

Identifying Adolescents' Perceptions of the Facilitators and Barriers to the
Promotion of Healthy Sexuality for Adolescents of Prince Edward Island

By

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DALHOUSIE UNIVERSITY

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DEDICATION PAGE

This thesis is dedicated to my family. To my husband, Brent and his continual support in my personal goal of lifelong learning. To my children, Victoria, Christopher, and Grace who are a constant source of pride and happiness. To my parents, Ronald and Rosemary MacDonald, whose continual support to their children, family and friends is a source of inspiration.

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ABSTRACT

According to several studies, there have been improvements in adolescent sexual behaviour; declining adolescent pregnancies, fewer adolescents having more than one sexual partner, and an increasing numbers of adolescents using contraceptives. Notwithstanding these improvements, there are concerns regarding adolescents' sexual health including adolescents' limited knowledge of sexual health issues, high rates of sexually transmitted infections and the need to eliminate barriers to adolescent sexual health services. The purpose of this study was to explore adolescents' perceptions of the facilitators and barriers to the promotion of healthy sexuality of adolescents living in PEI.

A qualitative descriptive design guided by CST and a socio-ecological framework was used to explore participants' perceptions. Six female high school students, 16-18 years of age, participated in a face-to-face semi-structured interview followed by a second face-to-face follow up interview. Seven themes emerged from the data that was analyzed through thematic analysis: *The Illusion of Accessible Resources; Risky Behaviours; Peer Pressure Alive and Well in High School; Cyberbullying; Parental Influence on Adolescent Decision Making; Inefficient and Underutilized School Health Resources; and Inefficient and Underutilized Community Health Resources*. While it is evident that some promotion of healthy sexuality of adolescents is occurring in PEI, more investigation and development is needed to better support adolescents with comprehensive school services including guidance and education. The results of this study can be used to guide this future development.

LIST OF ABBREVIATIONS USED

AIDS	Acquired Immune Deficiency Syndrome
BScN	Bachelor of Science in Nursing
CAAH	Canadian Association of Adolescent Health
CHNAC	Community Health Nurses Association of Canada
CHNC	Community Health Nurses of Canada
CPHA	Canadian Public Health Association
CSH	Comprehensive School Health
CST	Critical Social Theory
CYAS	Canadian Youth and AIDS Study
CYSHHS	Canadian Youth Sexual Health Survey
HAAT	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
HPV	Human Papillovirus
HSV	Herpes Simplex Virus
PEI	Prince Edward Island
PHAC	Public Health Agency of Canada
PID	Pelvic Inflammatory Disease
SRH	Sexual Reproductive Health
STI	Sexually transmitted Infection
UPEI	University of Prince Edward Island
WHO	World Health Organization

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First, I would like to thank the six participants who graciously volunteered their time to participate in this study. These young women shared their perceptions of the everyday reality of adolescents living in PEI. The knowledge that was created as a result of this study can be used for the future development of promotion of healthy sexuality of adolescents in PEI.

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Chapter One: Introduction

Adolescence is a critical time in an individual's development occurring between childhood and adulthood. It is a transitional period associated with profound biological, social, and psychological changes and is often accompanied by growth and exploration. It also represents a time of opportunity whereby education and development of skills towards the security of a healthy sexuality is optimal. Adolescence is also a time when young people are becoming increasingly aware of their sexuality and begin to explore it (both positively and negatively (Benda & Corwyn, 1998; De Graff, Vanwesenbeeck, Woertman, & Meeus, 2011; Galambos & Tilton-Weaver, 1998).

A number of Canadian adolescents are becoming sexually active (engaging in vaginal intercourse and oral sex) at a relatively young age. Since the beginning of the 1980s there has been a rise in the proportion of those reporting engaging in sexual intercourse by age 15 (Maticka-Tyndale, Barrett, & MacKay, 2000). A national survey conducted by the Canadian Association for Adolescent Health (CAAH) (2006) reported that 27% of adolescents between the ages of 14-17 are sexually active with 20% being sexually active at age 15 and 45% at age 17. Engaging in early sexual activity can have serious implications. The earlier adolescents begin to have sex, the longer they are exposed to the risks of unwanted pregnancy and sexually transmitted infections (STIs), specifically chlamydia and gonorrhea (Rotermann, 2008).

In the past 20 years of nursing practice, I spent a great deal of time trying to understand why adolescents continue to be faced with unwanted pregnancies and have the highest rates of STIs. I am equally interested in understanding the role our society plays if any, in preventing these outcomes. Over time, other questions have emerged as well which include: What are the facilitators and barriers that promote healthy adolescent sexuality? What support and guidance

are available to promote healthy sexuality among adolescent populations and who is providing this support and guidance? Who decides which resources should be available? What factors, beyond the control of adolescents, contribute to unwanted pregnancies and STI acquisition and transmission.

According to the *Canadian Guidelines for Sexual Health Education*, sexual health is a major component of personal health whereby the goals of sexual health education programs are “to help people achieve positive outcomes (e.g., self-esteem, respect for self and others, non-exploitive sexual relations, rewarding human relationships, informed reproductive choices); and to avoid negative outcomes (e.g., STI/Human Immunodeficiency Virus (HIV), sexual coercion, unintended pregnancy)” (Public Health Agency of Canada (PHAC), 2008, p.8). Additionally, sexual health education, being concerned with the well-being of individuals, is

a broadly based, community-supported process that requires the full participation of the educational, medical, public health, social welfare, and legal institutions in our society. It involves an individual’s personal, family, religious, social, and cultural values in understanding and making decisions about sexual behaviour and implementing those decisions (PHAC, p. 5).

It also involves a combination of learning experiences including “access to age-appropriate information, motivational supports, and opportunities to develop the skills needed for individual sexual adjustment and for satisfying interpersonal relationships” (Health Canada, 2003, p.6).

For the purpose of this study, I was interested in better understanding the promotion of healthy sexuality of adolescents. I was specifically interested in understanding the perceptions of adolescents, regarding the facilitators and barriers towards the promotion of healthy sexuality. To address this issue I collected data that was more reflective of adolescents’ perspectives in general

than about the participants themselves.

