

# The Ontario Sexual Health Education Update: Perspectives from the Toronto Teen Survey (TTS) Youth

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## **Abstract**

Sexual health education in schools is a controversial topic. In 2015 an updated version of the sex education program was introduced to schools in the Province of Ontario, Canada. The curriculum received strong criticism from some parents and lobby groups. Similar objections led to the Ontario Liberal government withdrawing the previous sex education program update in 2010. Public debates about the appropriateness of the new curriculum are primarily concerned with the extent to which parents were consulted. Absent from these discussions are the opinions of the curriculum's target group: students. What do young people have to say about their sexual health education, and how can this information be used to provide more effective programs in schools? In this article we draw on the findings of the Toronto Teen Survey (TTS) ( $N = 1,216$ ) to discuss youth responses to questions about their experience with sexual health education and the relevance of this information for school-based sexual health education (SBSE). Considering that TTS youth identified schools as their primary source of sexual health education, the survey findings have value for SBSE. In discussing the TTS data in the context of the updated Ontario sexual health curriculum, we provide a youth perspective on the revised sexual health education program that was implemented in the fall of 2015.

*Keywords:* sexual health education, schools, youth, Canada

## **Résumé**

L'éducation sexuelle dans les écoles est un sujet controversé. En 2015, une version mise à jour du programme d'éducation sexuelle a été introduite pour les écoles de la province de l'Ontario, Canada. Le programme a reçu de fortes critiques de certains parents et des groupes de pression. Des objections similaires menées au gouvernement libéral de l'Ontario de retirer la mise à jour précédente en 2010. Les débats publics sur la pertinence du nouveau programme sont principalement concernés par la mesure dans laquelle les parents ont été consultés. Absent de ces discussions sont les opinions du groupe cible du programme: les étudiants. Qu'est-ce que les jeunes ont à dire au sujet de leur éducation à la santé sexuelle et la façon dont ces informations peuvent être utilisées pour fournir des programmes plus efficaces dans les écoles? Dans cet article, nous nous appuyons sur

les conclusions de la Toronto Teen Survey (TTS) (N = 1,216) pour discuter les réponses des jeunes aux questions sur leur expérience de l'enseignement de la santé sexuelle et la pertinence de cette information pour l'éducation sur la santé sexuelle en milieu scolaire (SBSE). Considérant que la jeunesse TTS a identifié les écoles comme leur principale source d'éducation à la santé sexuelle, les résultats de l'enquête ont une valeur pour SBSE. En examinant les données TTS dans le cadre du programme de santé sexuelle mis à jour en Ontario, nous offrons une perspective des jeunes sur le programme d'éducation à la santé sexuelle révisé qui a été mis en œuvre à l'automne 2015.

*Mots-clés* : éducation à la santé sexuelle, écoles, jeunesse, Canada

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## Introduction

Sexual health education in schools is a controversial topic (Garcia, 2015; Shipley, 2014). After decades of debate, there is still little consensus about the content of school-based programs (Iyer & Aggleton, 2015), even when public opinion polls show that the majority support teaching sex education in schools (Shipley, 2014). The introduction of an updated version of the sex education program for Ontario schools in Canada has received strong criticism from some parents and lobby groups. Similar objections led to the Ontario Liberal government withdrawing the previous update to the sexual education program in 2010 (McKay, Byers, Voyer, Humphreys, & Markham, 2014; Cohn, 2015). Despite protests, the current Ontario Liberal government implemented the revised curriculum in the fall of 2015, the first update since 1998 (Ferguson & Rushowy, 2015). It is noteworthy that debates about the appropriateness of the new curriculum are primarily concerned with the extent to which parents were consulted. Absent from these discussions are opinions of the curriculum's target group: students. What do young people have to say about their school-based sexual health education (SBSE) and how can this information be used to provide more effective student programming? In this article, we draw on the findings of the Toronto Teen Survey (TTS) to discuss youth responses to questions about their experiences with sexual health education and the relevance of this information for SBSE.

