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Sex Information & Education Council of Canada
Conseil d'information & d'éducation sexuelles du Canada

QUESTIONS & ANSWERS:

SEXUAL HEALTH EDUCATION IN SCHOOLS AND OTHER SETTINGS



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INTRODUCTION

“ Sexual health is a central and multidimensional aspect of overall health and well-being. It involves the achievement of positive outcomes and the prevention of outcomes that can negatively impact sexual health. ”
(SIECCAN, 2019)

In principle, all people in Canada have a right to the information and opportunities to develop the motivation and skills necessary to prevent negative sexual health outcomes (e.g., sexually transmitted infections [STIs], sexual assault/coercion) and to enhance sexual health (e.g., positive self-image, capacity to have respectful and satisfying interpersonal relationships).

The Public Health Agency of Canada has recognized the importance of sexual health education in addressing a range of sexual health promotion issues among Canadians (Public Health Agency of Canada, 2008; 2010a; 2010b; 2013). Access to effective, comprehensive sexual health education is an important contributing factor to the health and well-being of people in Canada.

There are numerous avenues for the provision of comprehensive sexual health education across the lifespan. School-based programs are essential for providing sexual health education to young people. Additional settings, such as primary care and community organizations, are central for the delivery of sexual health education to adults and members of various populations who may not have continued access to high quality sexual health education.

Educators and other professionals in these fields should be supported in their efforts to provide effective sexual health education and ensure equitable access to sexual health education for people in Canada.

Canada is a pluralistic society in which people with differing philosophical, cultural, and religious values live together with a mutual recognition and respect for the basic rights and freedoms that all people are entitled to in a democratic society. Philosophically, the 2020 edition of SIECCAN's *Questions & Answers: Sexual Health Education in Schools and Other Settings* reflects the democratic, principled approach to sexual health education embodied in the updated 2019 *Canadian Guidelines for Sexual Health Education* (SIECCAN, 2019).

The *Canadian Guidelines for Sexual Health Education* are based on the principle that sexual health education should be accessible to all people and that it should be provided in an age appropriate, culturally sensitive manner that is respectful of an individual's right to make informed choices about sexual and reproductive health. This approach is aligned with *The Canadian Charter of Rights and Freedoms'* articulation of all Canadians' rights to personal liberty and security of person and freedom of thought, belief, and opinion.

Sexual health education, informed by democratic principles, provides people with complete and accurate information so that everyone has the capacity to make informed decisions that directly impact their own health and well-being.

SEXUAL HEALTH EDUCATION IN SCHOOLS

In order to ensure that youth are adequately equipped with the information, motivation, and skills to protect and enhance their sexual and reproductive health, **“it is imperative that schools, in cooperation with parents, the community, and health care professionals, play a major role in sexual health education and promotion”** (Society of Obstetricians and Gynecologists of Canada, 2004, p. 596).

As stated in the Canadian Guidelines for Sexual Health Education:

“Since schools are the only formal educational institution to have meaningful (and mandatory) contact with nearly every young person, they are in a unique position to provide children, youth, and young adults with comprehensive sexual health education that gives them the knowledge, motivation, and skills they will need to make and act upon decisions that promote sexual health and well-being throughout their lives.”

(SIECCAN, 2019, p.73)

As a fundamental part of its contribution to the development and well-being of youth, school-based sexual health education can play an important role in the primary prevention of significant sexual health problems. As documented in more detail elsewhere in this resource document, well-planned and implemented sexual health education programs can be effective in helping youth reduce their risk of STIs and unintended pregnancy as well as reduce homophobia and gender-based violence.

In addition, it should be emphasized that an important goal of sexual health education is to provide education on broader aspects of sexual health, including the development of a positive self-image and the integration of sexuality into rewarding and equitable interpersonal relationships (SIECCAN, 2019).

THE NEW 2020 EDITION OF SIECCAN'S QUESTIONS & ANSWERS: SEXUAL HEALTH EDUCATION IN SCHOOLS AND OTHER SETTINGS

Educators, public health professionals, administrators, and others who are committed to providing high quality sexual health education in the schools are often asked to explain the rationale, philosophy, and content of proposed or existing sexual health education programs.

The new 2020 edition of SIECCAN's *Questions & Answers: Sexual Health Education in Schools and Other Settings* document is designed to support the provision of high-quality sexual health education in Canada. It provides research-based answers to key questions that parents, communities, educators, program planners, school and health administrators, and governments often have about sexual health education.

The new edition retains the focus on sexual health education in schools from past editions, but has been expanded to include additional educators and settings that provide sexual health education (e.g., primary health care, parents/guardians, organizations serving seniors).

INTRODUCTION

The 2020 edition of the *Questions & Answers: Sexual Health Education in Schools and Other Settings* includes:

1. New data from SIECCAN's *National Parent Survey* (collected January 2020 by the Leger polling company), which examined the opinions and attitudes towards sexual health education of 2,000 Canadian parents and guardians with children in elementary or high school;
2. The latest research available from Statistics Canada and other sources.

The answers to common questions about sexual health education provided in this document are based upon and informed by the findings of up-to-date and credible scientific research. An evidence-based approach, combined with a respect for individual rights within a democratic society, offers a strong foundation for the development and implementation of high-quality sexual health education programs in Canada.

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PART A:

**COMPREHENSIVE SEXUAL
HEALTH EDUCATION:
AN OVERVIEW**

QUESTION 1:

WHY IS IT IMPORTANT FOR YOUNG PEOPLE TO HAVE ACCESS TO COMPREHENSIVE SEXUAL HEALTH EDUCATION?

Young people face several developmental tasks relevant to their sexual health and well-being during childhood and adolescence. For example, young people acquire a sense of autonomy, develop interpersonal relationships, establish a sense of gender identity and sexual orientation, and experience the social, physical, and mental changes associated with puberty (Rathus et al., 2020).

Comprehensive sexual health education can help youth navigate these developmental tasks by providing the necessary information and skills to enhance their sexual health and avoid negative sexual health outcomes.

ENHANCING THE SEXUAL HEALTH OF YOUNG PEOPLE

SEXUAL HEALTH AND WELL-BEING

Sexual health education should address the positive aspects of human sexuality (SIECCAN, 2019a). Sexual health is positively linked to overall health and has implications for psychological well-being (Anderson, 2013). Youth want to learn about issues related to sexual health enhancement, including pleasure, communication, how to have healthy relationships, and understanding identity

(Larkin et al., 2017; Phillips & Martinez, 2010; Pound et al., 2016; Wilson et al., 2018).

It is also important that youth develop a positive self-concept and cultivate healthy relationships (Hensel et al., 2011; Johns et al., 2018). Developing high quality relationships during adolescence and young adulthood is positively linked to indicators of well-being (e.g., happiness, life satisfaction) (Gómez-López et al., 2019).

Results from SIECCAN's (2020) *National Parent Survey* indicate that 84% of parents agree that sexual health education in the schools should **"incorporate a balanced approach that includes the positive aspects of sexuality and relationships, as well as the prevention of sexual health problems, such as STIs, unintended pregnancies, and sexual violence."** The majority of parents (87%-99%) agree that the following sexual health enhancement topics should be taught in school-based sexual health education: body image, self-esteem, attraction, love and intimacy, communication, sexual pleasure, and the emotional components of sexual relationships.

Sexual health education can help to enhance the sexual health and well-being of young people in Canada by **"addressing the individual, interpersonal, and positive aspects of sexuality"** (SIECCAN, 2019a, p.13) and equipping youth with the information and skills needed to make informed decisions.

REPRODUCTIVE HEALTH

It is imperative that young people be equipped to make informed and autonomous choices regarding their reproductive health. National surveys have determined that Canadian women under the age of 20 are more likely to experience an unintended pregnancy compared to women over the age of 20 (Oulman et al., 2015).

Moreover, it is likely that a large proportion of adolescent pregnancies are unintended (Di Meglio et al., 2019). Adolescent pregnancy rates are, therefore, a reasonably direct indicator of young people's (specifically women, trans, and non-binary youth) opportunities and capacity to control this aspect of their sexual and reproductive health (McKay, 2012).

In Canada, the pregnancy rate (i.e., live births/induced abortions) for younger (age 15-17) and older (age 18-19) adolescent girls and women has fallen significantly over the last several decades (McKay, 2012; Statistics Canada, 2020a). It is likely that access to, and use of, contraceptives has contributed to the decline in pregnancy rate (McKay & Barrett, 2010). According to data from the 2015/2016 Canadian Community Health Survey, among sexually active 15 to 24-year-olds, 60% reported using a condom and 48% reported using the birth control pill as a method of protection the last time they had sexual intercourse (Statistics Canada, 2020b).

A review of sexual health education interventions with adolescents determined the following:

Sexual health education increased knowledge about sexual health (including contraception) and also increased contraceptive/condom use (Salem et al., 2016).

Sexual health education can help young people become aware of the contextual factors that may influence their ability to negotiate safer sex and contraceptive options. For example, condom negotiation can be impacted by gender, relationship motivation, power dynamics in a relationship, and condom use self-efficacy (i.e., how confident one is in their ability to use condoms) (Closson et al., 2018; Langen, 2005; Skakoon-Sparling & Cramer, 2019).

Sexual health education can also help provide youth with the skills and information needed to navigate systemic barriers to access reproductive health services (SIECCAN, 2019a). Young people who receive comprehensive sexual health education that addresses individual, interpersonal, and rights-related aspects of sexuality are more aware of how to access health information and services and are more likely to report using sexual health services (Rohrbach et al., 2015).

Comprehensive sexual health education is needed to ensure that young women, trans, and non-binary youth have the continued capacity to make informed and autonomous decisions about their sexual and reproductive health.

It is essential that all young people in Canada receive concise, up-to-date, and medically accurate information about reproductive health and contraception options, in addition to information on how to access sexual health services.

PREVENTING NEGATIVE SEXUAL HEALTH OUTCOMES AMONG YOUNG PEOPLE

SEXUALLY TRANSMITTED INFECTIONS (STIs)

Sexually transmitted infections (STIs) can have a substantial negative impact on the health and well-being of youth in Canada. Chlamydia, gonorrhea, and HPV are common among young people and if left untreated, present significant physical, social, and mental health challenges (Choudhri et al., 2018a; Public Health Agency of Canada, 2014; 2017; Steben et al., 2018).

Chlamydia is one of the most commonly reported STIs in Canada, with numbers of newly diagnosed infections rising consistently since the 1990s (Choudhri et al., 2018a) and rates of reported cases increased by almost 50% between 2005 and 2014 (Public Health Agency of Canada, 2017). Though some of this increase may be explained by better screening practices and testing methods, the number of young people acquiring chlamydia is significant and reported rates are highest among youth and young adults (Choudhri et al., 2018a; Public Health Agency of Canada, 2017).

Similarly, gonorrhea rates also continue to rise in Canada and there is growing concern about the emergence of antibiotic resistant strains (Public Health Agency of Canada, 2013). Youth and young adults aged 15-29 reported the highest rates of infection (Choudhri et al., 2018b).

Human papillomavirus (HPV) is the most common STI in Canada and it is estimated that 75% of sexually active individuals will acquire at least one HPV infection in their lifetime (Koutsky, 1997; Public Health Agency of Canada, 2014). Research indicates that prevalence rates of HPV among young adults are also high, with estimates of over 50% (Burchell et al., 2010; Winer et al., 2008). Certain strains of HPV infections are responsible for several types of cancers, including cervical, anogenital, head, and throat cancers (National Advisory Committee on Immunization, 2016).

High rates of STIs among youth in Canada result in significant preventable negative health outcomes (e.g., cancer, chronic pelvic pain, infertility).

Sexual health education in schools can play an important role in ensuring that youth have the necessary knowledge to prevent STIs.

CONDOM USE

Condom use among sexually active Canadian youth is relatively high. According to data from the 2015/2016 *Canadian Community Health Survey* (Statistics Canada, 2020b), about 80% of sexually active 15 to 17-year-olds reported using a condom at last intercourse. **However, there is a persistent trend for high rates of condom use among sexually active teens to decline as they get older: condom use at last intercourse declined to 67% among 18 to 19-year-olds and 55% among 20 to 24-year-olds** (Statistics Canada, 2020b). In one Canadian study of university students, less than 50% reported using a condom at last intercourse (Milhausen et al., 2013).

There are several reasons young people may not use condoms during sexual interactions.

According to data from the 2015/2016 Canadian Community Health Survey, the following reasons were reported by sexually active 15 to 24-year olds for not using a condom at last sexual intercourse:

48% in a monogamous relationship

47% used another method

22% do not like condoms

10% no condom available

Statistics Canada (2020b)

The propensity for sexually active older teens and young adults in Canada to discontinue condom use is a clear indication that many young people in Canada underestimate their risk for STIs (e.g., reported rates of chlamydia and other STIs are highest among 20 to 24-year-olds).

Data from the 2015/2016 *Canadian Community Health Survey* indicated that:

26% of 15 to 17-year-olds and 23% of 18 to 19-year olds reported that they did **not** use a condom during last intercourse because they did not think they were at risk for contracting an STI (Statistics Canada, 2020b).

HPV can be easily passed via oral sex, even though few young people report using barriers during their last oral sex experience. For example, 7% of Canadian university students reported barrier use (e.g., condom, dental dam) the last time they gave oral sex; 6% reported barrier use the last time they received oral sex (SIECCAN, 2019b).

To reduce the burden of STIs on young people, it is necessary to deliver sexual health education that provides comprehensive information on STIs and STI risk reduction.

CHALLENGES FACING LGBTQI2SNA+ YOUTH

As discussed in Question 14, sexual health education in the schools is often presented predominantly or entirely within a heterosexual context and may, therefore, neglect the needs LGBTQI2SNA+ youth. Question 17 describes the additional challenges trans and other gender diverse youth face in schools and why it is necessary to teach about gender identity in comprehensive sexual health education.

PREVENTING SEXUAL AND GENDER-BASED VIOLENCE AND DISCRIMINATION

Question 7 considers how comprehensive sexual health education can help reduce sexual and gender-based violence. Question 16 addresses the importance of integrating the concept of consent into sexual health education curricula. There is an increasing awareness that this is necessary to promote equitable, healthy relationships and reduce the occurrence of sexual assault and coercion in Canada.

EDUCATING YOUTH ABOUT TECHNOLOGY

Questions 18 and 19 discuss the ways in which technology (i.e., smartphones and the internet) have fundamentally altered the way young people communicate about, are exposed to, and absorb sexuality related imagery and information. Sexting and online pornography pose challenges to the sexual health of young people and, as a result, these issues require attention within sexual health education curricula.

