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Ontario parents' opinions and attitudes towards sexual health education in the schools

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This study examined the opinions and attitudes of Ontario parents regarding school-based sexual health education (SHE). Results are based on surveys from 1002 parents with children attending publically funded elementary or secondary schools in Ontario, Canada. A large majority (87%) of parents strongly agreed or agreed that SHE should be provided in school and 84% believed that SHE should start by middle school. All 13 sexual health topics posed to parents were rated as important or very important to teach. These topics included puberty, abstinence, methods of contraception, sexually transmitted infections, skills for healthy relationships, communication skills, sexual orientation, and media literacy. Parents rated themselves, doctors and nurses, and the school system as the most competent sources of SHE. Parents also indicated that it is important for their children to learn from an up-to-date SHE curriculum. There were some small differences in the attitudes of mothers and fathers; however, parents with children in public and separate Catholic schools did not significantly differ in their support for SHE in the schools. This study confirms past research from across Canada indicating that there is strong and sustained parental support for broadly-based SHE in the schools.

KEY WORDS: Sexual health education; schools; parents; parental attitudes; curriculum

INTRODUCTION

Because they are the only formal institution to have meaningful contact with nearly every young person, schools are in a unique position to provide education that enables children and adolescents to acquire developmentally appropriate knowledge and skills related to sexual and reproductive health (McCall, McKay, & Society of Obstetricians and Gynaecologists of Canada, 2004; Public Health Agency of Canada, 2008). The *Canadian Guidelines for Sexual Health Education* recommends that such education address a range of topics including puberty, prevention of STI/HIV, effective contraceptive methods, interpersonal relationships, communication skills, sexual orientation, and media literacy (Public Health Agency of Canada). With the exception of Quebec, all provincial and territorial ministries of education include some form of sexual health education (SHE) within their curriculums (Joint Consortium for School Health, 2007). However, the extent and quality of SHE in Canada varies considerably from one jurisdiction to another (Ophea, Healthy Schools Healthy Communities, 2013).

The development and implementation of high quality broadly-based SHE programs for youth can be impacted by several factors. Perceived parental support for SHE in the schools is one such factor. Although several surveys, conducted in different parts of Canada, have indicated broad support for SHE in the schools among parents (see below), uncertainty about parents' opinions and attitudes toward school-based sexual health education can be an obstacle to the implementation and delivery of sexual health curricula in Canadian schools. For example, a proposed 2010 revision of the 1998 Human Development and Sexual Health section of the Ontario Elementary Health and Physical Education elementary level curriculum was withdrawn by the Ontario Ministry of Education and the pending revised secondary curriculum was not released (Ophea, Healthy Schools Healthy Communities, 2013). These decisions occurred in the wake of media news reports and commentaries implying or claiming that a large percentage of Ontario parents were opposed to broadly-based sexual health education in the schools. Surveys measuring levels of parental support for sexual health education in the schools provide important information to inform discus-

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sion and policy development regarding the appropriate extent and nature of sexual health education in Canadian schools.

Several surveys have measured opinions and attitudes toward SHE in the schools among samples of Canadian parents (Advisory Committee on Family Planning, 2008; Langille, Langille, Beazley, & Doncaster, 1996; McKay, 1996; McKay, Pietrusiak, & Holowaty, 1998; Weaver, Byers, Sears, Cohen, & Randall, 2002). All of these surveys, three of which are summarized below, found that a strong majority of parents favoured the provision of SHE in the schools.

McKay et al. (1998) examined the attitudes of over 6800 parents in southern Ontario toward school-based SHE. Overall, 95% of parents *strongly agreed* or *agreed* that SHE should be provided in the school system. Most parents (82%) were also supportive of a developmental approach to SHE that started in the primary grades and continued through high school. Parents were also asked at which grade level 15 different sexuality topics should be taught. There was strong support for starting topics like *building equal, healthy relationships* and *avoiding sexual abuse* early in the school years (K to grade 4). Moreover, the parents in this survey supported including what are often perceived as more controversial topics such as *sexual orientation* and *abortion*, by grades 9 to 12.

In a similar study, Weaver et al. (2002) examined the attitudes of more than 4200 parents in the province of New Brunswick toward school-based SHE. Nearly all the parents (94%) in this survey *strongly agreed* or *agreed* that SHE should be provided in school. In addition, 33% indicated that SHE should begin by grades K-3 with an additional 32% reporting a preference for it to begin by grades 4 to 5. Parents rated it as *important* to cover a full range of developmentally appropriate sexual health topics in the curriculum including puberty, safer sex, pleasure, and homosexuality. Parents were more divided on exactly what grade level specific sexual topics should be introduced in the curriculum, but the median response for most of the topics was grades 6–8. Weaver et al. also explored how parents provided SHE at home. Most striking was the finding that "despite their stated desire to do so, many parents indicated that they were providing "little or no SHE to their children" (p. 30). Parents who were more supportive of school-based SHE provided better quality SHE to their children at home, demonstrating the synergy between school-based and home-based SHE (Byers, Sears, & Weaver, 2008).

