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CANADIAN GUIDELINES FOR SEXUAL HEALTH EDUCATION

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INTRODUCTION

BRIEF HISTORY OF THE *CANADIAN GUIDELINES FOR SEXUAL HEALTH EDUCATION*

The *Canadian Guidelines for Sexual Health Education* were first published in 1994 by Health Canada with funding provided by the Government of Canada's Family Violence Initiative. In 1991, prior to the creation of the first edition of the *Guidelines*, the Expert Interdisciplinary Advisory Committee on Sexually Transmitted Diseases in Children and Youth (EIAC-STD) of Health Canada recommended that programs for sexual and reproductive health should be established and based upon national guidelines for sexual health education. A similar recommendation for the development of national guidelines was made by the Federal/Provincial/Territorial Working Group on Adolescent Reproductive Health.

A central theme that emerged from both the committee and the working group was the need for comprehensive and accessible sexual health education to empower individuals of all ages to deal with the range of sexual health issues they encounter at different stages in the lifespan.

The Committee and working group recognized that educational programs promoting "healthy sexuality" and "sexual health" were emerging as an important component of health promotion education in schools, public health units, and other community settings. They noted, as well, that no clear statement of principles of sexual health education existed to guide and unify those working in this area.[1]

The content of the first edition of the *Canadian Guidelines for Sexual Health Education* was developed by a national working group comprised of 13 individuals with expertise in various aspects of sexual health, including education, public health, women's issues, health promotion, medicine, nursing, social work, and psychology, as well as two working group co-chairs (Michael Barrett from the Sex Information & Education Council of Canada [SIECCAN] and William Fisher from the University of Western Ontario). SIECCAN provided research and administrative coordination.

In 2003, the *Canadian Guidelines for Sexual Health Education* were revised and published by Health Canada. Research and administrative coordination were provided by the Community Acquired Infections Division of Health Canada and SIECCAN, with input from members of a working group of reviewers and focus group participants with expertise in sexual health promotion and education.

In 2008, the *Canadian Guidelines for Sexual Health Education* were revised a second time and published by the Public Health Agency of Canada. Revisions for this edition resulted from review and input from experts in the fields of sexual health education and promotion including the Sexual Health Working Group of the Joint Consortium for School Health, the Sexual Health and Sexually Transmitted Infections (STI) Section, Centre for Communicable Diseases and Infection Control of the Public Health Agency of Canada, and SIECCAN.

The 2003 and 2008 revisions to the *Canadian Guidelines for Sexual Health Education* were primarily in the form of streamlining, including reference and language updating, as well as an expansion of the Research section. The overall objectives, structure, and content of the *Guidelines* remained consistent throughout the three editions.

THE NEW 2019 EDITION OF THE *CANADIAN GUIDELINES FOR SEXUAL HEALTH EDUCATION*

DEVELOPMENT OF THE 2019 *CANADIAN GUIDELINES FOR SEXUAL HEALTH EDUCATION*

In 2017, SIECCAN was funded through the Public Health Agency of Canada's (PHAC) HIV and Hepatitis C Community Action Fund to produce a series of resources to increase the capacity of the education sector to provide effective sexual health education. This included the creation of an expanded and revised edition of the 2008 *Canadian Guidelines for Sexual Health Education*.

The 2019 *Guidelines* were developed using information from three sources: 1) the results from an online consultation, 2) the contributions and feedback from both a working group and a reviewer group, and 3) updated, relevant scientific research on sexual health and sexual health education.

In the Fall of 2017, SIECCAN conducted a quantitative and qualitative online consultation. Over 200 people from across Canada involved in sexual health education, promotion, and research participated in the consultation.

The consultation consisted of the following four parts:	
1.	Evaluation of each section of the 2008 *Guidelines*.
2.	Suggestions for revising the structure and content of the *Guidelines*.
3.	Identification of settings and populations to be addressed.
4.	Specification of grade and age benchmarks for the provision of information and skills to prevent STIs.

The consultation respondents provided a wide-range of constructive suggestions for increasing the effectiveness of the *Guidelines*. Subsequently, a Working Group and a Reviewer Group, both consisting of individuals from across Canada with an extensive range of expertise relevant to sexual health education, were established to advise SIECCAN on the development of the revised *Guidelines*. The Working Group members participated in a two-day meeting to make recommendations for the revised content. The members of the Working Group and Reviewer Group provided multiple rounds of feedback on draft sections of the *Guidelines* written by SIECCAN.

GOALS OF THE 2019 *GUIDELINES*

The general goals of the *Canadian Guidelines for Sexual Health Education* have remained consistent across all three previous editions. These goals are indicative of the original rationale and intent of the *Guidelines* and also reflect how the *Guidelines* have been utilized by governments, administrators, program planners, and educators over the course of the three previous editions.

The general goals of the 2019 *Guidelines* are similar to previous editions:	
1.	Guide educators and others in the development, implementation, and evaluation of comprehensive sexual health education activities to enhance sexual health and well-being and to prevent outcomes that can have a negative impact on sexual health and well-being.

2.	Provide a framework for evaluating new and existing sexual health education activities/programs, policies, and related services available to people in Canada.
3.	Offer educators, program planners, and policy makers a clear understanding of the goals, key components, and settings for delivery of comprehensive sexual health education.

When creating the new edition of the *Guidelines*, one of SIECCAN's objectives was to provide a level of continuity and consistency with the previous editions. All editions of the *Guidelines* have been purposely structured to provide guidance for the provision of sexual health education that remains relevant and applicable over time. However, it has been over 20 years since the first edition of the *Guidelines* was issued and over 10 years since the last revision was published in 2008.

Therefore, it is important for the new edition of the *Guidelines* to accurately reflect key changes in Canadian society that are relevant to sexual health and well-being, to recognize and address the need for greater inclusivity in sexual health education, and to incorporate emerging priorities for the field.

Some changes include:

Changing demographics:
Canada's demographics continue to evolve and change (e.g., the aging of the population and in terms of cultural and ethnic diversity). Sexual health educators (and others) should be aware and consider the changing needs of people in Canada when creating and providing sexual health education programs and policies.

The Process of Truth and Reconciliation:
The process of truth and reconciliation between Indigenous people and non-Indigenous people is ongoing and multifaceted. Awareness and constructive involvement of the field of sexual health education is critical. It is important for sexual health educators to be aware of the intergenerational impact of colonialism on the sexual health and well-being of Indigenous people and to incorporate this awareness into sexual health education.

Technology:
The widespread adoption of technology (e.g., the internet, smartphones), as well as the popularity of social networking sites (e.g., Facebook, Instagram, Snapchat), has transformed how people learn and communicate about sexuality. These developments have profound implications for the content and delivery of effective sexual health education.

LGBTQI2SNA+ and other emerging identities:
The need to provide relevant and effective sexual health education tailored to the learning needs of lesbian, gay, bisexual, transgender, queer, intersex, Two-Spirit, nonbinary, and asexual youth must be a priority for sexual health education. All youth need to become informed through the sexual health education they receive about the diversity of sexual and gender expression.

Consent related to sexual activity and gender-based violence:
Understanding what constitutes consent, as well as the autonomy and ability to give, withhold, or withdraw consent, is a central component of sexual health. Integrating the concept of consent must be a priority for sexual health education. Addressing the topic of consent within sexual health education requires a necessary discussion of sexual and gender-based violence and our individual and community responsibility to prevent it.

IMPORTANT NEW CONTENT

CORE PRINCIPLES OF COMPREHENSIVE SEXUAL HEALTH EDUCATION

The 2008 *Canadian Guidelines for Sexual Health Education* included five guiding principles for sexual health education: 1) Accessible sexual health education for all Canadians; 2) Comprehensiveness of sexual health education; 3) Effectiveness of educational approaches and methods; 4) Training and administrative support; and 5) Program planning, evaluation, updating and social development.

The 2019 *Guidelines* are based on nine core principles that define and inform comprehensive sexual health education. These core principles are presented at the beginning of the document to emphasize their importance as the foundation for comprehensive sexual health education in Canada.

EDUCATORS AND SETTINGS FOR THE PROVISION OF COMPREHENSIVE SEXUAL HEALTH EDUCATION

Although previous editions of the *Canadian Guidelines for Sexual Health Education* were intended for application in a wide range of settings and populations, the primary focus was school-based sexual health education for youth. Brief mentions of other settings were interspersed within more general discussions of the field.

The current version of the *Guidelines* has adopted a broad approach that makes specific reference to the wide-range of settings in Canada that are appropriate for the delivery of sexual health education. The 2019 *Guidelines* include a new section that identifies key educators and settings that have important roles in ensuring equitable access to comprehensive sexual health education for all people in Canada.

BENCHMARKS FOR SEXUALLY TRANSMITTED INFECTION (STI) PREVENTION AND LINKING TO STI TESTING SERVICES IN SCHOOLS

This new section of the *Guidelines* provides specific benchmarks for integrating STI prevention efforts within a comprehensive sexual health education curriculum from Kindergarten to Grade 12.

STRUCTURE OF THE 2019 *CANADIAN GUIDELINES FOR SEXUAL HEALTH EDUCATION*

The 2019 *Guidelines* consist of seven sections. The first highlights the importance of comprehensive sexual health education to people in Canada. This is followed by a section outlining the core principles that should inform sexual health education programs and curriculums. Section three identifies the multiple factors that can influence sexual health and well-being and that should be accounted for in sexual health education. Sections four and five identify the goals and key components of comprehensive sexual health education and describe how to use theory to develop, implement, and evaluate sexual health education programs and curriculums. The sixth section describes specific settings and educators that are central to the delivery of comprehensive sexual health education. The final section outlines specific benchmarks for the provision of STI prevention information and the linking of youth to STI testing within school-based curricula.

Each section begins with a brief summary, followed by specific Guidelines statements. These Guidelines statements form the foundation of the document and should be referred to when planning, implementing, and delivering comprehensive sexual health education. Detailed information and

relevant research in each section provides context for effective and inclusive sexual health education programs and policies in Canada.

The Guidelines statements are not intended to provide specific teaching strategies or to constitute a comprehensive sexual health education curriculum.

The 2019 Canadian Guidelines for Sexual Health Education provides a framework for the development and evaluation of comprehensive evidence-based sexual health education in Canada.

REFERENCES

1 Health Canada. Canadian Guidelines for Sexual Health Education. Ottawa, ON. Health Programs and Services Branch, Health Canada: 1994; p. 4

THE IMPORTANCE OF COMPREHENSIVE SEXUAL HEALTH EDUCATION

Sexual health is a key component of overall health, well-being, and quality of life. It is a major determining factor in the well-being of individuals, partners, families, and communities. Furthermore, the sexual health of people in Canada has important social and economic implications for the country. Therefore, the development and implementation of comprehensive sexual health education aimed at enhancing sexual health and well-being and preventing outcomes that negatively impact sexual health should be a public policy priority.

The World Health Organization (WHO) defines health as 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.'[1] The WHO definition is consistent with a biopsychosocial approach that recognizes that health consists of biological, psychological, and social components and the interaction of these components contributes to overall health and well-being. A biopsychosocial approach to health differs from more traditional medical models that have been primarily concerned with the diagnosis and treatment of physiological health problems. A biopsychosocial approach is more holistic (i.e., it addresses the entire person) and suggests a positive component of health in the form of well-being.

Similarly, the WHO takes a holistic approach to defining sexuality and sexual health:

Sexuality is a 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 relationships. While sexuality can include all of 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.[2]

Sexual health is a 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.[2]

The WHO definitions of health, sexuality, and sexual health are supported by research indicating that sexual health and well-being are important contributing factors to quality of life and overall health and well-being.[3,4,5,6,7,8,9] Individuals are well aware of these connections: Surveys of young adult and midlife Canadians indicate that about 85% agree with the statement "I feel my sexual health contributes to my overall health and well-being."[10]

The key role of sexual health and well-being in contributing to people's overall health and well-being clearly suggests that sexual health education has an important function in Canadian society. Comprehensive sexual health education broadly aimed at equipping people throughout the lifespan to enhance sexual health and well-being (e.g., having respectful and satisfying interpersonal relationships, increased self-acceptance, increased capacity to access sexual and reproductive health services) and to prevent outcomes that can have a negative impact on sexual health and well-being (e.g., acquisition and transmission of sexually transmitted infections [STIs], unintended pregnancies, sexual coercion/trauma/abuse/harassment, relationship problems) should be a public policy priority.

THE ENHANCEMENT OF SEXUAL HEALTH AND WELL-BEING

Sexual health education has often focused primarily, if not exclusively, on the biological aspects of sexual health (e.g., reproduction) and the prevention of negative outcomes (e.g., STI).

Although the prevention of negative outcomes is a valid and important objective, the enhancement of sexual health and well-being is of equal importance.

Sexual satisfaction in romantic partnerships is positively linked to physical health, overall life satisfaction, and well-being.[3,11,12,13] For lesbian, gay, bisexual, and transgender individuals, feeling positively about one's sexual orientation or gender identity is also linked to greater health and well-being.[14,15,16] It is important that sexual health education effectively equips people with the information and skills to enhance their sexual health and well-being by addressing the individual, interpersonal, and positive aspects of human sexuality.

Youth in Canada also identify the enhancement of sexual health and well-being as an important component of their sexual health education. That is, youth report a desire to learn about content related to sexual health enhancement (e.g., healthy relationships, communication skills, pleasure) and rate these topics as valuable.[17,18,19,20,21] However, content related to enhancing sexual health and well-being often receives less emphasis; youth typically report that the biological aspects of sexuality (e.g., reproduction, puberty) and STI prevention and unintended pregnancy receive the most emphasis in their sexual health education.[17,18,19,20,21]

There is evidence that comprehensive sexual health education can be effective in enhancing students' sexual health and well-being. Sexual health education that addresses the individual and interpersonal aspects of sexuality has been associated with improvements in students' communication skills and their ability to access sexual and reproductive health services.[22] By incorporating the enhancement of sexual health and well-being as a primary objective, comprehensive sexual health education becomes more relevant to people's needs and can therefore make an important contribution to the broader health and well-being of people in Canada.

ENHANCING REPRODUCTIVE HEALTH

The Government of Canada is committed to advancing sexual and reproductive health rights.[23] Reproductive health includes the ability of individuals to decide whether or not to have children; to choose the number, spacing, and timing of children; and to parent their children in a safe and supported environment (i.e., without threat of violence). According to research published in 2015, there are over 180,700 unintended pregnancies in Canada each year.[24] Although many unintended pregnancies are not unwanted and result in positive experiences for parents and their children, the number of unintended pregnancies suggests that sexual health education can play an important role in equipping individuals to make autonomous and informed reproductive choices.

Comprehensive sexual health education can also help raise awareness of the social, historical, and systemic factors that affect reproductive health. Reproductive choices and access to reproductive healthcare services and supports can be impacted by marginalization and oppression based on race, gender, class, sexuality, and ability.[25]

Indigenous women, women of colour, individuals with disabilities, and LGBTQI2SNA+ people have historically had their sexual health disproportionality impacted by laws and policies that limited their sexual and reproductive rights (e.g., forced sterilization, systemic removal of children, lack of access to reproductive technology).

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

Comprehensive sexual health education can contribute to the enhancement of reproductive health by:	
1.	Providing the information, motivation, and skills to use effective contraception.
2.	Equipping individuals to navigate and overcome systemic barriers to accessing contraception and reproductive health care (including abortion and midwifery services).
3.	Linking individuals to reproductive health services and supports.

Research indicates that educational interventions can be effective at increasing contraceptive use among sexually active youth.[26,27]

PREVENTION OF OUTCOMES THAT CAN NEGATIVELY IMPACT SEXUAL HEALTH AND WELL-BEING

SEXUALLY TRANSMITTED INFECTIONS

Sexually transmitted infections (STIs) are a significant public health concern in Canada.[28] According to the Public Health Agency of Canada, STIs "levy a significant physical, emotional, social, and economic cost to individuals, communities, and society."[29]

Bacterial (e.g., chlamydia, gonorrhea, syphilis) and viral (e.g., Human papillomavirus [HPV] and herpes simplex virus [HSV]) STIs are common within the Canadian population[28,29,30,31] and a disproportionate number of cases of STI occur among youth.[26] In the period between 1996 to 2017, approximately 2300 new cases of HIV were documented each year (ranging from 2051-2712).[32] By the end of 2016, the estimated number of people living with HIV was 63,110 and it is estimated that 1 in 7 Canadians infected with HIV had not been diagnosed and were unaware of their infection.[33]

The health consequences of STIs include various cancers, chronic diseases, infertility, ectopic pregnancy, as well as fetal and neonatal complications. In addition, STIs result in a host of negative psychosocial outcomes including STI-related stigma.

The *Pan-Canadian Framework for Action: Reducing the Health Impact of Sexually Transmitted and Blood-Borne Infections in Canada by 2030* cites a lack of comprehensive sexual health education as a factor contributing to the high prevalence of STIs in Canada and identifies sexual health education as a critical component in reducing the number of new infections.[29] The Public Health Agency of Canada's *Population-Specific Status Report: HIV/AIDS and Other Sexually Transmitted and Blood Borne Infections Among Youth in Canada* identifies sexual health education as an essential tool in the prevention of HIV and other STIs among youth.[31]

It is critical that comprehensive sexual health education includes information and skills to equip individuals to reduce their risk for STIs and links people to STI testing provided in schools and other settings. There is ample evidence that STI prevention programming in educational settings are effective for

building communication and self-efficacy skills related to STI risk-reduction (e.g., using barriers).[34,35]

SEXUAL AND GENDER-BASED VIOLENCE AND DISCRIMINATION

Sexual and gender-based violence is a significant public health problem and human rights violation.[36] People of all genders and identities experience violence. However, in Canada, specific groups are disproportionately impacted by sexual and gender-based violence. These groups include women and girls, Indigenous people, LGBTQI2SNA+ individuals, people living in northern, rural, and remote communities, people with disabilities, individuals who are new to Canada, children and youth, and seniors.[37]

In 2014, there were approximately 636,000 self-reported incidents of sexual assault among people aged 15 and older in Canada.[38] Of these incidents, 87% were committed against women and 47% were committed against young women aged 15 to 24 years.[38] In 2017, police-reported rates of violence were higher for survivors who were young women and girls under the age of 24 years.[39] Young women and girls were more likely to experience sexual violence compared to boys and young men; rates were nearly 14 times higher for young women 18-24 years compared to young men of the same age. Gay, lesbian, and bisexual people are twice as likely to experience violence compared to heterosexual individuals.[40] In one national survey of Canadian high school students, 21% of LGBTQI2SNA+ individuals reported being physically assaulted or harassed because of their sexual orientation.[41] Transgender students reported higher levels of harassment and physical assault due to their gender expression when compared to other students with sexual minority identities and non-LGBTQI2SNA+ students.[41]

Comprehensive sexual health education can help reduce sexual and gender-based violence and discrimination in Canada in the following ways:	
1.	By promoting respect for human rights and gender equality.
2.	Teaching people the information and skills to ensure all partners feel safe and fully consent before and during sexual activity.
3.	By increasing people's awareness of the societal norms, attitudes, and practices which contribute to violence based on gender or sexual identity.