Personal Context in the Research

I first became interested in the promotion of healthy sexuality of adolescents, early in my career, when I was employed (i.e. from 1991-1995) as an outpost nurse in a First Nations community in Northern Manitoba. I experienced many adolescents who were seeking health care due to STI follow up, prenatal care or health care for their child(ren). I was overwhelmed with the large numbers of adolescents whom I worked with in this capacity. This overwhelming number was reflected in 1995 statistics which revealed that First Nations adolescent pregnancy rates were up to 4 times higher than the national rates (45.4 per 1000 adolescent females). The rate for adolescent females under the age of 15 was especially high, particularly on reserves at this time, with rates 18 times higher than in the general population (Wadhera & Millar, 1997).

As I continued to live and work in First Nations communities, I quickly began to wonder about the factors that were beyond the control of these adolescents and the role these factors played with respect to them becoming pregnant or contracting STIs. These young people lived in communities with limited opportunities for employment; high rates of family dependence on social assistance; limited opportunities for extracurricular activities; limited opportunities for education beyond grade nine; high rates of physical and sexual abuse; high rates of drug and alcohol abuse; and, overcrowded housing with no running water. The context of this environment seemed incredulous in a country like Canada, in which we pride ourselves as a developed nation.

As I considered the environment in which these adolescents lived, I also began to question the “choice” that these adolescents had with respect to their sexual activity. This questioning increased as I considered comments made by many of them. “I’m supposed to do it if he wants

it.” Everyone wants sex”. “I don’t even like sex.” My friends are all doing it.” “I saved myself for my boyfriend...we lost our virginity together... I was 12, he was 13.” “He won’t let me protect myself.” “He wanted me to get pregnant... it looks good on him... he’s 17 and has 3 kids.” “I got to live at his house because I had a kid.” Although some of the adolescent females indicated that they wanted to become pregnant as adolescent pregnancy is culturally acceptable and sometimes encouraged in First Nations communities.

When I left Northern Manitoba, since I was raised in a protective middle class Caucasian family, I naively believed that what I experienced was an “Up North” problem. I quickly became aware that this was not just an “Up North” issue when I worked as a Clinical Nursing Instructor in the Charlottetown Public Health Office where I teach community health nursing to second, third, and fourth year Bachelor of Science in Nursing (BScN) students from the University of Prince Edward Island (UPEI) (1997-present). The students and I work with many adolescents who are seeking STI follow up, prenatal care for themselves or health care for their child(ren).

Background to Study

Upon reflection of what I have experienced in Northern Manitoba and what I am continuing to experience within my clinical practice, I am repeatedly drawn to wondering about the theoretical context of health promotion in our current health care system and how it relates to the promotion of healthy sexuality of adolescents. According to the Canada Health Act (1984), Canadians are entitled to services that are “medically necessary for the purpose of maintaining health, preventing disease or treating injury and disability” (Yeo, Moorhouse & Donner, 1996, p. 215). Through this Act, one can assume that the health of Canadians is protected by virtue of providing a quality health care system that is governed by the principles of comprehensiveness, universality, accessibility, portability and public administration. However, it is becoming

abundantly clear that the Canada Health Act has a focus on health care services within the health care system rather than the health promotion and a population health approach (Glass & Hicks, 2000). Such a focus has resulted in the development of an elaborate and expensive health care system with little evidence that it has impacted the health status of Canadians (Evans & Stoddart, 1994; Glass & Hicks, 2000). Nationally, this is increasingly becoming an issue with respect to the challenge of creating and maintaining a long-term sustainable health care system that improves the health status of a population.

Social determinants of health. Many national and international documents have acknowledged that a health care system needs to change its focus from one that mainly provides health care services to one that examines the health of a given population. According to these reports, it is necessary that the factors that contribute to the health of the population be identified. Some of these landmark documents include: *A New Perspective on the Health of Canadians* (Lalonde, 1974); *Achieving Health for All: A Framework for Health Promotion* (Epp, 1986); and, *Ottawa Charter for Health Promotion* (World Health Organization(WHO), Health & Welfare Canada, Canadian Public Health Association (CPHA), 1986). These seminal papers have increased national and international awareness of and attention to the underlying conditions within a society that determine health, factors commonly referred to as the social determinants of health.

Historical development of health promotion. These social determinants of health have emerged to be significant to the promotion of health. According to Labonte (1993), there have been three major approaches to health promotion in the twentieth century: biomedical, behavioural, and socio-ecological. Labonte considers that all three of these approaches are relevant and applicable to health care professionals, depending on the situation and the purpose

at the time. In the eighteenth and nineteenth centuries, the biomedical approach was prominent in providing health through a lens that focused on decreasing physiological risk factors as a means of preventing disease and/or disability. Examples of such risk factors include hypertension, hypercholesterolemia, lack of immunity, etc. This approach, that considers health to be an absence of disease, remains a dominant model today with such strategies as screening for risk factors, and immunization programs (Cohen, 2008).

In the 1970s, a second approach emerged to enhance the health of a population, the behavioural approach. This model was first addressed in the *Lalonde Report* (1974), and acknowledged that the escalating costs of an elaborate health care system was having little effect on the status of health of the population. A focus of this report was to identify a “new perspective” that advocated for more time to be spent on the promotion of health as opposed to increasing services for the sick. This approach was particularly significant at this time, as morbidity and premature mortality were increasing with respect to chronic diseases and injuries despite the increasing trend of providing more services to the sick (Cohen, 2008). The *Lalonde Report* defined the concept of health as that of: “freedom from disease and disability” and also acknowledged the importance of promoting “a state of well-being sufficient to perform at adequate levels of physical, mental, and social activity” (p. 8). The report challenged the prevailing view that the provision of health services was the main aspect of health care. Furthermore, it acknowledged that health service should include a focus, not only on its organization and accessibility, but also on human biology, the environment, and lifestyle. However, lifestyle emerged as an integral focus of the *Lalonde Report* because “a large proportion of the premature mortality and morbidity occurring among the population at the time appeared to be due to individual behaviours or lifestyles that could be modified” (Cohen, 2008,

p. 95). Strategies were as such, developed to encourage the development of individual behaviours and lifestyles that promote health. Such a perspective evolved as the behavioural approach towards the promotion of health of a population. This approach, focused on changing individuals' behaviours to prevent disease and disability, continues to be popular, especially within health educational programs (Cohen).

