Creating safety for youth sexual health: Learning from experience

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Acknowledgments

This project would not have been possible without the support and contributions of several people.

I would like to thank Island Sexual Health for collaborating with me in this project. I am grateful to all the people who took the time to participate in the interviews and focus groups. In particular, thank you to my client, Bobbi Turner and to Jennifer Gibson for being interested in this project, their support and for their commitment to providing youth friendly sexual health services.

I would also like to thank Dr. Thea Vakil for her guidance and support at every step of this project. Thank you as well to the 2014 MACD Cohort for being such a supportive group of inspiring individuals.

Finally, I would like to thank my family and friends for their love, support and patience throughout this educational journey. Thank you for encouraging me and believing in me.
EXECUTIVE SUMMARY

Adolescence and young adulthood are crucial times in a person’s sexual development. In this time of cognitive, physical and emotional development youth often become sexually active and engage in exploration that may lead to risky behaviour with long term consequences. They are times when they are navigating societal expectations and pressures in regards to their sexuality and sexual wellbeing and when access to appropriate sexual health services and information can mitigate potential negative health outcomes. Island Sexual Health Society (ISH) currently plays a key role in providing this information and sexual health services for young people in the Greater Victoria area.

The objective of this project is to learn how youth-friendly services are defined and to provide ISH with informed strategies to increase the organization’s capacity to provide youth-friendly services. The research questions are as follows -

When youth access services at ISH:

- What are their experiences of the different programs?
- How do these experiences impact their sense of safety?
- What do youth need in order to feel safe when accessing sexual health services at ISH?

Background

ISH is a non-profit organization that provides clinical sexual health services, community education and outreach and product sales. The organization operates a central clinic and four satellite clinics including two in local high schools and one in Camosun College. ISH provides services to clients of all ages, however youth between the ages of 15 to 25 make up a majority of their client population. ISH has youth focused programs such as a sexual health education program in schools, a youth website and a youth advisory council. All services are confidential and free of charge.

Youth sexual health is a key health concern. Statistics indicate that youth have higher incidences of Sexually Transmitted Infections (STIs) than the rest of the population. Youth are also involved in higher risk sexual behaviours such as unprotected sex, multiple partners and sexual
activity at a young age. STIs and high risk sexual behaviours can have serious negative and long term consequences for youth. These consequences are generally of a preventable nature that can be addressed through access to sexual health services and information.

**Literature Review**
The literature review focused on the themes of youth-friendly sexual health services models, risk factors and protective factors to youth sexual health, barriers youth face in accessing sexual health services and barriers providers face in delivering youth friendly services. The literature review included academic articles and professional publications published since 2000. Earlier literature focused on teenage pregnancy as the key indicator for sexual health.

The first segment of the review provided an overview of how sexual health services are delivered, exploring different models of delivery as well as their strengths and weaknesses. The review then pointed to youth sexual health as a priority due to young people’s vulnerability to negative health outcomes and to the preventable nature of these outcomes. This section then explored the factors that place youth at risk and those that act as protective factors in their health and wellbeing. These factors were considered in relationship to the delivery of sexual health services. The literature identified youth in care, homeless youth, LGBTQ youth, Aboriginal youth and youth living with disabilities as particularly vulnerable to increased negative health consequences.

The literature review outlined barriers youth face in accessing services. The main barriers identified were fear of not being treated with respect and fear that services were not confidential. The literature also considered the barriers faced by service providers. Key barriers included not having sufficient training on how to work with youth and lack of adequate funding to provide appropriate services for youth. The literature also provided an overview of characteristics of youth friendly services and recommendations on how organizations can best deliver accessible services for youth.
Methodology
The project used a qualitative community based research approach. Three participant groups were identified and recruited using purposeful sampling. Group one included youth who are current or recent clients of ISH. Group two included staff and volunteers of ISH who interact with youth when they access ISH services and group three included community based youth workers who support youth in accessing ISH services. All participants self selected to participate in the project.

Focus groups incorporating community mapping strategies were used to gather information from group one participants. Focus groups are an appropriate research tool as youth generally feel more comfortable in a group of peers and more likely to engage in a group discussion than individual interviews. A total of 25 youth participated in three separate focus groups. Semi-structured interviews were utilised to gather information from participants in groups two and three. The interviews were approximately 45 minutes in length and included seven open-ended questions for staff and five open-ended questions for community youth workers. In total, 14 staff and volunteers and five community based youth workers participated in the interviews. A thematic analysis was used to reveal common themes within each group and across all three groups.

Findings and Discussion
The findings included participant views on characteristics of youth-friendly services, their thoughts on current ISH services and their recommendations for enhancing these services. The findings also included youth needs and realities and how these affect the approach to service delivery. Much of the findings from participants mirrored those in the literature review but included specific comments on ISH’s unique structure, design and approach.

Participants spoke about the special considerations that are necessary when providing services to youth. These include being aware of the high levels of anxiety and nervousness that youth experience when accessing sexual health services. A key finding was youth’s limited knowledge of their bodies and the medical system which impacts their ability to ask the right questions or to follow-up with treatments or testing. Participants described barriers youth face in accessing
services including hours, transportation and cost of services or birth control. While ISH provides
free services and birth control at reduced or no cost, the findings indicate that youth and youth
workers are not necessarily aware of this. Cost, real or perceived, will prevent young people
from accessing services.

Youth needs affect service delivery and program design. Participants talked about the urgent and
immediate nature of youth sexual health needs which require flexibility in scheduling and often
require additional staff time. Youth are also worried that services are not confidential and so
confidentiality needs to be explicitly stated. Often youth clients have complex needs beyond
what ISH is able to provide. Participants discussed the importance of a closer working
relationships with community youth workers and programs in order to provide further support to
youth.

In regards to youth-friendly services, an overarching theme was the importance of ensuring
youth have a positive experience in their interactions with staff at all points of contact. In general
participants described youth and staff interactions at ISH as positive. Examples of negative
experiences pointed to a lack of consistency throughout the different ISH service areas. A
common theme that arose from both findings and literature was the need for staff to receive
training on how to work with young people. Youth friendly services also include a flexible
approach that caters to specific youth needs and work to remove barriers.

**Recommendations**
Nine short and medium-term recommendations and four long-term recommendations have been
provided to ISH to assist them in increasing their capacity to be provide youth-friendly sexual
health services.

*Short and medium term recommendations:*
1. Establish an explicit organizational culture that values and respects youth and prioritizes
   providing high quality services to young people. This can be achieved through staff training
   and revising HR policies.
2. Further reduce barriers to youth access to services by providing choice of physician to see, addressing financial barriers and establishing youth-only clinic times.
3. Develop a close working relationship with community youth workers to address complex youth needs.
4. Examine ISH program design and structure to discern areas where relationship building with clients and continuity of care can be strengthened.
5. Increase the level of youth involvement and presence in ISH program design and evaluation through effective feedback tools and enhanced role of the Youth Advisory Council.
6. Develop strategies for reaching youth that identify as male.
7. Increase collaboration with other youth serving organizations to provide comprehensive services to youth. This includes direct updates to front-line youth workers, clear referral routes to other youth services, and knowledge sharing.
8. Increase the comfort and welcoming atmosphere of the clinic spaces.
9. Increase promotion of ISH services.

_Long-term recommendations_

1. Address the issue of 15-minute consultations by increasing nurse shifts and supplementing physician wages to increase their consultation times.
2. Expand hours and days of operations at existing satellite clinics.
3. Expand satellite clinics to create more accessible locations to more geographical areas of Greater Victoria.
4. Establish a youth-designated position at ISH.

**Conclusion**

This project grew out of ISH’s commitment to ensuring that youth have access to youth friendly sexual health services. that this project has captured how ISH currently offers youth-friendly services and provided the opportunity to hear from clients, staff and community youth workers how these services can be strengthened. The recommendations offer strategies for improvement based on the insights of research participants and are grounded in the literature. The project also highlights the importance of ensuring youth have access to appropriate, respectful and friendly sexual health services.
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CHAPTER 1: INTRODUCTION

Sexual health and sexuality are key developmental tasks in adolescence and young adulthood (Monasterio, Hwang, & Shafer, 2007, p. 302; Poon, Smith, Saewyc, & McCreary Centre Society, 2015, p. 5). This is a stage in life when young people physically and emotionally develop sexually, develop a cognitive understanding of sexuality, and potentially become sexually active. It is a time of exploration that may lead to risky behaviour and potential negative physical, emotional and mental implications (Falk, Pederson, & Stanger, 2006, p. 14; Monasterio et al., 2007, pp. 302, 304; Poon et al., 2015, p. 5). Youth are navigating societal expectations and pressures, and seeking access to accurate information and health services. Island Sexual Health (ISH) is a non-profit organization located in Victoria, British Columbia. It offers a variety of sexual health services to the Greater Victoria region. ISH aims to provide high quality health services through the provision of inclusive services and resources, empowering individuals to make their own choices, and celebrating sexual diversity (Island Sexual Health, n.d.-a, para. 3). While ISH provides services to all ages, youth are a large portion of the clients they serve (B. Turner, personal communication, Aug. 20, 2015). This project aims to provide ISH with recommendations for increasing its capacity for providing accessible sexual health services to youth.

Definitions

This project follows the definition of sexual health presented by the World Health Organization as:

“A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships…” (World Health Organization [WHO], n.d. para 8)

The WHO further states that respect of sexual rights are a part of sexual health. These include access to the highest attainable sexual health services as well as the right to seek out information on sexual health (WHO, n.d., para 9). Sexual health services can refer to both preventative and intervention strategies. Services may include disease prevention, identification and cure,
pregnancy prevention and care, information on sexual decision-making, gender and sexuality, and general services related to any aspect of sexual health and wellbeing.

For the purpose of this project youth is defined as people ages 15 to 24. This age range adheres to the definition of youth presented by the United Nations (United Nations Department of Economic and Social affairs, p.1, n.d.). The age range was selected in collaboration with the client who wanted to ensure the project looked at young people beyond the teenage years and into the early adulthood years. ISH runs three satellite clinics that target youth under the age of 25 in an effort to increase access for this age group.

Creating safety for youth sexual health is the main concept for this project. It was therefore important to explore this concept prior to the research. The concept was initially defined in collaboration with the client in setting the context. To set the stage for the research, safety was defined as the creation of a welcoming environment that is considerate of youth needs such as developmentally appropriate language, a client centered approach including the comfort of the physical clinic space and services that respect the confidentiality of clients.

**The Problem**

The client is interested and concerned to learn how youth define “youth-friendly and safe” services so that ISH may improve its service delivery to youth. Specifically, the project seeks to assess the experience of youth when they access services and offer strategies to remove barriers to access. ISH prides itself in providing the highest quality of care. However, the client is concerned that youth accessing ISH services do not always have a positive experience when accessing the range of services ISH offers and worries that this might deter youth from accessing important sexual health services and information (B. Turner, personal communication, May 2015). Of particular concern to ISH is identifying potential barriers for youth who already face multiple barriers due to marginalization and other risk factors. The client wishes to learn how to best deliver services that remove barriers to youth in accessing services.
Research Question and Project Objectives
The project aims to answer the following questions:

When youth access services at ISH:

- What are their experiences of the different programs?
- How do these experiences impact their sense of safety?
- What do youth need in order to feel safe when accessing sexual health services at ISH?

The objective of the project is to provide ISH with informed strategies that can assist the organization in preparing its staff and volunteers to provide services to youth.

Report Overview
The report is organized in eight chapters. After this introductory chapter, Chapter 2 provides background on the organization and the various services it offers. It also provides general statistics on youth sexual health and a discussion on what are considered sexual health services. The literature review is presented in Chapter 3. The review of the literature includes promising practices for youth sexual health services, identified barriers to access, and emerging youth needs in relation to sexual health. It also discusses the reasons why youth sexual health is a priority and the impact of youth not accessing health services. It also provides an overview of what are the characteristics of youth-friendly services. Chapter 4 provides information on the methodology used in this project. This chapter presents the methods used for selecting and interviewing participants. It provides an overview of the interviews, youth focus groups, and the community mapping tools used. Chapter 5 presents the findings of the research and is organized by each of the research groups: youth focus groups, ISH staff and volunteers, and community youth workers. Chapter 6 discusses the findings in relationship to the literature reviewed. Chapter 7 presents recommendations to ISH based on the analysis of the data gathered. Chapter 8 concludes the report.
CHAPTER 2: BACKGROUND

This chapter provides information on Island Sexual Health’s (ISH) mission and vision, funding structures as they affect services, services provided and client statistics. The chapter also provides information on youth sexual health statistics in Canada and BC. In particular, it looks at rates of Sexually Transmitted Infections (STIs), pregnancy and reported safe health practices among youth.

Project Client
ISH has been providing sexual health services to Southern Vancouver Island since 1986. The agency is a non-profit organization governed by a Board of Directors.

The organizational vision is:
“Island Sexual Health Society envisions a diverse community that celebrates healthy sexuality throughout life” (Island Sexual Health, n.d.-a, para. 2).

The organization’s mission as stated on its website is as follows:
“Island Sexual Health Society leads in delivering exemplary sexual health services to South Vancouver Island. Through the provision of clinical care and educations, we:

- empower individuals to make choices that enhance their sexual wellbeing;
- provide all inclusive services and resources that support sexual health;
- celebrate diversity of sexual expression.

Island Sexual Health Society defines sexual health as a state of physical, emotional, mental, and societal well-being related to sexuality”(Island Sexual Health, n.d.-a, para. 3)

ISH provides a variety of services and programs that include sexual health clinical services, community education services and outreach, product sales, and a volunteer program. The organization is also a teaching facility for 2nd-year medical school residents and hosts practicum students from university programs. The different program areas can all be a point of access for youth.
Clinical services
ISH provides clinical services at five separate locations in the Greater Victoria area. The main clinic is located on Quadra Street and is open six days a week. Four satellite clinics are located at the Landsdowne Campus of Camosun College, Royal Bay Secondary School, Belmont Secondary School, and the Tsawout health building. The satellite clinics are open one day a week for approximately four hours. The Belmont School clinic ceased operations in September 2016 and was replaced by a general medical clinic operated by Island Health. The main clinic operates on a booked appointment schedule but can accommodate drop-in clients. The satellite clinics operate on a drop-in basis.

Clinic services are limited to sexual health concerns due to designated funding for this area and organizational mandate. Services include testing for Sexually Transmitted Infections (STIs) and pregnancy, treatment of STIs, pelvic, testicular and genital exams, and vaccinations. ISH also operates an Intra Uterine Device (IUD) insertion clinic once a week at the Quadra Street location. Physicians provide prescriptions for birth control and medications for STIs. Clients can purchase these on site or from a pharmacy of the client’s choice. General Practitioners (GP) and nurses provide clinical services. ISH bills the Provincials Medical Services Plan for GP services under a fee-per-service structure. Island Health funds nurses at ISH. Clinical services also provide follow-up and education to clients requiring information on birth control options or those who receive an STI diagnosis. Nurses and volunteer Birth Control Educators provide follow-up services. Nurses do not operate under the Medical Services Plan fee for service schedule, they are able to provide longer consultation times than the 15-minute GP consultation times. Clients under the age of 18are initially scheduled with a nurse who provides a longer initial consultation to discuss issues that bring them to the clinic.

