HIGH SCHOOL STUDENTS’ SEXUAL HEALTH EDUCATION – A
RETROSPECTIVE APPRECIATIVE STUDY WITH UNIVERSITY STUDENTS IN
SASKATCHEWAN

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Danielle Nicole Schmidt, candidate for the degree of Master of Science in Kinesiology & Health Studies, has presented a thesis titled, *High School Students’ Sexual Health Education: A Retrospective Appreciative Study with University Students in Saskatchewan*, in an oral examination held on August 30, 2018. The following committee members have found the thesis acceptable in form and content, and that the candidate demonstrated satisfactory knowledge of the subject material.

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Abstract

The purpose of this qualitative research study was to explore first year university students experiences in relation to their sexual health education they received through high school in Saskatchewan, Canada. Using the appreciative inquiry method, my intent was to uncover participants positive experiences, paying little attention to negative ones, creating an environment where participants could build an image of an ideal future for sexual health education [SHE] in high schools. Research in Saskatchewan is limited on the subject, but Saskatchewan has some of the highest teenage pregnancy rates and sexually transmitted infection rates in the country (Public Health Agency of Canada, 2010) and studies have shown inconsistencies in curriculum and what is being taught (Options for Sexual Health, 2004). Using a purposive sampling technique participants were selected from a first year university class. I collected data from 39 participants via an online discussion forum, eight one - on - one interviews and a reflective journal. During the analysis phase of this project, through coding, theming and reflection four major themes emerged from the data. The teacher, the environment, the content of the class and interactive learning all played major roles in participant experiences that influenced their sexual health education in the classroom. Furthermore, through one - on - one interviews participants expressed their views on what they think an ideal SHE program looks like, discussing what core concepts SHE should provide students, best methods to provide the information and key qualities an educator teaching SHE should possess. Recommendations for direction of future research are presented.
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CHAPTER ONE: INTRODUCTION

Sexual health is an essential part of an individual’s overall health status throughout their life. Once puberty begins it is especially important for youth as during this time period they are experiencing many changes not only in their physical physique, but also in their emotional, mental and spiritual self that will affect their sexual health. However, sexual health is often a topic not acknowledged among young people, only to be discussed when it is too late and/or a health issue has developed. Sexual health education (SHE) in high schools is an important part of curriculum that provides youth with the education they need regarding their sexual health. There is a large body of literature that discusses SHE and adolescents, however there remains a gap in the literature involving SHE in high school students and Saskatchewan. This is troublesome because sexually transmitted infections (STIs) and teenage pregnancy rates in Saskatchewan are among some of the highest in the country (Public Health Agency of Canada [PHAC], 2014). Because the SHE needs of students’ are unique to the individual and students of Saskatchewan, research needs to be conducted at a local level, so results can be the most valid and reliable, relating directly to the people of Saskatchewan. Looking at SHE from a positive perspective has not been researched within Saskatchewan with high school students, thus it provides an opportunity to explore a unique perspective and gather valuable information that can assist with future SHE programs for high school students in the province of Saskatchewan.

I became interested in this topic through work experience while studying to become a Registered Nurse. It began when I was placed as a student at a non-profit community organization that worked with at risk population, providing education,
support, free testing, the needle exchange program and advocacy for youth and adults in relation to certain health issues in Saskatchewan. While doing my practicum at this program, sexual health was a prominent program initiative and providing SHE was a daily task. I discovered how important sexual health was and how it affected an individual’s overall health status. Next, as a nursing student I was placed in a local high school in Regina Saskatchewan. It was here that I became most interested in the subject of SHE because of a particular incident I had, after providing a presentation on smoking cessation, we (the nursing students) handed out a survey to students asking how the session went and what they would like to learn about next in relation to health. I was overwhelmed by the amount of responses that said topics about sex or sexual health. When we asked if we could present on the topic we were told we could not as it was a separate school and we were not allowed to discuss topics involving sex education. These experiences left me reflecting about the students and their experiences with SHE. They felt they needed information on a topic, however because of beliefs of the school division we were unable to provide them with this education. I thought to myself, how does one make a positive sexual health choice without the basic knowledge of sexual health? I also reflected on my experiences with SHE in high school. I also went to a Catholic high school in Saskatchewan and I felt my education about sexual health was very limited, gaining most of my information from friends, family and peers. I concluded my SHE experience through high school was not very beneficial, and felt many of my friends would say the same.

Lastly, the importance and need for SHE was reiterated to me as I began my career as a nurse. Sexual health was and continues to be a factor in my job as an
emergency nurse when providing care and education to clients, especially the younger population. These personal and professional experiences have inspired me to research this topic in hopes of helping young people receive the best SHE they deserve in order to achieve the best possible sexual health.

1.1 Purpose of the Study

The purpose of the research study was to explore the experiences of first year university students in relation to the SHE they received through high school. This research project seeks to gain a deeper understanding of the positive experiences participants have had, paying little attention to negative experiences, in hopes that focusing on the positives can lead to similar experiences for other students in the future.

1.2 Pilot Study

In preparation for conducting my thesis project, my supervisor and I conducted a pilot study after ethics were obtained through the University of Regina. We hoped to gain a better understanding of how young people feel about the SHE they received as a high school student in the province of Saskatchewan. Using the online survey tool, SurveyMonkey, 51 students in a first year University Kinesiology and Health Studies class at the University of Regina completed a questionnaire with 45 multiple choice questions and two open-ended questions assessing if certain sexual health topics were addressed in their classes. Participants were then asked to rate their level of importance to their sexual health on a Likert scale. Participants were also asked to rate their overall SHE experience. When asked about the importance of SHE in high school 88% of participants rated SHE as ‘important’ to ‘vitally important’ and only seven individuals rated SHE in high schools as either somewhat important or not important (Schmidt &
LeDrew, 2013). Although most of the participants believed SHE to be very important the majority were not satisfied with their SHE experiences in high school as only 33% of participants rated their SHE experience in school as ‘good’ or ‘excellent’ 33.3% stated it as “average” while the 33.3% of participants stated their curriculum as poor or non-existent. The findings show the inconsistencies in student’s experiences, making one wonder if it’s the differences in deliverances among SHE programs being taught. This was reiterated in the open-ended section of the survey where participants were asked to reflect on and comment about their experience with SHE. Results suggested participants had differing opinions on their experiences as responses and stories about SHE varied in topic, delivery and impact.

- “[At my school] it was a great experience and learning tool.”
- “I do not really remember the experience with sexual health in high school, therefore I don’t think it impacted me or was taught in a way that was beneficial, the topic was kind of just talked about briefly and that was it.”
- “Needed to connect more to students instead of just learning curriculum.”

The results from the pilot study were a helpful tool in directing my current thesis research.

**CHAPTER TWO: REVIEW OF THE LITERATURE**

2.1 What is Sexual Health?

It has become widely acknowledged that health is not merely the absence of disease, but involves a state of complete physical, mental and social well-being that recognizes the complex interactions between social, economic, physical and environmental factors that all contribute to a person’s overall health and well-being.
Sexual health is no different. According to the WHO (2002a), sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality. A person’s sexuality is a vital aspect in the development of a person’s identity and well-being. The WHO recognizes that sexual health requires sexual education that links an individual’s values and behaviour with their thoughts and feelings. Sexual health also acknowledges the influence of culture, sexual preference, religion, age, disability, and socioeconomic factors (Edwards & Coleman, 2004). To fully understand sexual health a person must have an understanding of sexuality (Edwards & Coleman, 2004). There is no international consensus on the concept or definition of sexual health because values and norms about sexuality depend on many factors including social, religion, science, medicine and individual experience (PHAC, 2003). The WHO also recognizes that for an individual to attain sexual health all of their sexual rights must be protected, respected and fulfilled (PHAC, 2008). This includes the rights of freedom from sexual exploitation, oppression and abuse (Edwards & Coleman, 2004). These rights also include an individual right to access timely, broadly based sexuality health education (PHAC, 2008).

SHE focuses on providing individuals and communities with information, motivation, and behavioural skills to not only avoid negative sexual health outcomes such as STI’s and teenage pregnancy, but also towards helping individuals and communities enhance their sexual health, leading to positive health outcomes (PHAC, 2008). While SHE is a broadly based phenomenon that needs active participation from the medical system, public health, social welfare, legal institutions, community groups and education
systems to be successful, this paper will focus on SHE in relation to the education system.

2.1.1 Defining sexual health, sexual health education and adolescence. In a descriptive overview Edwards and Coleman (2004) explain how the definition of sexual health has evolved over the years, especially within the last three decades. Publicly acknowledged health challenges that have arisen in the last century such as the “sexual revolution” in the 1960’s, the continual debate over reproductive and abortion rights, the gay rights movement, and the devastating effects of HIV/AIDS, have all impacted the evolution of the definition of sexual health (Edwards & Coleman, 2004). It must be noted that the definition of sexual health as a concept is shaped by political, social and historical events that happen in our world. It is important to understand the definition of sexual health in order to promote this aspect of health in society. Thirty-seven years ago the World Health Organization first published an internationally accepted definition of sexual health, defining the term as “the integration of somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love” (Edwards & Coleman, 2004, p. 190). This definition has since evolved in correspondence with transpired world events, political events and individual and group advocacy into WHO’s (2002a) most current definition:

*Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships. As well as the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence. For sexual*
health to be attained and maintained, the sexual rights of all persons must be
respected, protected and fulfilled.

Major differences between this definition of sexual health and previous
definitions include its comprehensive description, with inclusion of mental health, sexual
health as a right and the importance of the promotion of sexual health (Edwards &
Coleman, 2004). The progression of this definition showcases many similarities and
differences from the WHO’s first definition in 1975, but in order for the definition of
sexual health to remain relevant to the world, it must continue to be monitored and
adjusted as the world continues to change.

Adolescence, used interchangeably with the term youth in this paper is defined by
the WHO as young people between the age of 10-19 (2018).

2.1.2 Why is sexual health education important? Sexual health is an essential
part of an individual’s overall health status and is especially important for youth as many
changes occur not only in their physical physique, but their emotional, mental and
spiritual self that affects their sexual health (PHAC, 2003). Canada is home to diverse
societies, with many differing cultures, values and worldviews. As a result, there are
differing opinions about human sexuality. However, despite the differences, Canada
remains adamant that access to effective, broadly based sexual health is an important
influencing factor in the health and the well being of Canadian youth (PHAC, 2008). The
Sex Information and Education Council of Canada (2009) [SIECCAN] believes that
individuals have the right to information, insight and skills to prevent negative health
outcomes through SHE. Furthermore, a school-based education program is an essential
route for SHE for adolescents. The Public Health Agency of Canada (2008) recognizes schools as a great facilitator for SHE stating,

Since schools are the only formal educational institution to have meaningful (and mandatory) contact with nearly every young person, they are in a unique position to provide children, adolescents and young adults with the knowledge, understanding, skills, and attitudes they will need to make and act upon decision that promote sexual health throughout their lives (p.19).

2.1.3 Aims of sexual health education. SHE includes a multidimensional approach to learning that hopes to achieve positive outcomes as well as avoid negative outcomes. Positive outcomes include intimate, caring interpersonal relationships, positive self-image, self worth, delaying first intercourse and desired pregnancy (PHAC, 2008; SEICCAN, 2009). Current challenges within the spectrum of sexual health and youth include teenage pregnancy, high rates of sexuality transmitted infection, and dating violence (Kirby, 2007). Less dramatized, but influential negative outcomes also include feelings of exploitation, dissatisfaction and guilt (Kirby et al., 1994). These outcomes, positive and/or negative are influenced by education programs that foster an environment plausible to sexual health (PHAC, 2003). The costs associated with these outcomes are not only high for the individual, but for society as well (Saskatchewan Health, 2001). The community as a whole benefits from SHE programs the overall health and well being of the community is increased (SEICCAN, 2009). Conversely, the absence of SHE programing in a community can lead to many negative outcomes. From an economic standpoint Goeree and Gully (1993) estimated in 1990 that the total cost of chlamydia (a common sexually transmitted infection) and associated issues cost Canada $89 million in
healthcare. Since 1990, the yearly cases of chlamydia has increased (PHAC, 2008), therefore one can assume that the cost of the infections has increased. Furthermore, SEICCAN (2009) notes that teenage pregnancy and parenthood has consequences that affect not only the individual, but also the family and community from both an economic and social standpoint. Western countries’ rates of teenage pregnancy are a general indication of adolescent sexual and reproductive health (McKay, 2006).

The effectiveness of SHE programs has been a vigorously studied phenomenon with evidence from multiple peer reviewed articles and national government programs. Research shows that effective SHE programs have the ability to positively impact the behaviour of children, adolescent and young adults when it comes to sexual health (Bennet & Assefi, 2005; Boyce et al., 2006; Dodds, 2011; Kirby, 2007; Kirby, Laris, & Rolleri, 2007; PHAC, 2008). Kirby et al. (2007) were major players in assessing the effectiveness of SHE programs on an individual’s behaviour. Reviewing 83 studies from a variety of countries the researchers concluded that two-thirds of the reviewed programs had a positive impact on behaviour in relation to SHE. While the Kirby et al. (2007) study had limitations which included being bounded by particular geographical areas, dated studies and limited in-depth analysis of characteristics of effective programs, the study was encouraging (Kontula, 2010).

While SHE is the term often used in research papers and is used throughout this paper, it is important to note that when one is discussing educating about sexual health in the school one is teaching sexuality education. Sexuality education is not merely the biological aspect of sex. It is defined by Goldman and Coleman (2011) as a “relevant and equitable approach to teaching about puberty, relationships, sexuality, and reproductive
health and safety by providing scientifically accurate, realistic, and, in particular, timely information; that is, during primary school years before sexual initiation” (p.277). Thus, sexuality education begins in elementary school, far before high school begins. In addition, sexuality education programs taught in schools that are affective are part of a comprehensive health education program (McCall, n.d.). Specifically, the Saskatchewan Prevention Institute (2015), defines comprehensive sexuality education as a holistic approach to human development and sexuality, teaching individuals the benefits of delaying sex until they are emotionally and physically ready, but also ensuring they are taught how to protect themselves if they are going to engage in sexual activity.

Furthermore, this approach recognizes human rights, knowledge, values and skills to preventing negative health outcomes, increasing positive health outcomes and promoting gender equality (Saskatchewan Prevention Institute, 2015). In Saskatchewan, sexuality education, and comprehensive health education are approaches utilized in high schools and will be discussed later in the Saskatchewan and SHE section of this literature review.

2.2 Health Trends and New Challenges

Adolescent sexual health continues to evolve as does the definition of sexual health, but not in the major ways it is often portrayed in the media (Maticka-Tyndale, 2008). Maticka-Tyndale (2008) compared data from two Canadian national studies (National Longitudinal Survey of Children and Youth and National Population Health Survey) and various other large scale studies conducted in Canada (Boyce, et al., 2006; Roterman, 2008; Saewyc, Taylor, Homma, & Ogilvie, 2008) and found that since the 1970’s not many sexual health patterns have changed and to many people’s surprise, the age of first intercourse has remained stable (Maticka-Tyndale, 2008). The common
misconception that adolescents are engaging in sexual intercourse at an earlier age is false according to the data. Boyce et al. (2006) found similar results from the large scale national survey Canadian Youth, Sexual health and HIV/AIDS Study conducted in 2002. When comparing the results from a national 1988 Canada Youth and AIDS study (King et al., 1989) findings indicated that in the 2002 study, 40% of males in grade 11 had engaged in intercourse vs. the 49% in 1988 and 23% vs. 31% in grade 9. Females also showed very little change (Boyce et al., 2006).

Statistics Canada has been gathering data on teenage pregnancy for over a quarter of the century. The trends show a decline in the incidence of teenage pregnancy in the last quarter of the 20th century, with numbers continuing to decline in the beginning of the 21st century (McKay, 2006). This decline could be attributed to teens taking more control over their sexual health; accessing contraception, condoms, access to emergency contraception and seeking out abortions as necessary, more than any previous generation (Maticka-Tyndale, 2008). While it appears improvements have been made in some areas of adolescent sexual health, the fact that the incidents of teenage pregnancy numbers are so high to begin with remains an area of concern. Comparing sexual health to other countries with similar socio-political, economic and demographic characteristics as the United States of America (USA) and England is a complicated process with many confounding variables. McKay (2006) explains that comparing rates of teenage pregnancy and abortion is a hard concept as countries collect and analyze data in different ways, therefore direct comparison is difficult and would result in skewed information.

While there have been many improvements to the sexual health of Canadian adolescents, sexually transmitted infections remains a significant preventable health
issue. Rates for chlamydia among adolescents have steadily been on the rise for both 15-19 year olds and 20-24 year olds since the mid 1990’s to 2004 (Maticka-Tyndale, 2008). The STI gonorrhea is also on the rise, with highest reported rates in 2008 in both men and women being under the age of 30 (PHAC,2010). Maticka-Tyndale (2008) explains this does not necessarily mean that there has been an increase in prevalence rate, but can be attributed to the amount of people being tested, or more sensitive testing methods. Nonetheless, the high numbers and health consequences involved with STIs demand the need for more education, which could lead to a decrease in prevalence rate of STIs. Saewyc et al. (2008) had similar suggestions stating that while the trends in sexual health in BC adolescents are encouraging, there is much room for improvement. In Saewyc et al.’s 2008 study on trends in sexual health in adolescent students in British Columbia, it was found that more than one in ten sexually active youth did not use effective contraception in their last intercourse, and there was a decline in condom use for older youth as they turn to hormonal contraceptive, limiting protection against STI’s.

