

# Sexual Health Education



**T**his chapter is about sexual health education. Notice that we are not using the term “sex education,” which may be more familiar to you. The distinction between “sex education” and “sexual health education” is important for several reasons. First, as we shall see, school-based programs that provide information about sexuality tend to be controversial, with opponents of such programs sometimes claiming that “sex education” is inappropriately focused on teaching about, and inadvertently promoting, sexual behaviour among youth. Second, the term “sexual health education” implies a more specific focus on the health-related aspects of sexuality. Let’s begin, then, our examination of this topic with clear definitions of both “sexual health” and “sexual health education.” A World Health Organization (2006) working definition of sexual health is as follows:

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (p. 5).

Typically, education related to sexuality has been thought of as a mechanism for preventing problems such as sexually transmitted infections (STIs) or unwanted pregnancies. But, as the World Health Organization definition shows, education aimed at helping

people achieve and maintain sexual health is not just an exercise in problem prevention. A broadly based conceptualization of sexual health education balances problem prevention with a recognition that sexual health is a positive aspect of personal health and well-being. In stating the goals of sexual health education, the Public Health Agency of Canada's (PHAC, 2008) *Canadian Guidelines for Sexual Health Education* reflect this balanced approach. According to the *Guidelines*, the goals of sexual health education are:

1. To help people achieve positive outcomes (e.g., self-esteem, respect for self and others, non-exploitive sexual relations, rewarding human relationships, informed reproductive choices).
2. To avoid negative outcomes (e.g., STI/HIV, sexual coercion, unintended pregnancy) (PHAC, 2008, p. 8).

We'll return to the *Canadian Guidelines for Sexual Health Education* later in this chapter, but first, let's take a brief look at the history of sexual health education in the schools in North America.

## Sexual Health Education in the Schools: A Brief History

Christabelle Sethna (1994, 2010) at the University of Ottawa has done extensive research on early twentieth-century forms of sex education for youth. At the time, instruction related to sexuality often took the form of what was called “purity education” or “nature study.” Sethna documents how such teaching arose primarily out of concern about the spread of venereal disease (as STIs were called) which had increased during the First World War. Nature study focused on biological reproduction with the objective of inducing children to adopt standards of abstinence, chastity before marriage, and procreative marital sex. Nature study was a popular form of sex education in Ontario up to the 1930s, and again after venereal disease rates rose once again after the Second World War.

During the 1960s and 1970s, most students in Canadian schools received little, if any, sexual health education. During this period, information about sexuality was often provided in programs called “Family Life Education” (FLE), which focused on human reproduction, puberty, and, in some cases, birth control. A survey done in 1975 found that about one-third of Canadian schools provided some form of FLE (Barrett, 1990). In the 1970s, increasing concern about teen pregnancy combined with increasing societal openness about sexuality led to the gradual implementation of FLE programs in Canada.

In the 1980s and 1990s, alarm over HIV/AIDS, high rates of other sexually transmitted infections (STI) in youth, as well as a growing recognition that many Canadian youth were becoming sexually active in their teens, prompted most secondary schools in Canada to introduce some form of sexuality education. By the mid-1990s, every province and territory in Canada either mandated or strongly recommended, through provincial departments of education or health, that some form of sexuality education be taught in the schools (Barrett, 1994). More recently, the province of Quebec removed sexual health education from its formal curriculum in 2005, although the Quebec Ministry of Education recommends that teachers find ways to integrate sexual health issues into classroom teaching.

Because education in Canada is a provincial and territorial responsibility, the extent and quality of sexual health education in the schools can vary from province to province, from school board to school board, from school to school, and from classroom to classroom. And rather than being taught as a separate subject, sexual health education—which is only a small part of the overall school curriculum—is usually part of a broader health curriculum that covers a wide range of topics.

## Applied Knowledge

### educating Your Children about Sex

“Daddy, where do babies come from?”

“What are you asking me for? Go ask your mother.”

Most children don’t find it easy to talk to their parents about sex. Yet most young children are curious about where babies come from, how girls and boys differ, and so on (Pike, 2005). Parents who avoid discussing these matters convey their own uneasiness about sex, and may teach children that sex is something to be ashamed of.

Parents needn’t be sex experts to talk to their children about the subject. They can read books or surf the Internet to fill gaps in their knowledge, or consult books written for parents to read to children. They can admit they don’t know all the answers. Children often respect such honesty.

In answering children’s questions, parents need to think about what the children can understand. The four-year-old who wants to know where babies come from is probably not interested in sexual details. It may be enough to say, “From Mommy’s uterus,” and point to the abdominal region. Why say “tummy”? “Tummy” is wrong and confusing.

Sexual health educators offer the following pointers for discussing sexuality with children.

- Be approachable. Be willing to answer questions about sexuality.
- Use appropriate language. Children need to learn the correct names of their sex organs, and that the dirty words others use to refer to the sex organs are unacceptable in most social settings. Nor should parents use silly words like “pee-pee” or “privates” to describe sex organs.

- Give advice in the form of information the child can use to make sound decisions, not as an imperial edict. Parents who lay down the law may be less effective than parents who provide information and encourage discussion.

- Share information in small doses. Pick a time and a place that feels natural for these discussions, such as when the child is preparing for bed, or when you’re in the car.

- Encourage the child to talk about sex. Children may feel embarrassed about talking about sex, especially with family members. You can leave

a children’s book about sex around, or give it to the child with a suggestion such as “I thought you might be interested in this book about sex. If you want to read it, we can talk about it.”

- Respect the child’s privacy rights. Most of us—parents and children alike—value privacy at times. A parent who feels uncomfortable sharing a bathroom with a child can say so. The parent might explain, “I like privacy when my door is closed. If you knock, I’ll tell you whether you may come in. I’ll knock when your door is closed, too.” Fair is fair.

- By the time they are approaching

puberty, most children will have seen various forms of sexual imagery, including explicit sexual activity, on the Internet. Some children will find such imagery repellent or confusing, while others will be fascinated by it. Talking with children about what they have seen on the Internet is one way for parents to initiate a discussion about sexuality and relationships. Parents can help to dispel myths about sexual behaviour that are propagated on the web and counter it with factual information and discussion of healthy relationships.



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#### *Educating Your Child about Sex.*

*Answer the questions truthfully. Use language the child will understand, but don’t make it silly child language. In other words, don’t talk about “peepees” and “wee-wees” and “Mommy’s tummy.” Use words like “penis,” “vagina,” and “uterus.” Get a book with drawings or pictures.*

## Innovative Canadian Research

### Sexual health education in School SaCro SS Canada

The *Canadian Guidelines for Sexual Health Education* (PHAC, 2008) suggests that

Sexual health education should include an understanding of developmental changes (e.g., puberty), rewarding interpersonal relationships, developing communication skills, setting of personal limits, developing media literacy, challenging of stereotypes, prevention of STI/HIV, effective contraceptive methods, information on sexual assault/coercion, sexual orientation and gender identity and a critical examination of evolving gender-roles and expectations (p. 22).

