



# An Assessment of STD/HIV Prevention Health Care and Youth Service in Winnipeg: *The Youth and STD/HIV Prevention Project*

*Report prepared by:*

Paula Migliardi, John Schellenberg & Margaret Ormond

*Research Team:*

Margaret Ormond, John Schellenberg, Karin Linnebach, Paula Migliardi & David Gregory, with members of the Youth Working Group

*For:*

Centre of Excellence for Child & Youth Centred Prairie Communities

October 2002

STD/HIV Action Research for Prevention (SHARP)  
Sexuality Education Resource Centre, Winnipeg.

The Centre of Excellence for Child and Youth-Centred Prairie Communities is one of the five Centres of Excellence for Children's Well-being funded by Health Canada. The Views expressed herein do not necessarily represent the official policies of Health Canada.

Le Centre d'Excellence pour le Collectivités Centrées sur les Enfants et les Jeunes des Prairies est l'un de cinq Centres d'Excellence pour le bien-être des enfants financé par Santé Canada. Les vues exprimées ici ne représentent pas nécessairement la position officielle de Santé Canada.

Introduction .....	2
Youth and STD: the case of Winnipeg .....	4
Youth Health Care and Social Services .....	5
Research Approach .....	7
STD Participatory Research and Prevention .....	7
The Survey.....	9
Study Participants .....	10
Data Processing and Analysis .....	11
Youth Participation in Data Analysis .....	12
Study Results .....	12
Health Care Providers .....	13
Youth Clients and Services.....	13
STD Prevention Resources.....	18
Youth Service Providers.....	20
Youth Clients .....	20
Perceived Positive Qualities of Youth .....	21
Youth Services .....	23
STD Prevention Resources.....	25
Barriers to STD Prevention Services to Youth .....	26
<i>Limitations Faced by Providers</i> .....	27
Time.....	27
Resources.....	28
Accessibility .....	28
Other Factors.....	29
<i>Limitations Faced by Youth</i> .....	30
Invincibility .....	31
Lack of Knowledge .....	31
Access to Resources .....	32
Youth Behaviours .....	33
Power Relationships .....	34
Priority of the STD Prevention .....	35
Discussion.....	35
Future Research.....	43
Dissemination .....	44
Implications for the Centre of Excellence for Child and Youth Mandate .....	45
References .....	47
Appendix A: Survey Instruments .....	49

Table 1: Description of Clinic/Agency.....	11
Table 2: Description of Agency Services.....	11
Table 3: Number of Youth Receiving Services .....	13
Table 4: Number of STD Screens .....	13
Table 5: Number of STD Screens to Youth.....	14
Table 6: Agency STD Prevention Services.....	17
Table 7: Use of Printed STD Resources.....	18
Table 8: Description of Youth Clients.....	21
Table 9: Agency STD Prevention Services.....	23
Table 10: Referrals for STD Services.....	23
Table 11: Referrals .....	24
Table 12: STD Printed Resources Available for Clients.....	25
Table 13: Desire for More Printed Resources on STDs .....	25

## Introduction

*“When I was in medical school I was told that, if a child came into my office, examined the child, and then gave the child a tetanus shot, some antibiotics, and carefully dressed the wound, I would be a good doctor. If however, 100 children from the surrounding community came into my office, each with rat bites, and I sat in my office, examined the child, and then gave the child a tetanus shot, some antibiotics, and carefully dressed the wound and that was all – then I should have my medical license revoked”*

*(Bell 2001)*

This study is one component of a larger initiative on STD/HIV prevention with Winnipeg youth carried out by community-based researchers in partnership with the Faculty of Nursing, University of Manitoba. The initiative, based on health outreach and prevention services modelled in the 1990s at POWER (Prostitutes and Other Women for Equal Rights) and Village Clinic, was formalized at Sexuality Education Resource Centre (SERC) in 1999. A four-member Academic Advisory at the University of Manitoba was incorporated into the project in March 2000, and a number of youth aged 18 to 24 joined the project’s Youth Working Group in February 2001. Beginning with a capacity-building phase centered on enhancing the knowledge and skills to engage in community-based research and community development guided by rigorous scientific and ethical practice, this project has evolved into formal research work with the support of Health Canada’s Community-Based HIV Research Program (initially at National Health Research and Development Program, now housed at the HIV/AIDS Division in Ottawa). The objectives of the *Youth and STD Prevention Project: Phase I – Feasibility Consultation, Knowledge Transfer and Priority Setting for Youth-Led Research* have been to assess the feasibility of youth-led research in the area of STD prevention, disseminate key results of current literature and research findings, and set priorities for future prevention research. Youth participated in all aspects of research development, i.e., development of research questions, methodology, data collection and data analysis, as well as in the dissemination of results and creation of resource materials for youth.

The *Youth and STD/HIV Prevention* project has sought to integrate community-based research and action, build community and academic partnerships, and involve young people from Winnipeg's inner-city in the elaboration of effective STD/HIV prevention strategies. Given elevated and increasing rates of STD, especially in the inner-city, along with a clear link between STD infection and vulnerability for HIV infection, immediate and sustained action is justified. The young people who joined the initiative have constituted the Youth Working Group (YWG). Members of the YWG have been actively involved in project activities to date, including those aimed at skills development, mentorship, resource development and dissemination of information. Their role in the current project has been to participate in data analysis and provide feedback on the interpretation of findings as well as in the design and dissemination of a community report.

The initiative focussed on and incorporated vulnerable and at-risk youth/street-involved sectors, 14 to 24 years of age, with emphasis on non-school venues, the street, shelters, group homes, sex trade areas, and treatment and correction facilities. This decision was based on a preliminary review of the literature that showed gaps in peer education for sexuality education with youth other than high school and university students. In addition, the geographic focus of the initiative was to reach out and include youth from inner-city Winnipeg neighbourhoods (i.e., Point Douglas, the North End, Downtown, the West End, and Osborne Village), where higher STD rates and youth facing socioeconomic disadvantages are concentrated.

The aim of this study was to identify current STD resources and services in Winnipeg and to identify barriers hindering the provision of STD prevention by health care and youth service providers. The study also examined providers' perceptions of factors that prevent youth from avoiding STD. Other issues addressed were the sources of information about STD utilized by providers, and the youth with whom participants work with in the area of STD prevention. The overall goal was to generate insights about sectors that provide services to youth, and translating this knowledge into action. Recommendations regarding the gaps in service provision for STD prevention among youth will positively impact the well-being of inner-city youth at-risk for STDs.

## **Youth and STD: The Case of Winnipeg**

The *Youth & STD/HIV Prevention* project arose out of concern for the disproportionately higher rates of STD infection among Winnipeg youth aged 15 to 19, and the vulnerability of this population to the ongoing HIV epidemic.

Research on the prevalence of sexually transmitted diseases such as chlamydia and gonorrhea demonstrates that young people in inner-city Winnipeg are experiencing a STD epidemic and, consequently, have a great vulnerability to HIV infection. The *Enhanced STD Surveillance in Canadian Street Youth* study carried out in 1999 in Winnipeg demonstrated that street-involved youth have been shown to have a chlamydia rate of nearly 13 percent (Ormond 2000). In 1997, Manitoba had the highest rates of chlamydia among 15 to 24 year old females of any other Canadian provinces (200 cases per 10,000), double the national rate for females in this age group. The rates of gonorrhea and pelvic inflammatory disease (PID) among women were also the highest in the country (LCDC 1999). Preliminary findings from the 2001 *Enhanced STD Surveillance in Canadian Street Youth* indicate that the rates of gonorrhea and chlamydia among youth have increased in Winnipeg since the previous study in 1999. It is estimated that the chlamydia rate has increased from 13 percent in 1999 to 22 percent in 2001<sup>1</sup>.

Meanwhile, the pattern of HIV incidence in Manitoba has seen a dramatic shift according to risk categories since 1997, with the greatest increase in at-risk populations among heterosexual men – from 7% in the period 1985-96 to 21% in the period 1997-99; and heterosexual women – from 4% to 13% (Manitoba Health 2001). More HIV-positive diagnoses were made between 1997-99 than in any other year since the epidemic began in Winnipeg, and since 1999 an over-representation of Aboriginal people is found in new HIV cases (Schellenberg, Ormond and Linnebach 2001). Other recent research has demonstrated conclusively that STD infection directly increases biological vulnerability to HIV infection (Fleming & Wasserheit 1999). In Winnipeg, researchers found a geographic relationship between HIV prevalence and prevailing rates of other STD (Blanchard et al. 1996). This study found that higher rates of HIV and other STDs were associated with areas of lower socioeconomic status in Winnipeg (1996:8).

---

<sup>1</sup> Information from local researcher, Margaret Ormond, involved in the Winnipeg research.

Manitoba Health has set provincial goals that aim to reduce the overall incidence of chlamydia by 60 percent and the incidence of chlamydia among women aged 15 to 29 by 80 percent before 2010. Gonorrhea and syphilis are to be eliminated in the same time frame. Screening rates among 15 to 24 year old females and males are to be increased to 75 percent and 50 percent respectively by 2010, and urine testing for chlamydia and gonorrhea were to be made available to all in this age group by 2001 (Manitoba Health 1999). This project, which included youth (members of the population of interest) in strategy and skills development related to STD/HIV prevention, is predicted to facilitate and contribute toward the achievement of the provincial goals.

As well as a higher concentration of STD rates than the rest of city, Winnipeg's inner-city demonstrates also demonstrate lower household income, lower levels of formal education and higher unemployment. Demographically, Winnipeg's inner-city has a higher proportion of immigrant/refugee residents and higher representation of Aboriginal people than in Winnipeg as a whole (Winnipeg Regional Health Authority 2000). It is worth mentioning that a majority of Aboriginal population of Winnipeg is under the age of 25 compared to the total population of Winnipeg (53% vs. 34%) (Schellenberg, Ormond and Linnebach 2001).

With increasing evidence of the importance of STD control in the prevention of HIV, the results of this study support the need for STD prevention programs in areas of highest risk (Blanchard et al. 1996). It is clear that young people in Winnipeg are experiencing an STD epidemic, and thus are vulnerable to the HIV epidemic as it continues to emerge and evolve. Network analysis points out that risk of acquiring and spreading STD are high among youth who have highly connected sexual networks involving people who live in areas of high infectivity (Wylie & Jolly 2001).

