



**SEXUAL HEALTH EDUCATION AT SCHOOL AND AT HOME:
ATTITUDES AND EXPERIENCES OF NEW BRUNSWICK PARENTS**

Angela D. Weaver E. Sandra Byers Heather A. Sears
Jacqueline N. Cohen Hilary E.S. Randall
University of New Brunswick
Fredericton, New Brunswick

***ABSTRACT:** This study examined the attitudes and experiences of New Brunswick parents regarding sexual health education (SHE) at school and at home. Over 4200 parents with children in grades K-8 in 30 New Brunswick schools completed surveys. Ninety-four percent of parents agreed that SHE should be provided in school and 95% felt that it should be a shared responsibility between school and home. Almost all parents felt that SHE should begin in elementary (65%) or middle school (32%), although there was not consensus on what grade level various topics should be introduced. The majority of parents supported the inclusion of a broad range of sexual health topics at some point in the curriculum, including topics often considered controversial such as homosexuality and masturbation. Although parents indicated that they wish to be involved in their child's SHE, most of them had not discussed any of a range of SHE topics in a lot of detail with their child. Parents also indicated that they want more information from schools about the SHE curriculum, about sexuality in general, and about communication strategies to assist them in providing education at home.*

Key words: Sexual health education Schools Parents Parental attitudes

ACKNOWLEDGMENT: We would like to thank the parents who participated in this survey. We would also like to thank Mark Holland and Margaret Layden-Oreto of the New Brunswick Department of Education, the Directors of Education and principals of the participating school districts, Alexander McKay of the Sex Information and Education Council of Canada, Tricia Beattie, Krista Byers-Heinlein, Tammy Harrison, Jamie Hart, Justin Matchett, Shelly Matchett, and Jennifer Thurlow. We would also like to acknowledge the financial support of the New Brunswick Department of Education.

INTRODUCTION

Adolescents rate sex education as one of their most important educational needs (Cairns, Collins, & Hiebert, 1994). However, sexual health education (SHE) is often a controversial topic, with perhaps no other subject sparking as much debate. School administrators have identified fear of parental or community opposition as major barriers to the provision of SHE (Reis & Seidl, 1989; Scales & Kirby, 1983). Similarly, teachers in New Brunswick have identified anticipated reactions from parents to the inclusion of specific topics as the greatest barrier to their willingness to teach SHE (Cohen, Byers, Sears, & Weaver, 2001). Are parents in fact opposed to school-based SHE as often feared or do parents support the provision of SHE at school? The answer to this

question is important because parental support is strongly associated with the success of SHE programs (Rienzo, 1989). Further, discussion of sexuality in the home is an important component of students' overall SHE, and school-based SHE can make it easier for parents to discuss sexuality with their child (Berne et al., 2000; Parcel & Coreil, 1985). The purpose of this study was to evaluate parents' attitudes toward and experiences with SHE at school and at home, including their ideas about the timing and content of the sexual health curriculum and their involvement in providing SHE to their children.

Correspondence concerning this paper should be addressed to E. Sandra Byers, Ph.D., Department of Psychology, University of New Brunswick, Bag Service #45444, Fredericton, New Brunswick E3B 6E4. E-mail: byers@unb.ca



ATTITUDES TOWARD SEXUAL HEALTH EDUCATION

Although a vocal minority can create the impression that parental objections to school-based SHE are widespread, research has consistently found that parents support SHE at school. For example, McKay, Pietrusiak, and Holowaty (1998) reported that 95% of parents in one rural school district in Ontario agreed that SHE should be provided in school. The majority of parents (82%) felt that SHE should begin in the primary grades and continue through to high school. Similarly, 95% of parents of high school students in rural Nova Scotia supported school-based sexuality education (Langille, Langille, Beazley, & Doncaster, 1996) and 98% of urban Ontario parents were in favour of AIDS education in the schools (Verby & Herold, 1992).

As no large-scale study has been undertaken to assess New Brunswick parents' attitudes toward SHE, it is unclear whether results of studies conducted in other provinces can be generalized to New Brunswick. It is important to have information regarding the attitudes of New Brunswick parents as parental attitudes have the potential to affect educational policy, curriculum, and procedures in this province. Therefore, the first goal of this study was to assess parents' general attitudes toward SHE in the schools, including which topics they believe are important to their children's SHE.

Although the vast majority of parents support SHE, they do not necessarily share a common vision of the nature, content, and timing of an ideal SHE curriculum. Thus, they may agree that SHE should be provided in school, but they may disagree about how important it is to include some of the more "controversial" topics, such as masturbation or sexual orientation, or about the appropriate grade level for introducing specific topics. For example, McKay et al. (1998) found that the majority of parents felt that all of the sexual health topics listed in their survey should be included at some point in the SHE curriculum, although parents' views about the appropriate grade level for introducing each topic varied depending on the topic. However, McKay and colleagues did not assess parents' opinions about a number of important topics, such as masturbation, correct names for genitals, and wet dreams. Therefore, a second goal of this study was to investigate at what grade levels parents want various

sexual health topics to be introduced using a more comprehensive list of sexual health topics.

SEXUAL HEALTH EDUCATION AT HOME

Most parents believe that parents and schools should share responsibility for SHE. For example, McKay and colleagues (1998) found that most parents identified parents (88%), health professionals (88%), and teachers (77%) as appropriate people to provide SHE in the school and community. Similarly, in a study of 406 students in grades 7-12 in rural Ontario, students identified family and school as their two preferred sources of sexual health information (McKay & Holowaty, 1997).

