Alternative Spaces of Sex Education: A Look into the Lived Experiences of Young Queer Women

by

Clio Fregoli

A thesis submitted in conformity with the requirements for the degree of Masters of Arts

Department of Geography
University of Toronto

© Copyright by Clio Fregoli 2019
Alternative Spaces of Sex Education: A Look into the Lived Experiences of Young Queer Women

Clio Fregoli

Master of Arts

Department of Geography
University of Toronto

2019

Abstract

The classroom is a formative space for young women to learn about sexuality and sexual health; however, sexual health education is often engrained in heteronormative expectations of sexuality, which exclude the experiences and health concerns of young queer women. This provokes the question of where, and how, young queer women learn about sexual health. This project draws on 29 in-depth, semi-structured interviews with young queer women who attended public high school in Toronto. The results illustrate the exclusion of queer sexual health in Ontario’s Grades 9-12 1998 sex education curriculum, and both the benefits and drawbacks of learning about sex and sexuality from friends, family, the Internet, clinics and community organizations. This analysis of spaces of education expands our knowledge of how and where young queer women learn about sexual health, with the hope to ultimately improve sexual health education for young queer women in Toronto.
Acknowledgments

I would like to thank the many people who supported me and consistently lifted me up throughout this experience.

I am so grateful to Dr. Sarah Wakefield who dedicated so much time and effort to guiding me and supporting my work from the very beginning. Our meetings kept me organized and helped me trust that my ideas were valid.

I would like to thank Dr. Kathi Wilson who trusted in my research abilities before I began my Masters, and has encouraged me and guided me since. I would also like to thank Dr. Elspeth Brown who helped me understand and contextualize my research methods and sparked my creativity throughout our class together. I would like to thank Dr. Laura Pitkanen who opened doors into critical geography, and created such a welcoming and encouraging environment in her class. I would like to thank Dr. Ron Buliung for his insightful comments and meaningful discussion that helped guide this project.

I am so grateful to my family and friends who listened to me think through this thesis and reassured me to keep working and to keep writing. Thank you to my family who read drafts and made me feel like I was on the right track. Thank you for being patient with me and giving me the confidence I needed to complete this project. Thank you to my study partners, I could not have done this without you. Studying together has brought me so much joy and comfort and made this experience that much more meaningful. I feel so lucky to have had this special time together.

I would like to say a big thank you to Sam who endlessly encouraged me in all my moments of doubt. They reminded me of the importance of prioritizing the lived experiences of young queer women. Sam was incredibly patient, and validated both my work and process from the very first day.

Finally, I want to thank the participants of this study for taking the time to talk to me about their sexual health education experiences. This project exists because of your willingness to spend time and energy sharing your experiences with me. Having these intimate and vulnerable conversations is what makes this project so special, and I will hold on to that experience always. Thank you.
# Table of Contents

Acknowledgments........................................................................................................... iii

Table of Contents ........................................................................................................... iii

List of Appendices ........................................................................................................... viii

Chapter 1 Introduction .................................................................................................. 1

1 Introduction ................................................................................................................. 1

2 Methods ....................................................................................................................... 3

3 Research Participants ................................................................................................. 4

4 Significance of Study .................................................................................................. 5

5 Thesis Outline ............................................................................................................. 5

Chapter 2 Literature Review ......................................................................................... 7

1 Introduction ................................................................................................................. 7

2 Space .......................................................................................................................... 7

3 Space and Sexuality .................................................................................................... 9

4 Sexual Health Education at School ............................................................................ 10

4.1 Sexual Health Education Curricula ...................................................................... 11

4.2 Learning at School ................................................................................................. 14

4.2.1 School Environment ......................................................................................... 14

4.2.2 Gender Binaries at School .............................................................................. 15

4.2.3 Teachers at School ........................................................................................... 16

5 Alternative Spaces of Sexual Health Education ...................................................... 17

5.1 Networks of Friends and Family ........................................................................... 17

5.2 Online Spaces ....................................................................................................... 20

5.3 Community Organizations and Clinics ............................................................... 23

6 Conclusion ................................................................................................................. 24

Chapter 3 Methods ....................................................................................................... 25
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
<td>25</td>
</tr>
<tr>
<td>2</td>
<td>Methodology</td>
<td>25</td>
</tr>
<tr>
<td>3</td>
<td>Research Setting</td>
<td>26</td>
</tr>
<tr>
<td>4</td>
<td>Research Design</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>4.1 Participant Criteria</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>4.2 Recruitment</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>4.3 Interviews</td>
<td>32</td>
</tr>
<tr>
<td>5</td>
<td>Data Collection and Analysis</td>
<td>34</td>
</tr>
<tr>
<td>6</td>
<td>Positionality</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Chapter 4 School and the Sex Education Curriculum</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>1 Introduction</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>2 Literature Review</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>2.1 Sexual Health Education Curricula</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>2.1.1 Sexual Health Education</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>2.1.2 Intersecting Identities within Sex Education Curricula</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>2.2 Learning at School</td>
<td>42</td>
</tr>
<tr>
<td>3</td>
<td>Results</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>3.1 Sexual Health Education Curriculum</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>3.2 School Environment</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>3.3 Classroom Environment</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>3.4 Desire to Learn at School</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>3.5 The Impacts of a Limited Education</td>
<td>52</td>
</tr>
<tr>
<td>4</td>
<td>Discussion</td>
<td>54</td>
</tr>
<tr>
<td>5</td>
<td>Conclusion</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>Chapter 5 Alternative Spaces of Sex Education</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>1 Introduction</td>
<td>60</td>
</tr>
<tr>
<td>Chapter</td>
<td>Title</td>
<td>Pages</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>2</td>
<td>Literature Review</td>
<td>61</td>
</tr>
<tr>
<td>3</td>
<td>Results</td>
<td>62</td>
</tr>
<tr>
<td>3.1</td>
<td>Networks of Friends and Family</td>
<td>62</td>
</tr>
<tr>
<td>3.2</td>
<td>Online Spaces</td>
<td>66</td>
</tr>
<tr>
<td>3.3</td>
<td>Community Organizations and Clinics</td>
<td>70</td>
</tr>
<tr>
<td>3.4</td>
<td>Comfortable Spaces</td>
<td>71</td>
</tr>
<tr>
<td>4</td>
<td>Discussion</td>
<td>73</td>
</tr>
<tr>
<td>5</td>
<td>Conclusion</td>
<td>79</td>
</tr>
<tr>
<td></td>
<td>Chapter 6 Conclusion</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>Bibliography</td>
<td>88</td>
</tr>
<tr>
<td></td>
<td>Appendix A</td>
<td>104</td>
</tr>
<tr>
<td></td>
<td>Appendix B</td>
<td>106</td>
</tr>
<tr>
<td></td>
<td>Appendix C</td>
<td>107</td>
</tr>
</tbody>
</table>
List of Appendices

Appendix A: Summary of Participant Demographics .......................................................... 104
Appendix B: Recruitment Poster ....................................................................................... 106
Appendix C: Interview Guide .............................................................................................. 107
Chapter 1
Introduction

1 Introduction

Sexual health can be defined as a “state of emotional, physical, mental and social well-being with relation to one’s sexuality” (World Health Organization, 2006). It is a critical component of human health, and should include a positive engagement with sexuality, relationships and reproduction free from violence, stigma or discrimination (Centers for Disease Control and Prevention, 2012).

Sexual health education provides students with the opportunity to understand and enhance their sexual health. A formative space in which young Canadians learn about sexuality and sexual health is the high school classroom (Public Health Agency of Canada, 2003). It is the only formal educational institution to make contact with almost all youth in Canada. Through curricula taught in these classrooms, youth are meant to develop both knowledge and skills that will lead to optimal sexual health throughout their lives (Public Health Agency of Canada, 2003). Specifically, among many benefits, a comprehensive and up-to-date sex education curriculum should help avoid negative health outcomes such as unintended pregnancies and STI transmission; it should foster communication; it should help young people understand healthy relationships and boundaries; it should promote a sense of autonomy, value and respect over one’s body; and lastly, it should foster respect for different sexual orientations and gender identities (Bridges and Hauser, 2014).

However, researchers have noted that many high school sex education curricula include strict gender roles, and ignore non-normative, queer sexualities in their implicit narratives (McNeil, 2013). For example, studies have demonstrated that heteronormativity pervades sex education curricula in the United States (McNeil, 2013; Fields, 2012; Connell and Elliott, 2009), creating ambivalence towards LGBTQ+ students and enabling homophobic actions and beliefs in schools (McNeil, 2013). Heteronormativity can be understood as “the Western social norm, or assumption, that the overwhelming majority of sexual relationships in society are heterosexual… heteronormativity is the dominant sexual model of social, cultural, political, and economic organization, including the way it organizes identities, experiences, regimes of truth and
knowledge, and ideologies of gender and sex” (Jeppesen, 2016). Heteronormativity is constructed through different levels of power and privilege, where “state-sanctioned white middle- and upper-class heterosexuality is most rewarded” (Cohen, 1997 referenced in Garcia, 2009: 523).

Heteronormativity within sex education curricula privileges heterosexual relationships while devaluing other expressions of sexuality, thereby excluding and marginalizing queer youth. Comparatively little is known about these issues in a Canadian context. My research includes a nuanced and unique perspective while addressing this gap; it explores how young queer women experienced the 1998 Ontario Ministry of Education’s Grades 9-12 Health and Physical Education Curriculum, which includes a sexual health unit, shedding light on the inclusion and exclusion of queer sexualities.

Through the high school classroom and school setting, students are taught academic subjects along with an implicit education in societal norms, values and expectations. It has been argued that the school, as a site of knowledge and power, spatially produces and maintains assumptions about what defines ‘normal’ sexuality (Hubbard, 2008). It does so through the everyday activities and practices that take place in and through the space of the school. The classroom environment is also influenced by the role of the teacher (Ferfoja, 2007; Abbott et al., 2015), who determines the ways in which curricula is interpreted and delivered (Ferfoja, 2007). My research explores the high school classroom and the school setting as spaces of education, and how these spaces influence the ways in which young queer women learn about sexual health.

The high school classroom however, is only one critical space among many where youth learn about sexual health growing up. My research seeks to account for the alternative educational spaces in which young queer women gain sexual health information. These alternative spaces range from networks of friends and family, to online spaces, to community organizations and clinics. For example, networks of friends are argued to strongly inform young people’s sexual health knowledge (Graf and Patrick, 2015; Cheetham, 2014). Similarly, online spaces are a critical resource for youth seeking sexual health information (Shoveller et al., 2012; Kanuga and Rosenfeld, 2004; Hawkins and Watson, 2017), and can be particularly relevant to LGBTQ+ youth (Kanuga and Rosenfeld, 2004). And lastly, community organizations can foster supportive spaces in which LGBTQ+ youth can access sexual health information that might otherwise be
unavailable (Allen et al., 2012). Thus, my research accounts for these alternative spaces of education, recognizing the complex and intricate ways in which young queer women gain sexual health knowledge.

In order to examine the spaces and the ways in which young queer women learn about sexual health, my research set out to answer the following questions: 1) How do young queer women in Toronto experience sexual health education at school? And 2) How do alternative educational spaces contribute to their sexual health education growing up?

An analysis of the school setting and these alternative spaces of education will expand our knowledge of how and where LGBTQ+ women learn about sexual health, contributing to the greater conversation of sexual health education in Toronto. There is a lack of research that examines how these alternative spaces, in relation to the school setting, collectively inform young queer women’s sexual health education. My research addresses this gap by exploring how young queer women’s experiences of sexual health in Toronto have been impacted by the sex education they received at school, in comparison with that received in these alternative educational spaces. Throughout this thesis, space is characterized as “both the medium and outcome of social relations” (van Ingen, 2003; 204); a ‘space’ can thus be grounded in a physical materiality, but also can be understood as an abstract network of social relations, human activity and behaviour. I expand on the theoretical understanding of space that informs this project in Chapter Two.

2 Methods

To answer the research questions, I conducted 29 semi-structured, in-depth, retrospective interviews with young queer women who went to public high school in Toronto. These women were between the ages of 19 and 29 and currently reside in Toronto. The focus on lived experiences guided my choice to undertake qualitative research. Through an in-depth interview process I had the opportunity to learn about the intimate story of queer women’s lived experiences, as well as their interpretation of the sexual health curriculum. I chose to focus on Toronto as it offers many spaces and events for the LGBTQ+ community, and is well-known as a gay-friendly city (Nash, 2011; Petenbrink, 2018). As the largest and most diverse city in Canada, Toronto has a strong pull for queer-related research, and it provides a unique and
exciting opportunity to engage with young women in the LGBTQ+ community. My research setting is expanded on in Chapter Three.

This project uses a theoretical framework that draws on critical feminist and queer geography, as well as queer methodology. Critical feminist and queer geographies look at the ways in which spaces “are implicated in the constitution, formation and maintenance of normative sexual and gender identities” (Nash and Bain, 2007: 50). Critical feminist geography examines the ways that the intersecting forces of race, gender and class operate through space (Mollett and Faria, 2018). These frameworks are used when assessing the educational spaces of the classroom in relation to community organizations, networks of friends and family and online spaces, and the significance of sexual and gender identities and power relations within these spaces. A queer methodology was utilized to reflect the queer notion of research as unstable, contested, and unfixed, as well as situated within historical, geographical and social contexts (Browne and Nash, 2010). This methodology is further discussed in Chapter Three.

3 Research Participants

This thesis centers the experiences of young queer women living in Toronto. I use the term ‘woman’ to refer to any individual who self identifies as a woman, in an attempt to acknowledge and include the multiplicities of identities within the term ‘woman’. Throughout this paper, I use queer and LGBTQ+ interchangeably, as queer can be used as an umbrella term for lesbian, gay, bisexual, trans and queer identities (Nash and Bain, 2007). It can be used to identify all individuals who fall outside heterosexuality (McKenzie, 2015; Elia and Eliason, 2010). The participants in this study utilized a variety of terms to identify their sexuality; the majority identified as queer, with some identifying as bisexual, pansexual, gay and lesbian.

The participants in this study provided thoughtful and open recollections of their sexual health education experiences. The interviews discussed private and sensitive topics such as sexuality and sexual health, and the participants were extremely generous with their stories and with their time.

I chose to focus specifically on individuals who self-identified as queer women for several reasons. It has been argued that existing curricula in Canada create a gender normative depiction of women as passive and refraining from sexual activity, while young men are depicted as
having sexual agency and desire (Connell, 2005; Fields, 2012). This encourages and prioritizes a heterosexual narrative while negatively stereotyping all genders. In addition, this erases and ignores women’s sexuality. This erasure is exacerbated for queer women who are depicted in society as having low sexual desire, a lack of sexual motivation, and/or less assertiveness around sexuality (Cohen and Byers, 2014; Nichols, 2004). My research actively challenges these narratives by demonstrating the participants’ desire to learn about sexual health, and by illustrating the significance and relevance of sexuality and sexual health in their lives. This significance and relevance are explored in Chapter Four and Five.

4 Significance of Study

This research adds a nuanced perspective to a greater conversation about sexual health education in Ontario, as it acknowledges and prioritizes the unique experiences of young queer women and their relation to sexual health. By exploring the ways in which young queer women learn about sexual health, this research provides insight on the inclusivity/exclusivity of sexual health education, and its impact on young queer women’s experiences. This research is significant as it illustrates how both traditional and alternative spaces of education collectively inform the many ways in which young queer women learn about sexual health. Studying alternative spaces of education offers insight into how these alternative learning environments compare to normative, state-sanctioned spaces of education.

Through a detailed depiction of inclusion and exclusion of non-normative identities within both formal and alternative educational spaces, this research is contributing to the field of critical geography. This project contributes to the understanding of space as produced and productive, in the context of sexual health education spaces. It offers a new and exciting lens with which to analyse sexual health, through the examination of spaces of education.

5 Thesis Outline

This thesis consists of six chapters. Chapter Two critically presents the relevant literature on space and sexuality, sexual health education and alternative spaces of education, in an effort to contextualize the research questions and familiarize the reader with the necessary background information. Chapter Three describes the research methods and methodology involved in collecting, coding and analysing data. Chapter Four delves into the first research question by
examining the sexual health education of young queer women in high school. Chapter Five explores the second research question by examining the alternative spaces of education where young queer women learn about sexual health growing up. Both Chapter Four and Five present the qualitative data collected through the interviews and include a discussion of these results. Lastly, Chapter Six concludes the thesis, while reflecting on how the school works in conjunction with alternative spaces of education to inform young queer women’s sexual health education. This chapter provides policy prescriptions, limitations and discussions on future research.
Chapter 2
Literature Review

1 Introduction

As mentioned earlier, sexual health can be defined as a “state of emotional, physical, mental and social well-being with relation to one’s sexuality” (World Health Organization, 2006). Our sexual health has the capacity to affect our overall health and wellbeing, and it will be influenced by various intersecting social determinants of health, such as race, class, gender, sexual orientation, and ability. Sexual health can be examined through various avenues; my project targets specifically sexual health education, and the ways and spaces in which young queer women learn about sexual health.

Throughout this chapter, I contextualize my research within existing literature. First, I discuss the theoretical understanding of space, and explore the literature in which space and sexuality are connected. Next, I examine school as a site of knowledge, and the significance of sexual health education curricula. Lastly, I review the alternative spaces of education where young queer women learn about sexual health.

2 Space

Throughout the discipline of geography, the definition of space has been explored and contested in various ways. Within a scientific and positivist lens, space has been understood as a “geometrical system of organization which could be measured objectively and scientifically and which actively shaped social relations in ways that could be modelled and simulated” (Castree, Kitchin and Rogers, 2013: para.1). Through this lens, space is theorized as a scientific and measurable concept. This definition of space has been challenged within the field of human geography by more radical geographers, who conceptualized space as a product of social relations and practices. This understanding of space was most notably founded in Henri Lefebvre’s The Production of Space (Castree et al., 2013).

Within the context of this thesis, I am referring to the theoretical concept of space as both produced and productive; space “is continuously ‘produced’ through the dynamic
interconnections between and among places and social relations” (Lefebvre in Bondi, 2005:142). Space is not a neutral location where things simply take place, but rather space is created through the on-going and connected forces of physical landscapes, social relations and ways of being (Molotch, 1993). Through a Lefebvrean spatial analysis, van Ingen (2003) notes how space is “both the medium and outcome of social relations”, in which power relations are inscribed (van Ingen, 2003: 204). Social relations, involving human activity and behaviour, will thus be shaped by the space in which these relations take place, but will also create the space itself. In addition, space is a site of contestation, created by different ideas and tensions about what a space should be (Molotch, 1993); this contestation has the power to be both oppressing and enabling (van Ingen, 2003).

Similar to the idea of contestation within space, Cresswell (1996) explores the idea of transgressions within space. First, he discusses how certain ideas, values and assumptions of what is right or appropriate, can be transmitted and reproduced through a particular space, creating a normative landscape (Cresswell, 1996). Different understandings of what is or what is not appropriate in a certain space, will thus create different normative geographies (Cresswell, 1996). He argues that acts of transgression will demonstrate what is ‘in place’ and what is ‘out of place’ (Cresswell, 1996). Through these transgressions, the way “the world is defined, categorized, segmented, and classified is rendered problematic” (Cresswell, 1996: 26); the transgressions thus seek to challenge the taken-for-granted status quo within normative spaces, while also shedding light on the contesting forces that create a space. Cresswell thus explores how value and meaning are created within and across spaces.

It is important to look at space as multi-faceted and flexible, and constantly changing through the interactions occurring within that space. Space can produce relations and identities (Baydar, 2012) and affect the way women learn about sexual health; it is important to interrogate how spaces “are implicated in the constitution, formation and maintenance of normative sexual and gender identities” (Nash and Bain, 2007: 50). Spaces may therefore inform individual’s sexual and gender identities, and their understanding of sexual health based on these identities.
3 Space and Sexuality

Within the field of human geography, there is a growing body of work that examines sexuality in relation to space and place (Hubbard, 2008). This type of work began in the late 1970s and was further established in the 1980s as the field of human geography shifted away from positivism (Johnston, 2015), towards the inclusion of post-structuralist, feminist, and queer perspectives. This introduction of sexuality into geographical literature began primarily with research on gay and lesbian communities within urban cities (Lauria and Knopp, 1985; Castells and Murphy, 1982). For example, Lauria and Knopp (1985) analysed how gay male communities contributed to urban redevelopment and gentrification, as a spatial response to specific forms of oppression.

In the existing literature, there was a strong focus on the identities of gay men, and their role in the urban landscape. These studies assumed a rather stable and essentialized gay subject that did not trouble the idea of gender and ‘same-sex’ attraction (Nash, 2010).

The subdiscipline of queer geography was more formally established with the founding text *Mapping Desire*, edited by Bell and Valentine (1995). This book examined the “ways in which the spaces of sex and the sexes of space are being mapped out across the contemporary social and cultural terrain” (Bell and Valentine, 1995: 1). The subjects ranged from gay resistance to urban space to domestic environments, with a wide variety of scale from the body to the local to the global. This text looked at space as produced and ‘heterosexualized’, as opposed to ‘naturally’ and inherently ‘straight’ (Oswin, 2008).

In other queer geographical literature, Hubbard (2008) pulls our attention to the multiplicities within queer spaces, and reminds us that there is not one ‘gay community’ nor one ‘queer movement’, but many. Identifying spaces as exclusively gay or straight lacks a nuanced analysis that recognizes intersecting forces such as race, class and gender which affect and create those spaces (Hubbard, 2008). Within the past decade, some queer geography critiques and challenges more essentialist notions of identity, gender and sexuality. For example, as opposed to studying sexual minorities within space, queer geography employs an analysis of space through a queer lens that also examines race, class and gender (Nash, 2010). This understanding of space moves away from the binaristic understanding of space as either heterosexual or homosexual, and recognizes the complexities, diversities and normativities within and across space (Oswin, 2008).