The third approach that has emerged to enhance the health of a population is the socio-ecological approach. This approach emerged in the 1980s and identified that the promotion of health is beyond, yet inclusive of, both the biomedical and the behavioural approaches. This socio-ecological approach advocates that social change is the most important factor towards the promotion of health of a population. This new approach recognizes that social and ecological circumstances affect individuals' options and therefore can negatively impact their health. Two important reports that have directly impacted the development of this approach are the *Achieving Health for All: A Framework for Health Promotion* (Epp, 1986) and the *Ottawa Charter for Health Promotion* (WHO, Health and Welfare Canada, & CPHA, 1986).

The *Achieving Health for All* (Epp, 1986) document emphasized that the promotion of health move beyond the behavioural approach to the promotion of health of a population, for which both individuals and society are responsible. This is a particularly important observation as one considers the increasing relevance of the social determinants of health. This report further identified three challenges to the promotion of the health of a population: the need to decrease inequities among people and populations; the need to increase the focus on prevention; and, the need to increase peoples' abilities to cope. As a result of these challenges, three strategies were also developed to promote health. These strategies included fostering public participation, strengthening community health services, and coordinating healthy public policy.

The *Achieving Health For All* framework was presented at the First International Health Conference in Ottawa in 1986. This was quite significant as it directly influenced the actual development of the *Ottawa Charter for Health Promotion* (WHO, Health and Welfare Canada, CPHA, 1986), another document that has influenced the evolution of the promotion of health of a population. It defines health promotion as “the process of enabling people to increase control over, and improve their health” (WHO, Health and Welfare Canada, & CPHA, 1986, p. 5). This *Charter* further emphasized the need for equity in health and ensured that certain prerequisites for health such as peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity were available. It identified five strategies with which to promote health: (a) strengthening community action; (b) building healthy public policy; (c) creating supportive environments; (d) developing personal skills; and, (e) reorienting health services. It also highlighted the concept of empowerment as being integral to the promotion of health whereby empowerment refers to “an active, process that involves people discovering and using their own strengths so they can move towards more individual and community control, political effectiveness, improved community life, and social justice” (Community Health Nurses Association of Canada (CHNAC), 2008, p.11). Such an approach to health promotion fosters the development of a sense of control and self-efficacy and moves beyond the medical and behavioural approaches of health promotion towards a health promotional approach that acknowledges the determinants of health (Cohen, 2008).

Population health. Population health is an approach to health that addresses the social determinants of health. Specifically, it “refers to the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood

development, and health services” (Strategic Policy Directorate of Population and Public Health Branch of Health Canada, 2001, p.2). The goals of a population health approach are “to maintain and improve the health status of the entire population and to reduce inequities in health status between population groups” (Strategic Policy Directorate of Population and Public Health Branch of Health Canada, p. 2). A health care system that addresses these social determinants of health “examines the way in which these factors interact to influence the health of individuals, families, communities, and society” (Federal, Provincial, Territorial Advisory Committee on Population Health, 2000, p.6). Implicit within this approach to health promotion, one moves away from “blaming the victim” to recognizing that factors beyond the victim play an integral role in contributing to his/her health. It moves away from the lifestyle approach whereby “ill health is the result of personal failure” (McLeroy, Bibeau, Steckler, & Glanz, 1988, p. 351) and acknowledges that not all people are provided with the same opportunities that are known to promote health. The benefits of a population approach extend beyond improving the health status of a population. This approach also contributes to the “overall societal development which requires less support in the form of health care and social benefits, and is better able to support and sustain itself over the long term” (Strategic Policy Directorate of Population and Public Health Branch of Health Canada, p. 2).

Historical development of the social determinants of health. In the 1970s and 1980s Canada was among the leading countries in the world with respect to health promotion and focusing on the social determinants of health. During the 1990s, Federal and Provincial governments continued to devote attention to the social determinants of health. Some of the more prominent publications included: *Strategies for Population Health: Investing in the Health of Canadians* (Federal, Provincial and Territorial Advisory Committee on Population Health, 1994); *Taking*

Action on Population Health: A Position Paper for Health Promotions and Program Branch (Health Canada, 1998); and, *Toward a Healthy Future: Second Report on the Health of Canadians* (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999). Over the past decade however, Canadian public dialogue has been dominated by concerns about the escalating costs and delivery of health care, taking the focus away from the importance of addressing the social determinants of health (Glouberman & Millar, 2003).

Recently, Canada has become more involved in addressing health disparities and the social determinants of health. In, 2002, the *Romanow Report* emphasized the importance of addressing the social determinants of health to reduce inequalities and therefore improve health. The PHAC has created two collaborating centres that are focused on the reduction of health disparities: the National Collaborating Centre for Aboriginal Health and the National Collaborating Centre for the Social Determinants of Health (Health Disparities Task Group of the Federal, Provincial and Territorial Advisory Committee on Population Health and Health Security, 2005). Two position papers have also been presented by the Health Disparities Task Group of the Federal, Provincial and Territorial Advisory Committee on Population Health and Health Security in 2005: *Reducing Health Disparities-Roles of the Health Sector: Recommended Policy Directions and Activities* and *Reducing Health Disparities-Roles of the Health Sector: Discussion Paper*. These developments in Canada are consistent with the WHO's Commission on Social Determinants of Health's Discussion (2005) paper *Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health*, which was developed to help give direction to countries when addressing the social determinants of health. Understanding and recognizing the importance of the social determinants of health is essential to the development of a sustainable health care system that improves the status of health of a population.