## **Youth Health Care and Social Services**

Health and social services are regarded as one of the determinants of health. Health services are provided by physicians, nurses, dentists and pharmacists who focus on physical and mental health. These services, including health promotion and prevention programs and components of treatment services, contribute to population health. In

addition, social services address the basic needs of children and youth and their social and psychological development (Health Canada 1999).

Services that educate children and youth about health risks and appropriate choices, and promote and assist children and young people to adopt healthy living practices make potential contributions to keeping people healthy. Both social and health services promote healthy development of youth and children. A series of strategies are used to address this determinant of health. For instance, ensuring young people access to required medical and primary health care, educating health providers on the issues or concerns particular to young people about which they may be unaware, are examples of strategies that can enhance the health of young people.

Effective approaches to assist young people with their sexual health, and in particular to prevent STD, must be comprehensive and integrated. There is a need for approaches that include parents, teachers, community agencies, health and social service professionals and youth themselves. Health promotion and prevention strategies typically require health care providers and managers to use multiple means to disseminate information to different sectors of the population. In order to be effective and sustainable, these strategies and many other aspects of programs need to be implemented in settings where communities are involved and mobilized.

In a review of the literature concerning STD services for youth, Schellenberg, Ormond and Linnebach documented that many researchers have found that STD-related services such as risk assessment, counselling, screening and treatment are not routinely provided to adolescents by most primary care clinicians despite recommendations from medical associations (2001: 55). At the heart of the communication process is the development and maintenance of effective relationships between health care and other service providers and young people.

Other factors preventing effective communication and relationships between providers and youth include negative attitudes of providers and lack of trust by youth that health care providers will not keep discussions regarding sexual activity confidential. Research findings suggest that young clients who received a confidentiality assurance from health care providers were more likely of having discussed sexuality related issues, including STD (Thrall et al. 2000, see also Ford, Thomsen and Compton 2001).

Accessibility of services including convenient times and locations, appropriate outreach strategies (e.g., street outreach), condom availability and accessibility, meaningful sexuality education, the use of peer education and harm reduction strategies are other factors associated with appropriate sexual health service provision for youth (Schellenberg, Ormond and Linnebach 2001: 53-61).

Based on an ecological framework, which takes into consideration the interrelation of biology, psychology, interpersonal and social interactions, and structural or systemic influences on the spread of STD/HIV among youth, the literature advocates for a series of prevention efforts that deal with each one of the aspects that influence the spread of STD and their interrelation. Critical elements of STD/HIV prevention identified in the literature include:

- improved screening and treatment strategies including urine testing;
- increased and improved cognitive-behavioural approaches such as one-on-one and small group education and counselling initiatives;
- improved access to condoms and female condoms using youth-driven social marketing techniques;
- clearer understanding of risk and vulnerability factors as well as protective factors and those that enhance resiliency;
- increased awareness of the relational nature/context of sexual behaviour, condom use and STD/HIV spread including a greater focus on network analysis;
- increased use of peer educators including careful evaluation of such initiatives;
- addressing adolescent stereotypes and cultural biases towards young people;
- targeting structural barriers to prevention in order to address contexts of risk;
- an increased commitment to harm reduction, economic development and human rights frameworks in public health.

## **Research Approach**

### **STD Participatory Research and Prevention**

Community-based research reveals an important need to merge prevention research and action research at the community level. Researchers are encouraging collaboration between different sectors (i.e., academic and non-academic), the



participation of youth in research, increased use of qualitative research to enhance quantitative findings, distribution of information built in at every step of the research process, and refined methods for careful evaluation of prevention initiatives to establish successes and failures. Ruiz et al. (2000) recommend that funders of HIV prevention practice and research invest in strengthening local-level capacity to develop, evaluate, implement and support effective programs in the community.

The participatory approach to STD/HIV prevention research used in this initiative was intended to facilitate Manitoba Health' goals of reducing the incidence of STDs among youth in Winnipeg by placing the perspective of youth at the centre of strategy development for prevention, enhancing communication and knowledge transfer between public health systems and affected youth, and disseminating prevention information into existing youth communication networks (Ormond 2000).

The approach to research used in this project is community-based. This model emphasizes participation and influence of non-academic researchers in knowledge creation. Israel et al. (1998) describe the principles of community-based research as:

- including the recognition of and work with communities of identity (e.g., those with common interests, values, norms, geography, etc.);
- building on strengths and resources within the community;
- facilitating collaborative partnerships in all phases of the research;
- integrating knowledge and action;
- promoting an empowering process; and
- addressing health from both positive and ecological perspectives (1998: 178-180).

A focus on youth involves the incorporation of a community of identity within our research. More effective evidence-based prevention strategies are more likely to involve communities targeted for prevention services in the development, implementation and dissemination of programs and messages (Schellenberg, Ormond and Linnenbach 2001).

## The Survey

Questionnaires were developed and tested with non-medical and medical professionals in 1999. Originally, one instrument was designed for both medical and non-medical service providers; however, this was problematic given the differences in STD/HIV services provided by the different professional sectors. Two questionnaires were generated with many of the same questions asked to both groups. The questionnaires were self-administered and were mailed or hand-delivered to a wide range of agencies. A detailed mailing list was compiled prior to mailing using the physician directory of the Royal College of Physicians & Surgeons, a list of public health nurses supplied by the regional health authority, and a list of all youth-serving agencies listed in the 1999 edition of *Contact: A Resource Guide for Manitobans*. Permission was received from Child and Family Services to send the questionnaires to all social work personnel in Winnipeg. An effort was made to identify relevant nursing staff in Winnipeg's major hospitals. Finally, a list of all physicians, nursing staff and non-medical support in Winnipeg's community health centres was compiled. Researchers contacted the office of every potential respondent to ensure correct names and mailing information. This process generated a list of potential respondents that far exceeded the original plan.

The survey consisted of questions regarding the following themes (See also Appendix A):

Health Care Providers Questionnaire	Youth Service Providers Questionnaire
<ul style="list-style-type: none"> <li>• Type of Organization</li> <li>• Professional Background</li> <li>• Role in the Organization</li> <li>• Number of Youth Receiving Services</li> <li>• Number of STD Screens provided or prescribed</li> <li>• STD Services Provided</li> <li>• Materials Used to Educate Youth on STDs</li> <li>• Means to obtain updated information on STDs</li> </ul>	<ul style="list-style-type: none"> <li>• Type of Organization</li> <li>• Professional Background</li> <li>• Role in the Organization</li> <li>• Description of Youth Receiving Services</li> <li>• Positive qualities of youth Clients</li> <li>• STD Services Provided</li> <li>• Referrals to other health organizations</li> <li>• Materials Used to Educate Youth on STDs</li> <li>• Means to obtain updated information on STDs</li> </ul>

<ul style="list-style-type: none"> <li>• Barriers to provide the best possible STD Prevention Services to Youth</li> <li>• Perceptions of the barriers that youth may encounter in preventing being infected with STDs</li> </ul>	<ul style="list-style-type: none"> <li>• Barriers to provide the best possible STD Prevention Services to Youth</li> <li>• Perceptions of the barriers that youth may encounter in preventing being infected with STDs</li> </ul>
---	---

The *Youth & STD/HIV Prevention* initiative, including this study and the Youth Working Group component, were approved by the Education & Nursing Research Ethics Board (ENREB) at the University of Manitoba.

The original research plan included 50 in-depth interviews with health care and youth-service providers and focus groups with street-involved youth. The questionnaire included instructions for participants to contact the project researchers if they were interested in participating in an in-depth interview. While three participants requested a follow-up interview, these interviews were eliminated given the voluminous data set generated by the questionnaires.

In total, 1,317 questionnaires were mailed to health care and youth service providers (648 medical and 669 non-medical/social/youth service providers). The return rate was 38 percent or 502 complete questionnaires returned. Of this number, 301 represented medical agencies (60% of the returns) and 201 were completed by non-medical agencies (40% of the returned surveys). Return rates were 40% for physicians, 63% for nurses and 30% for non-medical service providers.

### **Study Participants**

Of the health care providers who returned a completed questionnaire, 57% were physicians representing various specialties including family physician (n=52), general practitioner (n=32), paediatrician (n=26) and, obstetrician and gynaecologist (n=12). Twenty-seven respondents did not state their specialty, while 22 indicated various other specialties. Thirty-five percent of the health care respondents were nurses, the majority of whom (71 out of 121 or 58%) identified themselves as working in the public health area, as educators and counsellors.

Respondents represented a variety of health care organizations (See Table 1 – Please note that figures total more than 100%).

Description of Clinic/Agency	% (N=301)
------------------------------	-----------

Medical Clinic	133	44%
Public Health Unit	84	28%
Community Health Centre	57	19%
Hospital	38	13%
Other	25	8%
Walk-in Clinic	24	8%
Education/Outreach	9	3%

**Table 1: Description of Clinic/Agency**

With respect to the respondents in the non-medical/youth service sector, the professional background of the respondents was almost equally distributed among “social work”, “counselling”, “education” and “school of life” (about one quarter of the participants per each professional background).

A number of diverse youth-serving agencies responded to the questionnaire. The categories that best described their organization are represented in Table 2 (Please note that figures total more than 100%).

Description of Agency Services		% (N=201)
Education/Training	96	48%
High School	10	5%
Clinic/Health Centre	34	17%
Shelter/Group Home	57	28%
Child Welfare/Protection	29	14%
Drop-in	33	16%
Recreation	16	8%
Referrals	56	28%
Other	56	28%

**Table 2: Description of Agency Services**

### **Data Processing and Analysis**

Quantitative data were processed and analysed soon after data collection. In the first phase of data handling, data were entered into Excel spreadsheets. Qualitative data were also entered into spreadsheets, and organized using Microsoft Word. Manual coding was applied to open-ended questions as part of skills development for community-based researchers. Members of the Youth Working Group participated in this process of manual coding.

