An Exploration of Transgender and Genderqueer Youths' Perceptions And Experiences of Sexual Health Education in Kings County, Nova Scotia

by

Emma Van Rooyen

Submitted in partial fulfilment of the requirements

for the degree of Master of Arts

at

Dalhousie University

Halifax, Nova Scotia

July, 2021

© Copyright by Emma Van Rooyen, 2021

Table of Contents

Abstract vi

List of Abbreviations Used vii

Acknowledgments viii

Chapter 1: Introduction 1

Background 1

Introduction to Kings County, Nova Scotia 6

Purpose of the Research Study 8

Research Questions 9

Study Design 9

Significance of the Study 10

Chapter 2: Literature Review 12

Defining Concepts 12

Key Constructs 14

Sexual Health: Definitions from the Literature 20

Research with Rural 2SLGBTQ+ Populations 22

Sexual Health and Education: The Needs of Trans and Genderqueer Youth 23

Supplementing Sexual Health Education: Beyond the Basics 29

Experiencing Erasure 30

Inclusion in Curricula and Experiences of Belonging 34
Sexual and Reproductive Health Rights 37
Implementation of Sexual Health Strategies 37
Comprehensive Sexual Health Education 38
The Current State of Sexual Health Education in Nova Scotia 40
Chapter 3: Methodology 47
Critical Qualitative Research Approach 47
Research Paradigms 47
Worldview 47
Queer Theory 49
Intersectionality 52
Social Ecological Model of Health 54
Research Method 55
Research Sample 55
Data Analysis 56
Ethical Considerations: Hidden or Hard to Access Population 58
Knowledge Translation 60
Chapter 4: Findings 61
Participant Definitions of Sexual Health 61
Social Norms and Definitions of Sexual Health 62

Sexual Health in the Classroom 63
What is Taught? 64
What Is Missing? 66
How Sexual Health Education is Taught 76
Alternative Sources of Sexual Health Information 81
Barriers to Change 83
Chapter 5: Discussion 85
Limitations 85
The Importance of Systems-Level Change 85
Sexual Health Education Action in Nova Scotia 87
A National Sexual and Reproductive Health Rights Strategy for Canada 90
Why it Matters 95
Experiencing Erasure 95
Healthy Relationships 96
Transphobia and Transmisogyny 97
Access to Reliable Sources of Sexual Health Information 98
Barriers to Change 99
Individual Level Barriers 99
Interpersonal Level Barriers 101
Organizational Level Barriers 103

Community Level Barriers 104
Policy Level Barriers 106
System Level Influences: Who Decides What is Taught 107
Recommendations for Further Action 110
Action on SRHR in Nova Scotia 110
National Action on SRHR 116
Queering Institutions 118
Chapter 6: Conclusion 121
References 125
Appendix A Interview Guide 153
Appendix B Demographic Information Form 154
Appendix C Recruitment Poster 155
Appendix D Social Ecological Model Map 156

Abstract

Background: Although sexual health education [SHE] is required in school curricula across Nova Scotia [NS], much of the content does not specifically address the unique information needs and lived experiences of transgender [trans] and genderqueer [GQ] youth. To supplement public school curricula, many youth access alternate sources of sexual health information. This study examined trans and GQ youths' perceptions of SHE taught in high schools in Kings County, NS. Specifically, this study investigates how these students access relevant SHE inside and outside the classroom and explored possible approaches to meeting the SHE needs of trans and GQ youth.

Methods: This qualitative study conducted semi-structured interviews with a diverse sample of trans and GQ youth between ages 16 and 23 who attend or attended high school in Kings County Nova Scotia within the previous two years. Interviews were audio-taped, transcribed and analyzed thematically.

Potential Impact: The results from this research will help inform the creation of policy and curricular recommendations for educators and policy makers to implement improvements to existing SHE to meet the needs of trans and genderqueer youth in rural Nova Scotia.

List of Abbreviations Used

- 2SLGBTQ+: Two Spirit, Lesbian, Gay, Bisexual, Transgender, Queer +
- CEDAW: Convention on the Elimination of All Forms of Discrimination Against Women
- CSHE: Comprehensive Sexual Health Education
- DEECD: Department of Education and Early Childhood Development
- PD: Professional Development
- PHAC: Public Health Agency of Canada
- RCE: Regional Centre for Education
- SEM: Social Ecological Model
- SHE: Sexual Health Education
- SIECCAN: Sex Information and Education Council of Canada
- SRHR: Sexual and Reproductive Health Rights
- UN: United Nations
- UNESCO: The United Nations Educational, Scientific and Cultural Organization
- WHO: World Health Organization

Acknowledgments

First, I want to thank the five people who participated in this study. Thank you for trusting me with your stories, and your insights. This project would not have been possible with out you, and I am grateful you were willing to talk to me about something so personal.

I am grateful to my committee members, Dr. Emma Whelan, and Dr. Lois Jackson and my external examiner, Dr. Margaret Robinson. Thank you for sticking it out with me. Your thoughtful feedback strengthened this study and helped me to do justice to participants' stories. Thank you.

To my thesis advisor, Dr. Jaqueline Gahagan. Thank you for your kind and gentle support over so many years, and most of all, thank you for not giving up on me. You nudged me back on track so many times I have lost count, and I would not have completed this without you. I sincerely admire your work and research and it has been a pleasure to work with you on this thesis project.

To my Public Health teammates, Ryan, and James. When I was losing focus (and steam) you encouraged me and helped to remind me why I am passionate about sexual health. Thank you for being my sounding board. I appreciate you both so much.

To Ma and Myra, thank you both for your support with editing and fine tuning. I love you both and I'm so grateful for the gift of your time and your insight.

To my closest pals and best friends, Shayna and Lisanne. You are the most insightful, compassionate, and supportive people I know. Thank you for always having my back, telling me I can when I feel like I can't, and seeing the best in me. I couldn't have done this without you.

Mum and Dad, thank you for your unfaltering belief in me. Thank you for always encouraging me to think critically, and to act from a place of loving kindness. Thank you for supporting me through the many ups and downs of this process. Thank you for listening to me and encouraging me when I needed it most (and when I was pretending I didn't). I love you both from the bottom of my heart.

Lastly, I want to thank Adrian, my partner in all things. You have always supported me to grow, learn and to push for change. Thank you for always being game to help me talk through an idea until I know what it is I'm trying to say. Thank you for having more faith in me than I have in myself sometimes. Thank you for making me laugh, giving me all of the hugs I ask for, and keeping our home running while I was deep in thesis-land. I love you wholly.

EXPLORING TRANSGENDER AND GENDERQUEER YOUTHS' PERCEPTIONS AND EXPERIENCES OF SEXUAL HEALTH EDUCATION IN KINGS COUNTY NOVA SCOTIA

Chapter 1: Introduction

Background

Available global estimates of the size of the transgender[1] population vary[2], however the actual percentage is thought to be higher than estimated, due to underreporting resulting in part from trans and queer phobia in society (Human Rights Campaign, 2014). Scheim and Bauer (2015) indicate that as many as 1 in 200 adults may be transgender, and a recent GALLUP poll conducted in the United States found that members of Generation Z[3] are significantly[4] more likely to identify as LGBT than the generations before them (Jones, 2021). The concept of gender roles and expression has continually evolved over time, and we see this reflected in the associated values espoused by youth. A recent survey conducted in the United States by research group J. Walter Thompson Intelligence found that only 48% of youth in Generation Z (youth ages 13 to 20 years old) identify as "completely heterosexual", while 56% of those

---

[1] Transgender: is an umbrella term for people whose gender identity does not match that usually associated with their physical sex characteristics. Although not all people who identify as transgender identify as being male or female, the term is often associated with transitioning between binary gender identities, i.e., male to female or female to male.
[2] The 2018-19 Nova Scotia Student Success Survey reports 10% of respondents in grades 7-10 identify as LGBTQ2+, and 9% indicate they are not sure how they identify. Of the 10% of students who identify as LGBTQ2+, 11% identify as transgender (Department of Education and Early Childhood Development [DEECD] & Communications Nova Scotia 2019).
[3] Jones (2021) for Gallup defines Generation Z as those born between 1997-2002.
[4] The Gallup poll found 15.9% of respondents from Generation Z identify as LGBT, compared to 9.1% of Millennials and 3.8% of members of Generation X (Jones, 2021).

surveyed reported knowing someone who uses gender neutral pronouns[5] (Laughlin, 2016). This survey also found that only 44% of the respondents always bought clothing targeted specifically at their gender group, and over a third felt that gender does not define a person as much as it used to for previous generations (Laughlin, 2016).

The Canadian Human Rights Act protects the rights of each Canadian to access "opportunity equal with other individuals to make for themselves the lives that they are able and wish to have and to have their needs accommodated" (Canadian Human Rights Act, 1985). Under this act, Canadians are protected, by law, from discrimination based on their race, national or ethnic origin, age and 11 other protected grounds, including gender identity and expression. Protections based on gender identity and expression were recently added. Gender identity and expression were not listed as prohibited grounds for discrimination in the Canadian Human Rights Act and the Canadian Criminal Code until June 19, 2017 (Canadian AIDS Society, 2019; Parliament of Canada, 2017). Nova Scotia's Human Rights Act, which exists for the purpose of "recogniz[ing] the inherent dignity and the equal and inalienable rights of all members of the human family" (Nova Scotia Human Rights Act, 1989) states that no Nova Scotian shall be discriminated against based on gender identity or gender expression[6] (Nova Scotia Human Rights Act, 1989). Yet, human rights legislative changes happened before the widespread social acceptance of trans and genderqueer people (Dysart-Gale, 2010). The sexual

---

[5] Comparatively, 65% of Millennials (ages 21-34) identified as "completely heterosexual" and 43% reported knowing someone who uses gender neutral pronouns (Laughlin, 2016).

[6] *Gender Expression:* is the demonstration of one's gender identity, often shown through clothing, behaviours, interests and/or chosen names. Gender expression can change over time and may not conform to an individual's gender identity.

health curricula delivered in publicly funded schools[7], as one example, has not kept up with the pace of human rights and other legislative changes (Action Canada for Sexual Health and Rights; Elia & Eliason, 2010; Meadows, 2018). The dominant social discourse around sexual health, gender, and sexuality continues to focus primarily on a binary, heteronormative[8] and cis-normative[9] understandings of gender identity and sexuality (Action Canada for Sexual Health and Rights, 2020; Elia & Eliason, 2010; Gowen & Winges-Yanez, 2014; McCarty-Caplan, 2013). Currently, the sexual health curriculum taught in Nova Scotia public schools does not explicitly or adequately address the needs of trans and genderqueer[10] youth (Action Canada for Sexual Health and Rights, 2020; Department of Education and Early Childhood Development [DEECD], 2016; DEECD, 2014). Since gender variance is, by definition, an identity outside of the current mainstream societal norm, it is essential that the needs of trans and genderqueer students be explicitly identified in sexual health curricula, or risk being overlooked, ignored or erased (Bauer et al. 2009; Saewyc et al., 2018).

According to an Australian study conducted by Gottschalk and Newton (2008), gay and lesbian people living in rural areas report experiencing homophobia similar to that experienced by their urban counterparts. However, the severity of these experiences is exacerbated by the small population size of rural areas, lack of supports, the relative lack of privacy and social conservatism that often exists in rural environments (Gottschalk & Newton, 2008; Koch &

---

[7] Both within Canada, and internationally.

[8] *Heteronormative:* The assumption that people fall into one of two gender categories: male or female, and that heterosexual relationships are the natural and normal form of sexual and romantic relationship.

[9] *Cis-normative:* The assumption that everyone is cisgender.

[10] *Genderqueer:* describes people whose gender identity is outside of the binary of female and male. Genderqueer is used by some to defy gender restrictions and/or to deconstruct gender norms.

Knutson, 2016; Oswald & Culton, 2003). The study by Gottschalk and Newton does not specifically address the experiences of trans and genderqueer people. However, just as gay and lesbian people experience discrimination and violence on the basis of perceived difference, so too do trans and genderqueer people (Koch & Knutson, 2016; Saewyc et al., 2018; Shipley, 2013). This overlay is discussed by Fox (2009), who states that homophobia is too narrow a term, which "does not capture the true essence of our experience as LGBTQ people… Transphobia and biphobia, although accepted terms, also suffer the same issues as homophobia" (p.131). Fox argues, instead, for use of the term "queer hate", which he contends describes discrimination against "the myriad of sexualities and sexual lives that are often placed on the periphery of society" (2009, p.131). Although sexuality and gender identity should not be conflated, Fox's point stands; 2SLGBTQ+ people experience discrimination and hatred, based on their perceived difference (Fox, 2009; Koch & Knutson, 2016; Shipley, 2013). Moreover, this difference is more visible in rural areas where there is less privacy, and smaller populations of 2SLGBTQ+ people (Willging et al., 2006).

As well as experiencing social discrimination and stigmatization, trans and genderqueer youth living in rural areas also contend with a lack of access to culturally safe and appropriate primary and mental health care services (House of Commons Standing Committee on Health, 2019; Koch & Knutson, 2016; Saewyc et al. 2018; Taylor et al., 2020). According to Horvath and colleagues (2014), as well as Koch and Knutson (2016) there is a general lack of mental health resources, and physical health services available to 2SLGBTQ+ people living in rural areas. This is, in part, due to the fact that there are an insufficient number of health professionals specifically trained, or willing, to address the physical and mental health needs of trans and

genderqueer people (Giblon & Bauer, 2017; Horvath et al., 2014; Rutherford et al. 2012; Saewyc et al. 2018). Although it is recognized that trans and genderqueer (as well as other sexual and gender-minority people) living in rural areas experience complex health, social and other challenges, there is a lack of health research which specifically investigates these challenges (Horvath et. al., 2014; Koch & Knutson, 2016; Ontario Public Health Association [OPHA], 2004; Whitehead et al., 2016).

The existing literature highlights the ways that trans, genderqueer, and 2SLGBTQ+ youth, have been historically excluded from, and denied influence over, school curricula (Abbott et al., 2015; Bradford et al., 2019; Elia & Eliason, 2010; Gowen & Winges-Yanez, 2014; Meadows, 2018; McCarty-Caplan, 2013) and how this exclusion can affect trans and genderqueer youths' mental health and well-being (Proulx et al., 2019; Saewyc et al., 2018; Taylor et al., 2020). The literature reviewed in Chapter 2 of this thesis emphasizes the importance of creating 2SLGBTQ+ inclusive curricula and Chapter 5 provides recommendations to educators and policy makers. The literature also outlines barriers to inclusion, including experiences of erasure and the social dominance of heteronormativity (Abbott, et al., 2015; Bauer et al., 2009; Bradford et al., 2019; Hobaica et al., 2019). Lastly, the existing literature outlines how trans and genderqueer youth access relevant sexual health education [SHE], outside of the classroom. These issues have implications for health promotion.

As a discipline, health promotion is generally absent from health literature addressing the needs of lesbians and gay men (Numer & Gahagan, 2009), and even less so in relation to

trans-related literature and practice[11] (Bauer, 2012; Mustanski et al., 2015). For example, there is a dearth of health promotion literature that identifies what sexual health information trans and genderqueer youth feel is missing from the sexual health curricula, or how to integrate relevant sexual health information into existing curricula (Bradford et al., 2019). This gap in the literature reduces the efficacy of sexual health promoters working to address the needs of trans and genderqueer youth. Addressing this gap, this exploratory qualitative research study collected data that may be useful to health promoters, policy makers, educators, and public health staff, in advocating for changes to policy and curricular requirements for SHE within the province of Nova Scotia, Canada. These data add to the limited body of knowledge shaping our current understanding of trans and genderqueer youths' perceptions and experiences with SHE in rural Nova Scotia's public schools.

Introduction to Kings County, Nova Scotia

Trans and genderqueer youth living in rural areas face a more complex set of challenges than their urban peers, challenges that are not adequately documented in existing literature (Bauer, 2012; Koch & Knutson, 2016; OPHA, 2004; Whitehead et al., 2016). Kings County is a rural[12] municipality in the Annapolis Valley. There are three towns in the county, Berwick, Kentville and Wolfville. The rural areas of the county consist of a mix of farmlands, woodlands, villages, two Mi'kmaq reserve communities (Glooscap First Nation and Annapolis Valley First Nation), and two army bases located in Aldershot and Greenwood. Since colonization, the

[11] See Colpitts and Gahagan, 2016, and Gahagan and Colpitts, 2017 how health promotion can address the needs of LGBTQ communities.
[12] See further discussion about the definition of the term "rural" in Chapter 2: Literature Review

communities along the valley floor have been primarily agricultural zones, while fishing, hunting and forestry have traditionally sustained people living on the two low-lying mountains, called North and South.

According to the 2016 National Household Survey, in that year 4.4%[13] of residents identified as First Nations, 3.2% of residents of Kings County identified as a member of a visible minority, 4.7% of residents identified as a first to third generation immigrant, and 86.1% of residents reported being at minimum a third generation Canadian (Statistics Canada, 2016). In 2016, 20.2% of residents between the ages of 25-64 years had not completed high school, 26.4% had only a high school education and 53.3% had earned a degree, certificate, or diploma from a postsecondary institution[14] (Statistics Canada, 2016). These statistics demonstrate that the population of Kings County is relatively culturally and racially homogenous, and thus provides insight into how difference may be perceived and treated. Kings County has established cultural traditions that celebrate heteronormative and cis-normative social and cultural norms[15]. In many rural communities, including Kings County, these traditions are actively preserved over many generations (MacDonald & Jolliffe, 2003). Macdonald and Jolliffe (2003) point out that the economic health of many rural communities relies on the maintenance of cultural traditions, to attract tourist dollars. Thus, community members who challenge cultural norms (i.e., heteronormativity and cis-normativity) and traditions may be seen as a threat to the economic health of a region.

---

[13] Resident statistic percentages based on number of total 60,600 residents responding to this section of the National Household Survey in 2011 (Statistics Canada, 2016)

[14] Education statistics based on 50,330 of 60,600 residents responding to this section of the National Household Survey in 2016 (Statistics Canada, 2016)

[15] For example: The Apple Blossom Princess/Leadership Competition (Colbert, 2015)

Although rural areas have specific identities that are tied to physical places and towns, cross-cutting demographic homogeneity reinforces cis/heteronormative customs. It is important to note, though, that there is no singular rural culture in Kings County, or any other rural place for that matter (Hart et al., 2005). Thus, even though there is no singular rural culture that exists in Kings County, the maintenance of heteronormative and cis-normative cultural traditions supports an exclusionary narrative, that helps to maintain social norms. Challenges faced by trans and genderqueer people living in rural areas, including exclusionary cultural traditions (Elia & Eliason, 2010; Gowen & Winges-Yanez, 2014; McCarty-Caplan, 2013), and the lack of privacy (Gottschalk & Newton, 2008; Oswald & Culton, 2003) are all present in Kings County. For example, in 2012 a transgender high school student from Kings County named Wallace did an interview with the Kings County Advertiser. About her life in Kings County, Wallace was quoted as saying "'Every single time I enter the public or set foot outside of my house, the world is far from welcoming to someone like me. I get called faggot every day'" (Elliott, 2012). She described having to change schools after receiving death threats, her struggles to access the health care services she needs and explained that trans people struggle daily to have their rights recognized in communities where they are underrepresented (Elliott, 2012).

Purpose of the Research Study

The primary purpose of this exploratory qualitative research study was to understand trans and genderqueer youths' perspectives of SHE in Kings County, Nova Scotia, to inform a set of recommendations for health promoters, policy makers, professionals in curriculum development and educators in Nova Scotia. Recommendations will outline the sexual health

information that trans and genderqueer youth participants of this study perceive to be relevant to their needs, and how they feel this information should be delivered to students. The purpose of this study is to contribute to the health promotion body of knowledge on this topic, with the goal of queering the discipline's understanding of and approach to sexual health promotion, thereby supporting social transformation and justice in relation to SHE for trans and genderqueer youth.

Research Questions

Four interrelated questions informed this study. The *primary research question* was: What are trans and genderqueer youths' perceptions and experiences of the sexual health education provided in public schools in Kings County Nova Scotia? The first *sub question* was: If not in the classroom, how are trans and genderqueer youth living in rural Nova Scotia accessing sexual health information relevant to their sexual health needs? The second *sub question was*: in what ways can the sexual health education curriculum in Nova Scotia change to become inclusive of the needs of trans and genderqueer youth? The third *sub question* was: What are the greatest barriers to meaningful change?

Study Design

This exploratory qualitative research study involved collecting data through semi-structured interviews with a sample of trans and genderqueer youth in Kings County, Nova Scotia. This site was chosen for the study because of my existing community connections in Kings County, and the trust I established with key community members during the 29 years I have lived in the area. My connection to Kings County and the people who live here was important to the success of the study. The community of trans and genderqueer youth is, as in

other similar rural areas, quite small and hard to access. The process of finding study participants was simplified because I know members of the 2SLGBTQ+ community in the county.

Study participants were recruited through The Valley Youth Project, Wolfville Pride, The Red Door Youth Health and Support Centre, as well as through word of mouth. This study included a purposive sample of 5 youth participants, between the ages of 16 and 23, (purposive sample size outlined by Baker et al., 2012, p. 8). Data were analyzed used inductively, following the six phases of thematic analysis outlined by Braun and Clarke (2006).

Significance of the Study

This exploratory qualitative research study has significance for the areas of health promotion, education, and primary health care. This study addresses gaps in the literature on the experiences of trans and genderqueer youth living in rural area of Canada (Laverty et al., 2021; Horvath et. al., 2014; Koch & Knutson, 2016; OPHA, 2004), and more specifically in Nova Scotia, where there is no baseline data that describes the sexual health needs of the province's youth.

The data from this exploratory qualitative research study describes the sexual health information the participants felt was relevant to, but missing from, the SHE they received in public school. This information is significant to educators, health promoters, and policy makers because understanding what SHE information trans and genderqueer youth want and need is the first step towards providing educators, administrators, RCEs and the provincial Department of Education and Early Childhood Development [DEECD] with the tools needed to address information deficits in the provincial health curriculum. This information is also valuable to

health promoters in the Nova Scotia Health Authority's department of public health, which identifies sexual health as a priority in its current protocols (Department of Health and Wellness, 2009). This study will inform the creation and delivery of inclusive sexual health promotion programming and policy.

The results from this exploratory qualitative research study provide an overview of how, why, and where, trans and genderqueer youth access sexual health information relevant to their needs[16]. This information is of value to educators, as the resources described by participants provide examples of information they felt relevant to their lives. This information is also valuable to the DEECD as it may inform the creation of lesson plans that include reliable and accurate information, relevant to the needs and experiences of trans and genderqueer youth.

[16] Mitchell et al. (2014), found that 78% of LGBQ (Lesbian, Gay, Bisexual, Queer/Questioning) youth, versus 19% of heterosexual youth reported accessing sexual health information online.

Chapter 2: Literature Review

Defining Concepts

It is important to define key terms and constructs for the sake of clarity and communication. Gender is a complex and contested concept (Stringer, 2013), and is thus difficult to define. However, most definitions, including that used by The Canadian Institute for Health Research [CIHR], describe gender as a socially constructed concept. Language is constantly evolving, and I recognize that as I write this thesis the language I choose to use becomes dated. I do my best to reflect the language of the moment as I write, recognizing that as our understanding, acceptance and celebration of gender grows the language used to describe it will continue to shift and evolve. Recognizing the contested and evolving nature of the concept of gender, the following terms represent most current language. Outlining these terms provides the reader with a foundational understanding of key concepts and facilitates communication by establishing a shared understanding.

Definitions provided throughout this thesis are adapted from and informed by Rainbow Health Ontario's Glossary of terms (The 519 Church Street Community Centre, 2014); from the *Trans, Genderqueer and Queer Glossary* with permission from JAC Stringer (2013) of the Trans and Queer Wellness Initiative, Ohio; from CIHR (2015) and the Trans Student Educational Resources (2017) glossary of definitions. *Gender:* is a social construct that determines the expected roles, behaviours, expressions and identities of girls, women, boys, men, and gender diverse people. Gender "influences how people perceive themselves and each other, how they act and interact, and the distribution of power and resources in society" (CIHR, 2015, para. 2). *Gender Identity:* is how a person perceives themselves as male, female, both, or neither,

regardless of their physical body. Gender identity is separate from "biological sex". 2S*LGBTQ+: is* an acronym referring to the wide spectrum of Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer and gender and sexual minorities. Variations of the acronym used in this study, reflect the language used by a cited author. The plus sign in this acronym represents a wide spectrum of gender identities and sexual orientations. Use of the plus sign in this thesis does not in any way indicate that the many identities not specifically referenced in the acronym are in any way less valid or deserving of consideration and recognition than those that are. Use of the plus sign was pragmatic, inserted for ease of communication, not to erase the identity of any person or group. *Cisgender:* describes a person who is not transgender, and whose gender identity, behaviours and appearance align with what their culture expects from a person with their biological sex characteristics.

I use the terms transgender [trans] and genderqueer to describe the exploratory qualitative research study's participants. These may not be the terms that participants would choose to describe themselves, as gender identity is sometimes fluid (Stringer, 2013), and language used to describe gender shifts and changes over time. My intention in choosing these terms was to be inclusive of participants with varying gender identities. I recognize that trans and genderqueer youth are not a homogenous group, just as people who identify as female do not share a universal experience.

Throughout the study I cite literature and research conducted with lesbian, gay and transgender populations, because there is insufficient literature written solely about the experiences of transgender and other gender variant people. It is important that I state that gender identity and sexuality should not be conflated, as they are not the same thing. However,

> these groups share the common status of ‘other’ because of their members' departures from heterosexuality and gender norms. Their ‘otherness’ is the basis for stigma and its attendant prejudice, discrimination, and violence, which underlie society's general lack of attention to their health needs. (Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, 2011, p.13)

Thus, although members of the 2SLGBTQ+ community are diverse in their age, social class, race and ethnicity, shared experiences of stigmatization make the use of LGB research relevant to elements of this exploratory qualitative research study.

Key Constructs

This study refers to several constructs which require further explanation. The first construct to be defined is *sexual health*. For the purposes of this study, I use the World Health Organization [WHO] (2006) definition, which states:

> Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. (p. 5)

The second key construct is *Sexual and Reproductive Health Rights* [SRHR] which is the term used to refer to the sexual health, sexual rights, reproductive health, and reproductive rights of all people (Starrs et al., 2018). SRHR is:

> A state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity.

> Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals to:
>
> • have their bodily integrity, privacy, and personal autonomy respected;
>
> • freely define their own sexuality, including sexual orientation and gender identity and expression;
>
> • decide whether and when to be sexually active;
>
> • choose their sexual partners;
>
> • have safe and pleasurable sexual experiences;
>
> • decide whether, when, and whom to marry;
>
> • decide whether, when, and by what means to have a child or children, and how many children to have.
>
> (Starrs et al., 2018 p. 2646)

SRHR is an important concept because, based on this definition, sexual health is a human right, as is the ability to define one's own sexuality, sexual orientation, and gender identity, whether to have sex, and with whom (Starrs et al., 2018). This definition also recognizes each individual's right to "have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence" (Starrs et al., 2018 p. 2646). Based on the definition of SRHR provided by Starrs and

colleagues (2018), sexual health education (see construct definition below) is a human right, which should be afforded to all people, regardless of gender identity (Office of the United Nations High Commissioner for Human Rights [OHCHR], 2020).

It is important to note here that the assertion that all people have the inherent right to sexual and reproductive autonomy and relevant SHE is a values-based political position. Existing research (described below) demonstrates the health benefits people experience when they have access to and control over their SRHR, and the harms experienced when they do not. However, it is not an objective fact that every person has access to their inherent human rights. Governments and institutions create the laws and policies that affect individual rights. The laws and policies a society creates reflect the political and social values of that society and are therefore subject to shift and change over time. In this thesis I argue that the SRHR of trans and genderqueer youth should be protected and upheld, and that these rights are infringed upon when the SHE delivered in public schools does not address their health needs. Existing research provides evidence that exclusion from curricula can contribute to increased negative mental health outcomes for trans and genderqueer students (for examples see Taylor et al., 2020; Taylor et al., 2011; Veale et al., 2015). It is my political position that the harms caused by exclusion are unacceptable, and that social institutions and governments have a responsibility to create policy and facilitate practices which address the harms experienced by trans and genderqueer youth, as described in the literature.

