Let’s Talk About Sex:

Independent School Teachers’ Experiences Implementing Sexual Health

By

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Abstract

This research project focuses on Toronto independent school teachers’ experiences implementing the updated Health and Physical Education (HPE) curriculum, with a specific focus on sexual health education. While there is some existing literature on the experiences of public school teachers’ experiences, there was a gap in the literature concerning independent school teachers’ experiences. Using qualitative methods, five HPE teachers from the Conference of Independent Teachers participated in semi-structured interviews. Data from these interviews were coded and analyzed to reveal moments of convergence and divergence with the literature reviewed. Findings from this study indicate that independent school teachers perceive their experiences implementing sexual health education as different than public school teachers because of the additional supports they receive as a result of working at an independent school. These supports include the freedom to change and modify physical spaces, the ability to work with a large department both in and out of the classroom, and the support they receive from parents. Overall, these findings suggest independent school teachers perceive that they receive additional supports than public school teachers and thus have a positive experience implementing sexual health education.

Key Words: Health and Physical Education, Sexual Health Education, Public Schools, Independent Schools, Equity
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Chapter One: Introduction

1.0 Introduction: Research Context

Sex education, and the debate over sexual health in schools, has been prevalent in Canadian society for almost a hundred years (Follert, 2015). Since that time, there have been periods of high and low tension. Recently however, the controversy over sex education reignited in Ontario with the introduction of a new Health and Physical Education (HPE) curriculum. Yet despite the controversy, the curriculum has been in place for a full school year. This means that there has been a lack of information about the efficacy of the new curriculum as well as how teachers experience implementing the new material.

Starting in 1900, the primary purpose of sex education in Canadian schools was to prevent medical infections that at the time were life threatening. Prior to, and just after the First World War, movements such as social purity and social hygiene argued that sex education, in 1918 called Family Life Instruction, in Ontario public elementary and secondary schools was necessary. Because of the spread of venereal disease, these groups feared for the moral and medical well-being of Canadian youth. In order to enforce the nuclear family, self-control, and heterosexuality, teachers, parents, and members of the clergy needed to instruct children on “the essential facts of life” (Sethna, 1995, p. 2). Feminist scholars who have studied sex education prior to 1950 have called this the “hidden curriculum” (p. 1). But sex education hit a standstill in 1948 when the Ontario Department of Education said that sex education would “shortly be abolished” if the Toronto District School Board did not agree to recommendations made by a “special committee” (p. 1). In 1950, the Ontario Department of Education removed sex education from public elementary and secondary schools. Sex education resurfaced in the 1960s when teen pregnancy was on the rise (Sethna, 1995). The purpose of sex education in twentieth century
Canadian society was to reinforce conservative morals. Today, however, the purpose of sex education has been centered on physical and emotional well-being.

The World Health Organization and the Sex Information and Education Council of Canada (SIECCAN) both argue that sex education should prevalent in schools because of its main propose: to enhance the well-being of Canadian youth (Smylie et al., 2008). SIECANN (2015) notes that sexual health education maintains the well-being of Canadian youth in two ways. First, sex education promotes positive outcomes of sexual health such as “mutually rewarding interpersonal relationships and desired parenthood, as well as the avoidance of negative outcomes such as unwanted pregnancy and STI/HIV infection” (p. 2). Second, all Canadians “including youth, have a right to information and opportunities to develop the motivation/personal insight and skills necessary to prevent negative sexual health outcomes” (SIECANN, 2015, p. 4). In other words, sex education has remained in Canadian schools because of its dual purpose to promote positive sexual health and to fulfill Canadians’ right to access sexual health information. Yet unlike most subjects in Canadian schools, the provincial governments and Ontario, specifically, have been hesitant to update the sexual health portion of the HPE curriculum.

In 2015, Ontario’s HPE curriculum received its first revision and update since 1998 (Ensslen & Ursel, 2015). Ontario’s new HPE curriculum was first introduced in 2010 when Kathleen Wynne’s predecessor Dalton McGuinty tried to implement a new curriculum. Unlike Wynne however, McGuinty backed down after facing widespread opposition and claims that the government did not consult with the public about changes to the curriculum. When Wynne was elected in 2013, she took a different stance on updating the curriculum. Wynne noted that the curriculum had not been updated since 1998 and that students today are facing different issues
with sexual health than in the past. As a result, Wynne argued that it was not the government who failed to do their job properly and instead the fault of those who critiqued the HPE curriculum (Goldstein, 2015). In order to fend off the backlash that Wynne’s predecessor received, Wynne defended the new curriculum by notifying the public that the HPE curriculum was written after consulting 4,000 school chairs, and 70 public-health parent organizations (Ross, 2015). But despite Wynne’s efforts to fend off critics, the new curriculum faced serious opposition.

Ontario’s new HPE curriculum was met with controversy and threats to pull children from schools after some parents argued that the curriculum was not age-appropriate and therefore did not belong in schools (Jones, 2015). Before the new HPE curriculum hit schools, protesters gathered on April 2015 to oppose Wynne’s revisions of the curriculum. Roughly 3000 people rallied in Queen’s Park, the legislature’s front lawn, chanting “Kathleen Wynne, we will not co-parent with you” (Ferguson, 2015). The protest in April became one of many leading up to the introduction of the HPE curriculum in schools with more protests taking place in June (Connor, 2015). According to Education Minister Liz Sandals, Conservatives were to blame for the protests (Ferguson, 2015). Yet parents and members of the clergy state that they attended the protests on their own accord because of the changes to the HPE curriculum.

The changes to new HPE curriculum reflect not only cultural changes in Canadian society but also acknowledge that students today are entering puberty at younger ages than in previous generations. So what has changed? In elementary school, grade one students will learn the proper names of all body parts, in grade three students will learn different family structures – including same-sex parented families, and from grade four to six students will learn about reproduction and consent. Because roughly 22 percent of Ontario teens are sexually active by
grade nine, the new curriculum has pushed content on sexual activity, pregnancy prevention, and sexually transmitted infections to grade seven in order for students to have the necessary information before making a decision. By the end of grade seven, students will be expected to “understand gender identity, and sexual orientation, and to consider decision-making around sexual activity, contraception and intimacy in relationships in Grade 8” (Ensslen & Ursel, 2015, para. 5). In high school, grade nine students will continue to learn about sexually transmitted infections and sexual activity, as well as understand factors that affect gender identity and sexual orientation. A particular focus will also be on healthy relationships and sexuality. Grade ten students will explore decision making and misconceptions about sexuality (Ensslen & Ursel, 2015). In grade 11, students will relate ideas about sexuality to mental health and also learn about proactive health measures like regular testing and screening. Finally, in grade 12 students will learn ways to maintain healthy relationships (Ensslen & Ursel, 2015). While in some instances minor, these changes are meant to meet the needs of Ontario students.

1.1 Research Problem

The process of implementing sex education in Canadian society has been a lengthy and complicated one, and the process of updated and implementing the new curriculum was also a long and controversial process. The literature explored in Chapter Two identified that there is a gap in experiences of independent school teachers in Ontario. Identifying potential barriers and supports teachers experience while implementing the new HPE curriculum can provide insight as to how things are going for these teachers. Moments of convergence and divergence within the literature about public school teachers’ experiences implementing previous HPE curriculum informs the findings of this study.
After exploring barriers and supports teachers encounter while implementing the changes to sex education, students’ classroom experience with the updated curriculum can also improve. The World Health Organization and the Sex Information and Education Council of Canada (SIECCAN) have highlighted the benefits of sex education in schools in order to improve the well-being of students. Student well-being can further improve once an investigation has been done into how teachers experienced the new HPE curriculum.

1.2 Purpose of Study

The purpose of this study is to explore Toronto independent school teachers’ experiences implementing the updates Health and Physical Education curriculum, with a focus on sexual health. For the purposes of this study, independent school teachers as those who work for a school listed in the Conference of Independent Schools of Ontario. The study explores whether they have similar or different experiences to those of public school educators when teaching sexual health. This study approaches teachers’ experiences through semi-structured interviews with HPE teachers in Ontario. By discovery teacher’s experiences with the new curriculum, it is my hope to provide a better understanding of supports or barriers that are in place for independent school teachers. If there are significant differences, this research study hopes to discover whether these differences are related to equity. Once identified, this research project can be used to potentially improve experiences for both public and independent school HPE teachers.

1.3 Research Questions

The primary question guiding this study is: what supports or barriers do independent school teachers’ experience while implementing sexual health? Sub-questions to further guide this inquiry include:
• Are these experiences similar or different than those of public school teachers as documented in the literature?
• If they are different, why are independent school teachers’ experiences unique?
• How do independent school teachers’ see their own interest in health in relation to teaching?

1.4 Background of the Researcher

The topic of sexual health education is particularly interesting to me because coming from an English background I wanted to see how relationships are discussed in other disciplines and thus looked to the Health and Physical Education curriculum. I have always loved studying ways in which authors depict relationships – my undergraduate honours thesis looked at the marriage between Macbeth and Lady Macbeth from William Shakespeare’s Macbeth. I have always been drawn to how romantic relationships are formed and maintained, and I remembered how much of the topics discussed in my English classroom overlapped with my Family Studies class.

When I graduated high school from New Brunswick, the government was just in the process of implementing a grade nine course titled Personal Development. As a result, my Health and Physical Education and Family Studies courses provided me with sexual health information. But my formative years with learning about sexual health came in elementary school. In both elementary and high school, I went to school with mostly the same people. Almost everyone belonged to upper or middle class, and an overwhelming majority of my peers were white. Our sexual health education did not segregate genders, which I thought made my classroom more open about discussing puberty specifically. But perhaps like most schools, most class time was devoted to discussing puberty, STIs, and pregnancy prevention. It was not until now as a teacher
candidate where I realized the importance of discussing healthy relationships and identity in a sexual health classroom.

As a secondary teacher candidate, I am specifically interested in sexual health education because of the impact it can have on adolescents. Discussing ways for teenagers to engage in healthy relationships and explore their identity is important for a students’ mental health. In Canada, 24% of deaths among 15-24 year olds is a result of suicide. More specifically, boys are three times more likely to die by suicide than girls (Centre for Suicide Prevention, 2012). My brother was one of those boys. In order to try to prevent suicide among our youth, teenagers need to talk about issues surrounding identity and healthy relationships. I hope to find out how teachers are experiencing discussing these issues in order to create a classroom environment where these issues are talked about.

1.5 Overview

To respond to the research question, this study interviewed five independent Health and Physical Education teachers about their experiences teaching the new Ontario Health and Physical Education curriculum, with a particular focus on the revised sexual health content. In Chapter Two, I reviewed the literature in areas of sex education in a broad Canadian context, focusing on experiences of public school teachers. Next, in Chapter Three I elaborate on the research design. In Chapter Four, I reported the research findings and discussed their significance in light of the existing research literature, and in Chapter Five I identified the implications of the research findings for my own teacher identity and practice, and for the educational research community more broadly. I also articulated a series of questions raised by the research findings, and pointed to areas for future research.
Chapter Two: Literature Review

2.0 Introduction

In this chapter I review the literature in the areas pertaining to the sexual health education in Canada, different types of sex education, and public school teachers’ experiences teaching sexual health education. I begin by defining sexual health education in a Canadian context. More specifically, I review the different types of sex education with particular reference to comprehensive sexual health education, abstinence-only sexual health education, and pleasure-based sexual health education. Particular attention was paid to comprehensive sexual health education because it is the program most employed by Canadian schools. In the section following, I explore public Health and Physical Education teachers’ experiences teaching sexual health education. This literature review highlights public school HPE teachers’ experiences because there was no literature about Toronto, or Canadian, independent school teachers. The end of this review explores the literature concerning the barriers and supports teachers encounter while teaching the sexual health education component of the HPE curriculum.

