DOCUMENT RESUME

ED 373 272 CG 025 530

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TITLE Adolescent Understanding of Key Variables Affecting Receptivity to Health Curricula.
PUB DATE Nov 93
NOTE 20p.; Paper presented at the Annual Meeting of the Australian Association for Research in Education (Freemantle, Western Australia, Australia, November 22-25, 1993).
PUB TYPE Speeches/Conference Papers (150) -- Reports - Research/Technical (143)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Acquired Immune Deficiency Syndrome; Adolescents; At Risk Persons; *Health Education; High Schools; *High School Students; *Sex Education; *Sexuality; *Student Attitudes; Venereal Diseases
IDENTIFIERS Australia

ABSTRACT

Adolescents comprise a substantial proportion of the at-risk population for sexually transmissible diseases (STD's) and AIDS. This study examines the link between sexuality education programs and student receptivity in Western Australian secondary schools. The researchers ask the question, "Given the same exposure to similar content and processes in sexuality education curricula in coeducational classrooms, will differences occur in receptivity between male and female high school students?" The question was answered in part by an instrument constructed to measure key constitutive variables of receptivity in the dimensions of "understandings" and "affects." The questionnaire was administered to high school students (N=533) and the results were compared to the empirical data derived from a social survey of 14-15 year old adolescents following similar health/sexuality education curricula. Two main findings emerged from the study: (1) the amount of health education, including sexuality education, that adolescent students received in high school influenced their receptivity towards the practice of responsible sexual behaviors attuned to community standards, thus potentially enhancing personally fulfilling relationships; and (2) girls exhibited higher receptivity to the messages of the sexuality education curriculum than did boys. Included are eight tables which present the statistical data. (RJM)

ADOLESCENT UNDERSTANDING OF KEY VARIABLES AFFECTING RECEPTIVITY TO HEALTH CURRICULA

by

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Paper presented at the Annual Meeting of the Australian Association for Research in Education,

Fremantle, 22-25 November, 1993

ABSTRACT

Adolescents comprise a substantial proportion of the 'at risk' population for sexually transmissible diseases (STD's) and AIDS. They are potentially amenable to the curricular influences of the high school in promoting lifestyle choices. In so doing curricula may have to cater for the different meanings attributed to sexuality and sexual relationships by boys and girls, in which receptivity to curriculum implementation predisposes individuals towards the adoption of a lifestyle conducive to healthy sexual behaviour.

In this study an instrument was constructed to measure key constitutive variables of receptivity in the dimensions of 'understandings' and 'affects'. It was administered to a sample of high school students (N = 533). Reliability coefficients were calculated for each of the instrument scales after they had been reduced using factor analytic procedures. Data were subjected to ANOVA, with sex and school as the dependent variables and eight instrument variables as the independent variables. It was found that as the amount of sexuality education increased the more receptive were adolescents to its content and processes.

ADOLESCENT UNDERSTANDING OF KEY VARIABLES AFFECTING RECEPTIVITY TO HEALTH CURRICULA

Introduction

The increasing incidence of sexually transmissible diseases (STDs) in young people, and the advent of Acquired Immune Deficiency Syndrome (AIDS), has provided high school teachers and administrators with an imperative in which sexuality education has to be accorded a higher profile either in its own right, or as an important component of health education and human relations oriented curricula. In this context sexuality education consists of exploring the whole person as a sexual being, going well beyond knowledge of the biological functioning of the human organism to include the examination of values, attitudes, personal and interpersonal behaviour and the development of attendant social skills. As a social intervention on the part of schools, sexuality education assumes an imperative because, in spite of continuing and intense medical research activity, devoted to the search for a vaccine, antidote or cure, prevention of STDs and HIV remains significantly dependent upon education as a preventive measure - at least in the foreseeable future (Mann, 1987). In the Foreword to a policy statement concerning Human Relations in Australian Schools the Director of the Australian Institute of Family Studies, Don Edgar, asserted that "...AIDS as a sexually transmitted disease makes sex education even more essential but it too raises questions of social relationships as well as specific sexual practices" (in Wolcott, 1987).