The Advisory Committee on Family Planning (2008) conducted a telephone survey of 800 parents of school-aged children in the province of Saskatchewan regarding their opinions about SHE. The survey instrument was modelled on the questionnaire used by Weaver et al. (2002) to survey parents in New Brunswick. Among the results were that 92% of the parents *strongly agreed* (47%) or *agreed* (45%) that SHE should be provided in the schools. A similar proportion (91%) indicated that SHE should begin in grades 6 to 8 or earlier. Of particular note in the results of this survey is that the percentage of urban and rural parents strongly agreeing or agreeing that SHE should be provided in schools did not significantly differ (93%, 91% respectively).

The purpose of the current study was to evaluate Ontario parents' current attitudes toward school-based SHE. This research follows up on two parental attitude surveys conducted over a decade ago (McKay et al., 1998; Weaver et al., 2002) to provide up-dated data on parental attitudes toward SHE in the schools. Increased media and public discussion of SHE before and after the withdrawal of the proposed 2010 revision of the 1998 Human Development and Sexual Health section of the Ontario Elementary Health and Physical Education elementary level curriculum by the Ontario Ministry of Education has led to renewed uncertainty regarding parental support for school-based SHE. Thus, the current survey was designed to clarify levels of parental support for school-based SHE in Ontario. In addition, given that the current curriculum for SHE in Ontario was written over 15 years ago, parents were asked about the importance of keeping the SHE curriculum up-to-date. We also examined whether there were differences in the attitudes of mothers compared to fathers and parents of children in public versus separate schools. Previous Canadian surveys measuring parental attitudes toward SHE in the schools have not examined potential differences in parental attitudes depending on the type of school that their children attend (e.g., Advisory Committee on Family Planning, 2008; McKay et al., 1998; Weaver et al., 2002). In Ontario, there are two basic types of publically-funded school boards: the public school boards and the separate Catholic school boards. Although both the public and separate schools boards are subject to the same provincial Ministry of Education mandates for the provision of SHE, it has been suggested that Catholic schools may teach the subject with more of an emphasis on Christian values (Meaney, Rye, Wood, & Solovieva, 2009). However, it is not known whether parents with children in public schools and Catholic schools differ in their opinions and attitudes toward sexual health education.

METHODS

Participants and Procedure

Participants were 1002 parents with children attending a publically funded elementary or secondary school in Ontario. About two-thirds of parents were mothers (62.1%). The parents ranged in age from 24 to 64 years-old ($M = 44.2$, $SD = 6.9$). In terms of education, 9.2% had completed high school or less, 10.3% had some community or technical college, 25.0% had completed a community or technical college, 6.8% had some university, 33.8% had a university degree, and 14.9% had a post-graduate degree. The median household income was between $80,000 and $100,000. Most (67.7%) had one or more children in a public school, 29.8% had one or more children in a separate school, and 2.5% had children in both school systems. Parents lived in Toronto (21.8%), the greater Toronto area (24.7%), East-Central Ontario (20.1%), Southwestern Ontario (28.9%), and Northern Ontario (4.6%).

The survey was designed by the first and fifth authors with the aim of replicating as closely as possible the previous surveys of parental attitudes toward SHE in the schools conducted by Weaver et al. (2002) in New Brunswick and McKay et al. (1998) in Ontario. The survey was commissioned by Ophea for the purpose of better understanding Ontario parents' opinions about the role of the school in providing SHE to their children. Data were collected from April 6th to April 23rd, 2013 by Environics Research Group. Participants were Environics online panelists who consented to participate in the internet-based survey. The Environics panel used for this survey consisted of Ontario residents aged 18 and over. Panelists are selected for recruitment to maintain a panel that matches as closely as possible the general population of Ontario. Panelists who met the eligibility criteria (i.e., parents with children in elementary or secondary schools) were invited to participate in the survey until the objective of collecting 1000 completed surveys was reached.