2.1 Sexual Health Education in Canada

According to the Public Health Agency of Canada’s (2008) Canadian Guidelines for Sexual Health Education sexual health education is defined as “the process of equipping individuals, couples, families and communities with the information, motivation and behavioural skills needed to enhance sexual health and avoid negative sexual health outcomes” (p. 5). This process of learning about sexual health is “broadly based” and “community-supported” (ibid.). Because sexual health education requires the “full participation” of the community, “educational, medical, public health, social welfare and legal institutions” must all be involved in the process
Since learning about sexual health involves teaching, schools have become the primary medium for Canadian youth to learn about sexual health.

In Canada education is a provincial responsibility and consequently, each province is responsible for creating and revising their curriculums. Like all other subjects in Canadian schools, the province is responsible for creating, implementing, and funding sexual health education. All Canadian provinces have curricula that include some content on sexual health (Zain Al-Dien, 2010). There has been a general consensus among provinces about the purpose of integrating sexual health education for two reasons. First, teaching sexual health education can help children make decisions that benefit their well-being. Second, in 2008 there was a movement in Europe and North America to treat sexual health as a human right (Zimmerman, 2015). Because of the above reasons sexual health content is often found in the Health and Physical Education curriculum of the particular province. But while sexual health education is taught in all Canadian provinces, the implementation and content not only differ from province to province but also between school boards (Connell, 2005). The following sections will provide a brief overview of three different models of sexual health education.

2.2 School-based Sexual Health Education

Research shows that there are a variety of factors which make schools an ideal place to learn about sexual health (Smylie, 2008). For instance, the length of schooling allows for students to learn about sexual health at different developmental stages (Kirby, 1992). Yet because formal education is a provincial responsibility in Canada, many provinces have taken different approaches to teaching sexual health education (Connell, 2005). These approaches mainly include comprehensive sexual health education and abstinence-based sexual health education.
2.2.1 Comprehensive sexual health education

According to the Public Health Agency of Canada’s (2008) Canadian Guidelines for Sexual Health Education, comprehensive sexual education “addresses diverse sexual health promotion and illness prevention objectives and provides information, motivational inputs and skills acquisition opportunities to achieve these objectives” (p. 21). In other words, comprehensive sexual health education looks at all areas that are relevant to sexual health. In this approach, teaching sexual health should be the shared responsibility of parents, schools, peers, government and the media.

The purpose of comprehensive sexual health education is to promote the well-being of children and adolescents by covering a variety of issues connected to sexual health. In order to survey an array of topics, sexual health education must go beyond teaching about the prevention of unintended pregnancy and STI/HIV education (Public Health Agency of Canada, 2008). These areas include sexual orientation, gender identity, personal well-being, sexual violence, and healthy relationships (Connell, 2005). Many of these topics are also connected to environmental factors that may alter a particular concept. Environmental factors like economic status, access to sexual health services, and community norms and expectations can dramatically influence one’s sexual health (Connell, 2005). Furthermore, in order to teach sexual health comprehensively, teachers should look at incorporating outside sources into the classroom such as councilors, public health workers, and other social services. Comprehensive sexual health education should “be provided from the beginning of elementary school to the end of high school” (Public Health Agency of Canada, 2008, p. 21). Put differently, sexual health education should be an integral part of schools and their surrounding community.
But while sexual health education is necessary in all schools, it should be discussed in a “safe, caring, inclusive, and nonjudgmental environment” (Public Health Agency of Canada, 2008, p. 22). The Canadian Guidelines for Sexual Health Education not only defines sexual health education, but also provides a checklist in order to ensure that sexual health is taught in a particular type of environment. The checklist includes points such as:

- “Age appropriate sexual health education is offered consistently from the beginning of elementary school through to the end of high school” (p. 21)
- “Comprehensiveness in effective sexual health education focuses on the needs of different groups and considers the various issues relevant to the sexual health of individuals within any group” (p. 21)

These guidelines set forth by the Public Health Agency of Canada, research provides further insight into comprehensive sexual education. While comprehensive sexual health education incorporates many facets of sexual health, there is still a strong focus on reducing negative outcomes of sexual activity such as pregnancy and sexual transmitted infections. Comprehensive sexual health education also tries to lessen risk of sexual activity but unlike abstinence-only programs, abstinence is not the only solution. Methods to avoid pregnancy in comprehensive sexual education include how to access, introduce, and use birth control devices (Stanton, 2010). While it is perhaps uncommon, some comprehensive sexual health education teachers also incorporate ideas such as pleasure and desire.

### 2.2.2 Pleasure-based sexual health education

Pleasure-based sexual health education is a fairly contemporary idea in the field of sexual health. As a result, there has not been an entire program designed around pleasure and desire in many Canadian schools. Instead, students may learn about pleasure and desire from “individual
teachers who deliver comprehensive sexuality education” (Connell, 2005, p. 266). Pleasure-based sexual health education therefore relies on the teacher. Several factors, including knowledge and comfort, influence whether a teacher will discuss pleasure and desire in their unit (Allen et al., 2014). Because of the reliance on a particular individual, pleasure-based sexual health is not as common in Canadian schools.

Although pleasure-based sexual health education is not common in Canadian schools, researchers have argued that because victimization and danger are discussed in sexual health education, pleasure and desire should also be included in the curriculum (Connell, 2005). The introduction of pleasure and desire into the curriculum might help to eliminate negative ideas about female sexuality, like ‘slut shaming,’ and may open the doors for women to experience pleasure by exploring their bodies at a younger age (Connell, 2005). Connell also argues that girls are often educated in how to fend off boys’ desires while leaving girls uneducated about their own desires. Researchers also point to the trend towards social justice education, and in that case, there is a connection between empowerment and pleasure in which boys have more power over girls (Oliver et al., 2013). But while those in favor of pleasure-based sexual health education see knowledge as power, others view this type of knowledge as infringing on their religious and moral beliefs.

2.2.3 Abstinence-only sexual health education

Abstinence-only sexual health education is a school-based program that maintains the belief that abstaining from sexual activity is the only way to avoid unwanted pregnancy and sexually transmitted infections (Zain Al-Dien, 2010). For many young people, there is a religious or moral belief that supports the choice to abstain from sex and sexual activity (McKay, 2014). In this regard, abstinence-only sexual health education supports an individual’s religious or
moral choice to abstain from sexual activity. Abstinence-only sexual health education not only reinforces abstinence, but also limits the wide variety of topics related to sexual health. For some religions, certain ideas and behaviours related to sexual health, and talking about sexual health in general, can be seen as ‘sinful’ (Zain Al-Dien, 2010). As a result, some have pushed for school-based sexual health education that only discusses abstinence. A common misconception however, is that comprehensive sexual health education does not encourage abstinence. Both abstinence and comprehensive models of sexual health encourage abstinence. The difference between the two is that abstinence based sexual health education enforces abstinence as the only option whereas comprehensive sexual health education will discuss topics like birth control and condoms.

2.2.4 Effectiveness of school-based sexual health education

According to the Public Health Agency of Canada (2008), in order for sexual health education to be effective, the teachings must be sensitive “to the diverse needs of individuals irrespective of their age, race, ethnicity, gender identity, sexual orientation, socioeconomic background, physical/cognitive abilities and religious background” (p. 5). Research done by Kirby (1992) shows that, in order for school-based sexual health education to be effective, a variety of characteristics must be present. Some of these factors include effective teacher training, support from ministries of health, school districts and community, and discussion and activities that address pressures related to adolescent sexual behaviour. These characteristics, along with comprehensive sexual health education, have been identified as the most effective ways to teach sexual health education in Ontario.

While schools are mostly agreed upon as being the most effective place to teach sexual health education, there is an ongoing debate surrounding which type of sexual health education is
the most effective in preventing negative sexual outcomes. There is little evidence to suggest that abstinence-only programs prevent negative sexual outcomes. Instead, a study done by McKay (2014) suggests that youth educated within an abstinence-only paradigm will avoid using contraception, which can increase the risk of unwanted pregnancy and sexually transmitted diseases. Although abstinence-only sexual health education is in place in some schools, the Public Health Agency of Canada (2008) and the Sex Information and Education Council of Canada (SEICANN 2015) recommend comprehensive sexual health education as the most effective way to promote child and adolescent well-being.

2.3 Teacher Experiences with Sexual Health Education

As stated in Chapter One, there is a gap in the literature concerning teachers’ experiences implementing the revised and updated content on sexual health in the 2015 Ontario Health and Physical Education curriculum. Consequently, the literature reviewed will look at past Ontario studies about teachers’ experiences teaching sexual health, as well as current research in other Canadian provinces about teaching sexual health. As argued in the preceding sections, schools have been identified and supported by the Canadian public as an effective place to teach children and youth about sexual health. But while schools may be an effective location for this work, teachers have varied experiences teaching sexual health. Because it is difficult to encapsulate experience, this literature review will look at perceived barriers and supports encountered by HPE teachers as a way of knowing about their experiences implementing sexual health education.

2.3.1 Supports for teaching sexual health education

The following information regarding supports for teaching sexual health in Canada is a study done from 1979. While this source is dated, there has not been another research study of
this scale done about supports for HPE teachers regarding sexual health in Canada. As such, it serves as an important starting point for this MTRP. Teaching materials for sexual health education can be one of the effective supports for HPE teachers (Herold & Benson, 1979). While teaching sexual health, educators have been found to use films or videos, followed by books or journals (Herold & Benson, 1979). Perhaps surprisingly, 30% of teachers surveyed by Herold and Benson were fairly satisfied with the materials they were able to access for teaching sexual health. There teachers’ most common criticisms were that the materials were of poor quality or were out of date. Another criticism was that the materials were too conservative or reinforced biases like people do not have sex before marriage and girls are not interested in sex. But despite the criticisms, the teachers noted that these materials allowed them to more effectively teach sexual health education.

Support from school boards, administration, and the provincial government were also cited by teachers in Herold and Benson’s (1979) study as important resources for teaching sexual health education. Many teachers stated that when their principals and vice principals supported sexual health education, they were more effectively able to teach sexual health. Administrators prioritizing sexual health education is a huge support for sexual health educators because with prioritization can come resources. Sexual health education is often not prioritized in schools because the topic solemnly appears on standardized tests (Goldfarb, 2003). Because classroom time is so valuable, teachers tend to focus on what their students need to pass these tests. As a result, school boards pay more attention to some subjects than others. Not only are school boards and administration significant sources of support, but provincial backing can also increase effective teaching practices. In a study by Ninomiya (2010), teachers noted that one of the most helpful supports for teaching sexual health education were curriculum updates. When the
curriculum was not updated by the provincial government, 42% of teachers said that this was their greatest need in order to effectively teach sexual health (Ninomiya, 2010). Curriculum updates are important because of the accompanying resources like new information and materials that often accompany these updates. Also, curriculum updates are a public demonstration of support.

Often when a government chooses to update a curriculum it indicates that the subject is valued within the school. While provincial governments can be effective resources for supporting HPE teachers, teacher research practices can be a significant resource for teaching sexual health. Teachers and their professional communities can become one of the most significant sources of support for teaching sexual health education (Herold & Benson, 1979). When teachers felt that they were not receiving enough external support, their interest in sexual health became a great motivating factor to seek out the necessary information. Roughly 51% of those teaching sexual health education cited that they had much interest with only 6% stating that had little or no interest (Herold & Benson, 1979). Those who said they had much interest in sexual health tended to spend more time on the subject in their HPE classes. When educators spend more time teaching sex health education, they increase their amount of experience. After a significant amount of time teaching, teachers can also become their own resource. Many teachers simply acquired the necessary knowledge by the number of years they have been teaching sexual health. Most teachers who cited that they felt they had a lot of information about sexual health had been teaching sexual health for 13.8 years (Tappe et al., 1997). Inexperienced teachers may also seek out more senior teachers for resources to support their teaching practice (Tappe et al., 1997). In other words, teachers and their professional communities can become an important support if
educators are unable to access support elsewhere. There are also supports found outside of the school and government that play a crucial role in the experiences of HPE teachers.

