If You Teach Them, They Will Come: Providers' Reactions to Incorporating Pleasure Into Youth Sexual Education

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ABSTRACT

OBJECTIVES: Sexual pleasure and satisfaction are integral components of the human sexual experience, yet these crucial aspects of sexuality are rarely placed on sexual education agendas. The objective of this paper is to explore the ways in which various groups of Service Providers (SPs) participating in the Toronto Teen Survey (TTS) understand the role of pleasure in sexual education for youth, highlighting the challenges and benefits of teaching pleasure in diverse settings.

METHODS: The TTS employed a community-based research (CBR) methodology. Between December 2006 and August 2007, 1,216 surveys were collected from youth in over 90 different community-based settings across Toronto by youth peer researchers. In 2008, 13 follow-up focus groups were conducted with 80 service providers from 55 different agencies around the Greater Toronto Area. All transcripts were input into qualitative data management software, NVIVO. Coding and analysis of data employed the constant comparative method.

RESULTS: SPs had a number of competing opinions about the inclusion of pleasure in sexual health education and programming. These concerns can be divided into three major areas: placing pleasure on the agenda; the role of gender in pleasure education; and the appropriate spaces and professionals to execute a pleasure-informed curriculum.

CONCLUSION: Access to resources, training and personal background determine SPs' willingness and ability to engage in the pedagogy of sexual pleasure. Medically trained clinicians were less likely to see themselves as candidates for instructing youth on issues of pleasure, believing that public health and health promotion professionals were more adequately trained and organizationally situated to deliver those services.

KEY WORDS: Adolescent; sexual development; education; health personnel; Toronto; Canada

La traduction du résumé se trouve à la fin de l'article.

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Sexual pleasure and satisfaction – experienced through physical, mental and emotional processes – are integral components of the human sexual experience, yet these crucial aspects of sexuality are rarely, if ever, placed on sexual education agendas. Nonetheless, working definitions of sexual health and sexual rights formulated at the WHO-convened international technical consultation on sexual health include “the possibility of having pleasurable and safe sexual experiences” and the right to “pursue a satisfying, safe and pleasurable sexual life”.¹ Moreover, a recent study out of the Institute of Development Studies at the University of Brighton, UK, demonstrates that, in terms of STI and HIV prevention, public health outcomes would benefit from the inclusion of discussions around positive sexual experiences.² Other studies have shown that failing to focus on sexual pleasure within relationships has an adverse impact on individuals' ability to negotiate safer sex.³ Taken together, these findings indicate the fundamental importance of emphasizing the role of sexual pleasure in sexual education and in sexual health provision. This emphasis is particularly significant in light of the fact that in the Toronto Teen Survey (TTS), youth have indicated that their three most-sought-after areas of sexual knowledge are healthy relationships, HIV/AIDS and sexual pleasure.⁴

The objective of this paper is to explore the ways in which various groups of Service Providers (SPs) participating in the TTS understand the role of pleasure in sexual education for youth, highlighting the challenges and benefits of teaching pleasure in

diverse settings. The paper will focus on SPs' differing reactions to youth's desire to learn about sexual pleasure, as well as issues of educational funding and debates around the most appropriate spaces for sexual education that incorporates pleasure.

Objectives

In 1988, Michelle Fine wrote the pioneering work on the critical need to include sexual pleasure in the education of girls and women, expressing concerns that, denied this critical knowledge of their own bodies, women would be unable to negotiate their sexual fears and desires.⁵ Twenty-five years later, researchers, advocates and educators are still calling for the inclusion of sexual pleasure in sexual education curricula.⁶ The connection between sexual agency and sexual

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desire is particularly relevant to youth sexuality as early education provides the basis on which adult sexualities are formed.⁷ Nonetheless, traditional sex education, with its emphasis on marriage and reproduction, continues to dominate sexual health curricula.⁸ Under the Bush administration, the “abstinence only before marriage” sexual health agenda dominated sexual education discussions in the United States and significant financial investments were made in ensuring that schools promoted this “less is more” approach.⁹ In Canada, conservatism at the federal level has also led government to espouse a movement toward the so-called family values approach.¹⁰ In 2010, the Ontario provincial government attempted to revise the outdated Health and Physical Education curriculum in the province to reflect a more inclusive, comprehensive approach to sexual health; however, following considerable conservative backlash, the government shelved the proposal and no such progressive change ever came to fruition.¹¹⁻¹³ As an institution, Public Health, too, has been primarily concerned with fertility and the control thereof, and on the prevention of sexually transmitted infections (STIs), emphasizing danger and disease over sex positivity.^{14,15} In this environment of repressed sexuality, sex is seen as necessitating regulation and control. Focusing on pleasure, then, finds little support in the midst of sexual avoidance outside of reproduction within the context of heterosexual marriages.³

