

Parent-child sexual health communication in Waterloo Region: A situational assessment

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Authors

Meghan Randall, Grace Bermingham, and Alyshia Cook

Editors

Chris Harold and Taheera Walji

Contributors

Stephen Drew, Harshani Gangodawilage, Amy MacArthur, Melissa MacLeod, Andrew Sardella, and Adele Parkinson

Project Team

This project was guided by the Sexual Health Youth Strategy Activity 7.1 Project Team. The following individuals were members at some point in the process: Grace Bermingham¹, Kathryn Bocking¹, Lyndsey Butcher², Alyshia Cook¹, Risa Gordon¹, Stacey Jacobs², Gayle Jessop¹, Mary Hall¹, Chris Harold¹, Barbara May Hutchison¹, Amy McArthur¹, Meghan Randall¹, Lesley Rintche¹, Andrew Sardella¹, Susan Smiley,¹ and Erin Walters¹

¹Region of Waterloo Public Health and Emergency Services

²SHORE Centre

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For more information about the situational assessment, please contact:

Information and Planning Program

Infectious Diseases, Dental and Sexual Health Division

Region of Waterloo Public Health and Emergency Services

99 Regina Street South, 2nd floor

Waterloo, Ontario N2J 4V3

Phone: 519-575-4400 ext.5322

Email: charold@regionofwaterloo.ca

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Executive Summary

Parents play an essential role in the sexual health education of their children. Family connectedness and communication within families can influence the sexual health behaviours of children and youth. Research supports that parents are interested in improving their parent¹-child sexual health communication, but need support in doing so.

The Waterloo Region Sexual Health Youth Strategy recognizes the influence of parents on the sexual health of children and youth. As a component of the Strategy, a situational assessment was conducted to identify the sexual health support needs of parents in Waterloo Region and effective strategies to increase parents' and guardians' awareness, knowledge, skills and confidence for talking with their children about sexual health. This information will be used to inform programs and services going forward.

The situational assessment aimed to answer the following research questions:

1. What parent-child sexual health communication supports currently exist in Waterloo Region?
2. What are the parent-child sexual health communication support needs of parents in Waterloo Region?
3. What are the gaps in the parent-child sexual health communication supports that exist in Waterloo Region as defined by parents and the literature?
4. Who are priority populations needing additional support when speaking with their children about sexual health? Do these populations require targeted parent-child sexual health communication strategies?
5. What are comparator Public Health Units (PHU) across Ontario doing to support parent-child sexual health communication?
6. How should Public Health and its community partners support parent-child sexual health communication in Waterloo Region?

To answer these research questions, the situational assessment included four components: a literature review, an environmental scan of local programs and services, an environmental scan of comparator health regions, and a survey completed by 917 parents in Waterloo Region.

Key findings of the situational assessment include:

- Evidence to suggest that parent-child sexual health communication influences behaviour is mixed. Although parent-child sexual health communication may have some effect on modifying risk-taking behaviour, its effects should not be overestimated.
- Multiple factors influence sexual risk-taking in youth, many of which are not directly related to parenting practices; however, parents remain the primary

¹ The term parents is used throughout the report to refer to parents, guardians, grandparents, or others who care for children up to 18 years of age.

educators of their children. To achieve maximum possible benefit, any parent-child sexual health communication interventions should be aligned or linked with parenting programs in general, as it relates to overall relationship quality, support and monitoring.

- Local survey data indicates a majority of parents have initiated sexual health-related conversations with their children. This survey data also suggests parents do not discuss certain topics, including some that greatly influence behaviour according to the literature (e.g. use of technology, pornography, oral sex). Other evidence suggests parents initiate conversations with their children too late in relation to initiation of sexual activity. Further, a previous study of local secondary school students noted that friends/peers are their primary source of sexual health information, with parents being the secondary source for females and the third source for males (the second being the internet).
- Certain populations are likely receiving little to no information about sexual health and may require targeted or more specific education and communication supports, including males, LGBT youth, youth living in rural areas, individuals with intellectual disabilities, youth from families with strong religious or conservative beliefs, and youth who are immigrants.
- Parents indicate that they require, and are interested in receiving, support to improve parent-child sexual health communication; however, few programs are available in Waterloo Region to meet this need.
- Overall, there are opportunities to improve the timing and quality of the conversations parents have with their children, and make them a trusted source of more accurate sexual health information.

1.0 Introduction

1.1 Waterloo Region Sexual Health Youth Strategy

The Waterloo Region Sexual Health Youth Strategy (SHYS) is a collaborative project between Region of Waterloo Public Health and Emergency Services (ROWPHE) and community partners, with the goal of promoting healthy sexuality among youth in Waterloo Region. The strategy provides a comprehensive, strategic direction for youth sexual health education, programs, and services in Waterloo Region for implementation over a five year period from 2012 to 2017.

The strategy is divided into three focus areas: Access, Education, and Parents. Within these focus areas, there are seven action areas and several activities to develop and implement.

Action Area 7 of the strategy focuses on “increasing parents’ and guardians’ knowledge, skills and confidence for talking with their children about sexual health”. There are three activities within this Action Area. This report relates to activity 7.1: Conduct a situational assessment to determine the sexual health support needs of parents in Waterloo Region and to determine which strategies are effective at increasing parents’ and guardians’ awareness, knowledge, skills, and confidence for talking with their children about sexual health.

This report presents findings from the situational assessment conducted to determine parent-child sexual health communication support needs of parents and guardians (herein referred to as parents²) in Waterloo Region.

1.2 Situational Assessment

The Population Health Assessment and Surveillance Protocol of the Ontario Public Health Standards (2016) defines a situational assessment as an assessment that influences planning in significant ways by examining the legal and political environment, the socio-environmental conditions and broader determinants of health, stakeholders, the health needs of the population, the literature and previous evaluations, as well as the overall vision for the project (p 19).

A situational assessment includes, but is not limited to the use of the following types and sources of information:

- Key facts, findings, trends, and recommendations from the literature;
- Data and analyses obtained from population health assessment and surveillance;
- Legal and political environments;
- Stakeholder perspectives; and
- Recommendations based on past experiences, including program evaluation information.

² The term parents is used throughout the report to refer to parents, guardians, grandparents, or others who care for children zero to 18 years of age.

The objectives of the parent-child sexual health communication situational assessment are to:

- Document existing sexual health supports for parents in Waterloo Region and surrounding areas
- Identify which topics parents discuss with their children
- Identify which topics parents intend to discuss with their children
- Identify barriers to discussing sexual health topics with children
- Identify information, program, and/or service needs to support parents in discussions about sexual health with their children

1.3 Research Questions

The situational assessment aimed to answer the following research questions (based on the objectives listed above):

1. What parent-child sexual health communication supports currently exist in Waterloo Region?
2. What are the parent-child sexual health communication support needs of parents in Waterloo Region?
3. What are the gaps in the parent-child sexual health communication supports that exist in Waterloo Region as defined by parents and the literature?
4. Who are priority populations needing additional support when speaking with their children about sexual health? Do these populations require targeted parent-child sexual health communication strategies?
5. What are comparator Public Health Units (PHU) across Ontario doing to support parent-child sexual health communication?
6. How should Public Health and its community partners support parent-child sexual health communication in Waterloo Region?

1.4 Methodology

The situational assessment was guided by the Evidence and Practice-based Planning Framework (EPPF). This framework was developed by Region of Waterloo Public Health to outline key stages in program or policy planning and modification. The framework offers a continuous cycle with seven main steps to guide program or policy planning, development, implementation and evaluation. The EPPF process combines sound decision making with multiple sources of evidence; as a result, decisions made regarding modifications to, or development of, programs have a strong and documented rationale.

In Spring 2014, a project team consisting of staff from Public Health and SHORE (Sexual Health Options, Resources Education) Centre (formerly Planned Parenthood Waterloo Region) was established. Team members collaborated on the planning, implementation, synthesis and interpretation of the information, and writing the final report.

The research questions were answered using the following strategies:

- Literature review
- Environmental scan: programs and services offered in Waterloo Region

- Environmental scan: Comparator health regions
- Survey of parents in Waterloo Region about parent-child sexual health communication

The findings from these four components of the situational assessment are presented in this report.

2.0 Literature Review

2.1 Methodology

A search for peer reviewed articles was conducted using various terms related to parent or guardian communication with children about human development and sexual health. Additional articles were located in the reference sections of some articles, as well as through targeted searches related to priority groups identified in the Sexual Health Youth Strategy (see Appendix 1).

A total of 106 articles were identified for review. Each article was appraised using a standard critical appraisal tool (see Appendix 2) to assess the quality of the study and its relevancy to the research questions. After all appraisals were completed, 34 articles were included in the literature review. Of these, five are systematic reviews representing findings from multiple high quality studies.

2.2 Results

2.2.1 Introduction

A number of overarching themes emerged in the literature about parental involvement in the sexual health education of their children and youth. The current portrait of sexual health education in households is strongly supported by research to include a few key characteristics. In particular, the research shows mothers as having the primary responsibility of providing sexual health support and information; sons receiving less sexual health information compared to daughters; sexual health information being provided too late in relation to sexual activity; and the presence of a number barriers preventing high quality, ongoing parent-child communication about sexual health. The literature also shows that parents are very interested in improving their parent-child communication related to sexual health, but need support in doing so.

a) How well are parents doing?

A study involving over 4,200 parents in New Brunswick reported that only one-third of parents felt that the sexual health education they or their partner provided to their children was excellent (9 per cent) or very good (29 per cent). Almost one-quarter of parents felt they have only done a fair (19 per cent) or poor (5 per cent) job providing sexual health education to their children. Further to this, the range of topics being discussed with children was limited. The same study asked parents to report on the sexual health topics that they had discussed with their oldest child within the kindergarten to grade 8 age range. Personal safety and correct names for genitals were

the only two topics that parents reported to have discussed in detail, while information on puberty, reproduction, sexual coercion and assault, sexually transmitted infections, and abstinence were discussed in general terms only. Birth control methods and safer sex practices, sexual decision making in dating relationships, and sexual pleasure and enjoyment had not been discussed overall (22).

When asked about the role of parents in providing sexual education, the responses from youth are mixed. In a Canadian study of high school and middle school students' perspectives on sexual health education in school and at home, 77 per cent of high school students and 69 per cent of middle school students felt that sexual health education should be a shared responsibility between school and home. When asked about how their parents have done in providing sexual health education, nearly two thirds (63 per cent) of high school students gave ratings of excellent, very good or good; compared to 42 per cent of middle school students who gave ratings of excellent or very good. Slightly more than one third (37 per cent) of high school and middle school students indicated that their parents had only done a fair or poor job. Eighty per cent of high school and 76 per cent of middle school students reported they were never or rarely encouraged to ask questions about sexuality in the home. When asked about whether they wanted their parents to talk to them more about sex, almost half of high school students (46 per cent) either strongly disagreed or disagreed and another 40 per cent were neutral. Of the middle school students, 39 per cent either disagreed or strongly disagreed that they wanted their parents to talk to them more about sex and another 40 per cent were neutral (16, 17).

b) Challenges with identifying programs or services

Finding the 'best' program or service to improve the quality and frequency of parent-child communication is challenging given that many studies use different criteria to evaluate their program's effectiveness. However, the literature shows strong support that some programs and services can effectively improve communication about sexual health between parents and their children or youth (herein referred to as parent-child communication) (4, 6). There is less evidence, however, that such interventions make a significant impact on the sexual health behaviours of children and youth, particularly over the long term (4, 5, 6). Rather, the literature identifies that better parent-child relationships overall, including good parent-child connectedness, better parent-child communication overall, and positive parent-child interactions, can have some impact on risk-taking in adolescents, including sexual risk-taking (1).

With regards to sexual risk-taking specifically, parenting style appears to play a role in influencing behaviour among children and youth, as it relates to:

- parent-child communication and relationships (4, 7, 8);
- parental monitoring of their child's behaviour (9-11); and
- parental disapproval of sexual activity (12, 13).

While findings are inconsistent for the positive influence of a single parenting characteristic on sexual behaviour (5, 10), some characteristics appear to be more

important, particularly parental monitoring of a child's whereabouts and activities. There is also evidence to support interaction between the parenting factors (10, 11).

The findings from the literature will be described using the following four headings:

- Barriers to parent-child communication about sexual health;
- Parental/guardian factors associated with positive sexual health communication and/or outcomes;
- Programs or services that have some proven effectiveness related to improving parent-child communication about sexual health and/or positive sexual health outcomes in youth; and
- Specific differences seen in some population groups related to parent-child communication about sexual health.

Where possible, information from systematic reviews was used to inform this section of the report. In order to provide greater detail in some instances, findings from single studies conducted in Canada or single studies that addressed issues not captured in the systematic reviews were also included.