LGBTQI2SNA+:

Lesbian, gay, bisexual, transgender, queer, intersex, Two-Spirit, nonbinary, asexual, and other emerging identities.

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QUESTION 2:

WHY IS IT IMPORTANT FOR ADULTS TO HAVE ACCESS TO COMPREHENSIVE SEXUAL HEALTH EDUCATION?

In adulthood, individuals face new challenges and developmental phases that have implications for their sexual health. People often establish committed interpersonal, romantic, and sexual relationships and some adults transition to parenthood.

Continued access to comprehensive sexual health education is necessary to ensure that adults have accurate, evidence-based information related to sexuality, as well as opportunities to develop the skills needed to enhance their sexual health and prevent negative sexual health outcomes.

ENHANCING THE SEXUAL HEALTH OF ADULTS

SEXUAL HEALTH AND WELL-BEING

Sexual health is considered an important aspect of quality of life for many adults, particularly for people in their 30s and 40s (Flynn et al., 2016). Positive aspects of sexual health are linked to indicators of personal and interpersonal well-being. For example, being more satisfied with one's sex life is associated with better physical health (Flynn et al., 2016; Heiman et al., 2011), life satisfaction (Stephenson & Meston, 2015), and relational well-being (Blumenstock et al., 2019; Quinn-Nilas, 2019).

Research indicates that sexual satisfaction fluctuates throughout the lifespan (Quinn-Nilas, 2019) and is impacted by several factors such as age, relationship length, sexual interactions with partners, biological changes in the body, and the presence or absence of young children (Blumenstock et al., 2019; Delicate et al., 2018; Heimen et al., 2011; Kluwer, 2010). A study in Canada examined the sexual lives of 2,400 midlife Canadians; 37% of women and 29% of men reported being very sexually satisfied (Blumenstock et al., 2019). Those who reported being emotionally satisfied, in greater overall health, and communicating with their partner were more likely to report that they were very sexually satisfied.

According to the *Canadian Guidelines for Sexual Health Education*, the overarching goal of comprehensive sexual health education is to **“enhance the ability of an individual to achieve and maintain sexual health and well-being over their lifetime”** (SIECCAN, 2019, p.34).

REPRODUCTIVE HEALTH

Adults require continued access to accurate sexual health information in order to maintain and enhance their reproductive health. Reproductive health is an important aspect of well-being and includes the **“ability of individuals to decide whether or not to have children; to choose the number, spacing, and timing of children; and to parent their children in a safe and supported environment (i.e., without the threat of violence)”** (SIECCAN, 2019, p.14).

Unintended pregnancies are common in Canada and can have significant implications for the well-being of women, trans, and non-binary individuals (Black et al., 2015; Oulmen et al., 2015; Society of Obstetricians and Gynaecologists of Canada, 2019).

Sexual health education can provide people with accurate information about contraception, family planning options, and abortion, obstetric, and midwifery care. Sexual health education can also help individuals develop the skills needed to use effective contraception and barriers when desired.

Comprehensive sexual health education can assist in raising awareness of the **“social, historical, and systemic factors that affect reproductive health”** (SIECCAN, 2019).

In Canada, Indigenous women have had their reproductive health disproportionality impacted by legislation, policies, and practices related to forced or coerced sterilization (Boyer & Bartlett, 2017; Stote, 2012). Trauma, as well as distrust of the medical system, can prevent women from accessing the sexual health care and services that they need (Boyer & Bartlett, 2017).

LGBTQI2SNA+ people face unique challenges when accessing assisted reproductive services, however their needs are often not considered in assisted reproductive legislation or available services (Marvel et al., 2016; Ross et al., 2014).

Sexual health education can help raise awareness of, and respect for, reproductive health rights and support people in building capacity to navigate systemic barriers to reproductive health services and supports.

PREVENTING NEGATIVE SEXUAL HEALTH OUTCOMES

SEXUALLY TRANSMITTED INFECTIONS (STIs)

Sexually transmitted infections (STIs) present numerous preventable health problems for adults in Canada. If left untreated, certain types of STIs can contribute to pelvic inflammatory disease (PID), chronic pelvic pain, ectopic pregnancy, and infertility; other STIs (e.g., HPV) are responsible for several forms of cancer (Public Health Agency of Canada, 2010; 2017a; 2017b).

Research indicates that rates of STIs among adults in Canada are increasing (McKay et al., 2016). For example, between 2005-2014, the rate of reported chlamydia infections increased by 68% among adults aged 25-29 (Public Health Agency of Canada, 2017a). In 2017, adults aged 30-39 had the highest number of new HIV cases (31%) (Haddad et al., 2017). A study of 35,000 people in Canada reported that 46% of adults aged 25-39 and 36% of adults over the age of 40 had ever been diagnosed with an STI (Bajaj et al., 2017).

STIs frequently do not have physical symptoms. This may influence whether or not individuals believe they are at risk for getting or passing an STI. Further, the stigma associated with STI testing can impact STI testing behaviour (SIECCAN, 2019). Self-reported rates of STI testing among Canadian adults indicates that one third of people aged 35-44 have never been tested for STIs (including HIV and Hepatitis C) (Public Health Agency of Canada, 2018).

LGBTQI2SNA+: *Lesbian, gay, bisexual, transgender, queer, intersex, Two-Spirit, nonbinary, asexual, and other emerging identities.*

The Public Health Agency of Canada conducted a survey on Canadians' awareness, knowledge, and attitudes related to STIs (Public Health Agency of Canada, 2018). Participants reported the reasons a person may decide not to be tested for STIs, despite being at risk. The top three reasons were:

1. Fear that the test results would be positive.
2. Fear of people finding out and being treated differently.
3. Not having any symptoms.

Finally, there is evidence that many single midlife Canadians are not overly concerned about contracting an STI and that levels of condom use are low (McKay et al., 2016).

Sexual health education is key to ensuring that adults:

Have continued access to accurate information about STIs.

Have opportunities to develop and maintain the motivation and behavioural skills needed to reduce their risk of STI transmission.

Increase their ability to access STI testing, management, and treatment services.

SIECCAN (2019)

There is evidence that sexual health interventions that include education are effective at improving safer sex behaviours, such as condom use, among adults (Hobgen et al., 2015).

PROBLEMS RELATED TO SEXUAL RESPONSE

Problems related to sexual response are relatively common among midlife Canadians (Quinn-Nilas et al., 2018; SIECCAN, 2017).

In one study of women and men aged 40-59 years:

40% of women and 30% of men reported a problem with sexual desire in the past 6 months.

29% of women reported difficulties with vaginal dryness.

24% of men indicated that they had problems related to erection and ejaculation.

Quinn-Nilas et al. (2018)

Importantly, problems with sexual response were related to both physical health and overall sexual happiness. For example, women who reported desire and orgasm problems, and men who experienced desire and erection challenges, were less likely to say that they were very happy with their sex lives.

It is important for Canadians to be knowledgeable about sexual functioning so that they can recognize significant changes and seek help when needed.

PREVENTING SEXUAL AND GENDER-BASED VIOLENCE AND DISCRIMINATION

As discussed in Question 7, sexual and gender-based violence is a significant concern in Canada and a violation of human rights.

Comprehensive sexual health education can help to alleviate sexual and gender-based violence and discrimination by:

Providing adults with accurate information related to consent and human rights.

Building capacity to engage in respectful, consensual, and satisfying relationships.

Increasing awareness of and ability to access supportive services.

SIECCAN (2019)

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QUESTION 2: WHY IS IT IMPORTANT FOR ADULTS TO HAVE ACCESS TO COMPREHENSIVE SEXUAL HEALTH EDUCATION?

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QUESTION 3:

WHY IS IT IMPORTANT FOR SENIORS TO HAVE ACCESS TO COMPREHENSIVE SEXUAL HEALTH EDUCATION?

In Canada, there are approximately six million people over the age of 65, representing 17% of the population (Statistics Canada, 2019). There is clear evidence that sexual health is a significant contributing factor to the health and well-being of older adults (Bauer et al., 2015; Erens et al., 2019; Graf & Patrick, 2014; Foley, 2015; Lee et al., 2016; SIECCAN, 2017; Smith et al., 2019).

There are several biological, psychological, and social changes associated with aging that can impact sexual health (e.g., the physical changes associated with menopause, experiencing sexual functioning problems, relationship problems, physical health problems, access to sexual partners). Although some of these changes present substantial challenges to sexual health, older adults also report continued sexual interest and describe sexual expression as important in their lives (Bauer et al., 2015; Santo-Iglesias et al., 2016).

As people in Canada live longer, healthier lives, it is necessary to recognize the importance of sexuality to older adults and to understand strategies for the enhancement of sexual health and the prevention of negative sexual health outcomes.

ENHANCING THE SEXUAL HEALTH AND WELL-BEING OF SENIORS

Sexual health is positively related to physical health and well-being among older adults (DeLamater, 2012; Smith et al., 2019; Santo-Iglesias et al., 2016). In a national survey of older adults in England, people who had any sexual activity in the past year also reported higher levels of life satisfaction (Smith et al., 2019).

In contrast to stereotypes of seniors as sexually inactive, research indicates that many seniors remain sexually active in their later years (Lee et al., 2016; Santo-Iglesias et al., 2016; Smith et al., 2019; Træen et al., 2019). The frequency of partnered sexual activity tends to decline as individuals age. However, in a longitudinal study examining the sexual health and well-being of older adults, 19% of men and 32% of women (aged 80 or older) reported sexual intercourse twice a month or more (Lee et al., 2016). Further, a majority of participants (aged 60 and older) frequently engaged in other sexual activities such as “kissing, fondling, or petting.”

PREVENTING NEGATIVE SEXUAL HEALTH OUTCOMES

PROBLEMS RELATED TO SEXUAL RESPONSE

Overall, the prevalence of sexual problems related to desire, arousal, orgasm, and pain rise with age (Foley, 2015; SIECCAN, 2017; Træen et al., 2017). These problems are often associated with other physical health conditions (e.g., diabetes), biological changes in the body (e.g., menopause, testosterone changes), relationship factors (e.g., access to a sexual partner), and/or mental health (e.g., depressive symptoms) (Foley, 2015; Lee et al., 2016; Træen et al., 2017).

QUESTION 3: WHY IS IT IMPORTANT FOR SENIORS TO HAVE ACCESS TO COMPREHENSIVE SEXUAL HEALTH EDUCATION?

Researchers in Canada and the United States examined the sexual health and well-being of older adults: 71% of participants experienced at least one sexual difficulty in the last three months and 27% indicated that they were “distressed” about the sexual difficulty (Santo-Iglesias et al., 2016). The most common difficulties included: feeling “turned off,” a lack of interest in sex, difficulty getting sexually excited or maintaining sexual excitement, and problems related to orgasm.

SEXUALLY TRANSMITTED INFECTIONS (STIs)

Although the prevalence of sexually transmitted infections (STIs) among seniors is generally low in Canada, the rates of reported cases of gonorrhea, chlamydia, and syphilis all increased between 2007 to 2016 for people aged 60 and over (Public Health Agency of Canada, 2016). Adults aged 50 or older represent over 20% of all newly diagnosed cases of HIV in Canada (Haddad et al., 2019).

A lack of barrier use and a misperception of STI risk may contribute to the rise of STIs among seniors. Studies demonstrate low rates of condom use (Oraka et al., 2018; Schick et al., 2010; Syme et al., 2017) and indicate that older adults underestimate their STI risk (Syme et al., 2017). Further, few sexually active older adults report that they have been tested for HIV and/or other STIs (Oraka et al., 2018; Schick et al., 2010).

There is evidence that sexual health education programs can help to increase HIV knowledge and improve perceptions of susceptibility among older adults (Negin et al., 2014).

Sexual health education is important for seniors to make informed choices about STI prevention and management.

THE IMPORTANCE OF COMPREHENSIVE SEXUAL HEALTH EDUCATION FOR SENIORS

Sexuality is vital to well-being across the lifespan, including the later years of life. However, there is currently a lack of sexual health information geared toward older adults (Bauer et al., 2015; Slinkard & Kazer, 2011). Seniors may feel uncomfortable raising or discussing their sexual health concerns with a healthcare professional or perceive care providers as uninterested or uninformed when it comes to their sexual health needs (Bauer et al., 2015).

LGBTQI2SNA+ seniors face additional barriers; older adults in LGBTQI2SNA+ communities may perceive healthcare providers as biased or may have had negative experiences with them (Bauer et al., 2015).

Comprehensive sexual health education, tailored to the needs of seniors, is necessary in order to provide older adults with the information, motivation, and skills needed to prevent negative sexual health outcomes and navigate the changes associated with aging in ways that help enhance their sexual health and well-being.

LGBTQI2SNA+:

Lesbian, gay, bisexual, transgender, queer, intersex, Two-Spirit, nonbinary, asexual, and other emerging identities.

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QUESTION 4:

WHAT ARE THE PRINCIPLES THAT INFORM AND GUIDE COMPREHENSIVE SEXUAL HEALTH EDUCATION?

Canada is a pluralistic society in which different people have different values and perspectives regarding human sexuality. At the same time, people in Canada are united by their respect for the basic and fundamental values and principles of a democratic society. An emphasis on democratic values (e.g., the right to make informed decisions about health and well-being) provides the overall philosophical framework for many school-based sexual health education programs in Canada.

The Canadian Guidelines for Sexual Health Education:

1. Have been used by communities as a basis to develop consensus on the fundamental values that should be reflected in school-based sexual health education.
2. Were formulated to embody an educational philosophy that is inclusive, respects diversity, and reflects the fundamental precepts of education in a democratic society.

SIECCAN (2019)

CORE PRINCIPLES OF COMPREHENSIVE SEXUAL HEALTH EDUCATION

The *Canadian Guidelines for Sexual Health Education* (SIECCAN, 2019) contain a set of nine Core Principles that define and inform comprehensive sexual health education.

Over 70% of parents in SIECCAN's (2020) *National Parent Survey* indicated that they agree with the principles presented in the *Canadian Guidelines for Sexual Health Education*.

* Text continues on next page.

QUESTION 4: WHAT ARE THE PRINCIPLES THAT INFORM AND GUIDE COMPREHENSIVE SEXUAL HEALTH EDUCATION?