Measures

The survey consisted of questions assessing demographic characteristics (e.g., gender, income, type of school child attended). It also included nine questions assessing attitudes and experiences with SHE in schools based on similar surveys by McKay et al. (1998) and Weaver et al. (2002). Q1 and Q2 assessed parents' general opinions, rated on 5-point Likert scales, about whether health education and SHE should be provided in schools. In response to Q3, parents indicated the grade level at which they thought SHE that is appropriate for the child's age and developmental level should begin (1–3, 4–5, 6–8, 9–12, or "There should be no sexual health education in schools"). Then, Q4 asked parents to indicate, on a 5-point scale ranging from *poor* (1) to *excellent* (5) the quality of the SHE their child/children had received in school; parents could also indicate that their child had not received SHE in school. In Q5, parents indicated how comfortable they were with their child receiving sexual health information from each of nine sources on a 4-point scale ranging from *not at all comfortable* (1) to *very comfortable* (4); parents could also indicate that they were not sure and these responses were coded as missing. Parents were asked to rate their own comfort having discussions with their child about sexual health on the same scale (Q6). Then, Q7 asked parents to indicate whether they felt they had adequate knowledge to provide SHE to their child on a 5-point Likert scale. Parents were then asked to rate how important it is for children to learn about each of 13 topics as part of SHE (Q8). These ratings were summed to provide a total score for importance of SHE ranging from 13 to 65. Finally, parents were informed that the current SHE content in the curriculum was written 13–15 years previously and asked to rate how important it is that students learn from a more up-to-date curriculum on a 4-point scale ranging from *not at all important* (1) to *very important* (4) (Q9).

Data Analysis

We examined descriptive statistics for all the variables. In addition, we compared mothers and fathers on all the variables using Analysis of Variance and report both the statistical significance and the magnitude (eta_p^2) of the effects. We also compared parents with children in public versus separate schools on these variables using the same procedure; the 25 parents with at least one child in each school-type were excluded from these analyses. Given the large sample size alpha was set at .001.

RESULTS

Attitudes Towards Sexual Health Education

The vast majority of parents were in support of school-based health education, with 94% of parents either agreeing (35%) or strongly agreeing (59%) that health education should be provided in school (see Figure 1). Similarly, the vast majority of parents supported the provision of SHE in schools with 87% either agreeing (42%) or strongly agreeing (45%) (see Figure 2). More than one-third of parents (37%) felt that SHE should start in elementary school, almost half (47%) felt it should begin in middle school (grades 6–8), and 14% felt it should begin in high school. Very few parents (2%) felt SHE should not be provided in school (see Figure 3). Figure 4 presents parents' evaluation of the SHE their children had received in school; the 306 parents (31%) whose child had not received SHE were excluded from this analysis. The most frequent rating was *good* (43%). About one quarter of parents (24%) rated the SHE their child had received as *very good* or *excellent*. About a third of parents (34%) rated it as *fair* or *poor*. Finally, most parents (93%) felt it was important or very important that their children learn from a SHE curriculum that was more up-to-date (see Figure 5).

Importance of Various Sexual Health Topics

Parents were asked to rate the importance of including each of 13 different topics in the SHE curriculum. Their median, mode, and mean responses are provided in Table 1. The median and modal responses for 12 of the topics indicated that parents viewed each of these topics as *very important*. Although media literacy was seen as somewhat less important than the other topics, it was still rated as *important* overall.

Parent Comfort with Various Sources of Sexual Health Information

Parents indicated the extent to which they were comfortable with their child receiving sexual health information from nine different sources. The mean ratings for each of these sources are provided in Figure 6. On average parents were only *comfortable* or *very comfortable* with four of these sources: themselves or their partner, a doctor or nurse, school, and non-

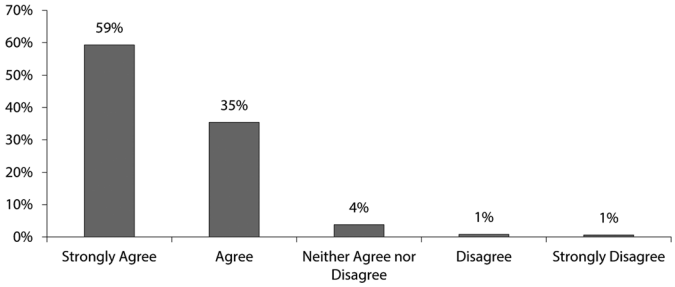

Figure 1. Percentage of parents agreeing with the statement "Health education should be provided in the schools."

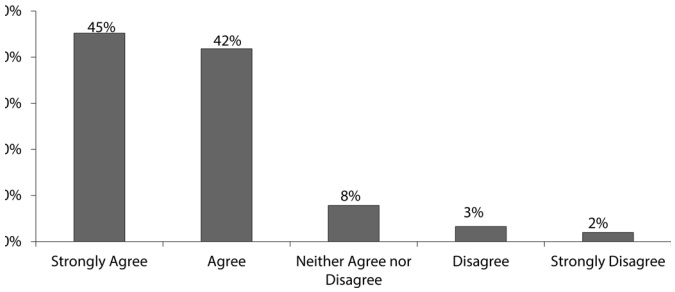

Figure 2. Percentage of parents agreeing with the statement "Sexual health education should be provided in the schools, as one component of overall health education."