Sexual health education can be effective in addressing discriminatory attitudes towards LGBTQI2SNA+ individuals.[42] Sexual health education related to sexual and gender-based violence can improve gender-equitable attitudes and prevent physical, sexual, and emotional violence in relationships.[43]

ACCESS TO COMPREHENSIVE SEXUAL HEALTH EDUCATION FOR ALL PEOPLE IN CANADA: A PUBLIC POLICY PRIORITY

Comprehensive sexual health education has the demonstrated ability to contribute to the enhancement of sexual health and to reduce the incidence of outcomes that can have a negative impact on sexual health and well-being.[22,34,35,44]

As such, access to comprehensive sexual health education should be a basic right for all people in Canada and a public policy priority.

Access to comprehensive sexual health education also has significant economic implications. Sexually transmitted infections, unintended pregnancies, sexual and gender-based violence, and discrimination against LGBTQI2SNA+ individuals result in substantial economic costs to Canadian society in the form of higher health care expenses and other expenditures.[24,45,46,47,48,49,50,51,52] Comprehensive sexual health education can help to alleviate these economic costs by addressing factors that contribute to the negative outcomes that impact on the sexual health and well-being of individuals, families, and communities.

Providing access to comprehensive sexual health education for all people in Canada is a shared responsibility that requires the participation of families, communities, schools, and all levels of government (including the medical and legal systems). The *Canadian Guidelines for Sexual Health Education* are intended to provide guidance and support to individuals, organizations, and governments in the development and provision of high quality comprehensive sexual health education.

REFERENCES

1 WHO. Preamble to the constitution of the world health organization as adopted by the international health conference. New York; 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p.100) and entered into force on 7 April 1948.

2 WHO. Defining sexual health: Report of a technical consultation on sexual health. Geneva, Switzerland: World Health Organization: 2002.

3 Flynn KE, Lin L, Bruner DW, Cyranowski JM, Hahn EA, Jeffery DD, et al. Sexual satisfaction and the importance of sexual health to quality of life throughout the life course of US adults. The Journal of Sexual Medicine. 2016;13;11:1642-50.

4 Laumann EO, Paik A, Glasser DB, Kang J-H, Wang T, Levinson B, et al. A cross-national study of subjective sexual well-being among older women and men: Findings from the global study of sexual attitudes and behaviors. Archives of Sexual Behavior. 2006;35;2:143-59.

5 Laumann EO, Gagnon, J., Michael, R.T., & Michaels, S. The social organization of sexuality: Sexual practices in the United States. University of Chicago, Press. Chicago: 1994.

6 DeLamater J. Sexual expression in later life: A review and synthesis. Journal of Sex Research. 2012;49;2-3:125-41.

7 Davison SL, Bell RJ, LaChina M, Holden SL, Davis SR. The relationship between self-reported sexual satisfaction and general well-being in women. The Journal of Sexual Medicine. 2009;6;10:2690-7.

8 Rosen RC, Bachmann GA. Sexual well-being, happiness, and satisfaction, in women: The case for a new conceptual paradigm. Journal of Sex & Marital Therapy. 2008;34;4:291-7.

9 Stephenson KR, Meston CM. The conditional importance of sex: Exploring the association between sexual well-being and life satisfaction. Journal of Sex & Marital Therapy. 2015;41;1:25-38.

10 Trojan/SIECCAN Sexual Health Study (2013, n = 1500), Trojan/SIECCAN Sexual Health at Midlife Study (2016, N =2400). Data available on request. Sex Information and Education Council of Canada (SIECCAN). www.sieccan.org

11 Gustavson K, Røysamb E, Borren I, Torvik FA, Karevold E. Life satisfaction in close relationships: Findings from a longitudinal study. Journal of Happiness Studies. 2016;17;3:1293-311.

12 Heiman JR, Long JS, Smith SN, Fisher WA, Sand MS, Rosen RC. Sexual satisfaction and relationship happiness in midlife and older couples in five countries. Archives of Sexual Behavior. 2011;40;4:741-53.

13 Sánchez-Fuentes MdM, Santos-Iglesias P, Sierra JC. A systematic review of sexual satisfaction. International Journal of Clinical and Health Psychology. 2014;14: 67-75.

14 Petrocchi N, Pistella J, Salvati M, Carone N, Laghi F, Baiocco R. I embrace my LGB identity: Self-reassurance, social safeness, and the distinctive relevance of authenticity to well-being in Italian lesbians, gay men, and bisexual people. Sexuality Research and Social Policy. 2019: 1-12.

15 Riggle EDB, Whitman JS, Olson A, Rostosky SS, Strong S. The positive aspects of being a lesbian or gay man. Professional Psychology: Research and Practice. 2008;39;2: 210-217.

16 Johns MM, Beltran O, Armstrong HL, Jayne PE, Barrios LC. Protective factors among transgender and gender variant youth: A systematic review by socioecological level. The Journal of Primary Prevention. 2018;39;3: 263-301.

17 DiCenso A, Borthwick VW, Creatura C, Holmes JA, Kalagian WF, Partington BM. Completing the picture: Adolescents talk about what's missing in sexual health services. Canadian Journal of Public Health. 2001;92;1:35-8.

18 Byers ES, Sears HA, Voyer SD, Thurlow JL, Cohen JN, Weaver AD. An adolescent perspective on sexual health education at school and at home: I. High school students. The Canadian Journal of Human Sexuality. 2003;12;1):1-18.

19 Meaney GJ, Rye B, Wood E, Solovieva E. Satisfaction with school-based sexual health education in a sample of university students recently graduated from Ontario high schools. The Canadian Journal of Human Sexuality. 2009;18;3:107-26.

20 Causarano N, Pole JD, Flicker S. Exposure to and desire for sexual health education among urban youth: Associations with religion and other factors. The Canadian Journal of Human Sexuality. 2010;19(4):169-85.

21 Byers ES, Hamilton LD, Fisher B. Emerging adults' experiences of middle and high school sexual health education in New Brunswick, Nova Scotia, and Ontario. The Canadian Journal of Human Sexuality. 2017;26;3:186-95.

22 Constantine NA, Jerman P, Berglas NF, Angulo-Olaiz F, Chou CP, Rohrbach LA. Short-term effects of a rights-based sexuality education curriculum for high-school students: A cluster-randomized trial. BMC Public Health. 2015;15;1: 293.

23 Govt of Canada. Sexual and reproductive health rights. Canada: 2018. Available from: https://international.gc.ca/world-monde/issues_development-enjeux_developpement/global_health-sante_mondiale/srhr_projects-projets_sdsr.aspx?lang=eng. Accessed March 20, 2019.

24 Black AY GE, Hassan F, Chatziheofilou I, Lowin J, Jeddi M, Filonenko A, Trussell J. The cost of unintended pregnancies in Canada: Estimating direct cost, role of imperfect adherence, and the potential impact of increased use of long-acting reversible contraceptives. Journal of Obstetrics and Gynaecology Canada. 2015;37;12):1086-97.

25 Luna Z, Luker K. Reproductive justice. Annual Review of Law and Social Science. 2013;9:327-52.

26 Lopez LM, Bernholc A, Chen M, Tolley EE. School-based interventions for improving contraceptive use in adolescents. Cochrane Database of Systematic Reviews. 2016;6.

27 Lopez LM, Grey TW, Chen M, Tolley EE, Stockton LL. Theory-based interventions for contraception. Cochrane Database of Systematic Reviews. 2016;11.

28 PHAC. Report on sexually transmitted infections in Canada: 2013-2014. Canada: Public Health Agency of Canada; 2017.

29 PHAC. A pan-Canadian framework for action: Reducing the ealth Imipact of sexually transmitted and blood-borne infections in Canada by 2030. Canada: Public Health Agency of Canada; 2018.

30 Rotermann M, Langlois KA, Severini A, Totten S. Prevalence of Chlamydia trachomatis and herpes simplex virus type 2: Results from the 2009 to 2011 Canadian health measures survey. Health Reports. 2013;24;4:8.

31 PHAC. Population-specific status report: HIV/AIDS and other sexually transmitted and blood borne infections among youth in Canada. Ottawa, ON: Public Health Agnecy of Canada; 2014.

32 Haddad N, Li J, Totten S, McGuire M. HIV in Canada–surveillance report, 2017. Canada Communicable Disease Report. 2018;44;12: 324-32.

33 Govt of Canada. Surveillance of HIV and AIDS Canada. 2018. Available from: https://www.canada.ca/en/public-health/services/diseases/hiv-aids/surveillance-hiv-aids.html. Accessed March 20, 2019.

34 Morales A, Espada JP, Orgilés M, Escribano S, Johnson BT, Lightfoot M. Interventions to reduce risk for sexually transmitted infections in adolescents: A meta-analysis of trials, 2008-2016. PloS ONE. 2018;13;6: e0199421.

35 Mon Kyaw Soe N, Bird Y, Schwandt M, Moraros J. STI Health Disparities: A systematic review and meta-analysis of the effectiveness of preventive interventions in educational settings. International Journal of Environmental Research and Public Health. 2018;15;12:2819.

36 WHO. Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva, Switzerland: World Health Organization; 2013.

37 Govt of Canada. It's time to acknowledge: Who is affected by gender-based violence? 2018. Available from: https://cfc-swc.gc.ca/violence/knowledge-connaissance/fs-fi-2-en.html. Accessed March 20, 2019.

38 Conroy S, Cotter A. Self-reported sexual assault in Canada, 2014. Canada: Statistics Canada; 2017.

39 Conroy S. Police-reported violence against girls and young women in Canada, 2017. Canada: Statistics Canada; 2018.

40 Simpson L. Violent victimization of lesbians, gays and bisexuals in Canada, 2014. Canada: Statistics Canada; 2018.

41 Taylor C, Peter T, with, McMinn TL, Elliott T, Beldom S, Ferry A, et al. Every class in every school: The first national climate survey on homophobia, biphobia, and transphobia in Canadian schools. Final report. Toronto, ON: Egale Canada Human Rights Trust.; 2011.

42 Gegenfurtner A, Gebhardt M. Sexuality education including lesbian, gay, bisexual, and transgender (LGBT) issues in schools. Educational Research Review. 2017;22:215-22.

43 Lundgren R, Amin A. Addressing intimate partner violence and sexual violence among adolescents: Emerging

evidence of effectiveness. Journal of Adolescent Health. 2015;56;1:S42-S50.

44 Pound P, Denford S, Shucksmith J, Tanton C, Johnson AM, Owen J, et al. What is best practice in sex and relationship education? A synthesis of evidence, including stakeholders' views. BMJ Open. 2017;7;5: e014791.

45 Chesson HW, Mayaud P, Aral SO. Sexually Transmitted Infections: Impact and cost-effectiveness of prevention. In: Holmes KK, Bertozzi S, Bloom BR, et al., editors. Major Infectious Diseases. 3rd edition. Washington (DC): The International Bank for Reconstruction and Development / The World Bank; 2017.

46 Kingston-Riechers J. The economic cost of HIV/AIDS in Canada. Canadian AIDS Society; 2011.

47 Tuite AR, Jayaraman GC, Allen VG, Fisman DN. Estimation of the burden of disease and costs of genital chlamydia trachomatis infection in Canada. Sexually Transmitted Diseases. 2012;39;4:260-7.

48 Hoddenbagh J, McDonald SE, Zhang T. An estimation of the economic impact of violent victimization in Canada, 2009: Research and Statistics Division, Department of Justice Canada; 2014.

49 WHO. The economic dimensions of interpersonal violence. Geneva, Switzerland: World Health Organization; 2004.

50 Badgett MVL, Park EA, Flores AR. Links between economic development and new measures of LGBT inclusion. Williams Institute, UCLA School of Law; 2018.

51 Banks C, Muhajarine N, Waygood K, Duczek L, Hellquist G. The cost of homophobia: Literature review on the economic impact of homophobia on Canada: Community-University Institute for Social Research; 2004.

52 Badgett MVL, Nezhad S, Waaldijk C, Meulen RY. The relationship between LGBT inclusion and economic development: An analysis of emerging economies. 2014.

CORE PRINCIPLES OF COMPREHENSIVE SEXUAL HEALTH EDUCATION

According to the World Health Organization (WHO) working definition:

> *"Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity."*[1]

Although the WHO definition includes "well-being in relation to sexuality," the terms "sexual health and well-being" are adopted in these *Guidelines* to emphasize that the goals of comprehensive sexual health education are not limited to the achievement of biological/physical wellness but also include psychological, emotional, relational, and social well-being related to sexuality.

Comprehensive sexual health education is a process that requires the participation of multiple sectors of society including the family and the education, public health, primary healthcare, community agency, care facility, and correctional institutions of Canadian society.

The goals of comprehensive sexual health education are to equip people with the information, motivation, and behavioural skills to enhance sexual health and well-being (e.g., having respectful and satisfying interpersonal relationships, increased self-acceptance, increased capacity to access sexual and reproductive health services) and to prevent outcomes that can have a negative impact on sexual health and well-being (e.g., acquisition and transmission of sexually transmitted infections [STIs], unintended pregnancies, sexual coercion/trauma/abuse/harassment, relationship problems).

The following core principles should inform, and be respected, in the planning and teaching of sexual health education in Canada.

COMPREHENSIVE SEXUAL HEALTH EDUCATION:

IS ACCESSIBLE TO ALL PEOPLE INCLUSIVE OF AGE, RACE, SEX, GENDER IDENTITY, SEXUAL ORIENTATION, STI STATUS, GEOGRAPHIC LOCATION, SOCIO-ECONOMIC STATUS, CULTURAL, OR RELIGIOUS BACKGROUND, ABILITY, OR HOUSING STATUS (E.G., THOSE WHO ARE INCARCERATED, HOMELESS, OR LIVING IN CARE FACILITIES).

All people should have access to age-appropriate sexual health information and resources beginning in early childhood and continuing across the life span. For sexual health education to be equally accessible to all people, programs must be designed and taught in ways that respectfully address the learning needs of the specific audience. These learning needs may be dependent on a range of factors including age, race, sex (i.e., variations in reproductive or sexual anatomy, including intersex), gender identity, sexual orientation, STI status, health status, geographic location, socio-economic status, cultural, or religious background, ability, or housing status (e.g., those who are incarcerated, homeless, or living in care facilities).

In order to develop and implement sexual health education programs which are fully accessible and relevant to target audiences, these stakeholders should be consulted and engaged in the planning, implementation, and evaluation process. For example, First Nations, Inuit, and Métis peoples may have distinct perspectives about what culturally safe sexual health education is in their communities and their community-specific values related to sexuality and sexual health must be respected.

PROMOTES HUMAN RIGHTS INCLUDING AUTONOMOUS DECISION-MAKING AND RESPECT FOR THE RIGHTS OF OTHERS.

Sexual health education should educate people about their human rights in relation to sexual and reproductive health. The content and guiding philosophy of sexual health education programs should be aligned with *The Canadian Charter of Rights and Freedoms* which outlines all Canadians' rights to personal liberty and freedom of thought, belief, and opinion. Sexual health education should encourage and facilitate a person's right to make informed, autonomous decisions. To promote human rights, sexual health education should also strongly emphasize that individuals have an equal obligation to respect the rights of others. Comprehensive sexual health education should empower people to recognize and respond to sexual health and well-being inequality or injustices that they, or others, may face.

IS SCIENTIFICALLY ACCURATE AND USES EVIDENCE-BASED TEACHING METHODS.

The content delivered in sexual health education programs should be grounded in current and credible scientific research evidence and best practice. The teaching strategies and methods utilized should be well-tested and empirically-supported by ethically and scientifically sound research.

Sexual health education programs should be based on theoretical models that can be used to plan, implement, and evaluate sexual health education programs. Theory is useful for sexual health education because theories specify relevant constructs and principles. Theory can guide curriculum development and allow for testing of the efficacy of the program.

Based on scientific findings, effective sexual health education programs integrate elements of 1) knowledge and understanding, 2) motivation, 3) skills, and 4) critical awareness of social-environmental factors that may enhance or prevent the achievement of sexual health and well-being.

IS BROADLY-BASED IN SCOPE AND DEPTH AND ADDRESSES A RANGE OF TOPICS RELEVANT TO SEXUAL HEALTH AND WELL-BEING.

There is a broad range of information, values, beliefs, attitudes, norms, and behaviours that contribute to sexual health and well-being. Although it is often necessary to target specific attitudes and behaviours within sexual health education program objectives, it is also important to recognize that achieving and maintaining sexual health and well-being involves a number of factors. Sexual health education programs targeted at youth, particularly school-based programs, should address–with sufficient depth–the range of factors that impact sexual health and well-being, including understanding, establishing, and maintaining healthy interpersonal relationships.

IS INCLUSIVE OF THE IDENTITIES AND LIVED EXPERIENCES OF LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER, INTERSEX, TWO-SPIRIT, NONBINARY, AND ASEXUAL PEOPLE (LGBTQI2SNA+), AND OTHER EMERGING IDENTITIES.

Sexual health education should be taught in a manner that does not assume that all individuals are heterosexual, identify with the sex they were assigned at birth, or have bodies that fit traditional biological definitions of male/female. Sexual health education programs should be relevant to and address the learning needs of LGBTQI2SNA+ people. Sexual health education programs should encourage acceptance and respect for the diversity of sexual and gender identities that exist in the community and include the critical evaluation of discriminatory attitudes and practices.

PROMOTES GENDER EQUALITY AND THE PREVENTION OF SEXUAL AND GENDER-BASED VIOLENCE.

Sexual health education programs should promote gender norms that contribute to gender equality and sexual well-being. Sexual health education should provide information about power dynamics and gender, as well as the diversity of genders, identities, and expressions to encourage acceptance and respect for diversity. Not all people are born exclusively male or female and not all people identify as strictly a man or a woman–some people identify as transgender, and others identify as genderqueer, agender, or other fluid gender identities.

