Expelling Pleasure? School-Based Sex Education and the Sexual Regulation of Youth

by

Erin Elizabeth Connell, B.A., M.A.

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Abstract

This dissertation advances the thesis that contemporary sex education - best understood as a 'regime of practices', a strategic model that moves beyond conceiving the school project in ideological terms – emphasizes the harmful consequences of sexual activity. By elucidating the dominant and contested strategies of the public school practices in Alberta, Ontario, Quebec and Nova Scotia, I argue that sexually transmitted infection (STI) and pregnancy prevention form the strategy that frames much of the regime, a strategy that is linked, particularly in its historical context, to health, risk and morality concerns. Despite pedagogical commitments to values clarification, certain values and choices are presented as wise for teens. Specifically, abstinence and risk reduction discourses support the strategic selectivity of the regime. Students are meant to learn that abstinence is a 'good' and 'healthy' choice in order to avoid the physical, mental, social and spiritual consequences of sex. The concern around HPV-induced cervical cancer is an exemplar of a medical model of abstinence, whereby medical 'truths' are deployed to support abstinence as a wise choice. And for those students who are sexually active, classroom discussions promote specific kinds of contraception and birth control methods, promote STI/HIV testing and support specific 'no' or 'low' risk sexual acts and behaviours, with the exception of oral sex, since its acknowledgement as a 'low risk' sexual behaviour would require the recognition of sexual pleasure in the lives of young people. These practices, along with those that emphasize the potential for sexual violence in the lives of young people, aim to address the tension and anxiety surrounding the transition from childhood to productive adulthood. And while 'transformative spaces' are created in some classrooms through critical pedagogical practices to enable discussions of pleasure, desire and sexual entitlement, this dissertation argues that health, risk and morality discourses contribute to regulatory practices whereby the school, as a site of responsabilization, normalization and surveillance, promotes a sexual regulation of youth. The health-risk-morality paradigm also - intentionally or otherwise - builds in anxiety and does so by drawing into the educational project the presumed anxieties of parents and educational administrators.

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Chapter One

The Dangers of Sex: Framing the School Project

[Nine youths] appeared today [in court] on morals charges stemming from the recent investigation into activities of a group of girls 12 to 14 years old... During the hearings, witnesses described, among other things, an all-night party, interludes in bedrooms at some of the accused's and the girls' homes, and an episode involving three youths, two juvenile boys and a 14-year-old girl, in a car parked behind a district church... [A] 14-year-old girl described two occasions, one an all-night party which she had arranged at the home where she was boarded... [D]uring the party, the girl assigned a room to each of the couples. A 12-year-old girl... admitted previous affairs with youths... [and] a 13-year-old girl testified as to an affair one night while she was babysitting at a Kitchener home... [C]ounsel for one of the accused describe the case as the most shocking he has encountered. He suggested the girls involved had a shocking degree of sexual knowledge... (*The Telegram*, 1951).

'Fooling around' and 'hookups' -- terms kids use to describe everything from kissing to groping, mutual masturbation to oral sex -- happen when couples are alone, and when they're in peer groups. They happen at school, in stairwells, in bathrooms between third and fourth period, and in the playground at recess. They happen in parks, on class trips and in cabins at camp. They happen at home and at after-school or weekend parties, whether or not parents are out... Kate is a stunning olive-skinned brunette, now in Grade 11... [She] explains that starting in Grade 7, about 15 boys and girls from her small, mixed-gender private school would gather every weekend, with no parents around. Typically, all the kids would be watching a movie when couples would break off from the main crowd and disappear into another room. Other times, they wouldn't be so discreet. On one occasion, she remembers sitting only a few feet away from a girl who was performing oral sex on a boy when another girl approached them. "Wow, I can't believe you're doing that," Kate remembers the newcomer saying. "Do you want me to hold your hair back?"... [Vanessa] describes the weekend parties that she says took place about twice a month last year at various friends' houses. Sometimes parents were home, but more often they weren't. Boys and girls from schools across the city would show up. Frequently, drugs and alcohol were involved. Boys would approach girls, a pickup would ensue, and the couple would withdraw into another room, she says. Sometimes, the two knew each other. Other times, they had just met (Wilson, 2004).

These two accounts, from two different time periods, illustrate an increasingly explicit media attention towards, as well as on-going concerns about, youth sexuality.

They illustrate the ways in which adolescent sex has consistently been constituted as an object of concern and inquiry, particularly where sexual behaviours intersect with drug

and alcohol use and other ‘delinquent’ behaviour, the apparent casualness of teen sex, the absence of parental/adult supervision, and the quest for peer acceptance and status. They also illustrate the ways in which teen female sexuality, in particular, is problematized. In its totality, adolescent sex has been and continues to be framed as risky and as dangerous. These dangers and risks have initiated a variety of ‘epidemics’: a teen pregnancy epidemic, a sexually transmitted disease (STD)¹ epidemic, an oral sex epidemic.

Indeed, as often cited by health professionals, policy makers and educators, the main concerns regarding teenage sexual activity in Canada are teen pregnancy and sexually transmitted diseases (Maticka-Tyndale, 2000; Maticka-Tyndale, 2001; Maticka-Tyndale, et al., 2001; McKay, 2004c). Rates of sexually transmitted infections (STIs) are generally assessed as unacceptably high in the teen population (McKay, 2004a: 130). For example, the chlamydia rate among 15-19 year-old females in Canada, the highest of any age group, rose from 971.3 per 100,000 in 1997 to 1443.6 per 100,000 in 2004 (Public Health Agency of Canada, 2007). And while HIV/AIDS did not spread in the general population as suggested originally, young people, in general, are deemed vulnerable to HIV infection as a result of many factors, including risky sexual behaviour, substance use (including injection drug use), and perceptions that HIV is not a threat to them (Public Health Agency of Canada, 2004). In addition, while there has been a long-term decline in teen pregnancy rates – from 45.5 per 1,000 in 1974 to 30.6 per 1,000 in 2001 (Statistics Canada, 2004) - it is generally assumed that most teen pregnancies are unintended (Henshaw, 1998).²

¹ I use STD (sexually transmitted disease) and STI (sexually transmitted infection) interchangeably throughout.

² Canada’s STD and teen pregnancy rates are generally in-line with international trends. For example, chlamydia is the most commonly reported STI in Canada, the U.S. and the U.K. The rate per 100,000

Both of these issues – STD and teen pregnancy – are not new but, in fact, are ongoing concerns. Along with both World Wars came high venereal disease rates among Canadian soldiers that were presumed to reflect STD rates in the civilian population. And while there have always been ‘teen moms’, there was a particular problematization of ‘teen pregnancy’ in the 1970s. In light of these problems, the ways in which the young should be educated and protected against these social ills have been highly contested. The debate has centered on two questions: what should be taught to young people and by whom.

As Alexander McKay points out, few topics have a more controversial history in Canadian public education than that of sexuality (McKay, 1998: 2). Debate has focused on the appropriate role of the school (will the teaching of sexuality complement that which is conducted in the home or usurp parental responsibility?) and appropriate content (will sex instruction incite sexual activity?). The introduction of sex education in Canadian schools was, as this dissertation will demonstrate, both haphazard and hesitant and it was only in direct response to what was deemed an AIDS epidemic that sex education came to be included in each province’s ministry of education guidelines during the 1980s.

Since the advent of AIDS, it has become widely recognized that schools are pivotal organizations in providing sex education (Health Canada, 2003: 17). According to Health Canada’s *Canadian Guidelines on Sexual Health Education* (2003), effective sex

population is 197.1 (Canada), 174.1 (U.K.) and 319.6 (U.S.) (Public Health Agency of Canada, 2007a: 7). In all three countries, the burden of infection lies disproportionately with youth and women as rates are consistently highest in women aged 15 to 24 and men aged 20 to 24 (*ibid*: 8). And although the United States has the highest teen pregnancy rate in the western world – a rate that is also nine times higher than that in the Netherlands - its teenage pregnancy rate declined 28% between 1990 and 2002 (Guttmacher Institute, 2006). With a rate comparable to Canada, the UK has the highest teenage pregnancy rate in Western Europe.

education programs have been described as emphasizing the harmful as well as the pleasurable aspects of sexuality. In bureaucratic terms, the *Guidelines* describe effective programs as those that aim to help people avoid the ‘negative outcomes’ of sex, including unintended pregnancy, HIV/STDs, and sexual coercion, and which seek to achieve the ‘positive outcomes’ of sex, such as self-esteem, respect for self and others, and rewarding sexual relationships (Health Canada, 2003: 1).

This dissertation advances the thesis that contemporary sex education - best understood as a ‘regime of practices’ – emphasizes the harmful consequences of sexual activity, often at the cost of considering the pleasurable consequences. The dissertation does so by elucidating the dominant and contested strategies of Canadian school-based sex education through a consideration of the public school practices in Alberta, Ontario, Quebec and Nova Scotia. I argue that sexually transmitted infection (STI) and pregnancy prevention form the strategy that frames much of the regime, a strategy that is linked, particularly in its historical context, to health, risk and morality concerns. Although ‘transformative spaces’ are created in some classrooms to enable discussions of pleasure, desire and sexual entitlement, this dissertation argues that health, risk and morality discourses contribute to regulatory practices whereby the school, as a site of responsabilization, normalization and surveillance, promotes a sexual regulation of youth. The health-risk-morality paradigm also - intentionally or otherwise - builds in anxiety and does so by drawing into the educational project the presumed anxieties of parents and educational administrators.

In making these claims, this dissertation makes two important contributions. The first is theoretical, where the school project is conceived as a ‘regime of practices’. The

second contribution is empirical, since there has not been a systematic analysis of sex education curriculum since new provincial curriculum guidelines were developed in the late-1990s. Indeed, the post-AIDS era is an interesting time for school-based sex education, in light of new concerns around oral sex, the human papillomavirus (HPV) and its link to cervical cancer and legislative changes to Canada's age of consent (re-named 'age of protection') legislation.

This dissertation describes the school project as a 'regime of practices', a strategic model which moves beyond restrictive-permissive ideology. Indeed, school-based sex education has largely been described in ideological terms, as occupying two or three ideological groupings along the conservative-liberal axis. For instance, Murray S. Davis contrasts the Johavanist with the Naturalist sexual ideology, Jeffrey Weeks considers Absolutist, Liberal and Libertarian ideologies and Steven Seidman dichotomizes the Romantacist and Libertarian ideologies (McKay, 1998: 37). In his book *Sexual Ideology and Schooling: Towards Democratic Sexuality Education*, Alexander McKay offers a synthesis of these typologies, which yields two opposing perspectives: 'Restrictive Sexual Ideology' and 'Permissive Sexual Ideology'. McKay describes the Christian origins of 'Restrictive Sexual Ideology', where sexuality is considered a negative force, polluting and corrupting human nature. Conservative in nature, the focus is on specific sexual acts as the object of moral evaluation – for example, the belief that sex should only be used for procreation or the idea that the only morally valid use of sex is within heterosexual marriage. All other acts are, by nature, immoral. 'Permissive Sexual Ideology', on the other hand, promotes a sexuality that is benign or positive in its ability to provide pleasure and to contribute to self-fulfillment and psychological adjustment.

Liberal in its orientation, Permissive Sexual Ideology promotes a person-centered ethics, or a focus on individual deliberation with respect to sexual choices. Institutions of the state do not belong in the bedrooms of its citizens as long as their sexual behaviours do not infringe on the rights of others and do not result in a demonstrated harm to society. Both ideologies have influenced sex education programs. The restrictive approach is best exemplified by ‘abstinence-only education’, which promotes sexual abstinence until marriage and discusses contraceptive methods only in order to emphasize their failure rates. An exemplar of the permissive approach is ‘values clarification’ programs which support the discussion of a comprehensive range of sexuality issues in order for individuals to make decisions that are best for them.

This dissertation, however, seeks to move beyond a dichotomous conception of the school project as restrictive or permissive ideology. The use of the Restrictive-Permissive dichotomy posits unified, logically consistent systems of belief that provide cognitive structure, collective purpose and conviction in the face of uncertainty. McKay notes that the division between Restrictive and Permissive Sexual Ideology is not always clear-cut – each ideology has its internal permutations that may overlap with other ideologies, although, he adds, there is little that can be agreed upon in this ideological diversity – and concludes that the Restrictive-Permissive paradigm best represents the main contours of the debate surrounding sex education.

However, I argue that relying on Restrictive-Permissive ideology to explicate sex education is insufficient, since there is more to sexuality than something to which society says yes or no. While I am not implying that this kind of abstraction is illegitimate, I question the level of abstraction. As structuring concepts, both Restrictive and Permissive

ideologies are presented as internally cohesive and their subjects are static and uniform. Possible areas of overlap are largely deemed inconsequential. However, it is precisely the areas of overlap, the collision of discourse, practice and interests, the shifts in play, the space that is created, in which I am most interested. Take, for example, the issue of teen pregnancy. Those who subscribe to Permissive Ideology would conclude that ‘teens should not have babies’ while those supporting Restrictive Ideology would conclude that ‘single teens should not have sex’ (McKay, 1998: 64-65). These two conclusions differ in moral perspective: one posits that decisions about sexual behaviour are derived from an external authority which prescribes pre-set standards of sexual conduct while the other posits that teens will choose for themselves how best to prevent pregnancy (*ibid*). However, abstinence can be deployed as both a pre-set standard *and* as a wise and healthy choice for teens. In this context, honesty, responsibility and equality can be deployed as sexual ethics supporting a theological moral framework and as sexual ethics supporting individual rights and moral autonomy. Hence, this dissertation aims to consider what happens when interests and strategies converge and diverge and what, ultimately, gets taken up and reflected in sex education discourses and practices. As such, I propose that school-based sex education can be understood as a ‘regime of practices’.

A regime is the current state of play in a particular field. In this case, the field is the school. By ‘school’, I am not referring to a specific institution but, rather, to a site that makes sense to its participants – a space of learning and discipline expressed through teacher-student relationships. The school provides a social space in which an ideal and morally imbued government of the body is deployed and, as such, has a goal or standard of the moral good. Indeed, the school, as a generator of strategies, aims to articulate its

sexual project against outside influences, particularly those connected to widespread concerns about an increasingly sexualized culture and the erosion of discipline and surveillance in the modern family.

Following Pierre Bourdieu, the school, as a 'field' is a locus of power relations – the place of a game where agents are located by their access to and possession of specific kinds of 'capital'.³ As such, a field, as a structure of objective relations between positions of force defined by the structure of the distribution of specific forms of capital, guides the strategies whereby occupants seek to safeguard or improve their positions (Bourdieu and Wacquant, 1992: 101). A field, then, is a site for a structured system of practices of agents and these practices presuppose and generate specific forms of interest (Bourdieu and Wacquant, 1992: 105). Practices are stabilized to the extent that the agents in the field with the greatest access to power have interest in the conditions for cyclical rather than divergent practices. Those who dominate in a given field are in a position to make it function to their advantage, but they must always contend with resistance. Historically dynamic, the configuration of these forces, and the field itself, can be either preserved or transformed. Given this dynamism, there is a certain cohesiveness to the field or what I call key regime elements; for example, sex is perpetually caught in a problem-solution matrix since practices are deployed to respond to teen pregnancy and STI prevention and control issues. However, at the same time, a regime does not impose unity on the field:

To understand social structures and processes, it is never enough to study a single functional stratum within a social field. To be really understood, these structures and processes demand a study of the relationships between the different functional strata which are bound together within a social field, and which, with the slower or more rapid shift of power-relationships arising from the specific

³ Capital refers to the economic, social, cultural and/or symbolic resources that are available to the individual. This access to capital distinguishes individuals from one another and serves as forms of advantage.

structure of this field, are for a time reproduced over and over again (Elias, 1982: 288).

Key to this study of the reproduction of structures and processes, then, is consideration of historical continuity and change – the pattern and process of patterning – in the practices advanced by agents in the field. The school, as a field, is a space of social relations whereby agents are anchored in certain forms of power, such as the disciplinarian and authoritative relationship between teacher and student. As a field, the practices of the school are made visible by the range of sex education strategies over time, how they were articulated and who articulated them. This method of analysis considers how practices and strategies get worked up by regime participants at particular points in history and why specific issues, such as teen pregnancy and STD rates, come to seize social attention at particular periods. Thus, what I call the strategic selectivity of the regime speaks not only to how sexual practices in schools are organized, but also to how the imperatives that drive sex education, the conditions that support it, and the subjectivities produced by it support a historically specific project.

The practices in a field can be analyzed as a set of strategies and tactics. By drawing on Bob Jessop's strategic-theoretical approach to the state (Jessop, 1990; Jessop, 2001), a regime can be seen as a system of strategic selectivity, a hegemonic project or, in Michel Foucault's terms, the choice of winning solutions (Foucault, 1983: 225). A regime is constituted in and through, but also generates, strategies; hence, the coherence of a regime can be best understood by analyzing the full range of struggles and contradictions. Again, a regime is also a product of past strategies and struggles – in this case, the regime is a product of historically continuous concerns around STD prevention and control - which emphasizes the importance of periodization and the study of the

variety of tactics within a given strategy. Indeed, quite diverse tactics can be followed in pursuit of a given strategy (Jessop, 1990: 199). While this plurality of tactics indicates possibilities of resistance, given the different position-takings in a particular regime, a successful strategy “must be adapted to the structural constraints in given circumstances and the prospects entailed for creating, transforming, or maintaining particular sites of social relations” (Jessop, 1990; 266). A successful strategy, then, points to the dialectic of structure and strategy, to the generation of regime effects, rather than to a structural determination. The balance of forces is related to strategically calculating subjects, who advance specific interests over time and through specific strategies, as well as the structural constraints entailed in a given situation (Jessop, 1990: 267). The strategies and tactics of a particular regime shape, and are shaped by, a global strategy or strategies, as a result of this dialectic between structure and practice. To this end, I will argue that the local strategies of STD and pregnancy prevention inform and are informed by global strategies of health, risk and morality. A regime, then, as a matrix of practices, is a summary concept, with an emphasis on structures rather than on the structural. It is a descriptive concept that outlines a state of play with no over-riding sense of rules. As such, expounding global strategies necessitates a descending as well as an ascending analysis of power and consideration of the ways in which power relations have been and continue to be utilised, transformed, and displaced by ever more general and global mechanisms (Foucault, 1980a: 99). This analysis specifies the production of relations of domination, possibilities for resistance and the strategists behind the strategies.

In this regard, I draw on Foucault’s analytic of power, an analytic that takes into account both the micro-physics of power (made intelligible by way of the analysis of

micro strategies and tactics) as well as the macro-physics of power (made intelligible by way of the analysis of global strategies as they emerge from local strategies and tactics). Indeed, Foucault insists that power is productive and positive, relational and ascending. Power relations are intentional and nonsubjective and are correlated with resistance. Inserted into a strategic framework, this micro-level analysis can relate to a macro-level analysis in three key ways. First, because power comes from below, “the manifold relationships of force that take shape and come into play... are the basis for wide-ranging effects of cleavage that run through the social body as a whole” (Foucault, 1978: 94). Major dominations, then, are hegemonic effects sustained by these confrontations. Second, it is difficult to reconcile how power relations are both intentional and nonsubjective *and* exercised with a series of aims and objectives. Therefore, by considering global strategies as they emerge empirically from local strategies, it may be possible to discern the interests behind a winning strategy. Third, if power is coextensive with resistance, consideration of how resistance is implemented at the local level might illustrate how such resistance is spread, “producing cleavages in society that shift about, fracturing unities and effecting regroupings” (Foucault, 1978: 96). A form of resistance considered in the dissertation is the creation of transformative spaces made possible through the practices and discourses of critical pedagogy which provide a counter-point to the dominant ways in which knowledge is organized and deployed as forms of regulation. In sum, an analysis of power that ascends from the micro-level to the macro-level explains how macro-social order is related to macro-social diversity (Jessop, 1990: 245).

This analytic also requires consideration of the specific technologies of power. This dissertation proposes that biopower is the most prevalent technology of power in a sex education regime of practices. Biopower is a government of the body that aims to regulate a population. The disciplines of the body (anatomo-politics) and the regulation of the population constitute the two poles around which the organization of power over life is deployed (Foucault, 1978: 139). Sex, Foucault argued, is a transfer point between anatomo-politics and biopolitical strategies. Indeed, “the political significance of the problem of sex is due to the fact that sex is located at the point of intersection of the discipline of the body and the control of the population” (Foucault, 1980b: 125). Biopower is a political technology concerned with the physical well-being, health and optimum longevity of a population and a management of life – a technology that increases “the scope of power for its own sake by bringing the bodies of the state’s subjects under tighter discipline” (Dreyfus and Rabinow, 1983: 137). Biopower concerns the strategies for intervening in life and health, where bodies become both the object and the instrument of power/knowledge relations.

According to Foucault, the truth of sex in Western civilization is articulated through *scientia sexualis* as opposed to *ars erotica*. *Ars erotica* draws the truth of sex from pleasure. Pleasure is understood as a practice, accumulated as experience, considered in relation to itself and located on the body. Truth, then, is experienced as pleasure and evaluated in terms of intensity, and knowledge must be deflected back into the sexual practice itself in order to shape it from within and to amplify its effects. The effects of this art include an absolute mastery of the body, a singular bliss, obliviousness to time and limits, and the exile of death and its threats.

In contrast to a regime built around pleasure, *scientia sexualis* transforms sexuality into a medicalized object that aims to discipline bodies and regulate populations. The medicalization of sex occurred in the nineteenth century by way of a scientific power-knowledge-discourse-pleasure originating in the techniques of religious confession, a technique that aimed to know the truth of sex and the truth of subjects (Foucault, 1978). As a medical and medicalized object, sex came to derive its meaning and its necessity from medical interventions. As an authority in hygienic matters, a ‘rarefied and neutral’ medical science sought to separate normal from abnormal sexuality. The deployment of sexuality as a medical object, the medicalization of sex, then, is tied to biopolitical tactics that aim to regulate individuals and populations. These tactics are discernable by explicating the configurations of truth, power and subjectivity underpinning the rationalities of health and medicine. This is not to say there is a complete absence of pleasure in *scientia sexualis* – there is pleasure in surveillance, pleasure in confession – instead, the emphasis is sexuality in its medical form. To this end, I argue that the medicalization of sex and the ways in which it functions through risk and morality concerns, aim to regulate the individual as well as the population (or, in Foucault’s terms, it is the shift from the pedagogization of children’s sex to the regulation of the population).

Medicalization, then, constitutes sexuality as a ‘health’ problem and employs data on adolescent sexuality – rates of teen pregnancy and STD, for example – to justify intervention. As such, there has been the creation and reinforcement of teens as an ‘at-risk’ population, one requiring adequate resources vis-à-vis governmental and administrative forms made justifiable by way of counting incidence of disease and of

pregnancy. The school, engaged in a specific population health strategy – where population is both an object of analysis and target of interventions – is the generator of strategies that employ biopolitical tactics by providing education and services and implementing policies that aim to prevent health problems, curb the economic burden placed on society as a result of the high costs of unintended pregnancy and STDs and promote a normative and ideal moral citizenry that will ensure the effective transition from childhood to productive adulthood. Indeed, by drawing on both hermeneutic and structural explanation, I argue that the sex education project is, in the main, driven by adult anxiety. This dissertation will discuss how the concern around certain dangers of teen sex are not empirically grounded – for example, the link between sex and cervical cancer – and will also describe how the sex education project is a flashpoint for and convergence of wider social and material concerns.

In sum, the way in which power relations function in the regime, the way in which techniques of biopower reverberate throughout the regime, facilitate the identification of micro-level strategies and their connection to and with global strategies. And by exploring this dynamic interplay, it is possible to discern the interests and values, the strategists behind the strategies, and the subjectivities they produce. First, I argue that interests can be revealed by way of careful examination of the strategies and practices in a specific field of power relations, but that it is necessary to delineate the strategies before discerning and as a way to discover strategists and interests. In order to diagnose interests, then, it is necessary to ascertain what makes such a program of action operative in the first place prior to describing the reasons according to which people act. Bourdieu notes how “each field calls forth and gives life to a specific form of interest... as tacit

recognition of the value of the game” (Bourdieu and Wacquant, 1992: 117). What is important to note here, however, is that for Bourdieu, interest is much more like ‘implication’ (*interressement*) than a structural notion of interest as position – it shifts with the state of play. As such, who does what and who wants what to happen have an ambiguous relation to what does happen. There are always unintended consequences which reshape what agents want and it is this force of circumstances that makes intentions and unintended consequences non-subjective. Essential to this, then, is consideration of whose voices drive or challenge the sex education agenda at any given time. The range of agents in the field – teachers, nurses, administrators, parents – likely all agree on goals of lower rates of unintended pregnancy and STDs to ensure the smooth transition from childhood to adulthood, although the tactics to pursue these strategies may be quite varied. There is no guarantee, however, that lower teen pregnancy and STD rates will be the outcome of any particular set of tactics, since who does what and who wants what to happen have an ambiguous relation to what does happen.

In addition to interests, it is also possible to discern the subjectivities that are produced by the dynamic interplay between micro-level strategies and their connection with global strategies. As a project of anxiety, as a convergence between the dangers of sex and pervasive, long-term socio-cultural issues, including the modern separation of sex for reproduction and sex for pleasure, the regime of practices produces regulated and regulating subjects. Subject positions are made available to and resisted by individuals in relation to the power-knowledge-discourse nexus, which determines how individuals come to govern and to constitute themselves in particular ways. To this end, the sexual citizen is constituted through regulatory and regulating processes. As a regulatory

process, particular ways of living, thinking, reasoning and engaging with self and others come to matter. And as a regulating process, subjects are involved in their own self-formation, as moral subjects of their own actions. As a practice of self-government, the subject constitutes itself vis-à-vis “models that he finds in his culture and that are proposed, suggested, imposed upon him by his culture, his society and his social group” (Foucault, 1989: 441). The constitution of subject positions involves techniques of the self that are also linked to practices which govern others. Educational institutions, then, are a particular exemplar whereby “one is managing others and teaching them to manage themselves” (Foucault, 1984: 370).

In addition to its theoretical contribution, the dissertation also makes an empirical contribution to our understanding of sex education in its historically specific contemporary context. Surveys describing the state and implementation of Canadian school-based sex education were conducted in 1964, 1971, 1977, 1984 and 1988 (Canadian Education Association, 1964; Vanier Institute for the Family, 1971; Deiseach, 1977; Nolte, 1984; Ajzenstat and Gentles, 1988). As will be discussed in the following chapter, these surveys, in their totality, reveal the slow and fragmentary introduction of school-based sex education in Canada until the advent of AIDS, upon which sex education became a formal part of the school curriculum. Since 1988, however, no other comparable surveys have been conducted. Indeed, there have been no detailed national studies of classroom content of sexuality education that would indicate the extent to which provincial guidelines and curricula are translated into classroom programming (Maticka-Tyndale et al., 2001: 25). This is a particularly timely project, then, since provincial ministries of education developed new curriculum guidelines in the late-1990s

and the Quebec government deregulated sex education in 2006. And in the post-AIDS era, new issues have emerged, such as oral sex, the human papillomavirus (HPV) and its link to cervical cancer, and recent changes to Canada's age of consent legislation.

As such, this study fills an important gap in our knowledge of school-based sex education. The present study focuses on the delivery of sex education as developed and implemented by a range of experts, including teachers, administrators, public health nurses, and community-based educators. The dissertation draws on ministry of education curriculum guidelines, policies and reports related to sex education in Alberta, Ontario, Quebec and Nova Scotia. In addition, all English-speaking boards of education and public health units/regional health authorities of the four provinces were contacted with a request for 'publicly available documents' pertaining to public school sex education, such as curricula, lesson plans, policies and reports. Those that responded with materials are included in the dissertation. In order to map an approach of community-based educators, the Planned Parenthood affiliates for Alberta, Ontario and Nova Scotia (there were no affiliates in Quebec at the time of writing) as well as Pregnancy Crisis Centres were contacted for similar documents and again, those that responded are included here. All materials were examined in order to explicate the common and divergent discourses and practices across and between provinces, boards of education, health authorities and community-based organizations. Indeed, documentary analysis revealed much consistency across programs, disciplines and provinces. In order to supplement the documentary analysis – to gauge how educators make sense of, use, negotiate and resist these official documents and discourses – interviews were conducted with twenty-six public school teachers, vice-principals, public health nurses, public health staff and

sexual health educators from community-based organizations as well as with a sexual health education and research consultant.⁴

The dissertation, then, focuses on the delivery of sex education and does not explicate the ways in which sex education is received, understood, made sense of and operationalized by young people. Though important, consideration of the experience of young people requires a separate study. Nor do I aim to present an analysis of what happens in every classroom across the country:

...the curriculum of the school is very much the creation of its staff – the teachers in the classroom – and in many ways it is best seen as the accumulation of individual classroom work. If one wanted to discover with accuracy what the curriculum was in any one school one would have to observe all the teachers of that school in their own classrooms (International Planned Parenthood Federation cited in Woodcock *et al.*, 1992).

Indeed, it has been noted that the content and extent of implementation of sex education vary considerably between provinces, school boards and schools (Barrett, 1994; Evans, 1999: 10; Maticka-Tyndale *et al.*, 2001: 25). In order to cope with this variability, this project considers the practices of four provinces, representing four different regions, in order to elucidate what practices and discourses are authorized, negotiated and resisted. Despite these documented concerns about variability, however, the present analysis reveals remarkable consistency across the four provinces.

What follows in Chapter 2 is a historical timeline of school-based sex education in Canadian schools, since the current sex education regime must be considered in the context of previous key moments. I trace the school project starting with its emergence through purity lectures and nature study in response to the venereal disease threat of the First World War, to the emphasis on venereal disease during the Second World War, to

⁴ Please see Appendix One for a copy of ethics approval and Appendix Two for the interview guide.

the emphasis on family life education in the post-war era, to the emphasis on family planning in response to the ‘teen pregnancy’ epidemic of the 1970s, to the AIDS education of the 1980s and to the sexual health education of the contemporary period. This timeline does not suggest distinct and discrete breaks between and across epochs. Rather, it is consideration of how the matrix of health, risk and morality concerns gets worked up by regime participants at particular points in history. I describe the school-based sex education project as one based on the dangers of sex, as elucidated by an intensification of health discourses. The medicalization of sex, however, also operates through risk and morality discourses, which aim to discipline and regulate the young.

In Chapter 3, I describe how the values clarification approach, the so-called ‘value neutral’ approach that aims to encourage the values development of the individual, is generally regarded as the approach that supports and frames the school project. I argue that contemporary practices and discourses do in fact encourage students to clarify their values and make decisions that are best for them, as explicated in values clarification and decision-making activities in the classroom and activities that encourage discussion of sexual matters with parents in the home. At the same time, however, I assert that the values clarification approach is not easily accommodated within a health-risk-morality paradigm. As a result, some values and choices are presented as good choices, as healthy choices, where educators are, in the words of one sexual health educator, “not making a value judgment, but making the case for it” (Sexual Health Educator, Alberta). In this chapter I argue that sex is still a moral question and that it is this morality that works through health and risk discourses.

In the next two chapters, I argue that the medicalization of sex education serves as a non-moral form of moral code to discourage premarital sex, in that morality discourses operate by and through health and risk discourses in order to support a sexual regulation of youth. In Chapter 4, I describe how abstinence is presented as a healthy and wise choice for teens in order to prevent pregnancy and STIs. Lesson plans list the reasons for abstinence, with a particular emphasis on the social, emotional, physical and spiritual consequences of sex. The recent concern around the human papillomavirus (HPV), a sexually transmitted infection, and its link to cervical cancer is a specific exemplar of a 'medical model of abstinence' where students are cautioned against an extreme (and relatively rare) consequence of sex. Students are also meant to learn the 'how-to's' of abstinence: sexual limit-making, refusal skills, and age-appropriate ways of showing affection, the latter illustrative of a 'no sex' sex education.

Although abstinence is presented as the only perfectly effective way to prevent pregnancy and STDs, information on managing the risks of sex for those who are sexually active is also imparted to students. In Chapter 5, I describe the dominant risk reduction strategies of the school. I discuss how certain interventions achieve a certain level of approval. Students are encouraged to make 'good' choices regarding pregnancy prevention, by using hormonal pregnancy prevention methods as well as condoms. Students are also encouraged to make 'good' choices regarding STI prevention, by engaging in 'no' or 'low' risk activities, with the exception of one particular low risk activity: oral sex. Indeed, in light of the 'oral sex epidemic' students are cautioned of the physical, emotional and social consequences of oral sex, which points to both the medical and metaphysical harms of sex. The insistence by educators that oral sex is an intimate

act, despite youth opinion that oral sex is ‘not sex’, illustrates how the sex education project is driven by anxiety – anxiety about adolescent sexual pleasure – as well as the ways in which adult meanings and interests are imposed on adolescent relationships.

In Chapter 6, I discuss how student sexual subjectivities are worked up by the current regime of sexual practices. Given the strategy of STI and pregnancy prevention and the tactics deployed to support this strategy, I argue that the student subject is constituted as heterosexual and gendered, and that these subject positions support a normalizing and regulatory school project. I also suggest that the ways in which the constitution of young people as regulated and regulating sexual subjects converge with protectionist concerns regarding the transition from childhood to productive adulthood and responsible citizenship – STD and/or pregnancy during the teen years would, in sum, ruin one’s life chances, particularly since, in the pregnancy discussion, the abortion option is conspicuously absent. In addition, activities that emphasize the potential volatility of teen relationships as well as recent changes to Canada’s age of consent legislation point not only to concerns about the young engaging sexually with one another, but also to their potential victimization by adults and ‘on-line predators’. Sex education, as a project of anxiety, emphasizes the dangers of sex; the focus is one of health-risk-morality rather than one of sexual socialization and sexual development.

In Chapter 7, I critically engage with what Michelle Fine calls the ‘missing discourse of desire’ (Fine, 1988) in school-based sex education by explicating the ways in which desire, pleasure and sexual entitlement are fostered within the school walls, to create what I call ‘transformative spaces’. ‘Transformative spaces’ are practices and discourses of critical pedagogy that resist the dominant way in which knowledge is

organized and deployed as a form of regulation and they support an approach to education that is dialogic and informed by student experience. As such, these practices and discourses do not operate solely as a form of resistance, they also have a distinct potential. However, because these transformative spaces do not resolve a number of key tensions, they do not comprise a counter-attack against the deployment of sexuality – they do not signal a regime change.

In conclusion, I engage with debates regarding the ‘failures’ of sex education. In Chapter 8, I answer the question: ‘Does sex education have to be a failed project?’ and conclude by discussing the ways in which the school project must move beyond the goal of behavioural change in light of contemporary, yet historically coterminous, socio-cultural issues and trends.

Chapter Two

From ‘Purity’ to ‘Sexual Health’: An Overview of Canadian School-Based Sex Education

This chapter provides an overview of what I consider to be the key moments in the history of Canadian sex education. However, it is important to emphasize that it is not an exhaustive account, since such a detailed examination would require extensive archival research, consultations and interviews and contact with most ministries of education, school boards and public health organizations across the country. The purpose of the chapter is to draw on the available literature to document the main themes and contours of the debate, since conceptualizing the current regime of sexual practices requires consideration of dominant and contested strategies in their historical context. In what follows, I trace the sex education project from its emergence in response to the venereal disease threat of the First and Second World Wars, to the teen pregnancy ‘epidemic’ of the 1970s, through the advent of HIV/AIDS in the 1980s and, finally, to my main concern here, the contemporary preoccupation with sexual health. From this trajectory, a number of themes and continuities emerge that provide a framework for understanding how the current regime is organized around the dangers of sex. Specifically, this review of the literature will demonstrate the ways in which the regime of practices is perpetually caught in a ‘problem-solution matrix’ since the main strategies of the regime are organized in response to venereal disease outbreaks and other ‘epidemics’. The tactics pursued in response to these problems - such as nature study, abstinence, family planning and values education – not only demonstrate the persistence and resilience of the medico-moral model, but also demonstrate remarkable consistency in the ways in which the discourses and practices of the regime shift in the context of

social, cultural, material and nationalist concerns, particularly as these concerns intersect with the modern separation of sex from reproduction. In their totality, the practices of the regime consistently constitute gendered and heteronormative, regulated and regulating, sexual subjectivities.

World War One: Nature Study and Purity Lectures

Significant material and social changes at the end of the 19th and early 20th centuries led to warnings about the many dangers of sex. The first material and social change was the threat of urbanization, and its associated risk for disease (syphilis and gonorrhea), exploitation, prostitution (including the ‘white slave traffic’), and unwanted pregnancies. The second social and material change was the invention of adolescence as a distinct, transitional developmental period that began at puberty and lasted until the early 20s (Hall, 1907). As Jeffrey Moran notes, the invention of adolescence rested on three important material changes of the 19th century: the increasingly distinct separation of children from the adult world due to a rapidly expanding school system and the curtailing of child labour; the decline of the average age of puberty or sexual maturation (due to greater disease prevention and good nutrition); and the increasing period of training and education with the concomitant delay of marriage (Moran, 2000: 15). Third, was the advent of the First World War and, more specifically, the high incidence of venereal disease in soldiers – the Canadian Expeditionary Forces had the highest rate of venereal disease amongst troops in Western Europe (Cassel, 1992: 147), a rate which was assumed to reflect the incidence of venereal disease in the general Canadian population (Buckley and McGinnis, 1982: 338). Significantly, this shift from gender-specific assumptions that

operated through male-defined norms of sexuality, crystallized in an expanded discourse on both male and female sexuality (Mort, 1987: 75).

Indeed, the main impetus for children's sex education was the moral and medical threat posed by venereal disease (Moran, 2000; Cassel, 1987; Adams, 1997; Sethna, 1995). The belief in the causal connection between children's ignorance of sexual matters and venereal disease led many to conclude that sex education could serve as a moral and medical prophylaxis against venereal disease. Tension existed, however, as to who would be the most appropriate educator of children in sexual matters: the parent or the school teacher. On the one hand, it was feared that school-based sex education would arouse the sexual curiosity of children; on the other hand, it was thought that parents didn't have the knowledge or comfort level to teach their children and thus the school needed to intervene.

Following the professionalization of medicine and the advent of 'scientific' medicine (e.g. the discovery of germ theory), physicians largely focused on the medical aspects of the venereal disease problem, such as diagnosis and treatment, and medical professionals, in the main, largely opposed sex education in the schools (Cassel, 1987: 103-115). Government regulation at the provincial and municipal levels focused on public health initiatives, such as the reporting of communicable disease and restricting the movement of infected individuals in order to control the spread of infection (Cassel, 1987: 104). Sex education, then, was largely a reformers' innovation (Cassel, 1987: 115) and from the end of the 19th century through to the end of the First World War, the social purity movement in Canada was a driving force behind children's sex instruction (Sethna, 1995).

The practices of the regime, then, were organized around the threat of venereal disease. The social purity movement pursued both home and school programs concurrently - the home and the school had to work together – and two primary tactics were pursued: mothers were trained to provide sex instruction, by way of nature study, to their children, and anti-masturbation purity lectures would be provided to young people in public schools.

