Everybody's doing it. Are we doing enough about it? Reflections by five young adult women on their formal and informal sexual health education

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Everybody's doing it. Are we doing enough about it? Reflections by five young adult women on their formal and informal sexual health education

The thesis is based on the recollections of sexual health education received by five women, between 23 and 29 years of age, in school and out of school contexts in Quebec. Through an open ended questionnaire containing six questions the women were asked to discuss their past sexual health education and comment on whether it prepared them for healthy sexuality in their lived experience. The five participants were recruited through an e-mail sent to 30 friends and acquaintances of the researcher, detailing the purpose of the project and soliciting their help in identifying five volunteer participants. Of the twelve responses received, ten met the criteria set for participating in the study. Five of them completed the questionnaires within the time frame specified. The following themes emerged from the data: technical information was given but was mainly with intent to discourage sexual behavior; the school context as well as discussions with parents created discomfort; the main problem identified was lack of emotional components in the curriculum, books and magazines, information received from friends and relatives, television as well as medical professionals. One source of information that was not identified by the participants but is prominent in the recent literature is the internet. Based on these results the thesis makes recommendations for improving sexual health education in schools as well as recommendations for more in depth research on this topic in the Quebec context.

Dedication

I would like to dedicate this work in loving memory of my grandmother, Muriel Smiley. I was lucky enough to have a beautiful relationship with my grandmother for twenty- seven years. My grandmother loved me unconditionally and supported all of my endeavors. She was proud of everything I did and accepted me for who I am. She listened, she laughed and I think about her all the time. I know she would be so proud of this accomplishment. I love and miss her. This work is in her honor.

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Chapter One

Problem Statement, Rationale and Research Questions

On the one hand, sex today is not a big deal. Yet on the other hand, it is all over the media, on billboards, in movies, in music videos. Everyone is talking about it and a large percentage of youth are doing it; the average age that both males and females have sex for the first time is 16.5 years. Youth are often engaging in sexual activities without knowing the potential consequences of their actions, or how to protect themselves. Therefore, ending sexual health education at the high school level simply does not support youth at a time in their lives when they need support and resources so desperately. Despite sexual health education being taught at the elementary and high school levels, there are many unwanted effects of sexual activity that are not only occurring, but are on the rise. Thirty- three percent of Canadians aged 18-19 have reported having sex without a condom (sexualityandu.ca, 2007). Close to 40,000 Canadian girls become pregnant each year and most of these pregnancies are unintended (Sex Information and Education Council of Canada, 2007). Chlamydia is the most commonly reported Sexually Transmitted Infection (STI) in Canada and is often asymptomatic. Females account for over two-thirds of all reported cases of Chlamydia; and among them, two-thirds of all reported cases are in the 15- 24 age group (seuxalityandu.ca, 2006). So on the other hand, not only does this make sex a big deal, it also makes it a big problem.

Furthermore, some youth believe girls who are virgins can never get pregnant (Sex, Etc., 2007). Another commonly held myth is that a girl cannot get pregnant if she has sex in the water (Sex, Etc., 2007). The only way to combat these, and all other myths,

is to provide youth with the facts, the resources and the support that they need through sexual health education. Education not only offers opportunities, but choice. Schools are a safe place to ask questions and get the correct information. It is our responsibility as educators, as administrators, as parents and as a society to provide our youth with the tools that they need to succeed in life. This includes comprehensive sexual health education. This research paper asks women to comment on the sexual health education in the school system, to look back, with maturity and distance, on their experiences and provide feedback.

Access to effective, broad and non-judgmental sexual health education and resources could be a contributing factor to creating healthy Canadian youth (Sex Information and Education Council of Canada, 2007). School-based programs have the opportunity to make accurate information, counseling and resources available to students in a safe and open environment. While students get their sexual health information through both formal and informal education, it is the responsibility of the school to offer programs that can help guide youth to make safe and healthy decisions confidently that are appropriate for them. As students are in school five days a week, numerous hours a day, this provides a unique institutional opportunity to equip youth with the resources, education and opportunities to learn how to make healthy, educated sexual choices and live healthier and safer lifestyles. In determining the extent of the effectiveness of school based sexual health programs in recent years, this research project asked young adult women who have been away from school for 2-5 years, to evaluate the sexual health education, both formal and informal, in view of their lived experience. It is expected that these women will be able to assess what aspects and sources of education were

useful and helpful in their real life experiences. Through these reflective and narrative assessments, the researcher hoped to uncover themes and approaches to sexual health education recommended by the participants and to make suggestions as to what constitutes an effective curriculum to prepare young girls in today's schools for the realities that they will face in turn.

Research Questions

This research takes a retrospective look at sexual health education by asking women, aged 23 to 29, that have been out of school for 2-5 years, to discuss their past sexual health education and comment on whether it prepared them for healthy sexuality in their lived experience. The main research questions are: Did these women's educational experiences, both formal and informal, prepare them for practicing a healthy sexuality? Is sexual health education working? Do students get anything out of sexual health education? What can be done to improve the quality of sexual health education in Québec?

This study is intended to cast a wide net and to uncover themes within sexual health education including missing pieces that would have been helpful to young women. The researcher intends to look at both formal and informal educational experiences that have influenced women's sexuality. In asking women to reflect on their experiences, they are made the experts in this research and are asked to share valuable knowledge that can be used to shape the education and experiences of the next generation.

The research questions are:

1) What do you remember about sexual health education in school (elementary, high school, CEGEP, university)? What did you learn? Did you feel comfortable in these learning environments?

2) What do you remember about sexual health education outside of school (home, friends, television, books, journals, periodicals, websites, etc…)? What did you learn? Did you feel comfortable in these learning environments?

3) Looking back, where do you feel that you got most of your sexual health education?

4) Please share any experiences with sexual health education (any type of education) that are memorable to you. What lessons did you learn?

5) As a woman, do you feel that you were adequately prepared, in terms of sexual health education (information on sex, love, decision making, diseases, empowerment and confidence), for your sexuality?

6) What would you change (topics you would want emphasized, not discussed at all) for the sexual health education of the next generation?

This research project is made resonant by the fact that the narratives of these young adults are based on their recollections of what they have experienced as young high school and college students and can now share what was helpful and what was not, based on life experiences. They can also suggest what could be helpful for the next generation based on their recent experiences and their reflections on what they went through or learned informally.

There are many documented definitions of healthy sexuality. Nova Scotia Health Promotion and Protection (2008) defines healthy sexuality as more than just practicing

safe sex; this term also includes healthy relationships, good self-esteem and feeling confident in making decisions. Health Canada (2006) defines healthy sexuality in an even more all encompassing manner by acknowledging all the aspects involved in this facet of health. Healthy sexuality does not solely involve avoiding negative sexual outcomes such as STIs and pregnancies. Rather, it involves acquiring the knowledge and skills to make healthy, safe and comfortable decisions that result in empowerment and positive sexual outcomes. These decisions maintain good sexual and reproductive health throughout life.

I have chosen not to define healthy sexuality research within this research or for my participants. I have made this decision because I feel that the research will be able to take on a more narrative feel if the women in this study are able to construct their own personal definitions of healthy sexuality. This will be helpful as the nature of this research asks participants to reflect upon their sexual health education and determine whether or not it prepared them for a healthy sexuality. I feel that they need to define healthy sexuality as the term is very broad and is different for everyone. I chose not to constrict the responses of my participants with a choice of definition of healthy sexuality. This decision was made in the hopes that I will be able to elicit and to understand the different meanings and nuances these women bring to the concept themselves.

Another term to clarify is the term informal learning. It is estimated that informal learning can account for up to 75% of the learning that occurs today (Conner, 2008). Formal learning is defined as structured or instructional learning such as courses, training session, workshops, classroom based learning, online learning, to give some examples. Informal learning is unstructured learning and is considered to be pretty much every type of learning that is not formally undertaken in a classroom. Examples include

conversations, experiences, meetings and other related sources of learning (Center for Learning and Performance Technologies, 2008). Informal learning does not share the structure on which formal learning tends to be based on (Conner, 2008). Informal learning occurs in everyday life and may not even be recognized by the individual as such (Herod, 2002). This learning does not necessarily happen during formal training sessions or in a school learning context and continues throughout the lifespan, although it can still occur in the classroom (Conner, 2008).

I have chosen to include informal learning experiences in this research. It seems that the definition of learning has grown both to include this concept of informal learning and to acknowledge its value. As this research is based on the experiences of the participants, it is presented in a narrative form. The participants were encouraged to share any sexual health educational experience that shaped them and their sexualities. Excluding informal education sources may have prevented the participants from giving clear descriptions of their experiences and may not result in a complete picture of the participants experiences in sexual health education. Therefore, I chose to include all forms of learning in order to see whether the experiences shared by the participants favor either formal or informal learning. This can be an important avenue for further research and can have some serious implications for the sexual health education curriculum as the Québec government has made serious changes to its sexual health education curriculum in recent years. In summary, this chapter places the research in context and presents the research questions. The next chapter will examine the literature related to the topic of this thesis.