The TTS was conducted with 1,216 youth in Toronto, the largest city in the Province of Ontario, between 2006 and 2007. The project emerged from a goal in Planned Parenthood Toronto's (PPT) strategic plan to increase positive sexual health outcomes for youth and to decrease the barriers youth face as a result of sexual health programs and services. PPT is a community health centre that offers a variety of clinical and health promotion services in the Toronto area. The organization initiated the project in response to requests from partner organizations for assistance in developing effective sexual health services for diverse youth populations in Toronto. A key goal of the study was to ascertain what youth want and need in terms of sexual health education (Flicker et al., 2009). Because the Ontario curriculum has not been revised since 1998, this is the first opportunity to consider the TTS findings in the context of changes to the province's school program.

## **Background**

Studies conducted since the implementation of the 1998 Ontario curriculum have shown a significant gap in the sexual health knowledge of youth (Boyce, Doherty, Fortin, & MacKinnon, 2003; Kumar et al., 2013), particularly teenagers under 16 (Byers, Cohen, Sears, & Weaver, 2003; Flicker et al., 2009). Teens' lack of knowledge about STIs and their consequences (Frappier et al., 2008) may be the cause of the increasing prevalence of STIs (Canadian Federation for Sexual Health, 2007; Cohn 2015; Kumar et al., 2013; SIECCAN, 2009). Although higher STI rates are fostering a potential for increased HIV infection among youth, a national study of students found their knowledge about the disease had declined since 1989 (Boyce et al., 2003). Youth were more likely to believe there is a cure for AIDS and fewer knew about blood tests for HIV (Boyce et al., 2003). More recent studies found that youth have a poor understanding of some of the risk factors for HIV transmission (Kumar et al., 2013). Also concerning are findings that some youth believe the birth control pill protects against HIV (White, Kelly, Oliver, & Brotman, 2007), their knowledge about emergency contraception is often inaccurate (Kumar et al., 2013; Langille & Delaney, 2000), and there is confusion about how to use condoms effectively (Boyce et al., 2003). The Canadian Federation for Sexual Health (2007) claimed that youth "are not acquiring sufficient knowledge and skills to protect themselves and practice healthy sexuality," and are receiving "little information beyond the basic 'plumbing' of sexual health" (p. 6). This statement is echoed by youth who complain that their sexual health education focuses too much on biology and is seldom sex-positive or culturally relevant (Causarano, Pole, Flicker, & the Toronto Teen Survey Team, 2010; Larkin et al., 2004; Martinez & Phillips, 2008; Flicker et al., 2009). Young people consistently express dissatisfaction with the quality of their sex education, which they often describe as "too little too late" (Causarano et al., 2010; Mkumbo, 2014).

Systematic reviews of SBSE have shown their effects are limited (Kirby, Laris, & Rolleri, 2007; Underhill, Montgomery, & Operario, 2007). However, even the harshest critics believe that schools are the best place for sexual education to happen. These include educators (Byers et al., 2004; Fine & McLelland, 2006), sexual health policy makers (Health Canada, 2008), students (Foster, Byers, & Sears, 2011; Mkumbo, 2014; Newby, Wallace, Dunn, & Brown, 2012), and parents (Barr et al., 2014; Weaver, Byers, Dears, Cohen, & Randall, 2002). For example, in one survey, over 90% of students

agreed sexual health should be taught in schools (Byers et al., 2003a), and surveys of Canadian parents found that over 87% of parents also agreed (McKay et al., 2014). The issue, then, is not about schools as the places for sex education, but how and what is taught (Mitchell, Walsh, & Larkin, 2004).

Although the need for effective sexual health education is widely recognized, there is disagreement about the best approach for improvement, ranging from promoting an abstinence only curriculum to promoting a more comprehensive one that takes a positive view of sexuality and recognizes youth as legitimate sexual beings (Barr et al., 2014; Fields, 2008; Ketting & Winkelmann, 2013). International organizations such as the World Health Organization (WHO, 2006) are shifting from education focused on HIV, STI, and pregnancy prevention to a model that goes beyond the risks of sexuality. From this broader perspective, sexual health includes having body autonomy, experiencing sexual pleasure, being free from coercion, and having a safe environment to explore sexuality, in addition to being equipped with the necessary skills and resources for risk protection (Flicker et al., 2009). The TTS findings can be used to develop programs and policies that take up this more comprehensive model. They also offer a youth perspective on what is needed in curriculum content. This is an important contribution because, although we know what youth do not like about their sexual health education, there has been almost no information about what it is they *want* to know. Providing a space for youth to identify their sexual health education needs may result in more successful outcomes. This was a goal of the TTS study.