Recent figures from the National Centre in HIV Epidemiology and Clinical Research show that the majority of AIDS cases occur in the 20-40 age group (November, 1992). Given there is an incubation period of 5 to 10 years between infection and manifestation of symptoms, a major target group for educational programs is the 15-25 age group. In Australia it has been shown that young people (13 - 19 year olds), although knowledgeable about the threat of AIDS, are poorly informed about how it is spread an

do not perceive they are at significant personal risk of becoming infected (Greig & Raphael, 1989; Youth Research Centre, 1989).

The present study arose from our concerns, and those of other health educators, that adolescents - particularly young heterosexual males - were not receiving and acting upon the responsible sexual behaviour messages being promoted in education campaigns concerning HIV and STDs. Young people appeared to be rationalising their concerns about HIV by stating that it was a problem only for members of specific groups or those indulging in 'high risk' activities. These groups or activities did not appear to fit the 'norm' of accepted sexual behaviour by young people. (Chapman & Hodgson, 1988; Greig & Raphael, 1989).

Research Design Considerations

Accumulating evidence showed that adolescents, particularly young heterosexual males, were not receiving and acting upon the responsible sexual behaviour messages being promoted in education campaigns in relation to HIV and STDs. Young people appeared to be rationalising their concerns about HIV by stating that it was a problem only for members of specific groups or those indulging in 'high risk' activities. These groups or activities did not appear to fit the 'norm' of accepted sexual behaviour by young people. (Chapman & Hodgson, 1988; Greig & Raphael, 1989).

Findings such as the above, in concert with the reality that some high schools were not offering any health education studies to their students at all, and a considerable number were not offering the units drawn from Stage 5 of the unit map of the Western Australian Health Education Unit Curriculum, which deals specifically with sexuality and related issues, led to the formulation of the following research question:

Given the same exposure to similar content and processes in sexuality education curricula in coeducational classrooms, will differences occur in receptivity between male and female high school students?

Exploration of this question was undertaken by examining gender differences to sexuality education. Year 10 students in Western Australian high schools were surveyed using the AQUARIUS instrument (Carter and Carter, 1993) in order to find out whether receptivity would be influenced by the amount of health education, particularly sexuality education, offered and taught.

The study was guided and informed by reference to a number of well recognised psychological theories and approaches with implications for health behaviours. These include the health belief model, the theory of reasoned action and social learning theory. The research, however, was guided principally by the basic tenets of self-efficacy (Bandura, 1990) that "perceived self-efficacy is concerned with peoples' beliefs that they can exert control over their motivation and behaviour, and over their social environment" (p.9).

METHODS

Instrument

An instrument was developed and the protocols for this are described in Carter and Carter (1993). The AQUARIUS questionnaire was constructed from statements derived from prior work carried out with students from the target population of 14-15 year old high school students, based on a constitutive definition of 'receptivity'. This was defined as 'the internalisation of those formal/informal and 'hidden' messages of sexuality education curricula predisposing individuals to modify their social behaviour towards the adoption of a lifestyle more conducive to healthy sexual behaviour' The definition is circumscribed by the key variables of:

relationships	**choice**
communication	**sexuality**
responsibility	**trust**
love	**risk**

These were integrated across the two superordinate dimensions of the instrument comprising 'understandings' and 'affects'.

(a) 'Understanding' dimension

TRUST, for you, means

	Strongly Agree	Agree	Disagree	Strongly Disagree
Knowing someone will keep your secret	.....	.....	.....	.....
Being able to rely on someone	.....	.....	.....	.....
Knowing people feel they can rely on you	.....	.....	.....	....
Being confident in your relationship with other people	.....	.....	.....	.....
People respect your rights to things, such as privacy	.....	.....	.....	.....
People believe in you and the choices you decide to make	.....	.....	.....	.....
Having faith in other people's decisions and actions	.....	.....	.....	.....

Figure 1: Illustrative items from the 'understanding' and 'affects' dimensions of the AQUARIUS instrument.