Chapter Two

Literature Review

It is important to acknowledge that there is an abundance of research under the sexual health education umbrella. While the clear majority of it comes from the United States, there is a large body of work available from European countries such as England and Norway, as well. There is also some research available on Canadian classrooms, programs and curricula, although not an abundance. Research based in Québec, in English, is scarce. There is certainly a gap in information and a lack of research into this area locally, which can potentially explain the lack of abundant resources available for my research.

Wiley and Howard- Barr (2005) acknowledge that the policy making process in education has become more politicized, with sexual health education being one of the more politicized topics within health education curricula. This sexual health education curriculum debate is even more heated as parents, teachers, administrators, school board members and other members of the community all have differing opinions as to what is both appropriate and worthy of including in the curriculum. This controversy is taken one step farther when policy decisions on regarding the creation of school based health centers (SBHC) are introduced.

Balanko (2002) affirms that sexual health education in schools has been surrounded by controversy since the 1960s. During this time sexual health education began to move away from the traditional Victorian and Christian influence and toward making the programs more comprehensive. Programs started teaching decision making

and the focus was on the options within sexual health that the students had as these programs evolved. In the 1970s, the curriculum began to expand and student input was considered. Much of the research done at this time focused on masturbation, menstruation and sexual enhancement. Concerns of promoting promiscuity through sexual health education were prevalent. In the 1980s, sexual health education was overcome by conservatism and religious and moral opposition, thus development was hindered as the focus shifted more towards religion than comprehensive sexual health education. The focus was on prevention, specifically of teen pregnancies. New programs encouraged behavior change instead of simply changing attitudes and knowledge. In the late 1980s, feminists began to critique sexual health programs for denying women and girls the opportunity to recognize and accept their sexual desires. The 1990s brought forth holistic health through comprehensive, theory based sexual health education and prevention programs. The goal was to change high -risk behavior. This era was not without its opponents, stating that these programs promoted promiscuity and therefore advocated for abstinence-only curricula (Balanko, 2002).

Gottlieb, Keogh, Jonas, Grunbaum, Walters, Fee et al.(1999) state that a comprehensive school health program is an effort to improve the student health that are more effective when they exist as a part of an integrated, coordinated system than when functioning in isolation from one another. This is a potentially effective approach to improving the health knowledge, attitudes and thus behaviors of youth. The authors conducted a survey and found that this program was best achieved at the post secondary level when colleges/ universities, state level organizations and school districts

collaborated together to work in a successful partnership to improve comprehensive school health.

According to Ottson, Streib, Clayton-Thomas, Riveira and Stevenson (2004), there has been a shift in the sexual health education needs in terms of curriculum in schools. The need for preventative, comprehensive interventions is now a priority in school sexual health education. This concept of comprehension emphasizes the need for messages in the classroom to be reinforced by support and enabled by positive choices. For example, health lessons about proper nutrition must be enforced by social and parental support and healthy food options in the school cafeteria. The authors believe that the success of a school health program is largely dependent on the support of that program.

Kilander (2001) found that a school health program should produce personal health outcomes such as maintaining a healthy body weight, as well as educational outcomes such as increasing knowledge and developing positive attitudes, habits and skills. The goal of health education is the development and practice of desirable habits and behaviors. This is best achieved when health and educational outcomes are combined in school health programs. The author found that few individuals are adequately informed with regard to health knowledge and are therefore not equipped to be able to make healthy decisions for their own needs. This creates a responsibility for adult education programs and voluntary health organizations to fill this void. The author also states that post secondary education does not necessarily add to the health information of students. The author concludes that a positive relationship between health information and health

practices exists, consequently highlighting the importance of health education as a tool to promote the changing of health behaviors.

There has been an abundance of research conducted on how to teach sexual health education in schools and debates on curriculum reform. Health Canada (2003a) has recognized the gap between theory and practice and found a major need to work towards bridging that gap. Recognizing the link between good health and learning is important and embracing the possibilities that are extended through school based sexual health education towards building healthier youth and communities is essential. Yet, in reality, schools lack the time, money and resources to be as effective as they can be. As well, Mehra (2003) recognizes that educators may be uncomfortable talking to students about sex and often fear parental backlash. Balanko (2002) identifies that tension exists as there is an innate assumption that sexuality education shapes the morals and values of our youth. This leads to a debate between restrictive and permissive ideologies in sexual health education. The restrictive ideology, being the more morally based school of thought, supports abstinence only curricula. The permissive ideology, on the other hand, views sex as both pleasurable and essential, hence advocating comprehensive sexuality education in schools. All of these factors need to be taken into account when designing health education curricula for schools and for training the practitioners of these curricula (Balanko, 2002).

Bondy (2005) conducted research looking at the experiences of teachers while teaching sexual health education. His rationale for this work was that the teacher is the one facilitating the sexual health education classroom as well as guiding the students' experience. Bondy (2005)'s findings indicate that many teachers felt unprepared to teach

many topics within health education and were untrained. As well, there was the issue of the instructors' own comfort level with both the subject matter and language required. Spain (1986) also looked at the role of the instructor in sexual health education; using college students and identical curriculums, three classes each received different instructors. The first class had a male instructor, the second had a female instructor and the third had two instructors, a team of one male and one female. The authors hypothesized that the class with the male and female team would demonstrate more sexual knowledge and more positive sexual attitudes. No significant differences between the groups were found. Matthews (2006) found that teachers felt that teacher training needed to be a priority in order to properly implement sexual health education in the classroom. Teachers also felt that Physical Education took priority over Health Education, and that a comprehensive sexual health program would be more effective if it were taught by a qualified Health Education teacher.

Kirby, Laris and Rolleri (2006) found that, contrary to the fear of sexual health education promoting promiscuity, these programs do not increase sexual activity, rather they delay or decrease sexual behaviors and increase contraception and condom use. The authors reviewed 83 studies that measured the worldwide impact of curriculum based sex and HIV education programs on sexual behavior among youth under the age of 25. Their findings concluded that two-thirds of the programs significantly improved at least one sexual behavior such as number of sexual partners, sexual risk taking and STI rates. Thus, the evidence for the positive impact of sexual health education programs in schools is strong and encouraging.

Allen (1992) studied the sexual knowledge, attitudes and behaviors of 17- 19 year olds. One of her significant findings, particularly within this research was that sexual health education did not provide the subjects with basic knowledge needed to make informed health decisions. Maristuen (2004) investigated the implementation of a sexual health education curriculum in a sixth grade classroom. The author reported that when used correctly, a sexual health curriculum could result in substantial learning gains, However, this curriculum can only be implemented with adequate teacher training and administrative support, neither of which are readily available.

Pinto (1994) investigated the relationship between type of sexual health education instruction and knowledge of sexual information in college students. The students were randomly assigned to 3 groups: a control group (i.e., no sexual health education), a traditional sexual health education instruction group (i.e., mainly birth control) and an experimental sexual health education group, (i.e., comprehensive sexual health education). The results showed that the experimental sexual health education instruction produced greater sexual health knowledge. Markiewicz (2005) examined the sexual practices of college freshmen and sophomore students with regards to the sexual health education they received in high school. This study looked at the differences in sexual behavior between students that received: no sexual health education, abstinence only sexual health education and comprehensive sexual health education. The researcher hypothesized that those students educated comprehensively would practice safer sexual behavior. Bond (1999) investigated the purpose, content, instruction and perceived value of required college health courses. It was found that most frequently the course purposes were to provide students with the health knowledge and skills necessary to make

responsible life decisions. However, students reported large no effect scores for some of the topics in these courses, particularly sexual health education.

Paryani (1999) evaluated adolescent's perceptions of the quality of sexual health education they received in schools. The majority of the study participants agreed that a sexuality course was beneficial and provided them with information that they did not previously have. This adds strength to the argument for sexual health education's effectiveness in helping adolescents to make healthy sexual decisions. Barker (2005) used a qualitative design to explore sexual health education and asked the students for their perspectives about what they learnt in a sexual health education course. The participants were high school students in Wyoming and were asked to keep journals documenting their feelings and experiences and to answer open ended questions. The author reported that especially at this critical stage of physical and social development, the students had many questions regarding sexuality and were eager to learn more. This creates potential opportunities for discussion in the classroom.

