

Mount Saint Vincent University
Department of Family Studies and Gerontology

**Let's talk about sex: A glimpse into Nova Scotia
youths' perceptions of high school sexuality education**

by
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Abstract

Let's talk about sex: A glimpse into Nova Scotia youths' perceptions of high school sexuality education

Teen sexuality is a topic of great importance because youth are becoming sexually active at ages that belie their teen years and are experiencing pregnancy and sexually transmitted infections (STIs) at high rates. Not only does this warrant attention, but it also necessitate research and education. Sexuality education is essential for providing sexual health to all Canadians, especially Canadian youth. Yet, even though all provinces and territories offer youth-based sexual health education, the comprehensiveness, effectiveness, and quality of the programs vary significantly. Further, the Canadian Guidelines for Sexual Health Education are not being adhered to in all Nova Scotia's high schools.

The main objective of this research was to investigate the perceptions of a select group of Nova Scotian youth with regard to sexuality education. Bearing in mind aspects of critical theory, particularly Comstock's (1982) method for critical research and Smith's (1995) notion of the *line of fault*, face-to-face interviews were conducted with ten Nova Scotian youth (eight females, two males) to determine their perceptions of the effectiveness of sexuality education in the Nova Scotia school system. All interviews were tape-recorded and later transcribed. Interviews were analyzed using grounded theory techniques (Bernard, 2000), relying primarily on open and axial coding.

Results indicated that participants were not satisfied with the sexuality education that they received in high school. Four themes were apparent. Interviewees felt that the

sexuality information that they received in high school was limited in its coverage. Although most participants realized that teachers have little control over sexuality education curriculum, they felt that their sexuality education facilitators were unqualified and uncomfortable. All youth interviewed expressed a desire to have additional and improved sexuality education resources in Nova Scotia's high schools. In addition, it was clear from the interviews that a holistic view of sexual health is not being promoted in Nova Scotia high schools. Several recommendations for sexuality education practice are provided.

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Chapter 1: Introduction

Teen sexuality is a topic of great importance because youth (individuals between the ages of 15 and 24) (The Youth Service of Canada, 2005) are becoming sexually active at ages that belie their teen years and are experiencing pregnancy and sexually transmitted infections (STIs) at high rates. For example, 12% of Canadian youth lose their virginity before the age of fifteen, 60,000 teenage females in Canada become pregnant each year, and approximately 3 million teenagers are infected with STIs annually (Kempner, 2001; Maticka-Tyndale, 2001). Not only do these statistics warrant attention, but they also necessitate research and education. Sexuality education is essential for providing sexual health to all Canadians, especially Canadian youth. Yet, even though all provinces and territories offer youth-based sexual health education, the comprehensiveness, effectiveness, and quality of the programs vary significantly (Barrett & Bissell, 2000).

This thesis offers a representation of youth sexuality and sexuality education in Canada, and provides an investigation of the perceptions of a select group of Nova Scotian youth with regard to sexuality education. To begin, I take an in-depth look at youth sexuality in Canada. Particular emphasis is placed on incidence of sexual activity, teenage pregnancy, STIs, and contraceptives. Further emphasis is placed on sexuality education in Canada, highlighting *The Canadian Guidelines for Sexual Health Education* (Health Canada, 2003) and recent sexuality education resources exclusive to Nova Scotia. Critical theory provides a theoretical framework for this study. The methodology allows for an investigation of what youth in Nova Scotia feel are gaps between their experiences and needs and the sexuality education they recently received.

This thesis also provides insight into the outcomes of youth-based sexuality education in Nova Scotia, focusing primarily on attitudes, communication skills, and sexual decision-making. Such a study has not been conducted in Nova Scotia since 1996 when the Nova Scotia Department of Health and Planned Parenthood Nova Scotia completed the resource booklet *Just Loosen Up and Start Talking!* It has been 11 years since this document was released and statistics regarding teen sexuality indicate changes in those years. For example, in 1996, 60% of youth surveyed in Nova Scotia experienced sexual intercourse by the age of 16 (Nova Scotia Department of Health & Planned Parenthood Nova Scotia, 1996). However, in a 2005 study conducted by Statistics Canada only 28% of youth in Canada between the ages of 15 and 17 reported having had sexual intercourse (Statistics Canada, 2005a). Notably, 5,066 participants (7%) in the Canadian study, age 12 and up, were from Nova Scotia, but it is unknown if both studies used a consistent definition of sexuality and/or sexual intercourse. As such it may not be plausible to judge the results of this Canadian study as an improvement for youth sexual activity rates in Nova Scotia.

In 2006 The Nova Scotia Roundtable on Youth Sexual Health released a *Framework for Action* that detailed a comprehensive strategy for improving the sexual health of youth in the province. The *Framework for Action* solicited input from numerous organizations dedicated to the advancement of youth sexual health, such as school boards, Planned Parenthoods organizations from around the province, Nova Scotia women, and youth centers. This framework boasts a youth-centered approach and the first-hand voices of youth were incorporated into the strategy. In 2004 the metro office of Planned Parenthood, now called the Halifax Sexual Health Centre, consulted with youth

(Nova Scotia Roundtable on Youth Sexual Health, 2006). Of particular significance to my research is the framework's focus on school-based sexual health education. This section of the framework is dedicated to improving youth-based sexual health education for youth in grades 4 to 11, and states that a review of current curriculum and resources will be conducted as a part of fulfilling the objectives set forth in the document (Nova Scotia Roundtable on Youth Sexual Health, 2006).

Although the Roundtable indicated that it will be engaging youth in “policy, programs, service delivery, supports, and education” (Nova Scotia Roundtable on Youth Sexual Health, 2006, p. 31) there are still two concerns regarding the input of youth in developing this framework: (a) upon finalizing the strategy it was reviewed by a number of youth-based organizations (Nova Scotia Roundtable on Youth Sexual Health, 2006), but not by youth themselves, and (b) the youth who were consulted by Planned Parenthood in 2004 were not representative of Nova Scotia youth, they were representative of metro Halifax youth only (Nova Scotia Roundtable on Youth Sexual Health, 2006). As such, the methodology advanced in my study partially fills this gap by providing a number of youth from various regions of Nova Scotia with the opportunity to share their perspectives of sexuality education in this province.

Chapter 2: Literature Review

There have been a multitude of studies regarding youth sexuality and sexuality education. Such studies have investigated topics ranging from defining sexuality to the implications of sexuality education on youth behavior. What follows is a review of literature that draws attention to youth sexual activity, contraceptive use, teenage pregnancy, sexually transmitted infections, sexual assault, attitudes surrounding youth-based sexuality education, gender and age in relation to sexuality education, and the relationship between sexuality education and knowledge and behavior. The majority of this literature is Canadian, unless otherwise stated.

Sexuality

Sexuality is a complex concept. When people use the term sexuality they may be referring to anything from sexual intercourse to sexual orientation. The term sexuality encompasses sexual intercourse, sexual orientation, and an array of other sexual emotions, activities, and decisions. The Canadian Guidelines for Sexual Health Education defines sexuality as “a central aspect of being human throughout life and encompasses biological sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction” (Health Canada, 2003, p. 4).

Sexual activity is typically a focus of sexuality, and studies that have investigated how young adults define sexual activities have yielded similar results (Bogart, Cecil, Wagstaff, Pinkerton, & Abramson, 2000; Health Canada, 2003; Randall & Byers, 2003). For example, a 2000 study of undergraduate students attempted to obtain a better understanding of the behaviors that young adults considered as sex by way of investigating the proportion of participants who would label various sexual behaviors as

“sex”, both from a male angle and a female angle (Bogart et al., 2000). This study inferred that males and females have the same perception of what is considered to be sex, and that youth were more likely to consider sexual activity to be sex if penetration occurred (i.e., vaginal or anal intercourse). Further, a 2003 study of 164 heterosexual students (62 men and 102 women) between the ages of 17 to 31 also attempted to identify which behaviors young adults considered to be sex (Randall & Byers, 2003). Again, the results of this study showed that males and females had similar perceptions of what constituted having sex, and a majority of participants were more likely to identify an activity as sex if there was penetration.

Sexuality encompasses more than just sexual activity however. It also refers to gender and relationships, sexual desires, excitement, and confidence, STIs, pregnancy, contraceptives, emotional and physical harm, and sexual orientation (Healthy Sexuality Working Group, 2004). Moreover, sexuality is expressed in many ways, including “fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships” (Health Canada, 2003, p. 4).

For many people the word sexuality has only one connotation: sexual orientation. Sexual orientation itself is a very complex concept, and it is only one aspect of the broader term sexuality. Further, a person’s sexual health is associated with their understanding of who they are as a sexual being (Health Canada, 2003), and sexual orientation is only one part of this as well. Sexual orientation refers to “an individual’s pattern of physical and emotional arousal toward other persons” (Frankowski, 2004, p. 1827). Encompassed within the definition of sexual orientation are heterosexual persons, gay and lesbian individuals, and bisexual persons. Sexual orientation is often confused

with gender identity. Gender identity usually encompasses all three sexual orientations, together with transgendered persons and transvestites (Frankowski, 2004).

Research suggests that transgendered individuals feel as if their chromosomal sex is not identifiable with their anatomic sex; they do not feel as if they are characteristic of their born gender. For the most part, a man may feel as if he should have been a woman and a woman may feel as though she should have been a man (Frankowski, 2004; Healthy Sexuality Working Group, 2004; Murray, 2002). Transvestites are men and women who dress in the clothing of the opposite sex as a means of contentment (Frankowski, 2004). Transvestites simply have a desire to appear in clothing that is typically meant for the opposite sex. There are no biological reasons why people choose to be transvestites (Bentler & Prince, 1970; Taylor & McLachlan, 1963). Transvestites and transgendered persons' gender identities, similar to other individuals, are not synonymous with their sexual orientation—persons who identify as being transgendered or a transvestite may identify as heterosexual, gay, lesbian, or bisexual.

Additionally, sexual orientation and gender identity are not the same as sexual behavior/activity. Sexual behavior/activity is a choice that individuals make when expressing their sexual feelings, not be confused with an individual's pattern of physical and emotional stimulation (Frankowski, 2004). For youth it is particularly important not to confuse sexual activity/behavior with sexual orientation. Individuals may not come out until late in their teenage years, if at all, whereas a high proportion of Canadian youth engage in sexual activity, either heterosexual or not, between the ages of 14 and 16 (Lehoczky, 2005; Maticka-Tyndale, 2001). Also, many youth identify as being gay, lesbian, or bisexual years after being attracted to persons of the same sex, and many

youth are not sexually active but identify as being non-heterosexual (Frankowski, 2004). Although statistics are not readily available regarding the proportion of gay, lesbian, and bisexual youth, a survey of 16 to 19 year old American youth found that 6% of female youth and 17% of male youth had experienced sexual activity with an individual of the same sex (Frankowski, 2004), there is no indication of whether or not these individuals identified as heterosexual, gay, lesbian, or bisexual. Similar data was not located regarding Canadian youth.

Incidence and frequency of sexual activity. As previously noted, the definition of sexual activity and sexual intercourse is something that varies from person to person. As a result, much of the literature pertaining to incidence and frequency of sexual activity uses a broadly based definition of activity within its research methodology. A large amount of the literature that will be referenced in this section included vaginal intercourse, anal intercourse, oral sex, and heavy petting in its characterization of sexual activity.

A 2001 study found that the average age at which a Canadian youth lost her or his virginity was 17 (Maticka-Tyndale, 2001). However, at the time of the study, 38% of Canadian youth reported initiating sexual intercourse when they were between the ages of 14 and 16. The study also found that by the age of 16 about 40% of male and female youth had engaged in sexual activity. At the age of 15 this statistic fell to 25% for women and 20% for men, and approximately 10 to 13% of youth experienced sexual activity for the first time when they were below the age of 15. A 1996 study of youth in Nova Scotia reported 19% of the youth surveyed had experienced sexual intercourse by the age of 13, and 60% of the teens reported being sexually active by the age of 16 (Nova Scotia

Department of Health & Planned Parenthood Nova Scotia, 1996).

More recently, in May of 2005, Statistics Canada (2005a) released a report regarding a longitudinal study that explored youth and sexual intercourse during the period of 1998/99 to 2000/01 and 2003. This study reported that in 2003 approximately 28% of 15-to-17-year-olds reported having had sexual intercourse at least once in their lives. By ages 20 to 24, the proportion was 80%.

Other interesting findings from this study were the incidence of having multiple partners and the association between incidence of sexual activity and smoking and drinking (Statistics Canada, 2005a). Smokers were more likely to engage in sexual activity, and drinking was associated with an increased incidence of activity for females, but not for males. This information suggests that if youth incidence of smoking and drinking were to decrease it is likely that the incidence of sexual behavior would also decrease. This information is not suggesting a causal relationship between smoking, drinking, and sexual activity but knowing this information may be useful when developing sexuality education curriculum. Other risky behaviour was that boys were more likely than girls to have more than one partner in the previous year. Fifteen-to-24-year-olds who had engaged in activity by the age of 13 were more likely to have had two or more partners in the past year than were teens who had engaged in sexual activity the first time at a later age.

Another Canadian study reported that the experience of coital intercourse is evident in unmarried women 13 years and older, and the age of first intercourse appears to be falling (Fisher & Boroditsky, 2000). This study found that older cohorts of coitally experienced unmarried Canadian women engaged in sexual intercourse for the first time

at an older age than younger cohorts of coitally experienced unmarried Canadian women. The three age groups of participants in the study were 15-to-17-years-old, 18-to-24-years-old, and 25-to-29-years old. Forty percent of women participants who were between the ages of 25 and 29 had experienced intercourse for the first time when they were 18 or older, whereas all of the women participants who were between the ages of 15 and 17 had already experienced sexual intercourse, implying that more recent cohorts of women are experiencing intercourse for the first time at earlier ages than older cohorts.

Contraceptives. Although youth engage in sexual activity, they are not always familiar with the various methods of contraceptives available to them. Contraceptives allow persons to have a greater control over their sexual health, as well as allow them to have greater control over their physical, mental, and emotional health (Fisher, Boroditsky, & Bridges, 1999). All contraceptives have an effectiveness rate, but none are 100% effective (Health Canada, 2003). Common contraceptives used by Canadian youth include the male condom, female condom, birth control pill, Depo-Provera, spermicide, sponge, patch, diaphragm, and cervical cap (Healthy Sexuality Working Group, 2004). However, although youth seem to be familiar with the male condom and birth control pill, they are less likely to be familiar with other methods of contraceptives (Fisher & Boroditsky, 2000).

There is not much research available on youths' use of contraceptives. The 1998 Canadian Contraceptive Study, which provided a comprehensive look at contraceptive attitudes and practices among Canadian women, is one exception. Nonetheless, it did not cover all youth. Women between the ages of 15 and 24 made up approximately 22% of the random sample and young men were not included (Fisher et al., 1999).

However, even though it did not focus on youth, the Canadian Contraceptive Study still had many interesting findings. For example, women between the ages of 18 to 34 were more likely than women aged 35 to 44 to be familiar with condoms. Women between the ages of 15 and 17 were more likely to favor the morning after pill than were older women. Overall, 59% of women surveyed used a method of contraception the last time they had intercourse, and this rose to 80% for unmarried teenage girls. Yet, only 60% of unmarried 15-17-year-olds reported always using contraception during the six months prior to the study. This statistic increased slightly for 18-to-24-year-olds, with 68% of them reporting always using contraception during the six months prior to the study. This study showed that although most women between the ages of 15 and 44 are familiar with and/or using contraceptives, the contraceptives that were being used and the frequency at which they were being used varied by age group.

Some interesting regional differences emerged as well. Of interest to this study was that women from Atlantic Canada were less familiar than women from other regions with IUDs, sterilization, and the morning after pill (Fisher et al., 1999). With regard to Atlantic Canada, as of 1996 57% of youth surveyed by Planned Parenthood Nova Scotia and the Nova Scotia Department of Health reported not always using protection (Nova Scotia Department of Health & Planned Parenthood Nova Scotia, 1996).

Specific literature does exist regarding condom and birth control pill usage. A recent Canadian study reported that “nearly 44% of sexually active 20- to 24-year-olds reported sex without a condom, compared with 33% of those aged 18 to 19, and 22% of those aged 15 to 17” (Statistics Canada, 2005a, para. 8). Thus, younger Canadian youth seem to use condoms less often than older youth. Reasons for not using condoms include

not expecting to have sex, using another method, and having a faithful partner (McKay, 2004).

The birth control pill has become increasingly popular in past decades. A 2003 cross-sectional Canadian study of grade nine and eleven students illustrated that pill usage is greater among older youth: “the percentage of female teens who used the pill at last intercourse was 39% among grade nine students and 54% among grade eleven students” (McKay, 2004, p. 75). However, Health Canada has expressed concern that youth are now *only* using the pill, as opposed to the pill and the condom. As such, Health Canada suggests that although more Canadian youth may be at decreased risk for pregnancy, they may be at a higher risk of acquiring an STI (McKay, 2004).