The next key construct is *health promotion*, which is “the process of enabling people to increase control over, and to improve, their health. [Health promotion] moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions''

(WHO, 2016, para. 1). The discipline of health promotion is action oriented and seeks to address health inequities and achieve justice. It is a “comprehensive social and political process, it not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health” (WHO, 1998, p. 351). The subset of health promotion most relevant to this study is *sexual health promotion*, which is “the process by which individuals achieve the ability to control and improve their sexual health” (Khalesi et al., 2016, p. 2489). A key health promotion concept is the *determinants of health*, which are “the broad range of personal, social, economic and environmental factors that determine individual and population health” (Government of Canada, 2020b, para. 1). Whereas the *social determinants of health* are “a specific group of social and economic factors within the broader determinants of health… Experiences of discrimination, racism and historical trauma are important social determinants of health for certain groups such as Indigenous Peoples, LGBTQ and Black Canadians” (Government of Canada, 2020b, para. 3). The determinants of health affect all health outcomes, including sexual health. For the purposes of this study *sexual health education* “is the process of equipping individuals, couples, families and communities with the information, motivation and behavioural skills needed to enhance sexual health and avoid negative sexual health outcomes” (PHAC, 2008, p. 5). SHE takes place in both formal and informal settings. SHE may be delivered through formalized curricula, through formal and informal networks of support or through the internet.

The third construct is *comprehensive sexual health education.* In this thesis I use The United Nations Educational, Scientific and Cultural Organization [UNESCO] (2018) definition of CSHE:

> Comprehensive sexuality education is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and understand and ensure the protection of their rights throughout their lives. (p. 16)

It is important to note that both the conceptualizations, and inclusiveness of comprehensive curricula vary across organizations and communities (Miedema et al., 2020). Miedema and colleagues (2020) encourage researchers and educators using the term CSHE to be "vigilant about how 'accepted' terminology – which may seek to convey a universality – can mask power dynamics, implicitly setting boundaries, and exclude … certain individuals and communities" (P. 748). For instance, Elia and Eliason (2010) note although CSHE includes 2SLGBTQ+ topics, it does not necessarily address contextual factors "such as racial/ethnic background, class status, educational level, gender-based discrimination, ability/disability status, and other forms of oppression" (p. 40). Contextual elements of health and sexuality are addressed through the next construct, *anti-oppressive, inclusive sexuality education*, which "is based on a social construction model with all of its messiness—acknowledging that human sexual desires, fantasies, thoughts, and behaviors are not always consistent or easily labeled, and that change,

and fluidity characterize much of human gendered and sexual behavior" (Elia and Eliason, 2010, p. 40). Anti-oppressive, inclusive sexuality education aligns with queer theories (see below) and builds upon comprehensive approaches to sexual health education. While recognizing its limitations, this study focuses on the implementation of CSHE as a pragmatic step toward what can "reasonably be expected" (Miedema et al., 2020 p. 757) in this cultural moment.

Youth who do not have their sexual health questions answered in the classroom may seek *alternative sources of sexual health education*, which are the on and offline resources that youth access for supplementary sexual health information (Action Canada for Sexual Health and Rights, 2020; DeHaan et al., 2013; Laverty, 2021; Mitchell et al., 2014). The next construct to be defined is *sexual health information* which describes the content of SHE, which varies based on the teacher delivering the lesson, as well as the provincial curriculum requirements (Cohen et al., 2004; Ontario Physical and Health Education Association, n.d.).

The final construct is *rural*. As stated by Hart and colleagues (2005), "Defining rurality can be elusive and frequently relies on stereotypes and personal experiences" (p. 1149). Yet, however difficult it may be to define, the designation "rural" has implications for policy creation and resource allocation (Hart et al., 2005; Koch & Knutson, 2016). Thus, it is important to do our best to understand the complex concept of rurality, so we may "specify which aspects of rurality are relevant to the phenomenon being examined and then use a definition that captures those elements" (Hart et al., 2005, p. 1149). In other words: how does rurality affect the delivery of SHE in Kings County?

In 2011 Statistics Canada created the designation Rural Area, which refers to any area that lies outside of a Population Centre (Statistics Canada, 2017), defined as any "area with a

population of at least 1,000 and no fewer than 400 persons per square kilometer" (Statistics Canada, 2017, para. 1). However, rurality is not only defined by population size and density; culture, social norms and expectations, community size, poverty[17], access to resources and economic opportunities are all elements that shape the experiences of trans and genderqueer people living in rural places (Koch & Knutson, 2016; Willging et al., 2006), including Kings County, Nova Scotia.

Based on the Statistics Canada definition, the vast majority of Kings County can be considered a rural place. The county is also a place with discernable social and cultural norms (Colbert, 2015), an elevated level of poverty (Frank et al., 2020) and limited resources for trans residents (Elliott, 2012). These are aspects of rurality "relevant to the phenomenon being examined" (Hart et al., 2005, p. 1149) in this study.

Sexual Health: Definitions from the Literature

As with many concepts, people often talk about sexual health without defining what it means, both to them personally as well as socially and culturally. Defining sexual health is challenging because it is a highly personal concept. Consequently, a definition that speaks to one person may not resonate with another. Regardless, it is still important to define what we mean by sexual health so that we can have shared conversations about how it affects our lives and our communities. It is also important to define sexual health because the information included in school-based sexual health curricula (and thus whose needs are being met) is

[17] The 2020 Report Card on Child and Family Poverty in Nova Scotia notes that poverty rates are high in both urban and rural areas of the province, however the highest rates of poverty are in rural areas where transportation creates significant barriers to service access (Frank et al., 2020).

shaped by the way a community defines sexual health (Nova Scotia Roundtable, 2006; SIECCAN, 2019).

The various definitions of sexual health contain several key elements: physical health, mental/emotional health and wellbeing, positive sexuality, healthy relationships, pleasure, safety, and the absence of violence and discrimination (American Sexual Health Association, 2020; National Coalition for Sexual Health, 2021; Options for Sexual Health, 2020; Sexual Health Ontario, n.d.; WHO, 2006). Of key importance is the insight sexual health is not just about disease prevention. These elements are represented in many of the other definitions put forward by public health agencies and sexual health organizations. Some definitions incorporate additional elements, such as consent, bodily autonomy, the spectrum of sexuality, trust, relationship types, intimacy, sexuality and aging, mental health, access to sexual health information and care, gender expression, gender identity and joy (American Sexual Health Association, 2020; National Coalition for Sexual Health, 2021; Sexual Health Ontario, n.d.). Options for Sexual Health (2020), based in Vancouver British Colombia, includes body image and self-esteem, reproduction, and anatomy in their definition. Inclusive definitions of sexual health communicate the basics of what sexual health is, while leaving room for people to adjust the definition based on their lived experiences or cultural context. An inclusive definition should provide structure but leave space for experiences that do not fit within the confines of the definition provided. The definition put forward by the Nova Scotia Roundtable on Youth Sexual Health (2006) states, sexual health "encompasses respecting, protecting and fulfilling the sexual rights of all people" (p. 1). Study participants, although finding the question difficult to answer, ultimately touched on many of these themes in their personal definitions of sexual health.

Research with Rural 2SLGBTQ+ Populations

The literature addressing the physical and mental health, social, health care needs, and unique lived experiences of trans and genderqueer people in rural areas is sparse, and further research is required in the field of health promotion (Horvath et al., 2014; Koch & Knutson, 2016; Eisenberg et. al, 2019; OPHA, 2004; Oswald & Culton, 2003; Rosenkrantz et. al, 2016; Willging et al., 2006). Existing literature establishes that, as is true for members of multiple marginalized groups, trans and genderqueer people living in rural areas are underserved, and face barriers to accessing health care including lack of transportation, lack of internet access, cost, safety, health provider competence in transgender medical care and resource availability; among others (Koch & Knutson, 2016; Taylor et al., 2020). A study based in Minnesota by Eisenberg and colleagues (2019) found that rural trans youth experience more bullying than their suburban counterparts. However, rural life also has benefits for trans and genderqueer people. For example, in their 2003 article Oswald and Culton (2003) report results from 428 participants asked what they considered to be the "best thing" about living in rural Illinois. Participants gave a variety of answers, but the most common were friends, family, partners and children, quality of life, and the local LGBTQ community (Oswald & Culton, 2003). The aspects of rural life identified in Oswald and Culton's (2003) survey are not limited to rural Illinois and can reasonably be considered to apply to other rural areas. However, there is a notable lack of research available that focuses on the experiences of rural gender minority[18] populations in

[18] *Gender Minority:* refers to all people who are not cisgender, the most prominent gender identity.

Canada, which Ontario Public Health identified as one of the limitations to the Trans Pulse project conducted in the province (OPHA, 2004).

Sexual Health and Education: The Needs of Trans and Genderqueer Youth

The SHE delivered in Canadian public schools often fails to meet the sexual health information needs of all students (Action Canada for Health and Rights, 2020; Laverty et al.,2021). In a recent Canadian study Laverty and colleagues (2021) conducted focus groups with Canadian youth ages 12-19 and found participants felt their SHE was too heavily focused on biological information and did not provide them with information most relevant to their lives (i.e., healthy relationships, consent, communication, gender and sexuality, and sexual pleasure). These findings are supported by a recent report from Action Canada for Sexual Health and Rights (2020), where participants reported their sexual health lessons were too short, delivered by teachers who were uncomfortable with the content, and focused narrowly on the biological aspects of sex, pregnancy and STI prevention. In addition to informational deficits and pedagogical challenges, these studies found sexual health curricula and resulting classroom lessons contained a significant heteronormative bias (Action Canada for Health and Rights, 2020; Laverty et al.,2021), a point which is significant to this study, as heteronormative curricula do not address the needs of trans and genderqueer students.

Authors Elia and Eliason (2010) and Gowen and Winges-Yanez (2014) describe ways LGBTQ youth are excluded from SHE, including the erasure of trans and non-binary[19] identities from curricula, and a lack of information about transgender health care. The above-mentioned

[19] *Gender Binary: is* the belief that there are only two genders, male and female.

articles and studies provide solid foundational information about inclusive curricula, while also highlighting the absence of academic research which describes the specific SHE needs of trans and genderqueer youth, and best practices for lesson plan delivery (Elia & Eliason, 2010).

There is a significant body of health literature addressing human immunodeficiency virus [HIV] and sexually transmitted infections transmission rates among trans, genderqueer and sexual minority (LGB) youth, and appropriate interventions for protection (Clements-Nolle et al., 2001; Herbst et al., 2008; Garofalo et al., 2006). Research into HIV transmission is important; however, it is only one element of sexual health. Bauer and Hammond (2015) note most of the research into the health of transgender women is limited in scope and does not capture their unique lived experiences. They note there is a significant body of research into "HIV-related risk among trans women who are sexually involved with cisgender men" (Bauer & Hammond, 2015, p. 1). The authors feel this limited scope of research "reinforces conceptualizations that all trans women medically transition through hormones and/or surgeries and are heterosexual with cis man partners" (Bauer & Hammond, 2015, p. 1). Bauer and Hammond (2015) argue that existing literature fails to consider the needs of trans women who choose not to medically transition, those with trans partners or those who do not participate in partnered sex (2015). This limited focus on research into the lives of trans women leaves a gap in the literature.

There is little academic research that expressly addresses how to teach trans and genderqueer youth about sexual health in the classroom (i.e., safer sex, STI prevention, how to talk about gender identity, transition, how to talk about your body) (Bauer & Hammond, 2015; Sevelius, 2009). The sexual health curricula guidelines prepared by the Public Health Agency of

Canada [PHAC] (2015), emphasize the importance of teaching SHE in an inclusive way, as do guidelines prepared by the Sex Information and Education Council of Canada (SIECCAN) (2019) and the Government of Nova Scotia's *Guidelines for Supporting Transgender and Gender-nonconforming Students* (2014). These guidelines do not, however, specify lesson plans[20] or provide educators with resources that explain how to implement changes to provide SHE that is relevant to trans and genderqueer students (for examples see PHAC, 2014; PHAC, 2008; SIECCAN, 2019). The focus of these government-produced resources is more about recognizing the existence of trans, genderqueer and other sexual minority students than about providing specific instructions to educators who may need supports to teach trans and genderqueer students about sexual health in a relevant way and use of these resources in the school system is not mandated, monitored or evaluated.

Although government agencies such as PHAC do not provide ready-made resources such as lesson plans or teaching manuals, such resources do exist (for examples see Alberta Health Services, 2019; Bryan, 2012; GLSEN, 2019; The Arc Foundation, 2019), and are available to educators who have the time and inclination to seek them out. However, these resources are supplemental, available to educators who are individually motivated to expand their lesson plans to be inclusive of 2SLGBTQ+ students in a meaningful way, but they are not required learning for all teachers. Until such time that CSHE is mandated by government policy, students' experiences will vary depending on the comfort-level of the teacher delivering the material, among other factors (Action Canada for Sexual Health and Rights, 2020).

---

[20] The SIECCAN (2019) guidelines do, however, provide CSHE content checklists to support lesson planning.

There are many people who play a role in delivering SHE to students, including parents and community sexual health organizations (Action Canada for Sexual Health and Rights, 2020). Effective delivery of CSHE relies on a multi-pronged approach, including community sexual health organizations and teaching staff, to developing and delivering content (Nova Scotia Roundtable on Youth Sexual Health [Nova Scotia Roundtable], 2006), however according to Action Canada for Sexual Health and Rights (2020),

> teachers are uniquely positioned to answer questions raised organically in class, address incidents to make them important learning moments, establish class norms, benefit from their students' trust as they spend months together, and integrate important learning opportunities in other lessons. (p. 57)

Because teachers spend so much time with students, they are uniquely positioned to integrate CSHE into lessons across the curriculum; however, to do this effectively requires support, and ongoing professional development [PD] (Action Canada for Sexual Health and Rights, 2020; Gahagan, 2015).

Health class is often seen as an unwanted assignment; given to the newest teachers, and teachers are not often given resources, education, or other support needed to deliver the material in a meaningful way (Action Canada for Sexual Health and Rights, 2020). Moreover, since health education is not a teachable subject covered in Bachelor of Education [BEd] Programs in Nova Scotia[21], teachers may not have the time, nor the resources required to

[21] As described by the Provincial Office of Teacher Certification, all potential "teachable" subjects are described in the Public School Program of Nova Scotia (DEECD, n.d. a & 2013). Although health education is listed in the Public School Program of Nova Scotia, it is not offered as a teachable subject in any of the recognized (DEECD, n.d. b)

invest into this class as they would into their core teachable subjects. A teachable subject requires a minimum of 30 credit hours (for a major) or 18 credit hours (for a minor) within an undergraduate degree and competition of a BEd teaching methodology course in the subject (DEECD, n.d. a). Providing educators with ongoing support and PD in SHE is important (Action Canada for Sexual Health and Rights, 2020; Gahagan, 2015), as when teachers do not feel comfortable, confident, or competent delivering SHE content, they are more likely to skip that part of the lesson, leading to inconsistent curriculum delivery (Burns & Hendriks, 2018; Clayton et al., 2018; National Children's Bureau, 2018). Teachers who receive support and PD are more likely to take a whole school approach to SHE, where sexual health topics are integrated into the school community instead of contained in a single class (Burns & Hendriks, 2018). Teachers who receive SHE PD are also more likely to deliver the pieces of the curriculum that address the spectrum of gender and sexuality (Clayton et al., 2018; National Children's Bureau, 2018). In a study conducted by Burns and Hendriks (2018) one of the respondent educators emphasized the importance of "something for the teachers so that they can understand and meaningfully include their LGBT students even if they have no previous experience or exposure" (p. 680). For teachers with no lived experience of being trans or genderqueer, PD may be their only opportunity to learn about the lives of their 2SLGBTQ+ students, and to prepare to answer questions those students may have. Another option or opportunity for teachers who do not have lived experience is to partner with community organizations or individuals in the

---

English-speaking, pre-service Bachelors of Education programs in the province: Acadia University School of Education (2021a & 2021b), Mount Saint Vincent Faculty of Education, St. Francis Xavier University (2017a & 2017b), or Cape Breton University Bachelor of Education (2021).

community that do. For example, The Youth Project, a community sexual health organization serving 2SLGBTQ+ youth, will visit classrooms and deliver workshops on sexual orientation and gender identity, as well as provide PD to teachers and administrators. Workshops are tailored to the grade level and address grade specific curriculum outcomes (The Youth Project, n.d.-b). Community sexual health organizations play an important role in the effective delivery of CSHE, through the delivery of CSHE content, and the provision of PD to teachers and staff (Action Canada for Sexual Health and Rights, 2020; Nova Scotia Roundtable, 2006; UNESCO, 2016). Individual community members are also a potential resource for teachers. In some high schools former students who are trans or genderqueer return to the classroom to talk to students about their experiences growing up in that community. Return students can share their firsthand experiences accessing relevant SHE information and accessing sexual health services. Their presence in the classroom can help to increase trans visibility and representation.

Providing classroom teachers with PD in CSHE is also important because training may make a teacher feel supported by their employer to deliver the content in their classrooms. As SHE is often contested and politicized, many educators see teaching it as a risky assignment (Preston, 2019). As such, having employer-support may be an important safety factor for an educator, allowing them to feel more comfortable delivering the curriculum (Burns & Hendriks, 2018). As one of the teacher respondents in the study from Burns and Hendriks (2018) described: “My knowledge comes from personal professional reading, not from employer-supplied resources and information . . . I am not comfortable with the notion of teaching this subject area, because of the lack of support from my employer in this area” (p. 679). Teachers who receive health-curriculum PD are also more likely to feel supported by their employer to

deliver the entirety of the curriculum which makes it more likely that they will deliver the more politicized elements of the curriculum (i.e., the spectrum of gender and sexuality), which make classrooms more inclusive for trans and genderqueer students (Burns & Hendriks, 2018).

As teachers do not often receive adequate SHE PD (Preston, 2019; Walters & Hayes, 2007), and for other reasons discussed in this thesis, trans and genderqueer youth do not often have their sexual health needs fully addressed or acknowledged in the classroom (Action Canada for Sexual Health and Rights, 2020; House of Commons Standing Committee on Health, 2019; Taylor et al., 2020; Taylor et al., 2013; Veale et al., 2015). Trans and genderqueer youth whose SHE needs are not being met in the classroom often seek out alternative sources of SHE (DeHaan et al., 2013; Mitchell et al., 2014), as described in the following section.

Supplementing Sexual Health Education: Beyond the Basics

Due, in part, to the variations in sexual health content and quality of instruction in the public school system (Action Canada for Sexual Health and Rights, 2020), youth of all genders access alternative sources of sexual health information through friends, blogs, social media, YouTube, pornography and other informal support networks (Laverty et al., 2021; Pinto et al., 2008; Muñoz-Plaza et al., 2002). These supplemental sources of information are especially important to trans and genderqueer students. According to current research, these informal sources of education and support enable trans and genderqueer youth to learn and teach one another about sexuality and sexual health in safer, more relaxed settings, on the internet or in LGBT-community groups (DeHaan et al., 2013; Mitchell at al., 2014). Informal networks, including online resources and communities, are an important part of SHE for trans and genderqueer youth. Mitchell and colleagues (2014) found that 78% of LGBQ (Lesbian, Gay,

Bisexual, Queer[22]/Questioning) youth reported accessing sexual health information online, versus 19% of heterosexual youth who participated in their online survey[23]. LGBQ youth reported accessing information online because of a lack of other options (Mitchell et al., 2014). Some participants felt that the SHE at their schools was irrelevant to them and did not meet their needs. One participant described the SHE in their school as "ridiculous", explaining that they:

> searched a lot of queer Web sites that had tips on what to do, how to do it, and when to do it. Because the sex [education] at our school is ridiculous. It's a frickin abstinence program. . . I felt it wasn't substantial enough information at school so I just figured… I need to research this myself (DeHaan et al., 2013, p. 429).

Alternative sources of SHE, both online and offline, provide trans and genderqueer youth with information that is not delivered in their sexual health classes, where their needs may not be prioritized, or even recognized (Action Canada for Sexual Health and Rights, 2020; DeHaan et al., 2013; Taylor et al., 2013).

Experiencing Erasure

Trans and genderqueer youth, as well as other LGBTQ+ youth, have some sexual health needs their cisgender peers do not (Elia and Eliason, 2010; Mitchell et al., 2014). For example, trans youth may want information about transition options. Queer youth may need information on how to have safe, non-heteronormative sex, and youth questioning their gender identity

---

[22] *Queer: is* an umbrella term that describes identities outside of the cis-normative, heterosexual or monogamous majority. Queer is often used interchangeably with 2SLGBTQ+.

[23] The sample for this study was 5907 youth from the United States, between ages 13 and 18 (Mitchell et al., 2014).

may want more information on gender identities outside of the cis-normative binary. To create 2SLGBTQ+ inclusive curricula, these differences must be recognized and incorporated into lesson plans (Action Canada for Sexual Health and Rights, 2020; Dentato et al., 2016; Elia and Eliason, 2010; McCarty-Caplan, 2013). Creating inclusive curricula is made difficult by what Namaste (2009) defines as erasure, ''a defining condition of how transsexuality is managed in culture and institutions, a condition that ultimately inscribes transsexuality as impossible'' (cited in Bauer et al., 2009, p. 350). Bauer et al. (2009) outline two distinct forms of erasure that affect transgender people. The first is informational erasure, which "encompasses both a lack of knowledge regarding trans people and trans issues and the assumption that such knowledge does not exist even when it may. It is manifest in research studies, curricula, and textbooks" (Bauer et al., 2009, p. 352). Informational erasure supports the existence of institutional erasure, which "occurs through a lack of policies that accommodate trans identities or trans bodies, including the lack of knowledge that such policies are even necessary" (Bauer et al., 2009, p. 354). Informational erasure can happen at both an individual-level and systems-level and become institutional erasure. Informational erasure exists in school curricula, where trans and genderqueer people are excluded. Institutional erasure exists at the provincial level, within the Nova Scotia DEECD, and at the individual school level, as demonstrated by an absence of policies addressing the needs of trans and genderqueer students, and the exclusion of trans and genderqueer identities from curricula (Action Canada for Sexual Health and Rights, 2020; Government of Nova Scotia, 2014). Experiencing erasure can cause youth to feel disconnected and excluded from their school community, which can contribute to poor mental health outcomes (Kosciw et al., 2020; Saewyc et al., 2018; Taylor et al., 2020; Veale et al., 2015).

Systems-level erasure ignores the rights and needs of a group and removes their agency to inform institutional policies.

In existing sexual health literature researchers often conflate gender diversity or variance with sexuality (Taylor et al., 2013). Transgender and genderqueer youth do not necessarily fit within the LGB acronym often used by health researchers and policy makers. Not all trans or genderqueer people identify as gay, lesbian or bisexual. Conflating gender identity and sexuality or sexual orientation is a form of informational erasure, as it assumes that all members of the 2SLGBTQ+ community have the same needs and does not recognize the need for education content and policies specific to gender variant people (Bryan, 2012; Kosciw et al., 2020).

As noted by Bryan (2012) teachers and educators assigned to teach SHE who do not receive sufficient training to respond to student questions about gender identity may be overwhelmed by the learning curve and be less likely to feel capable to teach this topic to their classes (Action Canada for Sexual Health and Rights, 2020; Bryan, 2012; Clayton et al., 2018; National Children's Bureau, 2018). One consequence of this phenomenon is the erasure of trans and genderqueer identities from the classroom learning environment, as gender identity is not commonly included in lesson plans (Action Canada for Sexual Health and Rights, 2020; Bryan, 2012; Preston, 2019). Another consequence of this phenomenon is the silencing of trans and genderqueer or questioning students, whose questions teachers are ill equipped to answer, and whose identities teachers do not necessarily understand (Bryan, 2012; Clayton et al., 2018; National Children's Bureau, 2018; Preston, 2019).

The successful delivery of anti-oppressive and inclusive sexuality health education requires that trans and genderqueer youth see themselves reflected in curricula. However, inclusion is just the first step. The content of the lessons and the ways in which lessons are delivered is equally important. To deliver CSHE relevant to trans and genderqueer youth, educators must consider the social contexts of their lives. As an example, in their 2015 article Bauer and Hammond discuss the ways in which transgender women's sexual health is affected by social norms and expectations. The authors argue that, to understand what is unique about the sexual health needs of transgender women, we must first understand the social context in which they live. They explain:

> Barriers to healthy sexuality can be complicated by a range of trans-specific factors, including beauty and body standards that favour cis bodies, structural barriers to transition, traumatic interpersonal experiences, and the internalization of all these by trans women over the life course. Underlying these barriers to healthy sexuality are systemic beliefs that trans women must always be different than cis women . . . and ongoing (potentially by family, providers, partners, or potential partners) belief that trans women are actually ‘‘men,’’ a notion that can cause great harm. (Bauer & Hammond, 2015, p. 2)

Effectively teaching trans and genderqueer youth about healthy sexuality and sexual health requires that educators are aware of the social contexts surrounding the lives of trans and genderqueer youth and incorporate this knowledge into their lesson plans and delivery. Experiences of erasure highlight the importance of queering educational institutions, in order that CSHE lessons are delivered in a way that addresses the context of the queer experience.

Inclusion in Curricula and Experiences of Belonging

In *Every Class in Every School: The first national climate survey on homophobia, biphobia, and transphobia in Canadian schools* Taylor et al. (2013) report that 2SLGBTQ+ students (inclusive of trans and genderqueer students) who were taught from an 2SLGBTQ+ inclusive curriculum reported feeling a stronger sense of belonging at their school, than those who were not. In *Being Safe, Being Me* Veale and colleagues (2015) reported that "[transgender] [y]outh in the Atlantic provinces had the lowest self-rated levels of connection to their school… and participants with higher levels of school connectedness were almost two times more likely to report good or excellent mental health compared to those with lower levels of connection to school" (p. 18). This finding is supported by the Nova Scotia Student Success Survey, which reported that only 54% of 2SLGBTQ+ students in grades 7-12 feel they belong at their school, while the average for all students in this age range was 74% (DEECD & Communications Nova Scotia, 2019). Multiple authors advocate for 2SLGBTQ+ inclusive curricula across all subjects, not only to ensure 2SLGBTQ+ youth feel included, but also to normalize 2SLGBTQ+ identities to the wider student population (Action Canada for Sexual Health and Rights 2020; Bryan, 2012; PHAC, 2014; SIECCAN, 2019; SIECCAN, 2010; Taylor et al., 2013), with the goal of "encourag[ing] understanding and respect among students, [in order to] … contribute to a supportive and safe school environment that is the right of all students'' (SIECCAN, 2010, p. 13). In Nova Scotia, 43% of 2SLGBTQ+ students in grades 7-12 reported feeling less respected than other students in their school, while the average for all student respondents in this age range was 29%. Of the 2SLGBTQ+ students surveyed 36% reported

feeling unsafe or threatened at school, whereas the average for all student respondents in this age range was 20.5% (DEECD & Communications Nova Scotia, 2019).

CSHE resources created specifically for trans and genderqueer youth do exist. For example, the Gay, Bi, Queer Trans Men's Working Group in Ontario (2015) has produced two versions of *Primed*^{2}*: A Sex Guide for Trans Men into Men* and Page (2017) with The 519 Church Street Community Centre in Toronto created *Brazen: Trans Women Safer Sex Guide*. *Primed*^{2} (Gay, Bi, Queer Trans Men's Working Group in Ontario 2015) provides sexual health information and advice for transgender men who want to have sex with men, describing to readers how to find sexual partners (cruising), how to safely disclose their transgender identity to a potential sexual partner, how to protect themselves from sexually transmitted infections, and how to have and enjoy sex with their partners. *Brazen* (Page, 2017) provides similar information, tailored to the needs of transgender women. The information provided in these two guides promotes safe and healthy sexual relationships and provides readers with information that improves their ability to make informed decisions, increasing control over their sexual health outcomes.