2.2.2 Barriers to parent-child sexual health communication reported by parents and youth

Parents recognize the importance of discussing sexual health with their children, but often struggle to do so. Some reasons for this include fear that they do not have the correct information about sexual health topics; fear that talking about sex may actually encourage sexual activity; conflict or ambivalence towards behaviours they encourage their adolescent to adopt versus what they know is more realistic or probable; embarrassment to discuss some topics; and the likelihood that mothers provide parent-child sexual health communication and fathers do not (4, 14, 15, 18, 21, 22, 23).

a) Knowledge

Parents fear that they do not have adequate knowledge to talk about sexual health with their children (14, 21, 23). Two studies highlighted parents' concerns with how little they had learned about sexual health from their parents and their desire to do better with their own children. Ironically, this was met with uncertainty about how to provide information to their children when they had no role model, or when they felt they did not have enough knowledge about the issues (14, 23). Further to fear about not having enough knowledge to talk with children and youth about sexual health, parents also consistently reported not knowing how to start conversations about sexual health, or expressed concern about whether they could handle questions that came up because of not having the right information (23, 24). A study from Thunder Bay asked parents to rate how they felt about discussing sexuality: 21 per cent reported not knowing where to start, while only 10 per cent reported not feeling equipped with the necessary information (24).

b) Involvement of fathers

Fathers are underrepresented in the literature on interventions related to parent-child sexual health communication, largely because mothers tend to assume the bulk of this

responsibility within households. A systematic review of interventions to improve parent-child communication about sex found only one intervention where primary participants were fathers. Of the remaining studies, one third were targeted to mothers, and despite the rest being targeted to both parents, mothers were the primary participants (4). Research shows that mothers are far more likely to communicate with their children about sexual health than fathers, and daughters are more likely to be recipients of communication than sons (14, 15, 18).

In a study of father-daughter communication about sexual health, fewer than 10 per cent of women indicated that their fathers prepared them “well” for dating and sexuality. When asked about barriers to father-daughter communication about sexual health, women discussed not have a good relationship to begin with, and their fathers’ struggle with seeing their daughters as sexual beings (18).

Research shows that the content of messages provided by fathers to their children are more likely to focus on healthy relationships, including topics such as dating, how to treat women, or how to expect to be treated, over other types of sexual health information (18-20). When asked about the variety of topics discussed, there was a significant difference in the mean scores of fathers’ reports of sexual health topics discussed compared to mean score of their daughters, with fathers reporting discussing a higher number of topics compared to daughters (20).

A study examining the timing and content of parent-child discussions about sexuality showed intended initiation of communication may be different for fathers compared to mothers. Not only did mothers intend to discuss sexuality at earlier ages, but they also anticipated being more effective (27).

c) Fear that talking about sexual health will encourage sexual activity

Concern that discussions about sex will encourage sexual behaviour was highlighted in the literature as a barrier to parent-child communication (15, 18, 21, 23). When parents in three different US cities were asked about problems they believed were associated with talking with children about sex, 32 per cent of respondents (n=131) were concerned that talking with their pre-adolescent children about sex might encourage them to have sex (23). This concern is not supported in the literature; rather, children whose parents discuss sexual health with them tend to delay becoming sexually active compared to children whose parents do not. Furthermore, once becoming sexually active, youth who engage in parent-child sexual health communication are more likely to adopt healthy sexual behaviours, including increased condom and other contraceptive use and fewer sexual partners (1, 7, 31).

d) Internal conflict

A qualitative study routinely observed uncertainty among mothers regarding how and when to talk with children about sex. Instructing children to abstain from sex until marriage, while knowing that this is unlikely and not part of their own personal experience was one area of internal conflict described by a number of parents. The study also highlighted the tension that mothers experience when advising their children

to resist sexual activity until marriage, while also providing information and access to contraception, “just in case” (15, 29).

e) Feelings of awkwardness and embarrassment

Numerous studies identified resistance on the part of children and youth as a significant barrier to parent-child communication about sex. Youths’ reactions to parents’ attempts at communication were reported to range from anger to annoyance or avoidance (15, 21, 23). Mothers also discussed their own embarrassment regarding not knowing how to start conversations or what to say when sexual health topics arise (15, 21, 23). In one study, a number of the participants reported feeling especially awkward talking with male children about sex. A number of qualitative studies found this discomfort to be related to a perception that it is not part of a mother’s role to talk about sex with their sons (14, 15, 29).

f) Fear of parental disapproval

Fear that talking about sexual health would result in their parents’ disapproval or disappointment emerged as a theme in a study from Nova Scotia. Female youth in particular indicated they did not talk openly with their parents for fear of not knowing how their parents would react to their questions, in addition to fear of upsetting their parents (14).

2.2.3 Parenting factors associated with positive sexual health communication and/or behavioural outcomes

The literature indicates that there are a number of factors within households that protect against sexual risk-taking among adolescents (1). While this report focuses on parent-child communication related to sexual health, the evidence suggests there is a combination of factors directly and indirectly related to parent-child communication that likely produce the positive effect. These include parental support and parental monitoring of children’s activities, among with other factors.

A systematic review which aimed to identify predictors (including parenting factors) of adolescent sexual behaviour discovered vast inconsistencies in the findings. After a strict screening criteria based on study methodology, the review found 69 studies that examined adolescent sexual behaviour. Table 1 provides a summary of the findings related to parenting characteristics. It is important to note that only one of the three most stable predictors of adolescent sexual activity and early initiation of intercourse is related to parenting (i.e. time alone with the opposite sex or being home alone without a parent). The other two stable predictors highlighted in the review include adolescents’ intentions or motivation to have sex and, to a lesser degree, perceived norms of sexual activity (i.e. peers’ sex behaviours, peers’ attitudes towards sex, and parental attitudes regarding sex) (13).

Table 1: Parenting factors associated with adolescent sexual behaviour

Parental factor	Findings (# of studies)
Involvement/closeness	<ul style="list-style-type: none"> • No effect (2) • Mixed effects (3)
Relationship quality	<ul style="list-style-type: none"> • Protective (1) • Mixed effects (2) • No effect (2)
Rules and strictness	<ul style="list-style-type: none"> • Protective effect (1) • No effect (2)
Support	<ul style="list-style-type: none"> • Protective effect (1) • Mixed effects (5) • No effect (7) • Risk factor (2)
Monitoring	<ul style="list-style-type: none"> • Protective effect (13) • Indirect protective effect; mediated through intention (4) • No effect (10)
Home alone/no supervision	<ul style="list-style-type: none"> • Risk factor (2)

Source: Buhi & Goodson (2007)

Given several studies found that increased parental monitoring exhibited a largely protective effect on sexual activity initiation, the authors further suggest parental monitoring as an area for focused inquiry.

Based on the findings summarized in Table 1, while somewhat inconsistent, monitoring and home alone/no supervision appear to be the most consistent parental predictors of sexual risk-taking in youth, with some aspects of parent-child relationships (support, closeness, quality) also potentially playing a role.

a) Parenting style

A literature review of parental influences on adolescent decision making and behaviours found some associations between parental communication, parenting style, and adolescent sexual activity and contraceptive use. The author highlights the research on a variety of factors related to adolescent decision making, including the influence of parent-child closeness on a variety of health outcomes, such as: sexual decision making; depression; substance use; and academic achievement. This type of parent-child relationship is mentioned as a thread throughout the research on good sexual decision making, with specific mention of the importance of parent responsiveness, having parents who are perceived by their children as warm and accepting, high family cohesion, and open communication that stresses responsibility and education.

Adolescents were more likely to refer to parents with an authoritative parenting style (demanding, responsive and monitoring) for moral decisions; whereas, adolescents with authoritarian parents (demanding but not responsive, expecting strict adherence to rules) were more likely to refer to peers for moral decisions (7).

A qualitative study examining parenting style and responses to children's sexual health questions identified a tendency for parents who typically have an authoritative parenting style to shift to an authoritarian style when faced with most questions about sex (50 to 78 per cent). The only topic area that resulted in a return to a more even split of parenting styles was puberty/body changes (28).

b) Parental monitoring of child's activities

The extent to which parental monitoring and supervision are associated with sexual risk-taking in youth is mixed in the literature, including systematic reviews. While Table 1 above summarizes these inconsistencies, another review found monitoring to decrease the risk of adolescent pregnancy more conclusively. Conversely, the review also found that less parental monitoring predicted early onset of sexual activity, less condom use, and for females, more sexual partners (7).

In their review, Kraus et al. suggest that the significant effect associated with parental monitoring is related to youth's perception of monitoring, rather than parent reports, indicating the importance of children's awareness that their activities are being watched. They also report that parental monitoring is most effective when it starts when children are young, if it demonstrates concern over distrust, and fosters responsibility (18).

Parental monitoring was also found to be a significant factor in lowering or reducing sexual risk-taking in other studies examining the relationship between adolescent risk-taking and parenting factors (10, 11, 25). One study found that adolescents who were closely monitored by their parents were more likely than their less monitored peers to demonstrate low sexual risk-taking, including having one partner and using a condom. The study also found that neither parent-adolescent communication nor parenting style demonstrated a direct relationship with sexual risk-taking; however, a significant interaction effect was found for parental monitoring and communication, resulting in lower risk-taking behaviours (10).

c) Timing of parent-child sexual health communication

Research suggests that parent-child discussions of some sexual health topics are provided too late in relation to children's sexual health behaviours. A study examining the timing of parent and child communication about sexuality relative to children's sexual behaviours broke sexual topics into three sets: the first coincides with the pre-sexual stage and includes topics such as menstruation, handholding and kissing. The second coincides with the pre-coital stage and includes topics such as genital touching and oral sex. The third typically occurs when children have initiated intercourse. The study findings indicate that over half of children engage in sexual touching before discussing the following with their parents: birth control, resisting partner pressure for sex, sexually transmitted (infection) symptoms, condom use, choosing birth control or partner condom refusal.

Over 40 per cent of children have intercourse before any discussing sexually transmitted (infection) symptoms, condom use, choosing birth control or partner condom refusal. While male and female children were vulnerable to this trend, males received

less information prior to engagement in sexual acts compared to females, with nearly two thirds (62.9 per cent) of males indicating that their parents had not talked about how to use a condom with them by the time they had initiated intercourse (26).

Similarly, a qualitative study of sexual health communication among black parents and children in Nova Scotia revealed that open and honest dialogue from an early age is a facilitator to later sexual health communication with children. Parents who reported good communication “insisted on the importance of laying the foundation for discussions about sexual health by speaking honestly and openly with their children about their bodies and sexuality from an early age using appropriate language” (p.6) (14).

2.2.4 Interventions to improve parent-child sexual health communication and/or sexual health outcomes in youth

Parent-child sexual health communication can be improved in quality, frequency and comfort through interventions targeting parents. The research findings show mixed support for different types of interventions, including workshops, peer-based, and multi-media; however, the evidence favours interventions that involve two or more sessions (as opposed to stand alone sessions), and which aim to improve the relationship and general communication quality between parents and children, rather than focusing on sexual behaviours alone (4).

A systematic review of interventions to improve parent-child sexual health communication uncovered only twelve studies (four of high quality), all based in the United States, that met inclusion criteria based on an 11-item methodological quality rating. Despite the low number of articles found, the review suggests that parent-adolescent communication interventions can have targeted effects, including improvements in the frequency and quality of sexual health communication, and greater comfort and self efficacy in talking about sexual health. Table 2 provides a summary of the interventions and their findings. The authors also discuss how parents’ approaches when talking with their children about sex may have a “tremendous impact” (p. 507). In particular, adolescents whose parents portray a non-judgemental stance, and engage in two-way conversation that is less directive, tend to report greater comfort when discussing sex with their parents (4)

Table 2: Summary of interventions to improve parent-child sexual health communication

Intervention	Site	Participants	Findings (P – parents; C – child/adolescent)
Keepin' in REAL*	Community	African-American (97 per cent)	<ul style="list-style-type: none"> Increased communication frequency when participated in >2 sessions (P,C) Increased number of topics discussed (P) Greater intention to discuss topics (P) Greater comfort to discuss topics (P)
Facts and Feelings*	Home	Caucasian American (95 per cent)	<ul style="list-style-type: none"> Increased communication frequency for video only and video and newsletter (P,C) Increased quality of communication (P)
Parents Matter!	Multi-site	African American (100 per cent)	<ul style="list-style-type: none"> Improved self-efficacy when participated in >2 sessions (P,C)
Strong African American Families*	Community	African American (100 per cent)	<ul style="list-style-type: none"> Increased number of topics and degree of detail discussed (P)
REAL men ^α	Community	African-American (97 per cent)	<ul style="list-style-type: none"> Inconsistent, non-significant increases in number of new topics discussed (P,C) Greater intention to communicate at 12 mo post-intervention, but not at 3 or 6 mo (P) Increased self-efficacy (P)
Talking Parents, Healthy Teens ^α	Worksite	Diverse	<ul style="list-style-type: none"> Increased number of new topics discussed (P,C) Increased number of repeat topics discussed (P,C) Improvement in communication openness (P,C)
Saving Sex for Later ^α	Home	Diverse (64 per cent African American)	<ul style="list-style-type: none"> Less likely to report low communication levels (P) Less likely to report low self-efficacy levels (P)
Huston ^α	School	Diverse	<ul style="list-style-type: none"> Increased communication frequency (P)
CHAMP ^α	Multi-site	African American (100 per cent)	<ul style="list-style-type: none"> Increased communication frequency (P) Increased comfort (P)
Lefkowitz ^α	NA	Diverse	<ul style="list-style-type: none"> No difference in communication frequency (P,C) No increase in communication topics discussed (P) Increased communication skills in multiple areas (P)
Families in Touch ^α	Home	Diverse	<ul style="list-style-type: none"> Increased communication frequency (P)
Parent, Young Adolescent Family Life Education Project ⁺	Multi-site	Diverse (77 per cent Caucasian American)	<ul style="list-style-type: none"> Small difference in attitude towards communication about sex (P)

*: studies considered by the authors to be of "high quality"; α: studies of medium quality; +: studies of low quality

(Source: Akers, Holland & Bost, 2010)

While programs or services to improve parent-child sexual health communication have some degree of effectiveness, a systematic review of parent and family-based program effectiveness shows that improved sexual health communication alone may not be enough to result in improved sexual health outcomes in youth. Rather, the authors found preliminary evidence that effectiveness was greater in studies aiming to address multiple risk behaviours. While the reason for this was unknown, the authors hypothesised that it may be because of the longer and more intensive nature of such programs. In addition, there is positive (though somewhat inconsistent) evidence suggesting that parent-based programs and services have higher success rates compared to family-based interventions, which had little impact on adolescent behaviour overall (5). Table 3 provides an overview of the evidence by intervention type.