Brock & Jennings (1993) took a reflective look at informal sexual health education by asking adult women to reflect on sexual health education bestowed upon them by their mothers. In asking both what the daughters remembered their mothers telling them about sex and what the subjects wished their mothers had told them about sex, the results were both negative and positive. On the negative side, the daughters recalled limited discussions about sex with their mothers consisting primarily of negative non- verbal messages and rules. On the positive side, the women revealed that they wished for comfortable discussion of feelings, choices and open talk. In order to supplement sexual heath education in the classroom, there are other forms of health

promotion that have been implemented in the schools and add to the comprehensive educational programs.

Senn, Desmarais, Verberg and Wood (2000) discuss programs that have been implemented to help Canadian youth get the sexual health information that they need. Incorporating life training skills into comprehensive sexual health education programs is one way to promote healthy behaviors. MacIntosh (2006) highlights an interesting program that engages youth and engages to their creativity while teaching them about sexual health education. The program consists of a peer led HIV prevention and sexuality education program for high school students aged 12- 17. These programs have been found not only to engage youth but also to increase their confidence in their ability to reduce risks (MacIntosh, 2006). Students reported gains in knowledge, improvements in behavioral and communication skills and increased compassion and tolerance. This is a very promising concept and something to be considered as youth have proven to be a very hard group to engage on this topic. In The Canadian Guidelines for Sexual Health Education (Public Health Agency of Canada, 2003) supports a framework that incorporates these broad principles, emphasizing the importance of nurturing the self-worth of individuals and highlighting the rewarding aspects of human sexuality while improving personal approaches to mature sexual relationships. These programs offer information that adolescents themselves have identified as critical to their development. These programs range from long term programs that require a lot of training and preparation to shorter presentation formats.

Health fairs are an example of a useful tool in sexual health education as a resource for youth. Choices Not Chances is an example of a health fair that is considered

to be the ideal health education program (Public Health Agency of Canada, 2003). This program consists of six interactive game stations that provide students with information about health and sexuality at their school during school hours. Choices not Chances is an excellent example of going beyond the basics and moving away from the anatomy only type of presentation. It invites discussion about the risks associated with sexual behaviors and the positive expression of romance and sex. This program, which has been tested at the high-school level, has been very successful in encouraging communication and providing youth with the information that they want in an enticing manner (Public Health Agency of Canada, 2003).

Bielay (1995) looked at the impact of popular magazines distributed in Canada that deal with sexuality and are being read by young Canadian women. The sample was obtained from three university classes at the University of Guelph. 251 single women between the ages of 18-25 completed the Hudson's sexual attitude scale and a scale that measured sexual topic content created by the researcher. The response rate was 55%. The most frequently read topics related to improving one's sex life, achieving orgasm, what men desire and sexual satisfaction. These findings suggest that sexual health educators should be aware of the impact of popular magazines on young women.

Agrell (2008) notes that not only has education in the area of sexual education changed, but also that the structure of education in general has changed over time. Many university courses are now being videotaped and broadcast on the internet. In terms of sexual health education, the internet is now a wealth of information. Websites like Sex Etc. offer young adults an anonymous forum in which they can ask questions that they might not otherwise feel comfortable asking and get responses from adult sexual health

experts. Questions regarding anal sex and how to make a girl orgasm are common on this website and may not be in classrooms due to the discomfort and embarrassment of both students and teachers. This is a unique opportunity for students to ask questions that are not being answered in the classroom or by their parents.

It is crucial that when examining sexual health education we take into account these newer and less traditional methods of education, empowerment and potentially negative messages. We must take an approach that looks at all angles, considers informal education and takes into account the impact that does not come from the classroom. However, it is important to note that while the internet offers a wealth of information, not all of it is accurate. Students need to be taught critical thinking skills so that they are able to recognize valid informational websites. While the internet can be an excellent resource for health information, it can also be a very dangerous one. Also it is now possible to practice communication skills online, a key component in sexual health education (Agrell, 2008).

In her research, Chaton (2007) highlights the importance of teaching children and youth to be media literate. This relates not only to internet use but to print and television as well. Chaton looked at fifth grade students and what was taught to them in their sexual health education curriculum. She found that while topics such as love, romantic relationships, dating and sexuality and the media were taught to the students, the students were receiving mixed messages as to what those concepts actually mean due to high levels of exposure from a highly sexualized media. Kon (2001) concurs that media representations of girl's health issues may not be parallel to what is healthy. Messages of what is ideal are bombarding young, impressionable girls through text, TV shows,

advertising, websites, magazines and books. Positive messages are lacking from the media, although its influence is powerful.

In 1999 began a new phase of Educational Reform in the English sector (Freeland, 1999). According to the Western Québec School Board (2008), this reformed curriculum is designed to better meet the needs of all students and create environments where all students can succeed. This reform is a completely new way of delivering the new program of studies and the curriculum. It is based on core competencies, cross-cultural competencies, integrated studies and lifelong learning. Students are being introduced to new learning methods and the time allotted for each subject in schools will be changed. The following subjects will be included in the reformed curriculum: French as a Second Language, Mathematics, Arts Education (i.e. Art, Music, Drama or Dance), Physical Education and Health and Moral Education (i.e., Catholic or Religious Moral Instructions or Protestant Moral and Religious Instruction). These changes will be introduced over time. In September of 2001, Elementary Cycle 2 (i.e., grades 3 and 4). In September of 2002, Elementary Cycle 3 (i.e., grades 5 and 6). In September 2003, Secondary Cycle 4 (i.e., grades 7, 8 and 9) and in September 2004, Secondary Cycle 5 (i.e., grades 10 and 11). This reform will take place across the province of Québec (Western Québec School Board, 2008).

In 2005, the government of the province of Québec cancelled class time for sexual health education (Head and Hands, 2008). The five hours per year that was previously allotted in class time for sexual health education was abolished (Amend, 2008). This made Québec the only province in Canada in which sexual health education is not a separate and mandated part of the school curriculum although the Ministry of Education

does state that students will still have access to resources in sexual health education such as nurses and psychologists at school (Whithers, 2008). Instead, teachers have been asked to incorporate lessons in sexual health education into other subjects (Whithers, 2008). Some believe this less structured approach will be beneficial to students, allowing for more organic discussions to arise (Agrell, 2008). In addition, this inclusive way of teaching sexual health education within other subjects will help students to understand sex and sexuality in an everyday context (Amend, 2008). However, critics say that this reform may deny students important information about their health, decision making and potential risks, such as STIs, as these reforms make it possible to go through schooling without a single sexual health education class (Elatrash, 2006). Within this approach, schools are free to choose how they want to spend class hours on the broad topics of not only sexual health education, but health and wellness (Whithers, 2008). The budget to bring in outside experts in the field of sexual health education to lead discussions and present information to the students has disappeared (O'Hanley, 2003). In essence, funding from the Québec government for sexual health education is simply gone (O'Hanley, 2003).

Introducing sexual health education into other subject matters, such as History or Mathematics, means more work for already overworked educators. Another potential problem is that these teachers may not be comfortable or trained to teach sexual health education (Elatrash, 2006). Some teachers may simply choose not to include projects and class discussions on issues relating to sexual health education (Lampert, 2003). O'Hanley (2003) states that it is very scary that this subject has become optional. Also, there may not be adequate time to allow students to absorb the information and ask questions; as

well, this may not be an environment that is comfortable for students to feel free to do so (Lampert, 2003).

Québec's Ministry of Education has also introduced a new approach to Health and Wellness called Healthy Schools. This program, currently taking place in six Québec schools, intends to bridge the gaps within schools, communities and public health agencies (Whithers, 2008). Yet this program will allow schools to focus on the health concerns that they believe are most affecting their students, such as obesity or physical activity. Sexual health education may not, in fact, be a priority (Whithers, 2008).

Encouragingly, organizations such as Montreal based Head and Hands are not only increasing their efforts to provide resources within communities, specifically to parents and children, they are outright fighting the decisions of this reform through petitions to reinstate sexual health education in Québec schools (Head and Hands, 2008). As well, the Head and Hands organization is working on a pilot project called The Sense Project that will offer sexual health education workshops in schools, anonymous counseling and training for students who wish to become peer educators (Head and Hands, 2008).

To summarize, this chapter reviewed the relevant literature on the topic of sexual health education, including specific references to the Québec context where the participants are located. The controversy over sexual health education is about the presumed negative consequences it may have on increased sexual activity among the students who are exposed to this curriculum and the objections of different stakeholders such as parents, religious schools and teachers who feel unprepared. The studies conducted with this in mind have not found any connection, causal or otherwise between

the curriculum of sexual health education and increased sexual activity among the students exposed to this education. In Québec, there existed in the eighties, a specific component of sexual education but with the recent reforms since the 1990s this was pulled out of the new prescribed curriculum (Balanko, 2002). Instead it was mandated that teachers mainstream this form of education throughout the curriculum incorporating this education in the different subjects they teach as part of the education plan. The next chapter will present the methodology followed and the data obtained.