Sexual health education programs should incorporate a trauma-informed approach that recognizes that many of the people receiving sexual health education may have experienced some form of sexual or gender-based violence. Sexual health education programs can play an active role in contributing to the reduction of sexual and gender-based violence by helping people become aware of societal norms, attitudes, and practices that contribute to violence (e.g., misogynistic beliefs, homophobia, transphobia). Gender may determine the amount of power, influence, and freedom a person has to consent, refuse, or participate in sexual activities and this may make them more vulnerable to violence.

Sexual health education programs should assert the right of everyone to: 1) set boundaries communicated verbally or non-verbally, understanding that consent can be withdrawn at any time and 2) clearly ask for and communicate affirmative consent (e.g., saying yes). Sexual health education should help individuals learn how to ensure that all partners feel safe and fully consent before sexual activity occurs.

INCORPORATES A BALANCED APPROACH TO SEXUAL HEALTH PROMOTION THAT INCLUDES THE POSITIVE ASPECTS OF SEXUALITY AND RELATIONSHIPS AS WELL AS THE PREVENTION OF OUTCOMES THAT CAN HAVE A NEGATIVE IMPACT ON SEXUAL HEALTH AND WELL-BEING.

An exclusive focus on the prevention of negative outcomes in sexual health education does not necessarily reduce negative outcomes. A prevention-only focus can result in a distorted view of human sexuality that emphasizes negativity and contributes to shame and stigma. Grounding sexual health education in an approach that combines both positive and relationship-enhancing aspects of human sexuality (e.g., having respectful and satisfying interpersonal relationships), along with the information and skills to prevent outcomes that can have a negative impact on sexual health and well-being (e.g., STIs), can empower people to protect and enhance their sexual health. A balanced approach to sexual health promotion incorporates both positive portrayals of sexuality and harm reduction strategies when necessary to reach program goals.

IS RESPONSIVE TO AND INCORPORATES EMERGING ISSUES RELATED TO SEXUAL HEALTH AND WELL-BEING.

In order to be relevant and effective, sexual health education must be responsive to people's current and changing sexual health education needs.

For example, modern communication technologies (e.g., cell phones/smartphones, social media apps/websites) have fundamentally changed the way people are exposed to, learn about, and communicate with respect to sexuality. These technologies can have benefits (e.g., increased access to sexuality information, connecting with relationship partners), but also pose significant challenges (e.g., misinformation, privacy, and exploitation risks of online communication).

Many people will be exposed to media portrayals of gender and sexuality (e.g., via social media, movies/television/music videos/online games, pornography) that challenge sexual health and well-being in either positive or negative ways. Sexual health education programs should facilitate the development of media and digital literacy skills that will enable people to critically evaluate the sexuality-related material they encounter, as well as develop the knowledge and skills to use communication technologies safely and respectfully.

IS PROVIDED BY EDUCATORS WHO HAVE THE KNOWLEDGE AND SKILLS TO DELIVER COMPREHENSIVE SEXUAL HEALTH EDUCATION AND WHO RECEIVE ADMINISTRATIVE SUPPORT TO UNDERTAKE THIS WORK.

Sexual health education is provided in a variety of contexts and settings. Educators should establish collaborative partnerships with students, parents, and health and community services to strengthen sexual health education. Ideally, individuals who provide sexual health education should be 1) knowledgeable about sexuality, 2) well-trained in the theory and practice of comprehensive sexual health education, and 3) administratively supported with appropriate institutional policies. Educators should also be provided with opportunities to develop their knowledge and skills to deliver comprehensive sexual health education on an ongoing basis including access to resources, in-service training, and professional development.

Parents and guardians are essential partners in the sexual health education of their children. Parents and guardians should also have access to resources to increase their capacity, knowledge, and skills to provide their children with accurate information about sexuality and sexual health and well-being. Faith leaders, cultural communities, community opinion leaders, and peers are examples of other groups that should have access to resources, training, and support to provide comprehensive sexual health education.

REFERENCES

1 WHO. Sexual health, human rights and the law. Geneva, Switzerland: World Health Organization: 2015.

THE DETERMINANTS OF SEXUAL HEALTH AND WELL-BEING:
IMPLICATIONS FOR COMPREHENSIVE SEXUAL HEALTH EDUCATION

A determinants of health perspective proposes that a broad range of personal, social, economic, and environmental factors influence individual and population health.[1,2] This perspective has been adopted by researchers, institutions, and governments, including the Government of Canada and the World Health Organization.[1,2]

A determinants of health perspective can be usefully applied to sexual health.[3,4,5] There are a wide range of determinants of health that have been shown to impact sexual health and well-being. Some of these are modifiable (e.g., attitudes) and others are not modifiable (e.g., age).

DETERMINANTS INCLUDE:	
individual factors (e.g., beliefs)	**interpersonal factors** (e.g., behaviours of partners)
community factors (e.g., access to sexual health services)	**broader societal factors** (e.g., cultural and societal attitudes related to sexual health)

This perspective also incorporates the interrelationship between different aspects of health. That is, sexual health is related not only to physical health, but also to the emotional and mental health of an individual, suggesting that many factors contribute to one's overall health and well-being.

The application of a determinants of health perspective is useful in a variety of contexts. However, this perspective is especially important for sexual health education provided to populations who have experienced discrimination, marginalization, stigmatization, or unequal access to services and may, as a result, be more likely to experience negative sexual health outcomes (e.g., STIs, unintended pregnancy, sexual coercion). These populations include girls and women; queer and trans youth and adults; lesbian, bisexual, and gay youth and adults; men who have sex with men; children, youth and adults with disabilities; Indigenous peoples; ethnocultural minorities; newcomers; and sex workers.[3,4,6,7,8]

Sexual health and well-being are determined and influenced by multiple factors.
The factors listed below influence sexual health and well-being at four basic levels: individual, interpersonal, community, and societal.

1. INDIVIDUAL	2. INTERPERSONAL
• Individual knowledge, motivation, attitudes, beliefs, values, and skills	• Attitudes and behaviours of partners, peers, families, and health professionals • Sexual health education provided by parents/ guardians and peers
3. COMMUNITY	**4. SOCIETAL**
• Access to comprehensive sexual health education in different settings (e.g., education, health, and community sectors) • Access to relevant comprehensive sexual health care and services (e.g., counseling and clinical services for STI testing, treatment, and prevention, contraception, pregnancy, reproductive choice, sexual assault services, and sexual function and psychosexual counseling and treatment)	• Government laws and policies related to sexual health (e.g., comprehensive sexual health education curriculums, sexual and reproductive health care and services, funding for vaccines and medications related to sexual health and contraceptives, funding for sexual health education training and research) • Societal structures and conditions (e.g., socio-economic status, housing status, levels of equality related to gender, sexual orientation, race, and Indigenous identity) • Cultural and social attitudes (e.g., societal attitudes towards sexuality/sexual health, gender, LGBTQI2SNA+ individuals; societal attitudes and beliefs about race, immigration status, and Indigenous identity; media messages about sexuality/sexual health, gender, race etc.)

GUIDELINES

SEXUAL HEALTH EDUCATION SHOULD TAKE INTO ACCOUNT AND INCORPORATE THE MULTIPLE FACTORS THAT INFLUENCE SEXUAL HEALTH AND WELL-BEING.

Sexual health education should equip individuals to understand and engage with–or modify–individual, interpersonal, community, and societal factors that affect sexual health and well-being. Sexual health education is more likely to be effective if it addresses sociocultural issues.[9]

Sexual health education programs need not address all factors that influence sexual health. The specific objectives of a sexual health education program, and the intended audience, should dictate the extent to which the program addresses different determinants of sexual health. For example, brief educational programs which seek only to provide generic information about a particular aspect of sexual health to a broad audience may be successful in increasing recipients' knowledge. However, it is unlikely that such programs alone will be fully effective in promoting specific sexual health behaviours unless they address the important interpersonal, community, and societal level determinants of those behaviours.

SEXUAL HEALTH EDUCATION SHOULD LINK PROGRAM RECIPIENTS TO APPROPRIATE HEALTH RESOURCES–ONLINE AND IN THE COMMUNITY–THAT ARE DELIVERED IN WAYS THAT REFLECT THE *CORE PRINCIPLES OF COMPREHENSIVE SEXUAL HEALTH EDUCATION*.

Sexual health education programs that collaborate and provide linkages or referrals to relevant resources in the community are more likely to achieve program objectives.[10,11] For example, sexual health education programs should partner with and link program recipients to appropriate services for STI testing and treatment, sexual assault survivor support programs, relationship counseling, sexual therapy, LGBTQI2SNA+ support, and contraception and reproductive health care. This includes ensuring and improving access to sexual health care and services that are culturally safe, trauma-informed, and able to address the needs of all people.

REFERENCES

1 Govt of Canada. Social determinants of health and health inequalities. Canada: 2018. Available from: https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html. Accessed February 5, 2019.

2 WHO. Social determinants of sexual and reproductive health: Informing future research and programme implementation. Geneva, Switzerland: World Health Organization: 2010.

3 PHAC. Chlamydia among young women: A resource for population specific prevention. Ottawa, ON: Public Health Agency of Canada; 2015.

4 Condran B. Addressing the dimensions of sexual health: A review of evaluated sexual health promotion interventions. National Collaborating Centre for Infectious Diseases: 2014.

5 Garrido M, Sufrinko N, Max J, & Cortes N. Where youth live, learn, and play matters: Tackling the social determinants of health in adolescent sexual and reproductive health. American Journal of Sexuality Education. 2018:1-14.

6 PHAC. Questions and Answers: Sexual health education for youth with physical disabilities. Ottawa, ON: Public Health Agency of Canada: 2013.

7 PHAC. Questions & Answers: Inclusive practice in the prevention of sexually transmitted and blood borne infections among ehtnoculturalminorities. Ottawa, ON: Public Health Agency of Canada: 2014.

8 Poon C, Smith, A., Saewyc, E., & McCreary Centre Society. Sexual health of youth in BC. Vancouver, BC: McCreary Centre Society: 2015.

9 Scott-Sheldon LA, Huedo-Medina TB, Warren MR, et al. Efficacy of behavioral interventions to increase condom use and reduce sexually transmitted infections: A meta-analysis, 1991 to 2010. Journal of Acquired Immune Deficiency Syndromes: 2011;58;5:489-498.

10 UNESCO. International technical guidance on sexuality education: An evidence-informed approach. Paris, France: United Nations Educational Scientific and Cultural Organization: 2018.

11 Pound P, Denford S, Shucksmith J, et al. What is best practice in sex and relationship education? A synthesis of evidence, including stakeholders' views. BMJ Open. 2017;7:5:e014791.

GOALS AND KEY COMPONENTS OF COMPREHENSIVE SEXUAL HEALTH EDUCATION

The purpose of this section is to outline and describe the goals and components of comprehensive sexual health education.

GUIDELINES

THE GOALS OF COMPREHENSIVE SEXUAL HEALTH EDUCATION ARE TO INCREASE THE CAPACITY FOR SEXUAL HEALTH ENHANCEMENT (E.G., HAVING RESPECTFUL AND SATISFYING INTERPERSONAL RELATIONSHIPS, INCREASED SELF-ACCEPTANCE, INCREASED CAPACITY TO ACCESS SEXUAL AND REPRODUCTIVE HEALTH SERVICES) AND THE PREVENTION OF OUTCOMES THAT CAN HAVE A NEGATIVE IMPACT ON SEXUAL HEALTH AND WELL-BEING (E.G., ACQUISITION AND TRANSMISSION OF STIS, UNINTENDED PREGNANCIES, SEXUAL COERCION/TRAUMA/ABUSE/HARASSMENT, RELATIONSHIP PROBLEMS).

In order to be effective, sexual health education programs should focus on both the positive and relationship enhancing aspects of human sexuality and the prevention of negative outcomes.

THE KEY COMPONENTS OF COMPREHENSIVE SEXUAL HEALTH EDUCATION INCLUDE INFORMATION, MOTIVATION/ATTITUDES, BEHAVIOURAL SKILLS, AND ENVIRONMENTAL FACTORS THAT AFFECT SEXUAL HEALTH AND WELL-BEING.

The content provided in sexual health education must be directly relevant to individuals' sexual health and well-being so it can be used to support people in making informed, autonomous decisions and to incorporate the information into behaviour when necessary. However, providing information alone is not enough to achieve the objectives of most sexual health education programs. Comprehensive sexual health education programs should also address motivation/attitudes, behavioural skills, and environmental factors that affect sexual health and well-being.[1,2,3,4]

TO INCREASE PROGRAM EFFECTIVENESS, COMPREHENSIVE SEXUAL HEALTH EDUCATION PROGRAMS SHOULD INCORPORATE THEORETICAL MODELS OF BEHAVIOURAL CHANGE INTO THE PLANNING, DELIVERY, AND EVALUATION PROCESS.

Well-tested theoretical models that can be used as the basis of comprehensive sexual health education include the Information-Motivation-Behavioural Skills Model (IMB), Social-Cognitive Theory, the Transtheoretical Model, and The Theory of Reasoned Action and Theory of Planned Behaviour.[5,6,7,8,9]

GOALS

The overarching goal of comprehensive sexual health education is to enhance the ability of an individual to achieve and maintain sexual health and well-being over their lifetime.

Specific goals are divided into two categories: those related to the enhancement of sexual health and well-being and those that seek to prevent outcomes that can have a negative impact on sexual health and well-being (see Table 1).

In addition, it is important that comprehensive sexual health education includes "ongoing discussions about social and cultural factors relating to broader aspects of relationships and vulnerability, such as gender and power inequalities, socio-economic factors, race, STI status, disability, sexual orientation, gender identity."[10]

To achieve the goals of comprehensive sexual health education, programs must include evidence-based, age-appropriate, and inclusive information, address attitudes and motivational factors, and teach relevant behavioural, relationship, and interpersonal skills.

Table 1: The Goals of Comprehensive Sexual Health Education

GOAL 1: **Enhancement of sexual health and well-being**	
1.1	Increase in self-acceptance, self-esteem, self-image, comfort, and confidence related to sexuality.
1.2	Increase in capacity to have and ensure healthy, consensual, respectful, equitable, mutually beneficial, and satisfying interpersonal relationships.
1.3	Increase in awareness of and capacity to access sexual and reproductive health services (including STI testing, treatment and prevention services, as well as contraceptive services).
1.4	Increase in awareness of, and respect for, human rights related to sexuality and reproductive health.
1.5	Increased capacity of parents and guardians, teachers, and sexual health educators to deliver high quality sexual health education (e.g., increased knowledge of teaching strategies, increased skills, and comfort).
1.6	Increased capacity for self and group advocacy related to sexual health and well-being.

GOAL 2: Prevention of outcomes that can have a negative impact on sexual health and well-being	
2.1	Decrease in the acquisition and transmission of STIs.
2.2	Decrease in unintended pregnancies.
2.3	Decrease in sexual problems (e.g., problems with sexual response, relationship problems that negatively impact sexual health and well-being).
2.4	Decrease in sexual coercion/trauma/assault/abuse/harassment.
2.5	Decrease in discrimination and violence based on sex (i.e., variations in reproductive or sexual anatomy, including intersex), gender identity, gender expression, sexual orientation, and STI status.

KEY COMPONENTS (THEORY)

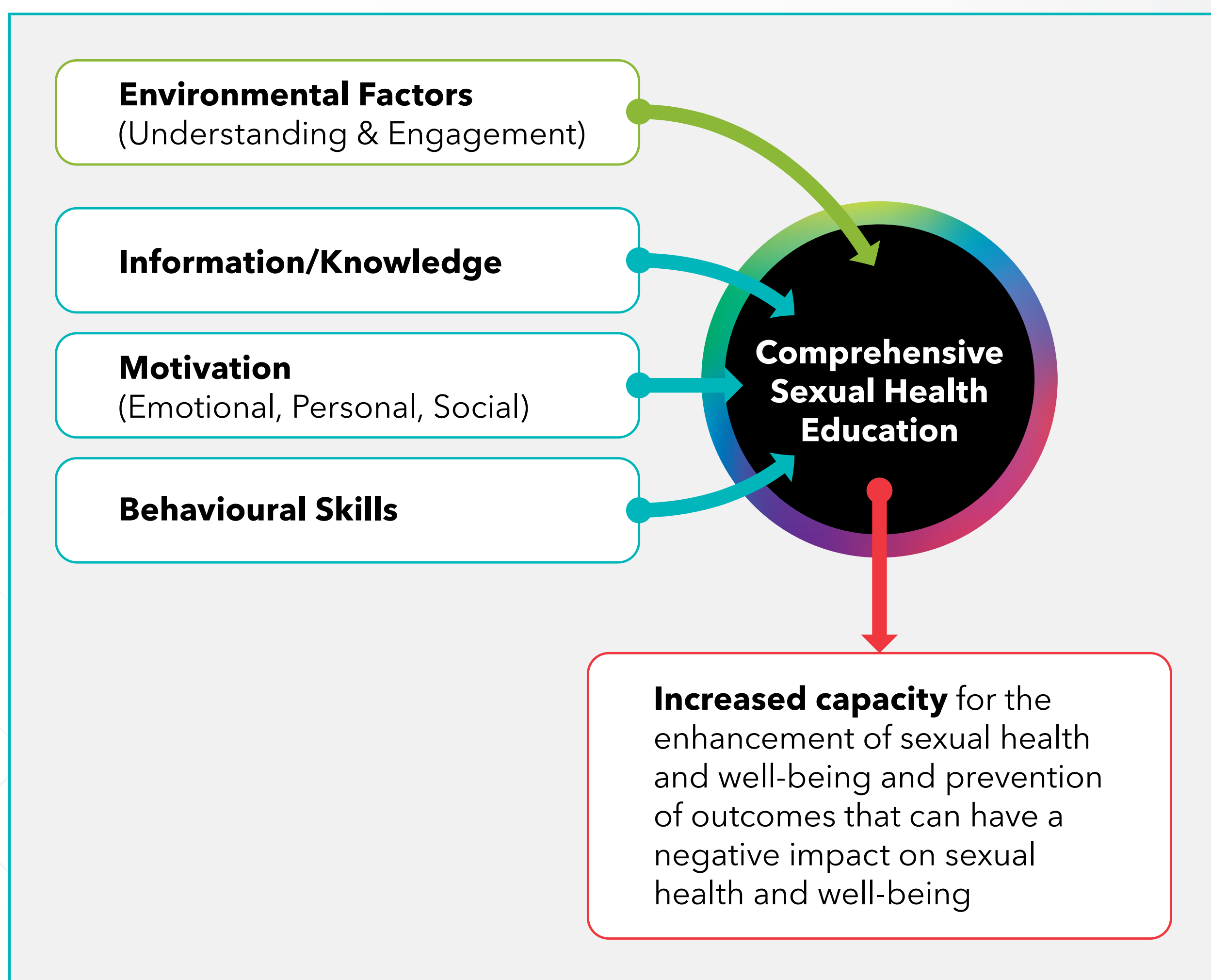
In the process of planning, implementing, and evaluating comprehensive sexual health education programs, it is important for policy makers and program planners to use well-tested and research-supported theoretical models to develop program components. There is clear evidence that integrating a well-tested theoretical model of behaviour change into the planning, delivery, and evaluation of a sexual health education program increases its effectiveness.[11]

There are a number of well-tested theoretical models that can be used as the foundation for comprehensive sexual health education programs (e.g., Social Cognitive Theory, Transtheoretical Model, Theory of Reasoned Action, and Theory of Planned Behaviour).[5,6,7,8,9]

The information-motivation-behavioural skills (IMB) model[1,2,3] is a well-tested theoretical model that has been used as the basis for a wide variety of effective sexual and reproductive health promotion interventions. Therefore, the IMB model is used in this section to illustrate the components of comprehensive sexual health education.