In 1900, the Ontario Women's Christian Temperance Union (WCTU) established both the Department of Purity and Mothers' Meetings (renamed the Department of Moral Education and Mothers' Meetings) and hired Arthur W. Beall to give his 'advanced purity lectures' to school children. The Mothers' Meetings emphasized that it was the role of the mother to provide sex instruction to her children. As a result of her inherent asexuality, "the mother was viewed as the perfect teacher who could maintain her children's confidence, tell her children the truth about sex without arousing their sexual instincts prematurely and inculcate in them the message that human sexuality was meant for reproduction within marriage" (Sethna, 1995: 37). Her role was to foster purity of thought and action in her children against the dangers of 'pollution' while also informing them of the process of reproduction. She could prevent children from consuming sexually stimulating food and substances (e.g. tea, coffee, meat, cigarettes), and would insist that her children exercise in the fresh air as well as have regular bowel movements, cold baths, wear loose clothing and sleep with their hands above the bed covers. She would explain nocturnal emissions, nature's way of eliminating excess fluid, to her son and menstruation, the preparation for motherhood, to her daughter. She would use nature study to explain the process of reproduction, which relied on an evolutionary approach,

starting with plant life and ascending to fish, and then moving to birds and mammals and finally to humans.

Nature study squarely situated the proper place of sex in healthy and responsible parenthood. The focus on the reproductive habits of plants, fish, birds and cats both emphasized a scientific approach to sexual matters and supported self-denial and chastity in adolescents. Indeed, in the course of nature study it was intended that,

...children would adopt the goal of healthy and responsible parenthood for themselves, understand the basics of reproduction without having their sexual instincts prematurely aroused, and be able to steel themselves with this knowledge when faced with the possibility of sexual corruption in word or in deed (Sethna, 1994: 192).

Nature study was also pursued as a way of teaching biological reproduction in some schools in Nova Scotia, Manitoba and Ontario at the end of the nineteenth and the beginning of the twentieth centuries. Elementary pupils were taught about the reproduction of plants and lower animals in co-ed classes. High school students were taught the basic facts of human reproduction, heredity and evolution in sex-segregated classes, which also opened the door to lectures on venereal disease in some classes. The “clean sexual enlightenment” (Porter and Hall, 1995: 227) of botany and nature study to discuss reproduction emphasized the science of sex, and resolved the anxiety and tension that existed between the need to discuss sexual matters and the fear of putting undesirable ideas into young minds. However, this approach fell out of favour in the schools after the 1930s (Sethna, 1994: 196).

In addition to its educational activities for mothers, the Ontario WCTU also hired the missionary Arthur W. Beall to give his ‘advanced purity lectures’ to public school children in 1900 and by 1912, Beall accepted the Ontario Department of Education’s

appointment as ‘Special Lecturer on Moral Subjects’. Between 1905 and 1911, 13,463 public school boys received these lectures (Bliss, 1974: 338). Significantly, Beall was the first Canadian to conduct sex education classes in schools and nothing similar to his lectures was put into effect outside Ontario (Valverde, 1991: 70; Cassel, 1987: 114). Indeed, Beall’s work was portrayed as integral to the fight against venereal disease (Sethna, 1995: 104).

Beall lectured on two basic themes: one promoted the idea that the body was ‘a living temple’ owned by God that had to be kept clean, and the other emphasized that indulgence in sex, as well as in tobacco and alcohol, was unpatriotic (Valverde, 1991: 71). His book, *The Living Temple: A Manual on Eugenics for Parents and Teachers*, was firmly grounded in eugenics ideology, one that sought improvement of the biological stock of the population by maximizing racial fitness in the nation state, a discursive complex of nationalism, population and sexuality, a clear articulation of health, risk and morality concerns. Specifically, this strategy of replacing ‘sex’ with ‘race’ and ‘racial fitness’ helped to address parental objections, since “racial truths looked at the sex organs from the health point of view, while ‘the sexual point of view’ looked at the same organs selfishly, as self-indulgence and self-gratification” (Mort, 1987: 186).

According to *The Living Temple*, Beall’s first six lectures were directed to a co-educational audience, where he urged both boys and girls to grow up to become good and responsabilized citizens of Canada: “A.1 men and A.1 women.” A sure way to become such an upstanding citizen is, he instructed, to ‘be clean’ in thought, word and deed. The clean life required that the bodies of these students belong to Christ – and that each boy

and girl was expected to pay rent on their individual 'Living Temple of the Living God' by keeping their body clean.

The first strategy of cleanliness challenged the double standard. By explicating the relationship between morality and chastity, Beall urged girls to be intolerant of a low standard for boys and as such, to "make the boys of Canada level up" (Beall, 1933: 31). Boys were urged to treat every girl they knew with the same respect they showed their mothers.

The second set of lectures, which was centred on the strategy of cleanliness or anti-masturbation, was directed to boys only. These talks explicated appropriate usage of the 'male part'. First, Beall explained the grave dangers of masturbation. The 'male part', he explained, like other glands in the body, secretes the 'life fluid', which functions to feed the muscles, the brain and the nervous system. The boy who masturbated, then, was wasting the precious life fluid. Beall insisted that masturbation led to nervous breakdown and castration and pointed to asylums in a number of cities that were filled with boys suffering these ills. Since he insisted that "the more you use the penis muscle, the weaker it becomes" (Beall, 1933: 67), Beall urged boys to keep the penis clean and untouched and to have only clean and noble thoughts. Second, Beall noted that boys around the age of 16 or 17 might sometimes experience the loss of the life fluid during sleep. The overflow was, however, normal unless the boy continued to have impure thoughts about girls. Again, Beall emphasized clean and noble thoughts. Last, Beall urged the boys to choose a chaste woman for marriage and to reserve the life fluid for fatherhood - illegitimate pregnancy was, as he described it, a crime worthy of the death penalty. In conclusion, boys were meant to sign a resolution promising clean thoughts, words,

actions and habits; reverence and honour of all womanhood; disengagement from all unclean conversation, songs, jokes and company; and patriotism both by standing up for younger brothers everywhere and by making Canada a clean land (Beall, 1933: 76).

In addition to the efforts of the Ontario Women's Christian Temperance Union, it is equally important to note that both tactics – nature study and anti-masturbation purity lectures – were present in the texts *What a Young Boy Ought to Know* (1897) and *What a Young Girl Ought to Know* (1898). These two volumes formed part of the *Sex and Self* series, which were the best-selling sex manuals in Canada from 1900 to 1915 (Bliss, 1970: 326).

Part One of *What a Young Boy Ought to Know* begins with the question 'where do babies come from'? The first chapters "are a heavily theological description of God's purpose in endowing plants, animals, and man with reproductive organs" (Campbell, 1979: 3), a developmental description from the life of plants, to the life of the baby oyster, to the life of Adam and Eve as the first parents. Part Two of *What a Young Boy Ought to Know* warns boys against the dangers of masturbation, that self-abuse causes the mind to fail, health to decline, idiocy and even death. According to the text, a boy who masturbates will have inferior offspring – a clear warning about the dangers of masturbation for race fitness and survival. The closing chapters urge boys to 'recover their purity' through self-control and to help their peers do the same (*ibid*).

What a Young Girl Ought to Know also commences with descriptions of plant reproduction, pollen and the role of bees, fish fertilization and the care of the young by mammals. The next chapter is on masturbation, but with a more gentle tone, as was deemed appropriate for their presumed lesser temptation (Campbell, 1979: 21). While the

young girl is warned of the dangers of masturbation – a practice that could result in constipation, for example - the emphasis on the chapter is one of physical hygiene; for example, a diet rich in milk, eggs, oatmeal, entire wheat flour, and fruits is recommended. In the text, girls are also encouraged to think ‘good thoughts’, to have good posture, to read books that lead to self-improvement, and to recognize the value of hard work. Menstruation is mentioned only obliquely, as a physical change that takes place at puberty (Campbell, 1979: 22). While *What a Young Boy* constitutes male sexuality as uncontrollable, dangerous, and active, *What a Young Girl* constitutes female sexuality as latent, passive, and put on hold until acquiring the role of wife and mother – a sexual double-standard that persists to this day.

In their totality, the discourses of nature study and purity lectures constituted gendered subject positions and located the proper role and place for sex in the married and committed relationship. Sexual activity outside marriage represented the erosion of self-control and self-discipline of the individual with disastrous consequences. The waste of sperm – through masturbation, nocturnal emissions, premarital sex - not only dangerously depleted the vital forces needed by adolescents for the maturation process, but also put the ‘race’ in danger since sexuality, if not understood and rationally controlled, could pose dangers to the nation (McLaren, 1990: 72). With clear links to the idea of the ‘spermatic economy’, the retention of seminal fluid was deemed necessary due to its vitalizing, strength-giving source of added physical and intellectual power. For example, Beall urged his young students to put their efforts into more refined activities: “far better to repress urges than to waste the energy in basically animal activities and instead use it for truly human, truly creative, intellectual and aesthetic purposes” (Bliss,

1970: 334). The practice of masturbation, in particular, as a “private fate and social disaster” (Hunt, 1998: 598), was linked to concerns related to individual self-discipline, self-control, character and respectability as well as to social and national well-being (Porter and Hall, 1995; Hunt, 1998; Moran, 2000). Significantly, this emphasis on the medical and metaphysical harms of sex and the concomitant discursive constitution of the regulated and regulating subject persists to this day.

World War Two: Education for Parenthood

After the First World War, a shift in discourse took place – there was a move away from the focus on venereal disease toward ‘education for parenthood’ – in a context of material and social changes. First, a new youth culture emerged in the 1920s and 1930s, marked most notably by changes in female dress, dancing and courtship (the shift from the chaperoned practice of ‘calling’ to ‘dating’, afforded by the mobility and privacy of the automobile) (Bailey, 1988), all of which led to pre-marital sexual activity, such as ‘petting’. Key to this new culture, then, was the separation between sex for procreation and sex as recreation. Second, concerns re-emerged around the venereal disease rates in army recruits during the Second World War. The discovery of penicillin as an effective treatment for syphilis and gonorrhea and the presumed promiscuity of civilian women who were allegedly giving sexually transmitted diseases to recruits and soldiers (as opposed to the prostitute women of the First World War) provided a new focus for educational efforts: promiscuity and safeguarding the family. Although the idea was to move away from a focus on venereal disease, the practices of the regime were still articulated through medical discourse and through a broader range of tactics:

monogamous heterosexual relationships, marriage and childbearing were promoted as the most effective prophylaxis against venereal disease (Sethna, 1995: 193).

It was, however, still hotly contested as to where sex education should take place: the school or the home. The federal Department of Health, established in 1919, housed a special Division of Venereal Disease Control that acted as a coordinating centre for health work, produced posters and pamphlets and funded provincial initiatives and organizations. On the subject of sex education, the Division squarely placed the responsibility of instruction on parents with the production of the pamphlet *Information for Parents – Teaching Sex Hygiene to Children*. The Canadian National Council for Combating Venereal Disease (renamed the Canadian Social Hygiene Council in 1925), which relied heavily on Division funding, also supported parental education of children. In 1925, the organization established an Education Division in order to provide information to parents on child study and sex instruction. Again, nature study was promoted as the preferred method to teach about reproduction and fathers were to explain nocturnal emissions to boys, and mothers were to explain menstruation to their daughters. Both boys and girls were to be warned about the dangers of masturbation: boys should be told that masturbation stopped them from growing big and strong while girls should know that masturbation made them physically unattractive (Sethna, 1995: 170) - an anti-masturbation strategy that focused on the more mundane, everyday anxieties of youth (Hunt, 1998). By age 16, both boys and girls were to be warned of the moral and hygienic dangers of venereal disease.

At the same time, because public support for the fight against venereal disease was high, there was increased pressure to provide sex education in the schools. Indeed,

by 1945, 10-11% of venereal disease cases were teenagers; thus “the overemphasis on the ‘youthfulness’ of those with VD meant that teenagers came to be seen, alternately, as responsible for the health crisis and as victims of it” (Adams, 1997: 108). A 1937 student assembly called for compulsory sex education in the schools. A May 1943 Gallup poll indicated that 76% of Canadians approved of giving a sex instruction course to students in high school. The press openly supported school-based sex education in response to venereal disease and juvenile delinquency concerns.⁵ The dominant discourse among educators at the time was that the school was the moral counterpoint to the inadequate home, the unattended church and the sordid street and as such “the school had to take its place beside the home and the Church as the chief influence in moulding the character and conduct of young people” (Sethna, 1995: 88-89). However, even with this growing support and momentum, little instruction occurred in the schools in any systematic way (Sethna, 1995: 233).

Yet, some hygiene texts did infiltrate various Ontario public schools. Some reference was made to masturbation and the ‘keys’ to self-control and self-discipline: clean genitalia, exercise, non-stimulating foods, loose clothing, hard beds, and fresh air. Neither reproductive anatomical information nor information on menstruation was provided. But, as historian Christabelle Sethna points out, it is certainly possible that women teachers gave information on menstrual hygiene to their girl pupils, given the availability of free booklets with titles such as *As One Girl to Another*, which urged

⁵ According to Tamara Myers (2005, 2006) juvenile justice was born in the reform schools of the nineteenth century and matured in the juvenile courts of the early twentieth century. Girls were constructed as sex delinquents and once brought to juvenile court were sent for medical verification of the state of their hymens and were required to submit to ‘sexual confessionals’. The young male body became a factor in delinquency cases when associated with violence and homosexuality and by the 1940s, the court engaged in more widespread policing of boys’ sexuality, focusing on boys’ sexual agency and heterosexual (mis)adventures.

teachers to acquire and distribute these booklets since mothers often hesitated discussing intimate problems with their daughters (Sethna, 1995: 231).

In addition, some provincial educational departments and school boards did experiment with and implement various sex instruction curricula. Most notable were efforts in Quebec, where the campaign against venereal disease was quite different from the one in English Canada. As historian Jay Cassel notes, campaign activities for the general public throughout the 1920s and 1930s - lectures, films, pamphlet distribution - reached a remarkable proportion of the population, likely due to support from the Catholic Church (Cassel, 1987: 223). Key to the success of campaign activities was the framing of venereal disease not just as a medical question, but also as a moral question, with its elimination necessary for the conservation of the home (Desloges, 1926: 434, 441). The Church supported the effort by exerting its moral influence - lectures were conducted by both a physician and a priest - which also fitted with its agenda for moral reform and spiritual revitalization. Talks were given in schools along with the showing of documentary films that depicted the facts of venereal disease, such as *Diagnostic et traitement de la syphilis* (1920), *Blenorragie chez l'homme* (1920), and *Hygiene sociale de la femme* (1920).⁶

In 1939, the Alberta Department of Education incorporated units on 'How we Began', 'Heredity,' and 'The Social Diseases' in Health and Physical Education courses. Teachers were "to emphasize that syphilis had become a world-wide 'scourge' and was a great menace to the young. Similarly, gonorrhea was considered an illness with serious consequences, one of which was blindness in infants" (Sethna, 1995: 211). After 1942

⁶ These films were produced by the American Social Hygiene Association (ASHA) and edited and adapted for use in Canada by the Canadian Social Hygiene Council (CSHC).

and with the support of the British Columbia Division of Venereal Disease Control, educational authorities in British Columbia taught students about syphilis and gonorrhea by way of a short film followed by a 45-minute round-table discussion led by a lecturer from the British Columbia Division of Venereal Disease Control. In conclusion, the lecturer was to inform students that they need not worry about venereal disease if they conducted themselves *as they should* since accidental infection is impossible (Rhodes and Capelle, 1944: 185, emphasis in original).

Despite support from the Ontario Department of Health, the Toronto Home and School Council, the Ontario Educational Association, the Junior Chamber of Commerce, and active members of the social hygiene movement, the introduction of sex education in Ontario schools was fragmented and inconsistent. On the one hand, the Toronto School Board, Ontario's largest school board, avoided integrating the topic into the schools for fear that, given its controversial nature, it might upset parents. On the other hand, the London School Board in Ontario, starting in 1942, brought in Miss Winnifred Ashplant, a nurse, to teach Grade 11 girls about heredity, human reproduction, venereal disease, and emotional and mental health. In 1947 Dr. Ernie Williams began giving boys the same lecture. The aim in the London School Board was to impart to students the proper roles and appropriate sex drives of males and females and to emphasize the development of sexual values and attitudes in young people (Cram, 1966: 13).

Perhaps in response to the efforts of the London School Board, a swell of momentum for and support of school-based sex education was revealed in a July 1944 Gallup poll that indicated that 93% of respondents wanted Canadian high school students to be exposed to lectures on the prevention of venereal disease. The Ontario Department

of Education in 1944 placed the study of venereal disease for the first time in the Health Education sections of Grades 10 and 12. The Department included several precautionary measures to assuage controversy: parents would receive informational letters from the Department of Education and teachers would be provided with special manuals; lessons on venereal disease would be introduced in physical education and health classes and as a part of a general discussion about communicable disease (along with TB and smallpox); students would be asked not to take notes but would be given a provincially produced booklet; and while teaching about venereal disease was permitted, it was not a mandatory course of study (Adams, 1997: 113-114).

Although the practice of providing sex education in the schools was haphazard at the time, several interesting themes emerge. The regime continued to be organized around a mixing of the moral and the medical. Certain consistencies with the anti-masturbation messages of the social hygiene movement persisted, including the message of self-control and self-discipline for young people as well as the promotion of the proper use of sex in the married relationship. At the same time, new tactics emerged. While individual female teachers likely provided menstruation information to female students, thus breaking silence around female reproductive anatomy and physiology, there was also an incitement to discourse around the problems of syphilis and gonorrhea. In addition, the pursuit of fear-based tactics – the use of films and slide shows depicting the horrors of these diseases, such as the potential repercussions for the unborn – persists, as this dissertation will argue, to this day.

The Post-War Period: The Family Living Approach

With the discovery of penicillin as an effective treatment for syphilis and gonorrhea in 1945, replacing complicated and potentially toxic arsenical treatment methods, venereal disease was no longer considered a public health crisis. However, new anxieties emerged in the post-war time of peace. Social changes included fears of Soviet expansionism and communism as well as changes to Canadian demography, resulting from an increased number of immigrants coming to Canada from southern and eastern European countries. Third, the eroticization of romantic relationships based on perceptions of equality and higher divorce rates, as well as increasing numbers of women entering the workforce led to changes in the family. Fourth, was a perceived loosening of moral values, as explicated in the publication of Alfred Kinsey's *Sexual Behaviour in the Human Male* (1948), which instigated discussion on a range of sex practices, such as homosexual acts, premarital sex, oral sex, anal sex, and masturbation. Fifth, was the 'youth problem' as evidenced by teenagers' growing economic independence and alleged lack of parental supervision as well as a burgeoning commercialized teen culture and teen consumer market. Last, were concerns over sex crime and sexual perversion, which led to the *Criminal Code* amendments of 1948, a 1952 Senate Committee concerned with Salacious and Indecent Literature, and the 1954 Royal Commission on the Criminal Law Relating to Criminal Sexual Psychopaths.⁷ In this context, the regime was still organized around a problem-solution matrix, as a response to the threat of venereal disease, but the 'family living' approach aimed to respond to a historically specific range of social and moral ills, such as sex crime, separations, divorce, promiscuity, and homosexuality as

⁷ These amendments essentially defined sexual deviation as uncontrollable and as an incurable illness or defect, as explicated in the new practice of sentencing 'criminal sexual psychopaths' to an indeterminate term as long as they remained a threat to others (Adams, 1997: 122-123).

well as to nationalist concerns, such as communist ideologies. The 'family living' approach aimed to shape a new kind of youth committed to the moral values of their communities (Adams, 1994: 72).

However, the inclusion of sex education in the schools was still a controversial matter. The project was still preoccupied with questions of how and by whom interventions should be carried out, particularly in the context of balancing the rights of the family and fulfilling state responsibility. Indeed:

To introduce sexual matters into publicly funded classrooms was to put the school into competition with the home and the church as the primary sites of young people's moral and, in the former case, sexual development. It was to upset notions of family privacy and of the division of labour between home/church and the school. To make that shift was to acknowledge that those institutions were no longer capable of fulfilling their assigned responsibilities (Adams, 1997: 114).

The demand for sex education in the schools was fuelled by myriad social and medical concerns of the time and, as a result, parents were deemed incompetent and too ignorant to provide sex instruction to their children in the home.

However, the process by which school programs were developed and implemented was not straightforward, uncontroversial or successful. For example, after a failed attempt in 1944, the Toronto District School Board once again debated the implementation of sex education in the schools in 1948. The program proposed in the 1948 *Report of the Teachers' Committee on Family Life Education* de-emphasized disease and instead stressed 'normal' boy-girl relationships and the necessity of a happy family life, in the context of a high standard of moral conduct and sexual self-control:

The first of the long-term aims was to enable pupils to appreciate and value the normal, natural, husband-wife-child relationship in the home, the cornerstone of successful, happy, family, life. The second long-term aim was to give students standards of values enabling them to distinguish what is good in sexual life from what is sordid, selfish or perverted...[S]hort-term aims intended to show that it

was important to protect the home, women and children, to help the adolescent boy and girl learn proper conduct in their relationships with each other, to emphasize that sex was a bodily function as well as a joyous emotion, to provide an adequate vocabulary of sex, to understand the biology of reproduction and to develop respectful attitudes towards the whole subject (Sethna, 1995: 270-271).

Although the program was given conditional approval, it was left to the discretion of principals whether or not to implement it in their schools, and members of the Ontario Department of Education were allowed to observe classes. Interestingly, parental opposition to the program never materialized – it was teachers who had expressed dissatisfaction with the curriculum's lack of moral content which led to its ultimate rejection by Board trustees.

A modified version of the program was developed in 1949 which de-emphasized the controversial information on physiology and excluded all mention of venereal disease. The context for boys included: body growth and development, importance of good grooming, understanding interests of the opposite sex, relationships (to family, to same-sex friends, to opposite-sex friends), poise, emotional control, and good habits in Grade 10. In Grade 11, boys were to be taught about high morals, wholesome relationships with boys and girls, sensible attitudes toward alcohol, gambling, emotional maturity and satisfying recreation and in Grade 12 they were to be taught about courtesy, respect for parents, responsibilities to the family, good citizenship (self-discipline, loyalty), and problems of modern living (racial discrimination, effects of technology and alcohol on society).

Grade 9 girls were to be taught about good posture, bathing, choosing appropriate recreation, assumption of adult responsibilities, and the hygiene of menstruation. In Grade 10, they were to be taught about the muscular, circulatory and respiratory systems,

first aid, and the effect of tobacco and alcohol on the body. In Grade 11, they were to be taught about the meaning of democratic citizenship, hobbies, recreation, job choices, emotional maturity, overcoming prejudice, getting along with family, “crushes” and mature friendships and getting along with boys, and in Grade 12 the focus was to be on child study. Indeed, the focus was on the ideology of the Canadian heterosexual nuclear family, rules and standards of conduct, rather than on providing any guidance around physical and emotional changes during puberty, dating, or sexual capabilities (Adams, 1997: 134). Even with its relatively benign focus, the program was dropped from the curriculum in 1952 due to continued diverging opinions on the nature of adolescent sexuality, on the rights of the family and on the limits of state responsibility for moral questions (Adams, 1997: 107).

School-based sex education was not the norm throughout the 1960s. The very first national survey on school-based sex education in 1964 revealed that none of the provincial departments of education reported having a curriculum provision for treating sex education as a separate subject or program (Canadian Education Association, 1964: 4). The most frequently cited reasons for this omission were that sex education was not seen as the responsibility of public schools and that there was no demand or request from parents for its inclusion. Thirty-five out of fifty-five school boards surveyed indicated that aspects of sex education were integrated into regular subject areas such as health, science, social science, home economics, personal and family living and guidance. The most frequently mentioned topics of instruction for Grades 7-9 were physical changes at puberty and dating manners, both for girls’ classes; the physiology of human reproduction, dating manners, considerations in choosing a mate, and factors conducive

to a happy marriage were most frequently mentioned for Grades 10-13. There was virtually no instruction for Kindergarten to Grade 6 and contraception was mentioned the least in the remaining grade levels. The continued focus on Family Life Education (FLE), as sporadic as it was, kept the topic of sex education “in a family context, as the objective is to create wholesome attitudes towards sex, and not merely [to] present information on reproduction” (Canadian Education Association, 1964: 13). Those school boards that did not include a provision for sex education noted a lack of authorization by departments of education and of qualified teaching personnel, and described sex education as a parental responsibility. At the same time, the majority of school boards acknowledged the need for teaching sex education in the face of diminished home influence and parental failure to meet this responsibility.

Another national survey conducted by the Vanier Institute of the Family⁸ in 1971 revealed similar results. In its sample, 68% of schools did not offer any Family Life Education, and for those that did, FLE was most often integrated into Health and/or Physical Education, Guidance and/or Counselling and Home Economics (Vanier Institute of the Family, 1971: 4). Only 16% of schools offered a separate sex education course.⁹ Interestingly, most schools offered FLE at all Grade levels, from elementary school to the last year of high school and the most frequently cited topics of instruction were sex education (78%), dating or boy-girl relationships (75%), and parent-child or intergenerational relationships (71%) (Vanier Institute of the Family, 1971: 7).

⁸ The Vanier Institute of the Family was established in 1965 immediately following *The Canadian Conference on the Family* convened at Government House by Governor General Georges P. Vanier and Mme Pauline Vanier. It is a national, charitable organization dedicated to promoting the well-being of Canadian families.

⁹ ‘Sex education’ was not defined in the report. However, one can assume that sex education at the time, in its historical context, would include instruction on reproduction, anatomy and hygiene.

Community reaction was viewed as a problem by only 9% of respondents and the primary problems reported were practical: lack of qualified staff, lack of teaching aids, and curriculum limitations. While respondents believed that FLE was a worthwhile subject in the school curriculum, many educators surveyed were not eager to assume the major responsibility for sex education, as almost half affirmed that parents should be primarily responsible.

While venereal disease no longer seemed to pose a threat to young people, new concerns emerged, such as a perceived increase in the rate of and severity of sex crimes as well as a perceived loosening of moral values. The school, however, was reluctant to play an active and consistent role in the provision of sex education. Nonetheless, at this particular time, the regime of practices continued to promote the proper place of sex within the married relationship and to promote wholesome attitudes toward sex. Specifically, students were to understand the opposite sex, to deal with crushes and to prepare for mature relationships. As this dissertation will later consider, the postponement of sex until ‘maturity’ is a message that is alive and well in contemporary abstinence discourse. In addition, sex education curriculum strongly intersected with moral education: emphasis was on qualities such as poise, high morals, responsibility, and sensible attitudes – the stuff of ‘good citizenship’, a discourse that has been revitalized with the introduction of character education in Alberta and Ontario. In their totality, the practices of the regime were organized in such a way that sex education “read like an indoctrination program in compulsory heterosexuality and social conformity” (Sethna, 1995: 300).

The 1970s: 'Teen' Pregnancy and Family Life Education

Another shift in sex education discourse took place in the context of social and material changes of the 1970s. The legalization of birth control (particularly the arrival of 'the pill') and of homosexual acts, the partial decriminalization of abortion, the advent of second wave feminism, an increasing age at first marriage and increased incidence of extramarital and premarital sex contributed to what was considered, by some, as proof of a sexually permissive culture. As a result of the 'sexual revolution', the reported STD rate among adolescents almost tripled from the early 1960s to the early 1980s, with most of the increase occurring in the late 1960s and early 1970s, though it is difficult to discern whether this was an actual increase in incidence or an increase attributable to better screening and reporting procedures (Herold, 1984: 138). Significantly, the sexual revolution also resulted in what was deemed an 'epidemic' of teenage pregnancy and as a result, support for and interest in school-based sex education intensified and efforts centred on two main tactics: the inculcation of values in adolescents and 'family planning'.

In fact, due to social ills such as divorce, child abuse, teenage pregnancy, and the working mother, perceptions persisted that the traditional family and religious institutions could no longer be counted on to prepare the young adequately (Arcus, 1992). As such, certain values needed to be inculcated in children to guide them in the new sexual freedom and to support their future serious consideration of childbearing and establishing a family: skills and personality characteristics had to be acquired in order to raise children well and to ensure satisfying marital relationships (Karal, 1984: 6-7). FLE programs focused on knowledge and content acquisition (human development, family,

responsibility); skill acquisition (decision-making and the concept of responsibility) and personal development goals (attitude and character development) (Karal, 1984: 12, 15).

Thus, sex education had two overarching goals:

The first is the raising of responsible young people who have clear and desirable values, who are able to relate maturely and closely to others, and who value family life as a major part of a fulfilling life. The second is the provision to these young people of the knowledge and skills that they will require to undertake and maintain a family and to carry out the role of caring for their children and rearing them with the same values and goals that they themselves have (Karal, 1984: 52).

For example, an evaluation of an FLE program in a school board in Vancouver, British Columbia revealed an emphasis on the factual, physiological aspects of sex as well on communication skills, customs of and potential problem areas in courtship and marriage, and awareness of what characteristics the opposite sex values most in seeking a mate in order to help a child to become a man or woman in society (Leslie, 1973: 2). The issues involved in FLE, then, extended beyond the physiological aspects of sex education to include character education and the promotion of important human values.

Second, the emergence of ‘family planning’ in sex education practices was a direct reaction to what was deemed the new ‘epidemic’ of teen pregnancy. Prior to the mid-1970s, the phrase ‘teen pregnancy’ was not used, although there had always been unwed or teen mothers (Pillow, 2004: 17). However, in the 1970s there was a shift in problem conceptualization, a shift in conceptualizing illegitimacy from one in terms of marital status to one in terms of age. Ironically, the emergence of the ‘problem’ of teen pregnancy occurred when birthrates were at their lowest. Total fertility rates in Canada reached their highest level in the postwar period in 1959 and declined every year thereafter (Wadhera and Silins, 1990: 27, 28). Teen pregnancy was, however, problematized in two ways. First, while birth data had been collected since 1921 by age

of mothers starting at 14 years old, Statistics Canada commenced collecting 'teen pregnancy' statistics in 1974, an articulation, I would argue, of teens as a risk population made justifiable by way of counting bodies. Second, the teen pregnancy epidemic of the 1970s was more of a teenage baby-keeping epidemic. The 'unwed mothers' of the 1950s, had shotgun weddings, carried to term in secret in maternity homes where adoptions were arranged, or, if wealthy and well-connected enough to find compliant physicians, had abortions (Schart, 1979: 64). During the 1970s, there was a sharp increase in the number of single mothers keeping their babies and by 1980, approximately 80% to 90% of pregnant teenagers were keeping their babies (Herold, 1984: 124). Thus, the 'unwed' mothers of the first half of the century, became the 'teen moms' of the 1970s, or 'children having children', a social ill linked with poverty, race, immorality and promiscuity (Pillow, 2004: 20, 34). In light of this social problem, the credibility of traditional socializing institutions was questioned, leading to a reconsideration of educational priorities (Ulis and McQuarrie, 1973: 2). The ability of traditional institutions to respond to such social problems was also influenced by wider welfare reform and the concomitant shift from a 'culture of dependency' to a 'culture of self-reliance'.

Because 'family planning' came to be regarded as being in the best interest of Canadian society (Deiseach, 1977: 31), support for school-based sex education intensified. An opinion poll cited 90% support of students, teachers and parents for school-based sex education, though the process by which a sex education course should be initiated continued to involve coordination and cooperation between teachers, students, parents, and interested community groups (Ulis and McQuarrie, 1973: 3, 4). And in 1972, the Family Planning Division of Health and Welfare Canada was

established to assist in the development both of local programs and provincial policy and to offer guidelines, consultation, funding and learning materials.

A repeat of the 1964 Canadian Education Association (CEA) survey published in 1977 reveals interesting results for the period. While only 32% of responding school boards indicated that they had FLE programs (and when the 214 school districts are taken as a proportion of all operating districts, it would appear that 21.4% or fewer school districts in all of Canada had FLE programs), a number of school districts indicated that they would be implementing FLE in the near future (Deiseach, 1977: 9). Family Life Education continued to be offered most commonly in Health, Religion, Home Economics, and Psychology courses, but instruction began in Kindergarten and continued to the end of high school. Although the focus continued to be on the ideology of the Canadian heterosexual nuclear family, particularly in the early grades (sibling relations, parent-child relations, and families were among the top five topics cited by survey respondents), topics related to family planning (conception and birth and birth control) were given due emphasis in the secondary grades. It would appear that inclusion of FLE became increasingly common, since teachers reported not having any unusual difficulty with FLE instruction, students appreciated the course, and parents were generally supportive of the program. In light of this, the author of the report concluded that any active resistance to FLE in schools was likely brought about by some pressure group, such as the Concerned Parents Action League of British Columbia or Renaissance in Manitoba.

In 1984, the CEA survey was repeated once again, this time by the Planned Parenthood Federation of Canada. The involvement of Planned Parenthood is significant,

I would argue, as it would seem to mark a shift in their activities from those that targeted married women in need of birth control services to limit family size to teenaged women in need of educational and clinical services. Of the 356 responding school districts, 50% offered an FLE program and another 33% were optimistic that they would implement some form of FLE within the next few years (Nolte, 1984: 13). Twenty five percent of schools offered FLE as a separate course, 40% integrated it into an existing course (usually either Health, Home Economics, Family Studies, Religion, Physical Education, or Science), and 35% offered FLE in both a separate and an existing course. Again, FLE was most likely introduced in Kindergarten – with a focus on family, family relations and values in the early grades – and continued until the end of high school. Often the ‘sex education’ part of FLE began in high school, the content of which reflected intensified concerns about teen pregnancy. Grade nine and ten students were to learn about conception and birth, alcohol and drug use, adolescence and peer groups, venereal disease, puberty, dating and going steady and birth control while Grade eleven and twelve students were to learn about birth control methods, premarital sex, parenthood/childcare, interpersonal communications, the unmarried mother, conception and birth, and family planning concepts (Nolté, 1984: 15). Survey respondents noted that only 3% of parents held a negative attitude toward FLE and little concrete opposition to sex education in school existed. That being said, and even though “proper sex education in school can replace the silence about sex in some homes”:

It’s still a matter of debate whether or not sex education belongs in the classroom. Proponents argue that sex education encourages responsible decision-making and may lessen adolescent pregnancy... Opponents maintain that sex education will only encourage teenagers to become ‘promiscuous’. They believe that such information should only be given by parents... (Nolté, 1984: 13, 15)

However, this debate – whether the school was an appropriate place for sex education – came to a decisive conclusion in the 1980s, marked by two epidemics: a heightened concern about the alleged teen pregnancy epidemic and the new HIV/AIDS crisis.

While the teenage pregnancy rate declined from 1975 to 1987, there was an increase in 1988 and 1989 (Wadhera and Strachan, 1991: 328). Teen pregnancy came to be articulated in terms of its social and personal costs, emphasizing the material interests of the regime. For example, the Nova Scotia Advisory Council on the Status of Women noted the public costs of teen pregnancy by way of therapeutic abortion and live birth health care services, family benefits to teenage mothers, foster or temporary care to children of unmarried mothers, and public health postnatal visits to teen mothers as well as the private costs of individuals requiring out-of-province abortion services and the dramatic changes to a woman's life, including educational and career plans as well as relationships (Nova Scotia Council on the Status of Women, 1990: 13-14). Indeed, the authors concluded their report by noting the unusually bleak life prospects for teen moms, citing higher suicide and child abuse rates, higher risks of death and medical complications and a proclivity to drop out of high school and live on welfare (Nova Scotia Council on the Status of Women, 1990: 68). Teen pregnancy was also articulated as a medical risk, that pregnancy before age 20 would result in a greater risk of a preterm or low birthweight baby or a baby with immediately identifiable congenital abnormality (Wadhera and Millar, 1997: 9). The teen mom drained the state and its resources due to her lack of sexual responsibility. Hence, the costs of teen pregnancy were deployed in order to argue for increasing family planning and sexuality education and services as an urgently needed response to increasing levels of sexual activity among teenagers.

On the one hand, the introduction of a new epidemic logic into the regime of sexual practices could be understood as a regime change. The main strategy of the regime broadened from STI prevention to also include teen pregnancy prevention and deployed two new tactics: values inculcation and family planning as well as new interests: material and economic. Also new was the provision of information on birth control in order for young people to negotiate the 'new sexual freedom'. On the other hand, the practices of the regime continued to both promote a compulsory heterosexuality and to deploy medico-moral tactics. Indeed, this resulted not only in an intensification of the medicalization of sex, but also a sophistication of the biopolitical apparatus to count bodies, to discern 'at-risk' populations and to justify intervention. Significantly, the female body, in particular, became problematized and responsabilized, a focus that persists to this day.

The 1980s: AIDS

While concern around teen pregnancy certainly put pressure on the school to provide some level of sex education, it was, however, without a doubt, HIV/AIDS that dramatically changed sex education in Canada. Where STD education was not a formal part of the curriculum, it may have been included in courses such as Environmental Health, Family Life Education, Biology, or Health. In provinces such as New Brunswick, Nova Scotia, Ontario and British Columbia, where STD education was a standard part of the curriculum, the teaching of it was inconsistent and left to the discretion of school boards (Canadian Public Health Association, 1987). In Quebec, however, STD education was made mandatory in the mid-1980s, perhaps because STD prevention was put in the

context of encouraging moral values and because the course itself was based on the findings from a province-wide survey of school boards, parents' associations and committees and other non-governmental groups (Canadian Public Health Association, 1987: 57). HIV/AIDS created a sense of urgency and it was the AIDS epidemic that forced a sex education agenda into classrooms.

The advent of AIDS significantly influenced sex education in three ways. First, the AIDS crisis enabled advocates and supporters of the school project to articulate sex education as a right - a right to information, a right to health, and a right of citizenship. Second, governments developed policies and guidelines for the development of sex education programs and services and all ministries of education introduced sex and/or AIDS education guidelines. Where sex education was once haphazard, sporadic or non-existent, the intention was to make it a part of the schooling process. Third, the AIDS crisis provided an opportunity for medical and social science researchers to collect data about adolescent sexual behaviour – data that were deployed both to argue for the need for and merits of sex education as well as to articulate the failures of particular approaches to educating the young.

First, the universal anxiety created by AIDS and the perceived vulnerability of youth to HIV infection certainly solidified support for the school project, as education came to be understood as the primary means to control or reduce the spread of HIV infection. AIDS prevention, particularly in the schools, came to be seen as a right of young people and as a project to be supported by governments. The *International Conference on Population and Development (1994)*¹⁰ declared that information and

¹⁰ The ICPD was convened under the auspices of the United Nations in 1994, and, as the largest intergovernmental conference on population and development ever held, endorsed a strategy that

services should be made available to adolescents to help them understand their sexuality and to protect themselves from unwanted pregnancies, sexually transmitted diseases, and the subsequent risk of infertility (United Nations, 1994, para. 7.41). *The United Nations Guidelines on HIV/AIDS and Human Rights (1996)* outlined how states should ensure the access of children and adolescents to adequate HIV/AIDS and sexuality information and education as well as access to confidential sexual and reproductive health services (United Nations, 1996, guideline 8(g), 8(h)). The United Nations Committee on the Rights of the Child supported the right of children to have access to adequate information related to HIV/AIDS prevention and care. The Committee also noted that effective HIV/AIDS prevention requires states to refrain from censoring, withholding or intentionally misrepresenting health-related information and sex education (United Nations, 2003, para.16).

