The Youth & STD/HIV Prevention Project

Summary & Community Report
October 2002

Project Overview

The overall goal of the *Youth & STD/HIV Prevention Project* is to enable community action on STD & HIV prevention for Winnipeg youth, through the development of community-based research addressing determinants of risk and protective factors for STD infection in high-risk community networks. An integrated approach to prevention of HIV and other infectious diseases, modelled by project workers in the 1990s at POWER (Prostitutes and Other Women for Equal Rights) and Village Clinic, has increasingly involved research techniques to inform service delivery, with the goal of turning acquired knowledge into action.

The position of the research team is that ambitious goals set by Manitoba Health (1999) to dramatically reduce annual chlamydia and gonorrhea infections and increase STD screening among youth by 2010 cannot be achieved without the respectful involvement of youth as equals in the development and implementation of prevention strategies.

Since the project came to Sexuality Education Resource Centre (SERC) in March 1999, the project has had the following results:

Assessment of STD Prevention Services: The results of this survey with over 500 medical and non-medical youth service providers are presented as part of this community report.

Literature Review : An Ecological Framework for Youth & STD/HIV Prevention. A thorough review of literature related to modern STD/HIV prevention practice in the social/economic context of adolescent development has led to the development of an ecological model that considers biological, individual, interpersonal and structural factors that impact on youth risk and resiliency.

Publication of STD/HIV Print Resources : Sex, Drugs & Prevention Pamphlet Series. This pamphlet series, now in its fifth printing, provides comprehensive clinical prevention information related to chlamydia, gonorrhea, herpes, genital warts, HIV, Hepatitis B & Hepatitis C, using street language in a youth-friendly format.

Academic Advisory & University Partnerships : This four-member advisory committee from the University of Manitoba has advised on project research since early 2000, and one member has joined the research team as co-investigator, facilitating access to formal Ethical Review and sharing research expertise.

Youth Working Group : This group of young people aged 18 to 24 have been involved in this project as paid workers since February 2001, informing and undertaking various project activities, including youth-led research workshops and print resource development.

Resource Development: Harsh Reality I & II. These youth-written and produced magazines present STD/HIV and Hepatitis prevention information in an entertaining context that addresses drug and alcohol use, mental health issues, gang involvement, prostitution and child welfare systems.

Community Partnerships : Kali Shiva AIDS Services, in formal partnership with SERC, has taken the lead on prevention services and resource development for youth while SERC has led the community-based research components of the project. Many other community partners serving youth in Winnipeg have been involved over the course of project activities.

Feasibility Consultation for Youth-Led Research : This formal research project involved in-depth interviews with 50 youth in Winnipeg in order to assess their interests, skill levels and training needs for the development of STD/HIV prevention research that would involve them in all levels of the research process, including the development of research questions, data collection and analysis, synthesis and dissemination.

Youth-Led Research Dissemination Workshops : This research component was based on the concept that dissemination of current research to youth should be integrated at each step of the research process. Members of the Youth Working Group led discussions of STD/HIV prevention and research in six youth venues and service agencies.

Communication Workshops with Youth & Researchers : This two-day workshop series brought together members of the Youth Working Group and health researchers and scientists in order to find common ground in a discussion of STD prevention, as well as assess barriers and facilitators of communication between people with diverse backgrounds and experiences.

Conference Presentations : Canadian Association of HIV Research. Researchers and Youth Working Group members associated with this project have presented on various project results every year since 1999, at annual conferences held in Victoria, Montreal, Toronto and Winnipeg.

An action research initiative by
Sexuality Education Resource Centre
in partnership with Kali Shiva AIDS Services

An Assessment of STD Prevention Services for Winnipeg Youth

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Goal

The aim of this study was to assess current STD-related services in Winnipeg and to identify barriers hindering provision of STD prevention by health care and youth service providers. The study also examined providers' attitudes and perceptions of factors influencing STD spread among youth.

Context

Young people in Winnipeg are clearly experiencing an STD epidemic, and thus are vulnerable to the HIV epidemic as it continues to emerge and evolve. Manitoba has the highest rates of chlamydia, gonorrhea and pelvic inflammatory disease of any other Canadian province. Chlamydia rates have increased steadily in the 1997-2000 period, with one study showing a jump in chlamydia/gonorrhea rates from 13% in 1999 to 22% in 2001 in a sample of street-involved youth. Meanwhile, the pattern of HIV incidence in Manitoba has dramatically shifted since 1997, with heterosexual activity now the main mode of transmission. Numbers of new infections have reached peaks not seen since the beginning of the epidemic in Winnipeg. Researchers have demonstrated conclusively that infection with all kinds of STD directly increases biological vulnerability to HIV infection.