Upon review of this discussion regarding the current context of health promotion and the evolving emergence of the importance of the social determinants of health and population health, it becomes clear that it is essential for this study to use a broad framework such as the socio-ecological framework as advocated by McLeroy et al. (1988). Using a socio-ecological framework for addressing the promotion of healthy sexuality of adolescents is increasingly being recognized by a number of researchers (Edwards, Mill, & Kothari, 2004; Frolich, Potvin, Chabot, & Corin, 2002; Langille, Corbett, Wilson, & Schelievert, 2010; Marston & King, 2006; Pavis, Cunningham-Burleu, & Amos, 1998; Shoveller, & Johnson, 2006; Shoveller, Johnson, Langille, & Mitchell, 2004; Shoveller, Johnson, Savoy, & Pietersma, 2006).

According to McLeroy et al. (1988), a socio-ecological approach to health promotion is one that “focuses attention on both individual and environmental factors as targets for health promotion interventions” (p. 351). It addresses “health promotion from a multi-component approach in which interventions are directed at changing the intrapersonal, interpersonal, organizational, community, and public policy factors which support and maintain unhealthy behaviours” (McLeroy et al., p. 351). Specifically, it addresses the social determinants of health at multiple levels: (a) the intrapersonal factors look at the characteristics of the individual; (b) the interpersonal factors look at the formal and informal relationships; (c) the organizational factors look at the social institutions with organizational characteristics; (d) the community factors look at the relationships among institutions and organizations; and, (e) the public policy level looks at the local, provincial, and national policies and laws. According to Edwards, Mill and Kothari (2004), using a socio-ecological model provides a foundation for “multiple intervention programs that are characterized by the use of multiple strategies targeted at multiple levels of the socio-ecological system and delivered to multiple target audiences” (p. 41). Nested within these

multiple interventions are the social determinants of health which can be considered not only as layers but also as interacting factors that ultimately affect the health of individuals, groups and communities.

Using a socio-ecological framework to carry out this study enabled me to broaden the lens with which to better understand `adolescents` perceptions of the facilitators and barriers of the promotion of healthy sexuality of adolescents in Prince Edward Island (PEI). According to Langille et al. (2010), there are varying characteristics of individuals and communities that can predispose adolescents to sexual risk taking behaviours that can lead to adolescent pregnancy and STIs. They, therefore, advocate for research to be carried out, in definable populations, that is focused on identifying the specific risk and protective factors of these sexual risk taking behaviours. In their study in Yarmouth, Nova Scotia in 2010 it was revealed that there was a strong association between the factors of the socio-ecological framework (intrapersonal, socioeconomic and community related factors) to the sexual activity of adolescents. The results of the study identified that the students with low educational aspirations, minimal affiliation with religious services, not living with both biological parents, having close friends in higher grades or not in school were more likely to have reported being sexually active and/or engaging in sexual activity before age 15. This is of particular importance as it demonstrates that the social determinants of health can place adolescents in vulnerable positions that place them at risk for adolescent pregnancy and contracting STI's.

Other studies have identified predictors of early sexual intercourse such as minimal interest in school, poor school performance, lack of parental support, history of sexual and physical abuse, and early pubertal development (Jaskiewicz & McAnarney, 1994; Kirby, 2001; Kirby, 2007). It has also been documented that adolescent pregnancies (Chen et al., 2007; Kearney & Levine

2007; Kirby, 2001; Kirby, 2007a; Luong, 2008) and STIs (Chacko, Wiemann, & Smith, 2004; Hardwick & Patychuk, 1999) are more prevalent among disadvantaged teens.

However, although the majority of adolescent pregnancies are unintended, there are some adolescents, who are choosing to become adolescent mothers. For example, in some populations, adolescent pregnancies are culturally acceptable as can be seen in First Nations communities. Others are choosing to become pregnant due to the impact of the recent trend of media glamorizing adolescent pregnancies with respect to reality shows involving “teen moms” and adolescent actors becoming pregnant.

Adolescent Pregnancy

Adolescent pregnancy is a significant issue. In Canada, in 2005, the adolescent pregnancy rate (includes all live births, therapeutic abortions, miscarriages and stillbirths) was 29.2 pregnancies for every 1000 women aged 15-19. The rate is higher in women 18-19 years of age than those 15-17 (49.0 versus 15.8 per 1000). Pregnancy rates also vary within Canada; rates tend to be higher in Northern Canada and the Prairie provinces than in other regions. In 2005, the Nunavut rate was 145.6 pregnancies per 1000 adolescents aged 15-19 years of age and in the Northwest Territories, Saskatchewan and Manitoba rates were 72.0, 43.6 and 42.8 per 1000 adolescents aged 15-19, respectively. In Prince Edward Island, where this study was carried out, the adolescent pregnancy rate was 19.3 per 1000 adolescents aged 15-19. Over time, the Canadian adolescent pregnancy rate has fluctuated but the overall trend in recent years has been a decline with the number of pregnancies per 1,000 women aged 15-19 decreasing from 45.6 in 1996 to 29.2 in 2005 (Statistics Canada, 2008a).

Despite this overall decrease in adolescent pregnancies, Canada’s adolescent pregnancy rate is considered to be moderate to high in comparison to other developed nations. For example,

some countries like Belgium, Germany, the Netherlands and Slovenia have very low pregnancy rates (all births and abortions); less than 20 per 1000 for adolescents aged 15-19. Higher pregnancy rates are reported for other countries such as United States, Belarus and Bulgaria; 70-99 pregnancies per 1000 adolescents aged 15-19 years of age (Singh & Darroch, 2000). In a recent article comparing Canada to Sweden, United States, and England/Wales, Canada had the lowest adolescent pregnancy rates (all births and abortions) for adolescents, aged 15-19 per 1000, in 2006, being 27.9 compared to 31.4, 60.3 and 61.3 respectively (McKay & Barrett, 2010). However, this rate is high compared to the 2006 Netherlands abortion/birth rate of 14.1 for adolescents aged 15-19 per 1000 (Van Lee, Van der Vlucht, Wijsen, & Cadee, 2009).