More recent understandings of sexuality and space examine how sexuality is “performed and
practised, spatially” (Hubbard, 2008: 654). Space is therefore producing and produced by performances and practices of sexuality.

In the early 2000s, queer geography expanded to include the notion of homonormativity. Lisa Duggan defines homonormativity as ‘a politics that does not contest dominant heteronormative assumptions and institutions, but upholds and sustains them, while promising the possibility of a demobilized gay constituency and a privatized, depoliticized gay culture anchored in domesticity and consumption’ (Duggan, 2002: 179). Duggan’s (2002) analysis explores the ways in which diverse pockets of the gay community, such as gay Republicans, reinscribe neoliberal values and beliefs which ultimately replicate oppressive institutions. Homonormativity is studied within the discipline of geography in different ways, for example through an analysis of gay public spheres as tied to spaces of consumption and gentrified neighbourhoods (Johnson, 2015).

Homonormativity is also studied in geography through discussions on the prevalence of white and cisgender individuals within both queer and state-sanctioned spaces (Johnson, 2015). Particularly, Jasbir Puar (2002) discusses the role of colonization in tandem with race, class and gender within the claiming of queer space. Puar argues for an interrogation of race, class and gender privileges that function within queer spaces (Puar, 2002). More recently, transgender geographies have included discussions on homonormativity, recognizing how trans bodies and identities complicate and destabilize notions of gendered, sexed and queered spaces (Nash, 2010; Doan, 2010; Browne, Nash & Hines, 2010). These geographies bring forth new approaches to understanding and analysing gender, sexuality and queerness within and across space.

Space provides an interesting lens with which to study the dissemination of sexual health knowledge. I will begin by exploring the space of the school, followed by a discussion on alternative spaces of education.

4 Sexual Health Education at School

In order to contextualize sexual health education in different school settings, I will begin by discussing sexual health education curricula, followed by an overview of the school as a site of learning. I discuss the role of sexual health education curricula, and the prevalence of
heteronormativity within such curricula. I then critically engage with the school as a site of knowledge production, and analyse the social norms and values it sustains.

4.1 Sexual Health Education Curricula

Sexual health is a critical component of human health, based on a positive engagement with sexuality, relationships and reproduction free from violence, stigma or discrimination (Centers for Disease Control and Prevention, 2012). Our sexual health has the capacity to affect our overall health and wellbeing, and it is thus necessary to have the opportunity to understand and enhance our sexual health. Our sexual health will be influenced by intersecting systems of oppression with regards to race, class, gender, sexual orientation, and ability.

One way to improve our sexual health is through sexual health education (sex education). Sex education targets physical health issues such as sexually transmitted infections, pregnancies, birth control, and reproductive health. For sex education to be informative on all aspects of sexual health, it should also target emotional and mental health issues, such as stable and healthy relationships, consent, self-esteem, body positivity, and sexual self-expression. Through sexual health education curricula taught in school classrooms, young adults are meant to develop both knowledge and skills that will lead to optimal sexual health throughout their lives (Public Health Agency of Canada, 2003). The school is argued to be an appropriate space to teach sexual health education given that the majority of youth attend high school, and therefore schools have the unique opportunity to engage meaningfully with the widest range of youth (Sorace, 2013; McKay et al., 2014). The school provides an opportunity for the students to deeply engage with sexual health topics, through interactive forms of learning such as teaching methods that allow students to brainstorm, role play and apply concepts to their own personal experiences (Kirby et al., 2007).

A research report created by Advocates for Youth (Bridges and Hauser, 2014) argues that sexual health education is important in sustaining young people’s health and well-being: among many benefits, a comprehensive and up-to-date sex education curriculum should help avoid negative health outcomes such as unintended pregnancies and STI transmission; it should foster communication; it should help young people understand healthy relationships and boundaries; it should promote a sense of autonomy, value and respect over one’s body, and lastly, it should
foster respect for different sexual orientations and gender identities (Bridges and Hauser, 2014). Consent is also deemed an important part of sex education in order for young people to make informed decisions about their bodies and their sexual health (MacKenzie et al., 2017). Sex education at school can be targeted as one way to prevent sexual violence and encourage health promotion; it provides a unique opportunity to engage youth in discussions surrounding safer sex and sexual agency, and consensual sexual activity (Powell, 2007).

A significant amount of research has explored sexual health education curricula in relation to the LGBTQ+ population. As mentioned previously, sex education is meant to discuss topics such as relationships, sexual activity and sexuality. For this reason, sex education has the unique opportunity to describe or explore the diverse range of relationships and sexualities that exist in today’s society; however, in many cases, studies have found that sex education continues to uphold heterosexuality as the most standard and accepted form of sexuality, thus favouring heterosexual relationships. Within the context of sex education curricula in the United States, research has demonstrated how heteronormativity is manifested through a denial or silencing of LGBTQ+ sexuality, relationships and desires (Fields, 2012; Gowen and Winges-Yanez, 2014), a prioritization and promotion of heterosexual relationships (McNeil, 2013), and the affiliation of heterosexuality with normality (Bay-Cheng, 2003). Through sex education curricula, youth are exposed to ideas of what constitutes proper and appropriate sexual behaviour. These sexual norms can enforce a narrow and homogenous conception of sexuality and sexual activity that excludes most LGBTQ+ students (Bay-Cheng, 2003; Fields, 2012; McNeil, 2013).

In the United States, there are two major camps of sex education curricula: Abstinence Only Until Marriage (AOUM) and the comprehensive sex education program (Fields, 2012). The AOUM program teaches that individuals should not engage in any form of sexual activity until they are married, while the comprehensive program offers alternatives if and when individuals choose to engage in sex. These alternatives include birth control, reproductive health information, information surrounding safer sex, as well as topics such as identity, relationships and intimacy (Elia and Eliason, 2010). The comprehensive sex education programs are argued to be more scientifically accurate, more inclusive, and more in tune with sexual behaviours of American youth (McCarty-Caplan, 2013). Although the comprehensive sex education curriculum is thought to be more progressive, both camps include narratives that prioritize heterosexual intercourse, ultimately excluding queer identities (Fields, 2012; Bay-Cheng, 2003).
Moreover, both comprehensive and AOUM curricula in the U.S. include gendered, racialized and classed assumptions and stereotypes surrounding sexuality (Bay-Cheng, 2003; Garcia, 2009). This reinforces the foundation of heteronormativity defined by McNeil, as privileging white, middle class, cis gender couples (McNeil, 2013). A U.S. study that interviewed young Latina girls about their sex education experiences, revealed how the participants encountered heterosexualized and racialized constructions that reproduced inequalities, and limited their access to accurate and relevant sexual health information (Garcia, 2009). For example, heterosexual, racial and classed assumptions and stereotypes constructed Latina girls as “at risk”, causing educators to prioritize certain lessons over others such as placing an emphasis on birth control and excluding information on LGBTQ+ sexualities (Garcia, 2009).

With respect to the large body of research that tackles heteronormativity within sex education curricula, there is a lack of research on effective curriculum changes to increase inclusion of the LGBTQ+ population into sex education. One study in Massachusetts found that LGBTQ+ students in schools with gay-sensitive HIV instruction had less negative sexual health outcomes, such as less substance abuse before sex, than those LGBTQ+ students whose schools did not have gay-sensitive HIV instruction (Blake et al., 2001). Although this type of research is limited, there have been studies that explore frameworks of what an LGBTQ+ inclusive education might entail. For example, in a qualitative study conducted in Oklahoma, LGBTQ+ youth suggested topics that would make a curriculum more inclusive, such as a discussion on sexual orientation and gender identity, access to LGBTQ+ resources, or a greater emphasis on relationships and sexuality; they discussed how this might create an environment where LGBTQ+ students felt safe and a sense of belonging in the school space (Gowen and Winges-Yanez, 2014). Other studies point to the need for LGBTQ+ affirmation within curricula, an increase in classroom time spent towards sex education, and more experienced training for educators (McCarty-Caplan, 2013). A more inclusive curriculum would also be founded on an anti-oppressive framework that recognizes the intersections of race, gender, sexuality, ability, and other forms of oppression (Elia and Eliason, 2010).

Sex education curricula is therefore a significant element when addressing youth’s access to sexual health education. Another significant factor is the overall school environment, which is discussed below.
4.2 Learning at School

4.2.1 School Environment

The high school classroom is the only formal educational institution to reach almost all young adults in Canada, making it the most traditional and standard space of learning. Through the school setting, students are taught academic subjects along with an implicit education in societal norms, values and expectations. These implicit lessons are on-going and will “shape the identities and prospects of individuals, and by extension, families, regions and nations” (Collins and Coleman, 2008: 293). The weight and power of school as an institution and a traditional space of learning affects the way students perceive the world and will affect their lives as they grow up. It is thus important to understand the way schools function as spaces of learning, and the type of norms and values they produce and sustain. Schools are also composed of on-going and ever-changing social climates; the social climate can be described as “the goals, norms, interpersonal relationships and teaching practices, organizational patterns, and school facilities present in a specific school” (Finell et al., 2018: 1505). The social climate will affect the perceived school environment.

For the purpose of this project, the school is examined as a traditional space of learning that forwards a particular narrative with regards to LGBTQ+ individuals. Through case studies in the United States, Sweden and Australia, research has argued that school environments reproduce heteronormative discourses (Gorski et al., 2013; Helmer, 2016; Dinkins and Englert, 2015; Reimers, 2017). As mentioned in Chapter One, heteronormativity can be understood as “the Western social norm, or assumption, that the overwhelming majority of sexual relationships in society are heterosexual” (Jeppesen, 2016). In school environments, heteronormativity is supported through institutional, school-wide practices and policies that silence non-heterosexual issues (Ferfolja, 2007), privilege heterosexuality, and assume students identify as heterosexual (Dinkins and Englert, 2015). It can also be enforced through educational contexts in which positive representations of non-normative genders and sexualities are marginalized (Helmer, 2016), and heterosexual gender norms are produced and maintained (Reimers, 2017). Heteronormativity can be sustained through a collective environment involving teachers, students and administrators, throughout all levels of education (Gorski et al., 2013).
Furthermore, the classroom and the school are contested spaces in which constructions of identity and social norms are produced and practised (Collins and Coleman, 2008; Holloway and Jons, 2012). It is argued that the school as a site of knowledge and power spatially produces and maintains assumptions about what defines ‘normal’ sexuality (Hubbard, 2008). Schools can perpetuate a dominant heteronormative narrative and enforce normative identities: what becomes “appropriate” sexual and gender identities is reinforced through “socialization, teaching regulation and the ongoing experiences of gender and sexual disciplining for “transgressions” (Shipley, 2013: 205). Sexual disciplining is seen through the bullying, harassment, and isolation of those who identify with non-normative sexualities (Gorski et al., 2013). The school space is therefore created through on-going processes of contestation. Although dominant heteronormative narratives can be produced in school spaces, schools cannot be defined as exclusively ‘good’ or ‘bad’. Even despite these dominant narratives, LGBTQ+ youth can and do experience connectedness with school that can affect their overall health and well-being; for example, school connectedness has been associated with reduced levels of depression and emotional distress, as well as lower levels of suicide and teen pregnancy (Saewyc, 2011). School spaces are constantly being reproduced and challenged, and can play a pivotal role in the well-being of youth.

4.2.2 Gender Binaries at School

School is a particularly significant space when discussing trans youth, given the strong gender binary imposed through washrooms, changing rooms and/or lesson planning (Smith, 2016). Considering the omnipresence of a strict gender binary, recent literature in geography has pointed to the ways in which trans individuals experience space differently from their cisgender peers, whether their peers are queer or not (Doan, 2010; Browne, Nash & Hines, 2010). Trans youth are more at risk in school settings than their cisgender peers, as they often face discrimination based on sexual orientation as well as gender presentation; these forms of discrimination can take place in unmonitored spaces within schools, such as hallways or locker rooms (McGuire et al., 2008). School can thus be a particularly trying space for LGBTQ+ youth, especially for trans youth, where a strict gender binary and privileging of heterosexuality are often imposed on students.
Throughout elementary school and high school, students are constantly divided by gender. For example, in a U.K. based project, teachers reflected on the ways in which their students were segregated, through “sport, school uniforms...and toilets” (Carrera et al., 2012: 1009). Similarly in the U.S., these divisions range from the school-wide level to the classroom setting to the curricula, and are deeply imbedded in the school system (Woolley, 2017). This underlying heteronormative binary influences the construction of identities and the social interactions that occur within the school setting (Woolley, 2017). In a study on trans youth in Australia, participants described how constant segregation by gender in class, specifically within physical education, caused discomfort and distress (Jones et al., 2016). Although this study is specific to the Australian context, it gives insight to the possible drawbacks and consequences of dividing students by gender. Overall, the constant segregation by gender can affect the classroom environment and the levels of comfortability for students within that environment.

4.2.3 Teachers at School

Another factor that highly influences the high school and classroom environment is school staff. Teachers have a strong capacity to influence the environment within a classroom (Ferfoja, 2007; Abbott et al., 2015), such as through their power to interpret and deliver curricula (Ferfoja, 2007). For example, it has been argued that providing a curriculum that discusses LGBTQ+ content can make the classroom environment safer and more inclusive (Steck and Perry, 2018). As well, teachers’ delivery of sex education curricula influence how students perceive the quality of those curricula; for example, the more comfortable teachers are with curricula, and the more open they are to responding to questions, the more students perceive a greater quality of education (Byers et al., 2013).

Moreover, teachers’ views and actions have the capacity to influence the culture of the classroom and sustain certain norms (Chambers et al., 2004). For example, a teacher’s perspective or bias against the LGBTQ+ population may influence the way that they approach LGBTQ+ issues in the classroom (Puchner and Klein, 2011). Teachers are also in a powerful position to address homophobia that takes place in the school at large (Goldstein et al., 2007). A study conducted in Yorkshire, England found that teachers, despite their desire to tackle homophobia, often inscribe heteronormative ideas and enforce a hetero/homo binary (Abbott et al., 2015). A study titled The Every Teacher Project, a large-scale survey of Canadian teachers on LGBTQ+ inclusive
education, found that educators who identified as LGBTQ+ were more likely to incorporate LGBTQ+ inclusive education in their classroom (Taylor et al., 2016). The study also found that although the majority of teachers approve of LGBTQ+ inclusive education, fewer teachers are comfortable engaging with that content in the classroom, and even fewer teachers actually practice it (Taylor et al., 2016). The teachers therefore play a critical role in the classroom, affecting and sustaining norms through their explicit and implicit lessons. Overall, the school is a pivotal environment in the everyday lives of youth, and a crucial point of analysis when examining sexual health education.

5 Alternative Spaces of Sexual Health Education

The classroom and school setting are one space in which young queer women learn about sexual health; there are also many alternative educational spaces in which this type of learning takes place. To contextualize the different alternative spaces of education within existing literature, I will begin by exploring networks of friends and family, followed by a discussion on online spaces, community organizations and clinics. I will conceptualize the spatiality of these different entry points into learning, and review the literature that discusses the advantages and disadvantages of relying on these spaces for sexual health education.

5.1 Networks of Friends and Family

One way in which young queer women learn about sexual health is through informal networks of friends and family. These networks create and sustain spaces where young people interact, grow up and cultivate ideas about themselves and each other (Korkiamäki and Kallio, 2018). Through an analysis of Finnish youth, Korkiamäki and Kallio explore “how [the participants’] friendships are socio spatially fluid and flexible rather than merely place based and bound by fixed categories” (2018; 80). Similarly, Bunnell and co-authors describe friendships as fluid networks that are less spatially bound than other processes of social ordering, such as a ‘household’ or a ‘neighbourhood’ (Bunnell et al., 2012). Friendships can therefore exist as fluid spaces composed of social interactions and behaviours, without being confined to physical locations; however, there can also be a strong material element to friendships, as they play out in different physical spaces such as interactions that happen at school, at a party or at someone’s house. Physical space can influence the nature of a friendship, or the boundaries and intimacies within a
friendship. For the purpose of this paper, I will be focusing on the social relations and interactions of friendships that create spaces and the fluidity of these spaces, as opposed to the grounded materiality of friendships taking place in different locations.

Many studies have suggested that friendships play an important role in young people’s lives as friends provide one another with everyday care (Blazek, 2011) and social support (Pahl, 2000). This can be especially true for young queer people, for whom access to a community and general social connectedness are associated with increased self-esteem (Detrie & Lease, 2007). It can also be tied to a sense of belonging which is beneficial for queer youth’s mental health (McCallum and McLaren, 2010). Research suggests that friendships may be of particular importance to queer people who rely on friends as their ‘chosen family’ outside of the heterosexual nuclear family (Roseneil and Budgeon, 2004).

Friendships can also strongly inform young people’s sexual health knowledge (Graf and Patrick, 2015; Cheetham, 2014). In a study conducted on life-long sexual health literacy, the findings indicated that in the study’s sample, the most common source of sexual health information came from friends (Graf and Patrick, 2015). These findings support previous studies that also suggest that young adults most frequently reference their peers as sources of sexual health information (Ballard & Morris, 1998; Sprecher, Harris and Meyers, 2008), as well as reference their friends as their most trusted sources of information on sex (Wight and Henderson, 2004 as cited in Cheetham, 2014). Approaching friends for sexual health information may be perceived as less embarrassing for youth and more appealing, as friends often share common experiences and/or values (Powell, 2008).

Informal learning through friendships can take the form of ‘friendship-based sexual health promotion’; friendships provide a space where individuals can share sexual health resources and lived experiences, leading to an increased knowledge in one’s general sexual health (Byron, 2017). Friendship networks lend themselves to informal opportunities for friends to check in with one another to process sexual experiences, and make informed decisions about their sexual health (Byron, 2017). In a study conducted on sexual well-being in Australia, the findings revealed that youth in high school who had more open sex-related communication with their friends had more positive emotions associated with sex (Mastro and Zimmer-Gembeck, 2015).
Overall, friends can play an important role in validating and supporting each other’s experiences and sexual choices (Cheetham, 2014).

In a study conducted on sexual communication between young gay men and their best friends, the authors explored barriers and facilitators to conversations about sex and sexual health; the findings suggest that levels of comfort and lack or presence of judgement can strongly influence young gay men’s ability to share sexual health information with their friends (McDavitt and Mutchler, 2014). There are therefore different factors that will influence youth’s ability to discuss sexual health with friends. Despite the potential advantages of learning through networks of friends and family, research has explored the possible barriers to accurate information when relying on these networks, such as peers who share inaccurate information or exaggerate their sexual experiences (Jones et al., 2011). Moreover, through an analysis of sexual health education websites in Australia, a study found that each professional sexual health organization discouraged individuals from relying on friendships for sexual health information, asserting that they should depend on reliable and expert knowledge from vetted online resources or from health care professionals (Byron, 2017). This study suggests that formal sexual health organizations in Australia discourage youth from relying on their friends for sexual health information, but believe that they should search for knowledge from experts in the field.

In addition to inaccurate or unreliable sexual health information, research has explored how friends may negatively influence each other’s sexual behaviour through peer pressure. For example, in a study conducted on youth’s experiences of sexual relationships in the UK, the findings suggested that young people may feel pressure from one another to engage in sexual activity to ensure their status in the peer group (Maxwell, 2006). A similar finding was present in a study conducted with Canadian youth that found that some participants felt the need to alter their sexual behaviour to be accepted among their peers (Shoveller et al., 2004).

Similar to networks of friends, family can play a large role in access to sexual health information (Jones et al., 2011; Jaccard, Dittus and Gordon, 2000; Mastro and Zimmer-Gembeck, 2015). Parent-adolescent communication regarding sexual health has been argued to impact youths’ sexual behaviour (Jaccard and Dittus 1991 in Jaccard et al, 2000). There are different factors that will affect parents’ level of communication with their children regarding the topic of sex and sexual health. For example, in a study conducted with over 700 African American youth and
their mothers in the U.S., the findings suggested that there are certain barriers that prevent communication between mothers and adolescents around sex and sexual health, such as a fear of embarrassing the teen or the fear that the teen might ask the parent something they do not know (Jaccard et al., 2000). Parents have different motivations for choosing to engage or disengage with their children on the topic of sexual health, and these choices can impact their children’s sexual health behaviour. Overall, the literature suggests that networks of family and friends can therefore be significant—yet limited—sources of sexual health information for youth.

5.2 Online Spaces

An additional space where youth learn about sexual health is online. The Internet exists as an online space, which is an abstract space that becomes concrete to its users through the screen (Kellerman, 2016), and through the effects that it has on everyday life in ‘actual’ spaces (Malieepard, 2017). The Internet is significant in the way that it offers an alternative space of learning that does not limit an individual to their physical location. Similar to a broader understanding of space, social relations both produce and are produced by online spaces; the Internet is argued to replicate social power dynamics to the extent that online spaces are ‘situated’ within the image of real-world spaces (Kitchin, 1998). Thus, the way that individuals experience online spaces will affect their everyday lives in tangible, ‘real’ spaces (Cohen, 2007), to the extent that online spaces and ‘real’ spaces are mutually constituted (Valentine and Holloway, 2002). Through this lens, I will examine the ways in which online spaces carry both advantages and disadvantages for LGBTQ+ youth with regards to sexual health education. I use the terms Internet and online spaces interchangeably.