2.3 Risk Factors for Negative Sexual Health Outcomes

Knowing this information, are there certain factors that put youth at an increased chance of engaging in sexual risk-taking behaviors leading to negative health outcomes? The Youth Risk Behavior Surveillance data outlines some potential sexual risk-taking drivers as being early sexual activity, multiple sex partners and unprotected sexual encounters (Centers for Disease Control and Prevention, 2007). Using a qualitative approach, Jones (2010) studied what drives adolescents to take part in these sexual risk-taking behaviors. The study concluded that there were both internal and external factors at play driving adolescents to make the decisions they did. Jones (2010) named factors
such as the media, peer influence, pressure to conform, desire for acceptance and love, curiosity, and autonomy over their own body as driving forces.

Gay, lesbian, bisexual, transgender, queer (GLBTQ) or questioning adolescents are another group of people whose sexual health is at an increased risk (Maticka-Tyndale, 2008). GLBTQ youth often struggle with their sexual health in isolation as research has steadily shown that because of their sexual orientation these youth are at increased risk of psychological and physical violence at school (Maticka-Tyndale 2008; Saewyc et al., 2006). Furthermore studies on the topic of young adults and sexual health is often focusing on heterosexual students, to bridge this gap a study conducted by Charest, Kleinplatz and Lund (2016) focused a study on emerging adults that included LGBTQ participants exploring how they obtained their sexuality information and its relation to sexual self-efficacy. The study found that heterosexual participants and GLBTQ participants obtained their health information from different sources, with heterosexuals receiving more from a school/university setting and they were also more confident in there sexual health practices than the GLBTQ participants (Charest et al., 2016). Further research and education that includes information unique to GLBTQ individuals is important to ensure sexual health of all is attained, not just the heterosexual population.

Just as health inequalities exist within communities, the same can be said for sexual health inequalities. Maticka-Tyndale (2008) explains that in Canada, adolescents who often experience poor sexual health are from lower-income families (Hardwick & Patychuck, 1999) or from rural areas (Devries, Free, Morison, & Saewyc, 2009). It is well known that Canada has a large Aboriginal population. Understanding this, Devries et al. (2009) studied risk factors specifically aimed towards Aboriginal youth. Their
findings indicated that sexual behavior in the young Aboriginal population was correlated with substance use, history of sexual abuse, and having lived on a reserve (Devries et al., 2009). Devries et al. (2009) indicates more research needs to be conducted on sexual health with Aboriginal youth, as their findings indicate unique findings specific to their population.

2.4 Sources of SHE for Youth

It has been established that education through school is vital to promoting the sexual health of the youth and similarly, that youth have expressed a need for sexual health information (Byers et al., 2003; Forrest, Strange, & Oakley, 2004). If a reliable source of information such as school SHE is not provided to them in a meaningful way, youth will look to venues for information that is not necessarily as accurate or trustworthy. Other sources that youth gather their sex education from include, but are not limited to are peers, television, magazines, books, and parents (Bourton, 2006).

Adolescents not only gather information from one another, but Boyce et al., (2006) found that peer influence and sexual activity held a connection. The study found that students who stated that more than half of all of their friends had engaged in sexual intercourse, 74-81% had also had intercourse. It was suggested that students who had intercourse were more likely to interact with other students who had similar experiences (Boyce et al., 2006). Byers, Hamilton, & Fisher (2017) found that participants valued information from their peers more than school education sources. Parents are another source of information that youth obtain sex education from. Many people believe that sex education should be a shared responsibility of both parents and schools (Byers et al., 2003; McKay, Pierusiak & Holowaty, 1998; Weaver, Byers, Sears, Cohen, & Randall,
Weaver et al. (2002) found that 94% of parents supported SHE being provided in school, with 95% of parents also agreeing that school and parents should share the responsibility. While the data found that SHE should be a shared task, approximately one-third of parents felt they or their partner had provided their child with excellent or very good SHE (Weaver et al., 2002). This is consistent with findings by Byers et al. (2003) stating students do not feel parents are providing quality SHE to them. Possible barriers parents are experiencing in teaching SHE to their children include inadequate knowledge, discomfort over topic, and anxiety (Weaver et al., 2002).

Another factor affecting the SHE of adolescents’ includes the media. The media often portrays sexual content in a glamorized way (Jones, 2010) and is a main source youth gather information about sexual health. Jones (2010) conducted a qualitative study where one seventeen year old youth explained television’s influence on her sex education stating that everyone these days knows about sex, not because of parents and school, but because of television where they show a lot of “stuff” about sex. Another youth in the study explained that its not always good education explaining it as “wrong sex” where sex is portrayed as funny, casual and without consequence (Jones, 2010). Lesta, Lazarus and Essen (2008) found similar results as Jones (2010); adolescent participants acknowledged the large amount of information available through television and magazines, however they did acknowledge that this source of information was not reliable, especially in comparison to teachers. In addition, participants recognized that they are at an age where vulnerability puts them in a position to be susceptible to inaccurate messages that were being portrayed by these media outlets (Lesta et al., 2008).
The media from an alternate view also has the ability to influence the general population about a geographical areas overall SHE status. For example, Maticka-Tyndale (2008) discusses the influence the media has had on society’s view of adolescents and their sexual health stating if one were to rely on media reports about Canadian youth and adolescents and sexual health, one would think times are troubled, with an increase is sexually promiscuity from our youth. The media often creates stories implying young people are beginning sexual activity at younger ages, with more high-risk behavior without looking at the evidence (Saewyc et al., 2008).

Conversely, as stated elsewhere in the paper there are many aspects of adolescent sexual health that are improving or remaining the same with statistics from previous decades in Canada’s youth. This media’s influence is important to be aware of because as a country, Canada is influenced when creating policy and programs for sexual health in Canada by this portrayal of Canadian youth as risk-taking and promiscuous youth (Maticka-Tyndale, 2008).

Community sexual health services are another potential source of information for adolescents, however many of these individuals are not utilizing this health service (Martin & Rabie, 2011). In order for young people to access health services, they need to be aware of how and when they can access the services, that consults are confidential and that they will not be stigmatized for accessing the service (Martin & Rabie, 2011). Community health services, like school SHE have the potential to provide accurate information and services to adolescents, decreasing the above stated barriers providing the youth with proper access to the sexual health services they have a right to.
2.5 Inconsistencies in SHE Programs

SHE is a broadly based term, and leads many to the question, what exactly is taught in a SHE program? While SHE programs are taught throughout the world and more specifically, throughout Canada, there is variance among curriculums being taught, with differing topics being covered (Barrett, 1994; Byers et al., 2017, 2003; Dodds, 2011). A 2004 study looking at effectiveness of SHE programs in British Columbian schools found that “good” SHE is hit and miss regarding timing, teaching and continuity of curriculum, with inconsistencies reaching across and even within school districts (Options For Sexual Health, 2004). Despite this concern, one thing remains clear, through evidence compiled by multiple studies; students have voiced their need for SHE and stated it as an important educational need (Byers et al, 2003; Cairns, Collins & Hiebert, 1994; Forrest et al., 2004; Hirst, 2004; Kirby et al., 1994; O’Higgins & Gabhainn, 2010).

In 2008, Maticka-Tyndale made recommendations to strengthen SHE and sexual health services to meet the needs of Canadian youth. Historically, curriculums have been created based on adults’ perspective, not taking into account young peoples views on their health needs (Byers et al., 2003; McKay, Fisher, Maticka-Tyndale, & Barrett, 2001). Researchers believe young people have much to teach the adults and hold valuable contributions to planning policy and delivery of effective SHE programs (Forrest et al., 2004; Hirst, 2004). Because the SHE curriculum varies widely across the world, country, and even among different school districts, one can assume that the educational needs of the students are different based on the differences in education they receive. Given the
literature, SHE programs should be diverse, flexible education approaches, noting that a “one-size fits all” approach does not fit all youth.

2.6 Listening to the Voices

2.6.1 Students and SHE. Numerous studies have been conducted focusing on what students feel their SHE needs are. Using both quantitative and qualitative techniques researchers have gathered in-depth, rich information about the subject. Byers et al., (2003) conducted a survey of high schools assessing student SHE needs and the perception of the quality of SHE they were receiving. The study concluded that students wanted a comprehensive SHE curriculum or course that covered a broad range of topics about sexual health. Furthermore, the majority of students requested more “controversial topics” (e.g. masturbation and homosexuality) to be included in the curriculum, with topics of most interest to them not being covered through school education (Byers et al., 2003).

SHE curriculums are often built on factual information with emphasis on potential negative outcomes such as STI’s and teenage pregnancy with little time spent on positive aspects of sexual health such as sexual pleasure (Causarano, Pole & Flicker, 2010; Forrest et al., 2004). Furthermore, the students concluded their education held little time for discussion about sexual feelings, emotions and relationships (Bourton, 2006; Forrest et al., 2004; O’Higgins & Gabhhaınn, 2010). The Byers et al. (2003) study, conducted in New Brunswick, Canada, also found that students felt their SHE needs were not being met with only 13% of students rating the quality of SHE they had received as good or excellent, with 55% stating their SHE through school as fair or poor. This coincides with
findings from Attridge (2011) suggesting students are leaving school with inadequate SHE.

Another common discovery in research was that students are receiving education on certain topics too late (Bourton, 2006; Meaney, Rye, Wood, & Solovieva, 2009; O’Higgins & Gabhhainn, 2010). Students felt that if they had received SHE education sooner, they would have been less inclined to experiment sexually, and the idea that being given limited information was more likely to increase their curiosity (Bourton, 2006). Meaney et al., (2009) assessed university students satisfaction with exposure to SHE topics. Comparing the time they learned about a specific topic to the preferred time to which they would have liked to learn about it, it was found that over half of the topics participants reported learning about in grades 9-12, they would have preferred earlier exposure in grade 6-8. Some of these topics included “birth control methods and safer sex practices”, “teenage pregnancy/parenting” and “sexual decision making”. This was reiterated by O’Higgins and Gabhhainn (2010) who concluded participants wanted regular, continuous, valued and integrated SHE delivered to younger students. Unfortunately, researchers in the study did not define the age of “younger”. The data gathered by multiple studies further shows that young people desire more knowledge about SHE, and that including the young population in policy and curriculum development can lead to more effective SHE programs.

In 2013, a fifth BC Adolescent Health survey was completed by almost 30,000 students across BC from grades 7-12. Students made suggestions for improvement of sexual health, with the findings suggesting “students felt that more accurate sexual health information would be obtained from teachers, parents, and other adults but reported that
they got most of their information from their peers. They were aware that peers may not give accurate information, but it was often the only source they felt comfortable accessing” (McCreary Center Society, 2015, p. 56). In addition participants expressed that sex education focused too much on mechanics of sex and not enough on STI prevention, contraception and sexual assault (McCreary Center Society, 2015).

2.6.2 Parents and SHE. Parental support of SHE programming is an important factor in providing effective SHE to youth. Pressures from parents to schools about SHE curriculum affects what is being taught in the classroom (Cohen, Byers, Sears & Weaver, 2001). Because parents have the ability to influence SHE programming, Weaver et al., (2002) completed a large scale study where 4,206 parents completed surveys assessing their attitudes towards SHE at school and home. Weaver et al. (2002) found that 94% of parents either agreed or strongly agreed that SHE should be provided by the school. This is consistent with the findings from McKay et al. (1998), suggesting that while school educators may fear teaching SHE curricula because of parental pressures, the majority of parents support SHE in the classroom. While it is becoming widely recognized that parents want SHE taught in the classroom, there is no clear consensus to when certain topics should be covered, or about the inclusion of more controversial topics such as sexual orientation and masturbation (Saskatchewan Prevention Institute, 2011; Weaver et al., 2002). However, Weaver et al. (2002) concluded that parents showed support for a comprehensive SHE curriculum, identifying a wide range of essential topics, including the more controversial themes.

Regarding SHE at home, parents identify that they would like to participate in teaching their children SHE, however few are actively doing so (Saskatchewan
Prevention Institute, 2011; Weaver et al., 2002). This is parallel with findings from a student participant survey, where only 36% of students rated their parents as doing an excellent or very good job at providing them with SHE and additionally, 80% of students stated that their parents rarely encouraged them to ask question regarding sexuality (Byers et al., 2003). These statistics are troublesome as parent-led discussions about sexual health allow parent(s) to discuss sexual health in a manner that is consistent with their family values (Jaccard, Dodge & Dittus, 2002). Family values may also have a negative impact on young peoples’ SHE as parents may solely discuss sexual health topics that correspond with their values such as abstinence and puberty, refraining from discussion about other important areas of sexual health such as contraception and STI’s (Saskatchewan Prevention Institute, 2011). The Saskatchewan Prevention Institute (2011) proposes meaningful approaches in engaging in effective parent-adolescent sexual health communication stating that communication about sexual health needs to be made a priority. For the communication to be effective it must be frequent, honest, open, and based on accurate information. The evidence speaks for itself, whether at school or home, communication about sexual health is necessary in helping youth to make healthy sexual health decisions in their lives.

2.6.3 Teachers and SHE. In Canada, it is widely known that within the school system teachers are most often the professionals teaching SHE to their students. Most teachers assigned to teach SHE acquire the necessary knowledge and skills on the job through in-service training or self-education (Fisher, Maticka-Tyndale & Barrett, 2001). Because teachers are the main source of education, thus influencing students experiences, it is important to provide adequate SHE to youth within the school curriculum. Dodds
(2011) explains that while a school may implement an excellent SHE curriculum, the teacher’s individual deliverance of the program affects its success. Furthermore, as discussed earlier in this paper, there are inconsistencies in the deliverance of SHE programs within Canada, provinces and school divisions, therefore one can assume that individual teachers’ instructional strategy for delivering the SHE curriculum differs from school to school affecting a student’s experience with SHE. Results from one study assessing what teachers ranked as their objectives in sex education to be in 1996 and 2006 found similar results, with teachers considering the most important objective to be educating students to act responsibly and to provide them with correct sexual facts (Kontula, 2010). According to a number of studies the level of comfort teachers have in teaching sexual education appears to differ greatly. Some studies have concluded, like findings with parents, teachers are more willing to educate students on “safer” topics such as those related to anatomy and physical development, and less likely to educate on “controversial” topics such as birth control, masturbation etc. (Cohen et al., 2001; Weaver et al., 2002). Weaver et al. (2001) explains this may be because teachers feel they have more knowledge about biological aspects and are more comfortable speaking about them. However, a study by Kontula (2010) found the opposite, stating that 4/5th of the teachers he studied considered it “easy” to talk about sexual issues with their students, as well as almost half of the teachers reported using personal life experiences in their teaching. It must be noted that this study was conducted in Finland, where social norms and the view of sexual health differs from Canada, and one-third of the participants had participated in further sex education training before the study (Kontula, 2010).
Canadian Guidelines for Sexual Health Education suggests mandated professional requirements for those who teach SHE, however a study assessing the effectiveness of SHE in British Columbia found that educators were not aware of any requirements. Furthermore, one participant stated that while she had received extra training she was aware that two co-workers who taught SHE had not received any additional training (Options for Sexual Health, 2004). Fisher et al. (2001) explains that many school boards rely on local sexual health community specialists and Planned Parenthood for expertise and resources.

When asking students what they felt should be required skills of someone teaching SHE, they suggested an educator who is confident, can relate to young people, and can comfortably discuss sex without being embarrassed (Bourton, 2006). Results from a study aimed at gathering high school students’ experiences found that 59% of students felt their teacher was either pretty comfortable or very comfortable teaching sex education, with 40% of students feeling that their teacher answered their questions very well or excellently (Byers et al., 2003). The inconsistency among students and their view of teachers as effective sex educators are highlighted in a qualitative study where participants voiced their need for educators who are expert, confident and trustworthy, and expressed difficulty in learning from a teacher who was embarrassed. Many reiterated the impact guest speakers made on them, and the impact of real-life stories (O’Higgins & Gabhainn, 2010). Seeing that teachers are the main resource students rely on for SHE in schools, the education system and government needs to equip teachers with the necessary confidence, skills and political education to overcome SHE barriers and deal with challenges associated with SHE (Hirst, 2004; PHAC, 2008). Currently in
Canada, teachers are the professionals teaching SHE to students following curriculum guidelines set out by the school division, which will be discussed in a following section of this paper.