Such international covenants provided a language and framework for proponents of the project in their advocacy efforts and solidified the already growing support for and implementation of programs in schools. According to Ajzenstat and Gentles in their 1988 survey, most provincial Ministries of Education introduced sex education or AIDS education guidelines during the 1980s and at least 57% of the school boards surveyed in British Columbia, Saskatchewan, Ontario and Nova Scotia had sex education guidelines (Ajzenstat and Gentles, 1988: 7, 16). While the authors note the variability of sex education programs taught in Canada's schools, they do describe how sex education is usually located in health or religion classes, and that most classes are coeducational and compulsory with an 'opt-out' provision (with the exception of Saskatchewan, which

emphasized the integral linkages between population and development and focused on meeting the needs of individual women and men, rather than on achieving demographic targets.

requires students to 'opt-in'). The ability of parents to opt their children in or out of sex education clearly reflects a partnership between the home and school, particularly since it is claimed that "the schools do no more than follow up the parents' teachings and reinforce the moral groundwork laid by parents" (Ajzenstat and Gentles, 1988: 25). Program content of the four provinces surveyed followed much the same formula as Family Life Education in the 1970s, where students in Kindergarten to Grade 6 were to learn about personal hygiene, feelings, and family relationships. Students from Grade 7 onwards were to learn about reproduction, conception, STDs, teen pregnancy, family planning and relationships. New was the inclusion of sexual abuse, usually in the lower grades and likely due to legislative changes in 1983 to Canada's rape laws that generated greater awareness and concern for sexual offences, particularly where the term sexual assault replaced rape, thus classifying it as a type of assault.

Also new, of course, was AIDS as a topic of instruction, at more senior curriculum levels. Indeed, AIDS was an important component of sex education for most boards of education and Ministries of Education. For example, the British Columbia Ministry of Education suggested its new sex education program was established chiefly as a reaction to AIDS and the Ontario Ministry of Education made AIDS education mandatory for all schools for the 1987/1988 school year (Ajzenstat and Gentles, 1988: 53).

While there was some variability between and across schools and school boards, it appears there were three main tactics that informed and shaped sex education practices in Canada in the 1980s: values clarification, abstinence, and humanist sexology.

First, many boards in the public school system deployed a tactic of values clarification that framed the discussion of sex/AIDS education topics. Such an approach encouraged students to develop their own views on moral issues by examining a range of choices and decisions – an approach that will be more fully considered in the next chapter. The teacher was not to impose his/her values or to indicate a preference and was to encourage the idea that all personally determined values are of equal worth, while also emphasizing how values change over time. So, for example, in this context, values did indeed change over time as a result of the AIDS epidemic, and the teacher would discuss the three guidelines published by the Canadian Federal Centre for AIDS that were central to school campaigns to reduce risk of HIV transmission in heterosexual activity: abstain from vaginal and anal intercourse; if either vaginal or anal intercourse are engaged in, they were to be exclusively in the context of a mutually monogamous relationship; and alternately, the use of condoms. Students would be free to discuss and consider these options and decide what would be best for them. However, those not supporting a values clarification approach argued for objective moral standards against which individual views could be measured, since students must be made to see the merit of universal values like ‘respect’ and ‘responsibility’ (Ajzenstat and Gentles, 1988: 58).

Second, the Prairie provinces, in particular, promoted abstinence as a key tactic in the regime of practices. A backlash against women’s liberation, gay rights and adolescent sexuality led conservatives to charge that sex education encouraged sexual activity and that there was a correlation between premarital sex and the broader provision and availability of sex education as well as contraception and abortion services. For example, one program called *Teen-Aid*, which promoted sexual abstinence before marriage as a

realistic and beneficial lifestyle for teens, was in use throughout many parts of Alberta and Saskatchewan. The program did not include information concerning contraceptive methods as it was deemed difficult, if not impossible, to present birth control information without conveying tacit acceptance of sexual activity to students (Smith, 1989: 26). The curriculum included instruction on body changes and reproduction as well as on dating, love, teen pregnancy and STDs. Peer pressure reversal techniques and assertiveness skills were taught and practiced that enabled students to say 'no' (Smith, 1989: 26). Detractors of the *Teen-Aid* abstinence-only program, however, noted the ineffectiveness of moralizing and preaching to young people, as they demonstrate a lack of respect for their emerging identity, maturity and personhood and would not prepare them for the 'real' world (Hextall, 1989: 8).

Third, according to sexologist Robert Gemme, the province of Quebec deployed a scientific, humanistic and non-confessional approach that facilitated a less ambivalent and restrictive cultural approach to sex than elsewhere in Canada (Gemme, 1990: 3, 10). Such a tactic emphasized the positive and life-fulfilling aspects of sexuality and, in particular, that sexual activities are part of the psych-socio-sexual development of young people. As such, programs emphasized premarital sex as an acceptable alternative to abstinence, non-coital sex as an effective method of preventing unwanted pregnancies or sexually transmitted disease while ensuring sexual fulfillment and penetrative sex as a variation instead of an intrinsic goal of the sexual encounter (Gemme, 1990: 6-7). This approach resulted in the lowest provincial teen pregnancy rate in Canada, made possible, Gemme claims, due to the establishment of the first academic Department of Sexology in the world at Université du Québec à Montréal (UQAM) in 1969. I would add that such an

approach and outcome were also due to the continued support of the Catholic Church in the province. In the 1920s and 1930s, the Church supported the school project in its efforts in venereal disease prevention, as discussed earlier in this chapter. In the early 1980s, the Comité catholique du Conseil supérieur de l'éducation also came out in support of the province's new Personal and Social Development program, in which sex education was situated, by stating that "the young are in need of sex education and they have a right to it" (Rousseau, 1981: 5). Still, the less restrictive approach of the province was not without controversy. A piece in a government newsletter by André Rousseau, sous-ministre adjoint au secteur primaire-secondaire, confronted accusations that the Ministère intended to impose nudity, sex games and exercises on young people in the new Personal and Social Development Program as totally unfounded and basically malicious. He then took the opportunity to describe the program as respectful of fundamental Christian values and as one that encouraged reflection upon the moral aspects related to sexuality (Rousseau, 1981: 5).

Amid this tension and debate, and even though the approach and tactics may have differed region to region, and likely school to school, it has been noted that the schools in Canada did a remarkable job in responding to the AIDS issue in the 1980s where, in an incredibly short time period, programs were developed, materials produced, teachers prepared and programs delivered (Canadian Association of Principals, 1991: 14). In places that had no formal education programs, steps were taken to ensure high school students received an AIDS presentation before the end of the school year. In schools and school boards where STD prevention was an established practice, AIDS education was incorporated into Health, Science or Home Economics courses and some boards created a

specific AIDS unit. Key messages for the younger grades were that AIDS kills, with an emphasis for its prevention on abstinence and responsibility, while key messages for the older grades included communications in relationships, responsibility for self and others, assertiveness and condom use (Canadian Public Health Association, 1987: 17). Students were also encouraged to demonstrate compassion and empathy, rather than fear and hatred, for people living with HIV/AIDS, which had important implications for the ways in which homosexuality would be dealt with in the classroom, as will be more fully considered in chapter six.

In addition to the formalization of sex education in Canadian schools – all Ministries of Education in Canada had approved curricula by the end of the decade (Barrett, 1990: 24) – the HIV/AIDS crisis also provided an opportunity for the collection of data about adolescent sexual behaviour. While data were available on teen pregnancy and reportable STDs as well as on age at first intercourse, little else was known about the adolescent sexual subject. The *Canada Youth and AIDS Study* documented the knowledge, attitudes and behaviour of over 38,000 Canadian youth with respect to AIDS and other STDs. While younger respondents in Grades 7 and 9 were not asked about their sexual behaviour in the same detail as Grade 11 and college/university respondents – perhaps due to ongoing concerns that speaking of sexuality would incite sexual activity and particularly in light of the fact that survey respondents required parental consent¹¹ – the study filled a gap in knowledge:

In Canada, until very recently, little research has been done on sexuality in general and virtually none on adolescents' sexuality... The widespread concern about AIDS has made it possible for us to collect nationally the data we need to

¹¹ All respondents required parental consent to participate in the study. Interestingly, the study garnered a national return rate of 77% of parental consent forms, a rate that was higher than expected (King *et al.*, 1998: 143).

describe this critical part of the experience of young Canadians (King *et al.*, 1988: 82).

The first major finding of the study was that young people were sexually active. In order of frequency, respondents cited deep kissing, petting above the waist, petting below the waist and sexual intercourse at least once. Nearly one-half of Grade 11 respondents had had sexual intercourse at least once (King *et al.*, 1988: 84). At least three-quarters of respondents accepted premarital sex in a loving relationship and fewer than 15 percent agreed that unmarried people should not have sex (King *et al.*, 1988: 77). Curiosity, love, and physical attraction were cited most frequently as reasons for having sexual intercourse, while loneliness, wanting to maintain a relationship, drugs and alcohol, and expectations of friends ranked lowest (King *et al.*, 1988: 91).

A second major finding of the study was a general lack of concern for or protection against risk. Indeed, study results indicated that while young people generally know more about AIDS than other STDs, their knowledge was particularly deficient in the area of protection against AIDS and many respondents indicated that they needed to increase their knowledge about AIDS (King *et al.*, 1988: 44). While pregnancy was cited as a worry across all groups of youth surveyed, fewer worried about AIDS and even fewer worried about other STDs (King *et al.*, 1988: 103). A substantial portion of sexually active youth held negative attitudes toward the use of condoms, and the majority reported using condoms only 'sometimes' (King *et al.*, 1988: 104).

The authors of the study concluded that young people had not internalized knowledge of the risk that AIDS posed to their future well-being. They noted that young people had a right to information, best provided to them by way of evaluated and

effective school programs, and proposed the following for AIDS/STD education programs:

First, the probability of contracting AIDS must be presented to young people in such a way that they come to regard it as substantial and very real. Second, learning activities must allow youth to meet with people who have AIDS to help them realize that AIDS can affect them. Third, alternate forms of sexual expression that do not involve risk should be discussed. And fourth, these programs must promulgate a set of values and the sustaining interpersonal skills that allow young people to discuss responsible sexual activity in an open manner (King *et al.*, 1988: 141).

The advent of AIDS, then, could be seen as signaling a regime change, due to the shift in the ways in which sex education practices and discourses were conceptualized and deployed. A certain explicitness was brought to the project as educators were forced, in the face of AIDS, to talk about vaginal and anal intercourse, condoms and safer sex. A new subject – the homosexual – was also introduced in sex education practices, not as a legitimate subjectivity, but as a diseased ‘other’ to whom students were to show empathy and compassion. At the same time, however, these discussions continued to take place with the aim of imparting values and within a context of a persistent anxiety that speaking of sex will incite sexual activity. And it was within this context of anxiety that messages of responsibility to self and others also persisted; for example, abstinence from sexual intercourse required the same self-discipline and self-control required of those who were once directed to abstain from masturbation. Moreover, the onset of another disease model facilitated the continued medicalization of sex and the ability of the state to ‘know’ and regulate the sexual subject, which has lasting repercussions in the contemporary period.

Sexual Health in the Contemporary Period

The conclusions posed by King *et al.* in the *Canada, Youth and AIDS Study* influenced the school project throughout the 1990s and into the contemporary, post-AIDS regime period. First, schools came to be recognized as pivotal organizations in providing sex education:

Since schools are the only formal educational institution to have meaningful contact with nearly every young person, they are in a unique position to provide children, adolescents and young adults with the knowledge and skills they will need to make and act upon decisions that promote sexual health throughout their lives (Health Canada, 2003: 17).

And survey and qualitative research indicated that school-based sex education was supported by parents (Verby & Herold, 1992; Langille *et al.*, 1996; McKay, 1996; McKay *et al.*, 1998; HKPU District Health Unit, 1999; McCall *et al.*, 1999; Weaver *et al.*, 2002), students (Langille *et al.*, 1996; McKay and Holowaty, 1998; HKPU District Health Unit, 1999; McCall *et al.*, 1999; DiCenso *et al.*, 2001; Noon and Arcus, 2002; Byers *et al.*, 2003a; Byers *et al.*, 2003b), and teachers (Cohen *et al.*, 2004; Bickerton and deRoche, 2005).

In the contemporary context, and with the recent exception of Quebec, all provinces and territories have curriculum guidelines that include sex education. For example, sex education is included in the Healthy Living Strand of the Ontario health and physical education program; in the Health/Personal Development and Relationships course in Nova Scotia; and in Health and Life Skills as well as Career and Life Management in Alberta. In Quebec, sex education is no longer the responsibility of one teacher, one professional, or one program, but of all members of the school team working in cooperation with one another and with partners in the community, which involves

integrating issues across subjects (i.e. English, moral education) and offering complementary educational services (i.e. theme weeks, clinical/counseling services, workshops). As will be further discussed in the next chapter, many school boards have developed policies on teaching sexuality or teaching controversial subjects. Such policies usually outline the appropriate discipline in which sex education is to be taught, the appropriate use of guest speakers and guidelines for informing parents about the content and rationale for sex instruction. It has also been noted that ideological controversies over school-based sex education are relatively infrequent and generally occur at the community or school-board level, rather than at the national level (Maticka-Tyndale *et al.*, 2001: 26). For example, in Nova Scotia, the Departments of Education and Health collaborated on the development of a student resource book, *Sex? A Healthy Sexuality Resource Book*, that is to be disseminated to every Grade 7 student in the province (Healthy Sexuality Working Group, 2006). While some parents and community members thought the resource was youth friendly, informative and appropriate, others feared it advocated a particular lifestyle, had obscene content and usurped parental responsibilities for educating their children. As such, it was left to the discretion of each school board to handle distribution issues. The majority of school boards have agreed to distribute the book and request that parents sign a consent form. Both of Cape Breton's English-speaking boards – Cape Breton Victoria Regional School Board and the Strait Regional School Board – decided against distributing the resource to their students. While this example points to the range of actors and interests influencing the state of play of the regime, in the main and in large part due to the AIDS crisis, it is generally accepted that

the school is the appropriate place for sex instruction of the young and the debate has shifted from 'where' and 'by whom' to questions of content - to 'what' and 'how'.

The 'what' and 'how' have been increasingly conceptualized as requiring the integration of AIDS education with other sexuality issues. The consensus of opinion was that "AIDS must be taught in the broader context of sexually transmitted diseases and the whole in the context of responsible sexual behaviour and lifestyle decisions" (Canadian Public Health Association, 1987: 12). Thus, 'AIDS education' evolved into 'sexual health education'. So, for example, when the 1988 *Canada Youth and AIDS Study* was repeated in 2003, it was renamed the *Canadian Youth, Sexual Health and HIV/AIDS Study*. This shift to 'sexual health' dovetails with the emergence and intensification of health promotion as a strategy in Canadian health care. Health promotion calls on both individuals and organizations to accept more responsibility and to be more active in matters affecting mental and physical health problems (Lalonde, 1974: 66). A key pillar of the health promotion approach is the consideration of one's lifestyle, which requires both the recognition and prevention of self-imposed risks, such as those associated with sexual behaviours.

The sexual health education project is best described in the Health Canada document *Canadian Guidelines for Sexual Health Education* that was produced in 1994 and revised in 2003. The *Guidelines* provide a framework for developing and evaluating sexual health education programs, policies and services. The document asserts that effective sex education should encourage young people to consider both the pleasurable and harmful consequences of sexual activity. Using bureaucratic terminology, the *Guidelines* promote a sex education that helps people to achieve 'positive outcomes',

such as self-esteem, respect for self and others, and rewarding sexual relationships, and to avoid 'negative outcomes', such as unintended pregnancy, HIV/STDs, and sexual coercion (Health Canada, 2003: 1). In order to achieve these goals, it is argued that sex education should be comprehensive in scope and include a range of topics such as developmental changes (puberty), relationships, communication, setting of personal limits, media, stereotypes, prevention of STI/HIV, effective contraception, sexual assault, gender-role expectations and sexual orientation (Health Canada, 2003: 20). In order to deal effectively with this range of topics, school-community partnerships have been encouraged (Canadian Association of School Administrators, 1990; Canadian Association of Principals, 1991; Health Canada, 2003) and a range of educators provide sex education in the classroom in addition to the teacher, such as the public health nurse, and/or a representative from Planned Parenthood, an AIDS service organization or rape crisis centre. While the use of the guest lecturer has been a consistent strategy of the school, pointing to the need for authoritative expertise, such arrangements have been increasingly formalized. For example, the Ontario Ministry of Health *Mandatory Health Programs and Services Guidelines* mandates each board of health to assist in school sexual health education curriculum development and implementation (Ministry of Health, 1997: 25).

Reconciling the 'what' and the 'how' of sex education has also required the development and implementation of programs that work. However, not only have a very large proportion of sex education programs not been adequately evaluated, but most programs have neither a theoretical nor empirical base, since many were developed in response to desperate local need and evolved based upon the good intentions, common

sense, available resources, local mythologies and energy of staff members (Roosa, 1991: 371). Yet, in response to what are deemed unacceptably high rates of sexually transmitted infections (STI) and unintended pregnancy in the teen population, there is now a large body of rigorous evidence in the form of peer-reviewed published articles that sex education programs can effectively reduce teens' risk of unintended pregnancy and SIT/HIV infection (McKay, 2004a: 132), which introduces a new set of biopolitical tactics with implications for social and moral regulation and population control. Research indicates that effective pregnancy and STI/HIV prevention programs should clearly provide directly relevant information and give students the opportunity to develop the motivation and personal insight to use the information and to develop the behavioural skills necessary to carry out health-promoting behaviour (Fisher and Fisher, 1998; Health Canada 2003). Effective sex education targets sexual behaviours that lead to unintended pregnancy and/or STI/HIV infection; delivers and consistently reinforces prevention messages related to sexual limit-setting and consistent condom use and other forms of contraception; and addresses social pressures related to adolescent sexual behaviour (Fisher and Fisher, 1998; Kirby 2001; McKay 2000). Following this, it is widely recognized in the literature that the two primary goals of effective sex education are to help young people delay first intercourse (though these studies avoid the follow-up question "until when") and to use contraceptives/condoms properly and consistently if and when they experience sexual intercourse (Kirby *et al.*, 1994; Brown and Eisenberg, 1995; Frost and Darroch Forrest, 1995; Kirby, 2000).

While on the one hand policy documents such as the *Canadian Guidelines for Sexual Health Education* promote a comprehensive sex education that emphasizes both

the ‘positive’ and ‘negative’ consequences of sex, on the other, it would seem that the main strategy of the regime emphasizes the harmful consequences of sex, specifically, unintended pregnancy and STI/HIV. I suspect that the emphasis on these two outcomes in particular is due to their measurable dimensions; as Maticka-Tyndale *et al.*, note, “they are often used as indicators, by proxy, of the state of adolescent sexual health in Canada and of the effectiveness of the federal and provincial sexual health promotion/prevention programs that seek to address these issues” (Maticka-Tyndale *et al.*, 2000: 41. See also Aggleton, 2000). An increase in any of these rates would be taken to point to the failures of our interventions and the poor status of youth sexual health, while a decrease would be taken to indicate successful interventions and a healthy youth population.

As discussed in this chapter, it is clear that, in their historical context, STD and unintended pregnancy concerns are not new. Indeed, venereal disease has been framed as a threat and provided the impetus for educational programs during both World Wars and the AIDS epidemic. And, as I will argue later in the dissertation, these concerns have provided grounds for teaching young people about abstinence in light of an ‘oral sex epidemic’ and human papillomavirus (HPV)-induced cervical cancer. Teen pregnancy is also not new. While there have always been ‘teen moms’, there was, in the 1970s, a shift in problem conceptualization with the emergence of ‘teen pregnancy’. And it is around these two problems, teen pregnancy and STD/HIV, that the regime of sexual practices has, in the main, been organized.

The main strategy of teen pregnancy and STD/HIV prevention informs and is also informed by health-risk-morality concerns as articulated through discourses of danger.

There has been a consistent fear or apprehension that talking about sexual matters will incite sexual interest. Educators have invoked euphemisms for speaking about sexual matters. In nature study, plant and animal reproduction served as metaphors for human reproduction. Within the anti-masturbation discourse, masturbation was referred to as 'pollution', the penis as 'the male part' and sperm as 'the life fluid.' I argue that, while we have abandoned the use of euphemistic metaphors in sex instruction in favour of proper terminology and correct terms in order to dissuade student use of slang, there are still apprehensions that speaking of sex will incite sexual activity.

Indeed, the discourse of abstinence continues to be a key tactic in the regime of sexual practices, given the apparent grave dangers of sex. The anti-masturbation concerns of the early twentieth century, venereal disease concerns of the First and Second World Wars, the teen pregnancy epidemic of the 1970s, and the AIDS epidemic of the 1980s all point to a mixing of the medical and moral, to an erosion of self-control and self-discipline of the individual leading to disastrous consequences. As historian Jeffrey Moran points out, AIDS, in particular, solidified the place of danger and disease in thinking about adolescent sexuality (Moran, 2000: 205), which points to the persistence and longevity of medico-moral discourse. And, as I argue below, such concerns are explicated through new issues, such as HPV and its links to cervical cancer and the so-called oral sex epidemic. Following this, I also argue that the presentation of the dangers of sex continue to mix medical fears and everyday anxieties – as causing cancer (physical harm) or a damaged reputation (metaphysical harm) and that a main tactic of educators continues to be one of the promotion of abstinence.

At the same time, the dangers and problems of sex have been defined differently at different moments for particular political and social needs. Social and material changes – urbanization, war, extended childhood/adolescence, familial reconfigurations, technological innovations – have informed and continue to inform sex education practices. And given the range of actors in the regime of sexual practices – teachers and school administrators, parents, students, governments, medical professionals, non-profit associations - sex education can be understood as a project of anxiety and an effort, though tactics may vary, to respond to the separation between sex for procreation and sex as recreation and to maintain order and social control. No where is this more evident than in attempts to link school-based sex education to education for citizenship and democracy during the First and Second World Wars and, as I argue below in chapter six, to the reintroduction of character education in the contemporary context.

Social and material changes have also informed and continue to inform the ways in which young people are conceptualized as sexual beings. Taken in its historical context, sex education has been and continues to be a gendered and heteronormative project. The assumption is that the student subject is heterosexual and, as such, key messages (wait for sex until married, use contraception) and strategies (prevent pregnancy, prepare for marriage) support an implied and compulsory heterosexuality. Sex education practices also organize gender in specific ways. Sexual scripts – that boys are active agents with an insatiable appetite for sex and girls are either passive/uninterested in sex or promiscuous/too interested in sex (the double standard) – have also been reflected in sex education programs. I advance the argument that the regime of sexual

practices continues to organize sexual identity and gender in heteronormative and gender-specific ways.

While there are in fact spaces of pleasure and resistance – the teachers of the 1940s who provided menstrual hygiene information to school girls or the contemporary school nurse who provides condoms to students - I argue that the school project is informed by anxiety with adolescent sexuality and sexual behaviour and reticence over talking about sex. The desire is to protect the young from the dangers of sex: I argue that the focus is one of health-risk-morality rather than one of sexual socialization and sexual development. An exemplar of this protectionism – legal changes to Canada's age of consent law – will be discussed later in this dissertation.

Put into its historical context, the regime of sexual practices emphasizes the dangers of sex and aims to protect the young from pregnancy and STD/HIV. The school project, then, is a regulatory one. The intensification of health discourses, the promotion of sex as a health issue justifies governmental intervention and makes the school project palatable, since prevention of socially, medically, and financially burdensome outcomes such as teen pregnancy and STD is seen to be in the interest of all. Educating the young on 'sexual health' rather than 'sexual activity' assuages fears and anxieties that speaking of sex will incite sexual experimentation. However, the project is not a morally neutral one. Morality works through health and risk discourses in order to regulate the conduct of the young. While the current preoccupation is one of 'sexual health', sexuality never loses its moral dimensions. Indeed, every topic in sex education inescapably involves instruction in values or moral standards (Ajzenstat and Gentles, 1988: 42). It is the topic of values to which we turn in the following chapter.

Chapter Three: Is My Choice Healthy? Clarifying Values in the Classroom

As the previous chapter described, sex education came to occupy a space in the Canadian public school curriculum after a rather slow and fragmentary beginning. Currently, all provinces, with the exception of Quebec, include sex education curriculum guidelines.¹² In the province of Quebec, sex education is to be integrated across subjects, to support an inter-disciplinary approach, the merits and limitations of which will be discussed in chapter seven.

This chapter describes how sex education continues to be a shared project between the school and the home. In particular, students are encouraged to reflect upon their family values in order to consider the ethical dimensions of sexuality. In order to accommodate the diversity of families, then, the regime of practices deploys a values clarification approach – a tactic of value neutrality whereby students are to clarify their own values on and make good decisions about sexuality issues. However, I argue that because the regime is largely framed by a strategy of STI and teen pregnancy prevention, a strategy that informs and is informed by a health-risk-morality paradigm, the values clarification approach is not easily accommodated. The practices of the regime, then, are a mix of both values clarification and objective moral standards to ensure that young people make good and healthy choices and decisions.

Despite the controversial nature of sex education, it is generally accepted that the school has an important role in providing it to the young. Indeed, the school aims to articulate its project against outside influences, since:

¹² Please see Appendix 3 for a description of the public school curriculum guidelines for three of the four provinces under study: Alberta, Ontario and Nova Scotia. The fourth province, Quebec, does not have curriculum guidelines.

...there's so much myth-guided, myth-led information on media, even Google, like when you Google an STD all these pictures come up that could be any ailment, any skin disease; you can't figure out what is what. They have so much myth-information... I think it's important to just somehow weed out the stuff that's not necessarily true on Google because they're all so computer based now. So I find it more important now than probably five or six years ago when I started teaching it. Because you hear all these myths, and I look at kids and say "Where did you get that information and it's not even close to being true". So, yeah, I think it [sex education] is important because they need the right information. There's so much wrong out there (Teacher, Quebec).

There is concern, then, that young people are exposed to misinformation from a variety of sources, including the internet. And although many educators continue to support the idea that the best source for sex education for young people is their parents, teachers, public health nurses and community-based sexual health educators aim to bring an expertise and professionalism to the subject not commonly found among most parents:

Well I, I think that in a perfect world parents would teach their kids about sex. Studies show that kids are getting most of their information from their peers, which is not always the best thing, but where they want to learn it is from their parents and that would be awesome but there are a lot of barriers to that happening unfortunately. And in the school system, right now it's the best place that they can get that information. Especially because they can bring in professionals or if a teacher has a lot of information and they feel really comfortable about talking about it ... (Sexual Health Educator, Alberta).

Ultimately, in my best scenario, you got parents who are highly engaged and the school is delivering factual information and parents are helping to sort through what this means for relational values for perspective. That's the best work. If parents want to educate themselves and be the deliverers of the actual information for the kids to have, then that's great. But most parents aren't going to develop a level of expertise to answer kids' questions appropriately... (Sexual Health Educator, Alberta).

Because it is assumed that parents can't (or won't) talk about sex with their children, educators have largely accepted their role in the provision of sex education. And in the main, it would seem that parents appreciate and accept the role of the schools in

educating their children in sexual matters, since they lodge so few complaints. As several educators put it:

You know, I've been teaching sex ed. for 19 years and I might have had in the 19 years 7 or 8 parents who were not very happy with me going into the classroom. That's not bad I feel (Sexual Health Educator, Nova Scotia).

I've been doing this for seven years [and] in the seven years I've never had a single phone call or complaint... But what I have had is occasionally once or twice a year a parent may phone me and inquire as to what we are going to be covering... but never once has there ever been a problem (Teacher, Ontario).

I've been teaching sex ed. programs in the rural south for 7 or 8 years now and I have covered [only] one complaint, a couple of years ago (Public Health Nurse, Alberta).

Complaints, then, are few and sporadic, indicating at least a modest level of support by parents for the school project. However, this support does not absolve the role of the family in the education of its children. Because sex education is often treated as a 'controversial' subject, a number of school boards have implemented sex education policies. Although the content of sex education is determined at the provincial/territorial through curriculum guidelines, and curriculum content that aims to meet these guidelines is developed by school boards, public health authorities and/or community-based organizations, several schools boards have developed a sex education policy in order to ensure that school personnel recognize both the sensitive nature of the subject and the important role of the family in the education of their children (see Table 1). In this regard, it is a generally accepted practice that teachers are to send a letter home to parents (see Table 2). These letters outline the objectives of the course and give parents an opportunity to opt their children out of the class to pursue an 'alternative learning experience' which usually involves independent study in the library.

Table 1 - Sensitive Issues (South Shore Regional School Board, 2005)

The South Shore Regional School Board recognizes that when offering courses such as Health, Personal Development and Relationships, Biology, Career and Life Management sensitive issues are addressed. These issues include, but are not limited to, sexuality, abortion, morality, conception, suicide, religion, and transmission of sexual and communicable diseases. The School Board recognizes that families, communities and religious groups hold divergent views on the teaching of such topics.

Procedure:

1. At all times, instruction in the classroom shall recognize the rights, values and beliefs of students and their parents.
2. Each year prior to the teaching of sensitive topics, the school principal or designate shall ensure that parents are informed about the topics.
 - a. Information provided to parents shall include a synopsis of the sensitive unit to be covered. This information can be included in the Teacher's Communication Plan to parents at the beginning of the school year.
 - b. Upon request, parents shall be given the opportunity to view or examine the teaching material as well as printed matter pupils will use in class.
3. With written permission, parents may have their child excused from participating in classes where sensitive issues pertaining to human sexuality are discussed.
 - a. Students with such permission shall be excused without question.
 - b. An alternative program shall be offered to students who are excused from class.

Table 2 – Letter (Calgary Board of Education, 2002)

Dear Parent/Guardian:

Our school is teaching the Alberta Learning Health and Life Skills curriculum in grades seven to nine. The program aims to enable students to make well informed, healthy choices and to develop behaviors that contribute to the well being of self and others. Three general outcomes serve as the foundation for Health and Life Skills. They include wellness choices, relationship choices and life-long learning choices.

Human sexuality education is offered in grade seven to grade nine as a mandatory component of the program of studies. Parents will retain the right to exempt their child from school instruction in human sexuality education. Students without parental permission will be provided with an alternative learning experience. Please sign the form below and return it to the school if you **DO or DO NOT** want your child to participate in the human sexuality education part of the program.

Home, school and community partnerships are critical to the delivery of this program of studies. Parents are encouraged to familiarize themselves with the program and participate through voluntary involvement in various activities. To begin, parents are invited to preview the program. A meeting for parents will be held on _____ at _____ in the library. Health teachers will be there to provide you with program information and to answer any of your questions. You can also view the program of

studies on-line at

http://www.learning.gov.ab.ca/k_12/curriculum/bySubject/healthpls/health.pdf. Finally, parents are encouraged to spend time each evening sharing your knowledge and values about human sexuality with your child through discussion and homework completion. If you would like additional information about this program, please call _____ at the school.

Yours truly,

(Clip and return to school)

☐ I, _____, **DO**
/ **DO NOT (please circle one)** want my child, _____, to
participate in the sexuality education component of the Health and Life Skills program. I
understand that he/she will be given an alternative learning experience during this time.

Signature: _____ Date: _____

Note: Please return this form whether you want or do not want your child to participate in the human sexuality education component of the Health and Life Skills program.

However, despite these measures, it appears that few parents exercise the 'opting out' option:

Probably one a year might opt their kid out [in the junior high] and the same in elementary. I've had probably one kid a year opt out as well... (Public Health Nurse, Alberta).

I would guess that out of 950 kids, there have been less than ten, maybe even less than five [that have been opted out]... (Teacher, Ontario).

No, nobody has, we don't have one that's out... Every single one of them is in a course that offers some component of that area. Because you know, what's the option? You sit in the library and do what? (Vice-Principal, Quebec).

And despite the recommended practice of sending a letter home to parents, it would seem that fewer parents are actually receiving them. As one educator commented:

I find that parents are not usually expecting parental consent forms over the last two years. *Why do you think that is?* Well, I think it's because it's part of the curriculum and if its part of the curriculum it is supposed to be taught and they are not allowed to be pulled out of the classroom... (Sexual Health Educator, Nova Scotia).

One teacher even refuses to promote the 'opt-out' option:

I haven't had an issue with parents yet and I usually send out a little 'heads-up' letter to all the parents to let them know that sex ed. is coming up. *Is it a heads-up letter or a parental consent letter?* No, it's a heads-up. I don't need consent to teach this subject, so I don't ask for it. I just tell them that it's coming and if they've got a problem, if they are concerned, they can contact me (Teacher, Quebec).

While the role of the school in providing sex education is generally supported and accepted, parents are still expected to play key roles in the education of their children, particularly where it comes to inculcating sexual values:

So we talk about the fact that teachers and nurses can present you with the facts that help you make informed decisions but your parents or your guardians are the only people in the world that can be your parents or your guardians and it's important that they maintain that role with you and that you allow them to maintain that role with you (Sexual Health Educator, Nova Scotia).

We have to be careful, well not really careful, but, you know, when we're in a classroom discussing values and morals and beliefs we have to be careful because our own personal values may not be the same as the students in the classroom. And that's where parents come in, eh? Very, very important that parents are doing education at home as far as the values are concerned, concerning sexual activity and when to be sexually active and the whole issue of abstinence (Public Health Nurse, Ontario).

... it's not my job to teach kids what their values are, that's their parent's job, you know? I'm going to come in and teach them about pregnancy and STIs because that's the prevention model (Sexual Health Educator, Quebec).

Hence, educators face the difficult task of educating students about sexual matters while also respecting parental and familial values. One way to negotiate this terrain is an intentional blurring of the home and school, where the teacher aims to 'teach like a parent':

I know that parents don't want their kids to be sexually active and I want kids to be kids as long as they can be, but the thing is, I also acknowledge the reality of the situation... I don't want kids to be out there having sex but the reality is still there... So I talk as a parent, I guess, because I have four children of my own (Sexual Health Educator, Nova Scotia).

When I do talk to parents who are considering opting in or out I explain to them that I am a mother first and foremost. I have two girls one 18 and one 21 and I teach from a parental point of view... I'm not going to teach their kids what I wouldn't want somebody teaching mine (Teacher, Alberta).

I have a family of my own so, you know, maybe that makes a difference (Teacher, Nova Scotia).

Although this example demonstrates the ways in which teachers take a specific moral position by 'teaching like a parent', many educators aim to support a 'values clarification' approach to sex education, which is a 'value-free' or 'value neutral' approach to exploring the choices and decisions issues related to sexuality (McKay, 1998: 82). Values clarification has been a preferred approach for the discussion of values in Canada over the last two decades. In a 1988 survey on the state of sex education in Canada, the authors note that the public system, for the most part, adhered to this philosophy (Ajzenstat and Gentles, 1988: 43).

Developed in the 1960s, values clarification became an accepted form of moral education in the 1970s. The approach gained particular popularity with the publication of the teacher text *Values and Teaching: Working with Values in the Classroom* (1966). The popularity of values clarification is attributed to its ability to negotiate and take into account an increasingly pluralist American society in considering subjects such as politics, religion, friendship, love, sex, race and money. Values clarification emphasizes a process by which students will come to exhibit the desired qualities typical of those who are able to have a clear sense of their own values (McKay, 1998: 84). The steps of this 'valuing process' are: prizing and cherishing; publicly affirming, when appropriate; choosing from alternatives; choosing after consideration of consequences; choosing freely; acting; and acting with a pattern, consistency, and repetition (Raths, Harmin and

Simon, 1978). This approach, then, aims to provide information free from moral indoctrination. Instead of imposing a set of values, the teacher is to support a subjective process whereby students assess the ethical dimensions of sexuality within their own personal values framework. As a technology of the self, the student is constituted as free and active in his/her self-formation and decision-making. The values clarification model is in stark contrast to one that aims to support unitary and 'objective moral standards', as can be found in the Catholic school system, with its "clear, concrete goals, rooted in a philosophical system... [such as those] firmly rooted in Judeo-Christian values" (Ajzenstat and Gentles, 1988: 56, 61). Thus, instead of telling students what to think, the values clarification approach supports the critical exploration of different ways of thinking, an approach deemed particularly necessary in a neo-liberal society that values self-reliance and self-regulation as well as within a multicultural and pluralist society:

Studying controversial issues is important in preparing students to participate responsibly in a democratic and pluralistic society. Such study provides opportunities to develop the ability to think clearly, to reason logically, to open-mindedly and respectfully examine different points of view, and to make sound judgments... [studying controversial issues should] promote critical inquiry and teach thinking skills (Alberta Education, 2005: 82-83).

Indeed, the values clarification approach has also been heralded as a key feature of effective sex education. According to Health Canada's *Canadian Guidelines for Sexual Health Education*, effective sexual health education provides opportunities for individuals to explore the attitudes, feelings, values and customs that influence their choices about sexual health and supports informed decision-making by providing individuals with the opportunity to develop the knowledge, personal insight, motivation and behavioural skills that are consistent with each individual's personal values and choices (Health Canada, 2003: 22-23).

In light of the widespread promotion and acceptance of the values clarification philosophy, several educators described incorporating it into their classroom practices:

[We're] trying to acknowledge that everybody brings their own set of attitudes and values and that we're not there to say what's right or wrong but that it's very much a personal belief and that it's a personal system of beliefs... just trying to reinforce, you know, these are the options, you make your own choices based on your personal attitudes and values. So that's the overall message. And we go into, depending on what the presentation is on, we'll go into talking about what attitudes and values are, how they are affected, how we form them, you know, what might challenge them, you know, doing that kind of stuff (Sexual Health Educator, Ontario).

So, a parent's comment would be, "You know, I'm a little worried that you are going to impart information to the children or the kids about certain values that we don't really adhere to in our family." And I go, "We're not here to teach values; we're here to provide a safe place for youth to talk about what they feel is their own values (Public Health Nurse, Nova Scotia).

Values clarification, then, is an approach that fosters the values development of young people and educators are to refrain from imposing their own values. In order to facilitate the values clarification approach, teachers are to prepare for the classroom by exploring and challenging their personal assumptions. For example, teachers are instructed to be aware of their own sexual attitudes and values; to reflect on how their attitudes and values impact on the students' learning; to be aware that sometimes silence, facial expressions or body language give students certain messages; to facilitate discussion of sensitive issues and not determine a "correct" position; to reinforce the principles of social justice, human rights and equity, and not offer personal opinions on sensitive issues; and to acknowledge that an excellent teacher does not need to know all things in all areas and that there are other available resources to meet the students' needs (OPHEA, 2000c: 6). Teachers, then, are not only to consider their own attitudes and values, but must also be aware of how their values might be reflected in their verbal and body

language. And by drawing on universal, democratic values such as human rights and equity, teachers are encouraged to facilitate a discussion that takes into account a range of perspectives, rather than to frame classroom discussion around a correct perspective. In order to avoid framing the discussion around a particular perspective, teachers are encouraged to answer student questions by explicating a facts-values-responsibilities-student self-esteem model (see Table 3).

Table 3 - Guidelines on Answering Questions about Sexuality (Toronto District School Board, 2002: 15-16)

When giving an answer, try to include the following aspects:

Facts:

- Start simple, build on information when appropriate for students.
- Be honest – give accurate information, clear up untrue stories.
- If you don't know the answer, it is okay to say so.

Values:

- Remember that there is a wide range of values held by your students and their families.
- Encourage students to discuss values/issues with their families.
- Be aware of your own values.

Responsibilities:

- Help students understand the consequences of and take responsibility for decisions and actions.

Self-esteem:

- Answer questions in a way that makes students feel good about themselves. Validate feelings.