Effective approaches to sexual health and STD prevention must be comprehensive and integrated. Accessibility of prevention services involves convenient times and locations, non-invasive testing such as urine screening, improved outreach to out-of-school youth and young men, availability of free condoms/female condoms, and carefully evaluated peer education initiatives. Structural barriers identified include poor understanding of factors which increase vulnerability to STD/HIV as well as those that protect youth and foster resilience, cultural biases that stigmatize young people, and systems/environments (justice, child protection, mental health) where risk for a variety of health problems may be inherent.

Methods

Self-administered questionnaires were developed and tested with non-medical and medical youth service providers in 1999. Detailed mailing lists of physicians, registered nurses and other youth service providers were compiled using a variety of sources.

In total, 1,317 questionnaires were mailed to health care and youth service providers. The final return rate was 38% or 502 complete questionnaires, including 176 physicians, 125 nurses, and 201 non-medical service providers. All study components were approved by the Education & Nursing Research Ethics Board at the University of Manitoba.

The participatory approach to research used in this initiative was intended to test the feasibility of youth involvement at all levels of the research process, including skills-building, resource development and knowledge dissemination. Data analysis involved feedback sessions with members of the Youth Working Group, including coding and category building, development of core themes and interpretation. Validation of data analysis was conducted by research team members and academic advisors at different stages of the data analysis process.

Participant Profile

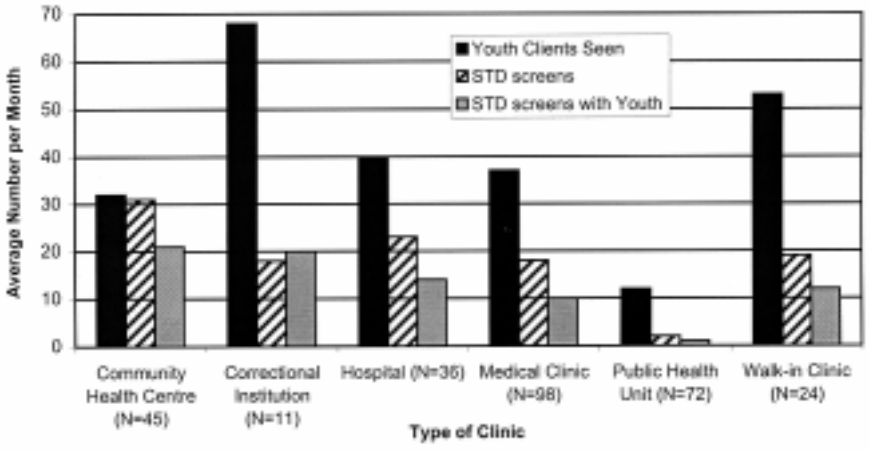
Medical service providers who returned a completed questionnaire (N=301) were physicians and nurses representing a variety of health care organizations, including community health centres, correctional institutions, hospitals, medical clinics, public health units and walk-in clinics.

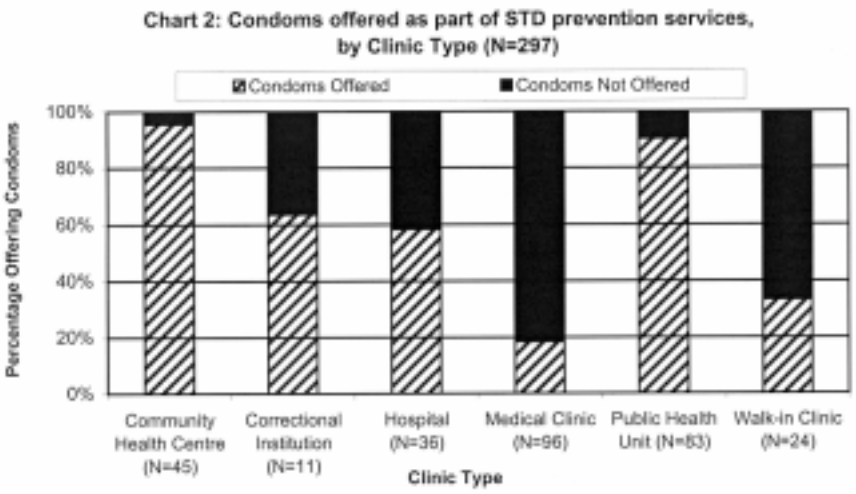
Respondents in non-medical youth service were mostly social workers, counsellors and educators working in a variety of agencies, including education/training programs, health centres including mental health and addictions treatment, group homes, shelters, child protection agencies, drop-ins, and recreation facilities such as community centres.