As part of an effort to advocate for a new sexual health curriculum for the province of Ontario, after a proposed 2010 revised curriculum was withdrawn by the provincial government in response to political and media controversy, the organization Ophea, Healthy Schools, Healthy Communities (2013) compared provincial sexual health curriculum documents from British Columbia, Alberta, Saskatchewan, Manitoba, and New Brunswick to the existing 1998 Ontario curriculum. (It is expected that the Ontario government will reintroduce a new curriculum in 2015):

- In all provinces included in the review, except Saskatchewan, it was recommended that children in Kindergarten or Grade 1 be taught the proper name for body parts, and in several provinces it specified that children identify terms such as “penis,” “vagina,” and “breasts.” In Saskatchewan, the curriculum documents did not recommend teaching the correct terminology for body parts until Grade 5.
- In all six provinces, the curriculum documents recommended that children be taught about the physical changes of puberty in Grade 5, with several provinces

also including information about psychological, social, and interpersonal changes. Alberta and British Columbia began teaching about puberty in Grade 4.

- In all six provinces, curriculum documents recommend teaching about abstinence from sexual activity in Grades 7 and/or Grade 8. In most cases, abstinence was presented as a “healthy” choice or as “the best and healthiest decision for adolescents.” Most of the curriculum documents provide opportunities for contraception and condoms for STI prevention to be discussed. For example, the Saskatchewan Grade 6 to 8 curriculum overview indicates that students who decide to become sexually active need information about effective methods to protect against pregnancy and STIs. In British Columbia, it was recommended that, as part of classroom activities, students in Grade 8 create a list of practices to reduce the risk of STIs.
- The provincial curriculum documents took very different approaches to teaching about gender identity, gender roles, and sexual orientation. In some provinces, these topics were not addressed at all, as was the case with the 1998 Ontario curriculum. In Manitoba, Grade 5 students were required to identify how social and cultural influences affect sexuality and gender roles, and these same topics were addressed in Grade 7 in Alberta. In New Brunswick, it was broadly recommended that Grade 8 students be required to discuss sexual orientation issues. In sum, specific information and discussion of gender identity and sexual orientation appeared to be lacking in the curriculum documents of all six provinces.

The findings of the Ophea review suggest that most schools in Canada do not provide sexual health education programs consistent with the breadth of content areas suggested by the *Canadian Guidelines for Sexual Health Education* (PHAC, 2008).

Sexual health education, therefore, often receives limited time and attention in the classroom.

In the elementary grades, instruction tends to focus on biological development and, as students approach their teen years, the changes associated with puberty. At the secondary school level, the most extensive coverage of sexual health topics

### Critical Thinking Question 5

On a scale of 1 to 10, how would you rate the sexual-health education you received in high school?

often occurs as part of a Grade 9 health course. Information on STIs is typically a central focus, although discussion of methods of prevention, such as abstinence and condom use, can be highly variable, depending on the school. Because of this variability, it's nearly impossible to reach general conclusions about the quality of sexual health education in Canadian schools.

A number of factors can influence the quality of sexual health education. The importance school administrators place on sexual health education, and the degree to which they sense community support for it, can dramatically influence the quality of the sexual health education that's delivered in the classroom.

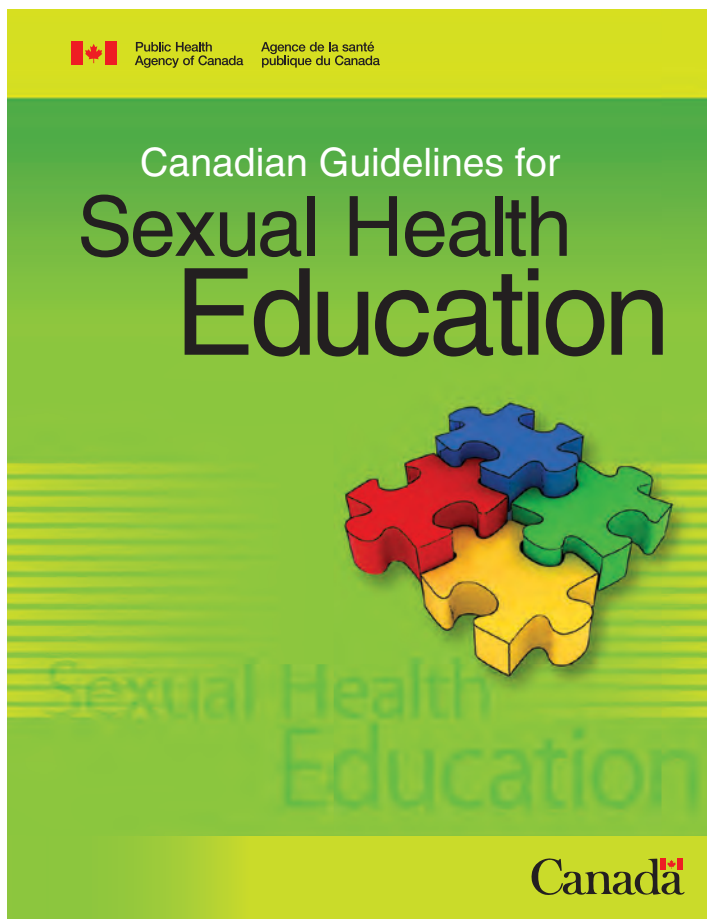
## The Canadian Guidelines for Sexual Health Education

To facilitate the development of broadly based sexual-health education programs, the PHAC (2008) has produced the *Canadian Guidelines for Sexual Health Education*. The first edition, developed by experts from across Canada, was published in 1994; the third and most recent edition appeared in 2008. The guidelines are designed to guide and unify professionals who provide sexual health education in Canada.

The *Guidelines* document is designed to provide curriculum and program planners, educators, and education policy makers, with a basic guide for the initiation, development, implementation, and evaluation of sexual health education programs in schools and communities (PHAC, 2008).

The *Guidelines* suggest a basic three-step process for the development of sexual health education programs:

- **Assessment and Planning.** In the first step, educators assess a target group's sexual health education needs and plan the education program accordingly. For example, peer educators at a university might ask students to fill out anonymous questionnaires that assess student's knowledge, attitudes, and skills related to STIs affecting young adults. Based on the student's questionnaire responses, the peer educators can plan an educational program or intervention that will address, and be specifically relevant to, the STI education needs of the students on campus.
- **Intervention.** In the second step, educators implement an educational program or intervention specifically designed to address the educational needs of the group identified in the assessment step. If, for example, the university peer educators discovered from the student questionnaires that many students on campus were unaware that most cases of STI have no symptoms (see Chapter 14), they could include the relevant information to close the student's knowledge gap related to STI in a brochure designed for campus distribution.