Teenage pregnancy. Nearly 60, 000 teenage females in Canada experience unplanned pregnancies each year (Maticka-Tyndale, 2001). In 1991, of female youth who gave birth—where youth was defined as being between the ages of 14 and 19—approximately half were under the age of 18 (Olsen & Weed, 1991). Results from a 2003 study indicate that the average teenage pregnancy rate in Canada was 54.46/1, 000 youth, with Nova Scotia falling below average with a teenage pregnancy rate of 31.5/1, 000 (McKay, 2004). Nova Scotia’s youth pregnancy rate was the third lowest in the country, two places below Newfoundland and Labrador and Prince Edward Island, and one place above New Brunswick (McKay, 2004).

Although there are a high number of births, the pregnancy rate for Canadian teens is actually decreasing—between the years of 1974 and 2001 the rate of teenage pregnancies in Canada decreased by approximately 20% (Buske, 2001). Specifically, with the exception of a period of time between the mid 80s and the mid 90s, teenage

pregnancy rates have been steadily declining:

The pregnancy rate among 15-19-year-olds declined from 53.7 per 1,000 in 1974 to 41.2 in 1988 and then rose to 48.8 in 1994 and then declined in each subsequent year to 38.2 in 2000. A similar pattern was seen in 15-to-17-year-olds with a pregnancy rate of 33.8 per 1,000 in 1974 and 21.6 in 2000. Among 18-19-year-olds over the same period, the rate declined from 83.7 per 1,000 to 62.8.

(McKay, 2004, p. 68)

Nova Scotia has also been experiencing a decrease in teenage pregnancies. According to one study, Nova Scotia teenage pregnancy rates have decreased from 45.2 per 1,000 in 1993 to 28.1 per 1,000 in 2002 (Langille, 2005).

Nevertheless, although Nova Scotia has one of the lowest teenage pregnancy rates in Canada, as of 1996, 15% of 220 youth surveyed reported having been pregnant (Nova Scotia Department of Health & Planned Parenthood Nova Scotia, 1996). Furthermore, a 2004 study found that the rates of teenage pregnancy vary per region in Nova Scotia (Langille, Flowerdew, & Andreou, 2004). Although the regions were not specified, regions with a higher level of education had lower pregnancy rates than regions with low levels of education, and regions with a high proportion of lone-parents and single families had higher youth pregnancy rates than those with a lower proportion of single families.

Canadian pregnancy rates referred to are not representative of the actual number of youth who gave birth because a number of youth experience fetal loss and some choose to have an abortion. In 2002, the rate of live births in Canada was 0.6 per 1,000 women under the age of 15, 14.9 for youth between the ages of 15 and 19, and 54.0 for women between the ages of 20 and 24 (Statistics Canada, 2005d). When compared to the

United States of America, Australia, and a number of European countries, Canada ranked fourth highest in terms of birth rates for 15-to-19-year-olds between the years of 1970-1995 (Maticka-Tyndale, 2001).

Further, the rate of induced abortions in Canada in 2002 was 1.7 per 1,000 for women below the age of 15, 18.4 for female youth between the age of 15 and 19, and 30.8 for women between the ages of 20 and 24 (Statistics Canada, 2005c). Provincially in 1997, Ontario had the highest rate of teenage pregnancies ending in abortion (58%), Prince Edward Island had the lowest (17%), and approximately one-third (37%) of Nova Scotian pregnancies were aborted (Buske, 2001). When compared to a number of other developed countries, Canadian youth are not significantly different in the number of abortions (Maticka-Tyndale, 2001). Additionally, a 2004 study showed that the numbers of induced abortions were increasing or staying the same in most Canadian provinces and territories, with Nova Scotia being among seven provinces that experienced a decrease in induced abortions. Overall, in 2004 24.7 per every 1,000 women in their 20s were inducing abortion when faced with pregnancy (The Daily, 2007).

Though not common, fetal loss also affects the adolescent birth rate in Canada. Canadian statistics show that in 2002, 0.1 per 1,000 women under the age of 15 experienced fetal loss, 0.6 women between the ages of fifteen and nineteen experienced fetal loss, and 1.6 women between the ages of 20 and 24 (Statistics Canada, 2005b).

Sexually transmitted infections. Sexually transmitted infections (STIs) are agents spread through sexual contact, needles used to tattoo or pierce, or the injection of drugs. The most common types of STIs present among today's youth are chlamydia, genital herpes, gonorrhea, hepatitis B, HIV/AIDS, human papilloma virus (HPV), syphilis, and

trichomoniasis (Healthy Sexuality Working Group, 2004). All of these infections are present among heterosexual men and women, gay men, lesbians, bisexual individuals, and transgendered individuals. With the exceptions of herpes, AIDS, and HPV, STIs can be cured if found and treated in time.

A 2004 report card of adolescent reproductive health indicated that STIs pose a considerable threat to the health of the younger Canadian population (McKay, 2004). Thus, it is imperative that preventative education start at ages prior to the teen years. Statistics Canada (2005a) accounts that “4% of 15-to-24-year-olds who had had sex at least once reported having been diagnosed with a STI” (p. 1). However, the exact number of STIs among this age group is probably higher than reported because the youth may not have know that they had symptoms of an STI or know the symptoms of STIs even to identify them (Statistics Canada, 2005a). Age does influence STI rates; youth aged 20 to 24 were more likely to have been diagnosed with an STI than 15-to-17-year-olds (Statistics Canada, 2005a). The 20 to 24 age group would have been experiencing sexual activity for a longer period of time and would have had a longer time to contract an STI. Further, youth who had engaged in intercourse by age 13 were more likely to report an STD than youth over the age of 13 when they first engaged in sexual intercourse (Statistics Canada, 2005a), implying that the earlier that youth engage in sexual activity the more likely they are to catch an STI.

Specific to Nova Scotia, 21 out of 220 youth surveyed in 1996 reported having a sexually transmitted infection and four of them did not seek help (Nova Scotia Department of Health & Planned Parenthood Nova Scotia, 1996). That is, approximately 19% of sexually infected youth in this study did not report their sexually transmitted

infection, which supports the contention that actual statistics regarding STI infection are much higher than reported.

Gonorrhea and chlamydia are the two most tracked and notable STIs present among Canadian youth. Gonorrhea is most common among 15-to-19-year-old women, and least common among male 15-to-19-year-olds (Maticka-Tyndale, 2001). Rates of gonorrhea decreased in Canada up until the late 1990s, and now they are on the rise again. Research shows that the gonorrhea rate among 15-to-19-year-olds increased from 51.7 per 100,000 to 71.0 per 100,000 between the years of 1997 and 2002 (McKay, 2004).

Canada has an approximate chlamydia rate of 1000/100,000 females between the ages of 15 and 19 and 100/100,000 males between the ages of 15 and 19. Chlamydia has serious health consequences if left untreated, and given that an estimated 40-70% of chlamydia cases are asymptomatic, many cases are left untreated (Maticka-Tyndale, 2001; McKay, 2004). If left untreated, 20-40% of chlamydia cases in women could progress into pelvic inflammatory disease, which may progress into infertility, ectopic pregnancy, and/or chronic pelvic pain. Further, the risk of HIV infection is increased by a factor of three to five when an individual has chlamydia (McKay, 2004).

HIV/AIDS is not extremely prevalent among youth. Nevertheless, teens and young adults have been affected globally; half of all new infections around the globe are occurring in individuals aged 10 to 24 (Public Health Agency of Canada, 2003). “As of June 30, 2002, 18,332 Canadian AIDS cases with age information had been reported. . . Of these, 627 were among youth aged 10 to 24 years” (Public Health Agency of Canada, 2003, p. 2). The highest rate of newly diagnosed HIV infections are among injection drug

users, with 500 new cases in 1996 and 300 new cases in 2000 (Jordan, Wong, & Patrick, 2000). In a Vancouver Injection Drug Study, the prevalence of HIV among participants 24 years and younger was 17% during the period of 1996-2001 (Public Health Agency of Canada, 2003).

Gay men make up 10% of 10-to-19-year-olds and 48% of 20-to-24-year-olds who have been diagnosed with HIV/AIDS in Canada (Public Health Agency of Canada, 2003). In addition, in 2003 the Public Health Agency of Canada conducted a study of 15-to-30-year-old gay and bisexual men, and concluded that if the men had engaged in prostitution they were more likely to have contracted HIV than men who had not engaged in prostitution.

Although females do not represent a large portion of individuals who have been infected with HIV in Canada, there have been a notable number of cases among all female Canadians from 1995 through to 2000. In 1995 there were 528 cases, 541 in 1996, 456 in 1997, 493 in 1998, 544 in 1999, and 544 in 2000 (Jordan et al., 2000). It is important to know that HIV infection among females fluctuates with age and has been reported to be highest among youth and young adults (Public Health Agency of Canada, 2003).

Of the little available information surrounding HIV rates among youth, there is a small amount of literature comparing STI rates for women who have sex with women, and men and women who have sex with both sexes. The lack of information regarding orientation and infection rate is also a missing element of the literature that unveils STI rates among youth. Specific to HIV infection, there is little information about HIV rates among heterosexual youth.

Sexual assault. Though much of the literature and research surrounding sexual health and sexual health education primarily focuses on STIs and pregnancy, the incidence of sexual assault among youth is also very common and cannot be overlooked (Nova Scotia Department of Health & Planned Parenthood Nova Scotia, 1996). Sexual assault is classified as:

. . . any kind of sexual activity that the other person doesn't consent [to]. . . the legal definition includes (among other things) oral sex, vaginal sex, anal sex, touching, kissing, grabbing, masturbating another person, forcing another person to masturbate [oneself], and masturbating over another person. (Healthy Sexuality Working Group, 2004, p. 33)

Sexual assault is something that can happen to, or can be perpetrated by persons of all ages, and contrary to popular belief, sexual assault can happen to both males and females and both males and females can commit it. However, women are much more likely to experience sexual assault than men (Kimerling, Rellini, Kelly, Judson, & Learman, 2002).

Sexual assault has an elevated presence among today's youth. A study of 220 male and female Nova Scotia youth found that 18% had had sexual intercourse as a result of pressure and 43% had been victims of date abuse. Forty percent of the aforementioned youth did not seek help following their sexual assault, and only 25% were able to obtain helpful assistance subsequent to their forced sexual experience. These statistics were not broken down by gender (Nova Scotia Department of Health & Planned Parenthood Nova Scotia, 1996).

As well, about 25% of sexual assault victims who contact the Canadian Sexual

Assault Center each year reported that drugs were a factor in their rape (Weir, 2001). Date rape drugs are often added to a person's drink causing drowsiness, dizziness, confusion, memory loss, and unconsciousness. The drug leaves the victim incapable of resisting or escaping unwanted sexual activity, and as such, victims are unable to call for help or say no (Healthy Sexuality Working Group, 2004).

Sexuality Education

In response to noted trends regarding teen sexuality, sexuality educators have developed sex education programs, also referred to as *sexual health education*, that enlighten youth about the challenges and risks of engaging in sexual activity (Cassidy & Powell, 2001). Both the World Health Organization and The Canadian Guidelines for Sexual Health Education define sexual health education by emphasizing education, prevention, and well-being, and they also highlight the importance of remaining open to different meaning and understandings (Health Canada, 2003).

Existing sex education programs include *comprehensive sexuality education* and *abstinence-based sex education*. On one hand, comprehensive sexuality education programs attempt to delay sexual activity, increase contraceptive use, and encourage responsible sexual decision-making (Eisen & Zellman, 1987). On the other hand, abstinence-based sexuality education programs attempt to prevent sexual activity based on the argument that premarital sex is unethical and that abstinence from sexual intercourse before marriage is the only acceptable behavior (Holmes & Toups, 2002; Kempner, 2001). As of 2003, only 14% of school based sexuality education programs in the United States were comprehensive, whereas 35% of the school based sexuality education programs were abstinence only, and 51% were abstinence centered (Bay-

Cheng, 2003). With the exception of a Nova Scotia study in which 36% of youth said that they were not able to access sexual health education at all (Nova Scotia Department of Health & Planned Parenthood Nova Scotia, 1996), I was not able to locate similar statistics for Canada. However, approximately 35% of grades seven, nine, and eleven students in a study of 11,125 Canadian youth said that they were not exposed to HIV/AIDS education at the secondary level at all in the past two years (Boyce, Doherty, Fortin, & MacKinnon, 2003). This statistic speaks volumes about the lack of sexuality education being offered in the Canadian school system.

The Canadian Guidelines for Sexual Health Education imply that Canadian programs ought to be focusing on diverse issues relevant in sexual health education, including sexuality, relationships, and personal development (Health Canada, 2003). These guidelines illustrate that the purposes of sexual health education are not only to avoid negative outcomes, but also to aid in reaching positive outcomes (Health Canada, 2003). The guidelines combine a here and now approach to sexual health education with a preventative approach that encourages rewarding sexual relationships, self-esteem, non-exploitive sexual relationships, and preventative education regarding unintended pregnancy, HIV/STIs, sexual coercion, and sexual dysfunction (Health Canada, 2003).

In Canada these guidelines are intended to govern the sexual health education offered to Canadian youth. The guidelines' guiding principles are very clear in stating that sexual health education is to be accessible, comprehensive, effective in its educational approaches and methods, presented by trained facilitators, and planned carefully, including an evaluation process and regular updating. Three of the goals and objectives of these guidelines are to:

- unite and guide individuals, professionals and agencies working in the field of health promotion.
- offer clear direction for further development of sexual health education policies and programs at all levels of government.
- provide a frame of reference for evaluating existing sexual health education programs, policies and related services available to Canadians. (Public Health Agency of Canada, 2003, sec. 2)

These guidelines are intended to ensure that sexuality education and information is available, as well as make certain that recipients of Canadian sexuality education have the tools to apply knowledge obtained. However, these guidelines are very broad and do not ensure acceptable sexuality education when read in the absence of the entire document. Additionally, the guidelines have not been adhered to across Canada. For example, youth in British Columbia, Quebec, and Nova Scotia have expressed concern that more coverage should be given to relationships, STI prevention, abuse and sexual assault, birth control, abortion, sexual orientation, affection, attraction, love and alcohol, and sex (Fisher et al., 2001; McCall et al., 1999). Also, it is apparent that sexuality education and/or resources are more readily available in more affluent communities (Langille et al., 2004). As such, poorer communities have seen the results of inadequate sexuality education. A 2004 study conducted in Nova Scotia illustrates this point by showing that poorer Nova Scotia communities have higher pregnancy rates (Langille et al., 2004).

In addition to the Canadian Guidelines for Sexual Health Education, other characteristics of effective sex and HIV education programs have been identified and

published in Canada (Fisher, McKay, Maticka-Tyndale, & Barrett, 2001). These characteristics include: (a) the reduction of sexuality activities that may lead to pregnancy, or HIV/STI infection, (b) the employment of theory, and (c) educating about abstinence, condom use, and contraceptives other than the condom. The characteristics serve to ensure that sexuality education teachers/facilitators have basic information about sexual activity and social pressures relating to sexuality education. Further, these characteristics encourage sexual health educators to practice effective communication, involve the students, embrace the age of the participants, provide a sufficient amount of time to effectively deliver the program, and have supportive and adequately trained facilitators (Fisher et al., 2001).

As previously indicated, recently in Nova Scotia, the Nova Scotia Roundtable on Sexual Health (2006) produced a framework outlining a plan of action that will advance the Canadian Guidelines for Sexual Health Education in Nova Scotia. This framework, which boasts a youth-centered approach, has five components:

1. Leadership and commitment: outlining the role of Nova Scotia Health Promotion and Protection in promoting healthy youth sexuality in Nova Scotia.
2. Community awareness and support: focusing on the importance of promoting healthy youth sexuality as a normal aspect of development in the community.
3. School-based sexual health education: acknowledging the importance of adhering to the Canadian Guidelines for Sexual Health Education in grades four through eleven.

4. Youth involvement and participation: acknowledging the importance of including youth in the development of sexual health education decision-making and development.
5. Sexual-health related services for youth: concentrating on developing new and existing sexual health services that are youth-centered.

The Nova Scotia Framework has yet to be implemented. However, an example of the Canadian sexuality health education guidelines at work were seen in the learning objectives of the *Choices and Chances* program offered to both students and parents in Whitehorse, Yukon (Wackett & Evans, 2000). Learning objectives for this program ranged from evaluating the effect of the media on physical appearance to considering ways of showing affection without intercourse, while still focusing on STIs, contraceptives, communication, personal space, puberty, and contraception. Further, facilitators of this program also communicated with parents about parent-child communication surrounding youth sexuality (Wackett & Evans, 2000).

