Educator Capacity Building Workshop On Sexual Health Education
Facilitator Guide

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For

Nova Scotia Association for Sexual Health

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Handouts

Introduction to Guide

This facilitator guide was developed for the Nova Scotia Association for Sexual Health in partnership with the Nova Scotia Department of Health and Wellness. The purpose of the facilitator guide is to provide educators, public health staff, and service providers with information to teach others about sexual health education.

Goal of Training Workshop

- To support educators to develop knowledge, skills, and comfort around teaching sexual health.

Workshop Objectives

- To increase educator comfort with teaching sexual and reproductive health related content in the P-9 Health Education Curriculum.
- To increase knowledge of evidence supporting sexual health education.
- To increase awareness regarding sexual diversity.
- To identify and explore personal values surrounding sexual health.
- To increase awareness of the impact of language on the way we communicate about sexual health.
- To address individual concerns regarding teaching sexual health.
- To increase knowledge of the Nova Scotia Learning Outcome Framework sexual health-related outcomes for primary to grade 9.
- To provide an overview of provincial and local sexual health resources.
- To provide an opportunity to network with others assigned to teach sexual health.

By the end of the training session, participants will be able to:

- Understand the concepts of sexuality, sexual health, and sexual health education.
- Discuss some of the myths and misconceptions surrounding sexual health education.
- Recognize the range of values and attitudes that people have regarding sexual health education.
- Understand appropriate use of language and terminology.
- Better understand their own values regarding sexuality and how their values may impact others.
- Know where to access local and provincial sexual health resources and services.

Workshop Overview

Morning Session

Introduction/Background

- Educators will be broken out into groups to introduce themselves to each other.
- Educators will be provided with sticky notes and asked to write any questions that they had about sexual health and to place them on the designated area on the wall. These questions will be answered throughout the day.

What are Healthy Sexuality, Sexual Health, and Sexual Health Education?

- Educators will review the concept of healthy sexuality, sexual health, and sexual health education

Why do we need to teach children about sexual health?

- Educators will be broken out into groups to brainstorm two reasons why we need to teach children about sexual health.

Myths and Misconceptions about Sexual Health Education

- Through an interactive activity, educators explored the myths and misconceptions surrounding sexual health education.

Evidence around Sexual Health Education

- Educators will be provided with a review of the evidence supporting sexual health education in schools.

Break

Values

- Through an interactive activity, educators will explore value statements by moving to different locations in the room if they agree, disagree, or neither agree or disagree with the value statement

Language

- Educators will review and discuss the use of language: mechanical terms, scientific terms, slang terms, silence, body language and the use of gender-neutral language when educating students about sexual health.

Barriers

- Educators will be broken out into groups to brainstorm the barriers they face to teach sexual health in their classrooms. The larger group will then come back together to discuss the barriers to teaching sexual health in their classrooms and the solutions to address these barriers.

Diversity

- Educators will review and discuss sexual orientation, gender identity, LGBTQQ, and teaching sexual health to students with intellectual disabilities and physical disabilities.

Managing Sensitive Issues

- Educators will be broken out into groups to brainstorm issues surrounding sexual health that they find sensitive to talk about in the classroom. The larger group will then come back together to discuss these issues.

Lunch

Afternoon Session

Nova Scotia Learning Outcome Framework

- Educators will review the learning outcomes from primary to grade 9 on sexual health.

Sexual Health Resources

- Educators will explore the provincial and local sexual health resources and services.

Break

Exploring the Learning Outcomes Specific to Sexual Health

- Educators will be broken out into groups: Primary to grade 3, grades 4 to 6, and grades 7 to 9 to review the curriculum outcomes and discuss how they would address the sexual health topics in their classrooms.

Evaluation /Wrap Up

Introduction/Background (Time: 15 minutes)

- Welcome everyone.
- Introduce facilitator's for the workshop.
- Have participants get into groups of 3 to 4 to introduce themselves to each other (name, school/organization, and their role within the school/organization).
- Have each participant in their group write down one sexual health question that they would like an answer to by the end of the workshop.
- Collect questions from participants.
- Have participants introduce each other in the group to the other workshop participants.
- Review the agenda for the day and the parking lot.

Parking Lot

- Provide each table with sticky notes.
- The parking lot is for ideas, topics, or questions that come up through the day that you want to talk about. If you have questions, ideas or topics that you want to talk about write them down on the sticky note and place on the parking lot. The parking lot will be checked throughout the day.

Setting Ground Rules

- Introduce the concept of setting ground rules in the classroom.
- Ground rules should be set when you first begin to talk about sexual health in your classroom
- Ground rules will help to foster a positive classroom environment.

Handout #1: Setting Ground Rules

What is Sexuality, Sexual Health, and Sexual Health Education? (Time: 10 minutes)

Learning Outcome:

- To understand concept of sexuality, sexual health, and sexual health education.

- Ask the group: *What does sexuality mean to you?*
- Review with the group the definition of sexuality.

Sexuality Definition

"Sexuality is the central aspect of being human through life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires,

beliefs, attitudes, values, behaviours, practices, roles, and relationships. While sexuality can include all these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious, and spiritual factors. " – World Health Organization, 2006a

- Ask the group: *How is sexuality different from sexual health?*
- Review with the group the definition of sexual health.

Sexual Health Definition
"Sexual health is the state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." – World Health Organization, 2006a

- Ask the group: *What is sexual health education?*
- Review with the group the definition of sexual health education.

Sexual Health Education Definition
"Sexual Health education is the process of equipping individuals, communities, families, and couples with the information, motivation, and behavioural skills needed to enhance sexual health and avoid negative sexual health outcomes." – Public Health Agency of Canada (2008) Canadian Guidelines for Sexual Health Education

Handout #2: Background on Sexuality, Sexual Health, and Sexual Health Education

Why do we need to teach children about sexual health? (Time: 10 minutes)

- Have participants break out into groups of 4 to 5 to brainstorm:
    - *two reasons why we need teach children about sexual health.*
- Give the groups 2 to 3 minutes to brainstorm.
- Have the small groups return to the larger group and ask the participants to provide some of the reasons they came up with of why we need to teach children about sexual health.

- After the group discussion, review with the participants the information from Meg Hickling about the reasons why children need to learn about sexual health.

Meg Hickling Background
Meg Hickling is a Registered Nurse who has been a sexual-health educator for more than twenty-five years. Her ability to convey difficult material with sensitivity, gentle humour and warmth distinguishes her as a remarkable teacher and role model. Meg is the author of the runaway bestseller "Speaking of Sex: What Your Children Need to Know and When They Need to Know It", which has become the resource for parents wishing to teach their children about sex. She is also the author of "More Speaking of Sex" and a video series, "Sex Spelled Out for Parents".
Source: http://www.scholastic.com/teachers/contributor/meg-hickling

Meg Hickling states that there are three reasons why children need to know information about sexual health:

1. Think about sexual health like a scientist. There is nothing shameful about the way we make babies and even less shame is learning about our bodies. We adults need to force ourselves, force our communities to grow up. We must become sexually mature to help our children.
2. Knowledge is protection. Offenders are skillful at choosing vulnerable children. Offenders know that children do not learn scientific vocabulary from watching television shows. If a child knows the appropriate sexual vocabulary, the offender knows someone has taught. By teaching the child about their body they know it is ok to discuss sex with their parents and are more likely to tell their parents if someone tries to take advantage of them.
3. When we teach children about contraception and how sexual intercourse happens, we are not teaching them to have sex or saying that it would be appropriate for them to have sex. What we are teaching children is “body science”. They may never have sexual intercourse, but they will always have bodies to care for, and sexual health is no different than nutritional health.

Source: Hickling, M. (2005). *The New Speaking of Sex. What your children need to know and when they need to know it.* Kelowna, BC: Northstone. Pages 29-30.

Handout #3: Excerpt from The New Speaking of Sex by Meg Hickling, RN

Another reason we need to teach children about sexual health is to combat hypersexualization.

Hypersexualization

- Ask the group: *What is hypersexualization?*
- Hypersexualization or sexualized culture refers to the overstated and excessive media and social portrayal of sexuality in western culture.

How is hypersexualization showing up in Nova Scotia?

- Appearance (clothing)
- Toys
- Sexual knowledge attitudes, beliefs
- Sexual behaviour
- Technology (on-line bullying, sexting)
- Advertising and media
- Porn (source of sex education)
- Homophobia (e.g.: homophobia bullying in schools)
- Dances and parties
- Links to substance use
- Sexual harassment at schools

(Source: Tobin. L. (2012/11/13). Sensing the Impacts of Hypersexualization and Opportunities for Change in Nova Scotia Presentation. Public Health Grand Rounds.)

Myths and Misconceptions on Sexual Health Education (Time: 30 Minutes)

Learning Outcome:

- Discuss some of the myths and misconceptions surrounding sexual health education.
- On the power point, there is going to be either a myth statement or a fact statement shown.
- The facilitator will read the statement out loud to the participants and the participants need to decide if the statement is a myth or a fact.

Activity: Myths or Facts (Power Point Presentation)

- At the end of the activity, the facilitator will ask the group the following question:
- What would you do if a parent or another teacher says to you "sexuality education teaches students how to have sex"? How would you handle it?

Handout #4: Myths and Misconceptions on Sexual Health Education

Evidence Supporting Sexual Health Education (Time: 10 minutes)

Learning Outcome:

- To increase knowledge of evidence supporting sexual health education.

- The Sex Information and Education Council of Canada (SIECCAN) developed Sexual Health education in the schools: Questions and Answers 3rd Edition resource.

- This resource provides answers to some common questions that parents, communities, educations, school administrators, government may have about sexual health education in schools. The answers to these questions are based upon and informed by the findings of up to date and credible scientific research.

- The handout "Evidence Supporting Sexual Health Education" will provide participants with key points of information for each question.

- Review with the participants some the questions and answers that are in the "Evidence Supporting Sexual Health Education" handout.

Handout#5: Evidence Supporting Sexual Health Education

Break (15 minutes)

Values and Language (Time: 30 minutes)

Learning Outcomes:

- Recognize the range of values and attitudes that people have regarding sexual health education.
- Understand appropriate use of language and terminology.
- Better understand their own values regarding sexuality and how their values may impact others.

Values (Time: 20 Minutes)

- Before teaching about sexual health, it is important for everyone to be familiar with their own beliefs and biases.
- Everyone needs to be clear about their own beliefs relative to those of your students and so you can manage your beliefs and values, and keep your values and beliefs out the classroom.

Handout: #6 For reflection: personal values and attitudes (Note: this activity is for participants to do at home)

Values Interactive Activity

- Designate 3 areas in the room: agree, disagree, neither agree or disagree/have not thought about it before
- Explain to the group that your going to read a value statement out loud.
- Participants will move to different locations in the room if they agree, disagree, or neither agree or disagreed with the value statement.

Facilitator Document #1: Value Statements

- After the activity has finished, debrief with the participants about how they would deal with value issues in their classroom.

Language (Time: 10 minutes)

- Language is one issue that can get in the way when talking about sexual health.
- We really don't have an agreed upon language to discuss sexuality and sexual health.
- We rely upon a mix of mechanical or scientific language, euphemisms, street language, silence, and body language.
- Review with the workshop participants the different types of language that is used when talking about sexual health (mechanical, scientific, euphemisms, street language, silence).

Different Types of Language

- Mechanical – systems, process, parts (example: reproductive system)
- Scientific – can convey a detached tone (example: oral sex)
- Euphemisms – change frequently, who knows what's really being said? (example: hump, screw)
- Street Language – can be offensive and "off-putting" (example: blow job)
- Silence – can be interpreted in many ways
  "We don't talk about it because….

- It's a secret
- It's bad
- We're uncomfortable
- We don't know what to say"

Body Language – can convey implied messages, level of comfort with the topic

- As educators, we need to set the guidelines/ground rules for appropriate language to be used in the classroom.
- As educators, we also need to think about the words that you are using and the message that you are conveying by the words that you use (ex: promiscuous)
- Some of the words that we may use may shut down a conversation, or make a student feel they are being judged (ex: promiscuous)
- For both educators and students, the language of sexuality, sex and sexual identity shapes our understanding of these issues. Special attention should be placed on the vocabulary used when speaking with young people.
- Keeping in mind about sexual **diversity** in the classroom.
- It is important not to use language that may exclude or alienate students. For example, the term "partner" should be used instead of boyfriend or girlfriend.
- When we are talking to students about sexual health, it is important to reflect on the language that is being used by the students. As educators, we do not need to reflect vulgarities, but technical or clinical language can also be alienating to students.
- Differences in sexual language use, for example "inappropriate language", is not always meant to be harmful, but often reflects a student's understanding and relationship to sexuality, sex and sexual identity.
  (Source: http://sexedtoolkit.com/how-to/)

Handouts #7: Sexual Health Language
Handout #8: Using Gender Neutral Language in the Classroom

When we talk about sexual health, we are communicating VIF (values, information and feelings).

Values

- Values are the beliefs that we have about what is right and wrong regarding sexuality.

Information

- Information is the facts we have about sexuality.

Feelings

- Feelings are emotions we have about sexuality – happy, excited, scared, sad, etc.

Barriers (Time: 20 minutes)

- Sometimes there are barriers to talking about sexual health in the classroom.

- Have participants break out into groups of 3 to 4, and brainstorm the following questions:

    - Do you feel there are barriers to teaching sexual health?
    - Do you have barriers within your school?
    - Are there barriers in your community?
    - Are there any personal barriers?

- Have the small groups return to the larger group and ask the participants to provide some of the barriers that they have to teaching sexual health and explore some possible solutions to address these barriers.

- Some of the barriers that were identified in the "Supporting Out Teachers in Implementing Sexual Health Education Outcomes: Stakeholder Consultation and Best Practices Literature Review Report" are:
    - Administration
    - Parents
    - Access to resources

Diversity (Time: 30 minutes)

- We are a diverse society. Our communities are homes to a variety of ethnic and religious backgrounds, languages, skin colours. In other words, we are not all the same.
- Sexuality is one of the ways that people are different from one another. Although the term "sexual diversity" can apply to many different aspects of sexuality (for example people are diverse in terms of their sexual likes and dislikes), it is usually used with respect to sexual orientation and gender identity.

- Ask the group the following question:
    - *What does "sexual orientation" mean?*
    - *What are some words that you think of when you hear "gender identity"?*
    - *What do you think "homophobia" means?*
    - *What do you think "heterosexism" means?*
    - *What do you think "transphobia" means?*

Sexual Orientation- a person's affection and sexual attraction to an other person.

Gay – a person who is physically and emotionally attracted to someone of the same sex. The word gay is commonly used to identify males only.

Lesbian – a female who is attracted physically and emotionally to other females.