## **Method**

TTS adopted a community-based participatory research (CBPR) model, a collaborative approach that involves all partners in the research process (Flicker et al., 2008; Minkler & Wallerstein, 2003). Having identified the needs of the project, PPT reached out to academic researchers, community partners, and youth participants who came together as the TTS team.

## **The Youth Advisory Board**

A unique aspect of the TTS was the involvement of a Youth Advisory Committee (YAC) in all stages of the project. Twelve teens (aged 13–17 years) were recruited for the YAC from PPT partner agencies across Toronto. The teens were diverse in neighbourhood geography, racial and ethnic background, newcomer status, and socio-economic status. Their role was to assist in the development of the survey, provide advice on how to create a youth-friendly and accessible protocol, and to administer the survey in survey collection workshops across Toronto. YAC members were trained to carry out these tasks and, in the process, gained valuable skills in research, public speaking, group facilitation, peer education, and sexual health. Some members also assisted with an extensive community-based media advocacy and dissemination plan.

## **Survey Design and Implementation**

The overall goal of the survey was to assess the current state of sexual health services and information in the Greater Toronto Area in Ontario and identify what would work best for diverse youth communities. Survey questions asked youth about sexual services available to them, the accessibility of those services, where they got their sexual health information, and what kind of information they needed. Questions related to sexual health education included a list of sexual health topics (birth control, sexually transmitted infections, HIV/AIDS, healthy relationships, sexual pleasure, sexual violence, and sexual orientation) and asked youth to identify which topics they had learned about and which topics they would like to know more about. They were also asked where they got their sexual health education and what information was most important to them.

Following ethical approval (Flicker & Guta, 2008), the YAC conducted 90 workshops in community-based settings, collecting 1,216 surveys from a diverse cross-section of youth. Adolescents between 13 and 17 years old were the target group, but members of the workshop older than 17 were allowed to participate. The YAC visited afterschool drop in programs, shelters, summer camps, community centres, group homes, and other spaces where youth congregate. After the survey was completed, the YAC facilitated a question and answer session with the group on topics related to healthy sexuality and distributed information on local community resources (Flicker et al., 2009; Flicker et al., 2010). A total of 1,014 questions were submitted in the 90 workshops. A qualitative analysis of

questions gathered in the question and answer period has been presented elsewhere (Larkin et al., 2009).

## **Participant Characteristics**

TTS participants are one of the largest and most diverse samples in Canadian studies on youth sexual health issues. Of the total sample, 85% self-identified as racialized youth, 33% were born outside of Canada, 17% reported a physical or cognitive disability or addiction, and 7% identified their sexual orientation as lesbian, gay, bisexual, two-spirit, pansexual, or “questioning.” Participants ranged in age from 13 to 18+; a high representation of the sample lived in underserved neighbourhoods. Of the total participants, 54% identified as female, 45% as male, and 1% as transgender.

## **Data Analysis**

Survey data were analyzed using SPSS software. The majority of analysis was an examination of percentages since descriptive statistics were considered to be most useful for community organizations to assess their own sexual health programs and services. The descriptive statistics are the basis of this article. In the following section we present analyses of participants’ responses to survey questions that asked about their experience with sexual health education and then discuss the implications for SBSE through a comparison of the 1998 Ontario sexual health education curriculum and the fall 2015 update. We also provide a brief overview of the relevant questions collected from students at the end of the survey workshops.