Results

Medical Services (N=301) – Chart 1 shows the approximate average numbers of youth clients and STD services provided in each type of clinic (based on respondent's memory of previous 12 months). While community health centres provide a higher proportion of STD screens with youth seen per month, average monthly youth contacts are not as high as in other types of clinics. Health professionals in youth correctional institutions see the highest number of youth per month with a relatively low proportion of screens. Practitioners in hospitals, medical clinics

Chart 1: Average numbers of youth clients and STD services per month, by type of clinic (N=297)





and walk-in clinics all see relatively high numbers of youth per month, with relatively low proportions of screenings. Nurses in public health units see the fewest youth and perform almost no STD screens. Chart 2 shows the proportion of health care providers who offer condoms. It is interesting to note that practitioners in community health centres and public health units are most likely to offer condoms while seeing relatively fewer youth per month, while those in other types of clinics who see far more youth, are least likely to offer condoms.

A majority of medical service providers reported providing STD prevention education (85%) and counselling (71%), as well as HIV tests (69%) and Hepatitis B vaccination (70%). Only 11% did not use some kind of STD print material such as pamphlets, posters or factsheets. About 60% indicated they would like or need more STD print resources.

Non-Medical Services (N=201) – Table 1 characterizes the range of youth clients seen by non-medical respondents, including street-involved youth, youth in care and incarcerated youth. Over 64% of respondents believed that their clients were at risk for STD infection, and only 10% thought their clients were well-educated about STD. A majority of respondents (54%) reported working with youth aged 15 to 19 who were not in school.
A majority of non-medical respondents reported that their agency provided STD education (70%) and counselling (57%). Only about 50% reported that they provide condoms. Almost 90% of the respondents referred their young clients to other agencies dealing with sexual health, mostly to community health centres (note relatively low monthly youth contacts at CHCs) Only 11% did not report providing STD print resources such as pamphlets, posters or factsheets, with 66% of respondents indicating that they would like or needed more printed resources on STD.

Table 1: Description of Youth Clients (15-19), N=201

Street-Involved	125	62%
In School	92	46%
In Care	100	50%
At Risk for STDs	129	64%
Well-educated about STDs	21	10%
Incarcerated (current or past)	72	36%
Other	20	10%

Positive Qualities of Youth – In order to gain insight into protective factors and youth resiliency, non-medical service providers were asked about positive qualities and strengths of youth they served. A large number of respondents reported help-seeking behaviours, information-seeking, and willingness to learn as positive qualities. Social support and ability to provide support/help to others were also seen as strengths, as were cultural connections and pride. A list of social skills and intellectual abilities were also mentioned, including ability to communicate, leadership, resourcefulness, problem-solving, intelligence, independence of thought, curiosity, sense of humour, spirit, energy and enthusiasm.

Barriers to Prevention – All providers (N=502) were asked what prevented them from providing the best possible STD prevention services, as well as their perceptions of factors restricting the ability of youth to prevent infection with STD.

1) Provider Barriers to STD Prevention Services:

• Lack of Time – Most important barrier faced by medical service providers, due to heavy workloads, increased numbers of patients or fee-for-service model. Limits on time providing education in schools or for one-on-one discussions.

• Lack of Resources – More frequently mentioned by non-medical than medical providers, including lack of material, human and funding resources. Lack of access to condoms and youth-friendly print resources.

• Poor Access – Especially for youth at risk, out of school youth and young males. Lack of outreach in youth venues. Lack of youth-centered services in a range of locations and times, confidentiality issues, lack of urine screening. Swamped teen clinics, long waits, lack of physicians. Lack of compliance and follow-up on the part of youth. A tendency for youth to present for care only after exposure to STD.