Utilizing the IMB model, the components of information, motivation, and behavioural skills can be used by educators as the basis for the planning, delivery, and evaluation of comprehensive sexual health education programs (Figure 1). Take note of the environmental component added to the model that indicates the importance of social, cultural, and structural factors in an individual's ability to enhance and maintain their sexual health and well-being.[4,12,13] The components presented in Figure 1 can also apply to educational and sexual health promotion programs targeting couples, communities, and populations.

Figure 1: Key Components of Comprehensive Sexual Health Education

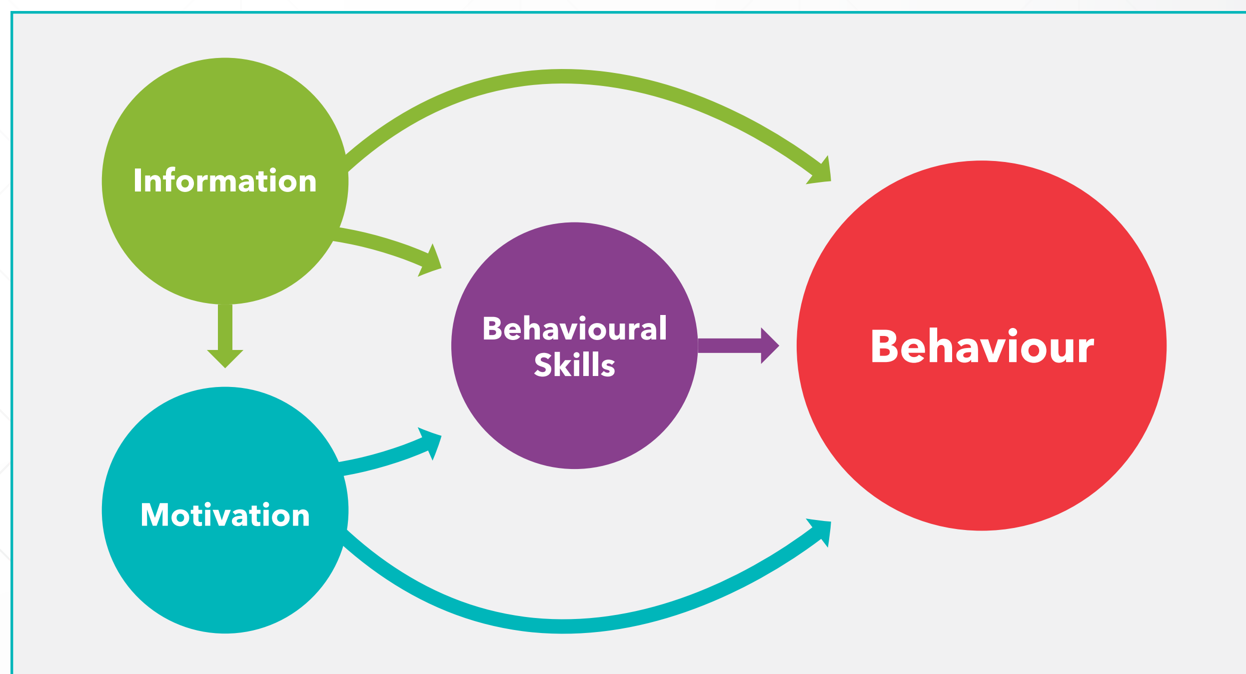


SPECIFIC COMPONENTS OF SEXUAL HEALTH EDUCATION USING THE IMB MODEL
1. Information/Knowledge
• Should be relevant to the individual's personal sexual health and well-being • Can be used to make informed, autonomous decisions • Can be translated into relevant behaviour change
2. Motivation
• Impact of social norms and peer pressure • Perceived vulnerability to negative outcomes • Perceived opportunity for positive outcomes • Emotional motivation: a person's level of comfort or discomfort with sexuality (e.g., feelings of self-acceptance and self-worth related to sexuality) • Personal motivation: beliefs and attitudes towards specific sexual health prevention or promotion acts • Social motivation: perceived social support or opposition for an individual's enactment of a sexual health prevention or promotion behaviour
3. Behavioural Skills
• Translating information/knowledge and motivation/attitudes into intentions, confidence (i.e., self-efficacy), and behaviour conducive to sexual health and well-being (e.g., using condoms, dental dams, other barriers [e.g., gloves], and/or birth control) • Communication through ongoing conversation (e.g., discussing consent, setting sexual limits, expressing sexual preferences; understanding and expressing nonverbal communication) • Accessing resources/health services
4. Environmental Factors (Understanding and engagement)
• Awareness of the ways that social, cultural, economic, political contexts can negatively/positively affect sexual health and well-being • Strengthening capacity for self and group advocacy related to sexual health and well-being • Strengthening access to user-friendly, stigma-free sexual and reproductive health services

UTILIZING THE IMB MODEL TO TRANSLATE THEORY INTO PRACTICE

The IMB model specifies that for sexual health education to be effective it must:	
1	provide information that is directly relevant to sexual health and well-being,
2	develop the motivational factors (individual attitudes/social norms) that influence sexual health behaviour, and
3	teach the specific behavioural skills that are needed to protect and enhance sexual health and well-being (Figure 2).
The three key elements of the IMB model[1,2,3] and research support for the model are described in more detail below.	

Figure 2: The Information, Motivation, Behavioural Skills Model for the Enhancement of Sexual Health and Well-Being and the Prevention of Negative Sexual Health Outcomes



Note: Adapted from Fisher, W.A., & Fisher, J.D. (1998). Understanding and promoting sexual and reproductive health behavior: Theory and method. *Annual Review of Sex Research*, 9,39-76.

INFORMATION

To be effective, comprehensive sexual health education programs should provide evidence-based information that is relevant and easy to translate into behaviours that enhance sexual health and prevent negative outcomes.

Information about the contexts in which individuals will be engaging in the specific behaviours and how to navigate these contexts is also important (e.g., identifying potential barriers to access for sexual health services and strategies for self-advocacy).

The information provided in sexual health education programs should be:

Directly relevant to the behavioural objective	**Easy to translate into the behavioural objective**
Example: If the objective is to increase contraceptive use, information directly relevant to achieving this objective would include informing a person about how a specific form of birth control works, how it is used effectively, how it can be accessed, what barriers they may face in accessing it, how to navigate those barriers, how it can be paid for, and how it can be discussed with a health care provider and with a partner.	*Example:* If the objective of a sexual health education program is to encourage STI testing, creating a directory of local, user-friendly, and accessible sexual and reproductive health services or resources is information that a person can use to engage in that behaviour.

MOTIVATION

Even people who receive sexual health information that is easy to translate into behaviour need motivation to act on what they have learned.

In order for sexual health education programs to achieve their objectives, program planners and educators should also focus on the motivations for potential change.

Motivations that influence sexual health and well-being behaviour typically take three forms:

Emotional motivation	**Personal motivation**	**Social motivation**
Someone's emotional responses to sexuality (i.e., their degree of comfort or discomfort) as well as their response to specific sexual health-related behaviours may influence whether or not they take the necessary actions to translate their knowledge into behaviour. People with negative emotional responses to sexuality are less likely to communicate with others about a sexual health issue. *Example:* If a program aims to help parents increase their ability to provide high quality sexual health education to their children, having parents examine their emotional responses to sexuality could be beneficial.	A person's attitudes and beliefs about a specific sexual and reproductive health behaviour strongly influence whether that person engages in that behaviour. *Example:* If the objective of a program is to increase the capacity for individuals to have consensual and respectful relationships, then it is important for people to examine their beliefs as well as their attitudes about sexual communication and consent. A person who has positive attitudes/beliefs about the importance of consent is more likely to bring it up and discuss consent with partners.	A person's beliefs regarding social norms (i.e., their perceptions of social support pertaining to relevant sexual and reproductive health behaviour) also influence their likelihood of acting on the program content they receive. *Example:* Sexual health education programs that focus on increasing self-acceptance among LGBTQI2SNA+ people could examine perceived social support for coming out. Young people who are in the process of questioning, understanding, and affirming their sexual orientation or gender identity are more likely to come out if they perceive their social group as supportive of LGBTQI2SNA+ individuals and identities.

BEHAVIOURAL SKILLS

Individuals who have the relevant information and motivation still may not engage in specific behaviours targeted by sexual health education programs if they lack the skills needed to enact the behaviours.

It is essential to teach the behavioural skills needed to accomplish objectives related to potential behaviour change.

For example, sexual health education programs for children with objectives related to reducing the risk of exploitation and abuse need to teach children the specific behavioural skills for disclosing inappropriate touch to trusted adults.

Behavioural skills related to sexual and reproductive health consist of the following:

The practical skills to engage in the behaviour	**The self-efficacy to engage in the behaviour**
This involves problem solving, effective communication, and the ability to evaluate ideas. *Example:* A person who can benefit from HIV pre-exposure prophylaxis (PrEP) can learn the practical skills for accessing and properly using the medication. They can also learn the skills needed to advocate for themselves and others in accessing resources when social barriers are present (e.g., when providers do not initiate STI testing or access to prevention strategies because individuals are perceived to be "not at risk" based on assumptions about their sexual identities and relationships).	This includes a person's belief in their ability to successfully manage a situation, accomplish a task, have healthy conversations with a partner, locate and access services etc. *Example:* A person must feel confident in their ability to have discussions regarding condom, dental dam, or other barrier use and/or consent with a partner in order to engage in these discussions. *Example:* A teacher must feel confident in their ability to teach the curriculum to their students and communicate with students when they pose questions in order to provide high quality comprehensive sexual health education.

RESEARCH SUPPORT FOR THE IMB MODEL

The IMB model is well supported by evaluation research demonstrating its effectiveness as the foundation for a range of sexual health promotion interventions, targeting STI/HIV prevention,[3,14,15,16] contraceptive use,[17] HPV vaccine uptake,[18] HIV treatment adherence,[14] and indicators of sexual well-being.[19]

Evidence of the IMB model's applicability and effectiveness has been demonstrated in different populations including young adult women[20] and men,[21,22] low income youth,[15] racial minority youth,[23] adolescent girls,[24] lesbian, gay, bisexual, and trans youth,[19] incarcerated youth,[25] men who have sex with men,[16] commercial sex workers,[26] and women who have experienced intimate partner violence.[27]

Table 2 provides examples of how the IMB components would apply to programs targeting seven different behavioural objectives that are linked to the overall goals of comprehensive sexual health education : 1) increasing the use of condoms, dental dams, or other types of barriers, 2) increasing STI testing, 3) accessing the human papillomavirus (HPV) vaccine, 4) increasing awareness and use of PrEP and post-exposure prophylaxis (PEP) for HIV prevention, 5) obtaining/discussing consent for sexual activity with partners, 6) building capacity for educators to teach a comprehensive sexual health education curriculum, and 7) increasing capacity for seeking support following sexual assault.

TABLE 2: INFORMATION-MOTIVATION-BEHAVIOURAL SKILLS FOR SEXUAL HEALTH ENHANCEMENT/NEGATIVE OUTCOME PREVENTION

OBJECTIVE 1: **Increase condom use, dental dam use, or other barrier use to prevent STI transmission**	
INFORMATION Acquire knowledge relating to:	• Basic information regarding anatomy, physiology, STIs, and pregnancy • STI risk behaviours and transmission • Effectiveness of condoms, dental dams, and other barriers in preventing STI transmission or acquisition • What a condom is, what a dental dam is, what other types of barriers are (e.g., gloves) • Where to access condoms, dental dams, and other barriers (including free and low-cost options) • How to use a condom, dental dam, and other barriers, correctly (e.g., checking expiration dates, applying and removing barriers, storage of condoms, dental dams, and other barriers) • How to discuss condom, dental dam, or other type of barrier use with a partner • Keeping condoms, dental dams, and other barriers available • Comfortable and pleasurable condom, dental dam, or other type of barrier use
MOTIVATION Discuss/ Address:	• Target audience's vulnerability to STIs • Ideas/beliefs about personal responsibility/safety • Ideas about sexual scripts and gender norms that impact condom, dental dam, and other type of barrier use • Individual/peer/public attitudes/norms towards using or not using condoms, dental dams, or other barriers • The specific benefits of condom, dental dam, or other type of barrier use to the individual

OBJECTIVE 1: **Increase condom use, dental dam use, or other barrier use to prevent STI transmission**	
BEHAVIOURAL SKILLS Practicing and applying the knowledge on:	• How to access condoms, dental dams, and other types of barriers • How to discuss condom, dental dam, and other types of barrier use with a partner • Scripting unilateral use of a condom, a dental dam, or other type of barrier • How to use a condom, dental dam, or other type of barrier (e.g., opening the package, putting a condom on, taking it off; placing the dental dam over a partner's vulva and/or anus so that it creates a barrier between the mouth and the genitals) • Skills for pleasurable condom, dental dam, and other type of barrier use (e.g., assessing condom fit, placing lube on the inside of the condom or dental dam) • How to discuss and engage in alternative types of sex if no condom, dental dam, or other type of barrier is available

OBJECTIVE 2: **Increase STI testing**	
INFORMATION Acquire knowledge relating to:	• STI risk behaviours, transmission, and acquisition • Asymptomatic nature of STIs • Destigmatising STIs and STI testing • The types and effectiveness of STI tests and their window periods • How to access STI screening, testing, and prevention services • The standards of confidentiality when accessing sexual health services • Benefits of testing for oneself and one's partner(s)

OBJECTIVE 2: **Increase STI testing**	
MOTIVATION Discuss/ Address:	• Target audience's vulnerability to STIs • Ideas/beliefs about personal responsibility/safety • Ideas/beliefs around STI testing and stigma • Positive peer/public attitudes/norms towards STI testing • Post-screening/post-testing peace of mind
BEHAVIOURAL SKILLS Practicing and applying the knowledge on:	• Locating and accessing STI testing services • Obtaining psychological support after receiving a positive diagnosis • Communicating results to partners

OBJECTIVE 3: **Accessing HPV Vaccination**	
INFORMATION Acquire knowledge relating to:	• What is HPV • How HPV is transmitted • HPV prevalence • HPV and risk of cancer • Who should have the HPV vaccine and at what ages • Who is eligible for free vaccines • HPV vaccine effectiveness and side effects • Where to access the vaccines • Insurance coverage and/or communication regarding financing
MOTIVATION Discuss/ Address:	• Personal/parental/institutional/societal attitudes towards getting vaccinated • Perceptions of social support for getting vaccinated
BEHAVIOURAL SKILLS Practicing and applying the knowledge on:	• Discussing HPV vaccination with providers, parents, partners • Accessing vaccination funding if necessary and options for financial support • Navigating HPV vaccination process

OBJECTIVE 4: **Increasing awareness and use of PrEP and PEP for HIV prevention**	
INFORMATION Acquire knowledge relating to:	• The purpose and role of PrEP and PEP in preventing HIV • How PrEP and PEP work • Effectiveness of PrEP and PEP • Recommendations for PrEP and PEP use • Importance of STI testing and safer sex practices in conjunction with PrEP/PEP use • How to access PrEP and PEP • Cost, insurance, and healthcare coverage
MOTIVATION Discuss/ Address:	• The advantages/benefits of PrEP/PEP in preventing HIV infection • The importance of adherence (taking PrEP and PEP exactly as prescribed) to maximize effectiveness • Personal/institutional/societal attitudes towards PrEP and PEP
BEHAVIOURAL SKILLS Practicing and applying the knowledge on:	• Locating and accessing PrEP or PEP from appropriate settings/healthcare providers • Initiating discussions regarding PrEP or PEP in healthcare settings and with healthcare providers • Initiating discussions and maintaining open dialogue regarding PrEP with partners

OBJECTIVE 5: **Obtaining/discussing partner consent to sexual activity**	
INFORMATION Acquire knowledge relating to:	• General and legal definitions of clear, affirmative consent and sexual assault • Factors that contribute to non-consensual sexual activity • Understanding nonverbal communication • Discussion of consent within relationships (e.g., consent should not be assumed just because people are already in a relationship) • Communication skills needed to establish shared interest and mutual understanding of desired sexual behaviours

OBJECTIVE 5: **Obtaining/discussing partner consent to sexual activity**	
MOTIVATION Discuss/ Address:	• Personal attitudes towards the importance of clear, affirmative consent • Ideas/beliefs about personal responsibility to ensure the safety of others • Ideas about perceived social support for obtaining clear, affirmative consent • Perceived costs and benefits of clear, affirmative consent • Personal comfort and competency in navigating conversations related to sexual behaviours, interests, and boundaries.
BEHAVIOURAL SKILLS Practicing and applying the knowledge on:	• Bringing up and discussing/communicating own consent and obtaining consent from partners (e.g., personal script for obtaining/giving consent) • Assessing verbal and nonverbal consent skills throughout the sexual encounter to ensure there is unambiguous, ongoing, clear, affirmative consent • Bringing up and discussing shared interest and mutual understanding of desired sexual behaviours

OBJECTIVE 6: **Building capacity for educators to teach a comprehensive sexual health education curriculum**	
INFORMATION Acquire knowledge relating to:	• Sexual health and well-being • Guidelines for comprehensive sexual health education • Importance of comprehensive sexual health education for target audience and their right to receive comprehensive sexual health education • Understanding of curriculum specifications • Where to access resources and professional development • How to develop lesson plans • How to answer student questions • How to enhance confidence and comfort discussing sexual health topics