Initially, data analysis was carried out through open coding. This process involved the examination of all responses to the open-ended questions, with potential categories noted in the margins of the data set. Second-level coding entailed a comparative analysis, where coded data were continually compared with data that surfaced from responses in other questionnaires and clustered according to similar properties. This step allowed the identification of major themes. Using the spike function in Word, responses were clustered under corresponding categories and themes.

### **Youth Participation in Data Analysis**

This project tested the feasibility of youth involvement at all levels of the research process, including skills-building, resource development and knowledge dissemination. The data analyst and one of the principal researchers carried out feedback sessions during the months of July and August, 2002, following principles of community-based research to build on strengths and resources within the community, and promoting co-learning, empowerment and collaboration. Members of the Youth Working Group took part in the sessions. The objective of the first session was to introduce qualitative data coding procedures and category building. Members of the Youth Working Group participated in exercises that facilitated development of core themes within the data set. In subsequent sessions, the YWG participated in data interpretation. Research findings were outlined and the participants were asked for their views on the findings and in particular on the congruency of findings with their own experiences and those of their peers. Members of the group provided ideas related to the development of a brief community report for youth and health care and youth service providers (See Dissemination, below).

Validation of data analysis was conducted by other community-based researchers and an academic advisor at different stages of the research and data analysis process.

## **Study Results**

## Health Care Providers

### Youth Clients and Services

Most of the health care providers indicated that they meet with youth on a regular basis. Over half of the respondents indicated that they see less than 30 young people per month in their practice. Nearly twenty percent were in contact with between 30 and 70 youth monthly. It is important to remember that these numbers are very approximate due to the self-report nature of the question, based on the providers' memory of services delivered in the previous year.

Average Monthly Youth (15-19) Contacts		N=301
None	21	7%
<30	166	55%
>30<70	64	21%
>70<100	18	6%
100+	26	9%
No Answer	6	2%

**Table 3: Number of Youth Receiving Services**

Respondents were asked to indicate the total number of STD screens they performed for the population in general per month. One third of the respondents did not personally provide or prescribe STD screens. The same proportion of health care professionals provided or prescribed less than 10 STD screens per month; 17% provided or prescribed between 10 and 30 STD screens and 13% provided/prescribed between 30 and 70 STD screens per month

Average Total Monthly STD Screens		N=301
None	99	33%
<10	100	33%
>10<30	52	17%
>30<70	39	13%
>70<100	4	1%
100+	5	2%
No Answer	2	1%

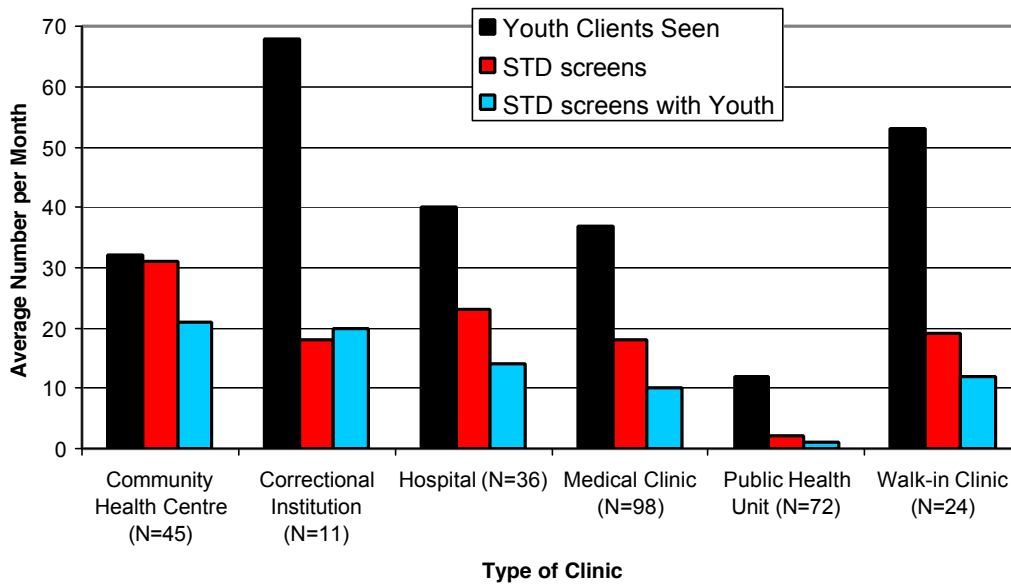
**Table 4: Number of STD Screens**

Medical providers were then asked to specify the number of *STD screens they provided or prescribed to youth aged 15 to 19*. About 35% of the respondents did not provide STD screening for youth, 40 provided less than 10 screens per month and 18 percent provided 10 to 30 screens for youth on a monthly basis.

Average Monthly STD Screens with Youth		N=301
None	106	35%
<10	119	40%
>10<30	53	18%
>30<100	18	6%
100+	1	0%
No Answer	4	1%

**Table 5: Number of STD Screens with Youth aged 15 to 19**

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



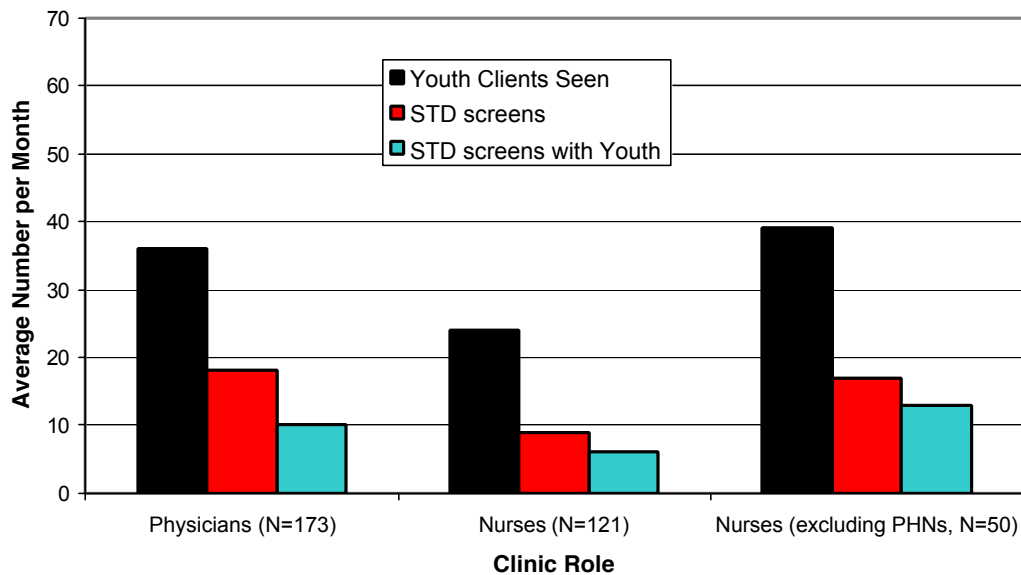
**Chart 1: Average Numbers of Youth Clients and STD services per month, by type of clinic**

Chart 1 shows the average numbers of youth clients and STD services provided by health care providers in each type of clinic specified by respondents. While community health centres provide a higher proportion of STD screens with youth

compared with the number of youth seen per month, their average monthly youth contacts are not as high as 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 performed in this population. Practitioners in hospitals, medical clinics and walk-in clinics all see relatively high numbers of youth per month, with relatively low proportions of screenings performed for this group. Nurses in public health units see the fewest youth and perform the fewest STD screens, likely due to the range of other public health activities reported by this group of health care providers.

Chart 2 (below) demonstrates that numbers and proportions of youth seen and STD screens performed vary little between nurses and doctors across clinic type. When public health nurses are excluded from the analysis, nurses in this study provided slightly higher numbers of STD screens with youth, and saw higher numbers of youth per month, as compared to physicians.

**Average numbers of youth clients and STD services per month, by clinic role (N=297)**



**Chart 2: Average Numbers of Youth Clients and STD Services**

Participants were asked to report the type of STD prevention service their agency or clinic provided. A majority of the respondents, about 85 percent, stated that their



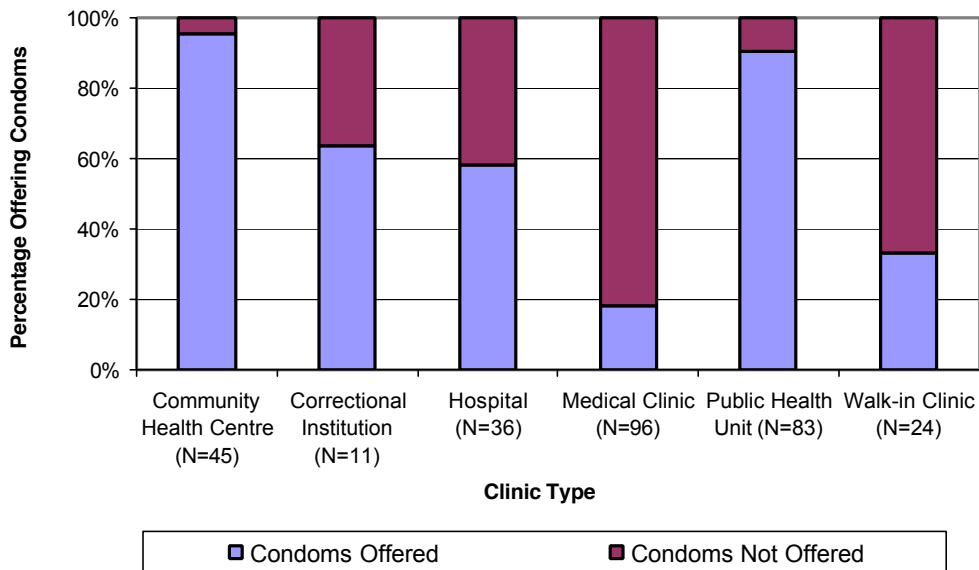
*agency or clinic provided education services in the area of STD.* About 60 percent of respondents indicated that they provide condoms; however, some specifically stated that condoms were only available in small numbers.