The *Canadian Guidelines for Sexual Health Education* state that comprehensive sexual health education:

Is accessible to all people inclusive of age, race, sex, gender identity, sexual orientation, STI status, geographic location, socio-economic status, cultural, or religious background, ability, or housing status (e.g., those who are incarcerated, homeless, or living in care facilities);

Promotes human rights including autonomous decision-making and respect for others;

Is scientifically accurate and uses evidence-based teaching methods;

Is broadly-based in scope and depth and addresses a range of topics relevant to sexual health and well-being;

Is inclusive of the identities and lived experiences of lesbian, gay, bisexual, transgender, queer, intersex, Two-Spirit, nonbinary, and asexual people, and other emerging identities (LGBTQI2SNA+);

Promotes gender equality and the prevention of sexual and gender-based violence;

Incorporates a balanced approach to sexual health promotion that includes the positive aspects of sexuality and relationships as well as the prevention of outcomes that can have a negative impact on sexual health and well-being;

Is responsive to and incorporates emerging issues related to sexual health and well-being; and

Is provided by educators who have the knowledge and skills to deliver comprehensive sexual health education and who receive administrative support to undertake this work.

SIECCAN (2019, p.23-28)

LGBTQI2SNA+: *Lesbian, gay, bisexual, transgender, queer, intersex, Two-Spirit, nonbinary, asexual, and other emerging identities.*

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QUESTION 5:

WHAT ARE THE KEY COMPONENTS OF EFFECTIVE SEXUAL HEALTH EDUCATION PROGRAMS?

The first and most vital components of effective sexual health education programs include ensuring that:

1. Sufficient time is allocated to the teaching of this important topic.
2. Teachers/educators are adequately supported, trained, and motivated to do so.

Society of Obstetricians and Gynecologists of Canada (2004); SIECCAN (2019)

The *Canadian Guidelines for Sexual Health Education* state that sexual health education should be “**provided by educators who have the knowledge and skills to deliver comprehensive sexual health education and who receive administrative support to undertake this work**” (p. 28). Further, educators in schools who provide sexual health education “**should have access to sufficient resources to teach sexual health education effectively, in-service training, and continuing education opportunities to increase their capacity to teach comprehensive sexual health education**” (SIECCAN, 2019, p. 74).

Effective sexual health education and promotion programs are based on theoretical models of behaviour change that enable educators to understand and influence sexual health behaviour (Albarracin et al., 2005; Kirby et al., 2007; Protogerou & Johnson, 2014; SIECCAN, 2019).

The *Canadian Guidelines for Sexual Health Education* (SIECCAN, 2019) provide a framework for implementing effective programming based on the Information-Motivation-Behavioural Skills (IMB) model of sexual health enhancement and problem prevention (Albarracin et al., 2005; Fisher & Fisher, 1998).

According to the IMB model, sexual health education must include the following components in order to be effective:

Provide **information** that is directly relevant to sexual health (e.g., information on effective forms of STI prevention, such as condoms or dental dams, and how to access and use them).

Address **motivational factors** that influence sexual health behaviour (e.g., discussion of personal ideas/beliefs about personal responsibility/safety).

Teach the specific **behavioural skills** that are needed to protect and enhance sexual health (e.g., learning to discuss condom/dental dam use with a partner.)

Consider and help raise awareness of **environmental factors** that can impact sexual health behaviour (e.g., discuss how access to certain forms of STI prevention, such as pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP) for HIV prevention- can be impacted by social, cultural, and structural factors). See Figure 1.

Figure 1. The Information, Motivation, and Behavioural Skills Model for Effective Sexual Health Education

<p>INFORMATION</p> <p>Relevant sexual health information</p> <p>Examples:</p> <ul style="list-style-type: none"> • Identifying effective forms of STI prevention • How to access condoms & dental dams 	<p>BEHAVIOURAL SKILLS</p> <p>Development of behavioural skills to put information into practice</p> <p>Examples:</p> <ul style="list-style-type: none"> • Communicating about condom/dental dam use with a partner(s) • Learning how to use a condom/dental dam
<p>MOTIVATION</p> <p>Motivation to use the information</p> <p>Examples:</p> <ul style="list-style-type: none"> • Personal vulnerability to STIs • Address individual, peer, and public attitudes towards using or not using condoms or dental dams 	<p>ENVIRONMENTAL FACTORS</p> <p>Understanding the importance of social, cultural, and structural issues</p> <p>Examples:</p> <ul style="list-style-type: none"> • Understanding how certain types of STI prevention may be impacted by social circumstances and access to services (e.g. PrEP & PEP; HPV vaccinations)

Support for the IMB model as a framework for developing behaviourally effective sexual health education interventions with youth has been provided in scientific evaluations (Fisher et al., 2002; Fisher et al., 2014; Knight et al., 2017; Morrison-Beedy et al., 2013; Mustanski et al., 2015).

See the *Canadian Guidelines for Sexual Health Education* (SIECCAN, 2019) for the use of the IMB model (page 39) and for the planning, delivery, and evaluation of sexual health programs (page 57).

There is an extensive body of research that has identified the key components of effective sexual health education and promotion programming. Research has clearly demonstrated that effective sexual health education programs will contain the components listed in Table 1 below.

(For a summary and review of this literature, see Albarracin et al., 2005; Denford et al., 2017; Fisher & Fisher, 1998; Fonner et al., 2014; Haberland & Rogow, 2015; Haberland, 2015; Kirby et al., 2007; SIECCAN, 2019; Pound et al., 2017; Protogerou & Johnson, 2014; World Association for Sexual Health, 2008).

Table 1. The key components of effective sexual health education and promotion programming.

1. A realistic and sufficient allocation of time and resources to achieve program objectives.
2. Provide teachers/educators with the necessary training and administrative support to deliver programs effectively.
3. Employ sound teaching methods including the utilization of well-tested theoretical models to develop and implement programming (e.g., IMB Model, Social Cognitive Theory, Transtheoretical Model, Theory of Reasoned Action/Theory of Planned Behaviour).
4. Use elicitation research to identify the participants' needs and optimal learning styles, including tailoring instruction to program participants' ethnocultural backgrounds, sexual orientations, and developmental stage.
5. Specifically target behaviours that can enhance sexual health and well-being and prevent negative sexual health outcomes.
6. Deliver and consistently reinforce messages related to the prevention of outcomes that can negatively impact sexual health (e.g., STIs, unintended pregnancy).
7. Include program activities that address the individual's environment and social context including peer and partner pressures related to sexual activity.
8. Incorporate the necessary information, motivation, and behavioural skills to effectively enact and maintain behaviours to promote sexual health and well-being.
9. Provide clear examples of, and opportunities to practice (e.g., role plays) sexual boundary setting (e.g., communication and understanding of consent), barrier use (e.g., condoms, dental dams), and other communication skills so that people are active participants in the program, not passive recipients.
10. Link people to school and/or community sexual health services.
11. Programs are conducted within a safe (i.e., stigma-free) environment.
12. Ensure that content is comprehensive (i.e., program provides a broad range of information that incorporates the positive aspects of sexuality and the prevention of negative sexual health outcomes; reflects diversity; is relevant to peoples' lives; includes a rights-based perspective to sexual health; avoids fear and stigma-inducing approaches to STI prevention; addresses issues of gender and power).
13. Incorporate appropriate and effective evaluation tools to assess program strengths and weaknesses to improve subsequent programming.

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QUESTION 6:

HOW CAN COMPREHENSIVE SEXUAL HEALTH EDUCATION HELP ADDRESS THE SEXUAL HEALTH EDUCATION NEEDS OF INDIGENOUS PEOPLES, INCLUDING FIRST NATIONS, INUIT, AND MÉTIS COMMUNITIES?

By Charlotte Loppie

Indigenous peoples in Canada represent diverse cultural groups (First Nations, Métis, Inuit), languages, traditions, and locations (i.e., reserve, rural, urban). However, many individuals, families and communities share a common history of colonization, which has impacted, among other things, their sexual health.

Sexual health education is most helpful when it balances the challenges and strengths of Indigenous peoples, communities, and cultures and acknowledges the unique historical, political, and social contexts that shape their sexual health education needs.

In order to ensure that sexual health education is inclusive of Indigenous peoples, individuals and communities should be meaningfully engaged in developing and implementing their own resources and programs. Sexual health education should also reflect cultural safety and respond to the *Truth and Reconciliation Commission of Canada: Calls to Action* (2015).

HISTORY

Before contact with European settlers, Indigenous peoples believed that sexuality was a gift from the Creator, encompassing physical, emotional, mental, and spiritual dimensions (i.e., wholism) (Allen, 1986). Indigenous peoples also believed that gender was not limited to the binary of male/female and that Two-Spirit people (i.e., those possessing both female and male spirits) were gifted community healers and family counsellors (Hunt, 2016). Gender roles within pre-contact Indigenous cultures were generally egalitarian and children were highly valued, so that abuse (including sexual abuse) was not tolerated (Anderson & Innes, 2015).

Colonization and the imposition of European concepts of sexuality and gender drastically and detrimentally impacted the sexual and reproductive health of Indigenous peoples.

Current sexual and reproductive health challenges facing Indigenous peoples include high rates of:

Sexual transmitted infections (including HIV) with limited access to prevention, screening and treatment (Wilson et al., 2013).

Teen pregnancy with limited access to prenatal, postnatal, and young family supports (Olsen, 2005).

Sexual and gender-based violence including Missing and Murdered Indigenous Women with limited federal, provincial, or local supports Anderson et al. (2018); Hawkins et al. (2009).

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In addition, changes in the social determinants of Indigenous health (e.g., dispossession of land and the reserve system, residential schools, poverty and systemic racism, etc.) continue to negatively impact health, including sexual health (Canada, Erasmus, & Dussault, 1996; Truth and Reconciliation Commission of Canada, 2015).

Many of the challenges to accessing resources and supports result from the geographic and/or racialized segregation of Indigenous peoples (Reading, 2015). For example, accessing sexual health education resources outside of the internet or the school system is very limited for those who live in remote communities (Banister & Begoray, 2006). As well, the exclusion of Indigenous peoples from sexual health education materials (e.g., Indigenous peoples are not portrayed visually or as examples) hinders their access to these resources as Indigenous peoples do not see their experiences reflected.

Culturally safe sexual health education is undertaken by professionals who engage in long-term, meaningful partnerships with Indigenous youth, adults, families, and communities. When sexual health education is directed toward Indigenous peoples, it is especially important that Indigenous peoples are invited to take leadership roles in the development, implementation, and evaluation of resources and programs (Rigby et al., 2010). As well, rather than using a deficit model, focused solely on the sexual health challenges facing Indigenous populations and/or communities, culturally safe education includes balanced curricula that draw on not only western - but Indigenous knowledge systems and concepts of sexuality.

** See next page for Suggested Readings.*

MOVING FORWARD

Article 24 of the *Truth and Reconciliation Commission's Calls to Action* calls upon health professionals to learn about **"the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism"** (TRC, 2015, p.6).

Culturally safe sexual health education takes into account the historic and intergenerational trauma experienced by many Indigenous peoples and does not assume that they have benefited from, or have trust in, systems of health and/or education.

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QUESTION 7:

HOW CAN COMPREHENSIVE SEXUAL HEALTH EDUCATION HELP TO ALLEVIATE SEXUAL AND GENDER-BASED VIOLENCE AND DISCRIMINATION?

Sexual and gender-based violence is a significant concern across the globe and within Canada (World Health Organization, 2013).

Sexual violence is **“any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work”** (World Health Organization, 2011).

Gender-based violence is **“violence that is committed against someone based on their gender identity, gender expression or perceived gender”** (Government of Canada, 2018a).

Research has documented the numerous negative effects of experiencing sexual and gender-based violence, including those related to reproductive health, physical health, mental health, and mortality (World Health Organization, 2011; 2013).

WHO EXPERIENCES VIOLENCE?

People of all backgrounds and identities experience violence.

However, there are particular groups in Canada that are disproportionately impacted by violence, including:

- Women and girls
- Indigenous peoples
- LGBTQI2SNA+ individuals
- People living in northern rural and remote communities
- People with disabilities
- People who are new to Canada
- Children and youth
- Seniors

Government of Canada (2018b); SIECCAN (2019)

WOMEN

87% of the 636,000 self-reported incidents of sexual assault in Canada in 2014 were committed against women (Conroy & Cotter, 2017).

According to police-reported sexual assaults between 2009 and 2014, the majority of survivors were young women and girls; 26% of survivors were children under the age of 13 (Rotenberg, 2017). In 2016, 79% of people who reported intimate partner violence to the police were women (Burczycka & Conroy, 2018).

LGBTQI2SNA+:

Lesbian, gay, bisexual, transgender, queer, intersex, Two-Spirit, nonbinary, asexual, and other emerging identities.

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A disproportionate number of Indigenous women and girls experience sexual assault, exploitation, and violence (Conroy & Cotter, 2017; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). **Indigenous women in Canada are three times more likely to report experiencing intimate partner violence compared to non-Indigenous women** (Boyce, 2016).

LGBTQI2SNA+ INDIVIDUALS

LGBTQI2SNA+ individuals are much more likely to experience violence and discrimination compared to heterosexual people (see Question 14 and Question 17) (Bucik, 2016; Simpson, 2018). Lifetime prevalence rates for experiencing domestic violence are nearly twice as high for transgender people (65%) as are they are for cisgender women (38%) and more than three times as high as the rates for cisgender men (17%) (Wathen et al., 2015). In the most recent Trans PULSE Canada report, 16% of trans and non-binary participants experienced physical violence and 26% experienced sexual assault in the past five years (The Trans PULSE Canada Team, 2020).

In a national consultation, LGBTQI2SNA+ youth in Canada emphasized experiences of harassment, sexual violence, bullying, and a lack of public safety (Wisdom2Action, 2019). An Ontario study examining the well-being of Indigenous gender-diverse individuals reported that 73% of participants had experienced violence due to transphobia; 43% reported physical and/or sexual violence (Scheim et al., 2013).

PEOPLE WITH DISABILITIES

People with disabilities report high rates of abuse and violence (see Question 7 and Question 15) (Burczycka, 2018; Cotter, 2018; McDaniels & Fleming, 2016; Stermac et al., 2018). Children with intellectual disabilities are more vulnerable to sexual abuse than

are children without disabilities, with prevalence estimates ranging from 14%-32% (Jones et al., 2012; Wissink et al., 2015).

A recent Statistics Canada report indicated that people with cognitive, mental health, sensory, or physical disabilities were between two to four times more likely to experience violence compared to those who did not have a disability (Cotter, 2018). Women with a disability were almost twice as likely to experience a sexual assault in the previous year compared to women without a disability.