**Figure 15.1** The *Canadian Guidelines for Sexual Health Education* were produced by the public health agency of Canada to assist educators, program planners, and policy makers in the development, implementation, and evaluation of effective, broadly based sexual health programs in Canada.

Source: Public Health Agency of Canada. (2008). *Canadian Guidelines for Sexual Health Education*. Catalogue No: HP40-25/2008E. Ottawa: Author. Retrieved from <http://www.phac-aspc.gc.ca/publicat/cgshe-ldnemss/pdf/guidelines-eng.pdf>

- Evaluation.** In the third step, educators attempt to measure the extent to which the educational program or intervention has been effective in reaching its objectives. After the brochure had been circulated on campus, the peer educators in our example could then again use a student questionnaire to assess if student awareness about cases of STI often not having symptoms had increased. The evaluation step can be particularly helpful in identifying how sexual health education programs or interventions can be improved the next time they are implemented.

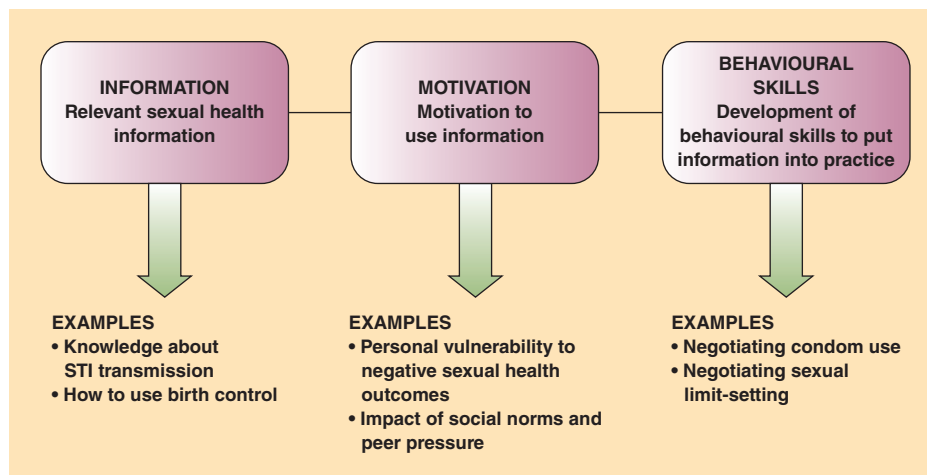
## Using Theory and Research to Inform Sexual Health Education

Sexual health education can take many forms and range in scope and comprehensiveness, from Twitter text messages containing small bits of sexual health information, to multi-session, intensive interventions designed to modify participants' sexual health-related behaviour in specific ways. School-based sexual health education for youth typically falls somewhere in-between these two ends of the continuum.

Ideally, sexual health education programs in the schools will be sufficiently comprehensive that they enable young people to protect and enhance their sexual health. The *Canadian Guidelines for Sexual Health Education* (PHAC, 2008) note that in order for sexual health education programs to be effective in promoting sexual health, including behavioural change, it is necessary that they incorporate an appropriate theoretical model to guide the creation and implementation of the program.

There are a number of appropriate theoretical models for application to sexual health education interventions. These include Social Cognitive Theory (Bandura, 2004) which focuses on personal, behavioural, and environmental factors that can be used to predict and change sexual behaviour, and the Transtheoretical Model, which suggests a five-stage process for behavioural change related to sexual health (Albarracin et al., 2005).

The PHAC (2008) *Guidelines* are based on the Information–Motivation–Behavioural Skills (IMB) model, which provides a relatively straightforward theoretical basis for developing and teaching sexual health education. For example, as applied to sexual health education for youth, the IMB model specifies that in order for it to be effective, it must provide *information* that is directly relevant to sexual health (e.g., information on effective forms of birth control and where to access them), address *motivational factors* that influence sexual health behaviour (e.g., discussion of social pressures on youth to become sexually active and benefits of delaying first intercourse), and teach the specific *behavioural skills* that are needed to protect and enhance sexual health (e.g., learning to negotiate condom use and/or sexual limit-setting) (see Figure 15.2).



**Figure 15.2** The IMB Model applied to Sexual health education

Source: *Sex Information and Education Council of Canada. (2010). Sexual health education in the schools: Questions and answers (3rd ed.). Toronto: SIECCAN.*

## Innovative Canadian Research

### the Information–Motivation–behavioural Skills (IMb) Model

William Fisher of the Department of Psychology and the Department of Obstetrics and Gynaecology at the University of Western Ontario, and his brother Jeffrey Fisher at the University of Connecticut, developed the IMB model through extensive research into factors that shape and drive sexual and reproductive health behaviour (Fisher & Fisher, 1992; 1998). The IMB model has been applied to a wide range of groups, including high school and university students, inner-city minority youth, STI clinic patients, low-income women, and men who have sex with men.

For example, Fullerton, Rye, Meaney, and Loomis (2013) found support for the IMB model in predicting hormonal contraceptive use, condom use, and dual (i.e., condom and hormonal contraception) protection

among a sample of 267 sexually active female Ontario university students.

Kiene et al. (2013) utilized the IMB model to understand the HIV transmission risk behaviour of a sample of 1388 HIV-infected male and female South Africans receiving antiretroviral therapy. The study indicated important directions for prevention efforts to curb HIV in South Africa.

The IMB model has also been successfully used as the theoretical basis for effective sexual health education interventions. For example, Fisher, Fisher, Bryan, and Misovich (2002) evaluated an IMB-based HIV risk behaviour change intervention provided to inner-city high school students in Connecticut. The evaluation found that sexually active students who completed the classroom IMB-based intervention were significantly more likely than a control group of students to be using condoms one year later.

## Effective Sexual-Health Education

Incorporation of a theoretical model such as IMB is just one of the key ingredients in effective education about sexual health. There has been extensive research into what's required for such education to be effective (Albarracin et al., 2005; Kirby, Laris, & Rolleri, 2007; World Association for Sexual Health, 2008). The Sex Information and Education Council of Canada (SIECCAN, 2010) has summarized this research, outlining ten key ingredients for effective sexual-health education, as shown in Table 15.1.

## Advanced Training in Sexuality for Professionals

A major limitation to the effectiveness of sexual health education programs is the lack of specific training in the area of sexuality for educators and health professionals. For example, two-thirds of New Brunswick elementary and middle school teachers report that they haven't received training to teach sexual health education (Cohen et al., 2004). Although many Canadian universities offer undergraduate courses in human sexuality, a surprising number have no sexuality courses.