Table 3: Intervention type and impact on parent-child communication and risk-taking behaviours

Intervention Type	Communication outcomes	Behavioural outcomes
Interactive parent education (multi-component)	strong	inconsistent
Interactive family-based education	moderate	no effect
Other: theatre, web-based, peer	moderate	unknown

Source: Downing, Jones, Bates & Sumnall (2011)

2.2.5 Differences seen in specific population groups related to parent-child sexual health communication

There are some discrepancies among specific youth population groups in terms of the sexual health communication they receive from parents. Youth who are male; lesbian, gay, bisexual or transgendered (LGBT); live in rural areas; have intellectual disabilities; are from households with strong conservative or religious beliefs; or are immigrants may have specific needs related to communication about sexual health that are not being addressed or met.

a) Males

The literature consistently shows that male children tend to receive less information related to sexual health from their parents. Further to this, the information they do receive comes at a later time compared to females (15, 26, 29). There are two main challenges that appear to prevent good parent-son sexual health communication. The first relates to the role of mothers in providing sexual health information to children. Across all studies, without exception, mothers have been identified as being the main provider of information related to sexual health. While this unequal distribution of sexual health communication roles alone may not be concerning, a number of studies showing resistance on the part of male children in discussing sexual health topics with mothers, and discomfort on the part of mothers in discussing sexual health topics with sons, which likely contributes to the issue (14, 15, 29).

A qualitative study of mother-child sexual health communication found that just one third of mothers interviewed were comfortable talking with their sons. The theme emerged in the context of speaking with sons about sexual health in general, as well as about male-specific topics (e.g. nocturnal emissions). The opinion that fathers should talk with sons about sexual health, or that it is not appropriate for mothers to take on that role seemed to be an underlying value for some mothers (15). Lack of personal knowledge about the male body or male feelings was another reason cited (15, 29).

b) Youth who are lesbian, gay, bisexual or transgendered

For the most part, the literature does not address parent-child sexual health communication as it relates to youth who are lesbian, gay, bisexual or transgendered (LGBT). A systematic review of parental influences on the health and well-being of LGBT youth identified a lack the research and programs related to parental influences on health of LGBT youth. The authors also observed that within the existing research, there was a trend to focus on negative over positive parental influences (12). Given that so little is known about parental communication with children who are LGBT, and that parents of heterosexual children tend to struggle with communicating about sex, it may be fair to assume that communicating about sex with LGBT children poses an even greater challenge for parents.

Similar to research focusing on the general population, Bouris et al. found an association between parent-child connectedness and LGBT youths' sexual behaviour. In addition, parental disapproval of sexual behaviour was specifically associated with older age of sexual debut; a finding consistent with children in the general population. Parent rejection during adolescence, which may be more common to the experiences of LGBT youth, was positively associated with sexual risk behaviours in adolescence, with "high levels of rejection emerging as particularly important" (p.301) (12).

c) Youth who live in rural areas

Most articles do not identify parents and youth living in rural areas as a population requiring more support related to sexual health communication. However, two articles referencing one study that examined rural women's perspectives on issues related to sexual health highlight certain challenges that are unique to living in rural contexts. Similar barriers were identified by mothers in rural areas as those identified in other studies of the general population (15, 21, 23). These included lack of interest among daughters, shyness and embarrassment for both daughters and mothers, mothers' perceived lack of knowledge, feeling that talking about sex may encourage sexual activity, and difficulty seeing daughters as sexual beings. Additional barriers were mentioned when mothers were asked specifically how living in a rural area can be a factor in their daughter's sexual risk-taking and/or access to sexual health services. These include conservatism or 'traditional' attitudes of local health care providers, fewer options for access to contraception, limited availability of information via the internet due to poor access, lack of privacy (e.g. more likely to know the staff at the local pharmacy), fear of stigma (e.g. being labelled sexually active), and fewer public spaces for youth which increases the likelihood of spending time in homes of other adolescents and the potential for risk-taking behaviours to happen "behind closed doors", including alcohol

and substance use, and/or sexual activity (21, 30). While these barriers do not directly relate to parent-child communication, it is possible that youth in households with low levels of sexual health communication may have fewer options for accessing sexual health information and services, and potentially more opportunities to be involved in private situations involving risk.

d) Individuals with intellectual disabilities

Individuals with intellectual disabilities experience the same range of sexual health needs as other people; however, they may not be able to communicate these needs and may struggle with learning appropriate sexual behaviour. Individuals with intellectual disabilities may also be more vulnerable to engaging in inappropriate sexual behaviours and experiencing sexual abuse (33, 34). Parents of individuals with intellectual disabilities face unique challenges in communicating with their children about sexual health. Some barriers that parents have expressed include: uncertainty about their child's ability to comprehend the information, belief that sexual health topics are not relevant to their child, and anxiety that their child may overgeneralize the information shared (33). In a study conducted by Ballan (2011), among parents who reported that they have discussed sexual health with their child with an autistic spectrum disorder, the majority of discussions were focused on sexual abuse and hygiene issues and did not cover the full range of sexual health topics. Targeted approaches are needed to support the sexual health communication needs of parents of children with intellectual disabilities (33, 34).

e) Youth from households with strong conservative or religious beliefs

Religiosity was found to be associated with less open and frequent communication about sex between parents and children (28). It is also associated with starting communication at a later age compared to the general population (27). However, being religious is shown to be a protective factor against sexual risk-taking overall (1). Similar to youth living in rural areas, it is possible that children from strong religious households who would benefit from receiving sexual health information and support at home (i.e. those who are sexually active) may not have access to such information and support from their parents.

f) Youth who are immigrants

Similar to religiosity, country of origin has been shown to influence parental attitude toward sexual health communication in the home. Depending on the person's country of origin and cultural beliefs, sexuality may not be seen as being appropriate to discuss with children and thus, youth who are immigrants, or whose parents are immigrants, may experience less parent-child sexual health communication (28). It should be noted; however, that immigrant youth may be less likely to engage in risky sexual behaviours due to other protective factors, including increased parental monitoring and religious affiliation (1).

2.3 Summary

Downing et al. (2011) explains that while sexual health communication is something that can be influenced through intervention, ultimately, it is not likely to lead to improved sexual health behaviours and outcomes in youth.

Generally, interventions showed more consistent effectiveness at improving the modifiable factors of risk taking, such as sexual communication. However, there was no evidence to suggest that improved communication, even in the long term, has an effect on sexual risk behaviours of intervention youth (p. 829) (5). While that should not negate the importance of good sexual health communication between parents and children entirely, program developers should be careful to not overestimate the potential impact of interventions to improve sexual health communication (4).

Multiple factors influence sexual risk-taking in youth, many of which do not relate to parenting practices. Furthermore, research indicates that interaction between factors influencing risk-taking can either magnify or mitigate their impact. The following lists include protective and risk factors associated with adolescent sexual risk-taking (1):

Risk factors:

- Having peers who approve of sexual activity and/or are sexually active
- Having an older partner, older friends
- Having peers who use alcohol, substances
- Having peers with pro-childbearing attitudes
- Experiencing family disruption (e.g. divorce)
- Living in a household with problematic alcohol or substance use
- Experiencing physical abuse or general maltreatment
- Having an older sibling who engaged early in sexual behaviour
- Dating, in a close relationship, having a new sexual relationship
- Frequent engagement in sexual activity
- Previous pregnancy
- Same-sex attraction

Protective factors:

- Living with two parents
- High quality family interactions, connectedness, satisfaction with relationships
- Greater parental supervision and monitoring
- Parental disapproval of premarital sex or teen sex
- Parental acceptance of contraception use for sexually active teens
- Greater parent-child communication about sex and condoms or contraception, before teens initiates sex
- Positive peer norms for condom, contraception use, use of condoms
- Partner support for contraception use, discussion about sexual risks
- Greater connectedness to school, better school performance, having higher education aspirations
- Having a religious affiliation, greater connectedness to community

- Greater internal locus of control
- Greater confidence in using, motivation to use and intent to use condoms
- Greater perceived negative consequences of pregnancy
- Older age at first sex

3.0 Environmental Scan: Waterloo Region

3.1 Methodology

In December 2015, community agencies in Waterloo Region that provide programs and services related to sexual health were reviewed, and those with a mandate to provide services to parents were selected for further investigation. Websites of the selected agencies were reviewed for any program, service, or support that addressed communication between parents and children. Follow-up phone calls were made to solicit more details about the programs and services as required.

The following five agencies in Waterloo Region were identified as providing support specific to sexual health communication with children:

1. Grand River Unitarian Congregation
2. K-W Counselling
3. Region of Waterloo Public Health and Emergency Services
4. Sexual Assault Support Center Waterloo Region
5. SHORE Centre

3.2 Findings

Table 4 provides a summary of services and supports provided in Waterloo Region related to sexual health communication with children. It is important to note that the table does not include one-to-one counselling services unless the service is promoted as a specific sexual health support for parents. Workshops and seminars were the most commonly provided supports; although, not all workshops were specific to sexual health topics.

Table 4: Sexual health services and supports for parents in Waterloo Region (December 2015)

Agency	Workshop	One-to-One support ³	Resources	Cost	Target population(s) ⁴	Program Description(s)	Type of Access	Frequency
Grand River Unitarian Congregation	◆			Yes	Children and youth	<ul style="list-style-type: none"> Our Whole Lives (OWL) program: comprehensive coverage of sexual health topics; parents do not participate but receive a talk on how to be “askable” parents at the start of the program 	Members only	When participant numbers allow
K-W Counselling	◆			No	General parent/ guardian population	<ul style="list-style-type: none"> 2-hour seminars on developing healthy parent-child relationships Sexual health topics are not addressed specifically 	Universal	According to annual schedule
Region of Waterloo Public Health & Emergency Services			◆	No	General parent/ guardian population	<ul style="list-style-type: none"> “The Talk” From Tots to Teens resource (stand alone and adapted for the Parent-Child Resource Guide) Sexual Health Education Begins at Home: How to talk to your children about sexual health resource Changing Me Puberty Kit 	Universal	On-going
Sexual Assault Support Centre Waterloo Region	◆		◆	No	Women who are immigrants; Families with children who have been victims of sexual abuse; Male youth	<ul style="list-style-type: none"> Program for women who are newcomers with focus on sexual abuse Displays available for parents’ night at schools related to sexual assault Taylor the Turtle sexual abuse prevention program Programs for males with focus on healthy masculinity, healthy relationships 	Universal	Regular
SHORE Centre	◆	◆	◆	No	Not specifically targeted to parents	<ul style="list-style-type: none"> Workshops on various sexual health topics often provided to existing groups and school classes Client support program Book resource list 	Universal	Upon request

³ Includes one-to-one support specifically promoted as a sexual health service; does not include general family or individual counselling.

⁴ Only workshops related to parent-child communication were included. Agencies may offer additional supports targeting other populations (e.g. educators).