SEXUAL AND GENDER-BASED VIOLENCE

The *Canadian Guidelines for Sexual Health Education* state that **sexual health education can “play an active role in contributing to the reduction of sexual and gender-based violence by helping people become aware of societal norms, attitudes, and practices that contribute to violence (e.g., misogynistic beliefs, homophobia, transphobia)”** (SIECCAN, 2019, p. 26).

According to the *Canadian Guidelines for Sexual Health Education*, sexual health education can help:

Promote respect for gender equality.

Provide people with the information needed to understand gender and power dynamics.

Develop the skills needed to navigate consensual interpersonal relationships.

SIECCAN (2019)

QUESTION 7: HOW CAN COMPREHENSIVE SEXUAL HEALTH EDUCATION HELP TO ALLEVIATE SEXUAL AND GENDER-BASED VIOLENCE AND DISCRIMINATION?

Programs that address gender norms, power dynamics, and other issues related to sexual and gender-based violence (e.g., consent, healthy relationships, nonviolent conflict resolution) are effective at improving gender-equitable attitudes, dating violence knowledge, and awareness of supportive resources (Bonar et al., 2019; De La Rue et al., 2017; Claussen, 2017; Lundgren & Amin, 2015; Vladutiu et al., 2011). In some cases, educational interventions also help to reduce self-reported perpetration of violence and the risk of sexual assault (Lundgren & Amin, 2015).

Bystander education programs focus on educating participants about the myths regarding sexual assault, how to notice high risk situations, and develop the skills to respond constructively to situations (Katz & Moore, 2013).

A meta-analysis of 12 studies examined the effectiveness of bystander education training. When compared with individuals in control groups, participants who had completed these interventions reported:

- A greater intent to help others;
- Higher levels of helping behaviours;
- Lower levels of rape myth acceptance; and
- Lower levels of rape proclivity (i.e., self-reported propensity to engage in sexually violent acts).

Katz & Moore (2013)

Research examining programs that specifically target sexual violence perpetration suggests that interventions are most effective when they involve comprehensive educational curricula that provide opportunities for individuals to develop appropriate behavioural skills (DeGue et al., 2014).

Sexual health education programs that are inclusive to LGBTQI2SNA+ people can help address discriminatory attitudes, foster a positive school environment, and create a safer space for all students (Gegenfurtner & Gebhardt 2017; Meadows, 2018; SIECCAN, 2019). Further, having a more extensive school-based sexual health education (e.g., covering more topics and covering them more frequently) is associated with students' and teachers' willingness to intervene when they witness the bullying of LGBTQI2SNA+ individuals (Baams et al., 2017).

Findings from SIECCAN's (2020) National Parent Survey indicate that parents in Canada support schools addressing sexual and gender-based violence.

- 83%** agree that sexual health education in schools should promote gender equality and the prevention of gender-based violence.
- 96%** endorse teaching about sexual consent

Parents also endorsed the teaching of specific topics related to the prevention of sexual and gender-based violence.

- 97%** indicate that sexual and gender-based violence should be taught in sexual health education.
- 98%** endorse teaching about nonviolent conflict resolution in relationships.
- 92%** endorse teaching about gender roles and stereotypes.

Comprehensive sexual health education that incorporates up-to-date, evidence-based standards and principles is critical to reduce the risk of sexual and gender-based violence among children, young people, and adults.

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QUESTION 7: HOW CAN COMPREHENSIVE SEXUAL HEALTH EDUCATION HELP TO ALLEVIATE SEXUAL AND GENDER-BASED VIOLENCE AND DISCRIMINATION?

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QUESTION 8:

WHAT ARE THE ECONOMIC BENEFITS OF IMPLEMENTING COMPREHENSIVE SEXUAL HEALTH EDUCATION?

Preventable outcomes that can negatively impact sexual and reproductive health pose a significant threat to the health and well-being of individuals, families, and communities in Canada.

Beyond the negative personal and social outcomes, preventable sexual and reproductive health problems also result in substantial economic costs to Canada in the form of health care expenditures, lost productivity, criminal justice costs, and other costs. Some of the substantial economic costs of negative sexual and reproductive health outcomes in Canada are documented below.

It can be conservatively estimated that the combined costs associated with preventable outcomes, such as sexually transmitted infections (STIs) including HIV, unintended pregnancies, sexual assault, and other sexual offenses in Canada exceeds \$6 billion annually.

The wide-spread implementation of comprehensive sexual health education programs is an important component of an effective strategy to reduce the economic and social costs to Canadian society of preventable outcomes that negatively impact sexual and reproductive health.

SEXUALLY TRANSMITTED INFECTIONS

According to the Public Health Agency of Canada (2018), STIs **“levy a significant physical, emotional, social, and economic cost to individuals, communities, and society”** (p.1).

It has been estimated that the lifetime treatment cost of each HIV infection in Ontario is approximately \$287,000 (Choi et al., 2016). When including expenses related to healthcare, labour productivity, and quality of life, the Canadian AIDS Society estimates that each new case of HIV infection results in \$1.3 million in costs per person (Kingston-Riechers, 2011). In total, spending on HIV/AIDS in 2017 in Canada was approximately \$686 million (Global Burden of Disease Health Financing Collaborator Network, 2018).

Reported rates of common bacterial STIs have increased in Canada. From 2008 to 2017, reported rates of chlamydia increased by 39%, gonorrhea by 109% and infectious syphilis by 167% (Public Health Agency of Canada, 2019). The direct and indirect costs resulting from infection and treatment of these preventable sexually transmitted bacterial infections is significant (Owusu-Edusei et al., 2013; Smylie et al., 2011; Tuite et al., 2012).

Specifically, Smylie and colleagues (2011) estimated that the direct and indirect costs associated with chlamydia and gonorrhea were up to \$178 million annually. Given the increase in reported cases of these STIs in recent years, the associated costs are also likely to have increased substantially.

Human papillomavirus (HPV) is the most common STI in Canada. HPV is the leading cause of cervical, oral, anal, vulvar, vaginal, and penile cancer. According to the Canadian Cancer Society (2016), there were 4,375 cases of HPV-associated cancers in 2016. Of this total, 35% were cervical cancers and another 35% were oral cancers.

QUESTION 8: WHAT ARE THE ECONOMIC BENEFITS OF IMPLEMENTING COMPREHENSIVE SEXUAL HEALTH EDUCATION?

A study of the direct medical costs of HPV-associated disease in the province of Manitoba indicated a median treatment cost of \$15,000 per case of cervical cancer and \$33,000 per case of oral cancer (Righolt et al., 2018). By extrapolating these costs to the treatment of cervical and oral cancer across Canada, the treatment costs of HPV-associated cervical and oral cancers is approximately \$73.5 million per year.

In addition, it has been estimated that the costs of treating genital warts caused by HPV in Canada are \$9.2 million annually (Lalonde, 2007). Colposcopy related to HPV infection is a frequent, invasive, and costly procedure (Benedict et al., 2005; Brisson et al., 2007).

There are also extensive medical costs associated with other STIs (Owusu-Edusei et al., 2013) including genital herpes (Szucs et al., 2001) and hepatitis B (Gagnon et al., 2004).

Based on the research examining the direct medical and other costs of different STIs, it can be concluded that the total economic burden of STIs in Canada very likely exceeds \$1 billion annually.

UNINTENDED PREGNANCY

A portion of unintended pregnancies are not unwanted and result in positive experiences for parents and their children. However, a large proportion of unintended pregnancies occur in people who do not want to be pregnant and these pregnancies result in considerable economic costs. Recent estimates suggest that there are more than 39,000 unintended pregnancies among adolescent girls and women aged 15-19 years annually in Canada, with associated direct costs of \$60 million (Black et al., 2019).

For women of all ages, there are an estimated 180,000 unintended pregnancies annually in Canada, with direct costs of about \$320 million (Black et al., 2015).

SEXUAL ASSAULT AND OTHER SEXUAL OFFENSES

In addition to the extensive negative personal impact on survivors and their families, sexual assault and other sexual offenses result in significant economic costs to Canada.

A Department of Justice report calculated that the combined criminal justice, victim, and third-party costs of sexual assault and other sexual offenses in Canada amounted to \$4.8 billion in 2009 (Hoddenbagh et al., 2014).

REDUCING THE ECONOMIC COSTS OF OUTCOMES THAT NEGATIVELY IMPACT SEXUAL HEALTH: THE ROLE OF SEXUAL HEALTH EDUCATION

In Canada, the combined economic burden of outcomes that negatively impact sexual health such as STIs, unintended pregnancies, and sexual assault and other sexual offences likely exceeds \$6 billion annually.

The wide-spread implementation of comprehensive sexual health education in Canada, particularly in schools which have the ability to reach nearly all young people, has the potential to significantly reduce these economic costs.

QUESTION 8: WHAT ARE THE ECONOMIC BENEFITS OF IMPLEMENTING COMPREHENSIVE SEXUAL HEALTH EDUCATION?

As shown elsewhere in this document, sexual health education programs that are well-designed and implemented can be effective in helping young people:

Reduce STI risk (see Question 9)

Increase contraceptive use (see Question 9)

Reduce the likelihood of non-consensual sexual activity (see Question 7 and Question 16)

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PART B:

**COMPREHENSIVE
SEXUAL HEALTH EDUCATION
IN SCHOOLS**

QUESTION 9:

IS THERE EVIDENCE THAT COMPREHENSIVE SEXUAL HEALTH EDUCATION CAN DECREASE NEGATIVE SEXUAL HEALTH OUTCOMES AND INCREASE POSITIVE SEXUAL HEALTH OUTCOMES AMONG YOUTH?

REDUCING NEGATIVE SEXUAL HEALTH OUTCOMES AMONG YOUTH (e.g., STI/HIV, UNINTENDED PREGNANCY)

A large body of peer-reviewed published studies measuring the behavioural impact of adolescent sexual health interventions has led to a definitive conclusion:

Adolescent sexual health interventions can have a significant positive impact on sexual health behaviours (e.g., delaying first sexual activity; increasing use of condoms and other contraceptives)

United Nations Educational, Scientific and Cultural Organization (2018)

The U.S. Centers for Disease Control and Prevention's (2019) *Compendium of Evidence-Based HIV Interventions and Best Practices for HIV Prevention* includes a number of programs for adolescents that have been rigorously evaluated and have demonstrated efficacy in reducing HIV/sexually transmitted infections (STI) incidence and sexual risk behaviours.

Reviews have also demonstrated the positive behavioural impact of well-designed sexual health education programs (Bennett & Assefi, 2005; Chin et al., 2012; Johnson et al., 2011; Kirby et al., 2007; Protogerou & Johnson, 2014). More specifically, research clearly indicates that education programs can be effective in increasing contraceptive use among sexually active youth (Lopez et al., 2016a; Lopez et al., 2016b) and in building communication and self-efficacy skills to reduce STI risk (Mon Kyaw Soe et al., 2016; Morales et al., 2016).

A systematic review summarizing 224 controlled trials on the effects of school-based interventions to improve sexual health reached the following conclusion:

"Comprehensive interventions, those targeting HIV prevention, and school-based clinics, were found to be effective in improving knowledge and changing attitudes, behaviors and health-related outcomes" (Denford et al., 2017, p. 33).

INCREASING POSITIVE SEXUAL HEALTH OUTCOMES AMONG YOUTH (e.g., ACCESS TO SERVICES, HAVING RESPECTFUL AND SATISFYING RELATIONSHIPS)

There is a small, but growing, body of research that has evaluated the effects of sexual health education on positive sexual and reproductive health outcomes. According to this research, sexual health education can be effective in enhancing the sexual health and well-being of youth (Constantine et al., 2015; Rohrbach et al., 2015; United Nations Educational, Scientific and Cultural Organization, 2018).

QUESTION 9: IS THERE EVIDENCE THAT COMPREHENSIVE SEXUAL HEALTH EDUCATION CAN DECREASE NEGATIVE SEXUAL HEALTH OUTCOMES AND INCREASE POSITIVE SEXUAL HEALTH OUTCOMES AMONG YOUTH?

The *Canadian Guidelines for Sexual Health Education* specify that in order to be fully effective, **sexual health education programs should focus on both the positive and relationship enhancing aspects of human sexuality, as well as the prevention of negative outcomes** (SIECCAN, 2019).

Historically, sexual health education has focused primarily, if not exclusively, on risk prevention. However, it is increasingly recognized that a prevention-only focus emphasizes negativity and can contribute to shame and stigma. **A more balanced approach to sexual health education can empower youth to protect and enhance their sexual health.**

Surveys of Canadian youth clearly indicate that youth want sexual health education programs to address positive components of sexual health, such as healthy relationships and communication skills (See Question 13).

One study compared the sexual health outcomes of high school students who participated in a rights-based sexual health education curriculum to a control group that received a standard sexual health education curriculum (Constantine et al., 2015). The rights-based sexual health education curriculum addressed many of the positive aspects of sexuality including relationships and sexual rights and included the social factors that affect the adolescents' sexual lives, such as gender roles and identity, sexual orientation, and power in relationships.

Compared to the control group, students who completed this program reported:

Greater communication about sexuality;

More positive attitudes about sexual relationship rights;

Greater access to sexual health information; and

More awareness of sexual health services.

Constantine et al. (2015)

When researchers followed up with participants a year later, they determined that the program had positive lasting effects (Rohrbach et al., 2015). For example, students in the rights-based education group reported more positive attitudes about sexual rights and were more likely to have accessed sexual health services.

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QUESTION 9: IS THERE EVIDENCE THAT COMPREHENSIVE SEXUAL HEALTH EDUCATION CAN DECREASE NEGATIVE SEXUAL HEALTH OUTCOMES AND INCREASE POSITIVE SEXUAL HEALTH OUTCOMES AMONG YOUTH?

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QUESTION 10:

ARE ABSTINENCE-ONLY PROGRAMS AN EFFECTIVE FORM OF SCHOOL-BASED SEXUAL HEALTH EDUCATION?

A substantial body of research evidence clearly indicates that most abstinence-only sex education programs are not effective in persuading youth to delay first sexual intercourse or in reducing unwanted pregnancy among adolescents

(Bennett & Assefi, 2005; Chin et al., 2012, Johnson et al., 2011; Kirby, 2008; Protogerou & Johnson, 2014; Underhill et al., 2007).

The term **abstinence** is commonly understood to mean not engaging in sexual intercourse until marriage.