## **Results**

Participants were asked where they were getting sexual health education and were given the following options: elementary school, high school, youth groups, religious groups, and nowhere. The vast majority of youth checked off one or more of these options, with high school (62%) and elementary school (62%) being by far the most common option. At age 13, 24% of the TTS youth reported they had never received sex education, although 5% of the 13-year-olds had engaged in vaginal or anal sex. Newcomer youth



(living in Canada less than three years) had significantly lower rates of sexual health education than the general sample.

The survey respondents were provided with the list of sexual education topics (see above) and asked to answer the following questions: “What kinds of things have you learned about?” and “What would you like to know more about?” They were encouraged to select all options that applied to them. The top three sexual health topics youth reported learning about were HIV/AIDS (78%), STIs (71%), and pregnancy and birth control (66%), although more young women than young men had learned this information. This top three list held constant across groups when analyzed by the demographics of gender, race, sexuality, disability, religious affiliation, and newcomer status. Of the overall sample, 13% of young men and 8% of young women (10% of the total sample) reported they had not received information about sexual health in any setting (see Table 1).

**Table 1.** Sexual health topics youth have learned about

HIV/AIDS	78%
STI	71%
Pregnancy & birth control	66%
Communicating about sex	61%
Healthy relationships	61%
Sexual violence/abuse	58%
Sexual orientation	51%
Sexual pleasure	42%
Nothing	10%

There is significant discrepancy between what youth are learning in sexual health education and what they want to know. Healthy relationships, HIV/AIDS, and sexual pleasure were the top three topics TTS youth wanted to learn about (see Table 2).

**Table 2.** Sexual health topics youth would like to learn more about

Healthy relationships	30%
HIV/AIDS	28%
Sexual pleasure	26%
Communicating about sex	24%
STI	23%
Pregnancy & birth control	22%
Sexual violence/abuse	21%
Sexual orientation	16%

Although HIV/AIDS was both one of their top three topics learned and a top three topic on their priority list, less than 30% of survey participants reported they had learned about healthy relationships, and no group included sexual pleasure in their top three topics learned. There were some small variances in the top three selections across groups. Newcomers and youth living with disabilities included pregnancy and birth control as a topic on their priority list. These were the groups more likely to report they had never received sexual health classes (18% and 9%, respectively). Lesbian, gay, bisexual, transgender, questioning, and two-spirit (LGBTQ2) youth included sexual orientation in their top three priority list, an important finding considering that sexually diverse youth reported higher risk behaviour and need tailored sexual health interventions (Pole, Flicker, & the Toronto Teen Survey Team, 2010). Common across all groups was a discrepancy in what youth had learned about sexual health and what they wanted to know (Causarano et al., 2010; Flicker et al., 2009).

The question and answer portion of the survey workshops was designed to give the youth an opportunity to get immediate sexual health information they wanted to know. Overall, questions about the relational and emotional aspects of sexuality (e.g., healthy relationships, communication about sex, and sexual pleasure) were more common than questions about STIs and pregnancy, a reflection of the learning priorities identified in the survey. “How do you recognize a healthy relationship?” one youth asks. Issues of trust were paramount: “What does ‘trust me, I’ll be safe’ mean when the guy doesn’t use protection?” Another asked about what it means to be loyal: “Is it bad to wonder what it’s like to be intimate with someone else when you’ve been with a person for a while?” Questions about sexual pleasure often focused on information not covered in the school

curriculum: “Where is the G spot?” or “What does an orgasm feel like?” Many youth also asked very basic questions about HIV/AIDS: “What is AIDS?” “How do people get AIDS?” This was especially surprising considering that HIV/AIDS was one of the top three topics learned across all demographic groups. In general, the questions covered a wide spectrum of sexual and reproductive topics that went beyond the content of the 1998 curriculum.

## **Discussion**

The TTS results are discussed in the context of the 1998 Ontario sexual health education curriculum that was in place until the fall of 2015. Responses from TTS participants offer a youth perspective on changes to the updated version. As debates about the curriculum will undoubtedly continue, the findings reported here provide a space for youth input into the public discussion and offer suggestions that could enhance the overhauled program.

