DEVELOPING UNDERSTANDING FROM YOUNG WOMEN'S EXPERIENCES IN OBTAINING SEXUAL HEALTH SERVICES AND EDUCATION IN A NOVA SCOTIA COMMUNITY:

LESSONS FOR EDUCATORS, PHYSICIANS AND PHARMACIES

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EXECUTIVE SUMMARY

People in their teens and early twenties are sexual beings, and many are sexually active. Young people are often able to develop the knowledge and skills required to protect their sexual health, and to take the action required for doing so. Unfortunately, many experience barriers to both accessing information, and to acting upon it.

The research outlined in this report represents an effort to understand the barriers which prevent young women from receiving maximally effective sexual health education in their schools, and related services from physicians and in pharmacies. Building upon survey work which we have carried out in the context of the Amherst Initiative for Healthy Adolescent Sexuality, we present in this report the lived experiences of young women in Amherst, Nova Scotia, as they have attempted to acquire and act upon knowledge related to this very important aspect of their lives. The research examines the experiences of these young women related to development of barriers to achieving sexual health.

This work was carried out as a partnership between members of the Department of Community Health and Epidemiology at Dalhousie University and the Amherst Association for Healthy Adolescent Sexuality (AAHAS). AAHAS is a non-profit society with a mandate to work with existing community resources to enhance and protect the sexual health of young men and women in Amherst. Young women representing the diversity of the Amherst community participated in in-depth interviews which examined their experiences in school-based sexual health education programs, in particular "Personal Development and Relationships", offered in grades 7 to 9. They were also asked to describe how their physicians approached the issue of sexual health, including providing information about sexual health and prescription of oral contraceptives. Finally, participants talked about what they had experienced in using pharmacies for access to condoms and oral contraceptives. Data from the interviews was analyzed using qualitative techniques to develop an understanding of how participants' experiences with sexual health education and services resulted in barriers to the most effective use of those community resources.

Barriers to sexual health education in schools related to three main areas:

- **school-based sexual health programs** (a repetitive and boring curriculum, avoidance of specific topics, contradictions with teachings from home and church, lack of relevancy on a temporal basis, and lack of credibility within schools themselves for sexual health education programs)
- **their teachers** (perceptions of their having different values from students and having judgmental attitudes, use of inappropriate personal examples in class, discomfort with certain sexual health topics, and in some situations, lack of knowledge of sexual health)
- **students themselves** (gender dynamics in sexual health education classes, and not seeing the teachers and guidance counsellors as resources for sexual health)

Key messages articulated by participants for educational policy makers and educators were:

- *schools should make sexual health education courses more difficult, with challenging projects and appropriate testing*
- *schools should pay particular attention to the creation of a comfortable learning environment for women, gay and lesbian youth, and students from all religious faiths*
- *schools should provide continuity of topics and teaching methods between sexual health education classes*
- *schools should develop methods for increasing the credibility of sexual health education*
- *teachers should carry out needs assessments for students at the beginning of the school year to add relevance to sexual health education*
- *teachers should use question boxes so that students can ask questions anonymously and avoid problems of embarrassment or ridicule in class*
- *teachers should establish ground rules in order to avoid inappropriate behaviour and responses in class*
- *teachers should make more use of guest speakers trained to teach sexual health topics*
- *teachers should include methods of teaching which allow students to explore how one might feel in different situations, and how one might handle those situations*

Participants talked about the following areas with respect to barriers to their making use of and being helped by physicians' services:

- **comfort and communication with the physician** (difficulty with trust in the physician-patient relationship, the age and (often) male gender of the physician, physicians' lack of time for discussion of sexual health, physicians' apparent reluctance to discuss sexuality)
- **barriers related to young women's needs for support for a high personal level of comfort in looking after their sexual health** (need for non-judgmental support for sexual health, the need for a confidential relationship with the physician and a lack of knowledge of their right to such confidentiality, apprehension about Pap testing)
- **physician access** (obtaining physician services in Amherst, impact of presence of parents at the physician's office)

Key messages articulated for policy makers and medical practitioners related to barriers at the physician level were:

- *physicians should introduce the subject of sexuality with young women in ways such as, "You are at the age where some people are choosing to become sexually active. If you ever want to talk about your options for sexual activity or birth control, we can do that."*
- *physicians should explicitly tell young women that their conversations and examinations are confidential, and that they will tell no one, not even their parents...even if they ask the doctor about it*
- *physicians should make young women feel that their sexual health concerns are real and legitimate*
- *physicians should acknowledge and effectively deal with any discomfort young women have in*

talking about sexuality and being examined
- *physicians should explain the Pap test in detail ahead of time, and not make it mandatory for obtaining oral contraceptives, at least initially*
- *ways should be explored to improve young women's access to family physicians services so that they can talk, and talk confidentially, with their physicians*

With respect to pharmacy services, participants located barriers in the following area:

- **personally felt/experienced barriers which interacted with barriers at the pharmacy itself** (the cost of condoms and oral contraceptives, embarrassment caused by the public aspects of condom purchasing)

Key messages provide by participants for overcoming these barriers at the pharmacy level were:

- *display and sell condoms in an appropriately private location in the pharmacy to increase young women's ability to purchase them in a confidential manner*
- *educate cashiers at pharmacies not to be (or appear to be) judgmental of young people purchasing condoms*
- *facilitate being able to call ahead when picking up prescriptions for oral contraception at the pharmacy, so that the prescription can be pre-packaged, reducing the probability that other customers will know what is being purchased*
- *make oral contraception available in a private location, such as the physician's office, to avoid having to purchase it in public*
- *make oral contraceptives available free when young women can't afford them*
- *make condoms available free at teen health centres*

It might be asked why we did not examine the positive aspects of sexual health education and services. After all, we could have examined what was working well just as easily as what was working poorly. We recognize that all those concerned with these issues are trying to deal as effectively as possible with this sometimes difficult area of health, and that very many things are done very well. Young people know a great deal about sexuality and sexual health, and much of this they have learned in school and from health professionals. Many young people make effective use of the health services provided them. However, it also must be recognized that many young people are not as sexually healthy as they might be, as comparisons with international data show. In this report we articulate lessons learned from young women's experiences in "the system", so that educators and health professionals will be better informed about what sorts of adjustments to that system are needed at both the policy and practice levels.

This research provides insights from young women's direct experiences with sexual health education and use of related health services in a Nova Scotia community. It is our hope that these insights will provide lessons for policy makers and service providers in the province, so that needed changes can occur to further protect and enhance the sexual health of our young people.

Developing Understanding From Young Women's Experiences in Obtaining Sexual Health Services and Education in a Nova Scotia Community

1.0 PROJECT SUMMARY

This project has built upon other work being carried out in the context of the Amherst Initiative for Healthy Adolescent Sexuality in Amherst, Nova Scotia. The work has involved Dalhousie and other Nova Scotia universities partnering with Amherst to explore the health services and education needs of young people, and in the use of a community development approach to meet these needs. Consensus about directions the community should take is built through a not-for-profit community group, the Amherst Association for Healthy Adolescent Sexuality (AAHAS).

As researchers, part of our role has been to assist AAHAS to determine barriers to accessing and using sexual health services and education by youth in Amherst. We have found through surveys that community resources often do not effectively reach and help youth, and that youth can identify systemic barriers to physician and pharmacist services, and school-based sexual health education. For example, we have found that many young people are kept from seeking physicians' services because of feelings of embarrassment and fear that physicians will inform parents about their sexual activity. We also have explored barriers to accessing school-based sexual health education, and services at pharmacies.[1] These surveys provide information as to which perceived barriers keep young people from accessing and using services and education for sexual health, and the proportions of young people affected by them. The deeper exploration of young women's experiences outlined in this report provides explanations for their perceptions of these barriers, and the opinions of young women as to which interventions can overcome them.

1.1 Research Objectives

The objectives of the project were: 1) to confirm or refute perceived barriers which young women in Amherst have to accessing and using sexual health services and education, as determined by our previous work; 2) to identify additional perceived barriers as perceived by these young women; 3) to explore the reasons for their having these perceptions, based on their lived experiences; and, 4) to ascertain how, in the views of these young women, such services can be best delivered within the current health and educational systems.

1.2 Background and State of Current Knowledge

The following section discusses background related to our partnership with the Amherst Initiative for Healthy Adolescent Sexuality, definitional issues in sexual health, aspects of gender and risk, barriers to young people's being able to achieve sexual health, and the need to explore those barriers more fully.

1.2.1 Partnership with the Amherst Association for Healthy Adolescent Sexuality

Working with schools and with Cumberland County Family Planning since 1992, we have found that young people attending high school throughout Cumberland County were not being effectively reached by sexual health services and related school-based education.[2,3] Subsequently, we began collaboration with a steering committee from Amherst to assess the potential for using a community development approach to address determinants of sexual heath in young men and women. This led to the formation of a unique not-for-profit society, the Amherst Association for Healthy Adolescent Sexuality (AAHAS), our community partner in Amherst. AAHAS is made up of young people, parents, citizens and representatives of governmental and non-governmental organizations with the commitment to work together towards helping young people with their sexual health. The goal of AAHAS is " To bring the community of Amherst together, through the use and enhancement of existing community resources, to improve the sexual health of Amherst's adolescents." Our role in working with AAHAS is to provide information, through surveys, focus groups and interviews, to support a number of approaches to enhancing adolescent sexual health in the community. Among other initiatives, which include working to support parents, provision of information related to sexual health through the local media, working with professionals, and enhancement of school-based education, AAHAS directs the work of a teen health centre located in Amherst Regional High School.

