

Sexual health education in the schools:

Questions & Answers Updated 2015 Ontario Edition

SIECCAN

THE SEX INFORMATION & EDUCATION COUNCIL OF CANADA

Q & A

Sexual health education in the schools: Questions & Answers (Updated 2015 Ontario Edition)



A resource with answers to your questions
about sexual health education in our schools

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Introduction

Access to effective broadly-based sexual health education that provides the necessary information and skills to enhance sexual health and avoid negative sexual health outcomes is an important contributing factor to the health and well-being of youth (Public Health Agency of Canada, 2008; Society of Obstetricians and Gynecologists of Canada, 2004). School-based programs are an essential avenue for providing sexual health education to young people. Educators, public health professionals, administrators, and others who are committed to providing high quality sexual health education in the schools are often asked to explain the rationale, philosophy, and content of proposed or existing sexual health education programs. This document, prepared by SIECCAN, the Sex Information and Education Council of Canada (www.sieccan.org), is designed to support the provision of high quality sexual health education in Ontario schools and across Canada. It provides answers to some of the most common questions that parents, communities, educators, program planners, school and health administrators, and governments may have about sexual health education in the schools.

Canada is a pluralistic society in which people with differing philosophical, cultural, and religious values live together with a mutual recognition and respect for the basic rights and freedoms that all people are entitled to in a democratic society. Philosophically, this document reflects the democratic, principled approach to sexual health education embodied in the Public Health Agency of

Canada's (2008) *Canadian Guidelines for Sexual Health Education*. The Guidelines are based on the principle that sexual health education should be accessible to all people and that it should be provided in an age appropriate, culturally sensitive manner that is respectful of an individual's right to make informed choices about sexual and reproductive health. This approach is aligned with *The Canadian Charter of Rights and Freedoms'* articulation of all Canadians' rights to personal liberty and security of person, and freedom of thought, belief, and opinion. Sexual health education informed by democratic principles provides people with complete and accurate information so that they have the capacity to make informed decisions that directly impact on their own health and well-being. As noted in Question 5 below, the *Guidelines* also specify that sexual health education should provide sexual health education programming that does not discriminate based on characteristics such as sexual orientation and gender identity which is consistent with the equality section of the *Charter of Rights and Freedoms* and the *Ontario Human Rights Code*. The answers to common questions about sexual health education provided in this document are based upon and informed by the findings of up-to-date and credible scientific research. An evidence-based approach combined with a respect for individual rights within a democratic society offers a strong foundation for the development and implementation of high quality sexual health education programs in schools.

1. Sexual health and youth: What are the key issues?

Sexual health is multidimensional and involves the achievement of positive outcomes such as mutually rewarding interpersonal relationships and desired parenthood, as well as the avoidance of negative outcomes such as unwanted pregnancy and STI/HIV infection (Public Health Agency of

Canada, 2008). Trends in teen pregnancy, sexually transmitted infections, age of first intercourse, and condom use, as well as challenges facing lesbian, gay, bisexual, and transgender (LGBT) youth, the impact of technology, and the need to address sexual coercion/assault are among the key sexual

health issues for youth in Ontario and across Canada.

It is likely that a large proportion of teen pregnancies, particularly among younger teens, are unintended. Teen pregnancy rates are therefore a reasonably direct indicator of young women's opportunities and capacity to control this aspect of their sexual and reproductive health (McKay, 2012). In Canada, the pregnancy rate (i.e., live births/induced abortions) for both younger (age 15-17) and older (age 18-19) teenage women has fallen significantly over the last several decades (McKay, 2012). Between 2001 and 2010, the teen pregnancy rate among young women aged 15 to 19 in Ontario declined from 30.6 per 1,000 to 21.2, a decline of 30.7% and during the same period the teen pregnancy rate for Canada fell less, (20.3%; McKay, 2012). Based on data from the Canadian Institute for Health Information and Statistics Canada, calculations indicate that for the years 2007 to 2013, the teen abortion rate in Ontario declined from 13.0 per 1,000 to 7.8, a decline of 40.0% (Sex Information and Education Council of Canada, unpublished data). In order to maintain these positive trends, it is essential that all young people in Ontario receive concise, up-to-date, and medically accurate information about contraception.

Sexually transmitted infections (STI) pose a significant threat to the health and well-being of Ontario youth. Chlamydia is of particular concern because, if left untreated, it can result in numerous negative health outcomes. Potential outcomes from undiagnosed infection for women include pelvic inflammatory disease (PID), chronic pelvic pain, ectopic pregnancy, tubal infertility, and increased susceptibility to HIV infection (Public Health Agency of Canada, 2010a). Reported rates (the number of positive test reports made to public health agencies) of chlamydia have been increasing steadily in recent years in both Ontario and Canada (Public Health Agency of Canada, 2014; Public Health Ontario, 2014). While some or all of this increase may be explained by improved screening practices and testing methods, the number of young people in Ontario acquiring

chlamydia annually is significant. The highest reported rates of chlamydia in Ontario are among young women aged 20 to 24, followed by those aged 15 to 19 (Public Health Ontario, 2014). Although definitive age-specific prevalence data for Ontarians or Canadians is not available, surveillance data from the United States indicates a chlamydia positivity rate of 8.4% among women aged 15 to 24 attending family planning clinics (Centers for Disease Control and Prevention, 2013).