Beyond the Talk: Community education program
The organization provides sexual health education to the community through workshops offered to schools and local organizations in the Greater Victoria community. The education program provides current and factual information, promoting positive sexuality and healthy decision-making. It also aims to prevent negative consequences of lack of information such as unintended pregnancies, STI’s and sexual exploitation (Island Sexual Health, n.d.-b, para. 1–3). In the 2014 – 2015 school year, ISH delivered 496 workshops and reached 12,537 participants. The majority
of the workshops were delivered to middle and high school students (Island Sexual Health, 2015, p. 12). The workshops provide information on sexual health and information on how to access ISH services and what to expect when attending an ISH clinic. They also provide information on the ISH website and texting program. An 8-hour curriculum that builds youths’ skills in talking to their peers on the topic of sexual health is available for school-based peer support or leadership programs. Schools and community groups contact ISH to book workshops. There is an honorarium of $60 per workshop; a sliding scale or no fee is available to groups that are unable to pay the cost.

The Beyond the Talk program includes a youth advisory committee (YAC) made up of youth volunteers. Members of the youth committee also represent ISH at community events, raising awareness about ISH services and promoting positive sexuality. Previous committee activities include the creation of informational posters for community youth services, developing safer sex matchbook packages to be handed out at events, and an art exhibition focused on youth’s stories of puberty (Island Sexual Health, n.d.-e). A youth-focused website provides information on sexual health in a manner that is accessible to young people. It includes content on topics such as maturation, birth control and pregnancy, STIs, relationships, sexuality and gender. It also provides links to additional resources and supports. Beyond the Talk also runs a texting line for youth. Youth can text any questions or concerns they have and receive answers from the education team in a confidential manner. The program receives 2 to 10 texts daily (Island Sexual Health, 2015, p. 13).

**Product sales**

ISH sells birth control pills and products at lower costs than other major pharmacies. Youth between the ages of 14 to 17 who face financial barriers to accessing prescription birth control can receive it at no cost through a pharmaceutical compassionate program. Clients of the clinics at Belmont and Royal Bay schools receive free prescription birth control thanks to a grant received by ISH to cover these costs. A variety of condoms and lube are available for free at all the clinic spaces and as well as by the education team at workshops. As part of product sales, ISH runs Frisky Business, a social-enterprise located at the main clinic. Frisky Business sells a variety of sexual products in a space that is aimed to provide a comfortable and respectful
experience for customers (Island Sexual Health, n.d.-c). Clients accessing prescription birth control at the main clinic, do so at the Frisky Business counter.

Volunteer program
ISH is not able to fully fund all the services required by its client population through MSP fees and grants (Island Sexual Health, 2015, p. 6). Its volunteer program allows it to provide a full range of client services. Volunteers play two key roles at ISH. Doctor’s Assistants (DA) assist in preparing the consultation rooms, guiding the client to the consultation room, providing support to the client when necessary during exams, and assisting doctors during consultations. They also assist in general clinic duties. The Birth Control Educators (BCE) provide individual education to clients on available birth control methods. They support clients in decision making and collaborate with physicians to answer further questions the client may have regarding contraceptive methods (Island Sexual Health, n.d.-d). Youth can volunteer for these positions at the age of 18 once they are no longer in high school. Educators are the first point of contact for youth under the age of 18 who come to the main clinic for the first time.

Client statistics
In the 2015 to 2016 fiscal year ISH recorded the following statistics:

<table>
<thead>
<tr>
<th>Table 1: Client Statistics Island Sexual Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total clients accessing ISH under age of 24</td>
</tr>
<tr>
<td>(Number indicate unique number of clients)</td>
</tr>
<tr>
<td>3,106</td>
</tr>
<tr>
<td>Youth accessing main clinic</td>
</tr>
<tr>
<td>(Total number of visits)</td>
</tr>
<tr>
<td>10,973</td>
</tr>
<tr>
<td>Youth accessing Camosun Clinic</td>
</tr>
<tr>
<td>(Number indicates total visits from Sept. to March)</td>
</tr>
<tr>
<td>238</td>
</tr>
</tbody>
</table>
Youth accessing Royal Bay Clinic *(Number indicates total visits from Sept. to June)*

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Bay</td>
<td>214</td>
</tr>
</tbody>
</table>

Youth accessing Belmont Clinic *(Number indicates total visits from Sept. to June)*

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belmont</td>
<td>400</td>
</tr>
</tbody>
</table>

**Youth Sexual Health: Statistics**

The following section provides information on current statistics on key indicators for youth health. Areas covered in this section include general safe sex practices and behaviours, pregnancy rates, and STI rates. These are Canadian statistics, and where indicated BC specific statistics.

*Sexual activity and safe sex practices*

Studies indicate that behaviour such as multiple sexual partners, unprotected sex and sexual activity at a younger age can increase youths’ exposure and risk of negative sexual health incidences (Rotermann, 2012, p. 1). Youth who engage in safer sexual behaviour report fewer incidences of STIs and pregnancy (Poon et al., 2015, p. 24). Canadian statistics show that in 2010 66% of youth had had sexual intercourse at least once. Sexual activity increased with age, with 30% of 15 to 17-year-olds reporting sexual intercourse, and 86% of 20 to 24-year-olds reporting sexual intercourse (Rotermann, 2012, p. 1). Statistics also indicate that 8% of females and 10% of males report having sexual intercourse before the age of 15 (Rotermann, 2012, p. 1). The most common age of first intercourse reported for youth in BC was 15 (Poon et al., 2015, p. 10). The Canadian Youth, Sexual Health and HIV/AIDS study shows that approximately half of grade 7 students report some level of sexual activity including deep kissing and sexual touching below the waist (Boyce & Doherty-Poirier, 2006, p. 62). The same study indicates that more than half of grade 11 students have engaged in oral sex (p.62). In BC, 18% of students in high school reported engaging in oral sex and 19% reported having sexual intercourse (Poon et al., 2015, p. 10).
Barrier methods such as condoms or dental dams are important in the prevention of STI’s and unintended pregnancies. Studies indicate that reported condom use among youth during their last sexual intercourse increased from 62% in 2003 to 68% in 2010 (Rotermann, 2012, pp. 1–2). Reasons given for not using condoms include not expecting sexual intercourse to occur, being under the influence of drugs and alcohol, being in a faithful relationship, and dislike of condoms (Boyce & Doherty-Poirier, 2006, p. 64). McCreary Centre’s report on youth sexual health indicates that in BC 70% of youth who engaged in sexual intercourse with someone of the opposite gender and 54% of youth who engaged in sexual intercourse with someone of the same gender used barrier methods (Poon et al., 2015, p. 16). The report also indicates that youth are less likely to use these methods when engaging in oral sex. Only 20% of 15-year-olds and 13% of 17-year-olds reported using barrier methods last time they engaged in oral sex (Poon et al., 2015, p. 15). In general, statistics show a higher concern with pregnancy prevention than STI prevention (Boyce & Doherty-Poirier, 2006, p. 62).

**Pregnancy**

Youth pregnancy is seen as an indicator of young women’s sexual and reproductive health and well-being (Mckay, 2013, p. 163). Pregnancy rates among Canadian youth have been decreasing over the past decades. The Canadian Pediatric Society reported that in 2003 the rate of pregnancies among women under the age of 20 was 27.1 per 1,000. This is comparison to 48.8 per 1,000 in 1994. From 2006 to 2010 the rates continued to decline in several provinces, including BC, but increased in others (Leslie, 2006). The national rate in 2010 was 28.2 per 1000 while in BC the rate was 29.5 per 1000 (Mckay, 2013, pp. 164–165). It is estimated that in Canada abortions make up 52.1% of the teen pregnancy rate, however due to study limitations, this data is not available for BC (Mckay, 2013, p. 169). The BC Adolescent Health Survey found that 1% of youth reported having been involved in a pregnancy. Of youth that did not use any birth control method, 25% reported being involved in a pregnancy compared to 4% of youth who reported using some sort of pregnancy prevention method (Poon et al., 2015, p. 24).

**Sexually Transmitted Infections**

Statistics show that youth have a higher incidence of STIs than the general population (Falk, E., Pederson, A., & Stanger, 2006, p. 14; Public Health Agency of Canada, 2013, para. 1). STIs can have significant negative consequences for the health of a young person. They can cause

In Canada incidences of chlamydia for youth have increased year after year since 1997 (Public Health Agency of Canada, 2013, para. 8). 80% of new cases in 2012 were among youth (Challacombe, 2013, p. 2). In 2010, the rate of chlamydia infections for young women in Canada between the ages of 20 to 24, was seven times higher the national rate (Public Health Agency of Canada, 2013, para. 8). The rates in BC are similar to those in Canada with the second highest rates being recorded for females ages 15 to 19 (BC Centers for Disease Control, 2015, p. 5). It is estimated that the increase in rates can be attributed to improved testing techniques and increase in routine testing for young women (BC Centers for Disease Control, 2015, p. 5). Other examples of STIs reveal a similar pattern. Rates for gonorrhea for the general population have increased in Canada and BC (BC Centers for Disease Control, 2015, p. 13). Young males ages 20 to 24 have the second highest rates of gonorrhea (BC Centers for Disease Control, 2015, pp. 13, 16). Youth have lower rates of syphilis than the general population in BC and while females have a lower syphilis rate than men, young women ages 20 to 24 have the highest rate of syphilis than women in other age groups (BC Centers for Disease Control, 2015, p. 27). Approximately one-quarter of new HIV diagnoses in Canada in 2013 were youth ages 15 to 29, with 79% of these being males. Of these, two-thirds were attributed to men who have sex with men (Challacombe, 2013, pp. 1–2). There is limited statistical information on other STIs such as herpes and HPV as incidences are not reported to health centers (Public Health Agency of Canada, 2013, para. 14).
CHAPTER 3: LITERATURE REVIEW

The purpose of this literature review is to explore the broad topic of youth sexual health and the various subtopics that are relevant to the research question. The discussion begins by providing a brief description of the various models of sexual health service provision. The review will consider the reasons why youth access to sexual health is important and the negative outcomes youth face if they do not access these services. It will further examine risk factors to sexual health as well as protective factors. This section will explore vulnerable youth populations including factors that put them at greater risk for negative health outcomes. The review will give an overview of barriers youth face in accessing sexual health services and barriers service providers face in delivering services to young people to access for youth and service providers. The literature review will include youth and service provider perceptions and how these play a role in barriers to access. Finally, the review will focus on characteristics of youth-friendly services and recommendations to create and enhance access to sexual health services.

The literature review was limited to material published after 2000 as teenage pregnancy tended to be the focus of earlier research and used as a key indicator of sexual health (Mckay, 2013, p. 163). The rate of teenage pregnancy in Canada dropped from 48.8 to 27.1 per thousand from 1994 to 2003 (Leslie, 2006, p. 1). Geographically, the search was limited to literature that focused on North America, Western Europe, and Australia because these societies share sufficient similarities to allow for comparison to Canadian youth sexual health. Search keywords included terms that could refer to the relevant age group: youth, teenagers, and young adults. These terms combined with topics of sexual health such as sexual health services, reproductive health services, pregnancy prevention, sexually transmitted infection, and contraception. Other relevant search terms included access to service, barriers to service, youth-friendly services, and sexual health needs of youth.

Sexual Health Services

Sexual health services encompass a variety of delivery models and service provisions. Sexually transmitted infection (STI) prevention and treatment and preventing unintended pregnancies are the main concerns of sexual health services (Goesling, Colman, Trenholm, Terzian, & Moore, 2014, p. 500; Rogstad, Ahmed-Jushuf, & Robinson, 2002, p. 421). The literature identifies five
main models of sexual health service delivery for youth: school based clinics, community based clinics, hospital based clinics, clinics within broader community services and outreach education services (Anderson & Lowen, 2010, p. 782; Tylee, Haller, Graham, Churchill & Sanci, 2007, p. 1567). Dehne and Riedner (2001) state that while school-based clinics are ideal for increased access and follow-up, these often leave out youth that are not attending school (p. 178). Kerr-roubicek and Elliott (2006) include an area-based youth health coordinator model, which comprises a key person to build collaboration between multiple stakeholders involved in the provision of youth health services (p. 53). Sexual health services are delivered through specialized sexual health programs or through general health services (Rogstad et al., 2002, p. 421). Several studies highlight the use of technology such as websites and social media to deliver sexual health information and engage youth in accessing health services (Evers, Albury, Byron, & Crawford, 2013, p. 264; Heath, Flicker, & Nepveux, 2013, p. 5; Widman, Nesi, Choukas-Bradley, & Prinstein, 2014, pp. 613–614).

**Youth Sexual Health as a Priority**

Adolescence and young adulthood is a time of change, development and transition. Youth are developing their independence and their ability to make informed choices (Braeken, Otoo-Oyortey, & Serour, 2007, p. 1721; Cook, Erdman, & Dickens, 2007, p. 187). These developmental changes can make youth more vulnerable to risk behaviour as their emotional and cognitive abilities develop (Tylee et al., 2007a, p. 1565). Cultural norms and peer influence impact young people’s sexual decision-making behaviours as well as their perception of risk and low sense of self-efficacy (Monasterio, Hwang & Shafer, 2007, pp. 305, 314). This is also a time when youth become increasingly concerned with confidentiality and autonomy (Tylee et al., 2007a, p. 1567). Anderson (2010) states that almost half of youth may be moderate to high risk due to their exploration of new behaviours combined with peer pressure and substance use (p. 780). Youth face higher risks in sexual health than adults and demonstrate a pattern of engaging in risky sexual behaviour (Cook et al., 2007, p. 188). These behaviours include multiple sexual partners, unprotected sex and sexual activity in their early teen years (Rotermann, 2012, p. 1). Youth are also a sector of the population that is less likely to access health services (Oberg, Hogan, Bertrand, & Juve, 2002, p. 320; Senderowitz, Hainsworth, & Solter, 2003, p. 1). In
particular, McCreary Centre’s report on youth health found that sexually active youth were less likely than non-sexually active youth to seek medical care (Poon, Smith, Saewyc & McCreary, 2015, p. 27). A study of youth access to health services indicates that services need to reflect the developmental needs of youth if youth are to access them (Tylee et al., 2007a, p. 1565). A recurring theme is a connection between STI rates and the need for youth specific services. Youth have higher rates of STI’s than the general population (Falk, E., Pederson, A., & Stanger, 2006, p. 14; Goesling et al., 2014, p. 499; Hudson, 2012, p. 444). High rates of STI’s and pregnancy provides evidence for making accessible sexual health services for youth a priority (Cook et al., 2007, p. 183; Goldenberg, Shoveller, Koehoorn, & Ostry, 2008, p. 718; Robertson, 2013, p. 493). Widman, Neis, Choukas-Bradley, and Prinstein (2014) point to the need to understand the factors that contribute to sexual health risk among youth (p. 612). Youth’s poor use of birth control and STI prevention methods also point to the importance of removing barriers to access in to prevent negative sexual health consequences (Tripp & Viner, 2005, p. 592).