Although there is variation in adolescent pregnancy rates, both nationally and internationally, pregnancy during adolescence is a significant social concern. It has tremendous implications for adolescents, their children, and society in general. Research supports that a large proportion of adolescent mothers are more likely to live in poverty (Baydar & Grady, 1993; Brown & Eisenberg, 1995; Bushnik & Garner, 2008; Health Canada, 1999; Luong, 2008; Singh & Darroch, 2000). Furthermore, research has revealed that adolescent motherhood may result in decreased opportunities for education and employment as well as having an increased risk of remaining single compared to adult mothers; all of which further increases their risk for lifelong poverty (Luong; Bushnik & Garner). However, according to Luong, increasing education above a post secondary level can counter the effects of adolescent motherhood. Nevertheless, poverty coupled with the added responsibility of premature parenting and meeting the needs of an infant or young child, can be very stressful for an adolescent who has not had time to deal with her own developmental issues (Baydar & Grady, 1993). This stress can be further exacerbated when adolescents become socially isolated from their family of origin, peers, and father of their child

(Holden, Nelson, Velasquez, & Ritchie, 2003). It is also well documented that many of these adolescent mothers are at an increased risk of becoming pregnant again. For example, approximately 25% of adolescent births are not first births (Kirby, 2001; Jaskiewicz & McAnarney, 1994; Kearney & Levine, 2007).

Besides the socioeconomic implications for adolescent mothers, adolescent pregnancy poses serious health risks for these mothers. Some obstetrical risks include pregnancy induced hypertension, anemia, poor weight gain and prolonged difficult labor (Paranjothy, Broughton, Adappa, & Fone, 2009; Stevens-Simon & White, 1991). Many adolescents elect to have a therapeutic abortion which increases their risks of hemorrhage, infection, cervical injury and uterine perforation (Brown & Eisenberg, 1995). In Canada, in 2005, 15.3 per 1000 adolescents aged 15-19 had abortions, just over 50% of the overall pregnancies of this age group (29.2). This rate reflects a trend that has been in decline; in 1996 the abortion rate was 22.1 per 1000 adolescents (Statistics Canada, 2008b). Adolescents who choose an abortion are four times higher to choose another abortion with a subsequent pregnancy than those who are pregnant for the first time (Millar, Wadhera, & Henshaw, 1997). Abortions during adolescence are also associated with emotional hazards which can be quite detrimental to the adolescent immediately after and many years after the procedure (Franz & Reardon, 1992; Gold, 1990; Strahan, 2000).

Adolescent pregnancy not only has an impact on the lives of adolescent mothers, it also has an impact on the lives of adolescent fathers. Some adolescent fathers attempt to stay involved in the lives of their children (Gavin et al., 2002) while others do not (Gavin et al.; Rhein et al., 1997). According to Brein and Willis (1997), eight out of ten adolescent fathers do not marry the adolescent mothers. Adolescent fathers who do provide support are affected in ways that are similar to adolescent mothers in that they are more likely to have decreased opportunities for

education and employment thereby increasing their risk for limited financial resources and decreased income potential (Brein & Willis, 1997; Hardy & Duggan, 1988; Hoffman, 2006).

Adolescent pregnancy also has implications for the child. Infants of adolescent mothers are at higher risk for low birth weight, mortality, illness, and injury (Chen et al., 2007; PHAC, 2008). Children of adolescent mothers are at risk for cognitive development issues (Chen et al., 2007; Miller, Benson, & Galbraith, 2001; Whitman, Borkowski, Schellenbach, & Nath, 1997), maltreatment (Flanagan, Coll, Andreozzi, & Riggs, 1995; Goerge & Harden, 2008) and are also more apt to drop out of high school than are children of adult mothers (Cameron & Hickman, 1993; Hoffman & Scher, 2008). Sons of young adolescent mothers are 2.2 times more likely to be incarcerated than sons of adult mothers (Scher & Hoffman, 2008), while daughters of adolescent mothers are at risk for adolescent pregnancy and therefore, perpetuating the cycle of decreased opportunities and risk for prolonged poverty (East, Reyes, & Horn, 2007; Hoffman & Scher, 2008; Miller et al.).

Clearly, adolescent pregnancy has significant implications for the health and well-being of adolescents and their children. There are also social implications. Societal costs include the direct cost of health services due to the physical and emotional conditions resulting from adolescent pregnancy. It is estimated that for every dollar that is spent on the prevention of teenage pregnancy, ten dollars could be saved on health services and long term income support to adolescent mothers (Orton & Rosenblatt, 1986). Many of these lone parent adolescent mothers require social assistance. For example, it was estimated that in 1985 the Alberta government spent 443 million dollars over a 20 year period to provide financial support to lone parent adolescent mothers after the birth of their first child (Bonham et al., 1987). In a recent report in the United States, it was revealed that adolescent childrearing cost American taxpayers about 9.1

billion dollars in 2004. Costs included those incurred for child welfare and health care as well as lost revenue in the payment of taxes (Hoffman, 2006).

Sexually Transmitted Infections

Besides the potential consequences of unwanted pregnancy, STIs are another threat to the health and well-being of adolescents. Currently, STIs constitute a major public health challenge in Canada. Nationally, the Surveillance and Epidemiology Section of the PHAC carries out surveillance of three reportable bacterial STIs: chlamydia, gonorrhea and infectious syphilis. There is also a national surveillance of HIV through the Surveillance and Risk Assessment Division, PHAC in cooperation with individual provinces and territories. Other significant viral STIs such as anogenital herpes simplex virus (HSV) and human papillomavirus (HPV) are not reportable at a national level (PHAC, 2007).

Bacterial STIs. Three bacterial STIs, chlamydia, gonorrhea, and syphilis, account for more than half of all reportable diseases indicating their potential impact on the Canadian population. Since 1997, there has been a steady increase in all three of these infections. This trend is not unique to Canada; other countries such, as the United States and the United Kingdom, have also reported rate increases except in gonorrhea, which is decreasing (PHAC, 2007).