Bisexual – a person who is attracted physically and emotionally to both males and females.

Transgender – a person whose gender identity, outward appearance, expression and/or anatomy does not fit into conventional expectations of male or female.

Two-Spirited –some Aboriginal people identify themselves as two-spirited rather than as bisexual, gay, lesbian, or transgender. Historically, in many Aboriginal cultures, two-spirit persons were respected leaders and medicine people. Before colonization, two-spirit persons were often accorded special status based upon their unique abilities to understand both male and female perspectives.

Gender Identity - person's internal sense or feeling of being male or female, which may or may not be the same as one's biological sex.

Homophobia - fear and/or hatred of homosexuality in others, often exhibited by prejudice, discrimination, intimidation, or acts of violence.

Heterosexism - the assumption that everyone is heterosexual and that this sexual orientation is superior. Heterosexism is often expressed in more subtle forms than homophobia.

Transphobia- ear and/or hatred of transgender individuals and is exhibited by prejudice, discrimination, intimidation, or acts of violence.

(Source: Public Health Agency of Canada. (2010). Questions and Answers: Sexual Orientation in Schools. Ottawa: Publisher)

Handout # 9: Teaching Sex Ed for Youth with Intellectual Disabilities

Handout #10: Teaching Sex Ed for Youth with Physical Disabilities

Managing Sensitive Issues (Time: 20 minutes)

- Have participants break out into groups of 4 to 5 to brainstorm:
    - What are some *sexual health issues that you find sensitive to talk about in the classroom?*
- Give the groups 5 to 8 minutes to brainstorm.
- Have the small groups return to the larger group and ask the participants to provide some sexual health issues that you find sensitive to talk about in the classroom.
- Some possible topic areas: age of consent, pornography, disclosures
- One issue that many educators may find sensitive to talk about is sexual violence.

Sexual Violence

- Ask the group: "*What is sexual violence?*"
    - Sexual violence is defined as: 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. (Source: World Health Organization (2012). Violence Against Women Fact Sheet. Retrieved from http://www.who.int/mediacentre/factsheets/fs239/en/

- Ask the group for questions that they may have around sexual violence, consent, or disclosures.

Handout #11: Managing Sensitive Issues: Questions and Answers

Afternoon Session

Nova Scotia Learning Outcome Framework (Time: 10 minutes)

Learning Outcome:

- To increase knowledge of the Nova Scotia Outcome Learning Framework sexual health outcomes for primary to grade 9.

- In the Learning Outcomes Framework, for grades primary to six, sexual health topics are covered in the health education outcomes. For grades seven to nine, sexual health topics are covered in the Healthy Living outcomes.
- Review with the participants the sexual health outcomes.

Handout #12: Nova Scotia Learning Outcome Framework: Health Education Curriculum Outcomes - Sexual Health

Handout #13: Nova Scotia Learning Outcome Framework: Healthy Living Curriculum Outcomes - Sexual Health

Sexual Health Resources (Print & Websites) (Time: 30 minutes)

Learning Outcome

- To know where to access local and provincial sexual health resources and services.

- Review with the participants the sexual health school collections contents, the print sexual health resources, sexual health resources that are available on-line and community resources.

Handout #14: Sexual Health School Collections Contents

Handout #15: Sexual Health Resources

Handout #16: Sexual Health Websites

Handout #17: Community Resources

Exploring the Learning Outcomes Specific to Sexual Health (Time: 1 hour)

- Participants are going to be broken into three groups: primary to grade 3, grade 4 to 6, and grade 7 to 9.
- In your groups, you will have the opportunity to ask the questions specific to your grade around the sexual health outcomes.
- In your groups you will discuss how you would address the sexual health topics in your classroom.
- After one hour, bring the smaller groups back together in the larger group for wrap up and evaluation.

Wrap Up/Evaluation (Time: 20 minutes)

- Does anyone have any final questions?
- I am going to hand out an evaluation form.
- Please leave completed evaluations at your tables.
- Thank you for coming.

Educator Capacity Building Workshop on Sexual Health Education Handouts

Handout #1

Setting Ground Rules

Sexual Health Education happens most effectively in a classroom where there is a mutual feeling of trust, safety, and comfort. Having ground rules in place can be a very successful way to facilitate a positive classroom atmosphere. You may want to choose the ground rules that fit your classroom from the suggestions offered below, or use the examples provided below to develop your own.

Effective ground rules consist of are:

- appropriate for the age and developmental stage of your students.
- agreed upon by everyone.
- well explained so that students are very clear about the expectations
- posted clearly in your classroom.
- referred to at the beginning and throughout the sexual health unit.

Ground Rules Example: Elementary

- No put downs
- No personal questions
- It's OK to pass.
- All questions are good questions.
- Use correct terms.
- Listen when others are speaking.
- Speak for yourself.

Ground Rules Example: Junior High

- We have personal boundaries that must be respected.
- We have the right to our own beliefs and opinions.
- We have the right to pass.
- We are responsible for our own learning.
- Our questions or comments will be respected and taken seriously.

Source: http://teachers.teachingsexualhealth.ca/teaching-tools/ground-rules

Handout #2

Background information on Sexuality, Sexual Health, and Sexual Health Education

Sexuality

"Sexuality is the central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationship. While sexuality can include all these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious, and spiritual factors." - World Health Organization, 2006a

Your sexuality includes:

- your body, including sexual and reproductive anatomy
- your biological sex – male, female or intersex
- your gender – being a girl, boy, woman, man, or transgender
- your gender identities – personal sense of "I am a man", "I am a woman" (which may not be the same as biological sex)
- your gender role – what roles do men and women take on? What's difference? What's the same?
- your sexual orientation – to whom are you sexually and emotionally attracted?
- your sex drive
- your sexual identity – the way you feel about your sex, gender, and sexual orientation

All of these different terms encompass healthy sexuality.

There are different ways to experience and express your sexuality. The ways you experience and express your sexuality include:

- your body image – how you feel about your body
- your desires, thoughts, fantasies, sexual pleasure, sexual preferences, and sexual dysfunction
- your sexual behaviours – that way you have sex including masturbation
- your sexual feelings – sexuality and sexual relationships including how you experience intimacy

It is not just about sex, but it is about a whole lot more.

Your sexuality and the way you experience and express it are influenced by:

- your biology
- your emotional life
- your family life
- your culture
- your ethical, religious and spiritual upbringing and experience
- your reproductive decisions – whether, when or with whom to become a parent
- your sexual health – how you protect your partner and yourself, now and in the future, from diseases and emotional harm

Sexual Health

"Sexual health is the state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." – World Health Organization, 2006a

"Sexual health is influenced by a complex web of factors ranging from sexual behaviour, attitudes, societal factors, to biological risk and genetic predisposition. It encompasses problems of HIV and sexual transmitted infections (STIs), unintended pregnancy, and abortion, infertility, and cancer resulting from STIs, and sexual dysfunction. Sexual health can also be influenced by mental health, acute and chronic illnesses, and violence" (PHAC, 2008, p.5).

Sexual Health Education

"Sexual health education is the process of equipping individuals, couples, families, and communities with the information, motivation, and behavioural skills needed to enhance sexual health and avoid negative sexual health outcomes" (PHAC, 2008, p.5).

"Sexual health education is a broad based community-supported process that requires the full participation of educational, medical, public health, social welfare, and legal institutions in our society. It involves individual's personal, family, religious, social and cultural values in understanding and making decisions about sexual behaviour and implementing those decisions" (PHAC, 2008, p.5).

"Effective sexual health education maintains an open and no discriminatory dialogue that respects individual beliefs. It is sensitive to the diverse needs of individuals irrespective of their age, race, ethnicity, gender identity, sexual

orientation, socioeconomic background, physical/cognitive abilities and religious background" (PHAC, 2008, p.5).

References

Canadian Federation for Sexual Health (2011). Healthy Sexuality. Retrieved from http://www.cfsh.ca/Your_Sexual_Health/HealthySexuality.aspx

Public Health Agency of Canada (PHAC) (2008). Canadian Guidelines for Sexual Health Education. Ottawa, ON: Author.

World Health Organization (2013). Defining Sexual Health. Retrieved from http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/index.html

Handout#3

Excerpt from The New Speaking of Sex by Meg Hickling, RN

Part 1: What Your Children Need to Know and When They Need to Know It
Chapter 1: Let's Talk

Several years ago, in a fifth grade classroom, I was teaching sexual health to a group of 10- and 11-year-olds. When I began to explain that the penis goes into the vagina for the sperm to be delivered to the ovum, the boys began to squirm and talk excitedly to each other.

"Oh yeah, I saw it in a movie, it is so gross! You have to take off all your clothes and lie on top of the girl and hold her really tight."

"Imagine having to do that to a dumb girl!"

Finally, they turned back to me and said, "If only guys had 'stretchable things,' then you wouldn't have to touch her, you could just spray her like a firefighter, to get the baby started!"

That's when I began to think about sexual health education as a "stretchable thing." Many parents had no information given to them by their parents, their churches, or their schools, when they were growing up, and they need to stretch their own knowledge and maturity levels to provide it for their children. And the information itself needs to be stretchable, simple to begin, a little and basic in the preschool years, but stretchable as they grow, or when they ask questions, or are exploited.

I rarely meet parents who don't want to talk, but I often meet parents who don't know how to talk about sexual health. I hope this book will help you to get started and to continue talking and learning.

Naming the Parts – the First Step in Communication

All parents give messages about sexual health from the time their child is born, whether they talk to their child or not. Non-verbal messages through touching, day-to-day child care, facial expressions and actions, all speak volumes to a baby and toddler about sexual health. It would be helpful if parents could name the genital parts as matter-of-factly as they name elbows. Think for a moment about how we teach babies to talk: "This is your nose; this is your chin; this is your bellybutton..." And then we make a giant leap to the knees!

Or we use baby talk such as "pee-pee," or cutesy names that have been handed down in dad's family for generations and only the Hendersons know what the word means.

We all need to learn vocabulary and to practice using it. When I first began teaching

young children, I would say, “Now, I’m going to teach you the polite words for your genital parts; penis is the polite name...” They would all look at me in a puzzled way and say, “Boy, my family must be really rude because we call it a ‘dinky’ at my house.” Or, “My granny must be rude because she calls it a ‘ding-dong.’”

I’ve changed. I now call them scientific words; penis is the scientific name... That lets Granny off the hook; she didn’t have these science lessons when she was growing up and she’s never had a chance to learn the scientific words.

If you didn’t grow up with these names, you need to practice. Say penis 50 times while you are vacuuming and hope your neighbor doesn’t call in for coffee while you’re doing it!

Begin the day your baby is born by naming the parts. “Now let’s wash your penis, or your vulva.” Then by the time your child is old enough to ask, “Why do boys have a penis and girls have a vulva?” you’ll feel comfortable.

As the child is able to understand more, you can begin to give him or her more complex information, such as, “The penis is designed to deliver sperm to the ovum to make a baby. It can deliver urine to the toilet too, but you don’t have to have a penis to urinate.”

Questions and Answers:

There are two pieces of old-fashioned and dangerous advice which parents would be well-advised to forget as we move into the 21st century. The first is not to tell a child anything until they ask. “If they’re not asking, they’re not ready,” say the old folks. Unfortunately, some children will never ask. It doesn’t occur to them to be curious in that direction. They ask about rockets, dinosaurs, or Ninjas, but not about bodies and sexual health. For other children, silence on the part of the parents becomes a profound message to the child that this is a taboo subject. “My family does not talk about this, it must be bad, and I’ll be in big trouble if I mention ‘it,’ or ask about ‘it.’” Another possibility is that someone else has told them a story – true or untrue – and the child has simply accepted it.

I often meet parents who say, “I want to be the one, or the first one, to tell my child the facts of life.” Well, if you want to be the first, you need not wait for questions – wake them up, tell them, and don’t forget to add your moral values and any religious beliefs you have. Children need guidelines and they appreciate reasonable limits. The second piece of dangerous, old advice is, “Only tell the child what you think they need to know at this time.” Parents always underestimate what their child “needs” to know. My attempt to maintain a sense of humor includes advising parents to “talk until your child’s eyes glaze over.”

You cannot tell a child too much; they only take in what they need to know for that moment. This is maddening for some parents. Again they sweat blood. They answer questions fully, thinking, “Thank goodness that is done (for life)!” Two days later

they find that the child didn't get it all, or that the child misunderstood what they said and that they have to say it again and again. Keep the doors open, be prepared to talk anytime, and allow, even encourage, the child to come back to a topic over and over.

In an ideal world, one that was truly sexually mature, any adult could answer children's questions with science and health information. But parents often say, "Well, I think that the dads should talk to the boys and the moms to the girls." No way! The best scenario has both parents able to talk to either gender with comfort. There is no reason why dads can't explain menstruation and moms can't explain nocturnal emissions. Single parents especially have to work extra hard at educating themselves about both genders. It is not good enough to say, "I don't know because I am not your gender." Get the books, the videos, the school nurse, or someone else to help you, and share the information together with your child. It is perfectly appropriate to say to your child, "I don't know, but let's find out together."

Grandparents Can Be Teachers Too

Grandparents often tell me that they'd love to talk to their grandchild (they want to do a better job than they did with the child's parents!), and they appear in my parent meetings at elementary schools these days. They tell me that they are providing after-school care for their grandchildren when both parents are at work, or even full care in their own homes.

Who gets the child's questions after school? Grandma or Grandpa often *feel* honored that they are hearing the questions, but like parents, they are hesitant about what or how much to say. Several have said that it is difficult to discuss the subject with the child's parents, and yet the grandparent knows that the child will not always get an answer if they use the old, familiar line, "Ask your mother."I am always delighted to see grandparents who are so committed to their grandchildren's health and safety. In fact, after listening to my presentation, they say, "I've learned so much tonight and I want to ask, where were you when I was growing up?"

I encourage them to answer the questions, to educate themselves and those parents, to demonstrate enthusiasm and joy about healthy attitudes throughout the whole extended family. There are wonderful moments in classrooms when children say, "Yes, my grandma talked to me about body science," or "My grandpa read a book about bodies with me." I always want to do a dramatic "thumbs up" and shout, "Yeah, for grandparents!"

Just for fun, here is a book that I recommend for older folks in their personal lives: *Sex May Be Wasted On The Young*, by Lee and Michael Stones (Captus Press, 1996).

Accept the Questions Graciously

Whether you're a parent or a grandparent, try to remember that when children do ask questions, no matter how hard the question or how shocking, never be mad!