Nonetheless, those in critical sexuality studies and many of those working on youth sexual health, not to mention many youth themselves, argue that youth sexuality should be discussed with the understanding that young people need assistance in navigating both danger and desire in a sexualized culture of opportunity and obstacles.^{6,16,17} Focusing only on discourses of risk fails to account for the complexities of young people’s lives, instead providing a one-dimensional approach to sexuality. As Tolman argues, the job of sexual health researchers, providers and policy-makers should be to create “enabling conditions,” namely the “structural social conditions of safety, resources and social norms” that would make sexual well-being, and, indeed, broader well-being, possible.¹⁷ A more comprehensive approach to sexuality education advocates a “rights-based approach to equipping young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexualities – physically, emotionally, individually and in relationships.”¹⁸ Teaching young people about pleasure provides them with the tools to negotiate what they do and do not want in sexual relationships and encourages conversation around agency and healthy relationships – all of which have the incidental outcome of reducing rates of STIs.

The question remains: If we espouse sexual education that is attuned to pleasure and to the social contexts of young people’s lives, who will teach them and where will they be taught? When asked these questions, SPs voiced an array of opinions, ranging from surprise that youth suggested they wanted to learn about pleasure, to concern about their capacity to provide this information, to advocating a sexual pleasure agenda. Because SPs ranged in disciplines and workplace environments, responses were influenced by time pressures, clinical pressures, and financial pressures, as well as by pressures around personal ethics and values.

METHODS

The TTS is a collaboration between community-based organizations, academic researchers and policy-makers, and was created to

Table 1. TTS Service Provider Demographics

		Total	%
Type of worker	Front-line worker	43	54
	Youth outreach worker	16	20
	Health care provider	17	21
	Manager or provider	13	16
	Government employee	6	8
	Other	23	29
Work with youth	Individually	17	21
	In groups	22	28
	Both	40	50
	No response	1	1
Populations you work with	Refugee & newcomer youth	33	41
	Immigrant youth	49	61
	First-generation Canadian youth	33	41
	Youth living with physical disabilities	15	19
	Youth living with cognitive disabilities	20	25
	Youth with addictions	33	41
	Youth with mental health disabilities	31	39
	Sexually diverse youth	51	64
	Youth in the foster care system	26	32
	Street-involved or homeless youth	32	40
	13-14 year olds	43	54
	15-16 year olds	54	68
	17-18 year olds	54	68
	Other	33	41
Services offered	Health clinics	43	54
	Youth drop-ins	33	41
	Regular youth group	36	45
	Sexual health workshops	47	59
	Peer-led programming	38	48
	School-based programming	38	48
	Summer camps	15	19
	Other	16	20
	No	26	33

achieve the overall goals of gathering information on barriers and facilitators to sexual health education and services, and developing strategies to increase positive sexual health outcomes for diverse youth in Toronto, Canada. The TTS employed a community-based research (CBR) methodology. As such, the project was committed to equitably involving young people and community partners in all phases of research while ensuring that the data collected led to social change. CBR initiatives are characterized by: ensuring the relevance of research questions to communities; engaging members of the community as active research partners; building capacities and skills among research partners; and attending to social change by ensuring that data are used to effect positive change.^{19,20}

Between December 2006 and August 2007, 1,216 surveys were collected from youth in over 90 different community-based settings across Toronto by youth peer researchers. Youth were recruited to a Youth Advisory Committee (YAC) to assist with both the development of the survey tool and the administration of the survey throughout the city.⁴ The YAC’s diversity, with respect to gender, race, sexual orientation, socio-economic status, religion, and immigration status, reflected the diversity of youth in Toronto as well as those surveyed. By involving youth as partners in all stages of the research initiative, the TTS increased levels of youth engagement, empowerment, project sustainability and uptake of data.