Other STIs are also common among youth and young adults. A study of students at a Canadian university found a prevalence of human papillomavirus (HPV) was over 50% in both females and males (Burchell, Tellier, Hanley, Coutlée, & Franco, 2010). Data from the *Canadian Health Measures Survey* indicate that approximately 6% of people aged 14 to 34 have acquired genital herpes (HSV-2; Rotermann, Langlois, Severini, & Totten, 2013) and it is likely that a significant proportion of these infections were acquired during adolescence or young adulthood. There is also growing concern about the emergence of antibiotic resistant gonorrhea in Canada (Public Health Agency of Canada, 2013). High rates of STIs among youth in Ontario result in significant preventable negative health outcomes for young people and entail significant costs for the health care system. Sexual health education in the schools can play an important role in ensuring that youth have the necessary knowledge about STIs and their prevention.

For a majority of Canadians, first sexual intercourse occurs during the teenage years (Rotermann, 2008, 2012). Data from Statistics Canada's *Canadian Community Health Survey* indicate that 35% of Canadian youth reported experiencing first sexual intercourse before age 17; over two thirds (68%) reported having intercourse before age 20 (Rotermann, 2012). A survey of Ontario youth found that among Grade 9-10 students, 18% of females and 25% of males reported that they had experienced sexual intercourse (Freeman, King, Al-Haque, & Pickett, 2012). By the time they have reached their early 20's, approximately

three quarters of Canadian young people have become sexually active to some degree (Milhausen et al., 2013; Rotermann, 2012). In addition, it should be noted that the percentage of Canadian youth who report that they have experienced sexual intercourse has remained stable since the mid-1990s (Rotermann, 2008, 2012). It is important that sexual health education in schools provide developmentally appropriate information that addresses the reality of the timing of initiation of partnered sexual behaviour among young people. This means, for example, that it is necessary and appropriate to provide information on delaying sexual first intercourse, the importance of condom use to reduce risk for STI, and contraception to prevent unwanted pregnancy before a sizable percentage of youth have become sexually active.

Condom use among sexually active Canadian youth is relatively high. About 80% of sexually active 15 to 17 year-olds report using a condom at last intercourse (Rotermann, 2012). However, there is also a persistent trend for high rates of condom use among sexually active teens to decline as they get older. Among the *Canadian Community Health Survey* participants, levels of condom use at last intercourse declined to 74% among 18 to 19 year-olds and 63% among 20 to 24 year-olds (Rotermann, 2012). A more recent study of Canadian university students found that less than half used a condom at last intercourse (Milhausen et al., 2013). The propensity for older sexually active teens and young adults in Canada to discontinue

condom use is a clear indication that many young people in Canada underestimate their risk for STI (Reported rates of chlamydia and other STI are highest among 20-24 year-olds). To reduce the burden of STI on young people and society generally, it is necessary to provide sexual health education that provides comprehensive information on STIs and STI risk reduction.

As discussed in Question #10 of this document, sexual health education in the schools is often presented predominantly or entirely within a heterosexual context and may therefore neglect the needs LGBT youth. In addition, LGBT youth often face high levels of harassment and violence while in school (Taylor et al., 2011).

As discussed in Question #11 of this document, rates of sexual assault in Canada are highest among young people aged 15 to 24 and young women are disproportionately the victims (Perreault & Brennan, 2010). There is an increasing awareness that to reduce the occurrence of sexual assault and coercion in Canada, sexual health education curricula must integrate the concept of *consent*.

As discussed in Question #12 of this document, technology (i.e., cell/smartphones and the internet) have fundamentally altered the way young people are exposed to and absorb sexuality related imagery and information. *Sexting* and online pornography pose challenges to the sexual health of young people and, as a result, these issues require attention within sexual health education curricula.

2. Why do we need sexual health education in the schools?

“Sexual health is a key aspect of personal health and social welfare that influences individuals across their life span” (Public Health Agency of Canada, 2008, p. 2). Because sexual health is a key component of overall health and well-being, “sexual health education should be available to all Canadians as an important component of health promotion and services” (Health Canada, 2003, p. 1).

In principle, all Canadians, including youth, have a right to information and opportunities to develop the motivation/personal insight and skills necessary to prevent negative sexual health outcomes (e.g., STIs including HIV, unintended pregnancy, sexual assault/coercion) and to enhance sexual health (e.g., positive self-image and self-worth, integration of sexuality into mutually satisfying relationships). In order to ensure that youth

are adequately equipped with the information, motivation/personal insight, and skills to protect their sexual and reproductive health, “it is imperative that schools, in cooperation with parents, the community, and health care professionals, play a major role in sexual health education and promotion” (Society of Obstetricians and Gynecologists of Canada, 2004, p. 596). As stated by the Public Health Agency of Canada (2008),

Since schools are the only formal educational institution to have meaningful (and mandatory) contact with nearly every young person, they are in a unique position to provide children, adolescents and young adults with the knowledge, understanding, skills, and attitudes they will need to make and act upon decisions that promote sexual health throughout their lives (p. 19).

As a fundamental part of its contribution to the development and well-being of youth, school-based sexual health education can play an important role in the primary prevention of significant sexual health problems. As documented in more detail elsewhere in this resource document, well-planned and implemented sexual health education programs are effective in helping youth reduce their risk of STI/HIV infection and unplanned pregnancy. In addition, it should be emphasized that an important goal of sexual health education is to provide education on broader aspects of sexual health, including the development of a positive self-image and the integration of sexuality into rewarding and equitable interpersonal relationships (Public Health Agency of Canada, 2008).

