for Scotland (HERuS), now NHS Health Scotland, and the Medical Research Council between 1993 and 1996 in Lothian and Tayside schools, and was then subjected to a randomised trial. The interim findings from the trial showed that, in comparison with conventional sexual education, SHARE is evaluated more highly by both pupils and teachers, it increases practical sexual health knowledge and it slightly improves the quality of sexual relationships, primarily through reduced risk. However, by the average age of 16 years, there was no impact on levels of sexual activity, condom use or sexual satisfaction amongst the target group (Wright et al., 2002). They are currently being followed-up to the age of 20 when the vast majority will have experienced sexual intercourse.

Following the trial HERuS has been keen to make SHARE available throughout Scotland. Hilary Dixon, who had already played a major part in developing the programme, was commissioned to revise the teaching pack and develop a training pack in the light of findings from the process evaluation (e.g. Bustin et al., 2002; Wright and Bustin, 2003), and to prepare a team of national sexual health trainers to be able to deliver a modified training course to teachers.

Since 2001 Healthy Respect, the Scottish National Destinations Project on sexual health, has been using SHARE as the basis for their multi-agency work in secondary schools (Reid, 2003). In 2003 the consultative draft of the Scottish National Sexual Health and Relationships Strategy recommended that SHARE should constitute part of the sex education curriculum throughout Scottish secondary schools (Scottish Executive, 2003).

Rationale for SHARE

The SHARE programme originated in the early 1990s from concerns about four aspects of young people’s sexual health: the increasing teenage abortion rate, the prevalence of HIV in the east of Scotland, increasing evidence of the high prevalence of Chlamydia and its links with subsequent infertility, and the reported high incidence of coercive sexual encounters. Several researchers, who had all been involved in primary studies of young people’s sexual behaviour, formed a group to attempt to address these issues. The SHARE programme was launched as a national multi-agency initiative.

Ten years ago (and still today) conflicting claims were made about the role of sex education in influencing sexual behaviour.

Ten years ago (and still today) conflicting claims were being made about the role of school-based sex education in influencing sexual behaviour. Many in the health promotion field argued that if were sufficiently early, comprehensive and skill-enhancing, sex education could substantially reduce sexual risk taking. Others, with a more sociological perspective
pointed to evidence that sex education cannot override the many other personal and social influences on sexual risk-taking. This suggests it is likely that the explicit discussion of sexual issues leads to greater sexual activity and risk-taking. In the early 1990s there was little evidence, based on rigorous evaluation, to support sexual education, towards these three positions, but increasing recognition of the need to rigorously evaluate sexual health interventions (Cokley et al., 1999). This has placed sexual health education, as a public health goal, to improve the health and social burdens of unwanted sexual outcomes (particularly HIV/AIDS), and the issues currently being investigated in sex education programmes of uncertain value.

At the same time the first wave of HIV-preventive interventions were found to be highly ineffective in modifying behaviour (Ellert, 1987, Fisher and Fisher, 1992). Some reviewers argued that this was primarily because the interventions were designed to change long-held sexual practices that had any clear theoretical basis (Fisher and Fisher, 1992), that is, the mechanism by which they were intended to work was unknown. However, this led to a new approach to sexual health education that focused on the health professionals, are less constrained by "Child Protection Regulations" regulating on notifications about pupils' disclosure of sexual experience. Counter arguments stress the value of knowing the pupils well and the responsibility that lies between the two sets of allowed exceptions and the rest of the curriculum. However, the overriding reason why teacher delivery was chosen was because it was the only way to attempt to comprehend the effective implementation of a substantial programme (this case 20 sessions). A further factor was the established policy of Scottish education to provide such programmes and the health promotion agency (HBES), who encourage primary reliance on teacher delivery.

The programme was designed according to four guidelines:

- be theoretically based and apply research findings on young people's sexual behaviour and the most effective youth interventions
- draw on the best existing materials and practices
- be readily sustainable
- be standardized for rigorous evaluation.