OBJECTIVE 6: **Building capacity for educators to teach a comprehensive sexual health education curriculum**	
	• How to deliver inclusive materials for individuals with a range of identities, biological differences, and abilities • Effective teaching strategies for sexual health topics • Strategies for dealing with parent/student discomfort • How to communicate and discuss sexual health and well-being with target audience
MOTIVATION Discuss/ Address:	• Perceived personal/parental/societal attitudes and values towards sexual health education • Perceived professional support for delivering curriculum • Perceived barriers and facilitators to curriculum implementation • Ideas and beliefs about professional responsibility • Personal comfort and competency with delivering materials for individuals with a range of identities, biological differences, and abilities • Identifying personal biases that may impact comfort delivering materials • The link between sexual health education and sexual health and well-being as a motivation enhancer
BEHAVIOURAL SKILLS Practicing and applying the knowledge on:	• How to develop a lesson plan • Teaching strategies • Dealing with parent/student discomfort • How to communicate and discuss sexual health and well-being with target audience • How to deliver materials for (and how to support) individuals from a range of identities, biological differences, and abilities

OBJECTIVE 7: **Increasing capacity to seek support following sexual assault**	
INFORMATION Acquire knowledge relating to:	• General and legal definitions of clear, affirmative consent and sexual assault • Healthy, unhealthy, and abusive relationships • Stereotypes and myths related to sexual coercion/assault (e.g., victim blaming, self-blame) • Available supports and services (e.g., personal, community, medical, legal) • Barriers to receiving help • Importance of disclosing to well-being • Confidentiality • Reporting and the legal system • Counseling • Strategies for supporting a person who discloses sexual coercion/assault
MOTIVATION Discuss/ Address:	• Perceived societal support for seeking sexual assault resources • Perceived support of family and peers to seek out sexual assault services • Perceived support for accessing legal (e.g., police) and healthcare (e.g., sexual assault centre, hospital) services related to sexual assault
BEHAVIOURAL SKILLS Practicing and applying the knowledge on:	• How to report sexual assault (e.g., within the legal system, healthcare system) • How to access various supports and services • Dealing with emotional barriers to reporting/disclosing • How to respond to a person's disclosure in a supportive capacity

ADDITIONAL THEORETICAL MODELS FOR THE DEVELOPMENT OF COMPREHENSIVE SEXUAL HEALTH EDUCATION PROGRAMS

There are a number of other well-tested and empirically supported theoretical models (described below) that can provide a solid foundation for the development of comprehensive sexual health education programs. However, it is important to note that models that address information or

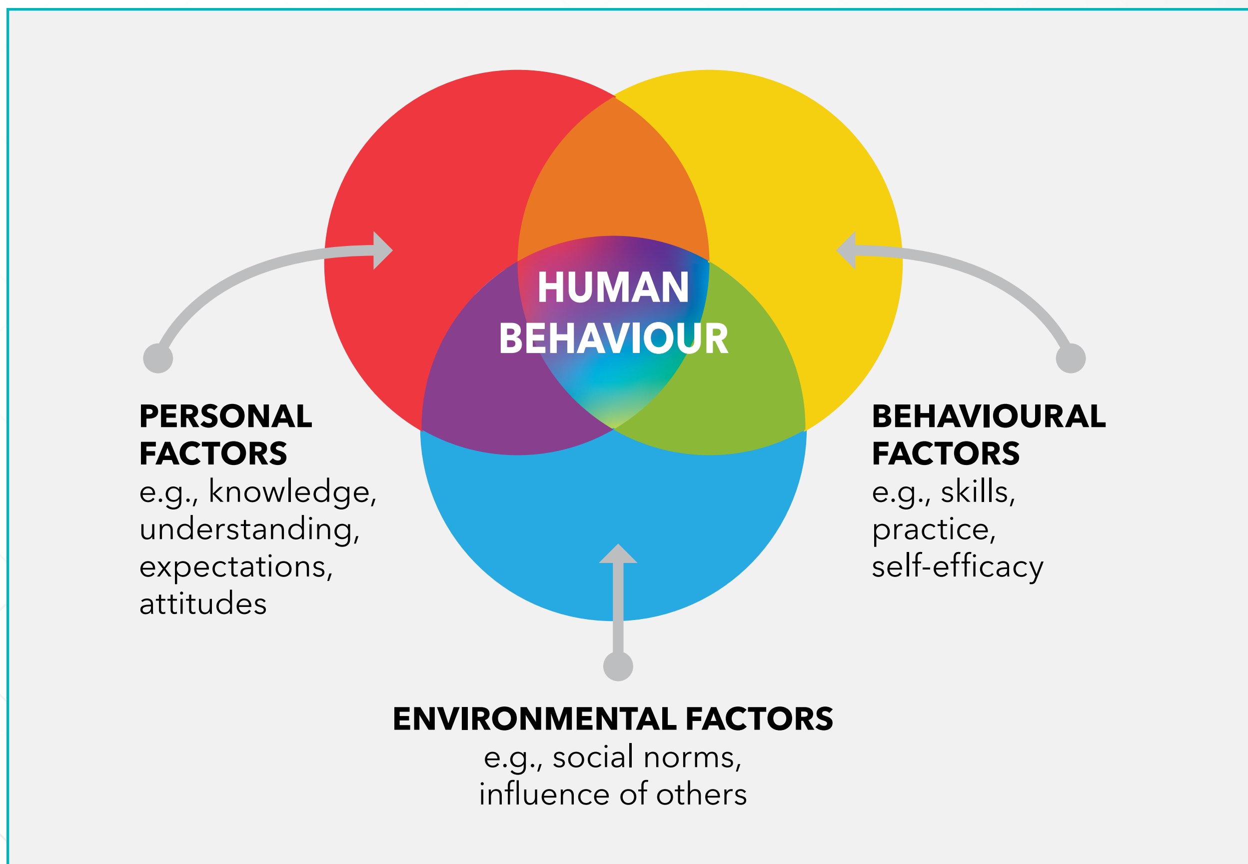
motivation alone (without attending to behavioural skills) are often insufficient to equip individuals to initiate and maintain patterns of sexual health behaviour.[1,2,3]

SOCIAL-COGNITIVE THEORY

Evaluation research indicates that health interventions informed by Social-Cognitive Theory (SCT) can help to enhance sexual health and well-being.[28,29,30,31]

SCT[6] suggests that people learn from one another by observation, imitation, and modelling. The theory provides a framework for understanding, predicting, and changing human behaviour and several of the components overlap with the IMB model. SCT identifies human behaviour as an interaction of personal, environmental, and behavioural factors (Figure 3).

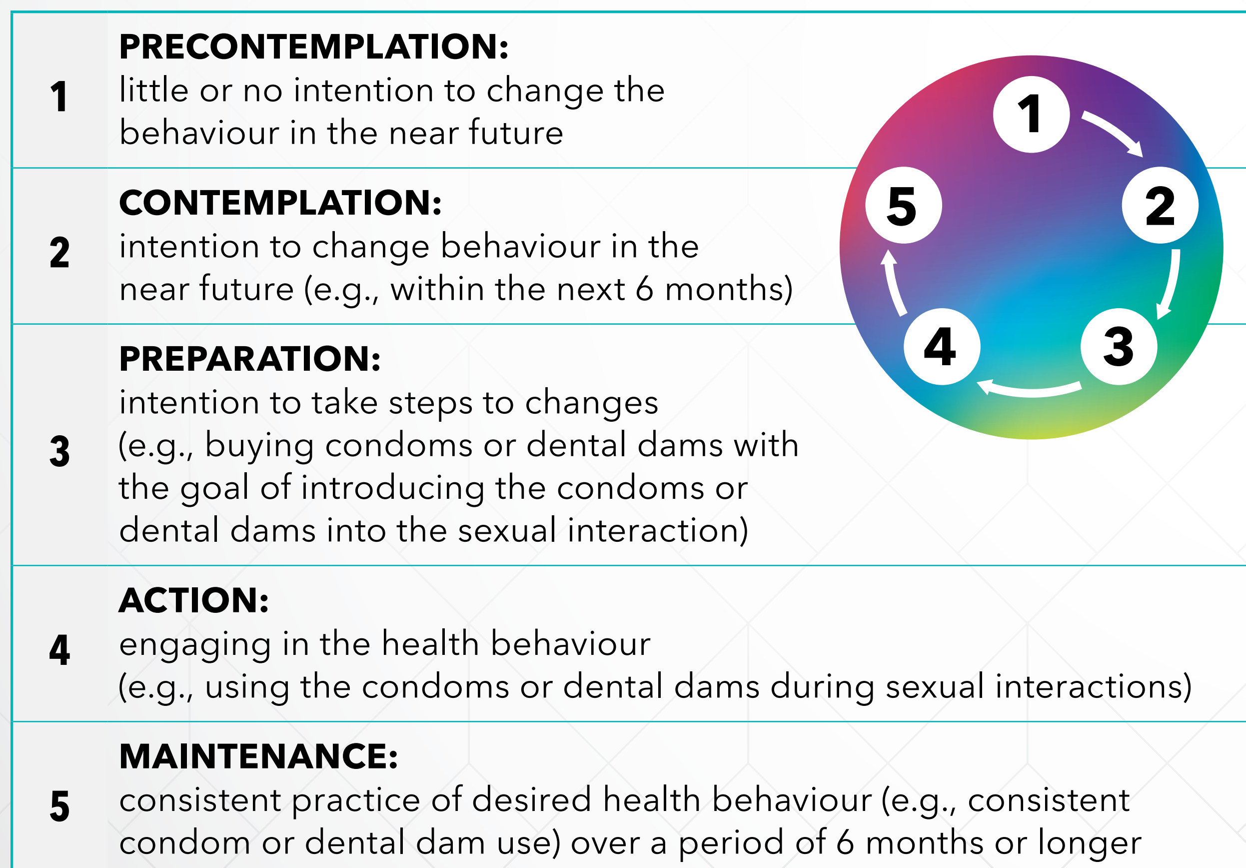
Figure 3: Social Cognitive Theory Factors



Social Cognitive Theory can be applied to sexual health education in several ways. For example, researchers applied SCT in an HIV and STI reduction intervention program at three public STI clinics.[31] The program activities targeted personal factors such as knowledge of condom use, and behavioural factors such as condom use self-efficacy, and how to discuss safer sexual behaviours with a partner. Consistent with SCT, developing an understanding about effective condom use and enhancing condom use self-efficacy was linked to higher condom use with a partner at a three-month follow-up.

TRANSTHEORETICAL MODEL

The Transtheoretical Model has provided the basis for effective STI and pregnancy prevention interventions[32,33] and the enhancement of sexual well-being.[34] This model considers behaviour change as a process rather than as an isolated event. According to the model, individuals participating in behaviour change interventions should be guided through a five-stage continuum:[9]



1	**PRECONTEMPLATION:** little or no intention to change the behaviour in the near future
2	**CONTEMPLATION:** intention to change behaviour in the near future (e.g., within the next 6 months)
3	**PREPARATION:** intention to take steps to changes (e.g., buying condoms or dental dams with the goal of introducing the condoms or dental dams into the sexual interaction)
4	**ACTION:** engaging in the health behaviour (e.g., using the condoms or dental dams during sexual interactions)
5	**MAINTENANCE:** consistent practice of desired health behaviour (e.g., consistent condom or dental dam use) over a period of 6 months or longer

The Transtheoretical Model has also shown promise for use in programs that aim to reduce the risk of dating violence among high school students.[35] For example, students completed an intervention focused on progress through the stages of change for using healthy relationship skills and skills for keeping oneself safe in a relationship. Those who completed the intervention were less likely to report several types of dating violence and more likely to report using healthy relationship skills compared to a group who did not complete the program.

THEORY OF REASONED ACTION AND THEORY OF PLANNED BEHAVIOUR

The Theory of Reasoned Action (TRA) and Theory of Planned Behaviour (TPB) are two related models that identify overlapping constructs as resulting in behaviour change. Both are well-tested and have provided the theoretical basis for effective interventions targeting STI prevention and condom use.[36,37,38]

The TRA is a theory that focuses on an individual's intention to behave a certain way.[5,8] This intention is determined by one or both of two major factors:

ATTITUDE	SUBJECTIVE NORMS
the individual's positive or negative feelings towards performing a specific behaviour	an individual's perception of social norms regarding the sexual health behaviour

The TPB is an extension of the TRA. The TPB proposes that behavioural intentions are a result of attitudes toward a behaviour, subjective norms toward the behaviour, and perceived behavioural control or the feeling that the individual can indeed perform the behaviour in question (i.e., self-efficacy). Research and interventions framed by the TPB have demonstrated the theory's applicability when targeting condom use among adolescents[36,39] and adults.[38] Research suggests that TPB constructs also predict HPV vaccine uptake among young adult women.[37]

The TRA and TPB have been incorporated into online multi-media programs to reduce unintended pregnancies and STIs among women.[40] For example, women who completed an interactive online program had more positive attitudes regarding communication with their partner and healthcare provider, increased self-efficacy for preventing pregnancy, and expressed greater intentions to use a contraceptive method and engage in STI risk reduction strategies.

REFERENCES

1 Fisher JD, Fisher WA. Changing AIDS-risk behavior. Psychological Bulletin. 1992;111;3:455.

2 Fisher WA, Fisher JD. Understanding and promoting sexual and reproductive health behavior: Theory and method. Annual Review of Sex Research. 1998;9;1:39-76.

3 Fisher WA, Fisher JD, Shuper PA. Social psychology and the fight against AIDS: An information–motivation–behavioral skills model for the prediction and promotion of health behavior change. Advances in Experimental Social Psychology. 2014;50:105-93.

4 Fuller TR, White CP, Chu J, Dean D, Clemmons N, Chaparro C, et al. Social Determinants and teen pregnancy prevention: Exploring the role of nontraditional partnerships. Health Promotion Practice. 2018;19(1):23-30.

5 Ajzen I, Fishbein M. Understanding attitudes and predicting social behaviour. 1980.

6 Bandura A. Social foundations of thought and action. Englewood Cliffs, NJ. 1986.

7 Bandura A. Health promotion by social cognitive means. Health Education and Behavior. 2004;31;2:143-64

8 Fishbein M, Ajzen I. Belief, attitude, intention and behavior: An introduction to theory and research. 1975.

9 Prochaska JA, Velicer, W.F. . The transtheoretical model of health change. American Journal of Health Promotion 1997;12;1:38-48.

10 UNESCO. International technical guidance on sexuality education: An evidence-based approach. Paris, France: United Nations Educational, Scientific and Cultural Organization. 2018.

11 Morales A, Espada JP, Orgilés M, Escribano S, Johnson BT, Lightfoot M. Interventions to reduce risk for sexually transmitted infections in adolescents: A meta-analysis of trials, 2008-2016. PloS ONE. 2018;13;6: e0199421.

12 Johns MM, Beltran O, Armstrong HL, Jayne PE, Barrios LC. Protective factors among transgender and gender variant youth: A systematic review by socioecological level. The Journal of Primary Prevention. 2018;39;3:263-301.

13 Sánchez-Fuentes MdM, Santos-Iglesias P, Sierra JC. A systematic review of sexual satisfaction. International Journal of Clinical and Health Psychology. 2014;14; 67-75.

14 Chang SJ, Choi S, Kim S-A, Song M. Intervention strategies based on information-motivation-behavioral skills model for health behavior change: A systematic review. Asian Nursing Research. 2014;8;3:172-81.

15 Morrison-Beedy D, Jones SH, Xia Y, Tu X, Crean HF, Carey MP. Reducing sexual risk behavior in adolescent girls: results from a randomized controlled trial. Journal of Adolescent Health. 2013;52;3:314-21.

16 Knight R, Karamouzian M, Salway T, Gilbert M, Shoveller J. Online interventions to address HIV and other sexually transmitted and blood-borne infections among young gay, bisexual and other men who have sex with men: a systematic review. Journal of the International AIDS Society. 2017;20;3: e25017.

17 Lopez LM, Tolley EE, Grimes DA, Chen-Mok M. Theory-based interventions for

contraception. Cochrane Database of Systematic Reviews. 2016; 11.

18 Fisher WA. Understanding human papillomavirus vaccine uptake. Vaccine. 2012;30:F149-F56.

19 Mustanski B, Greene GJ, Ryan D, Whitton SW. Feasibility, acceptability, and initial efficacy of an online sexual health promotion program for LGBT youth: the Queer Sex Ed intervention. The Journal of Sex Research. 2015;52;2:220-30.

20 Fullerton T, Rye B, Meaney GJ, Loomis C. Condom and hormonal contraceptive use by young women: An information-motivation-behavioral skills assessment. Canadian Journal of Behavioural Science/Revue canadienne des sciences du comportement. 2013;45;3:196.

21 Crosby RA, Salazar LF, Yarber WL, Sanders SA, Graham CA, Head S, et al. A theory-based approach to understanding condom errors and problems reported by men attending an STI clinic. AIDS and Behavior. 2008;12;3:412-8.

22 Jones J, Tiwari A, Salazar LF, Crosby RA. Predicting condom use outcomes via the information motivation behavioral skills model: An analysis of oung black men. International Journal of Sexual Health. 2018;30;1:1-11.

23 Bazargan M, Stein JA, Bazargan-Hejazi S, Hindman DW. Using the information-motivation behavioral model to predict sexual behavior among underserved minority youth. Journal of School Health. 2010;80;6:287-95.

24 Rye B, Yessis J, Brunk T, McKay A, Morris S, Meaney GJ. Outcome evaluation of Girl Time: Grade 7/8 ealthy sexuality program. Canadian Journal of Human Sexuality. 2008;17; 1-2: 15-36.

25 Robertson AR, St. Lawrence J, Morse DT, Baird-Thomas C, Liew H, Gresham K. The healthy teen girls project: Comparison of health education and STD risk reduction intervention for incarcerated adolescent females. Health Education & Behavior. 2011;38;3:241-50.

26 Zhang H, Liao M, Nie X, Pan R, Wang C, Ruan S, et al. Predictors of consistent condom use based on the information-motivation-ehavioral Sksills (IMB) model among female sex workers in Jinan, China. BMC Public Health. 2011;11;1:113.

27 Mittal M, Senn TE, Carey MP. Intimate partner violence and condom use among women: Does the information–motivation–behavioral skills model explain sexual risk behavior? AIDS and Behavior. 2012;16;4:1011-9.

28 Guse K, Levine D, Martins S, Lira A, Gaarde J, Westmorland W, et al. Interventions using new digital media to improve adolescent sexual health: A systematic review. Journal of Adolescent Health. 2012;51;6:535-43.

29 Kennedy SB, Nolen S, Applewhite J, Pan Z, Shamblen S, Vanderhoff KJ. A Quantitative study on the condom-use behaviors of eighteen-to twenty-four-year-old urban African American males. AIDS Patient Care and STDs. 2007;21;5:306-20.