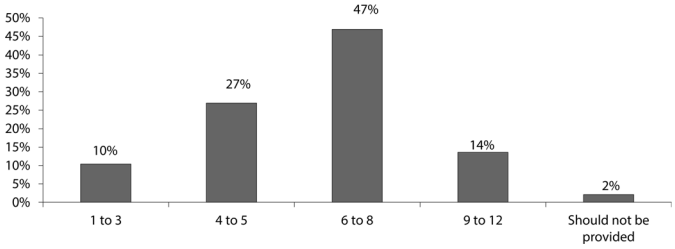

Figure 3. Percentage of parents reporting that sexual health education should begin at specific grade levels.

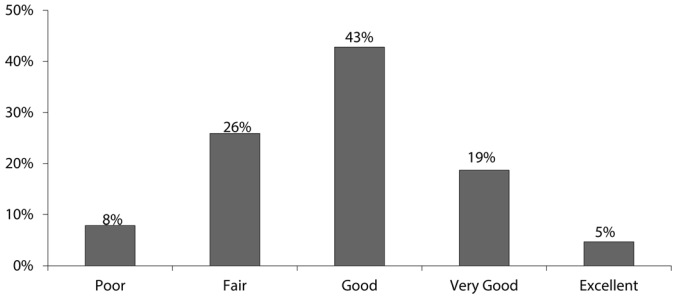

Figure 4. Quality of school-based sexual health education parents report for children have received SHE.

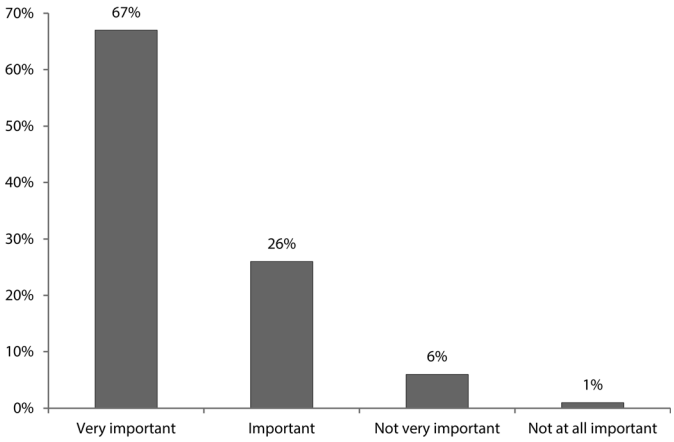

Figure 5. Parents' views on the importance of a SHE curriculum that is more up-to-date.

fiction books, in that order. In contrast, their average ratings fall between *not at all comfortable* and *not very comfortable* for the other five sources: fiction books, the child's friends, the internet, other media, and social media.

Parents were also asked to indicate their own comfort and knowledge in having sexual health discussions with their child. Most parents (89%) rated themselves as *comfortable* or *very comfortable* (see Figure 7). Most (83%) also agreed or strongly agreed that they had adequate knowledge to provide SHE to their child (see Figure 8).

Comparison of Mothers and Fathers

Table 2 provides the mean ratings for mothers and fathers and the total sample on all of the variables. There were only a few significant differences between the mothers and the fathers in the sample. The fathers on average felt that SHE should start in a later grade than did mothers. In contrast, mothers were significantly more likely than fathers to give higher ratings of importance for their children to learn from a more up-to-date curriculum. In addition, the mothers' total scores for Importance of SHE were significantly higher than those of the fathers. Mothers were somewhat more comfortable than were fathers with their child learning from reference books; they did not differ significantly in their ratings of any of the other sources. Mothers rated themselves as significantly more comfortable than did fathers in having discussion with their children about sexual health. Mothers also agreed more strongly that they had adequate knowledge to have these discussions. Even in cases where there were statistically significant differences in the mean ratings for mothers and fathers, visual inspection of the data indicates that the magnitude of these differences were not large.

Comparison of Public School and Separate School Parents

Table 3 also provides mean ratings for public school and separate school parents on all of the variables. The two groups of parents did not differ significantly on any of the questions.

Table 1. Importance Parents Assigned to Possible Topics in the Sexual Health Curriculum

Topic	Median	Mode	Mean	Standard deviation
Correct names for body parts, including genitalia	4	4	3.5	0.59
Physical, cognitive, emotional and social changes	4	4	3.6	0.55
Puberty	4	4	3.6	0.57
Reproduction	4	4	3.5	0.61
Abstinence	4	4	3.5	0.69
Methods of contraception	4	4	3.5	0.68
Sexually transmitted infections	4	4	3.7	0.56
Skills for healthy relationships	4	4	3.5	0.67
Decision-making skills	4	4	3.7	0.56
Self -esteem and personal development	4	4	3.7	0.50
Communication skills	4	4	3.7	0.54
Sexual orientation	3	4	3.2	0.86
Media literacy	3	3	3.1	0.84

Note. $N = 969$ to 996. 1 = not at all important, 2 = somewhat important, 3 = important, 4 = very important.