Parents' anger is what children fear most. If you can't think of an answer straight away, tell the child: "I need time to think about this, I promise we will talk about it after supper," or whenever. Please don't cross your fingers and hope that they won't ask again. If the child doesn't ask, bring it up and explain your unease if necessary. "My parents never talked to me, but I'm really proud that you asked me and I'm going to do my best to answer your question."Bedtime is a great time to talk to young ones because they'll do anything to stop you from leaving and turning out the light. This is a good time to get a book and to start reading to them or to answer questions they may have asked earlier that day on a crowded bus or at Christmas dinner!

One dad told me that his seven-year-old son asked, "What's a blow job?" at the Christmas dinner. This dad responded, "We'll talk about that at bedtime, son." I congratulated him on his wisdom, but he said, "Yeah right, Meg. My biggest problem was all my relatives begging to stay for bedtime too."

You may wish to talk to your child about good manners and/or privacy when giving them detailed information. It is perfectly all right to say, "I am really proud of you for asking this question and I know that you are grown-up enough to have a scientific answer. But perhaps it would not be a good idea to go to school tomorrow and tell

everyone what we've talked about. Some parents like to tell their children themselves and their children haven't asked them yet." Or, "Talking about bodies or sexual health embarrasses Granny – she didn't have this science when she was growing up. So is it okay if we don't talk about this on Sunday when Granny comes to dinner?"

Always praise your child for his or her maturity and set out your expectations for good manners. At the same time, don't expect them to always get it right. All of us love to have news to relay, gossip to pass on, and startling new discoveries to share. This kind of thing is the spice of human interaction, for children as well as for adults. Learning about vulvas should be fun as well as fascinating and they may pass on the good news to the cashier in a crowded supermarket. Ignore the smirks, the looks of horror, and the bashful red faces of the others in the grocery line. Be proud that your child is well- educated and protected. If and when we finally drag our whole society into sexual maturity, no one will be upset or think anything of a child's natural curiosity and willingness to share.

Some parents hesitate to tell their children the facts of life in a straightforward, truthful manner for fear that the child will tell the neighbors. My reply to that is, "If the neighbors are hearing the facts of life from a four-year-old for the first time, all you can do is feel sorry that no one has told them the truth before this!" Why would parents want to protect their neighbors and not their child? The only question a parent should ask is, "Did my child tell it correctly?"

Why Your Child Needs To Know This

Some people will say, "I don't think that children need to know about sexuality at this age; I want them to be innocent; I want them to enjoy their childhood."

I like to respond to this concern by pointing out three things.

First, I hear shame in those statements, a reflection of the adult's own childhood where sexuality information was considered to be secret, dirty, for adults only, and smutty. Many of us carry that teaching with us. But think about it like a scientist. There is nothing shameful about the way we make babies and even less shame in learning about our bodies. We adults need to force ourselves, force our communities, to grow up. We must become more sexually mature to help our children. Granted, it is very difficult to become more mature than our parents were, but our children are depending on us. Second, knowledge is protection. I don't enjoy visiting prisons, but I do it whenever I am invited because these men can teach me so much about how they exploit, seduce, trick, and trap children into exploitative situations.

Offenders become very skillful at choosing vulnerable children. (Most of them were abused themselves, so they know what to look for.) One thing offenders know is that children do not learn scientific vocabulary from watching Sesame Street or any other educational show for children. If a child knows appropriate sexual vocabulary, the offender knows that some enlightened adult, usually the parent, has taught them. The offender also knows that in the very teaching, the adult has said, "This is an acceptable topic for us to talk about. You are allowed, even encouraged, to know about your body." Because these children know that it's okay to discuss sex with their mom and dad, they are far more likely to tell their parents if someone tries to take advantage of them.

This is why sexually intrusive people will almost always choose a victim who knows nothing and hence, will not tell either. The silence on the part of the parent has become a powerful message not to talk about it.

So please, don't set your child up to be vulnerable. An innocent or uneducated child is unsafe and poorly protected.

(I do, by the way, have some sympathy for the abuser. This is not to excuse the abuse, but sometimes the stories of their own childhood abuse are enough to make you weep. And abusers often say, "If only I had had the education that you provide, Meg, when I was a kid, I might not be sitting in jail now with this trail of destruction behind me.")

Third, when we teach children about conception and how it happens through sexual intercourse, we are not teaching them to have sex. Nor are we saying that it would

be appropriate for them to have sex. Intercourse is an adult activity. As I've said, many children are very glad to hear that and will say, "I am never doing that."

What we are teaching children is "body science." They may never have sexual intercourse, but they will always have bodies to care for, and sexual health is no different than nutritional health.

Disabled Children

Parents of children with disabilities need to be especially proactive about providing sexual health education to their children, even in the preschool and primary years. Disabled children have the same right to be informed and they have an even greater need for the protection that this information provides. Research indicates that disabled children suffer up to five times more abuse than other children and youth.

Children with physical or intellectual challenges are often at greater risk of abuse or sexual exploitation as teens or young adults because they are more isolated in the community, and because they are often taught to be passive and obedient, and to trust all caregivers.

They may lack the boundaries, communication skills, and social skills which could help to keep them safe.

Although we often think of disabled children as asexual, this simply isn't true. They are sexual beings, just like everybody else. Disabled children usually go through puberty at exactly the same time as other children do and they have similar worries and concerns about body changes.

The challenge for parents and caregivers is that the health and safety concepts about sexual health need to be given again and again, with patience, humor, and compassion. Fortunately, there are wonderful resources available to help parents teach disabled children. Don't hesitate to call your local health facility for help. You may also encourage your local parent association to be actively involved in making resources available.

And remember, there's lots of fun to be had teaching children with disablilities – as this story illustrates so well: In a class of physically and mentally disabled teens, several boys told me that a famous porn star had died the day before. As I began to talk about AIDS in the pornography industry, one of the girls said, "Oh, I saw him in a magazine. He had a very long penis." Another girl, who had been silent all morning,

suddenly spoke and said, "He probably tripped over it and killed himself." It brought the house down, as they say.

What Your Children Need to Know and When They Need to Know It

Of course, children don't mature all at once and so their education doesn't have to

happen all at once.

Researchers have studied the sexual development of children from around the world, from many different countries, from all sorts of families, ethnic groups, economic and educational levels. Their findings are fascinating, but most parents have neither the time nor the inclination to read their massive volumes.

When I began teaching in the mid-1970s, I read their work and revised their theories of stage development to mimic the stages of education that children go through in the public schools.

After 20 years of honing my own observations and experience with children of all ages, their parents, and the professionals who work with children in medicine, education, theology and social sciences, I see the "stages" more as pads in a lily pond. We all spend time on the various pads at different points, depending on the situation, our own education, experience, and maturity.

Imagine a lily pond with "nirvana," the sexually mature adult island, in the middle. The ideal situation would be to spend as much time there as possible. Near the shore, there are the preschoolers' pads. Out a bit, but not far, are the primary pads. In the middle are the intermediate pads. And closer to the sexually mature island are the adolescent pads.

Each pad has wonderful flowers that we can pick and take with us, but there are also thorns that can get stuck in us and cause discomfort, pain, and even life-threatening illnesses.

Sometimes, through lack of education or positive life experience, people get stuck on one pad for a long time, or forever. Some people continually hop back and forth, never coming close to or reaching nirvana. And some are kept, by forces beyond themselves, on one or two pads.

In the next four chapters, I will be writing about the stages of sexual development that children and teens go through in most countries today. But in countries such as Sweden, Holland, and Protestant Germany, where sexual health education has been mandatory in the schools for several generations, children do not go through the magical thinking of the preschoolers, the bathroom humor of the primaries, or the "gross-me- outs" of the intermediates with anything like the intensity that children from other countries do.

Today, parents in Sweden, for instance, were brought up by parents who were well-educated and sexually mature themselves, who talked openly and factually about sexuality and sexual health, and who carried little of the emotional baggage and repression that others have around the issues of sexual health. The statistical evidence of health is there to see: lower rates of sexual abuse, sexual exploitation, abortion, suicide, teenage pregnancy, and STDs (sexually transmitted diseases). Perhaps, one day, we will learn by their example, and progress to new and brighter

islands of sexual maturity.

A "Triple-whammy"

It seems to me that parents today have a "triple-whammy." Most want to talk to their children more honestly than their parents did. (So do many grandparents!) So the first task is to educate ourselves with all the new information. The second task is to be more comfortable and to pass it on to our children. And the third task is to recognize that you are educating others in the family and community as well.

Here's a funny story which is also a great example of how everyone in the family and community could benefit from further education.

One mother of a preschool age daughter said that she had heard that you should tell children that boys have a penis and girls have a vulva.

So she taught her daughter that she had a vulva. Like all three-year-olds, the daughter was keen to share the news.

Not long after, grandmother arrived from Montreal for Christmas. An hour after Granny's arrival, the little girl asked, "Granny, do you have a vulva?"

"No, dear," said Granny, "I have a Toyota."

Handout #4

Myths and Misconceptions about Sexual Health Education

Myth: Kids these days are already way too active sexually and don't need information.

There is recent evidence that many young people are delaying their first sexual intercourse and that most youth do not regularly have sexual intercourse until high school or after (Boyce et al, 2003). Abortion rates are declining in Canada (Statistics Canada, 2005). And reports in the United States show a similar trend. However, those same reports have pointed out some worrisome issues and trends:

- Some young people are experimenting with sexual intercourse at a younger age
- Some youth are having sexual intercourse more often and with more partners
- Most youth did not know that people infected with STI or HIV can appear healthy
- STI rates, particularly Chlamydia, are highest among adolescents
- Over 40,000 teens aged 15 to 19 get pregnant each year in Canada.

Another reason children and youth need this information is to combat hypersexualization. Hypersexualization or sexualized culture refers to the overstated and excessive media and social portrayal of sexuality in western culture.

Myth: Sexuality education teaches students how to have sex.

There are a number of confusions about sexuality education, the worst one of which is defining it as sex education. *Sex* is used in our culture as a euphemism for sexual intercourse. Sexuality is a much broader issue and includes talking about values, decision-making, biology, emotions, gender identity, and sexual feelings. Classes do not include teaching about sexual techniques. Sexual health education emphasizes that abstinence is the best behaviour choice for adolescents, and that the next best alternatives are postponement of sexual intercourse, limiting the number of sexual partners, and the effective use of protection against pregnancy and sexually transmitted diseases.

Myth: Comprehensive sexuality education leads to increased rates of sexual behaviour in adolescents.

A World Health Organization literature review concluded that there is "no support for the contention that sex education encourages experimentation or increased activity. If any effect is observed, almost without exception, it is in the direction of postponed initiation of sexual intercourse and/or effective use of contraceptives."

Myth: Students in elementary are too young to need information about sexuality.
In every subject, students are given a foundation in the early school years that is expanded upon in later years. Children are often curious about issues related to sexuality and need accurate, age-appropriate information.[4] Students in elementary learn about physical, emotional and social changes that occur during puberty, the difference between gender roles and gender identity, the basic components of the reproductive system, the process of reproduction and how the reproduction system matures through process of puberty, an awareness of and ways to prevent blood borne diseases, concept of sexuality and sexual health, common STIs and ways to manage feelings and changes associated with onset of puberty.

Myth: Kids will pick up what they need to know on their own.
Parents, adults and society are already playing major roles in forming the knowledge, attitudes and beliefs about sexual health. Children learn by observing their parents, by talking with their friends, and by watching television, movies and other media. So, unless parents, schools, and other institutions take an active, planned role, we run the risk of kids growing up without guidance, being misinformed by their friends, or acquiring the commercial and exploitive values often promoted in the media.

Myth: We are not providing any sexual health education if we do not talk about it.
When we avoid talking about sexual health, we send the message that this subject is taboo or wrong in some way. We need to send messages that tell young people to be comfortable and unashamed of their bodies that physical affection is okay and that talking about sexual health does not lead to sexual activity.

Myth: If you talk with or educate young people about sexual health, they will experiment with sex.
Research shows the opposite. If children know more about sexual health, they are more likely to postpone initiation or use contraceptives (Frost & Darroch Forrest, 1995; Grunseit & Kippax, 1993; Grunseit et al., 1997; Kirby, 2000). A meta-analysis of published teenage pregnancy prevention program evaluations show that these programs do not increase sexual activity but do significantly increase contraceptive use among sexually active teens, and that those programs which include the distribution of contraceptives are the most effective (Franklin, Grant, Corcoran, O-Dell Miller & Bultman, 1997).

Misconception: If schools teach sexual health education, this will replace the role of parents.
In fact, several studies have shown that school-based sexual health education results in more child-parent communication.

Misconception: If teachers or parents are not comfortable taking about sexual health, then it is better not to discuss it.
It is natural to be uncomfortable talking about some or most parts of sexual health. It is okay for adults to admit that they are uncomfortable. By using techniques such as depersonalizing questions, protecting privacy, and using the proper terms of the anatomy and sexual practices, we de-stigmatize and normalize the discussion.

References
Alberta Health Services (2013) Teaching Tools: Myths & Facts
http://teachers.teachingsexualhealth.ca/teaching-tools/myths-facts

Sexualityandu.ca: Tools for Schools. Myths, Misconceptions, and Misinformation about Sexual Health Education and Promotion.
http://www.sexualityandu.ca/uploads/files/Myths_Fact_Sheet.pdf

Handout #5

Evidence Supporting Sexual Health Education

These questions and answers are from the SIECCAN. (2010). Sexual health education in the schools: Questions and Answers 3rd Edition.

1. Sexual health and Canadian youth: How are we doing?

"Sexual health is multidimensional and involves the achievement of positive outcomes such as mutually rewarding interpersonal relationships and desired parenthood as well as the avoidance of negative outcomes such as unwanted pregnancy and STI/HIV infection (Public Health Agency of Canada, 2008). Trends in teen pregnancy, sexually transmitted infections, age of first intercourse and condoms are often used to generally assess the status of sexual health of Canadian youth" (SIECCAN, 2010, p.2).

Teen Pregnancy

"With respect to teenage pregnancy, it can be assumed that a large proportion of teen pregnancies, particularly among younger teens are unintended and that such trends therefore reflect the extent to which young women have the capacity to control their sexual and reproductive health" (SIECCAN, 2010, p.2).
"It is likely that declining trend in teen pregnancy rates (in contrast to stable or increasing rates) may reflect increasing levels of effective contraceptive use, greater access to reproductive health services, exposure to higher quality sexual health education and/or shifting of social norms in a direction that provides greater support for young women's capacity to exercise reproductive choice" (SIECCAN, 2012, p.3).

Trends in Sexual Intercourse

"Most Canadian youth will have their first sexual intercourse at some point during their teenage years. In the most recent Canadian Community Health Survey (2009/2010), in response to the question "Have you ever had sexual intercourse?" 30% of 15 to 17 year olds and 68% of 18-19 year olds reported they had sexual intercourse (Roterman, 2012)" (SIECCAN, 2012, p.1).