However, the extent to which parents are actually providing quality SHE to their children is unclear. Respondents rarely identify their parents as a primary source of sexual health information (Ansuini, Fiddler-White, & White, 1996). Further, in one study, only 61% of students felt that their parents had done a good job providing them with SHE (McKay & Holowaty, 1997). Similarly, McKay et al. (1998) found that 70% of the parents they surveyed felt that most parents do not give children the SHE they need. Although 73% of the parents surveyed by McKay et al. (1998) felt that they had provided adequate SHE for their children, Welshimer and Harris (1994) found that only 52% of parents had confidence in their own efforts to provide SHE, and only 15% had confidence in other parents.

Unfortunately, these studies did not ask parents to provide further information on the nature of the SHE they had provided. Thus, their results provide a global assessment of SHE in the home, yet tell us little about what specific subjects parents are discussing with their children or how comprehensive their discussions are. For example, there may be topics that parents feel more comfortable with and subsequently cover in more detail. Conversely, there may be topics that parents typically do not discuss with their children. Therefore, a third goal of the study was to assess what topics parents are discussing with their child at home and in what level of detail.

If parents are not providing quality SHE at home, it is important to know how they can be encouraged to provide a level of education that will promote positive



sexual health outcomes for their children. There are a number of factors that may prevent parents from providing adequate SHE in the home. Many parents are concerned that they do not possess sufficient sexual health knowledge to educate their children (Croft & Asmussen, 1992). Further, they report that they do not know how much information is appropriate for various age levels (Geasler, Dannison, & Edlund, 1995). The final goal of the study, then, was to ask parents what could be done to support their efforts to provide SHE at home.

METHOD

PARTICIPANTS

In total, 9,533 surveys were distributed to parents of children in grades K-8 in 30 New Brunswick schools; 4,206 completed surveys were returned. Parents who received multiple copies because they had more than one child enrolled in grades K-8 in the selected schools were asked to complete only one copy and return the extra indicating that they had already completed the survey. Unfortunately, few parents did so. Because it cannot be determined how many parents received multiple copies but did not return the extras, it is not possible to calculate an accurate response rate. However, the minimum estimate of the response rate is 46% and it is likely that the precise response rate was significantly higher. The typical respondent was female (89%), lived in a city (45%) or rural community (38%), was in her 30s (54%) or 40s (34%), and had completed high school (37%) or a college, trade, or technical school education (35%). Sixty-eight percent of respondents had a child in grades K-5, 54% had a child in grades 6-8, 24% had a child in grades 9-12, and 12% had a child older than grade 12.

MEASURE

Parents completed a survey entitled "New Brunswick Parents' Ideas About Sexual Health Education" which was divided into six parts. Part A elicited parents' general opinions, rated on 5-point Likert scales, about SHE in the schools, such as whether SHE should be provided in the schools, whether the school and parents should share responsibility for the provision of SHE, and parents' perceptions of the quality of the SHE that their children have received in school. They also indicated the grade level at which they thought SHE should begin (K-3, 4-5, 6-8, 9-12,

or "There should be no sexual health education in schools"). Part B asked parents to indicate, on a 5-point scale ranging from 1 (not at all important) to 5 (extremely important), how important it is to include each of 10 topics in a sexual health curriculum. Parents were asked this question generally, and were not asked to respond with regard to a specific child. In Part C, parents indicated the grade level at which schools should begin covering each of 26 sexual health topics (K-3, 4-5, 6-8, 9-12, or "This topic should not be included"). Next, in Part D, parents were asked to evaluate the SHE they had provided to their children. Parents were provided with the same list of 10 general sexual health topics as in Part B and were asked to indicate on a scale from 1 (not at all) to 4 (in a lot of detail) how thoroughly they felt they had discussed each topic. They responded to this question with respect to their oldest child who was in grades K-8. In Part E, parents provided demographic information (gender, age, education level, and community type).

In Part F of the survey, parents were asked three open-ended questions. The first question invited parents to comment on SHE in the schools. They were then asked to indicate how the New Brunswick Department of Education or their child's school could support their efforts to provide SHE at home. Finally, they were asked whether they would be interested in attending a workshop on SHE if their child's school was to offer one and what topics they would like to see included in this type of workshop. To evaluate parents' responses to the open-ended questions, 1137 surveys (37%) were randomly selected from the 4206 completed questionnaires. In total, 547 of the 1137 questionnaires (48%) contained a response to one or more of these open-ended questions. Content analysis, commonly used in survey research to evaluate responses to open-ended questions (Weber, 1990), was used to evaluate parents' responses to these items. One of the authors reviewed all responses to each of these items and then read and reread the responses until patterns emerged. These patterns were labelled as themes. Because similar themes emerged for the first two open-ended questions, responses to these items were analyzed together.

PROCEDURE

This study was conducted in the spring of 2000 as



part of a larger project that also assessed teacher and student attitudes toward SHE. Thirty-three elementary and/or middle schools were selected geographically from around the province so that an approximately equal number of parents would have children attending rural and urban schools. Thirty of the 33 targeted schools agreed to participate.

Parents were informed about the survey by means of a notice in the school newsletter and/or a voice mail message system. Classroom teachers distributed the surveys, sealed in privacy envelopes, to students in their class, with the request that they take them home to be filled out by their parents. Surveys were returned to the school with the child, and then returned to the researchers by the school.