3.2.1 Seminars and Workshops

Workshops or seminars are provided by four agencies in Waterloo Region. Workshops provided by three of these agencies are open to the public. Sexual Assault Support Centre Waterloo Region and SHORE Centre provide workshops that relate specifically to some aspect of sexual health; whereas, workshops provided by K-W Counselling are aimed at improving parent-child communication overall, with sexual health being discussed only if brought up by participants. Workshops offered by the Sexual Assault Support Centre focus on topics related to sexual abuse/violence, in addition to more general workshops on healthy sexuality targeted towards males. SHORE Centre provides workshops for parents through community agencies, with past workshop locations including YMCA Immigrant Services (Immigrant Women Together), YMCA Ontario Early Years Centres and Monica Place.

The Grand River Unitarian Congregation offers 'Our Whole Lives', a multi-session sexual health education program, to congregation members who are children or youth. A comprehensive list of sexual health topics are covered throughout the sessions which are planned according to participants' ages. Parents do not attend the sessions but receive a brief talk at the beginning of the workshops on how to be an "askable" parent.

3.2.2 Counselling Services

SHORE Centre provides one-to-one counselling to parents who are seeking confidential assistance about talking to their child(ren) about sexual health through their Client Support Program. Through this service, parents are able to receive support in-person, over the phone or through e-mail.

3.2.3 Resources

The identified local community agencies have a variety of resources available for helping parents talk to children about sexual health. SHORE Centre has developed a resource that highlights books that effectively assist parents to talk to their child(ren) about sexual health. Sexual Assault Support Centre Waterloo Region (SASC) offers a resource –Taylor the Turtle – that parents can use to help facilitate discussions with their child about their rights, specifically with regards to sexual violence. SASC also offers resources through the Male Allies Program that provide assistance to parents in talking with their child(ren) about developing healthy, equal relationships. These two organizations provide community outreach by distributing these resources and additional information at various community events such as Waterloo Region Police Services open house day, and parent nights at schools in Waterloo Region.

Developed as a component of the Sexual Health Youth Strategy, Region of Waterloo Public Health distributes "The Talk" From Tots to Teens resource, which outlines age and developmentally appropriate topics related to human development and sexual health for parents to discuss with their children. This resource is available in an adapted format through the Parent-Child Resource Guide and is also available online. The Public Health website also includes a resource titled Sexual Health Education Begins at Home: How to talk to your children about sexual health, the Changing Me Puberty Kit, as well as links to other external resources. Use of the resources has not been evaluated.

4.0 Environmental Scan: Comparator Health Units

4.1 Methodology

In June 2014, a number of Ontario public health units were invited to complete a short electronic survey pertaining to supports they provide to parents regarding parent-child sexual health communication. Health units were invited to participate if they were either a comparator health unit⁵ or if they were part of the Central West Sexual Health Network. Table 5 lists the health units that were contacted.

Table 5: Health units invited to complete a survey

Comparator Health Units	Additional Health Units that are part of the Central West Sexual Health Network (Non-comparator)
Durham Region	Haldimond-Norfolk
Halton Region	Hamilton
Ottawa	Niagara
Simcoe-Muskoka	
Wellington-Dufferin-Guelph	

Findings from the survey do not include information from two comparator health units listed above. One comparator health unit indicated they do not currently provide support to parents on this topic area, while the other was unable to complete the survey.

4.2 Findings

4.2.1 Supports provided by Public Health Units

All of the health units surveyed reported providing some type of parent-child sexual health communication support. The range of supports provided across health regions includes:

- Online resources
- Booklets/books
- Pamphlets
- Newsletters
- Media campaigns (e.g. radio, billboards)
- Parent group sessions on puberty
- Community resource guides
- Phone support (e.g. Parent Talk Line, Kids Line)
- Referrals
- School nurse; and
- A parent conference.

In one non-comparator health unit, school nurses provide support to parents by phone, in addition to providing support to teaching staff, school administrators and students.

⁵ Region of Waterloo is included in Peer Group B among other health regions with similar socio-demographic and geographic characteristics, as defined by Statistics Canada <http://www.statcan.gc.ca/pub/82-221-x/2011002/regions/hrt3-eng.htm#b1> (Ontario only)

This health unit also provides a Parent Talk Line which is staffed by a Public Health Nurse during business hours. A phone line service is also offered by one comparator health unit. The Kids Line is available for parents to speak with a Public Health Nurse about parenting and child development questions. The health unit reports that if the topic of sexual health is brought up or the need is identified, the nurse will discuss age-appropriate sexual behaviour and discuss communication strategies that promote healthy sexuality. Similar to the non-comparator health unit, this service is offered Monday to Friday during business hours.

In another non-comparator health unit contacted, articles on HPV and how to talk to you child about sexual health are included in the elementary school newsletter which is sent home with students twice a year. This health unit has also produced radio ads targeted to parents on sexual health topics which are aired on a local station.

The Oral Health program at one comparator health unit provides a booklet entitled 'All Access Path to a Healthy Mouth, Healthy You'. This booklet is distributed to some schools and is available on the health unit's website and at their clinic. The booklet includes a wide range of topics, such as tobacco use; oral sex; oral piercings; eating disorders; herpes; and depression, stress and anxiety. It is intended for use by parents and children 13 years of age and older. Online and print resources are also provided to parents on talking to their child or teen about sexuality through a second comparator health unit. The resources include general information, answers to commonly asked questions, and links to external resources.

An annual parent conference is offered in one non-comparator health region, focusing on a different sexual health topic each year. Attendance at the events has ranged from 200 to 600 parents depending on the year, with parents of tweens (approximately 10 to 13 years) making up the highest percentage of attendees. Community partners, including school administrators, support the conference by promoting it to parents, particularly those who may be underserved. This health unit also distributes booklets to children in grades 5 through 8 which align with the Ontario Health and Physical Education curriculum and provides tips for parents. Additionally, the health unit produces booklets that are given to grade 8 students in both the public and Catholic boards on graduation night. The booklet is not tied to the curriculum and is also available online.

4.2.2 Consultation with families by Public Health Units

Of all health units contacted, only one non-comparator health unit indicated having formally consulted with parents about their parent-child sexual health communication support needs. This was in the form of an evaluation of their annual parent conference. One section of the evaluation asked parents to provide suggestions for improvements and ideas for topics for future conferences. The impact or effectiveness of the parent conference has not been evaluated.

4.2.3 Engaging parents to develop and/or provide sexual health communication supports

Of those surveyed, just one non-comparator health unit indicated some level of parent engagement in developing and/or providing sexual health communication supports. Specially, they indicated that parents have participated on their Sexual Health Network, a coalition of interested community groups, organizations and individuals committed to working together to assist young people and parents in the area of sexual health. There was no recruitment of parents to join the network; parents simply joined after hearing about the network via word of mouth.

4.2.4 Partnering with community agencies to develop and/or provide sexual health communication supports

Various community partners with a mandate to support children and their parents are members of one non-comparator health unit's Sexual Health Network. One comparator health unit also reported collaborating with school boards, other Public Health department programs and community agencies to solicit feedback on program development and delivery.

4.2.5 Priority populations identified for parent-child sexual health communication strategies by Public Health Units

All of the health units took a universal approach when providing sexual health supports to parents. One non-comparator health unit reported working with partners to recruit underserved parents; however, no formal processes to identify priority populations were shared by this, or any other, health unit.

5.0 Parent-child sexual health communication survey

5.1 Methodology

A questionnaire was developed by the project team to survey parents about their current parent-child sexual health communication practices, and to determine how to better support Waterloo Region parents when talking with their children about human development and sexual health (herein referred to as sexual health).

The target population for the survey was parents, step-parents and guardians of children and youth up to 18 years of age residing in Waterloo Region. This population was recruited through a number of strategies, including promotion through Public and Catholic school boards, Ontario Early Years Centres, licensed daycares, a media release and ROWPHE social media accounts (Facebook, Twitter). Additional efforts were made to focus promotional activities through community leaders and organizations that reach diverse parents groups, including Monica Place, YMCA Immigrant Services, and Kinbridge Salvation Army.

Parents with more than one child 18 years of age or younger were asked to answer the survey as it related to their child with the next birthday.

The survey was available online through Region of Waterloo's survey tool — iSurvey — and in print, when requested, between February and October 2015.

5.2 Limitations

Participants were recruited to the survey by convenience sampling, and as a result we are unable to determine an accurate response rate. Furthermore, our results are not generalizable to all Waterloo Region parents as we did not methodically sample parents from a variety of backgrounds. Where possible, we have provided comparisons between the demographics of survey participants and those of Waterloo Region residents overall. The survey was offered in English and may have been a challenge for some parents to complete.

The parent survey is also limited by self-reported data. There is a tendency for individuals to respond in a manner that would be viewed favourably by others (i.e. social desirability bias). This can lead to over-reporting or under reporting (for sensitive questions such as income). There is also a potential for recall bias with self-reported data, as participants reported on experiences that occurred in the past.

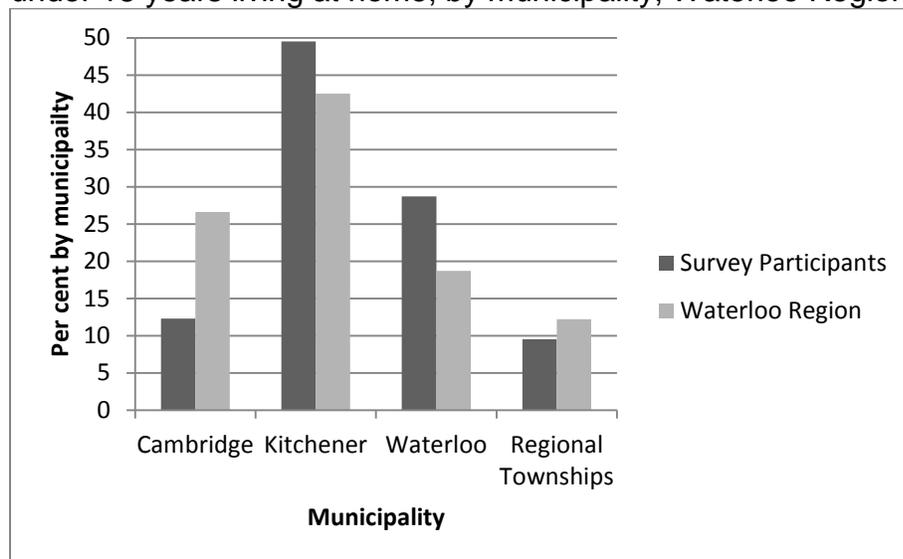
5.3 Results

Note: Differences noted between groups throughout the results section are statistically significant. Per cent totals may not add to 100.0 due to rounding.

5.3.1 Participant demographics

A total of 917 surveys were completed by parents in Waterloo Region. Participants included parents from all three municipalities (Cambridge, Kitchener, Waterloo) as well as the regional townships (North Dumfries, Wellesley, Wilmot, Woolwich), with slightly higher representation from Kitchener and Waterloo and lower representation from Cambridge and the townships overall compared to population proportions (Figure 1).

Figure 1: Place of residence of survey participants¹ and families with at least one child under 18 years living at home, by municipality, Waterloo Region²



Source: ¹Parent-Child Communication Survey (2015); ²Statistics Canada, 2011 Census

Half (50.8 per cent) of parents who completed the survey were 35 to 44 years old. The next most common age group was 25 to 34 year olds (28.0 per cent), followed by 45 to

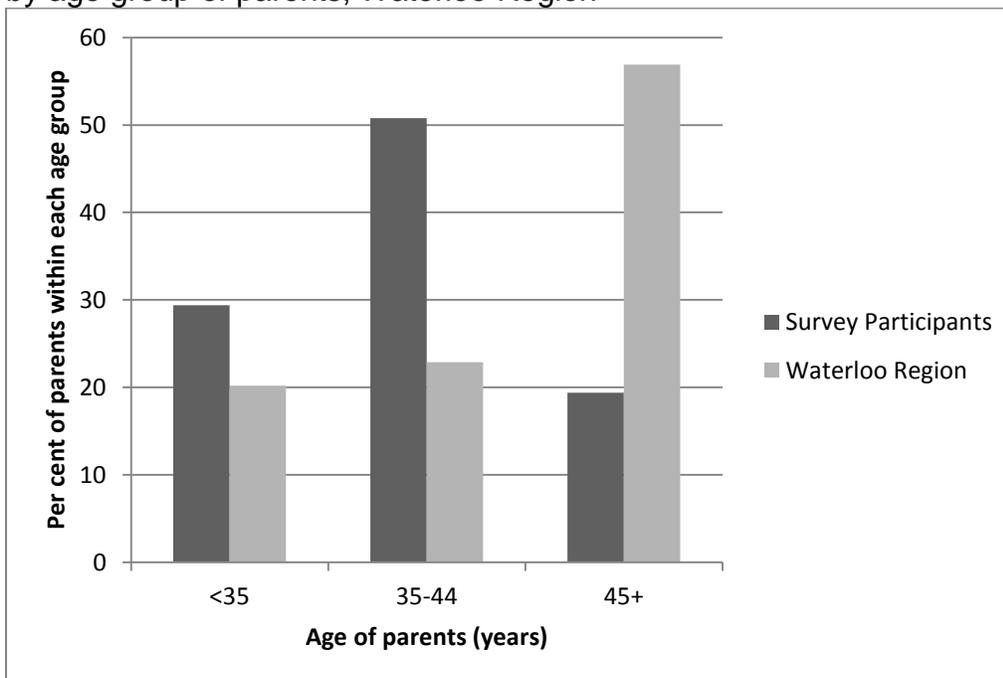
54 year olds (18.4 per cent). Very few respondents were under 25 years (1.4 per cent) or over 54 years (1.0 per cent).