1.2.2 Definitions of sexual health

We are sexual beings throughout our lifetimes. However, it is during adolescence that most of us become fully aware of our sexuality and when sexual health, if not positively promoted and supported, can lead to negative consequences.[4,5] The question, "What is sexual health?", has long been debated in the medical, academic and health promotion literature. The World Health Organization defines sexual health as,

> *...the integration of the somatic, emotional, intellectual and social aspects of sexual beings in ways that are positively enriching and that enhance personality, communication and love.*[6]

This definition is further subdivided in the WHO guide for professionals on sexual health promotion into the following three elements:

- *the capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic.*
- *freedom from fear, shame, guilt, false beliefs and other psychological factors that inhibit sexual responses and impair sexual relationships.*
- *freedom from organic disorders, diseases and deficiencies that interfere with sexual and reproductive functions.*[7]

An alternative definition provided by Marie Goldsmith[8] suggests three essential components to sexual health:

~ *absence and avoidance of STDs (including HIV)*
~ *control of fertility and avoidance of unwanted pregnancy; and*
~ *sexual expression and enjoyment without exploitation, oppression or abuse.*

Another definition, attempting to encompass issues of control, exploitation, STDs and pregnancy while acknowledging sexual pleasure comes from Peter Greenhouse, "Sexual health is the enjoyment of sexual activity of one's choice, without causing or suffering physical or mental harm."[9]

Regardless of which definition of sexual health is used, our research clearly indicates that there is a strong need for addressing young peoples' concerns for sexual health in Nova Scotia.[10,11,12,13]

1.2.3 Gender and risk

Constructs of masculinity and femininity are culturally entrenched and have dramatic impacts on sexual relationships between men and women. These relationships continue to be marked by an asymmetry that puts women at a disadvantage, both socially and sexually.[14] Research shows that women are subject to both subtle and overt sexual pressure from men.[15] Studies also show that women often assume the male is more experienced and that women can lack the confidence to express their sexual needs, often deferring decisions about sexual health to the male.[16]

The complicated nature of gender dynamics present in sexual relationships are highlighted by some of the findings of the Amherst project to date. Many of the sexual relationships among teens in Amherst are marked by a pronounced age differences with the male partner often being substantially older than the female,[1] as is seen in other studies.[17,18] Moreover, there is evidence suggesting that sexual coercion is a problem for Amherst teens,[19] as it is elsewhere.[20,21,22] This occurs in an environment which encourages sexual activity, and defines young people, especially young women, in terms of their sexual value, without promoting safer sexual practices.[14] It is clear that the power dynamics involved in sexual relationships can play a significant role in sexual risk taking, and that sexual health education and services have roles to play in addressing these issues.[23]

1.2.4 Adolescent sexual health

Almost 50% of Canadian grade 11 students have had intercourse,[24] as have more than 60% of Nova Scotia grade 12 students.[25] Students at Amherst Regional High School (ARHS) are equally sexually active, and many practice unsafe sex. Our 1996 student survey found that 40% of ARHS students had more than one sexual partner each year, that 22% of females lacked both oral contraception and barrier protection at last intercourse, and that only 41% used condoms regularly.[1] STDs and unwanted adolescent pregnancy can have short and long term negative effects with enormous costs to the individual, community, health and social support systems. STDs can lead to pelvic inflammatory disease, infertility, and the occurrence of ectopic pregnancy.[26,27,28,29,30] Young people are at high risk of acquiring STDs, with the highest rates of chlamydia being seen in 15-19

year old females.[31,32] Rates of teenage pregnancy have increased in Canada since 1987,[33] but are reasonably stable in Nova Scotia at about 45/1000,[34] with rates in Amherst being slightly above this level.[1] Adolescent pregnancy is usually unintended, and may result in low birth weight infants and preterm delivery, and a higher infant mortality rate.[35]

1.2.5 Barriers to young people's achieving sexual health

Effective approaches to helping young people with their sexual health are comprehensive, and involve parents, teachers, community agencies and leaders, health professionals, and youth themselves.[36,37]

Effective relationships between physicians and young people are crucial to prevention,[38,39,40,41] but sexuality education for physicians is often inadequate.[42,43] Physicians often do not take sexual histories from young people,[44,45,46] and physicians in Nova Scotia often do not ask about sexual orientation and practices.[47] In 1997, only 23% of ARHS students reported receiving helpful sexual health information from their family physicians,[1] a finding in keeping with work showing that many Nova Scotia physicians have difficulty helping young people with sexual health.[14] ARHS students have misconceptions about their right to confidentiality with physicians and many students (34%) believe that physicians require parental consent to prescribe oral contraceptives to women younger than age eighteen. Many students are embarrassed to talk to physicians about sex, fear that parents will be told about their sexual activity, and perceive that physicians lack respect for sexually active teens. Sexually active young women in Amherst who perceive these barriers are significantly less likely to have used contraception at last intercourse.[48]

Teachers often do not have backgrounds in health or sexuality.[49] Canadian sexual health teachers often lack knowledge in selected areas, and typically use limited classroom strategies for teaching sexual health.[50] Professional development activities for teachers often lack continuity, taking the form of occasional in-service sessions,[51] often for only a single day or less, with no provision for follow-up or linkage to other in-service sessions. These factors, combined with the fear of confrontation that comes from teaching value-laden topics[52] makes it unsurprising that teachers can restrict themselves to "safe" topics and narrow ranges of instructional strategies. At Amherst Regional High School, perceived lack of knowledge on the part of teachers, and the perception that teachers are embarrassed to discuss real sexual health needs were seen as barriers to getting sexual health information for 38% and 39% of female ARHS students respectively. In addition, 50% of female students indicated that school subjects not covering sexual health topics in enough depth was a barrier to getting the sexual health information they felt that they needed, and 26% indicated that fear of teachers and/or guidance counsellors telling their parents kept them from getting this information.[1] Higher mean scores on sexual health knowledge testing in female students in Amherst were associated with more use of contraception at last intercourse,[53] reinforcing the importance of knowledge to sexual health decision making.

While there is very little written concerning the roles of pharmacists in helping young people with

their sexual health, adolescent females in Amherst perceived lack of privacy (34%), embarrassment asking for oral contraceptives at a pharmacy (30%) and cost (19%), as barriers to their obtaining oral contraceptives at pharmacies. Each of these barriers was significantly associated with not using any form of contraception at last intercourse in young women in Amherst.[48] Since the pharmacy setting is the only source of access to oral contraception, and a major site of condom availability, it is clear that this source of service is an area where action can be taken to assist young people in maintaining and enhancing their sexual health.

1.2.6 The need to explore young women's experiences with sexual health education and related services

Our work with the AAHAS has identified challenges to accessing and using sexual health services and education for young women in Amherst. However, these observations from previous work do not explain why these challenges exist, an explanation necessary for informing health and educational policy change. The descriptive study outlined in this report has applied theme analysis within a phenomenological approach to a series of intensive interviews with young women in Amherst in order to ascertain their ideas, feelings, experiences, perceptions, perspectives, intentions, motivations and expectations of sexual health and education services in their community.[54,55,56,57,58]

1.3 Study Methods

1.3.1 Study design

This inquiry was a qualitative descriptive inquiry study which examined the experiences of young women in Amherst related to their perceptions of barriers to achieving sexual health, and their views as to the relative importance of those perceived barriers. It also provides recommendations for sexual health services and education based upon interviews with these women. The research was developed and planned with community partners, including the Project Coordinator, the Nurse Educator, and adolescent members of AAHAS, who provided background information as to possible experiential reasons for the perception of barriers to sexual health education and services, reviewed interview guides, helped with selection of participants and reviewed research findings as they were developed.

In-depth interviews using an interview guide (Appendix 1) were conducted with 28 young women in Amherst between April and July, 1998. Informed consent was obtained before each of the interviews (Appendix 2). Interviews explored participants' perceptions of barriers to their making effective use of sexual health education and services, and the experiential basis of the development of those perceived barriers. Interviews also inquired about participants' views as to how services and education could be improved. Following the interviews, and using the barriers identified by the young women themselves, a method for ranking the relative importance of barriers was developed, and 26 of the 28 women worked through the ranking exercise (Appendix 3). Next, follow-up

interviews to further explore and refine initial findings were carried out with 12 of the original participants. Finally, a discussion of key findings was presented to a group which included both participants and non-participants to validate and further develop the study results.

1.3.2 Study participants

Participants were recruited with the assistance of a key informant who was a student at ARHS and a founding Board member of AAHAS. She was assisted by another student with a different background and social network. The key informants' roles were as identifiers of potential participants, who were selected to include a broad age range and social background of adolescent women in Amherst. Inclusion of African Canadian women was assured by making contact with a women well-established in that community in Amherst. Very few First Nations people reside in the community and though an interview with a First Nations woman was arranged, that person had moved away before the interview could take place.

Participants in this study were 28 young women from Amherst or its immediate surrounding area, ranging in age from 15 to 18 years; seven were age 15, seven age 16, six age 17 and eight age 18. Participants represented a wide range of academic interest and performance. Three of the young women were African Canadian, the rest were Euro-Canadian. All were unmarried, though many were sexually experienced and several lived with partners. All had completed at least grade 9 at Amherst Regional High School, and with exception of two participants, all had completed their junior high school education (grades 7 and 8) in the Amherst area. Only one person declined to be interviewed, without giving a reason, and two potential participants did not appear for a scheduled interview; the reasons for this are also unknown. No parent of those younger than age 18 refused permission for their child to be interviewed. Twelve of these 28 women also participated in follow-up interviews.

1.3.3 Data management and analysis

Interview data were managed using QSRNUDIST 4.0 software.[59] This software helps to store, read, code, explore, present and write about qualitative data. Data from the barrier ranking exercise was analyzed using EpiInfo 6.04.[60]

Thematic analysis was done through coding in NUD*IST. A phenomenological approach was employed, and theme development was utilized to uncover and understand the nature of the experiences of the participants in obtaining sexual health education and services.[55,56, 61,62] Initial organizational categories emerged from the data, and relationships among and between participants' experiences with family, friends and related social-ecological factors were explored. Bias was checked for by incorporating the trustworthiness and credibility of the data through member checks and peer debriefing.[63]

1.3.4 Ethical considerations

Parents of potential participants who were younger than age eighteen, and participants themselves, were fully informed of the nature of the research, and of the voluntary nature of participation, including the lack of impact of non-participation on receiving health care and other services. Both parents and participants were asked to provide written indication of these understandings where the potential participant was younger than age 18 (Appendix 2). The confidential nature of participation was maintained during and following the study. Ethical approval was obtained through the Human Ethics Review Committee, Faculty of Graduate Studies, Dalhousie University.

1.3.5 Subjective location

Due to the nature of qualitative inquiry, the field researcher (EM) served as data collector and the filter through which the data were interpreted. Her background as a sexual health educator provided her with a solid understanding of the issues involved with adolescent sexual health. The field researcher felt she was able to enter this inquiry with interest and empathy for participants and with a non-judgmental attitude towards adolescent sexual behaviour. At the same time, the potential for bias and presumption was present. To the fullest possible extent caution was taken to prevent preconceived notions from guiding the direction of inquiry and the observations recorded. Care was taken that observations, hypothesis generation and analysis were guided as much as possible by the voices and experiences of the participants.