The Université du Québec à Montréal offers both undergraduate and graduate degree programs in human sexuality (in French). St. Jerome's University at the University of Waterloo offers an undergraduate program in sexuality, marriage, and family studies, directed by Dr. B. J. Rye. Programs are also offered at York University and the University of Toronto. Other Canadian universities, such as the University of Guelph, provide undergraduate and graduate courses and/or research specialization opportunities in sexuality. Through the Department of Gender, Sexuality and Women's Studies, Simon Fraser University offers programs at the undergraduate and graduate level. McGill University and University of Toronto

table 15.1

## the key ingredients for effective Sexual health education

1. provide sufficient classroom time to achieve the program's objectives.
2. give teachers the training and administrative support required for delivering the program effectively.
3. use a theoretical model such as iMb to develop and deliver the curriculum materials.
4. tailor the program to the students' characteristics, needs, learning styles, ethnocultural backgrounds, sexual orientations, and developmental stages.
5. target behaviours (e.g., unprotected sex) that lead to negative sexual-health outcomes (e.g., Sti s and hiv infection).
6. deliver and reinforce prevention messages that target the setting of sexual limits (e.g., delaying first intercourse) and the use of condoms.
7. include program activities that focus on students' social environments and social contexts (e.g., peer pressure).
8. incorporate the information, motivation, and behavioural skills necessary for students to refuse sexual activity and practise safer sex.
9. give the students opportunities to practise (e.g., role playing) the setting of sexual limits, negotiation of condom use, and other communication skills, so they're active participants in the program, rather than passive recipients of information.
10. evaluate the program's strengths and weaknesses, to improve future delivery.

Source: *Sex Information and Education Council of Canada. (2010). Sexual health education in the schools: Questions and answers (3rd ed.). Toronto: SIECCAN.*

have programs in Sexual Diversity Studies. York University and Carlton University offer programs in Sexuality studies. Nearly every university in Canada now has one or more faculty members who have specialties in sexuality and/or sexual health. They can be found in a range of disciplines, including psychology, sociology, nursing, medicine, education, social work, and public health.

The Guelph Sexuality Conference, offered by the University of Guelph, is the largest annual conference on human sexuality in Canada, providing a range of training opportunities for teaching and promoting sexual health. The Western Canadian Sexual Health Conference is another major conference, offered every two years.

## The Impact of Sexual Health Education: Abstinence-Only Versus Broadly Based Approaches

Traditionally, one of the most hotly debated topics related to sexual health education has been whether or not school-based programs should focus exclusively on encouraging teens to not be sexually active, or whether programs should take a more balanced approach that also includes information and skills related to contraception and STI prevention.

**abStinen Ce-only Y progra MS** Abstinence-only programs, as they are commonly called, seek to motivate teens to not become sexually active until they are older, and in the case of some programs, until they are married. Because they are focused on the goal of abstinence, these programs typically do not include information on birth control methods or safer sex practices, except to mention that they are not 100% effective in preventing pregnancy or STI. The underlying philosophy behind abstinence-only programs is that by not engaging in sexual activity, a teen cannot become pregnant or become infected with an STI. Being abstinent, according to the proponents of these programs, also allows teens to continue to



grow up without the burden of the potential emotional turmoil that can be part of the territory with relationships that involve sex. For schools that are affiliated with religious institutions or are located in communities that are perceived to be socially conservative, school administrators may feel obligated to instruct their teachers to stress abstinence primarily or exclusively when teaching about sexual health.

Community and school-based abstinence-only programs receive large amounts of government funding in the United States and, as a result, they are widely used in that country. In order to receive the government funding, a program must have “as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity” and teach students “that sexual activity outside the context of marriage is likely to have harmful psychological and physical effects” (Social Security Administration USA, n.d.). Abstinence-only programs are not nearly as popular in Canada as they are in the United States, but they have been used in some parts of the country.

Two key questions arise when critically assessing abstinence-only education. Are abstinence-only programs effective in reaching their goal of persuading youth not to be sexually active? And do these programs infringe on young people’s rights in regard to making autonomous and fully informed decisions about their sexual and reproductive health?

Let’s begin with the first question. Many studies have been conducted to see whether abstinence-only education works. Most have found that it does not. An evaluation of abstinence-only programs conducted for the United States Congress indicated that students who had taken abstinence-only courses were no more likely to be sexually abstinent, to delay first intercourse, or to have fewer sexual partners than students who didn’t receive such courses (Trenholm et al., 2007). Many other reviews of available studies have replicated the finding that abstinence-only programs are usually ineffective (e.g., Bennett & Assefi, 2005; Kohler, Manhart, & Lafferty, 2008; Protogerou & Johnson, 2014).

With respect to the second question, abstinence-only programs have been criticized as unethical, because they don’t provide the information young people need to make their own choices about sexual behaviour. In this respect, abstinence-only programs appear to be in conflict with *Canadian Guidelines for Sexual Health Education* (PHAC, 2008), which stresses that sexual-health education should support “informed decision-making” (p. 25). Others have argued that abstinence-only programs violate young people’s human rights by withholding potentially lifesaving information about the prevention of HIV and AIDS (Ott & Santelli, 2007).

**broadly based programs** Sexual health education can be *broadly based* in two distinct ways. A defining characteristic of broadly based sexual health education is that it incorporates a wide range of objectives and content areas. For example, broadly based sexual health education goes beyond the topics of the biology of human reproduction and pregnancy and STI prevention to address topics such as integration of sexuality into mutually satisfying relationships, sexual orientation, sexuality related gender-role stereotyping, gender identity and other topics that are relevant to the sexual health of students. In sum, it is the breadth of topic area coverage that partially defines broadly based sexual health education.

The second defining characteristic of broadly based sexual health education is that it allows space for students to use the information they have learned to make decisions for themselves. If we look at the example of education about STI prevention, we have seen that the abstinence-only approach communicates only one possible path for protecting oneself: abstinence. In contrast, a broadly based approach would provide education that equips students to delay involvement in sexual activity and develop personal limits for sexual behaviour, but it would also provide education to similarly equip students to, for example, negotiate condom use

with partners if they are sexually active. In sum, broadly based sexual health education is structured so that students are able to exercise informed decision-making (PHAC, 2008).

The defining characteristics of broadly based sexual health education (e.g., breadth of topic coverage, emphasis on informed decision-making) as described in documents such as the *Canadian Guidelines for Sexual Health Education* (PHAC, 2008) are roughly synonymous with what, in the United States, is called *comprehensive sex education*. For example, the Sexuality Information and Education Council of the United States (SIECUS, 2014) defines key aspects of comprehensive sex education as being evidence-informed, medically accurate and complete, and responsive to the needs of all people.