Table 6: Number and proportion of survey participants by age group

Age group (years)	Count	Per cent
0-24	13	1.4
25-34	257	28.0
35-44	466	50.8
45-54	169	18.4
55 or older	9	1.0
Missing	3	0.3
TOTAL	917	99.9

To facilitate further analysis of the influence of parent's age on parent-child sexual health communication, age ranges were collapsed into three groups: 34 years or younger, 35 to 44 years, and 45 years or older. Compared to the overall population of parents in Waterloo Region, survey participants were more likely to be younger than 35 years or 35 to 44 years and less likely to be 45 years or older (Figure 2).

Figure 2: Age of survey participants¹ and parents with at least one child living at home, by age group of parents, Waterloo Region²



Source: ¹Parent-Child Communication Survey (2015); ²Statistics Canada, Income Statistics Division, 2011, Annual Estimates for Census Families and Individuals

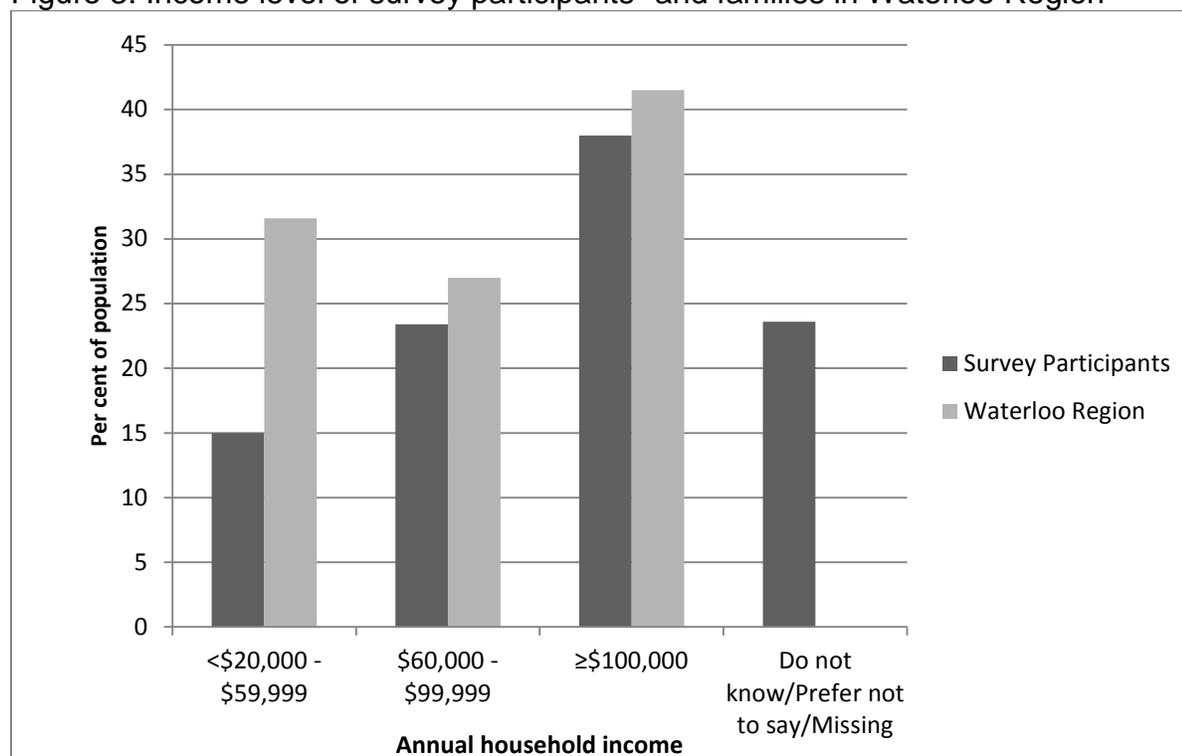
The majority of survey participants were female (86.5 per cent), Canadian born (75.7 per cent), and were part of a parenting couple (87.0 per cent). A large majority (76.3 per cent) of participants had completed a post-secondary degree (Table 7).

Table 7: Number and proportion of survey participants by level of education

Education level	Count	Per cent
Less than high school diploma	13	1.4
High school diploma	42	4.6
Some college or university	71	7.7
College or university degree, diploma or certificate	483	52.7
Graduate or professional degree	217	23.7
Missing	91	9.9
TOTAL	917	100.0

Of those who responded, the most commonly reported annual household income level was greater than \$100,000 (38.0 per cent), followed by \$60,000 to \$99,000 (23.4 per cent) and <\$20,000 to \$59,999 (15.0 per cent). Nearly one quarter (23.6 per cent) of participants did not report their annual income, which makes it difficult to compare the overall distribution of income levels among participants to that of the general population of parents in Waterloo Region (Figure 3).

Figure 3: Income level of survey participants¹ and families in Waterloo Region²



Source: ¹Parent-Child Communication Survey (2015); ²Statistics Canada, 2011 Labour Force Survey

Parents were asked to respond to the survey as it relates to their child with the next birthday at the time of the survey. Just over half (53.5 per cent) of respondents had a child age zero to eight years, while 45.9 per cent of respondents had a child age nine to 18 years.

5.3.2 Parent-child sexual health communication

The survey results showed that 674 (73.5 per cent) of parents reported that they have discussed some aspect of human development and sexual health (herein referred to as sexual health) with their child (Table 8).

Table 8: Number and proportion of survey participants by parent-child sexual health communication

Have you ever discussed sexual health topics with your child?	Count	Per cent
Yes	674	73.5
No, but I intend to	225	24.5
No, and I do not intend to	18	2.0
TOTAL	917	100.0

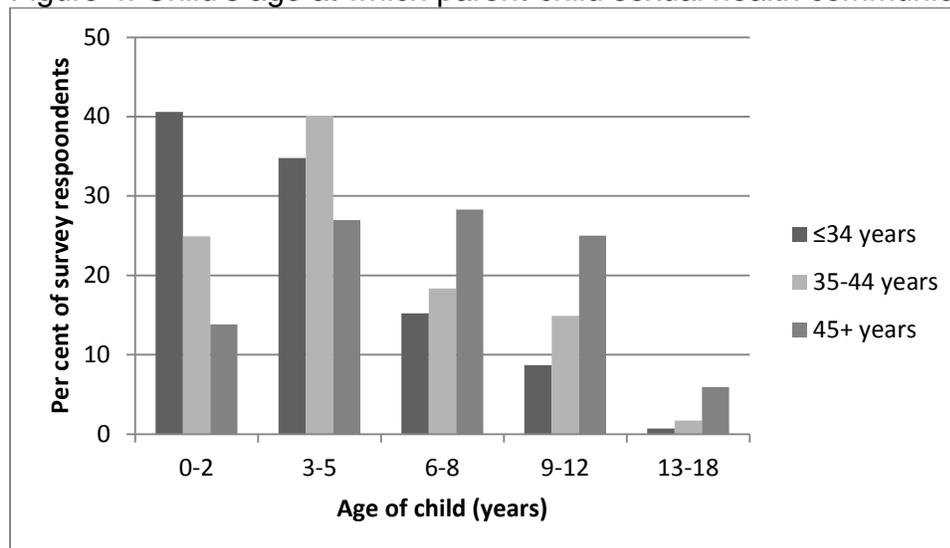
To obtain a better understanding about these conversations, parents were asked to provide input on several aspects of their experiences, including details about initiation of these discussions, specific topics discussed, and any differences between discussions with male and female children.

a) Initiation of parent-child sexual health communication

When parents were asked at what age they began discussing sexual health with their children, the most commonly reported time to start conversations was between the ages of three and five years old. Most parents (77.6 per cent) reported that they started talking to their child about sexual health before the age of nine.

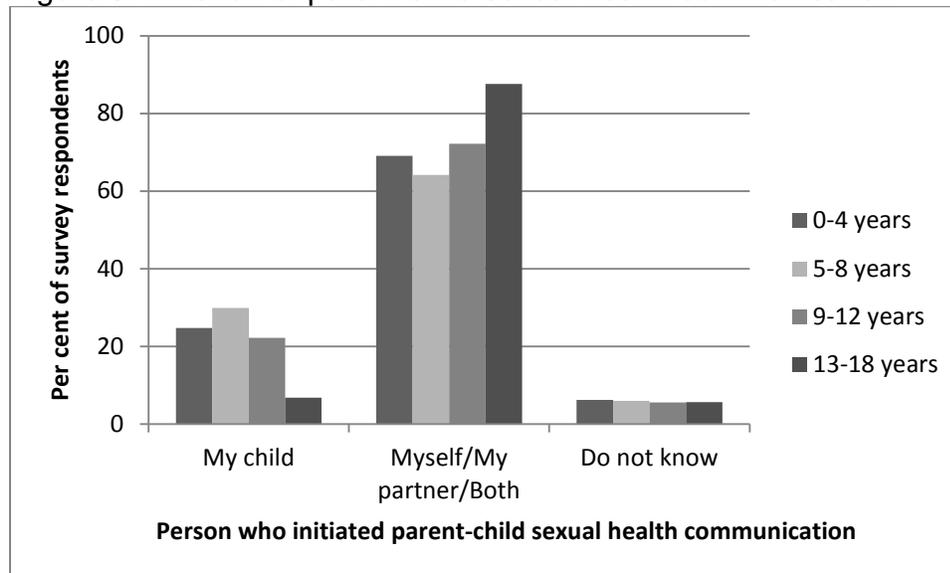
The age at which parents began discussing sexual health topics with their child was influenced by the age of the parent, with parents 34 years or younger being more likely to begin discussing sexual health when their child was two years old or younger than parents aged 35 years or older. Conversely, older parents (aged 45 years or older) were more likely than parents younger than 35 years to begin discussing sexual health when their child was between the ages of nine to 12 years (Figure 4).

Figure 4: Child's age at which parent-child sexual health communication was initiated



Parents most commonly reported that they had been the one to initiate the first sexual health discussion with their child (47.9 per cent). Nearly one-fifth of the time, the child (19.4 per cent) or both parents (19.4 per cent) initiated the conversation. This was influenced by both the age of the parents and the age of the child, with older parents (45 years or older) and those with younger children (12 years or younger) being more likely to report that one or both parents initiated the first sexual health discussion with their child (Figure 5).

Figure 5: Initiation of parent-child sexual health communication



When asked about who takes responsibility for parent-child sexual health conversations, more than one third (36.2 per cent) of parents indicated that one parent is exclusively responsible for discussing sexual health with their child, while 57.0 per cent indicated that both parents are involved in these discussions.

b) Sexual health topics discussed

Parents were asked about which sexual health topics they have discussed with their child. Analysis was conducted on the responses according to the child's age; less than nine years and nine to 18 years.

The most commonly discussed topics among parents of children less than nine years included:

- correct names for body parts;
- healthy relationships;
- similarities and differences between boys and girls; and
- teaching your child 'your body belongs to you' and to say no to behaviours that make them uncomfortable.