2.7 Effective SHE Programs

Today, the question is not whether SHE is necessary, but understanding the most effective model that will create behavior change in adolescents resulting in a decrease of negative health outcomes, while increasing positive health outcomes. Maticka-Tyndale (2008) expresses the challenges developing policy and programs in Canada as it is strongly influenced by the United States, despite distinct differences in demographics, sexual health attitudes and sexual health outcomes. Furthermore she suggests looking at other countries that have a strong record of sexual health such as Western Europe (Maticka-Tyndale, 2008). Typically, in Western Europe SHE is based on the assumption and acceptance that adolescents and young adults will engage in sexual activity prior to marriage. Programs are founded on values of responsibility, integrity, and respect for self and others. In contrast, the United States SHE programming through schools is focused on an abstinence until marriage view with parental approval required for certain health services (Maticka-Tyndale, 2008). Different countries have various approaches to the SHE program, but Canada is a unique place with its own needs based on its own population.

Canada has taken steps, creating a framework for improving the sexual health among residents through the creation of Canadian Guidelines for Sexual Health Education (PHAC, 2003; 2008). The aim is to unite and guide individuals working in the area of SHE and health promotion, with emphasis on those working on policy planning,
curriculum and program developers (PHAC, 2003). The framework reiterates the idea that effective SHE needs to be provided on an age appropriate, culturally sensitive manner that respects sexual diversity (PHAC, 2008).

Recent research has concluded that the most effective SHE integrates understanding, motivation and skill-building within the program. The Canadian Guidelines for SHE has embraced this research (PHAC, 2003; 2008; SIECCAN, 2009). This corresponds with the suggestion that effective SHE programming requires access to broadly based sexual education (Boyce et al., 2003; SIECCAN, 2009). Broadly based SHE provides individuals with a deep understanding of sexual health in relation to their needs; the confidence, motivation and insight to act on the acquired knowledge; and skills required to increase positive sexual health outcomes, and decrease negative outcomes (PHAC, 2008). To create this environment, effective school programs need classroom time allocated to the subject with teachers who are trained and confident to teach the subject matter (Hirst, 2004; SIECCAN, 2009). Byers et al. (2017) found that university students retrospectively looking back at their SHE education from high school rated the quality of the SHE they received more highly if extensive topics were covered, the topics were of interest to them and teachers used more methods in deliverance of the program.

Kirby et al. (1994), PHAC (2008) and SIECCAN (2009) express the need for effective programs to be based on teaching methods that have utilized well-tested theoretical models, for example the Social Cognitive Theory, Transtheoretical Model, Theory of Reasoned Action & Theory of Planned Behavior, and Information, Motivation and Behavioral Skills (IMB) Model. Specifically, the IMB model expresses that in order to have effective sexual health interventions three elements need to be present;
information needs to be provided that is relevant to the needs of the individual, information needs to address the motivational factors that drive the behavior change and lastly, teaches behavior skills that are needed to effectively achieve positive sexual health outcomes (McKay, 2001).

In 2007, the United States published “Emerging Answers”, part of a national campaign that worked to disseminate the latest research on teen pregnancy that provided clear implications for policy programs and parents. The author, Dr. Douglas Kirby, an American researcher has outlined 17 characteristics of effective curriculum. Based on the analysis of differing SHE programs in the United States, Kirby found 17 characteristics fall into three categories; the development of the curriculum, content of the curriculum and implementation of the curriculum. It was found that nearly all effective programs encompassed these characteristics with randomized trials demonstrating that programs with these characteristics were more likely to be effective than those without them (Kirby, 2007). Through the creation of the documents mentioned above, program planners, policy-makers, and individuals in situations of authority and power have resources available to assist in providing the best possible SHE for youth.

While research is positive, there is inconsistency of effective programs being implemented throughout Canadian high schools. The Canadian Guidelines for Sexual Health recommend SHE programs be based on a needs assessment that includes the community, with regular evaluations based on program objectives (PHAC, 2008). Although, an in-depth study in British Columbia found that participants were inconsistent in their opinions if this was taking place. Parents and students stated they would like to
be consulted more with all stakeholders in the study (students, educators, parents, public health workers) agreeing that broader assessment and regular evaluation with planning and revision should be utilized to improve programs (Options for Sexual Health, 2004).

2.8 Saskatchewan and SHE

While there is a large body of literature and studies in Canada on the topic of sexual health and SHE among young people, studies have been conducted at a national level or limited to a certain region or province, with research in Saskatchewan being very limited. This is troublesome because STI and teenage pregnancy rates in Saskatchewan are among some of the highest in the country (PHAC, 2010; PHAC, 2014). It was previously noted that in Canada highest rates of the reported STI’s gonorrhea and chlamydia were in young people under the age of 30 (PHAC, 2010). Further, national statistics from 2008 show that besides the Territories and Manitoba, Saskatchewan has the greatest reported rates of Chlamydia per 100,000 people at 512.1/100,000 (PHAC, 2010). In 2014 rates increased to 516.0 per 100,000 people putting Saskatchewan the highest province behind the territories. Similarly, reported cases of gonorrhea in Saskatchewan per 100,000 people in 2008 is 131.3/100,000 which is second highest of all of the provinces, again following Manitoba and the Territories (PHAC, 2010). In 2014, Rates in Saskatchewan for Gonorrhea decreased to 110.2 per 100,000 people but was still above the national average and put Saskatchewan as the highest province, just behind the territories. The Public Health Agency of Canada (2008) has also reported that Saskatchewan has the highest rates in Canada of HIV of 20.8/100,000, which is twice the national average of 9.3/100,000. However, it must be noted that the transmission of HIV in Saskatchewan is
different from the rest of Canada with highest reported rates of transmission through injection drug use and not sexual activity (Saskatchewan Ministry of Health, 2010).

Similarly, unplanned pregnancy is also an issue is Saskatchewan. While Statistics Canada (2012) explains that there has been an overall decline in teenage pregnancy rates in the last quarter century, teenage pregnancy rates still tend to be higher in the north and the prairie provinces. According to Statistics Canada, in 1997 teenage pregnancy rates in Saskatchewan were among highest in the country following behind Manitoba and the northern territories (Statistics Canada, 2012). Furthermore, in 2014 the Saskatchewan Prevention Agency reported adolescent pregnancy in Saskatchewan among the highest in the country. According to the Institute, between 2005 and 2010 the average adolescent pregnancy rate for 15 to 19 year olds in Saskatchewan was 45.9 per 1,000, compared to 29.3 per 1,000 across Canada (The Saskatchewan Prevention Institute, 2014).

There are 27 school divisions in Saskatchewan, offering kindergarten to grade 12. This includes eighteen public school divisions, eight separate school divisions and one francophone school division, with high school commonly from grade 9 to 12 (Government of Saskatchewan, 2018). While each division offers unique schooling to their students, the Saskatchewan Ministry of Education (n.d.) outlines the mandated curricula that all students throughout the province are taught. High school curricula include education about sexual health, and the Saskatchewan curricula incorporates SHE education into classes such as Health Education 9, Wellness 10, and for separate school students; Christian Ethics classes (Ministry of Education, n.d.). The Ministry of Education states that the Saskatchewan health education curricula aims “to develop confident and competent students who understand, appreciate, and apply health
knowledge, skills, and strategies throughout life” (2009, p. 4). The curricula does not provide detail on specifically what subjects on the topic of SHE are taught in high school, and below is an example of a health nine course outcomes list from The Ministry of Education that includes SHE:

Design, implement, and evaluate three eight-day action plans that demonstrate responsible health promotion related to comprehensive approaches to safety, non-curable infections/diseases, romantic relationships, healthy food policies, addictions, tragic death and suicide, chronic illness, and sexual health.

a. Discuss the elements of effective action planning for health promotion.
b. Plan the required steps to complete the health promotion action plans.
c. Distinguish and use criteria to assess the design elements of health promotion action plans.
d. Develop and use criteria to evaluate the implementation of health promotion action plans.
e. Recognize and establish the supports necessary to implement the health promotion action plans.
f. Apply the steps necessary to achieve self-selected health-enhancing goals.

(Health 9 Curriculum, Ministry of Education, 2009)

It must be noted that SHE in Saskatchewan begins much before high school, with a majority of sexuality education being completed in elementary school, and grade nine (Ministry of Education, 2009), and is taught prior to puberty beginning. This leads one to inquire if SHE should be included in the curriculum in grades ten through twelve. A study conducted by Byers, Hamilton and Fisher (2017) with participants from New Brunswick, Nova Scotia and Ontario reported that almost all participants reported receiving SHE in middle school, but approximately a quarter had not received SHE in high school. This finding should be kept in mind while reviewing the current study because while participants were asked about their memories from high school, this does not mean participants were not also recalling information from elementary school.
Education in Saskatchewan follows the Comprehensive School Health (CSH) approach, which addresses school health in a holistic, planned and integrated way to support student wellbeing, involving the school community and not just the classroom (Joint Consortium for School Health, 2018). Page nine of this paper further explores the concept of sexuality education and CSH. The Saskatchewan Ministry of Education (2015) expresses that education is founded on the respect for diversity of all students including those with gender and sexual diversity. The document *Deepening the Discussion: Gender and Sexual Diversity* is available to assist one to understand the unique education, health and safety needs of students and staff alike who self identify as gender and sexually diverse (Saskatchewan Ministry of Education, 2015). The Ministry of Education outlines the approach of Comprehensive School Community Health:

- Recognizing that young people who are healthy and feel safe learn better and achieve more;
- Understands that schools can directly influence students’ health, safety, attitudes and behaviours;
- Encourages healthy and safe choices while promoting students’ health, safety and well-being;
- Incorporates health and safety into all aspects of school and learning;
- Links health and education issues and systems; and,
- Needs the participation and support of families and the community at large

(Saskatchewan Ministry of Health, 2015)

Byers et al. (2003) stated that in Canada there is variance among what curriculums are being taught, with differing topics being covered. This changing delivery of SHE programming is not only seen throughout provinces, but within school districts
(Options for Sexual Health, 2004). This variation may also be happening in Saskatchewan high schools, as there is no evidence to the contrary. More research needs to be conducted in Saskatchewan for more conclusive answers to be made. Byers et al. (2017) further explain that although the government has standards recommended for SHE, educational outcomes and health curricula are provided through the provincial government, thus SHE is not constant across the country.

CHAPTER THREE: RESEARCH METHOD

3.1 Qualitative Research

A qualitative approach was used in this study to understand the experiences of high school students in relation to their SHE. Hearing their stories told through their words provides an authentic and in-depth look into their experiences (Marshall & Rossman, 2011).

The qualitative approach is a broad based approach to studying social phenomena that occurs in the natural setting, helping one understand and find new insight into phenomena (Marshall & Rossman, 2011). It is a method that assumes the world is made up of multiple realities, socially constructed by the views of differing individuals at the same time. A qualitative researcher is often immersed in their study, seeking to understand situations and events from the view of the participants (Fraenkel, Wallen & Hyun, 2012). Utilizing the qualitative approach allowed me to foster an environment that was safe, open and trusting in order to gain a good look into participant experiences with SHE from high school. Studies have found that having individual, young participant voices heard through testimonials, stories and real life experiences expressed through qualitative research has the power to influence policy about adolescent sexuality
(Tolman, Hirschman & Empett, 2005). In addition, SHE in adolescents can be considered a “sensitive topic” as it involves personal matters at an age in which youth are at a vulnerable state in their life. Morris (1991) explains that when studying sexual health topics with the younger population, qualitative research may be the best route as quantitative research cannot capture the complexity, questions, as well as meaning, or lived values of an individual, which is an important part of understanding sexual education.

3.2 Appreciative Inquiry (AI)

3.2.1. What is AI? I conducted the research study using the Appreciative Inquiry (AI) method. AI is a method that offers a positive, strength-based approach to the phenomenon one is studying, in this case research on SHE. AI looks for what is “going right” and moves towards it, accepting that the world is complex and subjective (Cooperrider & Whitney, 2005). AI has many truths and ways to reach a goal and believes language is a creator of reality (Watkins, Mohr & Kelly, 2011). This method stems from its central parents David Cooperrider and Suresh Srivastva of Case Western Reserve University in the 1980’s. It began as a change process for enabling transformational shifts within an organization (Watkins et al., 2011) based on the premise that an organization will change in the way that they inquire. Therefore, an organization that inquires into its problems will continue to find problems, but an organization that inquires into itself will discover more that is good, working towards the best becoming a commonality (Cooperrider & Whitney, 2005). AI stresses that its process will look different in every setting, emphasizing that it is a continually evolving method that will continue to change overtime (Watkins et al., 2011). While the process of AI cannot be
clearly defined, operational definitions have been outlined explaining the core of AI. Cooperrider and Whitney (2005) define the word appreciative as: “Appreciate is to Value; the act of recognizing the best in people or the world around us; affirming past and present strengths, successes, and potentials; to perceive those things that give life (health, vitality, excellence) to living systems. To increase in value, e.g., the economy has appreciated in value. Synonyms: value, prize, esteem, and honor.” (p. 2). Secondly, they define inquire as the act of exploration and discovery. It means to ask questions; to be open to seeing new potentials and possibilities. Synonyms: discover, search, systematically explore, and study (Cooperrider & Whitney, 2005, p.2). Given this, I found AI as the best approach to answer my research question.

3.2.2 The process of AI. The AI process begins with individuals sharing stories about positive experiences. For example, they dialogue about past and present achievements, assets, unexplored potentials, innovations, strengths, opportunities, and high point moments. This creates a “positive core”, which then relates directly to a changed agenda, creating energy towards a new dream (Cooperrider et al., 2008). Cooperrider et al., (2008) explains that once stories have been dialoged that are of a “life-giving force”, themes are generated from the shared stories. Topics are selected for further inquiry, then shared images of the preferred future are created and innovative ways in which these ideas can be made into reality are discovered. This process is known as the DNA of AI (Cooperrider, Whitney & Stravros, 2008).

Traditionally, change begins with defining a problem, then using problem-solving approaches to create change. AI argues this results in a slow process, looking backwards and not forwards, all while creating defensiveness among members (Cooperrider &
Contrasting this traditional method, AI does just the opposite by focusing on the positive of an organization. Instead of negation, criticism, and diagnosis, there is discovering, dream and design (Cooper & Whitney, 2005). Simply stated, AI makes a conscious choice to study the best of an organization or situation, assuming that there is something that is working well, and that strength can be a starting point for creating positive change (Cooperrider et al., 2008). Figure 1.0 shows the differing approaches to creating change versus the traditional problem solving method by Cooperrider and Whitney (2005).

Figure 1.

**Appreciate Inquiry Approach**

<table>
<thead>
<tr>
<th>Paradigm 1: Problem Solving</th>
<th>Paradigm 2: Appreciative Inquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Felt Need&quot;</td>
<td>Appreciating</td>
</tr>
<tr>
<td>Identification of Problem</td>
<td>&quot;Valuing the Best of What Is&quot;</td>
</tr>
<tr>
<td>Analysis of Causes</td>
<td>Envisioning</td>
</tr>
<tr>
<td>Analysis of Possible Solutions</td>
<td>&quot;What Might Be&quot;</td>
</tr>
<tr>
<td>Action Planning</td>
<td>Disclosing</td>
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<tr>
<td>(Treatment)</td>
<td></td>
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</table>

(From Cooperrider & Whitney, 2005, p.13)

When one utilizes the AI method, they most often follow the 4D Cycle that was created to meet the unique challenges of the organization involved (Cooperrider et al., 2008). The first D is discovery. This stage involves appreciative interviewing where every question is positive. Through inquiry people discover what gives life to their organization, department or community when it is at its best. In this stage, highpoints, values, and the root causes of success are discovered, as well as shared hopes and dreams.
for the future (Cooperrider & Whitney, 2005). Secondly, participants dream; after “what is” has been identified, “what might be” is discovered. This stage involves creating a positive image of the best possible future (Cooperrider et al., 2008). During this discovery phase key themes are outlined from times when the organization, system or community is at its best, creating a shared image of what they would like the future to be in which the best of the organization is the norm (Cooperrider & Whitney, 2005).

Thirdly, participants design proposals for the ideal organization by developing innovative ways to create a preferred future. More specifically, participants create a clear purpose, as well principals that are more than a vision; an inspiring statement of intention of what has worked in the past with new ideas for the future (Cooperrider et al., 2008). Lastly, destiny is to take place when the organization lives the purposes and principles they previously created, working towards sustaining an ongoing positive change and increasing the success of the organization (Cooperrider & Whitney, 2005).

**3.2.3. AI and the research study.** I chose to use this method for my research study because it has the ability to shed a new light on the topic of SHE with high school students. Research in Saskatchewan is limited in the area of SHE with high school students in comparison to other provinces and countries. Furthermore, studies conducted appear to take a more traditional approach to problem solving and change by identifying the problem and developing methods to fix it. To address this gap I used the AI method and as Hammond (2013) explains, “AI touches something important and positive and people respond” (p.47). The research study focused on discovery and dream, the first two D’s of the AI 4D Cycle. Specifically, this research focused on the discovery of
participants’ experiences, and secondly, a dream of what an ideal SHE future in high school.

3.3 Procedure and Data Collection

Data was collected through KHS 170 Lifestyle, Health and Wellness Course at the University of Regina. The professor and instructor of the class agreed to let me collect data from a class assignment (from individuals who have consented to participate) and recruit participants from the class. The study was conducted in two parts.