30 Markham CM, Shegog R, Leonard AD, Bui TC, Paul ME. + CLICK: Harnessing web-based training to reduce secondary transmission

among HIV-positive youth. AIDS Care. 2009;21;5:622-31.

31 Snead M, O'Leary A, Mandel M, Kourtis A, Wiener J, Jamieson D, et al. Relationship between social cognitive theory constructs and self-reported condom use: Assessment of behaviour in a subgroup of the Safe in the City trial. BMJ Open. 2014;4;12; e006093.

32 Gold MA, Tzilos GK, Stein L, Anderson BJ, Stein MD, Ryan CM, et al. A randomized controlled trial to compare computer-assisted motivational intervention with didactic educational counseling to reduce unprotected sex in female adolescents. Journal of Pediatric and Adolescent Gynecology. 2016;29;1:26-32.

33 Myers JJ, Shade SB, Rose CD, Koester K, Maiorana A, Malitz FE, et al. Interventions delivered in clinical settings are effective in reducing risk of HIV transmission among people living with HIV: results from the Health Resources and Services Administration (HRSA)'s Special Projects of National Significance Initiative. AIDS and Behavior. 2010;14;3:483-92.

34 Lee JT, Tsai JL. Transtheoretical model-based postpartum sexual health education program improves women's sexual behaviors and sexual health. The Journal of Sexual Medicine. 2012;9;4:986-96.

35 Levesque DA, Johnson JL, Welch CA, Prochaska JM, Paiva AL. Teen dating violence prevention: Cluster-randomized trial of Teen Choices, an online, stage-based program for healthy, nonviolent relationships. Psychology of Violence. 2016;6;3:421.

36 Escribano S, Espada J, Morales A, Orgilés M. Mediation analysis of an effective sexual health promotion intervention for Spanish adolescents. AIDS and Behavior. 2015;19;10:1850-9.

37 Gerend MA, Shepherd JE. Predicting human papillomavirus vaccine uptake in young adult women: comparing the health belief model and theory of planned behavior. Annals of Behavioral Medicine. 2012;44;2:171-80.

38 Tyson M, Covey J, Rosenthal HE. Theory of planned behavior interventions for reducing heterosexual risk behaviors: A meta-analysis. Health Psychology. 2014;33;12:1454.

39 Espada JP, Morales A, Guillén-Riquelme A, Ballester R, Orgilés M. Predicting condom use in adolescents: A test of three socio-cognitive models using a structural equation modeling approach. BMC Public Health. 2015;16;1:35.

40 Swartz LH, Sherman CA, Harvey SM, Blanchard J, Vawter F, Gau J. Midlife women online: Evaluation of an internet-based program to prevent unintended pregnancy & STIs. Journal of Women & Aging. 2011;23;4:342-59.

PLANNING, DELIVERY, AND EVALUATION OF COMPREHENSIVE SEXUAL HEALTH EDUCATION

The purpose of this section is to assist with the process of planning, delivering, and evaluating new comprehensive sexual health education programs.

TWO APPROACHES ARE PRESENTED:	
The first is a basic assessment and planning, delivery, and evaluation framework that may be useful for programs that are relatively limited in scope and objectives.	The second approach, Intervention Mapping, is an extensive, detailed framework better suited to programs that are greater in scope, include multiple objectives, and have access to more resources.

These approaches are introduced here to illustrate the assessment and planning, delivery, and evaluation process as it applies to the creation of new programs. Aspects of both approaches can be used to assess and modify programs that are already in place.

A starting point for assessing existing programs is to assess the extent to which an education program or curriculum is consistent with the *Core Principles of Comprehensive Sexual Health Education*. A sample checklist to assess existing programs in relation to the *Core Principles* is provided below.

GUIDELINES

EXISTING SEXUAL HEALTH EDUCATION PROGRAMS AND CURRICULUMS SHOULD BE EVALUATED TO ASSESS THE EXTENT TO WHICH THEY ARE CONSISTENT WITH THE *CORE PRINCIPLES OF COMPREHENSIVE SEXUAL HEALTH EDUCATION*.

Sexual health education programs and curriculums that are found to be inconsistent with the *Core Principles* should be modified accordingly. Existing programs and curriculums should also be evaluated with respect to their effectiveness in reaching their stated objectives.

TO ENSURE AND MAINTAIN EFFECTIVENESS, SEXUAL HEALTH EDUCATION PROGRAMS SHOULD USE–AT MINIMUM–A BASIC PROCESS THAT INCLUDES THREE DISTINCT STEPS: ASSESSMENT AND PLANNING, DELIVERY, AND EVALUATION (SEE FIGURE 1).

This approach is useful for programs that have limited program objectives or are limited in scope and resources.

THE ASSESSMENT AND PLANNING PHASE SHOULD IDENTIFY THE TARGET AUDIENCE'S SEXUAL HEALTH EDUCATION NEEDS WITH RESPECT TO INFORMATION, ATTITUDES/ MOTIVATION, AND BEHAVIOURAL SKILLS. PROGRAM AND EVALUATION GOALS SHOULD ALSO BE ESTABLISHED.

For example, questionnaires can be used to assess the target audience's current level of information, motivation, and behavioural skills concerning specific aspects of sexual health and well-being.

IN THE DELIVERY PHASE, PLANNERS AND EDUCATORS SHOULD PROVIDE PROGRAM ACTIVITIES AND MATERIALS THAT ARE BASED ON THE ASSESSMENT FINDINGS, THE IDENTIFIED GOALS/OBJECTIVES, AND EVIDENCE-BASED RESEARCH AND THEORY.

Programs should address the gaps in the target audience's sexual health and well-being needs.

EVALUATION MEASURES SHOULD BE USED TO DETERMINE IF A SEXUAL HEALTH EDUCATION PROGRAM HAS BEEN SUCCESSFUL IN REACHING ITS STATED OBJECTIVES.

Evaluation results enable program planners to identify strengths and weaknesses in a sexual health education program so that, if necessary, modifications may be made to increase the program's effectiveness.

INTERVENTION MAPPING PROVIDES AN EXTENSIVE AND DETAILED PROCESS FRAMEWORK FOR THE DEVELOPMENT OF THEORY- AND EVIDENCE-BASED HEALTH PROMOTION PROGRAMS.

The Intervention Mapping process consists of six steps:

1	Needs assessment;
2	Specifying programme outcomes;
3	Selecting theory- and evidence-based intervention methods and practical applications;
4	Designing and organizing the program;
5	Specifying adoption and implementation plans; and
6	Generating an evaluation plan.

This framework may be useful for programs that are larger in scope or have multiple objectives.

THE *CORE PRINCIPLES OF COMPREHENSIVE SEXUAL HEALTH EDUCATION*: A CHECKLIST FOR EVALUATING EXISTING PROGRAMS/CURRICULUMS

The following checklist, adapted from the *Core Principles of Comprehensive Sexual Health Education*, can be utilized as a basic method to evaluate existing sexual health education programs and curriculums. The checklist can be adapted to correspond to a program's audience and specific stated objectives.

The sexual health education program/curriculum:

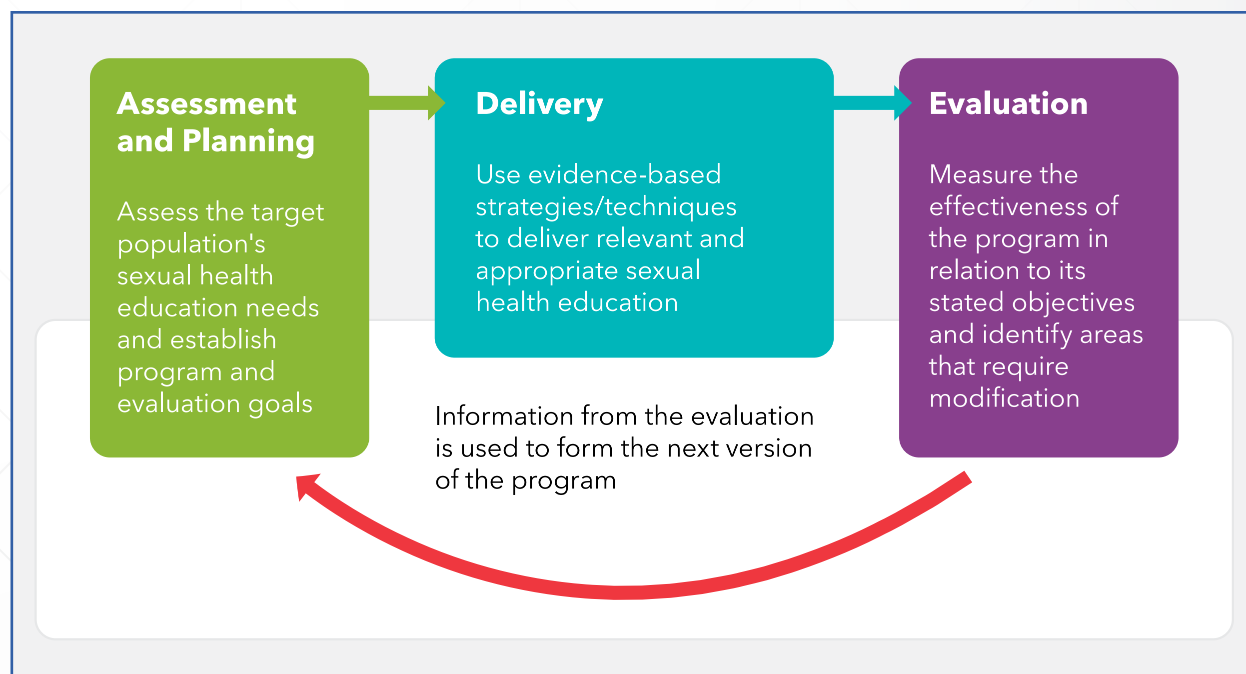
- Is equally accessible to all members of the intended audience, addresses the audience's specific learning needs, and is culturally-sensitive
- Respects/promotes human rights including autonomous decision-making and respect for the rights of others
- Is scientifically accurate and uses evidence-based teaching methods
- Is broadly-based in scope and depth and addresses the range of topics relevant to program/curriculum objectives
- Is inclusive of the identities and lived experiences of LGBTQI2SNA+ people
- Promotes gender equality and the prevention of sexual and gender-based violence
- Incorporates a balanced approach to sexual health promotion that includes the positive aspects of sexuality and relationships, as well as the prevention of outcomes that can have a negative impact on sexual health and well-being
- Is responsive to and incorporates emerging issues related to sexual health and well-being (e.g., addresses media/digital literacy skills)
- Is provided by educators who have the knowledge and skills to deliver the program or curriculum and who receive administrative support to deliver it
- Includes an assessment and planning, delivery, and evaluation process

BASIC PRINCIPLES OF ASSESSMENT AND PLANNING, DELIVERY, AND EVALUATION

In order to be effective, even relatively brief sexual health education initiatives/programs need to employ a basic assessment and planning, delivery, and evaluation process.

The three steps summarized below provide an outline of how to engage in this process (see Figure 1). In each step, the information-motivation-behavioural skills (IMB) model[1,2,3] (used to illustrate the components of comprehensive sexual health education; see Goals and Key Components) is applied to provide an example of how theoretical models can be used in the development, creation, and evaluation of sexual health education programs.

Figure 1: Three Step Process for Comprehensive Sexual Health Education



STEP 1: ASSESSMENT AND PLANNING

ASSESSMENT

- Assess the target population's sexual health education needs

  Effective sexual health education programs are based on a broad assessment and understanding of individual, community, and social needs.

  A needs assessment examines conditions within a community or target audience to determine the nature, depth, or scope of audience needs. This process involves collaboration with persons for whom the program is intended to be delivered.

  When possible, a community-based approach should be used to gather assessment information (i.e., engage meaningfully with the target audience to better understand what their specific needs are).

  Program planners should consider conducting a needs assessment, and/or a feasibility study (i.e., a study to assess the practicality of the program). Information from a needs analysis and a feasibility study will provide planners with information on what kind of programming is needed, and if the program is appropriate in terms of timing, resources, and audience.
- Determine baseline data related to specific sexual health attitudes, beliefs, social norms, knowledge, motivation, behaviours, and community-based outcomes. This can be completed using a variety of methods: e.g., existing data, focus groups, interviews, or surveys administered to a representative sub-sample of the target population.
- Use the information obtained in the assessment to establish specific program objectives.

STEP 1: ASSESSMENT AND PLANNING

PLANNING

- There are two kinds of planning that need to be considered: planning the program itself (i.e., the activities) and planning the evaluation of the program.
- Program planning should incorporate evaluation into the early planning stages. Careful program evaluation ensures that learning outcomes are clearly defined from the outset and are being met over time, which in turn can guide program delivery and modification. Program planning and design should be based on the current research, other program evaluations, and assessment of need.
- Determine the activities (using best practices, evidence-informed strategies, and information), outputs, and methods for collecting data.
- Determine methods for completing the analysis for outcomes (short, medium, and/or long-term).
- Determine roles and responsibilities with stakeholders.
- Develop a logic model or evaluation plan and ensure all necessary stakeholders are in agreement with the plan. The plan needs to be reasonable, feasible, and acceptable to stakeholders.
- Ensure that educators and program facilitators have appropriate training to implement the program and ensure that the program is implemented similarly across all educators and facilitators.
- Determine how the program will be evaluated. Program delivery evaluation consists of several forms, including *process* and *outcome* evaluation.

  The purpose of process evaluation is to improve the operation of an existing program and focuses on what the program does and for whom.

  The purpose of outcome evaluation is to assess the impact of a program and focuses on examining the changes that occurred as a result of the program and whether it is having the intended effect on stated objectives.

  The plan for evaluation should be built into the overall program plan, prior to its actual launch. This is especially important for outcome evaluation. In order to determine whether a program made a difference or not, there needs to be an understanding of how things were before the program was implemented (e.g., knowledge, attitudes, beliefs).

EXAMPLE

A needs assessment at a university campus might identify that LGBTQI2SNA+ students report experiences of discrimination and marginalization. Therefore, one program objective may be to enhance acceptance of gender and sexually diverse individuals.

In the assessment phase, a sub-sample of students may be selected to fill out a questionnaire to measure their:

- Knowledge related to the diversity of sexual and gender identities and expressions (information);
- Attitudes, perceptions, and social norms related to sexual and gender identities and expressions (motivation); and
- Skills and confidence in their own ability to identify and communicate about instances of homophobia, transphobia, etc. (behavioural skills).

STEP 2: DELIVERY

- Implement the sexual health education program based on the assessment findings and stated objectives.
- Incorporate evidence-based program materials.
- Apply theory-based components to achieve program objectives.
- For each target group, address where gaps exist in relation to the program objectives and needs of the individual.
- Use available assets to reach program objectives (e.g., community partnerships, physical structures, or locations where programs take place).
- Monitor program activities according to program design.

EXAMPLE

If the assessment phase of an intervention determined that seniors were at increased risk for STIs, the intervention phase may be designed to increase the use of barriers among seniors.

The intervention would be designed to:

- Fill knowledge gaps among the target group (information);
- Reinforce the group's personal views about barrier use and help them to personalize the risks of STIs (motivation); and
- Incorporate role-playing exercises to help individuals learn how to negotiate barrier use with partners and how to use a barrier (behavioural skills).

STEP 3: EVALUATION

- Evaluation is required to determine whether the program achieved its objectives. Therefore, evaluation methods should directly target the specific objectives outlined in the assessment and planning phase.
- Evaluation research enables program planners to identify strengths and weaknesses in the program so that, if necessary, modifications may be made to increase the program's effectiveness.
- Evaluation should also include a mechanism to capture any unintended outcomes that emerge separately from the stated objectives of the program. Such unintended outcomes may also identify particular strengths and weaknesses in the program that are not revealed by an analysis of just the stated objectives.
- It is important for program planners to consider and address factors that can have an impact on the validity of the evaluation findings.

    When possible, the evaluation of new programs should include a control group to ensure that observed changes are actually the result of the program and not the result of external influences.

STEP 3: EVALUATION

When there is a control group, program planners can ensure that all individuals in the target audience receive the potential benefits of the program by providing a modified/improved version of it to the control group after the evaluation process is completed (i.e., a staggered implementation approach).

Using different types of measures (quantitative and qualitative) can increase confidence in the evaluation data.

It is also necessary to document the extent and quality of the program implementation (i.e., process evaluation). If a program fails to meet its objectives, it is important to know whether it was a result of the core components of the program, or as a result of other factors (e.g., whether the program was not implemented as planned, a lack of sensitivity/ specificity of the assessment measures, a poorly conducted evaluation).

- Program planners should carefully consider if their evaluation procedures require review from a research ethics board. For example, projects that involve a staggered implementation approach or control groups should be assessed to ensure that no potential harms can result from using these evaluation procedures.

EXAMPLE

The evaluation phase of a community-based sexual health education program focusing on HPV-related cancer prevention might include the following steps:

- Determining specific and measurable program objectives, in this case:
  1) Increasing HPV-related knowledge
  2) Increasing HPV-prevention behaviours
- At the beginning of the program, participants would complete a questionnaire that assesses:

  Their knowledge of the prevalence, causes and preventive measures associated with HPV-related cancer (information),

  Their personal attitudes towards taking the necessary precautions to reduce their risk of HPV-related cancer (motivation,) and

  Their perceived ability and skills to change risk behaviours (e.g., barrier use) and seek screening/ vaccination services to reduce the risk of HPV-related cancer (behavioural skills).

EXAMPLE

- The questionnaire could directly assess the occurrence and frequency of risk behaviours (e.g., barrier-free oral, anal, or vaginal sex). In this case, the questionnaire should ask the participants whether they have been screened for cervical or anal cancer and, if so, how frequently and determine whether the participants have received the HPV vaccine.
- Use a staggered implementation approach: randomly split individuals (or any other units receiving the program, such as classes or schools) that have completed the questionnaire into two groups:
  1) A control group that does not receive the new sexual health education program (or receives a standard version of the program, until evaluation has been completed) and
  2) An intervention group that does receive the program.
- As part of the evaluation process, the questionnaire would be re-administered to both groups after the program has been completed to measure the extent of change in each targeted area in order to determine program effectiveness.
- Program planners would review the results in order to identify parts of the program that require modification. The control group would then receive a modified/improved version of the program.

INTERVENTION MAPPING

Intervention Mapping provides a process framework for the development of theory- and evidence-based health promotion and disease prevention programs.[4,5] Intervention Mapping is a logical process involving a series of sequential and iterative steps that guide development of evidence- and theory-based interventions.

Intervention Mapping uses a structured and detailed planning process to ensure that interventions are grounded in the needs of target audiences, informed by theory and evidence, and sensitive to the organizational, environmental, and cultural contexts in which they are embedded.[6]

The Intervention Mapping approach has been used to plan and develop a range of health promotion interventions and can be used for sexual health education programs with a wide variety of objectives.