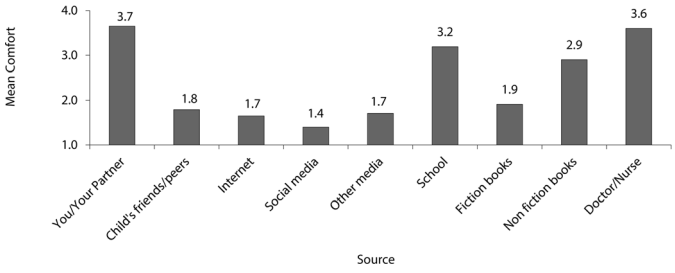

Figure 6. Average comfort level parents have for their child receiving sexual information from each source (higher number reflects more comfort)

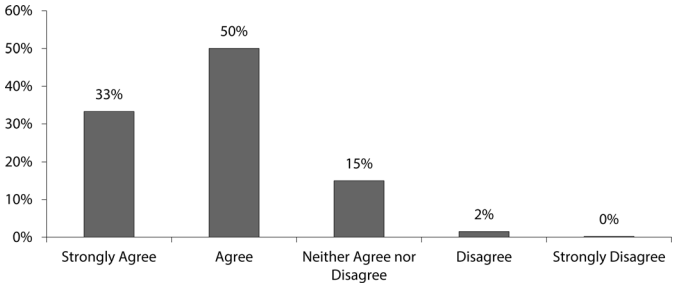

Figure 8. Percentage of parents agreeing with the statement that " you have adequate knowledge to provide sexual health education for your child/children."

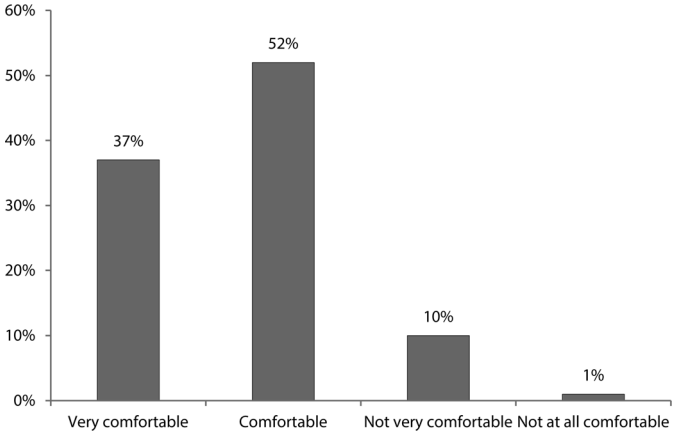

Figure 7. Parents' level of comfort having discussions with their child about sexual health.

DISCUSSION

The findings of this study indicate strong parental support for health education in general and sexual health education specifically in the Ontario publically funded school system. This was equally true of parents with children in public schools and in separate schools. This result is consistent with past Canadian studies of parents in New Brunswick (Weaver et al., 2002), rural Ontario (McKay et al., 1998), and rural Nova Scotia (Langille, et al.,1996) and Saskatchewan (Advisory Committee on Family Planning, 2008). Together, the results of these surveys suggest that there is strong and sustained support among Canadian parents for SHE in the schools.

When Should SHE Start?

The overall support for SHE extended to parents' views on when SHE should start. More than a third of parents responded that SHE should begin elementary school; a vast majority of parents indicated that it should begin during or before middle school (Grades 6–8). It should be noted that parents completing the questionnaire were not provided with a definition of SHE before responding to these questions. Thus, it is unclear, for example, if the respondent's interpreted topics such as correct names for body parts or changes associated with the onset of puberty, which are typically discussed in the elementary grades, specifically as SHE or if they considered these topics to be part of health education more generally. Parents who considered these topics as health education rather than as SHE specifically may have been more likely to indicate that SHE should begin in the later grades. Nevertheless, these results suggest that parents recognize the importance of a