There was, however, some conflict between these different guidelines. While a research-based programme is most likely to have a greater impact, conflicts can exist with current educational orthodoxy and a teacher-led programme which seriously challenges teachers' professional identity is unlikely to be readily accepted nationally. Furthermore, an ideal programme from a theoretical perspective is likely to be impractical for schools and too expensive to be sustained, while the requirement for standardisation, in particular, would preclude the widely accepted principle that materials should be adapted to the specific needs of individual classes. Such conflicts meant prioritising some principles over others. The programme delivered was the result of these different values and different guidelines have been described elsewhere (Wight and Abraham, 2000).

Development and piloting

In 1993 HBES funded preliminary research into the current provision of sex education in Scotland. Young people's perceiving sex education needs and the feasibility of a research-based intervention and its evaluation through a randomised trial. Senior teachers were interviewed in four schools in Edinburgh and four in Dundee, and groups discussion held with Secondary 4 pupils (aged 15-16) in five schools.

The original research team then developed learning objectives for a two year sex education course for 13-15 year olds. At this stage Halifax Damon was commissioned to assemble a team of those involved developing existing exercises, modifying existing exercises or writing new ones. An Advisory Committee made up of specialists in health education, Health Education Advisors in the LEAs, health promotion specialists and the Guidance Specialist for Her Majesty's Inspectorate of Schools met frequently to comment on various drafts.

Leaving Education and Training specialists in Britain, the Netherlands and the United States reviewed an early draft of the pack, and throughout the piloting phase teachers played a crucial role in helping to transform theoretically based exercises into workable classroom lessons.

The teacher classroom resource and teacher resource pack were piloted from 1994 to 1995 in Inverness. The programme was finally piloted in four schools with nine teachers and 17 classes. The training was evaluated through participant observation, questionnaires, interviews, semistructured interviews, and a health promotion index of knowing the pupils well and the responsibility that lies between the two sets of allowed exceptions and the rest of the curriculum. However, the overriding reason why teacher delivery was chosen was because it was the only way to attempt to comprehend the effective implementation of a substantial programme (this case 20 sessions). A further factor was the established policy of Scottish education to provide such programmes and the health promotion agency (HBES), who encourage primary reliance on teacher delivery.

The programme was designed according to four guidelines: to improve the quality of young people's personal, social and sexual relationships, particularly in the promotion of healthy and non-exploitative sexual experiences, to reduce the incidence of unsafe sex, and to reduce the rate of unwanted pregnancies.

It was aimed at 13-15 year olds, to cover the time of most sexual activity in the UK. This meant it could reach nearly all young people of that age and, unlike most service provision or community education, enabled as many young men as young women to participate. In fear of breaking the widely accepted principle that materials should be adapted to the specific needs of individual classes. Such conflicts meant prioritising some principles over others. The programme delivered was the result of these different values and different guidelines have been described elsewhere (Wight and Abraham, 2000).

How SHARE is intended to work: the theoretical basis

The SHARE programme draws heavily on both social psychological and sociological theories. This work is previously (Wight et al., 1998). Social psychological theory focuses on the role of individual cognitions in shaping sexual behaviour, while sociological theories focus on the components of society's thought processes. It is theorised that by modifying the relevant cognitions we can empower young people to manage sexual situations more effectively. SHARE is based primarily on an extended Theory of Planned Behaviour (Ajzen, 1991, 2001) which encapsulates the perceived benefits of the current, social approval, perceived self-efficacy, intention formation and context-specific planning. As these are discussed in turn.

People are only likely to respond to a threat if they think that they are personally at risk; the SHARE programme stresses this likelihood by getting students thinking about having sex without contraception and the widespread prevalence of sexually transmitted infections (STIs) such as Chlamydia, which is currently widespread particularly on HIV. People are more likely to do something if they think it is effective and have few costs, so SHARE presents condoms and contraceptive pill use in this light. Sexual interaction is inherently social and is therefore especially likely to be affected by anticipated social approval. By targeting young people to their peers and their boy/girlfriend's approval of safer sex or delaying sex altogether.