Choices and Chances met the Canadian Guidelines of Sexual Health Education because it involved youth and their families, embraced modern society by way of addressing the impact of media, attempted to improve self-esteem and positive relationships by focusing on physical appearance, and endeavored to avoid negative outcomes (i.e., teenage pregnancy) (Health Canada, 2003; Wackett & Evans, 2000). An evaluation of the program immediately following the end of the program, one month after the program, and three to four months after the program showed that the program was effective in increasing knowledge, motivation and personal insight, and skills (Wackett & Evans, 2000).

The most recent example of youth-based sexuality education in Nova Scotia comes in the form of an information booklet called *SEX? A Healthy Sexuality Resource*. Although it was not mandated for any group of people, it is intended for Nova Scotia youth between the ages of 12 and 17. This booklet was produced by the Nova Scotia Office of Health Promotion in 2004, in consultation with over 500 youth who told the developers exactly what they needed to know regarding sexuality and sexual activity. The booklet is a means of sexuality education and contains information regarding pregnancy prevention, sexual assault, STIs, sex, relationships, and decision-making (Healthy Sexuality Working Group, 2004). However, this resource is not a sexuality education *program*. Moreover, it is a resource that is available to most students but is not a mandatory part of sexuality education in Nova Scotia. This resource has not been able to reach all youth in Nova Scotia; though the booklet is inclusive of many of the areas of sexuality it has not become a compulsory part of sexuality education curricula province wide.

Additionally, *SEX? A Healthy Sexuality Resource* has not yet been reviewed. Nonetheless, based on media reports, initial reaction from youth seems to be extremely positive, whereas reactions from religious groups and parents seem to be mixed. For instance, one angry parent wrote:

Sex will be injected into the minds of our children. . . Do not teach my children “good” or “safe” contraceptive practices! Do not teach my children that they can “decide how far they can go!” Do not teach my children how and when to abort a fetus. (Canada Family Action Coalition, 2005, p. 1)

A message board on the Catholic World News website is just one of the many religious

disputes against the resource. One individual posted the following message:

It is truly frightening that the responsible people in government and education do not recognize that the hand of Satan is the force behind such publications that would deliberately steal the holy innocence from their own children. They should remember what Jesus said about the millstone around the necks of those who do such things. The United States had better be awake and on guard because this atrocity will be attempted here if it has not already been done. Canada has abandoned God. (Catholic World News, 2004, p. 2)

Despite such a reaction to this resource it is important that researchers and educators continue talking to youth, asking them what their perceptions of sexuality education are. Youth are the ones who best know what they want and need to learn regarding sexuality. There have been consultations with youth in Nova Scotia that focused on what youth know and want to know regarding sexuality and sexual health (Health Sexuality Working Group, 2004; McCall et al., 1999; Nova Scotia Department of Health & Planned Parenthood Nova Scotia, 1996), yet there is little literature focusing on youths' opinions of the sexuality education they have obtained. Youths' perception of sexuality education are an important gap in current sexuality education literature. Notably, the recent publication of *Framework for Action: Youth Sexual Health in Nova Scotia* (Nova Scotia Roundtable on Sexual Health, 2006) acknowledges the importance of youth-based sexual health services and the inclusion of youth in the development of such services and as such the importance of youths' perceptions of current and future sexuality education. If implemented properly, this framework will advance youth-centered sexual health education in Nova Scotia.

Similar to the *SEX?* booklet, background research for the *Framework for Actions* included consultations with a select group of youth and focused on what they knew about sexual health. My research, on the other hand, focuses on youths' perception of sexuality and sexuality education. *SEX? A Healthy Sexuality Resource* has been cited several times throughout this literature review because it is representative of a sexuality resource in Nova Scotia, which in turn is representative of my research proposal—examining the experiences that Nova Scotian youth have had with sexuality education at a secondary level. However, I will not be evaluating this resource alone, I will be gathering youths' perception of all sexuality education that my sample of youth has received in Nova Scotia classrooms.

Attitudes. The relationship between attitudes and sexuality education is circular. Attitudes affect what kind of sexuality education exists and sexuality education may or may not produce attitude changes in participants when it is present. Thus, this section discusses parental attitudes toward the concept of sexuality education being offered to their youth, as well as parental attitudes toward their role in delivering sexuality education themselves, and it illustrates the impact of sexuality education programs on participants' attitudes.

Sexual health guidelines aside, parents and guardians often have their own ideas regarding what their children ought to be learning in terms of sexuality education. When parents oppose sexuality health education, it is not uncommon to see letters to the editor, presentations to boards of health and education, protests, and media reports (McKay, Pietrusiak, & Holowaty, 1998). For the most part, people opposing sexuality education claim that sexuality education promotes sexual activity and increases the incidence of

sexual activity (Eisen & Zellman, 1987). However, there are also parents and guardians who feel that sexuality education delays sexual activity, increases contraceptive use, and promotes responsible sexual decision-making (Eisen & Zellman, 1987). In fact, focus groups with Nova Scotia parents revealed that most parents believe that sexuality education should be more comprehensive and more time should be devoted to sexuality education (McCall et al., 1999).

In 1998 McKay and colleagues surveyed 6,833 parents in six Canadian communities regarding their attitudes towards sexuality education in the public school system. Ninety-five percent of the parents surveyed agreed or strongly agreed that sexual health education should be taught in school, a similar statistic to a 1996 study conducted in Nova Scotia (McKay et al., 1998). Eighty-one percent of these parents felt that such education should “respect the different moral beliefs about sexuality that may exist in the community” (McKay et al., 1998, p. 143). Consequently, one could infer that though most parents agree that there should be sexuality education curricula included in their children’s education, they do not necessarily agree on what this curriculum should include. For instance, only 40% of parents felt that abortion and alternatives to abortion should be addressed in grades seven to eight, and 6% felt it should never be addressed in school curricula (McKay et al., 1998).

Parents were not as confident when it came to providing sexual health education at home. Seventy percent of them did not feel that they knew how to give their children the sexuality education they needed (McKay et al., 1998). Ultimately, the results of the study were favorable when determining parental attitudes surrounding sexuality education in the classroom, but not positive when inferring parents’ comfort level with

employing sexuality health education at home. *The Nova Scotia Roundtable on Youth Sexual Health* (2006) recognizes the significance of parents' roles in promoting youth sexual health, stating the increased knowledge, skills, and confidence of parents as a goal of their framework.

A variety of studies have examined the impact of sex education programs on participants' attitudes toward premarital sex, sexual choice, contraceptives, self-esteem, sexual satisfaction, STIs, AIDS, sexual expression, pregnancy, and abstinence (Holmes & Toups, 2002; Kirby, 2001; Olsen & Weed, 1991). In a study of 14 comprehensive sex education programs, Kirby (2001) reported that a majority of the programs "did not have measurable effects on self-esteem, satisfaction with social and sexual relationships, or attitudes toward birth control, gender roles, and sexuality in life" (p. 166).

Sex education programs emphasizing abstinence can be effective in producing a positive attitude change (Holmes & Toups, 2002). Olsen and Weed (1991) evaluated the effectiveness of three abstinence-based sex education programs on participant attitudes. Participants of the three programs were administered a pretest and post test survey to determine attitude change. The results showed that abstinence-based sexuality education can produce attitude change, which appears to be more positive among female youth than male youth, and also that both junior and senior high school students have positive attitude changes (Olsen & Weed, 1991). However, it is important to note that this research was based on an analysis of three abstinence-based programs, there was no comparison to other programs, and moreover, one of the programs was not entirely abstinence based. The program that was not completely abstinence based also addressed dating, peer pressure, marriage, parenting, teen pregnancy, and AIDS (Olsen & Weed,

1991). Given that there were only 105 participants and one of the programs was not entirely abstinence based, one could question the generalizability of the findings.

Similarly, Kirby (2001) reported that the abstinence-based program, *Human Sexuality: Values and Choices* pre and post test results suggested that in the short-term participants were considerably more accommodating of abstinence and less likely to engage in sexual intercourse upon completion of the program. However, this in no way implies that participants would not be just as accommodating to other forms of preventative education, and there is nothing to suggest that the participants' attitude change would translate into a change in behavior. The relationship between sexuality education programming and sexual behavior is examined later in this literature review.

Conversely, recent literature has expressed concern that “there are few sex education programs which embrace the idea that positive experiences of sexual desire and pleasure are integral to young people's health and well-being” (Allen, 2004, p. 1). The attitudes expressed by sexual health researchers when discussing the erotics of sexual health education are such that they believe that sexual activity has become directly associated with such factors as pregnancy, and as such sexual health does not focus on the positives of sexual activity, such as sexual desire and pleasure (Thorogood, 2000, as cited in Allen, 2004). Further, not only are sexuality education programs omitting material surrounding sexual pleasures and desires, they also are not acknowledging lesbian, gay, bisexual, transgender, and intersex identities, and usually only pay reference to men's (hetero) sexual desires (i.e., wet dreams) (Allen, 2004). Thus, comprehensive education may not really be “comprehensive” of all sexual choices. Essentially, comprehensive sexuality education provides a preventative and positive approach to

sexual behavior and sexual being, but it does not always account for sexual orientation, gender identity, and sexual gratification, all issues that youth have expressed an interest in learning in their sexuality education classes (McCall et al., 1999).

Knowledge. Several studies of abstinence based and comprehensive sexuality education programs have measured the impact of these programs on participants' sexual knowledge. The studies indicate that the impact of sex education on knowledge is nearly unanimous—sexuality education does increase factual knowledge about sexuality (Gottsegen & Philliber, 2001; Kirby, 2001; Wackett & Evans, 2000). For instance, data presented from approximately 300 males who were participants in *Wise Guys*, a sexual responsibility program, suggested that by the end of the program participant knowledge had increased significantly in comparison to a control group of 200 similar males (Gottsegen & Philliber, 2001). Research shows that such outcomes are more likely when “sexual health education integrates knowledge, motivation, and skill building in an environment conducive to sexual health” (Health Canada, 2003, p. 12).

A positive change in knowledge was a notable finding of *Reducing the Risk*, a sexuality education curriculum based out of the United States (Barth & Kirby, 1991). In a pre-test post-test comparison of the program participants' knowledge regarding contraceptives, it was determined that there was a considerable improvement in the participants' knowledge following the program. In fact, there was an 18% increase in the number of questions answered correctly following the sexuality education class.

The age at which teens receive sexuality education may be important in determining what they learn. There is evidence that younger participants with less knowledge retain the same amount of information, if not more, about sexuality as older

participants who may be already informed (Gottsegen & Philliber, 2001). For instance, the program *Choices and Chances* was presented to grade four to seven students in Canada, which meant that the participants ranged in age, and in an evaluation of the program, participants' average pretest score on the knowledge questions, which was 58.8%, did not vary significantly by age. This score increased to 65.6% immediately following the program and remained unchanged when given a follow up test three months later. At no point did age play a determining factor in these scores (Wackett & Evans, 2000).

Behavior. Knowledge and attitudes can only go so far, it is what the participants of sexuality education do that is key. *The Canadian Guidelines for Sexual Health Education* emphasizes the fact that the development of skills that support sexual health “helps individuals learn to evaluate the potential outcomes of their sexual health practices and to modify their behaviour as necessary” (Health Canada, 2003, p. 13). Studies examining the impact of sex education programs on communication and decision-making skills show mixed results (Barnett & Hurst, 2003; Kirby, 2001; Wackett & Evans, 2000). For example, when *Choices and Chances* participants were asked if they were confident in their ability to resist sexual pressure from others, 70.9% at pretests agreed or strongly agreed. This percentage dropped to 70.7% in a posttest one month later, and fell to 66.3% in a follow up test three months later (Wackett & Evans, 2000). However, Schinke, Blythe, and Gilchrist (1981, as cited in Kirby, 2001), developed cognitive-behavioral sexuality education, which showed a considerable impact on skills. An evaluation of this cognitive-behavioral training program found that upon immediate completion of the program the participants had better eye contact, were more likely to say “no” in response

to pressure, and were more willing to share responsibility for birth control (Kirby, 2001).

A study of sexual attitudes and behaviors in a community college human sexuality course showed that there was a positive correlation between sex education and the use of contraceptives (Feigenbaum & Weinstein, 1995). Gottsegen and Philliber (2001) further report that a positive relationship between contraceptive use and sexuality was observed among males who participated in the sexual responsibility program *Wise Guys*. Pre- and post-test studies of *Wise Guys* revealed that 22% of participants who had not reported using an effective method of contraception when having intercourse in the month prior to the program reported using an effective method of contraception by the end of the program (Gottsegen & Philliber, 2001).

Some researchers (e.g., Kirby, 2001), however, suggest that sex education does not appear to affect the incidence of sexual activity in such a positive way as it does contraceptive use. In a comprehensive sex education program designed to educate adolescence about the challenges and responsibilities of sex, a sexual activity pretest asked: "Have you ever had sexual intercourse with someone of the opposite sex?" If the teen answered "yes", a series of questions followed. A six-month follow up question was asked to a majority of the original participants, it was phrased: "Since you finished this program have you had sexual intercourse with someone of the opposite sex?" If the teen answered "yes" a series of questions followed. The results demonstrated that 62% of virgins remained virgins; 7% who had been virgins lost their virginity; 7% who were sexually active prior, were not any longer; and 25% who were sexually active, continued to be sexually active (Eisen & Zellman, 1987). It is important to note however, that there was no control group for this study, it was simply a before and after comparison of

participants and therefore the results cannot be compared to youth who did not participate in the program. Also, the participants of this study were on average 15.5 years old, which is also the average age at which 38% of Canadians lose their virginity. If the program were delivered to a younger audience it may have had more results as it would have been less likely that the participants had not already engaged in sexual activity (Statistics Canada, 2005a). Consequently there may have been a greater chance of delaying sexual intercourse, or at very least educating the youth before they were sexually active. For all intents and purposes, these results suggest that youth need to be educated at a younger age.

Gender and age. Sexual health education has commonly been aimed more towards females and older males than any other demographic, often assuming that younger males were irrelevant in promoting responsible sexual behaviour (Gottsegen & Philliber, 2001). However, in recent years there has been an increase in the amount of sex education programs targeting adolescent males and elementary aged school children (Gottsegen & Philliber, 2001; Wackett & Evans, 2000). When developing sexuality education programs program developers and family life educators are beginning to understand the diverse needs of their target population (Cassidy & Powell, 2001).

Sexuality education is a need of all boys, girls, men, and women in society. Yet, men have often been regarded as trivial to comprehensive sex education and females have often been the primary focus of abstinence-only-until-marriage programs (Gottsegen & Philliber, 2001; Kempner, 2001). Gottsegen and Philliber (2001) report that until the development of programs such as *Wise Guys*, a comprehensive sexuality education program for males, efforts to reduce teenage pregnancy and document the

sexual activity of teenagers did not usually include males, instead placing all responsibility for healthy sexuality on females. In a SIECUS (Sexuality Information and Education Council of the United States) report, Kempner (2001) further noted that abstinence-only-until-marriage programs contain gender biases. These programs describe females as “having the exclusive responsibility for engaging in or refusing sexual activity” and males as “having uncontrollable sexual feelings” (p. 43).

As mentioned earlier, age is an important factor to consider when delivering sexuality education and as such should be taken into account when developing sex education programs. Youth believe that sexuality education classes should be offered in elementary, middle, and senior secondary school (McCall et al., 1999). Yet, it is particularly important to understand that people of different ages have distinct sexual dilemmas, pressures, and concerns. For instance, mandated learning objectives for sex education of elementary aged school students typically include “sexual health related themes such as body awareness, puberty, STIs, health decision making, and interpersonal relationships” (Wackett & Evans, 2000, p. 265), whereas sex education programs for high school students typically deal with such topics as unintended pregnancy, sexual pressure and communication, contraceptives, sexual responsibility, STIs, HIV, and sexual values (Holmes & Toupes, 2002; Kirby, 2001). Colleges and universities offer sexuality education programs that deal with such controversial topics such as contraception, different types of sex, masturbation, abortion, sexual orientation, sexual response, and sexual dysfunctions (Feigenbaum & Weinstein, 1995).

Facilitation. Ensuring that youth are receiving sexuality education is one issue, but ensuring that teachers are receiving sexuality education, adequately trained to offer

such education, and presenting sexuality education effectively are other important issues as well. Sexuality education does exist in the Canadian school system; nevertheless studies suggest that teachers are not effectively trained to deliver such education (McKay & Barrett, 1999).

Very few teachers have ever received sexuality education themselves and many do not feel comfortable teaching the topic (Brick, 1992; McKay & Barrett, 1999). In fact, as of 1999, hardly any of Canada's Education Ministers had specific guidelines and qualifications for the teachers who facilitate sexuality education (McCall et al., 1999). Additionally, as of 1999 45.5% of Canada's Education Ministers did not insist on dedicating class time to sexuality education (McCall et al., 1999).