As described by Ullman (2017), educators' willingness and ability to deliver inclusive curricula is positively correlated to both the educational and social-emotional success of gender diverse students in Australia. Ullman (2017) found that students who connected to teachers who were overtly positive and supportive of gender diversity reported higher rates of school-based morale and lower levels of distress, as well as higher rates of academic success. Moreover, gender diverse students who reported transphobic behavior from teachers in their school experienced school-based distress and less confidence in academics (Ullman, 2017). As

such, it is not only important for 2SLGBTQ+ inclusive information to be delivered to students, it is also important that the educators delivering this material are vocally supportive of gender diversity, as their opinions on the social acceptability of gender diverse identities affect the social and academic success of gender minority students.

Vocal support for 2SLGBTQ+ students is one way that educators can actively include trans and genderqueer students in their classrooms. Another element of inclusion is the method in which content is delivered. SHE must be accurate, and comprehensive (see the next section for further discussion) and delivered in a way that is meaningful and relevant to students (Bradford et al. 2019; Frohard-Dourlent, 2018). In the United Kingdom a group of students started an organization called “Teaching the Talk”, designing and delivering PD modules that describe how they would like to be taught SHE (see www.teachingthetalk.com). The group developed modules for four topic areas: sex, gender, porn, and consent. Involving youth in the creation and delivery of curricula can help ensure content and lesson plans are relevant, engaging, and meaningful to the students they are intended to support (Frohard-Dourlent, 2018). Student engagement is one of the key conditions for the successful implementation of comprehensive school health (Storey et al., 2016), which is a health promotion approach to supporting the holistic health and wellbeing of the whole school community in relation to healthy eating, physical activity, healthy practices, and healthy relationships (Joint Consortium for School Health, 2008). Sexual health is a part of health promoting schools approach and is identified as a substantive area of focus in the *Nova Scotia Health Promoting Schools Provincial Guiding Document* (DEECD et al., 2015).

Sexual and Reproductive Health Rights

According to the UNESCO (2018) *International Technical Guidance on Sexuality Education*, the SRHR of young people between the ages of 12 and 29 are protected by international law[24]. SRHR include education and knowledge, choice, health care and safety (UNESCO, 2018). As such, access to CSHE is a human rights issue (Action Canada for Sexual Health and Rights, 2020; OHCHR, 2008; Starrs et al., 2018; UNESCO, 2018) which is not adequately addressed in any Canadian province, where curricula do not currently meet national[25] or international[26] education standards (Action Canada for Sexual Health and Rights, 2020). The lack of reliable access to classroom-based CSHE in Nova Scotia undermines the SRHR of the province's youth, as the "[a]chievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights'' (Starrs et al., 2018, p. 2646). If youth do not have access to reliable sexual health information, it is difficult to realize their SRHR.

Implementation of Sexual Health Strategies

Enacting legislation can be an effective way to protect and promote the SRHR of a population (Nova Scotia Roundtable, 2006; The United Nations Convention on the Elimination of All Forms of Discrimination against Women [CEDAW], 2016 b; WHO, 2010). In its framework *Developing Sexual Health Programmes*, the WHO (2010) lists laws, policies, and human rights as

---

[24] The SRHR of youth are protected by 5 pieces of international legislation: The Universal Declaration of Human Rights (1948), Convention on the Elimination of All forms of Discrimination against Women [CEDAW] (CEDAW, 1979), Convention on the Rights of the Child (1989/90), International Covenant on Economic, Social and Cultural Rights (1966/76) and The Convention on the Rights of Persons with disabilities (2006) (UNESCO, 2018).
[25] SIECCAN, 2019
[26] UNESCO, 2018

one of five domains integral to the successful development and delivery of sexual health promotion programs. The document states:

> Affirmative legal or policy interventions are critical for supporting existing sexual health interventions or for introducing new ones. Countries may use laws, policies and other regulatory mechanisms that are enshrined in international treaties to guarantee the promotion, protection and provision of sexual health information and services, and to uphold the human rights of every person within their borders… Such legislation is fundamental to the creation and maintenance of a sexually healthy society. (WHO, 2010, p. v)

Complementary action must be taken across all five domains to successfully implement sexual health promotion programming (WHO, 2010). The other four domains listed in the WHO (2010) framework are: education, society and culture, economics, and the health service. The Netherlands has enacted a multi-pronged SHE strategy that addresses these domains. Implementing this strategy has resulted in improved sexual health outcomes for Dutch youth (Schalet, 2011; Sedgh et al., 2015). Although it touches on all five domains, this thesis focuses on domains most relevant to health promotion, namely education and legislation, with the recognition that action in education and legislation must be accompanied by action in the other three domains to improve sexual health outcomes across the population.

Comprehensive Sexual Health Education

The goals of sexual health promotion can be achieved by implementing several strategies, including “educational, motivational, peer-group, and skills-building approaches” (Khalesi et al., 2016, p. 2490). Comprehensive sexual health education [CSHE] is the method

that health and education literature support as the most effective educational strategy to achieve the goals of sexual health promotion; that is for all people to control their sexual health by "acquiring the skills, knowledge and behaviours to maintain good sexual and reproductive health throughout life" (Government of Canada, 2016, para. 3). In the *Canadian Guidelines for Sexual Health Education,* SIECCAN (2019) advocates for CSHE as a way to promote a balanced approach to sexual health which includes "positive aspects of sexuality and relationships as well as the prevention of outcomes that can have a negative impact on sexual health and well-being." (p. 6). UNESCO's (2018) *International Technical Guidance on Sexuality Education* also advocates for the delivery of CSHE to students when both age and developmentally appropriate.

SIECCAN (2019) uses the UNESCO definition of CSHE in its guidelines, and advocates for the delivery of CSHE throughout the lifespan. The guidelines call for CSHE to be a public policy priority in Canada, as the delivery of CSHE contributes to individuals' quality of life, as well as overall health and wellbeing (SIECCAN, 2019). More specifically, the delivery of CSHE is connected to sexual satisfaction, as well as greater self-acceptance in gender and sexual minority populations (Hobaica et al., 2019; SIECCAN, 2019). CSHE is the standard advocated nationally and internationally, and the approach to SHE supported by sexual health researchers and organizations (Action Canada for Sexual Health and Rights, 2020; Nova Scotia Roundtable, 2006; SIECCAN, 2019; UNESCO, 2018). CSHE is also a concept which needs to be more defined to determine how knowledge about the approach has been produced and "whose political claims are being advanced and whose may be side-lined in these processes" (Miedema et al., 2020, p. 748). Miedema and colleagues (2020) remind us that the inclusion and delivery of SHE

is political, and values based, and caution against “framing of CSE-related goals as reflective of universal neutral ideals” (Miedema et al., 2020, p. 758). Miedema and colleagues (2020), point out that existing definitions of CSHE are ambiguous, and,

> While many (UN and other programmatic) reports refer to the purported efficacy of CSE programmes, there exists limited analysis of the theoretical and normative underpinnings of CSE, and how these might impact the comprehensiveness of sexuality education delivered within different contexts. (p. 749)

Miedema et al. (2020) advocate for further analysis of CSHE and caution educators and researchers not to oversimplify the relationship between knowledge and health outcomes. The authors reflect that much of the literature they reviewed on CSHE outlined “optimistic conceptions of knowledge – that is, as having the potential to lead to certainty and security, and away from the messiness of sexuality, and sexual and intimate relationships” (Miedema et al., 2020, p.758). Further analysis of CSHE as a concept is required; however, this analysis should not interrupt efforts to implement more inclusive SHE that challenges normative values and supports the needs of trans and genderqueer youth.

The Current State of Sexual Health Education in Nova Scotia

The Nova Scotia Roundtable was established in 1997, in response to findings of a province-wide sexual health survey of 220 youth (Nova Scotia Roundtable, 1999). The Nova Scotia Roundtable was “a multi-sectoral group of health professionals, educators, government and non-government policy and program staff” (p.4) whose role was to “collectively identify ways to respond to the advice from Nova Scotian youth for improving their sexual health” (Nova Scotia Roundtable, 1999, p. 4). The Nova Scotia Roundtable (1999) created *Just Loosen*

Up and Keep Talking, a guide for adult champions and youth co-facilitators to organize conversations about sexual health in communities throughout the province, with the goal of "increas[ing] awareness and creat[ing] community receptivity to youth sexual health" (Nova Scotia Roundtable, 1999, p. 2). Following the creation of the facilitation guide *Just Loosen Up and Keep Talking*, the Nova Scotia Roundtable participated as a part of the Healthy Sexuality Working Group (2004), contributing to the creation of *Sex? – A Healthy Sexuality Resource*, and following that, *Framework for Action: Youth Sexual Health in Nova Scotia* in 2006 (Department of Health Promotion and Protection, 2006). The Nova Scotia Roundtable's (2006) framework proposed a population health approach to addressing the sexual health needs of Nova Scotian youth, a health promotion approach supported by the Public Health Agency of Canada. A population health focuses on improving the health of a population, and "reduc[ing] health inequities among population groups by recognizing and responding to the broad range of factors and conditions that strongly influence health" (Nova Scotia Roundtable, 2006, p. 5). The Nova Scotia Roundtable's (2006) framework identified five action components[27] with associated objectives and activities, as well as timelines for implementation, accountability measures and a plan for ongoing evaluation. The Nova Scotia Roundtable's (2006) framework sought to align Nova Scotia's SHE curriculum with the SIECCAN guidelines, through the implementation of a comprehensive curriculum in the province. The Nova Scotia Roundtable is

[27] The five components were: 1) leadership and commitment, 2) community awareness and support, 3) school-based sexual health education, 4) youth involvement and participation and 5) sexual health related services for youth.

no longer active, and its 2006 framework was not resourced by any provincial government since its publication.

The booklet *Sex? - A Healthy Sexuality Resource* (Healthy Sexuality Working Group, 2004) was first created and distributed in 2004, through the Nova Scotia Office of Health Promotion, in partnership with the provincial departments of Health and Education. Reception of the resource varied across the province. The Strait Regional School Board voted to ban the resource, stating the information contained in it was inappropriate for children[28] ("Strait school board says no to sex book", 2004). The Tri-County Regional School Board initially voted to distribute the resource but subsequently questioned their decision after the fact ("Strait school board says no to sex book", 2004). The resource has not been significantly updated since 2004 and has long been in need of an update to address its use of gender-binary language, incorporate meaningful information about gender identity and sexual orientation and include sex positive messaging. Nova Scotia Public Health stopped distributing *Sex? - A Healthy Sexuality Resource* (Healthy Sexuality Working Group, 2004) to schools in 2019, as it was deemed out of date and no longer appropriate to distribute to students. As of 2021, the resource has been heavily edited and is being distributed again; however, a total overhaul of the content and form is still necessary[29].

---

[28] After the School Board vote The Department of Education intervened, informing the school board the resource would be distributed to schools as a reference tool for teachers ("Strait school board can't block sex book", 2004). This decision did not, however, ensure student access to the resource.

[29] In 2020 Public Health had planned to do a complete re-working of *Sex? - A Healthy Sexuality Resource* (Healthy Sexuality Working Group, 2004). However, this plan was interrupted by the COVID-19 pandemic. I was a part of a small working group of Public Health staff tasked with reworking the resource, until a meaningful engagement process could determine the content and form the new updated resource would take. This work is in process.

It is difficult to assess the current state of comprehensive sexuality education in Nova Scotia (or in Canada) because very little information about curriculum content and delivery is publicly available (Action Canada for Sexual Health and Rights, 2020). In their 2020 report *The State of Sex-Ed in Canada,* Action Canada for Sexual Health and Rights provides an overview of the information available through the DEECD, as well as data collected through interviews with educators working in schools located in the Halifax Regional Centre for Education [RCE]. The health curriculum in Nova Scotia is being revised on an ongoing basis (Action Canada for Sexual Health and Rights, 2020). As such the information in the Action Canada for Sexual Health and Rights report reflects a moment in time; however, it is the most current information publicly available.

According to Action Canada for Sexual Health and Rights (2020), SHE across Nova Scotia varies in both content and delivery. Several factors contribute to reported inconsistencies: time, teacher knowledge and comfort, availability and accessibility of outside resources, lack of consistent strategy, and lack of monitoring. Teachers in Nova Scotia are "expected to teach Integrated Learning for 200 to 240 minutes per week. This time is meant for explicit subject instruction in health, information communication technology, science, social studies, [and] visual arts… of the little time dedicated to health education, only a fraction of it is for sexual health outcomes on average" (Action Canada for Sexual Health and Rights, 2020, p.13). The limited time allocated to health education requires teachers to prioritize delivery of curriculum content. SHE is overshadowed by higher priority subjects (Action Canada for Sexual Health and Rights, 2020).

Reliable and ongoing access to professional learning opportunities, resources and the support of principals and school boards (now RCEs) are all essential to creating supportive environments for teachers to deliver CSHE (Action Canada for Sexual Health and Rights, 2020; Clayton et al, 2018; Gahagan, 2015; National Children's Bureau, 2018). The Action Canada for Sexual Health and Rights (2020) report notes, "A curriculum is a set of documents, but it is brought to life by teachers and instructors" (p. 13). Improving curricular documents (as the DEECD in Nova Scotia is currently doing) is an important step toward implementing CSHE in Nova Scotia classrooms; however, curriculum updates need to happen in tandem with the creation of environments that support teachers to bring the content "to life". Classroom teachers are responsible to deliver curricula, and need resources and supports to feel capable and confident doing so (Action Canada for Sexual Health and Rights, 2020; CEDAW, 2016a).

The Nova Scotia Roundtable's (2006) framework highlights the importance of a multi-sectoral approach to the delivery of CSHE in Nova Scotia public schools[30]. The Nova Scotia Roundtable's (2006) framework states, "Sexual health education needs to be linked to broader community health resources and strategies" (p. 37). This statement is supported by Action Canada for Sexual Health and Rights 2020 report, which advocates for government investment in community based SHE organizations and their participation in classroom learning. Community Sexual Health Centres exist across the province, however access to these services is often restricted in rural areas (Action Canada for Sexual Health and Rights, 2020). The Youth

---

[30] This approach is also supported by the UNESCO *Review of the Evidence on Sexuality Education* (2016), which states CSHE is most successful when "school-based CSE is augmented with community components or services, such as training for health providers, youth-friendly services, and work with parents" (p. 5).

Project is based in Halifax and has satellite locations in Cape Breton, on the South Shore and in the Annapolis Valley. The organization has an agreement with the DEECD to deliver training to school staff and does presentations to students about 2SLGBTQ+ experiences and issues. However, the organization lacks the resources to provide training and workshops to every school in the province. As Action Canada for Sexual Health and Rights (2020) summarizes, "where you live and your school's resources will determine your access to life-changing sexual and reproductive health information" (p. 63). This is especially true when under-resourced community organizations are relied upon to deliver school based SHE.

SHE is not currently prioritized in Nova Scotia, or Canada more widely (Action Canada for Sexual Health and Rights, 2020). There is no national or provincial-level sexual health strategy that mandates the delivery or quality of SHE in Nova Scotia, or the monitoring of sexual health outcomes[31]. As such, although the SIECCAN's (2019) *Canadian Guidelines for Sexual Health Education* is comprehensive, there is no mechanism in place to ensure that the guidelines are used in the development or delivery of provincial curricula (Action Canada for Sexual Health and Rights, 2020). In the absence of an overarching government strategy, "there are no safeguards that would make sure LGBTQI2S+ kids are also getting high-quality sex-ed that speaks to their lives, bodies, specific health needs, and experiences" (Action Canada for Sexual Health and Rights, 2020, p. 80). The lack of an organized strategy also enables the continued under-funding of SHE programming, as there is no longitudinal data available to form an accurate picture of the sexual health status of Nova Scotian youth.

[31] Nova Scotia Public Health monitors STI infection rates, however these data do not provide a comprehensive measure of the sexual health status of Nova Scotian youth.

There is no organized system in place to monitor and evaluate sexual health curricula and delivery in any Canadian province (Action Canada for Sexual Health and Rights, 2020). Monitoring and evaluation are key to ensuring the quality of education is consistent across jurisdictions, to inform updates to curricula over time, and to ensure curricula and classroom lessons meet national or international standards (Action Canada for Sexual Health and Rights, 2020). Monitoring and evaluation are necessary to ensure accountability for the quality and delivery of SHE, with the goal that all students have equitable access to the protective health and wellbeing benefits attributed to SHE (Action Canada for Sexual Health and Rights, 2020).

Chapter 3: Methodology

Critical Qualitative Research Approach

This study employs a critical qualitative research approach which Creswell (2014) describes as "for exploring and understanding the meaning individuals or groups ascribe to a social or human problem", a method which allows the researcher to prioritize understanding "the complexity of a situation" (p. 4). A critical qualitative research approach "seeks insight into the social world in order to help people change oppressive conditions… [and] to work toward human emancipation" (Esterberg, 2002, p. 17). The intention of this study is not only to determine the meaning study participants ascribe to their SHE experiences, but also to better understand "the material world and power relations within it" (Esterberg, 2002, p. 17) with the ultimate goal of contributing to social transformation.

Research Paradigms

Esterberg (2002) describes a paradigm as a worldview that "shape[s] research strategies… the methodological choices you make and the relationships you see between theory and data" (p. 9-10). This section describes the paradigms, theories and health models that underpin this study.

Worldview

As cited in Creswell (2014), Guba (1990) defines a worldview as "a basic set of beliefs that guide action" (p. 6). I conducted this study through use of a transformative worldview, which "holds that research inquiry needs to be intertwined with politics and a political change agenda to confront social oppression at whatever level it occurs" (Guba as cited in Creswell, 2014, p. 9). My worldview has been shaped by personal experience and theoretical study.

During my undergraduate studies I majored in sociology and focused my studies on social justice and advocacy related to affordable housing. My undergraduate experience shifted my worldview by providing me with the tools to better understand the root causes of inequity, discrimination, and marginalization. My worldview has also been influenced by the three years I spent as a municipal politician, witnessing the challenges created by bureaucratic and political jockeying influenced my worldview, as has working in both Primary Health Care and Public Health for Nova Scotia Health also influenced my worldview. As a result of my experiences, I better understand the pace of government and the nature of incremental social change, as well as some of the barriers and challenges that may prevent change from taking place. I have spent the past two years working as a School Health Promoter in the Annapolis Valley RCE, gaining invaluable insight into school-life, and the inner workings of the RCE. My time as a School Health Promoter affected my worldview in that I now have real-world experience practicing health promotion, and a more nuanced understanding of the challenges faced by sexual health promoters.

Despite being listed in the Public Health Protocols[32] (Department of Health and Wellness, 2009) that direct the work of the Healthy Communities Team (of which I am a member), it has been my experience that sexual health promotion is not a priority within public

[32] The Healthy Communities Protocol states the team will "seek to influence the establishment and implementation of evidence informed healthy public policies at federal, provincial, and local levels to improve the sexual health of populations by… advocating for Comprehensive Sexual Health Education and supporting the integration of sexual health-related issues in Health Promoting Schools [and] collaborating with partners to reduce homophobia, transphobia, and sexism and to support gender equity and inclusive environments" (Department of Health and Wellness, 2009, p. 8).

health[33]. Rather, focus is often directed to issues such as drug, tobacco and alcohol use, physical activity, and healthy eating environments. Working as a School Health Promoter reinforced for me the importance of transformative social change, while giving me the opportunity to understand the challenges of transforming a government health care system from the inside. Working in a large health system I see the push-pull of priorities, especially related to the disconnect between how decisions are made at the leadership level, and the experiences of staff working front-line positions. I also see the disconnects in communication and decision-making that exist between the provincial education and health systems, which have overlapping responsibilities, but are not designed or organized to easily collaborate with one another. Experiencing these disconnects in my work-life has shaped my worldview.

Queer Theory

Queer theory is difficult to define, as theorists do not all agree on a single definition (Halperin, 2005). In general terms, queer theory challenges heteronormativity and binary gender assumptions in social institutions, highlighting the way these socially constructed "categories exert power over individuals, especially for those who do not fit neatly within their normative alignments" (Valocchi, 2005, p.752). Queer theory is an approach to political action and disruption which can be used for "thinking through how to respond to institutional denials of difference" (Shipley, 2013, p. 197), such as the exclusion of trans and genderqueer students from public-school curricula. Queer theorists are not monolithic, there are disagreements

[33] There is a tension within Public Health. The Healthy Communities Team is tasked with health promotion activities, however, the public perception and traditional understanding of Public Health focuses on disease monitoring and control. This creates a push-pull within the organization, and uncertainty about the priorities of Public Health.

regarding the application and disruptive capacity of queer theory as it becomes normalized in academia (Halperin, 2005).

Normative categories of male and female exert power over trans and genderqueer youth by defining them as non-normative others, and exerting pressure on them to conform to heteronormative expectations (Shipley, 2013; Valocchi, 2005). In a 2013 article Shipley utilized Grosz's (2011) Theory of Becoming to argue that education systems try to prevent youth from becoming different, by denying such differences exist. Grosz's (2011) theory states, "[b]ecoming is the operation of self-differentiation, the elaboration of a difference within a thing, a quality or a system that emerges or actualizes only in duration" (as cited in Shipley, 2013, p. 198). Shipley (2013) argues when the topic of gender identity is absent from curricula and classroom lessons it potentially interrupts youths' process of becoming, by denying the existence of these differences and thereby denying youth the opportunity to explore and inhabit them. This exclusion, combined with "the ongoing performance of sexual normativity (e.g., by teachers and administrators)" reinforces heteronormative expectations, and contributes to the social exclusion of trans and genderqueer youth (Shipley, 2013, p. 199).

The process of becoming looks different for every young person and the outcome is not wholly predictable (Dyer, 2017; Shipley, 2013). As a result, it is difficult to identify a distinct cause and effect relationship between the exclusion of trans and genderqueer youth from curricula and harm done to individual youths' mental and physical health (Shipley, 2013). Shipley (2013) argues that interrupting the process of becoming does "ha[ve] lasting consequences, though they are not all necessarily known right away" (p. 198). Because it is difficult to identify a direct cause and effect it can be difficult to address these harms through

regulatory laws and policies. Regulations are intended to address identifiable categories (like those identified in the Canadian Charter of Rights and Freedoms), and since becoming is a process, not a category, it is difficult to use regulation to ensure access to it (Shipley, 2013). To prevent the harms caused to trans and genderqueer youth by exclusion from curricula Shipley argues we must queer education institutions by challenging the heteronormative assumptions ingrained in curricula and education policy, as well as the normative assumptions reinforced by the behaviour of staff and students in school environments (Shipley, 2013). In practice, queering public education institutions changes the ways these institutions deliver services, making them more responsive to the needs of queer people (Shipley, 2013).

Dyer (2017) advocates queering childhood education research, arguing that, "[a]pplying queer methods of analysis to studies of childhood can help to queer the rhetoric of innocence that constrains all children and help to refuse attempts to calculate the child's future before it has the opportunity to explore desire" (p. 292). Dyer is advocating for protection and/or creation of opportunities for children to explore their desires, and freedom to determine their sexuality or gender identity as they grow, rather than being assumed to be cisgender and heterosexual from birth (Dyer, 2017). Furthermore, scholarship on childhood sexuality "tend[s] to stabilize queerness as identity, instead of preserving something contingent" (Dyer, 2017, p. 291). Much existing scholarship refers to queerness as a static definable category, and in doing so limits the innumerable shapes that queerness can take (Dyer, 2017). Both Dyer (2017) and Shipley (2013) recognize, queering educational institutions is an essential part of "the queer project" (Shipley, 2013, p. 197). At a curricular level, Dyer (2017) proposes queer theory can contribute to the re-conceptualization of SHE by helping "to loosen the parameters of

normative development so that a deeper and more capacious theory of children's sexual education can be built" (p. 293). Dyer (2017) argues that an essential part of a broader theory of children's sexual education is the recognition of the ways race, socioeconomic position and colonization affect education and learning, challenging and disrupting normative assumptions about whiteness and colonization as well as gender and sexuality. As Dyer (2017) explains, "[q]ueer theories of childhood that do not account for histories of nation-states, slavery, or genocide cannot help effectively reimagine pedagogy of and for children" (p. 298). Dyer's argument highlights the importance of queer analyses to challenge normative assumptions which reproduce the status quo. This concept is further interrogated in the following section, which describes the ways in which intersectionality theory informed this study.

Intersectionality

Intersectionality theory is frequently used in health research, as it enables researchers to examine how multiple overlapping forms of oppression affect individual health outcomes (Hankivsky, 2012). Crenshaw's (1989; 1991) intersectionality theory has influenced my worldview and the design of this study. Based on Crenshaw's (1989; 1991) definition, intersectionality is a transformative theory, rooted in critical race theory. It describes how the many facets of a person's identity (i.e., race, gender identity, sexuality, socioeconomic class etc.) intersect to create overlapping forms of oppression that dictate a person's material living conditions. Crenshaw (1989) argues systems that cater only to the needs of the most privileged[34] members of a society or community are unjust, as "marginalizes those who are

---

[35] Cisgender heterosexuals also face overlapping forms of oppression, however in this study I focus on the specific privileges that stem from cis-normativity and hetero-normativity.

multiply burdened and obscures claims that cannot be understood as resulting from discrete sources of discrimination" (p. 140). In other words, when SHE focuses on the needs of straight, cisgender youth, transgender and genderqueer youth who already face oppression based on their socioeconomic class, race, etc. are further marginalized when their gender identity is not legitimized through inclusion in public school SHE (Frohard-Dourlent, 2018). Further to Crenshaw's (1989) point above, exclusion of gender variant identities from SHE curricula in Nova Scotia public school curricula does not stem from a distinct source of discrimination. The root causes of discrimination against genderqueer people, and 2SLGBTQ+ people in general, are complex (White-Hughto et al., 2015) and based on systems-level structures that systematically exclude trans and genderqueer people from positions of power and influence and marginalize their voices within a cis-normative society (Bauer et al., 2009; White-Hughto et al., 2015). There is no single "fix" that can end discrimination against 2SLGBTQ+ people. The complexity of the issues, and the multiple intersecting discriminations and oppressions that marginalize trans and genderqueer people are not easily communicated. Thus, it is easier to focus on dominant[35] narratives than to address the multiple "obscured" causes of oppression experienced by 2SLGBTQ+ people. As such, social policies and structures often exclusively represent the needs of people who are part of the sexual and gender majority.

Crenshaw's (1989; 1991) original application of intersectionality theory addressed the experiences of black women. Since the late 1980's the theory has been applied to the experiences of many marginalized groups, to argue that common experiences of

[35] Heteronormative and cis-normative.

"institutionalized discrimination, legalized marginalization, or sociopolitically sanctioned violence" (Hancock, 2007, p. 64) can be understood through an intersectional analysis. Hancock (2007) argues that the application of intersectionality theory reduces essentialism and captures the diversity of experiences within a marginalized group, making it an appropriate theory to inform this study. However, due to the small sample size of participants an intersectional analysis was not conducted with the study data, as the complex description of the participants required for an intersectional analysis (including age, race, religious belief, socioeconomic position, home community, education level etc.) would compromise their anonymity.

Social Ecological Model of Health

The Social Ecological Model of health [SEM] positions the individual within a larger set of social systems and environments. The model is used by health promoters and health promotion researchers to understand and describe how individual health outcomes are affected by the ways in which people interact with the social systems they participate in, and the environments they live in (Golden & Earp, 2012). The SEM describes a series of five overlapping and intersecting levels of influence that affect health outcomes: Individual, interpersonal, organizational, community and policy. In this study the barriers to the delivery of CSHE in Nova Scotia are mapped onto the SEM.

Research Method

Data were collected through qualitative semi-structured interviews conducted with five youth between the ages of 16 and 23 who self-identify as transgender or genderqueer[36]. Interviews were conducted in the rural community of Kings County, Nova Scotia.

Qualitative inquiry was an appropriate method for this study because, as Eiser and Twamley (1999) state, “qualitative work is particularly useful for new or sensitive areas where little may be known, or where the aim is to obtain understanding of more subjective and cultural aspects of [the issue]” (as cited in Biggerstaff, 2012, p. 184). This study aims to better understand trans and genderqueer youths’ subjective perceptions and experiences of SHE, which is a sensitive and personal issue. As such, interviews were conducted in a private space[37], agreed upon by both the participant and the researcher. Interviews were audio recorded, and transcribed. Each participant was asked interview questions (see Appendix A). The following section describes how youth were identified and recruited to participate in the study.