Sample: Is it okay to masturbate?

Fact – Masturbation is when a person touches or rubs their sexual organs for pleasure. Many young people and adults do it. Some don't.

Value – For some cultures or religions, masturbation is not acceptable. For others, it is okay. You will need to consider your personal values when deciding what is right for you.

Responsibilities – If a person does it, it should be done in a private place such as your bedroom or bathroom in your home.

Self-esteem – You can decide for yourself whether it's okay for you to masturbate.

The role of the teacher, then, is to correct misinformation, to encourage the consideration of a range of value positions and to frame student choices and decisions in a context of responsibility and empowerment.

Once in the classroom, teachers are encouraged to adopt an ‘askable’ approach to facilitate a value neutral exploration of sexuality issues by welcoming all questions; finding out answers to questions they don’t know; learning and using correct terminology; accepting questions as an indication of seeking knowledge; being non-judgmental and bias free; listening and maximizing teachable moments; and clarifying information (RNPHD, 1998a: 6; RNPHD, 1998b: 6; RNPHD, 1998c; RNPHD, 1998d). This approach is commonly facilitated by the development and imposition of classroom ‘ground rules’ (RNPHD, 1998a: 4; RNPHD, 1998b: 8; RNPHD, 1998c; RNPHD, 1998d; Algoma Public Health Unit; City of Hamilton, 2002: 57; City of Hamilton, 2002: 61; Windsor-Essex County Health Unit, 2005: 5; City of Toronto, 2006; PPFC, 2001: 24; Mitelman, n.d.; CRHA, 2006f). The purpose of ground rules is to foster a classroom where there is a mutual feeling of trust, safety and comfort in order to facilitate a positive classroom atmosphere. Ground rules are to be developed and agreed upon by everyone at the beginning of the sex education unit and should be posted in the classroom. As Table 4 indicates, ground rules aim to provide a safe space not only for students, by ensuring confidentiality and a climate of respect, but also for teachers. In this example, it is acceptable for teachers to blush or feel embarrassed and students are not to ask personal questions of the teacher.

Table 4 - Ground Rules (RNPHD, 1998a: 4; RNPHD, 1998b: 8; RNPHD, 1998c; RNPHD, 1998d)

1. No preaching; no put downs of others' values. All points of view are worthy of being discussed.
2. No questions are "dumb". Questions only indicate a desire for knowledge, they do not tell you anything else about the person asking the question.
3. It is acceptable for the teacher to blush, feel embarrassed or not know the answers to all the questions.
4. When possible, dictionary terminology should be used. When the student does not know the dictionary term, use the term she/he knows. The teacher or other students can supply the dictionary term.
5. No asking personal questions of the teacher or of the class.
6. Everyone has the right to refrain from activities or from answering questions they do not wish to answer. The teacher may also choose not to answer a question in front of the entire class.
7. No talking about class members' comments outside of the classroom.
8. The teacher will also respect the confidentiality ground rule, except where she/he is required by law to disclose information: i.e. sexual abuse.

The measures described so far, the self-reflection of the teacher in order to support a position of value neutrality and the development and implementation of ground rules to foster a safe learning environment, both aim to prepare the teacher and the class for the exploration of the ethical dimensions of sexuality. Upon laying this foundation, students are exposed to various activities that urge them to clarify their values on particular sexuality issues. A popular way to encourage the consideration of sexual moral values is the 'Take a Stand' activity (Calgary Pregnancy Care Centre, n.d.; CRHA, 2006e; PPAE, 2005; RNPHD, 1998d: 10; Windsor-Essex County Health Unit, 2005: 69; Toronto District School Board, 2002:13-14; PPFC, 2001: 42-43). In response to statements that deal with homophobia, relationships and dating, pregnancy and STIs, condom use, having sex, media depictions of sexuality, condoms, contraception, and abstaining from sex, students are to stand under one of three signs that best describes their position: agree, disagree, or unsure (see Table 5). Volunteers then explain their

position to the teacher and the rest of the class. The goal of the activity is not to achieve a values consensus on particular issues; rather, the goal is to explore and appreciate the range of diverse opinions within a single classroom.

Table 5 - Values Statements (PPFC, 2001: 42-43; Mitelman, n.d.)

1. Seventh and eight grades should be allowed to have parties at home without adult supervision.
2. Most 13 year olds are too young to “go out” with someone alone (no group and no adults).
3. Someone who comes to school wearing sexy clothing is asking to be sexually harassed.
4. It’s okay to make comments about people’s body parts, unless they say they don’t like it.
5. Gay, lesbian, and bisexual teenagers should be allowed to take their same-sex partners to school dances and other social functions.
6. It’s okay for two people of different races to date.
7. When a girl is out with a guy, it’s really up to her to make sure that things don’t go too far sexually.
8. Guys should only use condoms when they’re having sex with someone who has had many sexual partners.
9. It’s irresponsible for a teenager to have sex without using protection from pregnancy and STIs.
10. Talking someone into having sex before they are ready is taking unfair advantage of them.
11. Having sex with someone who you don’t really care about is wrong.
12. A girl who carries condoms in her purse is probably “easy.”
13. Choosing not to have sex is the best choice for teenagers.
14. If a guy and girl are having sex, and she gets pregnant, they should get married.
15. Teenagers are too young to be good parents.
16. There should be more restrictions on sexual images, language, and soliciting on the Internet.
17. Teen fathers should be forced to pay child support.
18. When faced with an unintended pregnancy, a woman should have the right to choose abortion.

In addition, students are encouraged to clarify their values in the context of their families’ values. One lesson includes a series of reflective questions that aim to link family values with a range of sexual choices and issues (see Table 6). In this lesson, students are encouraged to think about sex, dating and their futures in the context of their

familial expectations. Another method involves students completing an activity with their parent or guardian (see Table 7). The aim here is not only to encourage the exploration of personal values within the context of family values, but also to open the lines of communication between parent and child on matters relating to sex and sexuality: these activities can also be understood as ‘conversation starters’ and are illustrative of the shared commitment to sex education by both teachers and parents.

Table 6 - My Choice Quiz (City of Hamilton, 2002d: 143-145)

- What beliefs does my family have about dating and sex?
- How important are these values to me?
- What will happen if I choose behaviours that are disapproved of by: my parents, my friends, my family, my culture/religion/me?
- What are my future goals? (Check any of the boxes that apply to you):
 - ☐ High school graduation
 - ☐ College/university
 - ☐ Marriage
 - ☐ Good reputation
 - ☐ Financial security
 - ☐ Good relationships with parents
- What would be the impact of an unplanned pregnancy on the above future goals?
- What would the impact of an STD be on the above future goals?
- What do I want from a relationship?
- What consequences are there for a 13 or 14 year old boy/girl who chooses to be sexually active (physical, emotional, interpersonal/social, spiritual)?
- Are the consequences similar or different for girls and boys?
- What are the consequences of not being able or not feeling comfortable enough to communicate openly in a relationship?
- Explain how a person might feel when a 6 month relationship ends/breaks up.
- Who can I talk with about my thoughts related to dating and relationships?

Table 7 - Family Values (CRHA, 2006b)

The decisions you make about sexuality will be based, at least in part, on your family values. Talking with your family about these values can help you to make decisions about sexuality. Use this handout as a guide to interview someone in your family about the values they would like to share with you.

Step 1: Take this handout home. Share it with a parent, family member, or a trusted adult,

and ask that person if you can complete it together.

Step 2: Schedule a time for the interview. Give the person you will interview this handout so that they can think about the answers before the interview.

Step 3: Conduct the interview using the questions provided. Allow at least a half an hour.

Step 4: Both you and the person you interviewed sign the tear-off slip at the bottom of the page when the interview is complete. This tear-off slip can be handed in to show that you have completed the activity.

1. What are three personal or family values that you would like to share with me?

2. Over the next five years, how can I use these values to make good decisions about sexual behaviour?

We completed the "Family Values" Interview.

Student

Parent/Family Member/Trusted Adult

In addition to considering the ethical dimensions of sexuality, an additional goal of the values clarification approach is to establish the conditions for effective decision-making. The logic is that good decisions are made on the basis of one's personal values – personal values that are, of course, informed by one's familial values. In order to facilitate the decision-making process, educators present to students a rubric for decision-making. Essentially, these rubrics encourage students to identify problems, consider solutions, pick courses of action and then evaluate their choices. A popular rubric is the IDEAL model (RNPHD, 1998a: 30; RNPHD, 1998b: 25; RNPHD, 1998c: 6; RNPHD, 1998d: 11; OPHEA, 2000c: 80; City of Hamilton, 2002b: 14; City of Hamilton, 2002c: 28; City of Hamilton, 2002d: 10; PPFC, 2001: 229-233):

I - Identify the problem

D - Describe all the possible solutions

E - Evaluate the consequences of each solution

A - Act – choose a solution and try it

L - Learn – did it work? Why/Why not?

Students can then use this rubric in order to practice making decisions in a range of hypothetical situations, ranging from friendship dilemmas to negotiating independence from parents to sexual decision-making (CRHA, 2006a; CRHA, 2006b; CRHA, 2006e; City of Hamilton, 2002c: 12-16; City of Hamilton, 2002d: 9-29; OPHEA, 2000b: 191-192; OPHEA, 2000c: 81-84; Public District School Board Writing Partnership, 1999; RNPHD, 1998c: 6-7; RNPHD, 1998d: 11-13; Windsor-Essex County Health Unit, 2005: 96-103; PPFC, 2001: 229-233) (see Table 8). By taking the position of objective observer, students can anticipate, consider and problem-solve a range of future situations with which they may be faced.

Table 8 - Decision-Making Scenarios (OPHEA, 2000c: 82)

1. You are a group of Julie's best friends. She is 15 years old and has come to you for advice on whether or not she should enter into a sexual relationship with her boyfriend. They have been dating for three months.
2. Tommy is one of the best athletes in the school. He is the leading scorer on the basketball team, as well as the football team's star running back. Quite a number of girls in the school are attracted to him and he has had sex with a number of them. Tommy enjoys his popularity among the girls and is thinking about being sexually involved with more girls.
3. Your parents are leaving town for the weekend and you will have the house all to yourself. They specifically told you not to have friends over and definitely not to have any parties. Upon finding this out, your friends (both male and female) informed you that they will be coming over and will be bringing some alcohol with them.
4. Last weekend your best friend, Pat, met someone at a club. Pat is strongly attracted to this person and has come to you for advice on how far to go with this new friend.
5. Your brother Lucas has come to you for advice. He is only a year older than you and you have always been close, giving each other advice and support. He has been dating the same girl for about six months and she is pressuring him to have sex. Luke likes her a great deal but is not sure if he is ready to do it yet.
6. Sam and Chris are at a party. They have been dating for a long time but have decided to put off sex until later. Chris is willing but has decided to respect Sam's wishes and is content with kissing and making out, for now. At the party, Sam has a lot to drink and

seems eager to have sex with Chris. Chris wants to but is not sure what to do.

7. Mani has been dating someone for two weeks. They were introduced by a mutual friend. Mani does not feel ready to have sexual intercourse with this new friend, but is thinking about having oral sex.

8. Van and Nat have been dating for nearly a year. They have recently started having sex, using a condom and spermicide. Nat is home alone on a Saturday night when Van calls wanting to come over. Nat has run out of condoms and knows that all the drugstores are closed this late at night.

In sum, values clarification is the preferred approach to sex education, as opposed to one that imposes objective moral standards. The idea is that values clarification can sufficiently cope with the diversity of families in a multicultural society, a society in which there is no single moral standard. In addition, the values clarification approach is intended to set the foundation for effective decision-making. Hence, educators are to adopt a morally neutral position in order for students to explore their own personal and familial values in order to make good decisions.

However, I suggest that the current approach adopted by the schools is not entirely one of values clarification or of objective moral standards; rather, there is a mixing of the two. Teachers may in fact deploy pedagogical practices that support a values clarification approach, yet also ‘teach like a parent’ which puts into practice a specific moral position. In addition, although there is a range of classroom materials that purport to support a values clarification approach, some values and choices are presented as good choices, as healthy choices. For example, one values clarification and decision-making lesson concludes by stating: “a responsible decision-maker is one that will answer yes to the following questions: Is my choice healthy? Is my choice legal? Is my choice respectful of self and others? Is my choice safe? Is my choice what my parents or guardians would wish?” (OPHEA, 2000b: 225). As a political technology, values

clarification activities aim to constitute the regulated and regulating subject, sufficiently responsabilized to handle difficult decisions.

Hence, some choices are better than others. Because the regime is largely framed by a strategy of STI and teen pregnancy prevention, a strategy that informs and is informed by a health-risk-morality paradigm, the values clarification approach is not easily accommodated. Choices are framed in specific ways. Indeed, according to one program in Windsor called Dare 2 B Strong:

... we Dare you to be strong with the decisions in your life. Our decisions are based on what we value. Our choices have consequences. Make healthy choices and that will lead to healthy consequences... Be strong enough to say no to peer pressure. Be strong enough to say no to early sexual activity. If you have decided to have sex, be strong enough to ask your partner to get tested and to use the appropriate birth control (Windsor-Essex County Health Unit, 2005).

While educators may try to steer clear of imposing a unitary value set, certain decisions and choices are in fact described as more desirable than others; as one educator noted, she is “not making a value judgment, but making the case for it” (Sexual Health Educator, Alberta). As the following chapters will demonstrate, sex is still a moral question and it is this morality that works through health and risk discourses in order to frame and promote specific choices for youth.

Chapter Four

Just Say No: Abstinence and Postponing Sexual Involvement

Although values clarification is the preferred approach to sex education, as the last chapter described, certain values and choices are presented to young people as good, healthy and preferable choices. This chapter will describe how abstinence is deployed as a key tactic in the regime of practices, promoted as a wise and healthy choice for teens. Teens learn the reasons for and advantages of practicing abstinence and then learn a range of skills that enable them to 'say no'. However, I will argue that the claim that abstinence is the only perfectly effective way of preventing pregnancy and STIs is conceptually difficult to sustain. In addition, the physical and metaphysical harms that are presented to young people in order to support abstinence – harms such as a damaged reputation or cervical cancer – are not only supported by historically continuous concerns around health, risk and morality, but also constitute heteronormative and gendered, regulated and regulating, subjectivities.

In Canada, abstinence is an integral component of contemporary sex education practices, though it is not a legislative requirement as it is in the United States.¹³ Abstinence – or 'postponing sexual involvement' – is formally included in the mandated curriculum guidelines for both Alberta and Ontario. Even though abstinence is not a formal curriculum objective in Nova Scotia or Quebec, it is featured in learning materials and promoted by educators and administrators in both provinces. In the main, the abstinence message – the directive to postpone sexual involvement – is aimed at Grade 7 and Grade 8 students. However, senior students are also encouraged to practice

¹³ The U.S. federal government began supporting abstinence promotion programs in 1981 with the Adolescent and Family Life Act (AFLA). Since 1997, programs funded under the AFLA must have as their exclusive purpose the promotion of abstinence until marriage and cannot discuss contraceptive methods except to emphasize their failure rates.

abstinence since, in the discussion of birth control options and ‘safer sex’ practices, it is framed as the most effective pregnancy - and STD risk - reduction strategy, as will be explicated in the next chapter.

In Alberta, abstinence is first presented in the Grade 7 curriculum, where students are to examine abstinence and the decision to postpone sexual activity as healthy choices (Alberta Learning, 2002a: 12). Beyond Grade 7, abstinence continues to be promoted as a ‘good choice’ for teens; it is promoted as a contraceptive in Grade 8, as a ‘safer’ sex practice in Grade 9, and as a ‘sexually healthy action and choice’ in Grade 10 (Alberta Learning, 2002a: 12).

Abstinence is also first presented in the Ontario Grade 7 curriculum, where students are to explain the term abstinence as it applies to healthy sexuality (Ministry of Education, 1998: 18). In Grade 8, students are to explain the importance of abstinence as a ‘positive choice’ for adolescents (Ministry of Education, 1998: 19). As in Alberta, abstinence continues to be promoted in the higher grades; in Grades 9 and 10, it is framed as a method of pregnancy and STD prevention (Ministry of Education, 1999: 10, 15).

In the absence of curriculum guidelines, abstinence is, nonetheless, a central strategy of sex education practices in Quebec schools. In the words of one educator:

The first lesson is supposed to be, well, the choice of lesson we choose is to abstain, abstain, abstain, abstain.... Abstinence and stuff is normally the first thing we talk about... (Teacher, Quebec)

A Vice-Principal at another Quebec school reported the use of the program *Postponing Sexual Involvement*. This program aims to support adolescents in delaying sexual activity by helping them understand the various social pressures that encourage adolescent sexual

activity and by teaching teenagers skills that will enable them to set limits, resist peer pressure, and be assertive in saying no to sex.

Similarly, in Nova Scotia, while abstinence is not explicitly featured in the province's curriculum guidelines, it is also a central strategy of the school; as one teacher put it, "I certainly stress abstinence as a very, very intelligent choice at this age" (Teacher, Nova Scotia). And the Sexual Health Centre for Cumberland County in Amherst, Nova Scotia, developed an award-winning curriculum entitled *Worth Waiting: A Postponing Sexual Involvement Program*, which aims to help create awareness about pressures to have sex and hence to provide skills for healthy decision-making that encourages students to delay sexual activity.¹⁴

In their totality, the ways in which abstinence is featured in sex education discourses are remarkably consistent across all four provinces. Lesson plans aim to impart knowledge about abstinence by explicating the reasons for and advantages of practicing it. Following this acquisition of knowledge, activities aim to support 'skill development': that is, how to say 'no'.

With regard to knowledge development, there is a range of activities that explicate the many benefits of abstinence. A popular way to encourage students to consider abstinence is by brainstorming or generating a list of reasons in order to explain why teens choose to have sex and why teens choose to not have sex (Algoma Public Health Unit, 2003; Calgary Pregnancy Care Centre, n.d.; CRHA, 20006c; City of Hamilton, 2002c: 41-47; OPHEA, 2000a: 177; OPHEA, 2000b: 189; OPHEA, 2000c: 33; Public District School Board Writing Partnership, 1999; Thunder Bay District Health

¹⁴ *Worth Waiting* won the 2006 Helen and Fred Bentley Award for Excellence of Achievement, an award that is offered yearly to a Canadian Federation for Sexual Health (formerly Planned Parenthood) Member Association, which has shown outstanding achievement in the field of sexual and reproductive health.

Unit, 2005: 71-73; Windsor-Essex County Health Unit, 2005: 88-89; PPFC, 2001: 277; Mitelman, n.d.) (see Table 9).

Table 9 - Considering Abstinence (OPHEA, 2000a: 218-219)

Some Poor Reasons for Having Sexual Intercourse

- Curiosity
- To show that you really love the other person
- Too embarrassed to say “STOP”
- To feel loved
- To be more popular
- To rebel
- I was drunk! (or stoned)
- To feel independent
- To improve the relationship
- To go along with what others seem to be doing
- To prove that you’re a woman or that you’re macho
- To prove that you’re good at sex
- To prove that you are grown up

Reasons Why Many Teens Don’t Have Intercourse

- Practice abstinence for religious reasons and personal moral beliefs.
- Abstinence can be a sign of emotional maturing and integrity.
- Reduces the risk of sexually transmitted disease.
- The only method of birth control that is 100% effective.
- Shows that they can withstand peer pressure.
- Avoid upsetting parents.
- Allows the relationship to build and grow closer in non-sexual ways.
- In some ways, postponing is a test of love.
- Allows people to explore a wider range of ways to express love and sexual feelings.

The explicit message here is that all of the reasons teens might identify for having sex are “poor”. In the event that students do not naturally reach this conclusion, teachers are advised to direct the discussion to such a conclusion, since:

It will be important to bring out that some of these reasons [to have sex] will not meet the intended need, and in fact, will create many more problems. Other reasons may be appropriate in the future, but only when certain conditions (i.e. in

a committed relationship such as marriage) are in place (City of Hamilton, 2002c: 42).

Following this, classroom materials describe the ‘many’ problems that having sex will create (Calgary Pregnancy Care Centre, n.d.; CRHA, 2006e; OPHEA, 2000a: 174-175; Windsor-Essex County Health Unit, 2005: 84, 86-87; Toronto District School Board, 2002: 26-27; PPFC, 2001: 278-279; Mitelman, n.d.) (see Table 10). Students learn that there is a range of unpleasant consequences to having sex: there are emotional consequences (guilt, disappointment, sadness, anxiety, feeling used, anger, regret, depression), social consequences (a bad reputation, lack of life goals realization), spiritual consequences (conflict with spiritual beliefs) and physical consequences (pregnancy, STDs, cervical cancer).

Table 10 – Considering the Consequences of Early Sexual Intercourse (PPFC, 2001: 278-279)

Physical Consequences of Early Sexual Intercourse:

- Increased probability of pregnancy
- Increased probability of STIs (sexually transmitted infections) and associated complications (e.g. infertility)
- Increased probability of HIV
- Increased probable risk of cervical cancer for women (because possibility of more sexual partners, cervix at puberty more vulnerable)

Emotional Consequences and Relationships:

- Reputation can be affected (would it be the same for girls as for boys?)
- Guilt (about keeping this from one’s parents)
- May damage the relationship with one’s partner – or change it
- Relationship may not develop any further; partners may feel very awkward around each other
- May not take the time to develop emotional closeness with partner
- Friends may disagree
- Worries about pregnancy, STIs, etc. could take time and energy away from other activities
- May feel pressured, resentment in relationship
- May have a negative effect on self-esteem, especially if person feels “used”
- May feel regret
- May find it more painful to cope if the relationship breaks up

In particular, the contemporary concern around a specific physical consequence of sex – cervical cancer – figures prominently in abstinence discourses. Many curricula documents instruct educators to discuss the link between the human papillomavirus (HPV) sexually transmitted infection and cervical cancer (Calgary Pregnancy Care Centre, n.d.; CRHA, 2006b; CRHA, 2006e; Healthy Sexuality Working Group, 2006: 56; RNPHD, 1998c: 22; RNPHD, 1998d: 6, 39; OPHEA, 2000a: 175; OPHEA, 2000c: 64; Thunder Bay District Health Unit, 2005: 25; Lacroix and Cloutier, 2006: 7; Toronto Public Health, n.d.; Toronto District School Board, 2002: 26-27; Mitelman, n.d.). For example, educators inform students that sex for young women carries grave risk:

There are medical reasons for teens to postpone intercourse. Vaginal intercourse for females before the age of 20 years is a risk factor for cervical cancer. During adolescence, the process of maturation of cervical cells is most active and young women are more vulnerable to infection because of the cervical immaturity. Infection with some human papillomavirus (HPV) types is associated with cervical cancer (Toronto Public Health, n.d.).

Students are informed that the risk factors for developing cervical cancer are having HPV, having sex before the age of 18 or 20, having unprotected sex, and having more than one sexual partner in a lifetime since having more than one partner multiplies the risk of contracting STIs. In order to mitigate these risks, females are urged to get regular pap tests once sexually active or upon turning the age of 18 and all students are encouraged to abstain from sex, limit their number of sexual partners and/or use condoms. Future practices will likely also encourage young women to obtain the HPV vaccine – a point that will be explicated in the next chapter. However, the choices currently available to those who are sexually active are less than perfect:

The main ideas that were stressed regarding HPV and cervical cancer was to delay intercourse as late in life as possible and limit the number of lifetime partners. I tell them that condoms reduce the risk, but don't eliminate the risk of

HPV. Again, the lack of symptoms is stressed and having a negative STI test doesn't rule out HPV (Health Educator, Alberta).

Hence, condoms are not a sure way to avoid HPV and neither is STI testing. Students are reminded that abstinence is the only 100% effective method of preventing STIs, like HPV, and thus cervical cancer.

The threat of cervical cancer is also further reinforced by the presentations of guest speakers. For example, Teresa Norris visits many Quebec schools to talk to students in a sixty-minute presentation about a close friend who died at the age of 24 from HPV-induced cervical cancer:

She comes in, she talks about her activities when she was young and her friend, her very close friend, that she lost to cervical cancer as a result of HPV and she doesn't hold back anything – talks very straight to the kids. Some kids leave there crying and are very freaked out... (Vice-Principal, Quebec).

Freedom from cervical cancer, then, is one of the many advantages of abstinence (Calgary Pregnancy Care Centre, n.d.; CRHA, 2006b; RNPHD, 1998d; OPHEA, 2000a: 179; OPHEA, 2000b: 189; City of Hamilton, 2002d: 62) (see Table 11). Other 'advantages of abstinence' include freedom from pregnancy, freedom from a loss of reputation and protection from ruining the future.

Table 11 – Advantages of Abstinence Fact Sheet (RNPHD, 1998c)

Freedom from:

- Pregnancy
- STIs
- Bother & side effects of birth control
- Pressure to marry before you are ready
- Abortion decision
- Adoption issue
- Being used
- Guilt/doubt/disappointment/worry/rejection
- Cancer of the cervix
- Loss of reputation

- Ruining your future

Freedom to:

- Develop friendships
- Help others
- Enjoy being a teenager
- To be in control of your life
- To experience fuller communication in dating relationships
- Focus energy on establishing and realizing life goals
- Develop respect for self
- Develop unselfish sensitivity
- Resist temptation
- Understand sex
- Plan your future
- Have greater trust in marriage

Indeed, the guest speaker is once again deployed to explicate the dangers of sex and to promote the freedoms of abstinence. The teen mom or the person living with AIDS reinforces both the physical and moral consequences of sex (Public District School Board Writing Partnership, 2000; Windsor-Essex County Health Unit, 2005). For example, one woman living with HIV regularly visits schools in Southwestern Ontario in order to share her story:

I was thirty years old [when I was diagnosed with HIV]. I had never thought about my future... If there was anyone who should of [*sic*] crawled into a bottle of vodka and waited to die, it was me. For the next year, that's almost what happened. I was positive this was my punishment for being a bad person! ... I then proceeded to feel very sorry for myself. There were more than a few nights spent alone in my apartment, drinking and snorting coke, so I wouldn't have to feel how scared I was.

In sum, students acquire knowledge about abstinence by considering the reasons for abstinence (to circumvent the many harms and dangers of sex) as well as the advantages of abstinence (access to a range of freedoms). Following this deployment of information about abstinence, classroom activities aim to foster 'skill-building'; that is, students learn

the ‘how-to’s’ of abstinence.¹⁵ The first ‘how-to’ of abstinence is sexual limit-making. A popular activity is the physical intimacy ladder, whereby students are to identify ways of showing affection ranging from least to most intimate (CRHA, 2006e; Calgary Pregnancy Care Centre, n.d.; City of Hamilton, 2002d: 125-142; OPHEA, 2000b: 194; RNPHE, 1998d: 15-16; Thunder Bay District Health Unit, 2005: 77-78; PPAE, 2005; Sexual Health Centre for Cumberland County, 2007; Toronto District School Board, 2002: 27-30) (see Table 12). Students are then to identify where on the ladder they would cease sexual activity, or “at what point they would stop, talk and say no to sexual intercourse” (OPHEA, 2000b: 194). In order to further guide sexual limit-making decisions, teachers are to discuss possible “points of no return”: “kissing on the couch is likely to lead to further physical displays of affection... a couple at home alone is the location most likely to lead to risky behaviour” (City of Hamilton, 2002d: 92) and prolonged kissing and French kissing comprise “the Danger Zone, as teens tend to make different choices when they are sexually aroused” (Calgary Pregnancy Care Centre, n.d.). While students are informed that “sexual feelings and desires are natural... they do not have to be acted on... Avoiding behaviours that are conducive to sexual activity is an important aspect of abstinence” (Thunder Bay District Health Unit, 2005: 77-78).

¹⁵ The deployment of ‘skill-building’ tactics in the classroom has generally been understood as efforts to create a correct worker attitude – to steer students towards self-regulation in order to ultimately shape attitudes and dispositions toward a capitalist ethos (Agostinone-Wilson, 2006). In this context, ‘skill-building’ involves the acquisition of skills in order to successfully negotiate relationships, peer pressure and sexual decision-making, in order to constitute the regulated and regulating ideal and normative sexual citizen.

Table 12 - Line of Progression (Calgary Pregnancy Care Centre, n.d.)

1. Being together (dating)
2. Holding hands
3. Hugging
4. Kissing
5. Kissing – simple
6. Kissing – prolonged
7. Kissing – French
8. Making out
9. Sexual activity (oral sex, mutual masturbation)
10. Sexual intercourse

Another ‘how-to’ of abstinence is the development of refusal skills (Calgary Pregnancy Care Centre, n.d.; CRHA, 2006b; CRHA, 2006c; City of Hamilton, 2002c: 23-24; City of Hamilton, 2002d: 33-38; OPHEA, 2000a: 177; OPHEA, 2000b: 193-194; RNPHD, 1998d: 19; Thunder Bay District Health Unit, 2005: 93-98; Toronto Public Health, n.d.; Windsor-Essex County Health Unit, 2005: 90-91; SHCCC, 2007; Healthy Sexuality Working Group, 2006: 26-27) (see Table 13). Scripts and role plays aim to prepare students for real life situations by eliciting responses to sexual pressure. In response to “pressure lines”, students are taught how to say no - say no thanks, ignore the pressure, walk away, reverse the pressure, change the subject, and/or hang out with people who have chosen to avoid risk behaviours.

Table 13 - Refusal Skills Script (Windsor-Essex County Health Unit, 2005)

Elizabeth: I don’t know if I am ready for sex yet.

Peter: But everyone’s doing it! You’re such a prude.

Elizabeth: Not everyone is doing it, I’M NOT. Don’t believe everything you hear, 40% of 17 year-olds are virgins. I’m not a prude, actually I’m smart to wait for someone who respects me.

Peter: You can’t just get me all worked up and then stop!

Elizabeth: I'm not going to have sex with you for the first time just because you are uncomfortable down there. Anyways, if we have sex, I think you should wear a condom.

Peter: Condoms don't feel good. It's too unnatural.

Elizabeth: So is dying from AIDS or having a baby at my age.

Peter: We don't have to use condoms because you can go on the pill and anyways it will only be one time.

Elizabeth: I am not only worried about pregnancy, it only takes one time to get an STI or HIV.

Peter: So you think I have an STI, you think I'm dirty?

Elizabeth: Having an STI doesn't mean you are dirty, it means you didn't protect yourself. I don't know if your ex-girlfriend had an STI.

Peter: If you loved me you would have sex with me!

Elizabeth: If you loved me you wouldn't pressure me into having sex before I am ready.

Peter: C'mon, your place or mine?

Elizabeth: Both, you go to your place and I'll go to mine.

In order to reinforce the 'no' message, students are told that saying 'no' is a right:

Maintaining your rights requires saying NO. Here is the statement of your rights:

- You have the right to be yourself.
- You have the right to make your own decisions. Nobody has the right to pressure you to do things you do not want to do.
- You have the right to have your values respected.
- You have the right to go out with those who treat you as the special person you are.
- You have the right to care for and protect your reputation.
- You have the right to be free from guilt and fear (Thunder Bay District Health Unit, 2005: 13).

And students are also informed that just because they may have said 'yes' before, doesn't mean that they can't say 'no' later (Calgary Pregnancy Care Centre, n.d.; CRHA, 2006b; CRHA, 2006c; CRHA, 2006e; Algoma Public Health Unit, 2003; Windsor-Essex County Health Unit, 2005; PPFC, 2001: 265). 'Born-again virginity' or 'secondary abstinence' is another key feature of the abstinence discourse that allows the sexually active to return to abstinence:

Someone who is abstinent may have had sexual intercourse in the past, but is not currently sexually active. The choice to be abstinent can be made at any time, regardless of past experience. Just because a person has had sex before does not mean that that person must feel pressured to have sex again (CRHA, 2006c).

In addition to the development of refusal skills, students are also encouraged to consider age-appropriate ways to show affection (CRHA, 2006b; CRHA, 2006e; City of Hamilton, 2002c: 67-69; City of Hamilton, 2002d: 52-54; OPHEA, 2000a: 173; RNPHD, 1998c: 18; RNPHD, 1998d: 14; Thunder Bay District Health Unit, 2005: 77-78; Toronto Public Health, n.d.; Windsor-Essex County Health Unit, 2005: 76-77; SHCCC, 2007) (see Table 14). In order to delay sexual involvement, students are to generate a list of alternatives to sex. In this example, appropriate activities include talking on the phone, sending a card or a note, making a compilation of songs, videotaping a special message, dedicating a song on the radio, doing homework together, going for a walk, or washing a car together. Activities involving any kind of physical intimacy are generally limited to: giving or getting a hug, blowing a kiss, holding hands or walking arm in arm.

Table 14 – 82 Safe Ways to show someone you really, really like them (Sexual Health Centre for Cumberland County, 2007)

Tell the person that you like them. Give or get a hug. Make the person feel important and respected. Blow kisses. Have fun together. Tell the person that you care. Hold hands. Go for a bike ride. Give a special gift. Be there when a friend is needed. Spend time together. Go to a movie. Walk arm in arm. Make a special CD of love songs. Talk openly about your feelings. Share dreams with each other. Snuggle up together. Sit together in the park. Take a walk together. Go out to eat. Have a picnic. Play a game of frisbee. Give compliments. Go swimming. Just be close. Go shopping. Cook popcorn together. Do homework together. Throw a party together. Bake cookies. Go to the library. Browse in a museum. Just be there. E-mail each other. Exercise together. Gaze at each other. Wash each other's bikes. Go fishing. Talk to each other. Listen to hurts. Do a work project together. Choose a special, favourite song. Listen to joys. Use eye contact to share a private thought. Write each other letters. Talk on the telephone. Trust one another. Meet each other's family. Go hiking together. Send candy. Respect each other. Hide a love note where the other will find it. Write a poem. Send flowers. Give each other pet names. Rent a video. Do things for each other without being asked. Whisper something nice into each other's ear. Be best friends. Dance. Play music together. Laugh at something funny

together. Impress each other. Make a list of things you like about each other. Read a book and discuss it. Meet each other's friends. Go horseback riding. Cook each other's favourite food. Find out what makes the other happy. Make each other gifts. Be caring. Dedicate a song on the radio. Send a funny card. Share lifetime goals with each other. Call the radio for their birthday. Share funny jokes. Think about each other. Find out what makes the other sad. Go skating. Share an ice cream cone. Have your picture taken together. Make each other cards on the computer.

In order to reinforce all of these 'how-to's' - setting limits, saying no, and putting into practice 'age-appropriate' ways of showing affection – students at one school board receive a handout for their future reference that warns of all possible situations and places where abstinence is difficult to maintain (see Table 15).

Table 15 - Guidelines to Help a Person Remain Abstinent (Thunder Bay District Health Unit, 2005: 73)

1. Go with a group of friends to parties and other events.
2. Attend only supervised parties.
3. Avoid secluded places where you are put in a vulnerable position.
4. Avoid going out with people who have a reputation for drinking and/or using drugs.
5. Decide your alcohol/drug limit before being in a sexual pressure situation.
6. Decide your sexual limits before being in a sexual pressure situation.
7. Avoid falling for romantic lines.
8. Be honest, from the beginning, by saying you do not want to have sex.
9. Be clear about your intentions to avoid giving mixed messages.
10. Avoid "hanging out" with young people who pressure you to be sexually active.
11. Pay attention to your feelings: when a situation becomes uncomfortable, leave.
12. Get involved in activities (e.g. sports, clubs, hobbies).
13. Do not accept rides from strangers.
14. Avoid going to someone's room when there is no one home.

In the regime of sexual practices, abstinence is a key tactic that supports the dominant strategy of pregnancy and STI prevention. Indeed, abstinence is promoted as the best choice for young people, a message that shapes and is shaped by health, risk and morality concerns. Classroom practices support the thesis that there are no good reasons for young people to have sex, particularly in light of its physical, emotional, social and

spiritual consequences. Thus, there are myriad advantages of abstinence and students must simply set limits, say no and engage in age-appropriate ways of demonstrating affection in order to maintain the decision to remain abstinent.

The choice not to have sex should be available to and respected by all young people. However, there are several problems with the abstinence message. First, the term abstinence lacks conceptual clarity. In addition, there are problems related to the relevance of the abstinence message to young people. Lastly, there are problems related to the purpose of the abstinence message, that is, difficulties related to the reasons for and the ways in which abstinence is deployed.

First, there is a lack of conceptual clarity around the term abstinence. Students are encouraged to abstain from sex and postpone sexual involvement, but until when? Until they are in a monogamous, long-term, or married relationship? Until a woman's cervix has matured? Until students have mastered condom useage? Students are informed that they are permitted to engage in age appropriate behaviours to demonstrate affection – behaviours that are largely asexual – but when, precisely, is sex 'age appropriate'?

More fundamentally, there is no agreed upon definition of the term abstinence. Just what *is* abstinence? It has been noted elsewhere that abstinence is not clearly defined, resulting in conflicting definitions and meanings (Dailard, 2003: 4; Santelli, *et al.*, 2006: 73). Indeed, this conflict around meaning has resulted in the deployment of a range of definitions of abstinence. For example, abstinence has been defined as not having vaginal, oral or anal intercourse (Thunder Bay Public Health Unit, 2005: 70; Toronto Public Health, n.d.), as avoiding all sexual activities that lead to an exchange of bodily fluids (Windsor-Essex County Health Unit, 2005: 32; Healthy Sexuality Working

Group, 2006: 43), and as “keeping your clothes on and hands off body parts you weren’t born with” (Calgary Pregnancy Care Centre, n.d.). From this, abstinence could be understood as not having any kind of intercourse, or as refraining from all types of intercourse as well as kissing (since kissing will probably include an exchange of bodily fluids), or as refraining from all possible physical contact with another person. Given this ambiguity, educators negotiate the concept in different ways. One public health nurse, for example, described how her program avoids the term altogether, though the sexual decision-making process is firmly situated in a health context:

First of all, the word “abstinence” - we avoid it except in the cases where we’ve been producing material for the school board and the school board has said that’s the language the Ministry says we have to use... [so] instead of the message of “Don’t do it” it’s a message of “There are things that you probably will do some time in your life but there is no need to be doing them at this point in your life. You’re 13, you’re trying to sort out, you know, how you feel about this, is that the right thing, how your feelings are. There’s no rush.” That would be the public health part of our philosophy (Public Health Nurse, Ontario).

And another educator described how she arrives at a definition of abstinence by trying to build consensus in the class:

So, o.k., if I’m in a classroom and I pulled out a question that says “How do you define abstinence?”, I would throw it back to the class and say, “Well, that’s a really great question. How do you guys define abstinence? What does abstinence mean to you?”. And then we’ll come up with a group explanation. So, but I always have to be aware that I have to think of a bottom line, right. So a bottom line may be... that you are abstaining from sharing bodily fluids or that you are in close physical contact so that pregnancy or STI transmission could occur (Sexual Health Educator, Nova Scotia).

Such an approach is an exemplar of a student-centred practice since it takes into account and validates the perceptions and opinions of young people. It is also pedagogic since it encourages students to want to abstain. However, it does not necessarily resolve the question: from what are students abstaining? What is the ‘bottom line’? If students are

encouraged to ‘abstain from sex’, from what are they abstaining? What is sex? And who defines it? In light of the so-called ‘oral sex epidemic’, for example, educators are eager to define oral sex as sex and thus to frame it as an activity from which young people should abstain. However, young people consistently report that they don’t define oral sex as sex and as such, adolescents ascribe different meanings to the act than do their adult educators, as will be more fully discussed in the following chapter. Thus,

While everyone agrees that the implicit meaning of the term [abstinence] is abstaining from penile-vaginal intercourse, especially since the concept is often taught as a “method” of avoiding pregnancy, the consensus stops there. What is the specific behaviour that signals the end of abstinence and the beginning of sex (Remez, 2000: 302)?