A 1999 study of 91 teachers from random schools across Canada found that teachers who had taught an average of 20 units of sexuality education prior to participating in the study did not touch on sensitive issues, such as sexual orientation, oral and anal sex, masturbation, and sexual pleasure (McKay & Barrett, 1999). Further, they did not use interactive learning to teach the sexuality education topics that they did present. Avoiding sensitive topics is inconsistent with the Canadian Guidelines for Sexual Health Education, as the second principle of the guidelines stipulates:

Sexual health education should include important topics such as developmental changes, rewarding interpersonal relationships, communication, setting of personal limits, media, stereotypes, prevention of STI/HIV, effective contraception, sexual assault/cohesion, gender-role expectations, and sexual orientation. (Public Health Agency of Canada, 2003, p. 20)

This gap in sexuality education instruction is not surprising given that upon

assessing 105 B.Ed programs in Canada, only 15.5% of the programs reported training all of their students how to teach sexuality education (McKay & Barrett, 1999). However, before getting up in front of the classroom to teach youth sexuality education it is very important that teachers examine their own values regarding sexuality, learn about sexual development, learn and become comfortable with the language of sexuality education, analyze the media for messages of sexuality, practice answering difficult questions, and challenge false assumptions and promote thoughtfulness regarding sexuality (Brick, 1992), principles that are evidently not being achieved in B.Ed programs across Canada.

Further, Health Canada, through *The Canadian Guidelines for Sexual Health Education*, emphasizes that for sexuality education to be effective, educators should have a general knowledge of sexuality and sexual health issues and have the teaching skills needed to facilitate sexuality education. The teachers should be able to embrace the diversity of participants, have the capacity to discuss sexual health positively and in a sensitive manner, and be able to identify and understand participants' beliefs. The guidelines also suggests that educators have an understanding of educating about sexual orientation, that they possess sensitivity surrounding gender issues, that they be able to deal with sensitive and confidential issues, and that educators encourage and facilitate reflective processes. In addition, the guidelines stress the importance of educators understanding the professional code of ethics pertaining to sexuality education. These guidelines are not being adhered to in many classrooms across the country because sexuality education is not a fixed component of Canadian B.Ed programs, and teachers are often not receiving the appropriate training (McKay & Barrett, 1999). The Nova Scotia *Framework for Action* recognizes the need to educate sexual health educators and

puts forth the objective of providing sufficient resources and professional development for sexual health educators.

Summary

Sexual intercourse, sexual orientation, gender identity, contraceptives, pregnancy, and STIs are issues that Canadian youth are being faced with every day. Research shows that youth are engaging in sexual activity in their teen and pre-teen years, those who have engaged in sexual activity often report having more than one sexual partner, and teens are not using contraceptives every time they engage in sexual activity. Canadian STI and youth pregnancy rates continue to confirm the fact that youth are engaging in unsafe sexual activity, yet sexuality education is not a priority in Canadian school systems (McCall et al., 1999).

This literature review has examined Canadian sexuality education in enough detail to see the inconsistencies between the sexuality education that Canadian youth need and the sexuality education that they are currently receiving. For instance, studies constantly demonstrate the prevalence of sexual activity among youth, yet abstinence-based sexuality education still exists in Canada. It is time that the needs of the program recipients are met; it is time that the voice of youth is included in sexuality education curricula.

The Canadian Guidelines for Sexual Health Education (Health Canada, 2003) were created to provide a model for sexuality education that endeavors to avoid negative outcomes and also aids in reaching positive outcomes. All too often however, these guidelines are not adhered to or there is resistance to implying the guidelines to youth-based sexuality education. One of the principles highlighted in the guidelines is

comprehensiveness, a principle that is ignored by the presence of abstinence-based sexuality education. The guidelines emphasize the need for sexual health education for everyone, yet many individuals, parents included, have opposed various programs and materials that provide such education.

Nevertheless, there are people who agree that sexuality education should be offered in the secondary school system. Furthermore, there is proof that sexuality education is effective in reaching positive outcomes. Sex education programs can produce attitude changes (Olsen & Weed, 1991), increase factual knowledge about sexuality (Gottsegen & Philliber, 2001; Kirby, 2001, Wackett & Evans, 2000), and influence behaviour in a positive manner (Feigenbaum & Weinstein, 1995).

A very important gap in this literature review is an in-depth look at youths' perceptions of sexuality education. What youth feel is important to sexuality education and what they feel is lacking in the curricula that they have received is not well represented in current literature surrounding sexuality and sexuality education. Youth opinion is briefly referred to in my literature review, yet it is not represented with the vigor that it ought to be, such as the nominal consultation of youth in developing the Nova Scotia *Framework for Action*. As such, I partially fill this gap by exploring teens' perceptions of sexuality education in Nova Scotia high schools.

Chapter 3: Theoretical Framework and Methodology

Theoretical Influence

My theoretical framework is influenced by aspects of critical theory. Klein and White (2002) describe critical theories as “a diverse cluster of scholars and scholarship united by their criticism of positivistic science and many established ways of knowing” (p. 161). Guba and Lincoln (1994) elaborate on this definition by way of emphasizing that critical theories is a blanket term indicating numerous paradigms challenging the oppression that exists in society. In essence, critical theories are an intertwine of paradigms that evaluate marginalized situations and attempt to change social structures that subjugate individuals or groups of people (Guba & Lincoln, 1994; Klein & White, 2002).

Central to the supposition of critical theories is the concept of oppression. Oppression is action enabled through prejudice; it nullifies reality and prevents self-affirmation and change (Morgaine, 1994). Oppression, in the form of marginalization and exclusion, is something that Canadian youth have experienced when it comes to determining and assessing sexuality education programming. Historically, children and youth have not been seen as sexual beings; such values have led to youth being ignored with regard to learning about themselves as sexual beings or about sexuality at all. Moreover, not only are youth being blamed by society for being sexually active, they are also being exploited in the sense that society has created a situation that encourages and idealizes sexuality and sexual expression.

Through such avenues as religion and politics, society has over time instilled the ideology that youth are not expected to be sexual beings, often citing sexuality education

as encouragement for teen sexual activity. A system of conservatism, religion, and patriarchy was core to the high school system for many years. Although modern debate centers on whether or not sexuality education should be comprehensive or abstinence based, in past years it was a debate of whether or not youth should be exposed to sexuality education at all (McKay et al., 1998). In fact, it was only in the past decade that the Canadian Guidelines for Sexual Health Education named comprehensive sexuality education as one of the key principles.

The current context of sexuality education in the Canadian high school system still places youth on the bottom of the proverbial totem pole, with government, health groups, school boards, parents, and school officials all having the foremost say in sexuality education curriculum (McCall et al., 1999). With sexuality education curriculum being passed down by government officials (McCall et al., 1999) it is common that the input of youth is not solicited. Furthermore, Ministers of Education and Departments of Health are not asking students or parents if they are satisfied with the sexuality programming being delivered (McCall et al., 1999).

Essentially, youth are engaging in sexual activity, yet they are frequently excluded from the development of youth-based sexuality education. Current youth STI and pregnancy rates are two examples of circumstances that youth have participated in creating but it is difficult for them to change as a result of internalization of hegemonic values and beliefs around sexuality in teens.

Questions regarding sexuality commonly become internalized due to the fact that youth are not provided with an outlet to ask questions or are not comfortable asking questions because they are often afraid to deal with high school educators.

This research, which examined the experiences that Nova Scotia youth have had with sexuality education at a secondary schooling level, validates youths' perceptions of and experiences with sexuality education. Bearing in mind Comstock's (1982) method for critical research and Smith's (1995) notion of the *line of fault*, I carried out dialogue with a select group of Nova Scotia youth to determine their perceptions of the effectiveness of sexuality education in the Nova Scotia school system and to document their experiences.

Critical social science engages individuals in marginalized situations in creating social change (Comstock, 1982). Marginalized individuals are given the opportunity to enlighten society about their experiences, thus are able to influence social change (Comstock, 1982). This research contributes to that. It confronts the marginalization of youth in developing and evaluating sexuality education and solicits their input, providing them with the opportunity to express their views and describe their personal experiences about sexuality education in Nova Scotia.

Smith (1995) reinforces the importance of personal experiences in creating social change by means of accentuating the line of fault that exists between ideology, discourse, and the everyday worlds of those experiencing subordination. The line of fault assumes that "inquiry does not begin within the conceptual organization or relevances of the sociological discourse, but in actual experiences as embedded in the particular historical forms of social relations that determine that experience" (Smith, 1995, p. 49).

Essentially, inquiry begins with experiences, and letting the actors of those experiences be a part of the inquiry provides enlightenment (Smith, 1995). The conflict that exists between the ideology that youth are irrelevant to sexuality/sexuality education

and the reality that youth are engaging in sexuality education is one in which youth are losing. Youth are having sex, they are becoming pregnant, they are contracting STIs, and they are not always using contraceptives. It is essential that youth not be devalued in or excluded from the process of developing youth-based sexuality education for the reason that they inevitably have valuable input when it comes to designing programs directed towards them. As Smith (1995) suggests, “ideas produced by a ruling class. . . control the social process of consciousness in ways that deny expression to the actual experiences people have” (p. 55). Consequently, when reviewing youth-based sexuality education in Nova Scotia I relied upon discussion with those who necessitate and receive high school sexuality education—youth. By way of participating in dialogue with youth I shed light on their actual experiences with sexuality education.

Further, a line of fault also exists between the lack of sexuality education that youth get and the everyday messages that they receive from society. On one hand youth, are not properly educated about sexuality and either assumed not to be sexual or told not to be sexually active. On the other hand, sexuality is thrown at them with the message that engaging in sexual activity in their teen years is acceptable. Youth sexuality is sensationalized by society, for instance nearly half of the television shows most watched by youth have sexual content (Kaiser Family Foundation, 2005), yet youth-based sexuality education is not seen as essential, with only 15.5% of B.Ed programs in Canada teaching their students how to teach sexuality education (McKay & Barrett, 1999).

“Experts” such as teachers, parents, administrators, and churches control teens’ education without recognizing the discrepancy between professional forms of social relations and the reality of “actors’” experiences (Comstock, 1982; Smith, 1995).

“Experts” make decisions such as what should and should not be included in sexuality education curriculum without consulting the focal “actors”—youth—in sexuality education. Likewise, when developing sexuality education curriculum, the subordination of youth by persons who hold authority and influence enables unprotected sexual activity, STI infection, youth pregnancy, and other negative sexual outcomes. Essentially, society ignores the voice of youth by way of excluding them from a situation in which they are the key actors. Such exclusion creates a situation in which youth are afraid to ask questions about sexuality and are instead learning by doing.

Social structure is determined by the ruling class by means of ideas and images used to maintain domination and control of social relations (Smith, 1995). As a result of such order in social relations, not only are youth in the Canadian secondary school system left out of sexuality education construction, but they also receive sexuality education from educators who have often never received sexuality education themselves and do not feel comfortable teaching the topic (Brick, 1992; McKay & Barrett, 1999). In essence, Canadian high schools are faced with a situation where youth do not feel comfortable learning about sexuality and teachers do not feel comfortable teaching about sexuality. This is a systematic issue, and one that demonstrates the devaluation of sexuality education in Canada.

It is the responsibility of administrators, program developers, parents, and anyone else who is a part of the proverbial ruling class to ensure that youth are heard. Sexuality education needs to emerge from the needs of youth. It does not matter how many experts work to ensure that sexuality education is developed and available to youth if the experiences of youth are not incorporated into the programming. If society does not listen

to what it is that youth want to learn about sexuality, it is are merely reinforcing the values of those who develop the sexuality education curriculum.

Subsequently, this research provided youth with the opportunity to communicate their perceptions of sexuality education in the Nova Scotia secondary school system through a method of dialogue (Comstock, 1982). To ascertain youths' perceptions of the effectiveness of sexuality education at the secondary schooling level I used qualitative research methods. Qualitative research explores the way that the social order functions, offers awareness, and presents insight into everyday life (Berg, 1998; Comstock, 1982; Tesch, 1990). Likewise, the research relied on dialogue to engage participants in the research process (Comstock, 1982; Smith, 1995) and discover how they feel about the sexuality education curriculum they have experienced in Nova Scotia.

Sample

The sample for this study was ten university students who attended high school in Nova Scotia in the past three years and were at least nineteen years of age. This cohort of individuals was chosen because they would have experienced sexuality education curriculum at the secondary schooling level recently and would be able to recall their experiences when prompted by interview questions.

Participants were not asked to specify their age, however, based on when they graduated and the fact they had to be at least nineteen years of age to participate, it can be inferred that participants ranged in age between 19 and 21. Of the ten people who were interviewed, eight participants were female and two were male. Seven of the participants graduated from high school in 2004, two graduated in 2005, and one graduated in 2006. Participants attended high school in five different counties of Nova Scotia: five

participants were from Halifax County, two from Kings County, one from Queens County, one from Cape Breton County, and one from Digby County. All participants indicated that they had received no sexuality education since completing high school. When asked, six participants indicated that the last time that they had received sexuality education was three years ago, two said that it had been four years, and two indicated that it was in high school but could not recall the grade level.

The sample was selected using non-probability purposive sampling (Berg, 1998; Bernard, 2000). The sample was selected using this method because the informants had to serve the purpose of the study, which is to evaluate sexuality education in Nova Scotia from a youth perspective. Notably, it was important that the informants had experienced sexuality education at a secondary schooling level within the last three years so that the results of the study were recent and applicable to curriculum change.

Access to the sample was gained in two ways: (a) by making announcements in pre-approved classes at Mount Saint Vincent University, and (b) by putting up posters in the academic buildings at Mount Saint Vincent University. First, second, and third year classes were chosen because they had a concentration of students who were 19-years-old and older and had graduated from high school in the past three years enrolled in them; thus students enrolled in these classes were more likely to fit the demographic for my study. It was decided to post posters because it was a way of displaying information to the entire on-campus community.

E-mail contact was made with the professors of five chosen classes to gain permission to enter their classrooms during class time to describe the study at hand and seek out participants. When speaking to these classes it was emphasized that (a)

participation was voluntary; (b) information collected was confidential; and (c) to participate students must have attended high school in Nova Scotia in the past three years and must be at least 19 years of age. All students in the classes were given a brief description of the study, both verbally and on a small slip of paper, along with an e-mail address at which they could contact me and make arrangements for an interview if they wished to participate. Appendix A cites the invitation to participate in the study.

Posters (see Appendix B for an example), which were placed in Seton Academic Centre, Evaristus Hall, and the Rosaria Student Center, provided information about the study and eligibility information for prospective participants. The same e-mail address and procedure that was used in classroom recruitment was presented on the posters. To ensure that the posters were not overlooked they were colorful, creative, and several were larger than a typical 8 by 11 poster.

Interview Procedures

Information was collected using face-to-face semistandardized interviews (Berg, 1998). Semistandardized interviews, also known as semi-structured interviews, use an interview guide that covers an array of topics using prearranged questions, yet there is room for the interviewer to probe the respondents for further information (Berg, 1998; Bernard, 2000). The probing questions can be either pre-determined, or unscheduled, a result of necessitating more information than the respondent provides when answering the standardized interview questions (Berg, 1998).

Face-to-face interviews were selected as the method of data collection for several reasons. If the respondent did not understand a given question, or if they gave short ambiguous answers to the interview questions, I was able to probe for additional

information. This was particularly important to the topic at hand. Given that sexuality is often a sensitive topic, it was often the case that respondents did not want to get into great depth with their answers. By using a semi-standardized interview schedule I was able to ask additional questions to attain in-depth responses. Moreover, given that the sample size for the study was relatively small it was important that I gained as much information as possible from the ten students who participated (Bernard, 2000), and face-to-face interviews helped facilitate this. In addition, with face-to-face interviews I was placed in the room with the respondent, which provided assurance that the person who was supposed to be answering the questions was actually answering the questions (Berg, 1998; Bernard, 2000).

Questions in the interview schedule were open-ended to allow for a variety of responses, with the exception of closed-ended questions used to gain identifying information, such as when the student graduated from high school. Open-ended questions were important to the research at hand because I was attempting to draw together the experiences of youth with sexuality education curriculum—the respondents had to be able to express their feelings, views, and opinions in order to communicate their experiences. The questions in the interview schedule focused on (a) availability/accessibility of sexuality education resources and the promotion of healthy sexuality, (b) the knowledge reflected in the sexuality education programming, (c) the sexuality education facilitation process, and (d) respondents' attitudes surrounding sexuality and sexuality education.