What do we know about the potential behavioural impact of broadly based approaches to sexual health education? Opponents of school-based sexual-health education have often argued that teaching young people about sexuality, including birth control and the use of condoms to prevent STIs and HIV, gives them the green light to become sexually active. This has become a central question in debates about whether sexual-health education belongs in school.

A large number of studies have examined this question. A review of studies measuring the behavioural impact of sexual health education programs has found that “the evidence is strong that programs do not hasten or increase sexual behaviour” (Kirby, Laris, & Rolleri, 2007, p. 206). In other words, sexual health programs are unlikely to encourage young people to become sexually active at an earlier age.

According to the Sex Information and Education Council of Canada (SIECCAN, 2010), a large number of studies indicate that sexual-health education can have a significant, positive impact on behaviour. The Kirby, Laris, and Rolleri (2007) review of 83 sexual health and HIV program evaluations found that two-thirds of the programs had positive behavioural effects on youth. In particular, the review showed that sexual-health education can effectively equip youth to delay first intercourse and to use condoms if they’re sexually active. Other, more recent, reviews of the literature have confirmed the potential for broadly based sexual health education to reduce sexual risk behaviour (e.g., Protogerou & Johnson, 2014).

Have sexual health education programs in Canadian schools been effective in this regard? While many have provided youth with basic information, it’s unlikely that most programs have been extensive enough to have sustained effects on behaviour. While most sexual-health education programs in Canadian schools don’t contain most of these key ingredients, documents such as *Canadian Guidelines for Sexual Health Education* (PHAC, 2008) point the way to a new generation of programs that will potentially make more meaningful contributions to the sexual health of Canadians.

## Attitudes Toward Sexual Health Education

Media reports often suggest that sexual health education, particularly for youth in schools, is a highly controversial topic. But how controversial is it really? To be sure, sexual health education controversies do flare up from time to time. The 2010 media-driven controversy surrounding the sexual health education components of the Ontario Health Curriculum is one recent example.

Some have suggested that conflicts about sexual health education in the schools are often rooted in opposing ideological perspectives related to human sexuality. For example, McKay (1998) has suggested that those who argue strenuously that sexual health education does not belong in the schools or that programs should adopt an “abstinence-only” approach hold a restrictive sexual ideology that is based

on traditional moral standards for sexual behaviour. Restrictive sexual ideology stipulates that sexual behaviour should be limited to procreative heterosexual intercourse within marriage. According to McKay's analysis, on the other side of sexual health education conflicts are those who hold a permissive sexual ideology, based on the premise that sexual behaviour should be guided by secular moral principles such as honesty, equality, responsibility, and informed consent. People with a permissive sexual ideology typically support broadly based sexual health education, in which young people are provided with a broad range of information that they can use to make decisions about their sexual health. Ideologically based conflicts about sexual health education tend to be relatively rare in Canada but they are quite common in the United States, where the content of school curricula is frequently the subject of ideologically charged debate.

## Parental Attitudes

Although media reports sometimes give the impression that Canadian parents are divided in their opinions about sexual health education in the schools, a series of surveys of parents with school-aged children conducted in several parts of Canada, including New Brunswick (Weaver et al., 2002), Saskatchewan (Advisory Committee on Family Planning, 2008), and Ontario (McKay, Pietrusiak, & Holowaty, 1998; McKay et al., *in press*) suggest that parents have favourable attitudes toward the provision of sexual health education in the schools. In all of these surveys, more than 85% of parents *strongly agreed* or *agreed* with the statement "Sexual health education should be provided in the schools." Furthermore, parents in these studies also approved of providing youth with information on a wide range of topics including puberty, reproduction, healthy relationships, STI/HIV prevention, birth control, abstinence, sexual orientation, and sexual abuse/coercion. Because these surveys were voluntary, it is possible that some parents who were opposed to sexual health education in the schools would have refused to participate. Despite this caveat, among parents who did participate in the surveys, support for sexual health education in the schools was strong and consistent.

### Critical Thinking Question 5

In your opinion, should sexual health education in the schools provide students with the information, motivation, and behavioural skills to practice safer sex? If yes, at what grade level do you think education about safer sex should begin?

## Youth Attitudes

Several surveys have indicated that Canadian youth want sexual health education to be taught in school (Byers & Grenier, 2003; McKay & Holowaty, 1997). In a survey of New Brunswick high school students, 92% agreed that "sexual-health education should be provided by the schools." The students rated topics such as puberty, reproduction, personal safety, sexual coercion and assault, sexual decision-making in dating relationships, birth control and safer-sex practices, and STIs as "very important" or "extremely important" (Byers & Grenier, 2003).

Unfortunately, many students are disappointed with the quality of the sexual health education they received. In the New Brunswick survey, only 13% rated their sexual health education as very good or excellent (Byers & Grenier, 2003). In Newfoundland and Labrador, most adolescents felt they had only limited access to sex education and services (Johns & Lush, 2004).

A major criticism of school-based sex-education programs is that they focus on the negative. In an interview study, young adults in British Columbia and Nova Scotia expressed dissatisfaction because their sexual health education neglected the emotional and potentially positive aspects of sex. They felt these programs were concerned only with providing information about pregnancy and STI prevention (Shoveller et al., 2004).

The *Toronto Teen Survey* of 1216 ethnically and religiously diverse teens assessed their experiences with, and opinions about, sexual health education (Causarano et al., 2010; Salehi et al., 2010). Overall, 92% of the teens reported

that they had received some form of sexual health education through classes or workshops. When asked about which topics they had learned about, the most common were HIV/AIDS (78%), STIs (71%), and pregnancy and birth control options (65%). Under two-thirds of the teens had learned about communication about sex (61%) and healthy relationships (61%). Fewer teens reported that they had learned about sexual abuse/assault (58%), sexual orientation (51%), or sexual pleasure (42%). Interestingly, when the teens were asked what topics they wanted to learn more about, the order was somewhat different with healthy relationships being the most common response, followed by HIV/AIDS, sexual pleasure, and communication about sex.

A study of first-year university students in Ontario who were asked to assess the sexual health education they'd received in school presents a somewhat more optimistic picture (Meaney, Rye, Wood, & Solovieva, 2009). Overall, the students reported that they were generally satisfied with their school-based sexual-health education and the teachers who had taught it.

## Current Sources of Information about Sexuality

When a representative sample of Canadian 14- to 17-year-olds were asked to identify their sources of information about sexuality, they identified school as their number one choice (80%), followed by friends (76%), parents (63%), television (54%), books (52%), the Internet (44%), magazines (39%), doctors, (37%), chat lines (20%), and nurses (19%) (Frappier, et al., 2008). When asked which of these sources were most useful and valuable, they ranked school and parents highest.