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

" 'Sexual health education should be available to all Canadians as an important component of health promotion and services' (Health Canada, 2003, p.1). In principle, all Canadians, including youth, have the right to information, motivation/personal insight, and skills necessary to prevent negative sexual health outcomes (e.g. STIs including HIV, unplanned pregnancy) and to enhance sexual health (e.g. positive self-image and self-worth, integration of sexuality into mutually satisfying relationships)" (SIECCAN, 2010, p.4).

"In order to ensure that youth are adequately equipped with the information, motivation/personal insight, and skills to protect their sexual and reproductive health 'it's 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)" (SIECCAN, 2010, p.4).

"It should be emphasized that an important goal of sexual health education is to provide education on the broader aspects of sexual health including the development of positive self-image, and the integration of sexuality into rewarding and equitable interpersonal relationships" (SIECCAN, 2010, p.4).

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

"Parents and guardians are important and primary sources of guidance for young people concerning sexual behaviour and values. Studies conducted in difference parts of Canada have consistently found that over 85% of parents agreed with the statement "Sexual health education should be provided in the schools." And a majority of these parents approved of schools providing young people with information on a wide range of sexual health topics including puberty, reproduction, healthy relationships, STIs/HIV prevention, birth control, abstinence, sexual orientation, and sexual abuse/coercion" (SIECCAN, 2010, p.5).

In a study of 4,200 New Brunswick parents (Weaver et al., 2002), the following 10 topics were rated as important, very important, or extremely important for inclusion in the sexual health curriculum:

Extremely Important	Personal Safety, Abstinence, Puberty, Sexual Decision Making, Reproduction
Very Important	Sexually Transmitted Infections, Sexual Coercion/Assault, Birth Control Methods & Safer Sex Practices, Correct Names for Genitals
Important	Sexual Pleasure/Enjoyment

Source: http://www.sexualityandu.ca/teachers/making-the-case-for-school-based-sexual-health-education/parents-support-sexual-health-education-in-schools

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

"Surveys of youth have clearly shown that young people in Canada want sexual health education to be taught in schools (Byers, Sears, Voyer, Thurlow, Cohen, & Weaver, 2003a; Byers, Sears, Voyer, Thurlow, Cohen, & Weaver, 2003b; Mckay & Holowaty, 1997)" (SIECCAN, 2010, p.5).

For example, a survey of high school students in New Brunswick found that 92% agreed with the statement "Sexual health education should be provided in schools."

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

"Canada is a pluralistic society in which different people have different values perspectives towards human sexuality" (SIECCAN, 2010, p.6).
"The Public Health Agency of Canada's (2008) Canadian Guidelines for Sexual Health Education have been used by communities as a basis for development of a consensus on the fundamental values that should be reflected in school-based sexual health education. Guidelines were formulated to embody an educational philosophy that is inclusive, respects diversity, and reflects the fundamental precepts of education in a democratic society" (SIECCAN, 2010, p.6).

"Thus the Canadian Guidelines for Sexual Health Education are intended to inform sexual health programming that:

- Focuses on the self-worth, respect, and dignity of the individual
- Is provided in an age-appropriate, culturally sensitive manner that is respectful of individual sexual diversity, abilities, and choices
- Helps individuals become more sensitive and aware of the impacts their behaviours and actions may have on others and society
- Does not discriminate on the basis of age, race, ethnicity, gender identity, sexual orientation, socioeconomic background, physical/cognitive abilities and religious background in terms of access to relevant, appropriate, accurate and comprehensive information (Public Health Agency of Canada, 2008, p. 11-12)" (SIECCAN, 2010, p.6).

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

- Effective sexual health education recognizes that responsible individuals may choose a variety of paths to achieve sexual health;
- Effective sexual health education supports informed decision making by providing individuals with the knowledge, personal insight, motivation, and behavioural skills that are consistent with each individual's personal values and choices (Public Health Agency of Canada, 2008, p. 25)" (SIECCAN, 2010, p.6).

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

"The impact of sexual health education on sexual behaviour of youth has been extensively examined in a large number of evaluation research studies. A meta-analysis of 174 studies examining the impact of different types of sexual health

promotion interventions found that these programs do not inadvertently increase the frequency of sexual behaviour or number of sexual partners" (SIECCAN, 2010, p.7).

A study conducted by Kirby, Laris and Rolleri (2007) concluded, "The evidence is strong that programs do not hasten or increase sexual behaviour but, instead, some programs delay or decrease sexual behaviours or increase condom or contraceptive use."

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

"There is a large body of rigorous evidence in the form of peer-reviewed published studies measuring behavioural impact of well-designed adolescent sexual health interventions that leads to the definitive conclusion that such programs can have a significant positive impact on sexual health behaviours (e.g., delaying first intercourse, increasing use of condoms)" (SIECCAN, 2010, p.7).

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

"The primary objectives of "abstinence-only" programs are to encourage young people not to engage in sexual activity until they are married and to teach youth "…that sexual activity outside the context of marriage is likely to have harmful psychological and physical effects" (Title V, Section 510 of the U.S Social Security Act cited in Trenholm, Devaney, Forston et al., 2007)" (SIECCAN, 2010, p.8).
" 'Abstinence-only' programs purposefully do not teach young people the importance of consistent contraceptive use for unintended pregnancy prevention or condom use for STI/HIV infection prevention" (SIECCAN, 2010, p.8).

"As stated by the Public Health Agency of Canada's (2008) Canadian Guidelines for Sexual Health Education:

> Effective sexual health education supports informed decision-making by providing individuals with the opportunity to develop the knowledge, personal insight, motivation, and behavioural skills that are consistent with each individual's personal values and choices. For example, some adolescents engage in partnered sexual activities whereas others will make an informed decision to delay these sexual activities (p. 25)" (SIECCAN, 2010, p.8).

"It is important that school-based sexual health education for youth include, as one component of a broadly based program, the relevant information, motivation, and behavioural skills needed to act on and affirm the choice not to engage in sexual activity" (SIECCAN, 2010, p.8). "Educational programs that withhold information necessary for individuals to make voluntary informed decisions about their sexual health are unethical (World Association for Sexology, 2008)" (SIECCAN, 2010, p.8).

"Abstinence only programs show little evidence of sustained (long term) impact on attitudes and intentions. Worse, they show some negative impacts on youth's willingness to use contraception, including condoms, to prevent negative sexual health outcomes related to sexual intercourse. Importantly, only in one state did any program demonstrate short term success in delaying the initiation of sex; none of these programs demonstrates evidence of long term success in delaying sexual initiation among youth exposed to the programs or any evidence of success in reducing other sexual risk-taking behaviours among participants (online)" (SIECCAN, 2010, p.9). School-based sexual health education provided youth with the information, motivation, and behavioral skills to consistently practice effective contraception and safer sex practices such as condom use when and if they become sexually active.

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

"The first and most important ingredient of effective sexual health education programs in the schools are that sufficient classroom time is allocated to the teaching of this important topic and that the teachers/educators who provide it are adequately trained and motivated to do so (Society of Obstetricians and Gynecologists of Canada, 2004)" (SIECCAN, 2010, p.10).

" 'Sexual health education should be presented by confident, well-trained, knowledgeable and nonjudgmental individuals who receive strong administrative support.' (Public Health Agency of Canada, 2008, p. 18)" (SIECCAN, 2010, p.10).

"It is clear from the research on sexual health promotion that behaviourally effective programs are based and structured on theoretical models of behaviour change that enable educators to understand and influence sexual health behaviour" (SIECCAN, 2010, p.10).

The IBM model (below) specifies that in order for sexual health education to be effective it must provide information that is directly relevant to sexual health (i.e. information on effective forms of birth control and where to access them), address motivational factors that influence sexual health behaviour (e.g. discussion of social pressures on youth to become sexually active and benefits of delaying first intercourse), and teach the specific behaviour skills that are needed to protect and enhance sexual health (e.g., learning to negotiate condom use and/or sexual limit setting).

IMB Model (Source: http://www.tascc.ca/who)

Sexual Health Information

Examples: knowledge about STI transmission, how to use birth control

Sexual Health Motivation

Examples: personal vulnerability to negative sexual health outcomes, impact of social norms and peer pressure

Sexual and Reproductive Health Behaviour Skills

Examples: Negotiating condom use, negotiating sexual limit setting

10. What is the impact of making condoms available to teenagers?

"Research has clearly and consistently shown that making condoms accessible to young people does not result in earlier or more frequent sexual activity. These same research studies also show that condom distribution programs can significantly increase condom use among teens who are sexually active (Blake, Ledsky, Goodnow, et al., 2003; Guttmacher et al., 1997; Schuster, Bell, Berry, & Kanouse, 1998)" (SIECCAN, 2010, p.12).

11. Are condoms effective in preventing HIV and other STIs?

"According to the Public Health Agency of Canada (2002), 'Condoms used consistently and correctly provide protection against of spreading STIs including HIV' (p. 1)" (SIECCAN, 2010, p.12).

"The importance of condom use is echoed by the World Health Organization (WHO, 2000): 'Condoms are the only contraceptive method proven to reduce the risk of all sexually transmitted infections (STIs), including HIV' (p.1)" (SIECCAN, 2010, p.12).

"According to the U.S Centres for Disease Control and Prevention (CDC, 2008), 'Laboratory studies have demonstrated that latex condoms provide an essentially

impermeable barrier to particles the size of HIV' (pg. 2-3) and that 'Latex condoms, when used consistently and correctly, are highly effective in prevention the sexual transmission of HIV' (pg. 2)" (SIECCAN, 2010, p.12).

"There is strong evidence that consistent condom use significantly reduces the risk of transmission of Chlamydia and Gonorrhea (Gallo, Steiner, Warner, et al., 2007; Paz-Bailey, Koumans, Sternberg et al., 2005; Warner, Stone, Macaluso et al., 2006), herpes, (HSV-2) (Wald, Langenberg, Kratz, et al, 2005) and the Human papillomavirus (HPV) (Winer, Hughes, Feng et al., 2006)" (SIECCAN, 2010, p.12).

"In sum, there is strong and conclusive evidence that consistent condom use significantly reduces the risk of sexually transmitted infections. Sexual health educators have a duty to inform youth who are sexually active, or who will become sexually active about the benefits of condom use and to stress that '…like any other prevention tool, condoms work only when they are used. Consistent and correct use is essential for optimal risk reduction" (SIECCAN, 2010, p.12).

12. Should school-based sexual health education address the issue of sexual diversity?

"The Public Health Agency of Canada (2008) Canadian Guidelines For Sexual Health Education suggest that educational programs should address the sexual health needs of all students, including LGBTQ youth. As well, the guidelines note that an understanding of sexual diversity issues is an important component of sexual health education" (SIECCAN, 2010, p.13).

"Surveys of Canadian parents indicate that a majority want sexual orientation addressed in the school based sexual health education programs" (SIECCAN, 2010, p.13).

"A supportive, non-threatening school environment has been recognized as being one protective factor that can potentially reduce the risk of negative health and social outcomes among youth. The inclusion of sexual diversity issues in the sexual health curriculum can help encourage understanding and respect among students, and will contribute to a supportive and safe school environment that is the right of all students" (SIECCAN, 2010, p.13).

13. How should school-based sexual health education address the issue of emergency contraception?

The provision of accurate information about contraception allows youth to make informed sexual and reproductive health choices. With respect to emergency contraception (EC), it is important that clear information be provided about how the method works, when it is to be used for maximum effectiveness and where it can be accessed.

In Nova Scotia, emergency contraception pills are available without prescription at most drug stores. Customers may be required to ask the pharmacist for the pills. Prices vary from one store to another. Free EC may be available from hospital emergency departments. Youth Health Centre staff may be able to provide or assist youth to obtain EC.

14. How should school-based sexual health education address laws on the age of consent?

Age of consent refers to the age at which people are able to make their own decisions about sexual activity.
The age of consent laws apply to all forms of sexual activity, ranging from sexual touching (i.e. kissing) to sexual intercourse.

In 2008, the age of consent was raised from 14 to 16.

Effective sexual health education should provide students with a clear understanding on how the age of consent is interpreted under the law. Educators should make youth aware that the intent of the legislation is to target sexual predators not youth themselves and the new legislation does not affect the right of young people to access sexual health education or sexual and reproductive health services.

- A five year peer group provision allows youth aged 14 or 15 to have consensual sex with partners who are no more than 5 years older than themselves.
- Youth aged 12 and 13 can have consensual sex with other youth who are not more than two years older than themselves.
- Children under the age of 12 are unable to consent under any circumstances.

- The Criminal Code of Canada states that a person under the age of 18 cannot engage in anal intercourse except if they are legally married.

Someone under the age of 18 cannot legally consent to have sex with a person in position of authority, such as a teacher, a health care provider, coach, lawyer, or family member.

Persons under the age of 18 cannot legally consent to engage in sexual activity involving prostitution or pornography.

15. What are the social and economic benefits to society of implementing broadly based sexual health education in the schools?

"The primary goals of sexual health education are to provide individuals with the necessary information, motivation, behavioural skills to avoid negative sexual health outcomes and to enhance sexual health" (SIECCAN, 2010, p.15).
"Broadly speaking, sexual health education in the schools can make a significant positive contribution to the health and well being of the community. It is equally important to recognize that neglecting to provide broadly based sexual health education programs can have far reaching social and economic consequences" (SIECCAN, 2010. P.15).

"For example, untreated Chlamydia infection (a common STI among Canadian youth and young adults) can lead to severe medical conditions including pelvic inflammatory disease (PID), and infertility, and chronic pelvic pain and ectopic pregnancy (Public Health Agency of Canada, 2006). It has been estimated that in Canada the costs of these conditions are approximately $1,942 for inpatient PID treatment, $6,469 for ectopic pregnancy, $324 for chronic pelvic pain, and $12,169 for a lifetime cost of infertility treatment (Goeree, Jang, Blackhouse et al, 2001)" (SIECCAN, 2010, p.15). According to the Canadian Aids Society, HIV/AIDS is costing Canadians $1.3 million per each new diagnosis of HIV.

"The existing literature on the direct costs and economic benefits of conducting school-based sexual health promotion interventions with youth suggest that such programming is not only cost effective but often results in considerable costs savings (Wang, Burstein & Cohen, 2002; Wang, Davis, Robin, et al., 2000)" (SIECCAN, 2010, p.15).