1.4 Partnership Development

This project has allowed us to develop existing partnerships more fully. With the guidance and active participation of AAHAS we have been able to develop information which will be of very real interest and use to AAHAS in carrying out its mission. The project would not have been possible without the committed efforts of the Nurse Educator at the Teen Health Centre run by AAHAS, and the AAHAS Project Coordinator, who was involved with development of the interview guide and with identification of participants. Other partnerships have also been enhanced, both with Amherst Regional High School which facilitated interviews, and with Northern Health Region, with whom we work very closely in all aspects of the overall initiative.

1.5 Project Sequence

The project followed a sequence of development which allowed it to unfold in a manner which maximized community participation and adhered to its planned activities. Early on, community members were involved in defining the issues to be explored, development of instruments and identification of potential participants. As data were collected and preliminary analysis was carried out, instruments were further refined, questions clarified and issues explored in greater depth with participants. Finally, a review of findings with participants and other young women allowed the researchers to feel confident that the experiences of young women in Amherst had been well

explored and interpreted. With respect to research objectives, these have been well met. Barriers discovered during our initial survey work have been confirmed, other barriers identified, and the origins of such barriers in the experiences of the young women who were participants in this research project have been explored.

1.5.1 Pre-project preparation (February, 1998)

Prior to the project's implementation, consent forms for parents and participants younger than age 18 were drafted, as was an interview guide. A proposal for ethical review containing this documentation was sent to the Human Ethics Review Committee Faculty of Graduate Studies, Dalhousie University, and ethical approval was obtained.

1.5.2 Initial steps (March-April, 1998)

The field researcher visited Amherst on April 17 and spoke with community members, the Amherst Association for Healthy Adolescent Sexuality Project Coordinator and the AAHAS Nurse Educator. From these meetings, and with the help of the key informants a list of potential participants was generated. During this time period, the field researcher furthered the literature review on adolescent sexual health, as background research for the project. Throughout this process the field researcher also kept confidential field notes on process, partners and the community.

1.5.3 Groundwork (April-May, 1998)

The final draft of the interview guide was developed. The guide was piloted with the first key informant on April 26. Adjustments to language, ordering of questions and addition of questions were made. The field researcher met with the Healthy Adolescent Sexuality Project Coordinator on April 28 to discuss methods for making contact and personal and parental consent forms. The field researcher then met with both key informants to review the list of potential participants, and initial interviews were requested.

1.5.4 First interviews/identification of relative importance of barriers (May, 1998)

First interviews were held between May 5 and 13, 1998, with four to six participants interviewed each day. Interviews ranged from one hour to one and one-half hours in length. After each interview the field researcher prepared notes on the interview, the participant, and other related factors such as the environment and school events. Following interviews, the field researcher reviewed notes and audio tapes of the interviews and made adjustments and additions to the interview guide. Field notes with preliminary themes and ideas were taken, and notes for potential follow-up questions for each participant were written.

Initial interviews were analyzed and lists of barriers to sexual health education and services identified by participants were constructed. These lists were presented to twenty-six of the original

twenty-eight participants, who were asked to rank order the barriers which they felt hindered Amherst's young women in obtaining sexual health education and services. (Two young women did not get to the appointment for this exercise; reasons for this were not given.) Data from the ranking exercise were analysed using EpiInfo.

1.5.5 Follow-up interviews (June-July, 1998)

During this time period, follow-up interviews were conducted with twelve of the participants to verify information, and delve into more depth with respect to major themes emerging from initial review of the data.

1.5.6 Transcribing (June-August, 1998)

Transcribing of all of the interviews was carried out by an expert transcriber. Transcripts were reviewed and corrected, and electronic copies were formatted for use with NUDIST software.

1.5.7 Theoretical verification (November, 1998)

To verify research findings, the field researcher and one of the principal investigators (DL) carried out a feedback session on November 2, 1998, in Amherst. Thirteen young women took part in the session, seven of whom had participated in the study and six of whom had not. Research findings were outlined and those in attendance were asked for their views on the congruency of findings with their own experiences and those of their peers. These young women were able to clarify and confirm various aspects of the research findings.

1.6 Study Results

Results are presented in three sections: i) barriers to school sexual health education; ii) barriers to obtaining physician services for sexual health services; and, iii) barriers to use of pharmacies for sexual health needs. After a brief discussion of each identified barrier and its origins in the experiences of the young women, quotes using their voices are provided to give context to those experiences. Next, a table ranking the relative importance of barriers for young women is provided. Finally, a list of participants' recommendations for improvements in the three areas is given.

1.6.1 Barriers to school sexual health education

This section provides data related to the experiences of young women in obtaining sexual health education in the Amherst school system generally. Such education takes place in both junior (grades 7 and 8) and senior (grades 9 to 12) high schools. As such, it should be interpreted as providing information about sexual health education in both levels, and not to any one school in particular.

The main program which addresses sexual health education in Nova Scotia schools, including those

in Amherst, is Personal Development and Relationships (PDR). PDR is compulsory in grades 7, 8 and 9, and is delivered in five units: i) climate building (getting acquainted, program overview and expectation, student rights and responsibilities, and student commitment); ii) self-awareness and acceptance (self, feelings, decision making); iii) relationships (family, peers, community); iv) human growth and development (puberty, assertive behaviour, decision making); and, v) career planning (career awareness, preparation and planning).

Family Studies, compulsory in grades 7 and 8, and elective for grades 9 to 12, and a recently introduced program, Career and Life Management, address related issues (individual and family development, child studies) and provide some opportunity for discussion of sexual health topics.

Previous work we have carried out in Amherst[64] reveals that a fairly wide range of sexual health related topics are in fact addressed in the context of these programs. These include:

- *personal identity, self-concept, self-esteem, self-confidence*
- *connecting thoughts about self to intimate relationships and sexual behaviour*
- *feeling sexual arousal, feeling in love, dealing with rejection*
- *making decisions, being assertive, and communicating*
- *dating behaviours, including how to show respect and affection*
- *sexual behaviours, including abstinence, and specific sexual practices*
- *human development, including puberty, reproduction, anatomy and physiology*
- *sexually transmitted infections*
- *marriage and parenting*
- *sexual orientation*

Interviews with the young women established that barriers to sexual health education in Amherst schools relate to three central components: issues with the sexual health courses, factors related to teachers, and factors related to students themselves. These factors are themselves complex and interact with influences from parents, religious background, gender, the community and cultural norms and expectations. It appears that all of the barriers can be addressed pro-actively, with participants providing many insights into how to improve sexual health education in Amherst schools.

1.6.1.1 *Barriers related to sexual health education courses*

(i) course content being repetitive and boring, and lacking personal relevancy

A very prominent theme was that of PDR being repetitive and boring from year to year, with the same things being learned over and over again, albeit from slightly different perspectives and in differing levels of depth. PDR classes used a variant of the same text book each year, with little change in what was presented to students. Because of this, participants felt as if they were missing a lot of very important subject matter during PDR class.

Like a lot of things have been repeated like a lot. We don't really learn anything new. I don't know if there is anything new to learn but we don't go into like a lot of depth of like sexually transmitted diseases and things like that, and drugs and all that stuff... But it also gets sort of boring if you keep learning the same thing over and over.

They didn't teach me anything I didn't already know or because they just didn't do much in the way of trying to get you to understand. They just told you and that was it, and they moved on to something else.

In addition to this repetitiveness, methods of learning and testing (sheets to complete, multiple choice tests) were felt to be unrelated to the real world of sexual decision making that participants were experiencing. Participants had learned the basics of sexual health from a perspective that focussed on issues such as anatomy rather than their own experiences, feelings and interactions with others. A lack of personally relevant content was also articulated, and participants indicated feeling that a more realistic examination of the factors surrounding sexuality and sexual activity was needed. In sum, there was a dissonance between what went on in the classroom and in the everyday lives of these young women.

Ah, they never really talked about sex, they just talked about what happens during sex. Like the sperm goes up the fallopian tube, hits the egg... Like we don't care about that.

So like they would talk about maybe a condom every now and again... Like how to use birth control and a condom. They never talked about sex itself and when people start...the consequences. They never really talked about that. They just kind of skipped right over it...They just kind of beat around everything. Like they were almost scared to talk to us about it. They felt we were too young, and they didn't want to give us too much information for fear that it would upset our parents.

(ii) <u>topics not covered or avoided</u>

Unlike their experiences with other school subjects, students were aware that the content of the sexual health component of PDR varied from class to class. They believed that the reasons for these variations in course content related to the whim and comfort level of the teacher, who included or excluded material according to their own wishes, not necessarily considering the needs and wishes of students. Several topic areas were inconsistently covered, or not covered at all, and students indicated that this left a gap in their knowledge which limited their understandings of sexual health.

There are two PDR classes. We learned the condom thing, they didn't...Yes, the two classes are very different. They watched films and stuff, and we did like interactive stuff. Like our teacher, I think was more...just more comfortable with the whole sex thing than the other teacher.

Um, well, the actual sex act none of them handled well. They would never say anything.

It always started with sperm inside already. They never explained what happened to get it there, none of them did ever. I think they just assumed that we knew how that happened.

(iii) course material contradicting what students learn at home and through their church
Participants had difficult experiences in the sexual health components of PDR when the course material conflicted with what they learned at home and within the context of their religious teachings. Those with strong religious opinions or objections to course material talked about situations where they had been ridiculed by teachers and students when they expressed these points of view. Of all topics which created problems for these students, the most controversial was that of sexual orientation. Another concern expressed by participants included their parents' becoming upset over specific teaching methods in the class.

I told her [the teacher] ... Well, she was talking about being gay, and I said, "What makes you think it's right," and she just laughed. And I said, "Well, seriously, what makes you think it's right? Doesn't the Bible say it's not right?" And she just laughed all the harder, and I don't think it's right of her to do that.

What is taught by the church and your family is often contradicted in school and values get questioned and misunderstood.

(iv) Personal Development and Relationships offered at wrong times relative to sexual experience
Participants believed that teaching sexual health in the school was very important. However, these young women think about their sexuality in an event-oriented framework. Thus, prior to becoming sexually active, or even thinking about becoming sexually active, it is difficult for them to relate to the material that is being taught in PDR. Likewise, if they were already sexually active at the time of studying PDR, they often described feeling that the classes were too basic, that the classes presented material which did not meet many of their needs, and that they therefore didn't need the type of information and education provided at an earlier age.