In 2008, 13 follow-up focus groups were conducted with 80 service providers from 55 different agencies around the Greater Toronto Area. The primary goal of the SP focus groups was to ensure that front-line workers’ needs and challenges were addressed through the research project. The majority of the focus groups were held at Planned Parenthood Toronto. Groups were co-facilitated by the research project coordinator and one member of the YAC. In addition, at least 1 co-investigator on the project was present to assist and to take field notes. Each session began with a presentation of

Table 2. Codes From the Literature

1.	Pleasure v. STI focus (Hard vs. Soft Skills)
2.	Education
a)	teachers
b)	school boards
c)	provider education and training
d)	parents
e)	learning in school v. learning in the community
3.	Peer to Peer Models
4.	Sexual Health Services/Clinical Encounters
5.	Health Care Providers
6.	Accessibility
7.	Population Specific Needs
8.	Parental Issues
9.	Role Models, Leadership, Mentorship, Coaches
10.	Youth Empowerment/Youth Engagement
11.	Role of Religion
12.	Health Issues
13.	Misinformation, Myths and Lack of Knowledge
14.	Organizational Issues
15.	Priority Neighbourhoods
16.	Gender Differences
17.	Values
18.	Discourses of "Risk"
19.	Healthy and Unhealthy Relationships
20.	Legislation, Rights and Law
21.	Partners and Networks
22.	Service Continuum
23.	Systemic Issues
24.	Policy Environment
25.	Media/Getting the Word Out
26.	Lack of Evidence
27.	Changes to Policy
28.	Recommendations

the data from the TTS, including the data on young people’s desire to learn about sexual pleasure. There was an opportunity for questions from SPs, followed by a facilitated discussion on the major findings. SPs were then asked to comment on the results and to discuss the ways in which they can work more effectively to create a coordinated strategy. The findings on pleasure prompted the responses included in this paper. SPs included clinicians, social workers, shelter staff, group home staff, health promoters, teachers, and outreach workers; 53% were front-line staff, 16% were managers, 54% worked for health clinics, 19% worked in summer camps, and 41% worked in youth drop-ins. Each focus group lasted approximately three hours and provided an opportunity for SPs to respond to the youth surveys and to express their concerns and ideas.

Upon completion of the focus groups, all transcripts were input into qualitative data management software, NVIVO. Coding and analysis of data commenced using the constant comparative method outlined by Strauss and Corbin.²¹ A preliminary coding framework of relevant themes garnered from the literature was developed prior to conducting the focus groups. After the focus groups took place, the coding framework was revised to incorporate themes generated through an adaptation of the constant comparative methods used in grounded theory. This type of coding involves the development of codes that describe respondents’ accounts of participation in their own words. As codes were developed, they were applied and compared to newly collected data and modified as necessary. Descriptive codes were then combined to develop theoretical or analytical themes. Each transcript was reviewed by at least two research assistants, and an inclusive model was adopted to encompass both coders’ views. This paper is an analysis based on the feedback we received from SPs across Toronto. The researchers have not interpreted what SPs have said, but rather contextualized and presented their observations, critical commentary, and recommendations for change. This research

Table 3. Agenda Setting

	⇒	“Healthy relationships, sexual pleasure is a jumping off point to all the other issues, instead of just focusing on disease.” (Youth in Care)
	⇒	“So I think that organizing something that’s of interest that will be informative is the best way to go in order to get the youth to come and actually want to talk about it instead of focusing on any of them to say you know are you using condoms.” (Black Youth)
Putting pleasure on the agenda	⇒	“So that’s kind of the draw that we use to convey the sexual health information is you get to learn about sex.” (LGBT2Q)
	⇒	“How do we get pleasure into the funding agenda?” (LGBT2Q)
	⇒	“We can focus on pleasure within the prevention piece, through the HIV grants etc., we need to try and fit it in because youth is looking for it.” (TPH Staff)

received institutional research ethics approval from York University.

RESULTS

Results from the TTS demonstrate that while youth ranked sexual pleasure as one of the top three topics they wanted to learn more about, SPs had a number of competing opinions about the inclusion of pleasure in sexual health education and programming. These concerns can be divided into three major areas: placing pleasure on the agenda; the role of gender in pleasure education; and the appropriate spaces and professionals to execute a pleasure-informed curriculum.