However, abstinence may be given a range of definitions including:

- **Not engaging in intercourse until some point in the future**
- **Not engaging in any form of partnered sexual activity (e.g., sexual intercourse, oral sex, touching)**
- **Refraining from masturbation**

The term **abstinence** can be highly ambiguous and should be used with caution-if at all-in delineating the objectives of sexual health education for youth.

Rather than providing comprehensive and accurate information that youth can use to make informed decisions related to their sexual health and well-being, abstinence-only programs teach that **“abstinence from sex is the only morally acceptable option for youth, and the only safe and effective way to prevent unintended pregnancy and STIs. [The programs] generally do not discuss contraceptive methods or condoms unless to emphasize their failure rates”** (Kaiser Family Foundation, 2018, p. 1).

In Canada, many provincial/territorial ministries of education have mandated more balanced approaches to sexual health education curriculums. However, abstinence-only presentations and approaches continue to be offered in some settings.

Two key questions emerge when assessing the appropriateness of abstinence-only as a form of school-based sexual health education:

1. Are abstinence-only programs effective in persuading young people not to become sexually active?
2. Do abstinence-only programs respect young people’s right to make fully informed decisions in accordance with their own values about sexual and reproductive health?

The *Canadian Guidelines for Sexual Health Education* state that **“the content delivered in sexual health education programs should be grounded in current and credible scientific research evidence and best practice”** (SIECCAN, 2019, p. 24).

QUESTION 10: ARE ABSTINENCE-ONLY PROGRAMS AN EFFECTIVE FORM OF SCHOOL-BASED SEXUAL HEALTH EDUCATION?

Few cases of abstinence-based interventions aimed at younger youth (e.g., age 10-14) have resulted in reduced sexual activity (compared to youth who received no sex education). Furthermore, these programs neglect to provide important health information on unintended pregnancy and/or HIV/STI prevention for those students who become sexually active during the program or in the months or years afterwards (Chin et al., 2012).

In a systematic review examining school-based abstinence-only programs, Denford and colleagues (2017) reported that such programs are not effective in influencing behaviour in the intended direction and may, in some cases, increase sexual activity, STIs, and unintended pregnancy among teens. These findings are supported by recent research in the United States indicating that abstinence-only programming in some states increased teen birth rates (Fox et al., 2019).

By omitting the comprehensive and accurate information necessary to make fully informed decisions related to sexual and reproductive health, abstinence-only education is unethical (Santelli et al., 2017). Furthermore, abstinence-only programs are criticized for not presenting potentially life-saving information (e.g., the high effectiveness of condoms for HIV prevention) and ignoring the realities of youth who have already become sexually active. Further, young people who experience sexual abuse or exploitation are typically presented in an entirely heterosexual context in abstinence-only education programs, thus ignoring and stigmatizing LGBTQI2SNA+ youth (Society for Adolescent Health and Medicine, 2017).

A Core Principle in the *Canadian Guidelines for Sexual Health Education* (2019) states that “**sexual health education should encourage and facilitate a person’s right to make informed, autonomous decisions**” (SIECCAN, 2019, p. 24).

LGBTQI2SNA+:

Lesbian, gay, bisexual, transgender, queer, intersex, Two-Spirit, nonbinary, asexual, and other emerging identities.

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QUESTION 11:

DOES PROVIDING COMPREHENSIVE SEXUAL HEALTH EDUCATION IN SCHOOLS LEAD TO EARLIER OR MORE FREQUENT SEXUAL ACTIVITY?

The answer to this question is an unambiguous “no”.

There is a large and definitive body of research that clearly indicates that comprehensive sexual health education does NOT lead to earlier or more frequent sexual activity.

According to large sample studies conducted in the United States, United Kingdom, and Ireland, youth who received sexual health education at school, compared to those who did not, were more likely to report first sexual intercourse at an older age (Bourke et al., 2014; Lindberg & Maddow-Zimet, 2012; Macdowall et al., 2015).

Based on a meta-analysis of 174 studies examining the impact of different types of sexual health promotion interventions, sexual health education programs do not inadvertently increase the frequency of sexual behaviour or number of sexual partners (Smoak et al., 2006).

Specifically, a review of 66 studies measuring the behavioural impact of broadly-based sexual health education for youth that included information on abstinence, contraception, and sexually transmitted infection (STI)/HIV prevention (e.g., condom use) concluded that such programs do not hasten or increase sexual behaviour but rather that they result in “...reductions in both sexual activity and frequency of sexual activity among adolescents compared to adolescents not receiving the intervention” (Chin et al., 2012, p. 286-287).

Other reviews of studies measuring the effects of sexual health education have reached the same conclusion:

Sexual health education for youth does NOT result in earlier or more frequent sexual behaviour (Johnson et al., 2011; United Nations Educational, Scientific and Cultural Organization, 2018).

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QUESTION 12:

DO PARENTS SUPPORT SEXUAL HEALTH EDUCATION IN THE SCHOOLS?

Yes.

The majority of parents recognize that schools should play a key role in the sexual health education of their children.

A series of surveys involving a total of over 15,000 parents conducted in Ontario and other parts of Canada clearly demonstrate that a strong majority of parents support the teaching of sexual health education in the schools (Advisory Committee on Family Planning, 2008; Ipsos, 2018; McKay et al., 2014; McKay et al., 1998; SIECCAN, 2020; Weaver et al., 2002).

Figure 1 presents the cross-Canada results of the *National Parent Survey* conducted by SIECCAN (2020).

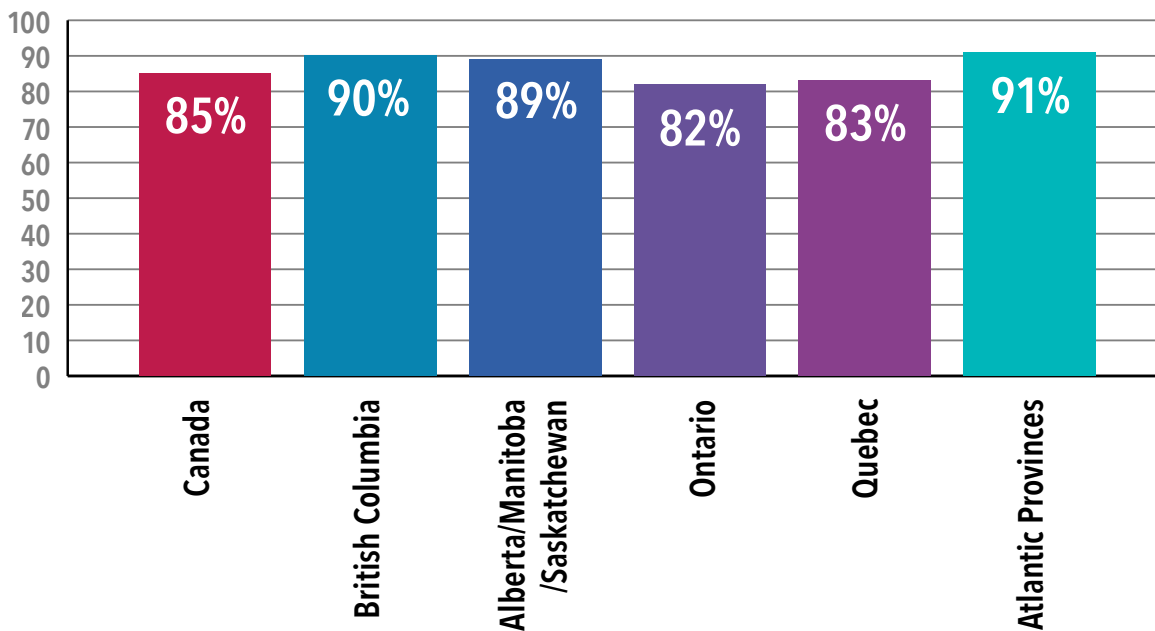


Figure 1: Percentage of parents/guardians agreeing with the statement "Sexual health education should be provided in the schools" N = 2000 (SIECCAN, 2020)

QUESTION 12: DO PARENTS SUPPORT SEXUAL HEALTH EDUCATION IN THE SCHOOLS?

In SIECCAN's (2020) *National Parent Survey*, 2,000 Canadian parents/guardians with children in elementary or high school were asked about their attitudes towards sexual health education. **The majority of parents indicated that all of the 33 potential topics in Table 1 should be included in the sexual health education curriculum.**

Table 1. Percentage of parents/guardians across Canada indicating that each topic should be included in sexual health education

Changes associated with puberty (e.g., physical, biological, psychological, emotional, social)	98.7	Sexual consent (e.g., asking for and giving consent for sexual activity)	95.8
Self-esteem and personal development	98.5	Dealing with pressure to be sexually active	95.6
Personal safety (e.g., abuse prevention)	98.4	Attraction, love, and intimacy	95.4
Correct names for body parts, including genitals	98.3	Sexuality and disability (e.g., physical disabilities, developmental disabilities)	95.0
Reproduction	98.2	Sexual problems and concerns	95.0
Sexually transmitted infections (STIs), including HIV	98.2	Sexual behaviour in relationships	94.8
Communication skills	98.1	Reasons to engage or not engage in sexual activity	94.6
Decision making skills	98.0	Sexuality and communication technology (e.g., "sexting")	94.3
Nonviolent conflict resolution in relationships	97.7	Sexual behaviour (i.e., variation in sexual behaviour; e.g., kissing, intercourse)	94.1
Bodily autonomy (e.g., choosing whether or not they want a hug)	97.0	Media literacy skills related to sexual content in advertising, TV, pornography, etc.	93.2
Body image	97.0	Gender roles and stereotypes	92.0
How to access sexual and reproductive health services	96.7	Abstinence	91.3
Sexual and gender-based violence/harassment/coercion	96.7	Sexual orientation	90.8
Safer sex methods (e.g., condom use)	96.6	Information about masturbation	90.2
Birth control methods	96.3	Gender identity (i.e., our internal sense of who we are; e.g., girl/woman, boy/man., etc.)	89.7
Prevention of sex trafficking	96.2	Sexual pleasure	86.8
Emotional components of sexual relationships	96.0		

The results of SIECCAN's (2020) *National Parent Survey* indicate that:

1. Parents support the inclusion of a broad range of topics.
2. Parents support a school-based sexual health education program that is both comprehensive and relevant to the lives of young people.

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QUESTION 13:

WHAT DO YOUNG PEOPLE WANT FROM SEXUAL HEALTH EDUCATION IN SCHOOLS?

Young people in Canada clearly want to receive relevant sexual health education in school (Byers et al., 2003a; Byers et al., 2003b; McKay & Holowaty, 1997).

Youth perceive schools to be a valuable and primary source of sexual health information (Charest et al., 2016; Frappier et al., 2008; Pound et al., 2016). However, few students report high levels of satisfaction with the school-based sexual health education they receive. **The sexual health education students receive may not be as relevant as they need or want** (Byers et al., 2003a; Byers et al., 2003b; Byers et al., 2017; Macdonald et al., 2011; Meaney et al., 2009; Pound et al., 2016).

Youth in British Columbia indicated via focus groups and surveys that it is important for sexual health education to be relevant to their current and future circumstances. These youth also noted discrepancies between what they learned about in sexual health education in school and what they found relevant to their lives (Youth Co., 2018).

Students perceive their sexual health education as being higher in quality when the content matches their interests and needs (Byers et al., 2013).

Youth participating in the *Toronto Teen Survey* ranked the topics they most want to learn about from sexual health education:

Healthy relationships	Pleasure
HIV/AIDS	Communication
Causarano et al. (2010); Larkin et al. (2017)	

Young people identify the following gaps in their sexual health education:

The enhancing and positive aspects of sexual health	Sexual and gender identity
Consent	Healthy relationships
LGBTQI2SNA+ relationships	Love
Intimacy	Emotional components of sexuality
Action Canada for Sexual Health and Rights (2019); Phillips & Martinez (2010); Pound et al. (2016); Wilson et al. (2018); Youth Co. (2018)	

Middle school students reported that most topics in sexual health education were not “covered well” - except for puberty (Byers et al., 2013). According to the *Canadian Guidelines for Sexual Health Education*, **comprehensive sexual health education that is relevant to people’s needs can make an important contribution to their sexual health and well-being** (SIECCAN, 2019).

It is necessary that sexual health education in the schools address the sexual health needs and concerns of youth in Canada.

LGBTQI2SNA+: *Lesbian, gay, bisexual, transgender, queer, intersex, Two-Spirit, nonbinary, asexual, and other emerging identities.*

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QUESTION 14:

WHY IS IT IMPORTANT FOR SCHOOL-BASED SEXUAL HEALTH EDUCATION TO BE INCLUSIVE OF THE NEEDS AND LIVED EXPERIENCES OF LGBTQI2SNA+ STUDENTS?

Sexual health education in schools has historically focused on providing information within a heterosexual context (Schalet et al., 2014). This often leaves sexual and gender diverse students without the relevant and necessary information to make informed decisions to protect and enhance their sexual health.

The *Canadian Guidelines for Sexual Health Education* state that sexual health education should:

Be inclusive of the identities and lived experiences of LGBTQI2SNA+ people.

Encourage acceptance and respect for the diversity of sexual and gender identities that exist in society.

SIECCAN (2019)

In Canada, creating school-based programs that are fully inclusive of the lives of students with diverse sexual orientations and gender identities has been challenging and, in some cases, has lagged behind the legal and human rights protections granted to sexual and gender minorities (Rayside, 2014).

Most Canadian school classrooms will have one or more students who identify as LGBTQI2SNA+.

In a demographic survey of junior and high school students by the *Toronto District School Board* (2013) in Ontario, 8% of Grade 9 to 12 students identified as lesbian, gay, bisexual, queer, or “not sure/questioning.” Similar percentages of youth identified as gay, lesbian, bisexual, or questioning in large samples of high school students in British Columbia (Peter et al., 2017; Smith et al., 2014).

Due to experiences of bullying, discrimination, and stigmatization, sexual and gender diverse youth often remain an invisible population in schools (Public Health Agency of Canada, 2010a; 2010b). The *Canadian Guidelines for Sexual Health Education* note that **an understanding of sexual diversity perspectives and issues is an important component of comprehensive sexual health education** (SIECCAN, 2019).

The sexual health education needs of LGBTQI2SNA+ students must be integrated within comprehensive sexual health education in the schools.