Agency STD Prevention Services		N=301
Education	255	85%
Counselling	215	71%
Hep-B Vaccine	212	70%
HIV Tests	208	69%
Pre/Post HIV Test Information	200	66%
Condoms	174	58%
Other	24	8%
None	10	3%

**Table 6: Agency STD Prevention Services**

Chart 3 shows the proportion of health care providers who offer condoms according to type of clinic. In a comparison with Chart 1, 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 correctional institutions, hospitals, medical clinics and walk-in clinics are least likely to offer condoms while seeing larger numbers of youth per month.

**Condoms offered as part of STD prevention services, by Clinic Type (N=297)**



**Chart 3: Condoms Offered as Part of STD prevention Services, by Clinic Type**

### STD Prevention Resources

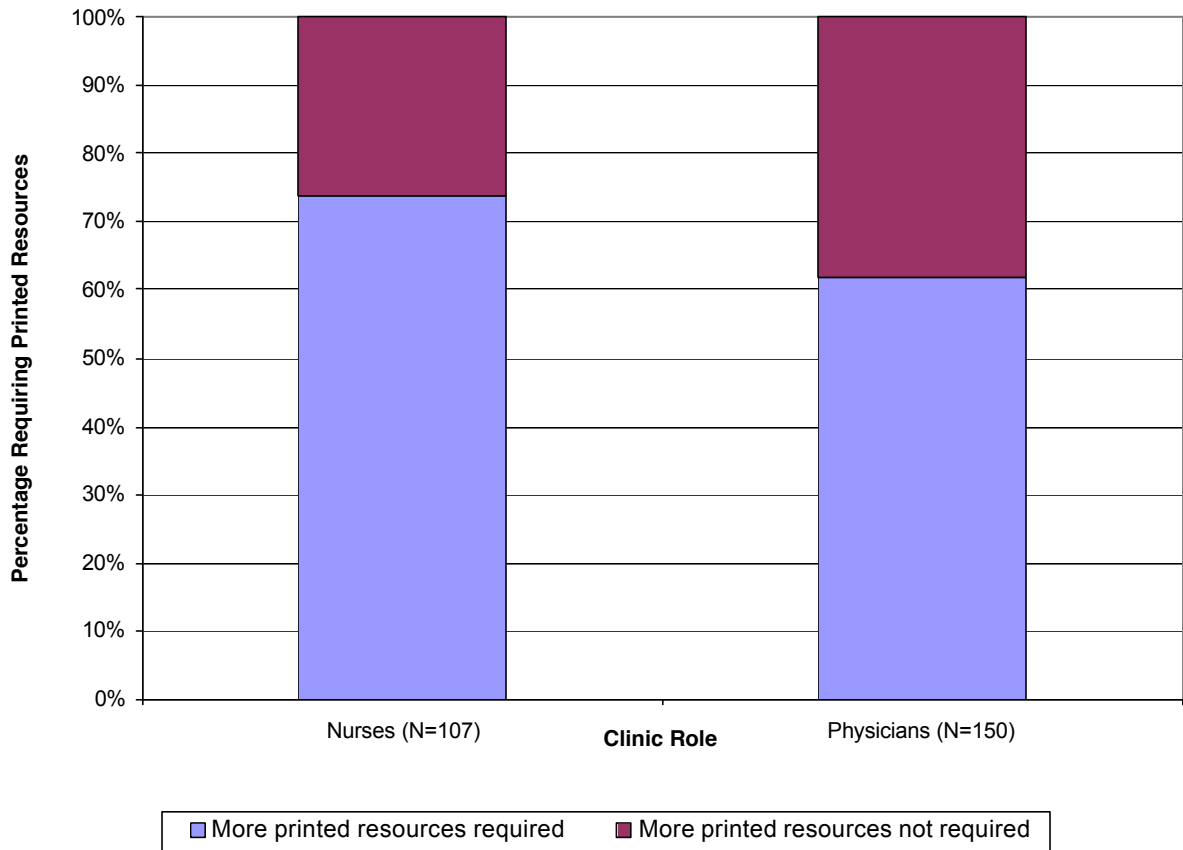
Participants made use of various printed resources to facilitate learning about STD. The most popular printed resources used to educate clients/patients were pamphlets with 87 percent of the respondents indicating their use. Posters and fact sheets were also widely used (52 percent and 47 percent of the respondents respectively). Eleven percent of the respondents did not make use of any printed materials as collateral STD teaching/learning resources. All of the respondents who did not make use of printed resources were physicians.

Use of Printed STD Resources		N=301
None	32	11%
Pamphlets	262	87%
Posters	158	52%
Factsheets	142	47%
Other	16	5%

**Table 7: Use of Printed STD Resources**

*About sixty percent of the respondents indicated that they would like or needed more printed resources on STDs. Nearly 29 percent did not desire or need additional printed information on the topic and 12 percent of the respondents did not answer the question. Chart 4 demonstrates that slightly more doctors than nurses reported that they did not require more printed STD/HIV prevention resources.*

**Need for more printed resources, by Clinic Role (excluding those who did not answer, N=257)**



**Chart 4: Need for More Printed Resources, by Clinic Role**

In order to learn about the ways participants gained knowledge on STD, the survey asked about sources of information they utilized on a regular basis. While some respondents indicated sources of information (i.e. from where they obtain their information), others indicated the type of materials or ways they obtain information. About 15 percent of the respondents did not provide information on this issue.

The main sources of information were the different levels of the government (about 46 percent of the respondents), in particular Manitoba Health, Health Canada, the City of Winnipeg and the Regional Health Authority (at the time of the research this was called the Winnipeg Community and Long-Term Care Authority or WCA), as well as the

public health sector. Respondents indicated receiving written information on STD from these sources. Other sources of information were community health centres such as community health clinics and hospitals, resource centres or other education-oriented programs and services, professional associations and the pharmaceutical industry.

Medical service providers also tended to obtain STD updates from colleagues (e.g., physicians and nurses and other educators and service providers). Professional development activities for health care providers took the form of occasional and short-term in-service sessions and medical rounds or to a lesser extent through their participation in conferences, symposia and workshops and medical rounds.

The most common types of material received by providers were printed materials. About 36 percent of the respondents indicated a number of sources and type of printed materials used as media to learn about STDs. Most of the health care providers obtained information through professional, peer-reviewed journals and other publications such as books and medical letters. Participants also indicated the use of pamphlets and factsheets. However, these later sources were identified less frequently.

Other sources of information were the Internet, with a few participants indicating the use of accredited websites such as the Canadian Medical Association and the Communicable Disease Control websites. Information phone lines were also mentioned as sources of information (e.g., STD info line and Facts of Life Line).

It is worth mentioning that some participants indicated that they use their own personal time or outside work time to obtain information or engage in research on STD.

## **Youth Service Providers**

### **Youth Clients**

Sixty-two percent of the respondents indicated that their agencies work with *street-involved youth*. Sixty-four percent indicated that they work with a majority of *youth clients at risk for STDs*. Youth clients *in care* constituted the profile of the work engaged in by 50% of the respondents' agencies. According to 46% of the respondents their youth clients are attending school and for 36% of them, clients are or have been incarcerated.

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%

**Table 8: Description of Youth Clients**

### **Perceived Positive Qualities of Youth**

Youth service providers described a series of positive attributes, qualities and strengths of youth clients they encounter in their practice. Positive qualities can count as factors that counterbalance vulnerabilities youth encounter and place them “at risk” for negative outcomes. From the perspective of youth service providers, these qualities may contribute to the ability of young people, especially those at risk, to develop resiliency in the face of stressful life experiences.

Providers indicated that the ability to seek help and communicate about their concerns was one of the most important qualities of their youth clientele. Youth ability and willingness to use the social service system to look for information, pursue counselling and other resources were also considered as a positive strength. Youth were perceived as striving to obtain information that would assist them in their decisions. They were also perceived as open in sharing their concerns about and health priorities with providers. One participant indicated: “[Youth are] willing to talk/discuss their sexuality, relationships, problems”. Some of the respondents indicated that youth are looking for trusted sources of information. As another respondent said “[youth are] willing(ness) to ask questions if they perceive they are not being judged”.

Another important recognized strength was the willingness and ability of youth to learn. Some of the respondents indicated that youth were willing to learn about sexuality related issues, including STDs, HIV and birth control methods. Some participants went further to explore the conditions that would facilitate a meaningful learning. While for a few respondents youth will seek and remember information “if caught in the right attitude” or “after initial resistance”, for others youth will learn if the information is presented “in a meaningful way”, “if someone is willing to teach them in a kind, respectful way”, and if they are taught outside of a school setting.

In contrast, some respondents indicated that their clients were already knowledgeable and aware of STD and health related issues. They stated: “[Youth are] aware of what precautions one needs to take in order to prevent the transmission of STDs”, “they are aware of sex and know the consequences of being unprotected”, and are “well-educated on practicing safe sex”.

Another positive characteristic was the ability and willingness of young people to improve or change. Providers perceived the youth to be motivated to change, succeed, improve their quality of life and situations, overcome personal barriers, work or continue their studies. A participant indicated that the availability of resources and support was important to facilitate change among youth.

In addition to these protective factors, other factors were the presence of social support and ability to provide social support to others. With respect to the presence of social support networks, participants indicated that they perceived that youth rely on “strong family ties”, “strong-knit relationships”, “strong community”, “a support network” and “strong peer influence and caring”.

Besides counting on social support networks a few participants indicated that youth counted on “strong cultural connections”. They were also perceived as wanting to become more involved in their cultures. Cultural connection and pride can be considered as significant protective factors in the lives of young people.

Youth were also perceived as being prepared to provide assistance to others and develop and maintain positive relationships. In the words of the participants, youth were “willing[ness] to help others in similar situations”, “be a good parent” and “[be able] to maintain positive relationships”. In sum, they were able to bond, attach and connect with other people (e.g., peers, family, own children).

Providers also indicated that youth possess a series of individual social skills such as “communication”, “some leadership abilities”, “resourceful[ness]”, “life skills” “ability to take responsibility” and “problem solving ability”. They were also perceived as intellectually apt, especially in street-related issues – e.g., “street smart”, “generally intelligent, well educated in street stuff” and “independent thinkers”, “curious” and “aware”. Other mentioned characteristics were: “sense of humour”, “spirited”,

“energetic” and “enthusiastic”. All these qualities may also characterize resiliency in youth.