Agenda setting

Youth engaged in the TTS survey indicate that the sexual education they currently receive is too narrowly focused on risks and biology, is not implemented early enough in their lives, discourages discussion and is generally not sex-positive in nature. Dailey defines sex-positive orientations as those that emphasize physical and emotional pleasure, and that affirm “the pleasures of touch, the requirements for orgasmic release, or the importance of trust and open communication in specific sexual interactions”.²² While SPs tended to agree with youth that sexual pleasure should be placed closer to the top of the sexual health agenda, they often differed on how to resolve the current problem. In order to provide effective services, then, the agenda advanced by SPs must come more into line with youths’ wishes and expectations. One of the major barriers to this objective lies in the fact that funding for sexual health and social services has been reduced and providers are working on shoestring budgets to manage the services they are currently providing. Funding is often short-term and therefore programs are often unsustainable; funding is directed at particular priority areas, such as reducing STIs and preventing pregnancy (in which sexual pleasure education is not included); and training opportunities for staff are unaffordable.²³

Many SPs recognized that sexual pleasure could be used as a catalyst for teaching youth about the full range of sexual health issues – including STIs and fertility: “Healthy relationships, sexual pleasure is a jumping off point to all the other issues, instead of just focusing on disease” (Youth in Care SP). Moreover, they realized that building programs around youth’s preferred learning areas encourages youth to visit clinics and engage in sexual health programming, but were often stymied on how they would convince funders of this approach. “Leading Together,” part of the Canadian

Table 4. Gender

Role of gender in pleasure	⇒	"I find a lot of girls are not comfortable with their bodies, and have not a good understanding of their sense of worth. Having sexual pleasure goes above and beyond enjoying sex, it is about knowing who you are, being comfortable, and loving your body, having a healthy self esteem." (All Toronto)
	⇒	"I still see young women being at a disadvantage of letting young men be the ones to lead the relationship in the heterosexual relationship." (Black Youth)
	⇒	"I'd like to see more young men's groups about pleasure. They need this focus too." (PPT Staff)

Government's strategy for reducing youth vulnerability to HIV, recommends that prevention programs be: age-appropriate, led by youth agendas, and relevant to agencies that serve youth communities.²⁴ Keeping in mind these commitments, service-providing organizations could make the case for the ways in which teaching youth about pleasure leads to better and more agentic decision-making, and gets youth involved in the type of programming they want to see created.⁶ Funders should be made aware of the recommendations outlined in documents like "Leading Together" and put forward by youth in studies like the TTS.

Gender

The current sexual agenda that advocates a "just say no" approach to sex tends to provide girls with scripts and strategies for fending off the sexual advances arising from boys' desires, but leaves girls uneducated about their own desires and their ability to make sexual decisions based on those desires, while failing to protect them from the possible dangers of unsafe sexual experimentation.^{6,25} SPs were attuned to this gender dynamic in their practices and noted that the discussion of female desire would assist young women in developing healthier self-images: "Having sexual pleasure goes above and beyond enjoying sex, it is about knowing who you are, being comfortable, and loving your body, having a healthy self esteem" (All Toronto SP). While the emphasis for boys is on erections and ejaculation (incidents of pleasure), girls are more likely to be taught about menstruation and reproduction.²⁶ Education that segregates pleasure from biology based on gender seems to indicate to young people that young women do not have sex for pleasure and that men do not have sex for intimacy – both of which are harmful through a gender lens.²⁷ While there is a substantial body of literature around the negative repercussions of this type of education on girls as noted above, there is significantly less that recognizes the ways in which masculinity too is affected by conceptions of male power, female submissiveness and heteronormativity.³ While boys may be learning more than girls about physical pleasure, it can be argued that they would benefit from a more relational, less phallogocentric understanding of pleasure. This lack of conversation around boys' sexuality was also mirrored in the SP focus groups, with several community workers in health promotion pointing to the need for more programming in healthy sexualities for young men: "I'd like to see more young men's groups about pleasure. They need this focus too" (PPT Staff).