Parents (Advisory Committee on Family Planning, 2008; Ipsos, 2018; McKay et al., 2014; SIECCAN, 2020), students (Narushima et al., 2020; Pound et al., 2016), and teachers (Meyer et al., 2015) in Canada want sexual orientation addressed in school-based sexual health education programs. In SIECCAN's (2020) *National Parent Survey*, 91% of Canadian parents indicated that sexual orientation should be taught in school-based sexual health education.

LGBTQI2SNA+: *Lesbian, gay, bisexual, transgender, queer, intersex, Two-Spirit, nonbinary, asexual, and other emerging identities.*

QUESTION 14: WHY IS IT IMPORTANT FOR SCHOOL-BASED SEXUAL HEALTH EDUCATION TO BE INCLUSIVE OF THE NEEDS AND LIVED EXPERIENCES OF LGBTQI2SNA+ STUDENTS?

A supportive, non-threatening, and inclusive school environment has been recognized as one protective factor that can potentially reduce the risk of negative health and social outcomes among youth (Gegenfurtner & Gebhardt, 2017; Public Health Agency of Canada, 2010a; 2010b; Snapp et al., 2015).

Egale Canada conducted a national survey on homophobia, biphobia, and transphobia with more than 3,700 students.

64% of LGBT students felt unsafe at school.

21% of LGBT students experienced physical harassment or assault due to their sexual orientation.

Taylor et al. (2011)

Students feel safer and report less bullying when schools have sexual health education curricula that is LGBTQI2SNA+ inclusive (Snapp et al., 2015).

In addition to the provision of LGBTQI2SNA+ inclusive sexual health education, schools can foster peer acceptance, school connectedness, and student safety by facilitating and supporting the development of Gay-Straight Alliances (Public Health Agency of Canada, 2010a). One survey indicated that 79% of parents and 88% of students agreed that students should be allowed to set up a Gay-Straight Alliances at their school (Ontario Student Trustees Association, 2011).

There is strong evidence that Gay-Straight Alliances are positively linked to feelings of safety for students (Li et al., 2019) and lower reports of victimization based on homophobia (Marx & Kettrey, 2016).

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QUESTION 14: WHY IS IT IMPORTANT FOR SCHOOL-BASED SEXUAL HEALTH EDUCATION TO BE INCLUSIVE OF THE NEEDS AND LIVED EXPERIENCES OF LGBTQI2SNA+ STUDENTS?

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QUESTION 15:

WHY IS IT IMPORTANT TO PROVIDE STUDENTS WITH PHYSICAL AND/OR DEVELOPMENTAL DISABILITIES WITH COMPREHENSIVE SEXUAL HEALTH EDUCATION TAILORED TO THEIR NEEDS?

Youth with disabilities report that they:

Do not receive sexual health education applicable to their needs.

Believe that disability-related stigma (e.g., the assumption that youth with disabilities are not sexual people or involved in romantic and sexual relationships) contributes to their lack of access to sexual health education.

Esmail et al. (2010); Frawley & Wilson (2016); Secor-Turner et al. (2017)

As stated in the *Canadian Guidelines for Sexual Health Education*, **youth with physical, intellectual, and developmental disabilities have a right to comprehensive sexual health education relevant to their needs** (SIECCAN, 2019).

In SIECCAN's (2020) *National Parent Survey*, an overwhelming majority of Canadian parents (95%) agreed that sexual health education should include information related to sexuality and disability.

The provision of sexual health education tailored to disabled youth is frequently overlooked or lacking- even though sexuality and sexual health is as integral to the overall health and well-being of youth with disabilities as it is for youth without disabilities (DiGiulio, 2003; East & Orchard, 2013; Holland-Hall, & Quint, 2017; McDaniels & Fleming, 2016; Public Health Agency of Canada, 2013; Secor-Turner et al., 2017; SIECCAN, 2015; Treacy et al., 2018).

While sexual health education provided to youth in schools should seek to be inclusive of the needs of all students, it is also necessary that youth are provided with educational opportunities specific to their unique needs.

Students with autism may need sexual health education curriculum materials adapted to their specific learning styles and needs (Sala et al., 2019). Youth with other types of developmental disabilities may require education tailored to their specific developmental level. Youth with different physical disabilities may require sexual health education specific to their disability in order to have the information and skills needed to protect and enhance their sexual health (DiGiulio, 2003; Esmail et al., 2010; Public Health Agency of Canada, 2013; SIECCAN, 2015).

Failure to provide comprehensive sexual health education that is inclusive of the educational needs of youth with disabilities places them at increased risk for:

Sexually transmitted infections (STIs)

Sexual exploitation

Lower quality of life

Lower self-esteem

Social isolation

McDaniels & Fleming (2016); Public Health Agency of Canada (2013)

Youth and adults with disabilities experience higher rates of sexual abuse, harassment, coercion, and assault than their non-disabled peers (Benoit et al., 2015; Jones et al., 2012; McDaniels & Fleming, 2016; Stermac et al., 2018; Wissink et al., 2015).

There is evidence that programs tailored to the specific needs of youth with autism are related to improvements in students' sexuality-related knowledge and personal boundaries (Sala et al., 2019).

Comprehensive sexual health education can help youth with disabilities to develop the skills needed to explore sexuality in positive ways and learn to make autonomous decisions regarding their sexual health.

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QUESTION 16:

WHY IS IT IMPORTANT TO TEACH ABOUT CONSENT IN COMPREHENSIVE SEXUAL HEALTH EDUCATION?

Sexual health education should reflect the basic fundamental values of respect for others and inform young people of their moral and legal obligations towards others. Educating youth about the ethical and legal aspects of consent is crucial for the development of safe and respectful interpersonal relationships and the prevention of sexual and gender-based violence.

The *Canadian Guidelines for Sexual Health Education* state that sexual health education should “**assert the right of everyone to:**

1. **Set boundaries communicated verbally or non-verbally, understanding that consent can be withdrawn at any time and**
2. **Clearly ask for and communicate affirmative consent (e.g., saying yes)”**

(SIECCAN, 2019, p. 26).

The concept of consent, as it applies to sexual behaviours and relationships, is an appropriate and necessary component of sexual health education in schools.

Two key aspects of consent include:

1. The ages at which a young person can legally consent to sexual activity.
2. The communication and understanding of consent or non-consent to engage in sexual activity with partners.

SIECCAN (2015)

Age of consent refers to the age that a young person can legally agree to sexual activity (Criminal Code, 1985a). In Canada, the age of consent was raised from 14 years old to 16 years old in 2008.

Effective sexual health education should provide students with a clear understanding of how age of consent is interpreted under the law. Educators should make youth aware that the intent of the legislation is to protect children and youth.

It is important for youth to understand that age of consent laws are designed to protect them from being sexually exploited or harmed by older people.

These laws do not make it illegal for youth to engage in consensual sexual activity with their peers.

Age of consent laws related to sexual activity do not affect the right of young people to access sexual health education or sexual and reproductive health services.

Although the age of consent to sexual activity is 16, there are several close in age exceptions.

12 and 13-year-olds can consent to sexual activity with peers who are not more than two years older than themselves.

Example: A 12-year old can legally consent to sexual activity with a 14-year old, but cannot legally consent to sexual activity with a 15-year old.

14 and 15-year-olds can consent to sex with peers who are not more than 5 years older than themselves.

Example: A 15-year-old can legally consent to sexual activity with a 20-year old, but cannot legally consent to sexual activity with a 21-year old (the 21-year old could be charged with sexual interference)

Criminal Code (1985a)

Each young person should be aware of the potential circumstances in which their relationships with peers younger than themselves are in violation of the age of consent laws.

There are also laws regarding consent and sexual exploitation.

The *Criminal Code* of Canada states that a person under the age of 18 cannot legally consent to engage in sexual activity with a person in a position of authority such as a teacher, health care provider, coach, lawyer, or family member (*Criminal Code*, 1985b).

Sexual health education programs should provide age-appropriate information regarding the age of consent to sexual activity so that young people are fully aware of the circumstances in which they may be sexually exploited by an older person, a person in a position of authority, or a person who has control/influence over their lives.

Children and youth are more likely to be sexually abused by someone they know and trust. The accused was known to the child/youth in 88% of the 14,000 police-reported cases of child/youth sexual assault in Canada in 2012 (Statistics Canada, 2012).

THE COMMUNICATION AND UNDERSTANDING OF CONSENT

Canadian law specifies that sexual activity must involve “voluntary agreement” and that when there is a “lack of agreement” expressed either verbally or through a person’s conduct, consent does not exist (*Criminal Code*, 1985b).

Furthermore, the law states that a person cannot consent to engage in sexual activity if they are “unconscious” or “incapable” of doing so (e.g., because of alcohol or drug intoxication).

As noted in the *Canadian Guidelines for Sexual Health Education*, comprehensive sexual health education in schools can help teach students the age-appropriate information and skills needed to ensure that “**all partners feel safe and fully consent before and during sexual activity**” (SIECCAN, 2019, p. 16).

LEARNING ABOUT CONSENT

In early elementary grade levels, sexual health education can provide foundational knowledge and skill development opportunities regarding general concepts of respect of self and others. This includes learning verbal and non-verbal communication skills (e.g., to listen, show respect for themselves and others, to advocate for personal needs). In later grade levels, it is important to provide students with a clear understanding of the meaning of consent as it applies specifically to sexual activity.

In SIECCAN’s (2020) *National Parent Survey*, parents endorsed the following:

96% indicated that the **concept of sexual consent** should be taught in sexual health education.

97% indicated that the **concept of bodily autonomy** should be taught in sexual health education.

84% agreed that sexual health education should **promote the right to autonomous decision-making and respect for others**.

It is developmentally appropriate for educational programs to provide information on sexual consent at the ages at which young people start to become sexually active.

To promote equitable, healthy relationships, and reduce the likelihood of sexual assault, young people need to learn the information, motivation, and behavioural skills to clearly ask for and communicate affirmative, ongoing consent (Shumlich & Fisher, 2019; SIECCAN, 2015; SIECCAN, 2019).

Sexual health education should provide students with the following:

1. The information needed to be able to identify when students have been sexually assaulted or abused;
2. Options for reporting sexual assault and abuse; and
3. Information on how to access survivor support services.

Comprehensive sexual health education can promote the development of interpersonal and social environments that are free of coercion by addressing issues of power dynamics and gender norms that contribute to unequal intimate relationships.

Programs that focus on gender-based inequality as it applies to sexuality can reduce the likelihood of non-consensual sexual activity (Lungdren & Amin, 2015), as well as reduce rates of sexually transmitted infections (STIs) and unintended pregnancy (Haberland, 2015; Haberland & Rogow, 2015).

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QUESTION 17:

WHY IS IT IMPORTANT TO TEACH ABOUT GENDER IDENTITY IN COMPREHENSIVE SEXUAL HEALTH EDUCATION?

Addressing gender identity in school-based sexual health education includes exploring ideas about gender roles and gender stereotypes and is, therefore, relevant to all youth. **Discussions of gender identity are particularly important for the health and well-being of gender diverse individuals.**

Gender identity refers to a person's internal sense of being a girl/woman, boy/man, both, neither, or another gender. This identity may or may not correspond to the sex a person was assigned at birth (i.e., female, male, intersex) (Egale, 2019; Public Health Agency of Canada, 2010).

Cisgender is a term that denotes when a person's gender identity corresponds to the sex they were assigned at birth.

Transgender (or 'trans') is an umbrella term that describes when a person's gender identity or gender expression is different from their assigned sex at birth (Egale, 2019; Ratus et al., 2020).

There are a range of gender identities, including agender, genderqueer, man, non-binary, transgender, Two Spirit, woman, and other fluid identities.

Sexual health education programs that address gender identity can help create safe and supportive school environments and contribute to the reduction of negative outcomes for gender diverse youth (Gegenfurtner & Gebhardt, 2017).

The *Trans PULSE Project* is a Canadian research project that examines the factors that impact the sexual and mental health and well-being of trans communities (Bauer & Scheim, 2015). In this research, 59% percent of trans and non-binary participants "knew that their gender did not match their body before the age of 10, and 80% had this knowledge by the age of 14" (Bauer & Scheim, 2015, p. 4).

For many transgender students in Canada, school can be a harsh and hostile environment (Greytak et al., 2008; Taylor et al., 2011; Veale et al., 2015; Wright-Maley et al., 2016). Trans youth experience high rates of harassment, bullying, and violence. In a national Canadian survey of high school students, 74% of trans youth reported verbal harassment due to their gender expression (Taylor et al., 2011).

In the Canadian Trans Youth Health Survey, transgender youth reported the following:

55% were bullied once or more in the past year at school

36% were physically threatened or injured

Veale et al. (2015)

Transgender youth are more likely to consider suicide compared to their cisgender peers (54% vs. 31%) (The Trevor Project, 2019). Data from the Trans PULSE project indicate that 31% of trans and non-binary participants in Canada considered suicide in the past year and 6% had attempted suicide (The Trans PULSE Canada Team, 2020).

QUESTION 17: WHY IS IT IMPORTANT TO TEACH ABOUT GENDER IDENTITY IN COMPREHENSIVE SEXUAL HEALTH EDUCATION?

Trans youth and adults who have social support are far less likely to consider and attempt suicide (Bauer & Scheim, 2015; Veale et al., 2015; The Trevor Project, 2019).

Creating safe and supportive school environments is one critical avenue for helping to protect and enhance the health and well-being of trans youth in Canada (Veale et al., 2015).

Feeling positively about one's gender identity is also linked to greater well-being among transgender youth (Johns et al., 2018).

Youth who live in their felt gender and are supported in using their chosen name report greater mental health

(Russell et al., 2018; Veale et al., 2015).

A recent Canadian parliamentary report from the Standing Committee on Health emphasized the importance of providing age-appropriate education about gender identity to children and youth of all age groups (Casey, 2019). It is, therefore, important that sexual health education play a central role in providing this education.

According to SIECCAN's (2020) *National Parent Survey*, 90% of parents want the topic of gender identity taught in sexual health education in the schools and the majority of these parents want education on gender identity to begin in the elementary grades. The majority of parents (73%) also agreed that sexual health education in schools should seek to reduce transphobia.

Several ministries of education in Canada have indicated that the education system should support gender diverse students and that trans-positive content should be incorporated into the teaching of all subject areas (e.g., Alberta Government, 2016; Department of Education & Early Childhood Development NL, 2016; Province of Nova Scotia, 2014; Saskatchewan Ministry of Education, 2015).