3. Do parents want sexual health education taught in the schools?

Parents and guardians are an important and primary source of guidance for young people concerning sexual behaviour and values. Many youth look to their parents as a valuable source of sexuality information (Frappier et al., 2008). Parents also recognize that the schools should play a key role in the sexual health education of their children.

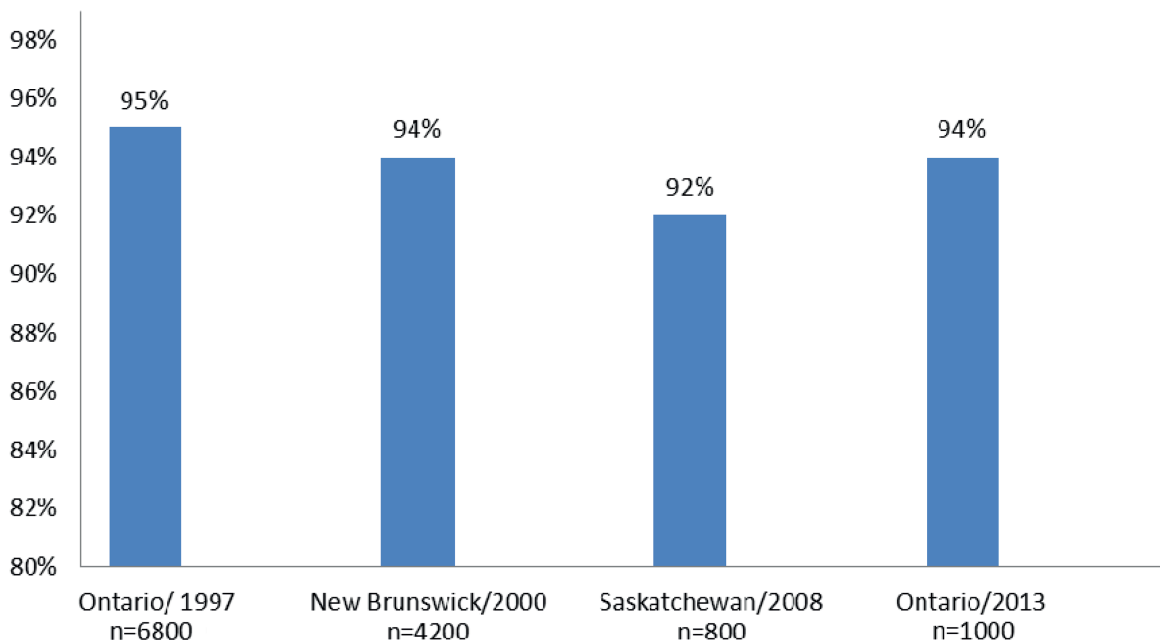
A series of surveys involving a total of 12,800 parents conducted in Ontario (McKay, Pietrusiak & Holowaty, 1998; McKay, Byers, Voyer, Humphreys, & Markham, 2014) and other parts of Canada (Advisory Committee on Family Planning, 2008; Weaver, Byers, Sears, Cohen & Randall, 2002) clearly demonstrate that a strong majority of parents support the teaching of sexual health education in the schools (See Figure 1).

In the most recent Ontario survey (McKay et al., 2014), parents rated all 13 of the following potential topics as important for inclusion in the sexual health education curriculum:

- Correct names for body parts, including genitalia
- Physical, cognitive, emotional, and social changes
- Puberty
- Reproduction
- Abstinence
- Methods of contraception
- Sexually transmitted infections
- Skills for healthy relationships
- Decision-making skills
- Self-esteem and personal development
- Communication skills
- Sexual orientation
- Media literacy

Figure 1.

Percentage of parents agreeing with the statement “Sexual health education should be provided in the schools”



4. Do young people want sexual health education taught in the schools?

Surveys of youth have clearly shown that young people in Canada want sexual health education to be taught in school (Byers, Sears, Voyer, Thurlow, Cohen & Weaver, 2003a; Byers, Sears, Voyer, Thurlow, Cohen & Weaver, 2003b; McKay & Holowaty, 1997). For example, a survey of high school youth found that 92% agreed that “Sexual health education should be provided in the schools” and they rated the following topics as either “very important” or “extremely important”: puberty, reproduction, personal safety, sexual coercion and sexual assault, sexual decision-making in dating relationships, birth control and safer sex practices, and STIs (Byers et al., 2003a). When asked what topics they wanted to learn more about from sexual health education, youth partici-

pating in the *Toronto Teen Survey* ranked healthy relationships, HIV/AIDS, pleasure, and communication highest (Causarano, Pole, Flicker, and the Toronto Teen Survey Team, 2010). National surveys of youth in Canada have found that schools are the most frequently cited main source of information on sexuality issues (human sexuality, puberty, birth control, HIV/AIDS) (Boyce, Doherty, Fortin & Mackinnon, 2003) and rank highest as the most useful/valuable source of sexual health information (Frappier et al., 2008). However, when Ontario students were surveyed, 45% indicated that sexual health education classes did not address the concerns they had encountered or expected to encounter (Ontario Student Trustees Association, 2011).