The interview schedule (see Appendix C) consisted of *essential questions*, *extra questions*, and *throwaway questions* (Berg, 1998). Essential questions centered

specifically on the research question and elicited compulsory information (Berg, 1998), (i.e., *Can you tell me about your sexuality education teacher?*). Extra questions were similar to the essential question, but they were worded differently to ensure that the respondents fully answer the questions being asked (Berg, 1998). In this case, extra questions were incorporated into the probing questions, such as *how do you feel about that?* Throwaway questions were questions that could have been included to build interviewer-respondent rapport if the respondent became uncomfortable (Berg, 1998). For example, incorporating a question such as *I forgot to ask you, did you have a text in your sex ed class?* subsequent to a sensitive question that had obviously made the participant feel uncomfortable may make them feel at ease as opposed to on edge. All participants were asked the same sixteen core and numerous probing questions. Probing questions varied by the comfort level of the interview and the flow of dialogue. Most all participants were asked all of the probing questions identified in the interview schedule. Throwaway questions were included in my interview schedule to allow me to maintain a level of comfort while still staying on subject. However, ultimately I did not need to use these questions. There were incidences during probing when there was a level of discomfort, however, I opted to discontinue probing as oppose to asking throwaway questions.

All interviews were tape-recorded and each respondent was asked to sign an informed consent form (Appendix D) prior to the start of the interview. At the beginning of the interview respondents were told that their participation would be kept confidential, and that they did not have to answer any question that they do not feel comfortable answering. Additionally, the respondents were made aware that they were permitted to

opt out of the interview at any time if they felt the need to do so.

Data Analysis

The information gathered during the interview process was analyzed using grounded theory techniques (Bernard, 2000). Grounded theory is a deductive approach to qualitative research whereby the researcher does not set out to support a theory. Rather, the researcher starts with an area of study and theories and themes emerge throughout the data collection and analysis process (Strauss & Corbin, 1990). For the purpose of my research grounded theory techniques were used to pull the data together, placing particular emphasis on identifying themes and linking them together (Bernard, 2000) rather than developing a theory.

The first step in analyzing my data was producing transcripts of the interview recordings (Bernard, 2000). I subsequently read the transcripts from each of the interviews to become immersed in the data and see what themes and ideas emerged, a process known as *open coding* (Bernard, 2000). During open coding I identified as many central ideas, words, and phrases as possible as the purpose of open coding is to stimulate ideas (Dey, 2004). Further, when reading the transcripts I highlighted repeated ideas and relevant text (Auerbach & Silverstein, 2003). Open coding was not conducted using a software program or computer. Rather, it was conducted using the ocular scan method, which involved eyeballing the text and marking it with highlighter pens (Bernard, 2000). The identified themes and ideas were tracked via memoing. Memos allowed me, as the researcher, to keep running notes about the direction of my analysis, impending *axial coding* (Bernard, 2000).

Once I had a feel for the data I proceed to code the text using axial coding, which

is a process used to connect categories and ideas that have been identified through open coding (Dey, 2004). Central to axial coding is the idea of constant comparison, whereby connections, consistencies, and inconsistencies amongst the data are highlighted and categories and subcategories are identified (Dey, 2004; Strauss & Corbin, 1990). Axial coding typically involves a number of steps essential to developing a theory (Strauss & Corbin, 1990), however, I did not develop a theory and I used axial coding to identify themes amongst the interview transcripts and linked those themes together.

The third and final step in analyzing data using grounded theory techniques is a process known as selective coding (Strauss & Corbin, 1990). In selective coding, specific code notes, theoretical notes, and diagrams are used to systemize the relationship between the themes and categories identified through axial coding and subsequently develop a theory or theories (Strauss & Corbin, 1990). Given that I did not set out to develop a theory I did not complete selective coding.

Ethical Considerations

The study at hand had minimal ethical risks. Nonetheless, there were ethical considerations warranted by the research described. All participants were made aware that participation in the study was voluntary, in particular it was emphasized that if they were not comfortable with a topic they had the right to pass on any questions or to withdraw from the study. Participants were also informed about the nature and the goals of the study prior to volunteering and preceding their interview. All participants were informed that the interview recordings and transcripts would be kept in a locked filing cabinet separate from their informed consent forms, and as such no one other than my thesis advisor and myself would have access to them. Further, they were made aware that

all audio recordings and informed consent forms would be destroyed within one year of the completion of the study and that the interview recordings and transcripts would be marked with a pseudonym rather than the name of the participant. Additionally, all participants were told that identifying information about them would be removed from their interview (e.g., other people's names or towns blocked out) when transcribing.

Participants were asked not to reveal identifying information in their interview, such as their name or the high school they attended (in the case that they did reveal such information it was not transcribed). Participants were given the right to withdraw any information that they had given at any time, and the right to refuse to answer any question. Participants were also informed that they could request a break at any time during the interview if they deemed necessary, and they were asked not to describe personal sexual experiences.

I interviewed participants on campus in an area that was private, where participants felt comfortable and would not be identified with the research. This area was selected to protect the confidentiality of the participants.

Finally, given that the participants were volunteering and that the research had potential to trigger uncomfortable memories, all participants were given contact information for Mount Saint Vincent University counselors in the informed consent form. Participants were informed of the location of the school counselors' office and given referring information in the case that they needed to talk to them following the interview, or upon reflection of the interview. Further, I contacted the counseling office at Mount Saint Vincent University prior to conducting the interviews to inform them of my study and the possibility that participants may be contacting them. Notably, all registered

students at Mount Saint Vincent University have access to the school counselor and it was not necessary for me to make arrangements for the participants to visit if they so needed.

Chapter 4: Results

Ten youth who attended high school in Nova Scotia expressed a number of common opinions about sexuality education in Nova Scotia high schools. Individually each youth enlightened me about their experiences with sexuality education, however collectively it was evident that (a) sexuality information was limited in its coverage; (b) sexuality education facilitators seem unprepared to teach sexuality education; (c) students desired sexuality education resources; and (d) sexual health (Health Canada, 2003) did not seem to be promoted in Nova Scotia high schools.

These Nova Scotian youth recognized that their sexuality education is ineffective and in need of improvements. From content to facilitation these youth believed that administrators need to pay closer attention to the lack of sexuality education in Nova Scotia's classrooms. Throughout their interviews, they identified strengths, weaknesses, and possible improvements to sexuality education. These youth indicated that they want to learn about sexuality, need sexuality education resources, desire trained facilitators that *want* to teach youth about sexuality, and need and want sexual health promoted at their high schools.

Sexuality Education is Limited in its Coverage

Youth expressed a variety of opinions about the sexuality education that they received in high school. Some youth felt that it was positive and others felt that there was nothing positive about it, some were satisfied and some were not, some felt that their sexuality education was thorough and some felt that it was brief, and some were simply annoyed with the sexuality education that they received in high school. Cumulatively, they identified twelve different topics that they learned about in high school sexuality

education, but repeatedly acknowledged the fact that the sexuality education that they received was brief and insufficient. Fay, a 2004 graduate from the South Shore, pointed out that “anything that was touched on it was so briefly touched on that I don’t really remember it. The course wasn’t long enough, there wasn’t enough time spent on anything”. Lori, a 2006 graduate from the Halifax Regional Municipality described the sexuality education that they received as being “really vague”: “It was really vague. There is not enough information in it, like they need to go more in detail, especially where people are getting pregnant and there is [sic] probably people who are getting STDs and don’t know”.

Participants commonly expressed frustration with the lack of information that they received with regard to certain topics, one of whom expressed extreme frustration about her sexuality education as a whole. Abby, a 2004 Queens County graduate, expressed frustration that “The sex ed part was just pushed aside or left to the end. We were all pretty annoyed with it”. A second student, Cody, echoed this dissatisfaction:

Well, I just don’t feel it was sufficient, you know? Everything was done in, I’d almost say weak circumstances, the [sexuality education teacher] never really approached it with a lot of respect, it was almost as if it was a joke to him too, maybe because it was embarrassing.

When asked if they had learned about body image, over half indicated that they had not. Students who did learn about body image said that they had learned about such topics as everyone’s body being different, eating disorders, and the media. Hannah, a 2005 graduate from Kings County, stated:

Like how, well we learned, I don’t know if you’d say body image, but like ah, eating disorders, how and why people have eating disorders because they do want to have the images [sic] that there is [sic] in the media. That was [sic] really the only things [sic] that we learned about body image.

Though not asked specifically, a number of participants indicated that they had learned about the male and female anatomy through their high school sexuality education, and most participants did not express an opinion about the fact that they learned about human anatomy. Nonetheless, a small number of students did imply that learning mostly about anatomy was not an adequate amount of sexuality education and one student did comment that she felt that the male body was covered more than the female body.

All but one of the participants indicated that they had not learned about relationships in high school sexuality education or had only briefly touched on the topic. There were no commonalities identified when students discussed what they learned about relationships. However, most students identified what they should have learned with regard to relationships as opposed to what they learned.

A majority of the participants who were asked if they had learned about personal decision making said that they had, most of who indicated that what they had learned was brief. Emma, a 2004 graduate from Halifax, said that she had “learned a little” but that it was “to do with career choices and that sort of thing”. However, participants mainly indicated that they had learned about personal decision making with respect to engaging in sexual activity. Cody, a 2004 graduate from Halifax:

Well, just like the fact that they are huge decision, especially at that age, they know that teens are very impressionable and I think that they try to instill that, that you don't have to do those things that you might regret later.

Most participants indicated that they had learned about sexual assault in high school, three students made a point of stating that what they had learned was brief and/or inadequate. For instance, Lorie stated that “they didn't tell us how to react, but they did

basically explain that it was anything that made you feel uncomfortable that didn't seem right". Similarly, Emma felt that they "basically just classified it by saying if this happens to you this is, you know, sexual harassment or sexual assault or whatever". Two of the ten participants indicated that they had not learned about sexual assault at all.

When asked if they had learned about sexual orientation in high school sexuality education, only four participants said that they had, two of whom indicated that it was briefly covered. Participants who did indicate that they had learned about sexual orientation stated that they had learned about such topics as attitudes and prejudice and what sexual orientation is. Students who said that they did not learn about orientation were bothered by the fact that it was not covered. With exclamation, Hannah stated: "*No!* That's a really, or you mean like whether someone is gay or bisexual? That was never talked about ever, it's like the unknown, no one discussed it, and it's horrible. Teachers didn't even accept it or want to accept it".

Nearly all of the participants said that they had learned about pregnancy in high school sexuality education, most of whom still acknowledged that this topic was only covered a little. When asked what they learned about pregnancy, responses commonly alluded to the use of contraceptives as a preventative measure. A number of students identified "options" such as abortion, adoption, and keeping the child as a topic that was covered with regard to pregnancy. Abstinence was also referred to when asked what was taught about pregnancy. By and large interviewees named contraceptives and abstinence as the two biggest focus of pregnancy education. Devin indicated that he "learned very fast that condoms are so important. Contraceptives and diaphragms, birth control, the female condom, um, stuff like that". Abby, on the other hand, indicated that "abstinence

was kind of pushed, it was kind of like out of sight and out of mind kind of thing, like, ‘Oh none of you are pregnant, so’”.

Most participants said that they had learned about contraceptives in high school. When discussing contraceptives a few participants said that they had learned how to put on a condom. For the most part, however, participants indicated that they had learned about available birth-control methods and how to use them or where to access them. Nonetheless, Emma was one of the majority of students who did not feel that there was enough attention paid to contraceptives, she said that “they just kind of mentioned [what] it was [with] a quick little picture on an overhead saying this is what this is and then they moved on”. A small number of participants said abstinence was the focus of their contraceptive education. Fay learned that safe sex was equated to not having sex at all; she indicated that her sexuality education teacher “just said that the safest way or whatever is abstinence, you know that little slogan that they all know”.

Learning about one’s self is a topic a small few participants identified as a part of the high school sexuality education. Devin, for one, said that “There was a lot of like, a lot of talk about the self, there was a lot of self involved, like don’t let others influence you, um just kind of with if you don’t want to then you don’t have to”.

Nearly all participants indicated that they had learned about STIs and AIDS in high school; however, exactly half of the participants indicated that AIDS was not covered in detail. STI education emerged as an exceedingly common response when discussing what participants had learned in their high school sexuality education. The depth of the coverage regarding STIs and AIDS was an exception, given that students did not proclaim that any other topic was covered in depth. Nonetheless, the depth of the

coverage varied from participant to participant, but for the most part participants were satisfied and were able to recollect and explain a lot of what they had learned about STIs. “Ah, it was probably the biggest thing that we learned about. We learned about a lot of things, like chlamydia, syphilis, herpes, ah crabs, gonorrhea, and stuff like that”, proclaimed Devin.

When asked if they had learned about vaginal sex in high school sexuality education most said that they had. When asked what they learned about it, participants commonly referred to STIs, pregnancy, and contraceptives. For instance Isabelle, a 2005 graduate from the Halifax Regional Municipality, said that her teachers “really didn’t go into detail with [vaginal sex], like here’s the contraceptives and here’s the STDs”.

Five of the ten participants said that they had not learned about oral sex through their high school sexuality and five said that they had. Most of those who said that they had learned about oral sex said that they only “kind of” learned about it. Though she was not satisfied with the depth of her oral sex education, Isabelle said that, “Yeah, they did mention it when they talked about like, they talked about dental dams and yeah, so I guess when she was talking about contraceptives she talked about it very short”. A number of the participants who answered “no” to this question did so with exclamation, so as to indicate that oral sex was positively not a topic that would have been covered at their high school. Becca, a 2004 graduate from a Halifax high school, was one of these students, she said:

No, oral sex and that kind of stuff were never talked about. But um, a lot of stuff is so common in high school and even junior high for some people and it is something that teachers know that you’re doing, and yet it’s also, like something that can really spread STIs and yeah, like there is no information given about it. [It] has to be ingrained maybe at a high school level or junior high or elementary level then maybe it wouldn’t be like tacky or weird. I think it’s kind of like

horrible that they don't talk about it.

Essentially, all participants did identify at least one component of their sexuality education that they were satisfied with; however, few of these participants merely felt that it was positive that they had received any sexuality education at all. For instance, Becca felt that the “. . . positive was that, like we actually had it, I guess that's better than not having it, and I mean I don't think they were intentionally trying to like skip over it either”. Many of the same youth who felt that the mere existence of sexuality education was a positive thing also gave the impression that they recognized that adults rule the school system and as such youth are commonly viewed as negligible.

There was one student whose experiences were an exception to this theme. Devin, who attended high school in Kings County, was the only participant who expressed near complete satisfaction with the sexuality education he received in high school, describing it as “very good”. Notably, Devin indicated learning about all topics that were asked in question five of the interview schedule. He was also by and large satisfied with the sexuality education teachers and the sexuality education resources that were made available, and at no point referenced being left out or talked down at, something referenced repeatedly by those who were less satisfied.

Um, they allowed us to understand, um we, we were allowed to know the precautions to be taken, what could happen, what should happen. Physically, we knew about or bodies, we knew what each person had, we knew that everything is not the same so you were comfortable with it, um to and extent, as comfortable as you could be, there is nothing that you can do to change that. Um, emotionally you, if, in order to become comfortable with it, it allows you to be confident and more happy, if you're not comfortable with yourself, you're going to be depressed, not going to like what's going on. The socio, the social, if you like, you know, you don't have to have sex, but if you are having sex you know that you shouldn't, it shouldn't be a big deal almost, and if you are having sex and a precaution isn't taken and you do develop something let your partners know what's going on.

In general, however, students generally described their sexuality education as “empty”, “brief”, and “horrible”. Moreover, a small number of participants actually described their sexuality education as being practically non-existent. Others indicated that there was nothing positive about the sexuality education that they received. Abby stated: “Um, I don’t know, it wasn’t very positive, I don’t, I never felt positive about it at all, like I would go home and complain to my parents and be like, ‘This isn’t cool, we’re not learning anything’”.

Typically respondents were satisfied with specific components of the sexuality education and offered suggestions for improvements to sexuality education curricula. Cumulatively, they identified twelve topics that they think should be covered in high school sexuality education. These topics are similar to the topics that participants identified as subject matter they learned about, but they also felt that the topics should be covered in high school sexuality education and/or covered in more depth.

A number of participants felt that there should have been more of a focus in their high school sexuality education on body image. Two of the most common themes that were identified in this regard were being comfortable with one’s self and the role of media. Fay felt that:

[You should learn] that you’re beautiful no matter what! I hate the media, the media makes people feel like they’re fat, ugly, useless and worthless, I don’t like that. Um, school definitely should touch on it a lot more and maybe incorporate like how to evaluate the media, I don’t know.

Participants commonly identified areas that they feel should be covered when discussing relationships, including how to have healthy relationships, same-sex and opposite-sex relationships, equality, and communication. Emma and Fay, respectively,

said:

Well we should have [learned about relationships], because you know there are homosexual and heterosexual relationships and everything, and we didn't cover that at all, and I think it's important to learn those things.

Um, communication definitely, especially for high school kids cause with them a boyfriend or a girlfriend is basically someone to hold hands with, make out with, and then from the guy's point get with. And then [with] relationships, communication talking, equality, um pretty much just like the main points of having a relationship but teach it on like a high school level, instead of a university level or adult level.

Another area that was identified as needing to be covered in high school sexuality education was personal decision-making. In particular, a number of participants felt that personal decision-making should cover the decision to engage in sexual activity and knowing which decisions are good for them and which ones are not.