3.3.1 Online discussion forum. Part A data was collected through KHS 170 class online discussion forum via URCourses. All students in the class participated in an online discussion forum throughout the semester as an assignment for the class. The instructor of the class posed questions related to what is being taught in the class and students would answer and create discussion with fellow classmates. Students of the class were split into six discussion groups and only members of the specific group were able to see that particular group discussion. While there were many discussions throughout the semester, one of the discussion forums posed questions revolving around students experiences with SHE in high school (Appendix A). Students answered the posed questions provided by the instructor and responded to each other’s posts. Once the discussion forum had been closed, and marks assigned, I distributed the confidentiality and consent form (Appendix B) to the class after explaining my research project and asked students for consent to allow their assignment from the discussion forum on SHE be used for data in my research study. The consent form had a box that offers two choices; first, the student could check a box consenting that their answers may be used for the study, or secondly the student can check no, they do not wish for their data to be
used. I collected the forms that had been filled out. Any student who filled out the form, regardless of response, received a bonus mark of 1%, ensuring the professor of the class did not know who had consented to the project. I then collected the data from the closed discussion forums from those who gave consent, using numbers and pseudonyms to ensure anonymity. A copy of the confidentiality and consent form was also posted on the URCourses KHS 170 website so students could view it online. This form had my contact information providing opportunity for students to ask questions, as well as follow up with the study.

3.3.2 One-on-one interviews. Part B of the data collection method was conducted using one-on-one semi-structured interviews. This method was chosen because of its ability to create a trusting environment, exploring experiences from the participant’s point of view (Marshall & Rossman, 2011). By using this method I worked towards uncovering the participant’s perspective of the phenomenon of interest as he or she views it, not how I view it (Marshall & Rossman, 2011). The interview as a data collection method has been a popular choice when studying the subject matter of SHE and adolescents (Bourton, 2006; Hirst, 2004; Jones, 2010; Lesta et al., 2008; Potsonen & Kontula, 1999). Lesta and colleagues (2008) describe their reasoning for choosing in-depth interview design for the topic of SHE as an “attempt to create a trusting, relaxed, comfortable environment that would allow the participants to express themselves freely and encourage deep inner perceptions, beliefs, attitudes and motivations to surface” (p. 238). This reasoning was built on the idea that the aim of the research was exploratory and based around a topic of sensitive nature (Lesta et al., 2008). Jones (2010) employed an interview technique that had minimal structure, open-ended and probing questions that
explored pregnant adolescents perceptions of school-based sexuality education. This design fostered trust and freedom of expression that did not suppress the participants’ stories and allowed for thick descriptions of their realities to be expressed (Jones, 2010). This coincides with Marshall and Rossman's (2011) view on qualitative research, stating that the interview should unfold the phenomenon as the participant views it, with the interviewer conveying an attitude that the participant’s views are valuable and useful.

Following suggestions from previously conducted studies on similar subject matter, interview questions were adapted from Michael (2005) following the AI framework, posing questions from a positive perspective. The Part B interview guide was created involving the data that was analysis from Part A of the data collection. Using a semi-structured interview guide with both open and closed questions, experiences were uncovered ensuring the participants perspective is intact. The interview guide was set up first to first seek more detail on participant’s experiences and second to explore participants’ thoughts on an ideal SHE curriculum.

Students were recruited for Part B of the study through an email sent from my URCourse account (Appendix C). Individuals who had wished to participate contacted me back via the course email or my personal email. Criteria to participate in the study was the same as previously stated. Interviews were audiotaped and recorded for transcribing purposes. Once the interviews were transcribed, transcripts were provided to each participant and he or she had the opportunity to review, and make changes for up to one week after they have received there transcribed interview. If no changes were made within that time frame, the data were used for the data analysis phase.
3.3.3 Reflective journal. Throughout the entire research process I kept a journal that gathered both reflective and descriptive information. I recorded my own thoughts, feelings, questions and ideas about my situation, as well as information about the setting, and any actions and/or behaviors I observed while data was collected. It also served as a timeline for the entire research process. This reflective practice may help readers see the nature of research outcomes, based on choices the researcher made during the research process. Ortlipp (2008) explains that this self-reflection is vital to the research process because of its ability to alter the research design, methods used, approaches taken, and can point out the messiness of research to the researcher who than can point it out to the readers, increasing trustworthiness of the research. The reflective process allowed me to reflect on all aspects of my experiences as a novice researcher, gaining a deeper understanding of the entire research process.

3.4 Data Analysis

Part A’s data collection was analyzed first to assist in development of the interview guide for part B. Because this was an exploratory study, inductive analysis was used which discovers patterns, themes and categories through the data (Marshall & Rossman, 2011). Data from Part A and Part B were both analyzed in a similar fashion that will be discussed later on in this paper. I also conducted a similar process with the reflective journal from the data collection process. It is important to note that I also looked for “outlying data” or alternative meaning to the data, challenging the patterns I found and looking for other explanations. Marshall and Rossman (2011) explain this importance, stating that alternative explanations always exist, and a researcher needs to identify them and demonstrate how the chosen explanation is most plausible.
3.5 Reflexivity

Reflexivity is a process in which researchers reflect on their identity including their personal belief systems, perspectives, personal assumptions, and goals, bringing the unconscious into consciousness, forcing the researcher and the reader to view how his or her experiences not only led to the research at hand, but affect the whole process (Ortlipp, 2008). Ortlipp (2008) explains that instead of controlling and limiting a researcher’s values, this approach acknowledges these values. Understanding who I am was an important part of conducting my qualitative research project. I am a white, young, educated professional working as a registered nurse. I grew up in a two-parent family in the middle-class of an average-sized urban setting, attending both an elementary and high school in the Catholic school system. It is also important to note I grew up in a setting where health and physical activity were important parts of my extracurricular life. It is important for me to reflect on my self-location as who I am has the ability to influence not only how I set up my research design, but my data collection and data-analysis as well. Having attended Catholic school, I realize that my SHE education may be very different from an individual who attended public school. Having grown up white in an urban setting with two parents who had a stable socio-economic status may have put me at an advantage to obtain the sexual health information I needed compared to some of the participants in this project.

According to the research, being from a rural setting, Aboriginal, low socio-economic status and being from a single family home may put an individual at higher risk for sexual risk taking (Maticka-Tyndale, 2008). It was important for me to locate myself in relation to participants who may have grown up under different social structures and
with differing views and how their life history has affected their sexual health and SHE.

My age also had the potential to influence the outcome of my study in relation to how the participants communicated with me. Being younger, did participants feel I was more relatable because of closeness in age, and open up and talk to me? Or did they take me less seriously because they feel I am younger? These were all what ifs, and ensuring I communicated with participants in a professional, but relatable manner was important. Participants were aware that I was a registered nurse, interested in health research. Nurses are widely considered trusting in public opinion, and I felt sharing that I am nurse increased the trust with participants. Furthermore, participants involved in this study were interested in the health field, potentially creating a common ground between researcher and participant. Keeping a reflective journal throughout the research process allowed me to follow my own growth as a researcher and interviewer that cannot be viewed through transcription or data alone (Ortlipp, 2008).

3.6 Ethical Considerations

Ethics in research should be at the forefront of a researchers’ mind throughout the entirety of the research process. Ethics refers to a question of what is right and wrong (Fraenkel et al., 2012). While it sounds like a relatively simple concept, it can become quite complex within the realm of research. To ensure a researcher carries out his or her project in the most ethically sound way, he or she has the fundamental responsibility to do all in his or her power to ensure respect, concern for the dignity, and welfare of the people who participate in the study, protecting them from any physical or psychological harm, discomfort or danger (Fraenkel et al., 2012). Furthermore, Marshall and Rossman (2011) express that the practice of ethical research is central to the trustworthiness of
study. This notion of trustworthiness or goodness of research is one of the researcher’s main aims when conducting any piece of research. Often the concept of ethics is reduced to procedural matters at the stage of gaining consent from ethics review boards. However, ethical considerations need to be reflected upon throughout every stage of a research study (Marshall & Rossman, 2011).

3.6.1 Ethics in SHE. To follow the above stated ethical concepts Marshall and Rossman (2011) express the need for researchers to focus on the relationships with participants, stakeholders and the larger community. Researchers need to be proactive and address potential ethical issues that may arise throughout their study at the proposal stage. The topic of researching SHE in high school students creates a few ethical concerns. High school students are typically 14-18 years old, while the World Health Organization [WHO] (2013) defines adolescents as individuals between the ages of 10-19 years old. Therefore this age group is at an age in which it is viewed as best practice to ask for parental/guardian consent to participate in a study. The WHO (2013) justifies conducting studies with adolescents on the topic of sexual health by expressing that by carrying out well-designed studies, information can be obtained that will enable the delivery of appropriate preventative and therapeutic services to this population group. In studies concerning sexual health of young people, requiring consent from parents may put them at risk if the parents are unaware and do not approve of their sexual orientation, or unaware of their sexual activity level (Chabot, Shoveller, Spencer & Johnson, 2012). It also has the possibility of silencing the voices of individuals who need it most (Flicker & Guta, 2008).

To avoid this ethical dilemma Meaney et al. (2009) took the route of recruiting
participants who were above the age of 18 through a first year university class. While this dismissed the potential ethical issues it created a limitation to the study. This limitation was the retrospective memory of the students; as time passed the possibility of ones recollections and perceptions held at the time of his or her SHE classes may differ from current perceptions (Meaney et al., 2009). To decrease the effect this limitation can have, one can recruit participants right out of high school who go straight to university, limiting the passage of time for possible perceptions to be changed. Based on this, I conducted the study within a well known first year university class that typically has students who have directly entered from high school and completing an undergraduate degree to decrease chances of retrospective memory.

3.6.2. Ethics and special populations. When researching SHE, there is a unique subgroup within the high school students. Here lies the gay, lesbian, bi-sexual and transgender or questioning (GLBTQ) population that researchers require specific research considerations. Extensive research in the USA has shown that youth who identify as GLBTQ are at a higher risk of psychological and physical assault and/or rejection by other students, co-workers, teachers, friends and family (Maticka-Tyndale, 2008). Conducting ethically correct research, specifically ensuring privacy, confidentiality and anonymity with these specific participants needs to be at the forefront of a researchers mind throughout the entirety of the study. They are a group of people whose voices need to be heard as studies have found that GLBTQ youth report high levels of distrust of health and social service providers, feeling they must mask their identities to receive better healthcare (Maticka-Tyndale, 2008; Mustanki, 2011). Developing trust with these participants, following ethical standards, justifying the benefit/cost ratio with research
ethics boards involving these individuals can give this special population group a voice, allowing their experiences to be heard. Researchers also need to take special consideration when working with population groups that live in rural communities and in places where there are higher concentrations of the Aboriginal population. Maticka-Tyndale (2008) explains that within these two groups of people geographical, social and economic factors interact to create environments in which youth may become sexually active at an earlier age, have earlier pregnancies, be victims of sexual abuse and be more susceptible to sexually transmitted infections. In rural communities there are higher proportions of people with lower-income, less than secondary education and exhibit less healthy behaviors than their urban counterparts (Canadian Population Health Initiative [CPHI], 2006). One study found that individuals receiving no sex education had some specific characteristics including residing in a rural community (Kohler, Manhart & Lafferty, 2008). These determinants of health are specific to rural areas and have the ability to affect ones sexual health. The CPHI (2006) also expresses that while rural communities see the importance of health promotion and disease prevention, strategies are often developed for larger urban communities and it is unknown if these strategies are effective in the rural communities.

While the participants in my study were in university and no longer in high school I needed to be sensitive to the fact that some of the participants may have been members of the populations mentioned above or experienced a negative health outcome related to sexual health. I needed to remain mindful of the specific ethics involved in every step of the research process. As a researcher it is a fundamental responsibility to ensure self-accountability, and one must uphold ethical standards that may be unique to a researchers
particular study and situation. Being respectful was of utmost importance while I interviewed participants and being mindful that each participant may have his or her own worldview that differ from my own. Participants from rural settings provided a unique perspective, with SHE being a more complex than my experience or others. These participants explained their struggle with trust as often the teachers, administrators, nurses, and pharmacists knew the participants and their family on personal levels in the community. I made sure their voices were observed and listened to, as this unique rural experience was included in my research and further discussed later in this paper.

3.7 Trustworthiness of Qualitative

Trustworthiness of qualitative research is viewed alternatively from the traditional validity and reliability concepts utilized in quantitative research and by positivists (Shenton, 2004). The trustworthiness of a study increases if the researcher is able to build a trusting relationship with participants, if the study is conducted and reported ethically, and there is a mix of people, processes, and structure (Marshall & Rossman, 2006). Lincoln and Guba (1985) proposed criteria for researchers to use to enhance and ensure trustworthiness of a qualitative study. These criteria include credibility, transferability, dependability and confirmability in place of the quantitative internal validity, external validity, reliability and objectivity (Lincoln & Guba, 1985).

Credibility, known as the “truth value” of the data (Lincoln & Guba, 1985) refers to how congruent findings are with reality (Shenton, 2004). To increase a study’s credibility, one must have prolonged engagement in the study and triangulation (Lincoln & Guba, 1985; Shenton, 2004). Shenton (2004) also suggests that researchers utilize research methods that have been successful in comparable projects and become familiar
with the organization and/or participants before the study starts. To facilitate credibility, I designed and carried out the study in the following ways:

- I met saturation while interviewing participants during my one-on-one interviews. This was noted in my reflection journal on June 12, 2014 after interview number seven. I wrote, “during today’s interview I noted that some words were sounding familiar as my participant was explaining her thoughts on SHE. The question box was brought up again” (p. 10). I noted the words open, comfortable, and not awkward were key words that almost every participant had mentioned during their interview. I felt that I was beginning to meet a level of saturation. I conducted two more interviews after this one to ensure saturation was met.

- I thoroughly researched other studies on the topic of sexual health, reviewing the different designs that were used, assessing and reflecting on which method would best gather the data with my participant pool.

- I reviewed the methods of research often utilized for SHE studies, researching the AI method, deciding to use this method for my study to provide a unique and differing perspective on the subject of SHE.

- I conducted a pilot study to gather preliminary findings that have helped guide my current research project.

- For the interview portion of the study, participants were provided with their transcript and invited to review and make changes to their interview to ensure their voice was heard as they intended.

- Triangulation refers to the use of different methods in hopes that the same
meaning will be expressed through differing approaches (Shenton, 2004), ensuring that the findings are a true representation of the participants’ views (Lincoln & Guba, 1985). By using different data collection methods, each method’s strengths will be enhanced and conversely limit each method’s weaknesses (Sherman, 2004). Triangulation was ensured in my study. Firstly, by completing a pilot study to help me understand the current state of SHE in Saskatchewan. This allowed me to focus on what my study's purpose would be. In addition, utilizing different data collection methods including an online discussion forum, one-on-one interviews, and a reflective journal. The discussion forum included data from 39 participants providing a varied and rich picture of experiences being shared. The eight one-on-one interviews gathered data that was more in-depth and holistic. Lastly, the reflective journal served as a tool for reflexivity throughout the project, helping me reflect on the purpose of the project along with my own thoughts and feelings to maintain an ethically sound study.

- I shared my data analysis with my supervisor to have a second set of eyes and different viewpoint working with the data.

Transferability refers to the extent in which findings will be useful in similar situations (Marshall & Rossman, 2006). To ensure transferability, the results must be understood within the context of particular characteristics of the study, therefore providing a thick description of the phenomenon being studied is invaluable, helping other researchers compare the data with their own situation (Shenton, 2004). Transferability was addressed in the study in the following ways:
• Participants provided context to their situation by expressing their age and the type of high school they went to in Saskatchewan. They also provided their age and interest in school. To ensure no one could be identified from the information pseudonyms were used, and no direct cities/towns or high schools were used. I also had the guidance from my supervisory committee to ensure anonymity and confidentiality is kept with participants.

• A rich description of Saskatchewan and information pertaining to the current state of SHE in the province was discussed to provide context to readers.

• I provided participant quotes as part of my research findings. This not only increases transferability of the study, but ensures the voices of my participants are being represented accurately throughout the study.

Dependability refers to when the researcher attempts to account for changing conditions in the phenomenon chosen for the study and changes in the design by having an increased understanding of the setting (Marshall & Rossman, 2006). This in-depth coverage allows readers to not only assess if the study relates to a similar situation, it allows one to assess the extent to which proper research practices were followed (Shenton, 2004). To ensure the study maintained a high level of dependability I did as follows:

• I kept a reflective journal where all aspects of the research process were recorded and reflected upon. Descriptive information involving information about the setting, timing of events, any participant interaction, as well as a reflection on my perceptions of the events.
• I kept in-depth notes on the process of analysis and reasoning’s for findings during the data analysis stage.

• I used multiple sources of data collection including an online discussion forum and one-on-one interviews, as well as journal. I reflected on increasing the depth of coverage of the phenomenon being studied.