Contrary to the media’s representation, the majority of Ontario parents support sexual health education (McKay et al., 2014). Parental support is not to be underestimated – a study done by McKay et al., which surveyed 6800 parents in Ontario found that 95% of parents strongly agreed or agreed that sexual health education should be provided in schools. McKay et al. also surveyed 4200 parents in New Brunswick and similar to Ontario, 94% of parents strongly agreed or agreed that sexual health education should be provided in schools. Parents from both studies also supported topics like building health relationships and avoiding sexual abuse in the early years. Furthermore, parents in New Brunswick rated it as important that a variety of topics, including puberty, safer sex, pleasure, and homosexuality. There was however, a division on when these topics should be introduced (McKay et al., 2014). Thus, some parents differed on the precise details of sexual health education.

What is particularly interesting about parental support is that it is enduring. Canadian parents, particularly in Ontario, demonstrated strong support for sexual health education in 1998, and again in 2014. It is yet to be known whether this support continues with the updated Ontario HPE curriculum. It is suggested, however, that with growing ethno-cultural diversity in Ontario parental support must once again be examined “with a specific focus on ethnicity, religious affiliation, country of birth and origin, as well as other salient demographic factors” (McKay et al., 2014, p. 166). Based on these factors, parents might be encouraging or reluctant to support sexual health education. While parents can strongly oppose sexual health education, there are

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1 Term used following McKay et al. (2014, p. 160).
other and more pertinent barriers that HPE teachers face when implementing sexual health education.

2.3.2 Barriers to teaching sexual health education

Canadian Health and Physical Education teachers have cited inadequate undergraduate training and pre-service teacher education as a major barrier to teaching sexual health education. Prior to entering a pre-service teacher education program, some American teacher candidates reported they did not receive enough information about sexual health in their undergraduate programs (Donovan, 1998). In an analysis by McKay (1999) of pre-service teacher education programs, about 40% of Canadian programs had the option for sexual health education training. From those universities, roughly 53.7% reported that it was compulsory that their students receive training in how to maintain health. Concerning sexual health, however, only 15.5% of the surveyed universities made a compulsory sexual health course. In those compulsory courses, about 11 different topics concerning sexual health were covered (McKay, 1999). Across all programs, the topics that were least covered were sexual orientation, masturbation, and human sexual response. Out of the surveyed schools, 26.2% had a non-compulsory course on sexual health education (McKay, 1999). In total, 39.3% of Canadian pre-service teacher education programs had a mandatory or optional course on teaching sexual health education (McKay, 1999). In the absence of pre-service training, it can be difficult for teachers to access the necessary information about sexual health, and to learn how to teach sexual health.

After graduating from a pre-service teacher education program and becoming teachers, teachers need to have enough information about how to teach sexual health (Cohen et al., 2001). A New Brunswick survey (Ninomiya, 2010) found that 65% of sexual health educators had no training in this area. When teachers are required to teaching sexual health education without any
effective professional development, their teaching can become ineffective. For example, Canadian teachers who lack adequate training “do not use interactive teaching methods, do not encourage questions, and provide limited coverage of some of the topics in the curriculum” (Cohen et al., 2012, p. 300). Most often, the most crucial and critical topics such as sexual orientation, abortion, and safer sex, are excluded from the lesson when teachers feel as though they lack the necessary knowledge (Goldfarb, 2003). There was also a connection between those who received training and educators who identify as comfortable teaching sexual health (Goldfarb, 2003).

Inadequate knowledge about sexual health can cause teachers to feel uncomfortable teaching the subject. Thus, another barrier arises when teachers do not feel comfortable teaching sexual health. Ninomiya (2010) found that a teacher’s comfort level depends on their experience and knowledge with sexual health. For instance, teachers who did not have any training said they were somewhat comfortable teaching sexual health. Sexual health teachers in Newfoundland and Labrador found that teachers who are uncomfortable teaching sexual health do focus on certain topics (Ninomiya, 2010). The least covered topics in order of most covered to least covered included sexual assault, vaginal/penile sex, contraception uses and mechanics, wet dreams/unwanted erections, mutual masturbation, oral sex, masturbation and pleasure, and anal sex. In this instance, teachers directly cited that the reason these topics were not discussed as much as the top three covered topics – safer sex practices, parenting and adoption, emotions and hormones – was as result of their comfort with the topics (Ninomiya, 2010). When teachers were comfortable with sexual health topics, they were more willing to cover a wide range of issues. Although closely related, it is important to separate knowledge and comfort because they are two
different and important factors to consider when exploring teachers’ experiences implementing sexual health education.

While knowledge and comfort are two significant barriers for Health and Physical Education teachers, the topic itself is also a barrier. An informal survey (Goldfarb, 2003) found that HPE teachers’ greatest concern about teaching sexual health was knowing what was appropriate for a classroom setting. One teacher questioned whether they would get in trouble for discussing contraception while another teacher worried that demonstrating how to use a condom with a penis model would be viewed as inappropriate. Not only were teachers concerned about how to appropriately teach sexual health, but also whether they should be talking about particular topics at all. For instance, teachers in Newfoundland and Labrador did not spend time on particular topics because they were “too controversial” (Ninomiya, 2010, p. 20). These topics include masturbation, sex toys and aids, and sexual practices. Teachers were also reluctant to discuss topics that may be controversial in their communities such as abortion, sexual identity, and how to implement contraception. Because sex has been stigmatized in North American culture, the topic of sexual health itself is considered controversial. In the face of controversy, school boards have been unclear about what teachers should and should not be teaching about sexual health (Goldfarb, 2003). One of the reasons why sex has been seen as controversial in North American culture is because of religious institutions.

Monotheistic religions have often had a conservative view about sex and sexual health education. As a result, religious institutions often oppose comprehensive sexual health education and consequently become a potential barrier to Ontario HPE teachers. While this literature review acknowledges Canada’s religious diversity, there will be a particular focus on Christian
and Muslim outlooks on sexual health education. The province of Ontario continues to have strong ties between education and the Catholic church. Thus, teachers experiences in Catholic schools might differ from those in public schools. Perhaps surprisingly teachers attitudes – regardless of public or Catholic schools – about abstinence did not dramatically differ. Both public and Catholic teachers encourage abstinence among their students. While there are much fewer Muslim schools than Catholic schools in Ontario, Islam has had a significant presence in Canada and specifically Ontario.

Sex education for some followers of Islam is part of the religious upbringing of adolescents and often includes Islamic knowledge where the Qur’an and Hadith are central (Zain Al-Dien 2010). Sex education, then, can become a way to further explore Islamic ideology. But sex education in Ontario is not based on Islamic morals. As a result, some Muslim parents have been found to believe that comprehensive sexual health education presents behaviours that are sinful as normal and acceptable (Zain Al-Dien, 2010). For example, pre-marital, extra-marital, and same sex relationships are forbidden in some sects of Islam and must not be treated as acceptable. Some Muslims are also not permitted to touch, date, or spend time alone prior to an Islamic marriage. With this in mind, some Muslims’ views on sexual health education may not align with Ontario’s HPE curriculum. It has been suggested that “Canadian educators must be aware that Muslim students try to live an Islamic life in a non-Islamic country” (Zain Al-Dien, 2010, p. 403). Thus a tension may arise when teachers try to navigate how to meet curriculum expectations while respecting their students’ religious beliefs. While a student’s religious affiliations may effect a teacher’s experience implementing sexual health education, student knowledge can also impact how educators teach the HPE curriculum.

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2 This decision is based on the availability of Canadian studies concerning religion and sexual health education.
Students’ previous knowledge and comfort has also been cited by educators as a barrier for teaching sexual health education (Herold & Benson, 1979). Based on their previous exposure, students can have drastically different levels of knowledge concerning sexual health (Herold & Benson, 1979). There was a gap between those who found the information extremely repetitive and those who felt the content was over their head. Usually, this knowledge depended on whether students discussed sexuality at home. Many students also had various misconceptions about sexual health and were therefore reluctant to new information. Teachers also encountered many students who were shy or embarrassed to discuss sexual health. As a result, teachers found it difficult to rely on class discussion. Because sexual health has been stigmatized by Canadian society, students were nervous to participate in class in fear that they would reveal something about themselves that they did not want their classmates knowing (Herold & Benson, 1979). But some teachers note that student shyness can be overcome by the teacher. These teachers noted that “students became more comfortable discussing topics once they realized that the teacher was not nervous or embarrassed.” In other words, students’ perceptions and knowledge about sexual health can impact how teachers implement sexual health education. The relationship between students and teachers can also impact experiences teaching sexual health.

Many teachers identify themselves as tolerant and non-judgment in relation to sexual diversity, yet one study (Ninomiya, 2010) showed that 61% of teachers were unaware of the sexual diversity in their classrooms. There was a broad perception among the surveyed teachers that their students were heterosexual (Ninomiya, 2010). Furthermore, discussions surrounding the “limitations of the curriculum in relation to lesbian, gay, bisexual, [transgender], [Two-Spirited], intersexed, questioning or queer youth,” were rarely or not at all discussed (p. 24). In other areas, teachers familiarize themselves with students’ abilities and perceptions in that
particular subject. Yet the stigma and public sentiment about sexual health education has potentially made teachers wary of addressing sexual diversity in their class.

Because their students belong to a different generation, it is important for teachers to try to bridge the generational gap in order to effectively meet their students’ needs. While there may be common experiences between different generations of teenagers, adolescents today are part of the social media revolution. Because of this, the government of Ontario argued that the HPE curriculum needed to be updated to include the technological advances that teenagers are immersed in today. While adults have access to technology, a generational gap occurs because teachers did not experience adolescence with social media and access to the internet. Students are increasingly using the internet as a medium for sexual health education (Allison et al., 2012). While there are many websites that can be used as effective tools for teaching sexual health education, there is also a lot of misinformation about sexual health (Holstrom, 2015). With a plethora of inaccurate information, teenagers may be learning about sexuality in a problematic way. Thus, educators are now teaching a generation of student who may have incorrect views on healthy sexual relationship or sexual health in general. It is perhaps more important than before that teachers take time to address these common misconceptions.

How much a teacher values sexual health education can also serve as a barrier for implementing sexual health education. Teachers who have a more favourable view of sexual health education are more likely to implement the program. When teaching sexual health, some teachers cited the most important topics were preventing pregnancy and sexually transmitted infections (Ninomiya, 2010). As a result, teachers tended to value topics that fall under “problem prevention and responsibility” versus “life enhancement” topics such as sexual feelings and expression, and masturbation and sexual pleasure. There are a variety of factors that might
influence a teacher to focus on “problem prevention and responsibility” but it is worth considering that a teacher’s own values might influence what topics are covered in their lessons. Apart from personal values, it is not entirely clear from the literature why a teacher may choose to prioritize sexual health education. For example, one study (Cohen et al., 2012) showed no difference between teachers who identified as male or female in regards to whether they focused on sexual health in their lessons. Although it has been difficult to explain why some teachers prioritize sexual health education, it is important to know the role of teachers’ personal values.

2.4 Conclusion

In this literature review, I first examined school-based sexual health education, different models of sexual health education, and sexual health education in Canada with a particular focus in Ontario. Particular attention was paid to teachers’ experiences of implementing sexual health education and perceived barriers and supports in doing so. While there have been studies of how Canadian public school teachers experience implementing sexual health education in the past, there is a gap in the literature pertaining to independent school teachers’ experiences of implementing the new Ontario HPE curriculum, including its sexual health content. This research study intends to shed light on the experiences of independent school teachers compared to public school teachers.
Chapter Three: Research Methodology

3.0 Introduction

In this chapter I describe the research methodology. I begin by reviewing the research approach and procedures before describing the main instruments of data collection. I then identify the participants in the study, list the sampling criteria, describe sampling procedures, and provide some relevant information about the participants. I explain data analysis procedures and review the ethical considerations pertinent to my study. Following this information, I identify both strengths and limitations related to the methodology. Finally, I conclude the chapter with a brief summary and rationale of key methodological decisions given the research purpose and questions.