Those who think they are able to do something successfully are more likely to intend to take that action and more likely to actually succeed, because they set themselves higher standards and suffer less stress. Perceived self-efficacy can be enhanced by careful explanation, by encouragement, by copying others' actions and by providing social rewards. The resources for the programme, although several exercises to enhance self-efficacy, including practical condom handling, the analysis of best practice negotiation of sexual encounters and role play.

Translating intentions into action is helped by developing detailed and realistic plans which allow the individual to translate their intention into actual action is to be carried out. Consequently, an important way in which SHARE aims to enhance self-efficacy is to help young people to rehearse what they believe is likely to unfold and what opportunities exist for taking and losing control, what on what you might say and what you can listen to others. Rehearsing and planning, young people can be better prepared to deal with challenging social situations in which they are likely to have little time for contemplation. Sexual negotiation is partially determined by the context in which it takes place, for instance by constraints of time (e.g. the return of the partner), previous experiences or prior expectations (e.g. having been invited back 'for a coffee'). SHARE therefore contains exercises to predict situations and plan how to respond to them, or perhaps avoid such circumstances altogether.

The sociological approaches that SHARE draws on are interactionism and functionalism. This theory is closely related to the sociological approaches that SHARE draws on are interactionism and functionalism. This theory is closely related to the sociological approaches that SHARE draws on are interactionism and functionalism. This theory is closely related to the sociological approaches that SHARE draws on are interactionism and functionalism.
encompass this diversity of experience. Whenever possible, therefore, the exercises are flexible enough to be appropriate for different levels of maturity and experience.

The main emphasis of SHARE is to teach pupils social skills to establish and maintain satisfactory boundaries to their intimate relationships and to take appropriate precautions if they have sexual intercourse. Given timetable

constraints, prioritising skills development inevitably excludes other important elements of sex education. SHARE is therefore seen as only one part of what should, ideally, be a curriculum of sex education starting in primary school. The latter is the most important element for those leaving school at the age of 16, for which this is likely to be their last formal sex education.

In line with recent findings on the most effective programmes (Kirkby, 1999), SHARE not only clarifies issues involved in sex education but also addresses the 'healthier choices', but also presents clear behavioural values. These are discussed in the first session (see below).

The Values of the Programme (Handout to pupils)

Our sexuality is a natural and healthy part of you. Each of you is a unique individual and may express it in different ways.

As teachers, we should try to make you feel that we would like to be treated.

We should protect ourselves and sexual partners from unwanted pregnancy.

We should explain and protect the sexual partners from unwanted infection.

In personal terms SHARE develops self-esteem and encourages a clearer understanding of what is sought in relationship. In professional terms it advocates improved communication to reduce the emotional risks of sexual relationships and to negotiate taking part in sexual education. On physical terms it teaches that the safest way to avoid the risks of sexual relationships is to abstain from sexual intercourse, but if one does have sexual intercourse the approach is to use condoms effectively.

The programme does not presume pupils' heterosexual attitudes and attempts to be inclusive of different sexual orientations and identities. Sexual orientation is discussed and information leaflets for young lesbians and gays are included with others in the class pack.

However, a decision was taken in the research materials not to include a session devoted explicitly to lesbian, gay, bisexual and transgender issues, partly because of the political sensitivity of such material. It was also felt that in a tightly packed programme with very specific aims this was difficult to incorporate, and that many of the teachers were ill-prepared to do it successfully. This is one of the issues which is now being considered for modification.

The main topics in SHARE, following a spiralling curriculum, are relationships, physiology, 'typical' experience of early sexual encounters, unwanted pregnancies, contraception and STIs, and skills for sexual negotiation, condom use and accessing local sexual health services (Table 1).