And grade 9 was the only time that they had like sexual education class. And they just stopped it at grade 9. And I think they should have it go up through all the years, up to grade 12. Because I mean as a person gets older, I mean they are going to experience new things and they're going to want to know what is going on. I mean it can't always relate to what is going on when you are in grade 9. It's different now. When I [reached] grade 12, it was not grade 9. I got a lot more questions.

I just find it kind of funny because I would sit in class and she would be talking about the first time like you have sex, and it's like, "That was a while ago for me." Because it's a year and a half. It will be 2 years. So then I would be thinking how to prepare for it and stuff, and I'd be like, "Well, I've already done that." It doesn't really matter to you. Like it wasn't worth hearing because I already knew about it.

(v) Personal Development and Relationships not supported by schools themselves

Students perceive that PDR is not important and not valued within schools' teaching and administrative structures. Students' experiences included PDR not being taken seriously by teachers, and hearing teachers and school administrators speak negatively about the course. Perceived lack of legitimacy of PDR is translated to students who learn from talking with others that different classes learn different things, or about the same things differently, as previously outlined. Sexual health education is perceived by students as of less importance to schools than other subjects, resulting in students having less value and respect for this aspect of their education.

> *He [the teacher] just went on. He thought it was a joke too. He thought we weren't ready for it or that we already knew it, and he didn't want to care. He was just kind of there and we were there, and we would laugh and that was it, and that was the class. Show up and laugh, and you would get a mark.*

> *I think [the teacher] took it as a big joke and so did most of the students. And I found it at times annoying myself. Because I mean I'm there to learn. I mean we're going to be pushed into it or, you know, walk into it some day ourselves. I mean I didn't want to treat it as a joke... I think that kind of took away from the learning experience of it.*

> *Some people came from Halifax and they were gay..to talk to us and that was great...And [teachers and administrators] were like, I don't know, they said things that were arrogant. And other people heard that and it didn't go over well. WHAT KINDS OF THINGS? Well, like they [the visitors] shouldn't be here and ... They [teachers and administrators] didn't want the peer counsellors to see them either.*

Students also sense that PDR is not a priority course and that PDR is assigned to junior teachers, and those who would rather not be teaching it, and who are often not trained in sexual health. PDR teachers were always referred to by participants in relationship to other subject responsibilities (e.g., English teacher, guidance counsellor, etc.) never primarily as the PDR teacher. This confirmed and reinforced the lack of legitimacy and which students perceive for the PDR teaching role.

> *They were just reading what they had to. I don't think any of them really wanted to teach it, they just had to. Somebody put the book in front of them and said, "Here, read this."*

> *Like in 7 and 8, it was just an instance where the full time teacher... Well, grade 7, our full time health teacher, PDR teacher was out with [an illness]. The substitute was just sort of thrust into the role so she didn't have a whole lot of time to prepare anything. And grade 8, they were just scrambling once again because the same teacher had decided not to come back. So they were scrambling for another teacher once again. And the teacher that taught us in grade 7 was really a phys ed teacher. And the one who taught us in grade 8 was really an English teacher. Like they were just scrambling for someone to fill the position.*

1.6.1.2 *Barriers related to teachers*

(i) teacher seen as having different values, as being judgmental, and unable to relate to students
Participants consistently referred to their teachers as being "old". This we came to interpret as meaning that students perceived their teachers as coming from a generation having different values about sexuality, which in turn became a credibility issue. They felt teachers were not able to relate to their experiences and were, or could be, judgmental about their sexual behaviour. These assumptions were often substantiated when the teacher spoke judgmentally, had difficulty covering certain topics (e.g., masturbation), spoke about sexuality from a purely biological standpoint, and/or emphasized course content that did not relate to the experiences of the young women (e.g., strongly encouraging abstinence to young women who were already sexually active). As a result, students felt less willing to listen to their instructors, and did not consider asking them questions, even when they wanted to.

> *The teacher doesn't remember what it's like being a teenager. If they do, they don't show it.*

> *They are old fashioned. A lot of their views come out when they teach. I mean, even when they don't want it to...Just like "Kids shouldn't be doing that." A lot of the teachers have that attitude. Like homosexuality. It just makes you not be able to trust them.*

(ii) teacher addresses issues using examples drawn from personal experience
Participants were uncomfortable in PDR when teachers described personal situations, drawing on their own life experiences. When examples from teachers' own experiences and those of acquaintances were used, students felt uncomfortable. Students welcomed instructors' openness, but were concerned that an appropriate distance from personal circumstances always be maintained during sexual health education.

> *[The teacher] told personal experiences and that kind of thing. Like not too deep but I don't think we really needed to hear them.*

> *...it was great that [the teacher] felt so comfortable or whatever. But [the teacher] was like telling us like things that happened to [the teacher]. Like you don't really want to hear that from a teacher.*

(iii) teacher discomfort discussing certain sexual health topics
Participants had experienced occasions when teachers were visibly uncomfortable discussing sexual health material. These signs were avoidance of using proper terminology (e.g., penis), and using awkward and less specific terms (e.g., private parts); turning away from the class when speaking; not answering questions; and avoidance of certain topics by teachers. There were also times where both male and female teachers did not discuss sexual health matters relating to women.

My first year of PDR, we didn't learn much because it was a male teacher and he just didn't like talking in front of girls about stuff like that.

He wasn't comfortable just because, you know. Like this was his first year teaching at our school, and it was a bunch of girls and everything. But, you know, he was really great about it. If we had any questions or whatever, he answered them. You know, he really tried to help out...WHAT DID HE DO THAT SHOWED HIS DISCOMFORT? Well, um, like you know, when he was talking about like periods and stuff like that. He was kind of like crunching up and all that stuff.

But you just sense which teachers are comfortable and which aren't. You know, I had an English teacher one year, and she was obviously not comfortable... You know, she had never taught PDR before, that kind of thing. You can almost tell when someone is comfortable with what they are talking about and when they are not just by body language and that kind of thing.

(iv) <u>teacher appears to lack knowledge necessary to teach certain sexual health topics</u>
Participants felt some teachers lacked knowledge about sexual health. It was acceptable for a teacher not to always know the answers to questions, but the way shortages of knowledge were handled was key. As long as teachers were willing to listen to questions, discuss them and look for more information, students respected teachers' knowledge base. If however, the teacher did not discuss subjects beyond the text book and avoided questions, students were less respectful of the teacher's abilities.

...she was an English teacher and stuff. And yes, she knew the facts but she just didn't...wasn't able to answer a lot of questions. She didn't research.

I don't think she did [have enough knowledge] because I don't think she was teaching PDR before. I think she was just kind of put into it. So it was a lot of notes... Like some questions she couldn't answer.

Some classes had made use of local expertise to teach ceratin sexual health topics. Students who had experienced guest speakers in the class praised these individuals for their knowledge and presentation styles, and for the increased comfort provided by asking questions of someone other than a teacher.

We had workshops here at the teen health centre, and it was voluntary. And my friend and I just came to see what was going on. And I think they were really good so maybe we could have workshops in the classroom.

And have maybe even the teacher not even there so that if kids do want to ask questions, it's not, you know, the teacher is here.

1.6.1.3 *Barriers related to students*

(i) gender dynamics of sexual health education classes

Sexual health education develops a dynamic different from most other classes in the school curriculum. Depending on the situation, topic, teacher and their classmates, students can be embarrassed, confused, bored, or offended. Participants spoke about the class gender dynamic, stating that there were always a few young men who made inappropriate jokes, and acted disrespectfully. Teachers' joking with male students created an uncomfortable learning environment, where students would not ask questions. Participants also spoke about male students acting disrespectfully in class, putting the female students down, and objecting to course material more often than their female classmates.

> *It was kind of like a problem because then you felt embarrassed to talk about things in front of the guys because they would make fun of you. AND SO WERE THERE TIMES WHEN YOU DIDN'T SAY THINGS? Oh, I kept my mouth shut. I never asked any questions or anything. I just listened.*

> *There should be like a maturity level. Like they should say, "When you go in this class, it's not a joke. It's serious. It is what is going on. It's what is going to happen to you and what is going to happen to you for the rest of your life, and you should take it serious." Because I mean it's no laughing matter. I mean you ain't going to laugh when you walk around town saying, "Well, I've got AIDS," you know. That is no laughing matter.*

(ii) students not wanting to use teachers or guidance counsellors as resources

Participants generally would not go to a teacher or guidance counsellor for questions or concerns about sexual health. Based on what they had heard and even observed, they were concerned their confidentiality would not be maintained, and about judgmental attitudes on the part of teachers. They were also concerned that if the teacher were judgmental, the student would still have to see them in class, and that this might affect the teacher's overall assessment of them.

> *Last year, a girl thought she was pregnant, and [the teacher] told other teachers, and students had overheard them say it. And that girl heard a teacher say it to another teacher.*

> *I was just worried that, okay, if a teacher thinks I might be pregnant, does that mean they're going to like change their opinion of me? Does that mean they're going to think less of me? And I found I was really worried about that and I didn't want to go and discuss it.*

> *I don't know, I just found that, "Okay, if I go to talk to my teacher about my boyfriend and what happened last night, is he going to think about that in class when he's teaching the class and looking at me?" I don't know, it's just I worked really hard to get the grade*

that I did, and to be responsible and everything else. I just didn't want... I don't know, I found I didn't want a teacher thinking, "Oh my gosh, she's having sex."

1.6.1.4 *Relative importance of barriers to sexual health education*

Table 1 shows the ranking of barriers to sexual health education. Barriers are ranked in order of how important participants saw them to the adolescent women of Amherst in general, as opposed to themselves personally, and are presented in descending order according to how often they were ranked as most important. Because barriers could be ranked as ties, the per cent column totals more than one hundred. The most commonly ranked primary barrier was perception of the legitimacy of PDR. As has been seen, this is related to values established through the approach to sexual health teaching taken by schools, including who teaches PDR and their preparation for that role, and the attitudes shown by teachers and administrators, which are translated by students one to another.