3.1 Research Approach & Procedures

The study was conducted using a qualitative research approach involving a literature review and semi-structured interviews with five teachers. Qualitative research is often defined through a comparison to its counterpart, quantitative research. It is important however, to define qualitative research without the need to reference quantitative research because that once again privileges quantitative research. Yet it is difficult to completely encapsulate qualitative research because it can take many forms. As a result, qualitative research is most simply defined as research which captures “in detail and/or depth something significant in the social world” (Johnson & Waterfield, 2004, p. 122). A qualitative research approach was most appropriate for
my study because of its historical uprising and its reflexive component.

Beginning in the 1990s, qualitative research started to appear in the academic world (Lichtman, 2013). Women and people of colour wanted to explore ways to research without resorting to quantitative methods which were developed within a white European and patriarchal ontological and epistemological framework (Lichtman, 2013). The purpose then of qualitative research was to find a way to research without the loaded history and consequences of traditional forms of research. It was the hope that through this alternative path, alternative voices would appear (Lichtman, 2013). The goal of my study was to bring light to teachers’ experiences implementing the new Ontario Health and Physical Education curriculum. The voices of government and opposition have controlled the media and in the processed silenced teachers’ experiences. Qualitative research then, is highly appropriate because of its intent to give a voice to those who have been silent. Furthermore, qualitative research developed out of a “dissatisfaction” with educational research findings from quantitative research (Lichtman, 2013, p. xvii). The findings were often vague and poorly “disseminated” (p. xvii). It is for this reason that this research project used a research method that provides adequate opportunities for detail and depth.

Qualitative research was also most appropriate for my study because of its reflexive component. This research method allows for “assessment of researchers’ subjective experience and their impact on the setting” (Johnson & Waterfield, 2004, p. 122). As a teacher researcher, I wanted the opportunity to acknowledge my own social position and experiences in relation to my topic. It is important to engage in reflexive practices throughout the entire research journey, particularly before and after my semi-structured interviews. The rationale for using semi-structured interviews will be explored in the following section.
3.2 Instruments of Data Collection

Interviews are one of the most common employed methods for gathering data in qualitative research. The purpose of a qualitative interview is to contribute to preexisting bodies of knowledge about a particular topic through the interviewees’ “life experiences” (DiCicco-Bloom & Crabtree, 2006, 314). As a result, interviews are arguably the most effective way to discover teachers’ experiences implementing sexual health education. Both unstructured and semi-structured interviews are used in qualitative research. Unstructured interviews are typically used in conjunction with other data collection methods. For the purpose of this study, semi-structured interviews were most appropriate because they allowed for structure in the time and scope allotted yet permitted participants to explore additional issues that arose when necessary.

Semi-structured interviews use a set of pre-determined questions but leave room for further explanation (DiCicco-Bloom & Crabtree, 2006). This is one of the merits of semi-structured interviews because it allowed for topics to emerge that I had not considered. I am not a Health and Physical Education teacher who has experience teaching sexual health and therefore can not accurately understand this life experience. I based my information on a wide body of literature about teaching sexual health but ultimately do not know individual teacher experiences. Semi-structured interviews allowed for some guidance while still leaving room for discovery. This interview method allowed for some flexibility on my part. Through my MTRP, I hoped to gain experience as an interviewer and therefore acknowledge that I am not a highly skilled interviewer. Semi-structured interviews allowed me to drop questions that I had prepared ahead of time that may not suit the moment of the interview (DiCicco-Bloom & Crabtree, 2006). My questions served as prompts for teachers to begin to explore aspects concerning their experiences with sexual health education that they may have been unaware of (DiCicco-Bloom & Crabtree,
I wanted to remain aligned with my research question but ultimately wanted to create a safe and comfortable environment for my interviewees.

While semi-structured interviews can take place in a group setting, part of creating rapport with my interviewees was the decision to do individual interviews. This decision was made because individual interviews allowed me to explore more personal matters with my interviewees (Creswell, 2007). I did not want my interviewee to feel as though they must conform to other HPE teachers’ experiences implementing sexual health education. As a result, I believed individual interviews would eliminate this potential for misrepresented experiences. Furthermore, I also believed that the goal of my research, and qualitative methods, is to give voice to individual experiences. It thus seemed counterproductive to conduct a group interview when I was looking to privilege each individual voice.

I organized my interview protocol into five sections beginning with the participant’s background, followed by questions about the process of switching HPE curriculums, then their perceived barriers to implementing sexual health education, along with their perceived supports to implementing sexual health education, and concluding with any information they wish to discuss that was not discussed and potential next steps. Examples of questions that were in the interview protocol include:

- How did you learn that you would be teaching an updated HPE curriculum?
- Can you describe how you first accessed the new information on sexual health from the updated Health and Physical education curriculum?
- What has been challenging about implementing sexual health education in your school?

3.3 Participants

In qualitative research, participants refer to those who provide data to the researcher. As a
qualitative researcher, it is my responsibility to ensure that my participants know all the details of my MTRP, are comfortable throughout the interview process, and are protected (Lichtman, 2013). While their experiences may differ, the participants in the study must share some common characteristics in relation to the research question (DiCicco-Bloom & Crabtree, 2006). In the following sections, I provide a rationale for all methodological decisions related to the research participants.

3.3.1 Sampling criteria

The following criteria was applied to teacher participants:

(1) Teachers have taught sexual health education in a Toronto independent school that follows the new Ontario HPE curriculum. My study explored teachers’ experiences implementing the updated HPE curriculum with a focus on sexual health. It was therefore essential that teachers had experience teaching the HPE curriculum in Toronto specifically. While the curriculum was updated throughout Ontario, Toronto’s demographic differs dramatically from other parts of Ontario. In order to try to have some consistency with available supports or barriers, I felt it was important to select teacher participants working in the same geographic area. After narrowing geography, I determined that a teacher would qualify as an independent school teacher if they worked for a school listed in the Conference of Independent Schools of Ontario.

(2) Teachers have experience teaching both the previous and updated HPE curriculum. This research project required teachers who had enough experience to provide insight into the process of changing to the updated curriculum. I not only wanted teachers who were actively teaching during this process, but also who had experience with perceived barriers and supports to teaching the previous curriculum. This decision was made in the hopes of having some
comparative analysis between what reportedly changed from teaching the old to the new curricula.

### 3.3.2 Sampling procedures

Unlike quantitative research, qualitative research does not rely on large numbers of participants because the goal of this research is not to produce generalized findings. Instead, participants are chosen because they have a certain amount of knowledge or experience with the research topic (Hennink et al., 2011). The two most common employed methods of sampling are purposive and convenience sampling. Purposive sampling means selecting participants who are “information-rich” based on the researcher’s set criteria (Hennink et al., 2011, p. 85).

Researchers typically use a variety of recruitment processes to target their population. Convenience sampling involves using participants who are accessible to the researcher. This method relies on a researcher’s connection to their desired participants (Emmel, 2013). While both purposive and convenience sampling have their merits and challenges, my study employed convenience sampling.

As a practicing teacher and teacher researcher, I have developed a fair amount of connections to experienced teachers. My experiences allowed me to make connections to a few experienced Health and Physical Education (HPE) teachers who met the conditions set out in my sampling criteria. Furthermore, I also formed relationships with practicing HPE teachers who developed networks with experienced HPE teachers. These relationships allowed me to gain access to seminars about teaching the new HPE curriculum where I was able to meet experienced HPE teachers. The potential issue with convenience sampling is that because I have a limited or developed relationship with these teachers, my participants may feel pressured or obligated to participate in my research. Despite this concern, I ultimately believed that my limited or
relationship with my participants would only help to build rapport with them. Because of my network and the merits of convenience sampling, I felt it was most valuable to employ this method.

3.3.3 Participant bios

Below are the background details of the five participants who contributed to this research about sexual health education. As mentioned above at the time of the interview, each teacher worked in an independent school in Toronto and had some experience with the previous and present Ontario Health and Physical Education curriculum.

At the time of the interview, Amanda had been working for the TDSB and independent schools for over 20 years. Amanda has a background in kinesiology, a Bachelor of Education, and was working on completing their Masters of Education. Amanda has taught sexual health to a variety of ages but mostly teaches in the intermediate/senior level. Throughout the years, Amanda has been the department head for Health and Physical Education. Amanda enjoys building relationships with students both in the classroom and through extra-curricular activities.

At the time of the interview, Bryn had been working with an independent school for almost 20 years. Bryn studied kinesiology and had received a Masters of Education. During their career, Bryn has worked with all levels and most recently had taught at junior level. Bryn has also held other positions within their school and enjoys connecting with students outside of the classroom.

At the time of the interview, Caroline had been teaching for three years at an independent school. Caroline majored in Health Studied during their undergrad and later received a Bachelor of Education. Between this time, Caroline spent time traveling. Caroline has
a passion for all things health and coaches outside of school. Caroline teaches at the intermediate/senior level.

At the time of the interview, **Dianna** had been teaching for seven years at an independent school. Dianna studied kinesiology and had a career in homeopathy before becoming a teacher. Dianna completed a Bachelor of Education and has been teaching at the intermediate/senior level. Dianna has a great passion for health and the outdoors. Besides teaching, Dianna loves spending time with her family.

At the time of the interview, **Emma** had been teaching at an independent school for six years. Emma has taught at the junior level but mostly teaches intermediate/senior. Besides a love for health, Emma enjoys spending time outdoors and has a passion for leadership and immersion learning.

These participant bios were meant to provide a brief snapshot and context for the findings presented in Chapter Four. As explained above, each participant had a strong interest in health.

### 3.4 Data Analysis

After conducting my semi-structured interviews, I began to analyze the data. In order to analyze data, researchers start with a unit of data which might be a word or a phrase. Once researchers have identified this unit of data, they compare that unit with other units of data. In this comparison, researchers look for common patterns throughout the data (Merriam, 2002). These patterns are then given codes are sorted into categories which are sometimes referred to as the template approach (DiCicco-Bloom & Crabtree, 2006). In this study, I employed the above method for data analysis. I transcribed the semi-structured interviews, coded the data, compared the data looking for common themes or deviations, and then discussed the significance of these findings.
During my data analysis, I remained as unbiased as possible. One of the possible limitations of qualitative data analysis is that myself, a human being, analyzed the data. Qualitative researchers have argued that “people tend to record as data what makes sense to and intrigues them” (LeCompte, 2000, p. 146). Because selectivity cannot be eliminated, it is important in my research to be cognoscente of how my choices might affect data collection and the rest of the data analysis process. Two methods to avoid this bias is through tacit and formative theories. Tacit theories guide daily behaviour while formative theories also guide behaviour but they are more formal (LeCompte, 2000). Using these two theories and being open to things that may not make sense to me or may be more mundane will help to diminish this limitation to data analysis.

3.5 Ethical Review Procedures

Ethical issues exist in all forms of research (Hammersley & Traianou, 2012). Generally, there are some ethical risks of qualitative interview research. The nature of qualitative research itself relies on a relationship between the researcher and the participant (Sanjari et al., 2014). Before the interview proper, the researcher must design an interview guide to ensure anonymity, confidentiality, consent, and the researcher’s potential impact on the participant (Sanjari et al., 2014). After the interview, the researcher must perform data analysis and report the findings. Thus, in qualitative studies, the researcher is involved in every part of the research process. The researcher is involved and responsible for all stages in the study. Put differently, a human being, not an instrument, is an integral part of the process. If we consider a human being to be the instrument of choice in qualitative research than their interpersonal skills become of major importance to the study (Sanjari et al., 2014). Because interpersonal skills vary from person to person, there is often chance for the inability to replicate each interview. There is no mold, per
say, but rather each interview in qualitative research relies on the particular relationship that forms between researcher and participant. Because a relationship may develop, qualitative research must take into account the ethical considerations that may arise such as anonymity, confidentiality, consent, and the researcher’s potential impact on the participant (Sanjari et al., 2014).