The Internet is a critical resource for youth seeking sexual health information (Shoveller et al., 2012; Kanuga and Rosenfeld, 2004; Hawkins and Watson, 2017). The particularities that render the Internet a unique space for youth to learn about sex education is that it is anonymous (Fergie et al., 2013), accessible (Chang et al., 2017), stigma-free, up-to date and convenient (Gray et al., 2005). Online resources also have the potential to empower youth in relation to their own health and sexuality: pursuing information online can allow youth to feel more in control of their own health (Gray et al., 2005). The internet provides an opportunity for youth to learn about sexual health in a private space without the fear of embarrassment or intimidation from their peers.
In addition, relying on the Internet over in-person meetings can help reduce stigma related to sexual health topics (Karamouzian et al., 2018).

Online resources can be particularly relevant for LGBTQ+ youth who are shown to rely on the Internet more frequently than their heterosexual peers (Craig et al., 2015; Craig et al., 2017). Through online sources, LGBTQ+ youth can access a space where they can explore and foster their sexual identities (Craig and McInroy, 2014; Hawkins and Watson, 2017; McInroy and Craig, 2018), through a platform that is anonymous and accessible (McKie et al., 2015). The Internet can provide a space where LGBTQ+ youth can support each other, receive support and cultivate their own stories and identities (Malieepard, 2017). Having access to this type of information online can contribute to the well-being and resilience of LGBTQ+ youth (Craig et al., 2017; Hawkins and Watson, 2017).

In a study conducted on LGBTQ+ youth’s use of the Internet, the majority of the LGBTQ+ youth participants found that the Internet was not necessary if offline sources were available and trusted (DeHaan, 2013); however, in many cases, offline sources such as family, friends or school based education are not available, sufficient or trusted, and thus LGTBQ+ individuals turn to the Internet to substitute this lack of information on sexual health. In fact, the Internet is most significant for those who do not have other alternatives (Mitchell et al., 2014). The Internet has also been argued to positively affect LGBTQ+ youth’s sexual health education as online sources are found to increase sexual health knowledge (Flanders et al., 2017; von Rosen et al., 2017). It is also often an unregulated space that gives young individuals the opportunity to explore their sexuality in ways they might not be able to offline (Szuks, 2013).

This type of unregulated space also contributes to the potential downfalls of accessing sexual health information online. Despite great progress, research has shown that online sexual health resources can be harmful or inaccessible to youth (Whiteley et al., 2012; Black et al., 2018). For example, some sexual health websites may have information that is unreliable or insufficient, or the websites themselves may not encourage active engagement from the users (Whiteley et al., 2012). This lack of engagement and interactivity online can affect the way that youth process these sexual health resources; for example, online resources that lack this interpersonal communication can be culturally inappropriate for Indigenous youth, for whom traditional practices involving interpersonal communication are essential (Black et al., 2018). In the study
conducted by Black and colleagues (2018), a hybrid form of education was provided where Indigenous youth were taught sexual health education through online interventions, paired with in-person discussions and activities. This type of hybrid education provides new opportunities that recognize the limits of online interventions as the sole source of information (Black et al., 2018).

There can also be a lack of accountability online which affects the accuracy and reliability of sexual health resources (GLSEN et al., 2013; Hawkins and Watson, 2017). Given the amount of information online, it can be hard for youth to distinguish which information is accurate and reliable and which is misleading (Kanuga and Rosenfeld, 2004). Youth may also be exposed to misinformation that can lead to harmful behaviour when used to guide their sexual health decisions (Hawkins and Watson, 2017). Other potential downfalls of the internet can be the potential for sexual exploitation online, such as online predators or involuntary exposure to pornography (Kanuga and Rosenfeld, 2004). Pornography online can be easily accessed, often involuntarily, given the potential overlap between sexual health topics and different forms of pornography (Kanuga and Rosenfeld, 2004).

Pornography online can be associated with potentially negative outcomes in the lives of youth; in a study conducted with 433 adolescents in New York City, exposure to pornography online was associated with high-risk sexual behaviours (Braun-Courville and Rojas, 2009). In a qualitative study conducted with 12 young adults in Halifax, pornography was argued to present both challenges and benefits to the participants’ sexual health (Hare, Gahagan, Jackson, and Steenbeek, 2014). For example, the fact that pornography displays a wide spectrum of sexuality was seen as a positive contribution to their sexual health knowledge (Hare et al., 2014). However, a few of the participants, particularly young men, discussed how overconsuming pornography negatively influenced their sex life offline (Hare et al., 2014). It is thus argued that pornography may influence youth’s sexual activity and sexual health education.

Overall, this section has explored the literature on both the advantages and disadvantages of youth’s reliance on online sexual health resources. The following section will explore the significance and limits of community organizations and clinics.
5.3 Community Organizations and Clinics

Community organizations are critical for LGBTQ+ youth as sites of positive social and psychological development (Allen, Hammack and Himes, 2012). Community organizations can provide physical spaces where LGBTQ+ youth can gather and form relationships, and build support; these sites also foster supportive spaces in which LGBTQ+ youth can access sexual health information that might otherwise be unavailable (Allen et al., 2012). Community organizations can give LGBTQ+ youth the opportunity to connect to a larger LGBTQ+ community, experience empowerment in light of discrimination, and have access to different support systems (Wagaman, 2016). Community organizations are strong examples of spaces in which LGBTQ+ youth resist and challenge their daily environments (Wagaman, 2016; Gamarel et al., 2014). They can provide a space where queer youth have culturally targeted information and have access to peer support and a safe environment (Allen et al., 2012). For example, a qualitative study conducted on LGBTQ+ youth of colour’s access to a community organization in New York City, suggested that the supportive, family-like community organization was very significant for LGBTQ+ youth of colour, as a space to resist prejudice and discrimination and learn how to cultivate a sense of self (Gamarel et al., 2014).

Overall, community-based organizations and programs for LGBTQ+ youth remain under-researched (Allen et al., 2012; Paceley, Keene and Lough, 2016; Wagaman, 2014). Despite the benefits of community organizations, there can be barriers that prevent youth from accessing these services (Wagaman, 2014). For example, in a study conducted on LGBTQ+ youth’s access to community organizations and support, the findings suggested that some queer youth do not know about the existence of these services or how to access them (Wagaman, 2014). In addition, even within LGBTQ+ specific community organizations, there continues to be exclusionary practices based on class, ability or gender identity (Wagaman, 2014). This sentiment was similarly found in a study on community organizations for a non-metropolitan LGBTQ+ population; the findings suggested that within non-metropolitan LGBTQ+ community organizations, there can be a lack of diversity and a lack of representation (Paceley et al., 2016).

Another space where LGBTQ+ youth may access sexual health information is within health care settings. For the greater LGBTQ+ population, heteronormativity within healthcare institutions can often be a barrier to care (Maticka-Tyndale, 2008; Knight et al., 2013; Bolderston and Ralph,
Heteronormativity within health care settings can prevent queer youth from disclosing or discussing their sexuality with their health care practitioners (Snyder, Burack and Petrova, 2017; Fuzzell et al., 2017; Meckler et al., 2006). Queer youth may also be exposed to negative attitudes or inappropriate comments from clinicians when expressing their sexuality (Coker et al., 2010; Snyder et al., 2017). These barriers can therefore impact queer youth’s access to care. For example, a quantitative study of U.S. youth conducted between 2009 and 2010 revealed that young queer women were less likely than their heterosexual peers to have a routine checkup within the past year (Luk et al., 2017). Despite a lack of research that provides examples of positive health care experiences for queer women, there are studies that suggest different ways in which health care settings may facilitate access to care: for example, by developing anti-discrimination government health policies with the aim of implementing equitable health care services (Rapid Response Service, 2014), or by ensuring that health care providers respect the privacy of their patients and build trusting relationships (Law et al., 2015). Another suggested way is to provide training for health care professionals to ensure competent and culturally targeted care for LGBTQ+ youth (Hadland, Yehia and Makadon, 2016).

6 Conclusion

In this chapter I have critically presented the relevant literature on space, space and sexuality, sexual health education in the school setting and sexual health education in alternative spaces of education. This chapter contextualizes the research questions and provides background information for the reader before engaging with the results of this specific case study. In the following chapter, I present the methods and methodology utilized in collecting, coding and analyzing data for this project.
Chapter 3
Methods

1 Introduction

In this chapter, I discuss the methods used to collect, code and analyse data, and provide rationale for my methodological choices. My methods reflect the tools used for data collection, while my methodology informed how I chose my methods and why (Browne and Nash, 2010).

2 Methodology

Within this research I followed a queer methodology, reflecting a greater queer notion of research as unstable, contested, and unfixed, as well as historically, geographically and socially contextual (Browne and Nash, 2010). Within both queer and feminist methodologies, qualitative methods are often utilized, in ways that contest the supposed reliability, generalisability and universality of conventional quantitative methods (Browne and Nash, 2010). Queer qualitative methods inform the understanding that my research project is situated within a cultural and geographic context that dictates normative sexual practices and behaviours (Nash, 2010).

Furthermore, my choice in methodology and research was informed by my own positionality; as a young queer woman from Toronto, my position as both an insider and outsider in relation to my research project influenced my methods and methodology. This will be further explored in the Positionality section of this chapter.

My approach to the research design was informed by seminal work within queer geography. Similar to Ferguson (2013), I employ a queer methodology to recognize how the interview process is comprised of a diversity of responses, and a multiplicity and fluidity of identities. For example, when interviewing the participants, this involved allowing them to define their own sexual identity and how that has changed over time, and how it may change in the future. I chose to approach the interviews recognizing the complexity and uniqueness of the responses from the participants, as well as recognizing the specific cultural and historical context of the research being conducted (Ferguson, 2013). For example, I approached each interview as opening a door to unique, diverse and situated stories. Additionally, Nash (2010) argues that queer research is distinguished by its “political commitment to promote radical social and political change that undermines oppression and marginalisation” (Nash, 2010: 131). In line with other queer
research, my research aims to destabilize the heteronormative underpinnings of sexual health education in Ontario, and promote social and political change to provide education that is applicable and relevant to the lives of young queer women.

Within this framework, I utilize in-depth, semi-structured interviews to answer my research questions. As mentioned previously, my research questions are the following: 1) How do young queer women in Toronto experience sexual health education at school? And 2) How do alternative educational spaces contribute to their sexual health education growing up?

3 Research Setting

The research took place in Toronto, Ontario. The location was chosen to provide a case study of the official Ontario Ministry of Education’s Grades 9-12 1998 *Health and Physical Education Curriculum* which includes the sex education unit. Ontario’s sex education curriculum is of particular interest, as it has been contested and re-evaluated since 2010. In 2010, revised curricula for both Grades 1-8 and Grades 9-12 were introduced to replace the 1998 curriculum. These 2010 curricula introduced discussions on sexual orientation, gender identity and consent. However, they were quickly repealed due to contestation and conservative backlash, until reinstated in 2015 after further consultation. In the summer of 2018, the Grades 1-8 2015 *Physical Health and Education curriculum* was once again repealed, this time by a new government comprised of some members who made the content of the curriculum an electoral campaign issue. This repeal was highly controversial and was met with protests from tens of thousands of students and hundreds of teachers (Teotonio, 2018; Teotonio and Ferguson, 2018).

Currently, as of spring 2019, sexual education in schools lack consistency across the board within Ontario; all high schools are learning the 2015 *Physical Health and Education curriculum*, whereas certain elementary schools have reverted back to the 1998 curriculum. For the purpose of this project, I discuss the participants’ experiences with the Grades 9-12 1998 *Health and Physical Education Curriculum*.

The participants’ in this study attended high school from the years 2003 to 2016; twenty-five out of 29 participants attended high schools within the Toronto District School Board (TDSB). All participants received the Grades 9-12 1998 *Ontario Health and Physical Education Curriculum* in grade nine. Health and Physical Education courses are mandatory in grade nine, and thus it is expected that each student who attends public high school in Ontario will have received some
form of sex education throughout their high school experience. The other five participants went to Catholic high school in Toronto; however, the schools they attended mandated the use of Ontario’s Grades 9-12 Health and Physical Education Curriculum, although the curriculum was taught through the lens of the Catholic faith (Health and Physical Education Brochure, 2016). The core of the curriculum in both circumstances still creates a desired consistency throughout all participants’ interactions with sex education curriculum.

The sex education unit of the Grades 9-12 1998 Physical Health and Education curriculum falls within the “Healthy Living” section. In this section, students are expected to learn about health, how to make healthy choices, and understand how that connects to everyday life (Government of Ontario, 2015). The content of the Grades 9-12 1998 curriculum included a discussion on reproductive physiology (Kumar et al., 2013), along with methods of preventing pregnancies, STIS and understanding ‘responsible’ sexual relationships (Connell, 2005). The curriculum highlighted the negative consequences of sexual decisions with a focus on disease, pregnancy and risk prevention (Larkin et al., 2017). It did not include discussions on sexual orientation or gender identity (Connell, 2005), same-sex families (Teotonio and Ferguson, 2018) nor did it explicitly discuss communication around sex, sexual pleasure or sexual abuse (Causarano, Pole and Flicker, 2010). Moreover, sexual activity was introduced through a lens of potential dangers and negative consequences (Connell, 2005). This curriculum was created before the widespread use of the Internet, social media and smartphones (Larkin et al., 2017; Kilborn, Lorusso and Francis, 2016). Consequently, it did not include discussions on Internet safety, sexting and cyberbullying (Teotonio and Ferguson, 2018). Improving upon the 1998 curriculum, the revised 2015 curriculum includes discussions on sexual orientation, sexuality, gender identity, cyber safety and consent (Bialystock, 2019).

The above mentioned political contestation and revisions surrounding Ontario’s sex education curriculum makes Ontario a particularly interesting and compelling location to study. This

---

1 In Toronto, there are two publicly funded school boards, the Toronto District School Board (TDSB) and the Toronto Catholic District School Board (TCDSB). They are both publicly funded under the same jurisdiction, which means that they are free for students to attend. Both boards adhere to the requirements and the curricula of the Ontario Ministry of Education, however the TDSB remains secular while the TCDSB provides a Catholic perspective.
project’s interrogations of the effects of the Grades 9-12 1998 curriculum on the lives of queer women, and the inclusion/exclusion of topics such as sexuality and consent, will greatly contribute to the on-going sex education curriculum debate.

To decrease possible differences based on geographical location, I narrowed the location from all of Ontario to the city of Toronto. I have excluded the Greater Toronto Area given that the inclusion of the suburbs may bring in too many confounding factors that I cannot accurately assess due to time constraints and depth of a Master’s thesis. I have narrowed the location of residence to Toronto for practical reasons, as well as personal and academic interest. Toronto offers many spaces and events for the LGBTQ+ community, and is well-known as a gay-friendly city (Nash, 2011; Petenbrink, 2018). As the largest and most diverse city in Canada, Toronto has a strong pull for queer-related research, and it provides a unique and exciting opportunity to engage with young women in the LGBTQ+ community.

As a city that provides many spaces and events for the LGBTQ+ community, there may be more options and opportunities for young queer women to learn relevant sexual health information outside of the school setting. A greater LGBTQ+ culture in the city may allow for more alternative spaces of education to exist. This may also contribute to the openness and acceptance of networks of friends and family with regards to sexuality and sexual health. It is important to consider these elements throughout the research project. Additionally, I myself live in Toronto and therefore had the opportunity to recruit and interview participants within Toronto. I am a part of the queer community in Toronto, as discussed in the Positionality section below, and am therefore personally interested in the experiences of queer women within Toronto.

4 Research Design

4.1 Participant Criteria

To qualify for the study, the participants had to self-identify as women, as LGBTQ+, be between the ages of 19 and 29, have gone to public high school in Toronto, and currently live in Toronto. I chose to interview participants who attended public high school in Toronto in order to examine their experiences related to the official Ontario’s Grades 9-12 1998 Health and Physical Education Curriculum, as mentioned above.
The age gap of 19 to 29 was significant, as it determined that each participant has received the same sex education unit within the Grades 9-12 1998 *Health and Physical Education Curriculum*. I chose to include an age range where the women still fall into the category of ‘youth’. Statistics Canada defines youth between the ages of 15 to 34 (Statistics Canada, 2018). I am following a guideline of Planned Parenthood Toronto, where youth are classified as up until the age of 29 (Planned Parenthood Toronto, n.d.). As a centre for advocacy of sexual education and as a highly regarded service centre for queer women, Planned Parenthood’s criteria of youth was deemed significant for the research study, and is therefore used as a model. Additionally, the focus on youth minimized the years between the time the interview took place and the participants’ high school education.

I chose to study queer women for several reasons, one being in relation to sexual health disparities. Throughout the fields of health and sexuality studies, research has shown sexual health disparities between heterosexual and non-heterosexual youth; these disparities range from higher pregnancy rates (Saewyc, 2011; Saewyc et al., 2007; Saewyc et al., 1999) to higher risk of STI transmission (Everett et al., 2014; Coker et al., 2010; Saewyc, 2011), to higher rates of sexual coercion (Everett et al., 2014). With regards to reproductive health concerns, bisexual and lesbian youth are shown to have higher pregnancy rates and/or an increased risk of teen pregnancy compared to their heterosexual peers (Goodenow et al., 2008; Saewyc et al., 1999; Stoffel et al., 2017), as well as are less likely to report using contraception (Coble et al., 2017); this suggests higher risk and vulnerability for young queer women.

Queer youth are also argued to have higher rates of unmet medical needs despite having higher mental health and health needs (Williams and Chapman, 2011). For example, quantitative data from a national sample of U.S. youth conducted between 2009 and 2010, demonstrated that young queer women were less likely to have a routine checkup in the past year in comparison to their heterosexual peers (Luk et al., 2017). These sexual health disparities shed light on the need to consider young queer women’s sexual health education experiences.

Despite a few individuals who identified as non-binary showing interest in the study, I only interviewed women who self-identify as ‘woman’. I found it necessary to narrow the participant criteria, as I felt that I could not accurately reflect the nuanced experiences of non-binary individuals within the scope of this Master’s thesis.
4.2 Recruitment

I began recruiting once I received ethics approval\(^2\). My recruitment strategy utilized both online and offline settings. The majority of my participants responded to a call for participation online where I used Facebook to share my recruitment poster (see Appendix B). I circulated materials within Facebook groups that were created by, and for, the queer community in Toronto, such as Bisexual Network of Toronto or Jobs for Queers Toronto. Through these groups, I was able to recruit specifically from the queer community. I also posted my research on the Rainbow Health Ontario website, which provides a space for researchers who are doing LGBTQ+ related work to share their projects. The Internet provided an opportunity to reach online communities that may be hard to access in offline settings (Madge, 2007). Facebook was a highly successful tool as it reached a large amount of individuals, and was the source of recruitment of almost one half of the participants. Additionally, it allowed individuals to message me directly, which proved an effective and convenient method of communication for both the participants and myself.

As I began interviewing, I used snowball sampling as a method for recruitment. I asked each participant to share my information with anyone who may be interested and fit the recruitment criteria. I made sure to do so in a way that the participants did not feel pressured to do so. I recruited seven women through the snowball strategy—approximately one fourth of my total participants. The snowball strategy provided an intimate opportunity for participants to show their enthusiasm and connection to the study, by sharing the recruitment information with their friends and their community.

The snowball strategy is used frequently within research on diverse sexualities and those who live outside the confines of heterosexuality (Browne, 2015). There are both advantages and disadvantages of relying on the snowball strategy to recruit participants. While disadvantages include potentially limiting the breadth of my research participants, snowballing provided access to networks that may not have been easily accessible otherwise (Browne, 2015). For example, individuals may not be out publicly or active within the queer sites and organizations I recruited from, but may still be connected to individuals who are active within these spaces.

---

\(^2\) I received approval from the University of Toronto Research Ethics Board under Protocol 35788.
In addition to online recruitment and snowballing, I recruited participants through community organizations, non-profits, and commercial spaces that were related to sexual health and/or geared towards the LGBTQ+ population. I recruited participants from community organizations, such as the 519 and the Sherbourne Health Centre. Where possible, I established relationships with the organizations and groups early on in the research process. For example, for personal interest I have frequented the Bisexual Women of Toronto (BIWOT) support group meeting held at the 519, and I chose to share my study with the group. For those organizations where I could not myself participate in a group, I contacted them in person or on the phone to ask if they could share my recruitment posters with clientele. Physical posters were put up within these organizations, as well as within commercial spaces in Toronto, such as the Glad Day Bookshop, and the women-oriented sex shop, Good for Her. I recruited two participants through this method.

One individual was recruited from an informal organization, Sqwish, which is a queer basketball league in downtown Toronto. I am a part of this community, and used my personal connections to recruit through this organization. Overall, given my involvement in the community, I did interview individuals that were friends, or friends of friends, as my study spread through word of mouth. There are both advantages and disadvantages of interviewing participants that I know personally. Given that these individuals are connected to me through our queer community, one disadvantage may be the possibility of commonality amongst them. It is important to recognize this, and therefore I only relied on immediate personal connections for a small portion of my research, which was five participants. In order to navigate the potential bias of knowing these individuals on a personal level, I reminded my participants of my role as a researcher, and stressed that the interview would be entirely confidential. There were also practical advantages to relying on my personal connections, such as moments in which our interactions were facilitated by an existing familiarity with one another, and the fact that it tended to be more convenient to set up interview times (Unluer, 2012).

I hoped to recruit a range of participants who self-identified as women, including trans women. Despite my desire to include a diverse depiction of gender identity, there was only one person from the trans community who reached out to participate in the study. In the end, she was unable to participate in the study for unknown reasons. I believe that I could have reached this population in a greater capacity had I specifically targeted my recruitment to the trans
community, which I failed to do. In retrospect, I feel that I could not have accurately reflected the nuanced experiences of trans women within the scope of this Master’s thesis. In future research, it would be important to include a study that focused on the particular experiences of trans individuals, and their sexual health education growing up.