Confirmability can be defined as how well the inquiry’s findings are supported by the data collected (Lincoln & Guba, 1985). The researcher must ask themselves if the study could be confirmed by another and if the interpretation of events would make sense to another (Marshall & Rossman, 2006). To ensure that the data collected was a true reflection of the participant’s views and not the researcher’s, I did the following:

• I developed a professional relationship with participants. There were no hidden agendas about the purpose of the study or why I was conducting it. It was known that I was interviewing the participants because I was interested in their stories related to the SHE they experienced. Participants could contact me easily through email or phone with any concerns or questions. I introduced myself in person to KHS 170 when recruiting participants, putting a face to my emails. In addition, I found that working as a bedside nurse enhanced my interview skills for the interview portion of my study. In nursing communication is a vital skill necessary in providing best possible care to patients, and I am required to conduct a health interview multiple times a day. While I am aware that this is not that same interviewing technique utilized in my study, it helped me prepare and become comfortable with interviewing and honing my skills as an active listener. It also helped me to develop an appropriate rapport with participants. SHE is a subject
individuals often find awkward or uncomfortable to talk about, so this trusting relationship was key to gathering data that is representative of the participants.

• I provided a detailed description of my values, beliefs and assumptions, reflecting on how my self location affects the study.

• I completed this study ethically, following appropriate informed consent processes and obtained University of Regina Ethics Board consent to conduct the study. Seidman (2013) express’ that it is a privilege to interview participants, and as an interviewer I have entered the lives of participants and they have entrusted me with a part of themselves. Therefore, I feel ethically it is only right that I do “good work” on behalf of my participants.

• I created triangulation through multiple sources of data collection.

• Throughout my research study I continually had the guidance and support from my supervisor. We had an open dialogue and she always had time to discuss any questions I had and provided invaluable advice and guidance on my thesis project, always providing feedback on any aspect of my study.

By taking the measures above, I worked to increase the trustworthiness of my study, build trusting relationships with my participants, and complete an ethically sound study in which future researchers, or stakeholders involved in SHE could be confident in utilizing in their own work.
CHAPTER FOUR: PRESENTING THE ANALYSED DATA

4.1 Part A: Online Discussion Forum

4.1.1 Part A and AI. The purpose of the study Part A: Online Discussion Forum’s was to explore students' experiences with SHE in high school using the AI method, specifically the discovery phase of the 4D cycle previously discussed. This discovery phase aims to appreciate and discover the best of “what is or was” (Cooperrider, Whitney & Stavros, 2003) and adapting this principle to my study; the best of what was students’ experiences in relation to their SHE in high school. The questions were posed within a group discussion forum, which allowed shared experiences to be exchanged, and conversation encouraged amongst participants. Specifically, two questions were asked of the participants (Appendix A). Question #1 explored participants experiences with SHE in high school, and question #2 was posed in a way that guided participants to explore positive experiences they had with SHE in high school, modeling the discovery phase of the 4D cycle by discovering the best of what was. Question #2 provided participants with the opportunity to talk about stories, assets, unexplored potentials, strengths, elevated thoughts, benchmarks, high point moments, and possible futures.

Through this positive inquiry involving stories and insights into participants' experiences, I also hoped to see possibilities of “what could be” or the beginnings of the dream phase of the AI’s 4D cycle. Cooperrider and Whitney (2005) explain that during the discovery phase appreciative inquiry draws one's eyes towards life where the interview stories and insights get put to use, and a future begins to form showing this outline of a new world. This is guided by the Principle of Simultaneity, which is central
to the AI theory. This principle is explained by Cooperrider and Whitney (2005):

*It is recognized that inquiry and change are not truly separate moments, but are simultaneous. Inquiry is intervention. The seeds of change—that is, the things people think and talk about, the things people discover and learn, and the things that inform dialogue and inspire images of the future—are implicit in the very first questions we ask. The questions we ask at this stage form what we “find”, and what we “discover” (the data) becomes the linguistic material, or stories, out of which the future is conceived, conversed about and constructed.* (p.7)

While I understood I was technically working within the discovery phase of the 4D cycle, I also reflected that I would be exploring the beginnings of the second phase or dream phase of the 4D cycle.

**4.1.2 Part A and self reflection.** Before I began the analytical stage of my study, I did what I called a “self-check” that was expressed through my reflective journal (2014). This reflective journal was an important piece of the study that not only increases the trustworthiness of a study, but also provides methods that increase creativity, critical thinking, differing techniques for analysis and new ways of discovery (Jasper, 2005). I wrote, “The discussion forums are closed today, meaning I can start gathering my data soon. I feel a little nervous. How does who I am affect this study? How would I have answered these questions if I had been in the class?” (p. 3). I wanted to make sure I was aware of who I was and how that would affect me as the researcher. Ortlipp (2008) explains this critical self-reflection allows one to consider the ethics involved in the power-knowledge relationship with the participants. Moreover, this reflexivity allowed me to identify any biases or prejudices I had on the subject, assess their influences on the
project, and make a decision about the appropriateness of their influence (Jasper, 2005). I concluded that I would have had a hard time expressing a positive experience with SHE in high school, and that most of the information that I gathered was from other sources such as friends and family. This belief can be explained by the fact that I went to a Catholic high school and it was an abstinence-based teaching model. In addition, topics involving SHE were barely touched on. I also reflected that I would have appreciated having a more in-depth education on the subject. This self-reflection allowed me to critically think and acknowledge that this was my experience and participants will have their own unique experiences that may likely vary greatly from mine. This critical self-reflection was not only important to the completion of my study, but throughout my masters program. My reflection journal will be shared throughout this paper, as it provided an important perspective on the data that was collected and reflection on me as a researcher.

4.1.3 Participant recruitment and data collection. KHS 170 had a total of 73 students. Of the 73 students, 47 completed consent forms, and of that group 39 consented to be participants in Part A of the study. As previously discussed, KHS 170 class was a University of Regina undergraduate class where the instructor had agreed to allow me to conduct my study. Part of the course consisted of students partaking in online discussion forums on URCourses. Each week the students answered questions the professor posed in the forum and responded to each other’s post about the topic, creating a discussion and dialogue among group members. In total there were six discussion forum groups and only members of each specific group could see their discussions. My study’s questions were posed to the class in forum six (Appendix A). Students participated in the
assignment forum like they normally would and once the forum was closed after the assigned due date, with marks assigned, I began recruiting participants for my study. I went to the class and spoke to the students about my study and invited them to participate. A recruitment and consent email was sent to the students URCourses email, and it was also posted on the URCourses website. Participants sent the consent form back to me through the course email or my personal email. My contact information was also provided for students who had any questions or concerns about the study. Students could check a box stating they consented to participate in the study or check a box stating no, they did not wish for their data to be used for the study. Either way, if a student sent the consent form in, they received a bonus 1% mark for KHS 170 class. The instructor did not know who specifically consented to be in the study. Of the 47 consent forms received, eight either did not consent to participate, they did not attend high school in Saskatchewan, or the consent form was filled out incorrectly and could not be used.

This study utilized a purposive sampling technique to recruit participants from KHS 170, an undergraduate course, with the instructor stating it often consists of first year university students. Therefore, it was assumed that this would minimize the time lapsed since high school for many of the participants. In addition, it was assumed that the students partaking in the health science course are interested in the health field. This was done to enhance individual’s interest and participation in the study. This purposeful sampling technique is widely utilized in qualitative research to gather in-depth information about the phenomenon of interest (Palinkas et al., 2015) thus choosing individuals who have knowledge or experience in the phenomenon of interest (Cresswell & Plano Clark, 2011).
4.1.4 Coding and theming. Once consent forms were received, I extracted all of the collected data from the online discussion forums and put them on Microsoft Word. I then printed the data from each discussion forum group, maintaining six separate forum groups to be analyzed. This was done so I could understand the discussion in chronological order. Bernard, Wutich and Ryan (2017) explain data as reductions of our experiences. In my specific case I needed to analyze my participants’ experiences with the SHE they received in high school. Following the analysis framework set out by Bernard and colleagues (2017), Creswell (2009), Seidman (2013) and Marshall and Rossman (2011), I began an inductive analysis of my data. Seidman (2013) explained the importance of beginning the analysis stage with an open attitude, allowing what is important to emerge through the text and no prior theory or hypothesis developed. Step one of the data analysis process consisted of reading the data. Reading and re-reading each participant's text allowed me to become very familiar with the data. I wanted to obtain a general sense of the information. There was already some words and phrases that jumped out at me. In my reflection journal (2014) I wrote, “As I was reading the forum posts for the third time I found words from participants already popping out at me. However I wanted to finish reading all the posts a few more times before going back and highlighting certain words, so I would pencil in notes in the margins expressing my thoughts as I read” (p. 5).

Step two of my data analysis consisted of developing codes and themes. In qualitative research Bernard et al. (2017) explains “looking for themes in written material typically involves pawing through texts and marking them up…” (p. 104). For me it began by highlighting. I would circle words or phrases that would stick out to me,
using different colours to decipher different thoughts. After going through my data
several times I found that the pink highlighted texts were similar in nature, while my
yellow highlighted text went together, and so on. Next, these highlighted words became
lists. I put topics or thoughts that seemed to go together on one list, while other words or
topics seemed to fit in a different category. I also created a list of outliers – words,
phrases or thoughts I found that didn’t seem to fit under any specific list. These lists
were created using pen and paper. I took words or sentences from the data and rewrote
them on separate pieces of paper under the categories I created. This process became the
“coding” process of my data analysis. Creswell (2009) describes this process as
organizing the material into chunks before bringing meaning to these chunks. Once I
created my lists I found that I could combine some lists together as they met similar
criteria, reducing my total list of categories. I would go back to my data, read again, use
highlighters and sticky-notes as my coding tools, and move chunks of data into lists they
fit under. I would search for commonalities, differences, and patterns. I would question
and reflect on the data. This process was anything but neat in nature, an organized mess
in my living room. My journal entry expressed this organized chaos:

> While analyzing my data today, I took a pause and looked around the room...
> there were piles of paper everywhere with highlighters, sticky notes, cut out
> papers throughout the room. But it all made sense and felt right. The data was
> coming together and the hours reading, coding, theming, and reflecting had
> created an analysis I feel represented my participants' experiences.

(Reflective Journal, 2014, p. 5)
4.1.5 Developed themes. After completing this labor-intensive practice, I began the next stage of my data analysis process; generating four themes that displayed differing perspectives of participants sexual health experiences in high school. The four themes were: (1) open and comfortable classrooms enhance SHE experiences, (2) teacher confidence and knowledge improves SHE experiences, (3) interactive and diverse teaching methods help students remember SHE and (4) meaningful content enriches students experiences with SHE.

Each of the four themes were found to be important parts of participants’ SHE in high school. Some students expressed they had positive experiences while others expressed they did not, but offered why it was not a good experience or what would have made it a better experience.

The chart below highlights the four major themes that emerged from the data. In Section 5.0 Discussing Emerging Themes, these categories will be discussed in more detail.

Chart 1.

*Emerging Themes (PART A)*
<table>
<thead>
<tr>
<th>Open and Comfortable Classrooms Enhance SHE Experiences</th>
<th>Teacher Confidence and Knowledge Improves SHE Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Comfortable atmosphere</td>
<td>- Open</td>
</tr>
<tr>
<td>- Trusting</td>
<td>- Confident</td>
</tr>
<tr>
<td>- Felt safe</td>
<td>- Question period where students’ could ask questions</td>
</tr>
<tr>
<td>- Open</td>
<td>and if the teacher didn’t know the answer, he or she</td>
</tr>
<tr>
<td>- Students could ask questions</td>
<td>would look it up or bring in guest speaker to answer</td>
</tr>
<tr>
<td>- Kind</td>
<td>the questions</td>
</tr>
<tr>
<td>- Approachable</td>
<td>- Kind</td>
</tr>
<tr>
<td>- Confidential</td>
<td>- Trustworthy</td>
</tr>
<tr>
<td>- “We could write down questions put it in a box and the</td>
<td>- Calm</td>
</tr>
<tr>
<td>teacher would answer. This promoted confidentiality</td>
<td>- Honest</td>
</tr>
<tr>
<td>and allowed opportunity to ask questions with no</td>
<td>- Understanding and helpful</td>
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<td>strings attached.”</td>
<td>- “Teacher treated us like we were adults”</td>
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<td>- “I think if more people talked more openly about</td>
<td>- The teacher was comfortable talking about the subject</td>
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<td>sexual health it would not be such a taboo subject</td>
<td>- [the teacher] “Did not make us feel uncomfortable.”</td>
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<td>and more people would have positive experiences to</td>
<td>- “The teacher told funny stories. Made the subject</td>
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<td>share.”</td>
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<td>- A lot of people are scared or uncomfortable of that</td>
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<td>type of class for personal reasons, but it is</td>
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<td>something that every teenager or young adult needs to</td>
<td>- “The teacher made us involved- could not sit back and</td>
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<td>experience and gain some type of knowledge from.”</td>
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<td>create an atmosphere of trust. They expressed how</td>
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### Interactive and Diverse teaching Methods Help Students Remember SHE

- Taught how to put on a condom with a banana or “woody”. Students had to demonstrate how to put on a condom
- Teacher included students in the learning process
- Guest speakers
- Handed out the different types of birth control options
- Presentations
- Planned parenthood came in and did extensive teaching about birth control and showed all the different methods available
- Workshops
- Pamphlets and handouts
- Health nurses came and spoke to the class
- Videos and images
- Made condoms available
- Baby project: “I’m fairly confident the purpose of the project was to make us not want kids at our age. It was a positive because it worked for me. I never dreamed it would be so hard, and it gave me a reality check on the subject…. Having a child is something you have to do to see how hard it is, not just read about it.”
- “We had question period every second Friday, if the teacher didn’t know the answer he would look it up or bring in guest speaker.”
- “Planned parenthood came in and talked about the tough stuff… teenage pregnancy, abortion, adoption.”

### Meaningful Content Enriches students Experiences with SHE

- Should be taught every year from an early age, expanding each year until you graduate. This way the subject is not so awkward
- Taught the “hard stuff”- abortion, adoption, teenage pregnancy
- Taught birth control methods
- Taught about STI’s, safe sex
- Teen pregnancy
- Anatomy
- Puberty
- Video/images
- Fully alive text
- Transgender, bisexual, gay relationships
- Respect towards bodies and other peoples bodies
- Catholic School – abstinence based
- “…Need to discuss teen pregnancy more as its becoming like a fashion trend”
- “Need more information on the emotional/mental aspects of SHE and also sexual orientation.”
- “We learnt about menstruation, hygiene and the major parts of the reproductive system as well and puberty. We learnt about abstinence, reproductive systems, STIs and methods to prevent pregnancy. So yes, I think I gained a positive experience from our sexual education classes.”
- “As part of my current clinical placement, myself and another nursing student are teaching sex education to grade eight students. We make every effort we can to make sure that the kids are comfortable talking about their body parts, reproduction, pregnancy, birth control etc., which I think is really valuable to the kids.”
4.2 Part B: One-on-one Semi Structured Interviews

The goals of the one-on-one interview was to take a more detailed look at participants' experiences with SHE in high school and to explore participants thoughts on an ideal SHE program through the lens of the AI framework. The Interview has been used in many studies to research SHE (Bourton, 2006; Hirst, 2004; Jones, 2010; Lesta et al., 2008; Potsonen & Kontula, 1999) because of its ability to create a trusting and comfortable environment that works on uncovering the participants perspective, not the researchers (Marshall & Rossman, 2011). During the interviews I strived to follow the interview techniques outlined by Seidman (2013) including listening more, talking less, asking questions when you do not understand, inquiring further when you want to hear more about a subject, and asking open ended questions that do not presume an answer.

4.2.1 Interview tool. Michael (2005) outlines interview questions from an AI perspective. Utilizing this interview tool, I adapted the interview guide that was already from an AI perspective to fit with my questions created after Part A data analysis. It is important to note that each question posed was positive in nature, an important basis of appreciative interviewing. This interview guide was semi-structured in nature with few close-ended questions and mostly open-ended questions. This interview guide can be found in Appendix D of this paper. Not all questions were used during an interview and new questions and unique questions were asked based on answers received from the participant during a particular interview. Seidman (2013) explains that the interview “…is not designed to test hypotheses, gather answers to questions, or corroborate opinions. Rather, it is designed to ask participants to reconstruct their experiences and to explore their meaning” (p. 94). In addition, the four themes that were discovered through
data analysis in Part A of the study were built on and utilized within the interview guide and interview process. Through careful analysis of Part A, I felt that the interview questions I developed created a dialogue that allowed for a more detailed look at participants' experiences from an AI perspective and thoughts on an ideal SHE program future.

4.2.2 Part B and AI. The interviews main focus was on the second D - dreaming in the 4D cycle. This dreaming phase is where an image of the best possible future is created, specifically for this study this meant exploring and discovering participants thought’s on an ideal SHE program. While interviewing the words ‘core values’, ‘wish’, ‘most important factors’, ‘peak experience’, and ‘heart’ were essential in conveying the positive focus on SHE the interview was taking on an ideal future for SHE in high schools.