According to the *Canadian Guidelines for Sexual Health Education*, comprehensive sexual health education programs should **"encourage acceptance and respect for the diversity of sexual and gender identities that exist in the community and include the critical evaluation of discriminatory attitudes and practices"**

SIECCAN (2019, p. 25)

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QUESTION 18:

WHY IS IT IMPORTANT TO TEACH ABOUT COMMUNICATION TECHNOLOGY SKILLS IN COMPREHENSIVE SEXUAL HEALTH EDUCATION?

Modern communication technologies (i.e., cell phones/smartphones, social media apps/websites) have fundamentally altered the way young people are exposed to and communicate about sexuality-related information.

The *Canadian Guidelines for Sexual Health Education* state that comprehensive sexual health education should be “**responsive to and incorporate emerging issues related to sexual health and well-being**” (SIECCAN, 2019).

By adolescence, virtually all Canadian young people have access to the internet and most own or have access to cell phones (Steeves, 2014). These modern communication technologies can help to enhance young people’s sexual health and well-being (e.g., by using technology to increase intimacy and communicate with relationship partners) (Van Ouytsel et al., 2018). These technologies also have the potential for negative outcomes (e.g., in the form of exploitation risks and privacy breaches) (Slane, 2013).

It is important that comprehensive sexual health education equip students with the knowledge and skills to use communication technology safely and respectfully.

Sending sexually explicit images, videos, or messages (i.e., sexting) is becoming more common among youth as access to digital technology increases (Gassó et al., 2019; Temple & Lu, 2018).

In a national Canadian study of youth between 16 and 20 years old:

41% sent a sext of themselves

66% received a sext

Johnson et al. (2018)

The research on the relationship between sexting and sexual health and well-being is currently **inconclusive**.

There is some evidence that sexting is linked to depression and anxiety (Gassó et al., 2019), but other research suggests there is no association between sexting and indicators of psychological well-being (Gordon-Messer et al., 2013). These mixed results may be due to the fact that most research has not distinguished between wanted and unwanted (i.e., coerced) sexting (Gassó et al., 2019; Slane, 2013; Temple & Lu, 2018).

In research that has made this distinction, teenagers who felt pressured to send sexts (compared to those who wanted to sext) reported more anxiety and problems related to sexting (e.g., having other students at school view the photo) (Englander, 2012).

A review of the qualitative research in this area indicates that for some young people, sexting is viewed as a fun experience or as a way to experiment sexually when they are not ready to engage in physical sexual activity (Anastassiou, 2017). However, young people also need to be aware of the social and legal consequences of sending sexts (Canadian Paediatric Society, 2014) and understand the role of consent in sexting.

Of Canadian youth between 16 and 20 years old:

19% sent unsolicited sexts

51% received unsolicited sexts

Johnson et al. (2018)

Young people need to be aware that it is a criminal offense to distribute or share a photo or video of a sexual nature of anyone without their consent (Criminal Code, 1985). **In Johnson and colleagues' (2018) study of Canadian youth between 16 and 20 years old, 42% of youth who had sent a sext reported that one or more of their sexts were shared without their consent.** For most youth, however, knowing the possible legal consequences is not enough to change behaviour.

Young people need to be taught to challenge traditional gender stereotypes and to recognize and confront moral disengagement mechanisms (i.e., victim-blaming, diffusion of responsibility), both of which are strongly correlated with sharing sexts without the sender's consent (Johnson et al., 2018).

Canadian parents want their children to develop this knowledge and these skills. In SIECCAN's (2020) *National Parent Survey*, 94% of parents indicated that sexuality and communication technology should be taught in school-based sexual health education.

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QUESTION 19:

WHY IS IT IMPORTANT TO TEACH ABOUT MEDIA LITERACY SKILLS IN COMPREHENSIVE SEXUAL HEALTH EDUCATION?

Comprehensive sexual health education can help students to develop the digital and media literacy skills needed to differentiate between positive and problematic representations of sexuality and relationships in media.

Young people in Canada use a variety of devices to access information and connect with online communities (Steeves, 2014a).

In a recent study of Canadian youth aged 14-15 years:

77% had their own smartphone

51% had their own computer

Brisson-Boivin (2018)

For young people, access to the internet is nearly universal; youth consume more of their media via the internet than through other mediums (e.g., television) (Steeves, 2014a). The majority of students use the internet as a source of information about health and relationship issues (Steeves, 2014a). Approximately 20% of Grade 11 students report using the internet to search for sexuality-related information (Steeves, 2014a).

The internet can be beneficial in enhancing young people's ability to learn about sexuality from credible sources and, at the same time, present challenges when the information is inaccurate (Springate & Omar, 2013). **Only two-thirds of young Canadians take steps to verify online information that they are seeking for personal use** (Steeves, 2014b).

The internet provides nearly unlimited access to sexually explicit material, a concern reported by both parents and youth (Brisson-Boivin, 2018; Livingstone et al., 2014). The percentage of Canadian young people accessing pornography on the internet is increasing. In a national survey of Canadian youth, approximately 30% of Grade 10 and 11 students reported looking for pornography online (Steeves, 2014c). Smaller studies in Canada and the United States have found higher percentages of adolescents reporting exposure to sexually explicit websites (Braun-Courville & Rojas, 2009; Peter & Valkenberg, 2016; Thompson, 2006).

The Canadian Guidelines for Sexual Health Education suggest that comprehensive sexual health education programs should **"...facilitate the development of media and digital literacy skills that will enable people to critically evaluate the sexuality-related material they encounter..."** (SIECCAN, 2019, p. 27).

To be relevant to young people's current educational needs, school-based sexual health education programs should assist young people in developing the critical media literacy skills to interpret and assess the sexual imagery on the internet that they are exposed to. In addition, youth need to develop the skills to differentiate between credible and problematic sources of sexuality information.

QUESTION 19: WHY IS IT IMPORTANT TO TEACH ABOUT MEDIA LITERACY SKILLS IN COMPREHENSIVE SEXUAL HEALTH EDUCATION?

Parents also agree that students should develop these skills. In SIECCAN's (2020) *National Parent Survey*, **93% of parents indicated that "media skills related to sexual content in advertising, TV, pornography" should be taught in school-based sexual health education.**

Media literacy education programs can have a positive impact on the sexual health of adolescents.

Students who completed a teacher-led, comprehensive sexual health and media literacy program reported:

Greater intentions and self-efficacy to use contraceptives;

More positive attitudes toward communicating about sexual health (with a romantic partner, parent, or trusted adult);

Reduced acceptance of strict gender roles and dating violence norms; and

Increased media skepticism and deconstruction skills.

Scull et al. (2018)

Media literacy interventions have also been shown to help students resist peer pressure and recognize misleading portrayals of relationships and sexuality in media (Pinkleton et al., 2012).

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PART C:

**COMPREHENSIVE
SEXUAL HEALTH EDUCATION
IN OTHER SETTINGS**

QUESTION 20:

WHY IS IT IMPORTANT TO SUPPORT PARENTS AND GUARDIANS IN THEIR ROLE AS SEXUALITY EDUCATORS OF THEIR CHILDREN?

As noted in the *Canadian Guidelines for Sexual Health Education*, parents and guardians **“play a pivotal and complementary role in the sexual health education of their children”** (SIECCAN, 2019, p. 73).

Parents and guardians believe it is important to talk to their children about sexual health (Wilson et al., 2010) and most parents say that they communicate with their children about some aspect of sexual health (e.g., reproduction, STIs) (Jerman & Constantine, 2010). Youth in Canada also agree that sexual health education is a shared responsibility between their schools and their parents (Foster et al., 2011).

Youth are more likely to use birth control and/or condoms (if sexually active) and have better communication with their romantic partners when they have good communication with a parent about sexuality (Widman et al., 2013; 2016).

Parents/guardians themselves may have grown up in an era or culture where discussing sexuality was taboo or where there was limited access to sexual health information.

Parents report the following barriers to talking with their children about sexuality:

Being worried that they do not know enough about sexuality themselves;

Thinking that their children are not ready to talk about sexual health; and/or

Feeling embarrassed or uncomfortable talking with their children about sexuality.

Jerman & Constantine (2010); Malacane & Beckmeyer (2016); Wilson et al. (2010)

Parents who are more knowledgeable about sexuality and more comfortable discussing sexuality communicate about a greater range of topics (e.g., sexually transmitted infection, pleasure, sexual assault, decision-making in relationships) and encourage their children to ask questions about sexuality more often (Byers et al., 2008).

In SIECCAN’s (2020) *National Parent Survey*, only 23% of parents/guardians encouraged their children to ask questions about sexual health *“often”* or *“very often”* in the past year. Parents and guardians who were more comfortable having discussions about sexual health with their child were more likely to report encouraging their child to ask questions.

Being encouraged to communicate about sexuality with parents is also important to youth. In a study of 600 Canadian students in Grades 6 through 8, adolescents rated the sexual health education they received from their parents as higher in quality if they perceived that their parents encouraged questions about sexuality more frequently (Foster et al., 2011).

QUESTION 20: WHY IS IT IMPORTANT TO SUPPORT PARENTS AND GUARDIANS IN THEIR ROLE AS SEXUALITY EDUCATORS OF THEIR CHILDREN?

Sexual health interventions that include parents can improve sexual health communication between parents and adolescents (Hobgen et al., 2015). Researchers who conducted a meta-analysis of programs targeting changes in parent and adolescent sexual health communication and behaviour outcomes observed the following: Parents who participated in the interventions reported increased communication scores and greater comfort compared to parents in control groups (Santa Maria et al., 2015). Sexual health education programs that incorporate parents can have a positive impact on adolescent sexual behaviour (e.g., increased condom use) (Santa Maria et al., 2015; Widman et al., 2019; Wight & Fullerton, 2013).

Given the important role that parents and guardians play in the development of their children, it is vital that parents receive access to sexual health education resources designed for their needs (SIECCAN, 2019). Such resources are necessary to help parents and guardians increase their knowledge, comfort, and ability to discuss sexual health education information with their children.

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QUESTION 21:

WHY SHOULD FACILITIES THAT SERVE SENIORS HAVE THE CAPACITY TO PROVIDE COMPREHENSIVE SEXUAL HEALTH EDUCATION?

In 2016, approximately 425,000 seniors in Canada lived in nursing homes or residential care facilities (Statistics Canada, 2017). Recent analyses indicate that 30% of people aged 85-89 reside in seniors' residences (Garner et al., 2018).

Given the importance of sexual health to older adults' health and well-being (see Question 3), it is necessary that comprehensive sexual health education in long-term care facilities be accessible to and suit the needs of seniors (SIECCAN, 2019).

Stereotypes of older adults often position sexual activity among seniors as inappropriate or assume that older people no longer have an interest in sex. As noted in Question 3, these ideas have been discredited. Seniors often report continued interest and engagement in sexual activity upon moving into residential care facilities (Bauer et al., 2013a; Elias & Ryan, 2011; Franowski & Clark, 2009).

Seniors living in long-term care facilities face several barriers that may limit their sexual expression:

A lack of privacy;

Poor health;

Cognitive impairment;

Knowledge and attitudes of staff, residents, and family; and/or

Lack of a partner

Bauer et al. (2013a); Elias & Ryan (2011); Mahieu & Gastmans (2015); Villar et al. (2014)

LGBTQI2SNA+ seniors face additional barriers regarding their sexuality; many LGBTQI2SNA+ seniors feel the need to hide their identity out of fear of social exclusion or due to experiences of stigmatization (Leyerzapf et al., 2018; Mahieu & Gastmans, 2015). Long-term care facilities should adopt strategies that are sensitive to the needs of LGBTQI2SNA+ seniors and help create an environment where they can safely express themselves (Sussman et al., 2018).

Researchers in Canada studied the types of strategies long-term care facilities used to help support LGBTQI2SNA+ older adults (Sussman et al., 2018). The most common strategies involved training staff, followed by offering LGBTQI2SNA+-themed programming to residents. Facilities that offered these strategies noted several benefits, including raised awareness and acceptance.

LGBTQI2SNA+:

Lesbian, gay, bisexual, transgender, queer, intersex, Two-Spirit, nonbinary, asexual, and other emerging identities.

QUESTION 21: WHY SHOULD FACILITIES THAT SERVE SENIORS HAVE THE CAPACITY TO PROVIDE COMPREHENSIVE SEXUAL HEALTH EDUCATION?

Supporting the sexual health of older adults and offering criteria for assessing a resident's ability to consent to sexual activity have been identified in guidelines for supporting adults living in long-term care (Vancouver Coastal Health Authority, 2009).

It is critical that individuals working in facilities serving seniors understand the significance of sexuality throughout the lifespan and have the capacity to provide comprehensive sexual health education and support for residents' right to sexual expression.

Staff working in facilities that serve seniors should be provided with opportunities to learn about the sexual health needs of older adults (SIECCAN, 2019). Participating in sexual health education programs can improve staff knowledge and attitudes regarding the sexual expression of older adults in long-term care (Bauer et al., 2013b; Walker & Harrington, 2002).

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QUESTION 22:

WHY SHOULD DETENTION CENTRES AND CORRECTIONAL FACILITIES PROVIDE ACCESS TO COMPREHENSIVE SEXUAL HEALTH EDUCATION?

According to Statistics Canada, there were an average of 38,786 adults in provincial, territorial, and federal custody per day in 2017/2018 (Malakieh, 2019). In the same year, there were 7,052 youth (on average, per day) in custody or in a supervised community program. Most people who experience incarceration report being sexually active in the months prior to being in custody (Kouyoumdjian et al., 2016); 17% of men and 31% of women report being sexually active during their incarceration (Thompson et al., 2010).

Individuals in detention centres and correctional facilities should have access to comprehensive sexual health education that is relevant to their needs (SIECCAN, 2019).

SEXUAL HEALTH ISSUES

SEXUALLY TRANSMITTED INFECTIONS (STIs)

People who have been incarcerated are at risk for adverse sexual health outcomes and report numerous barriers to accessing sexual health services (Bernier & MacLellan, 2011; Besney et al., 2018; Martin et al., 2012;

Kouyoumdjian et al., 2016; Thompson et al., 2010). STIs (e.g., chlamydia, gonorrhoea) are common among both youth and adults in custody (Besney et al., 2018; Kouyoumdjian et al., 2016). Bloodborne illnesses (e.g., HIV, Hepatitis C) are common among adults in custody (Martin et al., 2012; Nolan & Stewart, 2014; Stewart et al., 2014).