Intervention Mapping has been used to develop programs targeting:

- increasing the quantity and quality of parent-child communication about sexuality[6]
- promotion of STI testing among youth[7]
- HIV pre-exposure prophylaxis program implementation[8]
- creation of a website and web app to increase youth use of sexual health services[9]
- reduction of sexual orientation-based prejudice among high school students[10]
- the selection and dissemination of evidence-based sexual health education programs.[11]

INTERVENTION MAPPING AND THE PROCESS OF PROGRAM DEVELOPMENT
1. NEEDS ASSESSMENT
Meaningfully engage with community members and other stakeholders to identify the health issue or education need and the individual or environmental factors that contribute to it. For example, sexual health related statistics on the population group in question can help to identify the need for a sexual health education program. Focus group sessions and needs assessment questionnaires can identify the specific educational needs of the group.
2. IDENTIFICATION OF GENERAL PROGRAM GOALS AND SPECIFIC OBJECTIVES

Based on the needs assessment, program planners, in consultation with key stakeholders, identify what they hope will change as a result of the sexual health education program.

- What do individuals need to learn?
- What information, attitudes, and or behavioural skills need to be targeted?
- If the program will specifically target environmental factors outside of the individuals' control, what must be changed in the environment for the program to achieve its objectives?
- In sum, what are the determinants of individual and community change?

3. SELECTION OF APPROPRIATE THEORETICAL MODEL(S) AND STRATEGIES

Select a theoretical model that best matches the specific sexual health education program objectives (e.g., IMB model, Social Cognitive Theory, Theory of Planned Behaviour).

The selected theoretical model can then be used to develop and inform the strategies/methods that will be used to achieve the specific program objectives.

4. DESIGN OF PROGRAM

Program planners organize the strategies/methods into a realistic deliverable program feasible for the target audience and setting.

5. DEVELOPMENT OF PROGRAM IMPLEMENTATION PLAN

Develop an evidence-based plan for the adoption, implementation and sustainability of the program.

- This includes a specific schedule of interactions and information exchange between those who deliver the program and those who receive it.

6. DEVELOPMENT OF A PROGRAM EVALUATION PLAN

Generate an evaluation plan to measure the effect of the program in achieving the specific program objectives.

Process evaluations can also be useful in determining the ways the program can be improved the next time it is delivered.

Conduct outcome and process evaluations.

REFERENCES

1 Fisher JD, Fisher WA. Changing AIDS-risk behavior. Psychological Bulletin. 1992;111; 3: 455.

2 Fisher WA, Fisher JD. Understanding and promoting sexual and reproductive health behavior: Theory and method. Annual Review of Sex Research. 1998;9;1: 39-76.

3 Fisher WA, Fisher JD, Shuper PA. Social psychology and the fight against AIDS: An information–motivation–behavioral skills model for the prediction and promotion of health behavior change. Advances in Experimental Social Psychology. 2014;50: 105-93.

4 Bartholomew LKE, Markham CM, Ruiter RA, Kok G, Fernandez ME, Parcel GS. Planning health promotion programs: An intervention mapping approach. San Francisco, CA, 2016.

5 Garba RM, Gadanya MA. The role of intervention mapping in designing disease prevention interventions: A systematic review of the literature. PloS ONE. 2017;12;3: e0174438.

6 Newby K, Bayley J, Wallace LM. “What should we tell the children about relationships and sex?”©: Development of a program for parents using intervention mapping. Health Promotion Practice. 2011;12;2:209-28.

7 Wolfers M, de Zwart O, Kok G. The systematic development of ROsafe: An intervention to promote STI testing among vocational school students. Health Promotion Practice. 2012;13; 3: 378-87.

8 Flash CA, Frost EL, Giordano TP, Amico KR, Cully JA, Markham CM. HIV pre-exposure prophylaxis program implementation using intervention mapping. American Journal of Preventive Medicine. 2018;54;4: 519-29.

9 Newby KV, Brown KE, Bayley J, Kehal I, Caley M, Danahay A, et al. Development of an intervention to increase sexual health service uptake by young people. Health Promotion Practice. 2017;18;3: 391-9.

10 Mevissen FE, Kok G, Watzeels A, van Duin G, Bos AE. Systematic development of a Dutch school-based sexual prejudice reduction program: An intervention mapping approach. Sexuality Research and Social Policy. 2018;15; 433-451.

11 Hernandez BF, Peskin MF, Shegog R, Gabay EK, Cuccaro PM, Addy RC, et al. iCHAMPSS: Usability and psychosocial impact for increasing implementation of sexual health education. Health Promotion Practice. 2017;18;3: 366-80.

EDUCATORS AND SETTINGS FOR THE PROVISION OF COMPREHENSIVE SEXUAL HEALTH EDUCATION

In order to be accessible to all people in Canada, multiple sectors of society need to participate in the delivery of comprehensive sexual health education.

This section identifies key educators and settings that have important roles in ensuring equitable access to comprehensive sexual health education across the life span. A checklist of steps for providing brief sexual health education programs in diverse settings is provided below.

GUIDELINES

TO ENSURE THAT IT IS ACCESSIBLE TO ALL PEOPLE IN CANADA, COMPREHENSIVE SEXUAL HEALTH EDUCATION SHOULD BE PROVIDED IN, AND THROUGH, A RANGE OF RELEVANT SETTINGS.

These settings include:
- The home
- Schools, colleges, and universities
- Public health units/departments
- Health care settings (hospitals, public/community health clinics, primary care offices, college/university campus heath units/school nurse offices)
- Short and long-term care facilities serving children, youth, adults, and seniors with disabilities or chronic illnesses

- Community-based organizations serving: seniors (e.g., long-term care); LGBTQI2SNA+ youth and adults; Indigenous people including First Nations, Inuit, and Metis communities; ethnocultural minorities, newcomers and immigrant communities; street-involved youth and adults, vulnerably-housed individuals, people who use drugs, and sex workers
- Religious Institutions (e.g., churches, mosques, synagogues, temples)
- Detention and correctional facilities

POLICY MAKERS SHOULD ENSURE THAT INDIVIDUALS AND GROUPS WORKING IN A RANGE OF RELEVANT SETTINGS ARE PROVIDED WITH THE RESOURCES AND TRAINING OPPORTUNITIES TO INCREASE THEIR CAPACITY TO DELIVER COMPREHENSIVE SEXUAL HEALTH EDUCATION.

These individuals and groups include:

- Parents, guardians, and extended family members
- Community elders and other community leaders
- Teachers, educational assistants, school nurses, counselors and other trained sexual health educators (e.g., teachers specifically trained to provide sexual health education; sexual health educators from community-based organizations) in schools
- Public/community health department nurses, physicians, and educators
- Primary health care physicians and nurses
- Allied health professionals (e.g., midwives, doulas, physiotherapists, occupational therapists, psychologists, social workers)
- Health and education personnel working with children, youth, adults, and seniors with developmental, intellectual, and physical disabilities or chronic illnesses
- Indigenous midwives/doulas and other health providers in First Nations, Inuit, and Metis communities
- Personnel serving and working with seniors; LGBTQI2SNA+ people; ethnocultural minorities, newcomers, and immigrant communities; street-involved youth and adults, vulnerably-housed people, people who use drugs, and sex workers
- Detention and correctional facility personnel

PARENTS AND GUARDIANS SHOULD BE SUPPORTED IN THEIR ROLE AS SEXUALITY EDUCATORS OF THEIR CHILDREN.

Parents and guardians play a pivotal and complementary role in the sexual health education of their children. They provide guidance, communicate their values, and set behavioural expectations for their children related to sexuality.

Parents and guardians should be supported through access to sexual health education resources designed for their needs. As such, the home is a key setting for important aspects of sexual health education which can complement comprehensive sexual health education provided in schools and other settings. Parents and guardians should have the opportunity to provide constructive input to schools on the sexual health education needs of their children.

PROVINCIAL/TERRITORIAL MINISTRIES OF EDUCATION SHOULD ENSURE THAT CHILDREN AND YOUTH RECEIVE AGE-APPROPRIATE SCHOOL-BASED COMPREHENSIVE SEXUAL HEALTH EDUCATION FROM THE BEGINNING OF ELEMENTARY SCHOOL TO THE END OF HIGH SCHOOL.

Every provincial/territorial ministry of education mandates that young people receive some form of education on sexual health.

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

It is, therefore, essential that schools provide sexual health education beginning in the early school years and continuing to the end of the high school years that is consistent with the *Core Principles of Comprehensive Sexual Health Education*.

TEACHERS, EDUCATIONAL ASSISTANTS, SCHOOL NURSES, AND OTHER TRAINED SEXUAL HEALTH EDUCATORS IN SCHOOLS SHOULD HAVE ACCESS TO SUFFICIENT RESOURCES AND TRAINING OPPORTUNITIES TO PROVIDE COMPREHENSIVE SEXUAL HEALTH EDUCATION.

Teachers, educational assistants, school nurses, and other trained sexual health educators (e.g., teachers specifically trained to provide sexual health education) in schools play an essential role in the provision of comprehensive sexual health education to children and youth.

Colleges and universities responsible for the pre-service training of school teachers, nurses, and other sexual health educators should be strongly encouraged to provide access to in-depth training on the provision of comprehensive sexual health education.

Teachers, nurses, and other trained sexual health educators in schools who provide sexual health education should have access to sufficient resources to teach sexual health education effectively, in-service training, and continuing education opportunities to increase their capacity to teach comprehensive sexual health education effectively.

This includes training on how to implement sexual health education curriculum with diverse populations (e.g., LGBTQI2SNA+ students) and to effectively teach students the media and digital literacy skills to access accurate and unbiased sexual health information online.

PROVINCIAL/TERRITORIAL MINISTRIES OF HEALTH SHOULD ENSURE THAT PUBLIC HEALTH UNITS/DEPARTMENTS ARE SUPPORTED IN PROVIDING COMPREHENSIVE SEXUAL HEALTH EDUCATION.

Public health units/departments across Canada provide a range of important sexual health promotion services (e.g., STI testing and prevention, provision of sexual health information). In providing these services, they are well-placed to deliver specifically targeted sexual health education to people of all ages who may lack access from other sources.

Provincial/territorial ministries of health should support public health units/departments in providing comprehensive sexual health education. This should include providing public health unit/department nurses, educators, and other relevant personnel with opportunities for in-service and continuing education to increase their capacity to provide comprehensive sexual health education to the public.

PRIMARY HEALTH CARE PROVIDERS AND ALLIED HEALTH PROFESSIONALS SHOULD RECEIVE PRE- AND IN-SERVICE TRAINING TO FULFILL THEIR ROLES AS AUTHORITATIVE SOURCES OF SEXUAL HEALTH EDUCATION.

For many people in Canada, primary health care providers (e.g., physicians and nurses working in primary care offices, hospitals, public/community health clinics, college/university campus heath centres, and school nurse offices) are a preferred source of authoritative sexual health information.

Allied health professionals who work in primary health-care settings (e.g., psychologists, social workers, occupational therapists, physiotherapists) are also in a position to provide specifically targeted sexual health education.

Colleges and universities providing in-service training to primary healthcare providers should include sexual health education training consistent with the *Core Principles of Comprehensive Sexual Health Education*. In-service sexual health education training geared to specific health care settings should also be provided to primary healthcare providers.

Training in best practices and competency to work with LGBTQI2SNA+ individuals and other marginalized populations is essential to ensure that these populations have access to and receive accurate, supportive, and affirming sexual health education that meets their specific learning needs.

SHORT AND LONG-TERM CARE FACILITIES SERVING CHILDREN, YOUTH, ADULTS, AND SENIORS WITH DISABILITIES OR CHRONIC ILLNESSES SHOULD PROVIDE ACCESS TO COMPREHENSIVE SEXUAL HEALTH EDUCATION.

Children, youth, adults, and seniors with developmental, intellectual, and physical disabilities, as well as people with chronic illnesses, often lack access to sexual health education relevant to their specific needs. Every person has individual needs, strengths, and challenges. Comprehensive sexual health education should be adapted to clients' specific learning needs. Personnel in these facilities can be provided with opportunities for in-service and continuing education to increase their capacity to provide comprehensive sexual health education. Staff should be trained to connect individuals to appropriate services.

Colleges and universities providing pre-service training for front-line workers (e.g., caregivers, personal support workers, learning attendants) working with persons with developmental, intellectual, physical disabilities, and/or chronic illnesses should include sexual health training consistent with the *Core Principles of Comprehensive Sexual Health Education*.

SEXUAL HEALTH EDUCATION FOR INDIGENOUS PEOPLE, INCLUDING FIRST NATIONS, INUIT, AND MÉTIS COMMUNITIES MUST BE CULTURALLY SAFE AND EMBODY COMMUNITY-SPECIFIC VALUES RELATED TO SEXUALITY AND SEXUAL HEALTH.

Indigenous people, including First Nations, Inuit, and Métis communities, have their own distinct traditions, values, and communication practices with respect to sexuality and sexual health.

It is important for sexual health educators to be aware of the historical context of colonialism, imperialism, and capitalism and the intergenerational impact on First Nations, Inuit, and Métis people with respect to sexuality and sexual health.

Educators should actively engage in a respectful way with First Nations, Inuit, and Métis individuals and groups to tailor sexual health education to their specific needs and values.

There are a range of individuals (e.g., traditional midwives/doulas) and community and health organizations within First Nations, Inuit, and Métis communities that play active roles in providing sexual health education. Policy makers should ensure that these individuals and groups have access to sufficient resources and training opportunities to provide comprehensive sexual health education in their communities.

COMMUNITY-BASED ORGANIZATIONS SERVING LGBTQI2SNA+ YOUTH AND ADULTS ARE ESSENTIAL PROVIDERS OF COMPREHENSIVE SEXUAL HEALTH EDUCATION AND SHOULD BE ADEQUATELY FUNDED TO PROVIDE SEXUAL HEALTH EDUCATION AND SERVICES THROUGHOUT CANADA.

Community-based organizations play an essential role in ensuring and promoting the sexual health and well-being of LGBTQI2SNA+ youth and adults. Due to persistent and ongoing discrimination, violence, marginalization, and stigma, LGBTQI2SNA+ people face many obstacles and challenges in establishing and maintaining their sexual health and well-being.

Some LGBTQI2SNA+ youth and adults may not have access to comprehensive sexual health education programs in schools and healthcare settings that meet their needs. Therefore, it is important to offer sexual health education in community organizations dedicated to LGBTQI2SNA+ populations.

For many LGBTQI2SNA+ youth and adults, community-based organizations are the most important, if not only, source of sexual health education and services that meets their specific needs.

This may be of particular concern in the case of rural parts of Canada where adequate access to sexual health education and services for LGBTQI2SNA+ youth and adults is lacking. Access to accurate online resources is essential for individuals who cannot access face-to-face services. Policy makers should ensure that community-based and online organizations serving LGBTQI2SNA+ youth and adults across Canada are adequately funded to provide comprehensive sexual health education and services.

ORGANIZATIONS SERVING ETHNOCULTURAL MINORITIES, NEWCOMERS AND IMMIGRANT COMMUNITIES CAN PLAY AN IMPORTANT ROLE IN PROVIDING COMPREHENSIVE SEXUAL HEALTH EDUCATION.

For comprehensive sexual health education to be accessible to all people in Canada, it is necessary that programs addressing the community specific sexual health education needs of ethnocultural minorities, newcomers, and immigrant communities are developed and made widely available.

Ethnocultural identity shapes sexuality and sexual health attitudes and behaviours. For example, ethnocultural factors may influence attitudes towards marriage, gender identity and expression, sexual orientation, sexual health education, and sexual relationships. As a result, it is important that ethnocultural minorities, newcomers, and immigrant communities receive culturally-competent sexual health education that is inclusive of their diverse individual and group needs.

The goal of providing culturally-competent sexual health education should be balanced with the right of all people in Canada to receive education that is fully consistent with the *Core Principles of Sexual Health Education*.

In-person and online community organizations serving these groups are well-placed to provide sexual health education and policy makers should ensure that they have adequate resources and training opportunities to do so. Personnel working within these organizations should be properly trained to connect individuals to appropriate services.

RELIGIOUS INSTITUTIONS SHOULD SEEK TO PROVIDE SEXUAL HEALTH EDUCATION THAT IS CONSISTENT WITH THE *CORE PRINCIPLES OF COMPREHENSIVE SEXUAL HEALTH EDUCATION*

Many people in Canada look to religious institutions (e.g., churches, mosques, synagogues, temples) to inform their values and seek guidance from their religious leaders related to sexuality. As such, religious institutions may be involved in the provision of sexual health education.

Where religious institutions do provide sexual health education, they are strongly encouraged to consult the *Canadian Guidelines for Sexual Health Education*, with specific reference to the *Core Principles of Comprehensive Sexual Health Education*.

Religious institutions providing sexual health education should ensure that the personnel providing education are properly trained to connect individuals to appropriate sexual health services.

COMMUNITY-BASED ORGANIZATIONS SERVING STREET-INVOLVED YOUTH AND ADULTS, VULNERABLY-HOUSED INDIVIDUALS, PEOPLE WHO USE DRUGS, AND SEX WORKERS SHOULD LINK INDIVIDUALS TO SEXUAL HEALTHCARE SERVICES, HAVE STAFF THAT ARE PROPERLY TRAINED TO CONNECT INDIVIDUALS TO APPROPRIATE SERVICES, AND SHOULD BE ADEQUATELY FUNDED TO PROVIDE SEXUAL HEALTH EDUCATION AND SERVICES THROUGHOUT CANADA.

Street-involved youth and adults, vulnerably-housed individuals, people who use drugs, and sex workers often face many economic, physical safety, mental health, and social challenges. They are vulnerable to negative sexual health outcomes including sexual and gender-based violence, STIs, and unintended pregnancy.

Many street-involved youth are not in school and do not have access to school-based sexual health education. They often experience significant barriers to health care and other supports. Community-based organizations may be the only available and accessible source of sexual health education for street-involved and vulnerably-housed people. People who use drugs and sex workers may avoid contact with traditional service agencies for fear of judgment.

Harm reduction organizations also play an important role in linking these groups to sexual healthcare services. It is, therefore, essential that policy makers adequately fund organizations that serve these populations and ensure that staff are properly trained to provide comprehensive sexual health education and to connect individuals to sexual healthcare services.

ORGANIZATIONS SERVING SENIORS SHOULD PROVIDE ACCESS TO COMPREHENSIVE SEXUAL HEALTH EDUCATION.