4.2.3 Participant recruitment and data collection. Students were recruited for Part B of the study through course email to students in KHS 170 (Appendix C). Individuals interested in the study contacted me back through URCourses or my URegina email. Part B of the study took place following the completion of Part A. Criteria to participate in the study was outlined in section 3.3, but all participants were students of the KHS 170 class and attended high school in Saskatchewan. Nine participants agreed to be interviewed. One participant’s interview and data could not be included in the study because she had attended high school outside of Saskatchewan. Therefore, the study had a total of eight participants who met the study's criteria. The participants ranged in age from 18-25, and all eight attended public high school and were female. Originally interviews were to be face to face at the University of Regina. However, after discussing
dates and times through email with participants it was found that phone interviews were the best option. One participant consented to a face-to-face interview, which took place in a break out room at the University of Regina, while the other seven consented to phone interviews that took place when the participant was available. The seven phone interviews were conducted from my home office. This location allowed for an environment that was private, quiet, and comfortable. Consent and confidentiality forms (Appendix E) were signed and received prior to the interview or within a day of it being completed. All interviews were audio recorded for transcribing processes. Participants were made aware that the interviews were recorded in the consent form, but it was also discussed prior to beginning each interview, to ensure participants were okay with this strategy. The individuals who participated in the study received an additional 1% bonus mark in the KHS 170 class. The participant whose interview I was unable to use in the data analyze because he/she did not attend high school in Saskatchewan still received the bonus mark. For students who did not wish to participate in the study there were other educational opportunities within the class where a bonus mark could be obtained. The interviews took place within a six-week period and ranged from 15-17 minutes in length. Once an interview took place the data was transferred to a password-protected computer that only I was able to access. The data was then deleted from the audio recording device. Originally, the audio recorder was going to remain in a locked cabinet at the University of Regina, but because many of the interviews took place at odd hours and the interviews were conducted from my home, transferring the data to a locked computer and deleting it from the audio recorder was more convenient. I transcribed the interviews using the computer software FlipPlayer. This software allowed audio to be slowed down for an
easier transcription process. Once all of the interviews were transcribed, the written interview was emailed back to each participant with a transcription check email (Appendix F). Participants had one week to review and make any changes, or withdraw from the study. After this point, all data collected was utilized in disseminating the results of my research project.

4.2.4 Coding and theming. Thematic content analysis was conducted in the same way to Part A of the study as outlined in section 3.1.4. Each transcript was printed off and read multiple times so I became more familiar with the data. I realized while reading the transcripts I felt I had already became acquainted with the data because of being an active participant not only in the interview process, but through the transcription process. I recognized statements certain participants made, reflecting on the interview that took place, remembering certain topics or even the tone of voice the participant had. Now I was re-reading, viewing the data on a deeper level and from different angles. I derived codes from the data looking for words, phrases, ideas that repeated or seemed similar in nature. I also made note of outliers, so I could reflect on them and what they mean. Again, I made notes in the margins, used highlighters and created ‘coding lists’ during this process. I grouped certain codes together, eventually creating themes that emerged from the codes. Quotes were extracted that explained the discovered codes and supported the themes. It must be noted that one theme emerged from questions I posed during my interview guide that provided valuable information on the subject of SHE. I originally did not plan on using any interview questions as pre-determined themes, but during the data analysis stage, the data I collected based on these questions reflected the importance of including one – what is at the heart of a successful SHE program as one
The data collected provided stories about participants SHE experiences in high school, but foremost provided rich data discussing their opinions and thoughts on an ideal SHE program based on their own unique experiences. Four unique themes emerged from the data. The findings from the one-on-one interviews with university students revealed core concepts that SHE should teach; the best methods to provide SHE information; key qualities of an educator teaching SHE; and what is at the heart of a successful SHE program. The themes that emerged from this data can be seen in the diagram below. This theme diagram shows the relationship between the different themes and that while each is a unique theme, they are all inter-related and depend on each other in order to have a positive experience. Further discussion of the emerging themes found can be found in section 5.3 of this paper.
4.2.5 Diagram part B: Thematic analysis for sexual health education: One–on–one interviews.

Diagram 1.

*Diagram Part B: Thematic Analysis for Sexual Health Education: One - on - one Interviews*
CHAPTER FIVE: DISCUSSING THE EMERGING THEMES

5.1 Introduction

The purpose of the study was to explore the experiences of university students in relation to the SHE they received during their high school years. I wanted to gain a deeper understanding of the positive experiences participants have had, paying little attention to the negative experiences. This was done by utilizing an AI framework. I hoped that by focusing on the positive experiences only it would create an environment when participants see what is going right and imagine a future built of these positive experiences. I will begin this section of the paper by discussing the four themes that emerged from data collected in the online discussion forum and then the four themes developed through the one - on - one interviews. I will analyze the data in light of my research questions and reflect on the experience in relation to the AI approach.

In section 1.2 of this paper I discussed the pilot study that was conducted to prepare for my thesis project. In the study it was found that 33% of participants rated their SHE experience in high school as ‘good’ or ‘excellent’. 33.3 % stated it was ‘average’ and another 33.3 % of participants stated their curriculum as poor or non-existent (Schmidt & LeDrew, 2013). These findings show inconsistencies in student experiences. Common findings in studies concerning SHE in high school were that a variety of curriculums were being taught (Barret, 1994; Byers et al., 2003; Dodds, 2011; Options for Sexual Health, 2004). While analyzing Part A of the study, it became clear that participants had differing experiences: For some, sex was rarely discussed, “We briefly touched on what sex was” and “I don’t remember ever being taught anything about sexual health during high school.” For others, there was some discussion of SHE
in high school: “I wish that the school system had made sure that we at least had the basic knowledge of sexual transmitted diseases and how to practice safe sex.” At the end of the spectrum were comments indicating that SHE was useful and supported. One participant said,

_The teacher always expressed how she was always there if anyone needed to talk, she advocated for the students and the importance of this class”_ and “...although health class was something that was usually dreaded and kind of embarrassing back in high school, it did really provide some valuable information for later in life and I am glad they have these presentations for students.

I reflected on why the participants experiences varied so greatly when they all attended high school in Saskatchewan. I took into account that each participant had a unique lived experience; they would take in the information in their own way and recall the information in their own distinct way. Options for Sexual Health (2004) studied the effectiveness of SHE programming in British Columbia. It found that good sexual health was hit and miss and that teaching, time and continuity of curriculum were inconsistent even within school districts.

Through data analysis and reflection, it materialized that within my study there were many differing experiences among participants, similar to previous studies. Between Part A and Part B of my study a total of eight themes emerged from the data. Below I will first discuss the themes that emerged from part A: Online Discussion Forum that was outlined in Table 1: Emerging Themes (Part A) in section 4.1.5. Next I will discuss the themes that were highlighted in section 4.2.5 Diagram Part B: One - on - One interviews.
5.2 Emerging Themes Part A: Online Discussion Forums

Four themes emerged from the data from participants who expressed positive experiences and those with no or minimal experiences who expressed experiences they wished they could have had by building off the experiences other participants shared.

5.2.1 Open and comfortable classrooms enhance SHE experience. Dorman, Aldridge and Fraser (2006) explain the concept of environment when applied to education settings as the atmosphere, ambience, tone or climate that encompasses a setting. Environment was an important characteristic participants discussed when talking about their experiences. The words comfortable, trusting and open were often used to describe a positive SHE class. However, some lacked such a class describing it as “awkward” and “uncomfortable”, and an environment that was not very “trusting.” One participant explained,

*I think if more people talked more openly about sexual health it would not be such a taboo subject and more people would have positive experiences to share”, and “if more people could openly talk about these things it would benefit kids.”

Another participant noted, “From what I can remember the experience was a positive one, the environment was open for discussion and our teacher was really understanding and helpful... and did not make the students feel uncomfortable.

It was repeatedly expressed that teachers played a vital role in creating an environment that was open, trusting, and comfortable. A few of the participants shared stories that their teacher put out a question box where students could anonymously ask questions. In class the teacher would answer the questions. This box, as one participant put it,

“Allowed us a chance to get anything we wanted answered without being put on the
One participant story stuck with me about the importance of trust. She was from a small town and stated that her high school had a high teen pregnancy rate. She expressed that everyone in the town knows everyone that works at the pharmacy and at the hospital, as school social workers and as teachers. She explained that while there is an obligation for professionals to keep information confidential, it could be uncomfortable for a student to seek out information about sex and contraceptive methods. The 2013 BC Adolescent Health Survey had similar findings in which students from smaller communities expressed they had less access to sexual health information, and that privacy was an issue in their smaller communities (McCreary Center Society, 2015). The classroom environment is an important factor that affects a student's learning and research shows that students learn better in an environment that is positive and supportive (Dorman et al., 2006). This was reiterated in my study where participants expressed having an environment that was trusting, comfortable and open as important to a positive SHE experience in high school.

5.2.2 Teacher confidence and knowledge improves SHE experience. In the Saskatchewan school system, it is most often the teacher who delivers SHE to their students. Dodds (2011) expressed that while a school may implement an excellent SHE curriculum, the teacher’s instructional strategies and implementation of the program affects its overall success. The role the teacher plays in the overall experience a student has was expressed quite strongly in the online discussion forums. One participant explained, “The teacher always expressed how she was always there if anyone needed to talk, she advocated for the students and the importance of this class. It is because of her that I am not embarrassed to talk about this sensitive subject.”
When participants discussed their experiences with SHE, they stated that a teacher who was open, confident, honest and comfortable talking about the topic enhanced their experience. One participant stated that her teacher was too uncomfortable to discuss the topic, and a whole unit was skipped because the teacher was too embarrassed. Another participant gave an example, “We read out of a Fully Alive textbook...when the sexual health section came up, she gave us a brief explanation on the functions of sex, spoke very fast and uncomfortable.” In contrast another participant stated, “The reason why my experience was positive was because the instructor had touched on the subject in a great way and did not make the students feel uncomfortable.”

A study conducted by Bourton (2006) suggested that required skills of someone teaching SHE is confidence, ability to relate to young people, and ability to comfortably discuss topics without embarrassment. This was reiterated in a study by O’Higgins and Gabhainm (2010) which stated that students found it difficult to learn from a teacher who was embarrassed, and needed teachers who were experts, confident and trustworthy. As I reflected on how important the participants thought the teacher’s role was in SHE, I wondered how much training teachers received on the subject of SHE? The Canadian Guidelines for Sexual Health Education suggests mandated professional requirements for those who teach SHE. However, I wonder if this training is being conducted and or completed consistently in the Saskatchewan school systems.

5.2.3 Meaningful content enriches students experiences with SHE. As I set out to explore the experiences of university students in relation to the SHE they received through high school, it emerged that what was being taught in the classroom differed greatly among participants. There were participants from both Catholic and public high
schools involved in the study. While the Catholic school teaches abstinence based programming, many participants felt they should learn a comprehensive curriculum. One participant expressed her thoughts on this

*I wish the school system had made sure that we at least had the basic knowledge of STD’s and how to practice safe sex…class may have briefly mentioned that sex was a beautiful thing that God had created for marriage only.*

Another participant within the same discussion forum replied, “Like you said ‘Sam’ basic knowledge of safe sex and consequences of STI’s and pregnancies would’ve been beneficial to our generation and future generations.” Participants who had said they had memorable experiences with their SHE recalled being taught about how to properly put on condoms, basic anatomy, safe-sex options and contraceptives, possible outcomes if safe sex was not practiced, reproduction and pregnancy. The discussion among participants expressed that “We need to learn more than just body parts and how they work.” Through analysis, I discovered that participants valued a broad spectrum of concepts being taught, but particularly found importance in safe sex and STI’s. Basic biology was not enough, one participant expressed that, “…Birth control is a big one. I knew in my hometown everyone was scared to ask about it, and where to find the right information because you can Google anything…but [Google] is never actually what its going to be like.” Boyce et al. (2003), SEICCAN (2009) and the PHAC (2008) suggest that broadly based programming provides students with the confidence, skill and knowledge to increase positive sexual health outcomes. In the study participants were not specifically asked about the different subjects that are often taught in a sexual health class, therefore it cannot be assumed that other subject areas are not as important to them,
instead participants may not have recalled these memories.

5.2.4 Interactive and diverse teaching methods help students remember SHE.

Through the online discussion forum participants shared stories with each other. The data showed that being involved in the lessons and experiencing different teaching methods helped students remember the information they were being taught. One participant explained “One positive experience from my sexual education is that the teacher made us more involved in the actual lesson so that we had to pay attention and not just sit back and relax.” Pictures and videos were used and while one participant expressed, “There were definitely some images and videos I would like to erase from my memory, but I think it helped everyone in the long run.” Another participant explained the importance of being directly involved in the class by sharing a memory,

*The most memorable story on sexual education I can remember was when our teacher demonstrated to us how to properly put on a condom by using a banana.*

*Unfortunately, she did not bring enough bananas and some of the students had to practice by putting it on their fingers. This was a positive experience because if there was not a demonstration I don’t think anyone would have taken the time to read instructions on how to properly use a condom.*

Other participants shared stories involving the question box, or the ‘baby project’ where students had to carry a baby with them for a week with a partner and be responsible for it, mimicking having a real baby. Many participants remembered Planned Parenthood presenting to their class and handing out different birth control methods while they were being taught about it, discussing STI’s openly, and providing pamphlets on the subjects being taught. Getting the students involved and engaging the students with interactive
lessons was a consistent positive pattern that emerged during my analysis. Similarly, recent research has come to the conclusion that effective SHE integrates understanding, motivation and skill building in their program (PHAC, 2003; 2008). If SHE programming can be done in a way that is interactive and engaging to students, my analysis suggests students will get more out of the program.

5.3 Emerging Themes Part B: One-on-one Interviews

5.3.1 Core concepts SHE should teach. Broadly based SHE provides individuals with an understanding on the subject, and the confidence, motivation and insight to act on the acquired knowledge and skills required to increase positive sexual health outcomes and decrease the negative outcomes (PHAC, 2008). PHAC suggests that these positive outcomes include intimate, caring interpersonal relationships, positive self-image and worth, delaying first intercourse and pregnancies, and avoiding negative health outcomes. Negative sexual health outcomes include STI’s, teenage pregnancy, and dating violence (Kirby et al., 1994). Through my study, it was made clear that learning about STI’s, and safe sex including barrier use and precautions one can take to ensure he or she is safe, and avoid teenage pregnancy, was vital for their SHE. Additionally, responsibility, and the human body were viewed as important education points. One participant suggested,

You can’t just say don’t have sex anymore because the reality is that people are having sex, and they are having sex younger... I think that it’s really important to provide the proper information of what can happen if you have sex, the precautions you can take... and that if you want to go and have sex that you know
what to do and you know how to protect yourself… It’s important to have that knowledge because if you don’t bad things are going to happen.

Another participant explained,

You’re not invincible. I know a lot of people out there saying I’m not going to get pregnant or it’s impossible for me to get an STD because I’m only sixteen. And I think making it very clear that, you know, even if you only have sex once there is a very good possibility that it could happen to you… being safe, how to access safe barriers like birth control [is important].

One participant expressed that this does not only mean being safe physically, but being emotionally safe with dating as well. It was found to be significant for educators to be realistic with students about the possible consequences that can result from being sexually active and ensuring that students do not think that unintentional sexual health outcomes are ‘worst case scenario’ and won’t happen to them. Birth control methods are an important topic for participants to learn about. One participant suggested, “I think risks is the biggest thing that should be taught. And proper use of barriers…and it should be displayed…and how to properly use those barriers.” Participants noted that although birth control may be an awkward topic to discuss stating, “Its an embarrassing subject for some people”, the students felt the information was very beneficial and wanted resources on how to access the different methods. One individual explained when asked what she wishes for future students in the SHE “…learning [and understanding] the importance of safe sex and where they can go for condoms or birth control… I think a lot of students don’t know about that and they don’t go to their family doctor or shoppers drug mart…” Another participant explained that she now that she is
older she realizes that a person can “come and get them [birth control options] at school and you don’t actually have to buy them, and that the public health nurses [have] them,” but she did not know this in high school and felt it would be important information to have at that age. This participant also noted that being from rural Saskatchewan this is also more difficult to do, because it’s not even an option in her hometown.

Responsibility was noted to be of importance when learning about sexual health. When asked what is a core concept that should be taught in a SHE class one participant replied,

*Definitely responsibility...taking responsibility for your body and making sure that it’s protected. But also responsibility in [knowing] what sexual health is...[knowing] what exactly sex is because lots of people think it has to be intercourse but it could include foreplay or anything else under the umbrella.*

The participant further explained that a goal of SHE should be to ensure students “Are responsible when they enter into a sexual relationship. So they are responsible for themselves and the person they are with.” Another participant who stated she did not learn about SHE in high school and was now taking an anatomy class in university reported that the first time she learned about the reproductive organs was in this university class. Because of this, she suggested learning about the “anatomy and normal development of woman’s body” was a core concept SHE should teach, voicing that “in today’s society in the media and stuff [bodies] are not realistic, but if we don’t have essential health class, you get freaked out.”

It must be noted that during the interview process specific topics that are commonly taught in a SHE class were not offered to participants. Participants were
recalling their memory or thoughts on an ideal SHE program. Therefore, other topics could have been potentially viewed as important to participants but they did not come up during the interview process.