Part of the reason for choosing qualitative research was its purpose to reduce the colonial and privileged past of research (Lichtman, 2013). I wanted to preface my semi-structured interviews with an acknowledgement for the difficult feelings that may arise when my participants think of their relationship to the term research. I also wanted to create a safe environment for my participants by allowing them to choose the location of their interview, protecting their identity, understanding the flexibility of consent, and decreasing risk of unforeseen harm.

Several aspects of receiving participant consent is to issue a consent form and to properly inform my participants on the nature of my study. My participants signed a consent form which outlined that their consent can be revoked at any time throughout the interview and that they are free to refuse any question at any time. This ensured that there was no coercion and that my participants were volunteers (Hammersley & Traianou, 2012). I was also very explicit that my study was designed to explore their experiences implementing the updated sexual health content from the new HPE curriculum. There were no known risks to sharing this information, but I informed my participants that the interview might bring up traumas if they previously had a negative experience. I tried to limit this risk by providing my participants with the interview questions ahead of time. Participants identities remained confidential and any identifying markers related to their schools or students was excluded.
Participants were informed that all data, including audio recordings, will be stored on my password protected computer and will be destroyed after 5 years. This not only established transparency but also trust that participants know I value their anonymity. This trust was further established because I did not have power over my participants. As a practicing teacher who is unemployed and will be speaking with experienced teachers, my participants felt assured that I posed no threat to them. This removed the traditional hierarchical relationship between the researcher and the participant (Hammersley & Traianou, 2012). Sharing information and removing traditional power structures hopefully allowed my participants to leave their experience with a positive view of research.

3.6 Methodological Limitations and Strengths

Like with any research method, there are strengths and limitations. In qualitative research, these limitations include the following. As stated in the previous section, a researcher’s interpersonal skills heavily impact the interview process (Anderson, 2010). On the same note, because the instrument in qualitative research is a human being, there are biases that might accompany this person into the research process. The participant can also be affected by the researcher’s interpersonal skills or biases and might alter their responses as a result. Finally, the researcher will analyze and present the findings based on their professional judgement and data analysis (Anderson, 2010). Yet despite these limitations, there are also strengths to qualitative research. The ability to develop a relationship between researcher and participant might allow for issues to be examined more closely. The interview itself can be adapted in real time which can allow for more information to arise (Anderson, 2010). Each interview is based on human experience which can provide more compelling findings than quantitative research. The findings themselves are connected to each lived experience and which consequently avoids generalization
and reproduction of a single story.

Based on the ethical parameters of the MTRP, only teacher interviews were permitted. As a result, I could not explore student or parent experiences with the updated HPE curriculum. Yet as I outlined above, I wanted this study to highlight what I determined to be the voices that were silent in media coverage of the new curriculum, teachers. This restriction did not ultimately affect my decision to interview teachers. The ethical approvals for the MTRP also restricted the number of teacher participants. Research suggest that the inability to generalize findings based on small sample sizes is one of the greatest limitations to qualitative research (Jackson II et al., 2007). The purpose of my study however, was to give privilege to the individual experience versus a generalized or shared experience. As we have seen in a very public Canadian trial, voices are only heard when they are in numbers. Because my study is linked to sexual health, I thought it would be counterproductive to only recognize “truth” if it was shared by many. My hope is that there can be “truth” drawn from individual experience without the need to validate it through a collective experience.

3.7 Conclusion

In this chapter I described the research methodology as it pertains to qualitative analysis and processes. I began by exploring areas such as research approach and procedures, and instruments of data collection. I then explained my participant criteria, identified participants for the semi-structured interviews, and revealed relevant information about these teacher participants. I proceeded to describe how I have analyzed the data through units of data which I coded and compared to other units of data and then discussed these findings. Following this section, I explored possible ethical issues that may arise that are present in all forms of research. I then explored methodological limitations and strengths to qualitative research highlighting that
many were explored throughout the chapter, and investigated ones that had not come up in previous sections. I also provided a brief summary and rationale of key methodological decisions. Chapter Four of this research study will report the findings.

Chapter Four: Research Findings

4.0 Introduction

Chapter One of this study introduced the purpose and research question which was the following: What supports or barriers are unique to independent school teachers’ experiences implementing sexual health? The next chapter provided an extensive review of the literature about sexual health education (HPE) in Canada, with a specific focus on Ontario. A gap in the literature concerning independent teachers’ experiences teaching HPE emerged. Chapter Three of this study indicated the research methodology, including participant criteria. The participant criteria classified independent school teachers as those who work for a school listed in the Conference of Independent Schools of Ontario. This chapter presents and analyses the findings that emerge through the data analysis of five qualitative semi-structured interviews. Through these interviews with Amanda, Brynn, Caroline, Dianna, and Emma, I hoped to provide insight into my research question.

While there are similarities between independent and public school teachers’ experiences, these findings indicate that there are significant differences. By noting moments of divergence in the literature about public school teachers’ experiences implementing sexual health education, I identified unique supports and barriers experienced by independent school teachers. In order to identify significant divergences, this chapter is organized into the following themes:

4.1 Amount of physical spaces and teachers
4.2 Training and professional development opportunities

4.3 Parent community

4.4 Feelings of teacher discomfort

To begin each section, I provide the theme statement which connects to the literature reviewed in Chapter Two, followed by my findings. The first three themes highlight additional supports received by independent school teachers that were not present in the literature about public school teachers. The final theme discusses a sense of discomfort independent teachers feel in teaching the new curriculum that was also not present in the literature. The findings from this research suggest that independent school teachers may receive more supports than public school teachers when implementing sexual health education. The end of this chapter summarize the findings and begin to discuss recommendations and next steps, which will be further explored in Chapter Five.

4.1 Amount of Physical Spaces and Teachers

Independent school teachers reportedly transform physical spaces into safe spaces by allowing teachers to teach in teams and to select the learning space. The amount of available facilities and teachers reportedly allowed independent school teachers the flexibility to create a safe physical space to teach about sexual health.

Providing teachers with the flexibility to select a physical space where both they and their students feel comfortable creates a safe place to learn about sexual health. Despite construction in their classroom, Dianna had a choice to teach sexual health in the gym or in an alternative classroom. Dianna decided to select a place that was familiar to students and chose to teach in the gym. Dianna believed that teaching sexual health in the gym was different than “previous years” because the space allowed for their students to “sit in a big circle.” This formation was not
“new” to the students because they frequently sat in a circle during instruction. The routine was not only familiar but also allowed Dianna to “keep their [students’] attention” and as a result reportedly made the environment more engaging. The environment was engaging because Dianna could see all of their “students’ faces” which allowed them to constantly see which students needed to be more engaged. Because Dianna felt their students responded well to learning about sexual health in a space outside the classroom they planned to use this strategy in the future:

Based on how it went this year, I am going to go outside in a circle, you know get away from the school a little bit. It was really successful for me and it has been successful the past couple of years so I would continue doing that for sure.

Dianna’s experience suggests that if students and teachers feel they are learning about sexual health in a safe space than the experience will be more successful. In this instance, a safe space creates opportunities for the successful implementation of content and student learning. The freedom to stay in the school or leave also allowed Dianna the flexibility to decide what space they wanted to teach sexual health. While Dianna found success in the gym, Emma found teaching sexual health in the classroom to be more successful.

Unlike Dianna, Emma felt that the classroom was a safe space to teach and learn about sexual health. Emma explained the classroom was a “safe space” because all the Health and Physical Education teachers “share one classroom.” By sharing this space, Emma believed that students felt comfortable because the classroom was “kind of in its own wing.” Emma’s experiences suggest that having a space which feels separate from the rest of the school allows students to feel more safe while learning about sexual health. As a result, Emma believes that teaching sexual health in the classroom was “definitely better than doing it in the gym.” The
option for Emma to favour the classroom over the gym again alludes to the availability of facilities at their school. Emma’s experience further illuminates the importance of physical space when teaching sexual health. Independent school teachers also had the option to decide who occupies this physical space.

For many participants, there were describable benefits to being able to decide who occupies their physical space and to therefore choose to teach sexual health with other HPE teachers. Amanda, Emma, and Bryn believed teaching teach sexual health in pairs was beneficial to both the teachers and the students. For instance, Amanda thought this approach “worked well” because students always had a close relationship to at least one teacher in the room. With a non-semester school, teachers see their students less frequently. Thus, it can be difficult for teachers to have a close relationship with every student in the school. In Amanda’s case, teaching with a colleague allowed students to know at least “one teacher” in the room as opposed to feeling like students were learning from a teacher they did not know. Another benefit to teaching in pairs was that it allowed students to see there are variety of ways people view sexual health. Amanda explained they always emphasized the emotional side to relationships while their colleague tended to focus on the physical part of a relationship. Amanda thought this dual perspective was useful for students to observe because they could see two adults “respect” each other while having a “real dialogue” about issues in the sexual health unit. Instead of simply talking about healthy relationships, teachers could model what this looks like for students. This pedagogical technique was also useful for teachers because they were able to lean on their colleague for support. Many participants noted the importance of collaboration. For instance, Emma declared that “the best support we have is each other” when discussing collaborating with teachers in their department. In the instances described above, teachers must have a flexible time table and
freedom to co-plan and co-teach with other teachers in their department. Based on these participants’ experiences, teaching in teams allows for both students and teachers to benefit. In order for two teachers to occupy one space, the school would need to have enough staff. Bryn explained how they believe they have a larger HPE department than public schools.

Participants’ experiences highlight that they were able to create a safe space by choosing the space and choosing who occupies this space. The literature confirms that students need to feel comfortable when learning about sexual health (Ninomiya, 2010). The literature reviewed in Chapter Two did not highlight physical space as a factor for student and teacher comfort. The literature mentions how students are learning about sexual health in spaces other than the gym or classroom. In recent years, this space has become the internet (Allison et al., 2012). Besides this information, there was nothing found about transforming physical spaces into safe spaces for learning. The absence in the literature could suggest that physical spaces were not accounted for because teachers generally do not have a choice as to where they wanted to teach sexual health (Allison et al., 2012; Ninomiya, 2010). As well as an absence in the literature, it seems there was an absence of choice for public school teachers. It appears that in this study however independent school teachers had the option to teach in a classroom, gym, or wellness centre.

Furthermore, the reviewed literature did not highlight whether teaching in teams was more beneficial or possible. Yet as these findings suggest, the option for teachers to teach in teams was beneficially for their instruction and student learning. These findings matter and are important to the body of literature about teachers’ experiences implementing sexual health because they highlight potential changes schools can make to support their HPE teachers and also provide an important pedagogical tool for teachers. Not only did participants select the
physical space, they also had the option to seek additional training and professional development.

4.2 Training and Professional Development Opportunities

While public school teachers also have the option to participate in professional development and training, these independent school teachers felt “lucky” that their schools encouraged participation and that the size of their department allowed for teachers to share what they learned from these opportunities.

Participants felt that their school community was progressive and therefore encouraged HPE teachers to attend additional training or professional development opportunities related to sexual health. Participants expressed how their schools were supportive of implementing the updated sexual health component of the HPE curriculum. Emma believed their school was supportive of the changes because of the progressive nature of their school. Emma explained, “I guess I’m part of a really progressive school that is really supportive. I mean we definitely had to implement changes and this year right when it came out and um, everybody really just jumped on board.” Because Emma felt like their school was progressive and therefore open to the changes from the beginning, they felt supportive throughout the entire process. This support led to teachers feeling lucky about their circumstances and caused them to seek additional training. For example, Emma expressed how they were “lucky” their school “provided” teachers with “professional development opportunities” and allowed them to attend “anything else that really interested us.” In this case, Emma believed their school not only provided teachers with what they needed, but also what they were interested in. This is an important distinction because it suggests that Emma believes their school provides more than just what is necessary or what is
required. Instead, Emma thinks their school gives them the opportunity to pursue their interests related to sexual health. In order to meet the sampling criteria of this study, participants needed to have an interest in teaching sexual health. In turn, all participants cited how their personal interest in the content made them better teachers. Emma’s experiences may indicate that when teachers feel like their interests are supported by the school, they can more successfully seek additional training opportunities. This feeling made Emma believe they were “lucky.” There is a new level of support when teachers feel lucky to work at their school.