• Structural Factors – Fragmented services, lack of coordination and infrastructure, lack of clear government policies, support and commitment. Agencies and clinics not mandated for STD prevention, lack experience, confidence and comfort. Lack of sexual health curriculum, conservative nature of schools.

2) Perceived Youth Barriers to Preventing STD:

• Sense of Invincibility – The view that young people feel invincible, immortal, or misjudge risk was expressed by 43% of medical and 36% of non-medical providers. Invincibility was conceptualized as a way of thinking or feeling, related to developmental stage or as a natural part of adolescence.

• Lack of Knowledge – Poor or superficial information about STD, sexuality, safer sex negotiation skills, due to inaccurate knowledge of peers, low literacy or mental health issues. Results in decreased capacity for good decision-making.

• Access to Resources – Poor access to youth-appropriate services, condoms, print materials, peer education. Discomfort and embarrassment to seek services and information or purchase condoms.
• Youth Risk Behaviours – Impulsive and irresponsible behaviour, chemical dependency, inconsistent use of condoms, prostitution, serial monogamy.
• Power Relationships – Peer pressure, powerlessness of female youth in relationships, inadequate self-concept, low self-esteem.
• Competing Priorities – Lack of interest in STD prevention, apathy about STD, hopelessness
• Family Factors – Lack of open communication, afraid to discuss STD, parental objection to STD education in school.
• Societal Factors – Wider social issues, socioeconomic factors, poverty, conflicting media messages, "moral decline".

Recommendations

As well as a general call for increased funding for STD/HIV prevention services targetting youth in Winnipeg, the following specific objectives are recommended to meet provincial STD-reduction goals:

1. Improved Screening

• Immediate province-wide implementation and marketing of urine screening for chlamydia and gonorrhea.

• Addressing provider barriers to allow increased STD screening in medical/walk-in clinics, hospitals and correctional institutions where higher proportions of youth are seen.

2. Youth-Driven Outreach

• Improved coordination and referral mechanisms among non-medical youth services, STD-specific services and teen clinics, through common outreach initiatives.

• Development of youth-led outreach strategies to increase numbers of youth clients seen in community health centres where STD screening proportions are highest.

• Improved prevention-focussed outreach to out-of-school youth and young males.

3. Research/Knowledge Dissemination

• Youth-led social marketing of condoms, print resources and other STD prevention services.

• Improved dissemination of recent research information in youth networks using peer education strategies.

• Targetted research dissemination to service providers in order to counter youth stereotypes and cultural biases towards young people, including an increased focus on positive qualities and strengths of young people.

4. Brokering Systems

• Development of advocacy strategies and trusted resource people to increase accessibility of health and social services, including STD/HIV prevention, for youth involved in child welfare, mental health, education and criminal justice systems.

Lessons Learned

This research was conducted during the "capacity-building" phase of this project, in which project workers climbed a steep learning curve in research development and delivery Unanticipated factors that spring from efforts to involve youth in project delivery have complicated the pursuit of research and led project workers down unexpected paths. We believe this to be an inherent and positive quality of the action research process. Data analysis and synthesis took much, much longer and consumed more resources than we expected. The surveys themselves would have benefitted greatly from a longer development period. Planned follow-up interviews not conducted due to lack of time would have led to the refinement and verification of our results and recommendations. High return rates from doctors (40%) and nurses (63%) were likely the result of attractive and personalized presentation of the survey.

Conclusion

Our experience has demonstrated that the "context of risk" for youth in inner-city Winnipeg is characterized by high mobility, socioeconomic inequality, the young age distribution of Aboriginal and immigrant communities, and the close interface between drugs and social systems at distinct life stages (FAS/ child welfare, Ritalin/education, illicit drugs/criminal justice). As an integral part of this dynamic ecology, service providers interested in preventing the spread of STD & HIV among youth may be more effective if an active, respectful effort is made to identify, comprehend and reduce communication barriers. This involves an increased recognition of the providers' own perceptions and personal identity in service delivery, as well as structural adjustments allowing greater youth accessibility to potentially life-saving resources.

Next Steps

Project workers are currently seeking funding to formulate a community-based action research project involving inner-city youth at all levels of the research process, in order to understand and address factors that protect against STD/HIV infection. Resource development, outreach, information dissemination and training in research methodology for youth are key components of planned prevention initiatives.

Acknowledgements

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