Access to sexual health education is a major concern. Despite mandatory SBSE in Ontario, a significant number of TTS youth (10%) reported they had never received any sexual health education, and the numbers were higher for some populations. Sexual health programming for young students needs particular attention. Almost a quarter of TTS 13-year-olds had missed out on sexual health education, even though some in this age group were sexually active. The 1998 Ontario curriculum was missing a window of opportunity by not doing more to educate young students about safe sex practices before beginning their sexual lives. The updated program will help to address this gap by introducing topics on safe sex (e.g., pregnancy prevention) in the elementary school years (Ontario Ministry of Education and Training, 2015a).

Sexual health education is covered under the Ontario health and physical education curriculum. In the 1998 version, education on puberty and reproduction begins in Grades 5 and 6; matters related to sexuality are first mentioned in Grade 7 (Ontario Ministry of Education and Training, 1999a). Normally, health education is limited to one hour per week with sexuality being one item in a long list of topics teachers are expected to cover. The Ontario Secondary School Diploma requires only one compulsory credit in health and physical education, which means students can graduate from high school with as little as three hours of sexual health education (Martinez & Phillips, 2008). Schools

may be the most common place for youth to receive sexual health education, but the instruction they are getting is minimal. Although the updated curriculum provides a more comprehensive approach to sexual health education, the high school program will still be taught as part of a health and physical education curriculum that won't reach all secondary students (Leslie, 2014; Ontario Ministry of Education and Training, 2015b).

With no compulsory sexual health education past Grade 9, many high school students may still be on their own in obtaining sexual health information at a time when they are becoming sexually active. This spotty delivery of SBSE will continue to fall short of meeting the accessibility requirements of the *Canadian Guidelines for Sexual Health Education* and the overall goal that all students will get the information they need to live healthy sex lives. In the updated curriculum this problem will be offset, somewhat, by the introduction of a wider range of topics from Grades 1 to 8 in a curriculum that is compulsory for all elementary students (Ontario Ministry of Education and Training, 2015a).

TTS results show some disconnect between what youth are learning and what they want to know. An exception is HIV/AIDS, which TTS youth reported both as a top three topic they learned about and one of the priority topics they wanted to learn. The meaning of this finding is unclear: youth may want to know more about HIV/AIDS than their sexual health education provides, or there could be a mismatch between the information they are getting and what they want to know. In any case, considering that Canadian students' knowledge about HIV/AIDS has declined over time and is often inaccurate (Boyce et al., 2003; Kumar et al., 2013), the apparent attention given to this topic is encouraging. What remains unknown is the quality of the information since students' understanding of HIV/AIDS is often based on erroneous facts and misconceptions (Boyce et al., 2003; Kumar et al., 2013).

The major discrepancy in topics TTS youth have learned about and what they want to know is related to positive sexuality, most particularly, healthy relationships and sexual pleasure. In 1998, education about the negative consequences of sexual decisions prevailed with topics such as disease, pregnancy, and risk prevention dominating the curriculum. Nowhere was sexual pleasure mentioned as an expectation of healthy sexuality, a serious omission according to TTS youth who listed sexual pleasure as a topic they most wanted to learn about. Although the national guidelines stress the importance of addressing "the positive, life-enhancing, and rewarding aspects of human sexuality while also seeking to prevent and reduce negative sexual health outcomes" (Health Canada,

2008, p. 11), this balance is not evident in the former Ontario program. When a risk paradigm frames sexual health education, the negative consequences of sexual behaviour are exaggerated (Fields, 2008; Drazenovich, 2015; Iyer & Aggleton, 2015; Martinez & Philipps, 2008).