Bryn also used the word “lucky” to describe the opportunities their school gives their staff to attended conferences and professional development. Bryn believed that “public school teachers” do not have the “same access” as teachers in “independent schools” because they get to attended conferences specific to independent schools. Bryn’s understanding of “lucky” directly connects to the ability for teachers to have access to both information and resources. Like Emma, Bryn believes it is their school that makes them lucky and gives them access to resources public school teachers do not have. In some cases, this is access to other regions of the province.

Amanda expressed how they were able to seek additional support outside of the greater Toronto area. Amanda explained how their school allowed the staff to look outside their “body” and attend conferences in Guelph. Participants’ experiences suggest that independent school teachers believe they have access to more training and professional development opportunities than public school teachers. These findings are important because participants believe they can access information and opportunity if they need to. Based on these participants’ experiences, there is a sense of security that comes when teachers believed they can access knowledge particular to their subject. Even without attending the conferences, participants still had access to the resources.
Participants noted that limited time prevented them from attending all professional development opportunities however, because they were part of a large department they were still able to access information. Caroline explained how their department had a system to attend conferences that usually involved sending a “representative” from the department to “attend the conference then come back and share resources, you know, a resources bank that we would draw upon.” The ability for a department to be large enough that they could attend most additional training opportunities meant that all teachers had access to the material. Like Caroline, Bryn remembered how they were not able to go to the Ophea Conference this year but that “someone in my department went” and then passed along the resources. Compiling resources into a bank or database allows for teachers to easily access this information. Additionally, the size of the department allows for teachers to have the freedom to engage in additional learning opportunities. Because independent school teachers believe they can access information, they may be more comfortable implementing sexual health education.

While there is no literature that compares how many Toronto public school teachers and independent school teachers attend professional development opportunities, the literature does show that training made teachers more comfortable teaching sexual health (Cohen et al., 2012). These findings matter and are important to the body of literature about teachers’ experiences implementing sexual health because independent school teachers felt that accessing additional training gave them more access to resources they could use while teaching sexual health. As expressed above, participants believed that having a large repertoire of resources and the knowledge on how to use these resources was a significant support to comfortably implementing sexual health. This chapter will later explore how teacher discomfort can hinder a teacher’s ability to implement sexual health education. It seems however, that independent school teachers
will only become more comfortable as a result of their opportunities to seek additional support and access information. When a teacher has more knowledge and is therefore more comfortable delivering content, parents become more trusting.

4.3 Parent Community

Participants believed their parent community supported the sexual health updates because independent school teachers are trained experts as opposed to non-specialist teachers. Public schools often have a non-specialist teacher implement sexual health education and can be one of few teachers in the department (Cohen et al., 2012). The independent schools in this study each had a trained HPE teacher for each grade which increases the size of the department and parent’s trust.

Like with public schools, initially the media coverage of the new HPE curriculum caused some parents to become concerned as to what their child would learn during the sexual health unit. When parents brought these concerns to the teacher, however, they quickly felt at ease. Bryn remembered having an “uninformed, afraid” parent email them to voice their discontent based on “what they heard from the media.” As a department, Bryn and their colleagues thought of an appropriate response. They decided to reply to the email and explain that they were going to be addressing the topics in a sensitive matter and update parents on what was being taught as it happened. Bryn noted that this open response “usually set their mind at ease.” Because Bryn has a large HPE department, they were able to sit with their colleagues and form an answer that directly addressed parental concern. Bryn directly linked the size of their department to being in an independent school. They explained that public schools “aren’t afforded” as many HPE teachers as “independent schools.” It seems that the size of the department allowed for Bryn and
their colleagues to work together and ensure there was open communication with parents during the sexual health unit.

It appears that opening the lines of communication between independent school teachers and parents was possible because of the size of their HPE departments. Not only could HPE teachers’ answer parents’ concerns as a team, they also worked together to prepare a parents’ night. In preparation for the event, participants met with their department and their school’s curriculum lead and gathered resources to create a parent packet. Most participants had taken or adapted a ministry developed resources for parents. After the meeting, Bryn said their entire department studied the curriculum and the ministry resources for dealing with parents. Expecting an “onslaught of upset parents” Bryn and their colleagues were pleased to find that many parents were supportive of their implementation of the updates. Working as large department with the school’s curriculum lead, Bryn and their colleagues were able to put together informative resources for parents. Collaboration between a large group of HPE teachers and other staff at the school allowed for them to share and create parent resources. Like Bryn, Caroline, Dianna, and Amanda also thought their school had a supportive parent community.

Parents not only supported the updates but also expressed feelings of appreciation and gratitude towards participants for teaching sexual health. For instance, Caroline noted that the “parent community” was one of the many sources of support during their most recent experience teaching sexual health. Furthermore, Dianna explained that “none of my parents put up any fuss” after learning their school would be implementing the changes. Similarly, Amanda remembers having some difficulties with parents in the beginning of their career. They explained that while working at a public school some parents pulled their child from the sexual health unit. When asked if Amanda had any parents pull their child from class this past year or had any upset
parents they said “Um no, interestingly.” For other participants, parents exuded gratitude towards the teacher for teaching their child about sexual health. Dianna remembered one parent said “Thank god you’re doing this in class because I did not want to have these conversations.” One parent told Dianna they were glad to hear their child would be learning about consent. These participants report feeling supported by their parent community because they felt the parents trusted them because they were content experts as opposed to regular classroom teachers.

Each participant worked in a large department and were seen as content experts by their parent communities. For example, Bryn felt parents trusted in the department because there were many experts working together as opposed to a few. Compared to “public schools” which typically have “classroom teachers” teach sexual health, Bryn felt having more “trained phys. Ed” teachers made independent schools “unique.” Bryn went on to explain that the curriculum leads “trusted” the HPE teachers to handle the updates because they were viewed as “experts.” Because curriculum leads trusted their teachers it also allowed parents to trust the teachers at the school. The parent community at Bryn’s school had a deep trust for not only teachers but also curriculum staff in the school. Parents trusted in their teachers as HPE teachers because there is the assumption that the teacher is an expert in their content. Bryn’s experience as an HPE teacher was similar to other participants because as mentioned above, each participant had a supportive relationship with their parent community.

Based on information gathered from these participants, independent school HPE teachers from this study developed supportive relationship with parents because they had a large department of content experts. At first blush, these findings converge with the literature because 95% of Ontario parents support the implementation of sexual health in schools (McKay et al., 2014). Yet in this instance, parents placed value on the content and not the teacher’s ability or
knowledge of the content. In a study done by McKay et al. (2014), Ontario parents supported schools teaching sexual health education because they felt it was an important subject. But findings from the present study suggest parents place value on both the content and the teacher. Participants from this study expressed how they believed parents felt the content needed to be delivered by a certain kind of teacher.

These findings matter and are important to the body of literature about teachers’ experiences implementing sexual health because parents supported sexual health when they felt it was being implemented by a trained expert as opposed to a non-specialist teacher. Public support of Ontario’s education system is one of the ministry’s four mandates. Those who drive public support of Ontario’s education system tend to be parents. If parents believe their child is learning from a trained expert, they may be more supportive of not only classroom teachers but also of curriculum change. Thus, these findings show how the school community must believe teachers are experts in their content. But it seems that in independent schools, teachers are not the only experts in sexual health.

4.4 Feelings of Teacher Discomfort

Independent school teachers might feel uncomfortable about their lack of knowledge compared to their students, the potential to offend their students, and the generation gap between them and their students. Amanda explained that some teachers feel may uncomfortable about teaching students sexual health because they believe their students know more content than they do and they do not want to offend their students. Many independent schools only accept students who have demonstrated high academic abilities. According to their mission statements, on top of being high achieving, independent schools want students to explore their identity in the world. In order to foster personal growth, one school held many assemblies and panels where students
could explore issues related to their identity. Amanda recalled an event at their school when students on a panel said that if a someone uses the “wrong pronoun for certain students, it’s an act of violence.” At a staff meeting soon after, Amanda remembers their colleagues talking about having to teach gender identity in the sexual health unit and feeling uncomfortable about discussing this issue with students who have such a strong personal connection to the content. Amanda explained how teachers felt uncomfortable:

And now we get that kind of feedback of, it’s an act of violence, and well like now we don’t even wanna step foot and talk about that because we don’t wanna create an unsafe space, we don’t wanna create issues in the classroom where you feel we are not being respectful.

As previously noted, participants explained developing a safe space to discuss sexual health education was one of the most effective ways to deliver content. Amanda believed that the potential to offend your students would destroy that safe space for some students. These findings suggest that teachers from this study are not uncomfortable discussing issues like masturbation, pleasure, birth control, and instead are uncomfortable because they fear they might offend their students due to their lack of knowledge about this specific content and student identity. Based on many of their mission statements, these independent schools try to build a school community that encourages students to feel free to express themselves. In order for teachers to try to understand their students, teachers are encouraged to build strong relationships with students.

Amanda explained how they worked with a student who had changed their gender identity and accidentally called their student the wrong pronoun. Although Amanda reported that the student was “disappointed” the student took the time to talk to Amanda about it. Amanda believed that the student allowed them to take the time to navigate the issue and gave them the
“opportunity to kind of figure out and understand and do better.” Amanda remembered how grateful they were for this opportunity because it was “what we needed, it’s what anybody needs, when you’re growing and learning.” The discomfort resulted from a need to learn from students about sexual health and to learn about student identity. This diverges from the literature because teachers felt uncomfortable about having discussions around identity rather than around topics such as “sex, birth control methods and safer sex practices” (Cohen et al., 2004, p. 1). The discomfort experience by Amanda and their colleagues also results from a generation gap.

According to Amanda, a generation gap between teachers and students has caused some teachers to feel hesitant about teaching sexual health. They believe the gap between teachers and students developed because the field of gender and sexuality has only recently come into mainstream conversation. Amanda notes that there have been no “resources for a long long long time” and because the subject is new teachers have “not been trained to speak about it.” Amanda explained that students today have a much stronger understanding of some content in the HPE curriculum than teachers. For instance, Amanda believes that students today have a much greater awareness about using proper “terminology” concerning gender identity. Amanda thinks that in their twenty-years of teaching there has been an increase in what students today know about gender and sexuality. Amanda explains that “their [students’] knowledge base just continues to grow” while teachers “feel like we are trying to find ah...a platform to start from.” As students’ knowledge continues to develop some teachers feel that there is “this gap of knowledge and a gap of understanding” which caused Amanda to wonder “How do I, how do we, know how to navigate certain things.” Along with their colleagues, Amanda will try to navigate teaching sexual health alongside their students. In this instance, students are not a barrier because of their maturity or readiness to learn (Ninomiya, 2010). Instead, students have made teachers hesitant to
teach because they belong to an entirely new generation that are broaching topics related to gender and sexual identity in a more overt way.

In the literature surveyed about public school teachers’ experiences implementing sexual health education, there was nothing specific about a generation that discusses sexual health as the reason for the discomfort between teachers and students. Instead, the literature predicted there would be a generation gap between teachers and students when implementing sexual health but claimed that this gap was due to the technological revolution (Allison et al., 2012). Because of social media, students have a much different adolescent experience than their teachers. Yet the findings from this research suggest that there might be more at play than just technology in the generation gap between teachers and students and implementing sexual health education. Students from independent schools are encouraged to know content while exploring their identity. While participants voiced student identity as a positive, it also exposes a new discomfort among teachers about how to navigate these issues.