Though contested and dynamic, the “bottom line” and “implicit meaning” of sex is penile-vaginal intercourse, which supports an explicitly heteronormative project. The promotion of a narrow definition of sex as it is produced through abstinence discourses produces a specific sexuality and a specific sexual subjectivity. As a normalizing discourse and as historically continuous with calls for premarital chastity throughout the first half of the twentieth century, the proper place for sex is presented as the heterosexual, married relationship. Indeed, as one lesson pointed out, abstinence paves the way to greater trust in marriage. This narrative not only discounts the experiences and realities of gay and lesbian youth, but it is also not reflective of contemporary coupling patterns. Because many couples choose to cohabit and/or to delay marriage, there has been a gradual increase in age at first marriage. In 1973, the average age at which men (25.2 years) and women (22.8 years) married for the first time was about five years lower than in 2003 (Statistics Canada, 2007). In 2003, in Canada (excluding Ontario), the average age of persons marrying for the first time (to someone of the opposite sex)

was 30.6 years for men and 28.5 years for women.¹⁶ And according to the 2006 Census, unmarried people now outnumber legally married people for the first time and the proportion of common-law couples and lone-parent families has increased while the proportion of married families has decreased (Statistics Canada, 2007). These trends not only illustrate contemporary coupling patterns, but also the contemporary implication of the separation between sex for reproduction and sex for pleasure.

Despite the conceptual problems around abstinence and sex, abstinence is, nonetheless, promoted as a wise choice for teens. This “choice”, however, is constrained and the choices are unbalanced since the risks, as presented, disproportionately outweigh the benefits. Does a student want to practice abstinence or end up with cervical cancer? Or with a ruined reputation? Or with a STI? Put this way, the choice is really being made *for* young people. Ironically, however, this is a choice that doesn’t need to be made for young people; they are making these choices themselves. Less than 2% of Canadian youth have initiated intercourse before 14 years of age (Maticka-Tyndale, 2001: 9) - the age at which the bulk of the abstinence messaging is directed. And, contrary to popular belief, age at first intercourse has changed very little for men over time, and while the change has been more pronounced for women, the change has only served to close the gap between men and women: the median age at first intercourse has declined from 18 years for men born between 1942 and 1946 to 17 years for men born thirty years later (1972-1976) while the decline for women was from 20 years to 17 years, respectively (Maticka-Tyndale *et al.*, 2000: 46). The *Canadian Youth, Sexual Health and HIV/AIDS Study* also supports the thesis that there has not been a dramatic decline in age at first

¹⁶ Marriage statistics by sex are not available for Ontario as the province does not identify whether a marriage is opposite-sex, male same-sex, or female same-sex, or the sex of the person getting married. Hence, any national marriage statistics presented by sex for 2003 exclude Ontario data.

intercourse – in fact, figures indicate the opposite (Boyce *et al.*, 2003: 78) (See Table 16). According to data from the *Canadian Community Health Survey*, the average age of first intercourse for both sexes in 2003 was 16.5 years old, which hardly supports the thesis that there has been a dramatic decrease in the age of first intercourse (Roterman, 2005: 39). These data put into question the relevance of the abstinence message for young people. Instead, it may be more fruitful and worthwhile to unpack perceptions of increased sexual activity among young people: why are young people perceived as sexually promiscuous and engaging in sex at ever younger ages? How does this shape young people's perceptions of themselves and each other and the ways in which they define sex and sexuality? Consideration of the sociocultural influences and the multiple meanings attributed to sex and sexuality would contribute to a more meaningful discussion than that which the narrow parameters of abstinence allow.

Table 16 – Sexual Intercourse at Least Once

	Grade 9 males	Grade 9 females	Grade 11 males	Grade 11 females
1988	31%	21%	49%	46%
2003	23%	19%	40%	46%

But in this no-sex sex education, students are educated away from their sexuality. Adolescents are permitted to acknowledge their sexual desires, but not to act on them. Love and curiosity are not good reasons to have sex and teens are to explore non-sexual, “developmentally appropriate” ways to show affection. And there is a conspicuous absence in classroom activities of discussion about actual sexual practices. Activities may refer to kissing, hugging or ‘making out’, but there is no mention of key body parts, such as breasts, or of specific acts, such as mutual masturbation. However, these and other practices probably form a large component of lived sexual activity; for example, breasts

are often involved in the process of ‘making out’. This absence points to continued concern that speaking of sex will incite sexual activity, since the release of explicit information runs the risk of inciting that which is to be restrained (Mort, 1987: 216).

Moreover, this no-sex sex education also denigrates the reasons for which young people have sex. According to the *Canadian Youth, Sexual Health and HIV/AIDS Study*, grade 9 and 11 students cited “love for the person”, “curiosity/ experimentation” and “influence of alcohol/drugs” as the most common reasons for their first experience of sexual intercourse (Boyce *et al.*, 2003: 81). A discussion that legitimizes the reasons for which young people have sex – reasons that aren’t so divergent from those of adults – and unpacks the more potentially problematic antecedents, such as alcohol and drug use, would better prepare young people for negotiating their intimate relationships.

This isn’t to say that there is a total absence of such a discussion. Indeed, “abstinence education means that there must be a discussion of abstinence from *what*. Once the *what* is named, the terrain of sexual life has changed. Once there is discussion, there is the occasion for counter-discussion” (Gagnon and Simon, 2005: 261). Even though abstinence is promoted as the best choice for teens, there are, in fact, a few activities that encourage students to consider the conditions under which they might say yes to sex (CRHA, 2006b; Windsor-Essex County Health Unit, 2005; Toronto District School Board, 2002: 30; PPFC, 2001: 254; Mitleman, n.d.). For example, in “How Will I Know When I’m Ready?” in *Sex? A Healthy Sexuality Resource*, students are encouraged to consider whether having sex will be a good and comfortable choice, what sex means to them and how they will feel about it afterwards, what information they require in order to make the right choice, and how pressure, uncertainty and lack of readiness indicate a lack

of sexual readiness (Healthy Sexuality Working Group, 2006: 20-22). However, even this activity concludes with:

Caution! There is no “right age” for having sex. But one important thing to consider when making your decision is that having vaginal sex at a young age is risky for a girl. This is because the cells of the cervix are still developing and are more easily damaged. This puts girls at a higher risk for cervical cancer (Healthy Sexuality Working Group, 2006: 22).

This reassertion of the medical consequences of sex is clearly indicative of the general reticence to talk about sex. The abstinence discourse is a way of talking about sex without talking about sex. And there is no better way to avoid talking about sex and the pleasures of sex than by focusing on the many potentially disagreeable consequences of sex.

Abstinence is promoted as the best way to avoid the many dangers of sex - dangers that also intersect with broader anxieties, such as those related to other dangerous behaviours (alcohol and drug use; rides from ‘strangers’) and dangerous spaces (‘secluded places’, ‘someone’s room’, unsupervised parties). There is a clear convergence or combination of issues that stimulates social reaction, and as explicated in many classroom practices, those who abstain from sex circumvent many physical, social, emotional, and spiritual dangers.

The emphasis on the physical harms of sex medicalizes sex by way of the deployment of medical ‘truths’. Located within a medical discourse, abstinence signifies a responsible care for the self in the name of health (Hunt, 1999: 3). In particular, the contemporary concern regarding the link between HPV, a sexually transmitted infection, and cervical cancer is a clear exemplar of a medical model of abstinence, which involves the use of medical truths in order to support abstinence as a wise choice. HPV and cervical cancer are, in fact, potential health outcomes of sex. However, the generalization

of this risk to all youth is certainly overstated since cervical cancer is actually relatively rare - the 11th most common cancer diagnosis in Canadian women and the 13th most common cancer-related cause of death (Canadian Cancer Society & National Cancer Institute of Canada, 2006: 72). Cervical cancer mortality and morbidity rates have fallen significantly over the past three decades since Pap screening began in Canada (Public Health Agency of Canada, 2003) although incidence and mortality disproportionately affect marginalized groups not particularly well served by the health care system, such as Aboriginal women (Lippman *et al.*, 2007). Framing cervical cancer as an imminent threat is a new twist on an old theme: premarital chastity was promoted throughout the first half of twentieth century as a way to avoid the scourge of war-time gonorrhea and syphilis – diseases that were ‘rampant’ among military personnel and sure to spread to the civilian population. And the cervical cancer threat is also reminiscent of earlier and as yet unrealized HIV/AIDS messaging that we’re ‘all’ at risk for HIV, that HIV will spread to the general population resulting in an epidemic of sizeable proportion (see Fitzpatrick and Milligan, 1987; Fitzpatrick, 2001). Indeed, men who have sex with men still account for the greatest number of new infections in Canada (45% in 2005) (Public Health Agency of Canada, 2007b: 10) which would support the idea of targeting young, gay or bisexual males though there is risk, in doing so, of possibly reinforcing stigma and homophobia which is likely why the strategy of generalizable risk was deployed in the first place (Connell, 2001). Further, the Joint United Nations Programme on HIV/AIDS (UNAIDS) has recently come under fire for overestimating the number of worldwide HIV infections.¹⁷ As a biopolitical project, cervical cancer, like HIV/AIDS, justifies

¹⁷ Estimates in 2006 were 39.5 million worldwide infections. Estimates in 2007 were modified to 33.2 million worldwide infections.

intervention and regulation based on counting bodies. At the same time and as a project of anxiety, cervical cancer, like HIV/AIDS is a clear exemplar of an enhanced experience of social risk in circumstances in which objective measures of the incidence of specific risk do not support the experiential reaction (Hunt, 1999: 514). Lastly, cervical cancer, like HIV/AIDS, medicalizes sex and continues to push 'sex' into the realm of 'health' and thus encourages a continued preoccupation with risk, danger, morality and disease. Under the guise of medical truth, this practice of sex education serves as a non-moral form of moral code to discourage premarital sex and promote abstinence. Abstinence, then, is illustrative of the link between one's physical condition and moral character – it is a site where health and morals meet.

Indeed, the practice of abstinence is inextricably linked to good moral character and aims to ensure the successful transition from childhood to adulthood. By presenting sexual activity and personal and social achievement as mutually exclusive, the abstainer can develop 'unselfish sensitivity' and focus his or her energy on 'establishing and realizing life goals', a discourse that is reminiscent of purity lecturer Arthur Beall's directive to students to repress their urges and use them instead for creative and intellectual purposes. Abstinence, as a practice of self-government, is ethical work. The physical intimacy ladder activities, where students are to identify where on a continuum of sexual behaviours they would stop and say no to sex, is a political technology, a technology of the self, that aims both to regulate and to produce regulating subjects. It is a technology that combines certain key elements of self-governance, such as self-control and self-formation.

In fact, abstinence is described as a sign of emotional maturity and integrity that leads to an entire range of freedoms: freedom to develop friendships, to help others, to plan the future, to be in control of one's life and to develop respect for self - freedoms that are, apparently, unattainable for the sexually active, but available to those who repent. The fallen can revert to secondary abstinence. The guest speaker, the teen mom or the person living with AIDS, can seek moral rectitude by imparting lessons learned to the innocent. In fact, abstinence is not only a freedom; it is a right: students are told that they have the right to say no, the right to care for and protect their reputations, the right to be free from guilt and fear. While the original intent of 'rights' discourse in the realm of adolescent sexuality was to challenge the paternalistic character of sex education and disrupt the dominance of health and moral authoritarianism (Thomson, 1994: 56), the invocation here clearly turns this intention on its head. As a form of moral education, the abstinence discourse aims to save the young from not only the physical harms of sex, but also from the metaphysical harms – harms for which there is no evidence, as there are no reports that address whether the initiation of adolescent sexual intercourse itself has an adverse impact on mental health (Santelli *et al.*, 2006: 74).

Hence, the focus on the dangers of sex mixes medical fears and everyday anxieties. And these dangers also discursively constitute subjectivities, subjectivities that are also particularly gendered, a point that will be further elaborated in chapter six. Girls must abstain from sex in order to protect their reputations and avoid hurt and guilt. Girls must also avoid falling for romantic lines, for fear of being used, feeling guilty, and losing their reputations – even though the discourse of romance is alive and well in activities that encourage non-sexual ways of showing affection (writing a poem, sending

flowers, making a special CD of love songs, sharing dreams with each other). Girls must identify and enforce sexual limits and resist boys' pressure lines, which perpetuates the idea that females are passive and uninterested in, as well as the gatekeepers to, sex. Indeed, HPV and cervical cancer are modern examples of the historically continuous responsabilization of females for sexual regulation. Young women are educated away from positions of sexual self-interest and as a result, young men secure certain gains through such subjectivities. Sexual desire in males is deemed normal and natural and males are constituted as having a sense of entitlement to sex. While it must be recognized that unequal power relations between women and men may render young women vulnerable to coerced or unwanted sex, it must also be recognized that framing young men as sexually aggressive is not only detrimental to their self-image, but also poses an anxiety about whether they are behaving within the ethical parameters of what is wrong or right conduct (Connell, 2003: 260-261; Stoltenberg, 1989).

In a gendered and heteronormative context, the abstinence message exploits the potential dangers of sex. The physical and metaphysical harms are presented to young people in order to support the directive that abstinence is a good and wise choice for teens. This mixing of the medical and the moral, however, also frames other choices available to young people. For those (older) students who are sexually active or considering sexual activity, 'safer sex' strategies are discussed within a risk reduction paradigm; a paradigm that, as the following chapter will discuss is also framed by medico-moral considerations.

Chapter Five

The ABC's of Risk Reduction: Abstinence, Birth Control & Condoms

As the previous chapter demonstrated, abstinence is promoted as a preferred practice for young people; indeed, significant classroom time is dedicated to discussing the merits of postponing sex. However, abstinence isn't the only tactic deployed in support of STI/HIV and pregnancy prevention. The regime of sexual practices is also strongly informed by a risk reduction model.

This chapter will describe the ways in which young people are to both assess and personalize STI and pregnancy risk. While abstinence is still promoted as the most effective method of pregnancy and STI prevention, sexually active students are encouraged to make 'good' choices by engaging in 'low risk' sexual activities (with the exception of oral sex), by using contraception and condoms, and by getting tested regularly for STI/HIV. These tactics point to the continued medicalization of sex – the constitution of sexuality as a medical object that is sure to persist with the advent of the new HPV vaccine. However, I also argue that moral discourses operate through medical discourses, deploying a regulatory project supported by fear and anxiety.

In addition to abstinence, risk reduction is deployed as a key tactic in the regime of practices through which sex education is formulated and implemented. Sex education as risk reduction emphasizes behavioural change, much like the harm reduction model deployed in drug use prevention and treatment programs. In this context, risk reduction imparts information and includes skill-building activities that aim to prevent the dangers of sex for those who are sexually active. Significantly, risk reduction emerged as a strategy in response to the HIV/AIDS epidemic in the late-1980s and 1990s. Often

referred to as ‘safer sex’,¹⁸ risk reduction strategies have typically promoted contraception and condom use, STI/HIV testing, monogamy and non-penetrative sexual activities (sometimes referred to as ‘outercourse’).

Abstinence does not disappear from risk reduction strategies – a risk reduction approach to sex education is, in fact, also referred to as ‘abstinence-plus’ sex education. Indeed, effective sex education programs have been described as consistently reinforcing messages that support abstinence, contraception and condom use; focusing on behaviors that lead to unintended pregnancy or STI/HIV infection; providing information on the risks of teen sex; and providing examples of and practice with communication, negotiation and refusal skills (Kirby, 2001; Kirby *et al.*, 2007).

Hence, provincial curricular guidelines direct educators to provide information to their students about STI/HIV and contraception as well as to include skill-building opportunities that are meant to support the prevention of STI/HIV and teen pregnancy. In Ontario, Alberta and Nova Scotia, students first acquire factual information about STIs/HIV in grades 7, 8 and 5 respectively (Ministry of Education, 1998: 18; Alberta Learning, 2002a: 12; Nova Scotia Department of Education, 2003: 104, 106). In subsequent grades, students are meant to learn about contraception and condom use (in both grades 8 and 9 in Ontario and Alberta and grade 9 in Nova Scotia) (Ministry of Education, 1998: 19; Ministry of Education, 1999: 10; Alberta Learning, 2002a: 12; Nova Scotia Department of Education, 2000: 190). In grade 9 in Ontario and Alberta and in Grade 8 in Nova Scotia, students are meant to acquire communication and negotiation

¹⁸ The term *safer sex* has replaced *safe sex* for two key reasons. The first is the promotion of the idea that no sex is ‘safe’ sex, since contraceptives can fail, resulting in pregnancy, and condoms cannot provide protection against all forms of STDs. Second, is the realization that the risk of transmission of sexually transmitted infections in various sexual activities is a continuum rather than a simple dichotomy between risky sex and safe sex.

skills to support healthy choices in order to prevent STI/HIV and teen pregnancy (Ministry of Education., 1999: 10; Alberta Learning, 2002a: 12; Nova Scotia Department of Education, 2000: 112, 114). While there are no sex education guidelines in the Quebec curriculum, contraception and sexually transmitted diseases are flagged as “compulsory concepts” in the Mathematics, Science and Technology module, the significance of which will be discussed later in this chapter. The remainder of this chapter will describe and critically engage with the risk reduction discourse, which focuses on the provision of information and ‘skill-building’ opportunities.

The first main goal of STI/HIV and pregnancy prevention is the provision of accurate information. Lesson plans and activities aim to support the acquisition of student knowledge on the symptoms, transmission, treatment and prevention of STIs/HIV (CRHA, 2006c; CRHA, 2006e; City of Hamilton, 2002c: 89-99; City of Hamilton, 2002d: 98-101; OPHEA, 2000a: 180; OPHEA, 2000b: 202-207; OPHEA, 2000c: 45-56; RNPd, 1998c: 22-28; RNPd, 1998d: 39-48; Thunder Bay District Health Unit, 2005: 122-126; Windsor-Essex County Health Unit, 2005: 124-127; Healthy Sexuality Working Group, 2006: 43-56; Lacroix and Cloutier, 2006: 14-15; Toronto District School Board, 2002: 16-17, 39-42; PPFC, 2001: 336-338; Mitelman, n.d.). Similarly, students are exposed to the facts about various contraceptive methods, such as how to use them and where to get them as well as their effectiveness, cost and advantages and disadvantages (CRHA, 2006c; CRHA, 2006e; Healthy Sexuality Working Group, 2006: 71-91; RNPd, 1998d: 20, 22-27; OPHEA, 2000b: 196-200; OPHEA, 2000c: 45-56; Algoma Public Health Unit, 2003; Windsor-Essex County Health Unit, 2005: 113-115; PPFC, 2001: 280-288; Mitelman, n.d.). This knowledge acquisition is often accomplished

through research assignments, where students are to consult internet sites, pamphlets and/or books to locate and document the required facts about STIs and birth control methods (see Table 17, Table 18).

Table 17 – STI Research (PPFC, 2001: 337)

Name of STI:

1. What are the symptoms of this STI?
2. How is this STI transmitted from person to person?
3. What are some of the effects of this STI?
4. How can this STI be treated?
5. How can this STI be prevented?

Table 18 - Contraceptive Choices (OPHEA, 2000b: 232)

1. What is this method?
2. Who uses it? (male/female/both)
3. How is it used? How does it work?
4. What are some advantages of this method?
5. What are some disadvantages of this method?
6. How effective is this method? (in %)
7. Where do you obtain this method?
8. How much does it cost?

This deployment of facts serves two additional purposes. First, the acquisition of this information debunks a variety of myths and corrects misinformation about STIs and pregnancy. For example, students are assured that they cannot contract HIV from a toilet seat or prevent a pregnancy by douching; that many STIs have no symptoms and that one can get pregnant 'the first time' (CRHA, 2000a; CRHA, 2000c; CRHA, 2000e; Calgary Pregnancy Care Centre, n.d.; City of Hamilton, 2002c: 65-66, 100-101; City of Hamilton, 2002d: 49, 95-96, 105-109; Thunder Bay District Health Unit, 2005: 24-28, 106-109; 133-135; OPHEA 2000b: 236-239; OPHEA 2000c: 40-43; Windsor-Essex County Health

Unit, 2005: 126-127; RNPHD, 1998c: 28; Healthy Sexuality Working Group, 2006: 63; SHCCC, 2007; PPFC, 2001: 292-294, 331-332).

Second, it provides a base from which students can both assess and personalize STI and pregnancy risk. Indeed, many activities encourage students to categorize a range of sexual behaviours according to their level of risk: as either no risk, low risk, medium risk or high risk (CRHA, 2006c; CRHA, 2006e; Healthy Sexuality Working Group, 2006: 14-15; RNPHD, 1998d: 44; City of Hamilton, 2002d: 95; Thunder Bay, 2005: 126, 129-130; PPFC, 2001: 302-304). One activity that illustrates this categorization is Green Light, Yellow Light, Red Light (CRHA, 2006c; Thunder Bay, 2005: 130; PPFC, 2001: 302-304). Here, green light or low risk activities include kissing and hugging, yellow light or medium risk activities include mutual masturbation and red light or high risk activities include unprotected vaginal or anal sex (see Table 19).

Table 19 – Risk Behaviours (CRHA, 2006c)

Green Light	Yellow Light		Red Light
No risk	Very low risk >>> Low risk		High risk
<ul style="list-style-type: none"> - Massage - Dry kissing - French kissing - Abstaining from sex - Fantasizing - Self masturbation - Hugging - Using a condom with a mutually monogamous, uninfected partner 	<ul style="list-style-type: none"> - Properly using latex condoms for oral sex - Mutual masturbation 	<ul style="list-style-type: none"> - Unprotected oral sex - Intercourse using a condom 	<ul style="list-style-type: none"> - Unprotected vaginal or anal sex - Using the same condom twice - Sharing needles or sex toys

Of particular interest here is the contemporary treatment of oral sex as a risk activity.

Once framed in the safer sex literature as a “probably safe” practice in preventing HIV transmission (White, 2005: 233), students are strongly cautioned against the practice:

You might think, “Oral sex is safe. It’s not like we’re actually having sex. I’m flattered that someone wants me, and I’ll be more popular if I do it. It’s no big deal.” Think again! It is a big deal! You can get hurt physically. Oral sex can give you herpes and other STIs. Being alone with a stranger can be dangerous and having many sexual partners increases your risk of getting an STI. You can also get hurt emotionally. Oral sex – or any sexual activity – with someone who doesn’t know you or care about you can leave you feeling sad, bad, hurt and used (Healthy Sexuality Working Group, 2006: 24-25).

In light of media accounts that describe rainbow parties – where young girls wearing lipstick perform fellatio on guys – as well as accounts of sexual interference – an exemplar account was the legal case in Prince Edward Island where charges were laid against an 18-year-old celebrity male high school athlete for having received fellatio from two girls aged 12 and 13¹⁹ – educators are urged to dedicate significant classroom time to discussing oral sex. For example, one lesson plan describes how adolescents “trivialize oral sex”; hence, educators must not only impress upon students the intimate nature of oral sex, but also the range of consequences, particularly for girls, such as shame, humiliation, disgust, mistrust, abandonment, and dissatisfaction (Campanelli, 2006: 4-6). Indeed, for boys, oral sex is about power and pleasure and for girls, the practice is about powerlessness and trivialization. As one educator put it:

I say [to the class]: “imagine what this looks like.” I say: “where are the guys in this picture? Where are the guys in this scenario? Well they’re standing up and their pants are down.” And I say: “where are the girls? Well, they’re kneeling in front of the guys and their mouths are on their penises.” So I say “o.k. let’s get a good visual on that. What does that say about power?” And I get them to do a little look around and say: “what is happening to the guys’ reputation in this scenario? And what is happening to the girls’ reputation in this scenario?” And I always say: “guys, you see those girls down there, what do you say about those girls? You’re going to take one of those girls home to meet your parents?” I say: “guys, be honest with the girls that are in your class right now. Would you ever marry one of those girls? Nope.” You should just see the shock and the horror that comes over the faces of these young girls... (Sexual Health Educator, Nova Scotia).

¹⁹ See Curtis and Hunt, 2007 for a full account of the PEI case.

With a complete lack of mutuality – cunnilingus isn't mentioned in any of the classroom activities – the discussion of sexual risk reminds students that there are not only harmful physical consequences (STIs) but also harmful (and gendered) social and emotional consequences (damaged reputation). A clear and conclusive message about these activities is the reminder that abstinence is the only 100% effective way of preventing STI/HIV and pregnancy (Calgary Pregnancy Care Centre, n.d.; CRHA, 2006b; CRHA, 2006c; CRHA, 2006d; CRHA, 2006e; Healthy Sexuality Working Group, 2006: 43; RNPHD, 1998c; RNPHD, 1998d; OPHEA, 2000a: 174; OPHEA, 2000b: 197; OPHEA, 2000c: 43, 45; Thunder Bay, 2005: 70, 104, 108; Windsor-Essex County Health Unit, 2005: 32, 115; Toronto District School Board, 2002: 33; PPFC, 2001: 282, 293, 328) - a message that is further reinforced by emphasizing the horrors of STIs as well as the risks of birth control failure.

Indeed, consciously or not, some educators pursue fear-based tactics that sensationalize and magnify the threats of STIs/HIV. Many activities emphasize the long-term and serious consequences of STIs/HIV, such as cervical cancer, death, infertility, and pelvic inflammatory disease; in fact, students are warned of the effects of STIs/HIV on themselves and others:

If treatment is needed and not received or delayed, both males and females are at risk for long term complications. These could be pelvic inflammatory disease, cancers (cervix, penis, anus), infertility, or death (AIDS). Also, without treatment a person could infect a loved one (i.e. sexual partners, mother to baby during childbirth). With every STD infection there is more risk of permanent damage to the reproductive system. This means that for some people, when they decide to have children, it may be more difficult or impossible to conceive. Also, babies born to mothers with untreated STDs may be sick and may have long-term complications (City of Hamilton, 2002c: 95).

One public health nurse described her use of explicit photographs depicting individuals with severe STI symptoms, a pedagogic practice reminiscent of nineteenth and early twentieth century approaches to discussing syphilis:

I have nice pictures to show them of awful things... like I show them Chlamydia in somebody's eye. And they don't know Chlamydia can be in the mouth. They think it's just in your private parts, right. It's a reality check (Public Health Nurse, Nova Scotia).

And other activities aim to impress upon students the relative ease by which STIs, including HIV, are transmitted (Calgary Pregnancy Care Centre, n.d.; CRHA, 2006c; SHCCC, 2007; OPHEA, 2000b: 202-203; City of Hamilton, 2002c: 102-103; PPFC, 2001: 329-330). In the activity Handshake Virus, each student is given a card (one card has a dot or other identifiable symbol on it). Students then collect three signatures from their classmates. The teacher then asks the student with the marked card to stand up – and since the mark denotes an STI, every student who has that particular student's signature must stand up. And then any student who has the signature of any of those students must stand up, and so on. This activity is intended to be a metaphor for infection and communicable disease transmission – to illustrate how rapidly a disease can spread, particularly since it is impossible to tell who might have it. The message, then, is that we are all at risk.

Such activities that emphasize the worst possible symptoms and consequences of STIs/HIV – and their ease of transmission – aim to support and promote the abstinence message to young people. As one educator put it:

One of the things that I do is teach, deliberately teach, STIs before birth control and so often birth control is almost redundant - they're never ever having sex. [*So what's your rationale for teaching STIs before birth control?*] Because they're so shocked... I have so many kids walk out after the class on STIs going: "I'm never having sex, way too much information" (Teacher, Alberta).

Nevertheless, educators do impart information on birth control, condoms and testing services. Students acquire the facts about various methods of birth control through research activities such as those described earlier in this chapter. And educators are encouraged to use or borrow a birth control kit from their local health unit in order to help familiarize students with and demystify contraceptive methods (CRHA, 2006c; CRHA, 2006e; OPHEA, 2000c: 44; Algoma Public Health Unit, 2003; Toronto District School Board, 2002: 32; PPFC, 2001: 280). In this case, students can handle and examine packages of pills, condoms, IUDs and other contraceptive devices. At the same time, however, much emphasis is placed on the risks of birth control use – in particular, their risk of failure (see Table 20). Indeed, all methods to prevent pregnancy are described as carrying a risk of failure (Thunder Bay, 2005: 70). In one curriculum document, educators are encouraged to use the following jingle to illustrate that even the best birth control methods aren't 100% effective because "sperm are strong swimmers": "Break through the condom, swim through the foam, around the diaphragm, and home sweet home" (Windsor-Essex County Health Unit, 2005).

Table 20 – Summary Table of Contraceptive Efficacy (Trussell, *et al.*, 2007; Dailard, 2003)

Method	% of Women Experiencing an Unintended Pregnancy within the First Year of Use	
	Typical Use	Perfect Use
No method	85	85
Abstinence	???	100
Combined pill and progestin-only pill	8	0.3
Evra Patch	8	0.3
NuvaRing	8	0.3
Depo-Provera	3	0.3
Male Condom	15	2
Withdrawal	27	4
Fertility awareness-based methods	25	3-5 ²⁰

In this hierarchy of birth control methods, abstinence is promoted as the only 100% effective method of birth control (Calgary Pregnancy Care Centre, n.d.; CRHA, 2006b; CRHA, 2006c; CRHA, 2006d; CRHA, 2006e; RNPHD, 1998d: 22; OPHEA, 2000a: 174; OPHEA, 2000b: 197; OPHEA, 2000c: 43, 45; Thunder Bay District Health Unit, 2005: 70, 104, 108; Windsor-Essex County Health Unit, 2005: 32, 115; Toronto District School Board, 2002: 33; PPFC, 2001: 282, 293). After abstinence, preferred and promoted methods of contraception include hormonal methods (the pill, the patch, Depo- Provera, the ring) and the condom - the use of both pill and condom provide ‘dual protection’ against both STIs/HIV and pregnancy. Students are particularly cautioned against withdrawal and the rhythm method or fertility awareness: withdrawal is deemed “not effective,” “unreliable,” “not a contraceptive method,” “a myth method,” and “not recommended” (City of Hamilton, 1998d: 107; CRHA, 2006e; OPHEA, 2000b: 200; Thunder Bay District Health Unit, 2005: 109; RNPHD, 1998d: 25; Algoma Public Health

²⁰ Depends on method: the standard days method yields a 5% failure rate for perfect users; two day method 4% and ovulation method 3% (Trussell *et al.*, 2007).

Unit, 2003). And young women are warned that their menstrual cycles are too irregular for complicated and time-consuming fertility awareness methods (CRHA, 2006e; City of Hamilton, 2002d: 106; Thunder Bay District Health Unit, 2005: 52, 109; OPHEA 2000a: 191; OPHEA, 2000b: 200; OPHEA, 2000c: 53; RNPHD, 1998d: 21, 25; Mitelman, n.d.; PPFC, 2001: 288). In sum, students make the best choice (abstinence), good choices (the pill and the condom – preferably used together) and poor choices (withdrawal).

While the ideal might be to motivate students to abstain from sex entirely, an important component of the risk reduction discourse is to provide the information and means by which sexually active students can protect themselves from the harms of sex. For the sexually active (or those considering having sex), then, there is the potential to make good choices, by choosing a reliable method of contraception. Following this, lesson plans and activities encourage condom use and provide information on local services that offer STI/HIV testing and disseminate contraceptives.

There are two key objectives to imparting information about condoms. The first is to instruct students on how to use a condom (CRHA, 2006d; Lacroix and Cloutier, 2006: 16-17; PPFC, 2001: 289-291; Mitelman, n.d.; Windsor-Essex County Health Unit, 2005: 118-119). This involves navigating the many steps to proper condom usage (see Table 21). Some educators put a condom on a ‘woody’ (wooden penis) or roll a condom down over their fingers to illustrate the correct steps of condom usage (CRHA, 2006d; Toronto Public Health, 2006: 15; PPFC, 2001: 289). Others may describe how condoms can be used for oral sex: a dental dam can be created from a condom cut lengthwise (PPFC, 2001: 291; Mitelman, n.d.).

Table 21 – Steps in Using Condoms (Mitelman, n.d.)

1. Check the expiry date
2. Check for air in package
3. Open the package carefully. Never bite or use scissors
4. Take out condom from package
5. Find the direction the condom unrolls
6. Put the condom over the erect penis
7. Squeeze the tip, “reservoir end” to remove any air
8. Unroll condom to base of penis
9. Engage in sex
10. During sex, check if condom is still on properly
11. After ejaculation, hold the condom close to the base of the penis and carefully withdraw the penis making sure to take the condom with it
12. Roll condom up from the base of the penis
13. Wrap condom up and throw away in the garbage – not in the toilet

The second aim of condom education is to impart condom negotiation skills (CRHA, 2006d; Healthy Sexuality Working Group, 2006: 54-55; Lacroix and Cloutier, 2006: 16-17; PPFC, 2001: 307-311; Windsor-Essex County Health Unit, 2005: 118-119; Mitelman, n.d.) since it is generally believed that most young people are resistant to condom use (see Table 22). Students are encouraged to prepare their own responses to these condom excuses while the educator provides suggestions.

Table 22 - Dealing with Condom Excuses – Teacher Answer Sheet (Windsor-Essex County Health Unit, 2005: 120)

<ul style="list-style-type: none"> - I don't have a sexually transmitted infection. - I can't find a condom that fits. - I will pull out. - Sex doesn't feel as good with a condom. - If you loved me you wouldn't ask me to wear one. - Condoms spoil the mood. 	<ul style="list-style-type: none"> - Make sure it stays that way! - There are condoms that stretch big enough to fit any size. - Accidents happen. Pulling out is only 18% effective against pregnancy and 0% effective against STIs. - It feels good to know that I don't have to worry about pregnancy and STIs. - If you loved me, you'd protect me. - Using a condom can add spice to foreplay.
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- I'm too embarrassed to use a condom.	- Talking about condoms and protection ahead of time will ease embarrassment when things start to happen.
- I've already had an STI so I can't catch another one.	- Yes you can – you need to use a condom every time.

Some school nurses or school-based health centres have condoms to distribute without charge to students, though this practice is highly variable inter- and intra-provincially:

No one is allowed to [give out condoms]; however, I hear that other people do, other groups do. But we're not allowed to and it's not because the teachers wouldn't let us, it's because Edmonton school board policy, whereas just outside of here in Saint Albert, north of us, Saint Albert schools have condom machines in the bathroom or they're allowed to distribute them (Sexual Health Educator, Alberta).

There's no dissemination of condoms at the schools... It's a policy here at the health unit that we don't bring them to the schools. We let the kids know where they can come and access them for free (Public Health Nurse, Ontario).

And since 2005 – as part of an explicit strategy to reduce the province's rate of teen pregnancies and abortions - school nurses in Quebec have provided the birth control pill to female students without a prescription. The Quebec College of Physicians allows school nurses to prescribe a three-month supply of the pill, though these students must consult a doctor for a physical exam before getting the birth control prescription renewed.

However, if such services are not available in the school, community mapping activities (see Table 23) provide a way for students to become familiarized with services in their community; for example, where they can gain access to condoms, birth control and STI/HIV testing (CRHA, 2006c; CRHA, 2006d; CRHA, 2006e; OPHEA, 2000c: 39; City of Hamilton, 2002c: 70; City of Hamilton, 2002d: 147-149; Thunder Bay District Health Unit, 2005: 126, 128; Windsor-Essex County Health Unit, 2005: 129-131; PPFC, 2001: 299-301; Mitelman, n.d.). Often, guest speakers, such as public health nurses or

community-based educators, include information in their presentations about local services:

Every time that we go into the classrooms, we make sure we let the students know about the clinic and that they can come down for low cost birth control, pregnancy testing and STI testing and treatment – that sort of thing. And pretty much every time after I teach a class – I teach a lot of classes – we end up having people coming in after that class... (Public Health Nurse, Alberta).

Table 23 – Visit or Call a Clinic (PPFC, 2001: 300)

1. Name of clinic:			
2. Address and phone number of clinic:			
3. Clinic hours:			
4. The following services are available at this clinic:			
Birth control ____	Prenatal care ____	STI testing ____	
Pregnancy tests ____	Distribution of condoms ____	STI treatment ____	
HIV test ____	Support groups ____	Counselling ____	
HIV counselling ____	Referral to other agencies ____		
5. What is this clinic's policy on confidentiality?			
6. The following languages are spoken at this clinic:			
7. I felt the following level of comfort in this clinic (include things such as friendliness and helpfulness of staff, décor, magazines/pamphlets available in waiting room, etc.):			
1	2	3	4
Very comfortable	Comfortable	Uncomfortable	Very uncomfortable
8. I would/wouldn't tell a friend to visit this clinic for an examination/consultation about protection. Write two sentences telling why or why not.			
9. Something I learned at this clinic:			

In this context, much emphasis is placed on STI/HIV testing. Students are told that once they become sexually active, they need to have regular STI tests, particularly since STIs often have no symptoms. The idea is that knowledge of antibody, viral or bacterial status

will result in and reinforce behavioural change. Students are further advised to get additional testing under a range of circumstances:

- If you have sex without using a condom or if the condom breaks.
- If you find out that your current or past partner has an STI.
- If you find out that your partner is having sex with someone else.
- If you or your partner have piercings or tattoos.
- If you or your partner have ever injected drugs.
- If you are having sex with a new partner.
- If you or your partner have any STI symptoms.
- If you have been raped or think you might have been (Healthy Sexuality Working Group, 2006: 48).

In fact, STI testing is framed as an important responsibility to self as well as to others. A case study called “An Unusual 15 Year Old” is illustrative of this responsabilization:

A 15 year old came into the birth control clinic asking for a pregnancy test. Because she admitted to being sexually active, the nurse encouraged her to be tested for STIs. She agreed, although she said she felt well and had never been sick. They gave her an appointment to return in two weeks. Her results came back in; she did not return. The birth control clinic nurse called the school nurse and asked if she could locate the student. Fortunately, the school nurse was able to locate the student and asked her to return to the clinic for her results. She did. She was told she was not pregnant, but, she had 3 STIs! She was amazed! Because some of the STIs are reportable, contact tracing or partner notification has to be done. This 15 year old student was asked for her sexual contacts. She gave 8 names of young men. Some were virgins when they met her. Others had already had sexual partners. You can see the chain of how STIs are transmitted (through bodily fluids) from contacts. It is impossible to know these sexual contacts of sexual partners, even to know if they have ever shared a needle/syringe with someone even once. In 2 weeks, 20 people were found to be part of this one 15 year old's sexual partners! It also shows how quickly and unknowingly, STIs can be spread from person to person (Regional Niagara Public Health Department, 1998d: 43).

In their totality, then, risk reduction strategies aim to prevent the dangers of sex – most notably, STIs/HIV and teen pregnancy – by encouraging ‘good’ choices that support ‘healthy’ behaviours. Specifically, students continue to be encouraged to abstain from sex in order to reduce adolescent STI and teen pregnancy rates; however, the risk reduction discourse also includes information and skill-building opportunities for the

sexually active, such as condom and contraceptive usage and STI/HIV testing. Risk reduction, then, supports a government of the body, an authoritative duty to be healthy.