Research Sample

Data were collected from a very specific, and relatively small population of people. I used a purposive sampling approach to reach participants, who were intentionally selected based on the “specific perspectives [and experiences] they… have [had]” which made them uniquely qualified to answer questions about the research topic (Esterberg, 2002, p. 93). I recruited trans and genderqueer youth between the ages of 16 and23 who attended public

---

[36] Throughout the thesis I use they/them pronouns for all participants to preserve anonymity. However, these may not be the pronouns participants use in their daily lives.
[37] Interview spaces were chosen based on the preferences of each participant.

school in Kings County, Nova Scotia and had participated in the SHE portions of the curriculum. Interviews were conducted with five trans and genderqueer youth who were recruited through The Youth Project, “a non-profit charitable organization dedicated to providing support and services to youth, 25 and under, around issues of sexual orientation and gender identity” (The Youth Project, n.d., para. 1), as well as through Acadia Pride, Wolfville Pride, The Red Door, and through word of mouth. Allowing for recruitment through word of mouth was important, because the target population for this project was very small, and experiences marginalization. People referred, through word of mouth, by friends or trusted associates, may have felt more comfortable participating since they knew that someone they trust also trusts me.

My goal was to interview 5 and10 youth for this study. After over eight months of recruitment, I had interviewed five youth. Baker and colleagues (2012) point out that “a small number of cases, or subjects, may be extremely valuable and represent adequate numbers for a research project. This is especially true for studying hidden or hard to access populations” (p. 8). The sample size of five participants in this study was adequate because of the small study population, but also because of the specific geographic area of focus of the study (Creswell, 2014; Esterberg, 2002).

Data Analysis

Of key importance when analyzing data from this study was identifying transformational reforms which may “change [the] lives of the participants, [and] the institutions in which [participants] work and live” (Creswell, 2014, p. 9). Data from interviews were analyzed using inductive qualitative thematic analysis, following the six phases outlined by Braun and Clarke (2006):1) familiarization with the data; 2) generation of initial codes; 3) searching for themes; 4)

reviewing themes; 5) defining and naming themes and; 6) writing the report (Braun & Clarke, 2006, p. 16-23). This method of analysis was appropriate to this study because the phases are flexible and can be used as many times as necessary, to identify themes in the data (Braun & Clarke, 2006). Initially, I conducted what Braun and Clarke (2006) describe as a semantic analysis, where “themes are identified within the explicit or surface meanings of the data” (p. 84). Following the semantic analysis, data were interpreted in the context of exiting literature. As described by Braun and Clarke (2006):

> Ideally, the analytic process involves a progression from description, where the data have simply been organized to show patterns in semantic content, and summarized, to interpretation, where there is an attempt to theorize the significance of the patterns and their broader meanings and implications (Patton, 1990), often in relation to previous literature. (p. 84)

This approach is suited to inductive analysis as it allows the data to speak for itself.

Due to the exploratory nature of this study, the research questions guiding the study were open ended, allowing participants to define constructs and share their personal perceptions and experiences in relation to the topic. As Esterberg (2002) explains, “a good qualitative researcher must remain open to what the field setting or research site has to offer” (p. 29). The use of inductive thematic analysis allowed participants’ perceptions and experiences to direct the focus of the research, rather than my expectations as a researcher (Braun & Clarke, 2006). I am a cisgender woman; I am not a member of the trans or genderqueer community. Thus, the knowledge I have developed on this topic is theoretical, not based on personal experience. To understand the perspectives, prioritize and elevate the voices

of trans and genderqueer youth – I, as the researcher, must understand how my lived experiences influence the way I interpret the data.

Inductive analysis does not "take place in an epistemological vacuum" (Braun & Clarke, 2006, p. 12). Thus, this inductive thematic analysis was informed by Crenshaw's (1989, 1991) intersectionality theory and conducted through the lens of Queer Theory, considering the following question posed by Ludvig (2006), "who defines when, where, which, and why particular differences are given recognition while others are not?" (p. 247). Recognition of difference (specifically the ways in which trans and genderqueer youths' needs differ from the needs of their cisgender peers) is of key importance in this study, making Ludvig's (2006) question a relevant framework for analysis of the data collected.

Ethical Considerations: Hidden or Hard to Access Population

There are several ethical considerations associated with the study, in keeping with Creswell's comprehensive overview of ethical considerations (Creswell, 2014; Government of Canada, 2018). Prior to conducting interviews, I received ethics approval for this study from Dalhousie University. Written consent was received from each participant, at the start of each interview session. Due to the sensitivity of the subject matter, consent forms were given to participants one week in advance of the interview, in order to ensure plenty of time for reflection and to ensure their consent was given voluntarily (Creswell, 2014). The process of consent was ongoing throughout the interview, including regular check-ins with participants throughout the interview session, to ensure their continued comfort with the process. Also, because of the sensitive nature of the subject matter, I provided each participant with a list of support resources, in the case that the interview questions and/or discussion triggered past

traumas or caused the participant emotional distress. Resources included The Youth Project, The Red Door, and other relevant mental and sexual health support services.

Confidentiality was maintained using several measures, including holding interviews in spaces chosen, or agreed to by, the participant. Identifying information, such as names of people and places, was removed from the transcripts (Creswell, 2014). A unique identification number was assigned to each participant and identifying information was stored separately from the identification numbers. Data were stored on two password-protected external hard drives and were only accessible to my thesis supervisor and me. Any printed material (transcripts, matrices etc.) was stored in a locked filing cabinet in my home office. Throughout the thesis participants are referred to by common gender nonspecific pseudonyms to protect participants' identities.

I actively work on being an ally to the trans and genderqueer communities. That is, to be "someone who confronts heterosexism, homophobia, biphobia, transphobia, heterosexual and cisgender privilege in themselves and others" (Stringer, 2013, p. 1), but I am also an outsider. Since I am an outsider to the trans community, I made a concerted effort to be self-critical, remain self-aware and approach this research with humility, to be sensitive to the needs of my participants (Creswell, 2014).

I developed a community advisory committee of representatives from The Youth Project (both Halifax and Valley chapters), a health professional who works with trans and genderqueer patients, and members of trans and genderqueer communities. I consulted with this committee before I began my research and sought their advice on culturally competent ways to conduct

my research, create my interview questions, and practice knowledge translation without further marginalizing trans and genderqueer community members[38].

Knowledge Translation

The data from the study were written into this MA thesis and will also be communicated in the following ways. First, a summary report including recommendations will be written and directed to the attention of leadership at the Nova Scotia DEECD as well as the Nova Scotia Teachers Union. Second, I will incorporate the data and recommendations into my work as a school health promoter with Health Promoting Schools through Nova Scotia Health Department of Public Health. In my position I work closely with representatives from the Annapolis Valley RCE, supporting schools to identify and implement strategies that will help them achieve the wellbeing goals they have set for their school community. Third, I will share the data and recommendations from this study directly with AVRCE, and advocate for the recommendations from this study to be incorporated into school and school region-based programming and policy decisions. Fourth, I will make presentations at conferences and PD days, where possible. The findings will be provided to the Youth Project, for use in its advocacy work across the province. Lastly, the findings will be shared with study participants, where possible.

---

[38] Often opponents of inclusive sexual health education frame their resistance to curriculum changes as concern for the well-being of students (Bryan, 2012; Follert, 2015; Keenan, 2015). These arguments can further marginalize members of the LGBTQ+ community (Bryan, 2012).

Chapter 4: Findings

Participant Definitions of Sexual Health

When asked to define sexual health, the study participants were initially stumped. Rowan said, "I don't know… 'cause I was never like taught much about it." Asher said, "I don't know this is a hard one" and Ripley said, "I honestly have no idea what it [sexual health] means to me." For participants, defining sexual health was difficult, in part they said, because what they had learned about the concept did not resonate with their own lived experiences as a genderqueer or trans youth (Jo, Rowan, Asher, Blair & Ripley). After taking time to think about the question, participants offered definitions of sexual health. These definitions included the importance of a balance between mental and physical health, including safer sex (Jo, Asher & Blair), sex positivity (Jo & Blair), sexual experiences free from violence, choice and bodily autonomy, as well as the importance of pleasure (Jo). Blair spoke about identity and self-love, as well as self-acceptance, desire, and understanding sexual health as one part of a whole person. Jo felt it important to highlight the social element of sexual health. They described:

> [S]exual health is not an isolated thing, it's definitely something we do in relation to other people… I think that sexual health is a relational type of health… because it's like a social thing, even though we say it's a private thing, there's a lot of social aspects about it.

Jo's insight challenges the dominant narrative that individuals are solely responsible for their health outcomes and wellbeing[39]. Attributing sole responsibility to the individual for their health status ignores the effects of the social determinants of health, and the role that upstream (i.e., preventative) factors play in determining the health outcomes of individuals. This element of Jo's definition of sexual health goes beyond the frequently cited WHO definition, which focuses predominantly on the individual, and their resulting state of well-being. Jo's insight highlights the significant role social influence and status play in determining an individual's access to sexual health.

Social Norms and Definitions of Sexual Health

Social norms are instrumental in defining what a community considers to be sexual health. Asher touched on this point, and Jo pointed out, "because it's a social thing there has to be a community basis to sexual health, rather than just, like, it is your responsibility to be sexually healthy". These norms and expectations also shape how a community defines sexual health, which dictates how and what is taught as a part of SHE. As Jo described:

> Sexuality is a social thing. It's a social construct, and it's something that we're told by other people how we're supposed to experience it properly … as a community we're creating the norms and the values around sexual health. So, it's every community has responsibility for the community member's sexual health.

---

[39] This narrative is also challenged by the population health approach to sexual health promotion, as well as supported by SIECCAN, Action Canada for Sexual Health and Rights, the WHO, the Public Health Association of Canada, and the former Nova Scotia Roundtable on Youth Sexual Health among others.

Jo points out that communities define what sexual health is, and therefore have a responsibility to nurture the sexual health of community members.

Participants reported that the school based SHE they received was predominantly based on definitions of sexual health that did not meaningfully include gender or sexual diversity, and therefore did not meet their sexual health information needs. Blair said their SHE only included two gender identities. Asher also reported that their classes did not describe the existence of, let alone the lived experiences of, people who identify as non-binary. Ripley commented "I really wish people would realize that sex and gender are two different things 'cause that is not taught." Ripley's observation demonstrates that the definition of sexual health used to shape the SHE they received did not include the existence of transgender people and was based in a biological definition of gender. It is worth noting that if your SHE needs exist outside of the community's definition (i.e., how you are supposed to experience sexuality "properly") then your needs may not be met by community-supported (i.e., publicly funded) SHE. In the next section I will outline, in more detail, the information participants learned in their sexual health classes, and how this information was delivered.

Sexual Health in the Classroom

Each of the participants in this study was asked to describe their experiences learning about sexual health in public school classrooms across Kings County. The following sections detail what information participants were given; what information participants felt was missing as well as how sexual health lessons were delivered in the classroom.

What is Taught?

Each participant was asked to describe what sexual health information they were taught in their school. All participants described receiving similar sexual health information and messaging.

Hetero and Cis normativity. All five participants felt the sexual health information they were given was limited, in that they did not receive any significant or detailed education about non-heteronormative sexualities or minority gender identities. As a result, all the study participants felt their school based SHE was not relevant to their experience, identity or interests and therefore did not meet their educational needs (Jo, Rowan, Asher, Blair and Ripley).

Reflecting on what they felt was missing from their SHE each of the participants felt their SHE was almost exclusively heteronormative. For example, Jo noted that one of their teachers recognized the existence of a spectrum of sexualities but chose not to include them in the lesson plans. Jo said, “I remember my favorite quote from sexual health class in grade nine was ‘there are sexualities that aren't heterosexual, but we're not going to talk about that.’” Blair had a similar experience, describing their SHE as, “very binary oriented and it definitely had the perception that everyone was cis and straight.” The perception described by Blair underpinned many of the participants’ classroom experiences, which they said focused mainly on “male and female anatomy” (Ripley) STI prevention, contraception, pregnancy prevention, conception to birth (Blair), puberty and safe sex (Rowan). Although some of the lessons were partially relevant to participants’ personal identities, experiences and interests, participants felt there were significant elements missing from their educational experience. For instance, Blair

shared, “I didn't get all of the information I think would have been helpful especially with having sex with same sex partners or with partners who didn't have a penis basically.” While Rowan explained that although the sexual health content taught in their health class was coherent, it wasn’t relevant to them:

> It [sex ed] made sense, but it was kind of like, I don’t really care because that’s not what I want. *laughs* I mean with the female stuff; it was like I knew I didn’t quite fit with either or really…I went through puberty like a regular female should, but then I kind of went through puberty again because I took testosterone after, so it was kind of . . . like you don’t know what to expect. Even when they did talk about males going through their puberty it’s a little bit different, because you're going through like two of them. And you don't know exactly if you've gone through the exact same thing that a males gone through or not, so. I don't know, I didn't really feel like what they were speaking about was relevant to me, but I still sat there and listened anyway because it was school.

Several participants also reported that foundational information, necessary to introduce students to the concept of the gender and sexuality spectrum, was missing from their classroom learning. Asher said, “I think definitely one thing that would be really helpful would be to differentiate the difference between sex and gender.” The difference between sex and gender is a foundational concept central to both the recognition and inclusion of genderqueer and trans identities. Without the teaching of this and other foundational concepts, all five participants reflected they did not see themselves reflected in the sexual health curriculum they received. Rather, as Ripley described, participants learned about “male anatomy and

female anatomy and that was pretty much it." And, as Rowan observed, "it was basically all straight kind of health." Since participants did not see themselves represented in the sexual health information they were given, they were often challenged to see how the information they were presented with was relevant to their lives and experiences.

What Is Missing?

Each participant was asked to describe what sexual health information was missing from their school based SHE. Asher summed it up in one sentence when they said, "there was a lot of missing information." Reflecting on their experiences, participants contributed a significant list of topics they felt were important, which were either underrepresented or completely absent from the curriculum they received.

Healthy Relationships. Multiple participants reported they did not learn enough about how to create and maintain healthy relationships (romantic, sexual, and otherwise) with themselves or others (Blair, Jo and Ripley). As Blair described, "[sexual health education should be about] having a healthy relationship with your feelings about sex and your sexual desires… not having resentful feelings about your own sexual desires or lack thereof." They continued on to say that they did not feel that the school based SHE they received prepared them to build healthy relationships. Blair shared:

> I definitely didn't leave school with the knowledge that I needed [about sexual health]… I think I would have rathered have more preparation because some of the relationships I was in weren't very healthy. And it wasn't a very good learning experience to have. I really didn't feel that school prepared me for having a healthy sexual relationship with myself or others.

Reflecting on personal experience and learning, Jo described what they felt a healthy relationship with sexuality should look like:

> I think being able to make good [sexual] decisions for yourself, that you can live with and being able to evaluate your ability to engage in sexuality, your ability to self-reflect and know yourself and your boundaries and your limits . . . so that sexual activity is a good thing for you and not something that you're dependent on or avoiding for mental health reasons… I think that someone who is sexually healthy is able to have a good relationship with sexuality.

These two participants, and Ripley, did not feel that their school based SHE prepared them to have healthy relationships with sex and sexuality.

Sex Positivity. None of the participants described the SHE they received as sex positive. Jo addressed this directly when they said, "Another thing that I think we completely skipped in sexual health class was the idea of pleasure. Because I found out what a clitoris was in my second year of university. Not in grade 9 health class." None of the other participants spoke about pleasure. Reflecting upon the structure and requirements of classroom learning, Jo further noted, "When you try to make sexual health lecture style then you have to contort it into being more rigid and more 'this is right' 'this is wrong' so it fits the format." In other words, it is difficult to be sex positive if you are being asked to describe which aspects of sex and sexuality are "right" and which are "wrong".

Mental Health. Each of the five participants spoke about mental health outcomes, and multiple participants felt mental health was not adequately covered as a part of their school based SHE. Participants spoke about mental health in two distinct ways. First, they indicated

that they did not feel mental health as a key component of sexual health was adequately covered in their school-based experience. Secondly, participants spoke about the ways the school-based education they received affected their personal mental health outcomes.

Asher noted that they feel there is more to being sexually healthy, saying: “[sexual health is] about remaining healthy: emotionally, physically.” All the participants felt the information taught in their school-based sexual health classes focused too heavily on the physical aspects of sexual health, and not enough on the emotional and/or mental health aspects described by Asher. Jo and Ripley both felt that the limited nature of the information they were presented negatively affected their mental health. Jo described, “[b]ecause I was only presented one extreme as an option [abstinence], I went to the other extreme when that one didn't work. And that actually ended up being really damaging for my mental health and my relationship with sexuality.” Jo and Blair both drew direct connections between their individual mental health outcomes and information deficits in their school based SHE.

Gender Identity and Sexuality. Each of the participants in this study felt they received very little information about gender identity and sexuality in their school based SHE. As Asher said, “There should have been a lot more information about LGBT stuff. There was a lot of missing information.” Jo shared that they had been looking forward to learning about sexuality and gender, and even prepared for the class in advance. As they described,

> When I got my textbook, I flipped forward to the pages on sexuality and gender, um and there was only one paragraph on sexuality and gender. But I studied that paragraph so closely because I was like, ok I really want to have a good conversation about this when we get to it in class. And we never got to it. They completely skipped the one paragraph

> on sexuality and gender, which was really disappointing to me because I really wanted to have that conversation… we just talked about gender in terms of rigid boxes. And it was kind of taken for granted and assumed that gender is always the same thing. When it's not for a lot of people.

Unlike Jo, Rowan did not prepare for the gender and sexuality lesson in advance, as they had not yet learned about the concept of varying gender identities. They recalled, "I knew I was different, like ever since I was little, but I never really knew what the term was for it. So, I wish they would kind of include[d] that [gender identity] in school." Therefore, when neither topic was covered in their sexual health class, they remained in the dark about an important part of their identity.

Like Rowan, Ripley learned about trans and other genderqueer identities on their own. They shared, "[being transgender] was something I stumbled upon online." They went on to talk about how their cisgender friends have difficulty understanding them, because they do not know very much about trans people or identities. As they described, "I feel like [education about gender identity in school] would help [cisgender students] understand more like, what it's like to be transgender. Because I have a lot of friends who don't know anything other than what it is." Blair felt that the conflation of sex and gender in their sexual health classes was reinforced by the gendered way their teacher talked about anatomy. They felt, "[Sex Ed should include] discussions about anatomy to be less binary oriented, so that people don't have such a strong sense that certain anatomy can only be related to a certain gender." Blair felt anatomy could be taught accurately, without the need to assign gender to a specific set of sex organs.

In addition to a deficit of information about gender identities, all participants also felt there was a notable lack of information about the spectrum of sexualities and the different ways people have sex. As Jo recalled, in their grade nine health class the teacher told the students they would not be learning about different sexualities. Ripley felt frustrated by the purely cis-normative information presented in their classroom. They stated "[Sex] needs to be talked about in every way that it can happen." As Rowan pointed out, teaching students primarily about heterosexual sex assumes that this information will be relevant to most students. Yet, a group of students may be more diverse than teachers assume, and many of them may not be interested solely in heterosexual sex. Rowan reflected, "There might even be kids that are more over the percentage than cis kids that are there that want to learn about safer ways for them to do stuff with their partner." Limiting curricular content based on normative assumptions denies all students their right to accurate sexual health information.

Asher also felt they did not learn what they needed to know about sexuality, as they did not see their own experience reflected in the information presented. They shared,

> "[Sex Ed] didn't really matter to me… I'm not really interested in like, intercourse or anything like that. I'm actually asexual so… I feel like a teacher may or may not have brought up that those are possibilities [Asexuality/Aromanticism], but they didn't go into detail about it, and in the end a lot of kids ended up snickering about it."

Similar to the experiences of Rowan and Ripley, Asher did not see themselves reflected in the curriculum, and as a result did not receive the information they needed in order to explore their identity, and best care for their mental and physical health.

Transition. Each of the participants in this study spoke about it being difficult to get to know themselves in their teen years, because they did not know about trans and genderqueer identities, or the various processes of transition. Ripley described how they learned about trans identities, which eventually led them to understanding their own identity and beginning the process of transition. They reflected:

> I didn't even really get what [being transgender] meant. I just knew it was a way people identified and I was just like, oh ok I guess that's just something I will worry about dealing with later in terms of figuring out entirely what it meant… I feel like It took me a really long time to even come to the point where I even felt like I could, like, take the time to figure out who I am and who I wanted to be.

Rowan had a similar experience finding their identity and then navigating through their transition. They described, "I didn't even know what transgender was when I was in health class at school, even though I was trans so, I kind of had to figure it out on my own when I went through my transition, exactly what it is." The experiences these participants describe are examples of institutional erasure.

The process of learning about, and then navigating through the course of transition was challenging for participants in part because none of them learned about transition in their school-based sexual health classes. However, the process was further complicated by the fact that many of their friends, family and peers had the same deficit in information, without the personal motivation to learn. When asked if they felt learning about trans identities and transitioning in school would have helped their friends to be more accepting of their trans identity, Ripley said "I think it would have been helpful for me, cause I feel like it wouldn't be

such a big deal now for everybody around me to accept me. Cause, like, oh well I've known you for too long like this way, and it's hard for me to accept you now." Blair also talked about how important it is for cisgender people to know about and understand trans identities and experiences. As they explained, "people don't understand what trans people are. They don't understand what transitioning is. And I found specifically with trans women there's a lot of trans misogyny here because they just don't understand." Both participants felt that normalizing trans identities through education could help to make their communities safer places for trans people.

The long process of realizing their trans identity also caused Ripley stress in their romantic life. As they described, "[I came out to] my girlfriend at the time, which is my fiancé now, and she cried all night because she thought I was going to break up with her because I realized I was transgender." In the same vein, Rowan observed, "transgender people don't know what to expect when they're going to go through their transition, so it would be kind of cool to get, like, an outlook of what you'd be up against if you decided to go that route." Learning about gender identity and transition in school may enable trans and genderqueer youth to make informed decisions about if and how they choose to transition.

Physical Health. Although participants learned about sexual anatomy in their sexual health classes, most felt the information they were presented with was not relevant to them, because anatomy was taught as a binary concept, where anatomy and gender are mutually exclusive. Ripley described some of the potential repercussions associated with presenting anatomy as a binary concept. They explained how not knowing about trans bodies contributed to their decision to avoid accessing health care. They shared,

> I’ve never gone to a gynecologist, and I probably should because I still have, like all the female parts. But, I've never gone to one because I don't really know what they're for and I would feel really uncomfortable having to go through it. I had the option to once and I was just like, nah, I’m good. I’m not going to go through that. (long pause) I don't really know what else to say about that.

Through their own online research, Jo found information about people Assigned Female at Birth [AFAB], a shorthand used to describe genderqueer or trans people who were assumed female at birth, based on their sex organs. They resonated with the experiences of AFAB people online, which contrasted with their experiences in sexual health class where, as they said, “we didn't talk about those types of bodies.” Asher felt a lot of what they learned in sexual health class was irrelevant to them, because as they explained, “I'm actually asexual so, I just I feel like I would have liked to learn more about my body rather than what will happen if I get pregnant.” They felt that the binary approach to anatomy was not relevant to their experience as a genderqueer person, and the focus on pregnancy prevention was not relevant to them as an asexual person. Blair did not see their experiences reflected in the anatomy section of their sexual health classes either. They described, “I didn't necessarily have the best perception of myself because I always felt like I had to read myself as female based on my anatomy because that's what we were taught, versus how I really felt inside.” The exclusively hetero and cis-normative approach to teaching anatomy and physical health did not meet the needs of these two participants, who did not see themselves represented in the lesson plans. Learning about human anatomy is relevant to everyone but becomes less so when presented as a binary

concept. The above examples provided by participants highlight the importance of delivering sexual health information in an inclusive way, which makes the content relevant to all students.

Non-Normative Relationship Styles. Another topic study participants felt they did not learn enough about was non-normative relationship styles. As outlined in previous sections, all participants felt their SHE focused almost exclusively on heterosexual relationships, to the exclusion of all other relationship styles. Ripley stated, “I feel like they should branch off and try to educate people more on the types of relationships you can have.” Building on this theme, Jo reflected that what they learned about relationships focused on monogamous relationship styles. They shared, “I don't remember anything specifically about polyamory in my sexual health classes, but that itself is a problem, the fact that no one mentioned that polyamory is a thing.” Reflecting the other end of the relationship spectrum, Rowan felt the education they received assumed they would want to pursue a romantic relationship. They expressed, “I do believe that we shouldn't be teaching kids that it is absolutely vital to be in a relationship.” All participants felt they were only presented with one relationship option, which did not resonate with their interests or experiences.

Bodily Autonomy, Consent and Early Education. Most of the participants did not directly mention the concept of consent during their interviews. Several participants did touch on the idea when they talked about healthy relationships, but only Jo and Asher specifically mentioned it as a foundational element of sexual health, and a concept central to sexual health curricula. Although most participants did not specifically identify consent as an element missing from their SHE, the fact that it was rarely mentioned may indicate that participants did not

learn about it in detail. Jo did speak about consent directly and shared that they felt they should have learned about consent earlier than they did. They explained,

> I think that there needs to be a foundation of consent in all sexual health education, and that needs to be set so early, like I don't even think that start of public school's really enough to start talking about consent and bodily autonomy . . . I think that kids should be told about that from the time they're able to understand words.

Each of the participants expressed this idea in varying ways: they all felt that appropriate SHE needs to begin as soon as (or ideally before) students enter the school system. Several participants felt that if students begin to learn about sexual health as soon as they begin school it may help to normalize differences and increase students' ability to accept people who are different from them. As referenced earlier in this chapter, Ripley felt if their friends had learned about trans identities earlier on, it may have helped those friends to understand and accept them when they came out. Blair echoed this sentiment, saying, "I think that definitely having an understanding [about trans identities] from a younger age makes it a little bit easier to grow up with that knowledge rather than trying to obtain it as an adult." Asher also thought SHE could be improved by beginning the process earlier, because normalizing sexual health content would make for better learning environments. Asher said SHE and the learning environment would be improved by, "starting kids out early on, so they won't be giggly, and you know, making the teacher feel awkward about things." Normalizing sexual health conversations at a young age may contribute to the creation of better learning environments, as older students may be less "giggly" and disruptive if they are already comfortable having conversations about sexual health.

How Sexual Health Education is Taught

As well as describing the content of their sexual health classes, participants described some of the ways the information was delivered. This section describes the various ways in which participants remembered being taught in their sexual health classes. Participants recounted a variety of different teaching approaches, some they found engaging and effective, and others they did not. It is important to note that several participants acknowledged that their teachers were limited by time, comfort, and the material they felt supported to cover in class. The barriers experienced by sexual health teachers, and the opportunities to address some of the instructive challenges participants identify in this section will be unpacked in the discussion chapter.

Values-based. Pregnancy prevention was a key element in most participants' sexual health classes. However, pregnancy prevention was not a concern for any of the study participants, as none of them were interested in heterosexual intercourse. Although none of the participants was concerned about getting pregnant, some of them were interested in sex. Jo felt they did not receive the amount of information they needed to make healthy sexual choices, in part because they felt their sexual health classes presented abstinence as the "only right option". Teaching students predominantly about abstinence is a values-based approach to SHE, which does not improve sexual health outcomes (UNESCO, 2018).

In describing their experience, Jo shared, "there was a little bit of talk about making good sexual decisions, but it was all like you should wait, which I feel like, for me at least pushed me to not wait." Rowan and Blair also felt they were not given much guidance about how to make healthy sexual choices. For Jo, when they did decide to have sex, they did not

have the tools they needed to assess their emotional or physical needs. They explained: "[b]ecause I was told that waiting was the only right option, and that wasn't working for me, I assumed that the opposite of that is to just jump in and have sex with the first person who's willing. And that wasn't right for me." Abstaining from sex is the most effective way to prevent the transmission of STIs and to prevent pregnancy. However, teaching youth that abstinence is the right choice is a values-based, not evidence-based, position. If abstinence is not the right choice for someone, they have the right to be given the information required to make healthy sexual decisions.