Lost in a risk-based approach to sexuality are issues of pleasure and desire, something Michelle Fine (1988) first wrote about 20 years ago. Almost two decades later, Fine and McClelland (2006) argue that risk discourses continue to dominate sexual health education while the pleasures of sexuality are obscured or considered vices to be controlled. From this perspective, the positive approach to sexuality highlighted in the national guidelines (Health Canada, 2008) is unlikely to be achieved. When students complain that their sex education is “learning about birth control...and the ‘terrible’ things that happen if you have sex,” and that “nothing is pro-sex” (Mangiardi, 2009), the lessons are not about healthy sexuality. The 1998 curriculum included healthy relationships as early as Grade 4, but the topic of sexual intimacy was not introduced until Grade 10 (when health and physical education is not compulsory) and focused on the risks of sexual intimacy, such as STIs and HIV/AIDS (Ontario Ministry of Health, 1999b). In the updated curriculum, students begin to learn about healthy relationships in Grade 3 and by Grade 8 discussions of relationships evolve to include sexual intimacy (Ontario Ministry of Health, 2015a). Grade 7 students will be asked to consider desire and pleasure in their decisions related to sexual health (Ontario Ministry of Health, 2015a). Although attention to sexual pleasure in the new curriculum may not be as bold as Fine (1988) and the TTS youth would hope, it is definitely a step forward. With the revised program, students will be more likely to have an expectation that their sexual lives will be positive and fulfilling.

In the TTS survey, LGBTQ2 youth were the only group to include sexual orientation on the priority list of topics they wanted to learn. In sharp contrast to this finding, the former Ontario curriculum did not include sexual diversity as a topic at *any* level of sexual health education, so the needs of LGBTQ2 students were not addressed (Ontario Ministry of Health, 1999a, 1999b, 1999c). The absence of sexual diversity in SBSE has been linked to homophobic bullying that can lead to higher absenteeism and dropout rates for queer youth (Maticka-Tyndale, 2008; McCarty-Caplan, 2013; Taylor & Peter, 2011). Moreover, a heterosexist bias in sexual health education results in sexually diverse youth not learning critical information about their sexual health (Bay-Cheng, 2003). The revised curriculum takes a significant step in becoming more inclusive of diverse sexual

identities: Grade 3 students will learn about same-sex relationships; gender expression will be introduced in Grade 6; Grade 8 students will learn about transgender, transsexual, intersex, and two-spirit identifications; and the Grade 9 curriculum will include gender identity, sexual orientation, and resources available for support (Ferguson & Rushowy, 2015; Leslie, 2014; Ontario Ministry of Health, 2015a). Incorporating sexual diversity into early years of the curriculum can help meet the sexual health needs of sexually diverse youth, eliminate the homophobic climate they face in many schools (Maticka-Tyndale, 2008), and increase academic performance (MacCarty-Caplan, 2013). This also brings the curriculum in line with legislative changes that have legalized same-sex marriage (Government of Canada, 2005) and included sexual orientation as a protected right under the Canadian Charter of Rights and Freedoms (Government of Canada, 2013).

The 1998 sexual education curriculum was implemented before widespread use of social media and smartphones. A crucial update in the revised version is topics relevant to sexuality in an increasingly technology-driven world. In the new curriculum, discussions of online safety begin in Grade 4 and students learn about safety and sexting in Grades 7 and 8 (Ferguson & Rushowy, 2015). These are important lessons considering that between 15 and 28% of teenagers have reported sending an explicit image or text message (Leslie, 2014). Students also learn about cyberbullying, a form of harassment not covered in the former curriculum. The updated program provides sexual health education more relevant to today's technically oriented students who develop many of their relationships online.

## **Strengths and Limitations**

Major strengths of the TTS include the large sample size, the diverse cross-section of youth participants, and our community-based participatory approach: the study was initiated by PPT Toronto and involved PPT partner organizations in data collection and knowledge dissemination. An additional strength of this study is the meaningful involvement of youth as researchers. We fostered youth research capacity by involving the YAC in all components of the research from survey design to implementation and the dissemination of results. The peer to peer survey implementation model helped create a safe and welcoming environment for youth to ask questions.

The TTS data were not collected in schools so there may be concern in generalizing the findings to a SBSE curriculum, although the majority of TTS youth listed schools as their primary source of sexual health education. Even so, with a starting age of 13 for our survey sample, the TTS data are limited in assessing the earlier years of the new health curriculum. Since much of the controversy over the new curriculum is focused on children, strategies should be developed to bring the voices of younger students into the debate.