You should be able to know like what decisions are going to be good for you, what decisions are going to be bad for you, how you should go about analyzing a situation to decide on a decision you're going to make, for sure.

All participants at some point in their interview wanted better sexuality education with respect to contraceptives. The most common ideas expressed were having access to and/or learning where to access birth control, and learning how to use birth control. Lori felt that "in high schools people should actually have access to contraceptives and people to go talk to about what's available and stuff like that". Interestingly, students commonly associated contraceptives with birth control and not STI protection. Further, when discussing STIs and AIDS students commonly referred to learning about the after-effects of STIs and AIDS as appose to preventative contraceptives. Hannah was one student who clearly stated that she was not taught about STD prevention by using contraceptives, she said: "Even if you do wear condom, if it's not efficient then you can still get an STD [and] that was never told to us ever".

Notably, one participant repeatedly expressed interest in learning more about abstinence in high school sexuality education. Isabelle did not feel that abstinence should be the only thing taught, but that it should at least be presented as an option.

I kind of got the impression that it was, I know years ago they use to teach about abstinence, I kind of felt they were trying to pull away from that. I just think definitely we should have, they should have made abstinence an option, make it more appealing to not have sex.

No other participant expressed an interest in learning about abstinence. In fact, most participants felt that sexuality education focused on abstinence too much.

Pregnancy was a theme expressed by several participants when referring to what they feel should be taught in high school sexuality education. A number of participants referred to a high teen pregnancy rate at their school and/or in Nova Scotia as a reason that they should be teaching about pregnancy in high schools. Hannah stated:

I think that so many young people from my high school did get pregnant, a lot of young, I look back now, like I have friends who I went to high school with that have children, same age as me, but I was just talking to my friend the other day and she's seventeen and she's pregnant, so is her friend and it's because they still don't have any sex education.

The need to learn more about pregnancy in high school was also expressed when participants referred to the need to learn about contraceptives.

Even though students were generally pleased with their STIs and AIDS education, they also made suggestions for improvements to the profundity of STI and AIDS education in Nova Scotia's high schools. Participants felt that they should have been taught more with regard to such things as how STIs and AIDS are contracted, side effects, where to go to talk about STIs and AIDS, how and where to get tested, treatment methods, and societal attitudes surrounding AIDS. Hannah felt that her teachers "should have explained like, this is what chlamydia is, this is the side effects, sometimes you

don't even know if you have side effects, like go get checked out about it and yeah".

Emma agreed, feeling that:

It definitely should be covered cause a lot of people don't understand AIDS itself really because they don't understand how it is transmitted or anything, so a lot of prejudice I think goes in when somebody finds out that someone else has AIDS, it's kind of like a lot of big bold neon letters saying 'negative' sort of thing and it's really not that bad, I mean you can hang around this person or whatever, so yeah.

Most respondents identified a need to learn more about sexual orientation. Areas that participants felt should be covered with regard to sexual orientation included possibilities, resources, self-choice, relationships, and societal attitudes.

I think that definitely sexual orientation cause a lot of people are really homophobic and stuff like that and I think there is a problem with people being kind of ignorant and stuff like that, so I think it should be covered.

Most participants reinforced the importance of having sexuality education including information on sexual assault at one or more points in their interview. Some of the topics that participants felt that high school students should learn about were rape and date rape, what constitutes sexual assault, how to react, where to go if assaulted, who to talk to, self-help, and the emotional, mental, and physical impact of sexual assault.

That is something that should be covered completely, like some people, especially in high school, you get like some high schools, my high school had grade nine, so those young people, male or female, don't know maybe that they were sexually assaulted, they may think that it was their fault and they asked for it or something and don't know what it is and what they can do about it.

Vaginal sex, anal sex, and oral sex were all identified as areas that were insufficiently covered in high school. In fact, one-half of the participants acknowledged that they should teach more about oral sex in high school. Devin made the following point:

Anal sex occurs with both same sex and heterosexual couples and that should be,

cause that's a very dangerous form of sexual activity, so that should be talked about too and like people experience [it] and they could do some serious damage.

Becca was frustrated that they did not learn more about oral sex:

Hardly anyone I know uses a condom when performing oral sex or uses a dental dam or any of that stuff. I think it has to be ingrained maybe at a high school level or a junior high level or elementary level. I think it's kind of like horrible that they don't talk about it.

When expressing their opinions about their high school sexuality many participants were keen to point out that youth *are* engaging in sexual activity and it needed to be recognized when delivering sexuality education, reinforcing the current marginalization of youth in the development of sexuality education curricula. Becca stated:

They just assumed that we didn't know and weren't doing, I guess, what was already going on and I feel like they could have applied more meaning if they would have actually realized, like you know, a majority of these guys are probably already fooling around and you know this isn't safe, this isn't safe.

Clearly Becca, like the majority of the other participants, was not pleased with her sexuality education teacher for not applying adequate meaning when teaching about sexuality.

Teachers Seem Unprepared to Teach Sexuality Education

Interviewees were by and large disappointed with their sexuality education teachers. In particular, they felt that their teachers were uncomfortable and reserved when teaching sexuality education. Fay was one participant who felt that her sexuality education teacher was uncomfortable teaching about sexuality:

[He/she was] very nervous, very shy, especially when it came down to the nitty gritty of talking about sex itself and facts of like all kinds, very shy, face got beat red, like if you're going to teach it deal with it.

Participants frequently assumed that this discomfort was associated with the fact that

their teacher was not trained to be to a sexuality education teacher. Those who were taught sexuality education by a guest facilitator, such as the school health nurse, were generally pleased with their sexuality education facilitator.

In addition to feeling that their teachers were uncomfortable, a number of participants also felt that their teacher's disinterest in teaching sexuality education was associated with a lack of training. A few participants also felt that their teachers' discomfort impacted students' comfort level when learning about sexuality and how students perceived the sexuality education that they received. Lori felt a sexuality teacher "should be comfortable because if she isn't, by her feeling uncomfortable it's going to make other people feel uncomfortable". Hannah felt that her teacher's lack of training impacted the sexuality education that she received: "Yeah, she was really uncomfortable, like just, she was a gym teacher, what she felt like was a gym teacher, she wanted to be a gym teacher, she's not interested in teaching us anything at all basically". Notably, a few of the students who made reference to their teachers' uneasiness addressed the fact that school boards and/or politicians are the ultimate authority and the reason that their sexuality education was inadequate. Fay stated:

It needs to be a year-long course. You should not be taking any random teacher. I understand that the education committee people of Nova Scotia don't have much money, but maybe they should be taking the money and putting it there and hiring people who are specialized in the subject because there are people everywhere that could teach this subject.

It was also common for students to note that their teachers did not offer satisfactory, if any, responses to questions that were asked regarding sexuality. Moreover, there were seldom opportunities for questions to be asked. A few students remarked that questions were never asked, and several felt that this was due to their teacher's

discomfort and lack of interest. Isabelle clearly stated that in her sexuality education class “you wouldn’t really feel comfortable to ask a real question”. Additionally, Hannah said that in her sexuality education class:

If someone had a question, like “Ok, so can you get pregnant the first time you have sexual intercourse?”, which was never mentioned, I don’t think someone would have even asked that and she would have thought that was something that you shouldn’t have asked and she shouldn’t have to give an answer, like I can’t even imagine what she would have said, probably that we can’t discuss that because it’s [an] over[ly] controversial issue.

Participants who had a guest facilitator, such as a health nurse, teach their class were typically more satisfied with their sexuality education facilitator. They generally reported that guest facilitators were comfortable, approachable, and knowledgeable.

Becca and Emma, respectively, offered the following comments:

We had someone come in once and she demonstrated how to put on condoms and that was probably the best sex ed class that we had and that was also the same class that all the pamphlets were handed out.

We actually had someone to come in and do a presentation for the class and she was very comfortable talking, I think this is what she did for her career, she went around and did sex talks, and she was very willing to have us learn.

When discussing facilitation, a number of participants felt Sue Johansson, from the *Sunday Night Sex Show* and *Sex with Sue*, would have been an excellent guest speaker.

Participants felt that she was knowledgeable, comfortable, and confident. Sue Johansson was referred to in four interviews. Lori stated:

She’s kind of an icon, everybody knows who she is and so when they think about someone who knows a lot about sex they think about her, like that’s what I think about, and she doesn’t seem like the kind of person who would make people feel uncomfortable, and she’s kind of a little bit funny at the same time.

Though Sue Johansson is a costly guest speaker and likely unavailable to speak at all Nova Scotia high schools, students’ opinions of her material are a good indication of

what they are looking for in sexuality education. Further, high schools could provide students with resources material reminiscent of the material that Sue Johansson provides at her talks.

Students Desire Better Sexuality Education Resources

Having access to sexuality education resources in high schools was a topic that was discussed frequently by all interviewees. Most participants did reference at least a few sexuality resources that were available to them when they were in high school. Devin stated:

Yeah, there was always a poster like, um, about pregnancy always a poster about that, and like during like, there is a certain time of year about AIDS, like awareness week, um, there was always a poster about that, but there wasn't even any really big ones that I can remember.

Every participant made suggestions for improvements to sexuality education resources in high schools; a number suggested that students should have access to contraceptives in high school and that there should be sexuality resource rooms. Hannah felt that there should be an accessible and comfortable sexuality resource room, she said:

I think pamphlets should be available, like if there was a student services place in like a little office, and there should be a section in there where you can pick them up or maybe have a room like the one where always the door was closed and you can go in and take pamphlets and have them. And maybe they could be on sexuality and things concerning sexuality and other things as well, so people see you in there they don't think oh well they're in there getting information on sex, maybe have all kinds of pamphlets. Make it a little bit more comfortable so that people get more comfortable to go in there.

Participants' general opinions about the sexuality education resources that were available in their sexuality education classes and at their high school, in general, varied.

Grace, for one, felt that sexuality education resources should be less hidden, she said:

I think that the resources have to be more like opened up, not so much behind closed doors, like in the counselors office or in the health clinic. You should be

able to just walk down the hall and see a poster.

The most common sexuality education resources that were referenced by students were films, pictures, brochures, posters, and booklets. All participants mentioned that they had access to at least one of these resources and suggested that having access to one or more of these resources in high school is beneficial.

Films that were shown to students were about living with HIV, giving birth, pregnancy, and sexual orientation. A number of students, such as Becca, commented that the videos that they were shown were ineffective and outdated:

We never talked about things, we would basically just read the pamphlets, listen to the teacher and sometimes watch a video, and if we talked about the video it would be really superficial things, like they wore 80s clothes, we never talked about what happened really.

Pictures were generally used as a learning tool in the classroom. Participants commented that they were shown pictures of STIs, contraceptives, and male and female anatomy. Students did not offer opinions about the effectiveness of using pictures when teaching about sexuality. However, a number of participants did mention that the pictures of STIs that they were shown were unpleasant, using such descriptions as “gruesome”, “disgusting”, and “left many running and screaming”.

Pamphlets were referred to as a learning tool in the classroom and a sexuality education resource that students could access at their high school. Cumulatively, participants received pamphlets on a wide range of sexuality related topics, such as STIs, sexual assault, pregnancy, and contraceptives. Participants generally commented that pamphlets were useful sexuality education resources. A number of participants felt that it would be beneficial to have more sexuality related pamphlets available in high school. Isabelle made the point that “if you’re not comfortable talking to someone then it would

be nice to just pick up a brochure and discreetly read it”.

A number of participants felt that having sexuality education posters posted in high school was a valuable resource, however a few did not. Hannah felt that “the more people that see it are going to look at it and start to think about it”. However, Lori did not have the same opinion: “Um, my experience with putting posters up isn’t very good, people tend to rip them down or draw on them and stuff like that as a joke, so I don’t think they are taken seriously”.

A few participants said that they had sexuality education booklets available to them but did not typically offer an opinion about the effectiveness of the booklets. Several did comment that booklets were a good resource but it was also necessary to have someone to talk to about the booklet. Lori was quick to state that “like you can’t just pass around a book and expect people to read it, you have to get it out there and say it”. Interestingly, interviewees who referred to the *SEX!* booklet made available by the Nova Scotia Department of Health Promotion in 2004 had mixed opinions about the book. Hannah said that she “learned a lot from that book, it tells you everything you need to know really”. However, Lori “felt it was too vague. It was just common sense, like with the definitions and that sort of thing, like my class kind of made jokes about it after”. Essentially, although those who had used the resource felt that *SEX!* was a useful resource, some felt that it was ineffective, suggesting that book alone may not be helpful in the face of ineffective sexuality education programming. A few participants, such as Isabelle, expressed frustration about the debate that surrounded the *SEX!* booklet because they believed that adults were holding youth back from learning valuable information about sexuality.

I heard on the news, like I heard a guy, a politician, [say] that it was like a how to guide. I didn't find it a how to guide at all, it was nicely detailed but it wasn't overly comprehensive or anything. The book definitely helps. I don't find any part of it bad at all, like I don't know what they were talking about.

A number of participants acknowledged that having someone to talk to would have been an effective sexuality education resource. Participants referenced peer support and professionals, such as counselors and health nurses, when discussing having someone to talk to. Hannah feels that it is important “to have somebody that is educated, who knows what they're talking about and is comfortable with discussing it, comfortable answering questions and saying things that people normally don't want to say”. Hannah, also posed the question “if you don't have your parents to talk to and you don't have an educator at school to talk to, who do you talk to?”

Sexual Health is Not Promoted in Nova Scotia's High Schools

Prior to being asked about the promotion of sexual health at their high school, participants were asked to define sexual health. Not surprisingly, student's definitions were brief and none of the definitions fully encompassed the definition of sexual given by Health Canada (2003), which is “a state of physical, emotional, mental, and societal well-being related to sexuality” (p. 5). One participant was not able to give a definition, stating that they did not know. This person was given additional time to think about an answer but still was not able to give a definition.

Other respondents associated sexual health with such things as being comfortable with one's gender, having protected sex, having healthy sexual relationships, being physically and mentally prepared to have sex, keeping one's body clean, being comfortable with one's sexuality, and taking care of one's genitals. Becca and Devin, respectively, offered the following definitions:

Sexual health, um I would define it as including from how you would identify in your gender and sexuality and like um, to being safe. I don't know how I would put that in a definition, I guess just being careful and being aware of your sexuality and when you use it and what you do with it.

Um, being, being ah, physically and mentally, knowing the risks, knowing the precautions to take and what you're getting into by having sex, but at the same being safe and putting all that you know into effect. That way, physically you're protected and mentally you know you're protected, that's more of a security.

Participants were given Health Canada's definition of sexual health and asked if they felt that this definition was promoted at their high school. Devin was the only participant who felt that the definition was effectively promoted at their high school.

Yes. They allowed us to understand, um we, we were allowed to know the precautions to be taken, what could happen, what should happen. Physically, we knew about our bodies, we knew what each person had, we knew that everything is not the same so you were comfortable with it, um to an extent, as comfortable as you could be, there is nothing that you can do to change that. Um, emotionally you, if, in order to become comfortable with it, it allows you to be confident and more happy, if you're not comfortable with yourself, you're going to be depressed, not going to like what's going on. The socio, the social, if you like, you know you don't have to have sex, but if you are having sex you know that you shouldn't, it shouldn't be a big deal almost. And if you are having sex and a precaution isn't taken and you do develop something it let your partners know what's going on.

Most participants did not feel that the definition of sexual health was completely promoted at their high school, if it was promoted at all. Fay stated:

No, not at all. I think that's horrible, it's like the school board doesn't want to, I am not judging the school board I guess, but at the same time I am because they don't, cause they don't want to bring it into the school, they don't think it's important and it's too much of a hassle to get those parents that don't think that their child should be educated on sex at whatever age they are to accept it, and if you're going to have a sexual education class then you have to have it for all or for none and we just haven't got to that "for all" where we discuss everything.

All participants felt that it is important that healthy sexuality is promoted at the high school level. When asked, participants responded with such statements as "absolutely", "very important", and "for sure". "I think it should cause people are having

sex whether they like it or not and people are getting pregnant in high school”, said Isabelle. Participants suggested a number of ways to promote healthy sexuality in high school, including pamphlets, posters, booklets, sexuality resource rooms, talking about sexuality openly, having a health class, and having people who are trained to teach sexuality education facilitating sexuality education classes.

Summary

Overall, participants seemed to agree that their sexuality education did not satisfy what they would like to have learned when they were in high school. Four themes were apparent. Interviewees felt that the sexuality information that they received in high school was limited in its coverage. Although most participants realized that teachers have little control over sexuality education curriculum, they felt that their sexuality education facilitators were unqualified and uncomfortable. All youth interviewed expressed a desire to have additional and improved sexuality education resources in Nova Scotia’s high schools. In addition, it was clear from the interviews that sexual health, as defined by Health Canada (2003), had not been promoted in Nova Scotian high schools when these students were still in high school.