Authoritative. One participant felt their SHE was delivered in an authoritative manner, a teaching style which they felt did not suit the sensitivity of the subject matter or contribute to students' learning outcomes. Jo described:

> I think that being open with students and allowing students to actually learn is more important than teachers maintaining their authority. So, I don't know if those two things can coexist… I think that of course teachers need to have authority to a certain extent, but I think that students being able to learn important life skills is way more important. So, I would much rather see a culture change in the classrooms, than have the current culture hold students back from learning.

Jo imagined a less hierarchical classroom structure for learning about sexual health, where students not only shaped the learning experience, but also actively contributed to it as educators themselves. Several other participants spoke about accessing informal peer education from friends and family members, however Jo was the only participant to speak specifically about classroom structure.

Hands-off Teaching: Videos, Handouts and One-way Conversations. When asked how sexual health content was delivered, several participants described passive teaching approaches to delivering the subject matter, including a heavy reliance on hand outs, and videos. Asher described, "they just showed us a movie and the movie was like an hour, so they had to do it in two classes." Asher recalled that the video was a stand in for in-person instruction. They explained, "I don't remember a teacher ever being in the room [during sex ed], I'm pretty sure they all stepped out." The teacher was present in Blair's sexual health classes, but as they described, "It was mostly getting handouts and having the teacher read the handouts to us." Similarly, Rowan described watching videos, and PowerPoint presentations. In Ripley 's classes as well, the content was delivered passively, with an emphasis on memorization. Ripley explained, "We would just do like tests and it would be questions like, oh, what is this specific thing called? . . . I know that we did like diagrams on the board**."** Jo reflected on passive pedagogical approaches to delivering SHE when they said, "I just think that, it needs to be more, needs to be more conversation based rather than lecture based." Jo felt SHE would be more effective if teachers could "figure out ways to have conversations about sexual health rather than it being [a] one way [lecture]." Jo supported more conversational learning because they felt teaching SHE lecture-style required an oversimplification of the subject matter. They reflected,

> I think conversation-based learning would have been a more positive experience and I think a lot more applicable to something like sexual health. Like math I kind of get. One person really knows math; they tell you what to do. But sexual health and personal life decisions doesn't seem like something that should be taught lecture style.

Jo felt a more conversational approach to the subject matter would have been a more effective approach to teaching SHE. Conversation based learning requires that teachers be comfortable with the subject matter, and as Asher pointed out, some SHE teachers find the content embarrassing. Embarrassment and discomfort may contribute to teachers choosing to use less interactive instructional approaches when delivering SHE.

Interactive and Peer Led. Several participants spoke about interactive and engaging learning experiences in the classroom. Blair described a "cool teacher" who gave the class the opportunity to submit sexual health questions to an anonymous question box. They explained, "I really liked the anonymous questions because I think that gave people more opportunity to ask things that they might have been too embarrassed to put their hand up and ask about." Although Blair appreciated the anonymous question box, they also recognized the limitations of that approach, saying, "[b]ut the answers were still kind of brief and she sort of only had to stick with what the guidelines were for the learning outcomes." Rowan enjoyed the hands-on elements of their sexual health classes. They shared,

> We got passed around like condoms and stuff, and it was like, look and see what they are and everything. But that was pretty much what it was. The teacher would tell us like, what stuff was or they would show us and that was about it really… It was a good way to learn, it's kind of interactive, some people learn certain ways, I'd rather learn visually than see someone explain it to me.

Participants did appreciate some elements of their SHE, even when the content was not entirely relevant to their lived experiences.

All participants were students receiving SHE in their classroom. However, Jo also played the role of educator at their school when they and the other members of their Gender Sexuality Alliance [GSA] offered peer led SHE to their classmates. Jo described the challenges they faced in offering peer-led education, saying, “I think the hard part about the GSAs trying to do educational work in the school was . . . like if we went into a classroom then the class expected us to have all the answers, but we didn't.” They continued on to explain, “we tried to do educational work, but it was really difficult because we were doing our best, but we also didn't have a lot of information and a lot of places to go for information.” Jo felt their classmates expected them to provide answers to them, through a one-way transfer of information, like the lecture-style education most study participants describe receiving in their classrooms. However, the GSA members were not sexual health experts, which is why Jo felt there should have been more emphasis on classes learning together through conversation-style learning which would have tapped into the collective knowledge and experience of the students in the room. Jo felt students should learn from one another, as well as their teachers, because “students have such a vast array of experiences that could contribute to education.” Asher felt there should be more emphasis on peer to peer education because youth are more comfortable talking to other youth. Several other participants touched on this, when they spoke about learning from their peers (Blair and Jo), or siblings (Asher). Jo also pointed out that there is a lot of pressure put on teachers, and “It's totally teachers’ responsibility to stay informed, and be able to provide accurate and up to date information to students. But I also get that teachers in Nova Scotia have a really difficult lot.” Jo proposed, “conversation-based learning is so good because then no one has to have all the answers.” Jo’s preference for conversational learning aligns with the

anti-oppressive approach to CSHE, as it both empowers youth to be active actors in their own learning and growth, while still requiring adults to create and maintain safe spaces for learning.

Alternative Sources of Sexual Health Information

As well as speaking to their peers (Jo, Blair and Ripley) and siblings (Asher), participants reported accessing several other alternative sources of sexual health education and information, namely: YouTube (Jo, Blair), Facebook (Ripley and Asher), Google (Rowan, Asher and Ripley), Tumblr (Rowan and Ripley), The Youth Project (Rowan), movies (Ripley) and health professionals (Rowan). Participants accessed these alternative sources of sexual health information for a variety of reasons.

Accessibility. All participants looked for the sexual health information they needed in places that were easily accessible to them. Often the space most easily accessible to participants was the internet. Blair pointed out that the internet is a space where trans and genderqueer people can share the resources and information they think other people in the community may find useful. They said, "I've been able to find a few YouTubers that I really like, that sort of make their content because they didn't have the resources themselves and they wanted to make it more readily available to people". The internet also offered an accessible space for participants to explore their identities. As Ripley shared,

> [I Googled] how does a guy walk? Um, the difference in styles between men and women's clothing, how guys do things differently than girls, like in terms of sitting and standing. Like how they sit … how to present myself more as a guy… and when I was figuring out trans men, I Googled I think the definition first.

Not only were online spaces physically accessible to participants, but, as Blair touched on above, the information participants found online felt more accessible because it was more relevant to their lived experiences. Like Blair, Jo found YouTube videos helpful, in part because the YouTubers making the videos felt like peers. Jo explained,

> I think that with YouTube it was [different than a classroom] because the person wasn't an authority figure. It was because they were just other people talking about their experiences. And that made it feel more open to the opportunity of well... I can use this information to inform my own experiences. My unique experiences… [I trust YouTubers] because of the seeming peer relationships.

Ripley also used online resources to access sexual health information from their peers. Using social media, they were able to connect with peers from all over the world to ask questions and share information. They described, “There's so many different people out there that you can branch to and connect to. Like, I'm on 2 different transgender groups on Facebook… like a lot of people post there right, like on that one I think there's like a thousand people on it.” Accessing online spaces allowed for participants to find information through interactions with their peers, and allowed for those who wanted to, to remain anonymous. For example, Asher used Google to ask questions they felt they may be judged for. They explained, “[I use the internet to find information] mostly because of embarrassment to ask other people so I would just kind of Google it. It's a very judge free space when you're not involving other people.” As well as these benefits, using the internet allowed participants to direct their own learning.

Self Directed. All study participants accessed relevant sexual health information through self-directed online learning. Most participants found information on their own, and did their

own self-assessment of its accuracy, while Rowan had additional support from health professionals. Rowan recalled, “It was kind of interesting because I was like, I never learned about this in school. I had to learn from the social workers and psychologists, and they gave me stuff to look at online to look it up”. The other four participants did not have the support of health professionals to complement their self-directed learning. As Blair shared, “the knowledge that I needed… was gained through having to look for resources myself, and through personal experience.” Four of the five study participants learned about sexual health through trial and error, without the benefit of foundational sexual health information or on-going support from either education or health professionals.

Practicing self-directed learning allowed participants to research sexual health questions relevant to their lives and experiences, however Ripley touched on the fact that there is a lot of information available online, and some of it is not completely accurate. They shared that when they Googled a question, they would check the results from multiple websites, because “it's better to go through a couple different sites and see what a couple different sites say instead of just one site. Cause what one site says might not be the same thing as what another site says”. The internet provided participants with an accessible, judgement free space for self directed learning, however Rowan was the only participant who had support to identify reliable and accurate resources.

Barriers to Change

After we talked about each participant’s experiences in their sexual health classes, and where they looked for alternative sources of sexual health information, I asked each of them if they believe there are barriers to implementing comprehensive and inclusive SHE in schools in

Kings County. Rowan, Asher and Blair felt parents are the biggest barriers to change in the curriculum. Blair shared, “especially in rural areas there's a lot of discrimination and bias [against trans and non-binary people] that still exists, and so I know there will probably be some unhappy parents.” Ripley also felt there would be resistance to a more inclusive curriculum, in part because, as they said, “I honestly just think that a lot of people don't want to admit that [being transgender is] a reality.” While Rowan said, “I feel like maybe parents need to really like look [up information about transgender people and transitioning] and learn.” All participants perceived resistance to an inclusive curriculum, grounded in ignorance and transphobia. When asked what they perceive to be barriers to inclusive SHE, Jo said:

> Transphobia in general [is a barrier], and how difficult it is for trans people to find employment, or to be paid for their time and the education that they're doing. Because if there were more trans teachers then I feel like all teachers would feel more, like cis teachers, would feel more of a responsibility to represent information accurately, because they would have a resource to go to. So the fact that there is such rampant transphobia in society that keeps trans people from going into professions like teaching is a barrier.

Each of the participants in this study talked about individual-level experiences of transphobia, while Jo and Blair talked about community and systems-level transphobia and transmisogyny. Transphobia and transmisogyny at all levels create significant barriers to the delivery of CSHE in the classroom. These, and other barriers, are discussed in more detail in the following chapter.

Chapter 5: Discussion

Limitations

There were several limitations to the conduct of this study. First, the trans and genderqueer populations in rural areas are relatively small and hard to access due in part to distrust of outsiders, which may have contributed to the difficulty I experienced in finding participants (Taylor et al., 2013; Willging et al., 2006). Trans and genderqueer youth in rural areas are also more geographically dispersed than in urban areas, with less access to reliable public transportation, which may have limited potential participants (i.e., a potential participant may have seen recruitment materials, but not reached out to participate because they were not readily able to travel between communities). Finally, sex and gender identity are sensitive and personal topics, and potential participants may not have been willing to discuss these experiences with a researcher, leading to an over-sampling of participants comfortable discussion sexual health.

The Importance of Systems-Level Change

The longstanding marginalization of gender-diverse identities in western society has been reproduced through social systems and the enforcement of heteronormative social expectations (Abbott et al., 2015; White-Hughto et al., 2015) and of particular relevance to this study, within education systems (Dyer, 2017; Frohard-Dourlent, 2018; Shipley, 2013). As Helene Frohard-Dourlent (2018) states, “schools are key sites in which normative gender identities and practices are legitimized – through gender-segregated schooling, curriculum, school rituals, everyday practices and interactions between students and educators” (p. 329). In other words, schools are key in interrupting queer youth in the process of becoming and reinforcing

heteronormative and cis-normative values (Shipley, 2013). These systems-level norms create individual-level experiences of oppression and marginalization, for example the bullying and violence experienced by trans and genderqueer youth in their schools (Saewyc et al., 2018). These individual stories are often the focus of media reports[40], referenced in arguments supporting gender-equity and representation in the classroom. It is the role of the health promoter to look upstream, for the source of the discrimination, marginalization and health inequities experienced by individual trans and genderqueer youth. Most sexual health promotion programs and interventions utilize social psychological strategies to affect individual health behaviours. However, if health promotion only focuses on individual micro-level interventions it is limited in its scope and ability to contribute to widespread social and cultural changes. Policy is the tool the discipline of health promotion uses to facilitate macro-level social change, to create social environments that enable individuals to have increased control over their sexual health at the micro-level (Canadian Human Rights Act, 1985). Equitable sexual health policies and strategies, when meaningfully implemented, can increase individual youths' abilities to make informed sexual health decisions, and increase access to sexual health services. The interview data suggest that trans and genderqueer youth feel excluded from the SHE they receive in public school. Feelings of exclusion and lack of representation have been correlated with mental health challenges, and increased rates of suicidality in past research (Saewyc et al., 2018; Taylor et al., 2020; Taylor et al., 2011; Veale et al., 2015; White-Hughto et al, 2015). Therefore, I argue that the government of Nova Scotia should provide CSHE to

[40] In example, in January of this year an attack on transgender student in Mission B.C. made national news ("Vehicle parade in Mission draws strong support for transgender student attacked and beaten by peers", 2021)

students in Nova Scotia, to reduce the likelihood that trans and genderqueer youth will experience mental health challenges associated with experiences of exclusion.

Sexual Health Education Action in Nova Scotia

The Nova Scotia Roundtable's (2006) *Framework for Action: Youth Sexual Health* was intended to: "improve the sexual health of Nova Scotian youth . . . [and] provide a comprehensive, strategic direction for youth sexual health in Nova Scotia for implementation over the next five to seven years" (p. 7). Currently, the provincial sexual health curriculum is in the process of being updated[41] (Action Canada for Sexual Health and Rights, 2020), however the province has never implemented this framework. The Nova Scotia Roundtable's (2006) framework provided "strategic direction for a comprehensive approach to sexual health education, services and supports for youth throughout Nova Scotia" (2006, p. 7), and although significant time and resources were invested in its creation most of the recommendations were never resourced or implemented. The Nova Scotia Roundtable disbanded in 2008. In researching The Nova Scotia Roundtable for this study, it was difficult to determine why the group was discontinued. I wrote to former Nova Scotia Roundtable members, sexual health centre coordinators across the province, health researchers and past employees of the NS Department of Health and Wellness. Although most of the people I reached out to did not know what had happened to the group, several of the people I spoke to felt strongly that the work the Nova Scotia Roundtable started is as important and necessary now in 2021, as it was when it began in the 1990's. Only one person I contacted was able to speak to the circumstances that

[41] A recommendation described in The NS Roundtable's (2006) framework.

led to the Nova Scotia Roundtable disbanding. In an email, L. Tobin shared that the group wrapped up after,

> The Roundtable decided to disband around 2008, a couple of years after the launch of the NS Framework on Youth Sexual Health (which the Roundtable had been working on for many years). Several attempts had been made to engage youth in the work of the Roundtable and the Framework without success. The group decided to dissolve to make way for youth leadership. (personal communication, March 22, 2021)

After the group disbanded there was no longer any government organization specifically responsible for addressing the sexual health outcomes of Nova Scotian youth.

The Nova Scotia Roundtable's (2006) framework recommends the development of several more culturally responsive sexual health resources; however, to date the existing resources available to health teachers are outdated[42]. The province's *Guidelines for Supporting Transgender and Gender-nonconforming Students* (2014) includes a one-page overview describing the importance of trans and gender-nonconforming students seeing themselves positively represented across the curriculum, however, there is no specific direction regarding updating the curriculum or delivery of CSHE. The document encourages its readers to reach out to their school board (now RCE), equity and human rights representatives, as well as librarians for direction and material resources to support the representation of trans and gender non-conforming people in curricula (DEECD, 2014). The creation and distribution of the guidelines was not paired with provincial curriculum changes, leaving the choice whether to deliver

---

[42] See: *Growing Up Ok!* (NS Roundtable, 1991), *Sex? - A Healthy Sexuality Resource* (Healthy Sexuality Working Group, 2004), partially updated in 2016.

inclusive lessons up to the discretion of individual teachers. The Nova Scotia Roundtable's (2006) framework recommends a review of the provincial curriculum, and subsequent updates to bring it in line with the SIECCAN (2019) guidelines[43] (Nova Scotia Roundtable, 2006). Although significant planning work was completed in Nova Scotia in the late 1990's and early 2000's, sufficient political will to action these recommendations has not existed.

The piecemeal nature of actions taken to address youth sexual health outcomes in Nova Scotia demonstrate the importance of legislation. Although there has been significant work done to plan for meaningful change, without legislated commitment, the results to date have been piecemeal. In recent years, the social and political conditions necessary for meaningful action on youth sexual health in Nova Scotia appear to be improving. That is, considering the work currently being done to update the provincial curriculum, as well as *Sex? - A Healthy Sexuality Resource* (Healthy Sexuality Working Group, 2004), the increased availability and accessibility of gender affirming surgeries in the province (Cooke et al., 2019), the Strait Regional School Board's decision to allow the distribution of *Sex?- A Healthy Sexuality Resource* (Healthy Sexuality Working Group, 2004) in its schools ("Sex health guide to be released in Strait schools", 2013), Public Health's stated dedication to the implementation of CSHE (Department of Health and Wellness, 2009), and the inclusion of gender identity and expression in the province's human right's legislation.

Social norms (cis-normativity, entrenched gender-binary bias, gender roles, etc.) create the conditions for transphobia and the stigmatization of gender-minority identities (Frohard-

---

[43] Note: The first SIECCAN guidelines were released in 1994 (PHAC, 2008). The latest guidelines, which built upon previous revised versions, were published by SIECCAN in 2019.

Dourlent, 2018; White-Hughto et al., 2015), experiences reported by study participants. Although inclusive policies are an important part of the social movement toward gender-equity in education, the dominant culture that has supported and maintained historically exclusionary policies must shift in tandem. If movements toward equity for gender-minority people are not culturally supported, then inclusive and protective policies and legislation may not survive a change in government (Shipley, 2013).

A National Sexual and Reproductive Health Rights Strategy for Canada

The delivery of CSHE should be a public policy priority at provincial and national levels (Action Canada for Sexual Health and Rights, 2020; SIECCAN, 2019). An appropriately resourced national SRHR strategy (meaning a strategy with dedicated, ongoing, financial and human resources) for Canada would support efforts to make CSHE a priority (Action Canada for Sexual Health and Rights, 2020; CEDAW, 2016b). A resourced national SRHR strategy would potentially benefit the sexual health of Canadians[44], provide federal-level recognition of the importance of CSHE, and could strengthen legislated protection of the SRHR of 2SLGBTQ+ people (Action Canada for Sexual Health and Rights, 2020; CEDAW 2016b; SIECCAN, 2019; WHO, 2010). The recognition and protection of SRHR are important to combat erasure, normalize the spectrums of gender and sexuality, and to formalize the federal government's commitment to protect the rights of Canadians, as laid out in the Canadian Human Rights Act (1985). The Government of

[44] In example, The Federal Initiative to Address HIV/AIDS in Canada is a horizontal strategy implemented by the Government of Canada. It provides "funding for prevention and support programs targeting priority populations, as well as research, surveillance, public awareness, and evaluation" (Government of Canada, 2019, p. 2) to provinces across Canada. Evaluation of the initiative in 2019 found target populations reported increased understanding of the ways HIV/AIDS is transmitted, and increased application of preventative sexual health practices (Government of Canada, 2019).

Canada has a legal responsibility to protect the SRHR of its citizens (CEDAW, 2008; CEDAW 2016a). In 2008, and again in 2016, CEDAW called upon the Government of Canada to ensure the delivery of age appropriate sexual and reproductive education in all schools (CEDAW, 2016a). In 2016, after reviewing Canada's eighth and ninth reports on the convention, CEDAW (2016b) noted with concern "[t]he lack of a comprehensive set of national guidelines or standards for education on sexual and reproductive health and rights, which has resulted in severe discrepancies among provinces and territories in terms of curricula" (p. 13). And in 2019 the House of Commons Standing Committee on Health (2019) recommended,

> [t]hat the Government of Canada, through Health Canada, work with the provinces and territories to encourage the provision of age-appropriate education on sexual orientation and gender identity to children and youth of all age groups as well as parents and caregivers. (p. 42)

A national SRHR would support the work of The Government of Canada in achieving its commitments to CEDAW, as well as several of its other international human rights commitments[45], and its commitment to uphold the human and health rights of its citizens (Canadian Human Rights Act, 1985).

It is important to note that Canada is a federation of provinces and territories and that health and education spending and policy decisions are made by provincial and territorial governments. As such, a national SRHR strategy would not have the jurisdiction to dictate the education and health policies enacted in individual provinces and territories (Action Canada for

[45] Namely, the UN Convention on the Rights of the Child, and the Convention on the Rights of Persons with Disabilities (Government of Canada, 2020a)

Sexual Health and Rights, 2020). A resourced national strategy would, however, identify sexual health as a national priority, provide leadership and direction to the provinces, support a cohesive approach to the delivery of SRHR and offer sustainable funding to resource the implementation of provincial sexual health promotion programming and education which adheres to the SIECCAN Guidelines (CEDAW, 2016 b).

Enshrining SRHR in policy is important because smaller-scale policy changes and improvements to curricula are not systems level changes and are therefore more vulnerable to political whims and interference (see Strait Regional School Board example). As described by Preston (2018), "[e]ven within comprehensive sexuality education . . . studies have shown that neoliberal directives and political policies severely limit the curriculum and often erase the identities, experiences, and needs of marginalized groups" (p. 333). The implementation of a national sexual health strategy would potentially align sexual health with human rights, provide cohesive direction for sexual health promotion programming and preventative initiatives across the country, and provide decisive leadership to the provinces.

The implementation of a SRHR strategy would be an important step toward equitable access to CSHE for all public-school students in Canada (Action Canada for Sexual Health and Rights, 2020). For example, the Government of Ireland's National Sexual Health Strategy (2015) states "[e]veryone in Ireland will receive comprehensive and age-appropriate sexual health education/information" (p. 17). The Irish strategy reflects the language used by Starss and colleagues (2018) in their integrated definition of sexual and reproductive health rights. Were a

Canadian strategy created and implemented, the use of a human rights framework[46] would support the delivery of sexual health promotion programs and CSHE across the country. Access to education is essential to improving the spectrum of sexual health outcomes (Nova Scotia Roundtable, 2006; SIECCAN, 2019; WHO, 2010), and increasing individuals' ability to "make free, informed, and voluntary decisions on their sexuality, sexual orientation, and gender identity'' (Starss et al. 2018, p. 2655), thereby achieving the sexual health promotion goal of attaining control over their sexual health (Khalesi et al., 2016).

An appropriately resourced national strategy could build on existing research, policies, and related documents, including the Canadian Human Rights Act (1985), which protects Canadians from discrimination based on their gender identity (among 13 other protected grounds). In example, *The National Inuit Sexual Health Strategy* (Pauktuutit Women of Canada, 2017), and *It's Time: Canada's Strategy to Prevent and Address Gender-based Violence* (Government of Canada, 2017) were both created to respond to identified needs. A resourced national SRHR strategy would both respond to existing needs (for example: STI testing programs, access to birth control, etc.) as well as bring attention to the upstream causes of poor sexual health outcomes; integrating existing strategies, while also tying sexual health to the social determinants of health.

A national SRHR strategy is an important step for the Government of Canada to take to protect the SRHR of Canadians. However, there must also be commitment at provincial and territorial levels, where health and education decisions are made. A SRHR framework could be

---

[46] For examples see OHCHR, 2008 and WHO, 2010.

useful for provincial and territorial governments building capacity to deliver CSHE in their jurisdictions. Many arguments against the implementation of CSHE in Canada are based on religious beliefs and heteronormative values (Action Canada for Sexual Health and Rights, 2020). The debate has been framed as a tension between two sets of protected rights: the right to be free from discrimination based on gender identity, gender expression, sex or sexuality, and the right to be free from discrimination based on religious beliefs (Shipley, 2012). As Shipley (2012) points out, the assumption that religious rights and 2SLGBTQ+ rights are inherently in conflict over-simplifies the conversation. Many Canadians who are religious are part of communities represented by the 2SLGBTQ+ acronym. The two "worlds" are not mutually exclusive. As such, the needs, rights, and lives of religious and 2SLGBTQ+ people often overlap or are the same. Assuming the two are consistently at odds ignores the intersectional nature of identity and/or oppression. This is an important point, especially when it comes to framing discussions with interested stakeholders during the process of creating sexual health promotion programming and curricula. Finding shared ground and building relationships between stakeholders on all sides of the issue may increase buy-in, and reduce barriers to implementation (Shipley, 2012). A resourced national SRHR strategy would provide provincial and territorial governments with leverage, in the form of a national level commitment to protecting and upholding SRHR. Should provincial and territorial governments begin the work of implementing their own legislative protections of SRHR, they would have the commitment and support of the National government behind them.

Why it Matters

How much do we miss learning from one another, when we don't have a shared understanding of what we are talking about? And, how do we tend to our sexual health, and support the sexual health of others, when we don't know what sexual health is? Without a shared understanding and acceptance of what sexual health is, people will be excluded from the conversation, even if they are in the room while other people are having it.

Experiencing Erasure

Every participant in this study described experiencing some form of erasure during their time in rural public schools. Although some community members and organizations in Nova Scotia are working to use gender-inclusive language and provide relevant services, the dominant social narrative is that people are cisgender. In a culture based on the assumption that everyone who lives there is male or female, trans and genderqueer people become impossible (Bauer et al, 2009). If we don't know that a group of people exists, it is difficult to create a society that includes them as foundational members. The erasure of trans and gender queer people refers to the fact that trans and genderqueer people have not been represented in Canadian structures and systems (Bauer et al, 2009). In the education system trans and genderqueer identities have just recently begun to be talked about, but changes are slow, limited, and inconsistent. Gender and/or sexual diversity are often considered "special topics" not core curriculum. These are considered "special topics" because they deviate from the assumed gender-binary, which is considered the "standard" or "norm" in Canadian society.

The idea that there is a "standard" or "normal" way of being leads to stigmatization and marginalization of anyone who falls outside of that "standard" (Dyer, 2017; Shipley, 2013). To

resist the erasure of non-binary gender identities, it is important to differentiate what is common from what is normal. Cisgender people are more common than transgender and genderqueer people, however the prevalence of cisgender people does not mean that all people must adhere to cisgender norms. When we hold up one gender identity/expression as a standard then anyone who does not meet that standard becomes an "other", a position which can affect their health, as well as the social and educational opportunities afforded to them (Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, 2011). The erasure and othering of trans identities contributes to the marginalization of trans and genderqueer youth (Shipley, 2013). As participants described, representation of the wide spectrum of gender identities in sexual health curricula would increase visibility, and support systems-level and cultural shifts toward social inclusion.

Finally, studies suggest that CSHE improves children's acceptance of others, reduces societal stigma, improves sexual health outcomes, and improves students' self-esteem (Proulx et al., 2019; Taylor et al., 2011; UNESCO, 2016). Thus, it is not only important to trans and genderqueer students to receive CSHE. CSHE benefits all students in the sense that every student will have the information they need to care for their own sexual health, as well as understanding that the sexual health needs of others may be different than their own. Teaching inclusivity and acceptance through CSHE is an upstream sexual health promotion approach to shifting social environments to make them more inclusive and welcoming, and an approach to combating the erasure of diverse identities in the classroom and in the education system.

Healthy Relationships

A key theme from interviews was participants' challenges with forming healthy relationships, both with themselves and other people (Jo, Asher, Blair and Ripley). As participants pointed out, they did not learn about the kind of intimate relationships they wanted to have (i.e., non-monogamous, and/or non-heteronormative relationships), and if they did not have good relationship role models in their lives then it may be difficult to identify an unhealthy relationship, or the warning signs of one. When the spectrum of sexualities and relationship styles are not fully fleshed out, students may be left to explore their sexuality and relationship preferences without the emotional resources required to do so in a way that is safe.

A person's relationship with themselves may also be affected by the SHE they do or do not receive. Blair described feeling resentment about their sexual desires, as they did not feel they were given the information they needed to understand them. If your sexual identity is not represented in the curriculum, you may not be given the education you need to know yourself. A result of this may be that it takes longer to figure out who you are and solidify your foundational sense of identity. It may take longer to become (Shipley, 2013). A lack of identity has been associated with increased levels of anxiety and depression, poor self-image, suicidality, and internalized stigmatization in trans youth (Connolly et al., 2016). The delivery of CSHE is a demonstrated protective factor which can reduce the likelihood of youth developing anxiety, depression, and suicidality (Connolly et al., 2016).