Parents and guardians can play an important and constructive role in the sexual health education of young people. In the *Canada Youth and AIDS Survey*, about one-quarter of the boys said they could talk openly about sex with their fathers or mothers, while 37% of the girls said they could talk to their mothers, and far fewer (12%) said they could talk to their fathers (Boyce et al., 2003). About two-thirds of high school students in a New Brunswick survey rated the sex education they'd received from their parents as good to excellent, but about one-half didn't want to talk more with their parents about sexuality (Byers & Grenier, 2003).

In Regina, most high school students said they preferred learning about topics such as pregnancy and STI prevention at school. When the topics were dating and relationships, however, most preferred learning from personal experience, friends, and parents (Hampton et al., 2005).

In recent years, the Internet has become a key source of information about sexuality and sexual health. In a study of online sexual activity among Canadian university students, 17.6% of men and 31.2% of women reported that they had visited an educational website on sexuality in the previous month (Shaughnessy, Byers, & Walsh, 2011). A Swedish study found that adults of all ages sought information about sex online (Daneback et al., 2012). For example, 68% of women and 53% of men aged 25 to 34 reported that they had ever sought out sexuality information online, and 53% of women and 55% of men aged 50 to 65 also reported doing so.

There are many advantages to using the Internet as a platform for the delivery of sexual health information. For example, the information can be accessed anonymously, in private, and at any time a person chooses. The Internet can be useful as a sexual health education tool if a person feels embarrassed about seeking out information about a particular aspect of sexuality. For example, some people may feel embarrassed or ashamed to seek out information about sexually transmitted infections. The Internet can be an especially potent and accessible conduit for the provision of sexual health education to people who may feel isolated or stigmatized with respect to their sexuality. For example, for a young person who is queer or

### Critical Thinking Question

Have you ever used the Internet as a personal source of sexual health education? If yes, did you feel confident that the information you found was accurate?

transgender and living in a rural community, the Internet may be the only source of sexual health education that is relevant or available.

On the other hand, it can sometimes be very difficult to verify if the information about sexuality being displayed on a website or app is accurate and credible. As more and more people search the Internet to learn about sexuality and attempt to find the specific pieces of information about sexual health, providing students with the media literacy skills to identify reputable sources of information will become an important objective of school-based sexual health education.

Although its producers usually intend it to be used for sexual gratification rather than as a credible source of sexual health education, more and more people are acquiring their assumptions and beliefs about sexuality from online pornography. We don't yet have comprehensive research on how viewing online pornography may affect sexuality. We do know that plenty of people, including youth, look at online porn. A study of Canadian university students found that 72% of the males and 24% of the females had used the Internet to access sexually explicit material in the previous 12 months (Boies, 2002). In a more recent study of Canadian university students, 83% of males and 31% of females indicated that they had looked at sexually explicit videos or photos online in the previous month (Shaughnessy et al., 2011).

There's considerable concern about how online porn may affect young people (Bryant, 2010). As anyone who has surfed the net looking for sexual titillation knows, online pornography often presents distorted pictures of sexual behaviour and relationships. The question is, are people able to separate the fantasy life of porn from the reality of real-life sexuality and relationships, and use the Internet as a safe way to explore and learn about sexuality? Or is Internet pornography an influential source of very inaccurate information and harmful attitudes about sexuality? We don't have enough research yet to help us understand the role, for better or worse, of online porn in teaching people about sexuality.

## Innovative Canadian Curricula and Resources

There is a large and growing number of innovative Canadian curricula and resources, many of them available online, to guide and assist educators in providing sexual health education. In addition, there are a number of Canadian websites

*Sexual Health Education. Despite the availability of sexual health education in most schools, many young people learn about sex from their peers. Survey data show that most parents want sexual health education to cover abstinence, pregnancy, sexually transmitted infections, abortion, and sexual orientation.*



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designed to provide credible sexual health education to different audiences. Below is a sampling of some these materials.

An Ontario group led by University of Waterloo researcher B. J. Rye (2008) developed and tested *Girl Time: Grade 7/8 Healthy Sexuality Program*, based on the IMB model. The objectives were to encourage young girls to delay sexual intercourse until they were mature enough for it, and to practice safer sex when they were ready. Girls who participated in the program were more likely than nonparticipants to discuss sexual topics with their parents, feel confident about their ability to have safer sex (e.g., by obtaining condoms), and plan to engage in safer-sex practices such as abstinence (Rye et al., 2008).

Media Smarts, Canada's Centre for Digital and Media Literacy (2012) provides an extensive online lesson plan for grades 7 to 9 titled *I heard it 'round the Internet: Sexual health education and authenticating online information*. This lesson plan with student handouts is designed to help educators teach students how to find, access and evaluate information on sexual health on the Internet.

Based on consultation with 500 youth, parents, and experts in sexual health, the Nova Scotia Department of Health and Wellness (2014) produces a book called *Sex? A Healthy Sexuality Resource*. The book was first created in 2004 to be distributed to all Grade 7 students in the province. Designed to be colourful and practical in content, the book provides information on topics such as how to avoid STIs and how to talk to parents about sex.

Alberta educators and researchers have developed and evaluated a theatrical play for 14- to 16-year-olds (Esmail et al., 2007). *Are We There Yet?* is a theatre-based sexual education program based on learning theory. It uses a student-centred approach to present real-life situations that students can relate to. This encourages greater student participation in the play. Student evaluations indicate that the play is an effective means of providing sex education to youth (Esmail et al., 2007).

Developed by Alberta Health Services (2014), *Teachingsexualhealth.ca* provides an extensive range of lesson plans on sexual health topics, online workshops, information on instructional methods, and questions and answers often asked by students about sexuality in the classroom. The site also contains a parent portal that includes answers to common questions that children ask parents about sex and provides strategies for parents to talk to their children about sexuality.

The website *SexualityAndU.ca*, developed by the Society of Obstetricians and Gynaecologists of Canada, provides sexual health information for all age groups. This site contains a section for teachers that includes curriculum materials, as well as guidance for parents and health professionals about teaching sexuality. The website *WeKnowSex.ca*, developed by the Trojan Sexual Health Division of Church and Dwight Canada, in partnership with the Sex Information and Education Council of Canada, is designed to provide university student and young adult Canadian audiences with sexual health information specifically relevant to their needs.

## Meeting the Sexual Health Education Needs of Diverse Groups

### Sexual-Minority Youth

Many sex education programs don't address the needs of lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth. University of Alberta researcher Kristopher Wells (2009) has analyzed many of the difficulties LGBTQ people face, including feelings of isolation, fear of humiliation, and lack of social support. Grace and Wells (2006) have developed a series of professional-development workshops for teachers, to help them address sexual-minority issues in schools.