These findings matter and are important to the body of literature about teachers’ experiences implementing sexual health because this discomfort suggest that teachers required more training in order to teach the updated curriculum and to diminish the fear of offending their students. Furthermore, the findings might suggest that HPE teachers need professional development opportunities about the content related to sexual health as opposed to how to implement new policy. More recommendations and suggestion for further inquiry will be made in the Chapter Five of this research study.

4.5 Conclusion

After analyzing and comparing the data to the literature reviewed in Chapter Two, four major themes emerged: 1) teachers who have additional collaborating teachers and facilities can
reportedly create a physical space where both students and teachers feel safe; 2) the more teachers have the ability to attend training and professional development opportunities the more comfortable they feel teaching sexual health education; 3) parents trust their child to learn from teachers who are considered subject experts as opposed to non-specialist teachers; and 4) there is a feeling of discomfort among teachers when they fear they do not know as much as their student and/or when they fear they might offend them, and when they are unable to close the generation gap between themselves and their students. It is important to emphasize that each theme emerged after the data analysis showed a divergence between supports received by public schools and those receive by independent schools. The findings from this research suggest that independent school teachers may receive more supports than public school teachers when implementing sexual health education. The next and final chapter of this study will provide implications and recommendations related to the above findings about independents teachers’ experiences implementing sexual health education.
Chapter Five: Conclusion

5.0 Chapter Introduction

This chapter briefly revisits the findings of this study and their significance, which was explored in detail in the previous chapter. Based on the findings, this chapter explores then highlights broad and narrow implications of implementing sexual health. Following the implications, recommendations to improve teachers’ experiences implementing sexual health will be suggested. This chapter will conclude its contribution to the literature about sexual health education in Toronto schools by indicating areas for future research. The end of this chapter will reflect on the significance and goals of this study.

5.1 Overview of Key Findings and their Significance

In this study, four themes emerged based on semi-structured qualitative interviews with five independent school Health and Physical Education teachers from Toronto. The interviews were conducted using the following research question: What supports or barriers do independent school teachers’ experience while implementing sexual health? As highlighted in Chapter Two, there was literature about public teachers’ experiences but a gap in the experiences of independent school teachers. By noting moments of divergence in the literature about public school teachers’ experiences implementing sexual health education, I identified unique supports and barriers experienced by independent school teachers. Based on these divergences, four major themes emerged, as follows.

(1) Independent school teachers transform physical spaces into safe spaces by allowing teachers to teach in teams and to select the learning space. Participants believed they had the
flexibility to choose a space and who occupied that space when teaching sexual health. Ultimately, participants reported that this choice allowed teachers to turn physical spaces into safe spaces. In the literature, there was nothing found about public school teachers’ and the ability to transform physical spaces into safe spaces. The absence in the literature could suggest that physical spaces were not accounted for because teachers generally did not have a choice as to where they wanted to teach sexual health (Allison et al., 2012; Ninomiya, 2010). In this study, participants’ choice and availability of facilities and teachers suggests they were able to deliver sexual health education in a way that was more comfortable for them and their students.

(2) While public school teachers also have the option to participate in professional development and training, independent school teachers felt lucky that their schools encouraged participation and that the size of their department allowed for teachers to share what they learned from these opportunities. Participants in this study expressed feeling lucky for the opportunities afforded them to seek training and professional development. They directly cited this to feeling supported by their school community. Furthermore, participants also felt lucky to have such a large department, something they felt only independent schools could offer. The size of their departments allowed them to divide professional development opportunities and not feel pressured by time to attend because they knew at least one person from the department could participate. Participants’ experiences suggested that independent school teachers believe they have access to more training and professional development opportunities than public school teachers. These findings are important because participants believed they can access information and opportunity if they need to. Based on these participants’ experiences, there was a sense of security that comes when teachers believed they can access knowledge particular to their subject.
(3) Participants believed their parent community supported the sexual health updates because independent school teachers are trained experts as opposed to non-specialist teachers. Public schools often have a non-specialist teacher implement sexual health education and can be one of a few teachers in the department (Cohen et al., 2012). In this study, all independent schools where my participants teach reportedly had a trained HPE teacher which increased the size of the department and parents’ trust because teachers were valued as content experts. As explored in Chapter Four, participants felt that parents’ were supportive in their implementation of sexual health because the size of the department allowed for quick and frequent communication with parents. The size of the department allowed for teachers in this study to spend more time communicating with parents because they were not stretched too thin. For instance, participants could spend more time talking to parents because not all their time was wrapped up in looking for resources. Teachers in a larger department were able to have more support from their colleagues. Furthermore, participants reported that having more teachers in a department who are all trained HPE teachers allowed for parents to trust them as content experts as opposed to a classroom teacher responsible for teacher HPE. These findings are important to the body of literature about teachers’ experiences implementing sexual health because parents supported sexual health when they felt it was being implemented by a trained expert as opposed to a non-specialist teacher.

(4) While the literature suggests teachers’ experience feeling discomfort while teaching sexual health, participants from this study reported this discomfort was not a result of shyness. Instead participants from this study felt discomfort about their lack of knowledge compared to their students, the potential to offend their students, and the generation gap between them and their students. The literature predicted there would be a generation gap between teachers and
students when implementing sexual health but claimed that this gap was due to the technological revolution (Allison et al., 2012). Participants from this study felt a gap between their students because their schools accepted students with high academic abilities and encouraged personal growth. As a result, participants reported that their students often knew more than they did about topics such as gender and sexual identity.

Based on these four themes, this study suggested independent school teachers have more resources when implementing sexual health than public school teachers. Participants reported having more advantages because of their experiences working in a Toronto independent school. The next section of this chapter will explore both broad and narrow implications of these findings.

5.2 Implications

The following section will explore both broad and narrow implications of this study. Based on the finding, the section will first explore what is happening on a broad level connected to the educational community and then conclude with implications on a narrow level in relation to personal identity and practice. In conjunction, this section will serve to further investigate the findings and inform the next section concerning recommendations.

5.2.1 Broad: The educational community

This section explores the broad implications of this study about teachers’ experiences implementing sexual health education. The first implication of this study is that teachers who feel they have more freedom to reflect and modify the spaces they teach in may have greater success implementing sexual health. The next implication in this section is parents’ perception of teacher identity. Parents who believe that their child’s teacher was a content expert may be likely to support their teachers. The final implication in this section suggests that a curriculum update
might be needed to support students’ knowledge about sexual health. After exploring each implication in further detail, recommendations will be made in the following section.

Based on the findings of this study, administrators who allow for a more innovative form of teaching that let teachers to work together in the classroom and flow between spaces ensures that both teachers and students feel comfortable. Yet this study also implies that teachers themselves need to be open to seek new spaces and implement collaborative teaching pedagogies. Participants in this study thought about the most comfortable place for their students to learn about a particular subject. Instead of making a decision at the beginning of the year as to how their classroom would look, it appears what happened was teachers from this study were constantly reflecting on what would be the best space for their students to learn about sexual health.

Furthermore, participants shared that their students might be more comfortable with another HPE teacher and embraced this connection in the classroom. Instead of feeling insecure by some students connecting more with other staff, participants in this study welcomed this opportunity because it created a safer space to learn about sexual health. It seems therefore that both teachers and administrators were flexible and adaptive when thinking about creating a safe space for learning. When principals allow for and teachers embrace team-teaching students might be more comfortable with having more adults in the room. Students have unique bonds with their teachers and allowing for this relationships to support instead of hinder the implementation of sexual health might lead to a more positive experience for students. This study indicates that perhaps students feel more comfortable learning about sexual health when teachers can teach in teams. Teachers used their professional judgement to design a safe space
for learning. It appears however that their professional abilities allowed for more supports when implementing sexual health.

The findings from this study imply that parents in this study trusted and supported their child’s teacher. Participants in this study reported feeling supportive of their parent community because their parents’ regarded them as experts. As a result, teachers from this study did not need to justify their reasoning for teaching the new HPE curriculum. This study indicates that parents are perhaps more likely trust teachers when they believe their teachers are experts. Thus what happens in this case is that there is a distinct difference between classroom teachers and specialist HPE teachers. The difference in title and attributed knowledge based on that title is significant. Teacher education prepares teachers for a difficult career filled with layers of supports and barriers. Yet in this study, it seems like one of the potential greatest barriers of all can be avoided when teachers perform a specific identity.

Participants from this study all addressed having a great interest and passion for health. Many expressed how they wanted to become an HPE teacher not because they were necessarily a coach but to teach about topics related to health. Furthermore, participants all expressed that one of the greatest supports was their own interest and research about sexual health. This study indicates that teachers who became HPE teachers who focused on both physical and health education might have more positive experiences implementing sexual health education. But even these participants expressed that often times they found their students’ knowledge surpassed their own. In this instance, teachers’ tried to embrace their students’ knowledge instead of allowing themselves to feel insecure about their content awareness. This study indicates that teachers who allow themselves to be part of the learning process with students use student knowledge to help inform their sexual health unit. Thus, teachers who allow for a teacher student relationship that
empowers students to share their knowledge, even if it surpasses the teacher, could allow for students to support their teacher in the learning process.

5.2.2 Narrow: My professional identity and practice

As stated in earlier in this thesis, I wanted to explore teachers’ experiences implementing sexual health education because of my own interest in the topic and previous experience. I am not a HPE teacher and will mostly likely never teach sexual health. Yet conducting this research made me think differently about how I can support the HPE teachers in my school as an English and History teacher. For instance, this research has made me want to think about connecting with HPE teachers and doing a cross-curricular approach (while they teach sexual health I can explore literature or movements related to sexual health). This research has allowed me to see connections between two traditionally very different subjects.

During the early stages of this project I planned to explore both public and independent school teachers’ experiences implementing sexual health. Yet as my own identity as a teacher-researcher and a social justice teacher developed I wanted to look at this topic through an equity lens. After speaking to my first two participants I wondered if there was something unique to independent school teachers’ experiences and decided to pursue this avenue. Independent schools, especially in Toronto, are often perceived as a place of inequity because of the large tuition costs to attend these schools. As I worked through this research, my interest in sexual health merged with my desire to become a social justice educator. This new part of my teacher practice made me seek out OISE workshops, join OISE’s Mental Health Committee, and choose elective that focused on gender equity.

I also planned to explore sexual health because there was a direct link for me between healthy relationships and positive mental health. As explored earlier in my MTRP, my
experiences with my own relationships in high school and the loss of my brother due to unhealthy relationships made me interested to investigate if there was something different being done in Ontario schools as opposed to New Brunswick, where I grew up. Because of the scope of this study, I only had time to investigate the many layers involved in supporting teachers who are implementing sexual health. I was not able to get into more detail about how teachers might be encouraging and promoting healthy relationships in schools. I did, however, get to speak with five HPE teachers who were dedicated to their students and their practice. This left me feeling hopeful that teachers are taking time in their units to explore issues related to health just as much as they spend time on fitness and sport.

Furthermore, I was also able to explore how my own relationship with HPE teachers has changed. During high school I was never close with my HPE teachers despite having strong connections to most of my other teachers. I was never particularly seen as someone who excelled at sports and consequently was not confident during gym class. Now as a teacher candidate and researcher, I was easily able to communicate and connect with these teachers. This may be a new understanding of the profession or the connection these teachers all had to health. Regardless, conducting this study has made me rethink my relationship to HPE teachers and feel hopeful that schools are opening the conversation about healthy relationships between adolescents.

5.3 Recommendations

The following section will explore recommendations informed by the implications indicated above for several stakeholder groups in education with particular focus on Ontario. While there are mostly likely a wide variety of possible recommendations, this section will explore recommendations for school administrators, continuing education faculties, and curriculum writers. Within each recommendation, feasibility, time, and possible outcomes will
be explored. These recommendations might serve to level possible inequities suggested by this study between public schools and independent schools.