I hoped to recruit a diverse range of participants to reflect the multiplicities of identities among groups of women. Within the scope of this Master’s thesis, I have not had the opportunity to explore extensively the many intersecting identities such as race, class, religion and ability. Although I have included different narratives that explore how these intersecting identities affect one’s sexual health education, in future research it would be important to delve deeper into the experiences of specific marginalized groups.

4.3 Interviews

The use of qualitative research methods over quantitative came from my desire to go beyond a mapping of sexual health resources that exist across Toronto. My research aimed to focus on the in-depth experiences of queer women finding these resources, frequenting and interpreting these spaces, or having to create them themselves, rather than the location of these spaces or the amount of people who access them. Only through an in-depth interview process have I had the opportunity to learn about the intimate story of queer women’s lived experiences, as well as their interpretation of the sexual health curriculum. The focus on lived experiences has therefore guided my choice to pursue qualitative research.

I conducted 29 semi-structured interviews, which allowed for a two-way conversation as opposed to a strict question and answer format, while simultaneously focusing the discussion as to not move too far from the research topic (Dunn, 2010). For example, my interview guide focused on sexual health education spaces as a research topic, but allowed for flexibility in which aspects of these spaces got more attention depending on the participants’ experiences (see Appendix C). In order to create a list of flexible questions, I first created an interview research guide. The research guide was comprised of a list of general issues that I hoped to cover in the interviews, such as the ability to learn about queer sexual health at school, or the location and use of alternative sexual health resources (Dunn, 2010). Creating the research guide as a preliminary step solidified the main issues I addressed, and was used as a point of reference throughout the interview process.
In order to understand and assess the interview guide and the flow of the interview structure, I conducted two pilot interviews with women who identify as queer, and are between the ages of 19 and 29, but who did not go to public school in Toronto. This was a good introduction to test how the questions flowed, and how to probe in certain areas and expand on certain discussions. It was also an important step to help tweak questions to understand what was received well and what needed more work. After making adjustments based on the pre-interviews, I began interviewing. The process of adjusting the questions continued, and informed my process as I interviewed more women. I gave more weight to certain questions as the interviewing continued, and I could recognize which areas of the interview guide needed more attention. I tried to be as flexible as possible and used the research guide as a reminder of the most important topics to be covered, rather than a formula for the interview (Dunn, 2010).

Given that some of these women do not share their sexual orientation with their family or greater community, and due to the highly personal topics such as one’s sexual health, each individual’s identity was kept anonymous and confidential. In order to maintain anonymity and confidentiality, I asked each participant to choose a pseudonym for themselves. Some participants chose to include their own names. I kept all the interviews and transcripts locked on my computer, under the participants’ chosen name.

Throughout the interviews, we discussed very personal information with regards to the participants’ sexuality and sexual health. Thus, before the interviews began, we established a process of informed consent, meaning that the participants understood clearly the nature of the research and the ways in which the results might be used (Madge, 2007). I also provided information on help lines or crisis centres in case it was necessary, being sensitive to any pain or trauma that could arise throughout the interview process.

A large body of research studies the relationship between interviewer and participant, as many authors suggest it is necessary to establish a relationship of trust within interviews (Yow, 1995; High et al., 2014; Norkunas, 2013). A trusting relationship can allow for a more open, honest and in-depth conversation. Through my research, I attempted to form a trusting relationship with all participants. For some participants, we began the interview with a base level of trust, given that we already knew each other through personal connections. With others, it was important to cultivate trust in other ways. One way in which I attempted to develop trust was to be as open
and as honest as I could be throughout the whole interview. This often meant sharing my own sexual identity or sexual health experiences. I also attempted to build trust by creating a respectful, welcoming, and non-judgmental environment.

Throughout the interview process, I relied on different techniques to engage with participants. Primarily, this involved various follow-up questions to allow for an in-depth conversation. For example, in certain moments I would ask for clarification or comparison-type questions (Yow, 2005). Following Yow (2005), I aimed to avoid leading questions, and would ask participants about their general experience with sexual health education, and then clarify with follow-up questions as necessary. Before beginning the interviews, one of my hypotheses was that it would be difficult to find reliable sexual health information growing up as a young queer woman. However, there were instances when the participants described positive experiences accessing sexual health information. In order to prepare for the possibility of diverse and unique responses, I made sure to employ questions that allowed for a broad range of answers. For example, I asked “in what other ways [outside of school] did you learn about sexual health growing up?” as opposed to asking “was it challenging for you to access sexual health resources?” This approach hopefully created more unbiased questions and allowed for a diversity of responses based on the participants’ lived experiences.

Throughout the interview process, I made sure to respect the emotional boundaries of the participants (Norkunas, 2013), avoid judgment (Yow, 2005), as well as listen for non-verbal cues and allow for silences (High et al., 2014). These interview techniques helped the interview process in many ways, such as protecting both myself and the participant from emotional harm, creating a more welcoming environment, and engaging in more in-depth discussion.

5 Data Collection and Analysis

I continued the interview process until saturation occurred, which is the point in which no new substantive information is obtained (Palinkas et al., 2015). I began analysing themes as each interview happened, in order to determine if saturation had occurred. As I continued interviewing, it became clear that certain themes were consistently mentioned and discussed at length. Despite the uniqueness of each individual interview, there were commonalities across the interviews that determined when saturation occurred. Overall, I conducted 29 interviews.
I collected the data through audio recording of each interview. Audio recording provided the opportunity to be a more critical listener, as I did not need to be writing information down as the participant was talking (Dunn, 2010). It also allowed for a more natural style of discussion, more closely mimicking a conversation between two people. Audio recording was also necessary as I transcribed each interview directly from the recording, and used the transcripts to analyse the data. I used a transcribing service to transcribe 12 of the interviews due to time constraints. For those interviews, I double checked each transcript and made edits when necessary, to ensure that the interview was accurately transcribed. Both the transcribing service and I transcribed verbatim. Certain themes began to present themselves through transcribing and thus the transcribing process acted as a preliminary form of analysis (Dunn, 2010).

Thematic analysis was used when analysing and coding interviews, following Braun and Clark’s (2006) recommendations. Thematic analysis is used to identify, analyse, and describe patterns within the data. It is not strictly attached to one methodology or theoretical framework, and therefore allows the researcher to apply their own theoretical framework (Braun and Clark, 2006). Thus, I utilized a queer methodological framework to inform the analysis of the data which was discussed above.

Before coding and creating themes, I made analytical decisions based on the recommendations and work of Braun and Clark (2006). First, I reflected on what counted as a ‘theme’ in my research, which meant that as I generated themes, I would ask myself how they fit in relation to the overall research questions. I sought out a rich description of the data set overall, as opposed to a detailed account of one section. I chose a theoretical thematic analysis, meaning that there were preliminary notions of sexuality and sexual health education in Ontario that were applied to the data when generating themes. I identified themes on a latent level, which involved describing, analysing and further interpreting and conceptualizing the themes within my data. Finally, I relied on a constructionist thematic analysis as opposed to one that was essentialist or realist. This influenced how I theorized my data, as situated within a socially-produced context where both the interviews and participants’ lived experiences took place.

Braun and Clark (2006) provide a step-by-step guide to applying thematic analysis to the data. I chose NVivo software to assist with data analysis and coding. This primarily involved familiarizing myself with the data in an active way, such as looking for themes and patterns. I
then generated the initial codes, later to be grouped into themes. The analysis involved understanding the relationship between and across codes. I then reviewed the themes I created, confirming that they were consistent within the data set. Within this process, I defined the themes and reflected on how they contributed to the overall narrative of the research. Writing took place throughout this entire process. I produced the write-up portion of the thesis as my last step, which consisted of my findings and discussion explored in Chapter Four and Five.

The use of thematic analysis drew on previous studies within queer research (see Bradford et al., 2018; Morales, Corbin-Gutierrez and Wang, 2013). As a way to incorporate queer methodology within thematic analysis, Smith, Mccullough, Critchlow and Luke (2017) recommend maintaining open and fluid codes throughout the analysis to capture the ‘queerness’ of queer narratives. For example, this may involve a non-linear process of analysis, where the researcher can continuously go back and recreate codes or readjust codes. I used this within my research to recognize the different complexities and intricacies of each narrative, and to acknowledge how each interview was unique and situated within its own social, cultural, and geographic context.

6 Positionality

The position of the researcher in relation to their research and research participants has become an important point of reflection and analysis within feminist and queer geographical work (Hopkins, 2007). Critically reflecting on the researcher’s position allows for a greater understanding in how their intersecting positionalities and identities influence and shape the research process and outcomes (Hopkins, 2007). As an individual who identifies as a queer woman and who grew up in Toronto, I am deeply embedded within my research in ways that have both benefitted and challenged my research process. I am in the position of both insider and outsider in relation to this project. I chose to navigate my position as an insider when addressing the participants, while I also recognized my sites of privilege as a white woman within an academic institution. For example, my position as an insider created opportunities to build relationships of trust with my participants (Mohammad, 2001). However, my insider position challenged me to consistently question and recognize my bias, as to not distort the content based on my predetermined understandings and stance on the issues at hand (Mullings, 1999). For example, it was critical that I distinguish the participants’ experiences with sexual health education from the way that I had experienced my own sexual health education in public high
school in Toronto. Although my own experience contributed to my interest in this subject, it was important to recognize and actively listen to other women’s experiences, without projecting my own bias onto their narratives.

I also experienced and reflected on my position as an outsider. As a white woman coming from an academic institution, I recognize that I am in a position of power in relation to many of my participants. As mentioned earlier, I shared my sexual identity with each participant as a way to communicate this collective position; this often eased the interaction and allowed the conversation to go deeper. Revealing information about myself was one attempt to decrease power differentials within the interview, and create greater empathy amongst researcher and researched (McDowell, 2010). Sharing aspects of my identity if or when the participant asked, and being honest and open throughout the interview process was also a way to remain accountable to my research participants. I hoped to balance the power dynamic to the best of my ability by acknowledging my own embeddedness in the research, and my own experience with sexual health education as a queer woman.

Throughout the interviews, my positionalities as both insider and outsider were constantly changing throughout the interviews (Mullings, 1999; Mohammad, 2001). For example, there were moments in which this positionality felt contextual based on the location of the interview, such as when I was invited to participants’ homes or workplaces to conduct the interviews. I felt instantly connected to the participants as we shared the familiarity, intimacy, and safety of their home or workplace. My identity as a queer woman felt significant as it opened the doors for us to share this intimate space. Overall, as my positionality shifted from insider to outsider, I was constantly reflecting on my role with relation to the participants, and conceptualizing knowledge as situated and partial (Haraway, 1988). I hoped to construct a politics of engagement with my participants, in which we both partook in an on-going discussion that recognized each other’s positionality, and created a space in which we could mutually learn from each other (Katz, 1994).

I am extremely grateful for the opportunity to have had open and vulnerable conversations about sexuality and sexual health with a diverse group of queer women. These women were extremely generous and gracious with the information they shared with me, and I am honoured to have
fostered and participated in these discussions. Qualitative interviews provided the unique opportunity for me to deeply engage with the participants’ lived experiences.

Overall, throughout this chapter, I have discussed the methods and methodology utilized in collecting, coding and analysing data for this project. I have explored the many decisions behind the methods and methodology that guided this research, and shared my positionality. The following chapter, responds to the first research question, how do young queer women in Toronto experience sexual health education at school? I respond through a detailed literature review section, an analysis of the relevant data, and a discussion of the findings.
Chapter 4
School and the Sex Education Curriculum

1  Introduction

As discussed in the introduction and literature review chapters, sexual health is a critical component of one’s overall health and well-being. One way to increase agency and awareness of one’s sexual health is through sexual health education. The high school classroom is argued to be one of the most formative spaces for young women in Canada to learn about sexuality and sexual health (Public Health Agency of Canada, 2003). However, researchers have noted that many high school sex education curricula enforce strict definitions of gender roles and ignore non-normative, queer sexualities in their implicit narratives (McNeill, 2013; Fields, 2012). This narrative may be enforced more generally through the school environment, where heteronormative discourses are deeply embedded (Ferfolja, 2007). The privileging of heterosexual relationships can devalue other expressions of sexuality, thereby excluding and marginalizing queer youth. Within this context, this project asks, how do young queer women in Toronto experience sexual health education at school? This chapter explores this question through an analysis of the high school environment and sex education curriculum in Ontario.

Through this chapter, I will argue that the school is a critical location where participants want to learn about sexual health; the classroom environment, and the teachers influence within it, affect the way that the participants experienced their sexual health education; the sexual health needs of the participants were not addressed through the Grades 9-12 1998 Ontario Health and Physical Education Curriculum; and lastly, in the participants’ experience, the 1998 sex education forwarded a heteronormative narrative that constrained them to learn about sexual health and sexuality in their own time, and in different alternative spaces. This chapter suggests the need for more comprehensive sex education curricula that actively address queerness, sexuality, gender identity and consent.

2  Literature Review

In order to contextualize the lived experiences of the research participants, I will briefly include a discussion on sexual health education and curricula within schools in Canada. I have touched on
sexual health education curricula and the school environment more broadly in Chapter Two, but will now contextualize this study within the context of Canadian curricula and schools.

2.1 Sexual Health Education Curricula

2.1.1 Sexual Health Education

Many researchers have studied sexual health education within diverse Canadian contexts (see Byers, Sears, & Foster, 2013; Connell, 2005; Maticka-Tyndale, 2008; McKay, 2014; McKenzie, 2015; Shoveller et al., 2012; Flanders et al., 2017), with a smaller group examining Toronto in particular (Flicker et al., 2009). Despite the observed and studied benefits of sexual health in the lives of young people, the implementation of sexual health education in schools in Canada has been contested over time (McKenzie, 2015). For example, in Ontario as mentioned above, a new sex education curriculum was introduced in 2010 for both Grades 1-8 and Grades 9-12; however, due to community opposition from the conservative right and certain religious organizations, both were repealed by this same provincial government in 2010 (McKenzie, 2015). As mentioned previously, these 2010 curricula introduced discussions on sexual orientation, gender identity and consent. After further consultation, a slightly revised version of the new curriculum was reinstated for both age groups in 2015. In the summer of 2018, the Grades 1-8 2015 curriculum was once again repealed, this time by a new government who made the content of the curriculum a campaign issue. Currently, as of spring 2019, sexual education in schools lacks consistency across school boards within Ontario: all high schools are learning the 2015 Physical Health and Education curriculum, whereas elementary schools have reverted back to the 1998 curriculum. The reinstatement of the Grades 1-8 Health and Physical Education Curriculum from 1998 removes issues such as sexuality, gender identity and consent from class content. The results of this study will help situate the implications of the Grades 9-12 1998 curriculum, and situate the necessity of the revised Grades 1-8 and Grades 9-12 2015 curriculum.

In Canada, studies have shown that sexual health education is desired by both youth and parents (McKay and Bissell, 2010). In Ontario specifically, many parents believe that a comprehensive sexual health education program should be taught in elementary schools and high schools, and should be kept up to date with societal changes (McKay et al., 2014). Despite examples of small groups of parents who believe that schools should not provide sexual health education to their children, research has demonstrated parents’ strong support for sexual health education in school
(Weaver et al., 2002; McKay et al., 2014). The desire for sex education in school does not detract from parents’ desires to contribute to their children’s sexual health education. For example, two studies conducted in Ontario and New Brunswick indicated that parents believe that sex education should be the responsibility of both the school and the parents themselves (Weaver et al., 2002; McKay et al., 2014). In addition, a study conducted with elementary and middle school teachers in Canada, found that teachers’ willingness to teach sexual health can be affected by the anticipated reactions from parents (Cohen et al., 2012). Parents are therefore an important component of the implementation of sexual health education.

Between 2006 and 2008, an extensive study examining the state of youth sexual health, the Toronto Teen Health Survey, was conducted in Toronto. This was one of the largest, most comprehensive studies in Toronto to examine the ways in which youth learn about sexual health information, and the barriers to accessing sexual health services in the city. Among many findings, the report suggested that youth are most likely to seek sexual health information from their friends, but would rather access this information from professional sources such as doctors, nurses, teachers, etc. (Flicker et al., 2009).

With regards to sexual health services, the majority of youth surveyed did not access clinics and services for sexual health purposes, and the majority who did were female, older, sexually active and white (Flicker et al., 2009). The study found that there are many barriers that stop LGBTQ+ youth from accessing sexual health services, such as geographic complications in physically accessing the services, to a lack of nuanced services that understand and meet the particular needs of the community (Flicker et al., 2009). The Toronto Teen Health Survey thus provides a contextual background to the state of youth sexual health in Toronto. Building off of the Toronto Teen Health Survey, my research acknowledges and prioritizes the unique experiences of young queer women and their relation to sexual health, adding a nuanced perspective that contributes to the greater conversations on youth sexual health.

2.1.2 Intersecting Identities within Sex Education

Sexual health education in Canada is deemed important for all youth, regardless of their gender, race, class, religion, or sexual orientation (McKay and Bissell, 2010). However, in practice, there are disparities within sexual health education programs, privileging certain individuals while excluding others. Those with the poorest sexual health in Canada are youth living in poverty,
Indigenous youth and youth in rural areas, with sexual health being particularly threatened for LGBTQ+ youth (Maticka-Tyndale, 2008). In addition, in the Toronto Teen Health Survey mentioned above, it was found that those who are most at risk of not receiving sex education, particularly within the city of Toronto, are newcomers to Canada (Flicker et al., 2009). Although the focus of this project lies on a broad category of LGBTQ+ women, it is important to be conscious of the intersections and diversity within this group and how class, race and geography may also affect one’s access to sexual health education.

2.2 Learning at School

As mentioned in Chapter Two, schools can be examined as traditional spaces of learning that create and sustain different values and norms. Through research conducted in the U.S., studies have found that heteronormative practices within schools are sustained through a collective environment involving teachers, students and administrators, throughout all levels of education (Gorski et al., 2013). In the Canadian context, public schools have implemented diverse policies that address sexual orientation and gender identity in the school setting. The Toronto District School Board (TDSB) employs an Equity Foundation that seeks to ensure that “fairness, equity, and inclusion are essential principles of our school system and are integrated into all our policies, programs, operations, and practices” (Equity Foundation, 1999). The Equity Foundation recognizes the inequitable treatment of individuals based on diverse factors such as sexual orientation, gender, disability and race, and has developed steps to address these forms of inequity. Similarly, the TDSB created an Anti-Homophobia Education Resource Guide; this resource guide was part of an equity-oriented educational reform taking place in Canada in the early 2000s (Goldstein et al., 2007). Among many suggestions, the resource guide recommended that TDSB classrooms include learning materials that reflect the LGBTQ+ community (Goldstein et al., 2007). The Equity Foundation and the Anti-Homophobia Education Resource Guide were introduced in 1999 and 2006, respectively; the 25 of the 29 study participants who attended TDSB high schools were enrolled in high school during this time.

This strategy to encourage inclusivity can also be found at the provincial level. In 2009, the Ministry of Education in Ontario developed Ontario’s Equity and Inclusive Education Strategy. This strategy encourages equitable and inclusive education that promotes diversity within Ontario schools, including in relation to sexual orientation and gender identity (Ontario’s Equity
and Inclusive Education Strategy, 2009). Twenty-three out of 29 of my participants attended high school in Ontario while this strategy was implemented. These strategies and policies reflect the on-going desire of schools in Ontario to change and adapt to diversity in the school system, such as promoting inclusivity and awareness of the LGBTQ+ population. These advances reflect the schools acknowledgement of their social responsibility to protect, respect and encourage all students (McCarty-Caplan, 2013). These strategies and policies trickle down to both the students and educators; for example, a survey conducted on transphobia and homophobia in Canadian high schools found that schools with anti-homophobia policies were associated with less homophobic and transphobic comments (Taylor et al., 2016). In addition, teachers at schools with anti-homophobia policies consider the environment generally safer for LGBTQ+ students, as well as feel more support to practice LGBTQ+ inclusive education (Taylor et al., 2016).

Moreover, a necessary component to sex education in a classroom and school setting, is “a safe, secure and inclusive environment that is conducive to promoting optimal sexual health” (Public Health Agency of Canada, 2003); however, it is necessary to question if the classroom successfully promotes a safe and inclusive environment for people of all genders and sexualities. For example, the Final Report on the First National Climate Survey on Homophobia, Biphobia, and Transphobia in Canadian Schools, conducted in 2011, notes that 64% of LGBTQ+ students, and 61% of students with LGBTQ+ parents, reported that they felt unsafe at school (Taylor and Peter, 2011). This is exacerbated for trans students, with 78% feeling unsafe at school (Taylor and Peter, 2011). These statistics point to a significant issue of perceived lack of safety for Canadian LGBTQ+ youth within Canadian schools.

I have included a brief discussion on sexual health education and curricula within schools in Canada. Below, I provide the results and discussion of my data that explores how young queer women in Toronto experience sexual health education at school. My research contributes the unique and nuanced experiences of young queer women whose intersecting identities affected their experience of sexual health education at school.

3 Results

The qualitative results will explore three major topics: the sexual health education curriculum, the school environment, and the advantages and disadvantages of learning sex education at school. The results derive from the qualitative data of 29 semi-structured, in-depth interviews
that were discussed in Chapter Three. The participants for this study were individuals between the ages of 19 and 29, who self-identify as women and as LGBTQ+, who have attended public high school in Toronto and currently reside in Toronto. The interviews discussed the many ways and spaces in which the participants learned about sexual health growing up.