5. What values are taught in school-based sexual health education?

Canada is a pluralistic society in which different people have different values and perspectives towards human sexuality. At the same time, Canadians are united by their respect for the basic and fundamental values and principles of a democratic society. An emphasis on democratic values (e.g., the right to make informed decisions about health and well-being) provides the overall philosophical framework for many school-based sexual health education programs in Canada. The Public Health Agency of Canada's (2008) *Canadian Guidelines for Sexual Health Education* have been used by communities as a basis for the development of a consensus on the fundamental values that should be reflected in school-based sexual health education. The Guidelines were formulated to embody an educational philosophy that is inclusive, respects diversity, and reflects the fundamental precepts of education in a democratic society. Thus, the *Canadian Guidelines for Sexual Health Education* are intended to inform sexual health programming that:

- **Focuses on the self-worth, respect, and dignity of the individual;**
- **Is provided in an age-appropriate, culturally sensitive manner that is respectful of individual sexual diversity, abilities, and choices;**

- **Helps individuals to become more sensitive and aware of the impact their behaviours and actions may have on others and society;**
- **Does not discriminate on the basis of age, race, ethnicity, gender identity, sexual orientation, socioeconomic background, physical/cognitive abilities and religious background in terms of access to relevant, appropriate, accurate and comprehensive information** (Public Health Agency of Canada, 2008, p. 11).

These statements acknowledge that sexual health education programs should not be *value free*, but rather that:

- **Effective sexual health education recognizes that responsible individuals may choose a variety of paths to achieve sexual health;**
- **Effective sexual health education supports informed decision making by providing individuals with the knowledge, personal insight, motivation, and behavioural skills that are consistent with each individual's personal values and choices** (Public Health Agency of Canada, 2008, p. 25).

6. Does providing youth with sexual health education lead to earlier or more frequent sexual activity?

The impact of sexual health education on the sexual behaviour of youth has been extensively examined in a large number of evaluation research studies. A meta-analysis of 174 studies examining the impact of different types of sexual health promotion interventions found that these programs do not inadvertently increase the frequency of sexual behaviour or number of sexual partners (Smoak, Scott-Sheldon, Johnson, & Carey, 2006). More specifically, a review of 66 studies

measuring the behavioural impact of broadly-based sexual health education for youth that included information on abstinence, contraception, and STI/HIV prevention (e.g., condom use) concluded that such programs do not hasten or increase sexual behaviour but rather that they result in "...reductions in both sexual activity and frequency of sexual activity among adolescents compared to adolescents not receiving the intervention" (Chin et al., 2012, p. 286-287). Other

6. DOES PROVIDING YOUTH WITH SEXUAL HEALTH EDUCATION LEAD TO EARLIER OR MORE FREQUENT SEXUAL ACTIVITY? (CONTINUED)

reviews of studies measuring the effects of sexual health education have reached the same conclusion: Sexual health education for youth does not result in earlier or more frequent sexual behaviour

(Bennett & Assefi, 2005; Johnson, Scott-Sheldon, Huedo-Medina, & Carey, 2011; Kirby, Laris, & Roller, 2007).

7. Is there clear evidence that sexual health education can effectively help youth reduce their risk of STI/HIV infection and unintended pregnancy?

There is a large body of rigorous evidence in the form of peer-reviewed published studies measuring the behavioural impact of well-designed adolescent sexual health interventions that leads to the definitive conclusion that such programs can have a significant positive impact on sexual health behaviours (e.g., delaying first intercourse, increasing use of condoms). For example, the U.S. Centers for Disease Control and Prevention’s (2014) *Compendium of Evidence-Based HIV Preven-*

tion Interventions includes programs for adolescents that have been rigorously evaluated and have demonstrated efficacy in reducing HIV/STI incidence or sexual risk behaviors. For comprehensive reviews of the evaluation research literature demonstrating the positive behavioural impact of well-developed sexual health education, see Bennett and Assefi (2005), Chin et al., (2012), Johnson et al., (2011), Kirby, Laris and Roller (2007), and Protogerou and Johnson (2014).

8. Are abstinence-only programs an appropriate and effective form of school-based sexual health education?

In some parts of the United States, some communities and school boards receive federal government funding to teach *abstinence-only* sex education programs. (Broadly-based/comprehensive sexual health education programs are also eligible for U.S. federal government funding.) To receive U.S. federal government funding, an abstinence 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, 2015). To assess the appropriateness of abstinence-only as a form of school-based sexual health education, two key questions emerge. First, are abstinence-only programs effective in persuading young people not to become

sexually active? And second, do abstinence-only programs respect young people’s right to make fully informed decisions in accordance with their own values about sexual and reproductive health?

It should be noted that the term *abstinence* as it applies to education for youth is commonly understood to mean *not engaging in sexual intercourse until marriage* but abstinence may be given a range of definitions including not having intercourse until some point in the future or not engaging in any form of partnered sexual activity (e.g., intercourse, oral sex, touching), and others may also include refraining from masturbation in their definition of abstinence. In sum, the term abstinence can be highly ambiguous and should be used with caution, if at all, in delineating the objectives of sexual health education for youth.

A substantial body of research evidence clearly indicates that most abstinence-only sex education programs are ineffective in reducing adolescent sexual behaviour. For example, a multiple site randomized trial evaluation of abstinence-only programs that were eligible for and received the U.S. Federal government abstinence education funding found that students who had participated in these programs were not more likely to be abstinent or to delay first intercourse or to have fewer sexual partners than students who did not receive abstinence-only education (Trenholm et al., 2007). These findings, indicating that abstinence-only programs are not effective in reducing the likelihood that youth will engage in sexual intercourse, are consistent with the findings of other large scale studies (e.g., Kohler, Manhart, & Lafferty, 2008) and reviews of the program evaluation literature indicating that abstinence-only education is ineffective (e.g., Bennett & Assefi, 2005; Hauser, 2004; Johnson et al., 2011; Kirby, 2008; Protogerou & Johnson, 2014). In the few cases where individual abstinence-based interventions aimed at younger youth (e.g., age 10-14) have resulted in reduced sexual activity, compared to youth who received no sex education, these programs neglected to provide important health information on unintended pregnancy and HIV/STI prevention for those students who become sexually active during the program or in the months or years afterwards (Chin et al., 2012).