### Youth Services

Survey participants reported the type of STD prevention services their agency provided. A large number of respondents, 70 percent, indicated that their agency provided education services in the area of STDs. Fifty-seven percent of respondents indicated that their agency provided counselling services regarding STD prevention. Only about 50 percent of respondents reported that they provide condoms. HIV testing and pre-post HIV test information accounted for the work of 16 and 14 percent of respondents’ agencies.

Agency STD Prevention Services		N=201
None	32	16%
Education	141	70%
Counselling	115	57%
Condoms	98	49%
HIV Tests	33	16%
Pre/Post HIV Test Information	29	14%
Hep B Vaccine	22	11%
Other	34	17%

**Table 9: Agency STD Prevention Services**

Because social services do not provide health services such as clinical treatment and many of them do not specialize in sexual health, we asked the respondents to specify if they referred young people for STD prevention, testing or education services to other agencies. Almost 90% of the respondents referred their young clients to other agencies dealing with sexual health.

Refers for STD Services		N=201
Yes	177	88%
No	24	12%
No Answer	1	0%

**Table 8: Referrals for STD Prevention, Care or Treatment Services**



Youth service providers referred their young clientele for STD information and services to a variety of health care and social services with most of the participants referring to community health clinics. About 43 percent indicated that they provide referrals to Klinik Community Health Centre. Other community health centres mentioned were Village Clinic and Women’s Health Clinic (nearly 30 percent each), and Mount Carmel Clinic (about 15 percent)<sup>2</sup>. Other health centres such as Health Action Centre, Nor’west Co-op, and Youville clinic were also mentioned as points of referral to a lesser degree (less than 8 percent). Other sources of referral were public health services (about 10 percent) and other organizations and programs for youth or those that focus on STD or sexuality-related issues (e.g., Youth Resource Centre, phone lines, Sexuality Education Resource Centre, Street Connections).

A number of respondents referred their clients to other services and programs (i.e., health care providers or counsellors) within their own facilities. Over a quarter of the participants referred to outside health care providers including young people’s own family doctor.

Over 10 percent of youth service providers indicated they did not refer young clients to other STD prevention services. Most of them provided in-house education and counselling regarding STDs. Other respondents had not seen the need to refer their clients to services providing STD information or treatment services.

<b>Referrals</b>		<b>N=201</b>
Klinik	87	43%
Village Clinic	60	30%
Women’s Health Clinic	58	29%
Mount Carmel Clinic	32	16%
Other clinics and hospitals	48	24%
In house health care providers	17	8%
Outside health care providers	53	26%
Public Health Services/Nurses	19	9%
Non-clinical Health organizations/programs	34	17%
School	5	2%
Other	5	2%

**Table 9: Referrals**

<sup>2</sup> Health services available to youth have changed since the implementation of the survey. At the time of the data collection Village Clinic housed a teen-clinic and Mount Carmel Clinic did not have its teen clinic in place yet. Currently, there are two school-based teen clinics being managed in Elmwood High School and R.B.Russel High School. These clinics are being managed by Klinik and Mount Carmel Clinic respectively.

### STD Prevention Resources

The most popular printed resources used to educate clients/patients were pamphlets with 88 percent of the respondents indicating their use. Posters and fact sheets were also widely used – about 42 percent and 38 percent of the respondents respectively. About 10 percent of the respondents did not make use of any printed resources to educate their clients/patients on STD. A majority of the respondents who did not make use of printed resources to educate youth clients on STDs indicated that their agency did not provide STD prevention services.

STD Printed Resources Available for Clients		N=201
None	21	10%
Pamphlets	177	88%
Posters	85	42%
Factsheets	77	38%
Other	20	10%

**Table 10: STD Printed Resources Available for Clients**

Sixty-six percent of the respondents indicated that they would like or needed more printed resources on STD. Twenty percent did not desire or need more printed information on the topic and 28% of the respondents did not answer the question. Of the respondents who did not desire more printed information, 75% belonged to agencies that provide some type of STD prevention services.

Would like more printed resources on STDs		N=201
Yes	133	66%
No	41	20%
No Answer	28	14%

**Table 11: Desire for More Printed Resources on STDs**

We also inquired on sources of STD information utilized by youth service providers. Youth service providers gave similar responses to medical service providers. They indicated sources of information and type or medium of materials utilized. About 10 percent of the respondents did not provide information on this topic.

Primary sources of information were community health centres, clinics and hospitals, indicated by 43% of respondents. Different levels of government (i.e., provincial and federal) were sources of STD updates to a lesser extent (about 12 percent of respondents). Resource centres or other education-oriented programs and services were more utilized by this sector of service providers than by physicians and nurses (18 percent and 5 percent respectively).

Providers tended to obtain STD updates from physicians and nurses and other educators and service providers. Professional development activities for providers took the form of occasional and short-term in-service sessions or to a lesser extent through participation in conferences, symposia, workshops and medical rounds.

The most common types of material received by providers were printed materials. About 20 percent of the respondents indicated a number of sources and types of printed materials used as media to learn about STD. Unlike health care providers, most youth service providers obtained updates on STD through pamphlets and factsheets rather than through scientific journals.

Another important source of information is the Internet, with web-based information more popular among youth service providers than among medical providers. Information phone lines were also mentioned as sources of information (e.g., STD info line and Facts of Life Line). This group reported using information from the media (e.g., TV) to increase their knowledge on STD.

### **Barriers to STD Prevention Services to Youth**

This section discusses qualitative data related to the factors that prevent medical and non-medical youth service providers from providing the most effective STD prevention services possible, as well as the perceptions of service providers regarding the barriers that youth face in preventing infection with STD. Because these questions were asked to both groups of respondents, responses were pooled in the main qualitative analysis, resulting in an N of 502 for this set of data. The characteristics and attitudes of two sub-groups of medical service providers (those who provide few and many STD screens to youth, respectively) are also discussed below.

### ***Limitations Faced by Providers***

The analysis and interpretation of this question were difficult and the subject of much debate within the research team. A number of respondents indicated that young people's attitudes and behaviours prevent them from providing the best possible STD prevention services. An awareness that participants may have misinterpreted the question led to the reassignment of these types of responses to the following question, which asked participants to elicit the factors they believed made it difficult for young people to prevent infection with STD. Follow-up interviews would have helped to verify responses and expand interpretation of the results of these questions.

### **Time**

First, health care professionals claimed that lack of *time* was the major factor limiting the provision of appropriate STD prevention in their daily practice with youth. Over 30% of physicians and nurses (n=94) mentioned that lack of or limited time in general were obstacles to the delivery of STD education and prevention. Some professionals indicated more specifically that they faced limited time for one-on-one counselling or discussions regarding sexual health.

Heavy workload, increased number of patients and the remuneration model (fee for service) were also attributed as the main factors that limited the time professionals were able to spend with clients. For some physicians, running a fee-for-service practice did not make time spent on prevention profitable.

Many public health nurses mentioned that limitations on time spent providing prevention education in schools was an important barrier. STD prevention at schools was considered as insufficient or non-existent. Respondents considered that more time spent in schools to work with teenagers was necessary.

For non-medical professionals, time was not as frequently mentioned as a barrier to STD/HIV prevention. Only 10 percent of youth-service providers indicated that time limitation was an important factor that accounted for their difficulties in provision of counselling and education on STD.

## **Resources**

Limited availability of material resources was another significant barrier to the provision of STD prevention. Other barriers mentioned were the lack of personnel, educational materials, condoms and funding. The lack of funding for STD prevention was more important for non-medical service providers than for physicians and nurses; however improved remuneration for physicians may result in availability of more time with clients to deal with STD prevention and education.

Participants indicated that besides lacking human resources in general, they also lacked culturally competent personnel and female physicians to work with female clientele. Providers indicated lack of access or inability to afford health educators and speakers to provide education to their younger clientele as barriers to STD prevention education.

With respect to educational materials, participants indicated a lack of access to print and audio-visual materials and other teaching tools. Some of the respondents specified the lack of up-to-date, youth-friendly and culturally appropriate materials.

While 10 percent of health care professionals reported that limited access to resources was a problem, over a quarter of non-medical respondents mentioned that youth-appropriate resources were lacking. Respondents also mentioned that “culturally appropriate materials for Aboriginal culture [were] are not readily available” and that there was a lack of “innovative resources that would interest the youth” or of “printed resources geared for teens”.

## **Accessibility**

Health care providers identified a variety of factors embedded in the type of services delivered which act as barriers to attracting youth to clinical and preventive services. Although most service agencies provide services for youth, some respondents indicated that they do not have access to young populations “at risk”. Participants indicated that youth are a “difficult population to reach”, and that outreach to youth out of school was difficult. Some observed that attracting young males to their services presented difficulties. A few medical professionals pointed to a lack of outreach services

and strategies aimed at attracting young people to services, including going to the communities and locations where youth meet.

Other barriers to access mentioned were the absence of youth-specific or youth-friendly clinical services to refer to such as drop-in clinics in general or in different neighbourhood in Winnipeg, as well as limitations faced by teen clinics in accommodating increased demands for teen services. One participant indicated that “youth clinics we send our clients to often don’t take new patients”. For others, limitations were related to the manner in which services for youth were delivered. First, participants indicated the absence of services that provide STD prevention at locations and hours suitable for youth. Long waits were also considered as a deterrent for youth to seek health services. Second, providers believed that there was a lack of youth-friendly services. In the respondents’ words, there was limited “access to services that are youth-friendly, i.e., hassle free and spontaneous” or that “youth tend to avoid doctors and clinics unless they are youth-friendly”. A participant believed that “youth do not identify with us as information sources; [they] feel we will judge their behaviour”.

Health care providers observed that there was a lack of specific clinic services such as STD testing, reliable peer training and physicians. Lack of access to testing for young males and females, and in particular non-invasive testing (i.e. urine screening) for young men were also mentioned as barriers to STD prevention.

Health care providers, in particular physicians, considered lack of compliance and follow-up on the part of young people as an important difficulty in the provision of good STD prevention. The fact that youth seek health services only after exposure to STD also presents barriers to prevention work. Another important issue that emerged concerned confidentiality of services. Providers were aware that youth may have little trust in the health care system, or that youth may fear physicians will inform parents about their sexual activity.