Collectively, participants did indicate that they had learned about a variety of topics in their high school sexuality education class, but for the most part felt that there was much more that they should have learned. In general they were not satisfied with their sexuality education teachers and felt that sexuality education guest facilitators, such as the school health nurse, were better sex educators. Most participants did name at least a few sexuality resources that were available to them when they were in high school, but all indicated that there should have been additional resources. Only one participant said

that Health Canada's definition of sexual health was adequately promoted at their high school, and all participants felt that it was important to promote this definition at a high school level.

Chapter 5: Discussion

This study was influenced by aspects of critical theory with the purpose of examining youths' perception of high school sexuality education in Nova Scotia. Using semi-structured interviews, this study gave ten youth who had graduated from high school in Nova Scotia within the past three years with the opportunity to candidly discuss this topic. For years youth have been excluded from the process of developing and evaluating sexuality education curriculum in Nova Scotia. The present study recognized this segregation and provided these youth with the opportunity to comment on the sexuality education they received in high school, a process typically reserved for adults. Several themes emerged out of the data: (a) sexuality education is limited in its coverage, (b) teachers seem unprepared to teach sexuality education, (c) students desire better sexuality education resources, and (d) sexual health is not promoted in Nova Scotia high schools. The results were consistent with earlier Canadian studies in which Nova Scotian youth felt that there should be better coverage of sexuality education (Fisher et al., 2001; McCall et al., 1999). This reinforces the reality that there is a line of fault (Smith, 1995) between the ideology, discourse, and the everyday worlds of youth as sexual beings. Youth are often powerless when developing and assessing sexuality education and as such find it difficult to get their voices heard. Using dialogue as a step toward breaking out of the self-defeating behaviour (Comstock, 1982) of silencing youth, this study enabled youth to give expression to the actual experiences they have had with sexuality education.

In line with the notion that youth are marginalized when it comes to sexuality education, most respondents were not satisfied with the information offered in their

sexuality education classes. All of them at some point in their interviews indicated that there were topics not discussed or only discussed briefly. Some of the topics that participants indicated were not covered adequately were HIV and AIDS, relationships, and contraceptives, which are among the issues that the Canadian Guidelines for Sexual Education (Health Canada, 2003) consider imperative to sexual health education. Topics identified by interviewees as lacking in their sexuality education, such HIV and AIDS, are also considered problems by society, yet society still refuse to educate youth about these issues and aid in eradicating these problems. The findings of the present study are consistent with Canadian studies published five and seven years ago, findings that Nova Scotia youth feel that there should be more coverage of such topics as relationships, STI prevention, abuse and sexual assault, birth control, abortion, and sexual orientation (Fisher et al., 2001; McCall et al., 1999). That these findings consistent over a seven-year period, is reflective of the fact that youths' perceptions and recommendations have remained unheard when determining sexuality education curriculum.

The Canadian Guidelines for Sexual Education (Health Canada, 2003) state that sexual health education should be comprehensive and informed. Several studies have also shown that the knowledge reflected in sexuality education programs does produce a positive change in students' knowledge following the program (Barth & Kirby, 1991; Gottsegen & Philliber, 2001; Kirby, 2001; Wackett & Evans, 2001). The comments from most of the participants in the present study established that the reverse of these findings may also be true. When participants indicated that they did not receive comprehensive sexuality education, and when they felt that sufficient knowledge was not adequately reflected in their sexuality education programs, they also indicated that there was not a

positive change in knowledge. This literature, combined with the results of the present study, suggests that sexuality education must be comprehensive to produce a positive change in knowledge. It would appear that administrators, education departments, and educators are taking little notice of this need for comprehensiveness and as such youth-based sexuality education programs are suffering the result. Participants in this study clearly indicated that they do desire comprehensive sexuality education, yet, it is apparent that youth are being ignored and historical, hegemonic values and beliefs around sexuality in teens persist to produce ineffective sexuality education programming.

In this study all but one participant expressed extreme dissatisfaction with the sexuality education they received in high school. Participants often expressed frustration that educators were not recognizing the fact that youth are engaging in sexual activity and require adequate sexuality education. This reinforces the marginalization of youth and the exclusion of the experiences of the youth when developing sexuality education. Studies have also illustrated that youth are engaging in sexual activities in their teen years (Buske, 2001; Dyburgh, 2005; Klein, 2005; Langille, 2005; McKay, 2004), thus, the fact that participants indicated that youth are having sex in high school was not a new finding. What is noteworthy, however, is that even though much literature has been published regarding the frequency of youth sexual activity, such as the Statistics Canada (2005a) study stating that 28% of Canadian youth are engaging in sexual activity between the ages of 15 and 17, Nova Scotian youth are still not receiving satisfactory sexuality education. Given that the Canadian Guidelines for Sexual Health education stipulate that sexual health education should be regularly updated, it would make sense to interpret such studies as a sign that Nova Scotian sexual health education programming is not as

effective as it should be and needs to be restructured. Further, this finding is important because it shows that youth are aware that society does not want to recognize the fact that youth are engaging in sexual activity. It is clear that a line of fault (Smith, 1995) persists between the ideology that youth are not sexual beings and the reality that they are engaging in sexual activities and want to receive sexuality education.

Youth who participated in the present study often referred to their high school sexuality education as “poor”, “empty”, “brief”, and “horrible”, some even classified it as “non-existent” and said that there was nothing positive about it. The Canadian Guidelines for Sexual Health Education on the other hand, state that sexual health education should be effective, empowering, and positive (Health Canada, 2003). These descriptions could not be more dissimilar, and yet the Canadian Guidelines for Sexual Health Education exist for the purpose of providing teaching and curriculum strategies (Health Canada, 2003). Comparing interviewees’ description of their high school sexuality education to the Canadian Guidelines for Sexual Health Education, it is evident that the guidelines are not being adhered to in all high schools in Nova Scotia.

Previous literature regarding sexuality education facilitation suggests that teachers are not adequately trained to deliver sexuality education (McKay & Barrett, 1999). The results of this study are consistent with this research in that participants commonly felt that their teachers were not properly trained to teach sexuality education. Interviewees felt that their teachers were often uncomfortable and did not want to be teaching about sexuality, they often felt that this was associated with the fact that their teachers received inadequate sexuality education when they were in high school. A 1999 study of 91 teachers from random schools across Canada found that teachers who had taught

sexuality education did not touch on sensitive issues, such as sexual orientation, oral and anal sex, masturbation, and sexual pleasure (McKay & Barrett, 1999). This finding, combined with interviewees' perceptions of their sexuality education teachers, suggests that sexual health educators are not equipped to teach sexuality education. This deduction was not unanticipated given that in 1999 hardly any of Canada's Education Ministers had specific guidelines and qualifications for the teachers who were facilitating sexuality education (McCall et al., 1999), and that only 15.5% of 105 B.Ed programs in Canada reported training students to teach sexuality education (McKay & Barrett, 1999).

The Canadian Guidelines for Sexual Health Education (Health Canada, 2003) emphasizes that for sexuality education to be effective, educators should have a general knowledge of sexuality and sexual health issues and have the teaching skills needed to facilitate sexuality education. This principle was not adhered to in all of the high schools that the participants in this study attended. In addition to recognizing their teacher's discomfort, disinterest, and lack of knowledge, a number of participants also acknowledged that their teachers did not openly answer questions regarding sexuality and often devalued youth by talking down to them when teaching. Further, many participants recognized that their teachers were trained to teach other topics such as physical education, and as such they felt that was the reason why their teachers were uncomfortable and/or apathetic when teaching about sexuality. The Nova Scotia school board would never put a teacher in the classroom to teach math if they were not trained to teach math, why should sexuality education be any different? Both youth and teachers have been subjugated to participate in a situation in which they have no role in creating. This is a systematic issue that reflects the devaluation of youth and their need for

satisfactory sexuality education.

Interviewees' perceptions of their sexuality education teachers' discomfort is an apparent parallel to the reality that most of these teachers probably have never received adequate sexuality education themselves. Moreover, similar to other they may have been raised to internalize sexuality as personal and inappropriate for the classroom or in general. Now in a professional capacity, in which they influence children and youth everyday, many teachers' values influence their actions (Morgaine, 1994) and are not teaching sexuality education the way that it should be taught—bias free and inclusive.

Sexuality education resources have been identified as a means of achieving positive sexual health outcomes (Health Canada, 2003). Participants in the present study who identified having access to resources, such as condoms and written information, also felt that resources were an effective way of educating students about sexuality. Nonetheless, all participants did indicate that there needed to be more resources available and the resources needed to be current. Similarly, focus groups with youth in 1999 found that students desired better resources, these youth found that teachers were using the same outdated resources too often (McCall et al., 1999). One of the most common suggestions made by participants with regard to sexuality education resources was having access to contraceptives, such as condoms and the birth control pill, at their high school. As of 1996, 57% of youth surveyed by Planned Parenthood Nova Scotia and the Nova Scotia Department of Health reported not always using protection (Nova Scotia Department of Health & Planned Parenthood Nova Scotia, 1996), a statistic that would likely improve if youths' voices were heard and contraceptives were available in Nova Scotia's high schools.

Interviewees also referred to materials such as sexuality education pamphlets, posters, videos, and booklets as useful sexuality education resources. Of particular note is participants' perception of *SEX? A Healthy Sexuality Resource*. Only a few participants cited having access to this booklet, one participant did feel that the book was too vague, but others who had access to it felt it was an excellent sexuality education resource. This finding is of particular interest given that when the book was released in 2004, reactions from parents, religious groups, educators, and politicians were not overly positive; in fact many were outraged that this resource was available to youth. A participant who had access to the book in high school cited this controversy as "ridiculous". The use of this book has not undergone a formal review, although the voices of parents, educators and religious groups have been repeatedly reflected in local media. Although this study was not a complete or comprehensive review of the *SEX!* booklet, it provided a select few youth, who are the individuals who know best what they want and need to learn about sexuality, with the opportunity to express their opinions about this resource.

Health Canada's definition (2003) of sexuality encompasses physical, emotional, mental, and societal well being. Participants were asked specifically if they felt that this definition was promoted at their high school and only one interviewee felt that it was completely promoted. This is an interesting finding given that the Canadian Guidelines for Sexual Health Education (Health Canada, 2003) were specifically designed to aid in the promotion of this definition in schools, among other places. The Canadian Guidelines for Sexual Health Education is a 50-page document that details the most effective ways to promote healthy sexuality. It even includes a checklist so that educators are able to adequately meet the objectives set forth in the guidelines, yet this study has found that

interviewees did not feel that such a definition of sexual health was being promoted in their high school, but felt strongly that it should be encouraged. Clearly, youth not only need sexual health education, but they also want it and it is time that they are given the sexuality education that they desire. Internalized ignorance of the importance of sexuality education has created a line of fault that results in youth sexuality being ignored and “experts” inadvertently disregarding the weight of youths’ opinion in determining what should and should not be included in sexuality education curriculum. Social structure is determined by the ruling class by means of controlling social relations through ideas and images (Smith, 1995). If this “ruling class” would listen to the ideas of youth when controlling sexuality education curriculum, maybe the curriculum would give expression to what youth are asking for and need as opposed to what adults think should be incorporated.

Limitations

Several limitations were presented with this study. The biggest limitation was that the sample was not obtained from high schools. This limitation played out in three ways. First, the sexuality education that these ten youth received in high school may have changed since they left. Second, they may possibly have been ambiguous in recalling their experiences with sexuality education. However, these two limitations were minimized by the fact that they were out of high school for a maximum of three years. Additionally, given that the sample was not selected from high schools and participants were not asked to specify what high school that they attended, there is a chance that participants may have attended the same school.

A second limitation was that only university students were interviewed. Many

youth are not able to access a university education due to financial and/or academic barriers and these youth were not able to participate in this study. In fact, in 2005 29% of 232 families surveyed in Nova Scotia reported that someone in their family could not attend university for financial reasons (Canadian Federation of Students, Association of Nova Scotia University Teachers, and Nova Scotia Government and General Employees Union, 2005). This is a weakness because these youth were not given the opportunity to participate in my study, thus limiting the sample to youth with higher levels of education.

The third limitation was the diverse backgrounds the participants may have had and how these backgrounds may have affected their responses. For example, interviewees were not asked to specify their religion or sexual orientation, which may have influenced their experiences with sexuality education. The interview guide was designed to encompass the participants' experiences with sexuality education in the school setting, but the guide did not allow participants to give a background of their experiences. Furthermore, the participants' backgrounds were of concern because the sample population may have been exposed to dissimilar preventative sexual health services and social support outside of the classroom, which would have an impact on how they view sexuality education that they received at the secondary school level. Additionally, adolescents' access to preventative health services and social support varies according to region given that only half of health ministers report advertising preventative health services, and fewer than one half of Canadian school districts report using the media to promote healthy sexuality (McCall et al., 1999).

The fourth limitation of this study was the sample size that was decided upon. Although ten participants is not a small sample size when conducting qualitative

research, it does present limitations in terms of generalizing the results to the wider Nova Scotia youth population. Nonetheless, the goal of qualitative research is not to generalize and predict, it is to explore the way that society functions and present insight into everyday life (Berg, 1998; Comstock, 1982; Tesch, 1990). Moreover, the goal of critical science research is to engage individuals in marginalized situations in creating social change by way of enlightening society with their experiences by way of providing them with the opportunity to express their views.

The fifth limitation was due to the fact that the interviews were face-to-face. Although face-to-face interviews have many benefits, they also have weaknesses. In this case, the interviews were intimate due to the fact that the only the respondent and myself were present. As such, when discussing a topic as sensitive as sexuality and sexual identity the respondent may have become uncomfortable. Nonetheless I do not believe that interviewing in a group setting would have been more comfortable. I did however prepare to surmount any uncomfortable feelings that may have arisen by including throwaway questions in the interview guide. These questions were only to be used only when the need arose to reduce apprehension, and/or or any uncomfortable feeling that may have existed, however, there was never a need to incorporate these questions. Nonetheless, there were a few probes that were not used in all interviews due to the comfort level—theirs and mine. Moreover, there were a small few incidences where I did not probe students about what they had learned with regard to oral, anal, and/or vaginal sex because I felt uncomfortable to do so. Looking back the only reason that I can state for my lack of comfort asking these questions is the fact that I too have internalized the societal message that sex should not be discussed and when it came time to talk about them with certain

participants I simply could not do it.

The final limitation of the study was the fact that there was only one coder, and therefore this study lacks intercoder reliability. Intercoder reliability occurs when more than one coder analyzes the text or the unit of analysis (Bernard, 2000; Morse, 1997). However, one of the functions of interactive interviews is to have the opportunity to understand the data as it is being collected (Morse, 1997). This idea of learning from the participants was critical when coding and interpreting the data, and it can be argued that it would not have been beneficial to allow another researcher, who has not been exposed to the data collection process, to code the data for a second time (Morse, 1997).

Recommendations

As the literature review and results show, youth are engaging in sexual activity and need adequate sexuality education. There is much room for improvement to sexuality education curriculum in the Nova Scotia high school system. Participants who were interviewed for this study clearly indicated that the sexuality education that they received in high school was not adequate and that change to current sexuality education curriculum is necessary. Considering the input offered by participants of this study, as well as previous literature, what follows are recommendations for improvements to sexuality education in Nova Scotia high schools.

First of all, it is important that youth are involved in the development of high school sexuality education curriculum. Involving youth from the start will ensure that the sexuality education that youth receive is the sexuality education that they need and desire. As this study demonstrates, youth know what it is that they want to learn with regard to sexuality and they take notice of what they do not learn. Youth in this study have

suggested numerous ways that sexuality education could be improved in Nova Scotia high school. From content to facilitation methods, youth have valuable insight into what to include in youth-based sexuality education curriculum; it would be practical and valuable to seek out their opinion. Nova Scotia has begun this process by way of including youths' input into the framework for sexual health (Nova Scotia Roundtable on Youth Sexual Health, 2006). It is now necessary that the Roundtable engage youth in "policy, programs, service delivery, supports, and education" (Nova Scotia Roundtable on Youth Sexual Health, 2006, p. 31).

Second, sexuality education teachers have to be properly trained to deliver sexuality education curriculum. Very few teachers have ever received sexuality education themselves and many do not feel comfortable teaching the topic (Brick, 1992; McKay & Barrett, 1999). This finding was reinforced time and time again by the youth interviewed for this study. Youth are taking notice of the poorly prepared facilitators delivering sexuality education in Nova Scotia high schools. In no does this mean that blamed should be placed on the teachers delivering sexuality education because it is known that it is often not their choice to teach the topic and habitually the case that they were hired and trained to teach another topic; history teacher do not teach math, why are physical education teachers teaching sexuality education?