As noted earlier in this document, over two-thirds of Canadian youth will experience their first sexual intercourse before age 20, a sizable proportion become sexually active during the mid-teens, and these levels of teen sexual activity have re-

mained generally consistent over time (Rotermann, 2005, 2008, 2012). Young people have a right to receive sexual and reproductive health information relevant to their needs, circumstances, and choices. For most Canadian youth, that includes information on contraception for pregnancy prevention and safer sex practices (e.g., condom use) for HIV/STI risk reduction. According to the Public Health Agency of Canada's (2008) *Canadian Guidelines for Sexual Health Education*,

Effective sexual health education supports informed decision-making by providing individuals with the opportunity to develop the knowledge, personal insight, motivation and behavioural skills that are consistent with each individual's personal values and choices. For example, some adolescents engage in partnered sexual activities whereas others will make an informed decision to delay these sexual activities. . . . Effective sexual health education recognizes that responsible individuals may choose a variety of paths to achieve sexual health (p. 25).

Educational programs that withhold information necessary for individuals to make voluntary, informed decisions about their sexual health are unethical (World Association for Sexual Health, 2008). Abstinence-only policies may violate the human rights of young people because they withhold potentially life-saving information on HIV and other STI (Ott & Santelli, 2007).

9. What are the key ingredients of behaviourally effective sexual health education programs?

The first and most important ingredients of effective sexual health education programs in the schools are that sufficient classroom time is allocated to the teaching of this important topic

and that the teachers/educators who provide it are adequately supported, trained, and motivated to do so (Society of Obstetricians and Gynecologists of Canada, 2004). As stated by the Public

Health Agency of Canada (2008), “Sexual health education should be presented by confident, well-trained, knowledgeable and nonjudgmental individuals who receive strong administrative support” (p. 18).

It is clear from the research on sexual health promotion that behaviourally effective programs are based and structured on theoretical models of behaviour change that enable educators to understand and influence sexual health behaviour (Albarracin et al., 2005; Kirby et al., 2007; Protogerou & Johnson, 2014; Public Health Agency of Canada, 2008). The Public Health Agency of Canada’s (2008) *Canadian Guidelines of Sexual Health Education* provide a framework for implementing effective programming based on the Information-Motivation-Behavioural Skills (IMB) model of sexual health enhancement and problem prevention (Albarracin et al., 2005; Fisher & Fisher, 1998). For example, the IMB model specifies that in order for sexual health education 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 2). Support for utilizing the IMB model as a theoretical framework for the development of behaviourally effective sexual health education interventions with youth has been provided in several scientific evaluations (Fisher, Fisher, Bryan, & Misovich, 2002; Morrison-Beedy et al., 2013). For information on the use of the IMB model for the planning, implementation, and evaluation of sexual health education programs, see the *Canadian Guidelines for Sexual Health Education* (Public Health Agency of Canada, 2008).

There is an extensive body of research that has identified the key ingredients of effective sexual health promotion programming. (For a summary and review of this literature see Albarracin et al., 2005; Fisher & Fisher, 1998; Kirby et al., 2007; Public Health Agency of Canada, 2008; Protogerou & Johnson, 2014; World Association for Sexual Health, 2008.) This research has clearly demonstrated that effective sexual health education programs will contain the following ingredients, listed in Table 1 below.

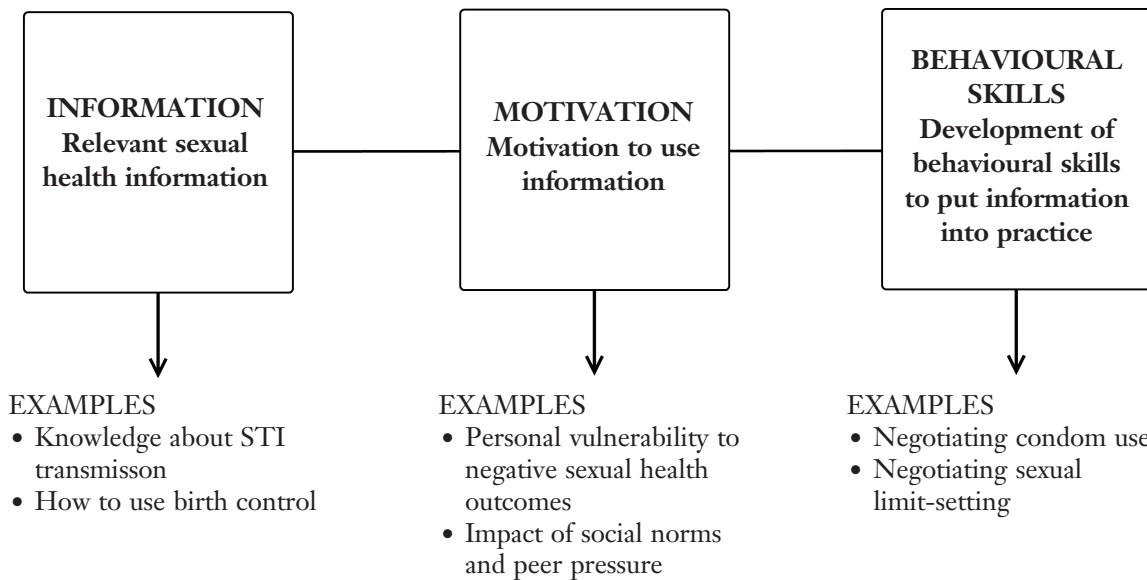
Table 1.