The negative outcomes of lack of access to sexual health services can be significant and long-term for young people (Bayley, 2003, p. 830; Tripp & Viner, 2005, p. 590). They include infertility, STI’s and unintended pregnancies (Hobcraft & Baker, 2006, p. 351; Maticka-tyndale, 2008, p. 89; Tripp & Viner, 2005, p. 590). Svoboda, Shaw, Barth and Bright (2012) point to the increased burden and risks that young mothers and their children face, such as poverty and increased health risks, as key reasons to ensure access to sexual health and pregnancy prevention services (p. 867). A decision to terminate unintended pregnancies can also have negative consequences on a young person’s emotional and physical well-being (Cook et al., 2007, p. 183). The impact of STI’s is more significant for youth than for adults as their reproductive system is still developing and they are more susceptible to infection (Monasterio et al., 2007, p. 314).

Incidences of disease and unintended pregnancies and their consequences can largely be prevented (Burke et al., 2014, p. 491; Goldenberg et al., 2008, p. 719; Kang et al., 2006, p. 49; Tylee et al., 2007a, p. 1565). Evidence shows that early detection and prevention services offered by youth-friendly sexual health services can reduce the impact of STI’s (Shoveller et al., 2009, p. 397; Tripp & Viner, 2005, p. 591). Research also shows that access to accurate and timely
information can help youth make positive choices on their sexual health (Bayley, 2003, p. 831; Boyce & Doherty-Poirier, 2006, p. 59; Robertson, 2013, p. 494). Bayley (2003, p. 831) views adolescence as a window of opportunity in which information and services can significantly enhance and change a person’s behaviours. Likewise, Hobcraft and Baker (2006, p. 351) speak to the necessity of tailoring sexual health services to the needs of youth to decrease long-term negative effects.

**Risk Factors for Youth Sexual Health**

Several factors place youth at risk for poor sexual health and sexual decision-making. Some of these factors occur in the youth’s environment such as poverty, family instability, exposure to abuse and neglect (James, Montgomery, Leslie, & Jinjin Zhang, 2009, p. 990; Leslie, James, Monn, Kauten, & Aarons, 2011, p. 27; Svoboda, Shaw, Barth, & Bright, 2012, p. 867). Hudson (2012, p. 443) also identifies lack of access to medical care and health information as a risk factor for poor sexual health. Other risk factors include alcohol use, smoking, delinquency and drug use (Boyce & Doherty-Poirier, 2006, p. 60; Leslie et al., 2011, p. 27; Tripp & Viner, 2005, p. 590). Some of the risk factors identified in the literature are intrinsic. They include depression, suicidality, anxiety, high impulsivity, psychological immaturity (Leslie et al., 2011, p. 27; Svoboda et al., 2012, p. 867). DiClemente, Salazar, Crosby and Rosenthal (2005) include a young person’s lack of skills in negotiating sexual activities and sexual safety as another contributing factor to higher risk (p. 827). These risk factors contribute to poor sexual health and to increased exposure to sexual violence, exploitation and coercion (Maticka-tyndale, 2008, p. 89).

There are specific populations of youth identified as vulnerable to higher risk for poor sexual health and higher consequences of poor health outcomes. These populations include youth in foster care, homeless youth, Aboriginal youth, youth living with disabilities and lesbian, gay, bisexual, transgendered and transsexual (LGBT) youth (Burke et al., 2014, pp. 491-494; Flicker et al., 2010, p. 134; Maticka-tyndale, 2008, p. 91; Oberg et al., 2002, pp. 329–333; Poon et al., 2015, p. 39). The literature reflected a main concern for the wellbeing of youth in care due to the high levels of abuse, neglect and violence that these young people have been exposed to and the impact of this trauma on their sexual behaviour (Hudson, 2012, p. 443; Leslie et al., 2011, p. 27;
Love, McIntosh, Rosst, & Tertzakian, 2005, p. 7). In general, youth in government care have a lack of adult relationships, engage in sex at a younger age than their peers, report higher incidences of teen pregnancy and are less likely to seek out support (Love et al., 2005, p. 10; Robertson, 2013, p. 494). Ensign (2004) identifies homeless youth as being critically underserved by the medical system and vulnerable to violence, abuse, and exploitation (p. 695). Oliver and Cheff (2012) support these findings and add that 95% of homeless youth were sexually active compared to 46% of the general youth population (p. 370). Aboriginal youth have poorer sexual health than the general youth population and experience high levels of psychological distress that expose them to poor sexual health outcomes (Banister & Begoray, 2006, p. 2006). Youth living with disabilities have compromised health issues, report higher involvement in risk-taking behaviour, have higher rates of mental health issues, and face limited access to information and sexual health services (McClelland et al., 2012, p. 809). Ginsburg et al. (2002) show that LGBT youth face social isolation, lack of support, report higher incidences of STI’s, are more likely to drop out of school and report suicidality (p.407). The study reveals that for youth, service provider characteristics such as friendliness and non-judgmental attitude is more important than any other factor. The McCreary Centre Society’s (2015) study on youth sexual health in BC indicates that youth in these groups who have intersecting risk factors are more likely to engage in higher risk taking and experience poorer health outcomes (p. 41). Existing services may overlook the specific needs of high-risk groups and authors suggest it is important to ensure that specialized services are available for these populations (Dehne & Riedner, 2012, p. 179,189; DiClemente, Salazar, Crosby, & Rosenthal, 2005, p. 826).

Protective Factors for Youth Sexual Health

Protective factors prevent and mitigate the effects of negative health outcomes and can lead to healthier sexual behavior (Poon et al., 2015, p. 42). There is general agreement within the literature that protective factors include positive connection to adults, connection to community, school and friends, hopes for the future, and healthy self-esteem (Anderson & Lowen, 2010, p. 783; DiClemente et al., 2005, p. 828; James et al., 2009, p. 991; Poon et al., 2015, p. 42). Ensign’s (2004, p. 703) study of homeless youth in Seattle, Washington, reports a positive relationship between youth having a positive connection with a health care provider and increased trust in adults. Oliver and Cheff also identify a positive connection as a protective
factor. (2012, p. 375). Similarly, a positive connection to a service provider increases young women’s use of contraception methods (Poon et al., 2015, p. 45).

**Barriers to Access – Youth**

Youth face a variety of barriers in accessing sexual health services and information. Several studies identify similar barriers that prevent youth from receiving the care they need to access prevention or treatment for sexual health issues. These barriers include lack of confidentiality, embarrassment, cost of services or treatment, lack of transportation to the clinic, and clinic hours that do not cater to their schedules (Anderson & Lowen, 2010, p. 780; Bayley, 2003, p. 830; Goldenberg et al., 2008, p. 724; Kang et al., 2006, p. 49; Masaro, Johnson, Chabot, & Shoveller, 2012, p. 2; Monasterio et al., 2007, p. 309; Tanner et al., 2014, p. 200; Tylee et al., 2007a, p. 1566). In a review of studies on youth sexual health, Monasterio, Hwang and Shafer (2007, p. 309) name confidentiality as a key barrier for youth. The studies show that youth would forego care if they were not assured confidential services. Studies also show that even if the clinic had a confidentiality policy but it was not explicitly explained to the young person, this would prevent them from disclosing intimate and potentially important information (p. 309).

A study of BC’s northern communities indicates that youth will travel to other communities in an attempt to ensure their confidentiality (Shoveller et al., 2009, p. 398). A Nova Scotia based study identifies confidentiality as the main obstacle to accessing services (Langille, Murphy, Hughes, & Rigby, 2001, p. 221). Clinic hours are problematic to young people. If hours of operation are during school hours, they are unable to access the clinic unless they skip school or the clinic is at their school (Goldenberg et al., 2008, p. 722). The cost and access to contraceptives are the main reasons youth give for not using birth control or safe sex methods (Braeken et al., 2007, p. 173; Falk, E., Pederson, A., & Stanger, 2006, p. 15). Youth report not being aware of services, their location, or how to access them as another barrier to accessing sexual health services (Anderson & Lowen, 2010, p. 780; Goldenberg et al., 2008, p. 722; Kang et al., 2006, p. 49; Senderowitz et al., 2003, p. 2; Tylee et al., 2007a, p. 1565).

Several studies point to youth’s experiences with service providers or fear of judgement as a barrier to accessing services. Negative experiences with providers, be it the front-office staff,
nurse or clinician can lead a youth deciding not to return to a clinic and prevent them from accessing future care (Buzi & Smith, 2014, p. 152). Hobcraft and Baker (2006, p. 353) explain that if youth are not greeted in a friendly manner with a smile, or if staff ask too many questions youth report feeling discouraged from seeking care. A negative experience can include a provider’s attitude, as well as a lack of knowledge or expertise in sexual health (Goldenberg et al., 2008, p. 719). Youths fear that judgement by service providers prevents them from accessing health services or discussing particular health concerns (Bayley, 2003, p. 831; Tylee et al., 2007a, p. 1566). They are also afraid of the procedures providers will use (Tylee et al., 2007a, p. 1566).

Vulnerable youth populations report similar barriers as mainstream youth. They also report specific barriers that affect them directly. LGBT youth report fear of homophobia, preventing them from revealing their sexuality to physicians and as a result do not deal with concerns linked to their sexual behavior (Ginsburg et al., 2002, p. 407; Tanner et al., 2014, pp. 192–193). Transgender youth report feeling segregated or excluded by heteronormative clinic practices such as intake forms that do not allow for them to select the gender they identify with or by physicians uneducated in the health needs of trans youth (Youth Gender Action Project, n.d., pp. 1–2). McClelland et al. (2012, p. 810) describe societal misconceptions about youth living with a disability as a major barrier to access. Providers view youth with disabilities as asexual or sexually inactive, and as not involved in risky sexual behaviour. Youth with disabilities also face limited sexual information that considers their disability (Heath et al., 2013, pp. 12–13). Youth in foster care report receiving no necessary information on sexual health from their caregivers and state that it is important that providers bring up the topic of sexual health directly with them (Hudson, 2012, pp. 444–445; Love et al., 2005, p. 15). Unstable foster placements lead youth in care to miss a lot of school days and as a result miss sexual education provided through the schools (Robertson, 2013, p. 495). Exposure to sexual abuse can lead youth to be more fearful of sexual health procedures (Oberg et al., 2002, p. 333; Robertson, 2013, p. 495). Homeless youth face similar barriers to youth in care such as lack of access to information and the impact of exposure to abuse and exploitation (Ensignment, 2004, p. 696; Oliver & Cheff, 2012, p. 371). Poor treatment by service providers is of particular concern to homeless youth as they experience maltreatment and marginalization is many aspects of their lives (Ensignment, 2004, p.
Besides the listed obstacles, Aboriginal youth face the additional barrier of racism and accessing services that are incongruent with their cultural approach to health (Banister & Begoray, 2006, pp. 172, 169).

**Barriers to Access – Service Providers**

Service providers report a variety of barriers that prevent them from providing quality services to youth. Insufficient or inadequate training on how to work with youth and how to talk to youth about sexual matters leads to discomfort and hesitation in approaching the subject (Goldenberg et al., 2008, p. 725; Hansen, Barnett, Wong, Spencer, & Rekart, 2005, pp. 41, 46; Kang et al., 2006, p. 50; Love et al., 2005, p. 19; Langille et al., 2001, p. 219; Masaro et al., 2012, p. 2; Oberg et al., 2002, pp. 321, 323, 328; Oliver, van der Meulen, Larkin, & Flicker, 2013, p. e145). A review of physician practices shows that physicians will not always bring up the topic of sexual health with youth (Monasterio et al., 2007, p. 310). Many providers identify the fee for service billing structure as a barrier (Kang et al., 2006, p. 50; Masaro et al., 2012, p. 3-4; Oliver, et al., 2013, p. e145) as the time allowed per patient under this structure limits the time they are able to spend with youth (Hansen et al., 2005, p. 46). The Toronto Teen Survey found that the billing structure and the funding available for clinical sexual health services focus on treatment and disease prevention, and does not allow for time to provide extra support, teaching youth about negotiating sexual decision-making, or sexual pleasure (van der Meulen, Oliver, Flicker, & Travers, 2010, p. 187). Providers also speak of insufficient funding limiting their ability to provide adequate care for youth (Goldenberg et al., 2008, p. 719; Hobcraft & Baker, 2006, p. 351; van der Meulen et al., 2010, p. 185). In addition, scarce resources often lead to providing services in unsuitable spaces (Masaro et al., 2012, p. 6).

Physicians often report viewing youth as children, with little knowledge or autonomy over own decisions thus do not engage youth as collaborators in their health care (Hobcraft & Baker, 2006, p. 352; Masaro et al., 2012, p. 8). A review of services indicates that often health care providers do not discuss confidentiality with youth and are unaware that this is a barrier for young people (Oberg et al., 2002, p. 323). Health care providers also express concern and frustration over youth not following up on treatment or testing (Goldenberg et al., 2008, p. 724; Masaro et al., 2012, p. 5). Some physicians identify the complex needs of youth patients as beyond what they
are able to address, yet report limited knowledge of other available resources for youth and how to access them (Kang et al., 2006, p. 50).

**Youth-friendly Services**

Tanner et al. explain that the term youth-friendly is often used but rarely defined (2014, p. 199). They state that a youth-friendly service provides easily accessible services oriented to meeting the needs of youth. Their research found that youth-friendly services include those that allow youth to have more privacy, have staff trained in youth services, and provide comprehensive services to address the complex issues youth face (p. 199). The World Health Organization provides a framework for youth-friendly services (Tylee et al., 2007a, p. 1567) which includes: equitable points of access, accessible points of delivery, acceptable points of delivery, appropriateness of services, and effectiveness of services (p. 1567). Main principles underlying youth-friendly services include addressing existing inequities and respecting youth’s right to access the highest possible standard of care (p. 1567). Youth-friendly services are those that have policies and characteristics meant to attract youth and offer a safe and respectful experience to them (Senderowitz et al., 2003, p. 3).

Several authors identify characteristics of a youth-friendly service. Characteristics include trained staff, respectful and non-judgmental treatment, privacy and confidentiality policies, and sufficient time for client and provider interaction. Facility qualities include a separate space for youth to wait, hours that consider youth schedules, convenient location and clinic space that is welcoming and comfortable. Program qualities include drop-in hours or appointments that are available in a short time, involving youth in the development and design of programming, information on available services, referral services, and diverse services to meet different needs. Providing information through alternate and innovative ways is also a youth friendly practice (Dehne & Riedner, 2012, p. 175; Ginsburg et al., 2002, pp. 410–411; Hobcraft & Baker, 2006, pp. 353–354; Hoffman, Freeman, & Swann, 2009, pp. 225–226; Monasterio et al., 2007, pp. 310–313; Rogstad et al., 2002, p. 421; Senderowitz, Hainsworth & Solter, 2003, p. 3).