(b) 'Affects' dimension.

TRUST is .....

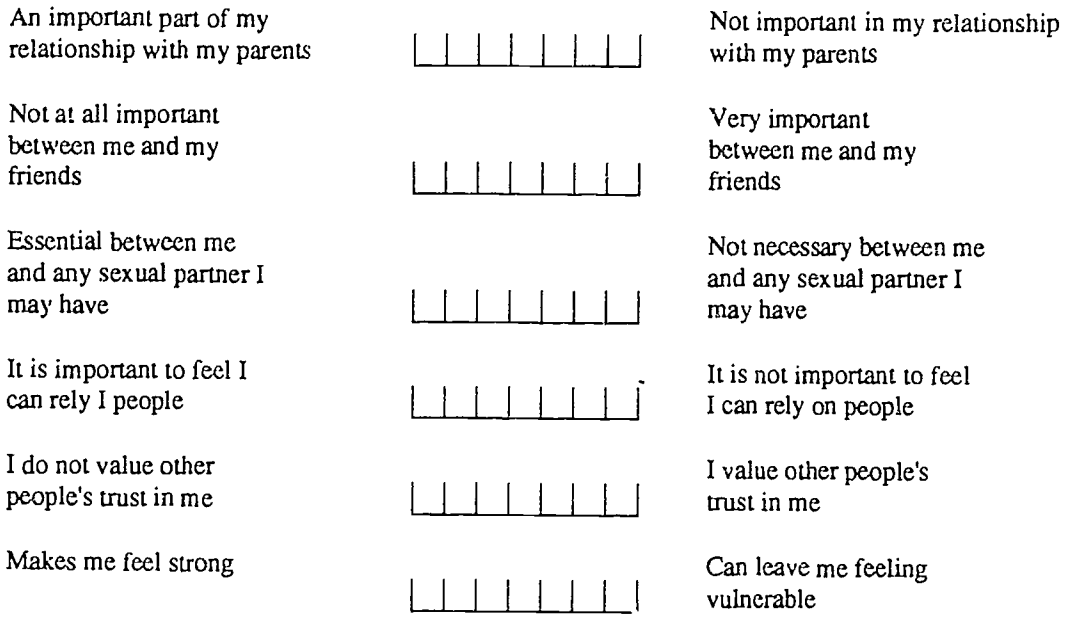

Figure 1: Illustrative items from the 'understanding' and 'affects' dimensions of the AQUARIUS instrument. (continued)

The structure of the instrument consisted of a four point rating scale applied to each of the statements within the understanding dimension of receptivity, and a semantic differential applied to the statements within the affective dimension see Figure 1). Reliability and construct validity of the instrument are comprehensively discussed by Carter (1993).

Items within the instrument were developed from the three essential components of receptivity which are:

* **The value and/or importance placed by an individual on each concept as it relates to sexuality.**

* **The personal understanding/meaning adolescents construct from these concepts;**

* **Whether the concepts were regarded by the individual as having relevance to sexuality and sexual behaviour.**

Sample

The sample was purposive to the extent that only metropolitan high schools offering units of study derived from a centrally developed K-10 Health Education syllabus, subsequently adapted to a statewide Unit Curriculum format, were selected. Only state schools were sampled since these could be guaranteed to follow the unit curriculum pattern of organisation. The schools and the range of health education units they offered were identified and verified with assistance from the Health Education Consultant based in the Western Australian Ministry of Education.

The scope of health education unit curricula provided across the seven schools drawn in the sample varied as anticipated. One school offered and required all students to study six units (ie., the maximum number that were available and could therefore be offered), one school offered five units, three schools had four units, one had three and the final school, at that time, offered no health education to students in years 8 - 10. With the school taken as the unit of analysis, this sampling design provided the requisite spread of curriculum units to allow for differences in receptivity on a range of offerings and stage of difficulty against gender to have the optimum chance of showing an effect. An important consideration in examining gender differences affecting student perceptions concerning sexuality education, was that in selecting schools from within the public education sector ensured a coeducational student sample for detailed study.