RESULTS

ATTITUDES TOWARD SEXUAL HEALTH EDUCATION

The vast majority of parents were in support of school-based SHE, with 94% of parents either agreeing (40%) or strongly agreeing (54%) that SHE should be provided in school (see Figure 1). Almost all parents (95%) felt that both the school and parents have a role to play in SHE, with 33% agreeing and 62% strongly agreeing that the school and parents should share this responsibility (see Figure 2).

Approximately equal numbers of parents reported that SHE should begin in grades K-3, 4-5, and 6-8 (33%, 32%, and 32% respectively). Thus, 65% of parents felt that SHE should begin in elementary school and 97% felt that it should begin in elementary or middle school. Only 1% of parents reported that SHE should not be provided in school (see Figure 3). In order to determine whether parental characteristics were associated with attitudes towards SHE, parents' age, level of education, community type (rural versus urban), and age of their oldest child were correlated with these three items. Because of the large sample size, only correlations accounting for more than 4% of the variance were interpreted. None of these characteristics significantly predicted parental attitudes towards SHE.

The median of parents' responses shows that parents rated each of the 10 listed topics as important to include in a sexual health curriculum (see Table 1). Parents rated personal safety, abstinence, puberty, sexual decision-making, and reproduction as extremely important. They rated sexually transmitted diseases, sexual coercion/assault, birth control methods and safer sex practices, and correct names for genitals as very important to the curriculum. Although parents felt that sexual pleasure/enjoyment was less important than the other nine topics, they still rated it as important overall.

Figure 1 Percentage of parents agreeing with the statement, "Sexual health education should be provided in the schools".

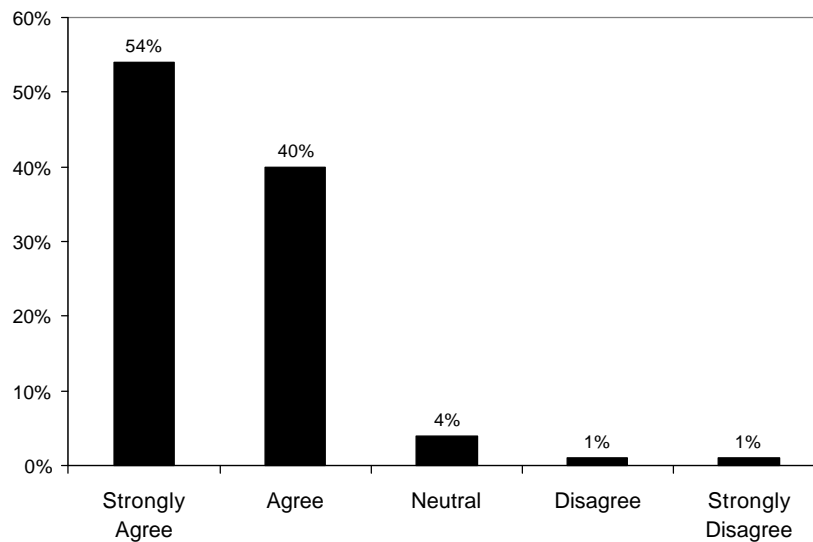




Figure 2 Percentage of parents agreeing with the statement, “The school and parents should share responsibility for providing children with sexual health education”.

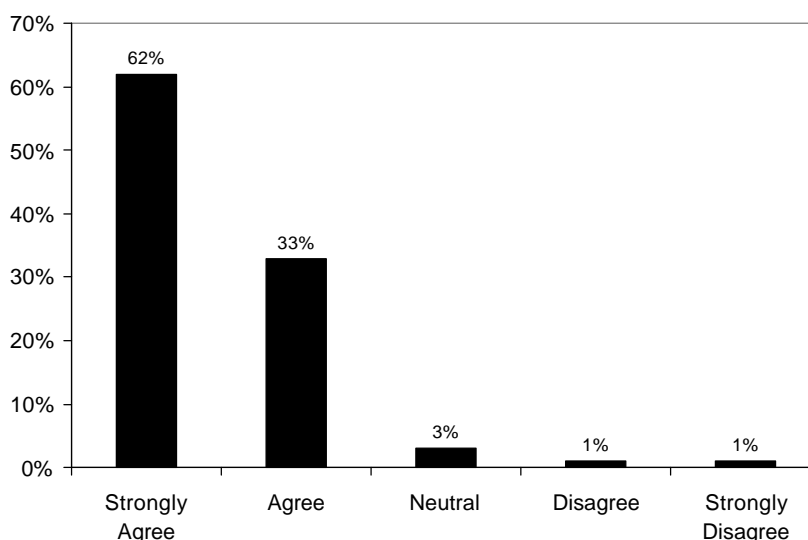
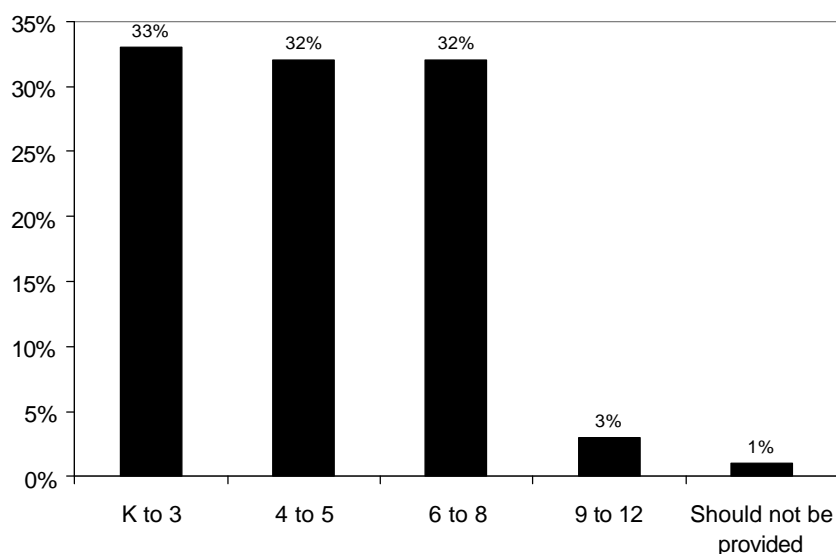


Figure 3 Percentage of parents reporting that sexual health education should begin at specific grade levels.