### **Structural Factors**

Macro-level factors contribute to the difficulties providers face in the development and implementation of STD prevention strategies. For health care respondents, services were perceived as fragmented, implying a lack of coordination of

services. Different sectors of the health care system were providing pieces of information and STD prevention in a fragmented manner without efficient communication among these sectors – in the words of one participant: “fragmentation of service provision (and) lack of coordination of services”. This group of respondents also indicated that there was a lack of infrastructure available for STD prevention. Lack of clear governmental policy and direction and government support and commitment to deal with STD were also considered as important barriers to prevention.

A few respondents indicated that STD prevention was not the focus of their work and therefore they were not providing these types of services. This was particularly true for youth service providers. Some of the youth service providers voiced that they did not have a mandate to provide STD prevention services. Nonetheless, most of them were referring their young clients to different health services when clients were in need of STD information or services.

A few participants, mainly nurses and youth service providers, mentioned that providers lacked experience and confidence in approaching the issue and that they were in need of education to reduce that deficit. Among youth service providers, a few revealed that staff’s level of discomfort in dealing with STDs and the stigma of the topic (i.e., STD/HIV) were also barriers to the provision of good STD prevention for youth.

Schools were perceived as lacking a mandated sexual health curriculum. The limited role of school in health promotion regarding sexual health and STD promotion was attributed to the conservative nature of the institution in sexual and reproductive health education.

Finally, it is worth mentioning that some participants did not find difficulties in providing STD prevention services and education.

### ***Limitations Faced by Youth***

Health care and non-health care service providers were asked to indicate the factors that they believed facilitated the transmission of STDs or infection of STD among youth. A number of individual, interpersonal and systemic risk factors were noted as contributors to the spread of STDs among youth. Health care and youth services providers did not significantly differ in their views regarding this topic.

### **Invincibility**

Overwhelmingly, both sectors of service providers considered that youth think and feel that they are *invincible*, that contracting an STD or experiencing an unplanned pregnancy “won’t happen to them” or that their “bullet proof mentality” and attitude of “denial” will protect them from STD. Nearly 43 percent (n=128) of health care providers and 36 percent (n=72) of youth service providers reported “invincibility” as a reason that makes it difficult for youth to prevent STD. Invincibility was conceptualized as a way of thinking, feeling, an attitude (i.e., teenager attitude), values, a “syndrome”.

Furthermore, some respondents attributed or related this sense of invincibility and risk-taking to the developmental stage of adolescence. Invincibility was regarded as a natural response for people going through their teen years. As one respondent indicated “the youth are at a stage in their growth and development where they feel they are immortal”.

Youth were believed to be present-oriented and therefore incapable of contemplating future consequences of certain practices and behaviours. Some respondents elaborated: “the adolescent brain is not focused typically on the future – which starts typically in the 20s”, “average adolescent behaviour includes lack of long-term planning or foresight of risky behaviours”.

From the perspectives of providers, physiological and psychological changes experienced by youth prevent them from making rational decisions. Risk-taking is considered to be hormonally induced. In the words of providers, adolescents are “risk takers with lots of libido”, and their “hormones are very intoxicating”.

### **Lack of Knowledge**

That youth lack knowledge about STD and other sexuality-related issues was mentioned as another factor impeding young people from preventing infection. “Lack of knowledge about risk factors” regarding the transmission and prevention of STD was mentioned by 30 percent of service providers and about one quarter of health care providers.



A few respondents emphasized communication of false information among young peers, low level of literacy among some sectors of the youth population, decreased capacity for appropriate decision-making, and superficial information as barriers for prevention. Lack of safer sex negotiation skills was also viewed as limiting prevention, in particular for female youth. In participants' words, adolescents and youth face "lack of skills to communicate/negotiate safe sex" or feel "uncomfortable negotiating condom use and saying no".

For some youth service providers, lack of knowledge was associated with learning disabilities and difficulties as well as mental health issues among their youth clients. These risk factors were assumed to have negative health outcomes within the young population.

### **Access to Resources**

Access to resources such as condoms due to cost and limited availability to free condoms was perceived by many participants as being barriers for youth. Lack of knowledge of where to obtain condoms without cost was an obstacle for the prevention of STD. Lack of availability of condoms where youth congregate (e.g. schools) was also considered as a shortcoming to health promotion and STD prevention.

Providers identified a series of issues concerning inaccessibility of services and educational resources. First, access to youth-appropriate services was perceived as a barrier. Health care providers observed that the "attitude of organizations create hostility/barriers for kids", that there is a "paucity of adolescent friendly health services", "a lack of hassle free services", and a "lack of sensitivity within the current system". Teenage boys were also believed to find medical clinics hostile due to invasive testing procedures and lack of understanding/empathy regarding issues concerning young men and sex.

Providers perceived that youth might feel that there is limited one-on-one contact with providers and that they may experience a lack of consistent medical provision leading to poor development of trusting relationship and open communication between youth and providers.

Some providers indicated that youth might lack knowledge of locations where services are available; including specific services such as counselling or testing, and may lack access to services in certain neighbourhoods and areas of the city (i.e., suburbs).

Providers perceived that the gender of the health care provider was also a limitation to the provision of sound STD prevention. Youth were believed to be more comfortable discussing sexuality related issues with a provider of the same sex. In addition, the mandate of certain health care services presents limitations to the provision of services to certain sectors of the youth population (i.e., male youth), limiting their options for STD prevention. The mandate of women-centered clinics to provide exclusive services to female youth was an example of this concern.

Other obstacles that were mentioned were the presence of inadequate education in family life education program at school (e.g., need for assertiveness training among youth for risk reduction), in particular the lack of teaching from public health nurses in schools and the lack of printed materials in schools. Lack of culturally appropriate approaches to deal with homophobia in Aboriginal culture was mentioned by one provider as a specific barrier faced by Aboriginal youth.

A few health care providers indicated that youth do not have access to peer education initiatives that might be more meaningful than other prevention programs. Youth encounters with people living with STD and HIV would increase the impact of education. “Not seeing enough ‘actual’ persons living with STD and HIV” was considered an obstacle for prevention.

### **Youth Behaviours**

Other factors identified by the providers that can jeopardize sexual health were related to youth *risk behaviours*. First, chemical dependency was related to poor or limited decision-making and self-risk regarding STD transmission. Some providers expressed that “alcohol and drug use affects responsible decision-making”, and “youth are often experimenting with other behaviours such as [alcohol]/drug use and it effects their decision-making”.

Youth were also perceived as engaging in impulsive behaviours. They “don’t want to interrupt sexual act/break the mood”, and they get caught in “spur of the moment

decisions without thought of consequences”. Not using condoms or using them occasionally and negative attitude on the part of male youth to condom use was also seen as a barrier to prevention. Providers indicated that youth were not “using protection consistently and with all partners”. For a youth service provider “the distinction between using a condom for prostitution and not using one for personal [use with partner]” was a problem. Others believed that youth have “no desire to wear condoms”.

Serial monogamy (i.e. a series of intense intimate relationships for brief periods) and prostitution were other contributing factors making it difficult for youth to prevent STD.

Youth were viewed by many providers as irresponsible in their sexual behaviours, and unable to take responsibility for their own and others’ health. Youth were viewed as being unable to act on prevention knowledge, in turn facilitating the spread of STD. In other words, they have “difficulty translating knowledge into behaviour change”.

### **Power Relationships**

Issues of control and power, including abuse issues, peer pressure to engage in sex, willingness to conform and fear of being rejected were described as factors that contribute to the spread of STD. A participant summarizes the negative aspects of peer pressure as follows: “[I found a] propensity for risk-taking behaviour in certain groups of youth, i.e., motivation for status/acceptance among peer groups may outweigh consideration of personal risk”.

Powerlessness on the part of female youth in heterosexual relationships was another issue raised by providers. Females were seen as being pressured by males to have unprotected sex. They were described as having low self-esteem and in need of building more assertive behaviour. One respondent indicated: “Guys pressure girls not to use [condoms] and I believe due to their low self-esteem and their need for affection, they agree. Same old issues – girls don’t stand up for themselves and value themselves. Girls need to be confident and feel that they have worth in order to speak up”. In all, young females were perceived as being vulnerable in sexual relationships with males.

### **Priority of STD Prevention**

Youth lack of interest in STD prevention and having to deal with other competing priorities were other factors identified in the spread of STD. Youth were believed to be “unconcerned” or “apathetic” about STD. This lack of interest leads to missed opportunities for prevention and not taking providers seriously. One participant indicated: “it seems as if in situations of poverty and homelessness, STD prevention becomes a very low priority. They feel they have bigger things to worry about”.

### **Youth Emotional Issues**

Youth emotional issues such as the reluctance to seek services and information and discomfort and embarrassment to seek services and information, purchase condoms and contraceptives, were all indicated as reasons that make it difficult for youth to prevent STD. Young people were seen as possessing an inadequate self-concept including low self-esteem and hopelessness.

### **Societal and Family Factors**

Some providers mentioned the influence of wider social issues in the spread of sexually transmitted infections among youth. The issues ranged from the role of the media (e.g., glorification of sex and lack of effective media information) to a modern “lack of morals”, as well as other socioeconomic related factors (i.e., poverty).

For several respondents the presence of apathetic and unsupportive parents or caregivers, parental objection to STD education in school, and the lack of open communication were central to the spread of infections among youth. Youth may have difficulty in introducing and discussing sex-related topics in communication with their families.

## **Discussion**

Health care and social service systems are mandated to reduce vulnerabilities that adolescents face (e.g., threats to their well-being, safety, diseases, crime). Provision of services such as STD screening and treatment, health promotion and prevention are all activities oriented to decrease these vulnerabilities. Despite the availability of services,

youth in Winnipeg experience high levels of STD and are likely to become more vulnerable to HIV infection. Epidemiological data confirm that although Manitoba Health has developed policy geared toward the reduction of STD in Manitoba, various infections are still a concern or becoming more widespread among certain sectors of the youth population.