Reference to the literature and the conceptualisation of the variables led to the partialling out of socio-economic status (SES) as a potential variable. The latter was rejected as substantively affecting responses to the AQUARIUS instrument. It was not a major consideration, therefore, in the sampling design.

The final sample (size N = 472) of Year 10 students drawn from 7 metropolitan Senior High Schools, represents a balance between the practicalities of including sufficient

numbers of schools within the sampling frame and eliciting student responses of the magnitude required to validly test the research question.

Data were collected in naturalistic settings. In order to control for the exclusion of possible extraneous and intervening variables classes taught by teachers with more than 2 years experience were surveyed, since it was felt that the teaching style of neophyte teachers was still evolving and thus likely to introduce great variability in the manner in which the health education curriculum was mediated to students. The health education teachers in the schools involved met this criterion.

The target population was all Year 10 students in the seven nominated schools. The rationale for selecting these students (aged 14-15 years) was that they were in their final year of compulsory education; would have completed the entire course of health education offered by the school, and would have completed Unit 5 (if offered by the school) which contains content specifically addressing the topics of HIV/AIDS and sexually transmissible diseases. While the sample was necessarily drawn purposively it was nevertheless representative on the criteria of size, age/sex/curriculum offerings, teacher background and experience and the prevailing pattern of urban high schools in the public sector in the Perth metropolitan region. With a 15% sample of the senior high schools in Perth which returned a 90% response rate from the Year 10 students in those schools, a sample of sufficient size to meet claims for both representativeness and proportionality can be sustained (Krejcie & Morgan, 1979). Similarly the measure of control over teacher background and experience, and with mixed ability coeducational classes, so that only the specific range of curriculum offerings varied across the schools, lends further support to claims for the representativeness of the sample within the identified target population.

Procedure

Telephone contact was made with the Principals of the nominated schools to outline the nature and purpose of the study and to request permission to carry out the research in their school. Each Principal was provided with a copy of the survey instrument, and a meeting proposed if further information was required. Once access to the school was obtained, contact was made with the Health Education Coordinator in each school in order to explain the nature of the instrument and the data collection procedure to be adopted, as well as to confirm student numbers and verify teacher experience Since it was intended that data collection would be carried out by a single person, scheduling was crucial, in order to minimise the number of return visits required to survey each school. Attempts were made to ensure that data collection would minimise disruption to classes and school routines; provide an environment which was as normal as possible for the students, and yet would ensure anonymity and confidentiality of the responses obtained from the students. Standardised administrative procedures were used for the administration of the questionnaire. A total of 472 questionnaires were correctly and fully completed representing a return rate of 90%.

RESULTS

The factor structure of each scale was first checked to ensure that a dependable score could be derived from each scale. Then the reliabilities of each scale were assessed before meaningfully investigating group differences. Multivariate analysis of variance was used to assess differences across schools and gender. Where there were overall significant differences, univariate ANOVAS were used to determine more specifically the nature of the differences.

Factor Analysis

The first step in analysing the data was to check the dimensionality of each of the scales to see whether it was meaningful to interpret a total score across the items. Principal axis factor analysis, specifying one factor was used for each scale.

With the exception of the scale Love, it is meaningful to interpret a total score across the items within each scale. The seven items from the "love" scale formed two factors, namely, Love (1), where the items related to love from a sexual perspective, and Love (2) where the items related more to relationships. This response pattern is likely to be affected by the messages received from a number of sources that impact on the social world of the adolescent, in addition to the content of the curriculum. The powerful messages of the media and the 'hidden' persuaders of advertising may be instrumental in this regard, but the extent of their influence is unknown and lies beyond the scope of this research.