### 3.1 Sexual Health Education Curriculum

To analyse how participants experienced sexual health education at school, it is necessary to begin by interrogating how they perceived and experienced the Grades 9-12 1998 *Health and Physical Education Curriculum*. Primarily, the participants expressed that they did not receive enough information or knowledge regarding their own sexual health at school. There was a lack of information on queer sexual health, gender identity and sexuality. The school did not provide an extensive sex education and was not a sufficient space to learn about sexual health. As Debbie put it, “everything I can think of that I learned about sex in high school was not from school” (Debbie). The sex education curriculum was limited in different ways. It was limited in the sense that it did not delve into queerness and sexuality, but it was also limited in terms of allocated time to the subject: “the fact that [sex education] stops in grade 9 really says something about the information that people are able to hold onto as they get older” (Shayna).

Some participants found that the curriculum was very scientific, with a large focus on anatomy and biology. For example, the curriculum would explain issues such as menstruation, but without discussing how that might affect someone’s life and what that might look like. It focused on safety and preventative elements of sexual health, mainly STIs and contraception, without delving into issues that touched on students’ emotional or mental well-being:

> And I remember thinking that it was incredibly rudimentary, it was kind of very much symptomatic, right, like learning all of the symptoms of different STIs, you're learning the facts about each contraceptive method. You're not necessarily learning the emotional or interpersonal nuances of why you might make different contraceptive choices, let alone learning anything about consent or about personal comfort. (Bronwyn)

Many participants found that the curriculum was very basic. For some, they felt that the sex education curriculum was just another box to be ticked or a requirement that had to be fulfilled. When discussing issues of safety and prevention, almost all participants agreed that these issues
were discussed in relation to heterosexual contexts. For example, being safe meant the prevention of pregnancies and STIs between heterosexual, cisgender couples. For the majority of participants, safety within queer relationships between two self-identifying women was not discussed. Shayna describes this concept very clearly:

A lot of the time when people talk about STIs it's within the context of "heterosexual" sex acts and then almost by default and by lack of mention there's this idea like "oh if I'm having sex with a partner who has the same body parts as me, or who is the same gender, then it's fine and I don't need to use protection". I think it's so dangerous not to talk about that because the fact is that young people are going to have sexual interactions with people with the same body parts as them so they need to know how to protect themselves. I don't feel like that was something I learned about at all and it was something I sort of had to scrap together as an adult with resources that I happened to have access to but then what happens when you don't have access to those resources? (Shayna)

With regards to queerness more generally, some participants found that the topic of diverse sexualities was discussed at some point during the curriculum; however, the students were not necessarily invited to engage with these ideas, but rather it was mentioned briefly or presented as an alternative lifestyle. The majority of participants found that queerness was not included in the curriculum. This lack of queer content made it hard for some people to engage with the class and feel seen:

I do wish that there were more things that were either explicitly about queerness so that I could feel seen in that room and that would promote my engagement with the content… as I was saying, I am a 29 year old queer woman and I still don't understand how to have queer safe sex. (Aviva)

For the majority of participants, there was a lack of discussion on gender identity and sexual orientation:

So yeah, I think there was very little content around queer sex or queer relationships, or different kinds of sexuality, different forms of sexuality. Yeah, let alone a nuanced discussion of any of that. (Bronwyn)

A few participants mentioned that their high school may have been open to these types of discussions had they come up. One participant discusses an instance when their teacher thoughtfully and thoroughly discussed dental dams as a form of protection, after being asked a question on the subject:
I remember really just no discussion of queerness whatsoever, absolutely not, but at the same time, I remember even at the time, being kind of frustrated with that, and asking some questions in this anonymous question box, and her answering them very frankly. I think I even asked something about, is there such a thing as safer sex between women, and she was actually like, yeah, absolutely, sometimes people will use different barriers. She described what the dental dam was. She was very willing to talk about it, but I think she just assumed that it wasn’t necessary unless someone brought it up, you know. She was, like, I’m happy to do it, but it’s not kind of part of the course that we’re going to talk about, because it’s not relevant to the majority of the class, I guess, right. So it wasn’t even—it wasn’t even active homophobia, it was just kind of this heteronormativity. (Simone)

Every participant expressed that there was missing information in the curriculum. Primarily, the most pressing subject that was missing was a dialogue on gender, sexuality and queerness, as discussed above. Second, the curriculum lacked a dialogue on consent:

It was very educational in terms of if you don’t use a condom it’s not safe. You know just very general. It didn’t get into the specifics of y’know, if you’re feeling pressure to have sex, for example, what are some ways that you can defer, or not do that, and what counts as…what is consensual and what’s not. (Katie)

Many participants found that consent was not incorporated into the curriculum. Alternatively, when it was included, it was not discussed enough. Students were taught that ‘yes means yes’ and ‘no means no’ but were not taught the complexities or nuances behind these ideas, and the gray areas in between:

I think they did kind of talk about consent but it was a bit too vague. It was just, no means no. But they didn’t really talk about the varying different circumstances of coercion or whatever that could be involved. (Sofia)

I think that consent is super, super important because it’s important to learn about consent even before you learn about sex. Because consent can be applied in so many non-sexual parts of your life. Learning that it’s not just like getting a nod or the shake of the head, it’s sort of understanding when you're walking into a situation, understanding where are the power dynamics, who has more power, and how does the person with more power make the person with less power know that they’re safe ya know? (Beth)

Participants found that they were not given the tools to understand consent and agency, especially in the context of a sexual or romantic relationship:

There was really no talk about how to protect yourself in relationships, how to be aware of signs of abuse, which I think are all huge things about sex ed. If you’re having sex with a person you need to be able to communicate your boundaries, you need to know that those boundaries are going to be respected and those weren’t things that we were ever
taught how to do. Those were things that I had to learn to navigate on my own because I was not explained how to and it was really hard. There was no talk about how to say no, about how to communicate about what you want. (Erica)

Other pressing issues that were missing from the curriculum were understanding relationship dynamics, the role of pleasure and desire, communication strategies and skills, mental and emotional aspects of sexual health, identity politics and reproductive issues. The curriculum itself also lacked an informed approach to sexual health that recognized different intersecting identities:

[Sex education at school] is very white centric, ya know like body hair and stuff is so different for white body hair than for brown and black body hair and having to navigate, is this normal for me to have body hair here when I wasn't taught that in school. (Mada)

These missing dialogues created huge gaps for the participants, and consequently they had to seek out information in their own time. As Maggie described it, “it wasn’t until I was actually exposed to these ideas in university that my entire perspective changed and it saved my relationship to myself” (Maggie).

Despite these missing elements, some participants found that the sex education curriculum was relevant to their lives at the time. Mainly, those who found it relevant were those who were interested in dating or engaging in sexual activity with cisgender men; it was useful in so far as the participants’ queer sexualities aligned with heterosexual sexual practices. Participants found that they were able to take some information from the curriculum, but ultimately it was not a sufficient education:

Again, very heterosexual relationships and I was like, okay, this applies to me in my circumstances at the moment. But it wasn’t until later on that I realized oh, okay, it wasn’t as full of an education as I probably could’ve got. (Kathrine)

Some participants felt that it wasn’t necessarily relevant to them at the time because they were not engaging in sexual activity at that point in their lives.

Some participants discussed gender roles and norms within the curriculum. One participant described how the curriculum included conversations about sexual awakenings for young men, whereas they were non-existent for young women. Another participant discussed the role of sexual agency within the curriculum:
In the curriculum at the time, it was really limited to, like, a guy might pressure you into having sex and here is how to say no when you don’t want to, right. That was the entirety of it right which I mean, is kind of – yeah, I feel like that’s pretty f*cked up that that was all that we got, because I mean, I guess it just boils down to men are out there trying to rape you and you don’t want them to, you have to fight them off, right. And not only is there this narrative about it being your responsibility to prevent sexual violence, there’s also this complete disavowal of your pleasure. Nowhere in that narrative is, maybe you’re going to want to have sex, right. (Simone)

This idea was also delved into through the lens of sexual expectations of young women:

At that time, a lot of us were starting to date and were in these kind of…just starting to navigate power dynamics between men and women and just learning about what was expected of us sexually and being so confused about all that—what boys want, what we want…we weren’t really ever taught to think about what we want. We thought about how to mould our sexuality into what boys find attractive, or, how can we make ourselves most desirable to men. And I think if there was some education on prioritizing your own pleasure or how to ask for what you want, what consent means—all of those things would’ve been so helpful and compelling. (Felicia)

Felicia is thus shedding light on her experience with social norms and expectations regarding gender and sexuality. She is highlighting her need for guidance to navigate power dynamics, agency and consent, and how she may have been better equipped to approach these subjects had she received a more insightful sex education.

3.2 School Environment

With regards to the high school environment, participants expressed mixed reactions. For many, their high school provided a relatively accepting environment where they could be open with their sexuality:

As the years went on I think by grade 12 the acceptance level was a little better, not 100% the best, but better in the fact that people started coming out and it wasn't a big deal and people started bringing their boyfriends to prom and it wasn't a big deal. (Ashlynn)

For others, high school was a neutral location, where non-normative sexualities were neither celebrated nor overtly discriminated against. As one participant mentioned, “At the time, we just didn’t talk about [non-normative sexuality]. There was no conversation about it. It wasn’t …judged, but it also wasn’t normal” (Camryn).

Some participants described overt discrimination and homophobia at school. The school was a straight space, where it was not safe to express queerness in any form. Shayna describes her
experience with homophobia at school: “I mean I would go to school every day and hear "that's so gay" and "no homo" and "faggot" all the time, multiple times a day” (Shayna). Others shared stories of students having to change schools after being outed as non-heterosexual. A few participants discussed how the school was an even more difficult space for trans students; they gave more examples of transphobia or trans erasure than homophobia.

The high school environment was also highly affected by social relations and interactions. The way that students behave, socialize and connect, influence social norms and values that collectively sustain a social climate. The acceptance of diverse sexualities and gender identities highly influence the type of social climate that exists. As one participant describes, “given the hierarchy of how high schools work, if you were gay you were essentially socially at the bottom” (Kai). Kai describes an association of gayness with a lower position in the high school hierarchy, ultimately influencing the high school environment more generally.

### 3.3 Classroom Environment

The classroom environment was also a significant factor in the overall high school dynamic. For many individuals, sex education was segregated by gender. Some participants found this to be discriminatory for trans and non-binary students. Although they personally might not have been negatively impacted by the segregation, they discussed how this may have negatively impacted their trans peers: “the fact that classes were split into genders is…uh…I was privileged enough not to worry about that but I’m sure people looking back were like…oh my gosh, f*ck.” (Chris).

Participants wondered why segregation by gender would be necessary when they found that every topic was pertinent to every student, regardless of gender. Some participants described segregation by gender without ascribing value to this type of classroom organisation. For two participants, being segregated by gender increased their levels of comfort discussing sex-related topics:

> I think also at the time, it felt much more comfortable to be just with teenage girls. So we could ask different questions and it didn’t always have this, like, ha-ha penis vibe. (Bronwyn)

Another element that highly influenced the environment was the role of teachers within the classroom. The teachers have the power to influence the delivery and reception of the sexual health education material, if it is comfortable, uncomfortable, informative, or engaging. For
many people, this was a disadvantage to the classroom, as the information they received was highly dependent on the individual teacher:

Often time teachers feel beholden to exactly what's said in the curriculum and not to deviate from it or they just really don't know how. The teachers don't need to be trained in any specific way and so you can write all the curriculum in the world and have it be amazing but then it's up to the individual teachers in terms of what they feel they are able to teach or just their own ideas and attitudes that absolutely come true. (Shayna)

The larger part of participants found that teachers negatively influenced the classroom based on their own interpretation of the curricula or delivery of the material. For one participant, the teacher completely dismissed sex between women when asked by a student how two women have sex; she responded by stating that two women cannot have sex. Unlike this participant’s experience, for most women there was not an overt denial of queerness, but rather a feeling of discomfort or unease with sexual health subjects. For example, the way Amina describes it:

I think I always remember sensing the discomfort of my teacher in engaging with all of it, you know. And that was just mirrored back in the classroom. (Amina)

Some participants however talked about the positive influences teachers have had on their classroom experience:

I remember that [our gym teacher] wanted to teach us how to put on condoms, and the last class of the unit, she brought in these bananas and she brought in these condoms, and she was like, “I wanted to show you how to put on condoms, but I was really worried that you’d get kind of grossed out by the lube on the condoms. So I drove around to, like, five different stores to try to find unlubricated condoms …” She just thought we’d find that to be too much, and she really wanted to just give us a stress-free experience. (Simone)

In this case, the teacher went out of her way to make the students feel comfortable and at ease while delving into sexual health topics.

### 3.4 Desire to Learn at School

Within the context of the school environment and the sexual health education curriculum, this project explores participants’ desires to learn about sexual health at school. Understanding these desires gives insight into the implications of the school environment and the sex education curriculum.
The majority of participants expressed a desire to learn about sexual health at school. Participants found the school to be a practical space to learn about sexual health and a space that had the greatest reach to young Canadian teens. When the participant Alice was asked if she wanted to learn about sexual health at school, she stated:

Yeah definitely because that’s where we learned about everything else and it would have been nice if the people that we trusted were able to give us some resources or some knowledge that we could actually use in a real way. (Alice)

The biggest advantage of learning at school was the possibility for engagement with ideas and human interaction. Some participants found a need for human connection and engagement with sexual health because of how personal the topic can be. They found that the school provided a space that could allow for this type of engagement:

I think because sexual health and sexuality are so subjective and so individual within each person that I think that's part of why that actual human interaction piece is so vital and is so helpful because you can actually talk things through and talk about like ya know your own personal needs or desires or experiences in a way where just in an informational article on a website might not address all of the specifics of your experiences with sexuality. (Shayna)

Other advantages of learning at school were that students were surrounded by their peers, that it gave students the opportunity to feel validated, and it had the potential to normalize sex and sexual health. Some participants found that the school was a space where they were expected to learn about the world, and that sexual health should be included in that realm.

Some disadvantages include the possibility of students being uncomfortable, embarrassed or judged in the classroom setting, as well as the influence of teachers in the classroom. For example, one participant found the classroom setting to be difficult because of the vulnerability of the subject:

Because it was quite taboo it felt like a very vulnerable topic to discuss and so I didn’t want to talk about it in front of other people. I do think if there was less hush hush-ness about it when I was younger then school might've been a fine place to learn about it. But because it was not really talked about in my youngest years, I was just too uncomfortable to be doing that in front of my peers. There was no way I wanted them to see me like that or, it was just very very shameful to be talking about sex at that age. I feel differently now, but in high school for sure. (Evelyn)
As mentioned above, teachers had a great influence in the classroom environment. Many participants found this to be a disadvantage to learning at school as the curriculum became very individualized based on the teachers values and assumptions. Beth discussed the difficulties of learning such intimate topics from high school teachers:

I think that it's also really hard sometimes for kids to either have appropriate boundaries or build appropriate trust if they are getting all of their sex education from someone who is also teaching them math. (Beth)

Further disadvantages of learning at school included the time constraints and regimented nature of schools; the sex education curriculum was not allocated enough time within the physical education curriculum, and/or sexual health or sexuality were not discussed in any other classes. Participants also found that the curriculum was not engaging in a meaningful way, and that students were simply passed down information as opposed to given the opportunity to digest and explore the ideas.

Keeping these disadvantages in mind, it is important to remember that the majority of participants did want to learn about sexual health at school. In addition, the environment of the school did not directly correlate to the participant’s desire to learn at school. In most cases, an accepting environment did coincide with people wanting to learn about sexual health at school. However, even those who faced a difficult environment at school, were still more likely to want to learn about sexual health at school.

3.5 The Impacts of a Limited Education

The participants expressed that having a substantial and thorough sex education would have benefitted their lives in the long run. Some participants discuss how this may have impacted their queer identity had they been exposed to a more comprehensive curriculum; they may have been more comfortable with their sexuality or come to terms with it earlier on. It may have allowed participants to have greater authority over their own sexual health:

Maybe if I had the opportunity to learn about [sexual health] in high school… maybe I would’ve felt more comfortable in who I was, and how my body worked, and what was going on with my body and what that meant. (Camryn)

Many participants discussed how they had to learn things from negative experiences, due to the lack of information growing up. For example, participants discuss instances where they did not
know enough information about STIs and thus were ill prepared when they had an STI. Some participants found that their relationships would be different had they had the opportunity to learn about various types of relationships and healthy boundaries. For example, some participants discussed situations where they experienced abusive or non-consensual relationships without realizing the weight of these experiences until later on in their lives:

Consent I don’t think is something I learned about really, until my twenties. And I had to go through a lot of not great sexual relationships before that was a concept that was understood. (Bronwyn)

There are things that have happened that I did not process very well. I just knocked it off as being like, oh it’s just a weird experience. And I’ll tell it to other people and they’ll be like, that was really bad. And then I was like, oh….is it? I thought it was just a shitty person, and they’re like, no no no! And I was like oh, am I supposed to feel differently about this? And it’s because no one ever taught me to expect better or to…take on warning signs…of like, this is when you should probably get out…This is not one of those things where you need to learn by doing. (Debbie)

The participants were therefore exploring what it means to have a limited education on consent and how that affected their lives later on:

I think a lot of people roughly our age are going through this weird thing where they're like woah…that thing that happened to me, fifteen years ago, ten years ago, is not okay. And its like, having to dig up an experience that happened that long ago, and realize that you didn't know about the nuances and the grey areas and the subtle ways in which consent can be given, not given, taken back or taken from you… (Evelyne)

In addition, having a restricted sex education had ripple effects on participant’s lives:

When I was younger and just having sex with as many people as I thought I should have sex with, I wasn’t taking into account how it was affecting my mental health, how it was affecting my social surroundings and my social relationships. Sexual health is important because it links to so many things. (Ashlynn)

These participants therefore shed light on the ways that a limited sex education has affected their lives. One participant, Erica, reveals how the sexual health education she learned as a teenager had a significantly positive impact on her life. Erica had the opportunity to volunteer with a sexual health organization while in high school, which was the source of her comprehensive education:

So I just think that sometimes in a way I almost took for granted all that information I had, and I think talking about that and hearing about those experiences of other people
makes you really aware of just how important it is, you know, like how much can be avoided, that I could basically coast through my life feeling really comfortable and secure with sexuality and having a lot of positive affirming experiences. Not to say everyone – I’ve had some shitty experiences where my consent has been violated or I felt weird, don’t get me wrong, but I think on the whole I’ve been very lucky to have the agency and awareness that has allowed me to be safe and happy, and I think that that’s something everyone deserves access to and needs access to. (Erica)

Erica sheds light on a few beneficial outcomes of having a comprehensive sex education, such as having agency and knowledge around her sexuality that has allowed her to be safe and happy. She demonstrates how sexual health knowledge can lead to a greater sexual health, as well as increased general well-being.

4 Discussion

As mentioned above, high school is a formative space where young students learn about social norms and values. These social norms and values will create and sustain an environment that dictates who is included and excluded within that space (Collins and Coleman, 2008). This environment will be affected by intersecting factors such as race, class, gender, sexuality and ability. The results from this study suggest that a number of high schools in Toronto cultivated a heteronormative environment. Although there is not direct homophobia in most cases, there is a production of heteronormativity that dictates what is ‘normal’ and socially acceptable on a daily basis. This production of heteronormativity is also created through the social climate, where non-heterosexuality is marginalized and understood as being at the bottom of the social hierarchy.

Certain participants did experience an accepting environment for LGBTQ+ students in their school; this acceptance may mirror the on-going strategies and policies of schools in Ontario to support and protect their LGBTQ+ students (McCarty-Caplan, 2013). The classroom environment is also a factor in determining how individuals perceive and experience the school setting. Primarily, the classroom environment was affected by gender segregation and the influence of the teachers. Similar to previous research, participants found that segregating the class by gender may cause distress or discomfort for trans and non-binary students (Jones et al., 2016). Some students were indifferent to segregation by gender and/or found it comfortable to be surrounded by other female students. Given that all the participants identified as cis women, they did not have the lived experiences of being a trans student in a segregated classroom.
The results suggest that the participants’ teachers highly impacted the classroom environment. These results support previous studies that argue that teachers’ views and actions have the capacity to influence the culture of the classroom and sustain certain norms (Chambers et al., 2004). The participants felt that their teachers had the ability to influence the environment based on their own preconceptions and values surrounding sexual health and sexuality. This can create an extremely individualized classroom environment based on the specific teacher in that classroom. Based on this individualized environment, it can be difficult to streamline sexual health education, and/or enforce an inclusive and welcoming environment for queer youth. For example, Simone sharing how her teacher answered a question on safer sex between women, reveals how sex education can be highly influenced by the teacher’s discretion, and the way they choose to approach the curriculum and the questions asked in the classroom.

With regards to the sex education curriculum, the results from this study support a similar narrative to previous research: the Grades 9-12 1998 Ontario Health and Physical Education Curriculum excludes sexual and gender minorities (Bay-Cheng, 2003; Fields, 2012; McNeil, 2013). Through the participants’ experiences, the curriculum forwarded a narrative of heterosexuality as the norm, and prioritized heterosexuality over non-heterosexual relationships and activities (Bay-Cheng, 2003; McNeil, 2013). For some participants, such as Mada, heterosexuality in the curriculum was also coupled with racialized assumptions that centered white bodies as the norm.

The privileging of heterosexuality is embedded into the curriculum in different ways. Safety and preventative care are taught through a heteronormative lens, given the expectation that sex involves vaginal intercourse between a cis woman and a cis man, and thus students will need to protect themselves from pregnancy. There were also few examples of nuanced understandings of STI transmission that take place outside of a heterosexual context. Participants found that sex between two women was not included within the curriculum. This exclusion denies women the opportunity to learn about safer sex in a queer context at school, which requires that they actively seek out information on their own. This exclusion also erases queer women from the curriculum, marginalizing their experiences and marking them as ‘other’.