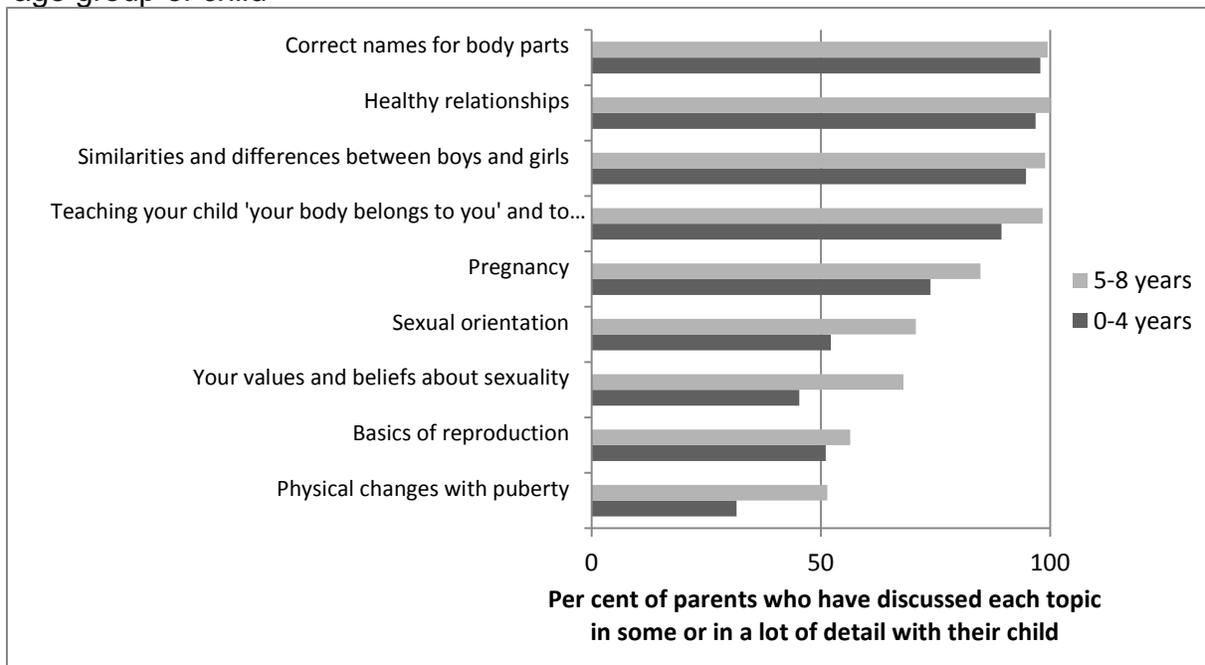
The least likely topics to have been discussed by these parents were:

- physical changes with puberty;
- basics of reproduction;

- values and beliefs about sexuality; and
- sexual orientation.

The level of detail in which parents discussed certain topics with their children also varied according to the age of their child. Parents of children age five to eight years were more likely to report discussing the following topics in some or in a lot of detail with their children compared to parents of less than five year olds: values and beliefs about sexuality; physical changes with puberty; pregnancy; and sexual orientation (Figure 6).

Figure 6: Topics discussed with children less than nine years in some or a lot of detail, by age group of child



Among parents of nine to 18 year olds, the most commonly discussed sexual health topics included:

- treating others with respect;
- correct names for all body parts;
- personal safety;
- self esteem; and
- peer pressure.

Conversely, topics that parents were least likely to have discussed with their nine to 18 year old child included:

- oral sex;
- masturbation;
- birth control and condoms;
- pornography; and
- sexually transmitted infections.

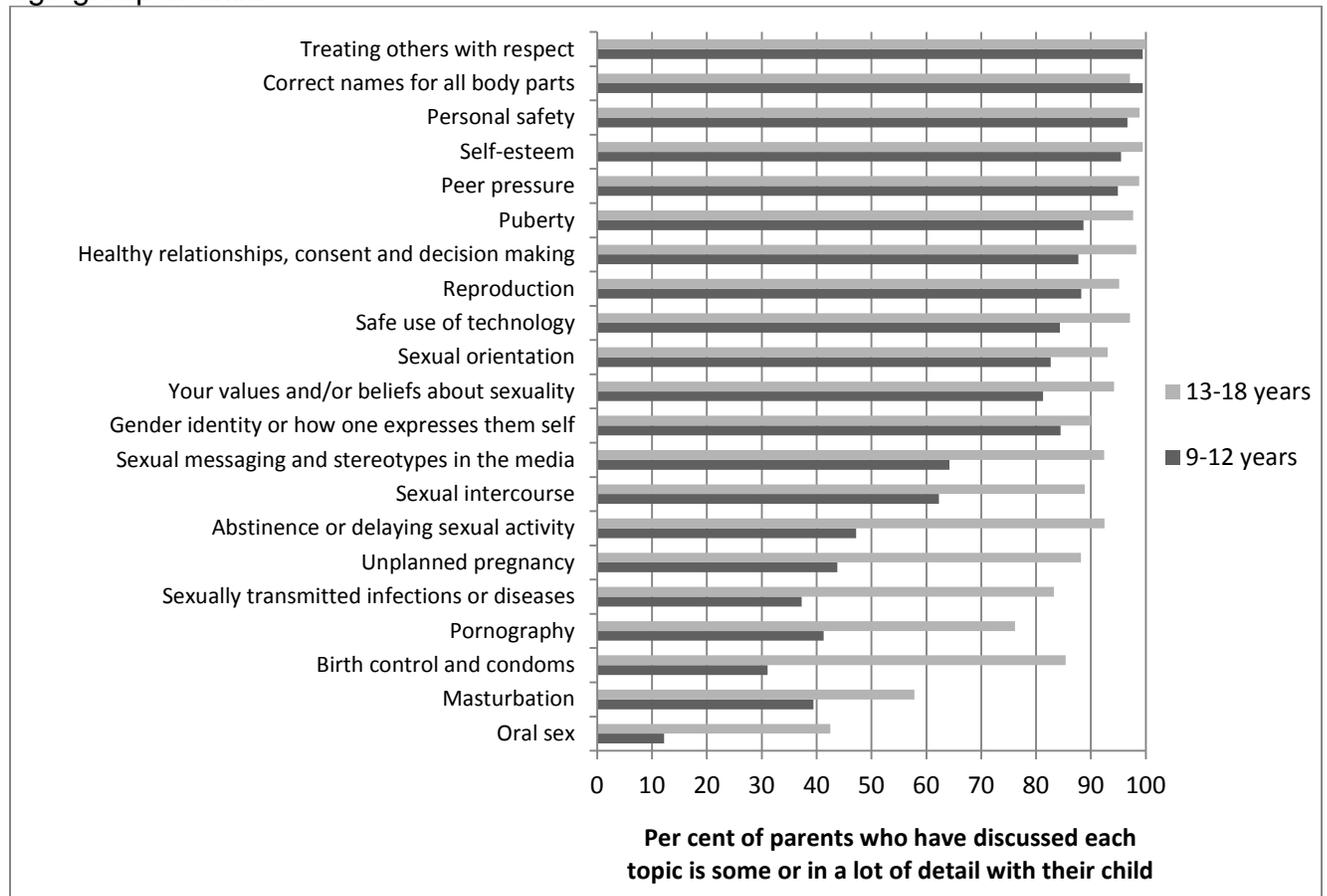
Further analysis revealed some differences in the level of detail topics were discussed according to the parent's age, the child's age, as well as the child's gender. Specifically, older parents (45 years or older) were more likely than younger parents to have discussed the following topics with their child:

- abstinence or delaying sexual activity;
- birth control and condoms; pornography;
- sexually transmitted infections,
- unplanned pregnancy; and
- values and/or beliefs about sexuality.

Similar to the trend seen among children aged less than nine years, the level of detail in which parents discussed certain topics with their children varied according to the age of their child. Parents of children 13 to 18 years old were more likely to report discussing the following topics in some or in a lot of detail with their children compared to parents of nine to 12 year olds:

- abstinence or delaying sexual activity;
- birth control and condoms;
- healthy relationships, consent and decision making;
- masturbation;
- oral sex;
- peer pressure;
- pornography;
- puberty;
- reproduction;
- safe use of technology;
- sexual intercourse;
- sexual messaging and stereotypes in the media;
- sexual orientation;
- sexually transmitted infections;
- unplanned pregnancy; and
- values and beliefs about sexuality (Figure 7).

Figure 7: Topics discussed with children nine to 18 years in some or a lot of detail, by age group of child



c) Differences between male and female children

Nearly one quarter of parents (24.0 per cent) indicated that their parent-child sexual health communication had not differed between their female and male children. For over half (54.3 per cent) of the parents who responded, this question was not applicable (i.e. only have one child 18 years of age or younger, or have children of the same gender) or not answered; however, a remaining 14.5 per cent of parents indicated that there was a difference in their discussions based on their child’s gender. The most frequently reported reason that parent-child sexual health communication differed between children was due to the difference in the male and female children’s ages. Another reported reason for the difference in discussions was gender-related physical changes.

Further analysis revealed that differences in discussions with male and female children are influenced by the age of the child as well as the parent’s age and relationship status. That is, parents of children ages nine years and older were more likely to report discussing topics differently with their male and female children compared to parents with children younger than nine years. Similarly, parents who are 35 years or older or who are single parents were more likely to report discussing topics differently with their opposite gender children compared to younger or coupled parents respectively.

There was also a difference noted in the level of detail that parents discussed certain topics based on the child's gender. Specifically, parents of boys were more likely to report discussing masturbation with their child compared to parents of girls, while parents of girls were more likely to report discussing unplanned pregnancy with their child compared to parents of boys.

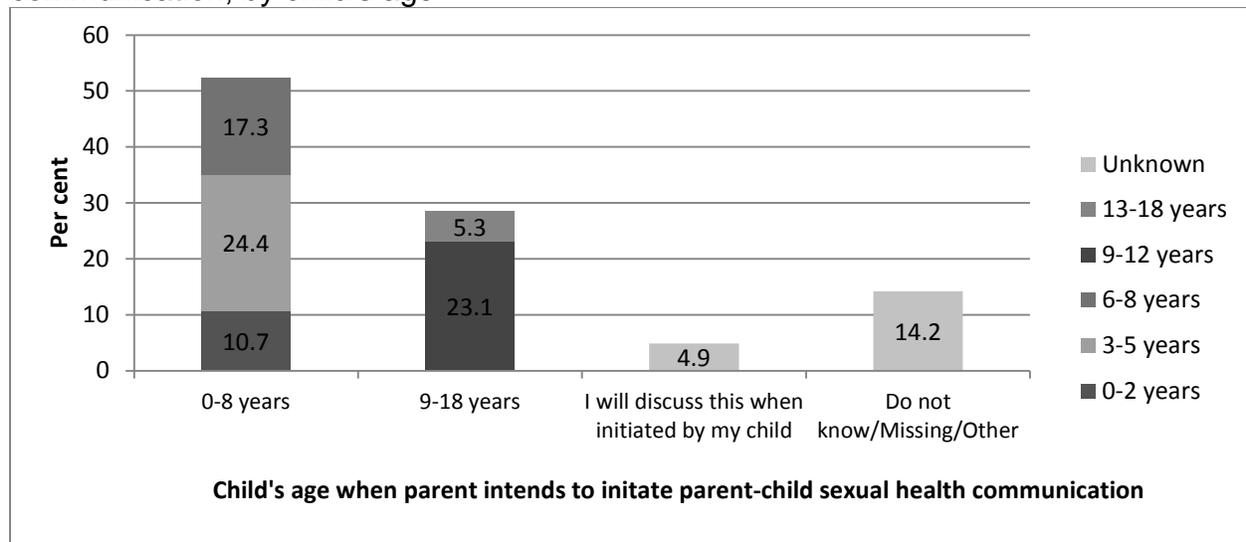
5.3.3 Parent-child communication: Parents who reported that they have not discussed sexual health with their children but intend to

Among the 243 parents (26.5 per cent of all survey participants) who reported that they have not discussed human development and sexual health with their child, the majority (92.6 per cent) reported that they intend to discuss this topic with their child in the future. Most of these parents (69.8 per cent) plan to share the responsibility of parent-child sexual health communication with their partner/the other parent.

a) Initiation of parent-child sexual health communication

When asked at what age parents intend to begin discussing sexual health with their child, over half of the parents (52.4 per cent) indicated before the age of nine years, while 28.4 per cent indicated between nine and 18 years. A small number of parents (4.9 per cent) indicated that they would discuss this when initiated by their child, while the remaining parents (14.2 per cent) did not know or did not answer this question (Figure 8).

Figure 8: Age at which parents intend to initiate parent-child sexual health communication, by child's age



b) Sexual health topics intended to be discussed

Parents were asked which sexual health topics they intend to discuss with their child. The five most frequently reported topics parents intended to discuss with their child of any age (zero to 18 years) included:

- personal safety;
- treating others with respect;
- correct names for all body parts;

- healthy relationships, consent, and decision making; and
- self-esteem.

Similar to parents who have already initiated sexual health communication with their child, there were differences in parent’s intentions to discuss these topics based on the child’s age. Parents of children less than nine years reported greater intent to discuss the five most frequently reported topics with their child throughout childhood compared to parents of children nine to 18 years (Figure 9).