Ensign (2004, pp. 700–702) explains that youth value health care providers that demonstrate understanding of their needs, especially if they belong to a vulnerable group such as homeless
youth. Youth want respectful treatment and to be a partner in their health care. Homeless youth spoke to the importance of providers understanding their defiant attitude as a survival mechanism that will diminish as trust is built (Ensign, 2004, p. 705). Youth value a provider that is not rushed, seems comfortable with them and confident in the procedures they carry out (Ensign, 2004, p. 703; Hobcraft & Baker, 2006, p. 352). Youth also explain that health care providers are often their main source of trusted information (Ensign, 2004, p. 705; Hobcraft & Baker, 2006, p. 353). Continuity of care helps youth gain comfort in disclosing sexual health concerns and accessing services (Buzi & Smith, 2014, p. 152; Ensign, 2004, p. 702; Robertson, 2013, p. 497). Furthermore, Tanner et al. (2014, p. 203) state that positive interactions with staff is key to maintaining youth engaged in services and ensure that they will follow-up with treatment.

**Recommendations for Creating Youth-friendly Sexual Health Services**

The literature recommends programs to attempt to meet criteria of youth-friendly service to ensure that sexual health services are accessible to young people. The recommendations focus on staff, structural and program design. Staff requires training on specific needs, challenges and issues that youth face (Burke et al., 2014, p. 492; Hoffman et al., 2009, p. 228; Kang et al., 2006, p. 57; Love et al., 2005, p. 25; Monasterio et al., 2007, p. 317; Oberg et al., 2002, p. 329; Oliver et al., 2013, p. e145; Senderowitz et al., 2003, p. 4; Travers et al., 2010, p. 195; Tylee et al., 2007a, p. 1571; Youth Gender Action Project, n.d., p. 5). Youth should receive a warm and welcoming experience at all points of access of the clinic (Hobcraft & Baker, 2006, p. 353; Oberg et al., 2002, p. 324; Tanner et al., 2014, p. 202). It is also important that the provider normalizes a young person’s concerns, is non-judgmental and provides accurate and clear information (Falk, E., Pederson, A., & Stanger, 2006, pp. 14–15; Ginsburg et al., 2002, p. 44). It is essential for service providers to explicitly state and explain their confidentiality policy and make it visible in the clinic space (Cook et al., 2007, p. 186; Hobcraft & Baker, 2006, p. 354; Monasterio et al., 2007, p. 310; Oberg et al., 2002, p. 323). Health care providers should take the initiative to address sexual health in a comfortable and timely fashion with young clients (Falk, E., Pederson, A., & Stanger, 2006, p. 15; Langille et al., 2001, p. 222). Where possible consultation topics should go beyond physical health to discuss sexual consent, healthy relationships, and risk factors (Burke et al., 2014, p. 492).
Authors indicate that it is vital that clinic location is convenient and easy to access (Oberg et al., 2002, p. 323; Shoveller et al., 2009, p. 400; van der Meulen et al., 2010, p. 189). Services should be widely promoted and visible so youth know what is available and how to access them (Braeken et al., 2007, p. 173; Burke et al., 2014, p. 492; DiClemente et al., 2005, p. 831; Senderowitz et al., 2003, p. 10; van der Meulen et al., 2010, p. 189). Some authors advocate for programs to increase privacy for youth such as the option for young clients to write down the reason for their visit rather than saying it out loud (Shoveller et al., 2009, p. 400) and to have a separate entrance or area for youth (Hobcraft & Baker, 2006, p. 355).

It is recommended that programs develop policies which allows for longer consultation times and relationship building with youth (Masaro et al., 2012, p. 7; Tanner et al., 2014, p. 204). To address the complex needs of youth, several studies endorse the provision comprehensive services or at the very least provide clear and supported referral pathways to other resources (Anderson & Lowen, 2010, p. 783; Oberg et al., 2002, pp. 334–335; Rogstad et al., 2002, p. 422). This includes increased collaboration between sexual health services and other support services for youth (Robertson, 2013, p. 496; Rogstad et al., 2002, p. 422). It is important for programs to develop resources and services that are inclusive and consider the specific needs of vulnerable youth populations (Dehne & Riedner, 2012, p. 179; Heath et al., 2013, p. 19; McClelland et al., 2012, p. 818; Youth Gender Action Project, n.d., p. 5). Affordable, readily available, and one-dose treatment options increase effectiveness of treatment and reduce barriers due to lack of follow-up (DiClemente et al., 2005, p. 829).

The literature points to engaging youth in the evaluation, design, and development of services (Anderson & Lowen, 2010, p. 782; Braeken et al., 2007, p. 174; Hobcraft & Baker, 2006, p. 355; Love et al., 2005, p. 23; McClelland et al., 2012, p. 818; Rogstad et al., 2002, p. 422; Senderowitz et al., 2003, p. 10; Tylee et al., 2007a, p. 1571). On-going evaluations will allow programs to assess their impact and level of youth friendliness of their services (Braeken et al., 2007, p. 174; Kang et al., 2006, p. 57; Love et al., 2005, p. 23; Youth Gender Action Project, n.d., p. 7). This includes creating methods and opportunities for youth to provide feedback (Ensign, 2004, p. 704).
Humour is an important aspect to consider in the development of education and promotional material (Evers et al., 2013, p. 269). Secondly, programs should expand sexual health education to include pleasure, consent, sexual violence and communicating about sexual needs (Braeken et al., 2007, p. 174; Love et al., 2005, pp. 15–16; Oliver et al., 2013, p. e144; Poon et al., 2015, p. 56). Several authors recommend that programs explore models of peer support and education as a method for health promotion (Love et al., 2005, p. 24; Oliver et al., 2013, p. e145; van der Meulen et al., 2010, p. 189). Lastly, the literature recommends programs use technology as a tool to inform and engage with youth (Cecchino & Morgan, 2009, p. 32; Evers et al., 2013, p. 268).

**Summary**

The literature reviewed included program evaluation, review of research studies, and scans on the topic of youth and sexual health services. It highlights the gravity of negative sexual health outcomes for youth as a consideration for the importance of accessible services. It further indicates that certain factors place youth at increased risk for risky sexual behaviour and negative sexual health outcomes. Some populations experience a higher burden of poor sexual health and have specific risk factors such as social isolation, a history of abuse, and lack of representation in the general youth population. Sexual health services play a role in increasing protective factors such as connection to adults and community.

Youth face a variety of barriers in accessing sexual health services. These include negative interactions with staff, inaccessible location and hours, and cost. While some barriers affect all youth, certain barriers such as heteronormative programs or assumptions of specific sexual behaviours affect vulnerable groups directly. Service providers also experience barriers to provide quality care to young people. These barriers include lack of training in working with young people, billing structures that limit consultation times and lack of resources to provide youth-friendly spaces. Characteristics of youth-friendly services and recommendations for programs to increase their capacity to provide youth-friendly services include qualities of staff and their approach to working with youth, staff training, and positive interactions with young people. Clinic space, location, and hours of operation are a way for programs to increase their
level of youth-friendliness. Involving youth in the design and evaluation of services is an additional way to increase a program’s ability to provide services to young people.
CHAPTER 4: METHODOLOGY

The project used a qualitative community based research (CBR) approach. CBR is a collaborative methodology that brings together academic research and community partners to address a community identified need (Strand, Marullo, Cutforth, Stoecker, & Donohue, 2003, p. 5). CBR works to engage community partners throughout the research process and in doing so allows for capacity building and learning by everyone involved (Strand et al., 2003, p.6). The researcher worked closely with the project client to design the methodology, ensure that the methods proposed were in line with Island Sexual Health (ISH) values and to inform the process throughout the project. Strand et al., (2003, p. 7) point out that CBR has the potential to motivate social change and is based on a commitment to social justice. These values reflect the objectives of the project in exploring potential barriers youth may face in their experience at ISH and providing strategies to remove them. The project used qualitative research methods to capture the experiences of youth, staff, volunteers and other youth service providers. Focus groups and semi-structured interviews provided a picture of the experiences and interactions of these groups with ISH services.

The researcher and project client identified three participant groups to give information from different perspectives. Youth who use ISH services to provide information as service users and offer insight on what they liked about the services as well as what would increase the youth-friendliness of ISH services. Staff and volunteers of ISH to talk about their experience as service providers and give information on what they need to better serve youth accessing ISH services. Youth workers to talk about their experience supporting youth to access ISH services. Youth workers can provide 3rd party information on youth’s experiences with services shared with the youth worker.

Sample

The project used purposive sampling to select research participants. Purposive sampling involves establishing criteria for participation to have information-rich samples (Patton, 2015, p. 264). The criteria for participation in this project were current or recent involvement with ISH services. This method provides a statistically representative sample that allows for
generalization to a broader and larger group (Patton, 2015, p. 264). Participation was voluntary for all groups. Groups selected were

- Group one: Youth who have accessed ISH services at any of the clinic locations.
- Group two: Staff and volunteers of ISH who meet youth accessing these services.
- Group three: Community based youth workers who support youth in accessing ISH services.

**Recruitment**

Recruitment for participants varied by sample groups. Posters advertising the focus groups were placed at the various clinic locations, ISH website and Facebook page. Small mini-posters were also available at the reception area for youth to take home. These mini-posters contained all the logistical information for the focus group as well as the researcher’s contact information. The researcher visited the Royal Bay and Belmont School clinics for two weeks prior to the focus group at each location and handed out mini-posters to young clients and explained the purpose of the group the importance of their voice to the project.

ISH staff and volunteers received an email from the Executive Director of ISH introducing the project. The researcher then sent an invitation to participate to all staff and volunteers. Those who decided to take part contacted the researcher who provided them with the consent form for their review. After feedback from an interviewee, the researcher forwarded participants the interview questions in advance. Three rounds of invitations to participate were sent over a period of three months. Fourteen staff and volunteers participated in interviews.

The project client identified key community organizations and youth workers that support youth in accessing ISH services. The researcher emailed them invitations to participate explaining that the client had identified them as potential key informants for this project. Interested youth workers contacted the researcher directly to set up interviews. Five community based workers participated in the project.
**Instruments**

The project gathered data using focus groups for youth and semi-structured interviews for adult participants. Focus groups were selected as they allow for multiple perspectives at one time and create a space where participants can learn from each other and add to each other’s information (Choak, 2012, p. 93). Youth also feel more comfortable in a group of peers where they outnumber adults and therefore more likely to engage in discussion than in an individual interview (Gallagher, 2009, p. 76). The focus group incorporated community mapping tools. Community mapping is a data gathering tool that values individual and community voices. It is an effective tool for engaging youth in research and allows them to express their voice in creative ways (Amsden & VanWynsberghe, 2005, p. 369).

The researcher hosted focus groups at four ISH clinic locations: Royal Bay Secondary, Belmont Secondary and two groups at the main clinic. In total 24 youth participated in focus groups hosted at the secondary schools and one participated at the main clinic group. School and clinic staff assisted in the selection of the date and time of the focus groups. The planned Camosun College group did not take place due to lack of participants.

Focus groups lasted approximately 90 minutes. The group involved numerous interactive activities that aimed to increase participants comfort level and engaged youth through different mediums (Choak, 2012, p. 93). As part of these activities, youth worked in small groups to answer two questions: *What is sexual health?* and *what makes a program welcoming and friendly to young people?* In a large group, youth mapped out which ISH services they were aware of. The map included clinic space, online services and staff. Engaging youth in qualitative research is often transformative in practice by creating learning opportunities for youth during the research process (Tisdall & Davis, 2009, pp. 4–5). In adhering to transformative practices, the researcher informed participants of any services they were unaware of. Participants wrote on sticky notes explaining how each area of service was youth friendly or could be improved. These notes were then placed on the map of services. Afterwards the researcher engaged the group in a discussion expanding on the comments they had written down. Youth were also invited to write anonymous feedback. The researcher took notes during the discussion as well as photographs of the maps, notes and any other written material produced by the participants. At the end of each
group, the researcher wrote down any observations from the group discussion and the
anonymous comments.

Participants from groups two and three participated in semi-structured interviews. Semi-
structured interviews have a set of main questions and invites new questions to be added as the
interview progresses (Choak, 2012, p. 92). Semi structured interviews were selected as they
allow flexibility in the process as well as add depth and richness to the information gathered
through the interview (Tucker, 2012, p. 34).

Interviews took place in person and were held at the time and location of the participant’s choice.
Interviews were held from March to June, 2016. Staff and volunteer interviews included 7
general questions (Appendix A). Community youth worker interviews included 5 questions
(Appendix B). The interviews were audio recorded and later transcribed by a third-party. During
the interview the researcher also took brief notes. The length of interviews ranged from 40 to 60
minutes. The researcher invited participants to email her additional information they felt they had
missed during their interview. No emails were received.

**Data Analysis**

The researcher analysed the interview notes, transcripts, focus group notes and content of
community maps. A content analysis was used to define major themes in the data. Content
analysis permits the researcher to generate knowledge grounded in the data and based on the
perspectives of the participants (Hsieh & Shannon, 2005, p. 1280). A thematic analysis was
carried out for each of the research groups. Themes arose from the analysis, identifying key topic
areas. Overarching themes from this analysis were developed to include all three groups.
Similarities and differences within each group and between the groups were identified and
analysed.

**Limitations**

The self-selection nature of the recruitment process is a limitation of the interviews. There was
no equal representation of the ISH service and program areas in the staff and volunteer interview
participants. This limits the perspectives to those program areas that had stronger representation
in the project. The researcher attempted to mitigate this limitation by making repeated invitations to participate and making her schedule as available as possible. She also consulted ISH staff to find out if there were reasons staff might be hesitant to participate or if staff were having negative experiences with the interviews. The feedback indicated that lack of time prevented participation.

The lack of participation in the planned focus groups at Camosun College and at the main clinic are a limitation. Youth perspective is therefore mostly limited to students attending Belmont and Royal Bay clinics. The majority of these students have not visited the main clinic so are not able to provide information on the services offered. Due to the timeline of the project and the annual closure of the Camosun clinic in April, the focus group was scheduled during exam week at the end of term. It is possible that this was a barrier to participation.
CHAPTER 5: FINDINGS

This chapter is presented in three parts. The first part discusses the findings of the youth focus groups, the second talks about the findings from the interviews held with Island Sexual Health (ISH) staff and volunteers, the third addresses the findings of the community youth worker interviews. Data were initially organized according to the interview and focus groups structure. A thematic analysis was then conducted to identify key themes in each of the research groups. The findings are presented according to the themes that arose from the data and are organized in a way that allows for a clear and logical presentation.

One of the three youth focus groups had a single participant. For the purposes of the findings, the responses of the single participant are incorporated into the findings of the two school focus groups. The sub-headings in the focus group section reflect phrases the participants used during the focus group. Staff and volunteer interview themes include current ISH youth-friendly practices, their understanding of youth needs, how these issues impact service delivery and recommendations to increase the organization’s ability to provide quality services to youth. The themes that emerged during youth worker interviews include the experiences of workers and youth at ISH, as well as comments on program structure and ideas for ISH to consider in their work with youth. Workers spoke about ways in which ISH already provides youth friendly services and ways in which they can improve upon these services. These are incorporated into each of the themes.