Sexual health and well-being remain fundamental aspects of the overall well-being of seniors (i.e., people aged 65 and over). Sexual health and well-being are also of equal importance for seniors living in long-term care facilities (e.g., retirement and nursing homes, assisted-living facilities).

There are many potential challenges to the sexual health and well-being of people living in long-term care facilities including loneliness, isolation, loss of a partner, and a range of physical and mental chronic conditions. Despite these challenges, many residents of long-term care facilities wish to maintain and optimize their sexual health and well-being and can greatly benefit from comprehensive sexual health education targeted to their specific needs.

Policy makers should consider the sexual health education of residents when creating and implementing policies related to long-term care facilities serving seniors. Comprehensive sexual health education in long-term care facilities should be accessible and tailored to residents' learning needs.

Personnel in these facilities should be provided with opportunities for in-service and continuing education to increase their capacity to provide effective comprehensive sexual health education to seniors, including LGBTQI2SNA+ seniors, and should include training to connect seniors to appropriate sexual health services.

DETENTION AND CORRECTIONAL FACILITIES SHOULD PROVIDE ACCESS TO COMPREHENSIVE SEXUAL HEALTH EDUCATION.

Youth and adults in the care of correctional facilities are at risk for negative sexual health outcomes such as STIs and sexual and gender-based violence. Some have become involved with the criminal justice system as a result of their perpetration of sexual and gender-based violence. Many youth and adults in the care of correctional facilities have no access to much needed sexual health education.

Policy makers overseeing facilities serving these populations should ensure that comprehensive sexual health education tailored to client learning needs is accessible and that personnel in these facilities are provided with opportunities for in-service and continuing education to increase their capacity to provide effective comprehensive sexual health education.

CHECKLIST STEPS FOR PROVIDING BRIEF SEXUAL HEALTH EDUCATION PROGRAMS IN DIVERSE SETTINGS

Educators in diverse settings conduct sexual health education programs of varying scope, depth, and length. In-person group education sessions, individual assessment and counseling, classroom lessons, provincial/territorial health and education curriculums, websites and social media platforms/campaigns, videos, apps, factsheets, and brochures are a few examples of the variety of methods and materials that can be used to provide sexual health education.

The objectives of sexual health education programs may vary from increased factual knowledge about a particular sexual health topic, to sustained individual/group behavioural change, to community or societal level structural changes involving sexual health and well-being.

Program planners involved in sexual health education should consult the Goals and Key Components and Planning, Delivery, and Evaluation sections of these *Guidelines* for information related to designing, delivering, and evaluating programs that are greater in scope or include multiple objectives. Program planners developing new sexual health education programs with limited objectives and brief duration can also use the check list below to guide new program development and delivery.

STEPS FOR PROVIDING BRIEF SEXUAL HEALTH EDUCATION PROGRAMS IN DIVERSE SETTINGS	
1	Ensure consultation with administrative and community stakeholders (including meaningful engagement with target audience, e.g., students).
2	Create statement of program rationale and objectives.
3	Review relevant literature, best practices, and programs with same/similar objectives.
4	Develop planning, delivery, and evaluation plan.
5	Ensure sufficient financial resources and personnel are in place to deliver the program.
6	Generate an assessment of program personnel comfort level, knowledge, and skills to deliver the program; provide training if necessary (e.g., community health educators and service providers may need to receive cultural competency training to deliver the program).
7	Review assessment and consultation with intended audience to determine audience-specific characteristics and needs.
8	Assess internal and external resources and connect to relevant community partners and services/resources as appropriate.
9	Develop program materials/resources.
10	Review of program for consistency with the *Core Principles of Comprehensive Sexual Health Education*.

BENCHMARKS FOR SEXUALLY TRANSMITTED INFECTION (STI) PREVENTION AND LINKING TO STI TESTING SERVICES IN SCHOOLS

Sexually transmitted infections (STIs) can negatively impact the health and well-being of young people in Canada, particularly if left untreated. There are a broad range of factors that increase a person's risk for acquiring an STI. These include societal structures and conditions (e.g., socio-economic status, housing status, levels of equality related to gender, sexual orientation, race, and Indigenous identity).

Comprehensive sexual health education should address these factors in seeking to equip youth with the information, motivation, and behavioural skills to reduce their risk of STIs. As a part of this process, it is critical to provide children and youth with timely and age-appropriate information related to personal STI prevention, testing, treatment, and management.

Comprehensive sexual health education can effectively assist youth and young adults in reducing their risk for STI acquisition or transmission and increase their capacity to access STI testing, management, and treatment services.[1,2,3,4,5,6]

This section outlines specific benchmarks for the provision of STI prevention information and the linking of youth to STI testing within school-based curricula.

GUIDELINES

THE MOST EFFECTIVE SCHOOL-BASED STI PREVENTION EFFORTS ARE INCORPORATED WITHIN A COMPREHENSIVE SEXUAL HEALTH EDUCATION CURRICULUM AIMED AT BOTH ENHANCING SEXUAL HEALTH AND WELL-BEING AND PREVENTING OUTCOMES THAT CAN HAVE A NEGATIVE IMPACT ON SEXUAL HEALTH AND WELL-BEING.

Sexual health education should include information directly related to STIs (e.g., STI stigma, risk, prevention, treatment, and management) and information that helps students build the skills needed to seek appropriate resources and make decisions that support their sexual health and well-being (e.g., developing healthy relationships).

SEXUAL HEALTH EDUCATION IN SCHOOLS SHOULD AVOID SHAME OR FEAR-BASED APPROACHES TO STI PREVENTION.

The stigma associated with STIs and STI testing can result in shame and avoidance of testing, treatment, and communicating with partners about barrier use during sexual interactions. Therefore, sexual health education should seek to reduce STI-related stigma.

THE DEVELOPMENT OF SKILL SETS AND THE PROVISION OF SEXUAL HEALTH INFORMATION SHOULD BEGIN IN EARLY GRADES (I.E., KINDERGARTEN THROUGH GRADE 3) AND CONTINUE THROUGHOUT STUDENTS' EDUCATION.

Learning about the proper names for one's body parts, appropriate hygiene activities, relationships, and consent are all integral concepts students must understand and apply to reduce their STI risk and enhance their sexual well-being.

STUDENTS CAN BEGIN BEING PROVIDED WITH INFORMATION RELATED TO THE HPV VACCINE IN GRADE 4 AND GIVEN MORE DETAILED STI INFORMATION IN AGE-APPROPRIATE WAYS THROUGHOUT GRADES 5-7/8 .*

Discussions and skill development related to the prevention, treatment, and management of STIs should continue throughout Grades 8/9-12 but include more detailed information.

** In some places in Canada, high school begins in Grade 7, Grade 8, or Grade 9.*

YOUTH SHOULD BE LINKED TO COMMUNITY STI TESTING SERVICES BY GRADE 7.

Students should also be provided with information linking them to community services that provide confidential counseling and information on sexual and reproductive health.

THE IMPORTANCE OF PROVIDING CHILDREN AND YOUTH WITH AGE-APPROPRIATE EDUCATION ON STIS AND STI TESTING SERVICES

STIs are a significant public health concern in Canada.[7,8] STIs can have a substantial impact on the health and wellbeing of Canadian youth, despite being largely preventable and treatable. A number of STIs are common among youth and young adults and can result in significant negative physical, psychological, and social outcomes.[7,9]

In most cases, STIs do not have physical symptoms. A person can acquire or transmit an STI even if no symptoms are present. If young people are unaware of this, they may not know that they should be tested.

The stigma associated with STIs and STI testing can also prevent individuals from being tested and therefore miss or delay treatment. Not having symptoms and fear of being judged or treated differently are common reasons why a person may not get tested or go to a clinic for services.[10,11] Fear of mistreatment by healthcare providers and fear of discrimination add additional challenges to obtaining STI testing for LGBTQI2SNA+ individuals.[12,13]

Having access to STI-related education and being linked to testing resources that appropriately address the diverse needs of young people within a comprehensive sexual health education curriculum is necessary for the prevention and management of STIs.

SITUATING STI PREVENTION WITHIN COMPREHENSIVE SEXUAL HEALTH EDUCATION

Comprehensive sexual health education incorporates a balanced approach to sexual health that includes both enhancing sexual health and well-being and the prevention of outcomes that can have a negative impact on sexual health and well-being, including STIs. There is clear evidence that comprehensive sexual health education has the potential to effectively assist youth and young adults in reducing their risk for STIs.[1,2,3,4,5,6]

Furthermore, many Canadians perceive sexual health education as a primary tool for promoting STI knowledge and testing.

Eighty percent of Canadians surveyed indicated that a key approach for encouraging STI testing was "increased sexual health education and information about seeking testing that is free of judgement and is culturally sensitive."[11]

Since schools are the only formal educational institution to have meaningful (and mandatory) contact with nearly every young person, they are in a unique position to provide youth with STI information and to link students to appropriate testing resources.

The most effective forms of school-based STI prevention efforts do not occur in isolation but are integrated within a broader comprehensive sexual health education curriculum.

COMPREHENSIVE SEXUAL HEALTH EDUCATION SHOULD INCLUDE:	
Information, motivation, and behavioural skills directly related to STI prevention, testing, treatment and management.	Information that helps students build the skills needed to seek appropriate resources and make decisions that support their sexual health and wellbeing.

School-based comprehensive sexual health education can play an important role in helping youth and young adults reduce their risk of STIs and in linking them to STI testing and treatment services.

Table 1 indicates key benchmarks for the provision of STI information identified by grade/age. Many of the benchmarks specifically address knowledge and skill development directly related to STIs. For example, beginning in Grade 4, students should understand what HPV is and why the HPV vaccine is important. This is in line with recommendations from Canada's National Advisory Committee on Immunization that students can begin receiving the vaccination at age nine.[9]

Other benchmarks in Table 1 identify areas and skill sets that are important for the development and implementation of STI-related prevention/ management skills. For example, understanding the concept of consent is central for young children as it helps them to identify their own (and others') personal boundaries and to develop a sense of bodily autonomy. As students get older, understanding how to set boundaries (communicated verbally or nonverbally) and clearly ask for and communicate affirmative consent is important for the discussion of safer sex practices.

The benchmarks identified in Table 1 below are ongoing throughout students' time in school and are cumulative. That is, information and skills that are acquired in the early grades should be built upon in subsequent grades.

Importantly, the benchmarks in Table 1 are not meant to constitute a comprehensive sexual health education curriculum but provide specific benchmarks for the provision of STI-related information and the linking of STI-testing within a comprehensive sexual health education curriculum.

TABLE 1: KEY BENCHMARKS FOR THE PROVISION OF STI-RELATED EDUCATION IN SCHOOLS

*Note: Benchmarks related directly to STIs are **bolded**.
Benchmarks for supportive information and skill sets indirectly related to STIs are not bolded.
The supportive information included here is not exhaustive and is not meant to constitute a comprehensive sexual health education curriculum.

KINDERGARTEN TO GRADE 3 (AGES 4-8)

BENCHMARKS RELATED TO STI PREVENTION	
Learn the accurate names for body parts, including genitals*	Learn what a vaccine is and what it does
Understand basic body care activities (e.g., hygiene)	Learn about consent and bodily autonomy (e.g., for hugs, for holding hands, personal safety)
Learn what germs are and how they can be transmitted	Learn to identify characteristics of healthy relationships

* *Educators should be aware of and inclusive to variations in reproductive or sexual anatomy, including intersex*

GRADE 4 TO GRADE 5 (AGES 8-10)

BENCHMARKS RELATED TO STI PREVENTION	WHEN TO LINK STUDENTS TO STI TESTING SERVICES AND RELATED RESOURCES
Understand what HPV is and why the HPV vaccine is important	**Based on recommendations from Canada's National Advisory Committee on Immunization, young people may begin receiving the HPV vaccine at age 9.[9] Therefore, in some provinces/ territories, students will begin receiving the HPV vaccine in Grade 4, while in others this will be in later grades/ages**
Understand that infections can be sexually transmitted	
Understand information related to reproduction	
Understand the physical, biological,* psychological, emotional, and social changes associated with puberty	
Understand personal hygiene behaviours associated with the onset of puberty	
Understand that consent is linked to partnered sexual activity	
Understand the relationship between sexual activity and pregnancy and reproduction	
Understand that people engage in sexual activity for many reasons (i.e., not just to make babies)	
Media literacy: understand the difference between good sources of information and inaccurate sources of information	
Learn how to communicate (e.g., with peers, caregivers)	

** Educators should be aware of and inclusive to variations in reproductive or sexual anatomy, including intersex*

GRADE 6 TO GRADE 8 (AGES 10-13)

BENCHMARKS RELATED TO STI PREVENTION	WHEN TO LINK STUDENTS TO STI TESTING SERVICES AND RELATED RESOURCES
Understand how STIs can and cannot be transmitted	BEGINNING IN GRADE 7:
Understand that many STIs do not have symptoms	Students should be provided with specific information on where they can obtain confidential STI testing within their community
Understand that there are different types of STIs (e.g., bacterial and viral) with different symptoms and health outcomes	
Understand that regular STI testing is needed once a person becomes sexually active	
Understand the importance of STI testing for the survivors in cases of sexual coercion/ assault	Students should be provided with confidential community and school counseling resources (e.g., school nurse, guidance counselor) to access if they are not comfortable speaking with someone in their family
Understand STI diagnoses and treatment	
Understand how STIs can impact a person's physical and emotional health and well-being	
Understand that there are a range of behavioural options to reduce the risk of STIs and unintended pregnancy (e.g., not engaging in sexual behaviours that involve risk for STI and pregnancy, using barriers, engaging in lower-risk sexual activities)	

BENCHMARKS RELATED TO STI PREVENTION	WHEN TO LINK STUDENTS TO STI TESTING SERVICES AND RELATED RESOURCES
Understand that STI prevention strategies may differ depending on the type of sexual activity (e.g., using a condom for oral, vaginal or anal sex with a person who has a penis; using a dental dam for oral sex with a partner who has a vulva)	
Understand the social and cultural factors associated with STI risk and prevention	
Understand how STI-related stigma and stereotypes impact people's lives	
Understand harm reduction strategies such as post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP)	
Understand how to access confidential STI testing and treatment services in their communities and understand the limits to confidentiality	
Address information, motivation, and behavioural skills to set sexual limits, practice safer sex (e.g., barrier use), disclose STI status, and discuss when to get tested with a partner	
Understand the extent to which different contraceptive methods do or do not protect against STIs	

GRADE 9 TO GRADE 10 (AGES 13-15)

BENCHMARKS RELATED TO STI PREVENTION	WHEN TO LINK STUDENTS TO STI TESTING SERVICES AND RELATED RESOURCES
Continue discussions from previous grades but in greater detail/complexity[2] (e.g., more elaborate biology, detailed discussions about interpersonal and social factors that impact STI risk and access to services)	**Reiterate information on counseling and sexual health services in students' communities**
Media literacy: identify credible sources of information about sexuality and STIs; critical assessment of the portrayal of safer sex practices in sexually explicit media	
Continue discussions on sexual decision making; understand how one's own actions can impact other people	**Provide opportunities for students to speak to a trusted healthcare provider (e.g., a nurse or social worker) through the school or link students to a trusted health care provider**
Understand the ethics of responsible sexual interactions	
Analyze strategies for choosing responsible and respectful sexual expressions	
Continue discussions about consent within sexual relationships	
Understand the impact of drugs and alcohol on consent, sexual interactions, and safer sex	

GRADE 11 TO GRADE 12 (AGES 15-17)

BENCHMARKS RELATED TO STI PREVENTION
Continue discussions from previous grades but in greater detail/complexity
Understand advanced information about STI management
Understand the ethics and legal aspects of STI/HIV status

REFERENCES

1 Chin HB, Sipe TA, Elder R, Mercer SL, Chattopadhyay SK, Jacob V, et al. The effectiveness of group-based comprehensive risk-reduction and abstinence education interventions to prevent or reduce the risk of adolescent pregnancy, human immunodeficiency virus, and sexually transmitted infections: Two systematic reviews for the Guide to Community Preventive Services. American Journal of Preventive Medicine. 2012;42;3: 272-94.

2 Morales A, Espada JP, Orgilés M, Escribano S, Johnson BT, Lightfoot M. Interventions to reduce risk for sexually transmitted infections in adolescents: A meta-analysis of trials, 2008-2016. PloS ONE. 2018;13;6: e0199421.

3 CDCP. Compedium of evidence-based interventions and best practices for HIV prevention. Centers for Disease Control and Prevention, National Centre for HIV/AIDS, Viral Hepatitis, STD, and TB. 2014. http://www.cdc.gov/ hiv/prevention/research/compendium/

4 Protogerou C, Johnson BT. Factors underlying the success of behavioral HIV-prevention interventions for adolescents: A meta-review. AIDS and Behavior. 2014;18; 10: 1847-63.

5 Denford S, Abraham C, Campbell R, Busse H. A comprehensive review of reviews of school-based interventions to improve sexual-health. Health Psychology Review. 2017;11;1: 33-52.

6 Fonner VA, Armstrong KS, Kennedy CE, O'Reilly KR, Sweat MD. School based sex education and HIV prevention in low- and middle-income countries: A systematic review and meta-analysis. PloS ONE. 2014;9;3: e89692.

7 PHAC. Report on sexually transmitted infections in Canada: 2013-2014. Ottawa, Canada: Public Health Agency of Canada; 2017.

8 Centre for Communicable Diseases and Infection Control. A summary of the Pan-Canadian framework on sexually-transmitted and blood-borne infections. Canada Communicable Disasess Report. 2018;44;7/8: 179-81.

9 PHAC. Updated Recommendations on Human Papillomavirus (HPV) Vaccines: 9-valent HPV vaccine and clarification of minimum intervals between doses in the HPV immunization schedule. Ottawa, Canada: Public Health Agency of Canada; 2016.

10 Flicker S, Flynn S, Larkin J, Travers R, Guta A, Pole J, et al. Sexpress: The Toronto teen survey report. Toronto: Planned Parenthood Toronto. 2009.

11 PHAC. Canadians' awareness, knowledge and attitudes related to sexually transmitted and blood- borne infections. Ottawa, Canada: Public Health Agency of Canada; 2018.

12 Scheim AI, Travers R. Barriers and facilitators to HIV and sexually transmitted infections testing for gay, bisexual, and other transgender men who have sex with men. AIDS Care. 2017;29;8: 990-5.

13 Shoveller JA, Johnson J, Rosenberg M, Greaves L, Patrick DM, Oliffe J, et al. Youth's experiences with STI testing in four communities in British Columbia, Canada. Sexually Transmitted Infections. 2009;85: 397-401.

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