References

SIECCAN (July/August 2012). Check the Research: Statistics Related to Trends in the Sexual Behaviours of Canadian Teachers. Retrieved from http://www.sexualityandu.ca/check-the-research

SIECCAN. (2010). Sexual Health Education in the schools: Questions and Answers: 3rd Edition. Retrieved from http://www.sieccan.org/pdf/she_q&a_3rd.pdf

Handout #6

For Reflection- Personal Values and Attitudes

In order to address sexuality with your students, it's important to have an understanding of your own attitudes and values regarding sexuality and your comfort level with various issues. Reflect on the sources of your values and attitudes and what you have learned:

- **Family** – how was sexuality handled in your family? Did you receive information on sexuality issues? Did you learn vocabulary relating to sexuality? Was it okay to ask questions?

- **School** – What information did you learn in school? Did you receive comprehensive sexuality information?

- **Friends/Relationships**: What did you learn from your friends? Have you discussed sexuality issues with sexual/romantic partners? How have your experiences shaped your beliefs about sexuality?

- **Media:** What sexual messages have you received from the media? How have these affected your attitudes/values and expectations about sexuality?

- **Culture:** What cultural beliefs about sexuality have you learned? How is sexuality regarded in the cultures you have grown up in?

- **Religion:** What beliefs have you learned? How is sexuality regarded?

- **Health System:** How has sexuality been regarded by the medical staff you have known? Have sexuality issues been seen as a priority?

Did you learn anything about yourself?

How do you think your values and attitudes about sexuality could affect your interactions with students around this topic?

Are there any issues with which you are especially uncomfortable? How will you handle this discomfort if you encounter it in a classroom?

Adapted from: Med II Human Sexuality Workshops Dalhousie Faculty of Medicine, LRC.

Handout #7

Sexual Health Language

Mechanical – systems, process parts
Example: reproductive system

Scientific – can convey a detached tone
Example: penis, vagina

Euphemisms – change frequently, who knows what's really being said?
Example: hump, screw

Street Language – can be offensive and "off-putting"
Example: blow job

Silence – can be interpreted in many ways:
"We don't talk about it because:
- it's a secret
- it's bad
- we're uncomfortable
- we don't know what to say

Body Language - can convey implied messages, level of comfort with the topic

Just Loosen Up and Keep Talking. Briefing Kit on Youth Sexual Health, 1998. Prepared by Judith L. Page for the Nova Scotia Round Table on Youth Sexual Health and the Health Promotion and Programs Branch, Health Canada, Atlantic Region, Canada. http://www.phac-aspc.gc.ca/canada/regions/atlantic/Publications/Just_loosen/index-eng.php

Handout #8

Using Gender Neutral Language in Your Classroom

What is gender-neutral language?
A way of speaking that minimizes assumptions about gender, sexual orientation or the biological sex of the people being refereed to. For example, the pronoun *he* may be replaced with *he/she* when the gender of someone is unknown.

Why use gender-neutral language in your classroom?

- Gender neutral language eliminates assumptions about someone's gender identity or sexual orientation based upon their appearance.
- It avoids reinforcing gender binaries and it respects diverse identities.
- The use of gender –specific language tends to be biased towards masculine words, contributing to gender power imbalances.
- The words children hear affect their perceptions of the gender appropriateness of certain careers, interests and activities.
- For students who identify as trans or intersex, constant reminders about gender binaries can be stressful and reinforce traditional gender roles and expectations.

How can you teach in a gender neutral environment?

- Never divide the class by gender or make statements just addressing one specific gender, such as "The boys in the class…"
- Avoid using words like chairman, fireman, and stewardess when discussing careers or occupations. These are gender specific. Instead use corresponding gender-neutral terms such as chairperson (or chair), firefighter, and flight attendant.
- Instead of using the term you guys, use gender neutral terms like everyone, people or class.
- Make your classroom free of negative jokes and comments.
- Avoid assigning classroom or school tasks based on historical roles of gender. For example, asking boys only to move chairs or desks.
- Include as many resources as possible in your classroom and curriculum that depict women and men in non-traditional ways.
- Ask students who identify as transgendered or intersexed which gender they would prefer to be identified with and address them as such.

Source: BC Teacher's Federation. (2012). Social Justice Issues: Sexual Health Education http://bctf.ca/SocialJustice.aspx?id=21406

Handout #9

Teaching Sex Education for Youth with Intellectual Disabilities

People with disabilities have the same sexual desires and needs as everyone else. These unique guides from www.sexualityandu.ca provide resources and information for teachers providing sexual education to youth with intellectual disabilities.

What are intellectual disabilities?

People with intellectual disabilities, also referred to as learning disabilities, experience a range of difficulties that can be mild to moderate, to severe limitations in functioning. Intellectual disability (ID) can also be described as below average intellectual functioning in the areas most typically of communication, social skills, health and safety, and functional academics.

Developmental disability is a term used to describe severe, life-long disabilities that may be attributed to mental and/or physical impairments, manifested before the age of 18.

The term is most commonly used to refer to disabilities affecting daily functioning in two or more of the following areas:

- capacity for independent living
- economic self-sufficiency
- learning
- mobility
- receptive and expressive language
- self-care
- self-direction

In general, someone is described as learning disabled if there is a large discrepancy between intellectual ability and achievement. The person with a learning disability may have low or high intelligence, but they simply learn below intellectual capability because of a processing disorder.

The developmentally disabled person has a severe and chronic mental impairment that may limit success in several major life areas, and this impairment begins in childhood. Usually people with mental retardation, cerebral palsy, autism spectrum disorder, various genetic and chromosomal disorders such as Down's syndrome and Fragile X syndrome, and fetal alcohol syndrome are described as having developmental disabilities. Developmental disabilities are usually classified as

severe, profound, moderate or mild, as assessed by the individual's need for support.

Learning disabilities are developmental disabilities. People with learning disabilities have a chronic mental impairment. However, they are not mentally retarded. Typically they have average to above-average intelligence, but simply cannot learn in certain processing modes, and they must compensate for this disability.

People with intellectual disability have the same sexual needs and desires as those without disabilities. Sixty-90% of people with mild disabilities report wanting to marry and have children in the future.

Sexuality education for people with ID is particularly important because of the high rates of sexual abuse. Some statistics suggest that as high as 80% of women who have ID and 50% of men with ID will be sexually abused before the age of 18. It is important that we teach skills that make it less likely for people with ID to be victimized and more likely to report it if it does occur.

Stereotypes of people with intellectual disabilities

Common stereotypes of intellectually disabled people regarding sex:

1. They will forever remain childlike
2. They are and always will be asexual
3. They are unable to understand their sexual desires
4. They have incontrollable sex drives
5. They are potential sexual deviants, and should be denied sex education in case it 'gives them ideas'.

Challenges for teaching sexual health to students with intellectual disabilities

Approximately 90% of people with ID have difficulty with abstraction. This means that they may have trouble with visualizing and seeing pictures in their heads in the same way as others may be able to. Therefore, when they listen to someone speak, they can often repeat what they have heard but may not fully understand.

It is also very important to model and explain social norms. For example, if we hug a person with ID because they did a chore around the house but we do not explain the connection, they may learn that it is appropriate to hug people without reason.

Sexuality education in the classroom breaks a social norm, because private issues are being talked about in a public space. This can sometimes result in a student leaving a sexuality education class and doing something inappropriate in the corridor. It is important to keep reinforcing the appropriate social norms and the difference between private and public places.

Every person with an ID learns differently. When teaching sexual health, it is optimal to teach the same thing in different ways, rather than using just one approach and teaching more slowly.

Things to consider when teaching sex education to intellectually disabled youth:

- Lack of knowledge about sexual issues. Any information may come from misinformed peers rather than reliable sources like books, parents or teachers. Parents and teachers have been traditionally less likely to speak about sex with youth who have disabilities;
- Mental age may be lower than their physical age;
- They may learn at a slower rate;
- May be at greater risk for sexual abuse because of their willingness to place total trust in others & their tendency to be overly compliant. May also be more dependent on parents and caregivers;
- May be overprotected from parents or caregivers. May have less opportunity for sex with oneself or with others due to a lack of privacy;
- May have difficulty with abstract thinking (ex: what is love?) or understanding the long term consequences of pregnancy or some sexually transmitted infections;
- Youth with intellectual disabilities may have trouble distinguishing between private and public behaviours, or private and public body parts.

Guidelines for teaching sexual health with students with intellectual disabilities

Repeat, repeat and repeat again. It is important to use repetition when teaching youth with intellectual disabilities. You can repeat the same concept from a few different angles to maximize the potential for understanding. Each lesson should begin with a review of the previous lesson(s).

Stay concrete with your examples. Many students with intellectual disabilities do not comprehend well abstract concepts such as love, or that a pregnancy results in having a baby nine months later. The examples used need to be concrete, in the present and almost tangible. Using pictures and videos is a good method.

Don't overload with information. Going slower with the information is better. If you had wanted to do two sessions of sex education with the group, then schedule four sessions so that you have enough time for the students to process the information, ask questions and have discussions. You can also leave a few days between each lesson so that students have the time to think about the information.

Assume that the students have not had any sex education before (unless you know otherwise). You should start with the basics.

Appreciate that the students ARE sexual and this may be expressed in various ways. For most students, talking about sex will not encourage them to try it. It will just make them more comfortable and informed on the subject for when the moment(s) happens.

Teach the right to refuse. Disabled people can sometimes be trained to be quite compliant.

Remember that context is everything! How does the information fit into their real life? Discuss social situations as examples.

Help youth to practice appropriate affection, with whom and where.

Discuss masturbation. It is important that all students understand the concept and value of masturbation (unless your values are in conflict with this). Students need to know that this is healthy and natural and is entirely appropriate if they are in the right place (private place).

A note about masturbation

It is very important that we prevent sexual behaviour such as masturbation or exposure of genitals in public places, because this behaviour is illegal.

Often people with ID that masturbate in public are told repeatedly to masturbate in their bedrooms. However, often people with ID cannot get excited or orgasm when they masturbate alone in their bedroom. This is because they may require visual stimulation (especially men), but they do not have the ability to visualize images in their heads.

A simple way to solve this problem is to give images (not necessarily pornography but images from magazines) so that they have a source of stimulation in their bedroom.

Source: http://www.sexualityandu.ca/teachers/teaching-sex-ed-for-youth-with-intellectual-disabilities

Handout #10

Teaching Sex Education for Youth with Physical Disabilities

People with disabilities have the same sexual desires and needs as everyone else. These unique guides from www.sexualityandu.ca provide resources and information for teachers providing sexual education to youth with physical disabilities.

What are physical disabilities?

The term "disability" refers to any condition that impedes the completion of daily tasks using traditional methods. Physical disabilities are mostly associated with physiological disorders, disfigurement or anatomical loss. Some of the affected body function categories include: neurological, cardiovascular, respiratory, reproductive, digestive and urinary systems.

There are many types of disability and levels of ability. With any type of disability, sexual relationships and pleasure are possible. However, the disability needs to be taken into consideration when two people consider how to be sexually active and the mechanics of it all. Certain positions might not be possible, so creativity and flexibility are essential. Open communication is key in any relationship involving a physically disabled partner. Some topics include: planning for sexual activity, likes and dislikes, sexual fantasies and ways of enhancing arousal. Anger, fear, frustration and a sense of loss (if there has been a loss of sensation) should also be discussed.

Physical disabilities often result in altered sexual function, which can negatively affect self image and self-esteem. Certain things may come into question, such as mobility, if you use a wheelchair or have a cast, there will be some sexual positions that may not be possible. Lack of muscle strength may limit a person in similar ways.

There are many challenges for people with physical disabilities. Typical arousal methods might not work if a person has a loss of sensation due to spinal cord injury. Muscles spasms can increase pleasure, but they can also decrease pleasure. An inability to sustain an erection can cause obvious problems and frustrations. Urinary or bowel incontinence can also result in unpleasant surprises. Fatigue may factor in to one's sex life, as some actions may be too strenuous. A respirator or catheter can inhibit spontaneity. Chronic pain can greatly decrease sexual pleasure. Deformity or amputations might lead to a lack of confidence and initiative in sexual relations.

Common issues with physical disabilities and sexuality - Some suggestions:

Loss of sensation

- Emphasize stimulation of unaffected body parts
- Discover new erogenous zones (areas sensitive to touch) if the genitals have been affected
- Explore the pleasure in watching your partner caress your genitals or performing oral sex

Lack of muscle strength

- If arms or hands are affected, use aids (vibrators) for stimulation. May need assistance
- May need help with masturbation (rocking in a waterbed can help with movement)
- Hand held or remote controlled toys may be useful

Muscle spasms

- Spasms can increase or decrease pleasure. Try to find positions that promote or inhibit spasms accordingly

Inability to achieve or sustain an erection

- Explore alternatives to intercourse
- Penis rings can help an erection by preventing the blood supply from leaving the penis
- Can discuss penile implant with your urologist
- Can use toys for various sensations

Urinary/bowel incontinence

- Talk to your partner about the possibility of an accident to avoid surprises and to ease anxiety
- Limit your fluid intake prior to sex and try urinating beforehand
- Keep towels nearby and protect the mattress with an under-pad if possible

Catheter use

- Ask a doctor if you can remove the catheter during sexual activities, make sure your bladder is empty first

Fatigue/endurance

- Find positions that require less physical exertion and take a less active role in sex
- Use sex aids or toys
- Activities other than intercourse can be less strenuous

Shortness of breath

- Use a well-ventilated or air-conditioned room
- Ask a doctor about using bronchial spray prior to sex
- Find positions that don't put pressure on the chest or diaphragm and don't require high energy

Pain in joints

- Find positions that don't put pressure on the joints. There are pillows designed to give you more comfort during sex. See www.liberator.com
- Incorporate heat treatment into love making

Pain in back/neck

- Keep the back & neck aligned as much as possible
- Keep back supported with a firm mattress
- Find a way to support your neck during oral sex

Medications

- Some medications may cause fatigue, lower sex drive or inhibit sexual pleasure. Talk to your doctor about the side effects of your medication.
- Try different times of the day to see when you have the most energy.

Premature ejaculation

- Talk to your partner about the condition to avoid surprises or misunderstandings
- There are alternatives to some medications that may cause less disruption. Talk to your doctor.
- Discuss this issue with a sex therapist if the condition persists and disrupts your sex life.