Significantly, risk discourses and practices point to the continued medicalization of sex. First, the social and medical construction of sexuality continues to normalize and regulate sexuality. In the contemporary era of 'sexual health', the alliance of sex with health carries an assumption of authority, normativity and objectivity – there is a danger in attempting to establish a norm for sexual health as it defines certain people's behaviour as 'healthy' and therefore defines as 'unhealthy' all those who do not fit within the accepted norm (Schmidt, 1987). Hence, many sexual health education efforts are predicated on the incorrect assumption that there is a 'natural', 'good' and 'wholesome' sexuality that will be discovered, realized and even created if we establish proper educational conditions (Naus, 1989). Second, it brings to the sex education project an objectivity, authority and legitimacy. Just as educators of the early 20th century were eager to liken sex education to education about race and racial fitness, the current preoccupation with health is a comparable strategy to assuage adult fears and concerns. Given the controversial nature of the subject, educators, administrators, health providers, advocates and others are eager to define sex education within a health frame:

Some people may find it difficult to discuss youth sexual health because they confuse the terms 'sexual health' and 'sexual activity'. Many people in society are uncomfortable with the fact that young people are sexually active... In order to discuss and encourage the promotion of youth sexual health, we need to separate the concepts of sexual health and sexual activity (Nova Scotia Roundtable on Youth Sexual Health, 2006).

Indeed, as one educator put it:

... sex education is really not about that it's about health education. It's about, you know, understanding the social practices and sexual practices of teens, understanding, you know, pregnancy and birth control, sexual anatomy, sexual

transmittable infections, HIV, using condoms and so on (Sexual Health Educator, Quebec).

The separation of sexual health and sexual activity inserts an unquestioned medical and scientific objectivity into the sex education project and thus assuages persistent and on-going fears that talking of sex will incite sexual activity. In fact, the only reference to sex education in the Quebec Education Program is located in a unit called “The Living World” in the Mathematics, Science and Technology module, where students learn about the survival of the species (human reproduction) as well as contraception and sexually transmitted diseases. This unit is contextualized by and directly follows a unit on “Diversity of Life Forms” that includes education on species, evolution and habitat. Significantly, this strategy is historically continuous with and largely reminiscent of nature study approaches of the early twentieth century that aim to support ‘clean sexual enlightenment.’ The health-science paradigm, then, brings an acceptability to the sex education project and, since sex is perpetually caught in a problem-solution matrix, the paradigm also offers empirical answers. Given the focus on health, and on STIs and teen pregnancy in particular, sex is something rational, something that is administered, whether it is a prescription for the birth control pill, a vaccination or STI screening.

Indeed, the medicalization of sex significantly influences the ways in which the regime of sexual practices is and will continue to be organized around technologies of sex. Students are exposed to a range of contraceptive methods, though abortion, a method of birth control that extends as far back as to Ancient Greece (McLaren, 1990: 6), is not mentioned anywhere. Good contraceptive choices for young people include the pill (or one of the other, numerous hormonal methods) and the condom. Poor choices include withdrawal. There are two different ways of measuring the effectiveness of contraceptive

methods: perfect use (according to clinical guidelines) and typical use (based on the average user who may not always use the method correctly or consistently). In the case of 'perfect' contraceptive use, the pill is 99.7% effective, the male condom 98% effective, withdrawal 96% (Daillard, 2003: 4). Yet, withdrawal is deemed not effective, unreliable, not a contraceptive method, a myth method, and not recommended. While withdrawal perhaps should not be promoted as a primary method of pregnancy prevention since its 'typical' effectiveness is 73%, it is, however, a "great deal better than nothing" and is always available as a back-up method (Miller, 2003: 190). By not discussing withdrawal in terms of efficacy and advantages and disadvantages, like other pregnancy prevention methods, the reasons for which people choose it to prevent pregnancy - such as health risks, side effects and lack of availability of technological methods - are overlooked (Bissell, 2003: 192). Such an omission also supports a general mistrust in non-technological methods of pregnancy prevention as well as mistrust of male self-control (*ibid*).

And it would appear that there will be an intensification of this reliance on technological interventions: we have the condom, the pill and now the vaccine. On July 18, 2006, Health Canada approved the vaccine Gardasil, manufactured by Merck-Frosst, for females ages 6-26.²¹ In clinical trials, Gardasil has been shown to be 100% effective in preventing the cervical cancer causing strains 16 and 18 and about 99% effective in preventing the four strains of HPV (6, 11, 16, 18) that cause about 90% of genital warts (Kaiser Network, 2007). Following approval by Health Canada, a federal advisory committee recommended immunization of all girls between the ages of 9 and 13 and the

²¹ A second HPV vaccine, Cervarix (GlaxoSmithKline), is currently undergoing regulatory review by Health Canada.

federal budget that was passed March 20, 2007 included \$300 million of funding for an HPV vaccination program. The HPV vaccine has been enthusiastically supported by the Federation of Medical Women of Canada, Canadian Cancer Society, Society of Obstetricians and Gynecologists of Canada, and the Canadian Pediatric Association. Newfoundland and Labrador, Prince Edward Island, Nova Scotia, and Ontario have all begun school-based vaccination programs and educators have begun to include information on HPV and the vaccine in their programs:

I am adding the HPV vaccine to my presentation and advocating to youth to check out the information provided by Cancer Care Ontario, local Health Units and to talk to their doctor and health care providers about the advantages of getting the vaccine. Empowering them to make the choice and advocate for themselves with parents and health care providers, especially if they have drug coverage (Public Health Nurse, Ontario).

I have been enthusiastically promoting the HPV vaccination... Hopefully a school vaccination program will be implemented soon (Sexual Health Educator, Alberta).

In a recent commentary in the *Canadian Medical Association Journal*, Lippman *et al.* raise a number of questions and cautions regarding the HPV vaccine and the apparent rush to vaccinate. First, there is no epidemic of cervical cancer in Canada to warrant the sense of urgency for a vaccination program. As described in the previous chapter, cervical cancer is actually relatively rare. In addition, given its slow progression, cervical cancer can be detected early through regular pap screening and, in fact, most HPV infections clear spontaneously. Lastly, much like the chicken pox vaccine, the efficacy of and length of immunologic protection is unclear. However, the excitement around the discovery of the first cancer vaccination, combined with Merck-Frosst's savvy and aggressive marketing campaign, have largely marginalized this debate. Indeed, according to one woman's confession in a Merck Frosst advertisement, "I chose Gardasil because

I'm smart and I look after my health." By overstating a problem and presenting a solution, Merck extends its conventional economic pharmaceutical interests (Gardasil is one of the most expensive vaccines on the market at over \$400 for three shots) into the realm of public morality. Merck has successfully promoted its vaccine as a medical necessity – the company even lobbied state lawmakers in the U.S. to make Gardasil vaccination mandatory – a necessity which seems to be unquestionably taken up by many in the sexual health and cancer prevention fields. The influence of pharmaceutical interests on both public policy and public interest appears to be both great and effective and also, in an era of neoliberalism, points to a continued material emphasis on the body – particularly the female body. In addition, the HPV vaccination program is illustrative of the range of interests represented and articulated in the regime of sexual practices: the market economy, the school, the health care profession.

However, could the advent of the HPV vaccine signal a regime change? Could the vaccine sufficiently 'liberate' young women so that they may pursue and enjoy their sexuality without fear of cervical cancer? It would seem that an absence of fear around pregnancy afforded by other technologies, such as the pill, certainly hasn't changed the contours of the debate. The continued emphasis on the dangers of sex points to the persistence and resilience of the medico-moral discourse in the regime of practices.

Indeed, as was discussed in the previous chapter, health discourses work through morality discourses. Sexuality was a source of moral regulation long before it became medicalized – the religious confession was central to transforming sex into scientific and medical discourse – and as such, the current emphasis on 'sexual health' imports social and moral values. Thus, while the pill and the condom are promoted as good choices for

young people who are sexually active, abstinence is promoted as the best way to avoid the scourge of pregnancy and STIs/HIV. The conceptual problems with the abstinence strategy – what is abstinence? From what are young people abstaining? What does it mean to “use” abstinence? What is sex? - were described in the previous chapter. What is equally problematic is the frequently invoked message that abstinence is the only 100% effective method of pregnancy and STI/HIV prevention. As Cynthia Dailard points out, this pronouncement conflates theoretical effectiveness with the actual practice of abstinence (Dailard, 2003: 4). While ‘perfect’ use of abstinence is 100%, ‘typical’ use of abstinence is empirically unknown. Some understanding of typical use comes from an examination of the virginity pledge movement in the United States. According to the *National Longitudinal Survey of Youth*, many teens who intend to be abstinent fail to do so and of those surveyed who were married, most pledgers (88%) had vaginal intercourse before marriage (Santelli *et al.*, 2006: 76). The abstinence message – that abstinence is the best and surest way to avoid STIs, cervical cancer and pregnancy – is, on its own, with no qualifier or explanation, inaccurate and largely unrealistic. It is an important exemplar of the way in which ‘health’ is used to achieve moral ends. Put another way, as a strategy of normalization and discipline, the regime of practices “invokes ‘correct’ answers based on questions that were political ‘givens’” (Stronach *et al.*, 2007: 229).

The medicalization of sex and the ways in which morality discourses operate through health discourses also emphasize individual responsibility and accountability by emphasizing risk. On the one hand, adolescent risk taking is explained away: teens are described as incapable of judging the future consequences of current acts and as believing they are immortal, while it is assumed that most adults are better at looking to their own

future or evaluating the consequences of proximate risks (Patton, 1990: 75). However, such is not necessarily the case. According to an Ipsos-Reid survey of 1,243 single and divorced/separated/widowed Canadians age 30 and over, only 40% of sexually active singles use a condom “all of the time” and 25% never use a condom (Canada News Wire Group, 2006).

At the same time, the discourse of risk offers optimism in that one can reduce risk through responsible action (Tiefer, 1996: 266). Girls are to negotiate condom use with boys, though there is very little context to explain why girls are responsabilized in this way. Young people are to get regularly tested for STIs that are easily transmitted – as easily and casually as a handshake – in order to avoid horrific consequences that visibly mar the body, such as chlamydia in the eye or mouth. This particular use of fear – the invocation of images of diseased body parts – is historically coterminous with STI prevention efforts during both World Wars, where social hygienists stressed the horrors of VD with the use of slides. And the case study about the “unusual 15 year-old” who had acquired three STIs upon which she had to identify all eight of her sexual partners (some were virgins!) is a parable of “irresponsibility and danger (as demonized) as well as purity (as a cautionary tale)” (Stronach, *et al.*, 2007: 220). Such tactics support sharp polarity between health and disease, good and evil and, by setting up a direct relation between cause and effect, point to simple, graspable solutions (Mort, 1987: 213). As a dividing practice, these strategies regulated the population by disciplining the individual.

As a project of regulation, these strategies also provoke fear and anxiety. Any young person could be a vector of disease, STIs invade the body in ways that cannot be disguised, cervical cancer can mean the end of a young woman’s life. Such fear tactics

are clearly reminiscent of nineteenth and early twentieth century approaches to discussing venereal disease. And this emphasis on the dangers, in the name of health, very nearly eradicates any discussion of the pleasures of sex. As Michelle Fine points out in her influential analysis of school-based sex education in New York City, the ‘discourse of desire’ barely exists in the formal agenda of school-based sex education and, if expressed, is immediately followed up with a reminder of the consequences (the discourses of sexuality as violence, as victimization and as individual morality) (Fine, 1988). While a more sustained engagement with Fine’s analysis follows in chapter seven, in the present context, I would suggest that the discourses identified by Fine are micro-strategies that can be articulated through and by a macro-strategy of health. The discourse of ‘sexuality as health’ legitimizes the discourse of morality, vis-à-vis its pseudo-scientific frame, by emphasizing the risks of sex that victimize young people, such as HIV/STIs, and the inherent dangers of adolescent relationships. This latter point – the dangers of adolescent relationships – will be more fully explicated in the following chapter.

There is little doubt that it is for this reason that oral sex has become such a flashpoint. The so-called oral sex epidemic, an ‘epidemic’ based almost entirely on anecdotal accounts and speculation, forces the acknowledgement that pleasure is part of teen sexuality and the decisions that teens make about their relationships and their behaviours (McKay, 2004b). There is a range of reasons for which young people may have oral sex: it’s exciting and orgasmic; it reduces the risk for pregnancy and disease; it is less intimate since it doesn’t require nudity, an extensive amount of time or eye contact; it maintains virginity; it doesn’t require a trip to the gynecologist; and it isn’t

‘sex’ (Barrett, 2004; Gelperin, 2004; Remez, 2000). Yet, instead of considering and incorporating these reasons into classroom discussions, many educators emphasize the possible (but unlikely) risk of STIs and the profound and far-reaching reputational effects, particularly for girls, since girls who ‘do it’ are not marriage material. In addition to highlighting these physical and metaphysical harms, educators also aim to counter the apparent sexual casualness of young people by insisting that oral sex is sex. Indeed, young people who fail to recognize this fact are “flawed, duped, incompetent or victimized” (Curtis and Hunt, 2007: 17). Such a paternalistic approach disregards the ways and contexts in which young people make sense of and negotiate sexual relations. One curriculum document, a minority within the dominant discourse, explicates this point in detail:

...we must be careful not to construct the oral sex “phenomenon” through an adult lens, because the adult lens, as well as the feminist perspective, would have us believe that engaging in and performing oral sex on boys is degrading to girls. While this certainly may be the case in some instances, a majority of teenage girls would construct their reality of this activity as power-enhancing since she has the boy’s “most prized possession” in her mouth. This is not to deny that there still exist double standards regarding male and female sexual behaviours, which is another reason why sex education is vital to dispel myths and to cut through age-old double standards. While some teens may experience oral sex as a casual activity, anecdotally we know that most teens do it in the construction of a monogamous intimate relationship. It is important to keep in mind, however, the way in which long-term relationships and monogamy are defined by teens, and that they tend to be shorter in length than adults’. Thus, a changing of partners is more rapid than in adulthood (Mitelman, n.d.).

However, there is a pervasive tendency to view adolescent sexual activity and relationships through an adult lens. And as the next chapter will demonstrate, the dominant characterization of adolescent relationships is one of abuse, victimization and danger – often with disastrous consequences.

Chapter Six

The Regulated and Regulating Sexual Subject

As the preceding two chapters described, the main goal in the regime of sex education practices is STI/HIV and pregnancy prevention. The emphasis on the risks and dangers of sex supports a normalizing and regulatory school project as students are meant to learn about the various reasons for and methods of abstinence as well as 'safer sex' strategies.

However, sex education is not only about deploying information on 'healthy' sexual behaviour and about supporting behavioural change. The regime of practices organizes sexual identity and gender in particular ways; indeed, the school is a site for the production of gendered and sexualized identities (Kehily, 2002: 50). This chapter will discuss this discursive constitution of subjectivities and, in particular, the ways in which the regime of practices produces and regulates the heterosexual and gendered subject. In addition, the chapter will consider the ways in which the constitution of young people as regulated and regulating sexual subjects also converges with protectionist concerns regarding the transition from childhood to productive adulthood and responsible citizenship. The chapter will conclude with a discussion of the ways in which our current socio-cultural context informs the regime of practices and how, in particular, the school project is a project of anxiety.

Thus far, the regime of sexual practices has been described as heteronormative, as supporting a heterosexual sex education. The abstinence discourse, for example, promotes a narrow definition of sex and presents the heterosexual, married relationship as the proper place for sex. However, this is not to say that homosexuality is not addressed

in the classroom. Sexual orientation is, in fact, included in classroom practices and discourses but in very particular and specific ways.

By way of classroom preparation, teachers and educators are provided with background information on how to address homosexuality. A few curriculum documents note that there may be gay, lesbian, bisexual or questioning youth in the classroom - and that teachers should be sensitive to this fact (CRHA, 2006b; CRHA, 2006d; CRHA, 2006e). According to one document:

Do not assume that all students are heterosexual or that their family members or friends are all heterosexual. Remember that not all students come from two-parent traditionally structured families, that not all children live with their biological parents and that some children are conceived by assisted reproductive technologies (Toronto Public Health, 2006).

To accommodate this diversity, educators are often instructed to use 'gender neutral' names and pronouns (PPAE, 2006; Windsor-Essex County Health Unit, 2005: 5; OPHEA, 2000c: 8; Mitelman, n.d.; PPFC, 2001: 24, 180; CRHA, 2006f). For example, educators are urged to use inclusive language: 'partner' rather than 'girlfriend/boyfriend' and 'lifetime commitment' instead of 'marriage' (PPFC, 2001: 180). And as a 'sensitive' and 'controversial' topic, teachers are also provided with tips on how to deal with student questions regarding homosexuality. As one document warns "by avoiding students' questions about homosexuality, educators may give messages that increase isolation, loneliness and lower self-esteem for young people experiencing homosexual feelings" (OPHEA, 2000a: 165). At the same time, however, student questions about homosexuality are presented as a particular exemplar of 'shock questions' that are intended to embarrass the teacher, test his/her ability to stay cool, show off or test if s/he really means that there are no stupid questions (OPHEA, 2000b: 10). For example, the

teacher is instructed to deploy a tactful response to the ‘shock’ question ‘how do gays do it?’:

Have students identify different ways people can be sexual with one another. Discuss whether there are many differences between what same-sex and opposite sex partners can do. There are very few differences. This strategy answers the question in a respectful way and validates that we all express ourselves sexually in a variety of ways (OPHEA, 2000b: 10).

In addition to this background information, curricula may include activities on ‘respecting diversity’. For example, Grade 8 students in Nova Scotia are to “demonstrate acceptance of and appreciation for their own and others’ sexual orientation” (Nova Scotia Department of Education, 2000: 88) and Career and Life Management (CALM) students in Alberta are to “examine a range of behaviours and choices regarding sexual expression” (Alberta Learning, 2002b: 9). However, I suggest that these objectives are more about supporting an anti-homophobia education rather than a discussion on sexual identity formation, an anti-homophobia education that originated at the advent of the AIDS crisis when students were encouraged to show compassion, instead of fear, for persons living with HIV/AIDS. Anti-homophobia activities impart information on homophobia and heterosexism, aim to challenge myths and stereotypes and may also explore the ways in which one can support a friend who ‘comes out’ (CRHA, 2006e; PPAE, 2005; Wichman, 2005: 71-91; PPFC, 2001: 191-192, 208-217; Mitelman, n.d.).

Some teachers invite guest speakers:

It’s a support group [gay, lesbian and bisexual community group] and each year I have a spokesperson who comes out and talks to the class and he talks about what it was like for him to come out and he also talks about homophobic beliefs and how damaging they can be etc. He’s quite blunt. I think the students seem to appreciate the fact that he is blunt because it’s hard for them to distinguish fact from fiction when they’re being fed facts and fiction at the same time by other students. So I find that, that’s why I keep saying to them, you know, we’re going to have to look at some of these myths that you people have in your mind and see

why they and why you have them and what the danger is of having them (Teacher, Nova Scotia).

Another way to unpack these myths and to engender a conversation regarding the ways in which one can understand and challenge homophobia is the Sexual Orientation Visualization Activity (Windsor-Essex County Health Unit, 2005: 55-56; CRHA, 2006e; PPFC, 2001: 191-192) (see Table 24). In this case, the educator reads a story about a straight person living in a gay world (the sexual majority becomes the sexual minority) in order to illustrate daily and persistent experiences of stigma and to provoke compassion. This is a strategy, then, much like the one employed to shore up empathy for people living with HIV/AIDS; students, as compassionate citizens, are urged to love the sinner even if they might hate the sin. Upon hearing the story, students are asked to describe how the story made them feel and to consider the ways in which homophobia can be challenged. In this vein, some schools have established 'Gay-Straight Alliances', which are groups that "allow students to meet and talk about issues relating to sexual orientation, work together to make schools safer for lesbian, gay and bisexual students, and to provide and receive support for all orientations" (Jamieson, 2003). Mobilization around these issues has also led to institutional support. For example, the South Shore Regional School Board in Nova Scotia was the first (and to date only) school board in Canada to introduce a 'Homophobic Acts Procedure' in their human rights policy (South Shore Regional School Board, 2006).

Table 24 - Visualization Story (PPFC, 2001: 192)

It is a beautiful spring morning as you awake. You take a shower, dress, and sit down to your breakfast. You glance outside and enjoy the tulips and daffodils that are finally starting to grow. It is a school day, but unlike any other because today, for one day in your life, you are a heterosexual person living in a gay world—and you are the minority.

You don't feel any different, and you wonder how your day will go. You glance at a magazine and listen to the radio. It's almost time to go to school, but wait... a magazine ad catches your eye. Two women models hold each other, sensuously displaying bathrobes on sale for half price. The cartoon on the opposite page tells of a funny mishap in a family of two men and their dog. You listen again to the radio playing a catchy song about the love between two women and the distance that keeps them apart. The doorbell rings and you grab your coat. Your friends have arrived and it's time to leave for school.

On the way to school, your friends are talking about their latest same-sex love interests. It seems normal: no one is surprised and the conversation continues. You would like to tell your friends about what you did this weekend and about the cute opposite sex person that you met, but now you are kind of afraid of how your friends will react. When you arrive at school, you go to your locker. At the locker next to you there is a group of students laughing as a joke about heterosexuals is shared. You leave, wishing you could have told them to shut up.

On your way to class, a group of guys purposefully bump into you, and they tell you they hate heterosexuals and that you had better stay out of their way. You make your way to class and take a seat. Your teacher is asking everyone to get into small groups: today you are going to talk about the characteristics you would look for in a perfect life partner. You feel like you are being forced to lie. You don't feel that you can tell your group how you would look for someone of the opposite sex. You look out the window as the bright spring day continues...

Sexual diversity, then, is specifically included in the curriculum in an anti-homophobia and anti-heterosexism context. It is likely that this inclusion, though still controversial, has been facilitated by recent socio-cultural changes:

So, there's going to have to be a discussion about homophobia and homosexuality and so on and acceptance of that or not. That's always a touchy one because of course people's personal or religious beliefs kind of stand in the way of these things but kind of makes it interesting in Canada because of the various laws that have been coming out about gay marriage and so on and there's more television shows that have openly gay characters that are now portrayed in a positive light and not stereotypical anymore. They just sort of fit in. The main character may

happen to be gay, so, there's more acceptance happening in popular culture (Teacher, Quebec).

However, although critically important, I would argue that anti-homophobia education is less about sex education practices and fits more with the anti-bullying/safe schools agenda.²² On the whole, sex education is still very much a heterosexual education. While there may be a unit or a class on homophobia and/or the teacher may use gender neutral pronouns, there is little that addresses sexual identity formation, including behaviours, contexts and choices for gay youth, let alone consideration of the important differences between male and female homosexuality.

In fact, the rare appearance of the gay subject outside this anti-homophobia agenda supports the regulatory and disciplinary goals of the regime. For example, one instance supports the abstinence message, where gay youth are discouraged from sexual experimentation as a way to explore sexual identity (Healthy Sexuality Working Group, 2006: 8-9; Toronto Public Health, n.d.). In this case, while there is potential for discussing the complexity around sexual identity formation, the bottom line objective is 'don't do it':

Some teens rush into a sexual relationship as a way of proving to themselves and to others that they are not gay or lesbian. This pressure can often lead to unhealthy choices. As teens become increasingly aware of their sexual thoughts and feelings, attractions to the same sex often occur. Some teens know for sure that they are gay and lesbian while others may feel confused. Some teens develop a crush on someone of the same sex and some individuals engage in sex play with a same sex partner. Whatever your situation, it is a good idea to postpone intercourse until you know yourself better and know what you want (Toronto Public Health, n.d.).

²² Bullying is defined as repeated aggression in which there is a power differential (Juvonen & Graham, 2001; Olweus, 1991; Ppier & Craig, 2000). Over the past decade, there has been increased national and international concern for bullying and other forms of aggression and violence among youth. At present, there is a groundswell of Canadian activities at local, provincial, and national levels to prevent and reduce risks of bullying and victimization and more recently, the commitment to and development of a national strategy to reduce bullying in Canada (Craig and Pepler, 2007).

An additional example supports a disciplinary project by perpetuating the idea that gay men are vectors of disease:

Corry's boyfriend Jerrod recently noticed an unusual discharge from his penis. When he got tested, the results showed that he had Gonorrhea. He accused Corry of giving it to him since he'd been faithful to Corry. Corry had had sex with other partners, but doesn't have any symptoms. Jerrod would like Corry to get tested, but Corry doesn't want to. What should Jerrod do? (CRHA, 2006e; Thunder Bay District Health Unit, 2005: 131).

This isn't to say, however, that educators aren't interested in including more on sexual identity into the classroom:

Um, we would like to do a bit more on homosexuality, we do touch on it. We're hoping to do a bit more on that I think. (*What would that look like?*) What would that look like? Bringing that into the awareness of students. We tend to, when we get up in front of the classroom, we tend to discuss it more from a heterosexual point of view and there, you know, we know statistically that there are a few students in those classes who are homosexual and we need to, you know, maybe just make a brief statement that all of the information that we're covering today applies to not just heterosexual relationships but also homosexual relationships. That there's really no difference in information other than same sex couples don't have to worry about pregnancy. All the other things are the same, the decision making process, you know the use of condoms for the prevention of STIs, they are the same (Public Health Nurse, Ontario).

But there are significant barriers to a more inclusive approach. One is time:

[I wish I could spend more time on] homophobia, [sexual] orientation and stuff. Again, sometimes we only have 50 minutes or we only have an hour and a half and if you do a whole class just on that - and I think it's important for a lot of the youth to know about it but often we don't get much time to talk about it and that's something that I'm kind of passionate about and like to teach more of but we have to do what ever they want us to come in and talk about and often we only have that 50 minute talk; that an hour and a half talk and then we have to make the best use of that time (Sexual Health Educator, Alberta).

And an additional significant barrier is parental anxiety, particularly where this anxiety is articulated on the basis of religious belief:

Do you, in your experience because you have been doing this for a very long time, do you find parents opt their children out? No, no. But this year I had more

questions than I've ever had, overwhelming... A flood of parents on my doorstep, phoning. I had several refuse and then currently I have one parent that opted out. And I haven't talked to them. I had one last week that had opted out and I phoned her and she has opted in. *OK what do you think has brought on this flurry of parental concern?* Several things, most of them seem to be in some way affiliated with the Jehovah's Witness Church... The number one concern is that I'm going to talk about homosexuality as a lifestyle... I'd say probably 15 to 20 people questioned me on that (Teacher, Alberta).

However, it would appear that regardless of time constraints and regardless of the anxiety or discomfort experienced by parents or educators, homosexuality is becoming a more open practice that will inevitably have to be incorporated into the official discourses of the regime:

This year, for whatever reason, we got a lot of girls coming out as lesbian. I don't know if it seems to be a trend. In one particular class even... *(Are these girls that are identifying as lesbian fairly open about it?)* Very much so. Making out in hallways. There's one particular couple that when it's time to go to class, it's usually just a quick little kiss on the mouth but sometimes hugging. It's really interesting to watch and of course most of the kids or the teachers have never seen that and so they're all walking by staring. *(It doesn't seem to attract any kind of harassment?)* Not that I've noticed... nothing that I've heard and I would imagine that there hasn't been any because other girls have been willing to come out to their friends. So I'm guessing that there is a fair bit of support or because otherwise they wouldn't come out. Which I find is absolutely fascinating. I'm very happy about it... It's absolutely fascinating. I think it's a good thing. I don't know how many of the girls are actually lesbian [but] they're willing to say "Yes, I think I like girls". Nice (Teacher, Quebec).

While there appears to be support for anti-homophobia education, there is very little, if anything, that addresses homosexual sexual identity formation and practices. Because the homosexual is the 'other', the assumed student subject is heterosexual. As a normalizing discourse, sex education practices are largely heteronormative and support and produce heterosexual subjectivity. However, as more students are open about and practice their homosexuality, there may be shifts or spaces created within this dominant

discourse. The creation and implication of these spaces, based on lived student experience, will be further considered in the following chapter.

An additional goal of sex education is to consider how various other identity influences, such as gender, shape sexuality. For example, Grade 8 students in Nova Scotia “demonstrate an awareness of social influences that contribute to gender stereotyping” (Nova Scotia Department of Education, 2000: 88), Grade 10 students in Ontario “describe environmental influences on sexuality” (Ministry of Education, 1999: 15), and Grade 7 students in Alberta “identify the effects of social influences on sexuality and gender roles and equity” (Alberta Learning, 2002a: 12). As such, some curriculum documents include activities on gender stereotypes, sex role stereotyping and sexual stereotypes (CRHA, 2006b; PPFC, 2001: 181-183; Windsor-Essex County Health Unit, 2005). These activities aim to define gender, explicate the social influences on gender roles (what it means to ‘act like a man’ or ‘act like a woman’) and then critically evaluate how gender informs sexuality (see Table 25). Such a discussion can lead to consideration of the sexual scripts available to men and women:

Guys will say, boys will tell you that this guy who loses his virginity, it’s like a passage to manhood or that it is used as a positive thing. Whereas if a girl, you know, loses her virginity, it’s kind of seen as giving something up of themselves and they clearly tell us that in their peer groups that if a guy sleeps around with many women that he is a stud or player or a pimp which are all meant as a positive thing whereas a girl in the same grade level of the same thing, she is called derogatory names, like a whore, a slut and things like that (Public Health Nurse, Ontario).

Table 25 – Gender Stereotypes (CRHA, 2006b)

Many people assume that because you are a boy or girl you should look, dress, act, talk and even think and feel certain ways.

For example:

Girls are meant to be housewives when they grow up, not doctors or lawyers

Real men don't cry

Girls who are skinny are more sexy

Girls who wear skimpy clothes are lookin' for sex

Guys who have big muscles are more sexy

None of the above are true... this is just what some people think! Every boy or girl is unique, and has different dreams and goals in their life...

Building on this, one educator illustrated how sexual stereotypes are perpetuated, by discussing the reputations of boys who receive oral sex and the reputations of girls who give oral sex:

I say, "girls what do you think about the guys in this scenario?" Oh yah, they're cool; they're the ones with a good reputation. I say, "what do you think about the girls?" Ah they're sluts, they're whores, they're bitches, they're whatever, right? I said, "o.k. those girls are your peers and who is perpetuating the stereotypes?" They get so angry. Oh yeah, it's not fair. The girls get this reputation; the guys get this reputation but I said, "but who is perpetuating the stereotypes? You are doing it to your fellow peers, right?" So I want them to have a kind of a social awareness and a social consciousness about how these stereotypes get entrenched (Sexual Health Educator, Nova Scotia).

The discussion of gender stereotypes ('real men don't cry' and 'girls are meant to be housewives') as well as analysis of sexual scripts, that males are sexual agents, initiators, and subjects while females are passive, responsive, and objectified, though valuable, is rather static and dated. For example, there is a range of life choices and careers available to and practiced by women. And women are not wholly sexually passive and objectified in the contemporary context. Significantly, one activity aims to explicate more the complexity and diversity of gender role and gender relations by pointing out that, while

the dominant heterosexual discourse constructs men's sexuality as active and women's sexuality as passive (girls want love, boys want sex), several studies now show that girls also take initiative in relationships:

In adolescence, seduction seems increasingly to be a quest for power, based on sexual provocation and acting out... girls and boys perceive their power in ultra-femininity and ultra-masculinity. Sexual seduction is, therefore, the use of power willingly and knowingly, with the intention of being enticing and sometimes provocative (Gagnon, 2006: 2-3).

The activity goes on to describe how boys might interpret this seduction as signs that girls are sexually active and experienced and as an invitation to join in sexual adventures. Girls risk being labeled 'easy' and developing an 'affective dependence'. Girls, on the other hand, might criticize boys for their multiple conquests and boys who fail in seduction techniques may question their masculinity and sexual orientation. The pedagogical aim, then, is to help adolescents recognize how their peers interpret this seduction and its consequences; that sexual seduction does not create intimacy, but rather the illusion of intimacy; and that being their authentic selves is the most advantageous tool of attraction. In conclusion, the activity describes how "the desire to please and seduce is, of course, perfectly legitimate, as long as this seduction is not just sexual" (Gagnon, 2006: 7).

This description of gender roles, on the one hand, is quite progressive, particularly where links are made between male sexuality, masculinity and homophobia. On the other hand, it does little to challenge or weaken the gender order and the politics of masculinity and femininity. Girls, in particular, are expected to meet a certain standard of attractiveness, but not to be too provocative. And the onus of responsibility is on girls to monitor the ways in which they present their bodies and sexual selves to the world, rather

than on boys (and adult men, for that matter) to be conscious of the ways in which they react to the female body. Hence, adolescent women continue to be in the precarious position of needing to present themselves as desirable to men, though not desiring; sexually responsive to male desire as well as sexually responsible (Holland *et al.*, 1999).

In addition, the discussion of gender and gender roles, similar to the discussion of homosexuality, is not integrated throughout the curriculum. First, consciously or not, many sex education practices perpetuate gender stereotypes. While stand alone exercises may attempt to deconstruct gender stereotypes, particularly as they intersect with sex and sexuality, many sex education strategies rely on the deployment of sexual scripts. For example, as described in chapter four, the abstinence discourse is extraordinarily gendered. Young people are urged to postpone sexual intercourse in order to avoid guilt, regret, a loss of reputation – gendered effects that all support the sexual double standard. In order to ‘practice’ abstinence, young people are to acquire refusal skills, which, as was previously described, largely involve girls refusing the sexual advances of boys, thus supporting the idea of male activity and female passivity. In addition, the ‘just say no’ message does not address the feelings of power and vulnerability experienced by young women in the negotiation of femininity and heterosexual relationships - the ways in which young, heterosexual women validate themselves through dynamics of desirability which requires the confirmation of men (Kehily, 2002: 69).

Second, many topics are addressed in the absence of a gendered context. For example, as described in the previous chapter, students acquire information on contraceptive methods: how to use them and where to obtain them as well as their efficacy and cost. In the process of acquiring this technical information, there is little

consideration of the socio-cultural context within which the practice of acquiring and using contraception occurs. In the main, birth control is presented as a female responsibility. While many contraceptive methods are for female use, there is little discussion as to how males can assist and support their female partners to ensure their use. Even with male-controlled methods, such as the condom, females are put in a position where they must 'negotiate' condom use and persuade their male partners to use them. There is also little attention paid to the context within which contraception is acquired; it is assumed that if a young woman knows where the birth control clinic is, she will have the capacity to utilize its services. However, as one nurse put it, "there's still a huge thing that if you go and get contraception, for a girl, that means you are a slut" (Public Health Nurse, Alberta). Hence, the 'catch-22' that many young women face - that if they have birth control they are perceived as sluts, if they do not, they risk possible infection and/or pregnancy - is largely ignored (Bay-Cheng, 2003: 69). The expression of young women's sexuality, then, is regulated by their need to manage their sexual reputations (Lees, 1993; Tolman, 1994; Tolman, 2002).

In their totality, sex education practices support a gendered sexual subject. While there may be some recognition of the complexity of male gender identity – the intersection of male sexuality, masculinity and homophobia – for the most part, traditional gender roles, particularly those of women, are entrenched. Much like that of the heterosexual sexual subject, the discursive constitution of the gendered sexual subject supports a regulatory and normalizing school project. However, this discursive construction is not always reflective of student practices:

...there's this whole thing around not accepting a gender identity. They are kind of pan-sexual. They don't want to succumb to a label, so they created another one.

They are not identifying with anything that is currently in existence so they created this like “I’m not anything. I am who I am and I’ll be with whoever I want to be and I’m not going to think about it. It will just happen as it is”. Which I think is really interesting that they’ve moved away from even all of the rainbow communities’ identities to just say I’m kind of like this free flowing, you know, entity that will connect with others. (*Is that more in terms of practicing gender or practicing sexuality or both?*) I think it’s both and there seems to be more of a fluidity and it’s interesting because I don’t even think, it used to be that some of the dividers used to be culture or race and those aren’t the dividers anymore. There just seems to be a real blendedness that seems to be going on and it’s just sort of in my experience with the youth that I’m talking to, it just seems to be more inclusiveness or acceptance or (*acceptance of diversity*) (Sexual Health Educator, Nova Scotia).

Moreover, the ways in which the gendered and heteronormative subject is constituted intersects with broader social and protectionist concerns regarding the transition from childhood to productive adulthood and responsible citizenship. In this vein, any number of events - an STI, an unintended pregnancy, an unhealthy or abusive relationship – signifies the range of disastrous consequences from which young people must be protected.

Indeed, it is both the uncontrollable sexual instinct of youth sexuality and the causal power of teen sex - that it will lead to innumerable pathologies - that has the potential to disrupt the smooth transition from childhood to adulthood. As one educator put it, “key things we hope kids would take away, is an understanding that this is more than a recreational activity; it has a significant impact on your life presently and potentially in the future” (Sexual Health Educator, Alberta). Built into the project is a dialectical assumption between childhood innocence and the wisdom of age, a developmental narrative that valorizes adult/mature/civilized knowledge claims (Patton, 1996: 44). It is clear that teen pregnancy and STI/HIV would, in sum, ruin one’s life, as exemplified in Personal Lifeline activities (Calgary Pregnancy Crisis Centre, n.d.;

CRHA, 2006b; OPHEA, 2000a: 186; SHCCC, 2007). Personal Lifeline activities require students to plot major events, such as their first 'real' job, marriage, parenting, graduation, and travel, on a timeline and then to consider how teen pregnancy or STI/HIV would disrupt these plans and goals. To reinforce this message, educators discuss the range of consequences that teen parents face. In one document, students are to consider the costs of raising a child:

Based on estimates from the economics section of Manitoba Agriculture, the cost of raising a daughter to age 18 in 2004 was an average of \$166,549. For boys, the figure was slightly higher – at \$166,972 – due to extra costs for food (CRHA, 2006e).

In addition, students are to consider the health and economic risks associated with teenage pregnancy and teen parenting:

1. Babies born to mothers under 18 had a mortality rate in the first year of life that was 1.9 times higher than those born to mothers aged 20-24.
2. Low birth weight babies are more commonly born to mothers less than 15 years of age, occurring at about twice the rate of those born to 20-24 year old women.
3. Maternal complications during labour and delivery are slightly higher among 15-19 year old women than those aged 20-24 years.
4. Teenage mothers are less likely to complete their education and more likely to have limited career options (OPHEA, 2000b: 223).

One document makes the claim that it is safer for young women to use the birth control pill rather than to be pregnant, which points to the material and economic interests of the regime:

From a health perspective, it is safer to take the pill than it is to be pregnant. During the first three months of pregnancy, 7 out of 10 pregnant teens do not see a doctor or go to a clinic, placing the mother's health at risk. Adolescent mothers are at increased risk for low birth weight and pre-term infants, as well as infant death. Oral contraceptives are one of the best-studied medications ever prescribed. Very few women taking the pill experience any negative side effects. An even smaller minority experience severe health problems. For non-smoking women under the age of 35, it is safer to use the pill than to deliver a baby (CRHA, 2006e).

In its totality, then, teenage parenting is presented as an undesirable and onerous job. An overhead transparency used in one activity explicates this point in a style reminiscent of a help wanted advertisement: “Babysitter wanted. 24 hours a day, 7 days a week, 5 years straight. Having a baby is a hard job. And you can’t quit” (CRHA, 2006d). Only one activity recognized the complexity of the issue by also considering the ‘facilitating and enriching elements’ likely to influence the lives of young parents, such as the emergence of a meaning to life, the development of autonomy and maturity, the adoption of better lifestyle habits, and the feeling of attainment (Bérard, 2007: 7).