Considering that our survey was conducted in Toronto, the largest city in Ontario, we cannot claim the data are representative across geographic settings, despite similar findings in other Canadian studies (Byers et al., 2003a; Byers et al., 2003b). Additionally, the new curriculum gives considerable attention to online issues that have probably become far more pressing since our survey. However, despite the time lag between the new curriculum and the TTS, no other study since has collected such extensive data on diverse students' opinions of their sexual health education.

## **Conclusions and Recommendations**

The TTS results show that youth can be a valuable resource in shaping a curriculum that meets their own needs. This finding is supported in other research conducted with students (Byers et al., 2003a; Byers et al., 2003b; MacDonald et al., 2011; Mkumbo, 2014; Newby et al., 2012). In a study with high school youth, Mangiardi (2009) asked students about sex education at their school and what they would change if they could. Similar to TTS findings, students complained the curriculum was too focused on the negative outcomes of sexuality to the exclusion of sexual pleasure. Students were also critical of the “textbook” approach to sexual health teaching that was focused on the terminology and technicalities of sex. Their suggestion for improving their sexual health education: ask students. Following up on this suggestion, Mangiardi collected information from students that could be used to transform the school's sexual education program. This practice could help ensure that the updated curriculum will be tailored to the various racial, cultural, and sexual identities of students. Providing a mechanism for student feedback on their sexual health education and an opportunity for them to identify new and emerging needs would enhance the power of the updated curriculum to be inclusive of the wide

range of students it is meant to serve (Byers, Sears, & Foster, 2013). Building sexual health education into ESL classes and other newcomer programs is particularly important as the TTS results show that newcomers are more likely to miss sexual health education offered in regular classrooms (Flicker et al., 2009).

The quality of sexual health education is determined not only by the content but also by the way it is taught. As such, the success of the revised curriculum will be dependent on the effectiveness of teachers who implement it (Byers et al., 2004; SIEC-CAN, 2009). But as Martinez and Phillips (2008) point out, teachers are under significant constraints due to the limited time allotted for sexual health education, and most are expected to deliver the program with minimal or no pre-service training (Garcia, 2015; Maticka-Tyndale, 2008). In a study conducted with teachers in the Province of New Brunswick, Cohen, Byers, and Sears (2012) found that only about one-third of participants had received any training to teach sexual health. Although the *Canadian Guidelines for Sexual Health Education* state that “sexual health education should be presented by confident, well-trained, knowledgeable, and non-judgmental individuals who receive strong administrative support from their agency or organization” (Health Canada, 2008, p. 18), this is not the context in which most teachers do sexual health education. For the revised Ontario curriculum to be effective, support for teachers will need to be a priority, particularly when research shows that teachers are uncomfortable or feel ill-equipped to deal with some topics added to the update, such as sexual pleasure and sexual orientation (Cohen, Byers, & Sears, 2012; Byers, Cohen, Sears, & Weaver, 2004). One way to address this situation is to draw on the expertise of sexual health service providers through partnerships with schools (Baraitser & Wood, 2001; MacDonald et al., 2011). As service providers serve youth in the local community, collaborations may allow for a pooling of human and economic resources, which are scarce commodities in the current fiscal climate. For example, Toronto Public Health (TPH) staff offer capacity-building support to help teachers develop comfort in teaching the updated sexual health curriculum, and they also give sexual health clinic tours to school groups. Other services sexual health providers may offer include in-class education to students, virtual or on-site tours of sexual health clinics, and information on youth services (Flicker et al., 2009). These activities provide training for teachers as well as an important resource contact. At the same time, service providers benefit from a direct connection to the community of youth they are required to serve. Such collaborations could help change the startling TTS finding that 83%



of TTS youth had never visited a clinic or doctor for any sexual health reason (Flicker et al., 2009).

Despite the protests of a vocal minority, the Ontario Liberal government insists the updated Ontario curriculum is here to stay (McConnell, 2015). The TTS findings add youth to the support the updated curriculum has received from the majority of parents, educators, and other stakeholders. Crucial to the success of the revised curriculum will be support for teachers who deliver the program and a mechanism for ensuring the content and approach meet the needs of diverse Ontario student populations.

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