Deformity

- A healthy body image is important
- Find different positions that are comfortable
- Talk about your feelings, concerns, and expectations with your partner

Lack of vaginal lubrication

- Use lubricants
- Go slow, prolong foreplay to allow lubrication to develop
- Incorporate relaxation techniques such as massage and heat therapy

Blindness or Visual impairment

- Emphasize body exploration through touch, smell, sound and imagination

Paraplegic or Quadriplegic

- Sexual function may be impaired but sometimes sensitivity in some areas can be increased
- The usual sensation of orgasm can be lost, but an orgasm sensation elsewhere in the body may be experienced

Wheelchair or casts

- Experiment with positions that allow for the most comfort
- The use of pillows can help with different positions

Spinal cord injury

- For a man, spinal cord injuries can affect orgasm, erections, and ejaculation
- Desire, pleasure and sensations to erogenous zones can usually still be experienced
- Even if they have lost all genital sensation, they may still capable of orgasms through stimulation of other body parts
- A penis ring can help a weak erection
- When an erection is not possible, implant devices can be an option (i.e. penile implant)
- Placing a powerful vibrator on the glans of the penis, or on the testicles, can sometimes help with ejaculation

Stereotypes of people with physical disabilities

1. People with physical disabilities are asexual
2. They are not models of beauty
3. "The Pitiful Handicap" (they should elicit sympathy, charity, pity because they have a poor quality of life)
4. "The Bitter Cripple" (they're angry and have a chip on their shoulder)
5. "The Inspirational Hero" (they've overcome obstacles despite disability so they're courageous and brave, media images used over & over again, like Christopher Reeves)
6. They are weak and dependent people
7. They are victims
8. They can't live alone or hold a job
9. They are sick or have something wrong with them and need to be cured
10. Their lives are totally different from people who do not have a disability
11. They always have problems with transportation
12. They are only attracted to other people with disabilities

13. They are infertile

Guidelines for teaching Sexual Health

There are many things to consider when delivering sex education to students with physical disabilities:

1. Lack of privacy & independence in daily living (ex: constant personal aid, may need help with intimate care like bathing)
2. They may have missed out on formal & informal sex education (schools don't typically adapt programs to their needs and friends and family may not include them in discussions)
3. Lack of social opportunities and obstacles to forming friendships (ex: don't have many opportunities to meet people and special schools can be far from home limiting the access to leisure events)
4. Disabled youth may be at greater risk of exploitations & abuse due to their vulnerability
5. Make sure that there is access to the facility where the education takes place (i.e.: ramps and elevators for mobility impaired people)
6. Make sure there are resources available to aid the visually impaired students (brail markings and resource people around facility for assistance)
7. Make sure there are resources to aid the hard of hearing students (available staff to communicate)
8. Have referrals on hand (other useful resources: associations, internet sites, peer groups, etc.)

Questions for a teacher preparing a sexuality education lesson:

1. Do I have a disabled student in my class?
2. What is the nature of their disability and what issues may arise for them from the content?
3. Has the pupil had the chance to speak to a staff member about concerns before the lesson?
4. Would the student find it helpful for me to talk to their parents to follow up on issues that arose for them?
5. How will I deal with any questions they may have?
6. Do I know anyone I can refer them to, if I can't answer their question(s)?
7. Are there any support groups for their condition that I may refer them to?

Source: http://www.sexualityandu.ca/teachers/teaching-sex-ed-for-youth-with-physical-disabilities

Handout #11

Managing Sensitive Issues - Questions and Answers

What do I do if I receive calls from angry parents?
Listen carefully and respond as best you can. If parents are angry and unwilling to listen, refer them to your school administration.

What does a teacher do with a multi-graded class?
As with other subject areas, the teacher will need to make the best decision for learning based on student needs.

What if a student asks a question (often done through the question box) that is beyond the outcomes of the grade level being taught?
Assess whether the question is related to information, feelings or values and how closely it does fit with grade level outcomes. Questions relating to values can be identified as such. As values and beliefs vary from family to family, students can be encouraged to discuss these types of questions with family members. Acknowledge varying feelings that arise with various questions. Depending on the curriculum relevance, background of student(s) and age appropriateness of the question, respond to factual questions in the most simple and straightforward way possible. As with other subject areas, teachers will need to make the best decision for learning based on student needs, and grade level taught.

What if a student discloses assault/abuse?
If a child discloses to a teacher or a teacher suspects child abuse (emotional, physical, sexual, neglect or a child witnessing violence) refer to your school board's policy on Reporting Child Abuse and Neglect. You have a legal obligation to report.

What if a student discloses confidential information or is asking about such issues as pregnancy, STI, sexual orientation or referral to a community agency?

- As these are very sensitive health topics, please handle with care and respect the student's right to confidentiality.
- Be sensitive to the particular circumstances of the situation, including such aspects as the age, developmental level and cultural background of the individual.
- Be careful not to impose your personal values.
- Teachers are expected to take an appropriate course of action depending on the particular circumstances of the situation. Options may be to assist or advise a student to talk to a non-judgmental guidance counsellor, a Youth Health Centre Coordinator, parents, or family doctor.

Alberta Health Services. (2013). Teaching Tools – Prepare Yourself: Managing Sensitive Issues. Retrieved from http://teachers.teachingsexualhealth.ca/teaching-tools/managing-sensitive-issues

Nova Scotia Learning Outcome Framework
Health Education Curriculum Outcomes - Sexual Health

Primary

Healthy Self

1.1 identify the proper names for parts of their body, including what areas are private

Healthy Relationships

2.3 recognize the diversity of family forms, including families with same sex parents

2.4 demonstrate an awareness of their need to feel safe, loved, protected, and cared for and the importance of having a safe and trusted adult in their lives who can play this role

Grade 1

Healthy Self

1.2.1 explore the concept of gender

Healthy Relationships

2.3 practice communication skills that promote healthy relationships and personal safety within a variety of contexts

Healthy Community

3.1 explain how media can be both helpful and harmful to their health

Grade 2

Healthy Self

1.3 demonstrate an understanding that decisions they and others make have positive and/or negative outcomes

Healthy Relationships

2.1 assess the qualities that make a good friend and practise ways to make and maintain friendships

2.3 demonstrate awareness that individuals and families have values, and that these values can contribute to healthy relationships and healthy decision-making

Healthy Community

3.1 differentiate between times when it is safe to share personal information including information on the internet and times when they should protect their personal information

Grade 3

Healthy Relationships

2.2 demonstrate an understanding that friendships can encounter difficulties and explore ways to manage these difficulties when they arise

Healthy Community

3.3 differentiate between media messages that promote health and media messages that are industry driven

Grade 4

Healthy Self

1.1 describe the physical and emotional changes that take place during puberty.
1.2 differentiate between gender roles and gender identity
1.3 demonstrate an awareness that values are an integral part in making healthy decisions and fostering healthy behaviour

Healthy Relationships

2.1 identify components of a healthy relationship
2.2 demonstrate an awareness of the link between positive self-identity and making healthy decisions that affect relationships and care of self

Grade 5

Healthy Self

1.1.1 demonstrate an understanding that sexual orientation is part of our personality and explore the harmful effects of homophobia
1.2 describe the male and female reproductive systems, explaining the process of reproduction and how the reproduction system matures through the process of puberty

Healthy Relationships

2.1 demonstrate an awareness of and ways to prevent common chronic and communicable disease, including HIV, Hepatitis B and C, and the potential impact of disease on the lives of themselves and their families

Healthy Community

3.1 assess sources of information via the internet for safety and reliability, and practise ways to enhance safe use of the internet
3.3 analyze gendered media messages related to body image and promote healthy messages within the school and community

Grade 6

Healthy Self

1.1 investigate the concept of sexuality and sexual health
1.2 describe the most common sexually transmitted infections for youth
1.5 identify and practice health enhancing ways to manage feelings and changes associated with the onset of puberty

Healthy Relationships

2.1 practice communication skills that keep relationships in their lives healthy, safe, and productive
2.2 create a personal value code of ethics on relationships within their lives

Handout #13

Nova Scotia Learning Outcome Framework
Healthy Living Curriculum Outcomes - Sexual Health

Grade 7

Healthy Self

7.1 identify what they value and set personal goals that contribute to their health and value system

7.3 demonstrate an understanding of the stages of pregnancy and prenatal development

7.6 differentiate between sexual orientation and gender identity

7.7 identify ways of maintaining sexual health

7.8 apply a series of decision-making steps to potential situations involving risk, including sexual decision making and decision making in relation to the use of alcohol

Healthy Relationships

7.14 describe different types of interpersonal relationships, the importance of respectful and non-violent relationships and examine the positive and negative reasons for starting and ending relationships

7.15 examine methods for contraception and the benefits/disadvantages of each Method

7.16 distinguish between positive and negative peer influence and acquire skills for resisting/asserting oneself in negative peer influence

Healthy Community

7.18 demonstrate an understanding that communities have resources that youth can access for help for a variety of health issues

7.19 recognize there are potential harms arising from use of alcohol, caffeine, and gambling along a continuum of use

7.20 analyze positive and negative outcomes of social networking and use of mobile devices

Grade 8

Healthy Self

8.1 analyze the relationship between values and personal health practices

Healthy Relationships

8.6 identify healthy and unhealthy relationships and demonstrate assertiveness skills to communicate thoughts and feelings within primary relationships

8.7 examine the role of bystander in cases where a peer/friend is experiencing emotional, physical, psychological harm and practise scenarios that show support and help

8.9 recognize the signs of pregnancy and the importance of early prenatal care

8.10 evaluate the different options related to unintended pregnancy and explore

the challenges related to each of these options, including the challenges of teen parenting

Healthy Community

8.12 recognize misconceptions and realities with respect to sexual assault

8.13 assess the benefits and risks of online technology and make healthy and responsible decisions that reduce the risk of exploitation and victimization

8.14 examine the media portrayal of sexual orientation

Grade 9

Healthy Self

9.6 identify ways of maintaining sexual health

Healthy Relationships

9.10 apply communication and interpersonal skills to discuss reproductive and sexual health issues

9.11 examine the cause and effect of unhealthy relationships and practise communication and assertiveness skills to confront unhealthy relationships

9.12 identify and practise negotiation, assertiveness, and refusal skills, related to sexual activity, alcohol, tobacco, cannabis, and gambling

9.13 analyze the role of alcohol in the decision-making process related to increased risk of unintended pregnancies, STIs, impaired driving, and injury

Healthy Community

9.16 examine issues around hypersexualization of children and youth and how these phenomena can contribute to violence, affect body image and self-esteem, and impact relationships

9.20 identify school and community-based resources and health services available to assist themselves or a friend if help or information in the area of sexual health, mental health, alcohol, and other substance use or gambling is needed, and practise how to make initial contact with such a service/resource

Handout #14

Sexual Health School Collection Contents - DEECD

The following is a complete list of titles that have been distributed to your school as part of the Sexual Health Primary–6 School Collection. Annotations for each title have been provided, along with the intended grade level curriculum fit, with reference to the book bureau stock code number should your school wish to order more titles. Each title in this collection was extensively reviewed and approved by teachers and consultants and are developmentally appropriate for the grade level specified.

The Bare Naked Book (18649) pays tribute to the wonderful diversity of the body from a child's point of view. This book of discovery shares the specialness of the body from hair (dripping, straight, tangled and curly) to toes (squishy, ticklish, stamping, and skinny). Illustrations and text of this book address curriculum outcomes within Health Education **Primary.** This title promotes healthy sexuality through the natural inclusion of gender anatomical references for boys and for girls.

Amazing You!: Getting Smart about Your Private Parts (18640) presents clear and age-appropriate information about reproduction, birth, and the difference between boys' and girls' bodies. Written with warmth and honesty and illustrated with whimsical pictures, this book promotes a healthy attitude about body image, promotes healthy sexuality. It addresses curriculum outcomes within Health Education **Primary**.

Do You Have a Secret? (18368) is a well-written book that explores the difference between a good and a bad secret? Through the storyline and the illustrations, the young reader is introduced to the concept of a safe and trusted adult with whom to share a secret that causes fear, sadness, or mixed feelings. This title addresses curriculum outcomes related to personal safety and emotional health within Health Education **Primary and 1**. This is a story that could be read as a whole class, small group, or an individual basis.

My Body Belongs to Me (1000433) is the critically acclaimed book that sensitively addresses physical boundaries in regard to personal safety. In a non-threatening, engaging manner, this picture book teaches children that when it comes to their body, there are some parts that are for "no one else to see" and empowers them to tell a safe and trusted adult if someone touches them inappropriately. Telling the story of a gender-neutral child who is inappropriately touched by an uncle's friend, this tale delivers a powerful moral when the youngster reveals the offender and the parents praise the child's bravery. Most importantly, this narrative assures children that sexual molestation is not their fault, and by speaking out, the child will continue to grow big and strong. A "Suggestions for the Storyteller" section is also included to assist in facilitating a comfortable and developmentally appropriate discussion alongside the story to support the teacher in addressing related outcomes in Health

Education **Primary and 1.**

Molly's Family (18648) is a tender story that celebrates diverse family structures. When everybody's family in Molly's class creates pictures of their families to display on the classroom wall, one of Molly's classmates exclaims that her family is not a family because "you can't have a mommy and a mama." Molly does not know what to think as no one else in her class has two mothers. After talking to Mommy, Mama Lu, and the teacher, Molly does some hard thinking and realizes that while many families are different in structure, all families can be happy, loving, and real. This read aloud addresses outcomes within Health Education **Primary**.

A Tale of Two Daddies (1000434) is a heart-warming book that provides a platform for discussing a timely topic—the love and support all children need, and want, from their parents and peers and addresses the topic of same-sex parents. *A Tale of Two Daddies* is told through a playground conversation between two children, one of whom is a girl who has two dads. This story addresses multiple outcomes within Health Education **Primary**.

And Tango Makes Three (18790) is the story of Roy and Silo, two male penguins who are "a little bit different." They cuddle and share a nest like the other penguin couples, and when all the others start hatching eggs, they want to be parents, too. Determined and hopeful, they bring an egg-shaped rock back to their nest and proceed to start caring for it. They have little luck, until a watchful zookeeper decides they deserve a chance at having their own family and gives them an egg in need of nurturing. The dedicated and enthusiastic fathers do a great job of hatching their funny and adorable daughter, and the three can still be seen at the zoo today. Done in soft watercolours, the illustrations set the tone for this uplifting story, and readers will find it hard to resist the penguins' comical expressions. The well-designed pages perfectly marry words and pictures, allowing readers to savour each illustration. An author's note provides more information about Roy, Silo, Tango, and other chinstrap penguins. This joyful story about the meaning of family is a wonderful addition to classroom collections on diverse family structures and is developmentally appropriate for discussions within Health Education **Primary.**

Who's in a Family? (1000124) uses clear text and bold illustrations to demonstrate the varying structures of a family both human and in the animal kingdom. The consistent message is woven throughout the story that family are those who love you. This resource addresses outcomes within Health Education **Primary**.

I Can Be Safe (18371) is a wonderful read aloud that offers advice on personal, social, and emotional issues confronting the young child. This book makes children aware of the things to know and do in order to be safe within various environments and includes such injury prevention strategies such as looking both ways before crossing the street, wearing special protective gear for sports, important information to know in the event of an emergency, and makes the importance reference to trusting your sense of intuition. This title addresses curriculum

outcomes related to injury prevention within **Health Education 1**.