HIV

According to one review, between 1% and 2% of men and 1% and 9% of women in custody were living with HIV (Kouyoumdjian et al., 2016). Correctional Service Canada estimates the prevalence of HIV in federal Canadian prisons to be 1.76% (Correctional Service Canada, 2016). However, access to HIV treatment in Canadian prisons can be interrupted or suboptimal depending on the location (Kouyoumdjian et al., 2016; 2019).

SEXUAL & REPRODUCTIVE HEALTH

Although little work has examined the reproductive health of incarcerated people in Canada (Kouyoumdjian et al., 2016), there is evidence that women in custody often experience problems related to their sexual and reproductive health (Bernier & MacLellan, 2011; Michel et al., 2012). For example, some women report challenges in accessing adequate birth control (Bernier & MacLellan, 2011; Paynter et al., 2019). Researchers in Ontario examined the rates of unintended pregnancy and contraceptive use for incarcerated women in the province: Incarcerated women had a greater unmet need for contraception compared to the general population (Liau et al., 2016).

ADOLESCENT SEXUAL HEALTH

Youth in custody also need access to comprehensive sexual health education. Researchers in British Columbia surveyed 114 youth currently in custody (Smith et al., 2013). The majority of participants (aged 16-18) reported experience with oral sex and/or sexual intercourse. Thirty-five percent said that they had ever been pregnant or been involved in a pregnancy; this rate was higher than rates reported for youth in schools. In a follow-up study, researchers interviewed a sample of young women in custody (Smith et al., 2014). Those who were sexually active noted a lack of knowledge about sexual health and birth control yet reported that the only time they received sexual health information was while in custody.

SEXUAL AND GENDER-BASED VIOLENCE

Addressing sexual and gender-based violence among these populations is also critical. Some individuals may be in custody due to perpetration of sexual and gender-based violence. Many incarcerated individuals have experienced sexual violence. According to a meta-analysis of 29 studies examining childhood abuse among incarcerated people in Canada, 50% of women and 22% of men reported experiencing sexual abuse before the age of 18 (Bodkin et al., 2019). Therefore, it is important that sexual health programs tailored to this population incorporate a trauma-informed approach (Bodkin et al., 2019; SIECCAN, 2019).

SEXUAL HEALTH EDUCATION INTERVENTIONS

Among people who are/were currently or recently incarcerated, educational interventions can be effective in:

Promoting sexual health knowledge;

Helping people acquire risk-reduction behavioural skills; and

Increasing engagement in safer sex behaviours

Azhar et al. (2014); Kouyoumdjian et al. (2015); Knudson et al. (2014); Ramaswamy et al. (2014); Robertson et al. (2011)

People who have been incarcerated have experienced or are at risk of experiencing various negative sexual health outcomes (e.g., STIs, lack of HIV care, challenges accessing birth control, high rates of sexual violence/abuse). This evidence speaks to the need for high quality, comprehensive sexual health education in detention centres and correctional facilities in Canada.

Individuals in detention centres and correctional facilities need access to comprehensive sexual health education in order to build their capacity to protect and enhance their sexual health and well-being both during the time of their sentence and upon their release.

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QUESTION 23:

WHY IS IT IMPORTANT FOR PRIMARY HEALTHCARE PROVIDERS TO PLAY A KEY ROLE IN PROVIDING SEXUAL HEALTH EDUCATION?

Primary healthcare providers (e.g., physicians, nurses, midwives) are in a unique position as they play an important role in providing accurate and relevant sexual health education to people across the lifespan (Fenell & Grant, 2019; Pascoal et al., 2017; Shindel & Parish, 2013). Primary healthcare providers are viewed as highly authoritative sources of health information and are likely to be the first point of contact for people of all ages who have sexual health concerns (Coleman et al., 2013; Shindel et al., 2016; SIECCAN, 2019a).

Canadian research indicates that approximately 52% of university students aged 18 to 24 and 58% of people aged 40 to 59 cite health care providers as a key source for sexual health information (SIECCAN, 2015; 2019b).

By proactively educating patients and clients about sexual health, and including the opportunity to ask questions about sexuality, primary healthcare providers can uncover existing medical sexual health conditions and pave the way for the provision of information, motivation, and behavioural skills to prevent sexual health problems and enhance sexual health and well-being.

PROVISION OF SEXUAL HEALTH EDUCATION FOR VARIOUS GROUPS

ADOLESCENTS

Pediatricians and family physicians are well-placed to provide important sexual health education to young people. As part of regular check-ups and health assessments, primary healthcare providers play an important supportive and authoritative role in providing youth with education on sexually transmitted infection (STI) prevention, contraception, and healthy relationships (Dawson, 2018; Marcell et al., 2017). In one study, physicians discussed sexuality in 65% of health maintenance visits with adolescents: In all of those conversations, the physician initiated the sexual health topic, suggesting that primary healthcare providers may need to be proactive in sexual health discussions with young people (Alexander et al., 2014).

CHILDREN AND ADOLESCENTS WITH CHRONIC HEALTH CONDITIONS AND/OR DISABILITIES

Physician-provided sexual health information may be especially beneficial to children and adolescents with chronic health conditions and/or disabilities (Breuner et al., 2016). The importance of primary healthcare providers' role in providing sexual health education can be magnified for youth with disabilities, who may not have received sexual health education in school tailored to their needs and who require specialized sexual health education and healthcare (Walters & Gray, 2018).

OLDER ADULTS AND SENIORS

Primary health care providers may be of particular importance in providing credible sexual health information to adults and seniors who no longer have access to sexuality education in schools.

QUESTION 23: WHY IS IT IMPORTANT FOR PRIMARY HEALTHCARE PROVIDERS TO PLAY A KEY ROLE IN PROVIDING SEXUAL HEALTH EDUCATION?

Older people often have questions, concerns, and age-related sexual health issues that may go unaddressed if primary health care providers do not proactively talk to and educate older people about sexual health issues (Pascoal et al., 2017).

INDIVIDUALS WHO EXPERIENCE MARGINALIZATION

Physicians and nurses can play an important role in addressing the unmet sexual health education needs of populations that experience discrimination, marginalization, stigmatization, or unequal access to services and may, as a result, be more likely to experience negative sexual health outcomes (SIECCAN, 2019a). This includes people with disabilities, LGBTQI2NSA+ individuals, Indigenous peoples, ethnocultural minorities, sex workers, and those who are new to Canada (SIECCAN, 2019a).

CULTURALLY COMPETENT CARE

The ability of primary healthcare providers to provide meaningful, inclusive, and relevant sexual health information and care to people from specific populations is often referred to as culturally competent care (see Public Health Agency of Canada, 2019). The provision of culturally competent sexual health education and health care is necessary to ensure that people feel they can communicate freely and honestly about their sexual health. In a study that examined the experiences of Iranian immigrants in Canada, most participants preferred to obtain sexual health information from a physician (Maticka-Tyndale et al., 2007). However, a perceived lack of cultural understanding from care providers often left participants with unanswered sexual health questions and concerns.

Transgender patients who perceive their healthcare provider as more knowledgeable about trans issues report less discomfort when discussing health issues with them (Bauer et al., 2015).

LGBTQI2SNA+ youth and adolescents highlighted the importance of:

1. Primary healthcare providers using inclusive language;
2. Primary healthcare providers' comfort level with LGBTQ2 sexual health issues; and
3. Primary healthcare providers consistently asking about sexuality/sexual behaviours.

Fuzzell et al. (2016)

Such actions can foster an environment where LGBTQI2SNA+ individuals feel comfortable disclosing their sexual health needs to primary healthcare providers and obtaining the sexual health information relevant to their needs.

BARRIERS TO PROVIDING COMPREHENSIVE SEXUAL HEALTH EDUCATION

It is important to note that primary healthcare providers can face barriers in providing sexual health education. For example, primary healthcare providers may have received little training on specific sexual health subjects and thus may be less comfortable providing information to patients.

Time constraints with patients may also limit the type of education they can provide: In

LGBTQI2SNA+: *Lesbian, gay, bisexual, transgender, queer, intersex, Two-Spirit, nonbinary, asexual, and other emerging identities.*

QUESTION 23: WHY IS IT IMPORTANT FOR PRIMARY HEALTHCARE PROVIDERS TO PLAY A KEY ROLE IN PROVIDING SEXUAL HEALTH EDUCATION?

an observational study of audio-recorded conversations between physicians and adolescent patients, sexuality-related conversations lasted an average of less than 40 seconds (Alexander et al., 2014). Given the important role that primary healthcare providers can play in educating people about sexual health, it is critical that primary healthcare providers receive appropriate training and resources.

Institutions that train primary healthcare providers should include information on—and address attitudes towards—sexuality and sexual health and help develop skills related to the provision of sexual health information (Shindel et al., 2016; SIECCAN, 2019a). Ensuring that primary healthcare providers have the capacity to deliver accurate sexual health information is necessary for enhancing individuals' sexual health and well-being (Coleman et al., 2013; Shindel & Parish, 2013; SIECCAN, 2019a).

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QUESTION 24:

WHY IS IT IMPORTANT FOR ORGANIZATIONS THAT SERVE PEOPLE WITH PHYSICAL AND/OR DEVELOPMENTAL DISABILITIES TO HAVE THE CAPACITY TO PROVIDE COMPREHENSIVE SEXUAL HEALTH EDUCATION?

Sexuality is a central aspect of being human and the expression of sexuality is a fundamental human right (World Health Organization, 2010). However, people with disabilities have historically had their right to sexual expression limited (e.g., forced sterilization) and their sexual health needs neglected (Campbell, 2017; SIECCAN, 2019). In 2017, more than 6.2 million Canadians over the age of 15 reported having one or more disabilities (e.g., physical, learning, developmental) (Statistics Canada, 2019).

Individuals and communities use different language to discuss and identify themselves and their relationship with disability. Some use person-first language (e.g., “a person with a disability”) and others use identity-first language (e.g., “a disabled person”). It is important for individuals working within organizations to understand the preferred language of the people and communities that they serve.

Recently, approaches to supporting the sexual health needs of people with disabilities have shifted to emphasize self-determination, human rights, and the importance of sexuality (Brown & McCann, 2019; Campbell, 2017). Misperceptions of people with disabilities as disinterested in sex, as well as a lack of training for care providers, persist as barriers to accessing appropriate sexual health services and education (Brown & McCann, 2019; Campbell, 2017; Sinclair et al., 2015).

Contrary to stereotypic views, most people with physical, intellectual, and/or developmental disabilities are sexually active and want to engage in romantic partnerships (Brown & McCann, 2019; Campbell, 2017; Kahn & Halpern, 2018).

In a population level study in the United Kingdom, the majority of adolescents and young adults with a physical disability reported that they had engaged in intercourse or oral sex (Kahn & Halpern, 2018). Similarly, a nationally representative study in England reported that most young adults with an intellectual disability had engaged in sexual intercourse (75% of men, 72% of women) (Baines et al., 2018).

Individuals with disabilities express a desire for autonomy related to their relationships and sexual decision-making (Brown & McCann, 2019). Disability can reshape and challenge conceptualizations of sex and sexuality that are based on heteronormative and ableist understandings of sexuality (Campbell, 2017; Kattari, 2015). However, this is balanced with potentially experiencing stigmatization and a risk of abuse and exploitation (Brown & McCann, 2019). For example, people with disabilities are disproportionately impacted by gender-based violence and experience higher rates of sexual abuse and sexual assault than people without disabilities (see Question 7 and Question 15) (Government of Canada, 2018; McDaniels & Fleming, 2016; Stermac et al., 2018).

QUESTION 24: WHY IS IT IMPORTANT FOR ORGANIZATIONS THAT SERVE PEOPLE WITH PHYSICAL AND/OR DEVELOPMENTAL DISABILITIES TO HAVE THE CAPACITY TO PROVIDE COMPREHENSIVE SEXUAL HEALTH EDUCATION?

It is imperative that people with disabilities have access to comprehensive sexual health education that helps build their capacity to make informed decisions about their sexual health.

Despite a clear need and desire for sexual health information, people with disabilities face significant challenges to accessing comprehensive sexual health education that suits their needs (Brown & McCann, 2019; Campbell, 2017; McCann et al., 2016; Medina-Rico et al., 2018).

The sexual health education that people with disabilities receive is often incomplete with too much emphasis placed on:

Physiological topics (e.g., menstruation, body parts).	Protective measures (e.g., abuse prevention).
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Little attention is paid to positive or enhancing aspects of sexual health, such as developing or maintaining relationships.

Brown & McCann (2019); McCann et al. (2016); Medina-Rico et al. (2018); Schaafsma et al. (2017); Sinclair et al. (2015)

Lesbian, gay, bisexual, and trans individuals with disabilities also note a lack of sexual health education tailored to their needs (McCann et al., 2016).

In order to enhance their sexual health and prevent negative sexual health outcomes, people with disabilities need access to sexual health education that covers topics relevant to their lives. Sexual health education can also provide people with disabilities with opportunities to build and practice relevant social skills (e.g., flirting, asking for/giving consent) (SIECUS, 2001). Meta-analytic research indicates that sexual health education programs aimed at people with intellectual disabilities are effective for improving global aspects of sexual health

(e.g., decision-making and social skills in relationships, decreasing inappropriate behaviours) (González et al., 2018).

A lack of sexual health training and knowledge among care staff can also act as a barrier to accessing information and the expression of sexuality for people with disabilities (Brown & McCann, 2019; Saxe & Flanagan, 2014; 2016). Research suggests that Canadian support workers hold overall positive attitudes regarding sexuality and disabilities (Saxe & Flanagan, 2016). However, research also indicates that there is a clear need for greater education of staff who work in organizations that serve people with disabilities (Brown & McCann, 2019).

Education and training of staff have been identified as key factors linked to the support of sexual health issues with people who have developmental disabilities (Saxe & Flanagan, 2014; 2016); sexual health intervention programs for people with disabilities are more effective when the programs include well-trained staff (González et al., 2018). People may have disability-specific concerns/questions that need to be appropriately addressed. Therefore, training individuals who work in organizations serving people with disabilities to provide relevant and comprehensive sexual health education is essential.

Finally, colleges and universities that provide pre-service training for front-line workers, as well as organizations that serve people with disabilities, can encourage access to sexual health education by including clear policies that mandate sexual health training for care staff (Brown & McCann, 2019; Saxe & Flanagan, 2016; SIECCAN, 2019; Sinclair et al., 2015).

Providing appropriate and ongoing sexual health training to staff in short and long-term care facilities is necessary to ensure that individuals with disabilities are supported in making decisions that enhance their sexual health and well-being and prevent negative sexual health outcomes.

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