**5.3.2 Best methods to deliver SHE to students.** In order for high school students to learn and retain information about SHE, the participants revealed that learning the information more than once, utilizing different mediums, including guest speakers and a ‘question box or period’ were valuable tools in providing a positive SHE experience. They also expressed the need to provide students with available community resources outside the school. One participant expressed her positive experience with SHE stating,

> It wasn’t just a teacher, we had multiple, different people come in. [This] was great because I know from lots of other programs [SHE is] just once and quickly... then you don’t always take in everything. But if you have it [SHE] from so many different people at different times, then you're more willing [to learn]...they may reiterate some information but you’re more willing to let it sink in.

The idea of involving services outside of the school is not new. Comprehensive School Health, an approach Saskatchewan schools follow, includes partnerships and resources in the community (Joint Consortium for School Health, 2018). To ensure students are supported and have the ability to reach their full potential as learners, Comprehensive School Health expresses that partnerships and services with the community are essential to the overall health and well being of all in the school community, linking education and health together (Joint Consortium for School Health,
The findings in this study suggest students value this partnership and service, and community involvement in their SHE.

Furthermore, it was suggested that SHE should be taught throughout high school, and not just in one grade or one class. Participants discussed people are often intimidated, embarrassed, and still growing at the high school age and do not understand the seriousness of consequences for sexual health. By continuing the education over periods of time, participants suggested more information was retained and it was more meaningful to them. The importance of learning SHE in high school was explained by one participant stating “It was like we had sexual health done in grade six...then once we got to high school it was never brought up again. But by then we were more mature and had more questions...but it never got brought up.” Another participant explained that in grade nine it was a mandatory class, but after that she was able to learn more in other grades explaining “Throughout high school you had to pick the class if you wanted sexual health education... it was kind of a lifestyles course, so their was a full unit on [SHE] as part of the course.” Having SHE continued throughout high school was reiterated as important when one participant explained,

When we go into high school and were in our first year were already so intimidated, with everything else going on... we don’t really understand how serious consequences of it can be...I think it could be continued throughout high school as part of health class.

One participant illustrated the value of a guest speaker when an individual from Planned Parenthood came in. She stated,
We had a lady who was way more hands on. She came and showed us how to put a condom on properly and everything. She would pass it around and let us look at pictures and that kind of stuff. Even though it was awkward and there was lots of giggling because it was with boys and girls, everyone knew everything about both genders, which I think is important.

Giving specific examples of different forms of available birth control methods, as well as explicitly showing students how to properly use each barrier was regarded as helpful. Planned Parenthood guest speakers and a visiting health nurse were cited by participants as valuable and important tools for providing students with relevant sexual health information. Other mediums participants suggested that enhance their experience included group presentations, which allowed student-led learning and interacting, PowerPoint presentations, a sexual health fair, diagrams, videos, and question boxes. The question box was highlighted as a very valuable and appreciated method of learning because of its ability to allow students to ask questions while remaining anonymous. Summarizing the value of the question box, a participant explained,

*We had a little question box so that if you were too embarrassed to ask, you could write in on a card and put it in a box...if anyone is comfortable enough to say something they will outright ask. And there also the kids that aren’t right? They won’t ask the questions, and then [they will] never find out the answer. So they probably felt more comfortable asking them on a question sheet as it wasn’t directly pointed right to them.*

The ability for students to ask their questions with anonymity amongst their peers was essential for a positive, meaningful learning experience. One participant also pointed out
that the question box was also beneficial to the teacher as it allowed the teacher time to find the needed information and be comfortable sharing it in a manner that was appropriate if they did not know the answer.

Another key finding was discovering if participants felt it best to learn when males and females were separated or together during class. A few participants expressed that while it was awkward, it was important to know information about both sexes. One participant stated,

*When you first begin learning about menstruation and stuff it would be embarrassing with the boys there [and we were separate]...but I think in high school it should be more mixed, it forces people to be a little more mature and take it more seriously.*

However, another participant expressed the opposite, stating that when she was learning about the pap smear she would have preferred being separated. She stated “*Separating the boys and the girls, I think that would be been really helpful to do because it was super embarrassing when our teacher put the video on [about it].”*

**5.3.3 Key Qualities an educator teaching SHE should possess.** In Saskatchewan, while guest speakers may come in and speak to classes, teachers are at the forefront of delivering the SHE program. Therefore, they are key stakeholders in a student’s experience. O’Higgins and Gabhainn (2010) found that students needed a teacher who was an expert, confident, trustworthy and did not embarrass easy when teaching students about SHE. Similarly, in the study participants overwhelming expressed the influence the teacher has on their SHE experience, and that a teacher who
was easygoing, humorous, honest and comfortable teaching the subject was fundamental in students having a positive and quality learning experience. One participant explained,

*If you’re going to be teaching sexual health you have to be comfortable talking about it, and you have to be knowledgeable...I find that when you leave those Sex Ed lectures, you still have so many questions that maybe didn’t get answered because the teacher didn’t broach them or you didn’t know how to ask it as a student. I think being honest and open to everybody [works best]... just say to them... I am totally okay with absolutely everything and if I don’t know the answer I will find out for you.*

Being comfortable with the teacher was important. Participants reiterated that if one does not feel comfortable with the teacher, one will not ask questions. In order for that comfortable learning environment to exist, the teacher themselves needs to be comfortable addressing the sensitive subject matter. If they are not comfortable, the students will not be. One participant explained that although there might be giggling due to the nature of the subject, the teacher needs to push through it and not get upset about it. Another participant offered advice to someone teaching the subject suggesting, “*If you don’t feel comfortable with it right away, just go over it, and practice it and make sure that your comfortable with it, because if your not comfortable than your students aren’t going to be comfortable.*”

Participants identified humour and an easy-going attitude as qualities needed by the teacher that would relieve the awkwardness and embarrassment students feel with the subject matter. This was illustrated when one participant shared a positive experience she had with her teacher:
They were really easy going and if things were really serious they would tell us ‘guys this is the time where we get serious’ and stuff like that. But if things were really funny they would let us know it was okay to laugh at some things. They were easy going and made us more comfortable. And they were very honest with us...I think honesty was a huge thing for everyone because being truthful is super huge for teens.

Similarly another participant reflected on her positive experience with SHE stating, “He [the teacher] was funny about it. It was a humorous environment where you didn’t feel embarrassed or awkward, and he just taught us the stuff we needed to know.” Allen (2014) explores the use of humour in sexuality education. While the author notes that humour can be used negatively to oppress, harass, disrupt the classroom, and undermine the teacher, the article explored positive ways in which the teacher utilized humour as a strategy to engage and interest students in the content, ‘liven’ the classroom activity and create an environment conducive to learning in an attempt to reduce embarrassment and tension on the subject (Allen, 2014). While this study discussed humour as a strategy, it did not imply if these strategies were effective. Participants in the current study suggested that humour allowed them to feel more comfortable, lightening the awkwardness that often follows the topic of sexual health.

Interestingly, one participant expressed that the age of the teacher plays a role, explaining,

As a teen you are going to listen to somebody who is more relatable to you...so if they are a young person who is closer to your age and there a female vs. an older
male; I’m going to listen to the younger female rather than someone who is closer to my grandpa’s age.

An interesting follow up to this suggestion would be if the “teacher that is older to her grandpas age” was easy-going, humorous and comfortable teaching the subject, would his or her age still matter?

The impact the teacher has on the student experience was proven to be highly valued by the participants in the study, and participants suggested that the teacher’s confidence and ability to share their knowledge in a way that was honest, comfortable, easy-going, and even humorous at times were important qualities in providing a positive SHE experience to high school students.

5.3.4 What lies at the heart of a Successful SHE program. The AI method looks at what is ‘going right’ within a system, moving towards it, exploring achievements, assets, unexplored potentials, strengths, and high moments. These memories are generated from share stories among a group and during this AI process shared images are created from the stories of a preferred future (Cooperrider et al., 2008). The AI process assumes that there is something working well and identifying that strength can be a starting point for an ideal future. Based on this theory, participants in the study were asked their opinions on what they think makes a successful SHE program, or, what is at the ‘heart’ of a successful program? This question was asked in each interview, although in different ways, often with different wording, but always near the end of the interview. All themes evolved from my study were developed from thematic analysis, with zero pre-determined themes. They all worked towards answering the above question. However, the question I asked during the interview process provided a
unique perspective on participants thoughts and visions of an ideal SHE program, so much so it was deemed necessary to share as a its own theme in my results.

Each participant shared individual ideas and opinions on what they thought was at the heart of a successful program. While not one answer was the exact same, they all shared common similarities. It was made clear that participants considered a teacher who is knowledgeable, easy-going, and comfortable with the topic vital to a successful SHE experience, and these traits create a learning environment that is open and safe where students can ask questions and have their opinions validated. The information participants value most learning about are topics that keep students safe emotionally or physically, decreasing chances of negative health outcomes. It was found that the information being taught needs to be provided in a way that is meaningful to students. These findings have all been discussed above, however, it is important to note how these findings while all independent and important, depend on one another for a successful SHE program. For example, participants discussed the necessity for a comfortable and open learning environment, but the teacher is vital in creating this, as well as the delivery or method of the program. The specific content being shared will also affect whether the information is well received. My analysis suggests each component is co-dependent on each other for success. One participant summarized this point well when she said,

*I think a successful health education would focus on definitely the risks associated with sexual activity, and there would be or as much as possible, an open environment where kids are welcomed to ask questions and not be ridiculed or made to feel embarrassed about their questions. Or if they believe in chastity,
their opinions are still validated even if it’s not the same opinion as the person giving the instruction or teaching it!

Her image of an ideal SHE program had many contributing findings from the study present, that needed to be present in order for her idea of a successful SHE to be attainable. Another participant expressed that a successful SHE program to her included a couple of contributing factors. She explained that, “Having a teacher who is outgoing enough- not someone who is friends with the students, but someone who they can really confide in and trust...Making it more of a ‘cool’ atmosphere for students, and the question box from when [she] was in high school were all important factors that needed to be in place for a successful SHE program to take place.

5.4 Reflecting on AI and my Research Study

The purpose of utilizing the AI framework during the online discussion forums was to ‘discover’ the best of what was for students experiences in relation to their SHE in high school. In addition, I also hoped to see outlines of “what could be” or the beginning of the dream phase of the AI 4D cycle through the stories being shared. I found utilizing this positive inquiry within the discussion forums of my study a challenge in some respects. I previously mentioned it was necessary to ask participants to share their experiences on the SHE they received in high school because the pilot study and prior research expressed very differing experiences for students (Barret, 1994; Byers et al., 2003; Dodds, 2011; Options for Sexual Health, 2004; Schmidt & LeDrew, 2013). For some of the participants, this immediately led to discussing they had a ‘poor’ experience in high school, but because I was not an active participant in the discussion forums I could not inquire further and delve deeper to discover a positive aspect of their schooling
and work towards discovering ‘the best of what was’. A few participants expressed not receiving a SHE, one individual stating, “To be completely honest, at my school my SHE was not positive for me, mostly for the fact that it was pretty much non existent”. While I was unable to reply at that time, I reflected on how I would have responded to that statement from an AI point of view. I knew during Part B of my study I had an active role as interviewer and how I responded would be important. I reflected deeper; AI makes the assumption that there is always something that is working well and that strength can be a starting point for creating positive change (Cooperrider et al., 2008), but what if there is truly is no experience to begin with? I went back and reviewed the AI method. The AI process begins with individuals sharing stories about positive experiences. Therefore, I reflected that while this participant may not have had an experience with SHE specifically, she would have stories to share about her experiences in the classroom in high school. I imagined I would start there, discovering positive experiences and or unexplored potentials and strengths or opportunities that could create the beginnings of a new dream in relation to SHE.

On the other hand, the second question I posed (Appendix D) during the discussion forum created a dialogue where many stories being shared created a ‘positive core’ of experiences that highlighted positive experiences, strengths, and high moments from their SHE class that then led to unexplored potentials and opportunities. While I analyzed the data I found that once one participant shared one positive story or memorable moment, it was like a ripple affect, and other students shared experiences and led to discussion on the ‘best of what was’. The AI framework suggests that inquiry and change are not separate moments and begin to happen simultaneously. I found this to be
true when reflecting on my data. During this discovery phase participants unknowingly, but naturally, moved to the beginnings of the dream phase of the 4D cycle, creating an image of the best possible future. Or in this case, an ideal SHE program for high school students. One participant suggested “**Kids should be taught how to use contraceptives at an early age, and that sex-ed shouldn’t just be a one day thing. Sex-ed is a concept that should be expanded upon every year until you graduate**”. After hearing another participant state she talked openly and confidently about the subject of SHE, another participant suggested “**If more people talked more openly about sexual health it would not be such a taboo subject, and more people would have positive experiences to share.**” I reflected that their dialogue not only involved the discovery phase of AI, but also moved into the beginnings of the dream phase of ‘what could be’.

During Part B The One-on-one interviews I witnessed the AI framework really come to life. My questions were adapted from an AI template and each interview was an ‘appreciative interview’ meaning all questions were positive in nature, and all inquiry focused on positive experiences, building of those experiences for thoughts on an ideal future. Negative experiences were of course brought up during the interviews, but through positive inquiry I felt I was able to negate the conversation away from what didn’t work and why, to what a participant enjoyed, learned, worked and why, or how he or she would build off her experience creating their thoughts on an ideal future for SHE. Avoiding these negative experiences was one of the biggest challenges during my research. Being aware when conversation turned to a more “negative conversation”, and bringing the interview back to the AI framework was key during interview process. In addition, reflecting after each interview helped me to prepare for this challenge during
next interview.

I began this journey to explore first year university students in Saskatchewan’s experience with their SHE in high school from a less utilized method of AI. This alternative approach to research was the opposite of the standard change method that defines a problem then uses problem-solving methods to find a solution. AI provided a unique look into the world of SHE in high school. While it presented some challenges, and challenged me as a researcher on how to maintain a positive environment when participant discussion turned negative about their experiences, I learned and witnessed the power of AI at how its ability to inquire in a positive way lead to more positive discovery. Through my data collection and analysis I saw participants ‘discover’ or reveal positive experiences, share these experiences with others and then I witnessed them draw on these strengths and ‘dream’ what they thought an ideal SHE program would look like to them. This research project did not divulge into the third and fourth D of the AI’s 4 D cycle, design and destiny phases. These phases involve participant designing proposals for the preferred future, creating a clear purpose of this future, and lastly destiny takes place when the group lives out these purposes they have created (Cooperrider et al., 2008). These next steps in the AI framework could be utilized in combination with these research findings for further research with inclusion of key stakeholders to create the positive change leading to an increase in success of SHE in Saskatchewan high schools.
CHAPTER SIX: IMPLICATIONS OF RESEARCH – SO WHAT?

In the world today, people obtain information many ways including consulting experts, reviewing books, reading articles, observing, asking peers, or past experiences. Fraenkel et al., (2012) explains that these sources are not always reliable; experts and documents can be wrong, and past experiences may have been poor examples, that is why research is so valuable. It provides another way of obtaining information that is accurate and reliable based on evidence. The WHO (2002b) expresses the importance of utilizing health research in policy-making which includes national health policies made by government, or policies made by local health services or clinical guidelines for professional bodies. The utilization of health research in policy-making can lead to desired health outcomes, with research contributing to agenda setting, policy formulation and implementation in the policy making process (Hanney, Gonzalez-Block, Buxton & Kogan, 2003; WHO, 2002b).

6.1 Importance of SHE Research

In the case of sexual health and SHE research, the extensive research on the subject has led to policy-making and program development. Kirby (2007) explains the importance of SHE research stating, “Having accurate, research-based information on what works to prevent teen pregnancy is critically important information for communities and practitioners trying to make informed decisions about preventing teen pregnancy” (p.6). In the United States, a country where traditionally abstinence-based SHE programs are most prominent, has research contradicting this and pushing for change with suggestions that there has been a major increase in the quality and quantity of evaluation research that has showed more comprehensive programs that include a wide range of
sexual health topics can delay sexual activity, improve contraceptive use and prevent teenage pregnancies (Kirby, 2007). Research has shown the most effective SHE integrates understanding, motivation and skill-building within the program (Boyce et al., 2003; SIECCAN, 2009). This broadly based SHE programming provides individuals with a deep understanding of sexual health in relation to their needs to acquire knowledge and skills to increase positive sexual health outcomes and decrease negative outcomes (PHAC, 2008).

Documents have emerged from research that not only facilitate program planning and policy development, but assist parents and educators on how to implement effective SHE programs. For example, Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases provides the latest research on teen pregnancy in easy to understand language that provides implications for policy, programs and parents (Kirby, 2007). In Canada, The Canadian Guidelines for Sexual Health Education is supported by the research, demonstrating the importance and need for research and evaluation for further evidence to assist in the direction SHE needs to take (PHAC, 2008). PHAC (2008) further states that research can assist in continuity of development of effective SHE programs that meet the needs of the population, and contribute to the decrease in negative sexual health outcomes. These Canadian guidelines that utilized research conducted in the area or focused towards program-planners, assisting curriculum development, policy-makers, healthcare professionals, at both the individual and organizational level (PHAC, 2008). The Canadian Guidelines for Sexual Health Education have embraced research on developing effective programs
based on a broad view with a more comprehensive program, rather than the traditional abstinence based curriculum (PHAC, 2008).