Youth Focus Groups

Twenty-five youth participated in the focus groups. Seven of the participants identified as male, the rest of the participants identified as female. Initially, youth participants expressed nervousness regarding their participation in the groups, unsure of the purpose or of the process. One participant had initially entered the clinic room for needed clinic services and expressed disappointment at having to wait a week to access services. The participant chose to stay for the duration of the group. As the focus groups progressed participants demonstrated eagerness in contributing their opinions and asked to have more groups to discuss their ideas. Working in small groups, youth first defined what sexual health and youth-friendly meant to them. They then discussed what ISH services they were aware of. Next, using a combination of written and verbal
discussion, participants explored the different services, and what aspects of the services they liked and considered youth friendly. Lastly, they recommended changes or improvements. They could also provide anonymous feedback.

*Everyone needs to know about sexual health*

In defining sexual health, youth said it included anything related to pregnancy and Sexually Transmitted Infections (STIs) prevention and testing. This includes information on Plan B (an emergency contraception pill) and different birth control options. Youth indicated that sexual health should also include information on how to make the topic of sex comfortable for both people involved and to help them gain an understanding of all aspects of sexuality including emotional, physical and mental. They said it was awkward to talk to their partners about sex and sexual health. The topic of consent was brought up by a couple of individuals which created a lively discussion with some youth saying that sex should only occur if it is consensual, with others agreeing but stating that unfortunately this is not always the case. They agreed it was important to establish clear consent and to ensure it was enjoyable for everyone involved. Several youth indicated that sexual health includes physical hygiene and learning about your body and how to keep it healthy. All participants agreed that it was important to ensure everyone had access to sexual health information and services. They commented that sexual health education started too late in the school system, and wondered if it would be possible to start earlier. The majority of the participants said they had received little or no sexual health education in their schools.

*Staff that smile when we come in*

In defining a youth-friendly environment, the majority of the participants pointed to a kind and welcoming attitude by staff. They gave examples such as staff greeting them and smiling when clients walk in, being enthusiastic and not awkward when talking youth. They said they could tell if an adult was uncomfortable with them and explained that this made them more uncomfortable. There was an overwhelming agreement that youth-friendly services include staff that talk respectfully to youth and are not judgmental about their choices and behaviours. They added that youth get judged a lot by adults, and that often adults do not understand their choices. As a result, they explained, youth will not reveal all their concerns or ask questions. Youth also
indicated that knowledgeable staff who are able to provide helpful advice are key to creating youth-friendly services. Participants indicated that a safe environment that feels like a community is also important.

**ISH is where we can ask questions about sexual health**

In discussing what ISH services they were aware of, all youth responded that ISH provides birth control and STI testing. In particular, they pointed to the availability of free condoms, prescription birth control methods and emergency contraception. One youth wrote that ISH had probably saved teens’ lives by having these services. This comment led to a dynamic discussion about the impact that lack of access to sexual health services can have on a young person’s life. They talked about unintended pregnancies and dealing with the long-term effect of STIs. Youth did not bring up the Beyond the Talk website, which is the ISH youth focused website offering youth-friendly information and resources. When asked directly about it, half of participants indicated awareness, the rest said that they would be interested in looking at the website. Participants at the school groups did not bring up the central clinic. When the researcher commented on it, the majority of the participants said they did not know about its existence. A couple of youth indicated that they were aware of it but did not know where the clinic was located. Neither did participants talk about the available texting services. Only one participant indicated having knowledge about the texting services once it was presented by the researcher. Participants were convinced that if more youth knew about the texting services a lot of young people would use it.

Participants knew that services were confidential and that parents would not find out about their visits. Some participants said that their parents knew that they attended the clinic, however they all felt it was extremely important that it was confidential as they knew a lot of youth who would not be allowed to access services. Youth asserted that ISH is where they can go to get information and help with any sexual health issue. A few of the youth mentioned the Youth Advisory Council (YAC). However, they indicated that they were unsure of its role and purpose. They said it could be a way for ISH to learn about what youth want and for youth to give more ideas.
They remember my name

After identifying the different ISH services and programs, youth discussed how and if these services were youth friendly. An overwhelming majority indicated that the clinic was accessible because of its location within the schools and many said that they probably would not access sexual health services if the clinic was not in the schools. They talked about the ease of being able to come to the clinic at lunch or between classes. They said school staff were generally supportive and understanding when they indicated they were going to the clinic. Likewise, a large number of youth stated that ISH services are youth-friendly because the staff is friendly and welcoming. They said that staff greet them and smile when they come in. They also liked the snacks offered at the clinic. One youth stated that staff remember their names and several youth enthusiastically concurred that this made them feel safe and welcome. They said that they were amazed at how the staff were able to remember so many names. Participants indicated that they trust staff at the clinics because they seem knowledgeable and comfortable with sexual health issues. They explained that this made it easy to ask questions or to talk to them about concerns. A couple of youth were convinced that there was not anything the ISH staff would not feel comfortable talking about in regards to sexual issues.

Another youth friendly quality identified was the flexibility to go into the consultation room with friends. Several participants said that when they feel shy or uncomfortable it is helpful to have friends accompany them. They added that sometimes they would take friends who might benefit from connecting to sexual health services but who are too shy to go on their own. They talked about how youth support each other in accessing services, telling each other about the clinic and sharing experiences and information. Youth repeatedly pointed to the importance of accessing free birth control, condoms, Plan B and get pregnancy and STI testing at the clinic. Some said that they probably would not be on birth control if it was not provided. Many explained that it was more comfortable and easier to come to the clinic to get condoms than buy them at a pharmacy. Participants enthusiastically agreed that because it was a sexual health clinic it was not awkward to talk about sexual issues, as it was already understood they were there to discuss sexual health issues. Youth indicated that they liked that the space was for youth only and that they liked the informal set up of the school clinics. Participants agreed that it would be awkward
to wait in a room that also had adults waiting to see the doctor. They explained it was a reason they did not go to walk-in clinics. They said adults make things more serious and uncomfortable.

*If I miss the clinic day, it’s a problem*

Participants shared ideas for changing and improving current ISH services. They insisted that ISH was already doing great work and they appreciated the services provided by ISH. All of the participants in the school focus groups agreed that their main recommendation was to increase the hours and days that services were provided. Several youth explained that it was problematic because if they missed the clinic day they had to wait a whole week to access services and supplies. Various participants gave the example of needing Plan B or pregnancy tests when the clinic was closed. They stated that these are urgent issues that require immediate attention and if not addressed could have stark consequences for them. After an animated conversation, they suggested at least two operating days, one at the beginning of the week to help with any post-weekends issues, and one at the end of the week so they could be prepared for the weekend.

Participants commented on the financial barriers youth face in regards to accessing birth control and Plan B. They stated that it is important that sexual health services keep this barrier in mind and make sure youth can access them at little or no cost. At the Belmont School clinic condoms are only available when the clinic is open. Participants identified this as a problem as they had no other place to access free condoms. They advocated having condoms available every day and in different areas of the school. They also requested that ISH allow them to take as many condoms as they wanted instead of limiting the amounts. Students at Royal Bay indicated that they appreciated the condom availability even on non-clinic days; however, they stated that often the condoms run out or the variety is limited. They also recommended having dental dams available, as this would send a clear message that all sexual orientations are valued and respected. This brought agreement from all of the participants and led to comments regarding other available resources and information. They noted that the information and resources available tend to be heteronormative and encouraged ISH to address this issue.

In regards to the clinic and waiting room space, youth offered various recommendations. Several youth indicated that the reception area at the school clinics are problematic as file names are
visible and the space does not offer sufficient privacy to talk to the medical office assistant. The students indicated that it was awkward to have the clinic space in a location where the principal could see them. Participants also recommended a separate, quiet area for clients who are shy or have anxiety. They said not all youth are comfortable waiting out in the open where other students can see them or where it can be loud and distracting. Youth also recommended that clinic spaces have more than educational information posters on the walls. They actively talked about ways to decorate the consultation rooms so they were less clinical and said it would help nervous students feel better. They further stated that spaces are more warm and welcoming if the posters and art pieces are not only focused on education or health. For example, inspirational posters, funny posters, or art made by youth. Participants indicated that it would be preferable for the bathroom to be in the clinic space so that they did not have to exit and go to a separate bathroom carrying a specimen for testing. However, they said it was not a major problem for them.

Participants felt that there was no sufficient information and promotion about ISH services, locations and hours. They said that many youth do not know about ISH or what is meant by sexual health services. They suggest posters inside bathroom stalls so students have privacy reading information. Youth brought up the need to increase sexual health education in schools and to include consent as part of this education. Many participants indicated that they did not feel they received sufficient information on the topic. They also stated that often male identified youth do not see sexual health as relevant beyond accessing condoms. They recommend raising awareness on how sexual health is also relevant to males. Numerous participants expressed concern on how and where they would access sexual health services once they graduated high school. They stated that they did not feel comfortable going to a walk-in clinic to talk about sexual health issues. Various youth explained that they had negative experiences at walk-in clinics and did not plan on returning. They said that they did not know how information was handled in a regular clinic and if it was also confidential or if their parents would be informed. Participants emphasized that providers need to understand that it is difficult for youth to go to the clinic and to be aware of the stigma that still exists around sexual topics. Consequently, they explained, staff needs to be really friendly, warm, welcoming and non-judgmental.
Staff and Volunteer Interviews

Fourteen staff and volunteers participated in the interviewees. Interviewees identified different ways in which ISH currently offers services that are friendly to youth. The main areas that emerged are program design, service delivery approach, and program structure.

Nine interviewees pointed to the education and outreach services as the main way in which ISH offers youth friendly services. They stated that education services decrease barriers for youth to learn about sexual health. They further felt that the informal and respectful approach of the education staff creates a safe learning environment for young people. They spoke highly of the facilitators and their friendly, approachable manner. They also pointed to the outreach activities, such as hosting informational tables at festivals and events as ways in which ISH raises awareness about services and sexual health in a youth friendly manner. One participant saw educating youth serving organizations on ISH services as another way in which ISH tries to reduce barriers to access. Ten interviewees identified the confidential nature of the services as a youth friendly quality. One of these participants indicated that this was a legal issue rather than a program design issue as in BC youth are able to access medical care without parental consent. Of these ten participants, half indicated that they were not sure how youth knew that services were confidential. Eight interviewees identified the texting services and the youth website as a way in which services are youth-friendly. Two of which indicated that while they knew about these services, they were not knowledgeable about how they worked.

The flexibility of ISH services to adapt and be flexible to individual youth needs came up as youth-friendly quality for eight interviewees. Six of them gave the example of scheduling youth with a nurse or educator and pointed to the flexibility to accept partial payments and to have the membership fee waived as another example of this adaptability. Three of the eight noted that being able to schedule youth with a nurse was essential in providing quality services to youth. They explained that the ability and freedom for the nurse to spend longer than fifteen minutes with a patient was important in creating comfort and safety for vulnerable youth. Nine people identified the access to birth control at no cost or reduced cost as vital to providing youth friendly services. They also expressed frustration at the reduced availability of free birth control
and commended the organization for working to find ways to ensure no youth walked away without birth control if they needed it.

In regards to service approach and delivery, seven interviewees pointed to the friendliness and welcoming attitude of the front desk staff. They added that this approach ensured youth had a positive experience at the beginning of their contact with ISH. Four of these commented that staff and volunteers tend to smile a lot and have a general easygoing attitude. Seven additional participants mentioned the general welcoming environment, stating that the waiting room was non-sterile and comfortable. One person illustrated this by explaining that the waiting room has a TV showing short and informational videos, has posters on the wall, and informational pamphlets about sexual health and other community resources. Several participants talked about staff efforts to make youth feel comfortable. Four of these commented that staff will greet youth at every step of the way, welcoming them and asking them how they are. One interviewee noted that often staff and volunteers will read the client’s body language or get a sense that there is more to their situation than they are revealing. They stated that staff will try to ensure the young person is able to get the support they need. Another staff member added that staff try to connect youth to additional support services. In total, six people described ISH health and information services as offering a non-judgmental and non-fear based approach that creates a youth-friendly environment.

Interviewees identified the ISH program structure as youth friendly. Nine respondents gave the example of the satellite clinics as a way in which ISH is trying to reduce barriers by bringing services to where youth are. Six other respondents pointed to the hours of operation that include evenings and weekends. Out of these, four stated that the option to have scheduled or drop-in appointments is a way to address youth needs for immediate or planned appointments. Participants had mixed views on the location of the central clinic. Four said that they thought it was accessible as it was on a main route. The majority stated that they thought it was possibly out of the way for youth in the downtown areas, although they understood that no matter where the clinic was situated it would be far away from certain neighbourhoods. Three people stated that the fact that the organization name included the words sexual health would make youth feel more comfortable to talk about sexual issues.
Understanding youth

Interviewees identified several issues that youth may be dealing with when they access ISH services. Twelve participants noted that often youth have limited knowledge about sexual health issues. Half of these further explained that youth need a lot of information regarding their bodies, sexual health and how the health system works. A couple of them indicated that they are aware that often youth do not want to go to their family doctor to discuss sexual health issues. The six participants added that youth often do not have the necessary information to make informed decisions, for example knowledge of their medical history. Six additional interviewees stated that often youth’s needs are of an urgent or immediate nature. Three provided examples of youth contacting ISH needing birth control on that same day, not understanding that they need a prescription or that they need to plan ahead to access it. They explained that youth are often surprised that they cannot simply buy the pills and depending on where they are in their menstruation cycle, it is imperative they get them that day. Seven other participants indicated that they thought youth would be nervous or anxious when they accessed services. They added that they are aware that mental health issues play a factor in youth behaviours and risk factors including involvement in high-risk behaviour. These behaviours include engaging in substance use, unsafe sex and engaging with multiple sexual partners. They talked about their concerns for youth engaging in these behaviours and hoped that the support ISH provided would help them make better choices. Four other respondents commented that past trauma would be a factor in youth’s ability to feel safe accessing sexual health services. In addition, two interviewees pointed to the lack of family or social support as risk factors for young people. Three people thought that youth experience relationship pressure and that they do not have the skills to negotiate sexual relationships. They said this impacts youth’s ability to make safe and healthy sexual choices.

Participants also identified barriers youth may face in accessing ISH services. Seven people identified stigma around sexual health, sexuality and gender as a main barrier for youth. Five more participants stated that youth fear that family members will find out that they access ISH services. Three of these added that youth worry about the general confidentiality of services. Five other respondents saw transportation as a major barrier as well as youth not being able to attend during clinic hours. They explained that if youth come during school hours, they skip
school, and if they come in the evening, they often have to explain to their parents where they are. They identified the time right after school as a key time for youth to attend the clinic. Four interviewees identified financial barriers to accessing birth control or medication. Four other participants also identified past negative experiences with the medical system as a barrier for youth. Three out of the fourteen interviewees stated that youth often do not know that ISH can help them overcome some of these barriers such as providing low cost birth control, and one added that youth not knowing about ISH services is a major barrier.