Spaces of pleasure

On the topics of where pleasure should fit into sexual health education and who should teach it, there were remarkable differences among and across SP focus groups. All service providers understood that sexual health education of some sort was being taught in

Table 5. Spaces of Pleasure

School	⇒	"I mean I think it's dangerous depending on the school system, but I think in terms of what parents would accept and not. But I think if you start normalizing sexual activity from a young age..." (All Toronto)
	⇒	"I would think the information would have to be given by some peers, not by a stuffy teacher you know." (All Toronto)
Clinic	⇒	"This is very biologically based - not "what does sex mean to you" or "sexuality" - but it could be ethically difficult for you." (TPH Staff)
	⇒	"Clinics have such pressure to deal with disease - that pleasure "are you enjoying sex?" gets lost - for both men and women." (TPH Staff)
	⇒	"We deal with the issue in the moment (the pregnancy or STI) - the healthy relationship is more of a soft skill. It's nice to work with the sexual health promotion because they are more able to do those broad things." (TPH Staff)
	⇒	"Like when folks are coming in for clinical services right it's like in dealing with the issue out right and when you know the community there's just you know we sit and we chat and have that kind of staff I think." (PPT Staff)
Community	⇒	

school curricula, but many thought that teaching pleasure in the classroom was fraught with ethical issues and would provoke considerable backlash from parents: "I mean I think it's dangerous depending on the school system, but I think in terms of what parents would accept and not" (All Toronto SP). Fine and McClelland have argued, however, that while sexual health education should be integrated into community programming, schools also have a critical role to play insofar as young people are required to attend together and are encouraged to interact with one another and with new forms of knowledge.⁶

Most SPs agreed that schools were best situated to reach the widest audience of youth, but they also voiced concern with the limitations of curricula that fail to address the priority issues identified by youth, including sexual pleasure. Indeed, a recent Canadian study demonstrates that the three topics that middle and elementary teachers were least willing to teach were sexual pleasure and orgasm, masturbation, and sexual behaviour.²⁸ SPs were especially concerned with addressing sexual diversity within schools and suggested that peer-to-peer education models might be the best strategy for engaging youth in discussion about their sexual health. The training of peer researchers in sexual health education and STI prevention has been well documented as an effective strategy.^{29,30} Indeed, the peer-based researcher model allows for culturally appropriate and insightful connections with communities that are typically defined as "hard to reach."³⁰ Since youth frequently turn to their peers for answers to their sexual health questions, the inclusion of diverse communities of youth in the planning and delivery of sexual health interventions and education is important.^{31,32} Equipping youth to engage their peers on issues of sexual pleasure demonstrates one way in which to advance a sex-positive sexual health curriculum.

In discussing the role of medical doctors in sexual health provision to youth, physician SPs revealed a number of challenges, especially in terms of education around sexual pleasure. Despite research indicating that adolescents and parents alike would like to see their family physician educating children about sexual health, primary care clinicians are not likely to provide this type of counseling.^{33,34} Physician SPs participating in the TTS focus groups identified a number of barriers to addressing the sexual health concerns of their patients: unease with sexual subject matter; inade-

quate training; time constraints; and concern that sexual education is outside their scope of practice. Breaking down these barriers requires changes in sexual health curricula, not just in schools, but also in medical school programs and training.^{35,36} The physician SPs also felt that their role as providers meant that their concern should be with biology and not with “soft skills” like counseling and education on topics like sexual pleasure: “We deal with the issue in the moment (the pregnancy or STI) - the healthy relationship is more of a soft skill” (Public Health SP). On a fee-for-service model, the disease focus is unsurprising as conversations about potentially sensitive issues of sexuality are time consuming and are disincentives under the current model of physician remuneration.²³

Physicians and community health promoters alike agreed that conversations around youth sexual pleasure were most likely to occur within the community context. These findings echo Tolman’s recent work, in which she notes that discourses of sex education have begun to focus on shifting sex ed outside of schools “where teens are unshackled by discursive restraints placed on adults.”¹⁷ Perceptions varied on whether these objectives were best met by a sexual health-specific clinic model or by a more general comprehensive health clinic. Some providers voiced concern with the visibility involved for youth attending a sexual health-specific clinic, but felt that these clinics were less likely to be judgemental and more likely to be sex-positive. Being comfortable talking about and using the language of sexual pleasure was seen as critical to delivering these messages to young people. Community workers believed that their training and experience best suited them to the task of teaching youth about sexual pleasure; however they also expressed the ways in which financial constraints and a lack of sustainable funding acutely affected their ability to deliver these types of services.