Chlamydia is the most prevalent bacterial infection around the world and it is the most common reportable STI in Canada. In Canada, in 2008, there were 248.9 cases of chlamydia per 100,000 population. This rate has increased by 80.2% since 1999. The rate increased in both men and women as well as in all age groups with the majority of cases (82.6%) in the under 30 years age group. For both sexes the highest rates were evident in the 20-24 age groups with women having more than twice the rate (1824.3 per 100,000 population) as men (884.2 per 100, 000). The highest rates, nationally, are in Nunavut, Northwest Territories and the Yukon

(PHAC, 2010a). It has been estimated that less than 10% of all chlamydia infections are actually diagnosed due to the frequent lack of symptoms (Spiliopoulou, Lakiotis, Vittoraki, Zavou, & Mauri, 2005). So we are only dealing with the “tip of the iceberg” when we are treating diagnosed chlamydia cases.

Gonorrhea is the second most common reportable bacterial STI in Canada with a rate of 38.2 per 100,000 of population in 2008. This rate represents an increase of 116.5% since 1999. This rise is evident in both sexes but is higher in females (151.1%) than males (95.1%). In 2008, the majority of cases were reported in the under 30 age group (71.5%) for both males and females. The highest reported rates in females was in the 15-24 year age group (186.6 per 100,000) while the highest rate in males was in the 20-24 year age group (165.4 per 100,000). Nationally, the highest reported rates were in Nunavut and the Northwest Territories (PHAC, 2010a).

Although chlamydia and gonorrhea can be easily detected and treated they are not considered to be innocuous as they do have a great impact on the reproductive and overall health of Canadians (PHAC, 2007). As these diseases disproportionately affect the younger population, particularly women, the consequences are more evident in women. Untreated chlamydia and gonorrhea can lead to chronic pelvic inflammatory disease (PID), chronic pelvic pain, ectopic pregnancy and other adverse pregnancy outcomes, and infertility. PID is a condition that is not well understood, being difficult to diagnose and treat. It can often be asymptomatic, especially when the source of the infection is chlamydia, which has been estimated to be the cause of between 20-40% of all diagnosed PID cases (Paavonen & Eggert-Kruse, 1999). The rates of PID are highest amongst those aged 30-39 and the lowest among those aged 15-19 (being 287.3 and 43.5 per 100,000 population) respectively (PHAC). PID is significant because it is considered to be “the single most important preventable cause of infertility and adverse pregnancy outcomes”

(PHAC, p. 3). For example, it is also considered to be a strong predictor for an ectopic pregnancy with studies revealing that a decrease in PID will result in a decrease of the rate of ectopic pregnancies (Kamwendo, Forslin, Bordin, & Danielsson, 2000).

Infertility is a visible issue in Canada with the highest rates amongst women 30-39 years of age and the lowest amongst women aged 15-24 (244.9 and 2.2 per 100,000 population respectively) (PHAC). Approximately 20% of infertility can be attributed to STIs (Campbell, 1999). Chlamydial PID is considered to be the leading cause of preventable infertility with 3% of all women with chlamydia becoming infertile (Paavonen & Eggert-Kruse, 1999) and 80% of women with tubal infertility being attributed to chlamydia (Spiliopoulou et al., 2005). Chlamydial PID is also considered to be the leading cause of ectopic pregnancy with the highest rate in women aged 25-29 and the lowest rate in women aged 15-24 (90.3 and 16.4 per 100,000 respectively) (PHAC). It has also been estimated that at least 2% of women with chlamydia will develop an ectopic pregnancy (Paavonen & Eggert- Kruse). This is significant as one considers the fact that ectopic pregnancy accounts for 10% of pregnancy-related deaths (Coste, Job-Spira, Fernandez, Papiernik, & Spira, 1991).

Males are also affected by both untreated chlamydia and gonorrhoea, but to a lesser extent. They are at risk for developing epididymitis and, rarely, infertility. However, both females and males who have chlamydia or gonorrhoea are at a higher risk for acquiring HIV once they are exposed to the virus and also have a higher risk of transmitting HIV. Having a diagnosis of an STI does have an effect on the psychological well-being of both males and females. This is an area that has not been well examined (PHAC, 2007).

Besides chlamydia and gonorrhoea there is also a national trend towards an increasing rate of infectious syphilis. In Canada, in 2008, the rate for syphilis was 4.2 per 100,000 population,

representing a 568.2% increase from 1999. There are more cases in men than women with males accounting for 86.1% of the cases. The highest rates among males were shared in the 25-29 and the 30-39 year age groups (13.3 per 100,000), while the highest rates in women were in the 20-29 year age group (3.6 per 100,000). The rate for adolescents aged 15-19 increased from 1.1 per 100,000 in 2006 to 1.6 per 100,000 in 2008. Nationally, the highest rates of infectious syphilis were in the Northwest Territories and Alberta (PHAC, 2010a). This increasing trend of infectious syphilis is of significance because untreated syphilis can have serious consequences. People contracting this disease are at an increased risk of acquiring HIV upon exposure and they also have an increased ability to transmit HIV. Untreated syphilis may enter a latent phase and have no consequences or it can lead to serious complications of the central nervous system, cardiovascular system, skin, eyes, and internal organs or may lead to death (PHAC, 2007).

Viral STIs. HIV/Acquired Immune Deficiency Syndrome (AIDS) is a disease that provides great devastation and sorrow as a global epidemic. While approximately 70% of all positive cases are of people living in sub-Saharan Africa, this epidemic is increasing in other parts of the world such as Eastern Europe and Asia. Globally, the number of people estimated to be living with AIDS was approximately 38 million in 2003 and, the number of AIDs-related deaths, more than 20 million since this disease was recognized in 1981. It has also been recognized that adolescents and young adults are the most affected and infected by this disease worldwide because of their increased rates of taking part in risky sexual behaviour and intravenous drug use (PHAC, 2004).