Impact on service providers
Staff and volunteers talked about the impact youth needs, issues and barriers have on their work. The majority of the responses included ways in which these needs affect their approach to delivering services. They also talked about ways in which staff should approach youth who attend ISH in order to ensure that young people have a positive experience. Nine interviewees stated that they need to be flexible and friendly in order to address these needs. Six of these stated that it is important that youth be approached with respect and empathy. In addition, five people explained that staff have to be careful on how they ask questions and give information, ensuring that it is clear and non-judgmental. Three others indicated that they verbally acknowledge how difficult it would be for a young person to come to the clinic. Five participants added that it is important that staff are comfortable and knowledgeable on how to engage youth. They noted that not all staff feel comfortable interacting with youth or have limited experience with youth. They are concerned that this affects youth’s experience of the different ISH services. Five more respondents described youth not having a consistent positive experience with different staff as problematic. They see this as a barrier for youth to feel safe and respected at ISH. In addition, they explained that building trust is difficult for youth as they see different staff each visit. Four others stated that it is essential that youth have a choice in their medical care, thus fostering autonomy. Two of the interviewees stated that they always ask a youth their name as a way to establish connection with them.

Eight interviewees talked about the impact of youth’s limited knowledge about sexual health and the medical system. Six of these stated that youth often do not know what questions to ask or how to explain their concerns and therefore staff have to be proactive in asking questions and
raising topics. They added that appointments with youth provide a key opportunity to educate them and give information. One person said that it is important to keep in mind that when you give one youth information, you are also reaching many more as they will tell their friends. This person further explained that it was important to offer factual and clear information that could help youth navigate misinformation they receive from the Internet or their friends. Five interviewees talked about the pressure they feel knowing they may be the main or only source of information or support for a young person. One of these shared that it was often emotionally difficult to hear some of the challenges young people face in their lives. This respondent added that the staff team at ISH is very supportive of each other in processing emotions and reactions that arise for staff dealing with difficult cases. The importance of explaining every step of a process or procedure to increase a youth’s comfort and understanding, was also brought up by four other participants.

Participants spoke about the challenges of working with young people. Four people talked about the difficulty of youth not following up on treatment, testing or coming back to the clinic when necessary. Four other interviewees explained that when they are deciding on a treatment option for a young person they have to consider which one they would be most likely to complete, consider other issues such as mental health, lifestyle, and cost. Five respondents brought up parent involvement. One of these stated that it was great to have parents involved as it helped with follow up and often decreased financial barriers. Three of them spoke to the difficulty of navigating parental presence and youth autonomy. Of these, two spoke of the challenge of dealing with parents who are upset their children have accessed services and prescriptions. Three people noted that patients under 20 often come to the clinic with a friend, a parent or a worker. They then have to navigate whether that person is comfortable with their presence or having to assess whether more than one of the youths need assistance.

Staff and volunteers also talked about the impact youth needs have on the logistics of providing services to them. A main issue that arose from the interviews was the additional time staff need in order to deliver quality services to youth. Eight interviewees indicated that it takes extra time and consideration to make youth comfortable and to be able to address their needs. Three then gave the example that youth often do not have their medical services number; staff therefore
have to spend time finding out the number. Five out of the eight staff explained that the 15-minute appointments allowed under the medical services billing system are insufficient for dealing with the complex needs of youth. Seven of the fourteen interviewed staff and volunteers stated that youth come in with many complex needs. They further explained that it takes time to explore history, risk factors and to uncover a young person’s concerns and needs. Five participants then described the challenge of doing a quick initial assessment to try to figure out the best service route for a young person that accesses ISH services. Three added that often what youth write down as their reason for the visit is often not their actual reason. This creates a challenge for staff in addressing their needs. Five additional staff stated that it is challenging when they have a full day’s appointment booked and a youth drops-in. They explain that they are aware that youth will not likely wait very long for an appointment so they have to work as a team to figure out a way to fit them in. Youth are often scheduled with a nurse to allow for a longer consultation time but four respondents stated that this is difficult as there are often no nurses in the evening or weekends when youth tend to drop in.

Half of the participants spoke about the need to stay current on youth issues and trends as well as being knowledgeable about youth resources so that they can refer youth. Six other interviewees stated that often youth needs are outside the scope of what ISH is able to offer. Four of these mentioned the difficulty they face in sending these youths away without additional supports.

Staff and volunteer recommendations
Participants offered recommendations on how to increase ISH capacity to provide youth friendly services. The recommendations covered four main areas: increasing staff capacity, increasing connections with youth organizations, increasing internal connections, and removing barriers for youth.

Ten interviewees identified staff training as a way to increase staff capacity. They suggested training to learn how to effectively interact with youth, population specific training such as working with street involved youth or youth dealing with mental health issues, trauma informed practice and more information on existing community resources. Three interviewees added that it would be essential to ensure that physicians attend this training, as often physicians do not
participate in staff trainings. Eight out of the fourteen participants indicated that it is vital that ISH is able to ensure uniform quality of care across all service areas. Two of these people suggested raising awareness on the impact of negative experiences on clients. They explained that this might help staff members understand the importance of positive experiences for youth. Three others recommended that ISH ensure that existing and new staff work well with youth. Six participants talked about the importance of establishing an organizational culture that values youth, acknowledges the barriers youth face, and values access to sexual health services.

Eight people expressed concerns of not being able to provide all necessary supports for youth. They said that in their interactions with youth they become aware of other issues that are affecting the young person’s well-being. Six of these interviewees recommended a designated staff to provide support and liaison for youth, this person would assist with follow-up and support youth in a referral process. Three other people suggested improving internal systems to be able to communicate to staff any concerns regarding youth clients. Two of the eight concerned staff stated that it would be helpful if they knew youth had additional supports. Two other participants explored the idea of a youth specific intake form which could include additional community supports the youth currently accesses and permission to connect with them.

Nine interviewees indicated that increasing collaboration and connection with youth serving organizations would be beneficial. This collaboration includes reciprocal knowledge sharing such as professional development opportunities to learn more about the organization’s area of expertise. Participants also mentioned the importance of youth organizations helping ISH keep current on youth trends and issues. Three out of the nine people talked about developing clearer referral routes to youth services. They added that often they are not aware of how to refer a young person to specific services. Two participants also advocated sharing patient files with the Victoria Youth Clinic as youth often access both clinics. They felt that this would minimize youth having to undergo the same exams at each clinic and help to develop continuity of care for vulnerable clients. In total, four interviewees stated that ISH should continue and increase their outreach activities so that other organizations are aware of ISH services.
Twelve participants provided ideas on how to further remove barriers for youth accessing ISH services. They recognized that funding would be a barrier for implementing some of these recommendations. Six of the twelve stated that ISH should explore having additional satellite clinics, particularly downtown. Four of the twelve participants recommended increasing drop-in times as well as hours of operations, especially on the weekend. They said evening and Saturday hours are popular which points to a need for the clinic to be open at these times. Three spoke about the importance of longer appointment times, scheduling nurses in the evenings and weekends, and recommended exploring the possibility of increasing the rate for doctors to fill shift times that are difficult to schedule. Two other people stated that ISH needs to decrease follow-up visits for procedures such as IUD insertion. They explained that it is problematic for youth to return over and over again for a single procedure and wondered if all the follow-up visits are necessary. They gave the example of another local clinic that does not require as many return visits for IUDs. One person thought that it would be useful to explore alternative follow-up routes such as texting or emails as more effective ways to connect with youth. Four of the twelve people thought it would be important to give youth choice on which doctor to see, to have an option for male or female doctor and to ensure youth have options for birth control and treatment. Of these, two proposed having physician names and photos at the waiting room so youth can decide which physician to see because youth often do not remember a doctor’s name but might recognize a face. In considering literacy barriers, one person suggested that youth be given the choice of filling out the intake form with a doctor or nurse, as they might not understand all the terms on the form. Another person suggested multi-language resources in the room for clients with language barriers.

Five people commented on the waiting room and clinic rooms. In order to make the waiting room more comfortable and youth friendly, one staff recommended having posters and art that are not about sexual health issues to provide the opportunity for youth to take their mind off their worries. Two people added that having materials such as games or colouring sheets would also help youth feel more comfortable. Two other respondents also stated that it is really important that confidentiality be made clear in the education services, at the waiting room and in the consultation. They suggest providing a thorough overview of services to first time clients to ensure they are aware of all ISH has to offer.
Staff and volunteers indicated that internal communication was another aspect that would increase ISH capacity to provide youth friendly services. Six people pointed out that often they are unaware of what other programs in the organization are doing. Half of these people gave the example that they are aware of the YAC but are not aware of what it does. Along with increasing internal awareness, five other participants suggested exploring how these program areas can better work together and support each other in delivering youth friendly services. Three of these interviewees advocated for clearer roles and connection between doctors, doctors’ assistants, birth control educators and medical office assistants. They added that by having clear roles, these positions can support and inform each other regarding needs of youth clients. A couple respondents talked about incidences where different staff can sense the young person is highly anxious or will need extra care. They explained that there is not always a clear process for informing the doctor of the situation. Four of the fourteen participants stated the need to improve internal communication to ensure staff is aware of current trends, programs, and issues. They acknowledged that the current email updates are useful, however indicated the need for increased staff connection. One of these suggested medical round-style information sessions.

Seven participants indicated a desire for a stronger youth presence at ISH. They stated that it was essential to increase feedback opportunities for youth. Currently clients are able to access a feedback form through the website. Two of the seven staff stated that youth would not necessarily take the steps to find the link in the website and therefore it was necessary to find immediate and easy options for feedback. They added that if a youth has a negative experience he or she would walk away and might not return. Among the participants recommending a stronger youth presence, four suggested that the YAC could have a more prominent role in the organization, for example as a board liaison or providing direct ideas to the organization on how to decrease barriers for youth. Two people thought it would useful to have youth, whether or not they were on the YAC, speak directly to staff on their experiences or on how to engage with youth in a friendly and welcoming manner.
Community Youth Worker Interviews

Five community based youth workers participated in the interviews. These youth workers work one on one with vulnerable youth in the Victoria area. As part of their work, they support youth in accessing ISH services. Youth workers indicated that the support they offer ranges from assisting youth in calling ISH, making appointments at ISH for youth, transporting them to ISH and upon a youth’s request accompanying them during the consultation. Workers offered insight into their experiences at ISH, talked about ISH staff interaction with youth, and posited their observations on ISH program structure. Throughout the interviews, they presented ideas for ISH to improve its services for youth and pointed out ways in which ISH currently offers youth friendly services.

Experiences at Island Sexual Health

Interviewees commented positively about ISH services and the value of ISH as a resource for youth in the community. They said that in general youth have a positive and friendly experience when they visit ISH. Participants also indicated that the confidential nature of the services helps youth who worry that their parents will find out about their visit. Three participants indicated that youth being able to get information about birth control options, see a doctor or nurse, access birth control, Plan B or STI medication, and get tested all at one location is extremely useful for young people. They also brought up the benefit of free or low cost options for birth control that ISH provides. Two other respondents indicated that they were not aware that free birth control was still available at ISH as they thought it had been cancelled a few years ago. All workers indicated that ISH services normalize sexual health and help youth feel more comfortable about the topic and that this helps remove barriers for youth who are nervous about talking to adults about sexual issues. Three made specific mention of the birth control education sessions, adding that these offer very thorough information to youth. One gave an example of supporting a young person who had complex needs and many questions; they said that after the session the youth was able to make an informed decision that was best for them.

Three of the workers said that front office staff and volunteers at ISH are friendly and welcoming and seem comfortable with youth and sexual health. Workers indicate that when a youth has a positive experience, they are more likely to return or to follow-up on treatment or testing. Four
workers commented on ISH’s response to feedback, explaining that ISH is very responsive and open to their feedback. Two then indicated that they are able to talk directly to coordinators to address any issues or concerns, or to share important information on youth they will be taking to ISH. All workers said that they recognize ISH’s efforts to provide youth friendly services and hope that the organization continues to be responsive and flexible to youth needs. One worker gave the example of staff’s flexibility when youth are late for an appointment and being able to still fit them in. Another worker said that ISH has gone out of their way to ensure one of their clients had access to free birth control. Two talked about the importance of ISH presence in schools and added that this presence has helped normalize sexual health and decreased pregnancies.

Workers talked about their experience in directly supporting youth at ISH. Four of them indicated that they do not believe ISH currently works sufficiently with youth workers to improve a youth’s experience and care. Three of these workers explained that often youth will not follow-up without additional support from their workers. One worker suggested that with a youth’s permission, ISH could contact the worker for follow-ups. All but one worker indicated that ISH could use the support of workers as resources for addressing concerns about a young person’s well-being. They thought workers could provide insight on what approach would work best with their clients and therefore could provide support to ISH staff as well as support the young person with additional issues. One worker explained that many youth would not access ISH services without the support of workers. They added that they work closely with their clients to explain the importance of accessing sexual health services and reducing anxiety and fear of these services. Three interviewees suggested that ISH establish clear lines of communication with front line workers. In particular, all workers recommend that ISH send out regular updates directly to community youth workers on program changes not just promotional pamphlets or posters.

Three participants shared experiences that they defined as negative and potentially detrimental to the youth. One worker talked about a young person, a recent survivor of a sexual assault. The youth described the interaction with the physician as cold, negative, and said this person did not feel the doctor listened. The worker explained that it had been a difficult decision for the youth to
disclose the assault to the doctor and the experience discouraged the youth from seeking further support for the assault. Another worker explained that a youth had requested a particular birth control; however, the physician disagreed and prescribed a different method. The worker explained that the staff did not engage the youth in a discussion of pros and cons of the method or the reasons why they had selected that particular method. A third worker provided an example of a youth feeling judged by the doctor about her lifestyle and behaviour choices. The three workers explained that one negative experience is sufficient to keep youth away from ISH services. They further stated that it does not matter if it is a youth’s first experience at ISH or has had several positive experiences. One worker added that depending on the experience it might also affect a young person’s decision to access other medical services. Two workers indicated that while in general the experiences are positive, they are inconsistent and can vary from doctor to doctor.

Four participants explained that often they refer or take youth to the Victoria Youth Clinic instead of ISH. Two of these workers said that the Victoria Youth Clinic is better suited to serving the needs of high risk and vulnerable youth as they have more available support and experience with this population. They further explained that ISH staff and program design is not always suited to meet the needs of marginalized youth. One worker added that the Victoria Youth Clinic works collaboratively with youth workers to support vulnerable youth. Another worker explained that the Victoria Youth Clinic is geographically more accessible, has no membership fees and provides free birth control. Two stated that youth show a preference for the Youth Clinic as it is a more informal environment, has snacks and offers drop in appointments.

All youth workers interviewed had engaged with the ISH education and outreach programs. They stated that the education program is an excellent and valuable resource in the schools and community. They commented that the information is presented in a clear, friendly, and engaging manner that allows youth to be comfortable in learning about sexual health. Three participants also indicated that the ISH educator has developed a close working relationship with the schools as well as with youth, this further decreases barrier to learning. One person said that because youth see the educator on a repeated basis, they feel safe with her and are able to ask questions or
bring up concerns. All workers expressed an interest in expanding the education services to ensure youth’s learning needs are met. In particular, they hoped it would include discussion on how to establish consent, sexual decision-making, risks of different sexual activities, and communication skills for talking about sex with partners. They recognized that educational activities are limited by funding restrictions.