Figure 9: Most common sexual health topics parents intend to discuss with their child (0 to 18 years), by age of child



Of the topics listed, those which parents were least likely to have intentions to discuss included:

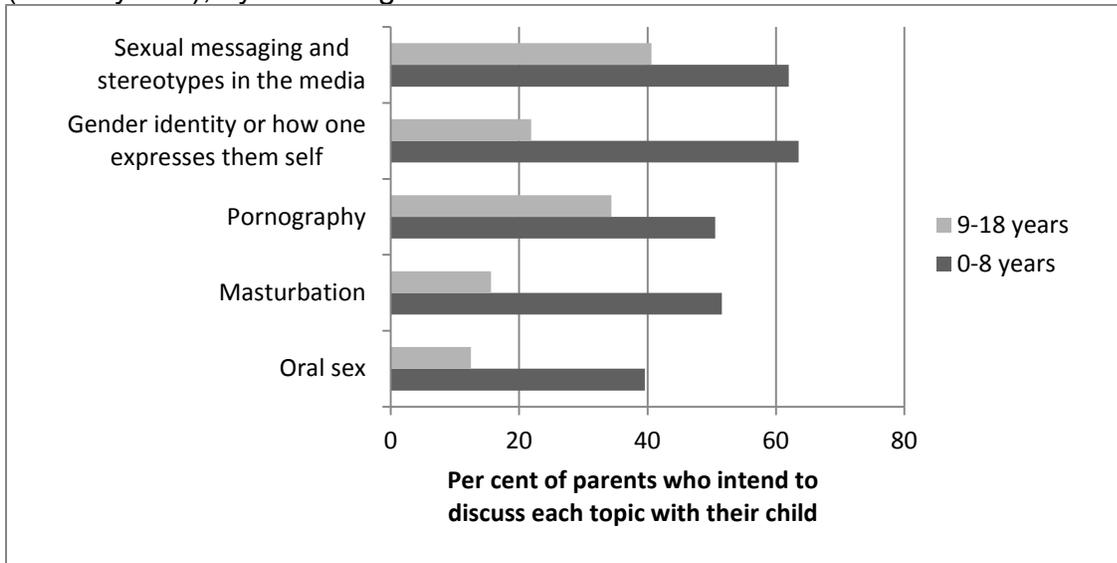
- oral sex;
- masturbation;
- pornography;
- gender identity or how one expresses them self; and
- sexual messaging and stereotypes in media.

There were also differences seen in parents’ intentions to discuss these topics based on their child’s age. Specifically, parents of children less than nine years were more likely than parents of older children (nine to 18 years) to report intent to discuss:

- oral sex;
- masturbation;
- gender identity or how one expresses them self; and
- sexual messaging and stereotypes in the media.

There was no difference in parents' intention to discuss pornography based on the child's age.

Figure 10: Least common sexual health topics parents intend to discuss with their child (0 to 18 years), by child's age



5.3.4 Parent-child communication: Parents who reported that they have not discussed sexual health with their children and do not intend to

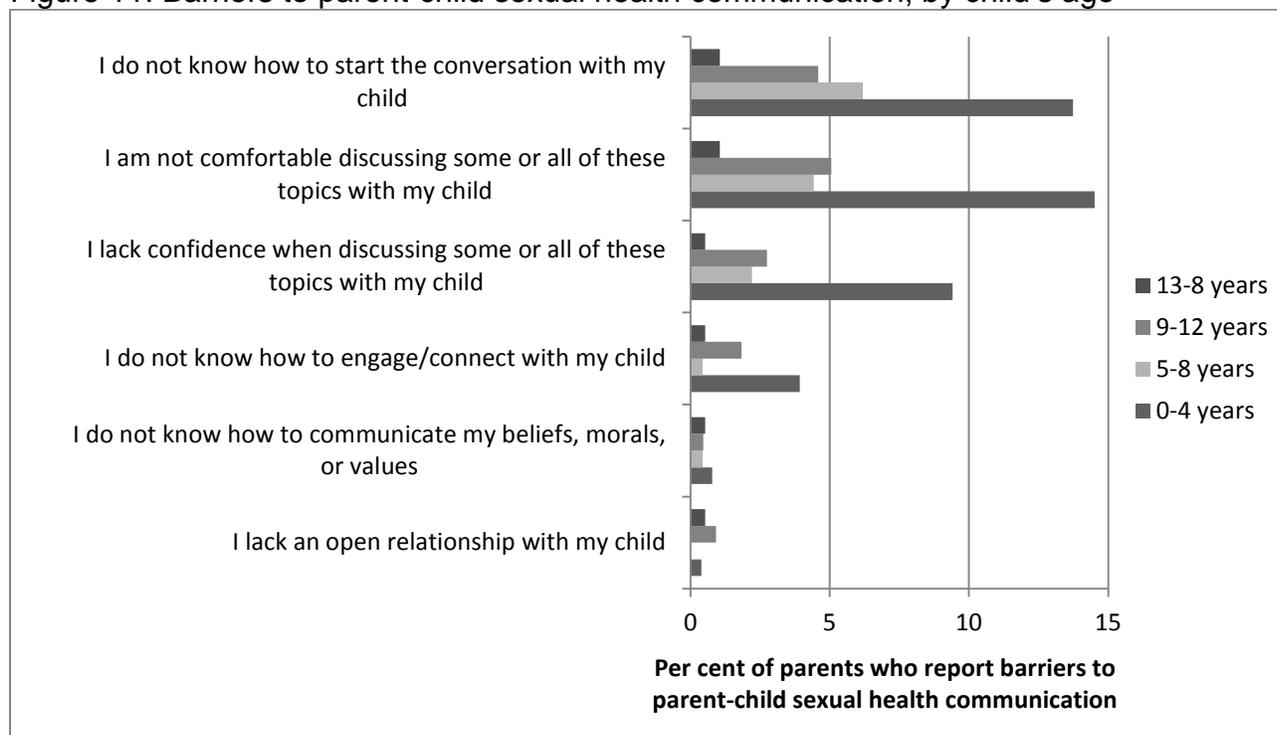
A small number (n=18, 2.0 per cent) of parents reported that they have not and do not intend to discuss sexual health with their children. The most commonly reported reason being that discussing sexual health might encourage them to experiment. Other responses included that their child was too young, their child could access information from many other resources, their child will find out about this on their own, it is not my or my partner's responsibility, I am too embarrassed or uncomfortable discussing these topics, I am not confident discussing these topics. No parents reported that it is the school's responsibility or that someone else will be speaking to their child on their behalf.

5.3.5 Supporting parent-child sexual health communication

a) Barriers to parent-child communication

Among the 899 survey participants who have already or plan to discuss sexual health with their child, 198 (22.0 per cent) reported finding it hard to talk to their child about these topics. The most commonly reported barriers were feeling uncomfortable, not knowing how to initiate the conversation, and lacking confidence. Parents of children less than five years were more likely to report discomfort and a lack of confidence when discussing some or all topics with their child, as well as and not knowing how to start the conversation compared to parents of older children (five years or older). Similarly, parents of children five to eight years were more likely to report not knowing how to start the conversation with their child compared to parents of children aged 13 years or older. There were no significant differences seen between parents of nine to 12 year olds and 13 to 18 year olds (Figure 11).

Figure 11: Barriers to parent-child sexual health communication, by child's age



Most (69.9 per cent) parents who have or who plan to discuss sexual health with their child revealed that they believe they possess enough knowledge about the topic to discuss it with their child. A further 21.6 per cent believe they somewhat possess enough knowledge about sexual health to discuss it with their child, while the remaining parents felt they did not have enough knowledge (2.0 per cent), did not know (0.2 per cent) or did not answer the question (6.3 per cent).

b) Accessing parent-child sexual health communication resources

Among parents who felt they lacked sufficient knowledge of sexual health topics, the majority (58.4 per cent) reported that they had not looked for information to support discussions with their child. A further 35.1 per cent reported that they had looked for information; 96.0 per cent of whom had found the information easily or somewhat easily.

A small number of parents (n=74, 8.2 per cent) reported having used a program or service in Waterloo Region that helped parents discuss sexual health with their child. However, of parents who have not or did not recall having used this type of program or service (n=752), 41.1 per cent indicated that they would use a program or service that helped parents discuss sexual health topics if offered, while another 30.5 per cent were unsure if they would utilize a program or service for this purpose.

There were differences in likelihood of having used a program according to the age of the parent as well as the child. Older parents (45 years or older) were more likely to have used any programs or services compared to younger parents, while parents of older children (13 to 18 years) were more likely to have used any programs or services compared to parents with younger children (12 years or younger).

c) Topics of interest

Parents who felt they lacked sufficient knowledge of sexual health topics were asked which topics they were interested in learning more about so they could discuss with their child. The most commonly reported topics were:

- safe use of technology;
- sexually transmitted infections;
- gender identity or how one expresses them self;
- sexual messaging and stereotypes in the media; and
- personal safety.

The topics selected least by parents included:

- correct names of body parts;
- unplanned pregnancy;
- sexual intercourse;
- reproduction; and
- birth control and condoms.

d) Resources to support parent-child sexual health communication

Parents indicated that their preferred types of resources to support parent-child sexual health communication would be internet websites, brochures/fact sheets, and information from their physician, nurse, etc. Resources that parents were least likely to indicate as being useful in helping to discuss these topics with their child included: radio show (call-in), presentations or workshops presented in the workplace, and television show (Table 9).

Table 9: Parent preference for format of resource to support parent-child sexual health communication

Resource Format	Count	Per cent
Internet websites	479	60.3
Brochures/fact sheets	434	54.6
Information from your physician, nurse, etc.	329	41.4
Library kits	247	31.1
YouTube or other online video hosted by an expert	220	27.7
Presentations or workshops delivered in the community	199	25.0
Other parent/peer groups	189	23.8
YouTube or other online video hosted by peer or other parent	172	21.6
Television	102	12.8
Presentations or workshops delivered in your workplace	76	9.6
Other	74	9.3
Radio show (call-in)	36	4.5

There were some differences seen in preference for different types of resources according to the age of the parent and of the child. Younger parents (34 years or younger) were more likely to indicate that library kits and workshops/presentations in

the community would be useful resources compared to older parents (45 years or older and 35 to 44 years, respectively).

Resources that parents would find helpful that differed by child’s age were library kits, other parents/peer groups, and presentations or workshops delivered in the community. Parents with younger children (less than nine years) were more likely to indicate interest in library kits than parents with older children (13 to 18 years). Parents with children less than five years old were also more likely to indicate interest presentations or workshops delivered in the community and in other parents/peer groups than parents with children five to eight years and nine to 18 years, respectively.

Parents further indicated that age-appropriate resources and resources parents can use with their child would be the most helpful in supporting parent-child sexual health communication. To a lesser degree, parents felt resources to give to their child and gender-appropriate resources would be useful in helping to discuss these topics (Table 10).

Table 10: Parent preference for types of resources to support parent-child sexual health communication

Resource Type	Count	Per cent
Age-appropriate resources	690	76.8
Resources to use with your child	556	61.9
Resources to give to your child	394	43.8
Gender-appropriate resources	383	42.6
None of the above	45	5.0
Other	22	2.4
Do not know	18	2.0

When asked about when a service or program would be most convenient to attend, parents preferred programs that were offered in the evening, but did not have a strong preference between weekdays and weekends. Parents reported that they would most like to use programs at home (online), community centres, libraries, and schools.

6.0 Synthesis and interpretation

6.1 Introduction

The Waterloo Region Sexual Health Youth Strategy recognizes parents as playing a primary and critical role in the sexual health education of their children. A key component of the 2010 Review of Public Health’s Sexual Health Services for Secondary School Students in Waterloo Region was to determine where youth access sexual health information. In a survey of over 1500 students in Waterloo Region, youth reported (65.2 per cent of students in Waterloo Region District School Board; 73.6 per cent in the Waterloo Catholic District School Board) that they are most likely to go to friends if they have a question about sexual health. While parents are listed second, they are not the main source of sexual health information for their children, based on this previous local data.

When analyzed by gender, the results showed that while parents remained the second most common source of information for females, for males, the internet ranked as their second choice, followed by parents in third. This research also highlighted a 2008 Canadian study that found that young men considered, in addition to friends, movies, television, and pornography to be primary sources of sexual health information. The study noted that these sources of information were not necessarily useful or educational (32).

This research led to the development of the Waterloo Region Sexual Health Youth Strategy. As a component of the Strategy, this situational assessment was completed to determine the sexual health support needs of parents in Waterloo Region and to determine which strategies are effective at increasing parents' and guardians' awareness, knowledge, skills and confidence for talking with their children about sexual health.

By means of a literature review, environmental scan, and survey of local parents, the situational assessment aimed to answer the following research questions:

1. What parent-child sexual health communication supports currently exist in Waterloo Region?
2. What are the parent-child sexual health communication support needs of parents in Waterloo Region?
3. What are the gaps in the parent-child sexual health communication supports that exist in Waterloo Region as defined by parents and the literature?
4. Who are priority populations needing additional support when speaking with their children about sexual health? Do these populations require targeted parent-child sexual health communication strategies?
5. What are comparator Public Health Units (PHU) across Ontario doing to support parent-child sexual health communication?
6. How should Public Health and its community partners support parent-child sexual health communication in Waterloo Region?

The findings of the situational assessment are synthesized according to these research questions below.

6.2 What parent-child sexual health communication supports currently exist in Waterloo Region?

The environmental scan highlighted the range of programs and services currently available in Waterloo Region to support parents in discussing human development and sexual health with their child(ren). These include workshops or seminars, which are available to the public through three community agencies, one-to-one support services offered through one agency, and a limited number of online or other resources.