In Canada an estimated total of 65,000 Canadian people are living with HIV/AIDS; this represents an increase of 14% since 2005. This increase in the number of people living with HIV/AIDS is a direct reflection of new cases and the improved treatment extending the lives of

those living with HIV/AIDS (PHAC, 2009). Men having sex with men represent the largest risk category of positive HIV tests (48% in 2008) while the heterosexual exposure category represents the second highest risk category (31% in 2008) and intravenous drug use represents the third highest risk category (17% in 2008) (PHAC, 2010b). An estimated 2,300-4,800 new HIV infections occurred in 2006; this represents a slight increase from 2005 (2,200 to 4,200). Of these new cases, 44% were attributed to men having sex with men, 36% to heterosexual men (non-endemic and endemic) and 16% to people using intravenous drugs (PHAC, 2010b). In 2008 males were nearly five times more likely to be HIV positive than were females and those over the age of 30 were more likely to have AIDS (83.1%) than those under the age of 30 (PHAC, 2009).

Being diagnosed with HIV is of great concern as there is no cure for this disease. The use of highly active antiretroviral therapy (HAAT) has been successful in increasing the median time for people diagnosed with HIV becoming diagnosed with AIDS (ten years) and has also increased the lifespan of HIV positive patients. However, this chronic disease places people at a great risk for developing a variety of AIDS defining conditions such as opportunistic infections, neurological diseases, and a variety of malignancies (PHAC, 2006b).

Economic burden of STIs. Besides the numerous medical and emotional consequences of STIs, the economic burden is tremendous as well. It has been estimated that the costs of treating STIs and associated mortality and morbidity is hundreds of millions of dollars annually in Canada (Campbell, 1999). In 1990, the economic costs of the easily preventable diseases of chlamydia and gonorrhoea were substantial with approximately 123 million dollars for chlamydia and 75 million dollars for gonorrhoea (Goeree & Gully, 1993). The direct health costs of HIV/AIDS in Canada in 1999 were estimated at 560 million dollars (Hellinger, 1993; Albert &

Williams, 1999). If these diseases were properly prevented and treated, the cost savings would be invaluable.

Purpose of the Study

The purpose of this qualitative descriptive (Sandelowski , 2000) exploratory inquiry is to address the research question: What are adolescents’ perceptions of the facilitators and barriers to the promotion of healthy sexuality of adolescents living in PEI? Healthy sexuality is considered to be a major component of personal health whereby the goals of the promotion of healthy sexuality are “to help people achieve positive outcomes (e.g., self-esteem, respect for self and others, non-exploitive sexual relations, rewarding human relationships, informed reproductive choices); and to avoid negative outcomes (e.g., STI/HIV, sexual coercion, unintended pregnancy)” (PHAC, 2008a, p.8). Considering the evolving importance of the social determinants of health and how they impact the health status of a population, this study was developed within a critical social theory perspective using a socio-ecological framework to determine how they affect the promotion of healthy sexuality of adolescents. Specifically, adolescents were interviewed to identify their perceptions of the facilitators and barriers that promote the healthy sexuality of adolescents living in PEI. The interview questions were designed to obtain data that was more reflective of adolescents’ perspectives in general rather than about the participants themselves.

Significance of Study

The adolescent pregnancy and STI rates in Canada are unacceptable, especially as one considers the extent of their health, social and economic impact. Even though the PEI rates of adolescent pregnancy and chlamydia are lower than the national rates, this study is significant as one considers that the reported rates of chlamydia and adolescent pregnancy may not be

reflective of actual rates. There is a need for improved epidemiological data collection that currently exists in PEI. The lower chlamydia rates may be more reflective of the fact that adolescents are not being tested for chlamydia because it is often asymptomatic and there are limited services available for testing. Equally important is the fact that as there are no abortion services available in PEI adolescent pregnancy rates may be under-reported especially for those who use private services outside PEI.

It is also important to consider that there are many programs that are being delivered to adolescents to prevent unwanted adolescent pregnancy and STIs that are proving to be ineffective. These programs include sex education programs in schools, public health programs, contraceptive counselling and provision of contraceptives in community clinics and multi-faceted community wide programs. Evaluation studies of specific interventions as well as systematic reviews and meta-analysis reveal discrepant evidence of effectiveness of these programs (DiCenso, Guyatt, & Griffith, 2002; Kirby,1997; Underhill, Montgomery, & Operio,2005; Kirby, 2001).

Obtaining the perspectives of adolescents about the facilitators and barriers that promote the healthy sexuality of adolescents will enhance current knowledge that will be useful to promote adolescent sexual health. Few studies have engaged adolescents to determine their views and no such studies have been undertaken in PEI. The findings from this study may inform health professionals involved with the development and funding of adolescent pregnancy and STI prevention programs and the promotion of healthy sexuality programs. The study findings may also inform a variety of professionals and lay personnel who are involved in the education, support, and guidance of youth. Finally, the findings may inform policy makers and administrators involved with the development and funding of healthy public policies that affect

the development of healthy sexuality of adolescents. These policies include those which have a direct influence on adolescent pregnancy prevention programs, STI prevention programs, and healthy sexuality programs as well as those broader policies that affect the “choices” youth have with respect to promoting healthy sexuality.

Study findings will also be useful for the practice of nursing. This is significant as the *Canadian Community Health Nursing: Professional Practice Model and Standards of Practice* (2011) acknowledge that community health nursing is grounded in health promotion and prevention, empowerment of individuals, groups, and communities; and advocacy for continuous development of partnerships within the community to enhance the well being of individuals, groups, and communities. The results of this study can be used to inform new multi-level strategies for the promotion of health within everyday clinical practice. For example, at this time, the public health nurses in PEI deliver sexual health education in the schools only when requested by the educational system to provide a PEI Department of Education and Early Childhood Development approved program to the students. The findings from this study can be used to inform and support the role nurses should have in promoting sexual health within the school system.