Transphobia and Transmisogyny

Transphobia is hatred for, and prejudice against transgender people, and transmisogyny is hatred for, and prejudice against transgender women. In their interview Blair described

experiencing transmisogyny, which they felt was common in rural areas of Nova Scotia. They also shared that when they engaged with people and talked about what it means to be trans, people were more accepting. People are fearful of what they do not understand, and fear can lead to violence and hatred. Research highlights the importance of representation and inclusion of trans and genderqueer people and identities in SHE curricula to reduce instances of discrimination and prejudice (Action Canada for Sexual Health and Rights 2020; PHAC, 2014; SIECCAN 2019; Taylor et al., 2013).

Access to Reliable Sources of Sexual Health Information

When youth have sexual health questions, they often go online to look for answers (Hare et al. 2015; Hare et al., 2014; Muñoz-Plaza et al., 2002; Pinto et al., 2008). Sexual health resources and messages on the internet may not provide youth with accurate sexual health information. For example, Sexually Explicit Internet Movies (SEIM) can provide non-judgmental spaces for youth to explore their sexuality, learn about positive elements of sexual health, non-normative sexualities, and build their sexual knowledge (Hare et al., 2015). However, the information and stories told about sexual health (e.g., desire, sexuality, consent) in SEIM may not be based on evidence or realistic interpersonal relationships. Most SEIM, after all, are not intended as sexual education tools. As highlighted in the results section of this thesis, having a non-judgmental space for learning online provides an important opportunity for trans and genderqueer youth to seek out sexual health information they are not receiving in the classroom. Evidence indicates that - like participants in this study- youth of all sexualities and gender identities are seeking out SEIM and other SHE resources online (Hare et al. 2015; Hare et al., 2014; Muñoz-Plaza et al., 2002; Pinto et al., 2008).

To ensure that youth are not relying on inaccurate or non-affirming sexual health information found online, it is important that SHE in our schools be comprehensive. If youth have a solid base of information, they may be better able to think critically about online materials. Teaching youth how to analyze a website for reliability would equip youth to explore less mainstream elements of sexuality online (e.g., BDSM, kink, etc.), and analyze the information they find (i.e., in terms of safety, accuracy, etc.).

Barriers to Change

Participants in this study described what they perceived to barriers to the implementation of CSHE in Kings County schools. To demonstrate how these barriers interact and overlap with those described in the literature (i.e., Dickson et al., 2020), I mapped the described barriers over the SEM, and described their location within the SEM, in this section. The creation of this map was informed by a study by McLeroy and colleagues (1988), which mapped barriers to the delivery of SHE experienced by classroom teachers and administrators in the rural United States on to the SEM. Utilizing the experiences reported by teachers in the Action Canada Sexual Health and Rights (2020) report on the state of sex education in Canada, the SEM map described below demonstrates potential barriers experienced by both adults and youth. For a visual representation of this section see Appendix D.

Individual Level Barriers

The individual level of the SEM describes how the knowledge, attitudes and skills of individual people affect health outcomes. In the context of SHE, individual influences include: the developmental history of the individual, their knowledge, self-perception, skills, attitudes, and behaviors (McLeroy et al., 1988). In other words, the individual level influences on a

person's sexual health outcomes are in part the skills and knowledge that they would ideally learn from the SHE curricula in their school. This section describes the ways in which individual administrators and classroom teachers may act to create barriers to the delivery of CSHE. It is important to note in this context, however, that the relationship between the five layers of the SEM are reciprocal in nature, and therefore individual level barriers are shaped by more upstream influences (e.g., organization and policy layers), not necessarily from individual failings. The identification of individual level barriers is useful as a tool to advocate for action to address upstream barriers, in order that these potential individual level barriers can be addressed in a systematic way.

Administrators. Support from school boards (or RCEs) principals and vice-principals is of key importance for the successful delivery of CSHE (Action Canada for Sexual Health and Rights, 2020; Preston, 2019). As school leaders, the knowledge (e.g., the importance of CSHE to student wellbeing over the life span) and attitudes (e.g., the level of priority attributed to the delivery of health curricula) of administrators toward the delivery of CSHE can affect classroom teachers' willingness and ability to deliver health education in a comprehensive way (Action Canada for Sexual Health and Rights, 2020; Preston, 2019). As a result, a lack of administrative support can act as a significant barrier to the delivery of CSHE in a school.

Classroom Teachers. To teach CSHE, classroom teachers need to be adequately trained in the subject area, and comfortable with the content[47]. In Nova Scotia, teachers responsible for SHE are required to pursue their own PD, as health education is not a required course in

[47] And/or partner with community sexual health organizations who offer workshops/modules delivered by 2SLGBTQ+ people with lived experience.

provincial Bachelor of Education programs (Action Canada for Sexual Health and Rights, 2020). The varying content knowledge of classroom teachers, their level of comfort with sexual health content, as well as the level of support they receive, are individual level barriers to the delivery of CSHE (Dickson et al., 2020) in Nova Scotia.

Another potential individual level barrier is the lived experience of teachers. Most classroom teachers in Nova Scotia are cis gender and heterosexual[48], and thus have not experienced homophobia, transphobia, gender dysphoria, been through a gender transition or other experiences unique to genderqueer and trans people. A lack of lived experience does not mean a cisgender, heterosexual teacher cannot deliver CSHE relevant to the lives of genderqueer and trans youth. However, a lack of lived experience does mean teachers will require PD to prepare them to deliver inclusive instruction (Action Canada for Sexual Health and Rights, 2020).

Interpersonal Level Barriers

The interpersonal level of the SEM describes the ways in which we interact with friends, family members and peers influence individual health outcomes. Participants in this study described four distinct interpersonal barriers to the delivery of CSHE, while several others arose in the literature.

Peers. Three study participants indicated they felt SHE should begin at a younger age (Jo, Asher and Blair) to normalize differences, and reduce transphobia and homophobia in

[48] I make this assertion based on population demographics. Specific demographic data addressing this question does not exist. However, in 2006 the Halifax Regional School Board distributed a demographics survey that asked staff members to disclose their sexual orientation. The survey was criticized for breaching teachers' privacy, and potentially putting LGBTQ teachers at risk of discrimination in the workplace due to the minority status of these staff members and previous experiences of workplace homophobia in the school board (Roberts, 2006).

younger generations. For example, Ripley shared that their peers refused to call them by their chosen name, and Asher described their peers laughing when their teacher described asexuality, leaving them feeling ashamed. The behaviour of classroom peers represents a potential interpersonal level barrier, in the sense that students contribute significantly to the culture and resulting safety of the classroom environment. This behaviour can contribute to the discomfort of teachers, and potentially the ability for genderqueer and trans students to participate, and exist safely in, the classroom.

Classroom Teachers. The individual barriers associated with classroom teachers also play a role in the way students relate to, or interact with, teachers. Participants described teachers skipping over the section of the text that discussed gender identity, recognizing but refusing to discuss non-normative sexualities, and being visibly uncomfortable with the sexual health content. The discomfort of individual teachers contributed to participants' feelings of shame, experiences of erasure, as well as their learning outcomes. Students' experiences of these barriers are further complicated by the interpersonal barriers teachers experience. These may include contending with co-workers or administrators who do not think students should be taught CSHE (Dickson et al., 2020).

Parents. As described in the results section, Rowan, Asher and Blair felt parents were the biggest barrier to the implementation of CSHE in Kings County schools. Parents communicate their opinions about CHSE to administrators and teachers and may keep their children home on days when sexual health information is being delivered. In this way parents represent a barrier to the delivery of CSHE through exerting pressure on teachers and administrators, and/or by keeping their children out of school and denying them access to SHE.

Community Members. A potential barrier to the delivery of CSHE is the existence of transphobia in our communities. Participants described experiencing transphobia in the rural communities in Kings County. Community members who are transphobic influence people around them, and may convince friends or family members involved in education not to deliver or support the delivery of CSHE. Transphobia plays a significant role in the politicization of SHE, which can manifest in curricular roll backs[49] (Ontario), and the repeal of protective policies (Alberta). The delivery of CSHE can be challenged by transphobia; however, it is also potentially an effective tool to combat transphobia through the normalization of all gender identities (SIECCAN, 2010). It is important to recognize and address this tension as a part of advocacy efforts for the implementation of CSHE[50].

Organizational Level Barriers

The organizational level of the SEM describes the ways organizations and social institutions interact with one another and the ways in which these interactions influence health outcomes.

A potential organizational barrier, connected to the culture and safety in the school environment, is school avoidance. The 2018-19 Nova Scotia Student Success Survey reports that 39%[51] of LGBTQ2+ students had missed school one or two times in the past month, and 35%[52] of LGBTQ2+ students had missed school three or more times over the same period (DEECD &

---

[49] The inclusive SHE curriculum introduced in Ontario in 2015 was repealed when a new government provincial came into power (Follert, 2015)

[50] The *Framework for Action: Youth Sexual Health* includes plans for community engagement, as a part of the framework (NS Roundtable, 2006). Engaging community in discussions about sexual health, gender and sexuality is one way to move toward social transformation, and combat transphobia.

[51] The average for all students (DEECD & Communications Nova Scotia, 2019).

[52] The average for all students was 25% (DEECD & Communications Nova Scotia, 2019).

Communications Nova Scotia, 2019). When asked why they missed school, 47%[53] reported they did not want to go to school, and 63%[54] reported missing school due to their mental health. School avoidance is a potential barrier to the implementation of a comprehensive curriculum in the sense that teachers cannot deliver lessons to students who are not present in the classroom.

Organizational barriers described by participants in surveys by Action Canada for Sexual Health and Rights (2020) and Dickson et al. (2020) include: the need for more health supports from nurses or other health professionals, a lack of resources to teach CSHE and the fact that CSHE is not a priority within their education systems, as teachers are not required to report on student outcomes or progress in health education. Participants in the survey by Dickson et al. (2020) also reported fears that participation in SHE may threaten their job security were there community or parent backlash and felt there should be more than one staff member responsible for delivering sexual health content.

Community Level Barriers

The community level of the SEM describes cultural values and norms, and the ways they influence health outcomes. As noted by Action Canada for Sexual Health and Rights (2020), the quality of SHE Canadian students receive is often dependent on the proximity of community-based sexual health organizations. Community based organizations (e.g., The Youth Project and Sexual Health Centres) in the province visit classrooms, deliver classroom sexual health content, offer PD to teachers, and run sexual health assemblies. However, these organizations do not

[53] The average for all students in this age range was 34% (DEECD & Communications Nova Scotia, 2019).
[54] The average for all students in this age range was 31% (DEECD & Communications Nova Scotia, 2019).

have funding or resources to provide this service consistently to every school in the province. The reliance on underfunded community organizations to supplement curricula creates a barrier to access for those students in schools where no such relationship exists.

As described above, the attitudes and knowledge of individual administrators can affect the delivery of SHE within a given school. Similarly, if the culture and resulting expectations within individual schools (as established by school staff and the wider community) do not support the delivery of CSHE, the school itself can become a barrier to delivery. In Nova Scotia, even if the local RCE values the delivery of CSHE, individual schools may not reflect that value, as the delivery of CSHE is not required by provincial law or policy (discussed below). As previously noted, curricular delivery and quality is inconsistent across the province. This inconsistency may be due, in part, to barriers created by the culture and expectations in individual school communities.

In their interviews Jo and Asher spoke about the role communities play in setting sexual health norms and values. As these two participants described, community norms and values often determine what is taught in the classroom. Speaking about communities in Kings County, Blair shared, “People [in this community] don't understand what trans people are. They don't understand what transitioning is.” As such, community norms and attitudes related to sexual health and identity present barriers to the delivery of CSHE in public school classrooms.

Participants in the survey by Dickson et al. (2020) described several community level barriers that apply to this study. They noted the lack of multilingual education resources for delivering SHE, supporting Jo and Asher’s point about community values creating barriers to classroom learning, and noted that unsupportive school boards can limit students’ accessibility

to SHE[55]. Participants in the survey by Dickson et al. (2020) also noted that community norms, including social and religious ideologies, could undermine effective policy discussions and decisions.

Policy Level Barriers

The policy level of the SEM describes the ways in which public policy (or a lack thereof) influences individual and community health outcomes. As described by Action Canada for Sexual Health and Rights, Nova Scotian students receive various levels and qualities of SHE (Action Canada for Sexual Health and Rights, 2020). Action Canada for Sexual Health and Rights' (2020) findings were supported by participants in this research study, who reported inconsistent experiences in their classroom learning, even within the same school region. The inconsistent delivery of SHE across the province is due in significant part to a lack of system-level leadership and commitment. Since the right to sexual health information is not protected by provincial education policy, SHE is subject to the influences of local culture and norms.

Public health nurses in Nova Scotia used to come into classrooms to deliver SHE (Action Canada for Sexual Health and Rights, 2020). These nurses were available to provide classroom teachers with SHE content and curriculum delivery. After the restructuring of the health system in Nova Scotia, Public Health nurses stopped coming into classrooms, and that resource no longer existed for teachers. Although Public Health nurses may not have challenged heteronormative assumptions, or delivered comprehensive, inclusive SHE, they did exist as content resources for teachers. After the restructuring of the health system, public health

[55] As seen in the example with the Strait Regional School Board in Nova Scotia.

nurses no longer delivered sexual health lessons in schools across the province. This change ended teacher and student access to the resources and support public health nurses provided (Action Canada for Sexual Health and Rights, 2020). The end of this relationship between Education and Health left classroom teachers to teach sexual health content without expert support, creating a barrier to the delivery of SHE delivered throughout the province.

Nova Scotia has a singular amalgamated school board, which along with the DEECD develops and implements education policy for the province. Provincial policy does not require classroom teachers to report on or track education outcomes for health classes. This issue was identified by interview subjects in the Action Canada for Sexual Health and Rights (2020) report, as well as by participants in the study by Dickson and colleagues (2020). Study participants in the Action Canada for Sexual Health and Rights (2020) report noted that Nova Scotia teachers are required to report on math and literacy outcomes, and as a result delivery of those subjects take priority over health education. The lack of provincial policy is also a barrier in that there is no protection or support for teachers subject to community backlash, and no system-level requirement that educators deliver CSHE in the classroom (Dickson et al., 2020).

Community sexual health organizations in Nova Scotia are underfunded, which is a barrier to the delivery of CSHE, as these organizations cannot afford to provide services to every school, creating inequitable access to community-level CSHE expertise (Action Canada for Sexual Health and Rights, 2020).

The final policy level barrier to the delivery of CSHE in Nova Scotian schools is the lack of PD provided to classroom teachers assigned to deliver health curricula.

System Level Influences: Who Decides What is Taught

Trans people are often regarded in society as "non-normative" and are devalued and rendered invisible within many social and health systems, including the education system (Dyer, 2017; Shipley, 2013). As described by White-Hughto et al. (2018),

> "systems enact a form of, symbolic violence [against transgender people] … [where] structures, such as communities, institutions, or governments perpetrate violence through the laws, policies, and community mores that restrict and forcibly reshape transgender individuals in ways that ultimately serve to maintain the power and privilege of the cisgender [population]" (p. 224).

Policies, and associated funding decisions, are created and implemented by leaders in government, and in community institutions. The individual bureaucrats, institutional leaders and politicians who make policy decisions influence the social and physical environments in which trans and genderqueer people live. These decision makers determine what and how curricula are delivered in public schools. These positions of power and privilege are most often held by white, heterosexual, cisgender men (United Nations, 2020; UN Women, 2021). Governments are tasked with making policy, funding and programming decisions that reflect the needs and wants of the electorate. In practice this means governments make decisions that will make them the most popular and play to the values of their electoral base[56]. As trans and genderqueer people are considered a "non-normative" minority group, their needs and safety are not prioritized by systems, resulting in the symbolic violence described by White-Hughto and colleagues. (2018).

---

[56] See previous examples in Ontario, Alberta and in the Strait Regional School Board.

At the end of each interview, study participants were asked who they think makes policy decisions related to SHE. Jo reflected, "[Those making decisions are] people with privilege. I think cis people are making these decisions. White people are making these decisions. Upper class are making these decisions." Jo's answer highlights the fact that most people making policy and funding decisions do not share the lived experience of trans and non-binary people. Jo further expanded on this thought, saying,

> I can clearly see that it's not people who are different, who are affected by difference, that are making the decisions about what differences get to be represented . . . who's making the decisions about what differences are given recognition in the classroom? Not people who are different.

SHE is political, and the lives and identities of 2SLGBTQ+ are often politicized and this politicization is used to argue against the delivery of CSHE in public schools[57]. Some people perceive sex, sexuality, and pleasure as taboo topics, especially when it comes to discussing them with children and youth. Asher commented, "it's a community decision… not even just people who are related to the school. Like, random people walking down the street." Asher and Jo's comments point to the political nature of the decisions that lead to curricular decisions at a provincial policy-level, as well as within individual schools. System level policy and funding decisions that shape our social, cultural and physical environments are most often made by people who do not share the life experiences of trans and non-binary youth and are influenced by political pressures at the community level. These decisions dictate which forms of

[57] In example see: (Alphonso & Gray, 2019; Campaign Life Coalition, n.d.; Follert, 2015; Masson, 2015)

“difference” (race, gender, socio-economic position, etc.) are discussed in classrooms, and which people are positioned as socially and culturally valuable, more worthy of acceptance and of human rights, which brings us back to Ludvig’s (2006) question: “who defines when, where, which, and why particular differences are given recognition while others are not?” (p. 247). The following section outlines recommendations for transformative actions on youth sexual health in Nova Scotia. These recommendations are informed by Ludvig’s question, with the goal of achieving equitable access to SHE and dismantling oppressive structures that contribute to the erasure of trans and genderqueer identities in our Health and Education systems.

Recommendations for Further Action

There are many opportunities to improve school based SHE across Nova Scotia, through micro and macro level upstream interventions and the creation of preventative policies. The next section describes these opportunities and outlines recommended actions.

Action on SRHR in Nova Scotia

Recommendation One: Reinstate the Nova Scotia Roundtable. I recommend the government of Nova Scotia reinstate the Nova Scotia Roundtable[58], as well as implement The Nova Scotia Roundtable’s (2006) *Framework for Action: Youth Sexual Health*[59]. This recommendation dovetails with the creation of a national SRHR strategy. Reinstating the Nova Scotia Roundtable would ensure that any action taken on SRHR and education in Nova Scotia is coordinated across and amongst government departments and community sexual health

---

[58] Pending assessment to determine membership, and with the addition of legislative decision-making powers. As with the original Roundtable, membership must include representatives from government, researchers, and community sexual-health organizations.
[59] Pending review and revision to ensure alignment with new evidence and resources published since its creation.

organizations. A newly reinstated Roundtable could coordinate provincial-level SRHR work with Health and Education, while connecting with a national strategy and associated resources, were a resourced national strategy put in place. Reinstating the Nova Scotia Roundtable would also restore the formalized working relationship between the DEECD and Nova Scotia Health, enabling coordinated work on responsibilities shared by both departments.

Recommendation Two: Implement the Nova Scotia Roundtable's Framework. The Nova Scotia Roundtable's (2006) framework is still relevant in today. The Nova Scotia Roundtable's (2006) framework recommends the development and "implementation [of] a comprehensive youth sexual health curriculum for grades 4 to 11" (p. 21) which meets the SIECCAN (2019) guidelines. The Nova Scotia Roundtable's (2006) framework identifies five goals for school-based CSHE: 1) the implementation of on-going PD and provision of supports for teachers; 2) dedicated funding for curriculum development and implementation; 3) the collaborative[60] creation of new culturally appropriate SHE materials; 4) the strengthening of school-community networks and: 5) a plan to create safe and supportive school environments. All five goals align with the findings of this study. Strengthening school-community networks is a goal I have not addressed significantly yet. Shifting cultural norms is essential to successfully implement CSHE, but this shift will not happen through policy implementation alone. Strengthening connections between schools and communities is key to changing community norms and reducing resistance from parents and community members who oppose comprehensive curricula (Nova Scotia Roundtable, 2006). Study participants identified parents

[60] Collaboration with key stakeholders in community and government (NS Roundtable, 2006)

as one of the most significant barriers to the implementation of CSHE in Kings County. Changing the minds of resistant parents and other community members is an important part of implementing CSHE in Kings County and the province.

The Nova Scotia Roundtable's (2006) framework supports changes that would address many of the concerns raised by the participants in this study and align with recommendations from the literature. Implementing the actions described in The Nova Scotia Roundtable's (2006) framework has the potential to improve sexual and mental health outcomes for trans and genderqueer youth in the province, as well as ensure their SRHR are respected and upheld. The following sections unpack recommendations by The Nova Scotia Roundtable, in current context, as well as two additional recommendations, I put forward, based on current literature and the results of this study.

Recommendation Three: A Comprehensive Curriculum and Associated Resources. The creation and well-resourced implementation of a comprehensive sexual health curriculum would improve the quality, consistency, and delivery of sexual health information for youth attending public school across the province, regardless of the limited access to sexual health resources experienced by those living in rural areas. With an updated curriculum comes the need for culturally responsive SHE resources. The process of updating the existing sexual health curriculum has already begun (Action Canada for Sexual Health and Rights, 2020). Following updates and improvements must come the creation of new resources to support its delivery. As recommended by The Nova Scotia Roundtable (2006), and SIECCAN (2019), these resources should be created in partnership with representatives from the Black and African Nova Scotian communities, Indigenous communities, and 2SLGBTQ+ communities to ensure they are

culturally responsive and intersectional. These resources should also reflect the learning needs and preferences of the youth for which they are created. As such, new sexual health resources should incorporate online elements[61], which could include videos, blog posts, a searchable website or a sexual health smartphone application[62]. As the Nova Scotia Roundtable's (2006) framework describes, youth must be meaningfully engaged in the development of SHE in Nova Scotia. As such, youth must be empowered to shape and inform the content and delivery of any new or updated SHE resources in the province[63].

Recommendation Four: On-going Teacher Professional Development and Supports. School-based educators are at the frontline of delivering sexual health curricula, however, they rarely receive significant PD training or support[64] to deliver this complicated, highly politicized subject (Preston, 2019; Walters & Hayes, 2007). Delivering PD to teachers is an effective strategy to increase teacher buy-in and uptake, to support the overall success of an updated curriculum, and the realization of its resulting benefits. Creation and delivery of this PD should be done in partnership with sexual health researchers, sexual health and 2SLGBTQ+-serving organizations[65], representatives from the Black and African Nova Scotian communities, Indigenous communities, and 2SLGBTQ+ communities to ensure they are culturally responsive and intersectional. Working collaboratively with community partners ensures PD modules

---

[61] See (DeHaan et al., 2013; Hare et al., 2015; Mitchell et al., 2014; Mustanski et al., 2015).
[62] These are the online resource types study participants reported accessing.
[63] This recommendation aligns with Nova Scotia Public Health's existing plan to facilitate a youth engagement process to inform the redrafting of *Sex? - A Healthy Sexuality Resource* (2016).
[64] Support for teachers can come from outside community organizations, like The Youth Project, from the DEECD curricular support staff or from health professionals.
[65] Such as: The Youth Project, Sexual Health Nova Scotia, Planned Parenthood, Avalon Sexual Assault Centre, and Phoenix Youth among others.

reflect the needs of diverse communities and taps into the expertise of sexual health educators and health promoters.

As well as on-going PD, some classroom teachers also receive support from outside agencies and community groups who offer evidence based SHE workshops and resources (Action Canada for Sexual Health and Rights, 2020). Supplemental support from community partners and agencies is important to "ensur[ing] the best possible outcomes" (Action Canada for Sexual Health and Rights, 2020). As described by SIECCAN (2019), "Comprehensive sexual health education is a process that requires the participation of multiple sectors of society including the family and the education, public health, primary healthcare, community agenc[ies] . . . of Canadian society" (p. 22). Strengthening school-community networks[66] can serve to increase the competency of classroom teachers, improve the quality of the SHE students receive, connect students with sexual healthcare supports, increase community support for the delivery of CSHE, and ensure meaningful representation of priority populations in classroom lessons (Action Canada for Sexual Health and Rights, 2020).

Recommendation Five: Accountability. Reinstating the Nova Scotia Roundtable would ensure there was an identifiable body, accountable to the public, mandated with improving the sexual health outcomes of Nova Scotian youth. This group would work between and within Health and Education at the provincial level. As described in The Nova Scotia Roundtable's (2006) framework, this group would be responsible for directing the work outlined in the

[66] There also exists a need to better resource sexual health centres and other community groups practicing sexual health promotion (Action Canada for Sexual Health and Rights for Sexual Health and Rights, 2020), however this element of the recommendation is beyond the scope of this study.

framework, reporting the groups' progress, and monitoring and evaluating outcomes. To protect this work when staff turnover takes place, membership in the newly formed roundtable should be written into the job description of all government employees made members and identified in each employee's work plan. Allocating and protecting staff time makes a strong statement about the government's commitment to do this important work.

The Nova Scotia Roundtable's (2006) framework includes suggested measures for ongoing evaluation. Each of the five overarching goals identified in the framework is accompanied by a list of "suggested success indicators'' (p. 2) to be used to evaluate how action on each goal is progressing. These goals include recommendations for action by government and community actors. The creation of an accountability body is necessary to ensure the work stays on track, and remains accountable to the public, and government decision makers and funders. Currently, there is little accountability for sexual health curriculum outcomes, as the DEECD does not require educators to report student outcomes from healthy living classes (Action Canada for Sexual Health and Rights, 2020). Implementing reporting requirements would significantly increase the likelihood that the information in a comprehensive sexual health curriculum would indeed be delivered to students in all classrooms across the province.

Recommendation Six: Health Education: A Teachable Subject. I recommend that health education be made an option as a teachable subject in all government-recognized Bachelor of Education programs in Nova Scotia. If health education were made a teachable subject, it would allow interested teachers to build competence and practice in the subject, and improve the quality of their instruction year over year through evaluation. It would also ensure that teachers assigned to teach SHE have professional competency in the content.

An important element of this recommendation is that the province designates instruction hours specifically for health education. Nova Scotian participants in Action Canada for Sexual Health and Rights' (2020) survey indicated that health education is not a priority in elementary education. One teacher participant from Halifax shared, "The attitude is if you get to sex-ed, then you get to it, but if you don't, you don't" (p. 51). Designating hours to sexual health instruction would demonstrate to teachers that SHE is a provincial priority and would allow teachers the time needed to deliver CSHE in the classroom.

Another important element of this recommendation is the implementation of reporting and monitoring requirements. As Action Canada for Sexual Health and Rights (2020) points out, "The lack of standardized testing, monitoring, and evaluation of sex-ed means that we don't get as much information about what ends up being taught (or not)" (p. 14). The lack of required reporting on SHE learning outcomes also means we do not know how well students are integrating the sexual health information they do receive. Implementing reporting requirements would provide educators, and the provincial government, with data to evaluate the effectiveness of their curricula, and to make changes accordingly.

National Action on SRHR

Recommendation Seven: A National Sexual and Reproductive Health Rights Strategy. CEDAW (2016b) recommends the Government of Canada, "[e]stablish national guidelines or standards to harmonize education curricula on sexual and reproductive health and rights among provinces and territories and allow the federal Government to hold them accountable for implementing such guidelines or standards" (p. 13). Further to this, I recommend the creation of a resourced national SRHR strategy for the Canadian context (as described earlier in

this chapter). The creation and implementation of a resourced national strategy would support Canadians in realizing their Right to Health, as described by the United Nations and WHO, by guaranteeing access to SHE, programming, and services. Regarding education, a national strategy would provide support, direction, and resource funding to provinces to implement comprehensive curricula that reflect the SIECCAN guidelines, as well as regularly monitor and evaluate such curricula. Ireland's national Sexual Health Strategy was created, in part, because sex has historically been a taboo subject in Irish culture (Government of Ireland Department of Health, 2015) not unlike in parts of Canadian society. The Government of Ireland's (2015) plan is to shift the country's culture, to reduce sex-associated stigma, reduce crisis pregnancies and rates of STIs in the population, by implementing 71 recommendations "that address a wide spectrum of sexual health services, from surveillance and prevention, to treatment, counselling and supports, to education and professional development" (p. 9). The Irish strategy affects multiple government departments, including education. It includes strategies for supporting educators to deliver comprehensive, sex-positive curricula to students, while also focusing on adult health-outcomes through the strategy's "life course" approach, which recognizes the importance of SHE and sexual health promotion through the life cycle, and the effect culture and environment have on sexual health outcomes (Government of Ireland Department of Health, 2015). Instituting a similar strategy, appropriate to the Canadian context, would demonstrate the Government of Canada's commitment to upholding the SRHR of Canadians across the life cycle, and would solidify the government's recognition of each Canadian's Right to Health (OHCHR, 2008).