The majority of workshops offered to the public are one-time events as opposed to ongoing programs. Some of these workshops address specific topics related to sexual health (e.g. sexual abuse), while most parent-focused programs are more general in content and are aimed at improving parent-child communication overall.

Two programs, Our Whole Lives (offered through the Grand River Unitarian Congregation) and Male Allies Program (offered through the Sexual Assault Support Centre Waterloo Region), are more intensive programs. It should be noted, however, that children/youth are the primary recipients of both programs, while parents receive some information through the programs related to communication with their children. It should also be noted that the Our Whole Lives program is only made available to members of the church and is not open to the public; therefore, the reach is quite limited.

Similar to workshops, the range of online, print or other resources that are available to parents address either specific sexual health topics or more generally, information on how to talk to your children about sexual health. A small number of survey participants (8.2 per cent) reporting having used a program or service in Waterloo Region that helped them discuss sexual health-related topics with their child.

6.3 What are the parent-child sexual health communication support needs of parents in Waterloo Region?

6.3.1 Initiation of parent-child sexual health communication

In general, the literature suggests that parent-child discussions of some sexual health topics are provided too late in relation to children's sexual behaviours. Overall, the majority of survey participants reported that they have or intend to discuss sexual health topics with their child(ren). Only a very small proportion (2.0 per cent) of participants reported that they do not intend to discuss these topics. However, the timing of when discussions are initiated and the extent to which certain topics are discussed may be problematic.

While it is never too late to initiate sexual health communication, it is important for parents to engage their children in these conversations as early as possible, as a means to build trust and support their child's well-being and safety. Parents are encouraged to begin these conversations in infancy (e.g. correct names of body parts) and continue to provide age-appropriate information and to share their values and beliefs throughout childhood and adolescence.

The majority of parent survey participants reported that they initiated (or intend to initiate) sexual health discussions with their child before the age of nine, with the most common age of initiation ranging between three and five years. A remaining 17.5 per cent of parents who have already discussed sexual health, and 28.4 per cent of parents who intend to discuss sexual health, report that these discussions began (or will begin) at age nine or later. This suggests that there is room for improvement to encourage Waterloo Region parents to begin discussing these topics with their children at an earlier age, and to continue these conversations as their children grow older.

6.3.2 Range and timing of sexual health topics discussed

The parent survey highlighted that all topics related to sexual health are not being discussed equally between parents and their children. There are some topics which

parents discuss in a lot of detail, some they discuss in only some detail, and others that they do not discuss at all.

Parents of younger children (eight years and younger) are most likely to have discussed with their child topics including healthy relationships, correct names of body parts, teaching 'your body belongs to you', similarities and differences between genders, while they are least likely to have discussed physical changes with puberty, basics of reproduction, and their values and beliefs about sexuality with their children. The likelihood that topics have been discussed in some level of detail increases with the age of the child, with parents of children five to eight years being more likely to have discussed values and beliefs, basics of reproduction, physical changes with puberty, and pregnancy than parents of children zero to four years.

Among parents of older children (nine years and older), the most commonly discussed topics include treating others with respect, self-esteem, correct names of body parts, personal safety and peer pressure, while the least common topics to have been discussed include oral sex, masturbation, pornography, birth control and unplanned pregnancy. Similar to the trend seen among younger children, as the age of the child increases from nine to 18 years, the likelihood that parents will have discussed a wider range of sexual health topics also increases. It remains however, that discussion of these topics may be initiated too late in relation to the age of initiation of sexual behaviours. Furthermore, differences are seen between males and females within this age group, indicating that information is not being shared consistently.

While parents may initiate parent-child sexual health communication prior to initiation of sexual activity, the findings in the literature suggest that certain topics are being discussed too late in relation to specific sexual behaviours. Parents could benefit from receiving support in providing age-appropriate information on the full range of sexual health topics to both their male and female children throughout their child's development.

6.3.3 Barriers to parent-child sexual health communication

The literature review suggests that both parents and their children experience barriers to sexual health communication. Among parents, barriers include a lack of knowledge (real or perceived), not knowing how to start the conversation or handle questions that come up, concerns that discussions about sex will encourage sexual behaviour, and personal conflict between wanting to instruct children to abstain from sex until marriage while acknowledging that is unlikely and also not their own personal experience.

For children, some of the reported barriers to parent-child sexual health communication include feelings of anger or annoyance when discussing sexual health topics with their parents, and fear of parental disapproval or disappointment if their parents find out about their sexual behaviour.

Among survey participants, the majority did not report finding it hard to talk to their children about sexual health; however, 22 per cent did report difficulties. The most common barriers reported by Waterloo Region parents included feeling uncomfortable,

lacking confidence, and not knowing how to initiate the conversation. It appears that these barriers decrease as the child ages, with parents of younger children being more likely to report these challenges compared to parents of older children. It is important to address these barriers, particularly to encourage parents to initiate these discussions with their children at an early age.

While a small number of survey respondents reported that they have not and do not intend to discuss sexual health with their child, information on their reasons for not discussing this topic can be useful in determining supports needed by parents in Waterloo Region. The most commonly reported reason for not discussing sexual health was the thought that it might encourage their child to experiment. This highlights the need to dispel the myth among parents that discussing sexual health topics will lead to increased sexual behaviour. These parents also reported similar barriers to communication as other survey respondents, including feeling uncomfortable or lacking confidence to discuss these topics with their children.

6.4 What are the gaps in the parent-child sexual health communication supports that exist in Waterloo Region?

The extent and reach of existing supports appears to be limited for the population of Waterloo Region. This is supported by findings of the parent survey, in which just 8.2 per cent of participants reported having ever used a program in Waterloo Region that helped parents discuss sexual health with their child(ren). Meanwhile, a greater proportion of parents (41.1 per cent) reported that they would use such a service, while a further 30.5 per cent were unsure, suggesting that additional supports, if offered, would be utilized by parents in Waterloo Region.

Parents in Waterloo Region could benefit from supports that address the barriers to parent-child communication, including practical information on age-appropriate topics to discuss, how to start the conversation and how to address questions as they come up. Strategies to increase parents' awareness of the importance of initiating discussions with their children early and continuing throughout childhood and adolescence also appears to be a current gap in supports currently offered in Waterloo Region.

6.5 Who are priority populations needing additional support when speaking with their children about sexual health?

The literature highlighted some discrepancies among specific population groups in terms of the sexual health communication they receive from their parents. Youth may have specific needs related to communication about sexual health that are not being addressed or met if they (are):

- male;
- LGBT;
- live in rural areas;
- have an intellectual disability;
- from households with strong conservative or religious beliefs; or
- are immigrants.

Specific efforts may be needed to provide support to parents of children within these populations to ensure that they are able to communicate appropriate information as it relates to sexual health.

While the evidence suggests that mothers are more frequently the providers of sexual health communication with their children compared to fathers, no information was found on how to better engage fathers in parent-child communication. Fathers may be a potential population to explore further in order to determine effective ways to provide support or whether or not targeted interventions for fathers are needed.

6.6 What are comparator Public Health Units across Ontario doing to support parent-child sexual health communication?

It can be useful to look to other regions, particularly those with similar socio-demographic and geographic characteristics to Waterloo Region, to explore what strategies are being employed elsewhere and to learn from their experiences.

The environmental scan revealed that a wide range of strategies are being employed by comparator health regions across Ontario to support parent-child communication, including print materials, online resources, media campaigns, parent information sessions/conferences, and phone support.

All of the strategies identified were implemented universally, while no health units had identified specific priority populations for targeted interventions.

7.0 Recommendations

7.1 Introduction

Overall, the literature supports that parent-child communication related to human development and sexual health can be improved in quality, frequency and level of comfort through interventions targeted to parents. While the evidence shows mixed support for different types of interventions, interventions that involve two or more sessions and aim to improve the relationship and general communication quality between parents and children appear to show some effectiveness. Numerous studies lend support to focusing on improving parent-child relationships overall, including parent-child connectedness, communication, and positive interactions rather than focusing on communication specific to sexual health. Further to this, greater effectiveness has been observed in studies aiming to address multiple risk behaviours, not just those related to sexual health.

The situational assessment has highlighted that while there is interest among parents in Waterloo Region to discuss human development and sexual health topics with their children, they require supports to remove barriers they experience in doing so. Waterloo Region parents have also indicated that they are willing to access supports that will help them discuss these topics with their children, if such supports are made available.

Specifically, Waterloo Region parents would most likely access resources that are age-appropriate, which can be used with their child, and are available through websites, brochures or fact sheets, or through their physician, nurse, or other health care practitioner. Library kits are another potential resource format, of particular interest to parents of younger children.

7.2 How should Public Health and its community partners support parent-child sexual health communication in Waterloo Region?

Based on the findings of the situational assessment, the following strategies are recommended to increase Waterloo Region parents' awareness, knowledge, skills and confidence for in talking with their children about sexual health.

1. Collaborate with existing groups already working with, or providing services to, parents (e.g. Children's Planning Table member organizations, school boards) to leverage connection between parent-child sexual health communication and parenting in general
2. Develop programs and services to increase parent-child communication, with emphasis on human development and sexual health, beginning the conversation early, and continuing discussions throughout childhood and adolescence
 - Address barriers to communication, including feelings of discomfort or lack of confidence, not knowing how to start the conversation, and fear that discussing sexual health will encourage sexual behaviours
 - Develop resources that provide age appropriate sexual health information for parents to use with their children
 - Develop targeted interventions for parents of identified priority populations (e.g. male, LGBT)
3. Develop and increase awareness of online resources for parents to access information on discussing human development and sexual health with their children
 - Include practical tips or guides (e.g. videos modelling parent-child conversations) on how to start the conversation
 - Include links to existing resources
4. Provide resources and/or training for health care providers to support parents in discussing human development and sexual health with their children
5. Partner with academia, if appropriate, to develop any interventions and/or evaluations

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APPENDICES

Appendix 1: Priority populations identified in the Sexual Health Youth Strategy

The following groups were identified as priority populations:

- Male youth;
- Youth from households of lower socio economic status;
- Youth who experience poor parenting;
- Youth who engage in risk-taking behaviours such as using drugs or alcohol;
- Youth who are struggling academically;
- LGBTQ youth;
- Youth who are struggling with low self esteem; and
- Immigrant youth.

Appendix 2: Critical appraisal tool

Article Title:

Article Number:

CRITICAL APPRAISAL TOOL	
PART 1: SCREENING QUESTION: Please read the full article and complete the critical appraisal question below.	
1. Are any of our research questions addressed?	If yes, please check the appropriate box.
<ul style="list-style-type: none"> a) What are the best methods to encourage and support effective parent-child sexual health communication? b) What are gaps in parent-child sexual health communication supports? c) Who are priority populations that need additional support when speaking with their children about sexual health? (Do these populations require targeted parent-child sexual health communication strategies?) d) How should public health and community practitioners support parent-child sexual health communication? 	<ul style="list-style-type: none"> <input type="checkbox"/> Question 1 <input type="checkbox"/> Question 2 <input type="checkbox"/> Question 3 <input type="checkbox"/> Question 4
<p>If you found that at least one of our research questions was addressed, please complete the detailed critical appraisal questions below.</p> <p>If you found that none of our research questions were addressed, stop and move to the next article.</p>	
PART 2: DETAILED QUESTIONS: PLEASE READ THE FULL ARTICLE AND COMPLETE THE CRITICAL APPRAISAL QUESTIONS BELOW.	
2. Was the recruitment strategy clearly explained?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	
Things to consider: <ul style="list-style-type: none"> ▪ How were the participants selected? ▪ If the study targeted a specific group (e.g. fathers), does it explain why that specific group was targeted? 	
3. Was the data analysis strategy clearly explained?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	
Things to consider: <ul style="list-style-type: none"> ▪ Was there a description of the study type? (e.g. randomized controlled trial, cohort/non-randomized control trial, cross-sectional study) ▪ Was there a description of the indicators measured? ▪ Was there a description of how indicators were measured? ▪ Was there a description of the analysis process (e.g. before/after, intervention/control)? 	

CRITICAL APPRAISAL TOOL

- Does the article discuss limitations of the analysis process?

4. Were the findings clearly explained?

Yes No Unsure

Things to consider:

- Do the findings reported in the discussion/ conclusion section correspond to the findings represented in the results section?
- Do the findings reported in the discussion respond to the research question proposed in the introduction?
- Are the results similar to those found by other studies on the same topic? If not, did the authors comment on the possible reasons for the discrepancies?

5. Are there any other relevant sources of information referenced in this article?

Yes No Unsure

If there are any references you believe would be useful to this review, please list the first author's name and highlight reference in the article:

6. Did the article provide any questions/topics used in their data collection tools?

Yes No Unsure

If yes, please list the sample questions or topics used:

Please proceed to the article summary sheet.