SIECCAN is an organization that assists in the design and evaluation of research on sexual health, working with public health agencies, educators community organizations, school board and academic institutions to ensure Canadian have access to high quality sexual health information, education and health services. SEICCCAN directly shows how evidence-based research has the ability to be put into practice and policy as professionals or individuals can utilize information provided by SEICCCAN that was learned through research to assist in the increased sexual health of Canadians. Research allows information to be brought forward that shows current state of affairs on a subject matter or experience, often encouraging some sort of change to improve something or reinforcing the status quo. It encourages accountability at the Governmental, school division, local and individual level, because once evidence is shown and education provided people then have the ability to do something about it or not.

Integrating research into my work is very important. In my current work as a registered nurse, the field is constantly evolving as new research emerges about best practice based on evidence that was conducted through research. When something new is learned and has the ability to enhance patients’ health outcomes, it is my duty to advocate for this new practice or possible policy for patients to ensure they are receiving the best care possible. Research in SHE is becoming more extensive, with an increase in quality and quantity over the years. As a researcher and as a professional working in the healthcare field, I feel it is my responsibility to ensure conclusions from my study are
heard amongst stakeholders in the project from participants, to educators, community programs and program heads.

6.2 Dreams for SHE

It was previously discussed that the dream phase of the 4D cycle entails creating a positive image of the best possible future based on stories shared during the discovery phase of the AI framework. This dream phase began in part B of my study and continues as I have outlined three specific recommendations or dreams for SHE in Saskatchewan. These dreams I have outlined are based on my data analysis and deep reflection in which participants outlined their thoughts on what an ideal SHE program looks like to them based on their personal experiences and thoughts. First, it was evident in my research that the individual educating the class plays a vital role in the students overall experience with SHE. My research suggested that if the SHE teacher was comfortable, confident and not awkward, students expressed more positive experiences. Similarly, participants expressed an ideal SHE where these attributes of the teacher were present. In Saskatchewan, teachers are most often the person delivering SHE in high school. Therefore, ensuring these individuals have the skills, resources and professional requirements to teach this sensitive subject will positively affect the student's experience. Providing additional workshops for teachers could enhance their confidence, level of comfort and skills needed to teach this subject.

All participants in the study attended high school in Saskatchewan and were from an urban or rural setting. Participants from Part A, Online Discussion Forum, attended both public, separate or private high school, while participants from Part B, One-on-one Interviews, all attended public high school. It was found that participant
experiences varied greatly among those who attended a similar high school setting. The participant experience varied greatly in what they were being taught, how they were being taught, and the length of time spent learning about sexual health in the classroom. Because of the inconsistencies in what is being taught and delivered to students, I make the recommendation for each school to review their SHE program. This includes reviewing the details of curriculum and the delivery of each program. By taking this step at a local level within each school, an increase in consistency of what is being taught and delivered to students in that school can take place. I also recommend school divisions organize division wide in-service opportunities for teachers delivering the SHE program in order to review curriculum, increase teacher competency and confidence, and plan for a more consistent, interactive delivery.

There is a large body of literature in Canada and North America on the topic of SHE and young people. However there is very limited research in Saskatchewan, even though STI and teenage pregnancy are among the highest in the country (PHAC, 2010). Furthermore, the SHE an individual receives can enhance sexual health, leading to positive health outcomes (PHAC, 2008). My research identified the teacher, the environment, the content being delivered, and an interactive classroom as important components in a positive SHE experience in high school. Further SHE research at the local level, specifically research within a school system with the involvement of teachers and administrators, would be valuable. This future research could provide the necessary evidence that would increase the accountability of government, school boards, and schools to ensure we are providing our youth with the SHE they require to make healthy sexual health decisions in high school and beyond.
6.3 Limitations

After conducting my research study, there are limitations that must be noted. First, the participants were all university students, thus all participants were using memory to reflect back to high school. Because of this, their perceptions of events and experiences involving their SHE in high school may have changed or be altered based on experiences they have had since that time in their life. Also, were participants recalling all events from high school, or just the ones they found most important, most dramatic, or were they recalling possible events that they wish they had? These are all possibilities because they are all recalling events. For example relationships and dating or two topics often discussed in SHE, but none of the participants discussed this. They may find this topic just as important as the topic’s STI’s and teenage pregnancy, but it was not discussed in this study.

Secondly, participants all attended the University of Regina, and were enrolled in KHS 170; a class that’s subject involved lifestyle and health. The assumption was made that participants had an interest and support for this area of study, and therefore, this can be seen as a source of bias. A future study in which participants are not involved in the health science sector would add another layer of data on the subject of SHE in Saskatchewan.

It must also be noted that study Part A: Online Discussion Forums, included both male and female participants that attended both public and separate high school. Alternatively, Part B: One - on - one Interviews, consisted of participants who were not only all female, but also all attended a public high school. This was randomly found and before this limitation was discovered and reflected upon, the class and time frame for the
study had ended. Despite these limitations, this study presents an fascinating and unique glimpse into the SHE experiences of high school students in Saskatchewan and there opinions on what an ideal SHE program looks like to them. In combination with other studies this research project can be transferable to other locations and school districts assisting in program development and advocating for SHE with high school students in the future.

In summary, this study provides further information on the topic of SHE in high schools students, and more specifically it discusses the experiences of high school students in Saskatchewan, Canada from an AI methodology. The study provides evidence that students’ SHE experience is influenced by the teacher, the environment in the classroom, the content of the class and interactive teaching methods. Furthermore, findings outlined students thoughts on an ideal SHE experience, outlining three important factors; core concepts SHE should provide, the best methods to provide the information and key qualities an educator should possess. Results highlight the need for future research to continue at the local level, working with stakeholders including students, teachers, schools, school divisions and the government. Future research should continue investigating the impact SHE has on an individuals overall health status and a research focus on an ideal or ‘good’ SHE program being delivered consistently to students in high school.
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Appendix A

Online Discussion Forum Questions

Question 1. Tell me about your experience with the sexual health education you received through your high school education

Question 2. From your high school sexual health education experience…

   a. Tell me two or three stories involving a positive experience you had with your sexual health education

   b. Reflect on why these experiences were positive (What made it a positive experience?)
Appendix B

Form of Consent and Confidentiality (Part A: Online Discussion Forum)
Participant Consent Form

Project Title: Sexual Health Education in High school Students - A Retrospective Appreciative Study with University Students in Saskatchewan

Researcher: Danielle Schmidt, Graduate Student
Kinesiology and Health Studies, University of Regina
(306) 533-9729  schmdani@uregina.ca

Purpose(s) and Objective(s) of the Research: The purpose of this research project is to discover university student’s opinions on their perceived experiences with sexual health education in high schools in Saskatchewan. The study will be conducted from an appreciative inquiry point of view that focuses on only the positive or best experiences students have had. It will also explore what students feel is an ideal SHE program in high school.

Procedures: As students in KIN 170 class you have completed a discussion forum revolving around the topic mentioned above. I would like to gather the data from that specific discussion forum for my research study. By filling out the form below you automatically receive a 1% bonus mark for the class. It does not matter if you agree for your data to be used or not. The study is confidential and no names or identifying information will be used. Your professor Dr. June LeDrew will be unaware of the students who agreed to participate in the study and those who did not, I (the researcher) will be collecting all consent forms and gathering the data from the discussion forum.

Potential Risks: There are no anticipated or known risks to you by participating in this survey. Because the topic is of a personal nature, if you feel discomfort answering any question, you may skip over the question.

Potential Benefits: This research project will help contribute to the body of knowledge about sexual health education in Saskatchewan. It has the possibility of improving the deliverance of sexual health education in local schools to provide the best possible sexual health education to high school students.

Compensation: Students will receive a bonus mark of 1% in KHS 170 for filling out this form. It does not matter if you agree for your data to be used or not.
Confidentiality: All data collected will be stored through the University of Regina in a locked and secure place, or on a password protected computer with only those
working on the project able to access the data. After 5 years the data will be destroyed when it is not longer needed.

**Right to Withdraw:** Participation in this research project is completely voluntary. Participating or not participating in the study has no bearing on your class standing.

**Follow Up:** To see results of the study you can contact Danielle Schmidt @ schmdani@uregina.ca

**Questions and Concerns:** Please direct any questions or concerns you have to Danielle Schmidt at the above listed email. This project has been approved on ethical grounds by the UofR Research Ethics Board on March 7th, 2014. Any questions regarding your rights as a participant may be addressed to the committee at (306-585-4775 or research.ethics@uregina.ca). Out of town participants may call collect.

**Statement of Consent:**
I have received a copy of this consent form for my records. I agree to permit Danielle Schmidt to use my discussion forum assignment on *Sexual Health Education in High school Students* for the research study Sexual Health Education in High school Students - A Retrospective Appreciative Study with University Students in Saskatchewan

☐ YES  (I consent - my answers may be used as data for the study)
☐ NO (I do not want my answers to be used in the study)

Signed: ________________________________ Date: _________________
If you agreed for your assignment to be used as data in research project *Sexual Health Education in High school Students - A Retrospective Appreciative Study with University Students in Saskatchewan* please answer the following questions:

1. Are you male or female?
2. How old are you?
3. What High School district did you attend?
   a. Public High School
   b. Catholic High School
   c. Other__________

4. Did you attend at least two years of high school in Saskatchewan?

5. Are you from a hometown where the population is….
   d. Less than 5000
   e. Between 5000 and 50, 000
   f. Between 50, 000 and 500, 000
   g. 500, 000 or more
Appendix C

Recruitment email (Part B In-depth One-on-One Interviews)
Dear KIN 170 student,

My name is Danielle Schmidt and I am a graduate student from the Kinesiology and Health Studies Faculty at the University of Regina. I am emailing to invite you to participate in Part 2 of my research study about students’ experiences with Sexual Health Education in high school. I am inviting you to participate in this study because you are a university student that has already participated in Part A of my study through URCourses discussion forum in your Kin 170 class.

If you decide to participate in this study, you will be asked to participate in a 1 on 1 interview with myself that will be approximately 30 minutes in duration. Questions will revolve around your experiences with sexual health education in high school to what do you think is an ideal SHE program and why. Interviews will take place at the University of Regina in a quiet office at a time of your convenience. Participants will be provided with a bonus mark in Kin 170 class for their efforts (The class is offering alternative options for earning a bonus mark if they do not wish to participate in the study) I will be using an audio recording device to assist with data collection. Participants will have the opportunity to review their interview and change or omit answers they so wish. Data collected will be completely unanimous and used for educational research purposes only. Remember, this is completely voluntary. You can choose to be in the study or not. If you'd like to participate or have any questions about the study, please email or contact me at schmdani@uregina.ca or by phone at (306) 533-9729. My supervisor Dr. June LeDrew can also be contacted for further inquiry at june.ledrew@uregina.ca.

This project has been approved by the University of Regina Reasearch Ethics Board Thank you very much and looking forward to hearing from you!
Appendix D

Potential Interview Questions (Appreciative Inquiry)

Adapted from Michael (2005) and Cooperrider, Whitney, & Stavros (2003)

How old are you?
Are you male, female or neither?
Did you attend a Public, Catholic or Private high school?
Did you attend high school in Saskatchewan?
Are you interested in a job in the health field? What are you taking in school?

1. Can you tell me a little history of your SHE education?
2. Do you think SHE education is important? When did you first realize the importance of learning about SHE education?
3. What are the core values that SHE education provides or should provide to students?
4. What part of SHE in school do you think students value most or should value most?
5. What sort of lessons took place in your SHE program? What do you wish took place? Did you actively participate in your lessons with SHE?
6. Reflecting on a positive SHE experience, what was the atmosphere in the room? (If you did not have one of these experiences, what was it like? Imagine if you took that (negative attribute away)...what would the experience have been like?
7. What would your advice be to an individual who is teaching SHE to high school students?
8. What skills should did or should an individual teaching SHE education possess?
9. What were some valuable resources that were utilized or should be utilized in SHE education?
10. What were the most important factors in the SHE education experience that helped (or would help) make it a peak experience? (...leadership, structure, rewards, skills, relationships etc.)
11. What approach should a SHE program take to impact you most in a positive way?
12. In a sentence or two to me can you describe your idea of what a successful SHE program for high schools students would look like to you?
13. What do you think is at the HEART of a successful SHE program?
14. If I asked you about what you wish for students for there school SHE education, what would you say?
15. What is the single most important thing SHE has provided to you?
Appendix E

Form of Consent and Confidentiality (Part B: In-depth One-on-One interviews)
**Project Title:** Sexual Health Education in High school Students - A Retrospective Appreciative Study with University Students in Saskatchewan

**Researcher:** Danielle Schmidt, Graduate Student
Kinesiology and Health Studies, University of Regina
(306) 533-9729  schmdani@uregina.ca

**Purpose(s) and Objective(s) of the Research:** The purpose of this research project is to discover university student’s opinions on their perceived experiences with sexual health education in high schools in Saskatchewan. The study will be conducted from an appreciative inquiry point of view that focuses on only the positive or best experiences participants have had. It will also explore what students feel is an ideal SHE program in high school.

**Procedures:** Students taking KIN 170 will have the opportunity to partake in Part B of the study by volunteering through URCourses with the researcher. A Recruitment form will be sent out to students of the class via URCourses email and for those wishing to participate a consent form will be sent back and provided at the interview for participant to sign. Approximately 6 to 10 students will partake in 1 on 1 interviews with the researchers discussing data obtained from part 1 of the study and also exploring what they feel an ideal SHE program looks like. Interviews will be approximately 30 minutes in length and will take place at the University of Regina in an available quiet room. A voice tape recorder will be used to assist in data collection

**Potential Risks:** There are no anticipated or known risks to you by participating in this survey. As some of the questions are of a personal nature, if you feel any discomfort from the question, the question can be skipped.

**Potential Benefits:** This research project will help contribute to the body of knowledge about sexual health education in Saskatchewan. It has the possibility of improving the deliverance of sexual health education in local schools to provide the best possible sexual health education to high school students

**Compensation:** Students will receive a bonus mark of 1% in KIN 170 for participating in Part B of the study. For students who do not participate there will be other educational opportunities within the class where a bonus mark can be obtained.
Confidentiality: The interviews will be anonymous with pseudonyms put in place of names. No data that has the ability to show the participants identity will be used. Any data collected from the interviews will be stored through the University of Regina in a locked and secure place, and/or on a password protected computer with only those working on the project able to access any data. After 5 years the data will be destroyed when it is not longer needed. Furthermore your professor, Dr. June LeDrew will be unaware of those students who participate, and those who do not, numbers will be used to provide the bonus marks at the end of the semester.

Right to Withdraw: Participation in this research project is completely voluntary. You can choose not to partake or refuse to answer any question (s) you are uncomfortable with and it will not have any bearing on your class standing. Once your interview has been transcribed and returned to you, you may review and make any changes you wish. You will have one week after you have been emailed your transcription to withdraw from the study. After this point, your data may have already been analyzed and utilized in disseminating the results of the research.

Follow Up: To see results of the study you can contact Danielle Schmidt @ dns621@mail.usask.ca

Questions and Concerns: Please direct any questions or concerns you have to Danielle Schmidt at the above listed email, or contact the U of R Research Ethics board at 585-4775 or research.ethics@uregina.ca.

Statement of Consent:

By signing below I am indicating that I have read the above information and understand the information provided, and all questions I had, have been answered to my satisfaction. I am consenting to participate in this research project and have my voice recorded. I also have received a copy of this form for my records.

____________________     ________________________               ___________
Name of participant     signature                     Date

Thanks for your participation!
Appendix F

Transcription Check E-mail

Dear __________,

I am happy to let you know that your transcription of the research study Sexual Health Education in High school Students - A Retrospective Appreciative Study with University Students in Saskatchewan has been completed. Attached to this email you will find a transcribed account of the interview you completed with myself. If you so wish I would like you to review your interview and make any alterations or add in any information you feel is important to your story. Please reply back to this email that either a. You are okay with the information as is or B. You have made some alterations and have attached any revisions in a different color so they can be made visible and added to the data collection. My email address is schmdani@uregina.ca or I can be contacted by phone at (306) 533-9729. Please reply within one week of this email being sent, if not reply is provided the data collected will begin to be analyzed and used within the study's findings.

Once again thank-you for participating in this research project and please do not hesitate to contact me with the information provided above. Your contribution to the study has helped me gain a deeper understanding of the current state of SHE in our province of Saskatchewan!

** Sorry for the delay in this transcription process. To refresh your memory in 2014 in your KHS 170 class with professor Dr. June LeDrew you participated in the above study for my research project. Due to personal circumstances I was unable to complete the study’s transcription/analysis at that time, but I am able to complete this project now.

Sincerely,

Danielle Schmidt