Chapter Three

Methodology and Presentation of Data

This qualitative research project is based on participants' personal experiences and engages them as expert informants on the subject of sexual health education. I have chosen young women that are of my generation and age group for specific reasons. First, I wanted to include participants that have been out of school long enough that they have had some time to reflect, but not too long that they will have forgotten all of their schooling experiences. I chose to look solely at women because I believe this topic casts a wide enough net in terms of themes that will be brought forth; more specifically, I am allowing the women to interpret these research questions and answer them based on their own experiences. Finally, I have excluded women who are pregnant and who are mothers because in looking to the future generation and making suggestions, I did not want my participants to be thinking of their own biological children and acting as protectors.

For this project, I decided to recruit between four to six women that have been out of secondary school for two to five years. If the participants are doing an undergraduate degree, or if they are currently pursuing graduate studies or have pursued graduate studies during the aforementioned time period, they are still eligible. I have chosen this time period so that these women will have been out of school long enough to be able to reflect on their schooling experiences, but not so long that they will not be able to remember what they learned and how they felt. It is true that women participating in this research have not been themselves exposed to the current context of sexual-health education. Their contribution to the study is through what they remember of their own time of schooling and how the education that they received shaped their experiences. Another

condition was to recruit women who were educated in the English school system in Québec, for which both public and private school graduates were deemed eligible. I chose this criterion as there are differences in cultures, learning environments and classroom etiquette in French and English schools. There are many French schools in Québec and the results of this research may not apply or resonate to those populations.

To recruit participants for this project, I sent an e-mail to thirty of my peers, both friends and acquaintances, detailing my study and asking for help in recruiting participants. In this e-mail, I outlined the research project, as well as the criteria to participate in the study. I asked everyone to forward this e-mail for me to help recruit participants (Appendix B). Throughout the next two weeks, I received 12 e-mails from potential study participants. Two of these participants were excluded from the study. The first potential participant had been out of school for less time than the cutoff of two years and a second potential participant had spent the first three years of high school studying in a French school and was thus excluded as well.

I then emailed the 10 remaining potential study participants and asked for their addresses. I mailed out 10 copies of the open ended questionnaire and consent forms including a self-addressed, stamped envelope so that they were able to confidentially return all study materials to me without my knowing their identities in terms of their specific responses to the questionnaire. I asked that the participants place their signature on the informed consent form, but fill in the pseudonym name that they would like me to use in this study, to preserve confidentiality. Five of the potential 10 participants returned the consent form and the responses to the questionnaire.

As mentioned previously, the data were collected with an open ended questionnaire consisting of six questions (see Appendix A).The purpose of this questionnaire was to allow the participants to answer based on what they have understood and how they interpreted the questions. This allows for the research to take on a narrative form, allowing the participants to be free to tell their stories. It also gave the opportunity to the participants to become expert informants; in this study the participants were the experts, I looked to them for their opinions, their feelings, their thoughts and their suggestions. As women who have gone through not only sexual health education in school, but their own processes of sexuality, they are the ones to be consulted as experts of their own sexuality.

In the first mailing, I also sought permission to contact participants with follow up questions a second time, if necessary. I explained to participants that this second communication would be done via e-mail and then the same procedures as the first questionnaire would be followed. These scenarios enable the researcher to get all the information needed to identify key themes in the research and also allows the participants to maintain their confidentiality and make their own choices as to how they want to participate in the research.

Turner, Ku, Rogers, Lindberg, Pleach and Sonenstein (1998) found that when assessing the health behaviors of youth (i.e., sexual practices, use of drugs and alcohol, etc.) the lack of privacy afforded in a face to face interview dramatically affects the respondent's honesty in answering sensitive questions. The authors found that more accuracy was obtained in allowing respondents to answer paper and pencil self-administered questionnaires. However, these written questionnaires require a sufficient

level of literacy from the respondents; as well often respondents are wary of the anonymity of their responses especially when asked about their personal lives (Turner et al., 1998).

In the case of the present study all five respondents were educated and literate. This is defined as having a minimal of a high school education. Thus, by using both a written questionnaire and a possible follow up, the research design adopted here would allow the participants subjects not only to express themselves but to clarify exactly what it is that they mean. It turned out that I did not need to communicate with the five respondents once I received their completed questionnaires, as the statements they made were clear and addressed the questions asked.

The Data

In this section, I will summarize the data collected from five respondents who returned the signed consent form and the open ended questionnaire responses.

Lainie

Lainie is a 27 year old single woman. She is a university graduate and has been out of school for the last five years. While Lainie attended three different elementary schools, she has strong recollections of what she learned in sexual health education in those years. She recalls that it was mostly technical information: anatomy, Sexually Transmitted Diseases (STDs), safe sex practices and pregnancy. Lainie was comfortable learning about these subjects, but she was not comfortable asking questions. She found that any discussion on the emotional components of the context in which sex took place was notably missing.

Lainie spent all five years at the same high school. Yet it was not at school where she learned about sexuality. Lainie recalls obtaining most of this information from books, television, friends and magazines. She specifically mentions two magazines: *Cosmopolitan* and *Glamour*. She also credits the *Oprah Winfrey Show* as a source of sexual health information. Lainie also credits her knowledge to medical professionals and experts such as family doctors and obstetricians appearing on talk shows. Lainie states that she learned about sex but not through formal sexual health education. When asked to share a specific memory of her formal sexual health education, Lainie was unable to recall one.

In recollecting, Lainie does not feel that she was prepared through her formal sexual health education for her sexuality. She also does not feel that she was prepared at a

young enough age. While Lainie does credit sexual health education for teaching her, as she calls it, the technical aspects, such as anatomy, STDs, safe sex practices and pregnancy, she feels that the emotional components of a healthy sexuality were lacking. In fact, Lainie feels that the emotional component was learned outside of the classroom.

When asked for her opinions on what should be taught in sexual health education in the future, Lainie focuses on the emotional element of sexuality and readiness for sex. She feels that questions such as how long a couple plans to stay together, how they would feel after having sex and what they would do if a pregnancy occurred are crucial in discussions in sexual health education. Lainie writes:

> An essential element to teach and discuss in early high school classes is the emotional piece and readiness for sex. Dr. Laura Berman (as seen on Oprah) recently interviewed a young couple (12- 15 years old) whereby thinking about some consequences of sex was addressed. Questions such as how long does the couple plan to stay together, have they discussed what they would do if they became pregnant, how they would feel after having sex, etc…these were not addressed through my formal education and watching the show made me realize how important these topics are as kids and teens begin thinking about sex.

Lainie also emphasizes that these topics should be discussed in sexual health education class in the early years of high school. Lainie is adamant about the fact that these issues were not addressed through her formal sexual health education.

Rachel

Rachel is a 23 year old single woman. She is a religious Jewish woman and therefore will not have any physical contact with a man until she is married. She was educated in religious Jewish schools. She attended Beth Jacob, an all-girls school, for both elementary and high school. Rachel states that she did not receive any sexual health education at school. However, she was taught about sexual abuse, molestation and different types of harassment. Being that she was learning in an environment that included only females, Rachel felt comfortable in this setting.

Rachel learned about sexuality by talking to friends and relatives, most specifically her sister and her male best friend. She felt very comfortable learning from those that she had close relationships with and that she trusted. She states that she would not have wanted to have these discussions with her parents as it would have been uncomfortable. Consequently, she did not learn about sexuality from her parents. Rachel uses the word comfortable in a lot of her answers; which suggests that her comfort level in discussing these issues is important to her.

Rachel also learned a lot about sexual health from her sister and her male best friend while she was in tenth and eleventh grade. She feels that was the appropriate age to do so.

> It was mainly friends and relatives that would talk to me about Sexual health. I find that's a great environment to learn about this. It's with people that you are comfortable with. I wouldn't have Wanted to learn anything from my parents – I didn't. I don't think

> I would have been as comfortable. My sister taught me a lot of what I know, along with a guy friend.

She feels that sexual health education is very important and that if it is not going to come from home, it should come from school at the age when she learnt about sexuality, tenth and eleventh grade. Rachel feels that even if sexuality is taught vaguely, it does have a place in the school in the older grades.

When asked about something memorable she learnt, Rachel writes:

> I definitely learnt that men "all" think the same way. When they say something sexual, they mean it in a sexual way. Unlike females who can accidentally say something that can sound sexual but said it without intention. Again, this was all learned through family and friends.