The Public Health Agency of Canada (2010a) has published a booklet called *Questions & Answers: Sexual Orientation in Schools*, which provides teachers and other school personnel with guidance on supporting sexual-minority youth. The PHAC (2010b) has also produced a parallel document, *Questions & Answers: Gender Identity in Schools*, to help support gender-variant youth.

Sexual minority high school students play important activist roles in challenging heterosexism and homophobia in schools. They promote inclusivity through such strategies as creating gay–straight student alliances, initiating positive-space campaigns, and sharing LGBTQ resources (Grace & Wells, 2007).

Teachers' organizations across Canada have adopted policies that support LGBTQ youth. The Alberta Teachers' Association has been in the forefront in fighting discrimination based on sexual orientation. Kristopher Wells (2006) has written a *Gay–Straight Student Alliance Handbook*, published by the Canadian Teachers' Federation. Its primary objective is to help Canadian educators create safe, inclusive, welcoming spaces for LGBTQ youth. Gay–straight student alliances (both student-run and teacher-supported groups) are an important means of achieving this objective. The Canadian Teachers' Federation has also published *Challenging Silence, Challenging Censorship: Inclusive Resources and Policy Directives for Addressing Bisexual, Gay, Lesbian, Trans-Identified and Two-Spirited Realities in School and Public Libraries* (Schrader & Wells, 2007), which discusses practical resources to help educators and decision-makers challenge discrimination and promote positive change for sexual minorities.

The development of these resources indicates that many Canadian schools are recognizing the need to address the requirements of sexual-minority youth. Although most Canadian classrooms likely have at least one non-heterosexual or gender-variant student, the bottom line is that sexual-health education is often taught in a strictly heterosexual context. A British Columbia study has found that parents, students, educators, and public health personnel acknowledge that sexual education curricula often fail to address the needs of sexually diverse students (Options for Sexual Health, 2004).

## Youth with Disabilities

As we discussed Chapter 4, physical and developmental disabilities can affect sexuality. Although young people with disabilities are as fully sexual as their peers, their specific sexual health education needs are often ignored. This may be the result of inaccurate negative stereotypes about the sexuality of disabled people. This lack of attention is especially problematic since studies indicate that young people with disabilities are more than twice as likely as young people without disabilities to be sexually abused (Murphy & Young, 2005).

In examining key issues related to sexuality and disability, Gina Di Giulio (2003) at the University of Ottawa has noted that the five principles of effective sexual health education outlined in *Canadian Guidelines for Sexual Health Education* can be applied to the development and delivery of education specific to the needs of people with physical and developmental disabilities.

Fortunately, as physically and developmentally disabled youth's right to broadly based sexual health education designed to meet their needs is increasingly being recognized, appropriate curricula are becoming available. The teachers' section of SexualityAndU.ca, for example, provides guides for teaching sexual health education to people with physical and developmental disabilities.

There is a growing awareness of the need for sexual health education programming specific to the needs of youth and young adults with autism spectrum disorders (ASD) (Tullis & Zangrillo, 2013). As is too often the case for adolescents with disabilities, teens with ASD may receive only broadly based sexual health education as a reaction to problematic behaviours they have exhibited. Tullis and Zangrillo

## Innovative Canadian Research

### Sexual health education For Youth with phYSiCal diSabilitie S

Lauri East and Treena Orchard at the University of Western Ontario interviewed youth with physical disabilities, as well as their parents and health providers, and explored attitudes and experiences related to sexuality and sexuality education (East & Orchard, 2013). The study included four youth (aged 15–20 years), four parents, and four health care providers, and used focus groups to explore the unique needs and challenges of youth with physical disabilities, as well as ways to improve the content and delivery of relevant sexuality education. Youth highlighted the need to discuss disability related issues in general sexual health education classes to counteract the myth that those with disabilities are asexual and to normalize the concept of sexuality and disability. As well, youth expressed a need for more sex positive discussions on topics such as masturbation, arousal, intimacy,

and relationships and less emphasis on protection and prevention. Most parents acknowledged the importance of sexual health education; however, some felt that it was not necessarily a priority for socially isolated children with few peer interactions. Parents did not always feel competent to deliver sexual health education to their children and preferred to pass on this responsibility to schools and health providers. Health care providers noted that they sometimes lacked relevant sexuality information on specific conditions and were often unable to address sexual matters due to lack of time and privacy concerns during appointments. Some health care providers also sensed parental and societal disapproval related to the provision of sexual health education for children with disabilities. In general, the study highlighted the need to address sexuality and disability issues among youth, parents, and health providers and to encourage sex positive messages and images of individuals with disabilities within society as a whole.

recommend a more proactive approach, suggesting that in some instances standard sexual health curricula can be adapted to the specific needs of ASD youth. However, some young people with ASD may require sexual health education tailored to their specific needs. Sexual health education for children with ASD may emphasize social rules and privacy issues, while for teens and young adults with ASD, education may focus specifically on social skills related to dating and sexuality.

## Adults

Sexual health education is usually associated with the need to provide children and adolescents with school-based programs. This is where the vast majority of research attention has been focused. In many respects, however, adults need sexual health education just as much. Many are at high risk for STIs and HIV. And as people grow older, they often have emerging concerns about sexual functioning and need related education and health services.

The most accessible and credible sources of sexual health education and services for many adults are their physicians. Research suggests that many patients are reluctant to ask their doctors about sexual concerns, and many doctors don't proactively bring up sexual health issues (Wittenberg & Gerber, 2009). A survey of Canadian women found that while 58% had one or more sexual concerns, only 34% had discussed a sexual issue with a doctor (Fisher, Boroditsky, & Morris, 2004).

A survey of North American medical schools also revealed that physicians in training often receive inadequate education in discussing sexuality with patients (Solursh et al., 2003). A study of sexual health curriculum and training in Canadian medical schools found that most programs placed considerable or heavy emphasis on topics such as contraception (98%), prevention of STIs (76%), and sexual



violence/assault (73%), but far fewer medical school programs placed the same level of emphasis on topics such as social and cultural differences in sexual beliefs and customs (27%), sexuality and disability (22%), and childhood sexuality (17%) (Barrett et al., 2012).

Fortunately, this situation appears to be improving. Physicians are increasingly provided with guidance on screening patients for STI and HIV risk and on providing STI and HIV education (PHAC, 2010). As public awareness of sexual dysfunction increases, patients may feel more comfortable asking their doctors about sexual function concerns. Television advertisements for erectile dysfunction medications that encourage men to ask their doctors about sexual functioning may make people more comfortable about such discussions.

This greater awareness of sexual function issues combined with a greater emphasis on sexual issues within the medical community has resulted in a substantial growth in the literature advising physicians about interviewing techniques for assessing sexual functioning in male and female patients. Since the 1970s, there's been an exponential growth in the sexual medicine field, to the point where it's now an established academic and clinical discipline (Schultheiss & Glina, 2010). Although there's controversy about the extent to which the medicalization of sexuality is appropriate (e.g., Tiefer, 1996), it's likely that people will increasingly view doctors as important sources of sexual health information and services.