The key ingredients of effective sexual health promotion programming

1.	A realistic and sufficient allocation of classroom time to achieve program objectives.
2.	Provide teachers/educators with the necessary training and administrative support to deliver program effectively.
3.	Employ sound teaching methods including the utilization of well-tested theoretical models to develop and implement programming (e.g., IMB Model, Social Cognitive Theory, Trans-theoretical Model, Theory of Reasoned Action/Theory of Planned Behaviour).
4.	Use elicitation research to identify student characteristics, needs, and optimal learning styles including tailoring instruction to student’s ethnocultural background, sexual orientation, and development stage.
5.	Specifically target the behaviours that lead to negative sexual health outcomes such as STI/HIV infection and unintended pregnancy.
6.	Deliver and consistently reinforce the prevention messages related to sexual limit-setting (e.g., delaying first intercourse, choosing not to have intercourse), consistent condom use and other forms of contraception.
7.	Include program activities that address the individual’s environment and social context including peer and partner pressures related to adolescent sexuality.
8.	Incorporate the necessary information, motivation and behavioural skills to effectively enact and maintain behaviours to promote sexual health.
9.	Provide clear examples of and opportunities to practice (e.g., role plays) sexual limit setting, condom use negotiation, and other communication skills so that students are active participants in the program, not passive recipients.
10.	Incorporate appropriate and effective evaluation tools to assess program strengths and weaknesses in order to improve subsequent programming.

Figure 2.

The Information, Motivation, Behavioural Skills Model (IMB) for effective sexual health education



10. Why is it important to integrate the educational needs of lesbian, gay, bisexual, and transgender (LGBT) students into school-based sexual health education?

In the past, sexual health education in schools tended to focus primarily, if not exclusively, on providing information within a heterosexual context and this often left lesbian, gay, bisexual, and transgender (LGBT) students without the relevant and necessary information to make informed decisions to protect and enhance their sexual health (Schalet et al., 2014). Most school classrooms will have one or more students who are not heterosexual. In a demographic survey of junior and high school students by the Toronto District School Board (2013), 8% of Grade 9 to 12 students identified themselves as non-heterosexual (e.g., lesbian, gay, bisexual, queer) or “not sure/questioning” in relation to their sexual orientation. Similar percentages of youth identified as

gay, lesbian, bisexual, questioning or “mostly straight” in a large sample survey of high school students in British Columbia (Smith et al., 2014). Due to experiences of bullying, discrimination, and stigmatization, LGBT youth often remain an invisible population in schools (Public Health Agency of Canada, 2010b; 2010c). The Public Health Agency of Canada’s (2008) *Canadian Guidelines for Sexual Health Education* suggest that educational curricula should address the sexual health needs of all students, including those who are gay, lesbian, bisexual, transgender, or questioning. As well, the Guidelines note that an understanding of sexual diversity perspectives and issues is an important component of sexual health education. Thus, the sexual health education needs

of LGBT students should be integrated within broadly-based sexual health education in the schools.

Surveys have repeatedly shown that a majority of Canadian parents (Advisory Committee on Family Planning, 2008; Weaver, Byers, Sears, Cohen, & Randall, 2002) including Ontario parents (McKay et al., 2014; McKay, Pietrusiak, & Holowaty, 1998) want sexual orientation addressed in school-based sexual health education programs.

A supportive, non-threatening school environment has been recognized as being one protective factor that can potentially reduce the risk of negative health and social outcomes among youth (Public Health Agency of Canada, 2010b; 2010c).

However, Egale Canada's national survey of more than 3700 students on homophobia, biphobia, and trans-phobia in Canadian schools found that 64% of LGBT students felt unsafe at school and 21% reported that they had been physically harassed or assaulted because of their sexual orientation (Taylor et al., 2011). In addition to the provision of LGBT inclusive sexual health education, schools can foster peer acceptance, school connectedness, and student safety by facilitating and supporting the development of Gay-Straight Alliances (Public Health Agency of Canada, 2010b). An Ontario survey found that 79% of parents and 88% of students agreed that students should be allowed to set up a Gay-Straight Alliance at their school (Ontario Student Trustees Association, 2011).

11. Why is it important to integrate the educational needs of students with physical or developmental disabilities into school-based sexual health education?

As noted in the *Canadian Guidelines for Sexual Health Education* (Public Health Agency of Canada, 2008), youth with physical and developmental disabilities have a right to broadly-based sexual health education relevant to their needs. Although sexuality and sexual health is as integral to the overall health and well-being of youth with disabilities as it is for their non-disabled peers, the provision of sexual health education for youth with disabilities that is specific to their needs is often overlooked or lacking (DiGiulio, 2003; East & Orchard, 2013; Public Health Agency of Canada, 2013a; Sex Information and Education Council of Canada, 2015a). Failure to provide sexual health education that is inclusive of youth with disabilities places them at increased risk for STIs/HIV, sexual exploitation, lower self-esteem, social isolation, and lower quality of life (Public Health Agency of Canada, 2013). Of particular concern is that in Canada, youth and adults with developmental and physical disabilities are much

more likely than their non-disabled peers to be the victims of sexual abuse and assault (McDonald, Wobick, & Graham, 2004).