Table 1. Ranking of Young Women's Barriers to Sexual Health Education (n=26)

Rank of Barrier		% Ranking Barrier #1*
1.	PDR is not taken seriously by some students	42
2.	PDR is repetitive (same material in grades 7, 8 and 9)	27
3.	Teachers at times appear to lack knowledge	23
	Male students acting up in class make the class uncomfortable	23
4.	Teachers are uncomfortable talking about sexual health	19
	Important topics are not covered	19
5.	PDR is boring (taught so it does not hold students' attention)	15
6.	Some topics are not covered well	12
7.	Subject matter about sexual health contradicts what the church teaches	8
	Subject matter about sexual health contradicts what parents teach	8
	Teachers use inappropriate personal examples when teaching PDR	8
8.	Teachers are too old to relate to young women	4
	PDR is offered at the wrong time to be relevant to students	4

* Students were able to rank barriers as "ties"

1.6.1.5 *Advice for improving sexual health education*

Participants highly valued sexual health education and recognized its relevance, necessity and importance. In particular, participants appreciated guest speakers who had been brought to the schools to teach on various sexual health topics, teachers' willingness to answer and/or research any question asked of them, and the interactive teaching methods used by some teachers. When asked about what could be done to improve school-based sexual health education in Amherst, many participants had very useful suggestions. The main themes which emerged from these discussions are those outlined in Table 2. These included specific policy actions which could be taken at the level of the school and techniques which individual teachers could use to improve the relevance and quality of sexual health education in the classroom.

Table 2. Participants' Suggestions for Improvements in Sexual Health Education

schools should make sexual health education courses more difficult, with challenging projects and appropriate testing
schools should pay particular attention to the creation of a comfortable learning environment for women, gay and lesbian youth, and students from particular religious faiths
schools should provide continuity of topics and teaching methods between sexual health education classes
schools should develop methods for increasing the credibility of sexual health education
teachers should carry out needs assessments for students at the beginning of the school year to add relevance to sexual health education
teachers should use question boxes so that students can ask questions anonymously and avoid problems of embarrassment or ridicule in class
teachers should establish ground rules in order to avoid inappropriate behaviour and responses in class
teachers should make more use of guest speakers trained to teach sexual health topics
teachers should include methods of teaching which allow students to explore how one might feel in different situations, and how one might handle those situations.

1.6.2 Barriers to obtaining sexual health services from physicians

Amherst is a community of 9700 people with a regional hospital. Most medical care is provided by the town's family practitioners, many of whom are overworked due to shortages of primary care physicians. Many women travel to Moncton, a distance of approximately 40 kilometres for specialist services related to sexual and reproductive health.

Barriers to obtaining sexual health services from physicians related to young women's comfort levels with their physician, their needs for support in development of a sufficient personal level of comfort in looking after their sexual health, and their access to physician services, including access to services where they could speak privately with the physician.

1.6.2.1 *Barriers related to comfort and communication with physicians*

(i) difficulty with trust in the physician/patient relationship

Participants expressed difficulty achieving a balance between knowing their physician well and being worried about how knowing him or her well might create the risk of their being judgmental or breaking confidentiality. Where there had been little contact between participants and their physician, there had not been the opportunity to build up the required trust. Discussing their sexual activity, asking for oral contraception, expressing concerns about pregnancy or sexually transmitted diseases, and anticipation of a physical examination including a Pap test were seen as very difficult under these circumstances.

HAVE YOU EVER TRIED TO GET INFORMATION ABOUT SEXUAL HEALTH FROM YOUR PHYSICIAN? Um, no, because I don't really know them well enough to do it. Because like where it's been switched around so much, I don't feel comfortable with them.

Not knowing [the doctor] well enough would be like talking about your personal life with a stranger...you don't know what the doctor will say or react to your questions.

Physicians were sometimes friends of participants' parents. Others had family members who worked at the doctor's office or attended the same church as the physician. Such relationships led to barriers related primarily to concerns about being viewed in a judgmental way, and worrying that the physician might tell their parents about their sexual activity. This situation is handled well when physicians assure young women about the confidential nature of their relationship. However, most participants had had little or no discussion with their physicians about their right to confidentiality in the doctor-patient relationship.

> *It's a small town, therefore young women usually know their physicians and may be uncomfortable talking to them [about sexual health] and not want parents involved.*
>
> *They [teenagers] are afraid for anyone to know because they don't want them to think any less of them. Like if they want to go out and experiment, type of thing, they don't want people judging them. Like especially the doctor.*
>
> *He's also a [certain religion] so he has opinions about things.. and he expresses them. Um, well, I'm a [certain religion] too so I go to the church. So um, he kind of, when I asked him for the birth control, he...kind of just gave them to me and passed them off... So it did make me feel uncomfortable.*

My parents are good friends with my physician so I was worried about confidentiality.

I don't know how to feel because I trust him but I guess I would feel kind of weird just because knowing... Like, he's my doctor and he's a good friend of the family.

(ii) their physician being older, and where examination was required, male

In ways similar to the barrier created by the perception of teachers being too "old" to provide sexual health education, participants referred to the older age of the physician as being a barrier to their feeling comfortable when obtaining services for their sexual health. This was manifested as concern that the physician was from a different generation, not wanting to talk with participants about their needs for sexual health. While discomfort with both male and female physicians around the issue of participants' sexual health was evident, if the physician was male, this was seen as a more pronounced barrier. Physician gender was most important when contemplating or actually undergoing physical examination, especially Pap testing.

That it's just basically like older male doctors usually. That, um, they talk about it but you just don't get the impression that they are willing to. And when they do, sometimes it's like sketchy details or whatever, when you are looking for concise facts.

I would prefer to go to a female doctor if I have to do anything with the female body part, like the female organs like for reproduction,[my] own reproduction.

Pap tests are new to young women and sound scary. No woman feels as if she can relate to a man [male doctor]...I hate the thought of someone else touching me.

(iii) their physician not having time for discussion of sexual health issues with them

Participants were made to feel uncomfortable with their physician when the doctor seemed rushed and not interested in discussing anything beyond a chief complaint. For many of these young women, their sexual health does not seem an immediate concern to their physicians, and they do not feel they can bring these issues up themselves. Many participants felt awkward making an appointment for the sole purpose of discussing their sexual health needs, which they felt might not be an important enough concern for such busy health care professionals.

If he seems really busy, like I feel bad going in like wasting his time.

People should be able to go see their doctor as someone who they should trust, and not be rushed or feel uncomfortable.

It seems that he's rushing you to get out there so you can't ask them anything, plus signs in the office say "keep it to one thing."

(iv) perceived physician reluctance to talk about sexual health issues

In the experiences of participants, if sexual health was ever discussed, it was up to the patient to bring it up with their physician since the physician had rarely raised the issue spontaneously with them. When the physician had not brought up sexual health before the participant became sexually active, participants felt apprehensive about bringing up the subject for the first time. This necessity for pro-actively broaching the topic of their sexual health could delay or even stop the participant from seeking physicians' services.

It sounds really weird but I think some of them are scared to talk about [sexual health]. That seems like my doctor was... Like it seems like he is scared to tell me stuff about it.

I've been there a couple of times without my mother, and he just hasn't said anything. Like I don't know if he thinks that he would be out of place mentioning it. I don't know. I think I would have to bring up the topic first.

I think that it's in a way, they need to approach us kind of. Like I think when you get like maybe seventeen, and you're coming in for regular visits or something, maybe they could say something like, "Do you have any questions about sexual health?" or, "Are you in a relationship?" Just kind of bring something up because then it doesn't leave it to us to say, you know, "Well, I'm in a relationship, and I want to get the pill," or whatever because I think that is hard for some people. Whereas if they bring it up first, just casually like asking them what is going on in their life kind of thing, that would be easier.

1.6.2.2 *Barriers related to participants' needs for non-judgmental support in development of a sufficient personal level of comfort in looking after their sexual health*

Participants expressed a need for support and understanding of the difficulties and fears they experience as they attempt to deal effectively with their sexuality. This was seen as being required from parents and physicians in particular, and included a need for general acceptance of their sexuality and sensitive treatment in their efforts to obtain services.

(i) the need for non-judgmental support for young women as they learn about their sexuality

There was a high degree of acceptance among participants that many of their peers are sexually active, and most seem to feel that their own sexual activity is acceptable. Yet, fear of stigmatization by other young people, especially physicians and parents, are of very real concern. Where parents were aware of their sexual activity, parental support was very important to the comfort of these young women in obtaining sexual health services from physicians.

They [teenagers] are afraid for anyone to know because they don't want them to think any less of them. Like if they want to go out and experiment, type of thing, they don't want people judging them. Like especially the doctor.
I just want people to be aware of what is out there and what is going on, and not feel

afraid or ashamed to talk or ashamed to buy the condoms or something. Because I think somebody should feel proud that they are... Like if they're going to be sexually active, to take care of themselves and do it the right way.

My group of friends...like they have good relationships with their parents, and they find it easy talking to them. And then they are not embarrassed to go to their doctor.

(ii) the need for a confidentiality and a lack of knowledge of their right to it

The concern for confidentiality expressed by participants who had not told their parents about their sexual activity is complicated by their lack of knowledge about there being no need for parental consent for them to obtain a prescription for oral contraception. Participants did not know of their right to confidentiality in obtaining this service, some having been misinformed by friends. This proved a barrier to young women in obtaining birth control.

It's just one of those things... I don't know. I've heard a couple of times that you can get them [oral contraceptives] without parents' permission but I don't really understand how you could like hide something like that from your parents.

I would be uncomfortable talking to him in the first place. And I would be kind of worried that he would tell someone, like my parents, that I was sexually active.

I'm just concerned about it because my doctor's secretary is my mom's best friend. But whenever I go to my doctor for something that I don't want my mom to know about, I just ask them not to put it on the records so the secretary can't see them and call my mom.

(iii) fear of having a Pap test

One of the most significant barriers for participants accessing sexual health services from their physicians was the participants fear of receiving a Pap test. Few participants had received a Pap test, but almost all were aware that they should have one after becoming sexually active. Very few of the participants had ever had a Pap test explained to them and while all expressed discomfort at the idea of having one, they weren't exactly sure what was involved or why the test is performed. In some cases the fear of a Pap test became a barrier to using oral contraception.

They [adolescent women] are afraid of the unknown, they don't know what happens during the [Pap] test or what to expect...I was afraid during my first Pap. I didn't know what to expect...

Like, if there was something wrong then I would go for one. But if I wasn't... I don't know, if there wasn't anything wrong that I could tell... like if I didn't see any need for it... but I would definitely do it if I needed one.

Well, when I went on the pill, he [my doctor], said I would have to go back in 3 months and get a Pap smear, but I didn't go because that really scares me.

1.6.2.3 *Barriers related to access to physicians*

Amherst is small town spread out over a relatively large area. There is no system of public transport, and many young women rely on their families for getting them to such places as the physician's office. As mentioned previously, there is a physician shortage in the town.