Further, it is likely that these teachers have never received sexuality education themselves and have internalized the hegemonic belief that sexuality education is unimportant and/or inappropriate. They too may feel shame about sexuality, which often develops when presumptions are taken for granted (Morgaine, 1994). The presumption that sexuality education is unimportant may have shamed teachers and administrators into

devaluing the importance of sexuality education and the value of having properly trained facilitators. It is time to break this cycle. Sexuality education has by facilitated by properly trained sexuality education teachers and everyone, including students and parents, have to learn that is acceptable to talk about sexuality.

Students commonly referred to their sexuality education class as being too short and/or brief. Sexuality education should be taught for at least a full semester during each year of high school. Moreover, the content of the sexuality education should follow the Canadian Guidelines for Sexual Health Education. The Canadian Guidelines for Sexual Health Education need to be more than a suggestion, it should be incorporated in education policy. It was not uncommon during the interview process to hear comments such as “I can’t really remember, we only spent an hour on it”, “it was pushed to the end”, or “we didn’t learn about that”, evidently this does not represent the Canadian Guidelines for Health Sexuality and is certainly not representative of comprehensive sexuality education. Sexuality education is very important and must be given the time it deserves. The Canadian Guidelines for Sexual Health Education (Health Canada, 2003), if followed properly, allow for comprehensive learning and certainly require more than a class or two.

Additionally, students also need to have access to sexuality education resources, such as literature, posters, and videos. Nova Scotian organizations, such as Sexual Health Centers and the Department of Health Promotion, have developed several resources that answer many of youths’ common questions about sexuality, yet many youth do not have access to this material at their high schools. The *SEX!* booklet is an example of a resource that, according to my research, many youth do have access to. Resources alone will not

suffice however. As this study illustrates, youth require “someone to talk to” about sexuality, such as a school health nurse or sexuality educator.

Lastly, the Nova Scotia Department of Education needs to make sexuality education mandatory in the Nova Scotia school system. Sexuality education must reach each and every youth for it to impact each and every youth. By way of making sexuality education mandatory in high school, the Department of Education will be ensuring that all youth at some point in their high school years receive sexuality education. There are a number of courses that are mandatory in high school, such as math and science, sexual health education is just as important and should be compulsory.

Areas for Future Study

As previously stated, two of the biggest limitations of this study were the small sample size and the fact that the interviewees were not currently in high school. With that in mind, I would suggest that a future study would duplicate the study at hand, with a *large* sample of *current* high school students in Nova Scotia. This research provided a select group of youth with the opportunity to offer a number of significant opinions about sexuality education in Nova Scotia; I believe that if the same type of interviews were to be done on a much larger scale the enhanced results could be pivotal to policy and curriculum change in the Nova Scotia school system.

Future research could also use the same methodology to complete interviews with high school teachers. It would be extremely valuable to hear what it is that teachers need and desire with regard to sexuality education and compare it to what it is that youth need and desire, and how they experience teaching sexuality education. Too often teachers are held responsible for curriculum development and facilitation when in fact they have very

little influence over either, much like youth. The opinions of youth and teachers together would provide a sound view of what is considered necessary to deliver effective sexuality education in the Nova Scotia school system.

Finally, a national review of sexuality education would be a very valuable study. Although this study focuses on sexuality education curriculum in Nova Scotia, there are many unfortunate common characteristics amongst sexual education curriculum across the country. It would be helpful to complete a study of sexuality education in Canada in which youth and educators are interviewed and school board and Department of Education policies surrounding sexuality education are compared. Such a study would be fundamental to the potential betterment of sexuality education in the Canadian school system and may possibly place the onus on policy makers to consult with youth, teachers, parents and administrators to implicate policy that makes sexuality education mandatory in the Canadian school system.

Chapter 6: Conclusion

The goal of this research was to investigate Nova Scotian youth's perceptions of the provincial sexuality education curriculum using critical theory as a framework for analysis. The findings were consistent with previous Canadian studies finding that youth in Nova Scotia felt that there should be better coverage of sexuality education (McCall et al., 1999; Fisher et al., 2001) and the critical theory assumption that there is a line of fault (Smith, 1995) between the ideology, discourse, and the everyday worlds of youth as sexual beings. Most participants in this study were not satisfied with the sexuality education that they received in high school and commonly associated their dissatisfaction with substandard facilitation, which is reflective of previous literature that suggests that most Canadian sexuality education teachers are both uncomfortable and untrained (McKay & Barrett, 1999). Additionally, most participants in this study did not feel that sexual health was promoted at their high school and were adamant that there should be additional and improved sexuality resources available in high schools, an appeal that could be easily achieved if the Canadian Guidelines for Sexual Health Education were being followed at all high schools in Nova Scotia.

If any one thing can be taken away from the data collected it is that Nova Scotia's youth need and desire additional and improved high school sexuality education. In not providing youth with the sexuality education they desire, oppressive groups, such as administrators and parents, are denying subjugated groups, in this case youth, the right to reach their full human potential. The Canadian Guidelines for Sexual Health Education (Health Canada, 2003) state that sexual health education should be comprehensive and the youth interviewed in this study clearly agree. An overwhelming majority of these

youth stated at some point in their interview that they were not satisfied with the sexuality education that they received, and all youth made recommendations for improvement to current sexuality education curriculum. There were ten youth interviewed for this study, but there are thousands more whose voices have not been heard and perceptions remained internalized. Ideas produced by a ruling class control social order and maintain domination (Smith, 1995). This is a hegemonic reality and one that the ruling class themselves can change by starting to dialogue with youth. Youth must be provided with an outlet to enlighten society about their experiences and ask questions that are too often internalized and adults must not deny expression of these experiences.

All of the youth interviewed felt that it was important that Health Canada's (2003) definition of sexual health be promoted at the high school level, yet none said that it was promoted at their high school. Youth are having sex, research has shown this for years and the youth in this study commonly confirmed it. Society is well aware that youth are sexually active, it is now time that they act on this recognition and provide youth with the sexuality education that they need and want. Is sexuality education being offered in Nova Scotia high schools? Yes it is. Is it adequate and effective? Not according to the youth who were interviewed for this study.

If statistics of high teenage pregnancy and STI rates in Nova Scotia are not enough, youth in this study are making it clear that they are having sex and they do want to learn about sexuality at their high school. Why then is it that this message is being ignored? Is it because the voice of youth is being drowned out by a society ruled by adults? Or because sexuality education is simply not a priority in Nova Scotia? It would

appear that both are true in their own right. Generations of internalized hegemonic beliefs around sexuality in teens have marginalized youth to the point that their call for sexuality education continues to be unheard and their role as sexual beings disregarded. Society has over time instilled the ideology that youth are not suppose to be sexual beings and has consequently denied them expression when developing sexuality education. However, in reality youth are sexual beings and their experiences are what matter most when developing sexuality education. Moreover, healthy sexuality is a part of one's overall health, thus it is unacceptable that society's ignorance has created a situation where youth are not able to reach their full potential as healthy beings.

This research obtained a considerable amount of data; however, it is a drop in the proverbial bucket compared to what it is left to be attained. Youth are the most valuable resource that Nova Scotia has when it comes to developing sexuality education curriculum and it is time that their voices are heard and their messages acted upon. There is an unfortunate gap between what youth know and what they need to know about sexuality and this gap can only be filled with sufficient and comprehensive sexuality education. The subordination of youth by those who hold power is putting youth at risk. Youth *are* having sex. Youth *are* getting pregnant. Youth *are* contracting STIs and HIV. Unfortunately however, adults *are not* doing what they can to educate them about sexual health and its many outcomes. Youth have spoken and their message is clear—they want and need sexuality education, it is up to everyone to ensure that this message is acted upon.

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Appendix A: Invitation to Participate

Text for Classroom Speech

I am conducting a study for my master's thesis research about individuals' experiences with high school sexuality education curriculum. I wish to interview 8-10 male and female Mount Saint Vincent University students, who are at least 19 years of age and attended high school in Nova Scotia in the past 3 years. I will ask some general questions to each participant in which I will get to know more about their experiences with sexuality education. I will be interviewing students about the availability/accessibility of sexuality education at the high school they attended, what they learned from the sexuality education they received, what their sexuality education teachers were like, and how they feel about sexuality education. Specific questions may also be asked, such as "did you learn about STIs and AIDS? If so, what?" The interviews will take approximately one hour to conduct and will be audiotaped. The goal of the study is to gain insight into the experiences that Nova Scotia youth have had with sexuality education at a secondary level, as well as to identify areas of improvement for current sexuality education curriculum.

I will be distributing an information slip to each one of you for your consideration. If you are interested in participating, please contact me at the e-mail address indicated on the slip. All e-mails will remain confidential. If you decide to participate you will be interviewed once, and I will work around your schedule to schedule the interview, which will take place in a private place that is comfortable for you. Thank you for your time and consideration. I look forward to hearing from you in the near future.

Slip of Paper Distributed in Class

LET'S TALK ABOUT SEX: A GLIMPSE INTO NOVA SCOTIA
YOUTHS' PERCEPTIONS OF HIGH SCHOOL SEXUALITY EDUCATION

I would like to interview MSVU students who attended high school in Nova Scotia about their experiences with high school sexuality education curriculum. If you are at least 19 years of age and attended high school in Nova Scotia in the past 3 years, please e-mail me in the Department of Family Studies and Gerontology at the Mount Saint Vincent University at chantal.brushett@msvu.ca to find out more about becoming a participant. All inquiries and participation will be kept confidential. If you have any questions regarding the study you may contact my thesis advisor Dr. Áine Humble, at aine.humble@msvu.ca or the University Research Ethics Review Board at research@msvu.ca.

Thank you,

Chantal Brushett

Appendix B: Sample Poster

Looking for students to discuss their perceptions of high school sexuality education

I would like to interview MSVU students who attended high school in Nova Scotia about their experiences with sexuality education.

If you are at least 19 years of age and attended high school in Nova Scotia in the past 3 years, please e-mail Chantal Brushett, Graduate Student, Department of Family Studies and Gerontology at Mount Saint Vincent University at chantal.brushett@msvu.ca to find out more about becoming a participant.

All inquiries and participation will be kept confidential.

This study has been approved by the Mount Saint Vincent University Research Ethics Board.

If you wish to speak to my thesis supervisor regarding my research please contact Dr. Aine Humble at aine.humble@msvu.ca.

Appendix C: Interview Schedule

ESSENTIAL QUESTIONS

Identity Questions

- 1) What year did you graduate from high school?
- 2) Without telling me what high school you attended, can you tell me what region of Nova Scotia you attended high school in?
- 3) How long has it been since you had sexuality education?

Core Questions

- 4) If you were to describe the sexuality education that you received in high school, how would you describe it?
- 5) What topics were covered in the sexuality education you received?
 - Examples of Probes
 - i. Did you learn about body image? If so, what?
 - ii. Did you learn about relationships? If so, what?
 - iii. Did you learn about personal decision-making? If so, what?
 - iv. Did you learn about sexual assault? If so, what?
 - v. Did you learn about sexual orientation? If so, what?
 - vi. Did you learn about pregnancy? If so, what?
 - vii. Did you learn about birth control methods? If so, what?
 - viii. Did you learn about STIs and AIDS? If so, what?
 - ix. Did you learn about vaginal sex? If so, what?
 - x. Did you learn about oral sex? If so, what?
- 6) What types of activities did you do in your sexuality education class related to these topics?
- 7) What did you think of the sexuality education you received?
- 8) Tell me about your sexuality education teacher(s).

- Probes

- i. How did your sexuality education teacher answer questions about sexuality?
- ii. Did your sexuality education teacher express his or her own personal opinion when discussing sexuality? If so, how?
- iii. How comfortable did your sexuality education teacher seem with teaching about sexuality?
- iv. Did your sexuality education teacher provide you with sexuality resource materials? If so, what?

9) What do you feel were the positive aspects of the sexuality education that you received in high school?

10) What do you feel were the negative aspects of the sexuality education that you received in high school?

11) Were there sexuality education resources available at your high school?

- Examples of Probes

- i. Were there sexuality education brochures available?
- ii. Was there sexuality education posters posted in your school?
- iii. Were there sexuality education information booklets available?
- iv. Where at school would you go if you needed information regarding sexuality?

12) What sexuality-related resources do you think should be available in high schools?

13) How would you define sexual health?

14) Health Canada (2003) defines sexual health as a “state of physical, emotional, mental and societal well-being related to sexuality”. Using this definition, would you say that sexual health was promoted at your school? Why or why not?

15) Do you think healthy sexuality should be promoted in high school? If so, how?

16) Is there anything else that you would like to talk about?

THROWAWAY QUESTIONS

- 1) Did you have a textbook in your sexuality education class?
- 2) Was sexual education mandatory in your high school?
- 3) If sexuality education were offered in university would you enroll?
- 4) Did you ever have presentations from people other than your teacher in your sexuality education class?
- 5) Did your sexuality education teacher teach any of your other courses?

EXAMPLE PROBING QUESTIONS

- 1) What exactly do you mean by _____?
- 2) Could you tell me more about _____?
- 3) Can you give me an example of _____?
- 4) How do you feel about that?
- 5) Can you tell me why you feel this way?
- 6) Can you tell me why you think that this is the case?
- 7) How was _____ different from _____?
- 8) What would you change in this situation/about this/etc.?
- 9) What do you wish _____?
- 10) What do you think would happen if _____?

Appendix D: Informed Consent Form

Informed Consent Form

Project Title:	Let's talk about sex: A glimpse into Nova Scotia youths' perceptions of high school sexuality education
Researcher:	Chantal Brushett Graduate Student Dept. of Family Studies and Gerontology Mount Saint Vincent University (t) 902-457-6467 (e) chantal.brushett@msvu.ca
Thesis Supervisor:	Dr. Áine Humble Assistant Professor of Family Studies and Gerontology Dept. of Family Studies and Gerontology Mount Saint Vincent University (t) 902-457-6109 (e) aine.humble@msvu.ca

The goal of this study is to gain insight into the experiences that Nova Scotia youth have had with sexuality education at a secondary level, with the purpose of identifying strengths and areas for improvement for sexuality education curriculum in Nova Scotia high schools. Eight to ten women and men aged 19 and over who attended high school in Nova Scotia in the past 3 years will be interviewed.

Your participation in this study will involve one interview, which will be audiotaped. You will be asked general questions about sexuality education. Specific questions about sexuality education may also be asked, such as "did you learn about STIs and AIDS? If so, what?"

All tapes will be transcribed. The only people who will see these typed transcripts will be the thesis advisor, Dr. Áine Humble, and Miss Brushett. Some exceptions to confidentiality exist: for example, I am legally obligated to report cases of suspected child abuse to the proper authorities. Your name, or the name of anyone else referred to in your interview, will not be transcribed; a pseudonym will be used in its place. The tapes and this form will be locked in separate filing cabinets, which no one other than the researcher and her thesis advisor will have access to. The tapes and the form will be destroyed within one year of the study being completed.

The information you provide will be written up in a thesis, and may be reported in an article or presented at a conference. The final written document may quote from your interview but will not reveal your name, the names of anyone you may refer to in your interview, or any other identifying information about you.

Participation in this study is voluntary and you have the following rights:

1. You may stop the interview at any time.
2. You may choose to stop participating in the study at any time.
3. You may refuse to answer any question.
4. You may withdraw information at any time.
5. You may contact the researcher, the thesis advisor and/or the university research director at any time if you have questions and/or concerns regarding this research.

Your participation in this study will contribute to an understanding of Nova Scotia youths' perceptions of high school sexuality education, which in turn may identify strengths and weaknesses in sexuality education curriculum in Nova Scotia high schools. In the case that your participation in this study triggers uncomfortable memories please feel free to contact the Mount Saint Vincent University counselors' office to speak with a professional counselor (contact information is provided at the end of this form).

This is to certify that I (print your name) _____ agree to voluntarily participate in this study. I am aware of the purpose of this study and that the interview will take approximately one hour. I am aware that my interview will be recorded and transcribed by the interviewer, but that any names or identifying information stated in my interview will not be transcribed from the audiotape. All of my questions and concerns to date have been answered to my satisfaction. I understand that I am free to stop participating in the study at any time. I have been given a copy of this form.

Participant Signature: _____

Researcher Signature: _____

Date: _____

If you have questions about how this study is being conducted and wish to speak with someone who is not directly involved in the study, you may contact the Chair of the University Research Ethics Board (UREB) c/o MSVU Research and International Office, at 457-6350 or via e-mail at research@msvu.ca.

I would like to receive a summary of the results of this study when it is completed.

Name: _____

Address: _____

If at any time following your interview you wish to discuss the interview process or content please contact my Thesis Advisor, Dr. Áine Humble, at aine.humble@msvu.ca or the University Research Ethics Board at research@msvu.ca. If at anytime following your interview you wish to discuss sexuality or sexuality education with a Mount Saint Vincent University Counselor please contact Gisela Low at **457-6567** to make an appointment. The Mount Saint Vincent University Counselors' office is located in Evaristus Hall, Room 218.