<table>
<thead>
<tr>
<th>Topic</th>
<th>Type of session</th>
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<th>Year 9</th>
<th>Year 10</th>
<th>Year 11</th>
<th>Year 12</th>
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Approximately one third of the curriculum was developed specifically for SHARE, one third comprises modified versions of pre-existing exercises and one third was adapted from other packs. SHARE has all ten characteristics Kirby identified as necessary for effective programmes (Kirby, 1999).

SHARE teaching materials

SHARE treatment involves active learning, through small group work, discussions, quizzes, games and role play. For the trial, in the first year (Session 8) all pupils were given a health promotion booklet to take home summarising the most important practices in contraception and STIs. This was so that they had access to the information at the time relevant to them, in case they were not paying attention during their lessons. A folder with leaflets was given to all pupils to provide basic health issues, including ones on gay and lesbian identity, was provided to each teacher to be lent to pupils in turn.

The main topics in SHARE, following a spiralling curriculum, are relationships, physiology, typical experience of early sexual encounters, unwanted pregnancies, contraception and STIs, and skills for sexual negotiation, condom use and accessing local sexual health services (Table 1).

Share is essentially a social skills programme designed to enable young people to make more informed choices about sexual activity and to develop the skills needed to protect themselves and their partners from unwanted sexual activity and infection.

In order to prepare teachers to deliver the SHARE pack they: participate in exercises from 15 of the 20 sessions: practice the delivery of challenging topics: share information about sexual issues; provide support; develop their own teaching skills; provide opportunities for peer teaching.

SHARE teacher training

For the trial, all SHARE teachers underwent a training programme, split into three modules (see Table 2 overpage). This was developed from more generic sex education training courses that the trainer, Hilary Crawley, had previously delivered to secondary school teachers throughout England and over many years. The course was piloted in Edinburgh with 10 teachers from four different schools in 1994, modified in the light of feedback and comments and further revised with a further 15 teachers in 1995. Further minor changes were made in the light of this second pilot. A similar five day course, though split into two shorter modules, was used then by Health Respect, and a variety of other models have been developed since.

The teacher training aims to enable teachers to deliver the SHARE materials with confidence. There are three objectives:

1. To make teachers more comfortable and confident to deliver sex education in general.
2. To prepare them to deliver the teaching pack.
3. To improve their understanding of the theoretical rationales for the methods involved in this behavioral change programme.

The course also provides the rationale for the programme by explaining and discussing it, by getting them to experience the methods themselves, by discussing their own mixed sex, active learning and target

gboarding, and by teaching them to apply these methods.

The training course is also meant to enhance development of the teacher as a whole by establishing a good relationship with them, raising their awareness of young people's sexual health issues, demonstrating the calibre of the teaching pack, promoting collegial support, respecting teachers' professional expertise and addressing the practical problems they raise. The trainer is particularly concerned to recognise teachers' existing skills and emphasise their abilities. This is done most explicitly at the start of the course, when teachers introduce themselves and the trainer highlights how much prior experience they already have, and during the course when trainers are asked explicitly to solve problems by their own expertise with their colleagues. The course is sufficiently flexible to address teachers' special concerns, with time allocated for specific issues identified by the trainee-identified topics. Games are used to relax, integrate and energise the participants, and the time is allowed to evaluate the extent to which the teacher training course achieved its objectives during the SHARE trial has been evaluated elsewhere (Wight and Buxton, 2003).

Conclusion

Initially designed as part of a research project, SHARE is increasingly being implemented in schools across Scotland. This is largely due to its positive reception by pupils and teachers and the rigorous evaluation of the piloting project (and its a lesser extent) outcomes. The principles underlying the original programme remain, including the importance of adequate teacher training, but it is being developed to be adapted in a variety of ways to meet the needs of pupils, schools and funding bodies. Some teachers have now been using SHARE enthusiastically for eight years (Reid, 2003).

References