Program structure
Community youth workers brought up different aspects of the ISH program structure that impact youth experience. Three interviewees stated that ISH has hours that work for youth schedules. For example, evening hours and Saturday. Two workers indicated that appointment based times are problematic for youth and their workers for two reasons. Youth needs, they explained, are often of an urgent and immediate nature. When a youth decides that he or she needs sexual health services it is best to provide them as soon as possible. One worker stated that often appointments are not available until a week after the initial call. A second reason given is that youth, particularly vulnerable youth, often are not able to keep scheduled appointments. Three workers suggested having drop-in times and consider having youth-only times during the week when youth could drop in. These three workers were unaware that ISH offers a mix of drop-in and scheduled appointments. One worker expressed concern that the clinic offers services to all ages and that adults might be filling up valuable appointment time that youth could use. This respondent added to have seen the adult use of the clinic increase over the years and, while aware that adults had a right to sexual health services, it was something she worried about.

Four participants brought up the financial barriers youth face. Two said that the membership fee is a barrier for youth. They added that it is important that ISH clearly present the membership as optional so that youth are able to make a decision. One worker said that youth have been asked for the fee and when they do not know it is optional they have left the clinic or simply not returned to the follow up appointment. This worker gave the example of helping a youth call ISH to make an appointment. When the ISH staff brought up the membership fee, the youth indicated to the worker that they could not pay and therefore would rather not go to the clinic. The worker encouraged they youth to explain their financial barriers to the ISH staff, at which point ISH staff reassured the youth that the membership fee was optional. The worker stated that while it was
great that ISH had reassured the youth, it was evident that if the youth did not have support, they would have probably hung up the phone and not made the appointment. One worker said the same was applicable to birth control and urged staff at ISH to ensure that when they explore birth control options they engage youth in a discussion exploring what their financial capacity is. This worker stated that it is important not to make assumptions about their ability to pay based on their appearance. Workers indicated that youth feel guilty about their inability to pay. Two workers commended ISH’s effort in reducing financial barriers and providing flexibility in payments.

Youth workers also brought up the issue of transportation. Four indicated that transportation is a major barrier to youth, particularly if they have to take more than one bus. While they commented on how nice and welcoming the central clinic was, they indicated that the former location on Fort Street was easier to access for youth. Three workers raised the importance of having more satellite clinics, especially downtown.

**Things to consider when working with youth**

Interview participants indicated that there were factors ISH needs to consider when delivering services to youth. Four pointed to the importance for youth to be able to develop relationship with doctors and nurses so they feel comfortable and safe to share sexual health concerns. Of these, two stated that there is little opportunity for youth to build relationships at ISH as they see a different service provider each time. This is different at the satellite clinics that have the same staff each week. All workers added that ISH has to ensure that doctors and nurses are youth friendly and like youth. Three people added that staff need to be sensitive to youth needs and limitations and understand teenage brain development. Two workers then stated that in order to mitigate inconsistent experiences with doctors, it would be important to give youth the choice of which doctor to see. They said this would give youth agency and would allow them to feel empowered to engage with physicians with which they felt comfortable. All workers were convinced that it is important to be aware that all youth are vulnerable and at risk. Four of them explained that ISH staff need to be aware that many youth accessing services have experienced some sort of trauma. They further explained that sexual trauma could make accessing sexual health services extremely difficult for youth and that youth can be re-traumatized through a
negative experience at a sexual health appointment. Another worker added that youth will not self-disclose trauma, so it is vital to work from a trauma informed lens and assume that there is potentially a history of trauma. Three interviewees brought up the importance of sensitivity to gender and sexual orientation. They also explained that ISH can increase their ability to serve youth by being more aware of the various issues youth face such as mental health, addictions, homelessness, abuse, and body image issues.

Community youth workers also brought up youths’ fears and anxiety in accessing sexual health services. They described youth as often overwhelmed when visiting the clinic. Three workers then talked about the stigma and shame that youth experience regarding sex and sexuality. In addition, one worker talked about the extreme fear of judgement youth have and how this can prevent youth from disclosing behaviours or concerns, or asking questions that would be useful in providing them necessary sexual health services. They explain that this reiterates the importance of treating youth in a non-judgmental and respectful manner. Three participants explained that it is important for staff to be aware that youth have limited knowledge about body parts or sexual health. Therefore, it is important to provide clear information and not assume the young person understands medical terms. They reminded ISH that youth get confusing messages regarding sex and sexuality and this plays a role in their behaviour choices and beliefs about sexual health. Two interviewees stated that youth need time to understand information and to bring up concerns; they explained that it is important to not rush them. They commended ISH for providing a comfortable pace in their clinics. Two participants recommended ISH explore options for youth to provide quick and direct feedback to the organization. They added that it was important for youth to know that they have a voice in expressing their thoughts about the services they receive. One said that this might help ISH being able to ascertain if there were particular problem areas in their services.
CHAPTER 6: DISCUSSION

The original objective of the project was to assist Island Sexual Health (ISH) in developing informed strategies to support its staff and volunteers in providing youth friendly sexual health services. It aimed to find out what youth’s experiences of ISH services where, how and if these experiences affected their sense of safety and learn what youth need in order to feel safe accessing sexual health services and education. This chapter integrates the findings from the three research groups with the literature reviewed. It will do so in relation to the research question and objectives of the project. The discussion section will first present an overview of youth needs and realities including cognitive and developmental factors, risk factors, and barriers that prevent access to sexual health services. It will then consider how these factors translate into service delivery for young people. Finally, it will discuss the research participants’ suggestions on how to increase the level of youth friendliness of ISH services and explore implications for action.

The Reality of Young People

The findings and literature point to the importance of considering young people’s realities and needs in providing youth friendly sexual health services. In general, young people experience heightened anxiety and nervousness in accessing sexual health services. This can be due to past trauma (Ensign, 2004, p. 696; Oberg, Hogan, Bertrand & Juve, 2002, p. 333; Robertson, 2013, p. 495), fear of judgment (Bayley, 2003, p. 831; Ginsburg et al., 2002, p. 407; Tanner et al., 2014, p. 192; Tylee, Haller, Graham, Churchill & Sanci, 2007, p. 1566) or previous negative experiences with health care settings (Buzi & Smith, 2014, p. 152). The findings of the project are consistent with the literature review results. Research participants spoke about the impact that trauma, in particular sexual trauma, has on a young person’s fear of accessing sexual health services. As youth will not disclose past trauma or current emotional state it is important for providers to be aware and treat youth in a caring, respectful and friendly manner. They also confirmed that negative interactions with service providers at any point of contact can prevent a young person from accessing services. Youth are also fearful of family knowing that they are accessing sexual health services. Confidentiality is therefore of vital importance to young people. Monasterio, Hwang and Shafer (2007, p. 309) explain that lack of confidentiality or perceived lack of confidentiality is a key barrier for youth in accessing sexual health services. This is also
reflected in the project findings. Participants identified the confidential nature of ISH services as important in allaying youth fears. Some participants explained that not knowing if a service was confidential would prevent youth from accessing a service. This has potential implications for ensuring that youth are informed of the confidential nature of ISH services.

Youth’s limited knowledge about sexual health, their bodies and the medical system is another recurring theme identified in this study. Participants noted that often youth do not know what sexual services are, how or when to access them, and how the system works in regards to billing, prescriptions, and testing. Therefore, it is challenging for youth to know what questions to ask or how to present their health concerns. Several participants indicated that the responsibility lies with the service provider to help identify health concerns or risk factors. The literature identified lack of knowledge about sexual health and services as barriers for youth to access services (Anderson & Lowen, 2010, p. 780; Goldenberg, Shoveller, Koehoorn & Ostry, 2008, p. 722; Kang et al., 2006, p. 49; Senderowitz, Hainsworth & Solter, 2003, p. 2). Tylee, Haller, Graham, Churchill, and Sanci (2007, p. 1565) explain that young persons’ cognitive development also plays a role in their understanding of sexual health and their bodies. The literature reflected extensively on the negative impact of youth not having access to sexual health service (Bayley, 2003, p. 830; Tripp & Viner, 2005, p. 590) and the importance of making sexual health a priority for decreasing rates of STIs and avoiding unintended pregnancies (Cook, Erdman & Dickens, 2007, p. 183; Falk, E., Pederson, A., & Stanger, 2006, p. 14; Goesling, Colman, Trenholm, Terzian & Moore, 2014, p. 499; Goldenberg et al., 2008, p. 718; Hudson, 2012, p. 444; Robertson, 2013, p. 493). While in general participants did not directly identify the negative consequences of lack of access to sexual health services, they spoke about the importance of creating services that are accessible and friendly so that youth will engage, use birth control, and follow-up with testing and treatment. One young participant stated that sexual health services save young people lives by allowing them to have access to birth control and treat STIs.

Risk factors for youth sexual health is a topic that was prevalent in the literature. These factors are seen as contributing to increased negative sexual health outcomes and poor sexual decision making (Boyce & Doherty-Poirier, 2006, p. 60; James, Montgomery, Leslie & Zhang, 2009, p. 990; Svoboda, Shaw, Barth & Bright, 2012, p. 867; Tripp & Viner, 2005, p. 590). The literature
also identified specific youth populations that are at higher risk for poor sexual health and face more barriers than their peers face. These populations include LGBT youth, youth in government care, Aboriginal youth, youth living with disabilities, and homeless youth (Burke, Coles & Meglio, 2014, pp. 491–494; Flicker et al., 2010, p. 134; Maticka-tyndale, 2008, p. 91; Oberg et al., 2002, pp. 329–333; Poon, Smith, Saewyc, & McCreary Centre Society, 2015, p. 39). This theme was not as prevalent in the project findings. Some participants spoke of the high-risk behaviour of some youth clients such as multiple sex partners, substance use, and unsafe sex practices but did not speak of the relationship to increased negative consequence. Vulnerable population groups were not directly identified in the findings; however, community youth workers did speak about the needs of more vulnerable youth that they work with. Staff and volunteers also indicated a desire to learn more about the needs of vulnerable and high-risk youth. A possible explanation for this discrepancy is that the interview and focus group questions did not query this topic. It is also possible that research participants talked about youth as a general population group rather than focusing on specific groups.

The findings coincide with the literature review pinpointing hours, location, and transportation as additional barriers youth face in accessing services. Participants articulated the importance of having hours of operation that cater to youth schedules. This includes having hours during the evening and weekend. They also communicated the challenge transportation poses for youth including the cost of fares and the number of buses required to visit a clinic. This is consistent with the literature which identifies these structural factors as barriers to access (Anderson & Lowen, 2010, p. 780; Bayley, 2003, p. 830; Kang et al., 2006, p. 49; Masaro et al., 2012, p. 2). Participants commended ISH for having satellite locations, particularly in schools, and encouraged the organization to open more locations. Cost was of major concern to research participants. They spoke about the severe economic barriers youth face and the gravity of ensuring birth control and treatment was financially accessible. Participants also emphasized the importance of ensuring that youth knew that there were options for dealing with costs otherwise youth will walk away from services and feel too embarrassed to seek support. This is in keeping with the literature that similarly identifies cost as a barrier and underscore cost as the main reason youth do not use contraceptive methods (Braeken, Otoo-Oyortey & Serour, 2007, p. 173; Falk, E., Pederson, A., & Stanger, 2006, p. 15).
Delivering Services to Youth

The study highlights the impact youth needs have on service delivery and program design. In particular, it emphasizes the necessity of flexible approaches to service delivery in order to accommodate youth needs. Due to their limited knowledge of sexual health and general discomfort about the issue, youth need longer time than adults to understand and process information and to establish rapport with service providers. Participants reiterated the importance of ISH having flexibility for longer appointments by using nurses and birth control educators instead of physicians who are limited by the current provincial billing structure. Participants also encouraged ISH to continue to look at ways to ensuring youth and providers have sufficient time in their appointments to discuss concerns and talk about topics such as consent, healthy relationship and sexual decision-making. Other areas identified as flexible included payments structure, being understanding of youth behaviour and openness to having youth be accompanied by one or more people in their appointment. Youth’s health concerns are often of an urgent and emergent nature; therefore, it is important to have the flexibility of drop-in appointments. This follows the literature with respect to the need for flexibility and adaptability of services as a key aspect of youth friendly criteria (Hobcraft & Baker, 2006, p. 355; Hoffman, Freeman & Swann, 2009, p. 226; Senderowitz et al., 2003, p. 3; Youth Gender Action Project, n.d., p. 7).

Furthermore, this study highlights the importance of quality interactions with clinic staff and volunteers to address the emotional safety of youth when they access services. Both literature and findings point to positive staff interactions as vital to youth friendly services. Research participants spoke repeatedly of staff that is welcoming, warm and friendly and greets youth with a smile. These interactions allow youth to become comfortable in seeking health services and allays some of the fears they may have of being judged or treated disrespectfully. Several studies also reported that interaction with staff are critical to a young person’s experience with services and their willingness to stay engaged with health services. (Ensign, 2004, pp. 700–702; Tanner et al., 2014, p. 203). The finding on the impact of negative interactions with staff reiterate the importance of staff and youth interactions. Participants explained that in general youth have positive experiences with ISH services, however they identified instances when interactions had not been positive. They spoke about the negative impact these had had on the young person
involved including a hesitation to return to ISH or to access further support. These findings mirror the literature reviewed which talks about the serious consequences of negative youth and staff interactions (Buzi & Smith, 2014, p. 152; Goldenberg et al., 2008, p. 719; Hobcraft & Baker, 2006, p. 353). Participants advise that ISH ensure staff are skilled and knowledgeable in how to treat youth. They point to providing training to develop staff’s capacity to interact with youth in a friendly, respectful and engaging manner. The literature suggests that staff be trained and equipped to deal with young people (Love, McIntosh, Rosst & Tertzakian, 2005, p. 25; Oliver, van der Meulen, Larkin, Flicker & Toronto Teens Survey Research Team, 2013, p. e145; Senderowitz et al., 2003, p. 4; Travers et al., 2010, p. 195; Youth Gender Action Project, n.d., p. 5). Some participants suggested that youth be given the choice of which doctor to see. Participants thought that this would have a twofold effect. One, it would allow youth to see physicians they felt comfortable with. Two, it would give a clear indication to ISH if there were problematic interactions with specific program areas.