CONCLUSION

Access to resources, training, personal background and dominant socio-cultural norms all determine SPs’ willingness and ability to engage in the pedagogy of sexual pleasure. Medically trained clinicians were less likely to see themselves as candidates for instructing youth on issues of desire and pleasure, believing that public health and health promotion professionals were more adequately trained and organizationally situated to deliver that type of service. Public health and health promotion SPs were apt to agree with clinicians, but were also concerned with the critical lack of funding that is crucial to their ability to deliver services that are relevant to the wants and needs of youth. The role of sex education in schools was not debated; however, the response of parents and teachers to a sexual health curriculum that included sexual pleasure was raised as a particular concern. Providers generally agreed that if pleasure was to be included in sexual education, it was best done within the parameters of public health and health promotion, especially within designated sexual health clinics.

SP recommendations began with the recognition that more comprehensive sexual education strategies needed to be developed within the health and social services sectors. Because of the obvious link between sexual and reproductive health and sexuality education, it seems wise to create an agenda that is not solely administered by one group of SPs, but that crosses within and between groups: educators and clinicians; departments of health and departments of social services; clinicians and health promot-

ers.³⁷ Clinical staff can learn from health promoters the ways in which young people are talking about sex and the role that clinical staff might play in addressing those concerns during general check-ups, while education professionals need to know how youth can access clinics and which clinics are best suited to the needs of young people. Providing youth with a complement of sexual education programs helps facilitate links between young people and the resources provided in their communities. The places for educating young people on sexual pleasure should not be limited to one type of service or another, but rather should exist in each service or program that youth might engage with when seeking sexual health information.

Recognizing that adolescent desire is formed, created and recreated in social contexts: on TV; in the community; in religious institutions; on the Internet; in cars and classrooms and clubs, is integral to realizing the importance of paying attention to sexual pleasure in sexual education curricula and programs.⁶ There is a critical co-constitutive relationship between pleasure and empowerment and between empowerment and sexual decision-making. In light of these arguments, Fine and McClelland advance what they call a framework of “thick desire,” which recognizes that young people should have the ability to fulfill a wide range of desires and allows for the act of wanting, not just sexually, but politically, socially and culturally.⁶ This understanding of desire intersects with race, class, gender, age, ability, sexuality and citizenship status; it advocates for youth’s ability to speak for themselves and to create the futures in which they want to live. SPs, of all varieties, alongside decision-makers and communities, have a role to play in achieving this highly desirable objective.

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RÉSUMÉ

OBJECTIFS : La satisfaction et le plaisir sexuels font partie intégrante de l'expérience sexuelle humaine; pourtant, ces aspects essentiels de la sexualité sont rarement au programme des cours d'éducation sexuelle. Nous explorons comment divers groupes de dispensateurs de services (DS) ayant participé à l'enquête Toronto Teen Survey (TTS) conçoivent le rôle du plaisir dans l'éducation sexuelle des jeunes, en soulignant les difficultés et les avantages d'enseigner le plaisir dans divers milieux.

MÉTHODE : L'enquête TTS fait appel à la méthode de la recherche communautaire. De décembre 2006 à août 2007, des jeunes chercheurs ont administré 1 216 questionnaires à d'autres jeunes dans plus de 90 milieux communautaires à Toronto. En 2008, 13 groupes de discussion de suivi ont été menés auprès de 80 dispensateurs de services issus de 55 organismes de la région du Grand Toronto. Les transcriptions de ces échanges ont été saisies dans un logiciel de gestion des données qualitatives (NVIVO). Pour le codage et l'analyse des données, on a fait appel à la méthode comparative constante.

RÉSULTATS : Les DS ont exprimé des opinions partagées au sujet de l'inclusion du plaisir dans l'éducation et les programmes de santé sexuelle. On peut classer leurs préoccupations en trois groupes : le fait même de mettre le plaisir au programme; le rôle des sexospécificités dans l'éducation au plaisir; et les endroits et les professionnels qui conviendraient pour instaurer un programme d'études qui tienne compte du plaisir.

CONCLUSION : L'accès aux ressources, la formation et les antécédents personnels déterminent la volonté et la capacité des DS d'enseigner le plaisir sexuel. Les cliniciens ayant une formation médicale étaient les moins susceptibles de se voir comme des candidats à l'éducation des jeunes au plaisir; ils considéraient que les professionnels de la santé publique et de la promotion de la santé étaient mieux formés et mieux situés sur le plan organisationnel pour offrir de tels services.

MOTS CLÉS : adolescent; développement sexuel; enseignement; personnel soignant; Toronto; Canada