PREFERRED GRADE LEVEL FOR INTRODUCING SPECIFIC SEXUAL HEALTH TOPICS

Parents were asked to indicate the grade level at which they thought schools should begin teaching each of 26 sexual health topics. The results are summarized in Table 2. There was strong support for the inclusion of all 26 topics in the curriculum; between 73% and 99% of parents wanted each topic included at some

grade level. Further, parents wanted most topics introduced by grades 6-8, and there were several topics that many parents thought should be introduced in elementary school.

The median responses of parents who felt that topics should be included in the curriculum indicated that they wanted personal safety to be introduced in grades

**Table 1 Importance Parents Assigned to Possible Topics in the Sexual Health Curriculum**

Topic	Median	Mode	Mean	Standard Deviation
Personal safety	5	5	4.6	0.7
Abstinence	5	5	4.2	1.0
Puberty	5	5	4.1	0.9
Sexual decision-making in dating relationships	5	5	4.1	1.1
Reproduction	5	5	4.0	0.9
Sexually transmitted diseases	4	5	4.6	0.7
Sexual coercion & sexual assault	4	5	4.5	0.8
Birth control methods & safer sex practices	4	5	4.3	1.0
Correct names for genitals	4	3	3.7	1.0
Sexual pleasure & enjoyment	3	3	2.7	1.3

Note: Response options: 1 = not at all important, 2 = somewhat important, 3 = important, 4 = very important, 5 = extremely important. $N = 3,941$ to $4,027$.

Table 2 Grade Level at which Parents Thought Specific Topics Should be Introduced

Topic	Median ^a	Percent indicating each grade level ^b				Should not be included
		K - 3	4 - 5	6 - 8	9 - 12	
Personal safety	K-3	58.8	23.3	15.5	2.4	0.6
Correct names for genitals	4-5	42.1	30.9	24.6	2.5	1.1
Body image	4-5	37.9	34.5	25.2	2.3	1.8
Sexual coercion and sexual assault	4-5	25.1	26.0	38.7	10.2	0.9
Puberty	6-8	2.6	43.2	50.9	3.3	0.5
Menstruation	6-8	1.4	42.3	52.0	4.3	1.3
Reproduction and birth	6-8	4.2	20.6	60.8	14.5	1.0
Being comfortable with the other sex	6-8	9.9	18.7	49.7	21.7	5.7
Abstinence	6-8	2.3	12.7	67.5	17.6	1.9
Sexually transmitted diseases/AIDS	6-8	2.3	14.7	67.8	15.1	0.5
Dealing with peer pressure to be sexually active	6-8	1.4	13.8	67.7	17.1	2.0
Teenage pregnancy/parenting	6-8	1.4	8.3	67.9	22.4	1.3
Communicating about sex	6-8	6.6	16.5	48.8	28.2	5.6
Wet dreams	6-8	1.7	19.9	62.5	15.8	11.1
Birth control methods and safer sex practices	6-8	0.5	6.8	64.1	28.6	3.0
Sexuality in the media	6-8	2.1	12.5	48.3	37.1	13.4
Masturbation	6-8	2.3	11.9	59.8	26.0	19.4
Sex as part of a loving relationship	6-8	2.1	7.5	46.6	43.8	10.6
Attraction, love, intimacy	6-8	2.3	8.3	47.9	41.5	9.8
Homosexuality	6-8	3.5	11.1	50.4	35.0	16.7
Sexual behaviour (e.g., French kissing)	6-8	0.9	8.4	59.3	31.4	14.8
Teenage prostitution	6-8	5.4	13.0	40.4	41.4	16.8
Building equal romantic relationships	6-8	1.4	5.2	44.2	49.3	9.8
Sexual problems and concerns	6-8	1.3	6.0	44.3	48.3	11.6
Pornography	6-8	1.1	7.6	49.8	41.4	25.1
Sexual pleasure and orgasm	9-12	0.4	2.8	37.8	59.0	27.4

Note: $N = 4,010$ to $4,111$ (all parents indicating preferences related to all grades)

^a The grade level by which 50% or more of parents wanted the topic introduced.

^b "Percent indicating each grade" is based on those who reported that they wanted the topic included.



K-3. Parents were divided with respect to correct names for genitals, body image, and sexual coercion and sexual assault. The median response suggests that parents wanted these topics introduced in grades 4-5, yet a substantial percentage of parents wanted them introduced earlier (25%-42%).