I Can Play It Safe (1000296) is a title that teaches children and helps adults reinforce seven important rules to personal safety in a non-threatening way. It covers topics like safe versus harmful secrets, safe versus harmful touches, and the importance of having a community of safe and trusted adults to turn to for help. Emphasizing the "check-in" rule and teaching kids to trust their gut instincts, this book gives children the knowledge and confidence they need to make good choices about their personal safety every day. This read aloud resource supports learning and teaching within multiple outcomes of **Health Education 1**.

William's Doll (1000137) is the story of a young boy who wants a doll and meets ridicule from his brother and his friends, and societal expectations of gender by his father regarding the toys that he should be enjoying. This story is a wonderful catalyst for discussion as students in grade 1 begin to explore the concept of gender with **Health Education 1.**

Winnie Finn, Worm Farmer (1000127) is a fun story about a creative young girl who has a love for wiggly things and can open discussion on the topic of gender. Engaging text accompanied with bright, energetic illustrations share Winnie's enthusiasm for worms and her desire to enter them at the county fair. Trouble is, there isn't a prize for worms. Readers will be surprised at how Winnie solves the problem. This resource addresses outcomes related to the exploration of gender within **Health Education 1**.

It's Not the Stork!: A Book about Girls, Boys, Babies, Bodies, Families, and Friends is a humorous, informative book for young children. Pregnancy, physical differences between boys and girls, and the diverse concepts of family are explored through the experiences of a funky green bird and a nervous little bee. The clearly written text and delightful, full-colour illustrations make it an engaging book to read and share. Teachers will find this a useful book to share in small groups or to share as a read-aloud to the whole class that will help answer the endless and perfectly normal questions that early elementary children ask about how they began in a way that is mindful of a child's healthy desire for straightforward information. This title is developmentally appropriate for and addresses specific curriculum outcomes within **Health Education Primary and 1.**

It's So Amazing!: A Book about Eggs, Sperm, Birth, Babies, and Families is a comprehensive book that uses appropriate language to deliver meaningful understanding to issues of healthy sexuality, puberty, and human growth and development. This book, with sensitivity but great accuracy, answers almost every question about reproduction, birth, and babies. It is a realistic resource that gives children a healthy understanding of the human body. This title is developmentally appropriate for and addresses specific curriculum outcomes within **Health Education 2, 3, 4, and 5.**

The Girl's Body Book: Everything You Need to Know for Growing up You is an invaluable resource for girls. This readable, reassuring, and illustrated guide provides clear, factual information on topics youth often find hard to talk about— their bodies, their feelings, their relationships, hygiene, exercise, teachers, peer pressure, sex, and siblings. This is a wonderful resource for the classroom for independent reading, and teachers of health education, healthy living, and guidance will find this a practical resource for reference in addressing issues of healthy sexuality, and emotional/physical/relationship changes that occur during adolescence. This title specifically addresses outcomes within **Health Education 4**.

The Boy's Body Book: Everything You Need to Know for Growing up You is an invaluable manual that every boy should own. This readable, reassuring, and illustrated guide provides clear, factual information on topics boys find hard to talk about— their bodies, their feelings, their relationships, hygiene, exercise, teachers, resource for the classroom for independent reading, and teachers of health education, healthy living, and guidance will find this a practical resource for reference in addressing issues of healthy sexuality, and emotional/physical/relationship changes that occur during adolescence. This title specifically addresses outcomes within **Health Education 4**.

The Remarkable Maria is the tender story of a little girl and her friends—Willie, her little sister; Mrs. MacKenzie, the next door neighbour; and Mrs. De Groot, the orphanage caregiver. Set in Paramaribo, South America, the beautifully illustrated text conveys a story of a young life full of carefree dreams and laughter combined with the sadness and challenges when a child is faced with HIV/AIDS, and other issues surrounding children's rights. It is a story of optimism, overcoming obstacles and issues of discrimination, and captures the positive affects of caring individuals. It is a powerful story to use to explore the concept of stigma, and addresses outcomes within **Health Education 5 and 6**. This story contains illustrations created by children of South America.

How the Cougar Came to be Called the Ghost Cat is the tale of young and adventurous cougar, Ajig, who decides to build a new home in a strange forest. When he finds that all of the animals in the forest are afraid of him, Ajig agrees to stop behaving like a cougar so that he can make friends. When Ajig tries to return to his birthplace, he learns that he is no longer welcome. Lost between two worlds, the young cougar becomes a "ghost cat." The story reflects the experience of First Nations peoples' assimilation into the Euro-Canadian school system, but speaks to everyone is marginalized or at risk. This read aloud resource, written in both English and Mi'kmaw addresses curriculum outcomes within **Health Education 4 and 5,** particularly to begin conversations around gender identity and homophobia.

In Our Mother's House is an engaging read-aloud picture book of a wonderfully unique family, living by its own rules, and held together by a very special love. In

their cozy home, Marmee, Meema, and the kids are like any other family on the block. However, when one family in the neighbourhood does not accept them, Marmee and Meema teach their children that different doesn't mean wrong. This resource addresses outcomes within **Health Education 5**.

It's Perfectly Normal—Changing Bodies, Growing Up, Sex and Sexual Health is an informative text that answers questions about the body changes during puberty and adolescence. Explicit information is imparted through illustrations and text that is presented with clarity, humour, and inclusiveness of diverse realities in a way that few resources of this kind are. This resource addresses specific curriculum outcomes within **Health Education 6** related to healthy sexuality. It is recommended that teachers be familiar with the contents of this resource and present it to the class as one that has valuable information related to healthy sexuality.

The Right Touch: A Read-Aloud Story to Help Prevent Child Sexual Abuse is a gentle and thoughtful book written as a teaching tool to help prevent child sexual abuse. As a way of teaching her little boy about this issue, a mother tells him a story of a child who was lured into a neighbour's home to see some non-existent kittens. Teachers may wish to utilize this title for reading in small groups of children and/or as needed to individual children. It is important that dialogue around issues of personal safety accompany the reading of this story, and that children are given the opportunity to discuss. Key messages include the importance of identifying a safe and trusted adult that you can share things with; on using your sixth sense to know when something does not feel right; and, that adults who love and care for you should not threaten and ask you to keep secrets. **This title is appropriate for sharing within a small group and as such is a title chosen for all staff to become familiar with and housed in a shared space. School administrators** and **guidance counsellors** will also find this title to be a worthy addition to their office collection.

Handout #15

Sexual Health Resources

Growing Up! Ok - Nova Scotia Department of Health and Wellness
Growing Up! Ok contains general information about issues relating to puberty, including discussions about being healthy and making healthy choices, physical development, changes in emotions and feelings, and discussions about relationships, sexuality, and sexual assault.

Sex? A Healthy Sexuality Resource – Nova Scotia Department of Health and Wellness
This resource is distributed in grade 7. This resource provides information about sexual orientation, gender identity, healthy and unhealthy relationships, sexual assault, consent, STIs, preventing pregnancy, and birth control.

Beyond the Basics: A Source Book on Sexual and Reproductive Health Education 3rd Edition
Canadian Federation for Sexual Health – www.CFSH.ca
This resource is a tool for educators who deliver sexual and reproductive health education from grade 4 to 12. This resource contains information on both what to teach and how to teach it.
There are 8 modules and include values; puberty and reproductive health; self-esteem; sexual identity; relationships, communication, and decision making; contraception and safer sex; and STIs and HIV. Beyond the Basics in on the Nova Scotia Department of Education and Early Childhood Development approved list.

Homophobia Hurts Teacher's Manual
The Youth Project - www.youthproject.ns.ca
This manual is designed for teachers and educators who are looking for more information on fighting homophobia in their school or classroom, providing support to LGBT students, or introducing these topics within the classroom. The manual has information on LGBT youth, strategies for teachers, educators and schools, sample lesson plans, and resources. Homophobia Hurts in on the Nova Scotia Department of Education and Early Childhood Development approved resource list.

Handout #16

Sexual Health Websites

Advocates for Youth
http://www.advocatesforyouth.org/lesson-plans-publications
This website has excellent lesson plans to that will support the Health Education Curriculum.

American Psychological Association - Sexualization of Girls
http://www.apa.org/pi/women/programs/girls/report.aspx
This report examines and summarizes psychological theory, research and clinical experience addressing the sexualization of girls. The report (a) defines sexualization; (b) examines the prevalence and provides examples of sexualization in society and in cultural institutions, as well as interpersonally and intrapsychically; (c) evaluates the evidence suggesting that sexualization has negative consequences for girls and for the rest of society; and (d) describes positive alternatives that may help counteract the influence of sexualization.

Canadian Guidelines for Sexual Health Education
http://www.phac-aspc.gc.ca/publicat/cgshe-ldnemss/index-eng.php
The Canadian Guidelines for Sexual Health Education provides a framework that outlines principles for the development and evaluation of comprehensive evidence based sexual health education. The *Guidelines* provide information to guide the efforts of professionals working in the area of sexual health education and promotion, including curriculum and program planners, policy makers, educators (in and out of school settings) and health care professionals.

Kids In the Know
www.kidsintheknow.ca
Kids In the Know is an interactive safety education program for increasing personal safety of children and reducing the risk of sexual exploitation. Using techniques to help children and youth identify high-risk behaviours and practicing assertiveness skills, it combines interactive lessons with activities to help give children the tools to keep themselves safe.

Media Smarts
http://mediasmarts.ca
MediaSmarts is a Canadian not-for-profit charitable organization for digital and media literacy. Our vision is that children and youth have the critical thinking skills to engage with media as active and informed digital citizens. There are lesson plans and resources for primary to grade 12. These lesson plans cover topics on advertising/marketing, body image, cyberbullying, cell phones, media, and alcohol marketing.

Nova Scotia Department of Education and Early Childhood Development - Learning Outcome Frameworks
http://www.ednet.ns.ca/psp-lof.shtml
This website will provide you with the learning outcome frameworks from primary to grade 12.

Public Health Agency of Canada
http://www.phac-aspc.gc.ca/std-mts/index-eng.php
This website will provide you with information on different sexual transmitted infections, emergency contraception, birth control, and latest statistics on sexual transmitted infections.

Public Health Agency of Canada – Questions and Answers: Gender Identity in Schools
http://www.catie.ca/en/resources/questions-and-answers-gender-identity-schools
This resource is intended to address the most commonly asked questions regarding the gender identity of youth in school settings. The goal of the resource is to assist educators, curriculum and program planners, school administrators, policy-makers, and health professionals in the creation of supportive and healthy school environments for youth struggling with issues of gender identity.

Public Health Agency of Canada – Questions and Answers: Sexual Orientation in Schools
http://www.cfsh.ca/files/PDF/WEB_Engl.SexualOrientation.pdf
This resource is intended to address the most commonly asked questions regarding the sexual orientation of youth in school settings. The goal of the resource is to assist educators, curriculum and program planners, school administrators, policy-makers, and health professionals in the creation of supportive and healthy school environments for youth struggling with issues of sexual orientation.

Public Health Agency of Canada – Questions and Answers: Sexual Health Education for Youth with Physical Disabilities
http://library.catie.ca/pdf/ATI-20000s/26289_B_ENG.pdf
This resource is intended to address the most commonly asked questions regarding sexual health education for school- aged youth with physical disabilities. The goal of this resource is to assist in the creation of supportive and healthy learning environments for school-aged youth with physical disabilities and in providing them with sexual health education.

Sex Information and Education Council of Canada (SIECCAN)
Sexual health education in the schools: Questions and Answers
http://www.sieccan.org/pdf/she_q&a_3rd.pdf
This resource provides answers to some common questions that parents, communities, educators, school administrators, and government may have about

sexual health education in schools. The answers to these questions are based upon and informed by findings of up to date and credible scientific research.

SexualityandU

www.sexualityandu.ca

A Canadian website that is committed to providing accurate, credible, and up-to-date information and education on sexual health. An initiative of the Society of Obstetricians and Gynaecologists of Canada, the site's mandate is to provide guidance and advice to help individuals develop and maintain healthy sexuality. This website has a dedicated section for teachers/educators.

Teaching Puberty: You Can Do It! DVD - Toronto Public Health

http://www.toronto.ca/health/healthyschools/sexual_health.htm

This resource is to teacher training resource to be used in preparation for teaching grade 4 to 6 puberty classes. It consists of discussion and modeling of the four basic sessions, interviews with experts discussing challenging issues and resource section.

Teaching Sexual Health

www.teachingsexualhealth.ca

This website is from Alberta Health Services. It has a section for teachers and parents. The section for teachers contains lesson plans for grades 4 to 12. There is also teaching tools, videos, power point presentations, games and illustrations.

The Youth Project

http://www.youthproject.ns.ca

The Youth Project is a non-profit charitable organization dedicated to providing support and services to youth, 25 and under, around issues of sexual orientation and gender identity. We have a provincial mandate so although we are located in HRM, we travel around the province to meet with youth in other communities. We provide a variety of programs and services including support groups, referrals, supportive counselling, a resource library, educational workshops, social activities, and a food bank

Handout #17

Community Resources

AIDS Coalition of Nova Scotia
http://acns.ns.ca

AIDS Coalition of Nova Scotia is an organization that promotes and supports the health and well-being of people living with and affected by HIV/AIDS. This organization provides a variety of programs, information, and services.

Avalon Sexual Assault Centre
http://avaloncentre.ca
Avalon Sexual Assault Centre provides services for those affected by sexual violence, with primary emphasis on support, education, counselling and leadership/advocacy services for women.

Nova Scotia Association for Sexual Health (NSASH)
Nova Scotia Association for Sexual Health (NSASH) is a non-profit, charitable organization dedicated to promoting healthy sexuality for all Nova Scotians in an environment that respects and supports choice. NSASH is made up of seven autonomous member-centres located throughout Nova Scotia (please see *Members list)*. **These Centres are excellent sources of support and resources** such as the "*I Can Wait*" DVD available from the Sexual Health Centre for Cumberland County and the free, downloadable pamphlets on the Sexual Health Centre Lunenburg County 's website. Centres may also provide local teacher capacity building in servicing. For further details, please see www.nssexualhealth.ca or contact one of the member-centres.