Accessing health care that's specifically relevant to their sexuality can still be a challenge for gay, lesbian, bisexual, and transgender people. Some doctors don't ask their patients about sexual orientation (Dahan, Feldman, & Hermoni, 2008).

## Education and Services in a Multicultural Society

Canada is a diverse country with respect to religion, ethnicity, and culture. With each passing year, our society becomes more ethnoculturally diverse as newcomers from a wide range of different cultural traditions immigrate to Canada. This presents a challenge to sexual health educators and health care providers. It's clear that ethnic differences extend to the realm of sexuality (Ahrols & Meston, 2010). Cultural background can influence attitudes towards issues such as marriage, sexual orientation, gender identity and expression, sexual relationships, and sexual health education in the schools.

Canadian studies have found, for example, that East Asian men have more conservative sexual attitudes than do men of European descent (Brotto, Woo, & Ryder, 2007) and that recent Iranian immigrants to Canada tend to have more conservative sexual norms and values (Shirpak, Maticka-Tydale, & Chinichian, 2007). Iranian women often have difficulty communicating with health care providers about issues pertaining to sexuality and reproductive health (Shirpak, Maticka-Tydale, & Chinichian, 2007). And a survey of Toronto teens has found that the extent to which they access and benefit from sexual health services varies with cultural heritage and length of residence in Canada (Flicker et al., 2009).

To constructively engage with individuals, families, and communities with ethnocultural minority backgrounds, it is important for sexual health educators to adopt an inclusive practice approach that acknowledges differences within and between cultural groups. An inclusive practice approach to sexual health education emphasizes the importance of self-determination, cultural uniqueness, and building the capacity to advocate for and access sexual health services (PHAC, 2014b).

An inclusive practice approach to sexual health education includes not just immigrant cultures, but also First Nations, Inuit, and Métis cultures, which have distinct values and norms pertaining to sexuality. This requires consulting and establishing partnerships with diverse communities to create and implement inclusive sexual health education programs and to deliver sexual health services.

# Summing Up

The purpose of sexual health education is to help people achieve positive outcomes (e.g., self-esteem, respect for self and others, non-exploitive sexual relations, rewarding human relationships, informed reproductive choices) and to avoid negative outcomes (e.g., STIs/HIV, sexual coercion, unintended pregnancy).

Early twentieth-century forms of sex education for youth often took the form of what was called “purity education” or “nature study.” During the 1960s and 1970s, sex education in Canadian schools was typically provided in “Family Life Education” classes.

The Public Health Agency of Canada has published the *Canadian Guidelines for Sexual Health Education* to guide and unify professionals who provide sexual health education in Canada.

The *Canadian Guidelines for Sexual Health Education* are based on the information–motivation–behavioural skills (IMB) model.

The Sex Information and Education Council of Canada (SIECCAN) has identified ten key ingredients of sexual health education.

Broadly based sexual health education programs cover a wide range of topics and are structured so that students can exercise informed decision-making.

Abstinence-only programs focus exclusively on persuading students not to be sexually active.

Research has shown that broadly based programs are more effective than abstinence-only programs in reaching their stated objectives.

Surveys of parents in Canada indicate that the vast majority of them approve of sexual health education in the schools, and most parents also approve of providing youth with information on a wide range of topics including puberty, reproduction, healthy relationships, STI/HIV prevention, birth control, abstinence, sexual orientation, and sexual abuse/coercion.

In recent years, the Internet has become a key source of information about sexuality and sexual health. However, online porn may be teaching unhealthy messages about sexuality.

The sexual health education needs of sexual-minority youth and youth with disabilities are not being adequately met.

Among the challenges facing Canadian sexual health educators is the need to provide high-quality education in the context of a multicultural society.

## Test Yourself

### Multiple-Choice Questions

- which province removed sexual health education from its formal curriculum in 2005?
  - Quebec
  - British Columbia
  - Ontario
  - New Brunswick
- which of the following is not one of the ten key ingredients of effective sexual health education identified by the Sex information and education Council of Canada?
  - Giving teachers training and administrative support.
  - Including a focus on students' social environments.
  - Bringing in guest speakers.
  - Evaluating to identify program strengths and weaknesses
- when surveyed, Canadian teens indicated that their most valuable sources of information about sexuality were
  - Schools and parents.
  - Parents and the Internet.
  - The Internet and friends.
  - Friends and television.
- the Canadian guidelines for Sexual health education are based on a theoretical model called the:
  - Social-cognitive model.
  - Trans-theoretical model.
  - IMB model.
  - Health-belief model.
- Canadian studies have found that:
  - Youth want sexual-health education taught in school, but parents don't.
  - Parents want sexual-health education taught in school, but youth don't.
  - Both parents and youth want sexual-health education taught in school.
  - Neither parents nor youth want sexual-health education taught in school.

6. according to the text, the government of which country provides large amounts of funding for abstinence-only sex education?
- (a) Sweden (c) Canada  
(b) United States (d) China
7. according to the results of the *Toronto Teen Survey*, when teens were asked what topics they wanted to learn more about the most common response was
- (a) Healthy relationships.  
(b) STIs.  
(c) Sexual abuse/assault.  
(d) Communication about sex.
8. according to the available research, which of the following statements about sexual health education is false?
- (a) Most evaluated abstinence-only programs have resulted in delayed first intercourse.  
(b) Most evaluated sexual-health education programs don't result in earlier or more frequent sexual activity.  
(c) Sexual-health education can result in more frequent condom use among sexually active youth.  
(d) None of the above.
9. according to the Shaughnessy et al. (2011) study, what percentage of male and female university students had visited an educational website on sexuality in the previous month?
- (a) 56.3%, 47.1%  
(b) 38.9%, 22.6%  
(c) 17.6%, 31.2%  
(d) 8.7%, 19.4%
10. in a study of Canadian medical school training, the topic that programs were least likely to place emphasis on was
- (a) Childhood sexuality  
(b) Prevention of STIs  
(c) Sexuality and disability  
(d) Sexual violence/assault

You'll find answers to the "Test Yourself" questions on [page xxx](#).

## Questions for Critical Thinking

- Should sexual health education in the schools stick to providing basic information about reproduction and sexually transmitted infections? Or should programs include topics like healthy relationships and sexual response? Explain your answer.
- Sexual health education in the schools can be a controversial topic. What are some of the reasons why it can be controversial?
- If you agree that young people should be encouraged to use condoms if they are sexually active, at what age do you think education in this area should begin?
- If you were given the task of designing a one-hour sexual health education session for the students at your college or university, what specific topics would you prioritize?