Rachel felt that it is important to learn about sexuality from someone close, trusted and with whom there is a level of comfort. To the question about change for the sexual education of the next generation, Rachel wrote:

> We didn't learn that much in school, but I do think it's important to learn from someone at some point and not just right before you get married. So for someone to be responsible in schools (religious ones) that something be taught vaguely, I think can be a good idea. I think this would only be necessary in the older grades. I think I turned out fine without learning anything in school, but I was lucky to have people outside of school to teach me. Again, some kind of recognition is

> important and if it won't be from home, it should at least be from school (10th or 11th grade).

Talia

Talia is a university graduate who has been out of school for two years. She recalls receiving sexual health education in grades five and six and in high school. She remembers these sexual health education classes being very sporadic. In fact, she recalls that the best part of sexual education class was missing a regular class from the curriculum in order to partake in the discussion on sexuality. Talia writes:

> I remember the lame movies we would watch in sex ed classes in High school. They were very clichéd and irrelevant. We learnt the basics about sex, sexual abuse/rape, birth control. The topics made everyone feel pretty uncomfortable, especially at that age. I don't think that sex ed was so much needed in elementary school but would've been more useful in CEGEP.

Talia does not recall receiving the bulk of her sexual health education from a school environment. Instead, she feels that she learnt more from the media; television, movies and magazines. Talia wrote:

> A lot of the information I got about sex was from the media (T.V., movies, magazines). Also, being the youngest child in my family I got a lot of information from my siblings. I found learning about sex in these environments to be more comfortable.

While Talia did feel prepared for a healthy sexuality, she does not credit the sexual health education that she received in a formal school setting. She does not feel that the sexual health education that she received at school was adequate.

Talia feels strongly that girls need to be empowered at a young age. She feels

> ..that girls need to be taught at a young age that they have the right to say no in situations where they might feel pressured. I think so many girls have sex at a young age because they are pressured into it or due to a lack of self-esteem/confidence.

Audrey

Audrey is 26 and single. She has been out of school for the last three years. She has a graduate degree. Audrey recalls her sexual health education in the form of Family Life Education in elementary school. She remembers learning about her body and about menstruation. She recalls having access to the book *Our bodies, Ourselves* and finding it very easy to understand and non-threatening. She felt that learning in this way was better than learning from her own teachers.

> We also had access to books: "Our bodies, Ourselves", that were much easier to understand and much better (aka non-threatening) to learn from my aging English or Math teacher.

Audrey recalls learning about STIs in grade ten. She recalls the educators as being young and knowledgeable, yet the experience left her with the distinct feeling that this was a scare tactic.

> I remember learning about STIs in high school. The educators were young, knowledgeable and knew how to work well with

> teenagers. However, this was in grade ten and I had the distinct impression that the session was intended as a scare tactic. Overall, these experiences were not comfortable for me. None of them left me feeling "prepared" for handling serious conversations about sex or sexual health in real life.

Audrey has always felt more comfortable with informal sexual health education. She recalls speaking with friends that she trusted, this allowed her to ask difficult questions and get honest answers, Audrey and her friends have learned together and supported each other through their experiences with sexuality.

> I have taken in a lot of information as a passive observer. I did not have valuable sex ed at home. I can't imagine how difficult it must be for parents to approach their kids for "the talk" and who prepares them for that? I'm already worried about how I'm going to handle it with my kids, and I don't even have any yet!

A specific memory that Audrey has of sexual health education was an episode of *Beverly Hills 90210* that she saw when she was in elementary school. She recognizes that the episode was likely intended for an older audience. In this episode, there is an assembly at the school about AIDS and the speaker is HIV positive. Audrey recalls this moment as the moment she learned about safe sex as a social issue. Before this, she did not know that there were things for a couple to discuss.

> I remember an episode of *Beverly Hills 90210* where the school had an assembly about AIDS and there is a speaker with HIV who addresses the students. Donna Martin has vowed not to have

> sex before marriage and is very vocal about this decision. I was in elementary school when this episode aired and I know that it was intended for an older audience, but it is what stands out for me as the moment that I learned about safe sex as a social issue. I don't think that I knew that there were things for a couple to discuss before this point.

Audrey tends to question the information that is out there. When asked if she felt prepared for a healthy sexuality, her answer was no. But she feels

> …that perhaps we are not meant to be fully prepared, perhaps we need to learn from a place of discomfort and make decisions that are unique to a specific situation.

Continuing with this theme of questioning, Audrey questions the current promotion of the HPV vaccination. She feels that there is too much promotion and not enough education. She feels that young girls, aged nine, who are being vaccinated are being introduced to the topic of sex from the angle of disease and danger. Audrey had questioned this topic and researched it on her own and she feels that once again sexual health is being used as a scare tactic.

> If HPV is sexually transmitted, why are women being vaccinated and not men? And girls and boys since they are starting to become sexually active at such a young age. That's one of my questions that I've had to research on my own. And I wonder what sexual health education has been given to nine year old girls as they are

> being introduced to the topic of sex from the angle of disease and danger.

Laila

Laila is currently a PhD candidate. She is 24 years old. She has been in school all of her life, except for one year in which she took a break between degrees. She does not have children and is in a common law relationship. Laila does not recall much regarding her formal sexual health education in school. She remembers that the sessions were done in fairly large groups and were coed. She also remembers feeling uncomfortable.

Laila's mother was very open about talking about sex. In fact, Laila and her siblings were shown a cartoon about where they came from. Laila writes:

> The movie only showed a sperm in a top hat waltzing with an egg (in a pink bow of course) – friends at school later cleared that all up. I did learn all the details from friends. I suppose I was more comfortable with friends than with my parents.

While Laila's mother was very open about sex and provided her with some of the basic information, Laila learned all of the details of sex from her friends. She was more comfortable talking about sex with her friends then with her parents.

Laila does not feel that formal, school based sexual health education prepared her for a healthy sexuality. However, Laila recalls receiving information on what to do from other informal sources. Laila does not recall talking about what it means to be involved in a sexual relationship until her late teen years.

When asked about her opinions for future sexual health education Laila stated that she feels that more time should be spent talking about pressure, decision making and empowerment.

> I would definitely spend time talking about dealing with pressure, decision making and empowerment. Kids learn the basics already but it is important to arm them with the skills to deal with being in a sexual relationship (i.e. assertiveness, communication). My current experience working with kids is that those skills are lacking for many. Also, I would emphasize safe sex behaviors perhaps more than abstinence because they need to have that knowledge.

In summary, this chapter presented the methodology adopted, the procedures followed to collect the data from the five respondents who were retained as participants in the study on which this thesis is based. The data are presented using verbatim quotes from the responses received from the open-ended questionnaire sent to the participants. The next chapter will analyze the data based on emerging themes and their resonance in the literature as reviewed in Chapter Two.

Chapter Four

Analysis of Data and Recommendations

Data Analysis

After receiving the completed questionnaire and consent forms, I began the analysis of the data by reading through the interviews, picking out different themes and highlighting each theme by color codes. In the interviews, the following themes were coded; technical information, discomfort, lack of emotional components in the curriculum, books and magazines, friends and relatives, television, medical professionals, no sexual health education at school, teachers attitudes about sexual health and the use of internet. Once these themes were identified, links were made with the existing literature on each topic, and finally future recommendations for research were made.

Technical information. This theme includes anatomy, STDs, safe sex practices and pregnancy. It also includes abuse and harassment as well as scare tactics used as educational tools to scare the students out of engaging in sexual practices. In her interview, Lainie states that sexual health education was mostly technical, and that this information included safe sex practices, STDs, pregnancy and anatomy. Rachel recalls being taught about sexual abuse, molestation and different types of harassment. Audrey remembers learning about her body and menstruation. She also recalls that while the teachers were young and knowledgeable, she left her sexual education class feeling that this education was in fact a scare tactic. Talia states that she too remembers being taught the basics: sex, sexual abuse, rape and birth control.

This technical information is not enough according to the respondents who state that they needed more information, more discussion on emotional components and more

discussion in the classroom. Lainie stated that while she was taught the more technical aspects of sexual health, any discussion on the emotional components of sex was noticeably missing from the curriculum. This is congruent with the literature reviewed previously. Nova Scotia Health Promotion and Protection (2008) defines sexuality as more than just safe sex. This term includes healthy relationships, self-esteem and comfort in making decisions. Health Canada (2006) adds that sexuality education must include the skills and knowledge to make healthy safe and comfortable decisions that result in empowerment and positive sexual outcomes. Laila agrees, stating that "…more time should be spent talking about pressure, decision making and empowerment."

In the late 1990s, the time when the women interviewed for this project were in school, the goal of sexual health education and prevention plans was to change high risk behavior. There was a lot of advocacy for abstinence only curricula (Balanko, 2002). Yet the research shows, and our respondents agree that this is not the only need. According to Ottson et al. (2004), the need for comprehensive interventions is a priority. This is not limited to technical information. Lainie concurs,

> … missing was the emotional element of sex, questions such as a couple`s readiness for sex, how they would feel after having sex and what they would do if a pregnancy should occur. These are crucial components in sexual health education and were noticeably missing from any curriculum that I was a part of.