Parents' median responses for most of the other topics indicated that they felt these topics should be introduced in grades 6-8, with a minority of parents (7% to 46%) wanting them introduced earlier. These topics included: puberty, menstruation, reproduction and birth, being comfortable with the other sex, abstinence, sexually transmitted diseases/AIDS, dealing with peer pressure to be sexually active, teenage pregnancy/parenting, communicating about sex, wet dreams, birth control methods and safer sex practices, sexuality in the media, masturbation, sex as part of a loving relationship, attraction, love, and intimacy, homosexuality, sexual behaviour, teenage prostitution, building equal romantic relationships, sexual problems and concerns, and pornography. However, parents were divided with respect to several of these topics. Although approximately half of parents reported wanting puberty and menstruation to be introduced in grades 6-8, an almost equal percentage of parents wanted them introduced earlier (46% and 44%, respectively). Similarly, median responses suggest that parents want sex as part of a

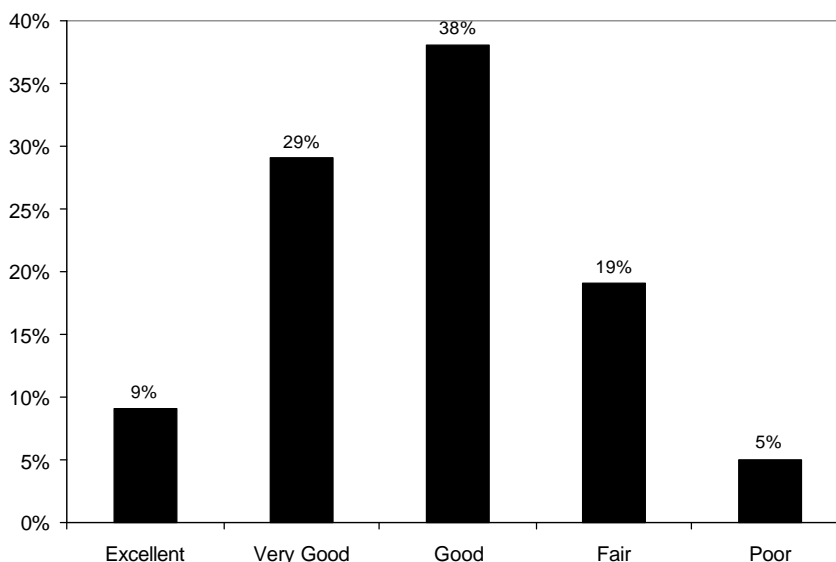
loving relationship as well as attraction, love, and intimacy introduced in grades 6-8, yet a similar percentage wanted these topics introduced in grades 9-12 (44% and 42%, respectively). Sexual pleasure and orgasm was the only topic with a median response indicating that parents wanted it covered in grades 9-12; yet, 41% of parents wanted even this controversial topic introduced earlier in the curriculum.

Topics that more than 10% of parents wanted excluded from the curriculum included wet dreams, sexuality in the media, masturbation, sex as part of a loving relationship, homosexuality, sexual behaviour, teenage prostitution, sexual problems and concerns, pornography, and sexual pleasure and orgasm. It is important to remember that these potentially controversial topics still had the support of the large majority of parents. For example, pornography and sexual pleasure and orgasm drew the highest percentage of parents who felt that these topics should be excluded. Yet, even for these two topics, 73% and 75% of parents, respectively, supported their inclusion in the curriculum.

SEXUAL HEALTH EDUCATION AT HOME

Only about one-third of parents felt that the SHE they or their partner had provided to their children at home was excellent (9%) or very good (29%) (see Figure 4). An additional 38% felt that they had done a good

Figure 4 "In your opinion, how good a job do you think you and/or your spouse or partner have done in providing sexual health education for your child/children?"





job. Almost one-quarter of parents felt that they had done only a fair (19%) or poor (5%) job providing SHE to their children. However, when asked about the level of detail they had provided their oldest child in K-8 on 10 sexual health topics, overall parents indicated they had not discussed any of these topics in a lot of detail (see Table 3). According to the median responses, parents reported discussing only personal safety and correct names for genitals in some detail. In contrast, they reported discussing puberty, reproduction, sexual coercion and assault, sexually transmitted diseases, and abstinence in general terms only. Overall, they had not discussed birth control methods and safer sex practices, sexual decision-making in dating relationships, and sexual pleasure and enjoyment at all.

Because it is likely that parents provide more detailed SHE to their children as they get older, depth of coverage was examined for each of the 10 topics by the child's grade level (see Table 3). Chi square analysis revealed significant differences in the depth of coverage of all topics based on the grade level of the child. In general, parents with a child in older grades reported discussing sexual health topics in more detail than parents whose child was in younger grades. Nonetheless, according to the median responses, even parents with children in middle school had not discussed any of the topics in a lot of detail with their child.

Examination of the median responses yielded two patterns. First, there are some topics that parents appear to discuss in greater detail as the child gets older. For example, parents with a child in grades K-3 had not discussed puberty at all, whereas those with a child in 4-5 had discussed it in general terms, and those with a child in 6-8 had discussed it in some detail. For reproduction and sexual coercion and sexual assault, a more detailed discussion appears to come with middle school (some detail) as both parents of early and late elementary students had discussed this topic in general terms only. Similarly, parents with children in elementary school tended not to discuss birth control and safer sex practices, sexually transmitted diseases, abstinence, or sexual decision-making with their children at all, whereas parents with children in middle school had discussed these topics in general terms. Some detail about the correct name

for genitals was given to children in grades 4-5 and middle school; early elementary school children had only been told the correct name for genitals in general terms. Second, some topics appear not to be discussed in greater depth as the child gets older—at least until the end of middle school. For example, on average, parents with children in elementary or middle school reported discussing personal safety “in some detail”, and sexual pleasure and enjoyment “not at all”.