	Statements							
	1	2	3	4	5	6	7	h^2
Relationship	.49	.42	.32	.57	.68	.53	.47	35
Communication	.22	.32	.65	.60	.51	.67	.42	34
Responsibility	.59	.44	.50	.45	.53	.51	.46	34
Love (1)	.29	.56	.51	.42	.16	.81	.71	38
Love (2)	.43	.19	.19	.20	.34	-.26	-.36	84
Choice	.43	.53	.54	.50	.45	.68	.72	39
Sexuality	.47	.42	.47	.57	.59	.33		33
Trust	.53	.61	.71	.60	.57	.65	.56	45
Risk	.37	.49	.60	.49	.49	.62	.47	36

Table 1: Factor loadings for each scale in the 'understandings' dimension of the instrument.

	Statements									
	1	2	3	4	5	6	7	8	9	h^2
Relationships 1	.67	.31	.18	.32	.40					38
Relationships 2	.07	-.17	.44	-.16	-.07					33
Communication 1	.80	.82	.25	.52	.27	.32				53
Communications 2	-.23	.01	-.01	-.14	.34	.49				63
Responsibility	.68	.62	.74	.64						31
Choices	.36	.49	.59	.74	.50	.06	.34			32
Love	.66	.78	.41	.54	.66	.40	.44	.48	.46	37
Sexuality 1	.62	.27	.69	.57	.25	.01	.50			37
Sexuality 2	-.03	.12	-.02	-.17	.19	.77	.08			68
Trust	.66	.52	.56	.75	.51	.51				45
Risk	.77	.71	.63	.41	.79	.55	.64			49

Table 2: Factor loadings for each scale in the 'affects' dimension of the instrument.

Tables 1 and 2 show the factor loadings for each item within the scales for both understandings and affects respectively. The communalities for each scale are also presented (h2). There was evidence of two factors for three of the affects scales: Relationships, Communication, and Sexuality (Table 2). Relationships (1) contained a sub-scale item "close relationships, particularly sexual ones are very important" with "close relationships, particularly sexual ones, are not important at all " as the bipolar opposite. This was reformulated as Relationships (2).

Within the Communications scale there were two factors, one of which related to the social/interpersonal dimension as a component of sexuality, the other formed from the two items "communication is ... not at all relevant in sexual relationships" and "very relevant to sexual relationships", and item number six, "learning about communication in sexuality education is very important" and "it is not important to learn about communication in sex education". These were separated to form a second item referred to as Communications (2).

On the Sexuality scale, one item was separated from the others and comprises the Sexuality (2) scale. This item elicits a score from students in response to "no matter what the situation, I always try to be just me" juxtaposed with "I change my image according to the situation in which I find myself". The remaining five scales in the affect dimension can be meaningfully interpreted as a total score across the items within those scales.

Instrument Reliability

Given that this was the initial use of the instrument consequent to a rigorous developmental process and pilot stage, the alpha coefficients in the understandings dimension of the AQUARIUS (Table 3), falling within the range of .58 to .80 are all acceptable, and these results provide confidence in the reliability of the newly developed instrument. With an established instrument, which has had the benefit of further iterations attendant to its use, reliability coefficients in the order of 0.7 or better could reasonably be expected.

In the affect dimension seven of the nine alphas ranging from Choice (0.55) to Risk (0.82) can be regarded as reasonable, but Rel-1 (0.43) and Comm-2 (0.40) are low and need to be treated cautiously in subsequent analysis and interpretation. The means and standard deviations for the understanding scales do not vary widely. There is, however, a different pattern in evidence for scores in the affects dimension with a higher range between the means for each item. Similarly there is a much greater variability in the scoring pattern within this dimension. Sexuality (2) and Relationships (2) were single item scales and these are not reproduced in Table 4 since no reliability can be attributed to them.

Scale (understandings)	No. items	Mean	sd	alpha
Relationships	7	11.08	2.51	.68
Communication	7	11.32	2.34	.66
Responsibility	7	10.61	2.45	.68
Love(1)	5	9.36	2.13	.58
Love (2)	2	2.35	.82	.80
Choice	7	11.51	2.71	.73
Sexuality	6	12.34	2.53	.58
Trust	7	10.13	2.68	.78
Risk	7	13.32	3.07	.67

Table 3: Means, standard deviations and estimates of reliability for the scales in the 'understandings' dimension.