(i) accessing a doctor in Amherst
Due to the shortage of practitioners in Amherst, it is often difficult to get an appointment, and participants expressed this as a major barrier to obtaining both general and sexual health services.

...they are all overworked big time, and there is not a lot of doctors in Amherst. And a lot of them are going away so, they are overworked.

DO YOU HAVE A FAMILY DOCTOR? Yes. We just lost him, and we had a different one. We've been switching around quite a bit because there is not enough doctors in town and everything. So we've been losing doctors like crazy.

(ii) parents being at the physician's office during appointments, or knowing the reason for the visit
Participants could be uncomfortable if their parents accompanied them to the physician's office, or if the young women had to make arrangements for a visit to the physician's office about which the parent had to be informed.

... but my mom came with me. And like I said, she wasn't too happy with the whole thing. And I kind of maybe felt like I had made a mistake... Well, not made a mistake but like disappointed her or something.

I have my license now so usually if I have a doctor's appointment, I can make it myself and just tell my parents, "I've got a doctor's appointment and I need the truck or I need the car," and I can go. But there is really no doctor's appointment that I have to make without my parents knowing that I'm going.

1.6.2.4 *Relative importance of barriers to obtaining sexual health services from physicians*

Table 3 shows the barriers to obtaining sexual health services from physicians as identified by participants, ranked according to how important participants saw them to the adolescent women of Amherst. Because barriers could be ranked as ties, the per cent column totals more than one hundred. Misinformation about the need for parental consent to obtain oral contraceptives, concerns about confidentiality, and fear of a Pap test, and concerns about physician gender were the barriers most commonly ranked first by young women.

Table 3. Ranking of Young Women's Barriers to Physicians' Services for Sexual Health (n=26)

	Ranking of Barrier	% Ranking Barrier #1 *
1.	Young women are concerned that parental consent would be required to get oral contraceptives	39
2.	Young women are concerned about confidentiality (worried the physician will tell someone, especially parents)	35
	Young women are uncomfortable with a physician if they are male	35
3.	Young women fear receiving a PAP test	31
	Young women are uncomfortable with physicians when they don't know them well enough (e.g., they are a friend of the family or attend the same church)	31
4.	Physicians do not bring up the subject of sexual health before being asked	23
	Young women feel sexual health is not important enough to trouble a physician with	23
5.	Physicians do not have the time (too rushed, too many patients)	15
	Young women are uncomfortable with physicians when they know them too well	15
6.	Young women lack transportation to see a physician	8
	Physicians who are too old do not relate well to young women	8

* Students were able to rank barriers as "ties"

1.6.2.5 *Advice for improving sexual health services by physicians*

Participants were asked to comment upon and discuss ways in which physicians could make changes in their approaches and practices which would improve sexual health services provided to young women. Much of the advice provided to physicians pertains to practical and easy to implement steps that medical doctors can take to make young female patients more comfortable in dealing with sexual health issues and to facilitate communication and discussion. These suggestions relate very much to the need for enhanced physician-patient communication in this sensitive, and for young women, often difficult, area of health. Table 4 provides a thematic summary which outlines the most common and insightful comments provided as advice with respect to physicians' services.

Table 4. Participants' Suggestions for Improvements in Physicians' Sexual Health Services

physicians should introduce the subject of sexuality with young women in ways such as,"You are at the age where some people are choosing to become sexually active. If you ever want to talk about your options for sexual activity or birth control, we can do that."
physicians should explicitly tell young women that their conversations and examinations are confidential, and that they will tell no one, not even their parents...even if they ask the doctor about it
physicians should make young women feel that their sexual health concerns are real and legitimate
physicians should acknowledge and effectively deal with any discomfort young women have in talking about sexuality and being examined
physicians should explain the Pap test in detail ahead of time, and not make it mandatory for obtaining oral contraceptives, at least initially
ways should be found to improve young women's access to family physician services so that they can talk, and talk confidentially, with their physicians

1.6.3 Barriers to receiving sexual health services in pharmacies

Amherst has six pharmacies located mostly in large chain stores. All provide traditional services, including condom sales. As with most pharmacies in the province, no particular additional effort is made to assist young people in meeting their needs for contraceptives and condoms. Amherst, however, is one of several communities in the province able to make free condoms available to teens at a teen health centre located in Amherst Regional High School.

1.6.3.1 Personally felt/experienced barriers which interacted with barriers at the pharmacy itself

Personally felt barriers of embarrassment and a feeling of loss of privacy in obtaining sexual health services at pharmacies interacted with the layout and structure of the pharmacies themselves, so that participants felt uncomfortable in using pharmacies to obtain condoms and oral contraceptives.

(i) <u>the cost of condoms and birth control pills</u>

The cost of condoms at pharmacies was considered a barrier to their use by participants. Participants considered providing free condoms through the teen health centre a partial answer to this barrier, but the centre is not open every day and is closed on weekends, and during the summer.

> *I don't know. Like stuff is so expensive like now, like birth control. You know, some of it is like $50 ... really expensive. And not a lot of people can afford it.*

> *People want us to protect ourselves but they make birth control so only rich or well off people can afford them. Most people don't have 15 extra dollars to spend on a box of 12*

condoms. Especially kids.

I don't have the money for the pill. A lot of people are the same way.

(ii) concern about embarrassment caused by the public nature of making purchases at pharmacies
Participants expressed being uncomfortable purchasing condoms at a pharmacy because of concern over being seen by someone they knew, and/or the reaction of the cashier, or pharmacist. Concerns over assumptions that may be made about their sexual activity, the number of partners they may have, or information getting back to parents were serious barriers.

Confidentiality is lost if someone you know is there, or works there [at the pharmacy].

Ah, it [purchasing condoms] was embarrassing. I waited around the store for about 20 minutes to make sure there was like no one around that I knew, and then I ran up to the counter.

I just wouldn't go do that [buy condoms at a pharmacy]. Too many people around in Amherst that know me. I wouldn't want them seeing me do that because this is a very gossipy town, and they would be talking about it all through town.

I know people who work at the drug store I go to. Like there are a couple from my church and stuff like that. So I'm like when I go for a prescription, and they're stopping and they're going to talk to me. I'm like, "Ah." So now I don't. I don't buy anything personal at their drug store.

Much of this concern related to structural barriers at the pharmacies, which make condoms available through aisle displays, which necessitate making condom purchases at the check-out counter. Thus, due to the physical layout of pharmacies, buying condoms can be a very public event, and participants expressed real concern with the lack of privacy this can create. On the other hand, purchasing oral contraceptives can be done more discretely, and thus presents less of a privacy issue.

You have to stand in the aisle to select and carry out the condoms to the front of the store. There's the prospect of seeing people, or a price check. Just being seen with such a big, obvious box. It's scary.

Well, just because you kind of have to parade through the store and then you have to stand in the line up, and everyone is sitting there. Then they are going through what you have [when purchasing condoms]. Like at least when I go to the pharmacy to pick up my birth control pill, I get to go to the back counter... And then I just have to pay them and then I stick them in my pocket and walk out. You know, it's so much smaller and it's so much more discrete.

1.6.3.2 *Relative importance of barriers to obtaining sexual health services from pharmacies*

Table 5 indicates which of the barriers was ranked as most important for young women in obtaining sexual health services in pharmacies. These related most strongly to the public nature of transactions for health protection in this personal aspect of young women's lives, and the concern that they have about having too much visibility in the community while doing so. Cost associated with acquiring oral contraceptives and condoms, on the other hand, was a minor concern relative to these issues of privacy.

Table 5. Ranking of Young Women's Barriers to Pharmacy Services for Sexual Health (n=26)

Ranking of Barrier		% Ranking Barrier #1 *
1.	Young women are afraid to be seen by someone they know while buying condoms	85
2.	Young women are afraid to be seen buying birth control pills	50
3.	The cost of buying birth control pills is too high	15
4.	Young women are concerned about the behaviour of the cashier (comments, jokes)	12
5.	The cost of buying condoms is too high	12

Students were able to rank barriers as "ties"*

1.6.3.3 *Advice for improving sexual health services from pharmacies*

Many of the participants had used pharmacies for sexual health services. They or their partners had purchased condoms, and many participants had obtained oral contraception at pharmacies, and also had been given instructions from pharmacists about their prescriptions. As seen above, a number of barriers to utilizing these services was identified by participants, with concerns about confidentiality when making purchases at the pharmacy being paramount. It is of interest that while young women seemed to be accepting of their own sexual activity and that of their peers, there was an intense concern that personal privacy in these matters be protected so that knowledge of their sexual activity would not become a matter of discussion for others in the community. Many participants had suggestions for improving sexual health services at pharmacies in Amherst, and these related most strongly to steps which pharmacies could take to create a more private atmosphere for acquiring oral contraceptives and condoms, and to steps which could be taken by other health service providers to overcome the barriers to privacy encountered when visiting the pharmacy. The main themes which emerged from these discussions included those outlined in Table 6.

Table 6. Participants' Suggestions for Improvements in Sexual Health Services from Pharmacies

display and sell condoms in an appropriately private location in the pharmacy to increase young women's ability to purchase them in a confidential manner
educate cashiers at pharmacies not to be (or appear to be) judgmental of young people purchasing condoms
facilitate being able to call ahead when picking up prescriptions for oral contraception at the pharmacy, so that the prescription can be pre-packaged, reducing the probability that other customers will know what is being purchased
make oral contraception available in a private location, such as the physician's office, to avoid having to purchase it in public
make oral contraceptives available free when young women can't afford them
make condoms available free at teen health centres

2.0 DISSEMINATION PLAN

Our initial efforts at dissemination will involve those with whom we have partnerships in Amherst, including the young women who worked with us as participants. As indicated, a feedback session was held with participants in Amherst in mid-November, 1998, and participants expressed a strong interest in receiving a final report summary. To facilitate and encourage local action in Amherst, distribution of the Executive Summary and/or the final report, as well as discussions of results are planned for our partners in that community, including the Amherst Association for Healthy Adolescent Sexuality, Amherst Regional High School, Northern Regional Health Board and Community Health Boards in the Amherst area. We will also make the tables relating to relative importance of barriers and advice given by the young women for improvements available as information sheets for schools, physicians and pharmacies in Amherst and throughout the province.