The position of the research team assumes that the ecology of human behaviour and patterns of social relationships are not independent of their social, economic and historical context. Although this study highlights some issues regarding the provision of health care and social services to youth, fostering a better understanding of and relationships between youth services cannot in isolation transform communities and address STD prevention issues. The findings presented in this study are likely to assist planners in the social service sector and health care system to address a series of issues that consistently undermine STD prevention objectives.

The characteristics of this short survey present some limitations to the full understanding of the provision of health and social services for youth in Winnipeg. Because in-depth follow-up interviews with health care and youth service providers were not conducted, this survey did not privilege in-depth explanations regarding STD prevention barriers and providers' understandings of the factors that facilitate the prevention of STD among youth. Therefore, findings from this survey provide us with insights that should guide action and future research. These findings confirm what other researchers have found in their inquiries on the best practices and shortcomings of health services geared toward young people.

Barriers to preventive services include values, beliefs and perceptions of providers and also clients, as well as inadequate skills, time, funds and technological resources to implement this approach. The Society for Adolescent Medicine (1997) found that health care providers were pessimistic about the effectiveness of preventive services and that they lacked comfort in engaging adolescents in discussions of health promotion.

Barriers identified in this study include:

- Limited time to engage in STD prevention
- Inadequate resources, including funding and youth-oriented and culturally appropriate instructional materials

- Shortcomings of services to reach out to young people
- Insufficiency of youth-centred/friendly agencies, including those that provide services at hours and locations that are suitable for youth, lack of appropriate outreach strategies,
- Absence of testing services (including non-invasive testing for young males),
- Absence of reliable, experienced and trained peer training and
- Absence of reliable and experienced health care providers in approaching sexually-related issues.

Perceptions held by providers about youth and their inability to prevent STD were documented in this study. The literature points out that values, beliefs and perceptions of providers regarding youth and adolescents shape the approach to service delivery and social policy (See Nightingale and Fischhoff 2001; Millstein and Helpen-Felsher 2001). Value judgments are intertwined in the process of identifying, measuring, and creating practices, programs and policies to address adolescent risk. As Mann & Tarantolo (1996) said in the ground-breaking book *AIDS in the World*, “How a problem is defined, determines what is done about it.”

Adolescence is a complex life stage and not well understood. Research on adolescent development emphasizes the ‘storm and stress’ model as inherent in the transition stage from childhood to adulthood. This cultural bias is based on the perspective that intensification of innate biological drives necessarily comes into conflict with social expectations of behaviour. Adolescents are often believed to be at particular risk because of cognitive deficits, which are seen as innate to this life phase. Decision-making in adolescents is commonly described as irrational, based on inadequate knowledge, psychological instability and lack of experience. According to Schellenberg, Ormond and Linnebach, “an overwhelming focus in the literature on factors that create vulnerability to a variety of harmful outcomes, including STD/HIV infection, ignores strengths and protective factors that enhance the resiliency and adaptation of individuals and communities in adverse circumstances” (2001: 38).

The widespread view among providers that young people feel or think of themselves as *invincible* conflicts with views widely expressed in the literature showing

that, contrary to popular belief, young people accurately assess the risks they face. The literature demonstrates that rather than feeling invulnerable, young people have serious concerns. These concerns are related to daily life contexts such as poverty, minority status, racism and violence. Practitioners should be able to assess the complexities of young people's lives, the factors that contribute to risk and protection in different settings as well as to learn from youth about their perceptions of vulnerability. According to Millstein and Halpner-Felsher, the literature clearly documents that adolescents worry about and feel vulnerable to AIDS, and that they also feel vulnerable to acquiring an STD (2001: 21). The authors also identify research that demonstrates that youth are able to recognize risk in real-life situations. Emergent research has established no significant differences in the perception of risk and abilities to recognize consequences between adults and young people (Millstein and Halpner-Felsher 2001).

Perceptions of risk and vulnerabilities shape programs and policies. If programs are based on the idea that young people feel invincible, they may be designed with an understanding that more manipulative or punitive interventions are needed. Adult interventions based in cultural bias towards young people are likely to be highly restrictive and paternalistic (Whaley 1999).

Professionals must be aware of their own values, perceptions and beliefs, which may translate into attitudes that create barriers to communication with actual and potential young clients. Such orientations can determine the ways that practitioners approach youth. Viewing adolescents as going through a stage of turmoil is likely to pathologize all youth and direct efforts towards the remediation or prevention of adolescents' innate and expected problematic behaviours, rather than towards the promotion of adolescent well-being and the accurate diagnosis and treatment of pathology if and when it does arise.

In this study, factors that predispose young people to harm are mainly understood by health and youth service providers as individual or psychological factors. While some health care and youth service providers have considered the influence of social and economic contexts on the spread of STDs, they were clearly in the minority. Much of the health promotion and prevention literature has shifted from a focus on individual, psychological factors to examine the interlocking set of factors that contribute to

vulnerability among young people. These inter-relations are complex and “the way in which protective factors work differ across outcomes” (Blum, McNeely and Nonnemaker 2001: 70).

Blum, McNeely and Nonnemaker (2001) indicate that the individual, familial, and social environments in which a young person lives can counterbalance vulnerabilities that place young people “at risk”. These counterbalancing elements are resources, assets, protective factors and resilience. From an ecological perspective it is useful and productive to understand vulnerabilities as “an interactive process between the social contexts in which a young person lives and a set of underlying factors that, when present, place the young person “at risk” for negative outcomes (e.g., school failure, unanticipated pregnancy, injury)” (Blum, McNeely and Nonnemaker 2001: 51). From that perspective there may be biological and cognitive factors predisposing an individual to vulnerability. Other vulnerabilities may result from living in disadvantaged environments.

Advocating the enhancement of resiliency at the individual and interpersonal level does not provide the complete answer to vulnerabilities faced by youngsters. While the focus of programs and services can take into account how to strengthen resiliency, this approach can conceal systemic and structural problems that contribute to vulnerability and risk among adolescents and youth. For instance, by itself, this approach can redirect the focus away from socioeconomic problems as important contributors to vulnerability and risk. If we believe that all youth at risk are resilient, we might be doing a disservice to this sector of the population. In that case, all factors – individual, interpersonal/inter-group and structural – must be taken into account when we try to develop solutions to the prevention of STD.

What is needed is the creation of programs that are grounded in an ecological multi-systems framework are needed. This model, as Forgey advocates, requires “an ability to utilize and interpret the research data on at-risk population characteristics and resiliency factors” (Forgey 2000: 223). Forgey also argues that the strengths perspective needs to be expanded further from clinical situations to be used in developing strategies to prevent the onset of problems (Forgey 2000).

Proper assessment of vulnerabilities and protective factors is required for successful interventions. Appropriate, culturally-responsive and youth-responsive health



and social services, as well as the increased availability of resources should contribute to averting the spread of STD in Winnipeg. Meaningful STD prevention services and education for youth can be assessed as sources of protective factors. The availability and accessibility of health care services are an important determinant of health. Appropriate services are those that are most suited to deal with concerns and problems people are experiencing because of their position in society. Appropriate services are those that endorse equality, attract and retain youth, maintain their cultural integrity, increase cultural identity and consciousness (e.g., Aboriginal youth) and contribute to self-esteem. Further, strengthening and improving health care and social services is an important strategy for building resiliency (Bell 2001).

The quality of interaction between young client/patient and provider is important in a successful assessment of vulnerabilities and protective factors in the lives of young clients. Of course, *time*, a precious and scarce commodity in health care services in particular, is needed to engage youth in an open dialogue regarding STD prevention.

Information on the incidence of STD among youth indicates that there is an increased need for availability of STD screening and treatment among adolescents and in particular among inner-city youth in Winnipeg. This would require innovative strategies to reach out to the different groups of youth, including:

- Availability of convenient hours and locations,
- Appropriate outreach strategies,
- Assurance of confidentiality,
- Promotion of an atmosphere that facilitates two-way respect and open dialogue.
- Access to non-invasive testing procedures such as urine screening.

Although some professionals may not experience problems addressing sexuality related issues with youth, others may be in need of education and preparation for adolescent preventive services.

The survey reveals that agencies are engaged in a number of STD preventive services such as counselling and education. However, the barriers that agencies face in the delivery of these services lead us to ask if education is educating. Only relevant services are deemed to produce desirable outcomes.

The variety of factors that affects youth health and well being calls for a multi-sectoral approach to service provision. The different sectors should increase communication to help in the development of holistic or ecological approaches to health. Something must be said for the organizations dealing with sexuality related issues. These organizations must take the lead in sharing information across sectors, including non-medical service providers, to increase knowledge and awareness regarding youth and STD-related issues. They are in a position to provide evidence-based research that would result in informed policies and program development. This flow of information should be continuous and not depend on periodic demands (i.e., in-service).

Although this study was meant to gain insight from health care and youth service providers with the intention to develop proposals to enhance the provision of STD prevention services and education to youth, some responses addressed the roles of other sectors in assisting young people with STD prevention. For instance, issues such as cost of condoms and embarrassment asking for condoms were mentioned as barriers to STD prevention. As found in a study in Nova Scotia regarding young females and barriers to optimal sexual health (Langille 1998), action can be taken by pharmacists to assist young people in STD prevention and sexual health. The development of mechanisms that assure confidential and private purchases could improve access to condoms (e.g., display of condoms in private location).

Certainly, we advocate for action based on evidence. However, action is sustained by political will and strong social policies. In the face of the incidence of STD and HIV in Winnipeg, Manitoba's policies regarding STD prevention need to be revised to accommodate appropriate courses of action and realistic and feasible objectives.

## **Recommendations**

The findings of this study support the following recommendations:

- Province-wide implementation and marketing of urine screening for chlamydia and gonorrhea.
- Youth-led social marketing of condoms, print resources and other STD prevention services.