Scale (affects)	No.items	Mean	sd	alpha
Relationships (1)	4	8.71	3.64	.43
Communication(1)	4	8.02	3.71	.64
Communication(2)	2	4.04	2.37	.40
Responsibility	4	8.49	4.04	.57
Love	9	20.76	8.05	.75
Choice	7	16.60	5.40	.55
Sexuality	6	18.42	6.10	.63
Trust	6	10.60	5.23	.74
Risk	7	23.43	8.82	.82

Table 4: Means, standard deviations and estimates of reliability for the scales in the 'affects' dimension

	Wilks' Lambda	F	df	p
sex	.96	2.15	9, 460	.02
school	.99	.54	9, 460	.85
sex & school	.99	.59	9, 460	.81

Table 5: MANOVA on the scales comprising the 'understanding' dimension of the AQUARIUS instrument.

	Wilks' Lambda	F	df	p
sex	.83	8.30	11, 447	.0001
school	.75	2.00	66, 239	.0001
sex & school	.83	1.22	66, 239	.10

Table 6: MANOVA on the scales comprising the 'affects' dimension of the AQUARIUS instrument.

Analysis of Variance Data

With sex and school as the dependant variables a Multivariate Analysis of Variance was carried out on the scores across the scales relating to the understandings and "affects" of the eight instrument variables. The results are shown in Tables 5 and 6.

For the understanding dimensions, the analysis showed a statistically significant difference between males and females ($F = 2.15$; $p = .02$) but not between schools. The univariate ANOVA (Table 7) indicated that the major contributors to the gender difference were Communication and Love (1). When interpreting these data it is important to note that the higher the means the lower is receptivity. This inverse relationship occurs because the response scales across the categories in the AQUARIUS increase from 1-4 understandings) and 1-7 (affects) respectively. Thus a tendency to score highly generally reflects a less than conducive predisposition, on the part of the respondent, to lifestyle elements leading to healthy sexual behaviour.

With respect to Table 7 the mean score for the females is lower than for males on the two statistically significant variables of Communication and Love 1, indicating a higher receptivity on the part of females to these variables. This finding aligns well with previously quoted research which shows that females place greater importance on the value of close, intimate relationships and good communication that do males.

In the affects dimension (Table 8) there are clear differences in the receptivity of females to males on all the items, except risk, with females consistently registering smaller means signifying higher receptivity to the variables.

	F	p	males	females
Relationships	2.50	.11		
Communication	7.34	.007	11.94	10.72
Responsibility	.10	.75		
Love (1)	4.84	.03	3.09	2.74
Love (2)	.53	.47		
Choice	1.60	.21		
Sexuality	1.63	.20		
Trust	.68	.41		
Risk	2.54	.11		

Table 7: Univariate Anova and means for the understanding dimension by gender

	F	p	males	females
Relationships (1)	12.22	.0005	9.32	8.11
Relationships (2)	1.23	.26		
Communication (1)	12.22	.005	8.63	7.42
Communication (2)	19.79	<.0001	4.49	8.14
Responsibility	4.34	.04	8.85	8.14
Love	61.43	<.0001	23.37	18.15
Choice	18.19	<.0001	14.06	12.40
Sexuality (1)	3.00	.0837		
Sexuality (2)	2.52	.1128		
Trust	19.17	<.0001	11.60	9.61
Risk	7.47	.0065	22.03	24.82

Table 8: Univariate Anova and means for the affect dimension by gender

For the variable Risk, high mean scores by both males and females (22.03: and 24.82 respectively) show low receptivity to this variable on the part of both sexes. It has been noted that females generally assume a stronger sense of responsibility in relationships than do males (Wright, Gabb & Ryan, 1991), and it is possible that this sense of responsibility means females are not as willing to take risks in sexual relationships as are their male partners. The variables of Relationships - 1, Communication -1 and Communication -2, Responsibility, Love, Choice, Trust and Risk, are statistically significant ($p.< .05$) within the broader pattern of higher receptivity of females to males across virtually all of the constituent variables comprising the "affective" dimension of the instrument. Thus it appears that females are more attuned in both the affects (attitudinal) and understandings dimensions towards what society regards as a positive and healthy sexual lifestyle.