In order to reach those with an mandate for creation of policy, copies of this report will be distributed to those in the Departments of Health and Education and Culture responsible for sexual health curricula and interventions at both the Provincial and Regional levels, and meetings will be arranged to discuss results and recommendations. Similarly, we will disseminate results to the Medical Society of Nova Scotia, the Nova Scotia Teachers Union, the Nova Scotia Pharmaceutical Society and Planned Parenthood Nova Scotia, where we hope to have mention of the research findings made in associated newsletters.

We believe that the results presented here are of real import for physician education, and will be meeting with medical educators in the Dalhousie University Faculty of Medicine to discuss findings and implications for physician training. In particular, we will link with Continuing Medical Education, Undergraduate Medical Education, the Department of Family Medicine, and the medical

communications project in the Division of Medical Education. Using such linkages, we will work with appropriate individuals to foster enhancement of physician education in the area of adolescent sexual health.

The project will be submitted for publication in *Health Promotion Atlantic* and the Canadian Women's Health Network Newsletter. We also plan several peer-reviewed publications based on further analysis of our data. Target journals include the Canadian Journal of Public Health, the American Journal of Health Promotion and the Canadian Journal of Human Sexuality. The former two journals will give wide exposure to the public health community in Canada, while the latter will make the findings available to Canadian sexuality researchers.

3.0 IMPLICATIONS FOR MCEWH MANDATES AND RESEARCH PROGRAMS

3.1 Generating new knowledge about factors influencing women's health

This project has involved young women in a small Nova Scotia community in research which has tapped their everyday experience to explore reasons behind their experiencing barriers to sexual health education and services. Moreover, the project has been able to develop an understanding of the origins of these barriers by exploring with young women what happens in their school and when they have attempted to obtain sexual health services from physicians and pharmacists. Although a fair amount is understood concerning what makes for good sexual health education[65] and health care services for young people,[38-41] very little previous work has been carried out which has attempted to articulate from young people's perspectives how barriers to obtaining them develop. The new understanding generated in this research as to how young women perceive the actions and words of their teachers, physicians, pharmacists and peers, and the existence of systemic factors which impede education and services, provides insights will be of real use in addressing these barriers.

3.2 Producing information reflecting gender-based realities in women's lives

Young women involved in this project were seen to deal with a number of issues which they attributed to gender. Whether this related to being examined by a male physician, to being in sexual health education class with male students who were behaving immaturely or to teachers who dealt inadequately with specific material and/or behaviours, it is clear that young women have to deal with issues directly connected to gender. In striving to overcome the barriers faced by young women in obtaining sexual health education and services, it is evident that the realities of being female, and of the issues raised by the interaction of genders must be considered part of the effort required for them to effectively do so.

3.3 Provide policy advice

The Women's Health Strategy of Health Canada call for research which increases knowledge and

understanding of women's health needs and supports the provision of effective health services to women.[66] With respect to the sexual health status of young women in Canada, in particular rates of adolescent pregnancy, Canada does not fare as well as some other countries, notably Sweden and the Netherlands, and the reasons for this discrepancy relate to accessibility of contraceptive services and sexual health education, and to links between these two type of service.[67] In the context of this project, young women have provided both data and opinion from their lived experiences in seeking services and education for sexual health from which much can be incorporated at a policy level. Much information was gathered concerning the reasons for the existence of barriers to education and services, and the views of the young women of their relative importance and methods for overcoming them. Those whose responsibility it is to provide the educational and service environments in which this seeking occurs will greatly benefit from this understanding, as well as the direct advice given by these young women about how that environment can be modified in ways which they feel would prove beneficial. It is our genuine hope and expectation that the findings of this research will be incorporated at a policy level so that the lives of young women can be made better.

3.4 Relevance to MCEWH Research Programs

Health services delivery, including education, is a recognized health determinant, with potential to impact the health of populations receiving such services.[68,69,70] Women's perceptions of barriers to accessing services will affect service use. This research augments our previous survey work in Amherst, Nova Scotia, which has catalogued barriers preventing young women from accessing sexual and reproductive health services and education, by increasing our understanding how, in the context of their lived experience, perceptions of those barriers have developed. Participants in the study have also provided solid recommendations which can be implemented by schools, teachers, medical practitioners and pharmacies to create a learning and service environment in which young women can more effectively take action to protect and enhance their sexual well-being. This process of listening to young women's voices about their experiences in learning about, approaching and obtaining health services and related education is relevant to Program 1 of the Centre, women's perceptions of their health and health determinants.

4.0 IMPACT ON POLICY -MAKING

In the Government of Nova Scotia's *Government by Design: Progress and Challenge 1995-1996*, the first stated goal under health is to "Provide affordable and accessible high quality health services in appropriate settings and locales that ensure a client-oriented focus".[71] Such approaches are compatible with health reform policy provincially and federally.[68,72] These goals, along with the Social Responsibility Goal of reducing teen (age 15-19) pregnancies per 1000 live births from 45.4 in 1994, to 41 in 2000, and again to 36 teen births per 1000 live births by the year 2005, are central to the policy context of our overall research effort in Amherst, and of the proposed research.

To achieve these policy objectives, it is necessary to have well-developed understandings of health

services and education issues, including challenges to access and use of those services currently available for use by young women. In carrying out this work, we have found that resources with a mandate for assisting young women with their sexual health are currently less than optimally suited to doing so, and thus in many important ways, fail. Our findings support our contention that providers have not considered sufficiently how to best provide services for young women in ways which overcome barriers to their effectiveness. Our research has explored the lack of such consideration through examination of the lived experiences of young women, adding depth and meaning to the understanding of the origins of barriers to service provision.

Sexual health services for young people in Nova Scotia are few, being currently (with the exception of metro Halifax) limited almost entirely to services provided by physicians. In Halifax, Metro Area Family Planning provides clinical services, and though this organization has affiliates in several communities, including Amherst, and though condoms can be distributed and important counseling can be obtained, other services can be limited in these affiliated centres. The Nova Scotia Department of Health in the mid-1980's established a system of sexuality education resource nurses (SERNS) for sexual health education, but this approach was, from the beginning, unable to provide adequate services due to lack of time and resources. School sexual heath education varies, with the nature of the information and the amount of time spent dependent on the approaches of individual schools and in some cases, teachers.[73] The paucity of sexual health services has resulted in systemic difficulties in serving young people well in this area of health. The findings of this report should, reviewed in consideration of other research,[74] encourage policy makers to make stronger efforts towards education and services in this important area of health.

With respect to areas where new policy directions (in addition to those related to improving existing services) could be informed by the proposed research, there is for example, potential for teen health centres to serve as vehicles for re-ordering service delivery. This research informs policy makers about the need to consider such new approaches, the potential for use of such alternative methods of service delivery as the nurse practitioner model, and the need to modify and enhance related professional education in all disciplines.

Appendix 1.

Developing Understanding From Young Women's Experiences in Obtaining Sexual Health Services and Related Education in a Nova Scotia Community:

Interview Guide

INTRODUCTION
Hi, my name is Emily Marshall. I am a student at Dalhousie University, and I am doing the interviews for this research project. Our goal is to understand the relationship between personal experiences in seeking and obtaining information and services related to peoples sexual health and how they relate to perceptions of barriers to services and education. We hope this information will help communities and those providing training and education services to do it better.

Before we get started, I want you to know that I am using a tape recorder. I will also be taking notes as we go along. There are no right or wrong answers. I am just interested in your opinions and experiences. If you don't want to answer any of the questions that is fine. You can also stop the interview at any time, without repercussion. Here is the consent form that explains a little more. Let's go over it together.

I think the interview should take about one and a half hours. Do you have any questions for me before we get started?

DEMOGRAPHIC INFORMATION (lead-in *I am just going to start with some general questions*)

What grade are you in?

How old are you now?

What is your ethnic background?

How would you say you are doing in school?
What are your grades like?

Do you know how far you want to go in school?
Do you plan to graduate?
Have you thought about going to college or university?

What about a future career? Do you have an idea of what you would like to do?

Do you have a job now?

Are you dating someone right now?
Tell me about that relationship?
(Have you had sexual intercourse?)

EXPERIENCE WITH SEXUAL EDUCATION IN SCHOOL

What kinds of sexual health education can you remember getting in school?
Classes
Teachers
Guidance counselors

What topics did they cover?- (STIs, pregnancy, contraception, relationships *look for positive/negative language. For each kind mentioned*)

Do you think they were good? Why/Why not?(For each one)

How do you think other students see them?(For each one)

Do you think the teacher knew enough? Why/why not? Can you think of a question or topic they did/did not handle well?

Did you ever feel a teacher (specify) avoided certain topics? Which ones-teachers/topics?

How do you feel about the idea of approaching teachers about sexual health issues?(Such as what kind of contraception to use, fear of pregnancy...)
Do you think the teachers/guidance counselors that you mentioned are approachable?
Have you ever thought about asking them a personal question? What happened?
Is there a time you or someone you know didn't go when you thought you might?
Would you worry about them being judgmental?
Do you know an example of this happening? Tell me about it.

Would you be afraid they might tell someone else/break your confidentiality?
Has this happened to you? To someone you know?
What happened?

So, have these concerns of (confidentiality, judgmental opinions, etc...) Stopped you from going to them? How about other students?

EXPERIENCES WITH PHYSICIANS

Have you ever gone to a physician for contraception?
What happened? Why did/didn't you?

What are the physicians rules about confidentiality?
Can they tell your parents? Would they?
Has this happened to you? Anyone you know?

Do you think a physician's opinion of a teenager would change if they went to ask about contraception?

Do you think they know enough?

Do you ever feel your physician avoids certain topics?

Has your physician brought up sexual health issues with your first, or do you have to bring it up first?

Do you remember the first time your doctor brought up contraception?
Do you know what prompted your doctor?
How did your doctor handle the talk?
How did your doctor make you feel? Why?

Have your concerns about (confidentiality, judgmental opinions, etc...) Ever stopped you from going to your doctor to ask about contraception?

What else might stop you?

EXPERIENCE WITH PHARMACY

Have you ever thought of going to a pharmacy for contraception? Did you?
Why/Why not?

When you go to the pharmacy (or think about going to the pharmacy),how do you feel about it?
Do you worry about:
-confidentiality? Why...can you think of an example?
-What people there will think of you?

What else might stop you from going to the pharmacy?

WIND DOWN

Can you think of positive times where a teacher/pharmacist/doctor encouraged your sexual health?

What kind of things would you like to see to help students with their sexual health?
Do you think it is important? Why/why not?

Is there anything else you would like to share at this time?