In the main, then, teen pregnancy is presented as a social ill, particularly given the risk of poor health and socio-economic outcomes that may lead to a reliance on social welfare. However, the problematization around teen pregnancy is historically specific; prior to the 1970s, the phrase ‘teen pregnancy’ was not used although there had always been unwed or teen mothers (Pillow, 2004: 17). This would seem to indicate a shift in conceptualizing illegitimacy from one in terms of marital status to one in terms of age. In the 1970s, teen pregnancy came to be conceptualized as an ‘epidemic’ – a conceptualization that was articulated by and through Statistics Canada commencing to collect ‘teen pregnancy’ statistics in 1974 (prior to 1974, the agency collected ‘birth data’), the establishment of the Family Planning Division of Canada Health and Welfare in 1972, which offered guidelines, consultation, funding and learning materials, and the adoption of provincial family planning policies throughout the decade (Orton, 1994). There was, then, a mutual creation and reinforcement of teens as a risk population and a state apparatus complete with resources for dealing with this group, made justifiable by way of counting bodies. Teen pregnancy was defined as a deviant behaviour, a

problematic consequence of sexual behaviour and one requiring adequate resources vis-à-vis governmental and administrative forms.

Teen pregnancy is still regarded as an ‘epidemic’ – or, at the very least, teen pregnancy rates are articulated as ‘unacceptably high’ - and teen parenting as undesirable. Ironically, total fertility rates in Canada reached their highest level in the postwar period in 1959 and declined every year thereafter (Wadhera and Silins, 1990: 27, 28). In fact, in Canada, the pregnancy rate for 15-19 year olds in 2002 was 33.9, the lowest in 14 years (and significantly lower than the rate of 53.4 in 1975) (Statistics Canada; Wadhera and Silins, 1990: 27). Like cervical cancer and HIV/AIDS, the anxiety around teen pregnancy – the idea that there is an ‘epidemic’ - is based on measures that empirically do not support the experiential reaction.

As classroom materials explicate, major concerns surrounding teen pregnancy are poor health and socio-economic outcomes for both mother and child. However, there are three problems with this articulation. First, research indicates that socio-economic disadvantage is correlated with but not necessarily a consequence of early childbearing; in fact, the negative consequences of teen pregnancy are largely dependent on race, ethnic background and income level rather than on maternal status (Bissell, 2000). In addition, research indicates that for women from disadvantaged backgrounds, the avoidance of a teen birth does not always improve future education or employment opportunities; hence there is little perceived economic incentive to delay childbearing (Bissell, 2000).

Second, the dominant discourse surrounding teen pregnancy and teen parenting obscures particular cultural contexts and specific social conditions:

Aboriginals acknowledged the vigour with which adolescent parenthood is frowned upon in the country at large. However, they were unwilling to censor Aboriginal women who become pregnant at early ages. Noting that early onset of parenting was common in traditional Aboriginal societies, participants agreed it is the breakdown in traditional support structures and values rather than teenage parenting per se which is responsible for the health and social problems teenage parents and their families often face (Dion Stout and Kipling, 1999).

Indeed, efforts to curb teen pregnancy in Aboriginal communities are sometimes perceived as importing white, southern values which is consistent with other practices of familial interference, from forced sterilization, to the removal of generations of Aboriginal children through the residential school system, to the uncountable children lost to the child welfare system (Ontario Federation of Indian Friendship Centres, 2002: 16). These efforts can also be perceived as clashing with Aboriginal values. For example, traditionally, all children are considered a gift from the Creator, and thus any critical response to pregnancy can be seen as disrespectful (*ibid*).

The final problem regarding the treatment of teen pregnancy and teen parenting in sex education practices is the conspicuous absence of abortion. Classroom materials rarely include information on abortion (or adoption, for that matter). This obscures the fact that a significant number of teens have abortions; in 2005, the induced abortion rate for 15-19 year old teens was 13.0 per 1,000 (Statistics Canada, 2008). In addition, it undermines the fact that teens often have questions and concerns about abortion; according to one educator “I always get questions about abortion” (Teacher, Quebec). The consequence of not including abortion in the classroom (unless a student asks a question about it) eclipses an opportunity also to discuss abortion as a form of birth control and the conditions under which abortion might be considered, such as contraceptive failure, misuse or lack of use and/or sexual assault. In the context of

Personal Lifeline activities, the exclusion of abortion also undermines a valid option whereby young women can avoid and be protected from the life altering perils of teen pregnancy.

However, it is not only imperative to protect the young from unintended pregnancy, but also from one another. Indeed, significant classroom time is dedicated to discussing relationships, in particular, what comprises a 'healthy' relationship and what comprises an 'unhealthy' relationship. A popular way to encourage consideration of healthy and unhealthy relationships is the Healthy vs. Unhealthy Relationships brainstorming activity, whereby students generate a list of characteristics that define a healthy relationship as well as characteristics that define an unhealthy relationship (CRHA, 2006d; CRHA, 2006e; Healthy Sexuality Working Group, 2006: 16-18; RNPHD, 1998d: 7-8; OPHEA, 2006c: 35; Windsor-Essex County Health Unit, 2005: 71-72; PPFC, 2001: 242-243; Mitelman, n.d.) (see Table 26). This activity is meant to encourage young people to reflect on ideal qualities in a dating partner, to consider how one might feel in a healthy or unhealthy relationship and to reflect on why someone might stay in an unhealthy relationship. The discussion on unhealthy relationships establishes the conditions for discussing abusive relationships and, in particular, sexual assault.

Table 26 – Relationships: Teacher Background Information (OPHEA, 2000c: 35)

How do you know if you are in a healthy or unhealthy relationship?

A healthy relationship is based on mutual respect, open communication and compatibility. One way of knowing if you are in a healthy or unhealthy relationship is to pay attention to how you feel when you are in the relationship.

Healthy Relationships: happy, relaxed, respected, confident, appreciated, accepted, energized, trusting, worthy, proud, satisfied, independent, interdependent

Unhealthy Relationships: unhappy, sad, nervous, scared, anxious, exhausted, disrespected, criticized, rejected, unworthy, ashamed, dependent, violated, abused

In fact, there is considerable emphasis in curricula on violence and sexual violence in relationships. Grade 9 students in Nova Scotia “identify and practice strategies for preventing sexual harassment or rape in dating relationships” (Nova Scotia Department of Education, 2000: 202) and grade 7, 8 and 9 students in Ontario as well as Grade 8, 9 and CALM students in Alberta will describe various types of harassment and abuse as well as solutions and strategies to address these forms of violence (Ministry of Education, 1999: 10, 18, 19; Alberta Learning, 2002a: 11; Alberta Learning, 2002b: 8). In particular, activities aim to define sexual assault and consent and address myths and stereotypes (Healthy Sexuality Working Group, 2006: 32-41; RNPHD, 1998d: 28-38; PPFC, 2001: 50-53, 377-378; CRHA, 2006d; SHCCC, 2007; Mitelman, no date) (see Table 27). Much emphasis is placed on the fact that most victims of sexual assault know their offender – depending on the source, anywhere from 79% to 90% of alleged offenders are known to the victim (RNPHD, 1998d: 33-34; CRHA, 2006d; SHCCC, 2007; Healthy Sexuality Working Group, 2006: 38). Some activities aim to provide advice on ‘safe dating’ (CRHA, 2006d; CRHA, 2006e; Healthy Sexuality Working Group, 2006: 38-39; SHCCC, 2007). For example, students are advised to: stay in places where other people

are around, be aware of the effects of substance use, know their limits around sexual activity, be honest with their dates and use assertive communication strategies (CRHA, 2006e).

Table 27 – Sexual Assault is a Criminal Offence (Healthy Sexuality Working Group, 2006: 32-34)

Any kind of sexual activity that the other person doesn't consent to is sexual assault. The legal definition of sexual assault includes (among other things): oral sex, vaginal sex, anal sex, touching, kissing, grabbing, masturbating another person, forcing another person to masturbate you, and masturbating over another person.

If you are sexually assaulted, it is never your fault. People who have been sexually assaulted often feel embarrassed or ashamed or that it is somehow their fault. It is not. No one "asks for it". You are not to blame because of the way you look, the clothes you were wearing, or where you were. You are not to blame because you were drinking or high. If you are sexually assaulted, the person who assaults you is committing a crime. Crime is the criminal's fault, not yours.

Anyone can be sexually assaulted – it makes no difference whether you are straight, gay, lesbian, bisexual, or transgender. Both males and females can be victims of sexual assault, and both males and females can commit sexual assault. No one has the right to force another person into having sex or any kind of sexual activity – not a partner, not a date, not a friend, not a relative, not a stranger.

Given the emphasis on the potential for abuse and assault, there is a clear emphasis on the possible dangers of teen relationships. The discussion on qualities to look for in a healthy relationship, by way of a brainstorming activity, is largely superficial and inconsequential given the emphasis on unhealthy relationships. Indeed, the contours of teen relationships are seldom addressed outside the paradigm of potential victimization. There is discussion of love, lust and infatuation that, significantly, normalizes the trajectory of teens' often short-lived romantic relationships:

It is developmentally appropriate for a teen to be in a lust relationship, since they often serve as practice for more mature relationships in the future. Teens can often use failed lust relationships to assess the undesirable aspects of such relationships (Thunder Bay District Health Unit, 2005: 84).

However, such discussions of love and lust are rare (Thunder Bay: 79-80, 83-86; PPFC, 2001: 247-250). On the whole, adolescents – particularly adolescent girls - are educated away from positions of sexual self-interest because they are the objects and potential victims of someone else's desire (Fine, 1988: 42).

Indeed, within this discourse of protection, girls are particularly responsabilized. The directives around 'safe dating' - know your limits around sexual activity, be honest with your date and use assertive communication strategies – specifically target girls. Some documents do promote 'safe dating' as a shared responsibility; for example, according to one document "it is always the guy's responsibility to control his behaviour and accept your sexual limits. It is the girl's responsibility to communicate these limits to him" (RNPHD, 1998d: 33-34). However, such an approach is not incorporated in, nor is it consistent across sex education practices. As such, reinforcing girls' ability and right to say 'no' is not enough if boys are not also taught to hear and understand the word 'no' (Whatley, 1987). Failure to do so implicitly exempts boys from such discussions, reinforces the tacit belief that male sexuality is biologically programmed and therefore unchangeable, and maintains the onus already placed on girls for managing and policing sexual behaviour (Bay-Cheng, 2003: 70).

The discourse of protection and the ways in which this discourse constitutes the subjectivity of girls, in particular, is informed by a wider context. Indeed, the school is a sexually saturated space, where the potential for sexual exploitation and inappropriateness haunts the classrooms and hallways. For example, one sex education program commenced as a result of cases of sexual interference between a teacher and a student:

One of the reasons that we threw that [information about student crushes on teachers] in there is because in our local community there have been some inappropriate relationships and you know boundaries were crossed and those teachers were actually – I don't know if they were formally charged yet – but they are going through the court system for sexual... what do they call it now? Not assault. (*Sexual interference?*) That's it. And so anyways they wanted us, non-school board reps., to help them with something that they recognize as a problem and what they were doing is teaching new teachers about appropriate versus inappropriate boundaries with students and wanting to protect themselves and then they were asking us, you know, as an outsider can you tell these kids that it is not appropriate (Public Health Nurse, Ontario).

And it is not only potential exploitative or inappropriate relationships between adult teachers and students that are cause for concern. Some educators are also concerned about an inappropriate age gap between students:

In grade 8 I tell them even in grade 8, I assume that you are not [sexually active] but that I am preparing you for high school because the grade 9s in this area are included in the high school and they're going to be with the grade 12 boys and... the grade 12 boys were like preda- they were like pedophiles with these grade 9 girls... And we do have a very high incidence of teen pregnancy in the area according to the Health Unit (Teacher, Alberta).

However, the potential for sexual exploitation and victimization also extends beyond the school walls and is deeply informed by wider socio-cultural concerns. Sex education practices aim to support a government of the self, a regulation of the self, through advice and directives that aim to enable students to conduct themselves in socially desirable ways when the eye of the school is not watching. This includes the deployment of advice that aims to prevent 'unsafe' dating practices and even advice to prevent child prostitution. Indeed, one curriculum document included a lesson on sexual exploitation in order to discuss the risk factors for turning to prostitution, the traits of pimps and recruiters, and what it's like to be a prostitute. The lesson is intended "to raise awareness in young people of the dangers and risks of the sex trade... [The aim] is

not to create fear but to increase knowledge and understanding so teens know how to avoid being approached and who to turn to for help” (CRHA, 2006d).

As a form of moral education, then, sex education practices aim to cultivate the responsible, healthy, respectful and disciplined subject – discourses that intersect with the new character education that has been recently introduced in both Alberta and Ontario (Ontario Ministry of Education, 2006; Alberta Learning, 2005). In fact, the goals of contemporary sex education and character education practices are mutually constitutive:

Character and citizenship education is a deliberate effort to cultivate civility, ethical behaviours, self-management skills and personal attributes that our society values in its school graduates, community members and employees. It represents a consensus on certain attributes or core values such as respect, responsibility, fairness, empathy and self-discipline that transcend socioeconomic and cultural lines (Alberta Learning, 2005: 1).

Character, then, as the visible outward sign of inner moral qualities, is, like sex, a project illustrative of the complex connection between ‘interior restraint’ – the disciplining of the will through practices of self-monitoring – and external conformity (Hunt, 1999: 156).

And as a project of anxiety, sex education practices also aim to regulate adolescent sexuality in an effort to restore social order and control. A convergence of elements sets conditions for intervention, including structural changes in inter-generational relations resulting from a prolonged period between childhood and adulthood (Hunt, 1999) that require a concomitant change in when and how sexual debut is appropriate. A clear exemplar is the recent change to Canada’s age of consent laws. Significantly renamed ‘age of protection’, the *Tackling Violent Crime Act* raised the age of consent from 14 to 16, though there is a close-in-age exception which would permit 14- and 15-year olds to engage in consensual, non-exploitive sexual activity with a partner who is less than five years older as well as clauses protecting marriages and

equivalent relationships. The *Act* aims to better protect youth from sexual predators in a range of spaces – predators who seek to lure the young on the streets as well as on-line predators in virtual spaces who aim to coerce the young into dangerous sexual encounters.²³ The *Act*, however, is not without controversy. When introduced in the House of Commons, proponents of Bill C-2 argued that the proposed new legislation would empower parents and law enforcement agencies to protect children under age 16 from sexual exploitation, would deter recruiters who aim to coerce the very young into prostitution, and would lead to more criminal convictions (Wong, 2006: 163-164). Opponents of the bill argued that the proposed legislation would result in an unwarranted restriction of the rights and privacy of youth and would discourage youth under the age of 16 from accessing preventative health care (e.g. birth control, STI testing) (Wong, 2006: 164). Opponents further pointed out that there is no evidence that raising the age of consent would better protect youth from sexual exploitation, that ‘age differential’ and not ‘age of consent’ should be the focus of legislation, and that it is the failure to enforce existing laws and not raising age of consent that needs to be addressed (*ibid*).

Thus, within and beyond the school walls, young people are constituted as sexual objects in need of protection, as articulated in sex education practices and legislative reform. In the context of a virtual epidemic of sexual exploitation of children, any situation can be construed as ‘abusive’ (Bauman, 1997: 150). While the concern regarding inappropriate sexual relationships in schools, for example, is nothing new (for example, see Curtis, 1994), it can affect the delivery of sex education practices. As one

²³ Changes to Canada’s age of consent laws were originally introduced by the Conservative government in Bill C-22 on June 22, 2006; however, the bill died once a federal election was called later that year. On October 18, 2007, the Conservative government re-introduced changes to age of consent as part of their Crime omnibus bill (*Tackling Violent Crime*). Bill C-2 received Royal Assent on February 28, 2008.

teacher stated, a potential barrier to or discomfort with teaching sex education is “due to recent cases of sexual interference by teachers with students - such cases contribute to a climate of trepidation and discomfort” (Teacher, Quebec).

This is not to say that children do not experience sexual abuse or sexual exploitation. Sexual abuse is real. It is a more a question of strategy and intention - how we conceptualize child sexuality, which includes responding to and raising awareness of child sexual abuse, as well as outcome and consequence, including the sexual sanitation of spaces and places and strained relationships. In the pursuit of protecting children, the question becomes what are the outcomes of our strategies? What strategies lead to what kinds of change? What are the intentions, consequences and unintended consequences of our strategies? It is precisely these questions of intention and consequence that will be revisited in the final chapter.

Chapter Seven

Beyond Desire as Interruption: Creating Transformative Spaces

“...the bottom line is that there’s too much on birth control and sexually transmitted infections and that’s only, I don’t know, 20% of the issue” (Sexual Health Educator, Alberta).

The preceding three chapters have described the ways in which the school project has been preoccupied with the dangers of sex, such as STIs, teen pregnancy or ‘unhealthy’ relationships that can disrupt the smooth transition from childhood to adulthood. Although best practices dictate that sex education should focus on the potential problems as well as the pleasures of sex, or, as Health Canada puts it, sex education should emphasize the ‘negative outcomes’ as well as the ‘positive outcomes’ of sex (Health Canada, 2003), it would seem that there is an absence of a discussion of the positive and pleasurable aspects of sexuality.

Such a conclusion is congruent with Michelle Fine’s ethnography of school-based sex education in New York. In her article *Sexuality, Schooling, and Adolescent Females: The Missing Discourse of Desire* (1988), Fine describes four major discourses of sexuality which characterize national debates over sex education and inform how sexuality is managed in schools. The first three discourses- sexuality as violence, sexuality as victimization and sexuality as individual morality - support the idea of sex as danger. Adolescent heterosexuality is equated with violence, such as abuse, incest, AIDS, and coercion (sexuality as violence); young women learn of their vulnerability to potential male predators and the subsequent need to defend themselves against disease, pregnancy, and “being used” (sexuality as victimization); and sex is treated as a test of self-control and self-respect (sexuality as individual morality). According to Fine, the

fourth discourse, the discourse of desire is largely absent from school-based sexuality programs. Naming desire, pleasure, and sexual entitlement barely exists in the formal agenda of school-based sex education. And any discussion of the pleasures of sex is immediately followed by a reminder of the consequences of sex; which is, according to Fine, 'desire as interruption'. Fine's thesis, the 'missing discourse of desire', has been readily deployed by other feminists in their analyses of school-based sex education (Allen, 2001; Allen, 2003; Bay-Cheng, 2003; Kehily, 2002; Thorogood, 2000; Connell, 2003).

In the current context, however, I wish to suggest that desire as interruption does not sufficiently capture the spaces that are created to discuss desire, pleasure and sexual entitlement. This dissertation has already alluded to the ways in which educators negotiate and resist the dominant discourse of sex as danger: the teacher who refuses to send permission letters home to parents; the educator who resists dominant conceptualizations of abstinence; the public health nurse who distributes condoms; the guest speaker who discusses homosexuality. This chapter will more fully explicate the ways in which desire, pleasure and sexual entitlement are fostered within the school walls, to create what I call 'transformative spaces'. 'Transformative spaces' refers to the physical and discursive spaces that are created as a result of critical pedagogical discourses and practices that empower students to discuss and negotiate their experiences, needs and limits. As the previous chapters have demonstrated, abstinence and risk reduction discourses are the dominant tactics that support the main strategy of teen pregnancy and STI prevention, as made possible by a convergence of interests which are sustained historically. At the same time, and as this chapter will describe, transformative

practices and discourses comprise a concurrent set of tactics that support the prevention message. These two sets of tactics are not illustrative of restrictive-permissive ideology; rather, they allude to the ways in which a range of interests are anchored in the regime. Grounded in and informed by critical pedagogy, transformative spaces, then, are not only about resisting the strategic selectivity of the regime – they do not operate solely as a form of resistance – they also have a distinct potential for challenging the dominant ways in which the regime of practices is organized and supported by health, risk and morality concerns.

Critical pedagogues argue that “school practices need to be informed by a public philosophy that addresses how to construct ideological and institutional conditions in which the lived experience of empowerment for the vast majority of student becomes the defining feature of schooling” (Giroux, 1999, 2). As such, critical pedagogy attempts to create new forms of knowledge through its emphasis on breaking down disciplines and creating interdisciplinary knowledge. Hence, it aims both to empower teachers and to teach for empowerment (McLaren, 2006). Critical pedagogy raises questions about the relationships between the margins and centers of power in schools. Critical pedagogues maintain that schools have always functioned in ways that rationalize the knowledge industry, in ways that reproduce class, race, ethnicity and gender relations (Giroux, 1981). In the current context, I suggest that the role of the school in processes of social reproduction also includes the reproduction of adult sexual anxiety. Critical pedagogy also aims to make curriculum knowledge responsive to everyday knowledge. Schools, then, are sites of possibility and classrooms provide the conditions for students’ self and social empowerment and, I would add, sexual empowerment. Critical pedagogy, then,

supports a dialectical understanding of schools – schools are sites for *both* domination and liberation. Specifically, a distinction is made between schooling and education: schooling is a mode of social control while education facilitates the social empowerment of the active subject (McLaren, 2006). This chapter, then, will describe the ways in which transformative spaces are made possible through critical pedagogical discourses and practices in two key ways: by challenging the organization and deployment of knowledge as a form of regulation and by supporting an approach to education that is dialogic and informed by student experience.

Significantly, critical pedagogy challenges the ways in which knowledge, discourse and power intersect in ways that produce historically specific modes of authority and forms of moral and social regulation (Giroux, 1989: 141). Specifically, there is distinct resistance to the idea of ‘sex as danger’. Several educators noted an inordinate focus on the ‘negative’ aspects of sex and sexuality, often at the expense of considering the ‘positive’ side of sexuality:

Something I think we should talk about that we don’t always get the chance, is talking about the positive side of sexuality, that it is a positive thing, that it’s healthy and to be able to explore that aspect of sexuality. That’s something we don’t often get to talk a lot about and the good feelings that go along with it. We spend so much time talking about the risks and what can happen. We should be talking about the good stuff, that it feels good and that’s OK (Sexual Health Educator, Ontario).

I think in an ideal world we’d all talk about sex with our kids in a way that, you know, honours them and doesn’t shame them and gives them, I don’t know, empowers them to make good decisions (Sexual Health Educator, Alberta).

In fact, several educators described the ways in which they attempt to incorporate the positive aspects of sexuality in their classroom discussions. Often referred to as a ‘sex positive’ approach to sex education, this incorporation of desire and pleasure

acknowledges and supports sexual entitlement and empowerment. According to one sexual health educator, being ‘sex positive’ means:

Having a comprehensive definition of sexuality; viewing sexual health as a basic human right, focusing on the life-enhancing aspects of sexuality as well as attention to the negative aspects, being non-judgmental and challenging narrow social constructs; using inclusive language rather than value-laden language which makes assumptions based on sexual orientation or gender stereotypes; [and] assisting individuals to be aware of the choices involved in sexual decisions (Tobin, 1997: 12).

With regard to classroom practices, one educator described how he frames his health promotion efforts with a ‘sex positive’ framework:

When I talk about [sex] I’ll say “You know, sex is wonderful, it feels good, it’s pleasurable, it’s orgasm, it’s all these things but there’s also some negative consequences of sex” and that’s when I bring in STIs and maybe pregnancies when we talk about youth and some other things and I’ll say “and that’s what we’re here to talk about, so you’ll know more about this stuff, have better skills, maybe better behaviour.” So I think we always talk about sex positively at the start of each workshop (Sexual Health Educator, Alberta).

A comparable approach is also reflected in the resource *Sex? A Healthy Sexuality*

Resource that is intended to be distributed to every student in the province of Nova

Scotia.²⁴ After discussing relationships, sexual violence, STDs and birth control options, the book concludes with the following message:

Sexuality is more than just sex. Sexuality is part of everyone’s personality and everyone’s life. It is a basic need and a part of being human. Sexuality includes everything in your daily life that makes you a sexual person – your gender, body, mind, spirit and emotions. Sexuality is about more than what you do. It’s about who you are and how you feel about yourself and your relationships with other people. Sexuality is about what feels right to you. It’s not about living up to someone else’s ideal or image. Your differences make you unique. They make you special. Your sexuality develops over time and will change as you grow and have new experiences. So what feels right to you will change, too. You matter.

²⁴ As described in chapter two, controversy regarding the content of the book resulted in a process whereby distribution issues were left to the discretion of each school board. The majority of school boards have agreed to distribute the book while both of Cape Breton’s English-speaking boards decided against distributing the resource to their students.

Take care of yourself, think about what is right for you, and enjoy your developing sexuality (Healthy Sexuality Working Group, 2006: 93).

While these approaches tend to operate as introductory or concluding remarks to an otherwise traditional discussion about sexual health, one educator described the way in which desire and pleasure provide a lens through which sex education happens. She described such a paradigm shift as follows:

I guess when I go in, as I always tell people that my goal is for kids to have the absolute best sex that they ever could. To me a lot of that is around safety as well and I'll talk about that, that you know when you're feeling safe, both physically and emotionally, sex is better, sex is hotter and I don't know... yeah that's what my goal is. Like I don't tell the kids that that my goal is so you can have the best sex ever but that's how I try and sort of approach it versus avoiding all the bad things instead of striving towards the best things, you know? In order to strive to a lot of that means waiting for people to figure out how to pleasure their own bodies, what makes their own body sort of tick and work and communicate with other people, that kind of thing. And that takes a lot of time and maturity kind of thing in a lot of cases... I don't know, I just think scaring the Jesus out of them around sexually transmitted infections is not a way to create change or empower people. You know, it's addressing some of the issues that are at hand, not that you can in an hour change their life by any means, but at least to get them to start thinking about things that they maybe just never reflected on before... (Sexual Health Educator, Alberta).

This challenge to the way in which sexual knowledge is organized and deployed in the classroom, then, serves two key functions: it helps to normalize sexuality and in doing so, it aims to support a health promotion message that is appealing and credible to youth (Tobin, 1997: 12-13).

Transformative spaces are also made possible by a critical pedagogical approach wherein education is dialogical. This is an approach to education where teacher and student are working with each other, as opposed to the 'banking' approach where the teacher makes 'deposits' in the student:

A careful analysis of the teacher-student relationship at any level, inside or outside the school, reveals its fundamentally *narrative* character. This relationship

involves a narrating Subject (the teacher) and patient, listening objects (the students). The contents, whether values or empirical dimensions of reality, tend in the process of being narrated to become lifeless and petrified...The teacher talks about reality as if it were motionless, static, compartmentalized, and predictable. Or else he expounds on a topic completely alien to the existential experience of the students. His task is to 'fill' the students with the contents of his narration (Freire, 1998: 54).

Instead, a dialogical approach begins "with the solution of the teacher-student contradiction, by reconciling the poles of the contradiction so that both are simultaneously teachers *and* students" (Freire, 1998: 53).

One educator facilitated a dialogical approach by having a conversation with students as opposed to following a lesson plan:

I'm not somebody that has a structured lesson plan. That doesn't work for me. Why it doesn't work for me is because I don't want to get hung up on reaching some goal or objective and get stressed if the conversation goes in a different direction and those [objectives] aren't met. What I want to do is have a free-flowing discussion and that's what I say I do. I have conversations with people. I don't do presentations. Period... To me it is about having an informative conversation; it's about correcting misinformation; it's about finding out what young people or young adults are concerned about; what's relevant to them and I want everyone to feel a level of comfort to be able to ask questions and get answers. That they need to have answers and it's not about making sure that I've told them every sexually transmitted infection that's out there... (Sexual Health Educator, Nova Scotia).

Another educator facilitated a class as a question and answer session:

I spent just recently two and a half hours in what was supposed to be a 45-minute junior high class... They did not let me go. They asked me every question I could possibly have come up with answers for in two and some hours (Sexual Health Educator, Alberta).

And a popular pedagogical practice that encourages young people to ask questions is the use of the anonymous question box. Several curriculum documents encourage the use of the anonymous question box in order to provide a way for students to ask questions related to sexuality without risking embarrassment or self-consciousness (Windsor-Essex

Health Unit, 2005: 10; City of Toronto; Toronto District School Board, 2002: 14; PPFC, 2001: 26; CRHA, 2006; Mitelman, n.d.) (see Table 28). For example, one teacher described setting up an anonymous question box that he called the 'everything you always wanted to know about sex but were afraid to ask' box.

Table 28 - Question Box (CRHA, 2006f)

Advantages of the question box:

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

The procedure is simple, but important to follow in detail:

1. Hand out identical slips of paper to each student (a small notepad works well).
2. Ask the students to write down any questions.
3. In order to prevent those with pressing questions from feeling uncomfortable, all students should write something on their slip of paper. If they don't have questions, encourage them to write feedback about how the class is progressing, or to write "no comment".
4. Pass around a container (e.g. a shoebox with "mail slot" in lid). Tell the students that you will answer the questions at the beginning of the next class period. This will give you time to research and prepare answers and to rephrase questions containing slang or shock terms.

In order to prepare the teacher, many curriculum documents cite a range of questions that students typically ask. As sexuality educator Stephanie Mitleman notes, student questions generally fall into six categories: what's true, what's right, what should I do, am I normal, can I hurt myself and how would I go about it (see Table 29).

Table 29 – What do they want to know? (Mitelman, n.d.)

What's true?

- "Is it true that you can get pregnant without having intercourse?"
- "Do girls like sex as much as boys?"
- "Do girls masturbate?"
- "Can you get diseases from oral sex?"
- "How do two men or two women have sex?"

What's right?

- "What do you think is the right age for sex?"
- "Is it OK to have sex even if you're not in love?"
- "How long into a relationship should people have sex?"
- "Are gays bad people?"
- "Do you think teenagers who are having sex are doing something wrong?"

What should I do?

- "What happens on a date?"
- "What kinds of things do you say to a girl when you are alone with her?"
- "If you're kissing and the other person puts their tongue in your mouth, does that mean they want to have sex with you?"
- "How can you tell if someone likes you?"
- "I am scared that if I don't have sex with my boyfriend he will dump me. What do I do?"

Am I normal?

- "Some guys are horny all the time. They have a problem, don't they?"
- "How does a guy know if he is gay?"
- "What happens if you are 13 and you still don't have breasts yet?"
- "Does everybody have pubic hair?"
- "How big is a penis supposed to be? Does it grow with the rest of your body?"

Can I hurt myself?

- "Does sex hurt?"
- "Is it safe to swallow sperm?"
- "How safe are condoms?"
- "If you have boners all the time, do you need to go to the doctor?"
- "Can you get AIDS and other STDs through oral sex?"

How would I go about it?

- "How do you know if you're doing it right?"
- "How do gay people have sex? What about two women?"
- "How do girls have orgasms?"
- "Are there certain ways a girl can turn a guy on without having sex?"
- "What are the best positions for sex?"

Significantly, the anonymous question box provides an important opportunity for students to ask questions about taboo and marginalized topics that are often excluded from curriculum documents, such as abortion or gay sex:

I've always had questions about abortion. Again a very touchy subject for a lot of people that I always preface with: "This is what abortion is. There are a lot of people who feel this way about it. I'm not telling anyone [that] it's right or wrong. We are going to have a discussion about it and everyone is going to have a different opinion... Generally, these topics are talked about in a very safe manner without getting into too much titillating details or disgusting details because you can sort of talk around some things (Teacher, Quebec).

Another [question] that happened to me at a school was how do gay people have sex? And the first time that I got that, I didn't know how to answer it. I was like on my toes that day, I tell you. I thought: does this student want to know sexual acts? and then I thought: if I answered by doing sexual acts and saying you know lesbians do this and bisexuals do this, you know, that would say that the relationship is all about sex and it is not. So the way that I chose to answer that was that there are many different ways that a couple can be sexually intimate with one another. That couples decide how they're going to be sexually intimate with one another. Not all homosexual couples decide that they're going to do a), b) and c). Just like all heterosexual couples aren't going to do a), b) and c). It is an individual choice that couples make (Public Health Nurse, Ontario).

In addition to these dialogical approaches – the conversation, the anonymous question box – recent changes to the Quebec sex education curriculum provide an opportunity for a whole-of-school dialogue on sex education. As of September 2005, the Personal and Social Development program, in which sex education was situated, was eliminated with the implementation of the new Quebec Education Program. The idea is to implement an interdisciplinary approach to sex education in Quebec schools. As such, the responsibility for sex education no longer falls on one professional, one teacher or a specific program, but rather becomes a responsibility assumed by all the members of the school team working in cooperation with each other and with partners in the community (Duquet, 2003: 23). So, on the topic of STD/AIDS prevention, for example, an English

language arts student could develop a research project; or a visual arts student could create an advertisement; or a science and technology student could evaluate the risk factors associated with different sexual behaviours (Duquet, 2003: 21). The merits of such an approach have been described as fostering the development of cross-curricular competencies, as providing an opportunity to group topics and issues together, and as providing an opportunity to share the responsibility for sex education amongst school personnel and community partners (Duquet, 2003: 22-23).

However, this new approach to sex education is not without its critics. A major concern is that the new approach will not be comprehensive enough if left to the discretion of individual teachers. To this end, a community-based youth health organization in Montreal launched a petition to reinstate formal sex education into Quebec schools (see Table 30). And according to one educator, despite the “beautiful vision” that the new model offers “there’s a real big difference... between what’s supposed to happen on paper and what actually does happen.” Indeed, the new approach has been described as challenging, especially with regard to the roles, responsibilities and training of teachers:

The issue is two-fold. One, it was never really clear who was sort of supposed to be in charge of all of this stuff. When you speak to the people who write the programs they say well it’s really up to the principal to be on top of this and to delegate who is going to do what and make sure that there is some level of consistency in the school because if we’re saying that anyone can teach, well, how do we know that first of all it’s actually taught and how do we know that every kid is kind of getting something similar across the board? So it was never really clear that it was the principal’s role to do that. Most schools I’ve spoken to don’t even know that that’s within their mandate to do. And the second piece is that there are lots of teachers who really do want to implement, you know and want to be involved in, you know, good sex ed. And, you know, and they are asked to do the subject with zero training: zero training at the university level and they get thrown into the schools with zero training with the schools. The schools don’t provide them with, school boards don’t provide them with appropriate

training and there's a lack of money and funds sort of across the board for this type of thing so the school boards will say that they don't have the money and they funnel it through individual schools and the individual schools will say they don't have the money and the teachers are, you know, some of them are left actually paying out of their pocket, you know, for resource materials and training (Sexual Health Educator, Quebec).

Table 30 – Petition to Save Sex Education (Head and Hands, 2006)

Did you know that Quebec's reforms to Quebec's public school education have in effect eliminated sexual education from the curriculum?

Quebec's education reform took full effect in September 2005. Consequently, students are no longer required to take a class that includes a sex education unit. In theory, essential sexual health information is to be integrated into regular classes. In reality teachers have been provided with little-to-no support to handle this. Teachers have to find their own methods of including sex education content into courses such as French, Geography, and Art. Given the lack of time, resources and training that is made available to teachers, Head & Hands thinks it is unlikely that students will receive adequate sex education.

Head & Hands believes that a proper understanding of sexuality is critical in reducing the rates of Sexually Transmitted Infections and unplanned pregnancies.

We are celebrating our 35th year of education and prevention work with youth in our communities. Support us by signing this petition, and let the Quebec Ministry of Education know that Quebec youth have a right to complete and accessible sex education in school. Please help us spread awareness by forwarding this petition to your friends and family.

TO: Monsieur Jean-Marc Fournier, Quebec Minister of Education
RE: Reforms to sex education

I recognize that a good sex education program is vital in preventing the spread of sexually transmitted infections, as well as unplanned pregnancies.

I, the undersigned, urge the Quebec Ministry of Education to reinstate in its required curriculum a sex education program that follows the Canada Health guidelines, stating that a good sex education program is:

- Accountable: including clear evaluation of material taught and learning outcomes.
- Diverse: teaching youth emotional and communication skills as well as health information.
- Structured: insuring clear course content and adequate class time and training for teachers.

I believe that Quebec youth have a fundamental right to complete and accessible education, in order to make informed decisions regarding their health and wellbeing.

At the same time, this new approach does present certain opportunities. For example, one teacher described the way in which sex education was brought into her math class:

We were talking about conversion - kilometres to millimeters - and it kind of led to a whole bunch of discussions about multiple babies and how you can have a baby girl and a baby boy. The kids were hilarious because they were asking me about things like hermaphrodites... and I was like "Wow, this is crazy" you know? It was a really good discussion and it lasted most of my math period and they thought it was the best math class ever... I've already had kids come up and say "How come you haven't talked about this in math? We don't talk about that in math. How come?" (Teacher, Quebec).

Such a conversation could very well be attributed to the interests and candidness of an individual teacher. However, this new approach to sex education may in fact facilitate the exploration of sex-related issues, rather than their dismissal as irrelevant to a particular lesson plan. A key question, however, is whether these conversations, in their aggregate, will comprise a comprehensive sex education.

In addition, this new approach to sex education has encouraged some teachers and educators to consider innovative ways for delivering sex education. For example, in one Quebec school, students are mandated to take a class called advisory, which was described as a cross between a homeroom class and a mentor-student relationship. Advisory occurs four times a week for 25 minutes. One Vice-Principal noted that advisory could provide a space and an opportunity to teach sex education:

I do think it is a potential way [to teach sex education] because it is happening for every student at the same time... And it's kind of, if built correctly, you can have a group of kids who work really well together and a community, depending on the chemistry in the class, right, which changes depending on the year. They can really support each other and you start building it early on. I wouldn't do sex ed until the very end once you have a familiarity, but if they have asked all sorts of other embarrassing questions and gone through activities where they have been sort of put on the spot and tried stuff, then when you get to that part they are much

more comfortable with each other than maybe in a [traditional] classroom setting (Vice-Principal, Quebec).

Indeed, advisory could also support an approach to sex education that is outside evaluative frameworks since advisory is not for credit and students do not earn grades. Such an approach embraces the rejection of an emphasis on scientific predictability and measurement by critical pedagogy, which is a particularly fruitful approach to a subject like sex education:

Teaching sexual and reproductive health education is not like teaching math or physics where the answer is right or wrong. We cannot teach someone to be, or not to be sexual, for we are sexual beings from the day we are born. Rather, teachers have the more difficult role of empowering youth with accurate information so they can make the best decisions for themselves (PPFC, 2001: 24).

The goal of empowering youth is not only accomplished by providing information, it is also accomplished by supporting a discourse of experience. The discourse of experience supports a view of pedagogy and empowerment that allows students to draw upon their own experiences. This mode of pedagogy, as an emancipatory curriculum, enables students to play an active role as producers of knowledge and to engage their knowledge and experience in order to authorize their own voices and social identities (Giroux, 1989: 148-149).

One educator described how she has increasingly turned to her students as a source of information and expertise:

When there's a lull [in the class], I'll say "Talk to me about what's going on; what are you guys experiencing?; what's new?; what's out there?; what do I need to know about it as a sexual health educator?" Because really they're the experts and as I get older they become more the experts because the older I get the further I'm removed from their experience... (Sexual Health Educator, Nova Scotia).