In addition to an affect attributable to gender differences, there was also an effect due to schools, as mentioned above (Table 9), in the affects dimension. The general trend shows an increase in the mean scores from School 1 through 7 across each of the variables. There is some variation to this pattern, however, with small fluctuations in mean scores across schools 3, 4 and 5, that vary from the general tendency. In this regard schools 3, 4 and 5 each provided 4 health education curriculum units for study by students. For school 4 in the Relationships -2 variable and school 2 in the Choice variable the mean scores fall marginally below school 1.

			School						
	F	p	1	2	3	4	5	6	7
			No. of Health Education Units taught in each school						
			6	5	4	4	4	3	0
Relationships (1)	4.06	.0006	7.46	9.49	8.64	8.34	8.13	9.51	10.50
Relationships (2)	4.07	.0005	3.15	2.64	3.15	3.06	3.82	2.63	3.26
Communication (1)	1.40	.211							
Communication (2)	2.75	.0124	3.43	4.24	3.93	3.77	4.38	3.94	4.96
Responsibility	3.37	.0029	7.64	9.06	8.38	8.34	7.68	8.78	10.59
Love	1.91	.076							
Choice	4.41	.0002	12.31	12.27	13.87	12.44	12.92	12.73	15.67
Sexuality (1)	1.84	.09							
Sexuality (2)	2.22	.039	1.98	2.15	2.62	2.68	2.07	2.06	2.37
Trust	2.70	.0138	9.15	10.16	10.69	10.96	10.62	10.92	12.41
Risk	.23	.96							

Table 9: Univariate Anova and means for the affects dimension by schools

In terms of Health Education curriculum provision in the other schools, School 1 provided all six curriculum units, School 2 five units, School 6 three units, and no health education was taught in School 7. With the exception of the means of the two variables mentioned above, there is a clear disparity between the means of School 1 (6 units) and School 7 (0 units), with the means of the latter consistently higher than for School 1. There is also a marked increase in the means across each of the variables between School 6 (3 units) and School 7. This pattern suggests for all the variables in the affective dimension there is a school effect on receptivity such that the latter increases (i.e. means decrease) with greater curricular provision.

Bearing this in mind, it should be noted that the variables most associated with a strong sense of responsibility and valued as being important in relationships, i.e. the variables Relationships-1 and Relationships -2, Communications (2), Responsibility, and Choice Sexuality 2 and Trust, are all statistically significant ($p. < .05$).

Summary and Conclusions

This study investigated the nexus between sexuality education programs and student receptivity in Western Australian state secondary schools. The study focused on those elements of the learning process which manifest in gender differentiated predispositions and responses to the health curriculum that is mediated by teachers to their students. This part of the learning process in health was captured by the construct of 'receptivity' which was defined as 'the internalisation of those formal /informal and 'hidden' messages of sexuality education curricula predisposing individuals to modify their social behaviour towards the adoption of a lifestyle more conducive to healthy sexual behaviour'.

In testing the research question against the empirical data that were derived from a social survey of 14-15 year old adolescents following similar health/sexuality education curricula, two main findings emerge for the sample studied, namely:

1). The amount of health education, including sexuality education, that adolescent students received at high school influenced the receptivity towards the practice of responsible sexual behaviours attuned to community standards and societal expectations and also potentially enhancing personally fulfilling human relationships.

2). There were differences in the receptivity of boys and girls towards the messages of sexuality education curricula, with girls exhibiting higher receptivity to the messages of the sexuality education curriculum.

Also, from visual inspection of supplementary anecdotal data, there was some evidence to suggest that, with increasing cumulation of learning experiences a convergence in receptivity occurred, regardless of basic gender differences - especially in the affective domain. This phenomenon provides a potentially fruitful avenue for further inquiry.

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