Table 2. Mean Attitudes of Mothers, Fathers and for the Overall Sample

Question	Mothers	Fathers	Overall	F	Eta_p^2
Provide health education[a]	4.54	4.50	4.52	.99	.001
Provide sexual health education[a]	4.28	4.23	4.26	.80	.001
In what grade should sex education start? (N.B. 2 = grade 4–5; 3 = grade 6–8)	2.54	2.87	2.67	34.41*	.033
Rate the quality of sex education (parents whose children have received SHE only)[b]	2.96	2.77	2.89	6.83	.009
Comfort of source[c]: parent	3.69	3.60	3.66	6.11	.006
Comfort of source[c]: friends	1.78	1.82	1.79	.65	.001
Comfort of source[c]: Internet	1.63	1.68	1.65	.99	.001
Comfort of source[c]: Social media	1.39	1.40	1.40	.10	.000
Comfort of source[c]: Other media	1.68	1.74	1.70	1.74	.002
Comfort of source[c]: School	3.21	3.18	3.20	.76	.001
Comfort of source[c:]: Novels	1.95	1.87	1.92	2.14	.002
Comfort of source[c]: Reference books	3.07	2.80	2.97	27.34*	.027
Comfort of source[c]: Doctor/Nurse	3.64	3.59	3.62	2.13	.002
How comfortable are you having discussions[c]	3.36	3.14	3.28	27.97*	.027
Agreement about having adequate knowledge[a]	4.23	4.07	4.17	12.64*	.012
Importance of broadly-based sex education	46.67	44.97	46.01	19.27*	.019
Importance of an up to date curriculum[d]	3.67	3.50	3.60	17.31*	.017

Note. *$p < .001$. $N = 955$ to 1023, except for quality of sex education $N = 714$. [a]Values range from 1 = strongly disagree to 5 = strongly agree. [b]Values range from 1 = poor to 5 = excellent. [c]Values range from 1 = not at all comfortable to 4 = very comfortable. [d]Values range from 1 = not at all important to 4 = very important.

Table 3. Mean Attitudes by School Type and for the Overall Sample

Question	Public	Separate	Overall	F	Eta_p^2
Provide health education[a]	4.49	4.61	4.53	6.94	.007
Provide sexual health education[a]	4.23	4.32	4.26	2.13	.002
In what grade should sex education start? (N.B. 2 = grade 4–5; 3 = grade 6–8)	2.68	2.64	2.66	.374	.000
Rate the quality of sex education[b]	2.84	3.01	2.90	5.19	.007
Comfort of source[c]: parent	3.66	3.65	3.65	.017	.000
Comfort of source[c]: friends	1.84	1.72	1.80	4.97	.005
Comfort of source[c]: Internet	1.68	1.60	1.65	2.24	.002
Comfort of source[c]: Social media	1.41	1.35	1.39	2.31	.002
Comfort of source[c]: Other media	1.71	1.69	1.70	.18	.000
Comfort of source[c]: School	3.20	3.21	3.20	.03	.000
Comfort of source[c:]: Novels	1.96	1.84	1.92	4.50	.005
Comfort of source[c]: Reference books	2.99	2.94	2.97	.75	.001
Comfort of source[c]: Doctor/Nurse	3.63	3.62	3.62	.04	.000
How comfortable are you having discussions[c]	3.26	3.31	3.27	1.22	.001
Agreement about having adequate knowledge[a]	4.14	4.22	4.17	2.44	.002
Importance of broadly-based sex education	45.66	46.72	45.99	6.53	.007
Importance of an up to date curriculum[d]	3.58	3.64	3.60	1.51	.002

Note. *$p < .001$. $N = 930$–998 except for q4 N = 694. [a]values range from 1 = strongly disagree to 5 = strongly agree. [b]values range from 1 = poor to 5 = excellent. [c]values range from 1 = not at all comfortable to 4 = very comfortable. [d]values range from 1 = not at all important to 4 = very important.

sequential, developmentally appropriate SHE curriculum that begins before the onset of adolescence. Furthermore, the parents in this study wanted their children to receive a comprehensive SHE curriculum that included a wide range of topics. In fact, parents rated 11 of the 13 sexual health topics (e.g., correct names for body parts, contraception, communication skills) that are currently part of the SHE curriculum as *very important*; the other two topics, sexual orientation and media literacy were rated slightly lower as *important*.

Parental Comfort with Sources of SHE

Parents rated themselves as the source they were most comfortable with their child or children coming to for sexual health information. In keeping with this finding, most parents

indicated that they are comfortable having sexual health discussions with their children and feel they have adequate knowledge to address sexual health questions. Parents also rated two other sources of information highly: doctors and nurses, and the school system. These findings are in keeping with other research that has found that Canadian parents believe that the SHE of their children should be a shared responsibility between parents and schools (Weaver et al., 2002). The present study did not assess parents' views of their sexual health knowledge and/or comfort for different topics. Thus, the extent to which parents' actually discussed each of these topics with their child and/or the quality of the parent-child sexual communication is not known. Qualitative research has found that parents who suggest they are 'open' to such discussions or "have talked" to their children about sexual health, reveal that most of this conversation is done on a very superficial level through indirect means (Hyde et al., 2013). Furthermore, Weaver et al. (2002) found that parents' ratings of the quality of their sexual communication with their child varied across topics. Parents also tend to struggle with what kind of sexuality related information is developmentally appropriate (Geasler, Dannison, & Edlund, 1995). The importance of making clear to parents and communities the sequencing of developmentally appropriate school-based SHE is well established. Among the eight principles of SHE specified by Ophea, Healthy Schools Healthy Communities (2014), is that "Sexual health education should be delivered in a developmentally appropriate manner, structured so that it meets the learning needs of children at different ages and stages of development" (p. 5). Ophea suggests that children in the early elementary grades should learn, for example, the proper names for, and functions of different body parts and learn to distinguish between appropriate and inappropriate touch.