The second most pressing issue that was missing from the curriculum was the topic of consent. The results support a previous study conducted in Australia that explored how youth lacked a
nuanced discussion of consent in sexual health education, despite the school’s position to provide the unique opportunity to discuss consensual sexual practice (Powell, 2007). Learning about consent at school would allow students to gain invaluable knowledge in a constructive setting, as opposed to learning about these issues through first-hand abusive and non-consensual experiences. In fact, some participants in this study experienced negative sexual health outcomes such as abusive relationships and non-consensual experiences that they tied to a lack of consent education. The participants suggest that consent education is formative to the process of establishing healthy boundaries and recognizing non-consensual acts. This finding supports results from previous research that suggest that teaching youth how to consent and have agency over their own bodies is fundamental to achieving optimal sexual health (MacKenzie et al., 2017; Bridges and Hauser, 2014). Moreover, including a nuanced discussion on consent within sex education could possibly allow for greater relationship dynamics, as well as the potential to lower rates of sexual violence (Willis, Jozkowski & Read, 2019). Consent education should therefore be considered a necessary component of sexual health education.

It is important to note that the two most pressing issues that the participants described as lacking from the 1998 curriculum, are the exact subjects that are up for debate within the Grades 1-8 2015 Ontario curriculum repeal. This finding suggests that young women do want and need to learn about sexual orientation, gender identity and consent in school, and excluding these topics is detrimental to their well-being.

Through sexual health education curricula, students are also taught social norms and values (Collins and Coleman, 2008). It is important for students to feel that their needs are reflected in the curriculum (Public Health Agency of Canada, 2003). Through the exclusion of sexual and gender minorities, the 1998 Ontario curriculum is implicitly teaching young women that their sexual health is unimportant or irrelevant if the type of sexual activity they engage in does not involve a cis man. In some cases, the teachers were open to discussing queer issues, but the onus was placed on the students to bring them up. This creates an association of heterosexuality with ‘normality’, while continuing to marginalize queer students (Bay-Cheng, 2003). There is also a strong focus on the role of biology and anatomy; this focus, without a discussion on gender identity, excludes those outside of the limited definition of male or female. Without extending discussions beyond strictly biological ideas, the curriculum enforces the notion that ‘natural’ sex happens between a cis woman and a cis man.
This study also points to the need for a holistic approach to sexual health. A comprehensive sex education should go beyond a basic understanding of STIs and pregnancy, and include emotional and mental health issues (Allen, 2005). Participants want to engage in discussions that acknowledge that sexual health affects us socially, emotionally and mentally. For example, as mentioned earlier, this might include a discussion on how to make certain contraceptive choices, or how one’s sex life might affect their social surroundings and relationships. A holistic approach would also help students understand their overall sexual health, without exclusively focusing on the prevention of STIs and/or pregnancy.

For some participants, a heteronormative curriculum was still partially relevant to their lives at the time. Although the curriculum did not touch on queerness, sexuality and gender more broadly, it did provide information that could be applicable to their everyday life. This however, is limited to those women who would be engaging in sexual activity with cis men, and thus, this finding further demonstrates the prioritization and privilege of heterosexuality in the curriculum. Simultaneously, this finding asks us to look beyond a hetero/homo binary, and understand the spectrum across which queer women exist.

The results from this study partially support previous research that discuss gender norms within sex education curricula. Some participants did find that the Grades 9-12 1998 Ontario curriculum enforced a narrative where women were depicted as passive with regards to sexual activity, only responding to male desires, which was previously suggested within literature (Bay-Cheng, 2003; Connell, 2005; Fields, 2012; Allen, 2005). The results also support the finding that female pleasure is ignored in sex education curricula (Tolman, 2012; Allen, 2005). For many participants, a discussion on desire, pleasure and particularly queer sex between women would have greatly enhanced their understanding of sexual health. The participants desire to include pleasure into the curriculum challenges the engrained social narratives in which female pleasure is inexistent or irrelevant.

The results of this study suggest that the participants did want to learn about sexual health at school. They found the school to be an appropriate venue to learn about sexual health that has the opportunity to reach a wide range of students (Sorace, 2013). Although the participants had a strong desire to learn about sexuality or gender identity in sex education classrooms, these topics
were not discussed or engaged with in any meaningful way. This shows a gap in education that needs to be addressed.

There were advantages and disadvantages to learning about sexual health at school. The biggest advantages to learning at school involved the opportunity for discussion and human interaction. Having the opportunity to really engage with the subject, ask questions and interact with these issues are important aspects of sexual health education (Kirby et al., 2007). One of the biggest disadvantages was the possibility for embarrassment or judgement. For some participants, sexual health education involved sensitive topics that were uncomfortable in a classroom setting. These advantages and disadvantages shed light on possible ways to approach sex education within a classroom; future interventions should promote forms of engagement while also recognizing and respecting the delicacy of the topic (Kirby et al., 2007).

Participants also struggled with the individualized interpretations of the curricula from their teachers. As mentioned above, studies have found that the way teachers interpret sex education curricula highly impacts the quality of sex education that students will receive (Byers et al., 2013). The way that the participants understood sexual health was thus strongly influenced by the context in which the teacher approached the curriculum, specifically how they included or excluded discussions on sexuality and sexual orientation. Overall, despite the disadvantages mentioned, the participants still wanted to learn about sexual health at school; the school setting was understood as a necessary, relevant and valuable space to learn about sexual health where the advantages outweighed the potential drawbacks. The school is therefore a critical location to target when addressing sexual health education.

The results of this study support research that advocate for the benefits of having a comprehensive sex education. For example, one outcome of a comprehensive sex education that goes beyond anatomy and prevention of STIs and pregnancy, is understanding healthy and unhealthy relationships, as well as avoiding negative health outcomes (Bridges and Hauser, 2014). Some participants expressed negative health outcomes, as well as a lack of understanding of healthy relationships, due to a limited and narrow sexual health education. One participant confirmed that having had a comprehensive sex education allowed her to feel comfortable and secure with her sexuality. These results reinforce the need for comprehensive sex education curricula as it can foster a positive and healthy relationship with one’s sexuality and increase
their overall well-being. The school provides a unique space that is ultimately missing a huge opportunity to teach a comprehensive sex education curriculum that includes queerness and consent, and provide young queer women with information that validates and normalizes their experiences.

Since 2015, the new *Health and Physical Education Curriculum* has been implemented in Toronto public high schools. These results suggest that the new curriculum will more greatly meet the needs of young queer women through the inclusion of gender identity, sexual orientation and consent. However, as mentioned above, as of 2018 certain elementary schools in Toronto have repealed the Grades 1-8 2015 curriculum and reverted to the Grades 1-8 1998 curriculum; although this study explores the high school curriculum, it points to the urgent need to re-implement the Grades 1-8 2015 curriculum as it addresses these critical topics.

5 Conclusion

Throughout this chapter, I have discussed and explored young queer women’s experiences with sex education curricula within high school environments. First, I argued that the school is a significant space in which participants want to learn about sexual health. Second, I argue that for certain participants, the classroom environment, and particularly the teachers’ influence, impacted their sexual health education experience. Third, I discussed how the Grades 9-12 1998 *Health and Physical Education Curriculum* is highly limited in the way it approaches sexual health needs that are specific to queer youth. Lastly, I argued that the sex education curriculum forwards a heteronormative narrative which forces young queer women to learn about sexual health on their own time and in different spaces.

Through this analysis, I have focused on the high school environment and the sex education curriculum taught in public high schools in Toronto. The school is only one space out of the many spaces where queer youth learn about sexual health. The following chapter will look at the alternative spaces of education, such as online, community organizations, through networks of friends and family, books and pamphlets, where young queer women learn about sexual health growing up.
Chapter 5
Alternative Spaces of Sex Education

1 Introduction

As discussed in the previous chapter, high school is one of the most formative spaces for young women in Canada to learn about sexuality and sexual health (Public Health Agency of Canada, 2003). It is only one space among many alternative spaces of education, i.e. spaces outside of the traditional space of the classroom, or the school at large that contribute to young women’s sexual health education. Space is not a neutral location where things simply take place, but rather, a space is created by interconnected and on-going forces such as physical landscapes, social relations and ways of being (Molotch, 1993). Space is characterized as “both the medium and outcome of social relations” (van Ingen, 2003; 204); a ‘space’ can thus be grounded in a physical materiality but also can be understood as an abstract network of social relations, human activity and behaviour. Within this chapter, I will be looking at a range of alternative spaces, from networks of friends and family, to online spaces, to community organizations and clinics. These spaces are significant as they collectively inform the diverse ways in which young queer women learn about sexual health; simultaneously, these spaces offer alternative learning environments to normative, state-sanctioned spaces of education. Throughout this chapter, I will discuss the significance of these alternative spaces for the participants.

Throughout this chapter, I will argue that:

1) networks of friends play an important role in the participants’ sexual health education, particularly through sharing lived experiences and through mutual validation;
2) despite both benefits and disadvantages to online access to sexual health information, online spaces were consistently utilized as sources of sexual health information in different capacities, making them a significant and relevant source;
3) and lastly, community organizations and clinics can provide in-depth sexual health information, however there are different barriers that affected participants’ access to these spaces.
2 Literature Review

When discussing sexual health education in the Canadian context, the majority of research has focused on one space, either looking at the school setting, online, or sexual health services. My research examines the significance of sexual health education at school in relation to alternative educational spaces, such as online or through friends. This analysis explores how these spaces function to collectively influence young queer women’s sexual health education.

To understand and interrogate different alternative spaces of education, I have provided an in-depth discussion on networks of friends and family, online spaces, community organizations and clinics in Chapter Two. In Chapter Two I also conceptualized the spatiality of these different spaces, and presented the literature that explores the advantages and disadvantages of these spaces in disseminating sexual health knowledge. I explored how networks of friends are argued to strongly inform young people’s sexual health knowledge (Graf and Patrick, 2015; Cheetham, 2014). This compares to networks of family, who are argued to play a large role in providing sexual health information to youth (Jones et al., 2011; Jaccard, Dittus and Gordon, 2000; Mastro and Zimmer-Gembeck, 2015). Moreover, online spaces are a critical resource for youth seeking sexual health information (Shoveller et al., 2012; Kanuga and Rosenfeld, 2004; Hawkins and Watson, 2017), and can be particularly relevant to LGBTQ+ youth (Kanuga and Rosenfeld, 2004).

Lastly, I explored how community organizations are seen to foster supportive spaces in which LGBTQ+ youth can access sexual health information that might otherwise be unavailable (Allen et al., 2012). This contrasts to clinics and healthcare institutions, which have been argued to implicitly or explicitly promote heteronormativity in ways that can be a barrier to queer youth accessing care (Maticka-Tyndale, 2008; Knight et al., 2013; Bolderston and Ralph, 2016). Thus, my research accounts for these alternative spaces of education, recognizing the complex and intricate ways in which young queer women gain sexual health knowledge.

I have therefore included a brief discussion on different alternative spaces of education, referencing a more thorough review in Chapter Two. Below, I provide the results and discussion of my data that explores how alternative spaces of education contribute to the sexual health education of young queer women in Toronto. I include the unique perspective of young queer women and their relationship to these alternative spaces of education.
3 Results

The qualitative results will explore the following alternative spaces of education: networks of friends and family, online resources, community organizations and clinics. The results derive from the qualitative data of 29 semi-structured, in-depth interviews with participants. The participants for this study were individuals between the ages of 19 and 29, who self-identify as women and as LGBTQ+, who have attended public high school in Toronto and currently reside in Toronto. The interviews discussed the ways and spaces in which the participants learned about sexual health, and the significance of each alternative space of education. The results will discuss the advantages and disadvantages of each alternative space as defined by the participants.

3.1 Networks of Friends and Family

The participants relied on their friends for a variety of reasons. Some participants relied on their friends for information as a way to substitute the lack of information that was provided at school. Many participants had positive experiences learning about sexual health from their friends as it provided unique learning opportunities:

What I learned from peers … was very valuable to me. (Ruby)

Participants relied on their friends in different ways when it came to the type of sexual health information they discussed. Some participants relied on friends for more standard sexual health information such as how to stay protected during sex, how to define or recognize an STI, or where to find resources. Friends who shared their own personal experiences allowed for growth and learning opportunities amongst each other:

Yeah, so, she got [herpes] and she freaked out, and that made me google it. Cause I was like, what is this? And I was reading more about it, and I was like, this is fine. This is not bad. So I learned more that way, and she would tell me about her check-ups and stuff…. So that made me more aware, of oh it’s not just some wives’ tale that people get STIs - it’s a thing. (Katie)

While also relying on the internet, Katie learned about herpes through her friend’s experience. Some participants found that they weren’t necessarily gaining specifically sexual health knowledge from their peers, but they were gaining validation from sharing their experiences, as Simone illustrates:
I think that in some ways, social learning was really positive to me, but I think it was definitely because of the people I was surrounded with. And I don’t think I got a lot of accurate information about sexual health kind of stuff, right. I got more just, kind of validated that these are things that other people are thinking about. Or these are ways that people can be. (Simone)

With certain participants, having a queer community strongly influenced their level of reliance on friends; those with a queer community shared more information and relied on one another, while those who did not have a queer community could not ask their friends questions about queer sexual health. For example, Chris had the opportunity to discuss sexual health information with her friends through her queer community:

Honestly, I learned the most from my peers. Y’know, the queer community and like, just talking to people. (Chris)

Similarly, Simone found that her friend group was particularly validating when it came to sexual health information:

And I think it was nice and validating, but I think I was kind of lucky that I had a friend group that was like that. So I feel like, yeah, there can be real positives to having that kind of peer group. (Simone)

In contrast, Lillian found that she had sex-related conversations with her friends but it did not involve a discussion on queerness:

But yeah since most of my friends weren't gay or whatever, were only hooking up with the opposite sex. There wasn't much to learn from that angle I guess. (Lillian)

Moreover, many participants discussed learning from friends as an informal way of learning:

Like us all hanging out together. And being like...shooting the shit at 2am. And being like, oh, have you heard this? Did you hear this? That’s not true... running it past each other kind of thing. (Debbie)

The lack of formality posed certain disadvantages to the participants. Some found that topics involving sex and sexuality were discussed in a catty way as a means to judge, as opposed to in an instructive way:

So it was mostly us talking about other people and not talking to those people about their experiences. It was very like, “how many people has she slept with? Do you think she’s a virgin?” So we talked about it in a very shitty way, about other people, and I guess maybe
if we’d been doing it ourselves we would've talked about it more, but it was very much
everybody talking about everybody else. (Camryn)

Some participants found it alarming that they were learning sex education exclusively from their
peers. They found that peers were sharing information that was unreliable or potentially
inaccurate, or simply their peers did not have an in-depth understanding of sexual health. Sofia
shares her experience of discovering that her friends knew very little about sexual health:

I remember even talking with some of my peers about sex ed and them not even knowing
stuff that I knew….that was eye opening…thinking that me, as somebody who is still
kind of ignorant about sex, and [hearing from] someone who is even more ignorant about
it. (Sofia)

Another disadvantage is that different peoples’ levels of experience would affect the amount they
were able to learn from their peers. For example, both Kathrine and Simone shared experiences
where they could not necessarily learn from their peers as they were more experienced
themselves:

I was probably the first one who was sexually active, so I didn’t have anyone to turn to.
(Kathrine)

In terms of friends, I had friends who were as interested in sex as I was. I had friends that
we would have pretty frank conversations about sex and about masturbation and I had
some friends that I went to a sex shop with and bought vibrators, and it was this big kind
of, like, formative moment for all of us. But I was actually the first person in my friend
group to actually have sex and a lot of people, by the time they’d left high school, they’d
still not had sex. So it’s definitely in my friend group it just wasn’t really a thing we were
actually doing. I was the only person with kind of a serious relationship. So yeah, I think
we talked about it, but it wasn’t really something that I was learning a lot of first-hand
accounts. (Simone)

Some participants discussed how they could not share information with their friends because of
their different levels of acceptance when it came to sex and sexuality:

I would talk about it with friends but (sigh) I guess because I went to a catholic high
school and it was a taboo topic, a lot of my friends were just like “ew” or they would shut
down conversations about it. (Ashlynn)

It was therefore not always possible for participants to share their experiences and engage with
sexual health topics with their friends.
For some participants, the physical space in which friendships took place were relevant to the conversations they were able to have about sexual health. For example, Lillian describes how she would learn information about sexual health at her summer camp, in a cabin with 10 other girls. Physical spaces were significant as they allowed for certain exchanges of information. For example, Aviva talks about a physical space that exposed her to a greater queer community:

[My friends and I] would go every month to Buddies and Bad Times [where] they had the Homo Night, it was our thing. It was an all ages queer dance party. (Aviva)

It was in this space where Aviva was exposed to a greater queer community which informed her understanding of queer sexual health topics.

Unlike through networks of friends, many participants did not learn sexual health information from their family networks. Certain participants had positive experiences where they were able to chat openly with their parents, or they felt that they could ask questions when necessary:

I always felt really comfortable and I also knew that [my mom] wouldn't judge me or make me feel guilty for thinking about these things so that was also a place where I felt good going to. And I'm... I'm very lucky cause obviously not everybody has that which is why sex ed in school is so important because that's where that comes in. (Shayna)

And it was interesting because [my mom] had a really opposite experience growing up, so it was her complete lack of information and the shame that it was shrouded in, it really bothered her that she was basically traumatized around sex from a young age because her mom was so secretive and taboo about it, that I think she just was really committed to not putting me through the same thing. So she tried really, really hard to always be an open source of information without judgement. (Erica)

For many participants however, they could not rely on their family for sexual health information. Even when parents were interested in discussing sexual health, participants may not have felt comfortable having these conversations with their parents. Or, the parents themselves were not providing a space to have these conversations:

They knew I was fooling around or stuff but we kept our distance with that. They knew, but I would never talk about it. And they didn’t want to know…It’s like, we’re not gonna talk about it…ever. (Katie)

There were also instances where participants found that their parents gave them inaccurate information. For example, one participant shared how her mom said that she could not use a
tampon if she had not had penetrative sex, or another participant whose mom said that she would not be able to orgasm until her late twenties.

### 3.2 Online Spaces

Many participants relied on online spaces for sexual health resources. For some participants, the Internet was the main source of their sex education:

> I’d say like pretty much all of my information came from [the Internet]. (Kathrine)

> I would say like 80 to 90 percent of my education in sexual health would come from the Internet. (Ashlynn)

For some, the Internet was the only possible space to learn about sexual health:

> At the time it felt like my only option was learning from the Internet. (Mary-Lynn)

Participants discussed a variety of online resources that ranged from videos, to blogs to columns, to Tumblr and YouTube:

> Yeah so I did research a lot, and I would read a lot of advice columns and blogs because I wanted the interpersonal issues of people who were dating to make sense. (Beth)

Participants also expressed a big range of Internet use, from asking specific sex education questions, to more general knowledge about queer history or queer relationships, to meeting people online. For Ruby, the Internet became a space where she was able to visualize a queer lifestyle or even a queer future:

> I remember following so many queer people, specifically lesbians. I was obsessed with lesbian couples that were like “We’re a married lesbian couple living in Arizona. We have two dogs.” [laughter] I would check their Tumblr every day… So there was definitely something very appealing about the adult normal queer lifestyle that I was like [gasp], look what it can be…. the great thing about the internet that it’s like there’s queer people everywhere. Everywhere. Which is kind of amazing. (Ruby)

Participants described many advantages to using online resources. First, the Internet can offer an extensive amount of information. Unlike other venues, the Internet provides both privacy and anonymity:

> It’s more private. You google something and you can just read it, without having someone be there to watch you read it. (Katie)
The Internet can provide a space that is free from embarrassment and free from judgement:

I think that forums and sharing information with people without having to be face to face with them is really important because a lot of the time the only thing that stops people from asking questions is embarrassment. We’re not going to be able to make this a fully sex positive culture, and so that shame is still gonna be in a lot of people, no matter how many new parents are trying to be more sex positive and open with their kids, there are gonna be a lot of people growing up who are not introduced to that sort of openness. And so I think having some sort of private channels is really important. (Evelyn)

Online spaces function in a way that allows for flexibility, and participants found that they could not otherwise access this information:

I think learning on the Internet meant that I could seek it out when I felt ready and when I wanted to know something specific and it was very much self-directed in that way which I think can be really valuable and I think is something that's really amazing about online resources to this day. (Shayna)

Online spaces also provided a sense of community and fostered connection in both local and global contexts for many participants:

There was a forum you could chat with people, and then there was a board called when girls like girls, and I was just like my God, that was a huge awakening for me… [laughter] I didn’t make any comment for so long but I would just look through and I was amazed that there were this many young women my age that were also feeling like this, both in Canada, but also all over the world and they were all connecting around these things, around having crushes on their best friends, around what it’s like to be in a locker room with other girls and how hard it is and, you know, what it’s like when your family won’t accept you. (Erica)

This was especially validating when it came to queerness and sexuality, as described by Lillian and Ashlynn:

And then when I realized I had feelings for women I probably went online and was like let me research things. Because also not many people were out as anything, especially grade 9 unless they were like a really flamboyant male, there weren't many females out. (Lillian)

I think because there's so many people online from the queer community that are so willing and open to talk about their experiences that I found that that's how I was able to find my sexuality, and find who I was based on those experiences and relating to them, and being like wow I feel this way, or wow I relate to this person, and it was easier for me to understand who I was based on those experiences that people would share. (Ashlynn)

The Internet also provided an opportunity to share ‘real-life’ stories:

I felt like the people's experiences that I was reading about or the videos that I was watching
was real, it wasn't put through a filter of government or teachers or curriculum and the law and all that, I felt like it was just, I guess unfiltered, real life experiences (Ashlynn)

However, this inclusion of personal anecdotes was also found to be a disadvantage. For example, some participants discussed the lack of reliability and credibility of online resources:

Straight up google, whatever resource, no vetting process to see the credibility of these sources... (Maggie)

That was particularly true for health-related information:

The Internet. That’s my clinic. It’s like, what is this? Oh you have cancer. (Katie)

Moreover, the Internet included information that was inaccurate:

There was a lot of stuff that was badly and misinformingly written so there was a lot of stuff that was like, I found out that was absolutely not a thing. (Beth)

Another disadvantage that the participants noted was due to the abundance of information provided online. Some participants found this abundance to be overwhelming and an information overload:

If there was something you didn’t know, you could google it. But…google is also…an uncurated…. barrage of answers to questions you didn’t even think you had, or you never wanted to know, so…I found myself googling a lot of things, to try and learn it, and tell my friends, cause I was kind of the mother hen in my friend group. So, by doing that, I got some good information. But I also knew way too much and …yeah, I uh…learned too much. (Debbie)

Other participants found it to be confusing:

Sometimes the Internet left you with even more questions, even more confusions, so it was good for getting new language, but sometimes it was like oh that didn't help because now I have all of these other questions, and now I need all this other help because I don't understand this new information that I have and you begin to think, oh what's true and what's not and stuff like that. (Alice)

While other participants found this abundance to be intimidating:

Yeah, it is intimidating ‘cause again there are so many choices. You don’t know where to start. It’s just so much easier to have someone just be there and guide you through and be like, this is a cool place to go check out. This is someone cool you can talk to. (Chris)

Lastly, some participants described the Internet as lacking an element of human interaction:
But I think because sexual health and sexuality are so subjective and so individual like within each person that I think that's part of why that actual human interaction piece is so vital and is so helpful because you can actually talk things through and talk about, ya know, your own personal needs or desires or experiences uh in a way where in an informational article on a website might not, it might not address all of the specifics of your experiences with sexuality. (Shayna)

One of the consequences of a lack of human interaction is that participants had to process this type of information on their own:

Even if you have a list of sites that you're told are trustworthy and you're going on those sites, you don’t really have anyone to process the information with, right. So you get all this information that’s really good, but then what do you – right, what do you do once you've learned about this? (Simone)

Within the realm of online spaces, participants discussed learning about sex and sexuality through pornography and the media. A few participants discussed how they experienced pornography as a form of sex education:

I would find [sexual health education] through porn as well, that would be a different type of education, but it was education still to me because um, even though it was a more entertainment based learning it was still learning. (Ashlynn)

However, many participants who watched pornography described their understanding of pornography as unrealistic and unrepresentative of the realities of sex:

And I think I was pretty good at separating out, what was a fact about the kind of sex you could actually have, versus what was just kind of, like, pure fantasy kind of stuff. (Simone)

As one participant described it, the representation of sex that she saw in pornography was unappealing and alarming:

I think I discovered porn in high school and was like, what! The f*ck is this! ‘Cause again you have no concept, and as an adult now, you’re like, okay, porn is not real sex and you can find real sex but it’s largely not representative of what you're going to be doing. But at the time I was like what is going on here. What is happening? And I think that was the beginning of figuring things out. Of being like, oh, this is what sex is like, and this is what it sounds like. And this is what it looks like. Which, oh god, no wonder it was so terrifying…I was just like I don’t want to do that. (Camryn)

Many participants did not watch pornography at all in high school. Overall, less than half of the participants actually brought up pornography throughout the interviews. As one participant describes:
I find that I was kind of either really lucky or really sheltered in that I didn't really encounter porn online. (Alison)

A few participants brought up the media as a potential resource for sexual health information. Some participants discussed the importance of queer representation in the media, while others discussed how the media gave stereotypical or misinformed representations of queer women:

And you’re learning all the wrong things from TV and porn. But that’s your only frame of reference so you're like, well…this is how I have to do it. (Debbie)

The media is thus one of many different forms of online resources. Online resources offer a complex and unique avenue to learn about sexual health. As discussed above by the participants, there are many advantages and disadvantages to learning about sexual health online.

3.3 Community Organizations and Clinics

For the majority of participants, community organizations were not sought out or accessed. However, those participants who did engage in community organizations found it very beneficial and insightful. As Erica explains:

The thing is I had the privilege of getting sex education through another conduit, which was that I was volunteering at the LGBT Youth Line at the time and that meant getting extensive training around sexual health, around identity, around relationships, around consent. (Erica)

Only a few participants actually mentioned accessing services from well-known organizations such as Planned Parenthood; however, those who did access these organizations found them to be very helpful and informative resources. For example, Planned Parenthood provided health options that other sexual health clinics did not, or provided sexual health products at reduced prices. Similar to sexual health clinics, only some participants actually accessed these spaces but for those who did, they found it helpful and beneficial. For example, Aviva mentions:

Yeah I’ve gone [to a sexual health clinic] for STI and pregnancy tests and UTI treatment and free condoms and um, lower cost birth control…I feel good about going there, they have weekend appointments which is really nice too. (Aviva)

Despite the benefits of community organizations and clinics, it was often a question of access. Certain participants were unaware of the organizations or services provided or were not able to access them:
Because I was in high school and I was living with my parents at the time, I couldn’t really go out much and stuff right? So I feel like the majority of the stuff I did end up learning or the stuff I needed to learn, I learned in university where I could go and explore. (Chris)

With regards to clinics more generally, and health care-practitioners, some participants expressed having had negative experiences or were treated poorly. For example, Kai was misinformed at a health clinic:

I remember I went to a sexual health clinic and I still to this day don’t know if I was misinformed, he was a male doctor and it was at a walk in in Etobicoke and I was like, “yeah so I’m sleeping with women, from here on out I’m only sleeping with women and not sleeping with men, and I’ll check in if that changes but what’s the deal like what do I do”, and he was like “yeah you only need to get checked every four years if you’re just sleeping with women.” (Kai)

Some participants felt that they could rely on their doctors as a source of sexual health information; however, a few participants mentioned that they did not feel comfortable discussing sexuality and sex related topics with their doctors, or the doctors themselves would not provide enough information. Mada and Diana explore the role of health care practitioners through their experiences as women of colour:

I've been to doctors before and shared a concern and they're like “oh nothing's wrong” and it's like..... okay sure but I came all the way here and you're telling me there's nothing wrong sort of thing ... I think that concerns me the most is when I feel like I have a problem and then they say nothing’s wrong and I hope it goes away but like ya know, why is that happening in the first place… yeah especially women of colour and black women getting dismissed the most. (Mada)

I did end up getting an STI a year or two after and the first thing that was told to me from a doctor was that I should be grateful that I didn't get HIV … so a statement like that makes me think like okay, first this is really racialized but also I'm just like … so it's clearly beyond sex ed it's doctors don't even know how to deal with people like this so yeah I really think that it's just a series of different kind of systems failing me that led me to that. (Diana)

These experiences speak to the ways in which intersections of identities affect access to care. Overall, there were different barriers that restricted the participants’ ability to increase their sexual health knowledge through community organizations and clinics.

3.4 Comfortable Spaces

Considering the many advantages and disadvantages of learning about sexual health from different alternative spaces, the interviews with participants also included a discussion on where
they felt most comfortable learning about these topics. There was a very wide range of responses, from being alone to being with friends, to online, to being at home, to being with their partner. What was most pertinent was that over two thirds of participants expressed that they were most comfortable when having these conversations with their friends. This was followed by the internet, and then community organizations.

Primarily, most participants found that they were most comfortable discussing sexual health related topics with their friends. For most participants, these types of discussions with their friends happened in informal settings:

I think when my friends and I are just kind of having fun. And we’re just talking about who we’re seeing and stuff, and just sharing stories. That’s pretty comfortable. When you just talk about your experiences and stuff. Yeah, I would say that’s when I’m the most comfortable talking about that stuff. (Katie)

For some participants, discussing with friends was particularly comfortable as they shared commonalities within the group that fostered open, understanding and supportive conversations. For example, some participants felt most comfortable within a group of friends that were exclusively women, or a group that were specifically women of colour, or a group that were majority queer:

I think [I could talk about sexual health] mostly with my queer friends, I don't know I feel like I have a group of queer friends and a group of straight friends and I love them both but [laughter] [sexual health] only gets talked about in one of the groups usually. (Blue)

Another space that participants found to be most comfortable when discussing sexual health was online. The Internet, as mentioned above, provided anonymity and a lack of judgment:

Most comfortable was probably on the Internet. The level of anonymity. Yeah and just like you can’t feel judged when you’re just like “I’m a username” you know. [laughter] It’s like no-one knows what you’re up to. You’re just a number on the screen and that’s amazing. (Ruby)

Community organizations were also particularly comfortable as everyone in that space shared similar values as well as a desire to learn more and be involved in their community:

I definitely feel like once I was doing this training at Planned Parenthood, is that felt like this amazing space where it was like, finally I was with a lot of people who were also really interested in sex, right. Because we were all—I mean, yeah, we were all teenagers for the most part… And you know, we were all just kind of learning along and really interested, and
actually had some kind of interest and passion for it, and wanting to be [there] – even when things felt awkward. (Simone)

I learned a ton and that space made me feel so safe and comfortable and validated, just to be around a bunch of other queer people from so many different walks of life too. (Erica)

Although the majority of participants felt most comfortable either with friends, online or with community organizations, some people found that they did not feel comfortable discussing sexual health in any space. Some found that they were most comfortable when they were alone. Some participants discussed how the classroom might have been a comfortable space had it been facilitated in the right way:

I think it's so important to have some sort of older person whether it's a mentor or a good teacher leading some sort of discussion in smaller intimate groups… you are learning with people that you feel comfortable with so that has nothing to do with gender and you're co-learning with an adult who is teaching this and meaningful but also concrete ways and so whether that's using case studies or people as examples, just like real talk. That is what I feel like would be the most comfortable version cause obviously you are always talking about it with your friends and that could maybe be your more comfortable way but we're not privy to the way like at the time our friends perpetuating stigma or misinformation and it's just like okay, so that needs to be facilitated. (Diana)

Lastly, a few people mentioned that they felt comfortable discussing with their family, or discussing with their health care practitioners:

I definitely have really good memories of this sexual health clinic that was like, first of all, a block away from the school, and was just very non-judgemental. I didn’t want to go to my family doctor ‘cause I didn’t know if they would judge me about starting to have sex….and it just felt like a supportive non-judgemental space where your questions could be answered. And you could get good treatment. (Felicia)

Thus, the majority of participants felt comfortable discussing sexual health in some capacity. For most, this was among networks of friends.

4 Discussion

There are many spaces in which queer youth learn about sexuality and sexual health. These different alternative spaces, in combination with the traditional space of the school, inform the participants’ sex education as a whole. Networks of friends and family provide opportunities for youth to learn about sexual health. Through informal exchanges, youth share experiences and resources that can increase their sexual health knowledge. The results from this study support
previous research that suggests that youth rely on their friends for sexual health information (Graf and Patrick, 2015; Cheetham, 2014; Ballard and Morris, 1998; Sprecher, Harris and Meyers, 2008). More than two thirds of the participants identified that they felt most comfortable engaging with these topics with their friends. This alludes to the participants’ need for a trusting, safe and non-judgmental environment in order to feel comfortable discussing sexual health information.

Through a collective sharing and processing of sexual experiences, participants had the opportunity to increase their sexual health knowledge, which supported similar findings in a previous study (Byron, 2017). For example, Katie’s friend, who by sharing and processing the experience of having an STI with Katie, helped Katie understand what an STI really was, and what it meant to have an STI. Participants also discuss relying on their friends for validation surrounding sexuality and sexual experiences. This was similarly discussed in a study on youth’s access to sexual health services, in which it was argued that peer-to-peer validation can positively affect youth’s sexual decision making (Cheetham, 2014). Although participants might not have gained traditional sexual health information from their peers, they felt that their experiences could be validated and normalized through their friendships, making them feel understood and accepted. The way that participants discussed and shared sexual health information with their friends demonstrates how sexual health and sexuality are embedded into the lives of youth growing up, and therefore it sheds light on the significance and relevance of these topics.

Having a network or community of friends has been shown to be very important for individuals who identify as LGBTQ+ (Detrie and Lease, 2007; McCallum and McLaren, 2010; Roseneil and Budgeon, 2004). Similarly to these studies, some participants found that having access to a network of friends who identified as queer influenced the level of support they received around sexual health. For example, for some participants, accessing queer sex education was dependent on their friend group; some individuals found that they could not talk about sexual health through a queer lens due to the fact that their friends did not identify as gay. In comparison, another participant describes learning about sexual health from her peers, specifically within a queer community. This suggests that the type of sexual knowledge that is shared among friends may vary based on the identities within that friend group; learning about sexual health through a queer lens may be more likely when an individual is surrounded by a queer community. This
exchange of information is therefore contextual to specific friend groups and to the various identities and experiences that create those groups.

This type of informal learning through friends can also present challenges to learning about sexual health. For example, participants discussed how their peers might share information that is inaccurate or unreliable. This was similarly discussed in a study on sexual health sources, in which the young teens who were interviewed suggested that they felt that their peers might have incorrect information about safe sex, or lie or exaggerate with regards to their sexual experiences (Jones et al., 2011). This study also contributes to research that explores the difficulty with peer-to-peer exchanges of sexual health information; it provides a unique account of the difficulties that the participants’ faced when relying on friends to learn about sexual health, such as different levels of sexual experience among friends or discussing these topics in a catty or judgmental way. This result supports previous findings from Chapter Four that argue that the school is a significant space to learn about sexual health; the school has the power to provide accurate and reliable sexual health information that may not be accessed through informal discussions with friends.

The way that the participants discuss learning from their friends demonstrates how space is not bound by the physicality of where these friendships take place, but rather these spaces are created and sustained through the ways in which young people interact and cultivate ideas about themselves and each other (Korkiamäki and Kallio, 2018). For example, the way the participant Debbie describes the spaces in which she learned about sexual health with her friends, alludes to the fluidity and flexibility of those spaces; they are not defined by the physical location of where these interactions take place, but rather by the social relations, human activity and learning taking place within them. As mentioned in Chapter Two, I have focused on the social relations and interactions of friendships that create spaces; however, physical space can influence the nature of a friendship, or the boundaries and intimacies within a friendship. A small number of participants did discuss the physical materiality of where their friendships and exchanges of sexual health information took place, but overall, it was not a key theme. For example, Aviva and Lillian describe how certain physical spaces were distinct in their memories of sharing sexual health information among friends, respectively a queer theatre company in Toronto and a girl’s cabin at summer camp in Ontario. Despite these instances, overall the material places did not stand out in terms of participant responses.
Within this study, the majority of participants did not rely on their family for sexual health resources. There were a few examples where participants felt comfortable discussing with their parents (particularly their mothers), but most participants felt that they could not discuss sexual health topics with family. It is unclear if this lack of engagement with parents is related to the sexual identity of the participants; this could be pursued in further research.

Similar to networks of friends, many participants turned to online spaces for sexual health resources. The results support various studies that suggest that the Internet is a critical platform for youths’ engagement with sexual health information (Shoveller et al., 2012; Kanuga and Rosenfeld, 2004; Hawkins and Watson, 2017). Similar to previous research, the findings suggest that the Internet is an important space to learn about sexual health as it provides both privacy and anonymity (Fergie et al., 2013). Participants describe the Internet as flexible, convenient and accessible (Gray et al., 2005; Chang et al., 2017), as well as a space where they can be free from embarrassment or shame. The Internet can also be an appealing space due to the lack of stigma (Gray et al., 2005). This suggests that sexual health can be highly stigmatized, specifically queer sexual health, as people seek out anonymity and judgement-free environments when engaging with these topics.

The Internet can be particularly relevant for queer youth. The results from this study support previous studies that illustrate how the Internet can help queer youth foster their sexual identities (Craig and McInroy, 2014; Hawkins and Watson, 2017; McInroy and Craig, 2018), as well as contribute to their well-being and resilience (Craig et al., 2017; Hawkins and Watson, 2017). As mentioned by Ruby, Erica, Lillian and Ashlynn, the Internet provided the opportunity to engage with queer content and relate this queer content to their own lived experiences. Ruby, for example, was able to visualize a queer future through her exposure to a Tumblr page that followed a married lesbian couple, and Erica was able to connect with girls who were similarly discovering how to navigate their queerness in their everyday life, such as how to make sense of having a crush on your best friend. This exposure to queer content can contribute to the participants’ well-being and resilience as it normalizes and validates their experience, while also connecting them to a larger LGBTQ+ community online. This supports research that suggests that an online queer community can be significant for youth who are constructing their own sexual identities (Maliepaard, 2017). Lastly, these experiences online demonstrate the participants’ need to feel represented and validated in their queerness growing up; this need
provides additional incentive into why sex education curriculum should recognize sexual orientation and sexuality.

Relying on online spaces to learn about sexual health can present challenges. Similar to previous research, participants found that the Internet was not a consistently reliable or accurate source of information (Whiteley et al., 2012; GLSEN et al., 2013; Hawkins and Watson, 2017). Many participants suggested that there were disadvantages to learning from the Internet given the abundance and overload of information. For example, Chris discusses how it can be hard to navigate the abundance of information and evaluate which sources are educational and valuable and which are not, which supported findings from a previous study (Kanuga and Rosenfeld, 2004).

Participants also felt that online resources are insufficient as they often lack the element of interactivity. Research has suggested that active engagement with sexual health information may be a necessary component to effectively processing this information (Whiteley et al., 2012; Black et al., 2018). As mentioned by Shayna, given the subjectivity of sexuality and sexual health, interactivity can play an important role as it provides youth with an opportunity to digest and engage with this information and reflect on how it is relevant to their needs. Another potential challenge to accessing sexual health resources online can be exposure to pornography (Kanuga and Rosenfeld, 2004). For those participants who did mention having access to pornography, the majority did not consider pornography a form of sex education, and many did not encounter or engage with pornography very much during their adolescence. In comparison to a previous study, the participants did not discuss learning about the spectrum of sexuality and sexual diversity through pornography (Hare et al., 2014). Pornography was thus not a significant component to the sex education of the young queer women in this study.

The results of this study can also help us conceptualize the spatiality of online spaces. Research has suggested that online spaces can be understood through the on-going interaction and connection with offline spaces. Social relations and exchanges of information are produced within online spaces and have concrete impacts on the participants’ everyday lives (Cohen, 2007; Malieeprad, 2017). For example, through exposure to a discussion of queer sexual health online, participants can situate and cultivate their own sexual identities and sexual choices that affect the way they navigate their everyday lives. Similarly, social relations and power dynamics that take
place in the participants’ lives offline will influence the type of spaces that are created online (Valentine and Holloway, 2002). For example, the participants’ lack of sex education in offline settings influenced how useful, significant and relevant an online space was, and thus contributed to the creation of that online space.

In addition to online spaces and networks of friends and family, participants learned about sexual health through community organizations and health clinics. The results of this study support previous research that explore the various benefits of community organizations for LGBTQ+ youth (Allen et al., 2012; Wagaman, 2016; Gamarel et al., 2014). Primarily, the participants found that community organizations provided extensive sexual health information that was relevant to queer youth, similar to a previous study (Allen et al., 2012). Second, the participants commented on how community organizations provided a space to connect to a community that shared similar values, which supported findings from a previous study (Wagaman, 2016). Despite these benefits, there were only a few participants who actually accessed and utilized these services. This may be due to the fact that those participants who accessed these spaces were invested in learning more about sexuality and sexual health, and therefore seeking out this information was a priority in their lives. This may also be due to the fact that some participants did not know about these services or were unable to access them. This hypothesized reason would be supported by a previous study that suggests that LGBTQ+ youth do not participate in community organizations because they do not know about their existence or do not know how to access these services (Wagaman, 2014).

Only a few participants relied on clinics for sexual health information. Those who did had mixed experiences: some found clinics to be helpful and a reliable source of information, while others felt that they were misinformed or treated poorly by health care practitioners. Many studies explore heteronormativity as a barrier to health care for the LGBTQ+ population (Maticka-Tyndale, 2008; Knight et al., 2013; Bolderston and Ralph, 2016). Despite participants who suggested that they could not discuss sexual health and sexuality with their doctors, it is unclear the extent to which their sexuality played a role in this inability. An additional barrier to accessing sexual health information in a clinical setting came from doctor’s assumptions about race, class and gender: two participants discussed how their doctors made assumptions about their health based on their identities as women of colour. This speaks to potential biases in health
care settings with regards to race, gender, class and sexual orientation. It also reinforces the notion that intersecting identities will affect one’s access to sexual health education.

5 Conclusion

Throughout this chapter, I have discussed the significance of different alternative spaces in the sexual health education of young queer women in Toronto. I have discussed the spatiality of these spaces as well as the advantages and disadvantages to the participants’ reliance on these spaces. The results suggest that there are many alternative spaces of education that participants use to either substitute or supplement the sexual health education taught in the traditional school setting. These spaces collectively inform the participants’ sexual health education. The implications of these findings, as well as findings from the previous chapter, will be further explored in the following chapter. I analyse the overall findings as a whole, as well as the connections between the two research questions. I explore limitations of the study, future research and policy suggestions.
Chapter 6
Conclusion

This thesis offers insight into where and how young queer women in Toronto learn about sexual health growing up. It explores how young queer women experience sexual health education at school and within alternative educational spaces. I have contextualized my project using critical geographical literature to examine the concept of space and how it relates to sexuality and sexual health. Through the use of in-depth, semi-structured interviews, I hoped to capture the intimacy and vulnerability with which these women have shared their sexual health experiences.