SUPPORTING PARENTS' EFFORTS TO PROVIDE SHE AT HOME

Three primary themes emerged from the content analysis of parents' responses to the open-ended questions representing their general comments about SHE in school and suggestions for how their efforts to provide SHE at home could be supported.

Theme #1: Evaluation of current curriculum. Many parents made evaluative comments, positive and negative, about the current sexual health curriculum. Some parents took the opportunity to indicate strong support for SHE in school.

Parent 1: It is extremely important that children learn correct information early. If well-rounded information is provided, sexual education doesn't promote sexual activity. I feel it is gaps in accurate information that leads to experimentation and unwanted consequences. Some kids will experiment with or without knowledge so it is best to prepare them.

Other parents made negative comments about the sexual health curriculum, such as suggesting that SHE should not be provided in school.

Parent 2: I feel sex education should not be taught in schools, because many of the topics would necessarily promote a moral agenda which may not be in keeping with that of the home. I do not believe birth control should be promoted in school, and issues such as homosexuality and relationships have no place in an academic institution. Issues such as avoiding sexual abuse and awareness of



Table 3 Depth of Parents' Coverage of 10 Sexual Health Topics with Children in Various Grade Levels

Topic	Median	Grade	Depth of Coverage			
			Not at all	In general terms only	In some detail	In a lot of detail
Personal safety	3	K-3	11%	27%	34%	28%
	3	4-5	10%	21%	38%	31%
	3	6-8	7%	21%	37%	35%
Abstinence	1	K-3	83%	9%	5%	3%
	1	4-5	60%	21%	13%	7%
	1	6-8	28%	27%	24%	21%
Puberty	1	K-3	58%	27%	13%	2%
	2	4-5	23%	29%	36%	12%
	3	6-8	8%	23%	44%	25%
Sexual decision-making in dating relationships	1	K-3	88%	8%	3%	2%
	1	4-5	73%	19%	6%	2%
	2	6-8	41%	30%	18%	11%
Reproduction	2	K-3	31%	42%	23%	4%
	2	4-5	22%	36%	33%	9%
	3	6-8	11%	30%	40%	19%
Sexually transmitted diseases	1	K-3	83%	11%	4%	2%
	1	4-5	54%	25%	15%	6%
	2	6-8	22%	32%	29%	17%
Sexual coercion and sexual assault	2	K-3	49%	25%	17%	10%
	2	4-5	29%	30%	28%	13%
	3	6-8	17%	29%	33%	22%
Birth control methods and safer sex practises	1	K-3	87%	9%	3%	2%
	1	4-5	66%	20%	11%	4%
	2	6-8	36%	31%	21%	12%
Correct names for genitals	2	K-3	14%	41%	32%	14%
	3	4-5	10%	33%	41%	15%
	3	6-8	9%	35%	38%	19%
Sexual pleasure and enjoyment	1	K-3	88%	8%	3%	1%
	1	4-5	78%	18%	4%	0%
	1	6-8	60%	27%	10%	3%

Note: Percentages are within grade levels.
 Chi Square analysis of variance variance ($p < 0.001$, $df = 6$) showed significant differences in depth of coverage of each topic according to grade level.
 Response options: 1 = not at all, 2 = in general terms only, 3 = in some detail, 4 = in a lot of detail.
 N = 3,946. Responses applied to one child in one grade: K-3 = 1,120 (28%); 4-5 = 742 (19%); 6-8 = 2,084 (53%).

sexual coercion are issues of safety, and appropriate to a school health curriculum.

parents suggested ways in which it should be restricted.

Some parents suggested ways in which the current SHE curriculum should be expanded whereas other

Parent 3: *There should be more updated info. {sic} And at a younger age, not*



outdated general videos. It should be a course once or twice a week for several weeks.

Parent 4: *The present program places too much emphasis on knowing all of the parts of the male and female anatomy. The amount of and level of vocabulary is excessive for middle school.*

Theme #2: Quality of teaching. Some parents mentioned the teaching methods used for SHE and the importance of the quality of teaching. They indicated that they want their children to have a comfortable and qualified teacher and are concerned that an uncomfortable teacher would impart negative messages. Some parents provided suggestions regarding who should be involved in providing SHE (e.g., a public health nurse) and what training would be important (e.g., in-service training).

Parent 5: *Make sure the educators are completely comfortable with the topic. When they are uncomfortable the children recognize this and it becomes a giggle session. Not every teacher can teach this, perhaps a special health education teacher is needed.*

Theme #3: Need for support for parents. Some parents suggested ways in which they could be supported in their efforts to provide SHE to their children. Many expressed interest in attending a SHE workshop and wanted general information on a wide variety of sexual health topics. Some parents indicated that they would like to learn strategies for approaching and discussing sexual health topics with their children at home.

Parent 6: *Respecting your body. How to help girls not succumb to pressures from boys. How to make sex something normal not hush hush or dirty.*

Parent 7: *All of the topics, especially how to keep the communication open to our kids so we can discuss these with them.*

Some parents indicated that they would like increased

communication with the schools about the SHE their children would be receiving. Parents felt that information on sexuality and suggestions on how to discuss topics with their children could help them respond to questions at home, and they suggested various ways the school could provide such information.