Paryani (1999) did a study in which adolescent perceptions of the quality of sexual health education received in schools was evaluated. The majority of the participants in this study agreed that sexual health education was, in fact, beneficial and

did provide them with information that they did not previously have. Not only that, but the students had many questions and were eager to learn more. The research participants in this project seem to agree. All participants stated that sexual health education was useful and that they learned from it. They stated that they learned from these experiences, they did not learn enough. This is very important, as students and previous students have stated that sexual health education is beneficial. And yet despite this reality, the Québec government has removed all sexual health education classes from the curriculum, which is not what the studies are showing to be beneficial to our youth (Western Québec School Board, 2008).

Discomfort. The theme of discomfort is closely related to the theme of technical information. Both themes link to what specifically is in the sexual health education curriculum and what is notably missing. Balanko (2002) identifies that this tension or discomfort exists as there is an innate assumption that sexuality education shapes the values and morals of our youth. This tension and discomfort are likely due to the sensitive subject matter that is, in fact, sexuality. The respondents of the present study stated not being comfortable in sessions of formal sexual health education, especially in asking questions.

The respondents in this study discuss being more comfortable talking to friends or siblings than teachers or parents. Also, they stated that they felt more comfortable getting information on sexual health education from people that they were close to and who they trusted. Lainie was comfortable learning about the subjects taught in sexual health education, but not comfortable with asking questions. For Rachel, the level of comfort seems very important to her. She used the word comfortable in many of her answers; this

means emotionally comfortable, specifically learning from people with whom she feels emotionally comfortable. Talia remembers feeling very uncomfortable in classes involving sexual health education. She was more comfortable getting the information from people close to her, such as her siblings, and asking them questions. There was also the issue of getting the information in a one on one setting or in smaller groups. Another suggestion was that the curriculum be presented to same sex groups: women only groups would be preferred for this type of sensitive educational matter (Rachel). All of the women have stated that they were more comfortable learning about sex outside of the classroom. This is a problem if we are to continue formal sexual health education as it will never be as successful as it can be if students are not comfortable with it.

Lack of emotional components. The subjects discussed a lack of the emotional aspects of sexual relationships within the sexual health education that they received. It was also suggested that self-esteem be used a building block within this educational program. Lainie stated that while she was taught the more technical aspects of sexual health, any discussion on the emotional components of sex was noticeably missing from the curriculum. She learned the emotional components of sexuality outside of the classroom.

Yet there is no direct sexual health education program in Québec anymore since the most recent Education reform (Western Québec School Board, 2008). The new program eliminates sexual health education form the curriculum and instead asks teachers of all subjects to incorporate lessons of sexuality into their lesson plans. This program is based on core competencies, cross-cultural competencies, integrated studies and lifelong learning (Western Québec School Board, 2008). This is expected to lead to more organic

conversations and help students to understand sex and sexuality in an everyday context (Amend, 2008). Yet again, noticeably missing here is any discussion of emotional components in a sexual health education program. And as this study's participants agree that this is truly important … in the future, sexual health education should largely focus on the emotional element of sexuality and readiness for sex (Lainie).

Books and magazines. The respondents stated that they received much of their sexual health education outside of the school context, specifically from books and magazines. It was stated that learning about sex from books was less threatening. Laila recalls being …shown a cartoon about where they came from. In this cartoon the sperm, wearing a top hat, was waltzing with the egg, wearing a pink bow (Laila). She states that this cartoon left intercourse unexplained. She filled in the gaps by talking to friends. Audrey specifically recalls the book *Our Bodies, Ourselves*. Reading this book, she learned a lot about sexuality. She found the book to be both easy to understand and non-threatening. Lainie credits magazines such as *Cosmopolitan* and *Glamour* as sources of information. Bielay (2005) looked at the impact of popular magazines dealing with sexuality that are being read by young Canadian women. He found that the most frequently read topics related to improving one`s sex life, achieving orgasm, what men desire and sexual satisfaction. This is not necessarily comprehensive information, nor does it deal with emotions and technical information, which the participants in this research project felt were important components in their sexual health education. Educators must be aware of the impact of these readily available popular magazines on Canadian adolescents.

Television. Television is another popular culture outlet that provided the subjects with sexual health education. Lainie credits the *Oprah Winfrey show* as a source of information as family doctors and obstetricians appeared on the show. Talia also learned about sex from the media, she credits television, movies and magazines as information sources. Talia specifically recalls watching R rated movies at a young age where she learned what she openly admits was likely inappropriate at that young age. Audrey also specifically recalls an episode of the television show *Beverly Hills 90210,* a popular show among teenagers. This particular episode dealt with the issue of AIDS. This was the first time Audrey thought of sex as a social issue and realized that there were important aspects that couples should discuss.

As with the internet, students must be taught to be media literate as they are getting receiving messages from the media (Chaton 2007). Chaton (2007)'s study looked at the messages fifth grade students were receiving from exposure to highly sexualized media. Kon (2001) agrees that media representations of women`s health issues may not be parallel to what is healthy as positive messages are lacking from the media. Women are frequently exposed to the media: sexual health education should be a key component in dispelling those myths and creating a healthy sexuality for the future.

Friends and family. This theme seemed to be closely connected to the theme of discomfort as the five respondents were in fact more comfortable going to friends and family with their questions and concerns about sex. They discussed being more comfortable talking to friends or siblings than teachers or parents as they felt more comfortable getting information on sexual health education from people that they were familiar with. Lainie received some sexual health education from her friends. Rachel

received her sexuality information by talking to family and friends, most specifically her sister and her male best friend. She feels that it is important to learn about sexuality from someone close to you. She did not discuss sexuality with her parents as that was too uncomfortable for her. Talia asked her sexual health questions to her siblings. Audrey spoke about sex with friends that she trusted. Laila's mother was very open about sex with Laila and her siblings, although Laila chose not to talk about sex with her. Instead, Laila chose to talk to her friends about sex and get her information from them. If sexual health education were more comprehensive in the classroom, more present and more needs based, would there be such a need to talk to others outside of the classroom?

Brock and Jennings (1993) took a reflective look at sexual health education by asking daughters what they remember being taught to them about sexuality from their mothers. The daughters wished their mothers had taught them more and recalled discussions with negative non- verbal messages and rules. Access to comprehensive formal sexual health education in the classroom could reduce these limited discussions and instead include plenty of comprehensive information to aid in making healthy decisions.

Medical professionals. The participants in this study did state that they received some information on sexual health from medical professionals. Lainie credits family doctors and obstetricians appearing on talk shows for information on sexuality. Yet this is not commonly mentioned in the research or in the literature. There is a shortage of more than 800 family doctors in Québec (The Gazette, 2008). Perhaps that lack of family doctors in Québec is the reason that this is not discussed by the research participants. Further research could be done on this issue looking at whether adolescents have access

to family doctors and obstetricians. Also, it is important to examine whether doctors and other health professions like school nurses or community health clinic, Centre Locale de Service Communautaire (CLSC) personnel receive training and feel comfortable discussing about sexual health matters with their young adult patients.

Insufficient sexual health education at school. Perhaps most shocking is this theme. Almost all of the subjects do not have any recollection of any formal sexual health education at school. Some of the women stated that the education in sexual health was very sporadic, not enough time was dedicated to this important subject. Rachel does not feel that she received any sexual health education at school. She attended an orthodox Jewish school. Others felt that the sexual health education at school was inadequate and did not leave them prepared for a healthy sexuality. Laila did not feel that enough emphasis was placed on safe sex behaviors which she feels are crucial in preparation for a healthy sexuality. Instead, the emphasis was on abstinence. Allen (1992) found that sexual health education did not provide students with basic knowledge needed to make informed, safe health decisions. Markiewicz (2005) found that students educated in sexual health matters would practice safer sex behavior. Yet in 2005, the Québec government cancelled class time for sexual health education. The five hours that were previously allotted were abolished (Amend, 2008).

Yet in the literature examined and the research result from this project, all signs point to sexual health education being beneficial. The women interviewed for this project wanted more sexual health education, not less. They did not feel prepared and felt that the education that they did receive was not comprehensive, was missing key components and did not necessarily prepare them to make healthy decisions regarding sexuality.

Teachers. Teachers and the issues surrounding them were briefly discussed in the research by one participant, who stated that "…the educators were young, knowledgeable and knew how to work well with teenagers" (Audrey). None of the other research participants discussed the educators. Audrey thought that the approach used by the young and knowledgeable educators was one of inducing fear to stay away from sexual activity.