However, a more systematic approach is evident in two Nova Scotia initiatives: the Nova Scotia Round Table on Youth Sexual Health and the Nova Scotia Youth Health

Centre model. The Nova Scotia Round Table on Youth Sexual Health was established in 1997 following the release of *Just Loosen Up and Start Talking*, a report generated from interviews gathered from 220 Nova Scotia youth regarding their sexual health needs:

The purpose of this multi-sectorial group of health professionals, educators, government and non-government policy and program staff was to collectively identify ways to respond to the advice from Nova Scotian youth for improving their sexual health. “Just Loosen Up and Start Talking,” emphasized the need for collaborative action. It also emphasized the need to start dialogue, using the information, insight and experience of Nova Scotia youth. Underscored was the necessity of involving and supporting youth in being active and valued partners in determining their sexual health (Nova Scotia Round Table on Youth Sexual Health, 1999).

The Round Table emerged out of youth experience and aimed to include youth experience by bringing young people to the table. Since its establishment in 1997, the Round Table released a second report, *Just Loosen Up and Keep Talking* which provides communication materials useful to presenters in order to increase awareness and create community receptivity to youth sexual health. In 2006, the Round Table released the *Framework for Action: Youth Sexual Health in Nova Scotia*. Premised on the fact that youth continue to be at risk for poor health outcomes stemming from their lack of knowledge or ability to apply knowledge, as well as broader gender-based expectations about sexual norms and behaviours, the purpose of the *Framework* is to provide a rationale and strategic direction for a comprehensive approach to sexual health education, services, and supports for all youth throughout Nova Scotia (Nova Scotia Round Table on Youth Sexual Health, 2006: 7). A key strategic objective is youth involvement and participation in each of these domains, that youth will be meaningfully engaged in policy, programs, service delivery, supports and education (Nova Scotia Round Table on Youth Sexual Health, 2006: 27). As one educator noted, the involvement of youth in the

implementation of the *Framework* is effective, in that it allows adults to hear “This is what I want and this is what I need” rather than adults saying “Well, youth need this”.

The Youth Health Centre model in Nova Scotia also adopts an explicitly student-centred approach. Youth Health Centres provide health promotion, health education and health counseling and support services on a range of issues, including those related to sex, such as dispensing birth control, providing STI testing and treatment, and counselling on pregnancy options or sexual orientation as well as non-sexual matters, such as eating disorders and suicide intervention (see Table 31). Youth Health Centres are staffed by a public health nurse and student volunteers and rely on a specific youth-centred approach:

A youth centred approach means that youth are engaged. Youth engagement is when youth meaningfully participate in all aspects of the youth health centre, including governance, program planning and implementation, evaluation, building partnerships, and communication. Youth health centres deliver programs and services in response to the needs and interests of youth... A truly youth centred environment enables young people to act as initiators and to share the decision making process with adults. Most importantly, engaged youth assure that the decisions made concerning youth health centres accurately reflect the needs of the young people they serve (Nova Scotia Health Promotion and Protection, 2006: 11).

Currently, there are 41 Youth Health Centres in the province; 37 are school-based and four are community-based. The fact that a majority of these centres are school-based means that students can access health services during the school day and receive continuity in care:

I’m all for teen health centres. I’m all for the fact that they’ve got somebody on site that is a medical professional... that they can address not only sexual health but they’ve got the opportunity to build a rapport with the kids so that if they come in with a sexual health issue, they may also be identifying a mental health issue that interferes with sexual health decision making; they may be able to identify an alcoholic or drug issue that could be interfering with sexual reproductive health. So they actually have an opportunity to address it in a more

holistic manner. So they're seeing the sexual piece within the context of a whole person's experience (Sexual Health Educator, Nova Scotia).

In their totality, then, Youth Health Centres foster student empowerment through their operations framework – the youth centred approach – and facilitate sexual competency through the availability of services within the school walls.

Table 31 – Youth Health Centre @ Halifax West (Halifax West Youth Health Centre, 2004)

What is the Youth Health Centre?

The Youth Health Centre is an area of the school dedicated to the health and wellbeing of students of Halifax West High School and its feeder schools. It is located in room A274. There are couches, and pamphlets in the waiting area. Feel free to stop by, hang out, and get some information!

How do you See the Public Health Nurse?

- Make an appointment.
- Drop in during the hours that the Youth Health Centre is open.
- Be referred by guidance counselors, parents and other school staff.
- Go by yourself or in a group.
- Bring a friend if you don't want to go alone.

What Else Should I know?

- After hour appointments are available.
- Visits are an excused absence.
- We are open most afternoons.
- You can sign up for appointments during the lunch hour.
- Don't be afraid to just drop in and say hi!

Who Needs to Know?

No one! Whatever you discuss with the nurse is confidential. This means that the nurse will not tell anyone what you have said and won't tell anyone you came to see her unless if she has your permission to do otherwise. EXCEPT: if you threaten to harm yourself or anybody else; child abuse or incest. (If you have questions about this ask the nurse. The nurse will tell you what they must report by law.)

Get Involved!

Get involved in one of our programs as a volunteer or member. We are always looking for new ideas, and more hands to help with the many programs we are running. Your opinion is important to us. Join the Youth Health Center School Committee, and help make decisions on what you want in Youth Health Centre. You can sign up on the Youth Health Centre's website or stop by the center. You can also leave your suggestions on the website or at the centre.

In sum, transformative spaces are made possible through critical pedagogical discourses and practices in two key ways. These practices and discourses resist the dominant way in which knowledge is organized and deployed as a form of moral regulation and support an approach to education that is dialogic and informed by student experience. As mentioned at the beginning of this chapter, these discourses and practices operate alongside abstinence and risk reduction tactics, though they often aim to achieve the same goal of teen pregnancy and STI prevention. Nonetheless, these transformative spaces have a distinct potential for challenging the dominant ways in which the regime of practices is organized and supported by health, risk and morality concerns. Might this, then, signal the possibility, the space, for a regime change? Might this internal contradiction disrupt practices and interests? Indeed, delineating practices of freedom by which one could define sexual pleasure and passionate relationships is the key to the counterattack against the deployment of sexuality (Foucault, 1989: 433). Are transformative spaces, then, practices of freedom? Can these transformative spaces change the ways in which the health-risk-morality nexus shapes and is shaped by a strategy of teen pregnancy and STI prevention?

These transformative spaces do have a particular historical specificity – they are linked in their logic to previous practices: the mothers of the turn of the 20th century who explained nocturnal emissions to their sons; the 1940s teacher who provided menstruation information to her female students; and the teachers of the 1970s who provided secondary students with information on birth control and contraception. While these practices may provide internal differentiation, historical unevenness and internal

contradiction, they do not necessarily disrupt the sexual order. Specifically, these practices have not successfully resolved three key tensions.

First, sex education continues to be a project of anxiety. There is still concern, even within these transformative spaces, that speaking of sex may lead to sexual experimentation and that sex education practices should articulate ‘clean sexual enlightenment’. While it is quite revolutionary to hear of an educator who tries to teach sex education with the goal of ensuring students have the “absolute best sex that they ever could”, she doesn’t inform her students that this is her goal. And while a teacher may set up an anonymous question box in his classroom, he also aims to address questions “in a very safe manner without getting into too much titillating details or disgusting details”. In addition, teachers are cautioned to review all anonymous questions before answering them in class, in order “to avoid being caught off guard” and to have time to “rephrase questions containing slang or shock terms”. The anxiety concerning the link between speaking of sex and sexual experimentation is succinctly captured in the words of one teacher: “you’ve got to be careful because you don’t know which [students] you are giving ideas to and which ones you are educating” (Teacher, Quebec).

The second tension, which is related to the first, is that there continue to be significant limitations on the delivery and practice of sex education. Consistent with survey results of the Canadian Education Association (1964 and 1977), the Vanier Institute for the Family (1971) and Planned Parenthood Federation of Canada (1984)²⁵ as well as research studies (for example, see McKay and Barrett, 1999), teachers continue to report that they do not have the time and appropriate training and resources with which to

²⁵ Please refer to Chapter Two for a full summary and discussion of these surveys.

teach sex education. While this concern was articulated in this chapter in the context of sex education reforms in the province of Quebec – it is unclear whether or not students will receive adequate sex education as a result of limitations on time, resources and training, as further exacerbated by the new program – these concerns are not unique to the province of Quebec. They were also articulated by teachers, educators and public health nurses in the three other provinces under study:

Teachers don't put sexual health in high priority.... And they are not given any training, you know, and background and support and a lot of time they are just doing it on their own. I mean it would be really good if it were more mandated within health and the school (Public Health Nurse, Alberta).

So there are no standards... Like nobody is saying if you are going to teach sex ed. go to this web site and use these resources. They are left to completely go wherever to find whatever resources (Sexual Health Educator, Nova Scotia).

What we're finding is that not all curriculum is created equal and for whatever reason, the curriculum is so jam-packed with other things, especially literacy, that [sex education is] often left until the end [of the school year] and if the teachers run out of time, they don't see it as an equal because it is not something that's tested and it's not something they have the resources for (Public Health Nurse, Ontario).

Third, these practices and discourses do not disrupt the linking of 'sex' with 'health'. These practices and discourses continue to support a regulatory function. For example, 'sex positive' discourses are deployed through a health promotion lens. And according to the 'Petition to Save Sex Education', the 'right' to sex education is clearly framed as a strategy in order to reduce rates of STIs and unplanned pregnancies.

Similarly, the key rationale for the *Framework for Action: Youth Sexual Health* is the fact that youth continue to be at risk of poor health outcomes stemming from their lack of knowledge or ability to apply knowledge. As I have argued in this dissertation, the health project is not morally neutral given its normative and regulatory dimensions. However, it

bears repeating that this reliance on the health discourse is also likely strategic. As one educator put it, “there will always be some opposition in the field of sexual health.” Thus, framing sex as an area of health frees it for objective, less emotional study and consideration (Szasz, 1980: 122). ‘Sexual health’ inserts legitimacy into the school project and is a way to buy credibility with adults; it is a way to assuage adult fears and anxieties.

Hence, the transformative spaces in the regime of practices do not resolve these tensions. However, an even more fundamental issue that prevents a shift in play, a shift towards practices of freedom, is the strategic selectivity of the regime. Because the main strategy is one of teen pregnancy and STI prevention, the focus is on behaviour and behaviour change. It is precisely this focus that has led to charges of sex education as a failed project. The next and final chapter will engage with this debate: is sex education a failed project?

Chapter Eight

A Failed Project?

“In effect, ‘sex education’ becomes the impossible object, forever rehearsing its own postponement – as the sexual act, the sexual relationship – in a series of paradoxical education events that exhibit, inhibit and prohibit its subject matter. Little wonder that it ‘does not work’ since it is far from clear what it is supposed to be doing, educationally speaking” (Stronach et al., 2007: 228).

“This is clearly an area where good intentions are not enough. Too quickly, programs can become the empty rituals that serve to lessen the anxieties of parents and educators (i.e., “something is being done”) and, at the same time, only reinforce the children and adolescents’ already well-developed belief in the unhealthy and hypocritical posture of adults toward sex” (Gagnon and Simon, 2005: 90).

“Projects of governance consist first and foremost of “attempts” that are always “productive” in the sense that their limited successes and failures induce further attempts” (Hunt, 1998: 583).

Rather than relying on ‘restrictive’ and ‘permissive’ ideology to explicate the state of sex education – ideologies that invoke internal cohesiveness and a uniformity of subjects - this dissertation proposed that sex education can be understood as a ‘regime of practices’. As a summary concept, with no over-riding sense of rules, ‘regime’ enables the diagnosis of historically specific local strategies that shape and are shaped by global strategies; a dialectic between structure and practice. In turn, the identification of the strategic selectivity of the regime enables the elucidation of a range of interests, as well as the ways in which the strategic selectivity of the regime constitutes regulated and regulating subjects.

By deploying regime analysis, this dissertation describes how the school project is framed by a strategy of STI and teen pregnancy prevention that, in its historical context, informs and is informed by health, risk and morality concerns. Although values clarification – a pedagogical approach that aims to be value free and value neutral –

rather than approaches that aim to indoctrinate morally is the preferred approach to teaching sex education in Canada, I have argued that there is a mixing of the values clarification and moral indoctrination approaches. In fact, certain decisions and choices are presented as ‘good’ and ‘healthy’ choices to young people.

Specifically, abstinence and risk reduction discourses support the strategic selectivity of the regime. Students are meant to learn that abstinence is a ‘good’ and ‘healthy’ choice in order to avoid the physical, mental, social and spiritual consequences of sex. The concern around HPV-induced cervical cancer is an exemplar of a medical model of abstinence, whereby medical ‘truths’ are deployed to support abstinence as a wise choice. And for those students who are sexually active or who will become sexually active, classroom discussions promote specific kinds of contraception and birth control methods, promote STI/HIV testing and support specific ‘no’ or ‘low’ risk sexual acts and behaviours, with the exception of oral sex, since its acknowledgement as a ‘low risk’ sexual behaviour would require the recognition of sexual pleasure in the lives of young people. As articulated by a coalition of interests, this project of governance, these practices, along with those that emphasize the potential for sexual violence in the lives of young people, aim to address the tension and anxiety surrounding the transition from childhood to adulthood, thus constituting the regulated and regulating, gendered and heteronormative, sexual subject. As a project of anxiety, these practices aim to foster both self control and social control: for example, the intensification of society’s ability to regulate adolescent sexual behaviour through legal control (the new ‘age of protection’ law) when combined with sex education, teaches adolescents to police themselves and each other.

At the same time, some educators do, in fact, negotiate and resist this dominant discourse of 'sex as danger.' In the regime of sexual practices, physical and discursive spaces are created as a result of critical pedagogical discourses and practices that empower students to discuss and negotiate their experiences, needs and limits. These 'transformative spaces' facilitate a resistance to the dominant way in which knowledge is organized and deployed as a form of regulation and support an approach to education that is both dialogic and informed by student experience. However, although these practices and discourses have a distinct potential, they do not signal a regime change. Because these transformative spaces continue to support the main strategy of STI and teen pregnancy prevention, they do not resolve the linking of 'sex' with 'health.' Nor do they challenge the idea that the school project is one of anxiety since, for example, concerns still abound that speaking of sex will incite sexual activity, concerns that are not empirically supported.

Hence, certain challenges to the school project persist. A key challenge is the fact that sex education continues to be a controversial topic. After a slow and fragmentary introduction into the public schools, educators and school administrators still struggle with the 'what' and the 'how' of sex education. In the main, the school project has been a reactionary one, deemed necessary by 'soaring' rates of STIs during both World Wars as well as by teen pregnancy, HIV/AIDS and oral sex 'epidemics', reactions that are not sustained empirically. And although the school project has been justified vis-à-vis these epidemics, in concert with the perceived inability of parents to provide sex education to their children, sex education is still considered a controversial topic and is often marginalized, in terms of classroom time, teacher training and learning resources.

At the same time, the invocation of an epidemic logic has not only provided an opportunity to talk about sex, an ‘incitement to discourse’, but it has also made the school project more palatable. Proponents of sex education have been able to justify their efforts strategically in order to curb undesirable and socially and economically costly outcomes. Indeed, the prevention of disease and the prevention of ‘children having children’ rationalize the school project: how can one argue with these aims? Sex is a ‘health’ issue; after all, sex education is not about sex, it is about health education.

Given the intensification of the medicalization of sex, there is little doubt that the measurable aspects of STI and teen pregnancy prevention also justify the school project. With objectivity, the state of adolescent sexual health can be quantified by the presence of disease and the absence of pregnancy, a biopolitical tactic that provides a rationale for intervention. In addition, the act of counting attributes of bodies provides indicators that measure the effectiveness of sex education efforts, to ascertain whether sex education ‘works’ or not. This, of course, begs the question: does sex education ‘work’?

Several sex education programs have been ‘rigorously’ evaluated in order to determine whether or not they effectively delay sexual intercourse, improve birth control use and foster a greater reliance on safer sex strategies in order to reduce the incidence of teen pregnancy and STIs. The question, do these programs work, and the corresponding answer, is hotly contested and fiercely debated, and certainly points to the critical role of the media in presenting ‘morality as melodrama’, by attempting to identify problems and possible solutions (Mort, 1987 : 213). In an article in 1994, that received considerable attention in the popular press, Barbara Dafoe argued that ‘comprehensive’ sex education programs that provide information on contraception and safer sex had not influenced

adolescent sexual behaviour and concluded by calling for an exclusive focus on abstinence (Dafoe, 1994). Critics of her conclusions were quick to point out that Dafoe inaccurately cited the program *Postponing Sexual Involvement* as an example of a successful abstinence program and also misled readers by omitting research that clearly indicated the efficacy of comprehensive approaches to sex education (McKay, 1994). More recently, a meta-analytic study conducted by Canadian researchers in 2002 that also garnered national media attention, demonstrated that sex education and, in particular, pregnancy prevention programs, do not work (Dicenso, *et al.*, 2002). The findings of this study were largely refuted by explicating methodological problems; for example, by identifying certain programs that were not included in the meta-analysis and questioning those programs that were included in the study (McKay, *et al.*, 2001).

Indeed, proponents of ‘comprehensive’ sex education frequently rely on the work of Douglas Kirby who has generated the most comprehensive reviews to date that measure the impact of curriculum-based sex and HIV education programs for youth. Kirby (2001, 2007) identifies the following key curriculum goals and objectives of effective sex and HIV education programs:

1. Focus on clear health goals – the prevention of STD/HIV and/or pregnancy.
2. Focus narrowly on specific behaviours leading to these health goals (e.g. abstaining from sex or using condoms or other contraceptives), give clear messages about these behaviours, and address situations and social pressures that might lead to them and how to avoid them (e.g. communication, negotiation and refusal skills).
3. Address multiple sexual psychosocial risk and protective factors affecting sexual behaviours (e.g. knowledge, perceived risks, values, attitudes, perceived norms, and self-efficacy) (Kirby, 2001; Kirby 2007).

Hence, programs that effectively target these objectives have a greater propensity for delaying or decreasing sexual behaviours or increasing condom or contraceptive use.

However, even with such seemingly conclusive *knowledge* about the efficacy of sex education programs, it is uncertain whether these practices curb undesirable sexual *behaviour* and support desirable sexual behaviour. As one teacher lamented:

I said to our health nurse one day, with all this information that's being given out and all of our efforts, why is it that we're still seeing STDs and STIs? We're still seeing pregnancies. And she said, you know, we're not making the impression that we thought we would make. I just found that kind of frightening. You know, like how can that be because, to me, we're doing a lot and we're still not seeing the results (Teacher, Nova Scotia).

Of course, school-based sex education efforts do not exist in a socio-cultural vacuum; in addition to sex education, teen pregnancy and STI rates are determined by a range of influences, including societal attitudes towards adolescent sexuality, socio-economic factors, access to sexual health services, and access to educational assistance programs (Darroch *et al.*, 2001).

But it would seem that it is precisely this focus on STI and pregnancy prevention that is a major obstacle to 'effective' sex education, since the concomitant focus is one of behavioural change. In its historical context, sex education has been an instrument for sexual and social reform with a goal of supporting improvement in behaviour and not necessarily one of fostering sexual enlightenment (Moran, 2000: 219). The medico-moral discourse has shown remarkable persistence and resiliency. In order to curb STI and pregnancy rates, efforts have emphasized the regulation of individual conduct, and the failure of programs stems from the assumption that controlling behaviour is the answer (Cassel, 1987; Brandt, 1987; Moran, 2000). However, this goal of controlling behaviour is problematic on a number of fronts. First, implicit to this goal is a naïve and simplistic view of human nature that assumes that an individual's behaviour is free from external forces and that lifestyle is strictly voluntary (Brandt, 1987: 202). Second is a problematic

equating of sexuality with other risk-taking behaviours, such as smoking, drinking, poor diet, driving too fast; “behaviours for which, of course, individuals can in part be held accountable, but the question of to what extent and whether they should be is not as simple” (Brandt, 1987: 202). In addition, classrooms cannot be sealed off from the outside world, which makes it a nearly impossible goal for the school to counteract or modify ‘improper’ information that students learn on the outside (Moran, 2000: 220). Lastly, facts seldom alter sexual behaviour, since a student’s response to education is itself socially determined; hence, for example, “the critical question is not whether students understand the mechanics of the condom but whether their vision of their own life is such that preventing pregnancy or avoiding disease is important enough for the condom to seem relevant” (Moran, 2000: 222).

This focus on behaviour and behaviour change, then, has facilitated an interaction between different forms of authority and expertise, strategies and tactics, in order to deploy a distinctive regime of power-knowledge-discourse. The practices of the regime support a national pedagogy and employ an acceptable public rhetoric. Indeed, the ways in which morality and risk discourses work through health discourses enable mobilization around the regulatory key message: ‘something needs to be done.’ On the one hand, this ‘something’ has been met with suspicion since there continues to be a STI epidemic among youth and unacceptably high rates of teenage pregnancy. On the other hand, all attempts, whether successful or not, initiate future attempts.

So, does sex education have to be a failed project? According to Frank Mort, the counter-attack against projects of sexual regulation requires an extensive challenge to the hegemony of preventive medicine (Mort, 1987: 218) which is a particularly fruitful

conclusion, since this dissertation has emphasized the persistence and resilience of the medic-moral discourse and the specific ways in which morality and risk discourses work through health discourses to both frame and justify the school project. Spaces for such a challenge exist on the level of hegemony, discourse and strategy. Spaces are created because hegemony does not win universal support (Jessop, 1990: 211) - there can be multiple interests in conflict with one another in a particular field. In addition, discourses are never complete and self-sufficient; they change through processes of interpenetration by which new elements become added and others fade or are jettisoned (Hunt, 1999: 89). And in terms of strategy, we would do well to note that present projects of governance are not unique. In fact, “rejecting everything that has not yet worked means ignoring the context of past projects and potentially discarding strategies... that might work differently now” (Patton, 1996: 140).

Perhaps these spaces will open up as a result of certain contemporary practices, such as those in Nova Scotia and Quebec, which were described in the previous chapter. Although I discussed the ways in which these practices do not signal a regime change, they challenge the dominant ways in which the regime of practices is organized. In Nova Scotia, there is a recent and systemic commitment to the regular and active engagement of young people. By bringing youth ‘to the table’ in a meaningful and sustained way, perhaps there is *potential* for programs and services to be developed and implemented in ways that are relevant for young people and that foster sexual empowerment and sexual competency. In addition, the new Quebec model, which supports an inter-disciplinary approach to sex education, also holds *potential* promise in fostering discussion about sex education in a range of settings and with a range of individuals. The key question,

however, is what conditions are necessary for sustained resistance to take flight, which points to critical issues of agency and institutionality. It would seem that such approaches are only feasible when matched with a commitment to time, learning resources and teacher training.

With this in mind, it will be most interesting to see how the convergence of interests – teachers, administrators, medical professionals, parents, pharmaceutical companies – as articulated in the school project will respond to certain socio-cultural changes, and how strategies and practices will be reshaped and rearticulated. There continues to be a distinct interest in protecting the young and the innocent from the dangers of sex. Yet, there is a profound paradox to such an aim, since the innocence of children has itself become increasingly problematic, due to the prolonged period of adolescence, expansion of youth consumerism, the elaboration of youth cultures (Hunt, 1999: 211) and earlier onset of puberty, and hence sexual maturity, particularly for girls (Herman-Giddens, *et al.*, 1997).

In addition, youth identity is becoming increasingly complex. Indeed, the evolution of youth sexual identities opens up sexual possibilities. More young people are identifying themselves as gay or bisexual or, in refusing such categorizations, adopting pan-sexual identities and lifestyles. The inclusion of school-based anti-homophobia curricula begins to address such diversity. In addition, as Canada continues to rely on immigration to meet labour market needs, there will be a corresponding increase in ethnocultural diversity. This, in itself, makes the values clarification approach one worth pursuing; on the other hand, the teaching of sexual values can be seen as redundant since

key values, such as cooperation, respect and integrity, cut across all facets of life (Levine, 2002: 224).

We are also experiencing an era of unprecedented access to information. There is little doubt that the internet – as both a site of danger and a source of knowledge – plays an extraordinary role in the sex education of young people. Young people have become savvy consumers of information and users of technology. It is ironic that the Nova Scotia resource *Sex? A Healthy Sexuality Resource* was met with a certain level of controversy from adults and, at the same time, met with disappointment by youth:

So there's a lot of controversy around [the book] but, you know, the kids are really bored with it. I was at a high school a couple of weeks ago and I had one in my hand and one of the students said "Oh, the *Sex?* book? Miss, that's boring." With all the controversy that's built up with the *Sex?* book, and they get it, and they're like "Oh my God, is that all it is?" They seemed disappointed. So I said "Well, it's not like teen kama sutra for sexual activity." He said "But Miss, we already know most of that stuff" (Sexual Health Educator, Nova Scotia).

These socio-cultural issues are certainly historically coterminous; for example, the storm and stress theory of adolescence continues to problematize the tumultuous transition from childhood to adulthood. The increasing diversity of society has lead to calls for a mobilization around shared values, which is consistent with earlier commitments to race and nation. And the concern around access to on-line pornography is consistent with concern around access to *Playboy* at the local corner-store. However, it is ultimately these trends and realities, in their contemporary context, with which the regime of practices will have to negotiate and to which it must respond.

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Annex 1

Office of Research Services
 5th Floor, Tory Building
 1125 Colonel By Drive
 Ottawa, ON K1S 5B6 Canada
 Tel: (613) 520-2516
 Fax: (613) 520-2521
 www.carleton.ca/ors

Ethics Approval Form

This is to certify that the Carleton University Research Ethics Committee has examined the application for ethical approval. The committee found the research project to meet appropriate ethical standards as outlined in the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* and, the *Carleton University Policies and Procedures for the Ethical Conduct of Research*.

X New approval

☐ **Renewal of original approval**

Original date of approval:

Date of approval for change	10 November 2006
Researcher	Erin Connell
Status	Ph.D. Candidate
Department	Department of Sociology and Anthropology
Supervisor	Professor Bruce Curtis
Title of project	Sex in Schools: Canadian School-Based Sex Education as a Regime of Practices

Co-investigators: **None**

Ethics approval expires on: **10 November 2007**

All researchers are governed by the following conditions:

Changes to the project: Should there be any changes to the project the researcher is required to advise the Carleton University Research Ethics Committee of the changes prior to the continuance of the research.

Adverse events: Should any participant suffer adversely from their participation in the project the researcher is required to report the matter to the Carleton University Research Ethics Committee.

Suspension or termination of approval: Failure to conduct the research in accordance with the principles of the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* and the *Carleton University Policies and Procedures for the Ethical Conduct of Research* may result in the suspension or termination of the research project.

 Leslie J. MacDonald-Hicks
 Research Ethics Committee Coordinator
 For the Chair of the Carleton University Research Ethics Committee
 Prof. Antonio Gualtieri

Appendix 2

Interview Guide

The interviews followed an open-ended interview format using the following themes and questions:

Content and delivery

- To what grade(s) do you teach sex education?
- What are the main curriculum support documents that you use and why?
- Which topics, in your opinion, are covered extensively? Not enough? Why?
- How much time is dedicated to sex education in a given school year?
- In your opinion, what is the rationale for school-based sex education?

Policies: How policies are/are not put into practice

- How do certain school board policies affect the delivery of sex education? For example:
 - Policies that insist on parental consent for sex education (do parents often opt their children out of sex education classes?)

Support

- Is sex education generally supported by the school? Students? Parents? School board? Explain.

Clinical Services in Schools

- What sexual health services are provided in the school?
- Which services are accessed the most? The least?
- What services do you wish could be provided? What are the obstacles preventing such provision?
- Are such clinical services generally supported by the school? Students? Parents? School board? Explain.

Appendix 3

Provincial Curriculum Outcomes

Alberta Learning

Health and Life Skills²⁶

“The aim [of the course] is to enable students to make well-informed, healthy choices and to develop behaviours that contribute to the well-being of self and others.”²⁷

Grade 4

- Describe physical, emotional and social changes that occur during puberty; e.g., menstruation, secondary sexual characteristics, changing identity and moods

Grade 5

- Identify the basic components of the human reproductive system, and describe the basic functions of the various components; e.g., fertilization, conception

Grade 6

- Identify and describe the stages and factors that can affect human development from conception through birth
- Examine and evaluate the risk factors associated with exposure to blood-borne diseases - HIV, Aids, Hepatitis B/C; e.g., adults sharing needles, body piercing, tattooing, helping someone who is bleeding, being sexually active

Grade 7

- Examine the human reproductive process, and recognize misunderstandings associated with sexual development
- Identify the effects of social influences on sexuality and gender roles and equity; e.g., media, culture
- Examine the influences on personal decision making for responsible sexual behaviour
- Examine abstinence and decisions to postpone sexual activity as healthy choices

Grade 8

- Recognize and accept that individuals experience different rates of physical, emotional, sexual and social development
- Determine the signs, methods and consequences of various types of abuse; e.g., neglect, physical, emotional, sexual abuse
- Identify and describe the responsibilities and consequences associated with involvement in a sexual relationship
- Describe symptoms, effects, treatments, prevention's for common sexually transmitted diseases; i.e., chlamydia, HPV, herpes, gonorrhea, hepatitis B/C, HIV

²⁶ Alberta Learning. *Health and Life Skills: Kindergarten to Grade 9*. Edmonton: Author, 2002.

²⁷ Ibid, p. 1

- Identify and describe basic types of contraceptives; i.e., abstinence, condom, foam, birth control pills

Grade 9

- Apply coping strategies when experiencing different rates of physical, emotional, sexual and social development; e.g., positive self-talk
- Evaluate implications and consequences of sexual assault on a victim and those associated with that victim
- Determine "safer" sex practices; e.g., communicate with partner, maintain abstinence, limit partners, access/use condoms/contraceptives properly
- Identify and describe the responsibilities and resources associated with pregnancy and parenting
- Develop strategies that address factors to prevent or reduce sexual risk; e.g., abstain from drugs and alcohol, date in groups, use assertive behaviour

Career and Life Management (Grades 10, 11 or 12)²⁸

“The aim of senior high school Career and Life Management (CALM) is to enable students to make well-informed, considered decisions and choices in all aspects of their lives and to develop behaviours and attitudes that contribute to the well-being and respect of self and others, now and in the future. CALM is the core course for health literacy at the senior high school level in Alberta.”²⁹

Examine the relationship between commitment and intimacy in all its levels.

- Identify expectations and commitments in various relationships
- Examine a range of behaviours for handling sexual involvement
- Describe how personal values' play a role in relationships
- Explain the role of trust and ways to establish trust in a relationship
- Develop strategies for dealing with jealousy

Examine aspects of healthy sexuality, sexual wellness and responsible sexual behaviour.

- Explain the ongoing responsibility for being sexually healthy
- Examine a range of behaviours and choices regarding sexual expression
- Describe sexually healthy actions and choices for one's body, including abstinence
- Analyze strategies for choosing responsible and respectful sexual expression
- Describe the ways in which personal values influence choices
- Assess the consequences of being sexually active

²⁸ Alberta Learning. *Career and Life Management*. Edmonton: Author, 2002.

²⁹ Ibid, p. 1

Ministry of Education, Ontario

Healthy Living Strand, Health and Physical Education³⁰

“The healthy living strand will provide students with the knowledge and skills they need to develop, maintain, and enjoy healthy lifestyles, as well as to solve problems, make decisions, and set goals that are directly related to personal health and well-being.”³¹

By the end of Grade 4, students will:

- identify the physical, interpersonal, and emotional aspects of healthy human beings;
- describe the four stages of human development (infancy, childhood, adolescence, and adulthood) and identify the physical, interpersonal, and emotional changes appropriate to their current stage;
- identify the characteristics of healthy relationships (e.g., showing consideration of others’ feelings by avoiding negative communication);
- identify the challenges (e.g., conflicting opinions) and responsibilities in their relationships with family and friends;

By the end of Grade 5, students will:

- describe physical, emotional, and interpersonal changes associated with puberty;
- identify strategies to deal positively with stress and pressures that result from relationships with family and friends;
- identify factors (e.g., trust, honesty, caring) that enhance healthy relationships with friends, family, and peers;
- describe the secondary physical changes at puberty (e.g., growth of body hair, changes in body shape);
- describe the processes of menstruation and spermatogenesis;
- describe the increasing importance of personal hygiene following puberty;

By the end of Grade 6, students will:

- identify the major parts of the reproductive system and their functions and relate them to puberty;
- relate the changes at puberty to the reproductive organs and their functions;
- apply a problem-solving/decision-making process to address issues related to friends, peers, and family relationships;

By the end of Grade 7, students will:

- describe age-appropriate matters related to sexuality (e.g., the need to develop good interpersonal skills, such as the ability to communicate effectively with the opposite sex);
- explain the male and female reproductive systems as they relate to fertilization;

³⁰ Ministry of Education. “The Ontario Curriculum Grades 1-8: Health and Physical Education” Toronto: Author, 1998.

³¹ Ibid, p. 10

- distinguish between the facts and myths associated with menstruation, spermatogenesis, and fertilization;
- identify the methods of transmission and the symptoms of sexually transmitted diseases (STDs), and ways to prevent them;
- use effective communication skills (e.g., refusal skills, active listening) to deal with various relationships and situations;
- explain the term abstinence as it applies to healthy sexuality;
- identify sources of support with regard to issues related to healthy sexuality (e.g., parents/guardians, doctors);

By the end of Grade 8, students will:

- identify the physical, emotional, interpersonal, and spiritual aspects of healthy sexuality (e.g., respect for life, ethical questions in relationships, contraception);
- identify local support groups and community organizations (e.g., public health offices) that provide information or services related to health and well-being;
- apply living skills (e.g., decision-making, problem-solving, and refusal skills) to respond to matters related to sexuality, drug use, and healthy eating habits.
- explain the importance of abstinence as a positive choice for adolescents;
- identify symptoms, methods of transmission, prevention, and high-risk behaviours related to common STDs, HIV, and AIDS;
- identify methods used to prevent pregnancy;
- apply living skills (e.g., decision-making, assertiveness, and refusal skills) in making informed decisions, and analyse the consequences of engaging in sexual activities and using drugs;
- identify sources of support (e.g., parents/ guardians, doctors) related to healthy sexuality issues;

Healthy Living Strand³²

Overall Expectations: Healthy Living

By the end of Grade 9, students will:

- identify the factors that contribute to positive relationships with others;
- explain the consequences of sexual decisions on the individual, family, and community;
- demonstrate personal strategies to deal effectively with the social influences that contribute to the use and abuse of alcohol, tobacco, and other drugs (e.g., cannabis);
- identify strategies to minimize potentially dangerous situations (e.g., violence prevention, injury prevention).

Specific Expectations: Healthy Growth and Sexuality

By the end of the course, students will:

- identify the developmental stages of sexuality throughout life;

³² Ministry of Education “The Ontario Curriculum Grades 9 & 10: Health and Physical Education”. Toronto: Author, 1999.

- describe the factors that lead to responsible sexual relationships;
- describe the relative effectiveness of methods of preventing pregnancies and sexually transmitted diseases (e.g., abstinence, condoms, oral contraceptives);
- demonstrate understanding of how to use decision-making and assertiveness skills effectively to promote healthy sexuality (e.g., healthy human relationships, avoiding unwanted pregnancies and STDs such as HIV/AIDS);
- demonstrate understanding of the pressures on teens to be sexually active;
- identify community support services related to sexual health concerns.

Overall Expectations: Healthy Living

By the end of Grade 10, students will:

- explain strategies to promote positive lifestyle choices and relationships with others;
- demonstrate understanding of the factors affecting human sexuality as it relates to themselves and others;
- demonstrate understanding of the issues and coping strategies related to substance use and abuse;
- explain how healthy eating fits into a healthy lifestyle.

Specific Expectations: Healthy Growth and Sexuality

By the end of the course, students will:

- describe environmental influences on sexuality (e.g., cultural, social, and media influences);
- explain the effects (e.g., STDs, HIV/AIDS) of choices related to sexual intimacy (e.g., abstinence, using birth control);
- identify available information and support services related to sexual health concerns;
- demonstrate understanding of how to use decision-making skills effectively to support choices related to responsible sexuality.

Department of Education, Nova Scotia

Health Education³³

“Health education curriculum recognizes that emotional and social development, academic achievement, and the development of intellectual and physical skills are equally important in the development of active, healthy citizens. This curriculum offers opportunities that will help students become caring, thoughtful individuals who make informed choices, taking responsibility for their well-being and personal development.”³⁴

Grade 5 Outcomes

Students will be expected to:

³³ Nova Scotia Department of Education “Health Education Curriculum: Grades 4-6” 2003.

³⁴ Ibid, p. 1

- demonstrate a knowledge of the physical and emotional changes that take place during puberty
- demonstrate a knowledge of the symptoms and prevention of sexually transmitted infections
- demonstrate a knowledge of the symptoms and prevention of HIV/AIDS
- demonstrate strategies for managing feelings associated with the physical and emotional changes of puberty

Grade 6 Outcomes

Students will be expected to:

- identify the consequences of being sexually active
- identify and examine reasons why some young adolescents are sexually active

Health/Personal Development and Relationships³⁵

Grade 7 Outcomes

Students will be expected to:

- identify positive and negative reasons for taking risks
- explain the relationship between risk-taking and self-image
- assess their own risk-taking in a variety of contexts
- identify and practice strategies for making decisions in situations that involve risk
- identify and practice strategies for dealing with change in peer relationships
- identify and practice ways of supporting healthy self-concept and decision making among peers
- identify roles, rights and responsibilities involved in various relationships
- demonstrate respect for the feelings and beliefs of others
- identify types of abuse and demonstrate knowledge of laws related to assault and abuse
- identify and practice healthy ways of expressing emotions
- identify and practice strategies for managing stress and solving problems associated with the changes and challenges of adolescence

Grade 8 Outcomes

Students will be expected to:

- identify risks and related precautions of being sexually active
- demonstrate self-knowledge, self-respect and assertiveness in sexual decision making
- evaluate options and consequences related to teen pregnancy
- identify and practice strategies for avoiding potentially dangerous situations
- identify and practice strategies for preventing sexually transmitted diseases
- identify and practice strategies for preventing HIV/AIDS
- demonstrate empathy toward people living with HIV/AIDS
- evaluate the impact of media on self-image and lifestyle choices

³⁵ Nova Scotia Department of Education “Health/Personal Development and Relationships: Grades 7-9” 2000.

- identify personal, social, and cultural influences related to sexual identity and decision making
- demonstrate acceptance of, and appreciation for, their own and others sexual orientation
- identify traits of healthy relationships
- identify and practice strategies for communicating personal needs in relationships
- identify and practice strategies for balancing personal values and needs with the need for peer acceptance
- demonstrate a knowledge of symptoms, risk factors, and management strategies for various types of cancer

Grade 9 Outcomes

Students will be expected to:

- demonstrate an understanding of the stages of pregnancy and prenatal development
- identify the risks of smoking, drinking, and other drug use during pregnancy
- evaluate the safety and effectiveness of various methods of contraception
- identify and practice strategies for preventing sexual harassment and date rape in dating relationships
- expressing strong feelings such as anger, fear, and rejection in healthy ways
- evaluate trustworthiness of alternative products and therapies used for the prevention of treatment and disease
- define and practice strategies for maintaining a general sense of health and well-being
- demonstrate attitudes and strategies needed to face and deal with problems
- identify and practice strategies for dealing with the challenges of peer relationships