Parent 8: *I think that it would be very beneficial for parents to know the topics that would be discussed before the children are actually exposed to it so that when they come home and start asking questions, we would be prepared for it and can respond to them openly and honestly, without being embarrassed or at a loss for words.*

Parents were asked to indicate whether they would be interested in attending a SHE workshop for parents if it was offered at their child's school. Fifty percent of parents indicated that they would be interested in attending the workshop, 20% were not interested, and 30% were not sure. Parents who indicated that they would be interested in attending a SHE workshop were asked to list the topics that would especially interest them. Of the 569 parents who indicated an interest, 362 parents (64%) commented. Nineteen percent of those parents indicated that they would like general information on *all* topics. Specific topics that parents frequently mentioned include sexually transmitted diseases and AIDS, puberty, menstruation, correct names for genitals, contraception, teen pregnancy, teen relationships, teen sexuality, dating, peer pressure, sexual decision-making, sexual coercion, sexual assault, sexual harassment, and personal safety issues. Almost one-half of parents (45%) expressed a desire to learn strategies for approaching and discussing specific sexual health topics with their children at home, including peer pressure to have sex, how to answer children's questions in a way that is appropriate for their age, and how to communicate about sexual health information in a way that makes their child feel comfortable.

DISCUSSION

The vast majority of parents in New Brunswick support school-based SHE. Ninety-four percent



agreed that SHE should be provided in school. This result is consistent with findings of 95% of parents in support of SHE in rural Ontario (McKay et al., 1998) and 95% in rural Nova Scotia (Langille et al., 1996), and suggests that the fears teachers and administrators have of parental and community opposition may reflect the opinions of a small, vocal minority and not the opinions of most parents. Studies like this one can help reduce the fears administrators and teachers have about parental opposition to SHE at school. Themes that emerged from the open-ended questions suggest that some parents would like to see the current SHE curriculum begin earlier and be more comprehensive, while other parents are concerned about children receiving too much information at a young age.

Clearly, most parents want SHE to begin by middle school and many feel that at least some topics should be introduced earlier. In response to the question about the grade level in which age-appropriate SHE should begin, 65% of parents wanted age-appropriate SHE to begin by grades 4-5, and 33% by grades K-3. Thus, it appears that many parents want children equipped with knowledge and skills to keep themselves sexually healthy *before* they begin engaging in sexual relationships. Given that this survey did not provide details about what topics and what depth of coverage would be considered "age-appropriate" SHE at each of these levels, it is possible that some additional parents would support SHE in the younger grades if they knew more about the specific curriculum. Thus, it appears that there is substantial support for introducing SHE in the early elementary grades that, at a minimum, includes personal safety, correct names for genitals, body image, and sexual coercion and sexual assault. However, as there is no consensus as to when in elementary school various topics should be introduced, parents need to be kept informed of the content and rationale for the sexual health curriculum.

Further, parents rated each of 10 sexuality topics as important to the curriculum. This suggests that parents want a comprehensive SHE program that includes a full range of topics that go beyond biology, such as sexual decision-making and sexual pleasure and enjoyment. There was also support for including a broad range of sexual health topics in middle school,

including some that may be considered controversial, such as masturbation, homosexuality, and sexual pleasure and orgasm. It appears that parents recognize and support their children's need for information about a broad range of sexual health issues. They also appear to support a developmental approach to SHE in which children learn the foundations of sexual health (e.g., correct names for genitals) in elementary school and, as they develop, new knowledge is introduced which builds on this base.

Parents showed support for a comprehensive SHE curriculum that starts in elementary school and thus identified a wide range of topics as important. This endorsement may reflect an awareness that parents alone are unlikely to provide comprehensive SHE at home. Almost all parents (95%) reported that the school and parents should *share* responsibility for SHE provision. However, very few parents felt that they had done an excellent job of providing SHE and few parents had discussed sexual health topics in detail with their children. While parents tended to discuss many sexual health topics with their children in greater depth as they grow up, even parents with children in middle school had not discussed any of the listed topics in a lot of detail, and some topics (e.g., sexual decision-making, sexual pleasure and enjoyment, sexual transmitted diseases) had been discussed in general terms only or not at all.

Given the variability in the implementation of SHE in schools (Barrett, 1994), and our finding that parents seldom provided detailed information on SHE topics, it seems likely that many students are not receiving the kind of comprehensive and diverse education about sexuality that their parents endorse. It is probable that "safer" topics receive more coverage at home and at school, exposing students to a limited range of sexual health information. For example, parents in this survey reported that they discussed personal safety and correct names for genitals in more detail than birth control methods and safer sex practices. Even parents of students in middle school were more likely to have discussed the biological aspects of reproduction than birth control methods, safer sex, or sexual decision-making. Similarly, New Brunswick teachers reported being more willing to teach topics related to anatomy and physical development and less willing to teach about topics



such as masturbation or sexual problems and concerns (Cohen et al., 2001). These are topics that, traditionally, classroom teachers have not covered, opting instead to stick to the safe biological aspects of sexuality because they feel they have knowledge about, and are comfortable with, these topics (Cohen et al., 2001). Parents appear to be aware of many teachers' low levels of comfort with some sexual health topics. Although not a focus of this survey, in response to the open-ended questions, a number of parents commented on the importance of teachers being both qualified to teach SHE (i.e., knowledgeable) and comfortable with discussing sexuality if children are to be fully educated about important sexual health issues.