On the other hand, in the literature, there is a strong body of research on teachers and educators with regards to sexual health education. And much of it does not follow the same line of thinking as Audrey did. The majority of the research looks at teachers discomfort and lack of preparation and training in teaching sexual health education. Mehra (2003) found that educators may be uncomfortable talking about sex, and may fear parental backlash. Bondy (2005) surveyed teachers and found that teachers felt unprepared and untrained. This impacts the students and the capacity for learning in the classroom. Matthews (2006) teachers found that teacher training must be a priority in order to implement proper sexual health education practices in the classroom.

The Internet. The internet as a source of information is a theme found in the recent literature but is absent from the respondents' narratives. Taking into consideration the age of the women who participated the study on which this thesis is based, we know that the internet was not nearly as popular or accessible when they were in school, as it is today. These women were doing their schooling at a time where the internet was not well developed and was not easily accessible. This fact may account for the fact that the women did not talk about the internet as a factor in their sexual health education. This is very different from the role that the internet plays in our lives today (The Foundation for Critical Thinking, 2011.)

Today, the internet is an important tool for information. On the internet, we can find both comprehensive, scientifically fact based information that is accurate, and some information that is completely inaccurate. There are many websites that offer students the opportunity to learn more about sexuality. The internet can be an effective complement to traditional sexual health education, but should not replace existing formal and informal sexual health education practices. Also, as with any practices using the internet, critical thinking skills are necessary. Critical thinking skills are defined as a method of thinking that looks at assumptions (Foundation for Critical Thinking, 2011). According to this source, to think critically one must conceptualize, analyze, synthesize and gather information before making decisions and taking action. These skills are crucial not only in looking towards the internet for resources and information on sexuality, but sexual health education as a whole.

Opportunities and Challenges for Futures Research

While compiling data there were so many future research questions that could, and should be looked at. In this section, I will examine potential future research possibilities based on the results that came from this project. In this research, the subjects were women who have been out of school for two to five years and were asked to reflect on sexual health education. This was a very specific study, and it would be useful to see if the same results would emerge when looking at other populations. Future research could look at men and ask them the same questions. Other populations to look at with regards to sexual health include parents, current students, health professionals and teachers. The difference, if any, in public and private schools in terms of sexual health education could be examined as well as in the French language schools. Future research

could look at parents, both mothers and fathers, and ask them what they would like to see in a sexual health curriculum for their children as well as for themselves. This research could benefit from their experiences.

Another population that could be crucial in this research would be talking to family doctors, nurses and obstetricians. How prepared do they feel in educating their patients about sexuality? Is sexual health education a part of their practice? Should it be? How can doctors be better prepared to be teachers?

In the literature there was a lot of research looking at teachers. The women interviewed also mentioned lack of teacher preparedness and enthusiasm. More comprehensive research looking at educators should be done. Research could be done at the university level, looking at the preparation teachers to be are given in their coursework on sexual health education. These same questions could be asked regarding readiness and comfort to teachers currently in the classrooms. A look at male versus female teachers and seasoned versus new teachers would yield interesting results. This research could have an impact on the new policies within sexual health education. This kind of research would be relevant to all teachers in the school as sexual health lessons are now being incorporated into other subjects (Whithers, 2008). Looking at whether this phenomenon of teaching sexual health lessons within other subjects instead of on its own is beneficial for the students is critical. This research should be conducted sooner rather than later as that is the current policy in Québec (Western Québec School Board, 2008).

That being said, future research could examine precisely the fact that sexual health education has been abolished (Amend, 2008) and is now being incorporated via

lessons into other subjects (Whithers, 2008). This is very relevant, as the participants in this study all agreed that there was not enough sexual health education.

Another useful future research topic would be to look at the impact of the Internet on sexual health education. This was not mentioned by the participants of this study, likely as the internet was not as prevalent when they were in school as it is today. There is not much information out there. Also, some of it is correct and most of it is erroneous or simply misleading. Yet, the internet is where young people today get so much of their information (Media Awareness Network, 2009). Future research could look at specific websites and disseminate guidelines as how to discriminate between credible and non-credible information. The research could ask teachers how they incorporate the internet into their sexuality education. The same could be asked of parents and students. The potential of using the internet as a tool for sexual health education is great. This is also a very important topic to study as young people today are spending up to 31 hours a week on the internet (AOL Tech, 2009).

Another useful venue to pursue for future research would be to look at health fairs and their impact on sexual health education. Health fairs are a relatively new phenomenon in sexual health education (The Canadian Guidelines for Sexual Health Education, 2003) and accessing their impact would be useful. Research could look at the impact of health fairs as a resource on parents, educators and, of course, students.

A methodological point has to be made as well in planning future research on this topic. While the anonymous, open ended questionnaire used in this thesis was a useful choice for this thesis project, it is felt that more in depth research methods, such as one on one interviews and focus groups will facilitate a deeper exploration and elicit insights and

promising venues for a better understanding of the challenges and opportunities available to educators, both in formal and informal settings where sexual health education occurs.

Conclusion

As a teacher and health educator, this project is very relevant to my own work. I teach sexual health education. I am a CEGEP teacher, and in our Physical Education curriculum, we include a module on risky behaviors, in which we teach sexual health education although very briefly. It was my goal with this project to see what was in the sexual health curriculum followed by women who were my peers as represented by the five respondents in this study. I also wanted to know how women my own age felt about the adequacy of their formal sexual health education in preparing them for a healthy sexuality. My results, while disappointing, unfortunately did not surprise me.

The Québec government has cancelled sexual health education and is now incorporating it as lessons into all subjects (Western Québec School Board, 2008), in spite of the fact that rates of STDs and teen pregnancies are on the rise (sexualityandu.ca, 2007). The research that I reviewed suggested that adolescents want and need more comprehensive sexual health education. My own study participants seem to support the idea that: there was not enough sexual health education in the classroom and it lacked major components such as emotional aspects and comfort levels.

Thus, I would recommend that sexual health education be returned to the classroom as its own comprehensive subject. This subject matter should be taught weekly, if not more often, and should start from the early years of schooling. However, educators must be trained and prepared properly to teach these courses at the appropriate level in each grade. I also feel that those educators that are comfortable teaching sexuality education should choose to do so, not be forced as part

of another subject matter that they teach. This effort should also become a priority of university level education in relation to teacher education, medical schools and the programs that prepare public health professionals for their practice upon graduation. Sexual health education needs to be comprehensive, not only to include technical information but emotional components as well. An environment must be designed where students feel comfortable asking questions and can receive reliable information that will help them to make informed health decisions.

Sexual health education must also become a collaborative effort. Formal sexual health education should occur in the classroom, but parents also need to talk to their children about sex at home. Older siblings should initiate these dialogues with their younger siblings. Doctors and other health professionals, school nurses and counselors, as well as religious educators in private religious schools, need to start educating their patients, students and youth they care for, about sex in contexts and environments where the young person concerned feels comfortable. Along with sexual health education, media literacy and critical thinking skills must be introduced in the curriculum to prepare students in sifting through popular media presentations of sexuality (The Foundation for Critical Thinking, 2011).

Let us return to the originating question: Are we currently doing enough in terms of sexual health education? The research results presented in this thesis and the related literature review suggest that we are not attentive enough to the needs of our youth in terms of sexual health education. But both the literature review and the study have also shown the need to supply information to our youth. Therefore, formal public and private education institutions should be responsible in developing

informative, credible programs and effective strategies to make sexual health education a priority.

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APPENDIX A

Sample questionnaire- open ended questions for study participants:

1) Demographic questions:

Age

Marital Status

Do you have children?

Where and when did you attend elementary school?

Where and when did you attend high school?

Where and when did you attend CEGEP? (if applicable)

Where and when did you attend university? (if applicable)

How many years have you been out of school?

Where and when did you attend graduate school? (if applicable)

2) Open ended study question

All of these questions are open ended and ask the subject to reflect on past experiences.

A note of explanation of the term "educational experiences" was included with the questionnaire: Education does not only take place in the classroom. Although, when it does it is called formal education. Many other types of educational experiences teach us and prepare us for the future. These include such examples as: what we learn at home, from our families, from our friends, from the media and from our peers, just to name a few. This is known as informal education. I would ask you to consider all types of educational experiences when answering this questionnaire. Anything that resonates with

you, any memories that you have are very relevant to this research. Anything that you learnt, wherever and from whomever you learnt is important.

1) What do you remember about sexual health education in school (elementary, high school, CEGEP, university)? What did you learn? Did you feel comfortable in these learning environments?

2) What do you remember about sexual health education outside of school (home, friends, television, books, journals, periodicals, websites, etc…)? What did you learn? Did you feel comfortable in these learning environments?

3) Looking back, where do you feel that you got most of your sexual health education?