While sexual health education provided to youth in schools should seek to be inclusive of the needs of all students, including youth with disabilities, in some instances educational opportunities specific to the unique needs of students with disabilities needs to be provided. For example, youth with Autism Spectrum Disorder may need sexual health education curriculum materials adapted to their specific learning styles and needs, youth with other types of developmental disabilities may require education tailored to their specific developmental level, and youth with different physical disabilities may require sexual health education specific to their disability so that they have the information and skills to protect and enhance their sexual health (DiGiulio, 2003; Public Health Agency of Canada, 2013a; Sex Information and Education Council of Canada, 2015a).

12. Should learning about the concept of consent be integrated into school-based sexual health education?

Within a democratic society, sexual health education reflects basic fundamental values of respect for others and informs young people of their moral and legal obligations towards other people. Consistent with this approach, the Public Health Agency of Canada's (2008) *Canadian Guidelines for Sexual Health Education* indicate that sexual health education should address the impact that behaviours and actions may have on others. As such, the concept of consent, as it applies to sexual behaviour, is an appropriate and necessary component of sexual health education in the schools. Two key aspects of consent pertain to (1) the ages at which a young person can legally consent to sexual activity and (2) the communication of consent or non-consent to engage in sexual activity with another person (Sex Information and Education Council of Canada, 2015).

Age of consent refers to the age at which people are able to make their own decisions about sexual activity. In Canada, the age of consent was raised from 14 to 16 in 2008. Effective sexual health education should provide students with a clear understanding of how age of consent is interpreted under the law. Educators should make youth aware that the intent of the legislation is to protect children and youth from adult sexual predators. It is also important for youth to know that the law is directed at adult sexual predators, not youth themselves, and that this law does not affect the right of young people to access sexual health education or sexual and reproductive health services.

Although the age of consent to sexual activity is 16, there are several *close in age exceptions*. One close in age exception is that 12 and 13 year-olds can consent to sexual activity with peers who are not more than 2 years older than themselves. The other is that 14 and 15 year-olds are able to consent to sex with partners who are not more than 5 years older than themselves (Government of Canada, 2015). For example, a 14 year-old can legally consent to sexual activity with an 18-year-

old. However, a 15-year-old cannot legally consent to engage in sex with a 21 year-old and in that case the 21 year-old could be charged with sexual interference. The Criminal Code of Canada states that a young person under the age of 18 cannot legally consent to have sex with a person in a position of authority, such as a teacher, health care provider, coach, lawyer, or family member (Government of Canada, 2015). Sexual health education programs should provide age appropriate information regarding the age of consent to sexual activity so that young people are fully aware of the circumstances in which they may be the victims of sexual exploitation by an older person or a person in a position of authority. Furthermore, each young person should be aware of the potential circumstances in which their relationships with peers younger than themselves is in violation of age of consent laws.

In Canada, sexual assault, including unwanted sexual touching, as well as violent sexual attacks, disproportionately affects young women with young people aged 15 to 24 almost twice as likely to be sexually assaulted as those aged 25 to 34 (Perreault & Brennan, 2010). Canadian law specifies that sexual activity must involve "voluntary agreement" and that when there is a "lack of agreement" expressed either verbally or by physically resisting, consent does not exist (Government of Canada, 2015). Furthermore, the law specifies that a person cannot consent to engage in sexual activity if they are "incapable" of doing so (e.g., because of extreme alcohol or drug intoxication; Sex Information and Education Council of Canada, 2015b).

Broadly-based sexual health education in the schools "Helps individuals to become more sensitive and aware of the impact their behaviours and actions may have on others..." (Public Health Agency of Canada, 2008, p. 11). In early elementary grade levels, sexual health education can provide foundational knowledge and skill development opportunities regarding general concepts of respect of self and others. This can include learn-

ing verbal and non-verbal communication skills (e.g., to listen, show respect for themselves and others, to advocate for personal needs). In later grade levels, it is important for sexual health education in the schools to provide students with a clear understanding of the meaning of consent as it applies specifically to sexual activity. It is developmentally appropriate for educational programs to provide information on sexual consent to young people as they approach the ages at which a sizable proportion of young people become sexually active. To reduce the likelihood of sexual assault and to promote equitable, healthy relationships, young people need to learn the communication skills to express non-consent (i.e., refusal) to engage in sexual activity and to ensure that mutual consent exists between partners if sexual activity does occur through the expression of affirmative consent (Sex Information and Education Council

of Canada, 2015). In addition, sexual health education should provide students with the information necessary to be able to identify when they have been sexually assaulted or abused.

To contribute to a reduction in sexual assault among young people, sexual health education can promote the development of interpersonal and social environments that are free of coercion. To do so, sexual health education programs can address gender norms within society that contribute to unequal intimate relationships. Focusing on gender-based inequality as it applies to sexuality in sexual health education programs may not only reduce the likelihood of non-consensual sexual activity, research indicates that sexual health education programs that incorporate issues of gender and power are more likely to be effective in reducing STIs and unintended pregnancy (Haberland, 2015).

13. Should learning about the risks of sexting and online pornography be integrated into school-based sexual health education?