Updating the Curriculum

Of those parents who said their child had received SHE, the most frequent assessment of the quality of that education was "good," which was the midpoint on the rating scale, between "poor" and "excellent." That is, although parents indicated that they support SHE in schools, they also indicated that they have reservations about how well this has been executed in the classroom. It is not known how their ratings of SHE compare to their ratings of other topics covered in schools (e.g., math, science) – that is, whether they view the quality of SHE as similar or different to the quality of instruction of other topics. Nonetheless, their reservations may reflect the comfort and pedagogical approach of the teachers delivering the curriculum. Research in New Brunswick has documented that on average teachers are only somewhat comfortable teaching sexual health topics, in part because they feel only somewhat knowledgeable about the topics and only about one-third had received any training to teach sexual health (Cohen, Byers, & Sears, 2012; Cohen, Byers, Sears, & Weaver, 2004). However, it may also reflect their evaluation of the curriculum, given that the current curriculum, the Human Development and Sexual Health component of the Ontario Health and Physical Education curriculum, was developed in 1998. In keeping with this view, virtually all of the parents in the current study felt that their children needed to learn from an up-to-date SHE curriculum. This may reflect parental concern that an SHE curriculum created over a decade in the past may not address currently relevant and emerging issues with significant implications for sexual health. It is notable that the parents in this survey were less comfortable with the internet and social media as sources of SHE for their children. They may also recognize that the development of critical literacy and safety skills related to the internet and social media are important components of SHE that meets school-aged students' current needs. Other sexual health issues such as negotiation of sexual consent and other legal aspects of sexuality which have become increasing prominent in recent years may be underlying parents' perception that the Ontario curriculum needs up-dating.

Differences Between Mothers and Fathers

Parental gender differences were found on several questions within the survey, all of which were in the same direction. That is, the mothers had a slightly more favourable opinion toward some aspects of SHE than did fathers. Mothers suggested that SHE should start somewhat earlier, rated the quality of SHE received by their child(ren) as a little better, rated themselves slightly more comfortable and knowledgeable having sexuality discussions, and rated most of the topics (and overall) covered under the SHE curriculum as somewhat more important than did fathers. However, mothers and fathers did not differ on their overall support for SHE in schools. Furthermore, the significant differences between the mothers and fathers were very small accounting for less than 1% of the variance. Similarly Weaver et al. (2001) found no differences between mothers' and fathers' attitudes toward SHE. Thus, in practical terms the attitudes of mothers and fathers were highly similar.

Differences Between Parents With Children Attending Secular Public Schools and Parents With Children Attending Catholic Schools

Because Catholic schools have an explicitly religious orientation, it is sometimes assumed that they take a more conservative, Christian values-based approach to the teaching of sexual health education compared to secular public schools. To the extent that these assumed differences in approach may also be reflected in parental attitudes, we might expect that parents with children in Catholic schools would differ from parents with children in secular public schools in their attitudes toward sexual health education in the schools. However, we found no significant differences between parents with children in Catholic schools and parents with children in secular public schools on measures of level of support for sexual health education in the schools, what grade sexual health education should begin, or on the importance of a broadly-based sexual health education curriculum.

Limitations

There are several limitations that need to be highlighted to place the results in the proper context. Although the study was conducted with the intent to obtain a representative sample of Ontario parents, the survey respondents were disproportionately well-educated, middle to upper-middle income, and disproportionately mothers rather than fathers. However, the sample was more representative than a convenience sample would have been and was geographically representative. In addition, parents who did not reply to the survey may also be different in significant ways than those who did reply. It is also often the case that volunteers for sexuality surveys, as compared to non-volunteers, hold more liberal sexual attitudes (Wiederman, 1999; Wiederman & Whitley, 2002).

Conclusion

This study adds to the growing body of survey research documenting Canadian parents' strong support for broadly-based SHE in school starting by middle school. The results from this study can play an important role in informing the development of policy regarding SHE in the schools, particularly in the province of Ontario.