The creation of a resourced national SRHR strategy would support advocacy efforts of educators, Department of Education staff, sexual health promoters, health practitioners, academics, and community sexual health organizations for meaningful provincial commitment to SRHR. A national commitment to SRHR would provide these groups leverage in their advocacy for a provincial-level SRHR approach, as a national strategy would provide decision makers the financial, informational and human resources to shift cultural norms and implement new programs and policies. A national strategy alone may not result in provincial level commitment to SRHR but, a multi-directional approach may prove effective[67] (Taylor et al., 1997). The combination of grassroots advocacy from the stakeholders listed above, and the backing of a federal strategy has the potential to influence provincial-level decision makers to act on SRHR in Nova Scotia.

Queering Institutions

All the recommendations above are important steps toward integrating trans and genderqueer youths' sexual health information needs into public school curricula. However, including gender and sexuality in curricula does not necessarily lead to acceptance. As Shipley (2013) points out, there is a significant body of literature which questions normative assumptions of gender and sexuality and provides insight into the many varied ways people "live out their gendered and sexual identities" (p. 196). Despite this, Shipley (2013) contends, there is a significant gap between what research tells us, and the lived experiences of queer

[67] In example, Matsubayashi et al. (2011) found that the presence of comprehensive national suicide prevention strategies can reduce rates of death by suicide, and Taylor et al. (1997) note the importance of community involvement in the successful creation national suicide prevention strategies.

youth participating in public education. Many people live outside of hetero and cis normative assumptions, yet queer youth in school continue to experience harassment and there continues to be public resistance to inclusive curricula (for recent Canadian examples see Campaign Life Coalition, n.d.; Clancy, 2019; Jones, January 8, 2019). Schools are social spaces where normative identities are reinforced and reproduced and anyone considered non-normative is disciplined for their difference (Shipley, 2013). Shipley (2013) contends that push back against inclusive curricula is "resistance to destabilizing sexual identity within the institution of education" (p. 196). It is not enough to change the content of curricula if trans and genderqueer identities continue to be framed as identities defined by their difference or deviance from heterosexual and cisgender norms. Therefore "the queer project of destabilizing identity norms" within educational institutions continues to be necessary (Shipley, 2013, p. 205).

Recommendation Eight: Queer Sexual Health Education. I recommend queering educational institutions in Nova Scotia. The project of queering education means disrupting normative assumptions of gender and sexuality in our schools, the provincial school board, and the DEECD, in order that all expressions of gender, sexuality and identity become possible. Queering education in Nova Scotia is an ongoing long-term project, which will require incremental changes, and the involvement of sexual health advocates from multiple sectors.

> **Recommendation Nine: Queer Health Promotion.** School and community health promoters working for Public Health in Nova Scotia can play an important role in this project by queering our own practice and using queer analysis in our work with our education partners. It is essential that sexual health promotion initiatives intended to meet the needs of gender diverse people are informed by queer theories, because "devoid of such theoretical work, health promotion

research and practice can unwittingly harm the populations it serves" (Numer & Gahagan, 2009, p. 156). Health promoters work to shift policy to create cultural and environmental changes to promote and support health. Applying a queer analysis to our work in sexual health may help health promoters to shift the social and cultural environments we work in, to create environments where CSHE can be implemented and normalized in public schools. Much like queering educational institutions, though, queering the discipline of health promotion is an ongoing project.

Chapter 6: Conclusion

The primary purpose of this study was to understand trans and genderqueer youths' experiences with, and perceptions of, the classroom based SHE they received at public schools in Kings County, Nova Scotia. Understanding participants' experiences and perspectives was fundamental to informing the recommendations of this study, which can inform the work of health promoters, policy makers, politicians, professionals in curriculum development and educators across the province of Nova Scotia, including rural settings. The secondary purpose of this study was to contribute to the discipline of health promotion's body of knowledge on SHE. The final, and underlying goal of this study was to create a narrative representation of the data collected, to support social transformation and justice in relation to SHE for trans and genderqueer youth. The second and third goals of this study will be supported by knowledge translation activities and resources I will create and distribute after the thesis is complete.

This exploratory qualitative research study was conducted through a critical lens, shaped by the researcher's transformative worldview, underpinned by queer theory, and informed by the theory of intersectionality. Results were mapped onto the SEM, providing an advocacy and policy-making tool for health promoters and other interested community organizations, health advocates, policy makers or politicians. Data were collected through semi-structured interviews with five youth who attended public school in Kings County, and analyzed through an inductive thematic process, following the six phases described by Braun and Clarke (2006). Study limitations included the fact that the trans and genderqueer community in Kings County is small and hard to access, and geographically dispersed in a rural setting. Also, sexual

health is a potentially sensitive topic, which not everyone may feel comfortable discussing with a researcher.

Ensuring that the SRHR of trans and genderqueer youth in Nova Scotia are respected and upheld requires the changing of both physical and social environments throughout our communities. Changing wider community-level environments, to improve people's ability to have agency over their health outcomes, is the role of the community health promoter. My focus in my job as a School Health Promoter is to change the social and physical environments in schools, ensuring that all members of the school community are empowered to have control over their own health outcomes. Participants in this study did not receive the type of sexual health information they needed to prepare them to make sexual health and relationship decisions which would best support their physical and mental health outcomes. Research with youth from across Canada demonstrates that much of the SHE offered in public schools does not meet the SRHR needs of students (Laverty, 2021). Results from this study, as supported by sexual health literature, demonstrate that trans and genderqueer youth cannot access their SRHR through means of the SHE currently being delivered in public schools in Kings County.

Delivery of SHE is inconsistent across the province due to individual, interpersonal, organizational, community and policy-level barriers[68]. To address the barriers to the delivery of CSHE in Nova Scotia, concurrent action must be taken in all 5 levels of the SEM. The recommendations described in the Nova Scotia Roundtable's (2006) framework address barriers at multiple levels; addressing the social and physical environments in our communities,

[68] As described in the SEM diagram, Appendix D.

while simultaneously taking government-level action to create policy and legislation which supports the sexual health of youth in the province. Reinstatement of The Nova Scotia Roundtable, and implementation of The Nova Scotia Roundtable's (2006) framework would demonstrate government commitment to this work, ensure accountability and be a significant step toward the consistent and quality delivery of CSHE to students across the province. Reinstatement of The Nova Scotia Roundtable and implementation of The Nova Scotia Roundtable's (2006) framework would also significantly support action on the rest of the recommendations put forward in the final chapter of this study.

This study described the experiences of a small group of youth in Kings County, Nova Scotia. Further research is needed to fully understand the sexual health status, and the informational needs, of all trans and genderqueer youth in Nova Scotia. Action Canada for Sexual Health and Rights' (2020) report, *The State of Sex-Ed in Canada,* provides a brief overview and evaluation of the SHE content and delivery in Nova Scotia schools, however, further evaluation is required to understand and improve upon the current state of SHE. Research and evaluation will provide health promoters, educators and community sexual health organizations with the data needed to deliver sexual health promotion programming. The discipline of health promotion is one which seeks to empower people to have control over their own health and seeks to address health inequities and achieve justice. The findings of this small study point to larger problems. It is the role of health promoters to respond to the existing health evidence and take the actions required to empower trans and genderqueer youth to have more control over their sexual health outcomes. These data will enable health promoters to advocate for policy changes in health and education systems, policy makers to inform their

decision making with reliable information, and curriculum development specialists to create CSHE curricula that reflect the needs of the population. The availability of reliable, inclusive, and current data will also allow health promoters to foster cultural changes, to support SRHR. The creation of a resourced national SRHR strategy for Canada is supported by multiple community organizations and recommended by the United Nations. Implementing a national strategy would provide financial and human resources to the provinces, and another level of policy for provincial actors to reference in their advocacy efforts to make change at the provincial level.

Participants in this study shared their thoughts and experiences about the SHE they received (or wished they had received) in public schools. Their personal stories provide a narrative that enriches, contextualizes, and supports existing sexual health evidence provided by trans and genderqueer youth in Nova Scotia (DEECD & Communications Nova Scotia, 2019; Nova Scotia Roundtable, 2006), and across the country (Bauer et al. 2009; Dickson et al., 2020; Ontario Public Health Association, 2004; Saewyc et al., 2018; Scheim & Bauer, 2015; Taylor et al., 2020; Taylor et al., 2011; Veale et al., 2015). Study participants' stories provide an opportunity for policy decision makers to make informed changes to health and education systems and programs to serve the sexual health interests of trans and genderqueer youth in our communities. These stories contribute to the body of knowledge in the field of health promotion, provide educators with data to inform their lesson plans and delivery and demonstrate the importance of meaningful action on SRHR in the province of Nova Scotia.

References

Abbott, K., Ellis, S., & Abbott, R. (2015). "We don't get into all that": An analysis of how teachers uphold heteronormative sex and relationship education. *Journal of Homosexuality, 62(12)*, 1638–1659. https://doi-org.ezproxy.library.dal.ca/10.1080/00918369.2015.1078203

Acadia University School of Education. (2021a). *Elementary Program.* https://education.acadiau.ca/files/sites/education/NewSite2020/PDF%20forms/Elementary%20Program.pdf

Acadia University School of Education. (2021b). *Secondary*. https://education.acadiau.ca/13031.html

Action Canada for Sexual Health and Rights. (2020). *The State of Sex-ed in Canada.* https://www.actioncanadashr.org/resources/reports-analysis/2020-04-03-state-sex-ed-report

Action Canada for Sexual Health and Rights. (2018). Submission to Education Consultation in Ontario: December 2018. https://www.actioncanadashr.org/sites/default/files/2019-03/Ontario-CSE-submission-FINAL.pdf

Alberta Health Services. (2019). *Comprehensive School Health*: *Teaching Sexual Health.* https://teachingsexualhealth.ca/teachers/sexual-health-education/understanding-your-role/get-prepared/comprehensive-school-health/

Alphonso, C. & Gray, J. (2019, February 28). Teachers Free to Use Own Judgement for Sex Ed, Ontario court Rules as it Dismisses Legal Challenge of Curriculum. The Globe and Mail. Retrieved from https://www.theglobeandmail.com/canada/article-ontario-court-

dismisses-legal-challenge-to-governments-sex-education/

American Sexual Health Association. (2020, September 22). What is sexual health? http://www.ashasexualhealth.org/sexual-health/

The Arc Foundation. (2019). *SOGI 3 Teaching Resources.* https://bc.sogieducation.org/sogi3

Baker, S. E., Edwards, R., & Doidge, M. (2012). How many qualitative interviews is enough?: Expert voices and early career reflections on sampling and cases in qualitative research. Retrieved from http://eprints.ncrm.ac.uk/2273/4/how_many_interviews.pdf

Bauer, G. R. (2012). *Making sure everyone counts: Considerations for inclusion, identification, and analysis of transgender and transsexual participants in health surveys*. In Institute of Gender & Health Canadian Institutes of Health Research (Ed.): What a Difference Sex and Gender Make: A Gender, Sex and Health Research Casebook. Vancouver, Canada: Institute of Gender and Health, Canadian Institutes of Health Research. Retrieved from https://cihr-irsc.gc.ca/e/44734.html#a08

Bauer, G. R. & Hammond, R. (2015). Toward a broader conceptualization of trans women's sexual health. *The Canadian Journal of Human Sexuality, 24*(1) 1-11. DOI: 10.3138/cjhs.24.1-CO1

Bauer, G. R., Hammond, R., Travers, R., Kaay, M., Hohenadel, K. M., & Boyce, M. (2009). "I Don't Think This Is Theoretical; This Is Our Lives": How Erasure Impacts Health Care for Transgender People. Journal of the Association of Nurses in AIDS Care, 20(5), 348–361. http://doi.org/10.1016/j.jana.2009.07.004

Biggerstaff, D. (2012). *Qualitative research methods in psychology*. InTech. Retrieved from http://wrap.warwick.ac.uk/45345

Bradford, N.J., DeWitt, J., Decker, J., Berg, D.R., Spencer, K.G., & Ross, M.W. (2019). Sex education and transgender youth: 'Trust Means Material by and For Queer and Trans People.' *Sex Education*, *19*(1), 84–98. https://doi.org/10.1080/14681811.2018.1478808

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. http://doi.org/10.1191/1478088706qp063oa

Bryan, J. (2012). From the Dress-Up Corner to the Senior Prom: Navigating Gender and Sexuality Diversity in PreK-12 Schools. Plymouth, United Kingdom: Rowman & Littlefield Education.

Burns, S., & Hendriks, J. (2018). Sexuality and relationship education training to primary and secondary school teachers: An evaluation of provision in Western Australia. *Sex Education, 18*(6), 672-688. https://doi-org.ezproxy.library.dal.ca/10.1080/14681811.2018.1459535

Campaign Life Coalition. (n.d.). *Ontario's Radical Sex Ed Curriculum* https://www.campaignlifecoalition.com/sex-ed-curriculum

Canadian AIDS Society. (2019). Trans Rights Legislation in Canada. Retrieved from https://www.cdnaids.ca/trans-rights-legislation-in-canada/

Canadian Human Rights Act (R.S.C. 1985, c. H-6). https://laws-lois.justice.gc.ca/eng/acts/h-6/page-1.html#h-256800

Canadian Institute for Health Research [CIHR]. (2015). Definitions of Sex and Gender. Retrieved from http://www.cihr-irsc.gc.ca/e/47830.html

Cape Breton University Bachelor of Education. (2021). *Admission Requirements.* https://www.cbu.ca/academics/programs/bachelor-of-education/

Clancy, C. (March 26, 2019). UCP education platform reignites fierce debate over rules around gay-straight alliances in Alberta schools. *The Edmonton Journal.* https://edmontonjournal.com/news/politics/ucp-education-platform-reignites-fierce-debate-over-rules-around-gay-straight-alliances-in-alberta-schools

Clayton H. B., Brener N. D., Barrios L. C., Jayne P. E. & Everett J. S. (2018). Professional Development on Sexual Health Education Is Associated With Coverage of Sexual Health Topics. *Pedagogy in Health Promotion: The Scholarship of Teaching and Learning 4*(2) 115–124 https://doi.org/10.1177/2373379917718562

Clements-Nolle, K., Marx, R., Guzman, R., & Katz, M. (2001). HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. *American Journal of Public Health*, *91*(6), 915- 921.

Cohen, J., Byers, S., Sears, H., & Weaver, A. (2004). Sexual Health Education, Attitudes, Knowledge, and Comfort of Teachers in New Brunswick Schools. *The Canadian Journal of Human Sexuality*, *13*(1), 1-15.

Colbert, Y. (2015, June 29) Apple Blossom Competition Changes Rules for Queen and Princess. *CBC News.* Retrieved from http://www.cbc.ca/news/canada/nova-scotia/apple-blossom-festival-changes-rules-for-queen-and-princess-1.3132456

Colpitts, E. & Gahagan, J. (2016). The Utility of Resilience as a Conceptual Framework for Understanding and Measuring LGBTQ Health. International Journal for Equity in Health, 15(60). https://doi.org/10.1186/s12939-016-0349-1

Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People:*

Building a Foundation for Better Understanding. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK64810/

Connolly, Zervos, Barone, Johnson, & Joseph. (2016). The Mental Health of Transgender Youth: Advances in Understanding. *Journal of Adolescent Health, 59*(5), 489-495.

Cooke, A. (November 10, 2020). *Nova Scotia begins covering breast reduction surgery for non-binary people.* CBC News. https://www.cbc.ca/news/canada/nova-scotia/msi-begins-covering-breast-reduction-surgery-non-binary-1.5796325

Crenshaw, Kimberle. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics In *University of Chicago Legal Forum.* (Vol 1989: 139-67). Retrieved from http://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?article=1052&context=uclf

Crenshaw, Kimberle. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review,* 43(6), 1241-1299.

Creswell, J. W. (2014). Research design: Qualitative, quantitative, and mixed methods approaches. Los Angeles: Sage.

DeHaan, S., Kuper, L. E., Magee, J. C., Bigelow, L., & Mustanski, B. S. (2013). The Interplay between Online and Offline Explorations of Identity, Relationships, and Sex: A Mixed-Methods Study with LGBT Youth. *Journal of Sex Research*, *50*(5), 421–434. http://doi.org/10.1080/00224499.2012.661489

Dentato, M., Craig, S., Lloyd, M, Kelly, B., Wright, C. & Austin, A. (2016). Homophobia within schools of social work: the critical need for affirming classroom settings and effective

preparation for service with the LGBTQ community. *Social Work Education*, 35(6), 672-692. https://doi.org/10.1080/02615479.2016.1150452

Department of Education and Early Childhood Development [DEECD] & Communications Nova Scotia. (2019). *2018-2019 Student Success Survey*. Government of Nova Scotia. https://plans.ednet.ns.ca/sites/default/files/documents/2018-2019_StudentSuccessSurvey.pdf

Department of Education and Early Childhood Development [DEECD], Department of Health and Wellness & Nova Scotia Health. (2015). *Nova Scotia Health Promoting Schools Provincial Guiding Document.* Retrieved from the Joint Consortium for School Health website: https://www.jcsh-cces.ca/images/150213_HPS_Guiding_Document_2015_final_v1.0.pdf

Department of Education and Early Childhood Development [DEECD]. (2015). *Learning Outcomes Framework Grades 1-6.* Retrieved from the Nova Scotia Department of Education and Early Childhood Development website: https://www.ednet.ns.ca/files/curriculum/P-6LOFs-Oct1-2015.pdf

Department of Education and Early Childhood Development [DEECD]. (2014). *Guidelines for supporting transgender and gender-nonconforming students*. Retrieved from http://alltitles.ebrary.com/Doc?id=11037802

Department of Education and Early Childhood Development [DEECD]. (2014). *Learning Outcomes Framework.* Retrieved from Department of Education website https://www.ednet.ns.ca/files/curriculum/LOFs-7-9-Jan7-2014-web.pdf

Department of Education and Early Childhood Development [DEECD]. (2013). *Public School Program Document.* Government of Nova Scotia. https://www.ednet.ns.ca/homeschooling/files-homeschooling/docs/psp2013-2014.pdf

Department of Education and Early Childhood Development [DEECD]. (n.d. a). *Office of Teacher Certification: Endorsation of Regular Certificates.* Retrieved from the Nova Scotia Office of Teacher Certification website: https://certification.ednet.ns.ca/endorsation-regular-certificates

Department of Education and Early Childhood Development [DEECD]. (n.d. b) *Office of Teacher Certification: Recognized Educational Programs.* Retrieved from the Nova Scotia Office of Teacher Certification website: https://certification.ednet.ns.ca/recognized-institutes

Department of Health and Wellness. (2009). *Nova Scotia Public Health Healthy Communities Protocol.* Retrieved from Department of Health and Wellness Website. https://novascotia.ca/dhw/publichealth/documents/09-Healthy-Communities-Protocol.pdf

Department of Health Promotion and Protection. (Oct. 12, 2006). *Launch of Youth Sexual Health Strategy* [Press release]. https://novascotia.ca/news/release/?id=20061012006

Dickson, E., Parshall, M., & Brindis, C. (2020). Isolated Voices: Perspectives of Teachers, School Nurses, and Administrators Regarding Implementation of Sexual Health Education Policy. *The Journal of School Health, 90*(2), 88-98.

Dyer, Hannah. (2017). Queer futurity and childhood innocence: Beyond the injury of development. *Global Studies of Childhood, 7*(3), 290-302. https://doi-org.ezproxy.library.dal.ca/10.1177/2043610616671056

Dysart-Gale, D. (2010). Social Justice and Social Determinants of Health: Lesbian, Gay, Bisexual, Transgendered, Intersexed, and Queer Youth in Canada. *Journal of Child and Adolescent Psychiatric Nursing, 23*(1), 23-28. https://doi.org/10.1111/j.1744-6171.2009.00213.x

Eisenberg, M. E., Gower, A. L., McMorris, B. J., Rider, G. N., & Coleman, E. (2019). Emotional Distress, Bullying Victimization, and Protective Factors Among Transgender and Gender Diverse Adolescents in City, Suburban, Town, and Rural Locations. The Journal of Rural Health, 35(2), 270–281. https://doi.org/10.1111/jrh.12311

Eiser, C. & Twamley, S. (1999). Talking to children about health and illness. In M. Murray, & K. Chamberlain (Eds.), *Qualitative health psychology: Theories and methods* (pp. 133-147). SAGE Publications Ltd. https://www.doi.org/10.4135/9781446217870.n9

Elia, J.P. & Eliason, M. (2010). Discourses of Exclusion: Sexuality Education's Silencing of Sexual Others, *Journal of LGBT Youth, 7*(1), 29-48. https://doi-org.ezproxy.library.dal.ca/10.1080/19361650903507791

Elliott, W. (2012, February 23). Transgendered High School Student Shares Her Experience. *Kings County Advertiser.* Retrieved from http://www.kingscountynews.ca/news/2012/2/23/transgendered-high-school-student-shares-2905493.html

Esterberg, K. (2002). *Qualitative Methods in Social Research.* Lowell, Massachusetts: McGraw Hill Companies.

Follert, J. (2015, June 3). Sex education in Ontario schools dates back more than 100 years: Experts say curriculum changes, debate stays the same. *Metroland Media.* Retrieved from http://www.durhamregion.com/community-story/5646753-sex-education-in-ontario-schools-dates-back-more-than-100-years/

Fox, C. (2009). Editorial: Queer Hate. *Gay & Lesbian Issues and Psychology Review, 5(3)* 131.

Frank, L., Fisher, L. & Saulnier, C. (2020). *Report Card on Child and Family Poverty in Nova Scotia: Willful Neglect?* Canadian Centre for Policy Alternatives. https://www.policyalternatives.ca/publications/reports/2020-report-card-child-and-family-poverty-nova-scotia

Frohard-Dourlent, H. (2018). "The student drives the car, right?": trans students and narratives of decision-making in schools. *Sex Education 18*(4):1-17. *https://doi.org/10.1080/14681811.2017.1393745*

Gahagan, J. & Colpitts, E. (2017) Understanding and Measuring LGBTQ Pathways to Health: A Scoping Review of Strengths-Based Health Promotion Approaches in LGBTQ Health Research. *Journal of Homosexuality*, *64*(1), 95-121. DOI: 10.1080/00918369.2016.1172893

Gahagan, J. (2015) *Exploring the School Climate for Gender and Sexuality Minority Students and Staff in Nova Scotia*. Nova Scotia Teachers' Union. https://nstu.blob.core.windows.net/nstuwebsite/data/documents/pdf/gendersexualminorityreport.pdf

Garofalo, R., Deleon, J., Osmer, E., Doll, M., & Harper, G. W. (2006). Overlooked, misunderstood and at-risk: Exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *Journal of Adolescent Health*, *38*(3), 230–236. http://doi.org/10.1016/j.jadohealth.2005.03.023

Gay, Lesbian and Straight Education Network [GLSEN]. (2019). *Advocate for Inclusive & Affirming Curriculum*. https://www.glsen.org/inclusive-curriculum

Gay, Bi, Queer Trans Men's Working Group. (2015). *Primed² A Sex Guide for Trans Men into Men.* Toronto, Ontario: Ontario Gay Men's Sexual Health Alliance. Retrieved from https://www.catie.ca/en/resources/primed-sex-guide-trans-men-men

Giblon R., & Bauer G. (2017). Health care availability, quality, and unmet need: a comparison of transgender and cisgender residents of Ontario, Canada. *BMC Health Services Research; 17*:283. https://doi.org/10.1186/s12913-017-2226-z

Golden, S. & Earp, J. (2012). Social Ecological Approaches to Individuals and Their Contexts: Twenty Years of Health Education & Behavior Health Promotion Interventions. *Health Education & Behavior, 39*(3), 364-372.

Gottschalk, L., & Newton, J., (2008). Rural Homophobia: Not Really Gay. *Gay & Lesbian Issues and Psychology Review, 5*(3), 153-159.

Government of Canada. (2020a). *Reports on United Nations Human Rights Treaties.* https://www.canada.ca/en/canadian-heritage/services/canada-united-nations-system/reports-united-nations-treaties.html#a3

Government of Canada. (2020b). *Social Determinants of Health and Health Inequities*. https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html

Government of Canada. (2019). *Horizontal Evaluation of the Federal Initiative to Address HIV/AIDS in Canada 2013-14 to 2017-18.* https://www.canada.ca/en/public-health/corporate/transparency/corporate-management-reporting/evaluation/report-horizontal-evaluation-federal-initiative-address-hiv-aids-2013-2014-2017-2018.html

Government of Canada. (2018). *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans – TCPS 2 (2018).* Retrieved from Government of Canada Panel on Research Ethics website: https://ethics.gc.ca/eng/policy-politique_tcps2-eptc2_2018.html

Government of Canada. (2017). *It's time: Canada's strategy to prevent and address gender-based violence.* Retrieved from Government of Canada Publications website: http://publications.gc.ca/site/eng/9.839055/publication.html

Government of Canada. (2016). *Sexual Health and Promotion.* https://www.canada.ca/en/health-canada/services/healthy-living/sexual-health-promotion.html

Government of Canada. (1986). *Ottawa Charter for Health Promotion: An International Conference on Health Promotion.* Retrieved from the Public Health Agency of Canada website: https://www.canada.ca/en/public-health/services/health-promotion/population-health/ottawa-charter-health-promotion-international-conference-on-health-promotion.html

Government of Ireland Department of Health. (2015). *National Sexual Health Strategy*. Retrieved from the Government of Ireland website: https://health.gov.ie/healthy-ireland/national-sexual-health-strategy-2015-2020/

Gowen, L. K., & Winges-Yanez, N. (2014). Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning Youths' Perspectives of Inclusive School-Based Sexuality Education. *The Journal of Sex Research*, *51*(7), 788–800. http://doi.org/10.1080/00224499.2013.806648

Grosz, E. (2011). *Becoming Undone: Darwinian Reflections on Life, Politics, and Art.* Durham, N.C.: Duke University Press.

Guba, E. G. (1990). *The Paradigm Dialog*. Sage.