- Improved coordination and referral mechanisms among non-medical youth services, STD-specific services, teen clinics, perhaps through common outreach initiatives.
- Improved prevention-focused outreach to out-of-school youth and young males.
- Organizations that provide sexuality related information and education, including STD information, should focus their work on the divulgence of information to other services providers (e.g., health care and youth service providers) on a regular basis.
- Organizations that provide sexuality-related information and education should offer continuous education and skills that are not routinely included in the training of health care and other professionals (e.g., techniques for raising issues of sexuality with young patients/clients, for increasing level of comfort in discussing these issues, for non-threatening ways to approach young patients/clients).
- Promotion and support of the establishment of an appropriate and effective mandatory sexual health curriculum in schools.
- Promotion of development and evaluation of social policies that encourage and support actions to prevent the transmission of STDs.
- Addressing providers' barriers to allow increased STD screening in medical clinics, walk-in clinics, hospitals and correctional institutions where a higher proportion of youth are seen.
- Targeted research dissemination to service providers in order to counter youth stereotypes and cultural biases towards young people, including increased focuses on positive qualities and strengths of young people.
- Development of programs that focus on strengths of youth participants rather than on their "deficiencies" and problems.
- Development of outreach strategies that increase accessibility to services and provision of information for youth taking into account diversity within the young population (e.g., transient/mobile youth)

## **Future Research**

With this research we gained insights on the experience of providers in the area of STD prevention with youth. However, it also compelled us to keep asking questions. This research should be used in the formulation of further research initiatives related to STD & HIV prevention with youth in inner-city Winnipeg. Future research should examine:

- An in-depth exploration of provider perceptions of adolescence and youth;
- Impact of providers' and policy makers' perceptions of youth in their professional practices and social policies;
- Accessibility and outcomes of STD prevention services. Evaluation of the impact of local STD prevention services should be conducted to determine best practices and shortcomings of services and programs. In addition to research with youth clients the research should include the voices of young people who do not make regular use of services.
- Interrelation of effects of service delivery system components and the health policy climate.
- Characteristics of providers, their knowledge, attitudes, training and experience, including cultural competence knowledge, skills and use of existing guidelines for prevention and sexual health.
- Organizational characteristics such as location, hours of operation, waiting time, etc.
- Number and type of services, the type and regularity of contact between agencies and the policy environment.

On the other hand, this short study also suggested the need to learn more about:

- Adolescents' and youth's attitudes and perceptions toward youth/social services and health care services, resulting in improved communication between sectors.
- Adolescent perception of risk and vulnerability among youth.
- Specific individual, social, cultural and environmental factors that encourage and reduce the transmission of STD within specific sectors of

the youth population (e.g., inner-city youth, street-involved youth, transient youth) that is more vulnerable to infections.

## **Dissemination**

In the months of April and May, 2002 the Youth Working Group designed and delivered Dissemination Workshops on current STD & HIV prevention research information. Five workshops were held with a total of 58 youth in 5 Winnipeg agencies. The locations of the workshops were: Training and Employment Resources for Females (TERF), Ma Mawi Wichi Itata Centre, Thunderbird House, Nine Circles and Powerhouse. The organizations chosen provide services to diverse group of youth.

A number of issues were presented and discussed by use of an informal approach. The main topics included a discussion on resources created by the group, i.e., *Harsh Reality* (a prevention book created by YWG members in 2001), peer education and basic STD/HIV information, with specific STD research information including preliminary data on the perceptions and beliefs of health care providers regarding the factors that prevent youth from obtaining STD/HIV prevention and other findings from studies on youth and STD in Winnipeg (biological vulnerability of young women to STD infection due to developmental stage, the relationship between having STD and being at higher risk for HIV, among others).

For the purposes of the workshops, the YWG developed fact sheets with information on findings regarding STD in Winnipeg. One of the fact sheets depicted preliminary data on the perception of health care providers and youth workers on what makes it difficult for youth to prevent being infected with STDs.

The final product of this project is the development of a community report disseminating our research results to research participants and others. This report will facilitate and encourage local action in Winnipeg. The report will be mailed to the respondents and other youth serving agencies, as well as posted on the Sexuality Education Resource Centre website. The Youth Working Group will design an information sheet with data from the study to be included in *Harsh Reality II* (soon to be released).

A follow-up evaluation of the reception of the community report will be designed to gain further insights on the issues of Youth and STD/HIV prevention by youth workers and health care providers. A short questionnaire will be included within the report. Participants and other readers will be encouraged to provide feedback by answering to the evaluation form and mail or email the complete questionnaire to the researchers. Other options will be to contact the researchers by phone or email for comments and questions. The feedback obtained from health care and youth service providers will assist us to verify and clarify the research findings and suggestions.

### **Implications for the Centre of Excellence for Child and Youth Mandate**

This project has explored the services provided and barriers to provision of services from the perspective of health care and social service providers. The insights produced in this project may assist future researchers to explore the reasons behind the barriers experienced by providers. The project also produced some insights on what may prevent young people from obtaining the best possible STD prevention education and services.

The new understanding generated in this study on how providers perceive the barriers to the provision of STD prevention, including their perceptions of adolescence and youth and their understanding of the risk and vulnerability factors that put youth at risk for STD, provide information that will be of real use in addressing barriers and creating “youth-friendly” education and service strategies in Winnipeg.

The Centre of Excellence is interested in improving the well-being of Winnipeg children and youth. Health services, including health promotion, prevention and education, constitute an important determinant of health. As such, health services have the potential to impact the health status of youth in Winnipeg. The Centre of Excellence by supporting increased understanding of barriers faced by those who provide services to young people has contributed to solutions that can remove the barriers to benefit those in need of appropriate services.

Finally, by engaging youth in the process of research, the project has been able to draw experiences and expertise of the sector that receive services, as well as from their strengths, and stimulate reciprocal transfer of knowledge, skills, capacity, and power. The

success of this project in involving youth in community-based research, in this case through data analysis and dissemination, demonstrates that the participatory model works toward the mandate of the Centre of Excellence, which aims at including different sectors of the population, in particular children and youth, to address the issues that children and youth are facing in Winnipeg.

## References

Bell, Carl

2001 "Cultivating Resiliency in Youth" *Journal of Adolescent Health* Vol. 29.

Blanchard J., M. Dawood and M. Fast et al.

1996 *The Geographic Relationship between HIV and other Sexually Transmitted Diseases in Manitoba: Results of an Unlinked Serosurvey [draft]*, Manitoba Health.

Blum, R. C. McNeely and J. Nonnemaker

2001 "Vulnerability, Risk, and Protection" in Fischhoff, B., E. Nightingale and J. Iannota (eds.) *Adolescent Risk and Vulnerability: Concepts and Measurement* Washington D.C.: The National Academy of Sciences.

Fleming, D. T. and J. N. Wasserheit

1999 "From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection" *Sexually Transmitted Infections* Vol. 75, 3-17.

Ford, C., S. Thomsen and B. Compton

2001 "Adolescents' Interpretations of Confidentiality Assurance" *Journal of Adolescent Health* Vol. 29.

Forgey, M.A.

2000 "Capitalizing on Strengths: A Resiliency Enhancement Model for At-Risk Youth" in Norman, E. (ed.) *Resiliency Enhancement: Putting the Strengths Perspective into Social Work Practice* New York: Columbia University Press.

Health Canada

1999 *Healthy Development of Children and Youth. The Role of the Determinants of Health*, Ottawa: Author.

Israel, B., A. Schulz, E. Parker and A. Becker

1998 "Review of Community-Based Research: Assessing Partnership Approaches to Improve Health" *Annual Review of Public Health*, Vol. 19.

Langille, D. et al.

1998 *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*, Nova Scotia: Maritimes Centre of Excellence for Women's Health.

Manitoba Health

1999 *Discussion Paper for the Development of a Provincial Sexually Transmitted Disease Control Strategy*, Manitoba: Communicable Disease Control Unit, Public Health Branch.

2001 *Chlamydia, Gonorrhoea and Hepatitis B Rates 1996-2000*, Manitoba: Communicable Disease Control Unit, Public Health Branch.

Mann, J. and D. Tarantolo



1996 *AIDS in the World II: Global Dimensions, Social Roots, and Responses*, Global AIDS Policy Coalition, Oxford University Press.

Millstein, S. and B. Halpern-Felsher

2001 “Perceptions of Risk and Vulnerability” ” in Fischhoff, B., E. Nightingale and J. Iannota (eds.) *Adolescent Risk and Vulnerability: Concepts and Measurement* Washington D.C.: The National Academy of Sciences.

Nightingale, E. and B. Fischhoff

2001 “Adolescent Risk and Vulnerability: Overview” ” in Fischhoff, B., E. Nightingale and J. Iannota (eds.) *Adolescent Risk and Vulnerability: Concepts and Measurement* Washington D.C.: The National Academy of Sciences.

Ormond, Margaret

2000 *Enhanced STD Surveillance in Canadian Street Youth, Final Report – Winnipeg, Manitoba: Who did finance/publish this?*

Schellenberg, J. with M. Ormond and K. Linnenbach

2001 *Youth & STD/HIV Prevention in an Ecological Framework*, Manitoba: Sexuality Education Resource Centre.

Ruiz, M., A. Gable, E. Kaplan, M. Stoto, H. Fineberg and J. Trussel (eds.)

2000 *No Time to Lose: Getting More from HIV Prevention*, Washington, D.C.: Institute of Medicine, National Academy Press.

Society for Adolescent Medicine

1997 Clinical Preventive Services for Adolescents: Position Paper, *Journal of Adolescent Health*, 21

Thrall et al.

2000 “Confidentiality and Adolescent Use of Providers for Health Information and for Pelvic Examinations” *Archives of Paediatric Adolescent Medicine* Vol. 154, September 2000.

Whaley, A.L.

1999 “Preventing the High-risk Sexual Behaviour of Youth: Focus on HIV/AIDS Transmission, Unintended Pregnancy, or Both?” *Journal of Adolescent Health* Vol. 24, 376-82.

Winnipeg Regional Health Authority

2000 *Winnipeg Health Region – Demographic Profiles: Volume 1* Winnipeg: Author.

Wylie, J. L. and A. Jolly

2001 “Patterns of Chlamydia and Gonorrhoea Infection in Sexual Networks in Manitoba, Canada” *Sexually Transmitted Infections*, Vol. 28, No. 1, 14-24.

## **Appendix A: Survey Instruments**