The degree to which a plurality of parents participating in this survey expressed support for SHE in the schools suggests that parental agreement with the provision of SHE extends across demographic groups not specified in the data collection in the current study. While the current study captures the broad plurality of parental opinion, given the extensive and growing ethno-cultural diversity in Ontario and other parts of Canada, future research should examine parental opinions and attitudes toward SHE in the schools with a specific focus on ethnicity, religious affiliation, country of birth and origin, as well as other salient demographic factors. In addition to the collection of quantitative data that more precisely accounts for possible ethno-cultural differences in parents perspectives toward SHE, future research should employ qualitative methods (e.g., focus groups) to better understand the perspectives of parents from different ethno-cultural backgrounds.

REFERENCES

Advisory Committee on Family Planning (2008). *Sexual health education survey: Urban and rural comparative.* Conducted by Fast Consulting, Saskatoon, SK for the Advisory Committee on Family Planning, Saskatoon, Saskatchewan. http://www.skprevention.ca/wp-content/uploads/2013/01/7-504-ACFP-Education-Survey-Report.pdf Accessed: 30/7/2014.

Byers, E.S., Sears, H.A., & Weaver, A.D. (2008). Parents' reports of sexual communication with children in kindergarten to grade 8. *Journal of Marriage and the Family*, *70*(1), 86–96. http://dx.doi.org/10.1111/j.1741-3737.2007.00463.x

Cohen, J.N., Byers, E.S., & Sears, H.A. (2012). Factors affecting Canadian teachers' willingness to teach sexual health education. ^. *Sex Education*, *12*(3), 299–316.

Cohen, J.N., Byers, E.S., Sears, H.A., & Weaver, A.D. (2004). Sexual health education: Attitudes and knowledge, and comfort of teachers in New Brunswick schools. *Canadian Journal of Human Sexuality*, *13*, 1–15.

Geasler, M.J., Dannison, L.L., & Edlund, C.J. (1995). Sexuality education of young children: Parental concerns. *Family Relations*, *44*(2), 184–188. http://dx.doi.org/10.2307/584807

Hyde, A., Drennan, J., Butler, M., Howlett, E., Carney, M., & Lohan, M. (2013). Parents' constructions of communication with their children about safer sex. *Journal of Clinical Nursing*, *22*(23-24), 3438–3446. http://dx.doi.org/10.1111/jocn.12367 Medline:24028084

Joint Consortium for School Health (2007). *Sexual health: Quick scan of activities and resources in Canadian schools.* http://www.jcsh-cces.ca/upload/Sexual%20Health.pdf

Langille, D.B., Langille, D.J., Beazley, R., & Doncaster, H. (1996). *Amherst parents' attitudes toward school-based sexual health education*. Halifax, Nova Scotia: Dalhousie University.

McCall, D., McKay, A., & Society of Obstetricians and Gynaecologists of Canada (2004). School-based and school-linked sexual health education and promotion in Canada. *Journal of Obstetrics and Gynaecology Canada*, *26*, 596–600. Medline:15193207

McKay, A. (1996). Rural parents' attitudes towards school-based sexual health education. *Canadian Journal of Human Sexuality*, *5*, 15–23.

McKay, A., Pietrusiak, M., & Holowaty, P. (1998). Parents' opinions and attitudes toward sexuality education in the schools. *Canadian Journal of Human Sexuality*, *7*, 139–145.

Meaney, G.J., Rye, B.J., Wood, E., & Solovieva, E. (2009). Satisfaction with school-based sexual health education in a sample of university students recently graduated from Ontario high schools. *Canadian Journal of Human Sexuality*, *18*, 107–125.

Ophea, Healthy Schools Healthy Communities (2013). *Sexual health education in schools Across Canada.* https://www.ophea.net/sites/default/files/pdfs/advocacy/ADV_SexEdReportFINAL_31MY13.pdf

Ophea, Healthy Schools Healthy Communities (2014). *Addressing human development and sexual health within the Ontario health and physical education curriculum.* http://www.ophea.net/sites/default/files/ADV_SexEdElectronic_20JN14.pdf

Public Health Agency of Canada. (2008). *Canadian Guidelines for Sexual Health* (3rd ed.). Ottawa, ON: Public Health Agency of Canada.

Weaver, A. D., Byers, E. S., Sears, H. A., Cohen, J. N., & Randall, H. E. S. (2001). *New Brunswick parents' ideas about sexual health education.* Report prepared for the New Brunswick Department of Education.

Weaver, A.D., Byers, E.S., Sears, H.A., Cohen, J.N., & Randall, H.E.S. (2002). Sexual health education at school and at home: Attitudes and experiences of New Brunswick parents. *Canadian Journal of Human Sexuality*, *11*, 19–31.

Wiederman, M.W. (1999). Volunteer bias in sexuality research using college student participants. *Journal of Sex Research*, *36*(1), 59–66. http://dx.doi.org/10.1080/00224499909551968

Wiederman, M.W., & Whitley, B.E. (2002). *Handbook for conducting research on human sexuality*. Mahwah, NJ: Lawrence Erlbaum Associates.