5.3.1 School administrators

As was explored by the first implication of this study, when teachers felt like had the flexibility to change spaces and decide who occupies these spaces they were able to more effectively implement sexual health education. It would be impractical to suggest that schools build additional facilities to allow teachers more choice as to where they teach sexual health. Similarly, although many new teachers would appreciate it, it would also be counterproductive to recommend boards hire more teachers so that teachers have the option to team teach. In order to feasibly work within the current system, principals and vice-principals can allow teachers to use whatever spaces are within or outside the school. Teachers might not be aware they are capable of changing spaces so it might be further beneficial for administrators to explicitly tell their staff they have the freedom to move around the school as they see fit. Also, principals and vice-principals can suggest to their HPE teachers that they can connect with their department and create a schedule that allows for team teaching. Because teachers are often aware of their ability to work with particular staff members, it would be more effective to allow the department to configure this option if they wish. Time-wise, this recommendation would only involve a few meetings with administration and teachers in order to communicate that there can be flexibility in how teachers implement sexual health in a safe space.

5.3.2 Continuing education faculties

Parents who believed their child was learning from a specialist teacher were typically supportive of sexual health education because they believe their child was learning from a content expert. Participants from this study reported that independent schools had more trained
HPE teachers as opposed to classroom teachers implement sexual health. Once again, it would be impractical to suggest the board hires more trained HPE teachers if this is not financially feasible. Thus, continuing education faculties could suggest acquiring an Additional Qualification (AQ) in Health and Physical Education for public school classroom teachers who are teaching HPE. If possible from the school, money allocated to professional development could be used towards supporting this AQ course. Likewise, in the interest of ensuring parent support, faculty of education programs who typically charge around $600 for such a course could provide a one-time discount for teachers who meet the above criteria. While this recommendation would involve the cooperation of schools and continuing education faculties, it could serve as a start to changing how parents perceive teacher identity of classroom teachers who are required to teach HPE. It would also provide those teachers with additional financial security if the AQ could help raise their pay grade.

5.3.3 Curriculum developers

Participants noted that their students’ knowledge about sexual health often surpassed their own. While participants from this study saw this as an advantage, they reported that some of their colleagues felt insecure by this dynamic. Inquiry-based learning allows for the relationship between students and teachers to change. Instead of the banking model of education where students passively listen to the teacher who is considered the expert, inquiry-based education values student knowledge and places students and teachers on the same level. If the hierarchy between teachers as knower and student as recipient changed, HPE teachers might more easily embrace themselves as learners alongside their students. While inquiry-based learning has made itself into some Ontario curriculums, teachers often feel they do not know what inquiry-based learning actually looks like. Curriculum writers could more easily connect
theory to practice and provide teachers with concrete lesson plans and strategies to implement inquiry-based learning in the HPE classroom. Curriculum writers could work in collaboration with teachers engaging in inquiry-based learning and researchers in the field. This collaborative approach would ensure the connection between theory and practice. Teachers who feel insecure by students’ knowledge could then rethink the pedagogies around why the teacher must be a content expert and embrace a model of education which is student driven.

5.4 Areas for Further Research

While the findings of this research paint a picture for some independent HPE teachers’ experiences implementing the new Ontario HPE curriculum, there has been little research about public school teachers. Given the scope of this research study, it was difficult to interview more teachers and have a comparative between public school teachers and independent school teachers. Thus, current public school teachers’ experiences are one area of further research for this study. This study also focused on the downtown Toronto area, Canada’s most urban multicultural setting. Further research findings might be communicated to teachers, whether in a public school or an independent school, in rural areas of Ontario. This research could highlight rural Ontario teachers’ experiences implementing the new HPE curriculum.

As expressed earlier, one of the limitations of this research is the scope of the MTRP. As part of the program, our parameters were to interview teachers. It is therefore important to gather an array of experiences about the new Ontario HPE curriculum. These additional experiences could include administrators, curriculum writers, parents, and students. Research about each of these experiences would help to close gaps in the literature which currently exists. These voices could also provide more experiences about sexual health education and might help to diversify understandings of peoples’ relationships to sexual health education. This would allow for a
multitude of perspectives, eliminating a single story narrative, and open the possibility for further research.

5.5 Concluding Comments

This Master of Teaching Research Project explored independent teachers’ experiences implementing sexual health education. It was of particular interest to me as an History and English teacher candidate to investigate another subject that pays particular attention to our youth’s mental health. The research matter for teachers who are trying to navigate what can be a particularly sensitive subject to teach. Furthermore, this research is important to those I suggested are involved in the recommendations. As stakeholders, there is the opportunity to make changes which will help not only teachers but more importantly students. I hope that this research provided a starting point for those looking for outcomes of the new curriculum and for HPE teachers. I hope that further areas of this research are explored by other teacher-researchers and those in the field. As a teacher-researcher, this was my first opportunity assuming this identity. While it was trying at times, I hope other teachers will engage in a relationship with research that allows for an investigation into our own practice as teachers. Ultimately, like all healthy relationships, my relationship with this MTRP was nothing short of rewarding.
References


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Appendix A: Consent Form

DATE

Dear ______________________________.

My name is Rachel Burton and I am a student in the Master of Teaching program at the Ontario Institute for Studies in Education at the University of Toronto (OISE/UT). A component of this degree program involves conducting a small-scale qualitative research study. My research will focus on veteran teachers’ experiences implementing the new Health and Physical Education (HPE) curriculum with a particular focus on sexual health. I am interested in interviewing teachers who have experiences teaching both the previous and new HPE curriculum. I believe that your knowledge and experience will provide insights into this topic.

Your participation in this research will involve one 45-60 minute interview, which will be transcribed and audio-recorded. I would be grateful if you would allow me to interview you at a place and time convenient for you, outside of school time.

The contents of this interview will be used for my research project, which will include a final paper, as well as informal presentations to my classmates. I may also present my research findings via conference presentations and/or through publication. You will be assigned a pseudonym to maintain your anonymity and I will not use your name or any other content that might identify you in my written work, oral presentations, or publications. This information will remain confidential. Any information that identifies your school or students will also be excluded. The interview data will be stored on my password-protected computer and the only person who will have access to the research data will be my course instructor Dr. Lee Airton.

You are free to change your mind about your participation at any time, and to withdraw even after you have consented to participate. You may also choose to decline to answer any specific question during the interview. I will destroy the audio recording after the paper has been presented and/or published, which may take up to a maximum of five years after the data has been collected. There are no known risks to participation, and I will share a copy of the transcript with you shortly after the interview to ensure accuracy.

Please sign this consent form, if you agree to be interviewed. The second copy is for your records. I am very grateful and appreciative for your valued participation.

Sincerely,  

Rachel Burton
Consent Form

I acknowledge that the topic of this interview has been explained to me and that any questions that I have asked have been answered to my satisfaction. I understand that I can withdraw at any time without penalty.

I have read the letter provided to me by Rachel Burton and agree to participate in an interview for the purposes described. I agree to have the interview audio-recorded.

Signature: ______________________________________

Name (printed): ________________________________

Date: __________________________
Appendix B: Interview Protocol

Thank you for participating in my research study.

Your participation is much appreciated. The aim this study is to investigate experienced teachers’ experiencing implementing the updated Health and Physical Education (HPE) curriculum with a particular focus on the revised content on sexual health. This interview should take approximately 45-60 minutes, and is comprised of approximately 20 questions. The interview protocol is divided into 5 sections, beginning with the participant’s background, followed by questions about the process of switching HPE curriculums, then their perceived barriers to implementing sexual health education, along with their perceived supports to implementing sexual health education, and concluding with any information they wish to discuss that was not discussed and potential next steps.

I want to remind you that you can choose not to answer any question, and can remove yourself from participation at any time. I would also like to bring to light that research might be a triggering term for some. I would now like to take a moment to acknowledge the native land we are on [insert based on location]. Do you have any questions before we begin?

To begin can you state your name for the recording?

Part 1 – Background Information

1. How long have you been teaching the Ontario Health and Physical Education (HPE) curriculum?

2. Were all of these experiences teaching HPE in Toronto?
   a. if no, how many years have you taught in Toronto?

3. Before you began teaching, did you receive any training on how to teach the sexual health component of the HPE curriculum?
   a. if yes, can you explain briefly what this training was?
4. When you first began teaching HPE, were you responsible for teaching about sexual health?
   a. if yes, why?
   b. if no, why?

5. Can you tell me how long you taught the sexual health component of the previous curriculum?

Part 2 – Switching to the Updated Curriculum

6. Can you walk me through how your structured a typical sexual health unit prior to the new curriculum?
   Used previous experiences to guide your daily lesson instruction?
   Used a unit plan provided by the department or fellow teacher?
   Used a unit plan from the web or online Ministry of Ed. Resources?
   Selected the most important content from the curriculum and developed the unit around this information?

   a. Were there any supports you can identify to helping you teach sexual health before?
      a. if yes, can you list these supports?
      b. if no, what supports would have been helpful?

   b. Can you identify any barriers to your past teaching of sexual health?
      a. if yes, can you list these barriers?

9. Moving more towards the present, can you tell me about how you found out the curriculum would be updated?
   Administrators?
   Access to new curriculum via web or mail?
   Given form the department?
   Personal development workshop?

10. In order to adapt to these updates, did you receive any assistance?
    a. if yes, by whom or what?
       Fellow teachers?
Professional development?
Administrative assistance?
Department assistance?
External (sexual health experts/nurses) resources provided by the school?
  b. if yes, was this assistance sufficient?
  c. if no/little, what assistance would you have wanted to receive?

11. Can you walk me through how you structured a sexual health unit on a revised section of the new curriculum?

  Made revisions based on your previous unit?
  Made a new unit alongside fellow teachers?
  Were provided with a revised sexual health unit by the department or administration?

  a. Were there any supports you can identify to helping you teach this revised section?
    a. if yes, can you list these supports?
    b. if no, what supports would be helpful?

  b. Can you identify any barriers to teaching this revised section?
    a. if yes, can you list these barriers?
    b. if yes, do you think these barriers are exclusive to the new curriculum or do they apply to sexual health education in general?

13. Can you identify a section of the curriculum that has been revised which you have taught both before and after the change?

  Masturbation?
  Gender identity?
  Consent?

  To the best of your memory, can you provide me with a brief account of teaching this section before the curriculum update?

  Now, could you tell me about your most recent experience teaching this section since the update?

  Did anything strike you as particularly different in the previous experience with that section and the most recent?

  Your comfort level?
  “Smoothness” of the lesson?
  Student reactions/engagement?
Part 3 – Perceived Barriers

13. In your experiences with other parts of the curriculum, do you think these barriers are exclusive to teaching sexual health?

   a. if yes, can you be specific about which ones are exclusive to sexual health?

14. What do you believe has been the greatest challenge over the last year to teaching sexual health?

   a. again, do you think this challenge is exclusive to the new curriculum?

15. How have you dealt with these identified barriers?

Part 4 – Perceived Supports

16. In the last year have you received any supports to teaching sexual health?

   a. if no, why?
   b. if yes, are any of these supports the same as the previous supports you received when teaching the old curriculum?

17. Can you tell me about some of these supports?

   a. Which one do you think was the most helpful?

18. Do you consider yourself a source of support?

   a. if yes, why?
   b. if no, can you explain why?

Part 5 – Next Steps

18. What kinds of supports would you like to see available for yourself and for other HPE teachers?

19. In your opinion, would some of these supports eliminate or help to reduce some of the barriers you discussed?

   a. if yes, why?
   b. if no, why?

20. Do you have anything else you would like to discuss about your experiences teaching the revised sexual health content from the updated HPE curriculum?
21. Do you have any advice for other teachers?

We have now reached the end of the interview. Again, thank you so much for your participation.

I have thoroughly enjoyed our discussion today. Thank you for your time and considered responses.