Modern communication technologies (i.e., cell phones/smartphones and the Internet) have fundamentally altered the way young people are exposed to and absorb sexuality related imagery and information. By the time they reach adolescence, virtually all Canadian young people have access to the Internet and most own or have access to cell phones (Steeves, 2014). The Internet provides nearly unlimited access to graphic sexual imagery and cell phones can be used for various forms of sexual communication. These modern communication technologies can be beneficial in enhancing young people's ability to learn about sexuality from credible sources but at the same time, sexting and online pornography may present challenges to young people's sexual health and well-being (Springate & Omar, 2013). As a result, it is important that these issues are addressed

within broadly-based sexual health education curricula.

A national study of Canadian school students found that among Grade 10 and 11 students with a cell phone, 11% and 14% respectively reported that they had sent a sext of themselves to someone (Steeves, 2014). Young people need to be aware of the social, psychological, and legal consequences of sending sexts (Canadian Paediatric Society, 2014). In particular, young people need to be aware that it is a criminal offense to distribute or share a photo or video of a sexual nature or that depicts nudity without the consent of the person in the photo or video (Government of Canada, 2015).

Research indicates that the percentage of Canadian young people accessing pornography on the Internet is increasing: A recent national

13. SHOULD LEARNING ABOUT THE RISKS OF SEXTING AND ONLINE PORNOGRAPHY BE INTEGRATED INTO SCHOOL-BASED SEXUAL HEALTH EDUCATION? (CONTINUED)

survey of Canadian youth found that about a third of Grade 10 and 11 students reported looking for pornography online (Steeves, 2014) and smaller studies in Canada (Thompson, 2006) and the United States (Braun-Courville & Rojas, 2009) have found higher percentages of adolescents reporting exposure to sexually explicit websites.

The *Canadian Guidelines for Sexual Health Education* (Public Health Agency of Canada, 2008) suggests that sexual health education programs provide students with training in media literacy "...to help individuals identify and de-

construct hidden and overt sexual messages and stereotypes" (p. 25). To be relevant to young people's current educational needs, it is increasingly important that school-based sexual health education programs assist young people in developing the critical media skills to interpret and assess the sexual imagery on the Internet that they will inevitably be exposed to. In addition, youth need to develop the skills to differentiate between credible and problematic sources of information about sexuality sourced from the Internet.

14. What are the social and economic benefits of implementing broadly-based sexual health education in the schools?

“Sexual health is a major, positive part of personal health and healthy living” (Public Health Agency of Canada, 2008, p. 8). According to the World Health Organization (2010), “Sexual health is fundamental to the physical and emotional health and well-being of individuals, couples and families, and to the social and economic development of communities and countries” (p. 1). In sum, there is a growing recognition that the attainment and maintenance of sexual health for individuals, couples, and families is an important component of the overall well-being of the community (World Association for Sexual Health, 2008). Broadly-based sexual health education in the schools can make a significant positive contribution to the health and well-being of the community by equipping young people with broadly-based sexual health education that enables them to make informed choices about their sexual and reproductive health.

Preventable sexual and reproductive health problems constitute a significant threat to the health and well-being of individuals and families in Ontario. Many of these problems disproportionately affect youth and young adults. Beyond the negative personal and social outcomes, preventable sexual and reproductive health problems

result in substantial economic costs to the province in the form of health care and other expenditures.

Based on statistics from the year 2010, approximately 9,000 young women under the age of 20 become pregnant in Ontario each year (McKay, 2012). Over half result in abortion, indicating that a substantial proportion of these pregnancies are unintended. For younger teens in particular, unintended pregnancy and childbearing can have social and economic consequences for the young woman, her family, and the community (Lavin & Cox, 2012).

Sexually transmitted infections are preventable but continue to be a significant public health concern in Canada (Public Health Agency of Canada, 2013b). According to the *Ontario Burden of Infectious Disease Study*, of the ten most burdensome infectious agents in Ontario in terms of morbidity and mortality, three are sexually transmitted (Human papillomavirus [HPV], Hepatitis B virus [HBV], Human immunodeficiency virus [HIV/AIDS]; Ontario Agency for Health Protection and Promotion/Institute for Clinical Evaluative Sciences, 2010).

According to data from the Ontario Ministry of Health and Long-Term Care, there were 781 newly diagnosed cases of HIV in the province in

2012 (Public Health Ontario, 2014). In addition to the loss of life, personal suffering, and lost productivity, the Canadian AIDS Society (2011) estimates that each case of HIV infection results in \$250,000 in health care costs.

Of cases of reportable disease in the province of Ontario, nearly two thirds (64%) involve sexually transmitted infections (2006 data: Ministry of Health and Long-Term Care, 2009). Chlamydia, which is transmitted through sexual contact in most cases, is the most frequently reported reportable disease in Ontario (Public Health Ontario, 2014). Individuals with a chlamydia infection often have no symptoms and left untreated, the infection may lead to chronic pelvic pain, pelvic

inflammatory disease, ectopic pregnancy, and/or infertility. In Ontario, the highest reported rates of Chlamydia occur among females aged 20-24 and 15-19 (Public Health Ontario, 2014).

In sum, the burden of preventable sexual and reproductive health problems on the people of Ontario is significant. Given the negative health and personal consequences of these problems, access to high quality sexual health education in the schools is properly viewed as the right of all youth. Given the broader social and economic costs of these problems, the provision of sexual health education in the schools serves the public interests of the people of Ontario.

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