Despite their stated desire to do so, many parents indicated that they are providing little or no SHE to their children. This is consistent with research showing that many students report that their parents have not done a good job providing SHE (Byers et al., 2001; McKay & Holowaty, 1997). It is important to look closely at the reasons why parents are not engaging in such discussions. For example, barriers, such as inadequate knowledge or personal discomfort or anxiety, may be keeping parents from having open discussions about sexual health with their children. Parents indicated two main ways that the schools could support their efforts to provide SHE in the home. First, they would like to have information from schools concerning sexuality in general. Second, they would like to be informed about the education their child will be receiving before they receive it so they will be prepared for questions that may arise at home. Taking steps to address these concerns would help provide parents with the tools they need to initiate sexual health discussions with their children. Many parents indicated an interest in attending a SHE workshop, if their child's school was to offer one. Schools might consider offering workshops for parents that cover a range of sexual health topics. Such workshops should also provide information about how to talk to a child in a way that is age-appropriate and makes the child comfortable.

The results of this study must be considered in light of its limitations. First, although there was a good response rate to the survey, with at least 46% of parents returning completed questionnaires, it may

be that parents who did and did not return the survey differ in important ways. As a result, the extent to which the findings of this study can be generalized to all New Brunswick parents or to parents in other regions of Canada is not known. Second, the survey was completed primarily by mothers, so it is not clear how well these results reflect the attitudes and experiences of fathers regarding SHE at school and at home. Third, this study used only the survey method to assess parents' attitudes and experiences. Interviews or focus groups with parents might well have highlighted other salient issues. Finally, the cross-sectional nature of this study limits our understanding of parents' ideas about SHE to one point in time. Longitudinal studies that collect information from parents as their children progress from elementary to middle school may develop a more accurate picture of parents' attitudes and experiences with SHE at school and at home.

CONCLUSION

This study adds to a growing body of literature documenting Canadian parents' strong support for comprehensive SHE in school starting in elementary school with all topics introduced by middle school. Although most parents would like to have a role in their child's SHE, few are actively discussing sexual health topics in great detail with them. Schools have a role in supporting parental involvement in their children's SHE. Based on parents' own suggestions, there are a number of ways in which this can be accomplished, such as providing parents with sexual health information before it is disseminated to their child and providing information on how to discuss sexual health topics with their child. Involving parents in the school-based SHE their children receive could promote more discussion in the home and help encourage healthy and safe sexual development.

References

- Ansuini, C.G., Fiddler-Woite, J., & Woite, R.S. (1996). The source, accuracy, and impact of initial sexuality information on lifetime wellness. *Adolescence, 31*, 283-289.
- Barrett, M. (1994). Sexuality education in Canadian schools: An overview in 1994. *The Canadian Journal of Human Sexuality, 3*, 199-208.



- Beazley, R.P., Langille, D.B., Richardson, H.R., & Delaney, M.E. (1997). Factors influencing condom use among students attending high school in Nova Scotia. *The Canadian Journal of Human Sexuality*, 6, 185-196.
- Berne, L.A., Patton, W., Milton, J., Hunt, L.Y.A., Wright, S., Peppard, J., & Dodd, J. (2000). A qualitative assessment of Australian parents' perceptions of sexuality education and communication. *Journal of Sex Education and Therapy*, 25, 161-168.
- Byers, E.S., Sears, H.A., Voyer, S.D., Thurlow, J.L., Cohen, J.N., & Weaver, A.D. (2001). *New Brunswick students' ideas about sexual health education*. Fredericton, New Brunswick: University of New Brunswick, Department of Psychology.
- Cairns, K.V., Collins, S.D., & Hiebert, B. (1994). Adolescents' self-perceived needs for sexuality education. *The Canadian Journal of Human Sexuality*, 3, 245-251.
- Cohen, J.N., Byers, E.S., Sears, H.A., & Weaver, A.D. (2001). *New Brunswick teachers' ideas about sexual health education*. Fredericton, New Brunswick: University of New Brunswick, Department of Psychology.
- Croft, C.A., & Asmussen, L. (1992). Perceptions of mothers, youth, and educators: A path toward détente regarding sexuality education. *Family Relations*, 41, 452-459.
- Geasler, M.J., Dannison, L.L., & Edlund, C.J. (1995). Sexuality education of young children: Parental concerns. *Family Relations*, 44, 184-188.
- Langille, D.B., Langille, D.J., Beazley, R., & Doncaster, H. (1996). *Amherst parents' attitudes towards school-based sexual health education*. Halifax, Nova Scotia: Dalhousie University.
- McKay, A., & Holowaty, P. (1997). Sexual health education: A study of adolescents' opinions, self-perceived needs, and current and preferred sources of information. *The Canadian Journal of Human Sexuality*, 6, 29-38.
- McKay, A., Pietrusiak, M., & Holowaty, P. (1998). Parents' opinions and attitudes toward sexuality education in the schools. *The Canadian Journal of Human Sexuality*, 7, 139-145.
- Parcel, G.S., & Coreil, J. (1985). Parental evaluations of a sex education course for young adults. *Journal of School Health*, 55, 9-12.
- Reis, J., & Seidl, A. (1989). School administrators, parents, and sex education: A resolvable paradox? *Adolescence*, 24, 639-645.
- Rienzo, B.A. (1989). The politics of sexuality education. *Journal of Sex Education and Therapy*, 15, 163-174.
- Scales, P., & Kirby, D. (1983). Perceived barriers to sex education: A survey of professionals. *Journal of Sex Research*, 19, 309-326.
- Verby, C., & Herold, E.S. (1992). Parents and AIDS Education. *AIDS Education and Prevention*, 4, 187-196.
- Weber, R.P. (1990). *Basic Content Analysis (2nd ed.)*. Thousand Oaks, CA: Sage.
- Welshimer, K.J., & Harris, S.E. (1994). A survey of rural parents' attitudes toward sexuality education. *Journal of School Health*, 64, 347-352.