Halperin, David M. (2003). The Normalization of Queer Theory. *Journal of Homosexuality, 45*(2-4), 339-343. https://doi-org.ezproxy.library.dal.ca/10.1300/J082v45n02_17

Hancock, A. M. (2007). When Multiplication Doesn't Equal Quick Addition; Examining Intersectionality as a Research Paradigm. *Perspectives on Politics, 5*(1), 63-79. https://doi.org/10.1017/s1537592707070065

Hankivsky, Olena. (2012). Women's health, men's health, and gender and health: Implications of intersectionality. *Social Science & Medicine (1982), 74*(11), 1712-1720. https://doi.org/10.1016/j.socscimed.2011.11.029

Hare, K., Gahagan, J., Jackson, L., & Steenbeek, A. (2015). Revisualising 'porn': How young adults' consumption of sexually explicit Internet movies can inform approaches to Canadian sexual health promotion. *Culture, Health & Sexuality, 17*(3), 269-283. https://doi.org/10.3138/cjhs.2732

Hart, L., Larson, E., & Lishner, D. (2005). Rural Definitions for Health Policy and Research. *American Journal of Public Health, 95*(7), 1149-1155, https://doi.org/10.2105/AJPH.2004.042432

Healthy Sexuality Working Group. (2004). *Sex? – A Healthy Sexuality Resource*. Nova Scotia Department of Health and Wellness. https://novascotia.ca/dhw/healthy-development/documents/11032_SexBook_En.pdf

Herbst, J. H., Jacobs, E. D., Finlayson, T. J., McKleroy, V. S., Neumann, M. S., Crepaz, N., & the HIV/AIDS Prevention Research Synthesis Team. (2008). Estimating HIV Prevalence and Risk Behaviors of Transgender Persons in the United States: A Systematic Review. *AIDS and Behavior*, *12*(1), 1–17. http://doi.org/10.1007/s10461-007-9299-3

Hobaica, S., Schofield, K., & Kwon, P. (2019). "Here's Your Anatomy…Good Luck": Transgender Individuals in Cisnormative Sex Education. *American Journal of Sexuality Education, 14(3*), 358-387. https://doi-org.ezproxy.library.dal.ca/10.1080/15546128.2019.1585308

Horvath, K. J. PhD, Lantaffi, A. PhD, Swinburne-Romine, R. PhD & Bockting, W. PhD. (2014). A Comparison of Mental Health, Substance Use, and Sexual Risk Behaviors Between Rural and Non-Rural Transgender Persons. *Journal of Homosexuality*, *61*(8), 1117-1130, https://doi.org/10.1080/00918369.2014.872502

House of Commons Standing Committee on Health. (2019). *The Health of LGBTQIA2 Communities in Canada.* Government of Canada. https://www.ourcommons.ca/Content/Committee/421/HESA/Reports/RP10574595/hesarp28/hesarp28-e.pdf

Human Rights Campaign. (2014). *Transgender Visibility: A Guide to Being You*. Washington, D.C. Retrieved from http://www.hrc.org/resources/transgender-visibility-guide

Joint Consortium for School Health [JCSH]. (2008). *What is Comprehensive School Health?* http://www.jcsh-cces.ca/upload/JCSH%20CSH%20Framework%20FINAL%20Nov%2008.pdf

Jones, A. (2019, January 8) *Ontario fights legal challenge over decision to repeal sex-ed curriculum.* CTV News. https://ottawa.ctvnews.ca/ontario-fights-legal-challenge-over-decision-to-repeal-sex-ed-curriculum-1.4245034

Jones, M. J. (February 21, 2021). *LGBT Identification Rises to 5.6% in Latest U.S. Estimate.* Gallup. https://news.gallup.com/poll/329708/lgbt-identification-rises-latest-estimate.aspx

Keenan, R.C. (2015, March 5). Hesitant parents explain their unease with revamped sex ed curriculum. *The Globe and Mail.* Retrieved from http://www.theglobeandmail.com/life/parenting/hesitant-parents-explain-their-unease-with-revamped-sex-ed-curriculum/article23312617/

Khalesi, Z. B., Simbar, M. A., Seyed A., & Zayeri F. (2016). Public sexual health promotion interventions and strategies: A qualitative study. *Electronic Physician, 8*(6), 2489-2496.

Koch, J., & Knutson, D. (2016). Transgender Clients in Rural Areas and Small Towns. *Journal or Rural Mental Health. 40*(3), 154-163. http://dx.doi.org/10.1037/rmh0000056

Kosciw, J. G., Clark, C. M., Truong, N. L., & Zongrone, A. D. (2020). *The 2019 National School Climate Survey: The experiences of lesbian, gay, bisexual, transgender, and queer youth in our nation's schools.* GLSEN. https://www.glsen.org/sites/default/files/2020-11/NSCS19-111820.pdf

Laughlin, S. (2016, March 11). Gen Z goes beyond gender binaries in now Innovation Group data. *J. Walter Thompson Intelligence.* Retrieved from https://intelligence.wundermanthompson.com/2016/03/gen-z-goes-beyond-gender-binaries-in-new-innovation-group-data/

Laverty, E.K., Noble, S.M., Pucci, A., & MacLean, R.E.D. (2021). Let's talk about sexual health education: Youth perspectives on their learning experiences in Canada. *The Canadian Journal of Human Sexuality*. https://doi.org/10.3138/cjhs.2020-0051

Ludvig, A. (2006). Differences between women? Intersecting voices in a female narrative. *European Journal of Women's Studies*, *13*(3), 245–258.

Macdonald, R. & Jolliffe, L. (2003). Cultural Rural Tourism Evidence from Canada. *Annals of Tourism Research. 30*(2) 307-322. https://doi.org/10.1016/S0160-7383(02)00061-0

Masson, S. (2015, March 31). Scott Masson: Why the critics of the Ontario sex-ed curriculum are right. *The National Post.* https://nationalpost.com/opinion/scott-masson-why-the-critics-of-the-ontario-sex-ed-curriculum-are-right

Matsubayashi, Tetsuya, Ueda & Michiko. (2011). The effect of national suicide prevention programs on suicide rates in 21 OECD nations. *Social Science & Medicine (1982), 73*(9), 1395-1400.

McCarty-Caplan, D. M. (2013). Schools, Sex Education, and Support for Sexual Minorities: Exploring Historic Marginalization and Future Potential. *American Journal of Sexuality Education*, *8*(4), 246–273. http://doi.org/10.1080/15546128.2013.849563

McLeroy, K., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly, 15*(4), 351-377.

Meadows, E. (2018). Sexual Health Equity in Schools: Inclusive Sexuality and Relationship Education for Gender and Sexual Minority Students. *American Journal of Sexuality Education*, *13*(3), 297–309. https://doi.org/10.1080/15546128.2018.1431988

Miedema, E., Le Mat, M.L.J., & Hague, F. (2020). But is it Comprehensive? Unpacking the 'comprehensive' in comprehensive sexuality education. *Health Education Journal, 79*(7), 747-762. https://doi.org/10.1177/0017896920915960

Mitchell, K. J., Ybarra, M. L., Korchmaros, J. D., & Kosciw, J. G. (2014). Accessing sexual health information online: use, motivations and consequences for youth with different sexual orientations. *Health Education Research*, *29*(1), 147–157. http://doi.org/10.1093/her/cyt071

Mount Saint Vincent Faculty of Education. (2019a). *Bachelor of Education - Elementary.* https://www.msvu.ca/wp-content/uploads/2020/05/Bachelor20of20Eudcation20-20Elementary20September202019.pdf

Mount Saint Vincent Faculty of Education. (2019b). *Bachelor of Education - Secondary.* https://www.msvu.ca/wp-content/uploads/2020/05/Bachelor20of20Education20-20Secondary20September202019.pdf

Muñoz-Plaza, C., Quinn, S. C., & Rounds, K. A. (2002). Lesbian, gay, bisexual and transgender students: Perceived social support in the high school environment. *The High School Journal, 85*(4), 52–63. https://doi.org/10.1353/hsj.2002.0011

Munro, N. (June 28, 2019). Nova Scotia to cover breast augmentation surgery for transgender people. *The Chronicle Herald.* https://www.thechronicleherald.ca/news/local/nova-scotia-to-cover-breast-augmentation-surgery-for-transgender-people-327968/

Mustanski, B., Greene, G., Ryan, D. & Whitton, S. (2015). Feasibility, Acceptability, and Initial Efficacy of an Online Sexual Health Promotion Program for LGBT Youth: The Queer Sex

Ed Intervention. *The Journal of Sex Research, 52*:2, 220-230. https://doi.org/10.1080/00224499.2013.867924

National Children's Bureau. (2018). *Statutory RSE: Are teachers in England prepared?* Retrieved from https://www.sexeducationforum.org.uk/sites/default/files/field/attachment/Statutory%20RSE%20-%20are%20teachers%20in%20England%20prepared.pdf

National Coalition for Sexual Health. (2021). *Sexual Health*. https://nationalcoalitionforsexualhealth.org/sexual-health/what-is-sexual-healt

Nova Scotia Human Rights Act (R.S. 1989, c. 214). https://cdn.dal.ca/content/dam/dalhousie/pdf/library/Style_Guides/apa_style7.pdf

Nova Scotia Roundtable on Youth Sexual Health. (2006). *Framework for Action: Youth Sexual Health in Nova Scotia.* https://0-nsleg--edeposit-gov-ns-ca.legcat.gov.ns.ca/deposit/b1054561x.pdf

Nova Scotia Roundtable on Youth Sexual Health. (1999). *Just Loosen Up and Keep Talking.* https://www.novascotia.ca/dhw/publications/public-health-education/11025_justloosenkeeptalkingbook_99_en.pdf

Numer, M., & Gahagan, J. (2009). The Sexual Health of Gay Men in the Post-AIDS Era: Feminist, Post-Structuralist and Queer Theory Perspectives. *International Journal of Men's Health, 8*(2), 155-168.

Office of the United Nations High Commissioner for Human Rights [OHCHR]. (2020). *Information Series on Sexual and Reproductive Health and Rights Lesbian, Gay, Bisexual, Transgender and Intersex Persons*. Retrieved from the United Nations Human Rights,

Office of the High Commissioner website: https://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_LGTG_WEB.pdf

Office of the United Nations High Commissioner for Human Rights [OHCHR]. (2008). *The Right to Health Fact Sheet 31.* Retrieved from the United Nations Human Rights, Office of the High Commissioner website: https://www.ohchr.org/Documents/Publications/Factsheet31.pdf

Ontario Public Health Association [OPHA]. (2004). *Trans Health Project: A position paper and resolution adopted by the Ontario Public Health Association (OPHA*). The Public Health Alliance for Lesbian, Gay, Bisexual, Transsexual, Transgendered, Two-spirit(ed), Intersexed, Queer and Questioning Equity, an OPHA workgroup. Retrieved from the Ontario Public Health Association websites: https://opha.on.ca/OPHA/media/Resources/Position-Papers/2003-06_pp.pdf?ext=.pdf

Ontario Physical and Health Education Association [OPHEA]. (n.d.). *Sexual Health in Schools Across Canada.* Toronto, Ontario: OPHEA's Curriculum Advisory Council. Retrieved from the OPHEA website: https://www.ophea.net/sites/default/files/pdfs/advocacy/adv_sexedreportfinal_31my13.pdf

Options for Sexual Health. (2020, August 6). What is Sexual Health? https://www.optionsforsexualhealth.org/facts/sex/what-is-sexual-health/

Oswald, R. & Culton, L. (2003). Under the Rainbow: Rural Gay Life and Its Relevance for Family Providers. *Family Relations, 52*(1). 72-81, http://www.jstor.org/stable/3700162

Page, M. (2017). *Brazen: Trans Women Safer Sex Guide.* Toronto, Ontario: The 519 Church Street Community Centre. Retrieved from https://www.catie.ca/en/resources/brazen-trans-womens-safer-sex-guide-0

Parliament of Canada. (2017). *Bill C-16.* Retrieved from https://www.parl.ca/DocumentViewer/en/42-1/bill/c-16/first-reading

Pauktuutit Women of Canada. (2017). *Inuit Sexual Health Strategy.* https://www.pauktuutit.ca/wp-content/uploads/Tavva_SexualHealth_English.pdf

Pinto, R. M., Melendez, R. M., & Spector, A. Y. (2008). Male-to-female transgender individuals building social support and capital from within a gender-focused network. *Journal of Gay & Lesbian Social Services: Issues in Practice, Policy & Research, 20*(3), 203–220. https://doi.org/10.1080/10538720802235179

Preston, M. (2019). "I'd rather beg for forgiveness than ask for permission": Sexuality education teachers' mediated agency and resistance. *Teaching and Teacher Education, 77,* 332-340. https://doi.org/10.1016/j.tate.2018.10.017

Proulx, C., Coulter, R., Egan J., Matthews D., & Mair, C. (2019). Associations of Lesbian, Gay, Bisexual, Transgender, and Questioning–Inclusive Sex Education with Mental Health Outcomes and School-Based Victimization in U.S. High School Students. *Journal of Adolescent Health, 64*(5), 608-614. https://doi.org/10.1016/j.jadohealth.2018.11.012

Public Health Agency of Canada [PHAC]. (2014). *Questions & answers gender identity in schools.* Ottawa, Ontario: Public Health Agency of Canada. Retrieved from https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-

sexually-transmitted-infections/reports-publications/questions-answers-gender-identity-schools.html

Public Health Agency of Canada [PHAC]. (2008). *Canadian Guidelines for Sexual Health Education.* Ottawa, Ontario: Public Health Agency of Canada. Retrieved from http://sieccan.org/pdf/guidelines-eng.pdf

Roberts, S. (May 31, 2006). Halifax teachers survey raises privacy concerns. *The Globe and Mail.* https://www.theglobeandmail.com/news/national/halifax-teachers-survey-raises-privacy-concerns/article18164212/

Rosenkrantz, D., Black, W., Abreu, R., Aleshire, M., & Fallin-Bennett, K. (2016). Health and Health Care of Rural Sexual and Gender Minorities: A Systematic Review. *Stigma and Health, 2.* 229-243. https://doi.org/10.1037/sah0000055

Rough, B. J. (2018, August 29). *Why It's Best to Start Sex Ed When Kids Are Young*. The Atlantic. https://www.theatlantic.com/family/archive/2018/08/the-benefits-of-starting-sex-ed-at-age-4/568225/

Rutherford, K., McIntyre, J., Daley, A. & Ross, L. (2012). Development of expertise in mental health service provision for lesbian, gay, bisexual and transgender communities. *Medical Education, 46.* 903-913. http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2923.2012.04272.x/epdf

Saewyc E., Frohard-Dourlent H., Ferguson, M., Veale J., (2018). *Being Safe, Being Me in British Columbia Results of the Canadian Trans Youth Health Survey.* University of British Columbia.

http://apscsaravyc.sites.olt.ubc.ca/files/2018/04/SARAVYC_Trans-Youth-Health-Report_BC-V2-WEB.pdf

Scheim, A. I. & Bauer, G. R. (2015). Sex and Gender Diversity Among Transgender Persons in Ontario, Canada: Results From a Respondent-Driven Sampling Survey. *The Journal of Sex Research*, *52*(1), 1-14. https://doi.org/10.1080/00224499.2014.893553

Sevelius, J. (2009). "There's No Pamphlet for the Kind of Sex I Have": HIV-Related Risk Factors and Protective Behaviors Among Transgender Men Who Have Sex with Nontransgender Men. *Journal of the Association of Nurses in AIDS Care*, *20*(5), 398–410. http://doi.org/10.1016/j.jana.2009.06.001

"Sex health guide to be released in Strait schools". (Oct 4, 2013). https://www.cbc.ca/news/canada/nova-scotia/sex-health-guide-to-be-released-in-strait-schools-1.1912171

Sex Information and Education Council of Canada [SIECCAN]. (2019). *Canadian Guidelines for Sexual Health Education.* Retrieved from the SIECCAN website: http://sieccan.org/sexual-health-education

Sex Information and Education Council of Canada [SIECCAN]. (2010). *Sexual health education in the schools: Questions & Answers (3rd edition).* Retrieved from the SIECCAN website: http://sieccan.org/wp-content/uploads/2018/05/SIECCAN_Q-A-Sexual-health-education-in-the-schools.pdf

Sexual Health Ontario. (n.d.) *Sexual health and you*. https://sexualhealthontario.ca/en/sexual-health

Shipley, H. (2013). Queering Institutions?: Sexual Identity in Public Education in a Canadian Context. *Feminist Teacher, 23*(3), 196-210. https://doi.org/10.5406/femteacher.23.3.0196

Shipley, H. (2012). Human rights, sexuality and religion: Between policy and identity. *Diversity Magazine: Ontario Human Rights Commission*. http://www.ohrc.on.ca/en/creed-freedom-religion-and-human-rights-special-issue-diversity-magazine-volume-93-summer-2012/human-rights-sexuality-and-religion-between-policy-and-identity

Starrs, A., Ezeh, A. C, Barker, G., Basu, A., Bertrand, J., Blum, R, . . . Ashford, L. (2018). Accelerate progress—sexual and reproductive health and rights for all: Report of the Guttmacher–Lancet Commission. *The Lancet (British Edition), 391*(10140), 2642-2692. http://dx.doi.org/10.1016/ S0140-6736(18)30293-9

Statistics Canada. (2016) Census Profile, 2016 Census. Retrieved from Statistics Canada website https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=CD&Code1=1207&Geo2=PR&Code2=01&Data=Count&SearchText=Kings&SearchType=Begins&SearchPR=01&B1=All&GeoLevel=PR&GeoCode=1207&TABID=1

Statistics Canada. (2017) *Population Centre and Rural Area Classification 2016.* Retrieved from Statistics Canada website https://www.statcan.gc.ca/eng/subjects/standard/pcrac/2016/introduction

St. Francis Xavier University. (2017a). *Elementary Focus.* https://www2.mystfx.ca/bachelor-of-education/elementary-focus

St. Francis Xavier University. (2017b). *Secondary Focus.* https://www2.mystfx.ca/bachelor-of-education/secondary-focus

Storey, K.E., Montemurro, G., Flynn, J., Schwartz, M., Wright, E., Osler, J., Veugelers, P.J., & Roberts, E. (2016). Essential conditions for the implementation of comprehensive school health to achieve changes in school culture and improvements in health behaviours of students. *BMC Public Health, 16*(1), 1133. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-016-3787-1

"Strait school board says no to sex book". (Feb 11, 2004). *CBC News*. https://www.cbc.ca/news/canada/nova-scotia/strait-school-board-says-no-to-sex-book-1.470866

"Strait school board can't block sex book". (Sep 03, 2004). *CBC News.* https://www.cbc.ca/news/canada/nova-scotia/strait-school-board-can-t-block-sex-book-1.475557

Stringer, JAC (Ed.). (2013) *Trans, Genderqueer, and Queer Terms Glossary.* Cincinnati, Ohio: The Trans and Queer Wellness Initiative. Retrieved from https://23u0pr24qn4zn4d4qinlmyh8-wpengine.netdna-ssl.com/wp-content/uploads/2015/10/Trans_and_queer_glossary.pdf

Taylor, A.B., Chan, A., Hall, S.L., Saewyc, E. M., & the Canadian Trans & Non-binary Youth Health Survey Research Group. (2020). *Being Safe, Being Me 2019: Results of the Canadian Trans and Non-binary Youth Health Survey. Vancouver, Canada: Stigma and Resilience Among Vulnerable Youth Centre*. University of British Columbia. https://www.saravyc.ubc.ca/2020/03/18/being-safe-being-me-2019/

Taylor, C. & Peter, T., with McMinn, T.L., Elliott, T., Beldom, S., Ferry, A., Gross, Z., Paquin, S., & Schachter, K. (2011). *Every class in every school: The first national climate survey on homophobia, biphobia, and transphobia in Canadian schools. Final report.* Egale Canada Human Rights Trust. Retrieved from Egale Canada website: https://egale.ca/wp-content/uploads/2011/05/Every-Class-In-Every-School-Final-Report.pdf

Taylor, E., Jantzen, A., & Clow, B. (2013). *Rethinking LBGTQ Health.* Halifax, Nova Scotia: Atlantic Centre of Excellence for Women's Health. https://cdn.dal.ca/content/dam/dalhousie/pdf/diff/ace-women health/3/ACEWH_rethinking_LGBTQ_health.pdf

Taylor, S. J, Kingdom, D, & Jenkins, R. (1997). How are nations trying to prevent suicide? An analysis of national suicide prevention strategies. *Acta Psychiatrica Scandinavica, 95*(6), 457-463.

The 519 Church Street Community Centre. (2014). *Glossary*. Toronto, Ontario: Rainbow Health Ontario. Retrieved from http://www.rainbowhealthontario.ca/glossary/

The Youth Project. (n.d.-a). *About Us*. http://www.youthproject.ns.ca/about.php

The Youth Project. (n.d.-b). *Education.* https://youthproject.ns.ca/education/

Trans Student Educational Resources. (2017). *LGBTQ+ Definitions.* Retrieved from http://www.transstudent.org/definitions

Ullman, J. (2017). Teacher positivity towards gender diversity: Exploring relationships and school outcomes for transgender and gender-diverse students. *Sex Education, 17*(3), 276-289. https://doi.org/10.1080/14681811.2016.1273104

United Nations. (2020). *Policy Brief: The Impact of COVID-19 on Women.* Retrieved from UN

Women website: https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/policy-brief-the-impact-of-covid-19-on-women-en.pdf?la=en&vs=1406

United Nations Educational, Scientific and Cultural Organization [UNESCO]. (2018). *International Technical Guidance on Sexuality Education: An evidence informed approach.* Retrieved from: https://www.unaids.org/sites/default/files/media_asset/ITGSE_en.pdf

United Nations Educational, Scientific and Cultural Organization [UNESCO]. (2016). *Review of the Evidence on Sexuality Education. Report to inform the update of the UNESCO International Technical Guidance on Sexuality Education*. Retrieved from UNESCO Global Clearinghouse on Global Citizen Education: https://www.gcedclearinghouse.org/sites/default/files/resources/180165eng.pdf

The United Nations Convention on the Elimination of All Forms of Discrimination against Women [CEDAW]. (2016a). *List of issues in relation to the combined eighth and ninth periodic reports of Canada.* https://digitallibrary.un.org/record/845392?ln=en

The United Nations Convention on the Elimination of All Forms of Discrimination against Women [CEDAW]. (2016b). *Concluding observations on the combined eighth and ninth periodic reports of Canada.* https://digitallibrary.un.org/record/3802136?ln=en

The United Nations Convention on the Elimination of All Forms of Discrimination against Women [CEDAW]. (2008). *Concluding observations of the Committee on the Elimination of Discrimination against Women: Canada.*

https://www2.ohchr.org/english/bodies/cedaw/docs/co/CEDAW-C-CAN-CO-7.pdf

UN Women. (2021). *Facts and figures: Women's leadership and political participation*. https://www.unwomen.org/en/what-we-do/leadership-and-political-participation/facts-and-figures

Valocchi, Stephen. (2005). Not Yet Queer Enough: The Lessons of Queer Theory for the Sociology of Gender and Sexuality. *Gender & Society, 19*(6), 750-770. https://doi-org.ezproxy.library.dal.ca/10.1177/0891243205280294

Veale J, Saewyc E, Frohard-Dourlent H, Dobson S, Clark B & the Canadian Trans Youth Health Survey Research Group (2015). *Being Safe, Being Me: Results of the Canadian Trans Youth Health Survey. Vancouver, BC: Stigma and Resilience Among Vulnerable Youth Centre, School of Nursing, University of British Columbia.* https://apsc-saravyc.sites.olt.ubc.ca/files/2018/03/SARAVYC_Trans-Youth-Health-Report_EN_Final_Web2.pdf

"Vehicle parade in Mission draws strong support for transgender student attacked and beaten by peers". (January 17, 2021). *CBC News*. https://www.cbc.ca/news/canada/british-columbia/vehicle-parade-in-mission-draws-strong-support-for-transgender-student-attacked-and-beaten-by-peers-1.5877139

Walters, A., & Hayes, D. (2007). Teaching about Sexuality: Balancing Contradictory Social Messages with Professional Standards. *American Journal of Sexuality Education, 2*(2), 27-49. https://doi.org/10.1300/J455v02n02_03

Waterloo Region District School Board. (2020). *Administrative Procedure 1238 Exemption From Instruction Related To The Human Development And Sexual Health Expectations.*

Retrieved from: https://www.wrdsb.ca/wp-content/uploads/1238-Exemption-from-Instruction-related-to-Human-Development-and-Sexual-Health-Expectations.pdf

Whitehead, J., Shaver, J., & Stephenson, R. (2016). Outness, Stigma, and Primary Health Care Utilization among Rural LGBT Populations. *PLOS ONE*, *11*(1), e0146139. https://doi.org/10.1371/journal.pone.0146139

White-Hughto, Reisner, & Pachankis. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Social Science & Medicine, 147*, 222-231. 10.1016/j.socscimed.2015.11.010

Willging, C. E., Salvador, M., & Kano, M. (2006). Pragmatic help seeking: How sexual and gender minority groups access mental health care in a rural state. *Psychiatric Services, 57*, 871–874. http://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2006.57.6.871

World Health Organization [WHO]. (2016). Health Topics: Health Promotion. Retrieved from http://www.who.int/topics/health_promotion/en/

World Health Organization [WHO]. (2010). *Developing sexual health programmes: a framework for action*. https://apps.who.int/iris/bitstream/handle/10665/70501/WHO_RHR_HRP_10.22_eng.pdf;jsessionid=68AF431163A524AA29100B18F4C679C5?sequence=1

Word Health Organization [WHO]. (2006). *Defining sexual health: report of a technical consultation on sexual health, 28–31 January 2002*. World Health Organization Retrieved from http://www.who.int/reproductivehealth /publications/sexual_health /defining_sexual_health.pdf

World Health Organization [WHO]. (1998). *Health Promotion Glossary*.

https://www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf?ua=1

Appendix A
Interview Guide

Interview Guide: Questions for Research Participants
Research Project: An Exploration of Transgender and Genderqueer Youths' Perceptions and Experiences of Sexuality Health Education in Kings County, Nova Scotia
Researcher: Emma Van Rooyen
Institution: Dalhousie University
Supervisor: Jacqueline Gahagan

Preamble:
My name is Emma. I am in my second year of my studies at Dalhousie University. This research project is being conducted as a part of the requirements for my graduate degree in Health Promotion from Dalhousie University, and you have been asked to participate because of your personal life experiences.

During the interview I will ask you a series of questions. You do not have to answer any question you do not wish to, and can stop the interview at any point if you do not want to continue.

Thank you for agreeing to participate. Do you have any questions before we begin?

Interview Questions

1. What does sexual health mean to you?
2. Can you tell me about how sexual health education is/was taught in your school? What information was included? What was missing?
3. Was the information relevant to you? If so, how? If not, why not?
4. Do you have any suggestions for ways to improve sexual health education in NS schools, relative to the needs of trans and genderqueer youth? (Probes: information to add, different ways of teaching the information, etc.)
5. When you look for information on sexual health, where do you go? Who do you ask? (Probe: If youth accesses a lot of information online- do you feel sexual health resources are limited in the area where you live?)
6. Why are these the places/people where/who you go/ask for insight on this topic?
7. What do you see as the barriers, and opportunities, to adding inclusive sexual health education to the high school curriculum in schools across Nova Scotia? (Probe: do you think these barriers are different where you live then they may be in Halifax and other urban areas?)

Appendix B
Demographic Information Form

Demographic Information Form

Research Project: An exploration of genderqueer youths' perceptions and experiences of sexuality health education in Kings County, Nova Scotia
Researcher: Emma Van Rooyen
Institution: Dalhousie University
Supervisor: Jacqueline Gahagan

Please take a few moments to tell me a little bit about yourself.

Age
What is your age?

____

Gender
What is your gender identity?

____

Ethnicity, Race and Culture
Please tell me a little bit about your ethnicity, race and/or cultural identity.

Economic Class
How would you describe your family's economic class (ex. Working class, middle class etc.)

____

Community of Residence
Where do you live?

____

High School
Are you currently a student at this school?

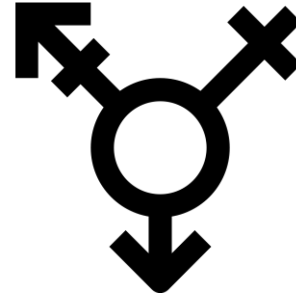
____

Which high school(s) did/do you attend?

____

Appendix C
Recruitment Poster

WANTED:
Trans & Genderqueer Graduates of
Nova Scotia High Schools
With an interest in
Sexuality Health Education



Did you participate in a sexuality health education program in a high school in Nova Scotia? Do you identify as genderqueer, transgender or gender non-conforming? Are you over the age of 20?

Dalhousie Graduate Student Emma Van Rooyen (Department of Health Promotion) is looking for volunteers to advise her graduate research project:

AN EXPLORATION OF TRANSGENDER AND GENDERQUEER YOUTHS'
PERCEPTIONS AND EXPERIENCES
OF SEXUAL HEALTH EDUCATION IN RURAL NOVA SCOTIA

Volunteers will be asked to review and provide feedback on interview questions, and research approaches, as well as to provide guidance to the researcher regarding dissemination of research findings.

If you are interested, please contact researcher Emma Van Rooyen:
Phone: (902) 300 3494
E-Mail: Emmav@dal.ca

DALHOUSIE
UNIVERSITY

Research Project: An exploration of genderqueer youths' perceptions and experiences of sexual health education in Nova Scotia
Researcher: Emma Van Rooyen
Contact: emmav@dal.ca or
(902) 300 3494
Supervisor: Jacqueline Gahagan
Contact: jacqueline.gahagan@dal.ca or
(902) 494 1155

Appendix D Social Ecological Model Map

Barriers to Implementation of Comprehensive Sexual Health Education
in Kings County, NS