4) Please share any experiences with sexual health education (any type of education) that are memories to you. What lessons did you learn?

5) As a woman, do you feel that you were adequately prepared, in terms of sexual health education (information on sex, love, decision making, diseases, empowerment and confidence), for your sexuality?

6) What would you change (topics you would want emphasized, not discussed at all) for the sexual health education of the next generation?

APPENDIX B- SAMPLE EMAIL RECRUITMENT LETTER

To whom it may concern,

My name is Erin Goldstein and I am a graduate student in the department of educational studies at Concordia University working on my MA Thesis Project. Since my research involves young women in my age group (23-29), I am reaching out to friends and acquaintances to help me find participants for my project.

My research looks at sexual health education: where we get it, its adequacy and what we should change for the next generation. In asking you to look back on the sexual health education that you received, you can comment with distance and maturity and assess whether or not you felt well educated and prepared. This research is **completely confidential.** No real names are ever used and your answers are kept confidential. This research does not ask personal sexual questions, it is not looking for personal experiences. Rather, I will ask you to comment on what you knew, where you learnt it and whether it was enough. You are the expert.

This research asks for a very small time commitment. You will be sent a questionnaire with six questions to fill out. You send this back to me by mail without your name on it, I will never know who answered what. You will also be asked for your consent for a follow up mailing based on the themes emerging from the analysis of the questionnaire, if need be. This research may be published.

You are eligible to participate in this study if:

1) You are female
2) You do not have children

3) You are between the ages of: 23- 29 years old.
4) You were educated in Québec in the English school system.
5) You have been out of school for between 2- 5 years. (If you are enrolled in, or completed a graduate degree during that time you are still eligible).

Thirty- three percent of Canadians aged 18-19 have reported having sex without a condom (sexualityandu.ca, 2007). Females account for over two-thirds of all reported cases of Chlamydia; and in that, two-thirds of all reported cases are in the 15- 24 female age group (seuxalityandu.ca, 2006). These are just some of the recent statistics, there are many more. Your input can help change what the next generation, your children, learn in school. We can help prepare young girls to make smart, well-informed sexual decisions. If you are interested in participating in this research, or would like some more information, please do not hesitate to e-mail me.

Thank you for your help!

Erin Goldstein

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Arpi Hamalian

Professor, Department of Education, Concordia University, MA Thesis Advisor

(514) 848- 2424 ext. 2014

ARPIHAM@hotmail.com

APPENDIX C- INFORMED CONSENT FORM

This is to state that I agree to participate in a program of research conducted by *Erin Goldstein* of the *Educational Studies department* at *Concordia University.* The researcher can be reached at 514-983-9141 or by e-mail at erin_shauna@hotmail.com
She is working with her MA Thesis advisor, Arpi Hamalian, (514) 848- 2424 ext. 2014, or by e-mail at ARPIHAM@hotmail.com

A. PURPOSE

I have been informed that the purpose of the research is as follows: To ask women to look back, with maturity and distance on their sexual health education, both formal and informal in order to assess whether or not this education prepared them for a healthy sexuality. The participants will then give their suggestions for future sexual health curriculums, thus helping shape the sexual health education of future students.

B. PROCEDURES

Interested participants will be asked to contact the researcher by e-mail. Interested participants will have received a forwarded copy of the researcher's call for study participants (Appendix C). Once the researcher has received an e-mail from a potential participant, the researcher will check to ensure that the participant is eligible to participate in the study and that she understands what is being asked of her and her options to discontinue at any time.

Once the researcher has cleared study participants and participants have agreed to participate, the researcher will ask them for their address. The researcher will then mail

them an informed consent from, the open ended research questionnaire and a self addressed, stamped envelope. The researcher is sending the participants a self- addressed stamped envelope so that they are able to confidentially return all study materials to her without the researcher knowing their identities in terms of their responses to the questionnaire. The researcher will ask that the participants sign their signature on the informed consent from, but fill in the pseudonym name that they would like used in this study. This is a way for the researcher to get informed consent while keeping the identities of my subjects confidential. The informed consent documents, and all other papers pertaining to this research, will be kept in the researcher's home office. As the researcher lives alone, no one else has access to this information.

The data will be collected with an open ended questionnaire. This questionnaire consists of six questions (see Appendix A) that are very broad, left open to the understanding of the participants. This will allow the participant to answer based on what they have understood and how they have interpreted the question. This allows for the research to take on a narrative feel, allowing the participants to be free to tell their stories. It also allows for the participants to become expert informants; in this research the participants are the experts, the researcher am looking to them for their opinions, their feelings, their thoughts and their suggestions. As women that have gone through not only sexual health education in school, but their own processes of sexuality, they are the ones to ask, they are the experts on this subject.

The researcher will also seek permission to contact them with follow up questions a second time, if need be. This contact would be done via e-mail and then the same procedures as the first questionnaire would be followed. These scenarios enable the

researcher to get all the information needed to identify key themes in the research and also allows the participants to maintain their confidentiality and make their own choices as to how they want to participate in the research.

This research may be published; if this is the case any publications will use the pseudonyms of the participants.

C. RISKS AND BENEFITS

The risks to the participants in this study are very minimal. Due to the nature of the research, sexual health education, there is a risk of heinous discovery or embarrassment. Should this occur, the researcher has obtained the proper referral names and numbers for counseling services at Concordia (see Appendix E). Participants are free to decline answering any question that makes them uncomfortable. They are also free to withdraw from the study at anytime and will be constantly reminded of that option.

Participants will benefit in this study by offering their perspectives on the sexual health education that they have received. They will also benefit by participating in a follow up questionnaire, if they choose to do so, and expressing their feelings on the themes emerging from the first questionnaire. The participants will benefit from this research by being able to give their opinions for sexual health education for future students, thus making suggestions for change for the future.

D. CONDITIONS OF PARTICIPATION

- I understand that I am free to withdraw my consent and discontinue my participation at anytime without negative consequences.

- I understand that my participation in this study is CONFIDENTIAL
- I understand that the data from this study may be published, keeping the identities of the respondents anonymous.

I HAVE CAREFULLY STUDIED THE ABOVE AND UNDERSTAND THIS AGREEMENT. I FREELY CONSENT AND VOLUNTARILY AGREE TO PARTICIPATE IN THIS STUDY.

IN ORDER TO KEEP THE IDENTITY OF THE PARTICIPANT CONFIDENTIAL, PLEASE SIGN YOUR LEGITIMATE SIGNATURE BUT PRINT THE PSEUDONYM YOU WISH TO HAVE USED FOR YOU IN THIS STUDY.

NAME (Please print pseudonym): _____

SIGNATURE (legitimate): _____

If at anytime you have questions about your rights as a research participant, please contact Adela Reid, Research Ethics and Compliance Officer, Concordia University at (514) 848-2424 ext. 7481 or by e-mail at areid@alcor.concordia.ca

APPENDIX D- RESOURCES FOR HEINOUS DISCOVERY

Due to the fact that this research asks questions of a personal and sexual matter there is a risk for heinous discovery. Since I am not an expert in counseling, I felt that it was important to be prepared in case any of my subjects needed some further resources. I met with Dr. Jeffrey Levitt of Concordia's Counseling and Development Services and we discussed my research. He suggested that I find the phone numbers for local CLSCs as referrals and resources. This would be a free and accessible service to any of my study participants.

The following is a list of phone numbers of local CLSCs:

- Ahunsic – 514-381-4221
- Bordeaux-Cartierville – 514-331-3120
- Côte-des-Neiges – 514-731-8531
- Faubourgs – 514-527-2361
- Hochelega-Maisonneuve – 514-253-2181
- Lac-St-Louis – 514-697-4110
- LaSalle – 514-364-6700
- Mercier-Est / Anjou – 514-356-2572
- Métro (Downtown) – 514-934-0354
- Montréal-Nord – 514-327-0400
- NDG / Montreal-West – 514-485-1670
- Olivier-Guimond – 514-255-2365
- Parc Extension – 514-273-9591
- Petite Patrie – 514-273-4508
- Pierrefonds – 514-626-2572
- Plateau Mont-Royal – 514-521-7663
- Pointe-aux-Trembles / Montreal East – 514-642-4050
- Pointe Sainte Charles – 514-937-9251

- René-Cassin – 514-488-9163
- Rivière-des-Prairies – 514-494-4924
- Rosemont – 514-524-3541
- Saint-Henri – 514-933-7541
- Saint Laurent – 514-748-6400
- Saint Léonard – 514-328-3460
- Saint-Louis-du-Parc – 514-286-9657
- Saint-Michel – 514-374-8223
- Verdun / Côte Saint-Paul – 514-766-0546
- Vieux Lachine – 514-639-0650
- Villeray – 514-376-4141

(Momtreal, 2007).