Yarmouth Centre for Sexual Health
12 Cumberland St, Yarmouth, NS, B5A 3K3
Tel. (902) 742-0085, Fax (902) 742-6068
E-mail: yarmouth@NSSexualHealth.ca

Sexual Health Centre Lunenburg County
4 Hillcrest St, Unit 8, Bridgewater, B4V 1S9
Tel. (902) 527-2868
Fax (902) 527-2868 (call first)
E-mail: LunCo@NSSexualHealth.ca
Web: www.theSHaC.org

Sheet Harbour Sexual Health Centre
22756, Suite 216, Hwy #7, Sheet Harbour, B0J 3B0.
Tel. (902) 885-2789 Fax (902) 885-2629
E-mail: sheetharbourshc@hotmail.com
Web: www.sheetharboursexualhealth.com

Sexual Health Centre for Cumberland County
PO Box 661, 11 Elmwood Dr, Amherst, B4H 4B8
Tel. (902) 667-7500 Fax (902) 667-0585
E-mail: shccc@ns.aliantzinc.ca
Web: www.amherstsexualhealth.ca
& www.forgirls.ca (GoGirl:Self Esteem Workouts website)

Cape Breton Centre for Sexual Health
PO Box 1598, 150 Bentinck St, Sydney, B1P 6R8
Tel. (902) 539-5158
E-mail: pp.cb@bellaliant.ca

Pictou Co. Centre for Sexual Health
503 Fredrick Street, New Glasgow
Tel. (902) 695-3366
Email: pppc@ns.sympatico.ca
Websitewww.pictoucountysexualhealth.com

Halifax Sexual Health Centre
#201 - 6009 Quinpool Rd.
Halifax, NS B3K 5J7
Tel. (902) 455-9656 Fax (902) 429-3853
Email: ED@HSHC.ca
Web: www.HSHC.ca

Public Health Services
http://novascotia.ca/DHW/about/phs-offices.asp

The Nova Scotia Association of Women's Centres
http://www.womenconnect.ca/index.htm
This website will provide you with information about the various women's centres across the province. Many of these centres do work around a variety of sexual-health related issues including sexual violence.

The Youth Project
http://www.youthproject.ns.ca
The Youth Project is a non-profit charitable organization dedicated to providing support and services to youth, 25 and under, around issues of sexual orientation and gender identity. We have a provincial mandate so although we are located in HRM, we travel around the province to meet with youth in other communities. We provide a variety of programs and services including support groups, referrals, supportive counselling, a resource library, educational workshops, social activities, and a food bank.

Handout #18

Different Teaching Methods to Teach Sexual Health

There are different teaching methods to teach sexual health. Ask the group if they have used the question box before? Did it help you in teaching about sexual health?

Question Box

The question box will help students clarify and validate information that is being presented. Questions related to sexuality may seem more challenging or create discomfort for educators. One of the challenges facing teachers discussing human sexuality in the classroom is dealing effectively with questions from students.

Advantages of the Question Box

- Anonymity provides a way for students to ask questions related to sexuality without risking embarrassment or self-consciousness.
- Time between lessons allows teachers to prepare an answer ahead of time and to avoid being caught off guard.
- Capitalizing on "teachable moments" is effective and can enrich the classroom experience.

Procedure

This technique is most effectively utilized in classrooms where teachers encourage trust, comfort, and ground rules are in place. The procedure is simple, but important to follow in detail.

1. Hand out identical slips of paper to each student (a small notepad works well).

2. Ask the students to write down any questions.

3. In order to prevent those with pressing questions from feeling uncomfortable, all students should write something on their slip of paper. If they don't have questions, encourage them to write feedback about how the class is progressing, or to write "no comment".

4. Pass around a container (e.g. a shoebox with "mail slot" in lid). Tell the students that you will answer the questions at the beginning of the next class period. This will give you time to research and prepare answers and to rephrase questions containing slang or shock terms.

Important Information About Feedback

- Research indicates that for feedback to be effective it should always be given in a timely manner. Once a week is reasonable for responding to question box questions.

- Appropriate feedback is complete, accurate and considers the age and developmental stage of the students.
- The anonymous nature of the question box may enable a student struggling with personal issues to raise these issues safely. Teachers can provide support to students, and in some cases teachers are legally obligated to refer students.

Tips on Answering Question Box Questions

Group together common questions. Tell the class "there were many questions about… so I am addressing them all in this answer". This saves processing time and possible duplication. It also normalizes the question.

Acknowledge *respectfully* those questions that you could not understand or that seem to be "off topic". State "there were a few questions that I could not read," or "there were a few questions that don't seem to relate to our course content." Conclude by saying, "Please see me individually if you don't hear your questions answered today."

Use proper terminology whenever possible, e.g., There's a question here about "jerking off". "Lots of people have questions about masturbation…" Although slang terms are sometimes used it is important to correct the slang term with the proper term. It is important to also acknowledge the slang term that is used. This way students who perhaps do not know the proper term will be able to match up the proper term with the slang term.

Defer lengthy discussions concerning questions that relate to future course content. Try to answer questions briefly, and indicate that the topic will be discussed further during an upcoming lesson, e.g., "there are some questions about contraception which we will be discussing next class. If you still have a question, or don't understand, you can re-submit your question then."

Defer a question and find the correct/current information you require to answer it. It is OK to say, "I don't know for sure, but will try to find out and get back to you next class."

I am going to ask a couple of typical questions you may get in a question box. How would you respond to these questions:
What is a wet dream?
Is it bad to have sex when you are 13?
How do gay men have sex?

Role Play

Role-play is learning how to best handle a situation by practicing interactions and trying out different approaches. Students may act out situations, problems, and issues in a safe setting and develop skills that promote sexual health. Role-play is a

very effective instructional method proven to increase self-efficacy and impact student behaviour[2]. Role-play requires careful preparation to ensure a structure emphasizing healthy sexuality through practicing basic learnings, such as abstinence negotiation.

Advantages of Role Play

- Provides opportunity for students to assume roles of others, therefore appreciating another person's point of view.
- Allows for a safe exploration of solutions and an opportunity to practice sexual health skills.
- Tends to motivate students to learn.
- Promotes and develops critical and creative thinking, attitudes, values, and interpersonal and social skills.

Procedure

1. Prepare class for role-play

- Present an artificial problem, situation or event that represents some aspect of reality.
- Define the problem, situation and roles clearly.

2. Give clear instructions

- Determine whether role-plays will be carried out using student volunteers in front of the class (the teacher may or may not play a role), in partnerships/small groups with every student playing a role, or in small groups with role-players and observers.
- Divide students into groups.
- Model the skill with a scripted role-play.
- Suggest including a few-minute time limit; and the opportunity to perform more than one skill practice.

3. Act out role-plays

- Students follow the procedure outlined by the teacher to act out role-plays.
- Unless the teacher is playing a role, it is helpful to walk around the room and observe how students are experiencing the role-play and offer coaching to students who are stuck.

4. Discussion (small group and whole class)

- Begin by allowing players to communicate feelings experienced during the role-play.

- Have students identify sexual health skills that were demonstrated during the role-play.
- Determine actions that strengthen or weaken these skills (i.e. body language).
- Discuss how this role-play is or isn't similar to real life.
- Identify ways of using identified sexual health skills in real life situations.

Alternatives to Traditional Procedure

- Have students write role-plays as scripts.
- Have students write down responses and then role-play in front of the class.
- Have students generate a list of challenging "lines", then have a student read the lines to the class and have each student give a response.
- Have students develop and act out plays.

Tips for Using Role Play

- Begin with fairly easy situations and work up to more challenging ones.
- Be aware that some students may feel threatened or self-conscious. Using humour can help dispel embarrassment. Using role-plays that exaggerate weak responses might break the ice.
- Reduce the level of abstraction or complexity so that the students may become directly involved with underlying concepts.
- If students find it difficult to determine skills which model sexual health, they could observe successful role models or ask experts to suggest approaches.
- If attempting an unscripted exercise, be sure it is the correct approach for your students' comfort level.

We are now going to do a role-play. Are there any volunteers? We will go through a role-play to see how it would work in a classroom. What are some sexual health topics that students could role -play?

Small Group

Another instructional method that you can use when teaching about sexual health is using a small group.

Advantages of Small Groups

When students work in small groups, they think through an idea, present it to others so that they can understand, and often exchange alternative ideas and viewpoints. Students learn faster and more efficiently, have greater retention, and tend to be more positive about the leason[1]. This:

- Encourages positive attitudes toward sexual health;
- Increased students' self-confidence;
- Promotes intellectual growth[4;] and,
- Enhances social and personal development.

Procedure

There is no one "right way" to approach small group activities. Teachers must choose models and methods that match their particular teaching styles, their students and lesson content. Following some basic steps at the beginning will help small group activities be more effective.

These basic elements of cooperative learning should help you get started[2].

- Positive interdependence
- Social skills
- Individual accountability
- Group processing

1. Positive Interdependence

Students need to work cooperatively with all members of the group and contribute to the goal. To increase comfort level of students working in groups they are unfamiliar with set up an icebreaker for them to get to know each other before the lesson begins[1].

A common icebreaker involves pair students together, with each gathering basic information and interesting facts about their partner. The group reconvenes and each student presents their partner to the group[5]. Students tend to be less embarrassed and more willing to share with the group.

Also remember ground rules helps to provide transparency on acceptable behaviours and attitudes during the session[5].

2. Social Skills

Small group work requires students to listen to one another, ask questions, clarify issues, and re-state points of view. Teach students these skills through demonstration and direct instruction[1]:

- Listening when others speak
- Eye contact and positive body language
- Encouragement and respect
- Speaking quietly and without hostility

3. Individual Accountability

For small group work to be successful teachers must ensure that the lesson includes an opportunity for individual accountability. Each member of the group must be motivated to contribute to the final goal[1,5].

4. Group Processing

Have students reflect on the positive ways the group interacted together to achieve their goal. Ask students to write down what was helpful in getting the group to achieve their goal. This opportunity for reflection will clarify the processes and improve their cooperative learning skills[2]. Students should be encouraged to ask questions and seek answers as a group[5].

Types of Small Group Activities

Think-Pair-Share: Students work independently to write down thoughts or ideas about a topic, and then share these ideas with a partner. Partners probe one another to ensure complete understanding.

What sexual health topics could students focus on in a think pair share?

Jigsaw: Divide class into groups. Assign each group a separate topic. Everyone in each group must be become an expert on the topic by the end of a given time. Form new groups made up of one member of each original group. “Experts” share findings from various topics from their original groups with the new group members.

What sexual health topics could students focus on in a jigsaw?

Group Investigations: Students work to produce a group project, which they may have a hand in selecting.

Snowballing: Students are divided into pairs, with each pair being given the same material on a sexual health topic. They then join with another pair to compare and contrast differences in their understanding. The groups combine again, and repeat the compare-contrast process[5].

Class Discussion

Discussions offer students a chance to express opinions and exchange information safely within the classroom. Discussions take place after the facilitator has provided material

through a lecture, digital media, or reading[1]. Talking about sexuality with students can be challenging because it is a subject that touches on our privacy and our vulnerability.

Advantages of Classroom Discussion

- Helps build a positive classroom climate.
- Leads to student interest in sexual health[1].
- Leads to recall[1].
- Leads to analysis[1].
- Results in students feeling more positive about themselves and the learning environment.
- Normalizes changes students may be experiencing.
- Allows more students to be involved and express their ideas.

Procedure

1. Set up an atmosphere ensuring sensitivity during the activity.

- Ensure ground rules promote respectful interactions during discussions are in place.
- Facilitator should introduce topic for discussion, through a short lecture, video, or skit.
- Defining terms is important, to ensure all students are at a similar level of understanding.

2. Hold the discussion.

- Encourage students to participate in the discussion by asking questions, making suggestions and expressing ideas.
- Probe, prompt and redirect students to enhance the discussion.
- Encourage students to recall, analyze, generalize and personalize the information.
- Ensure correct information is being shared among the class.

3. Conclude the discussion.

- Find consensus, a solution, clarification of insights gained, or a summary (preferably one provided by the students).

Tips for Using Class Discussion

- Introduce facts and refute inaccuracies and myths.
- Be consistent with conventions such as hand raising and listening to the speaker. Some teachers find it helpful to use an object such as a talking stick.

- Maintain students' integrity through respecting their questions and responses[2].
- Use "wait time", the pause between asking a question and soliciting a response, to increase participation and improve the quality of student responses.
- Use open-ended questions to encourage higher-level thinking.
- Remain conscious of your own values and reactions during the discussion. The teacher must model sensitivity and respect.

Digital Media

Digital media can be an entertaining way to introduce content and raise issues in the sexual health classroom. Many digital media formats and videos are available. It is important to find the right media and to use it effectively to ensure student learning is optimized. It is always a good idea to have digital media approved by administration.

Advantages of Digital Media

- Keeps group's attention.
- Stimulates discussion[1].
- Illustrates complex, abstract concepts through animated, 3-D images or technologically advanced media.

Procedure

1. Preview the media

- Use only those parts of the media that match the lesson's objectives.
- Ensure the media is appropriate for the grade and age.
- Provide an opportunity for parents or other community members to preview the media.
- Evaluate your resource before the class views it.

2. Prepare the classroom

- Check equipment (projector, computer, DVD, website, remote control).
- Arrange seating.
- Cue the media ahead of time.

3. Include lead-in activities

- Review vocabulary or key concepts.
- Ask students to make predictions about what they will see and learn.
- Provide focus questions in advance.

4. Segment your viewing

- Pause the media before and after important points are made to highlight a certain idea or to check for comprehension.
- Solicit inferences and predictions or ask students to make connections to other topics or real-world events.
- Use "pause" to create a still picture when important visuals are used.

5. Include follow-up activities

- Many programs come with a teacher's guide that provides activity suggestions.
- Small Group Discussion.
- Role Play.

Tips for Using Digital Media

- Don't forget that every type of media comes with a "stop" button.
- Leave the lights on to reinforce the fact that media is not passive entertainment.
- Try eliminating either the sound or the picture. Taking sound out allows you to provide your own narration that is tailored to your students' needs. Taking the picture away (turn down the brightness) encourages students to concentrate on the message.

Source: http://teachers.teachingsexualhealth.ca/teaching-tools/instructional-methods

Value Statements

I am conscious of my own sexual attitudes and beliefs when discussing sexual health with my students.

I am uncomfortable raising certain sexuality topics with students.

I do not make assumptions regarding the sexual orientation or gender identity of the students or the people that I work with.

Having sex before marriage/life time commitment is wrong.

It is important for students to know how to use birth control and practice safer sex (use condoms).

It is important to be in love with your partner before you have sex with them.

There is too much pressure for teens to be sexually active.

Most teens would be better off waiting until they are older before being sexually active.

It's ok for a pregnant teen to choose to have an abortion, if that's what she decides is best for her.

Abstinence is the best choice for teenagers.

Having casual sex with multiple partners is acceptable as long as partners practice safer sex.

I don't think gays or lesbians should be allowed to adopt children.

A woman who dresses in sexy clothes is asking for trouble.