Through this thesis, I have explored the following two research questions: How do young queer women in Toronto experience sexual health education at school? And how do alternative educational spaces contribute to their sexual health education growing up? In response to the first question, I analysed the participants’ experience at school and their relation to the sex education curriculum within the Grades 9-12 1998 Ontario Health and Physical Education Curriculum. I argue that the study results suggest that young queer women want and need to learn about sexual health and believe that school is an appropriate and desirable space for this form of education.

High school is a traditional and formal space of learning where students are taught norms and values surrounding sexuality; this study supports previous research that argues that teachers’ views and actions have the capacity to influence the culture of the classroom and sustain certain norms (Chambers et al., 2004). The participants felt that their teachers had the ability to influence their classroom environment and the way that sexual health education was taught. This study contributes to literature in the field of education and geography by including a nuanced discussion from the perspectives of young queer women. It adds to the conversation by suggesting that teachers influence the level of inclusion or exclusion of young queer women in their classroom through the environment they create and sustain.

This study found that the Grades 9-12 1998 curriculum forwarded a heteronormative narrative and was insufficient in addressing sexual health needs of young queer women. My research is contributing to literature that argues that sex education curricula exclude sexual and gender minorities (Bay-Cheng, 2003; Fields, 2012; McNeil, 2013), by including the unique context of young queer women from Toronto. As mentioned above, most literature pertaining to the heteronormativity of curricula is focused in the U.S., while my research provides the unique
example of a Canadian case study that particularly centers young queer women. This study suggests that the 1998 sex education curriculum excludes a necessary discussion about sexuality, sexual orientation, gender identity, and consent, and consequently erases the identity of young queer women. Through the Grades 9-12 1998 curriculum, the young queer women were implicitly and explicitly taught a heteronormative sex education that forced them to learn about sexual health in alternative spaces, and in doing so, left them to figure out their health needs on their own.

In response to the second question, I analysed the spaces where young queer women indicated as places of learning about sexual health outside of school; this study identifies networks of friends and family, online resources, community organizations and clinics as key sources of sexual health information. These different alternative spaces, in combination with school, inform the participants’ sex education as a whole. This study suggests that youth rely on their friends for sexual health information, supporting previous research that makes similar claims (Graf and Patrick, 2015; Cheetham, 2014; Ballard and Morris, 1998; Sprecher, Harris and Meyers, 2008). This study uniquely addresses the experiences of young queer women relying on their friends, and contributes to this literature by adding that having a community or group of friends that either do or do not identify as queer, influences the participants’ abilities to rely on their friends for sexual health information. Overall, these networks of friends play a significant role in queer women’s sexual health education, specifically through sharing lived experiences and/or validating one another’s sexuality and sexual choices.

This study suggests that queer women rely on online spaces for sexual health information in different capacities, making them a significant and relevant source. This study supports previous research that discusses how and why youth access online sexual health resources: there are advantages to online spaces such as anonymity (Fergie et al., 2013), confidentiality and convenience (Gray et al., 2005; Chang et al., 2017), which are positioned against the disadvantages, such as lack of interactivity, reliability and accuracy (Whiteley et al., 2012; GLSEN et al., 2013; Hawkins and Watson, 2017). This study uniquely contributes to this literature by including the perspective of young queer women in Toronto; it suggests that the Internet has the ability to contribute to the participants’ well-being and resilience as it normalizes and validates their experience, while also connecting them to a larger LGBTQ+ community online.
Lastly, this study suggests that community organizations and clinics have the ability to provide meaningful sexual health education to queer youth; however, there are different barriers that affect participants’ access to these spaces. For example, participants were unaware that these organizations existed, were unable to access them, or experienced different forms of heteronormativity and/or racial and class bias within clinic settings. My research supports previous research that argues that heteronormativity within healthcare institutions can often be a barrier to care (Maticka-Tyndale, 2008; Knight et al., 2013; Bolderston and Ralph, 2016).

Throughout this thesis, I have explored the concept of space. I recognize space as going beyond a neutral location where things take place; rather, space is created by intersecting and moving forces such as physical landscapes, social relations and ways of being (Molotch, 1993). Space is characterized as “both the medium and outcome of social relations” (van Ingen, 2003; 204); a ‘space’ can thus be grounded in a physical materiality, but also can be understood as an abstract network of social relations, human activity and behaviour. Each space that is studied in this thesis both produces and is produced by social relations. The school is a space that creates and is created by social norms and values. These social norms and values dictate who is included and excluded in that space (Collins and Coleman, 2008). Relationships among friends create fluid and flexible spaces that are characterized by the interactions of these friendships, where youth cultivate ideas of themselves and others (Korkiamäki and Kallio, 2018). Online spaces are created by social interactions and power dynamics from youth’s lives offline (Valentine and Holloway, 2002). As well, online spaces create social relations that then can also affect youth’s lives offline (Cohen, 2007; Malieepard, 2017). Therefore, these different spaces are all collectively created, and creating, sustained by, and sustaining, social relations and interactions.

Cresswell (1996) explores the idea of transgressions within space, which he argues, demonstrate what is ‘in place’ and what is ‘out of place’ (Cresswell, 1996). The non-heterosexual identities of the participants in this study worked as transgressions within the space of a heteronormative school setting. These transgressions demonstrated what was considered ‘normal’ and ‘in place’, such as heterosexuality within the public school setting where the young queer women were taught the sex education curriculum. This is compared to that which was ‘out of place’, such as a non-heterosexual identity that sought to be seen or recognized within the public school setting, that was otherwise ignored and marginalized. Different understandings of what is or what is not appropriate will create different normative geographies (Cresswell, 1996). For example, what is
appropriate to include within a sex education curriculum may vary based on a teacher or classroom or school, and this is reflected in the diverse ways in which the participants’ discuss their relation to sex education in the classroom. Space can also be understood as a site of contestation (Molotch, 1993; Cresswell, 1996) that can be both oppressing and enabling (van Ingen, 2003). For example, participants who had honest and open conversation with friends about queer sexuality and sexual health created spaces of resistance and empowerment, which counter exclusive and potentially oppressive spaces of classrooms that failed to acknowledge these topics.

The participants’ sexual health education is informed collectively by school, online spaces, networks of friends and family, community organizations, clinics, and more. Chapter Four and Five have discussed in-depth the significance of these spaces. It is important to examine how these spaces overlap and influence one another. Primarily, the school is understood as a valuable and appropriate space to learn about sexual health. However, as discussed in Chapter Four, there are disadvantages to learning at school that influence youth’s engagement with sexual health. Many participants relied on the Internet in ways that their school was unable to approach sexual health topics. For example, similar to previous research, the participants’ discuss the importance of privacy and anonymity (Fergie et al., 2013), which may not be achievable when learning about sexual health in a classroom setting. Some participants also sought out queer communities online which they did not have access to in their classroom or high school.

Despite these challenges, schools are in the position to provide online resources to youth that are accurate, reliable and up-to-date (Jones et al., 2011). This would allow for the opportunity for youth to learn about sexual health in a classroom setting, and then access more information online based on their own interest. This would also provide them with the opportunity to learn at their own pace, in a more convenient way (Gray et al., 2005), and provide the opportunity to go deeper into topics that are most relevant to their lives. The school system could help youth navigate the overload of information online, and direct them to the right resources. Thus, the school and online spaces can be extremely useful sources of sex education when working in conjunction with one another.

Second, the data has shown that similar to previous research, youth rely on their friends to learn about sexual health (Graf and Patrick, 2015; Cheetham, 2014). The participants’ felt most
comfortable learning about sexual health from their networks of friends, felt validated through their friendships and had the opportunity to share their experiences; however, as demonstrated in previous research, friends are not always a reliable source of information and can be misinformed or lacking a nuanced understanding of sexual health (Jones et al., 2011). It is also unlikely, and unreasonable, to expect youth to exclusively rely on one another for their sexual health information.

In order for sexual health knowledge to be disseminated among friends, these individuals must first learn this information themselves. Thus, educating youth through sexual health education at school, as well as through reliable and accurate online resources, could lead to a dissemination of more in-depth knowledge among friends. If young queer women receive this education at school and online, they are in a greater position to share reliable information with one another. Knowing that young queer women rely on their networks of friends for this type of education, and that thus, friends contribute to their sexual health knowledge production, it is important to provide opportunities for these women to receive a sound and relevant sexual health education.

This study specifically identifies a need for a comprehensive sex education curriculum, as well as a classroom and school environment that fosters inclusion of the LGBTQ+ population. As mentioned above, a comprehensive sex education in school would allow for a more accurate and reliable dissemination of sexual health knowledge among queer youth and their networks of friends. A revised curriculum in school, coupled with a provision of reliable online resources from the school itself, would integrate the advantages of collectively addressing online and offline learning opportunities.

A comprehensive sex education would incorporate a holistic approach to sexual health. It would go beyond a basic understanding of STIs and pregnancy, and would include emotional and mental health issues (Allen, 2005). Participants in this research wanted to engage in more discussions that acknowledge that sexual health affects us socially, emotionally and mentally. Thus, a revised curriculum should provide youth with tools to communicate and reflect on their sexual health needs. The results of this study support past research that advocates for the benefits of having a comprehensive sex education, such as understanding healthy and unhealthy relationships, as well as avoiding negative health outcomes (Bridges and Hauser, 2014).
Elia and Eliason (2010), McCarty-Caplan (2013) and the Toronto Teen Health Survey Report (Flicker et al., 2009) provide wonderful, in-depth suggestions on how to create LGBTQ+ inclusive and anti-oppressive sex education curricula. One suggestion is the need for LGBTQ+ affirming sex education that explicitly recognizes diverse sexualities, sexual orientations and gender identities, and addresses the value in each and every student in the classroom (McCarty-Caplan, 2013); a need for this type of affirming sex education was similarly expressed by the participants in this study. Inclusive and anti-oppressive sex education would also involve a curriculum that recognizes intersectionality of oppressions, and includes a discussion on how each individual’s unique positionality can affect their sexual health (Elia and Eliason, 2010). For example, the curriculum might recognize and acknowledge how young queer women have unique needs, desires and health outcomes that are distinguished from the greater LGBTQ+ population, and how these are further connected to one’s class, race, religion or ability.

This study also suggests a need for inclusive environments in the classroom and school setting. The participants described how teachers strongly influence these spaces; this finding suggests that teachers are an appropriate target for intervention. This study therefore recommends an increased need for LGBTQ+ inclusive training for teachers within the TDSB. Additionally, this study suggests a greater need for LGBTQ+ teacher and administrative representation in schools (McCarty-Caplan, 2013). The school can also be an appropriate space for providing inclusive LGBTQ+ resources and spaces for students. For example, McCarty-Caplan (2013) suggests the need to continuously support and expand Gay-Straight-Alliances (GSAs) in schools. GSAs can help create a welcoming, supportive and inclusive environment to queer youth, as well as foster greater understanding of LGBTQ+ issues to all students (McCarty-Caplan, 2013).

Moving forward, it is important to discuss the limitations of this study. First, this study is specific to the social, political and geographic contexts of the 29 participants. It is not generalizable to the experiences of all young queer women in Toronto. Half of the participants are white, which likely affected the homogeneity of responses. This study found some interesting differences between the experiences of white participants and participants of colour, but a more in-depth analysis of the experiences of specific marginalized groups would be necessary to draw firm conclusions about the significance of these differences. Future research could explore a more nuanced discussion surrounding the intersections of sexuality and sexual health with diverse identities of race, gender, class and ability. This could also involve recruitment strategies
that specifically target certain groups, in order to prioritize voices that are often silenced or marginalized.

This study asked participants to recollect their high school experiences. The research therefore reflects a memory of how and where the participants learned about sexual health. It is possible that some participants did not recall an exposure to sexual health information, or that sexual health information was not relevant to them at the time, and therefore did not come up during the interviews. As a result, the findings may reflect a broader, more general understanding of the ways and spaces in which young queer women learn about sexual health. In the future, it could be interesting to study with youth in the moment they are experiencing the curriculum, during their high school years.

Lastly, the research subject and recruitment materials may have encouraged participation from individuals who are specifically interested in sexual health. Those who responded to the study may be particularly comfortable with their sexuality and may be more willing to discuss their sexual health education experience growing up. The research therefore may not include the experiences of those individuals who are not open publicly with their sexuality, nor those individuals who find sexual health education to be irrelevant.

Despite these limitations, the study addresses a gap in the literature as it examines the significance of sexual health education at school in relation to alternative educational spaces. It provides an analysis of how these spaces function to collectively influence young queer women’s sexual health education. My research adds a nuanced perspective as it acknowledges and prioritizes the unique experiences of young queer women and their relation to sexual health. Sexual health is a prominent component of one’s overall health and requires extensive attention. By exploring the ways in which young queer women learn about sexual health, my research highlights significant gaps in education and provides insight on the inclusivity/exclusivity of sexual health education and its impact on queer women’s experiences.

Nash (2010) states that “queer geographies seek to demonstrate that gendered, sexualised and embodied experiences and identities are socially constituted within power relations that order social relations and social spaces in hierarchical ways” (Nash, 2010: 142). My research contributes to the literature in critical geography as it demonstrates how the participants’ experiences occur within power relations that impact how sexual health education is understood.
in different social spaces. It gives a detailed depiction of inclusion and exclusion of non-normative identities within both formal and alternative educational spaces. This project also contributes to the understanding of space as produced and productive, in the context of sexual health education spaces.

The results of my research will be shared with the women I interviewed, academic researchers and will be open and available for any policy makers. I would like to influence policy, as a means to affect change for queer women’s lives in Toronto. I hope that by sharing the results of this research with the women I have interviewed, it will promote a sense of solidarity amongst a diverse group of women. I hope that this project speaks to the importance of sexual health education, and speaks to the resilience and strength of young queer women who find ways to learn about sexual health and explore their sexuality despite being excluded from formal educational spaces.
Bibliography


organization of San Francisco’s gay community’, in N. Fainstein and S. Fainstein (eds), Urban Policy under Capitalism, Beverly Hills: Sage.


Mohammad, R. (2001). “Insiders” and/or “outsiders”: positionality, theory and praxis. in M.


Woolley, S. W. (2017). Contesting silence, claiming space: gender and sexuality in the neo-
https://doi.org/10.1080/09540253.2016.1197384

http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/


## Appendix A

### Summary of Participant Demographics

<table>
<thead>
<tr>
<th>Person</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Sexuality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alice Tremble</td>
<td>28</td>
<td>Black American/Bajan</td>
<td>Queer</td>
</tr>
<tr>
<td>Alison</td>
<td>25</td>
<td>White</td>
<td>Queer/Bisexual</td>
</tr>
<tr>
<td>Amina</td>
<td>27</td>
<td>Somali</td>
<td>Queer</td>
</tr>
<tr>
<td>Ashlynn</td>
<td>23</td>
<td>Salvadorian</td>
<td>Bisexual</td>
</tr>
<tr>
<td>Aviva</td>
<td>29</td>
<td>White</td>
<td>Queer</td>
</tr>
<tr>
<td>Beth</td>
<td>26</td>
<td>Black Caribbean</td>
<td>Queer</td>
</tr>
<tr>
<td>Blue</td>
<td>20</td>
<td>White</td>
<td>Queer/Lesbian</td>
</tr>
<tr>
<td>Bronwyn</td>
<td>27</td>
<td>White</td>
<td>Queer/Gay</td>
</tr>
<tr>
<td>Camryn</td>
<td>26</td>
<td>White</td>
<td>Queer/Bisexual</td>
</tr>
<tr>
<td>Chris</td>
<td>23</td>
<td>Chinese</td>
<td>Gay/Lesbian</td>
</tr>
<tr>
<td>Claire</td>
<td>21</td>
<td>White</td>
<td>Queer</td>
</tr>
<tr>
<td>Debbie</td>
<td>26</td>
<td>Caribbean</td>
<td>Bisexual</td>
</tr>
<tr>
<td>Diana</td>
<td>22</td>
<td>Ethiopian</td>
<td>Bisexual</td>
</tr>
<tr>
<td>Erica</td>
<td>24</td>
<td>White</td>
<td>Queer Femme</td>
</tr>
<tr>
<td>Evelyne</td>
<td>26</td>
<td>White</td>
<td>Queer</td>
</tr>
<tr>
<td>Felicia</td>
<td>29</td>
<td>White</td>
<td>Queer</td>
</tr>
<tr>
<td>Kai</td>
<td>26</td>
<td>Estonian/Trini/Nigerian</td>
<td>Queer</td>
</tr>
<tr>
<td>Kathrine</td>
<td>28</td>
<td>Chinese/German/Hungarian</td>
<td>Queer</td>
</tr>
<tr>
<td>Katie</td>
<td>22</td>
<td>Chinese</td>
<td>Queer</td>
</tr>
<tr>
<td>Lillian</td>
<td>23</td>
<td>White</td>
<td>Gay/Lesbian</td>
</tr>
<tr>
<td>Mada</td>
<td>20</td>
<td>White/Japanese/Middle Eastern</td>
<td>Queer</td>
</tr>
<tr>
<td>Maggie</td>
<td>26</td>
<td>White</td>
<td>Queer</td>
</tr>
<tr>
<td>Mary-Lynn</td>
<td>25</td>
<td>White</td>
<td>Bisexual</td>
</tr>
<tr>
<td>Monty</td>
<td>26</td>
<td>Persian</td>
<td>Queer/Bisexual</td>
</tr>
<tr>
<td>Ruby</td>
<td>25</td>
<td>White</td>
<td>Queer</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Ethnicity</td>
<td>Sexual Identity</td>
</tr>
<tr>
<td>--------</td>
<td>-----</td>
<td>------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Saturn</td>
<td>23</td>
<td>White</td>
<td>Pansexual</td>
</tr>
<tr>
<td>Shayna</td>
<td>27</td>
<td>White</td>
<td>Queer/Lesbian/Gay</td>
</tr>
<tr>
<td>Simone</td>
<td>24</td>
<td>White</td>
<td>Bisexual</td>
</tr>
<tr>
<td>Sofia</td>
<td>23</td>
<td>Peruvian</td>
<td>Queer/Bisexual</td>
</tr>
</tbody>
</table>
Appendix B

Recruitment Poster

RECRUITING

Alternative Spaces of Sex Education:
A Look into the Lived Experiences of
Queer Women in Toronto

If you self-identify as a woman and
· are between the ages of 19-29
· identify as LGBTQ+
· went to public high school in Toronto
· currently live in Toronto

You are invited to participate in an interview discussing:

Your experience with
sexual health education
inside & outside
the school setting

The interview will take 30-45 mins
Participants will be compensated for their time

If interested please contact:

Clio Fregoli
Master’s Graduate Student
Department of Geography
University of Toronto

clio.fregoli@mail.utoronto.ca  (514) 449-6719
## Appendix C

### Interview Guide

<table>
<thead>
<tr>
<th>Topics</th>
<th>Questions</th>
<th>Probes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introductory</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) <strong>Can you tell me a bit about yourself?</strong></td>
<td>(start with probes right away)</td>
<td>• Your age, your pronouns, background, where you grew up?</td>
</tr>
<tr>
<td>2) <strong>What are the terms you use to refer to your sexuality?</strong></td>
<td></td>
<td>• Have you always used those terms? Have they changed since high school? How?</td>
</tr>
<tr>
<td><strong>Sexual Health in High School</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) <strong>How would you describe your high school’s acceptance of queer people?</strong></td>
<td></td>
<td>• How were the terms “queer” or LGBTQ+ used at your school? Were you open about your sexuality in high school? Are you open about your sexuality now?</td>
</tr>
<tr>
<td>4) <strong>Can you talk about your experience with sexual health education in high school?</strong></td>
<td></td>
<td>• Did you find the sex ed curriculum to be relevant to your life?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Did queer sexual health fit into your health curriculum? How?</td>
</tr>
<tr>
<td>5) <strong>Did you want to learn about sexual health at school?</strong></td>
<td></td>
<td>• Was there an opportunity to do so?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Positives and negatives of learning about sexual health at school</td>
</tr>
<tr>
<td>6) <strong>Did you find that the school gave you enough information and knowledge regarding your own sexual health?</strong></td>
<td></td>
<td>• If so, how? If no, what was missing?</td>
</tr>
<tr>
<td>7) <strong>In what other ways did you learn about sexual health growing up?</strong></td>
<td></td>
<td>• Did you ever seek out sexual health information? If so,</td>
</tr>
<tr>
<td>Alternative Resources/Spaces</td>
<td>8) Did you use the internet to access sexual health resources?</td>
<td>• If so, how? If no, why not? How much compared to other resources? What type of websites did you turn to?</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>9) How did learning from the internet compare to learning from different sources and from different places?</td>
<td>• What were some advantages and disadvantages of learning both online or offline?</td>
</tr>
<tr>
<td></td>
<td>10) Were there spaces where you felt most comfortable discussing or learning about sexual health?</td>
<td>• What were those spaces? What about them made them comfortable? Who was a part of these spaces? Did you ever create them yourself?</td>
</tr>
<tr>
<td>Overall Experience with Sexual Health Education</td>
<td>11) Do you think sexual health education is important?</td>
<td>• What aspects of sexual health education are important to you?</td>
</tr>
<tr>
<td></td>
<td>12) Are you satisfied with your knowledge of sexual health?</td>
<td>• Where would you like to see improvement in your knowledge of sexual health?</td>
</tr>
<tr>
<td>Final Thoughts</td>
<td>13) Is there anything you would like to discuss that you haven’t shared yet?</td>
<td></td>
</tr>
</tbody>
</table>