These are all of the questions I have for you at this time. How are you feeling?

*I may be contacting you for some follow-up, to clarify the information you gave me. In the mean time you can contact me at any time at ****. If you have any concerns or questions you can also call ****. I am also going to give you a referral list in case you want to talk to anyone at these services. Let me just go through what they offer.*

Do you have any questions?

Well, then thank you very much for your time. This has been very helpful.

Appendix 2.

Developing Understanding From Young Women's Experiences in Obtaining Sexual Health Services and Related Education in a Nova Scotia Community

Parent/Guardian Consent Form

TO: **Parents or /Guardian of [daughter's name]**

RE: **Permission for your daughter to take part in a study to examine female adolescents' experiences in obtaining sexuality and reproductive health education and services.**

We would like you to consider permitting us having your daughter [daughter's name] take part in an interview for purposes of a research study. We wish to know more about the experiences young women in Amherst have in obtaining sexuality and reproductive health education and services. Participation is voluntary and you do not have to agree to allow us to ask your daughter to take part. Even if you agree initially that your daughter can be asked to take part in the interview, she may refuse to participate, or if she agrees initially, may withdraw at any time.

Who is conducting the study? The study is being conducted by researchers from the Faculty of Medicine at Dalhousie University, in cooperation with the Amherst Association for Healthy Adolescent Sexuality. This Association is composed of a wide variety of individuals and community groups and agencies, including the administration of Amherst Regional High School, and the Nova Scotia Department of Health. Interviews will be carried out by Ms. Emily Marshall, who is working under the supervision of Drs. Donald Langille and Janice Graham, both members of the Faculty of Medicine at Dalhousie University.

How will the study be conducted? About 30 female adolescents from the Amherst area are being asked to take part in these interviews. Each interview will take about 1.5 hours each to complete. Interviews will take place in the Teen Health Centre located in Amherst Regional High School during regular school hours. Participation will be voluntary and no one will be told that your daughter took part in the study. Responses will be kept confidential, so that the information given can not be linked to individuals who participate. No one, including parents of participants, will have access to information which can be linked to individuals. Your daughter may refuse to participate and can withdraw from the study at any time.

Potential Benefits of the study. The study is being carried out to determine the experiences that young women in Amherst have obtaining sexuality and reproductive health education and services. We want to understand how those experiences result their perceiving barriers to obtaining such education and services, so that efforts to remove these barriers can be undertaken, and more effective education and services can be provided young people in Amherst. The information will also be helpful to other communities as they attempt to deal with this important area of health.

Potential Risks of the Study. We foresee no risk to participation in the study. Such interviews are often carried out in research projects, and we are not aware of any associated risks.

We would like to include your daughter [daughter's name] for participation in such an interview. We ask that you please complete the attached form, indicating that WHETHER OR NOT YOU GIVE PERMISSION FOR HER PARTICIPATION, and have your daughter return it Ms. Christina Chitty, Nurse at the Teen Health Centre, Amherst Regional High School.

Developing Understanding From Young Women's Experiences in Obtaining Sexual Health Services and Related Education in a Nova Scotia Community

Parent/Guardian Consent Form

I have read the information in the attached memo and am indicating my decision about my daughter [daughter's name] participating in the study as marked (please check one response):

I AGREE _____

I DO NOT AGREE _____

That my daughter [daughter's name] may participate in the interview being carried out as part of this research project.

Parent/Guardian's Name (Please print): _____

Parent or Guardian's Signature _____ Date _____

If you have any questions or concerns about the study, please contact:

Dr. D.B. Langille
Dept. of Community Health & Epidemiology
Faculty of Medicine
Dalhousie University
Clinical Research Centre
5849 University Avenue
Halifax, N.S.
B3H 4H7
Phone: 1-902-494-1312
Fax: 1-902-494-1597

Developing Understanding From Young Women's Experiences in Obtaining Sexual Health Services and Related Education in a Nova Scotia Community

Consent Form For Interviewees

TO:

RE: Permission for your participation in a study to examine adolescents girls' experiences in obtaining sexuality and reproductive health education and services. We are asking you to consider taking part in an interview to help us better understand the experiences adolescent girls in Amherst have in getting education and services related to sexual and reproductive health. We want to talk to you about how those experiences lead to the formation of barriers to girls' getting such information and services. After you have read this page, which contains information about the study and the interview, we would ask you to indicate your decision about participation on the attached consent form. Participation is entirely voluntary, and you may refuse to take part. Even if you agree to take part in the interview, you may withdraw at any time.

Who is conducting the study? The study is being conducted by researchers from the Faculty of Medicine at Dalhousie University, in cooperation with the Amherst Association for Healthy Adolescent Sexuality. This Association is composed of a wide variety of individuals and community groups and agencies, including the administration of Amherst Regional High School, and the Nova Scotia Department of Health. Interviews will be carried out by Ms. Emily Marshall, who is working with Drs. Donald Langille and Janice Graham, both members of the Faculty of Medicine at Dalhousie University.

How Will the Interview be Conducted? The interview will take about 1.5 hours each to complete. Participation is voluntary and no one will be told that you took part in the study. Responses will be kept confidential, so that what you say in the interview cannot be linked to you personally. You may refuse to answer any question asked of you. You may withdraw from the study at any time, without any impact on your ability to use health services, such as the Teen Health Centre at the high school. With your permission, the interview will be taped so that we have a complete record of your responses.

What Takes Place After the Interview is Finished? The results will be typed out (transcribed) so that analysis of your responses can take place. Your name will not appear on the transcriptions. No one, other than the interviewer, will be able to link your responses to you personally. Your responses will be combined with those of other girls, so that we can have a better overall understanding of the issues in which we are interested. The tapes and transcriptions will be stored in a safe and secure area at Dalhousie University, and will be destroyed once the study has been completed.

Potential Benefits of the study. The study will help us understand how the experiences adolescent girls have in trying to obtain education and services related to sexual health result to barriers to their getting such information and services. With this information, we can work to remove these barriers, and more effective education and services can be provided young people in Amherst. The information will also be helpful to other communities as they attempt to deal with this important area of health.

Potential Risks of the Study. We see no risk to your participation in the study. Such interviews are often carried out in research projects, and we are not aware of any risks which they can create.

I have read and I understand the attached information. I understand that participation in the interview is voluntary, that I may refuse to participate in the interview, or withdraw from it, at any time, and that I can refuse to answer any question. I understand that no person other than the interviewer, [name of interviewer], including my teachers and my parents, will know what my responses to the interview questions are. I also understand that after the study, all records of my individual participation will be destroyed.

I am indicating my decision about participating in the study as marked (please check one response):

YES, I AGREE TO PARTICIPATE IN THE STUDY BY TAKING PART IN THE INTERVIEW, AND TO HAVING THE INTERVIEW TAPED. _____

NO, I DO NOT AGREE TO PARTICIPATE IN THE STUDY _____

Participant's Name (please print) _____

Participant's Signature _____ Date _____

If you have any questions or concerns about this study, please contact:

Dr. D.B. Langille
Faculty of Medicine
Dalhousie University
Clinical Research Centre
5849 University Avenue
Halifax, N.S.
Phone:1-902-494-1312
Fax:1-902-494-1597

Appendix 3.

Developing Understanding From Young Women's Experiences in Obtaining Sexual Health Services and Related Education in a Nova Scotia Community:

Follow-up Questionnaire-PHYSICIANS

For young women generally, how important do you think the following are in hindering adolescent women from going to a physician to discuss their sexual health: (please rank the most important to the least important. You may use the same number twice, and do not need to number things that you consider unimportant)

___ Physicians do not bring up the subject of sexual health before being asked

___ Young women do not have a personal physician

___ Young women lack transportation to see a physician

___ Young women have to get a lift to the physician with a parent

___ Physicians do not have the time (too rushed, too many patients)

___ Physicians seem uncomfortable with discussing sexual health

___ Young women feel sexual health is not important enough to trouble a physician with

___ Young women are concerned about confidentiality (worried the physician will tell someone)

___ Young women are concerned that parental consent would be required to get oral contraceptives

___ Young women fear receiving a PAP test

___ Young women are uncomfortable with physicians when they don't know them well enough (e.g., they are a friend of the family or attend the same church)

___ Young women are uncomfortable with physicians when they don't know them well enough (ie., don't see them often enough to feel comfortable with discussing personal matters such as sexual health)

___ Young women are uncomfortable with a physician if they are male

___ Physicians who are too old do not relate well to young women

___ Young women are uncomfortable with physicians when they are male

___ Physicians make young people feel uncomfortable when discussing sexual health

Appendix 4

Developing Understanding From Young Women's Experiences in Obtaining Sexual Health Services and Related Education in a Nova Scotia Community:

Follow-up Questionnaire-PHARMACY

For young women generally, how important do you think the following are in stopping adolescent women from going to a pharmacy for sexual health services: (please rank the most important to the least important. You may use the same number twice, and do not need to number things that you consider unimportant)

___ Young women are afraid to be seen by someone they know while buying condoms

___ Young women are afraid to me seen buying birth control pills

___ Young women are concerned about the behaviour of the cashier (comments, jokes)

___ The cost of buying condoms is too high

___ The cost of buying birth control pills is too high

___ They don't see buying condoms as their responsibility, it should be the man who gets them

Appendix 5

Developing Understanding From Young Women's Experiences in Obtaining Sexual Health Services and Related Education in a Nova Scotia Community:

Follow-up Questionnaire-EDUCATION

For young women generally, how important do you think the following are in stopping adolescent women from receiving a complete sexual health education in school: (please rank the most important to the least important. You may use the same number twice, and do not need to number things that you consider unimportant)

___ PDR is boring (i.e., is taught so that it does not hold students' attention)

___ PDR is repetitive (they teach the same material in grade 7, 8 and 9)

___ The teacher is too old to relate to young women

___ Important topics are not covered (specify_____)

___ Some topics are not covered well (specify_____)

___ Teachers are uncomfortable talking about sexual health

___ PDR and other classes teaching sexual health are not taken seriously by some students

___ Subject matter about sexual health contradicts what parents teach

___ Subject matter about sexual health contradicts what the church teaches

___ School administration does not support PDR, so it is less important to students as a subject

___ Teachers' values are different from those of young women today

___ Teachers use inappropriate personal examples when teaching PDR

___ PDR comes at the wrong time for students to be relevant (___too early/___too late)

___ Teachers at times appear to lack knowledge

___ Male students acting up in class make the class uncomfortable

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