Connected to the theme of staff and youth interaction, the study also delineates the value of building relationships with youth. The literature identified relationships with adults as a protective factor to enhance a young person’s wellbeing (DiClemente, Salazar, Crosby & Rosenthal, 2005, p. 828; Ensign, 2004, p. 703; Oliver & Cheff, 2012, p. 375). McCreary Centre’s report (2015, p. 45) on the sexual health of youth in BC specifically identifies a positive connection with a health care provider as increasing a young person’s use of birth control. Likewise, research participants identified the importance of building relationships. A participant’s comment about how much it meant to them that staff remembered their name when attending the clinic illustrates this point. The findings further indicate that there are limited opportunities for youth to build an ongoing relationship with health care providers at ISH. Relationship building is also connected to the importance of continuity of care in the care of a young person’s sexual health and general well-being. Participants commented on the need for procedures that would allow for increased continuity of care of young patients, particularly those that demonstrate higher risk. This information adheres to the literature which holds that continuity of care also helps to address youth’s complex needs (Buzi & Smith, 2014, p. 152; Ensign, 2004, p. 702; Robertson, 2013, p. 497).
Another predominant theme in the study is the complex needs of youth that are beyond the scope of services provided by ISH. The findings demonstrate that this affects staff’s experience in providing services to young people. Participants talked about the challenge of not being able to address health needs that are beyond sexual health and not being knowledgeable about other resources youth can access. They also expressed worry that some youth do not have additional support to deal with the other issues affecting their well-being. This is consistent with Kang et al., (2006) who found similar results in their study of service providers. In order to address this, the literature recommends that youth health services be comprehensive in nature or at the very least have clear connections to other youth services in order to facilitate referrals (Anderson & Lowen, 2010, p. 783; Oberg et al., 2002, p. 334; Robertson, 2013, p. 496; Rogstad, Ahmed-Jushuf & Robinson, 2002, p. 422). The findings similarly highlight the need for increased connections with other youth programs. In particular, working with youth workers who attend the clinic with youth, building a strong working relationship with them to help address youth needs and support youth in following up with testing and treatment. Participants also endorse clear referral procedures, collaborating with youth programs to build staff capacity and increase awareness about available services. Several staff suggested having a designated person at ISH to assist youth who need further support and referrals. This would address the concern of continuity of care and the concern that some youth leave ISH with unmet needs.

**Improving ISH Youth Friendly Services**

The literature advocates for youth to be involved in the design, implementation and evaluation of sexual health services (Braeken et al., 2007, p. 174; Ensign, 2004, p. 704; Hobcraft & Baker, 2006, p. 355; McClelland et al., 2012, p. 818; Rogstad et al., 2002, p. 422). Similarly, the findings point to increasing opportunities for youth involvement at ISH. This includes enhancing the role of the Youth Advisory Council, have youth deliver presentations to staff on how to work effectively with youth, and obtaining more feedback from youth on ISH services.

Participants found that in general the ISH clinic spaces were more comfortable than other clinics. They also contributed ideas on how to improve the physical environment of the clinic. They suggested adding art and posters not related to health or education. As well as adding activities for youth to do as they wait such as colouring sheets or games. Some participants proposed
having separate areas for youth to wait, especially for youth experiencing high levels of anxiety. They also advocated for increased varieties of barrier methods to be available in the clinic spaces and ensuring these are always available to youth. This is consistent with the literature that speaks to the importance of a comfortable environment and clean clinic space (Senderowitz et al., 2003, p. 3; Tylee et al., 2007b, p. 1567).

The literature demonstrates the need for sexual health services to be widely promoted so youth are aware of their existence, their location and how to access them (Braeken et al., 2007, p. 173; Burke et al., 2014, p. 492; Shoveller et al., 2009, p. 400; van der Meulen et al., 2010, p. 2010). The findings point to an insufficiency in awareness of ISH services and procedures. Participants indicated that they lacked information on a variety of ISH related issues. Examples include locations and hours of all the clinics, availability of birth control at no cost, existence of the texting services, possibility of drop-in appointments, and the range of available ISH services. They recommended more promotional materials such as posters, widely distributed in areas frequented by youth. As ISH already has promotional material available in the community and on their website, it would be advisable to study best information routes to reach youth. Participants also advise ISH to send information directly to youth workers as they can then use this information to support youth in accessing ISH.

The study underscores the important role that ISH education and outreach services play in promoting services and making sexual health information accessible to youth. The services were consistently described as engaging, youth friendly, approachable, respectful, informative and non-judgmental. The results of the study indicate that the education programs need to continue in this manner and provide insight into ways of enhancing these services. Participants suggest that sexual health education incorporate consent, sexual decision-making, skills for communicating about sex, and sexual pleasure. Participants specifically recommend increasing ISH’s connection to youth that identify as male, increasing their awareness of how sexual health is relevant to them and their role in sexual relationships. In general, the findings point to a need for more sexual health education in the schools and community to provide information to youth, decrease existing stigma around sexual issues, and increase youth’s comfort in accessing services.
Summary

The discussion chapter provides insight into aspects of ISH that parallel youth-friendly criteria outlined in the literature review. These include flexible and adaptable services, staff that is generally friendly to youth, and reducing barriers such as cost and hours of operation. This chapter also discussed how the needs of young people affect their access of sexual health services. These realities include emotional needs, developmental needs, and logistical needs. The analysis suggests that it is important to consider these needs when delivering sexual health services to youth. The discussion considered how these needs affect service delivery. For example youth’s emotional and developmental needs means they require more time than other clients and also require positive and respectful interactions with staff. It emphasized the crucial role positive interaction and relationships play in creating safety in sexual health services for youth. The discussion also highlighted the importance of having trained staff that is comfortable in interacting with young people. It also identified specific barriers such as cost, transportation and hours of operation. It concluded by presenting research participants’ recommendations to ISH in the following main areas: involvement of young people in developing ISH services, physical clinic space, promotion of services and sexual health education.
CHAPTER 7: RECOMMENDATIONS

This chapter provides recommendations to increase Island Sexual Health’s capacity to provide youth friendly services. These recommendations are presented respectfully and with the awareness of resource limitations. The 13 recommendations arise from the research findings and analysis. Nine of the recommendations are divided into short-term (within one year) and medium-term (within 3 years) strategies and are presented in order of priority. These nine recommendations are suggested as short to medium term as an initial assessment indicates that they would not require significant financial resources or major changes to policy. Each recommendation has an overarching topic and is organized in specific strategies. Four additional recommendations are longer term and will require substantial planning and funding.

1. Establish an explicit organizational culture that values and respects youth and prioritizes providing high quality services to young people:

**Short-term**

a. Provide training for staff and volunteers on:
   i. Trauma informed practice
   ii. Working with specific vulnerable populations: Aboriginal youth, LGBTQ youth, youth living with disabilities, youth in care and homeless youth.
   iii. Communicating effectively with young people

In order to address the logistical challenges of all-staff meetings, the organization would make it a requirement for staff to attend a specific number of trainings per year. For example, ISH could offer 10 trainings in one year and staff and volunteers would be required to attend five of these.

b. Disseminate results of this report to increase staff understanding of the needs of youth and the grave consequences of lack of accessing sexual health services.

**Medium-term**

c. Develop and implement policies that delineate how staff and volunteers are expected to interact with clients, particularly youth. These policies can be used in hiring process and procedures. They can also be used during staff performance evaluations.
2. **Further reduce barriers to youth access to services:**

*Short-term*

a. Provide youth choices on which physician or nurse to see. In addition, have a list of names and photos of the physicians on shift.

b. Display signs in all areas of the clinic, explaining that there is support for dealing with the costs of prescription birth control and membership fees.

c. Instruct staff to bring up the topic of financial barriers with youth.

d. Include a discussion of potential financial barriers and available options in the birth control education sessions.

*Medium-term*

e. Establish youth-only clinic times at the Quadra Street location. At these times the clinic can create a more informal atmosphere by having louder music, snacks and schedule staff that have demonstrated an interest and high level of skill in working with young people.

3. **Develop a close working relationship with community youth workers to address complex youth needs:**

*Short-term*

a. With a youth’s consent, actively involve the youth worker during the consultation in the discussion of the young person’s concerns, follow-up plans and need for additional support.

b. With a youth’s consent, do follow-up calls to both youth and youth worker.

c. Add the option of providing the name of their youth support worker and consent to share information in the intake form.
4. Examine ISH program design and structure to discern areas where relationship building with clients and continuity of care can be strengthened:

*Short-term*

a. Offer returning youth clients the option of being scheduled with the same nurse or physician.

b. Develop effective pathways between medical office assistants, doctor’s assistants, physicians, birth control educators and nurses to communicate concerns regarding a particular client.

5. Enhance the level of youth involvement and presence in ISH program design and evaluation:

*Short-Term*

a. Develop feedback tools that are quick and easy to complete:

i. A simple three to four question anonymous feedback sheet that youth can fill out at the end of their visit. As an incentive, they can be given the option of entering a monthly draw for a gift card if they choose to leave their E-mail address. Questionnaire should include the services youth accessed during their visit. Alternatively, install a tablet or iPad with the feedback questionnaire. This device can be securely displayed outside the consultation room area.

ii. Invite accompanying youth workers to provide feedback via the questionnaire or via e-mail.

*Medium-term*

b. Broaden the current role of the Youth Advisory Council (YAC):

i. Create a YAC liaison position to serve on the Board of Directors

ii. Involve the YAC in providing feedback and insight into program design

iii. Invite the YAC to lead bi-annually youth evaluation of ISH services.

c. Invite youth from the YAC or other youth groups to talk at a staff professional development session on youth needs, fears, challenges and how to talk respectfully with young people.
6. Develop strategies for reaching youth that identify as male:

Short-term
a. Continue to deliver the Man-Made program. The Man-Made program is a series of workshops for male identified persons. The workshops deal with a variety of sexual health related topics. The program was launched in September 2016 after the interviews for this project were completed.

Medium-term
b. Gather information from young people who identify as male to ascertain strategies to reach more male-identified youth.

7. Increase collaboration with other youth serving organizations to provide comprehensive services to youth:

Short-term
a. Send email updates directly to community youth workers and school counsellors outlining clinic services, programs and changes.
b. Maintain an updated contact list of community youth workers and school counsellors.

Medium-term
c. Establish clear referral routes to support services to youth in the areas of mental health, addictions, and relationship violence. Educate staff on these referral routes and have the forms available in the consultation rooms.
d. Deliver presentation on ISH services to youth serving organizations.
e. Invite youth service organizations to deliver presentations to staff and volunteers on their area of expertise and special considerations when working with the youth population they serve.
f. Explore the viability of sharing client files with the Victoria Youth Clinic.
8. Increase the comfort and welcoming atmosphere of the clinic spaces:

*Short-term*

a. Display confidentiality policy in all areas of the clinics. The policy should be clearly articulated in simple and easy to understand language. Include confidentiality policy on promotional and information tools.

b. Include youth made art on the walls and include posters that are not related to health education.

c. Offer age-appropriate colouring sheets and games in the waiting room.

9. Increase scope of promotion for ISH services:

*Short-term*

a. Include a complete overview of services in the intake package for new clients.

b. Continue to have posters displayed in schools and other locations youth access such as recreation centres and libraries. Explore the possibility of placing the posters in bathroom stalls at these locations.

*Medium-term*

c. Involve the YAC members in developing youth-friendly promotion strategies.

d. Include Quick Response Codes on promotional material.

e. Develop small waybill-style promotional materials that can be left in reception areas of various services. Information should be easy to read and clearly laid out and include: Beyond the Talk website, texting program, available services, and hours of operation.

*Long-term recommendations*

ISH would work towards these long-term goals while implementing the short and medium term recommendations.
1. In order to address the barriers presented by 15-minute appointment times:
   a. Increase nurse positions to expand hours in which nurses are available to meet with youth clients.
   b. Augment physician wages to permit them to have consultations longer than 15-minutes when they are scheduled with a youth client.

2. Expand hours and days of operations at existing satellite clinics.

3. Expand satellite clinics to create more accessible locations to more geographical areas of Greater Victoria.

4. Establish a youth-designated position to support youth in any necessary referral process, be the main liaison person for youth workers and address any concerns regarding youth clients at ISH.
CHAPTER 8: CONCLUSION

This research was concerned with developing strategies to assist Island Sexual Health (ISH) in enhancing the sexual health services it offers for youth. In particular, it was interested in assessing the experience of youth when they access services and learn how youth define “youth-friendly and safe” services. Another aim of the project was to determine how the organization can support staff in providing youth-friendly services. The project did this through a review of current literature on the themes of sexual health services, smart practices for youth friendly services, and existing barriers to sexual health access. The project also gathered data through youth focus groups and interviews with staff, volunteers and community youth workers. These methods allowed participants to share their experiences and provide insight into ways current services can be strengthened.

The results of the research support the idea that youth are particularly vulnerable to negative sexual health outcomes due to developmental processes and specific risk factors. It also complements earlier studies that point to youth sexual health as a priority and recommend youth-friendly services be given special consideration. In regards to providing youth-friendly services, a significant theme that emerged from the research is the importance of positive interactions between youth and service providers. These interactions play a major role on whether a young person accesses services and how comfortable they feel discussing their health concerns. It highlights the importance of increasing staff capacity to provide positive experiences for youth. The complex needs of youth were also underscored in this study. These impact youth’s experience of services and in turn affect service delivery.

The recommended strategies for improving existing ISH services evolved from the analysis of the literature and data gathered. The nine recommendations focus on staff capacity building, collaboration with community youth services, removing barriers to access and enhancing current youth involvement in the organization. The report also puts forward four long-term recommendations that entail significant planning and funding. The recommendations focus on addressing the challenge of short consultation times, increasing access to service by expanding satellite clinics and having a designated staff position to work with youth clients.
Island Sexual Health is recognized in the community as an important resource for youth in the area of sexual health services and education. Community participants reiterated that while they had ideas for improvement, they valued and appreciated the quality of services ISH currently provides for youth. Youth participants in particular spoke highly of the role ISH plays in their sexual wellbeing. As an organization, it has demonstrated a commitment to providing youth-friendly services. Staff and volunteers involved in this project expressed a willingness to work towards enhancing current services for youth as well as a curiosity in learning how to best do this. This project highlighted how the organization currently offers quality services to young people. ISH should proudly raise awareness about the vital role it plays in the field of accessible sexual health services and reducing negative health outcomes for youth in Greater Victoria. The project also provided an opportunity to learn from staff, volunteers, youth and community workers about areas ISH can improve upon. Through the literature review, this project revealed current promising practices in delivering youth-friendly services and highlighted areas where ISH is successfully implementing these. It can further deepen its commitment to youth by continually re-assessing its services and prioritizing access for vulnerable youth. This commitment includes taking on a leadership role in increasing awareness about the serious consequences youth, and in turn the wider society, face if youth do not have access to quality sexual health services.
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Appendix A: Staff and Volunteers Interview Questions

1. How do you think ISH provides services that are friendly to youth ages 15 - 24?
2. What is your experience when youth access services at ISH?
3. What do you think are some of the needs or issues youth that access ISH services face?
4. How do their needs impact your ability to provide service to them?
5. Is there anything else that you think ISH could be doing to provide services for youth?
6. Is there anything that ISH could do to support you or other staff in better providing services to youth?
7. Anything else that you would like to add?
Appendix B: Community Youth Worker Interview Questions

1. What is your experience when you support youth in accessing ISH services?

2. What have youth shared with you about their experience accessing sexual health services?

3. What are ways in which ISH programs are safe and accessible to youth?

4. What are some ways in which ISH programs can increase their safety and accessibility for this population?

5. What do you think is important for ISH to know about youth in order to be able to provide safe and accessible services?