Summary

In summary, a number of Canadian adolescents are becoming sexually active at relatively young ages, placing them at risk for unwanted pregnancies and STIs. As discussed, engaging in early intercourse poses consequences that can have serious implications on adolescents, their children, their partners, and society in general. The significance of this study is that it will enable a better understanding of adolescents’ perceptions of the facilitators and barriers that promote the healthy sexuality of adolescents.

Chapter Two: Literature Review

This chapter provides the theoretical and empirical evidence on topics that are relevant to the purpose of this study to explore the perceptions of adolescents regarding the facilitators and barriers to the promotion of healthy sexuality. In this chapter, the literature is organized into four major sections. The first section focuses on adolescent sexual behaviour including a specific sub-section on the local context of PEI. The second section addresses the interventions designed to have an impact on sexual health including a sub-section on the challenges to overcome with respect to these interventions. The third section presents a discussion on youth participation as well as a sub-section regarding the perceptions of youth regarding the barriers and facilitators to the promotion of healthy sexuality. The fourth section addresses the social determinants of health and how they relate to the promotion of the healthy sexuality of adolescents. Finally, a summary of the issues and gaps in the literature will be presented.

Adolescent Sexual Health Behaviour

As the focus of this study is to better understand the facilitators and barriers to promoting healthy sexuality of adolescents, it is essential to better understand current adolescent sexual health behaviour. According to the Canadian Federation for Sexual Health (2007) there have been improvements with respect to adolescent sexual health behaviour. These improvements include declining adolescent pregnancies, fewer adolescents having more than one sexual partner, and increasing numbers of adolescents choosing to use contraceptives. Notwithstanding these improvements, there are some concerns regarding adolescents' sexual health. These concerns include adolescents' limited knowledge of sexual health issues, high rates of adolescent STIs and the need to eliminate barriers to adolescent sexual health services (Canadian Federation for Sexual Health).

Recently, adolescent sexual health behaviour has received significant public attention and a substantial body of research has been developed. This attention is important as it has been recognized that adolescents are at a higher risk for unintended pregnancy, they represent a disproportionate number of diagnosed STIs compared to the rest of the population, and they are at the greatest risk for the long-term complications of STIs (Fisher & Boroditsky, 2000; Maticka-Tindale, Barret, & McKay, 2000). Adolescent sexual health behaviour has been researched through various national surveys. One of these national surveys, the *2005 Canadian Community Health Survey*, reported that 47% of adolescents aged 15-19 have engaged in sexual activity at least once in their lives; this is down from the results in 1996/97 (Rotermann, 2008; Galambos & Tilton-Weaver, 1998). Sexual activity decreased for females from 51% to 43% while it remained the same at 43% for males. The likelihood of adolescents engaging in sexual intercourse rose as the adolescents became older (29% at ages 15-17; 65% at ages 18-19). One third of the 15-19 age group reported having had intercourse with more than one partner (40% of males and 27% of females) which was about the same as 1996/97. It was also noted that males were more likely than females to use a condom during last intercourse (80% versus 70%) with the percentage of females using a condom increasing from 2005 (65%) and the percentage of males remaining the same (Rotermann, 2003). The use of condoms at time of last intercourse decreased with increasing age amongst both sexes; 81% of 15-17 year olds reported using a condom at last intercourse while the figure for 18 and 19 year olds was 70% (Rotermann, 2008).

Another national surveys was conducted by the Canadian Association for Adolescent Health (CAAH) (2006) regarding the sexual risk behaviours of Canadian adolescents. This was a national study that was involved 1,171 online interviews with adolescents aged 14-17 years of age and 1,139 online interviews with adolescent mothers aged 14-17 years of age. This study

reported that 27% of adolescents between the ages of 14-17 are sexually active with 20% being sexually active at age 15 and 45% at age 17. Of these adolescents, 38% reported engaging in casual sex, 16% reported having partners who have had multiple sexual partners, 68% have had oral sex and 25% had not used protection against STI's during their last sexual encounter.

A third national survey that was carried out, the *Canadian Youth, Sexual Health and HIV/AIDS Study* (CYSHHS) (2003), was conducted by providing questionnaires to adolescents in grades 7, 9 and 11 from all provinces and most territories (Boyce, Doherty, Fortin, & McKinnon, 2003). The purpose of the study was to understand how the social determinants of health affected Canadian adolescents. The grade seven questionnaires asked limited questions about sexual experiences while the grade nine and eleven questionnaires explored sexual behaviours in more depth. This study was undertaken to provide a contemporary picture of the sexual behaviour of Canadian adolescents after an initial study was carried out by the *Canada Youth and AIDS Study* (CYAS) in 1989. In terms of sexual behaviour, these two studies reported similar data. For example, 23% of males and 19% of females in grade 9 reported having at least one sexual encounter while 40% of males and 46% of females in grade 11 reported having at least one sexual encounter. However, it was noted that females showed little or no change between the two time periods (1989-2002) while males reflected a trend to lower percentage of sexual activity (31% versus 23% in grade 9 and 49% versus 40% in grade 11). Of these students, about 33% of the students in grade 9 and more than 50% of the students in grade 11 reported having oral sex at least once while 75-80% of grade 9 students and 64-75% of grade 11 students reported using condom protection against STIs on the last sexual encounter. Also of interest, adolescents reported engaging in sexual intercourse with fewer partners in 2002 than in 1989. The number of students reporting three or more sexual partners had decreased. Serial monogamy

tended to prevail in the younger adolescents with more long term relationships occurring as the adolescents increased in age. Furthermore, those who were sexually active cited personal reasons such as love, curiosity, and experimentation for their decision to be sexually active.

The CYSHHAS of 2003 also noted some disturbing trends with respect to the sexual health knowledge between data collection periods. For example, students in the latter study demonstrated overall lower levels of sexual health knowledge. With respect to specific knowledge items only 40% of grade 9 students and 53% of grade 11 students knew that Vaseline is a poor lubricant with condoms. Furthermore, some students had the misconception that there was a vaccine to prevent HIV/AIDS while 66% of grade 7 students and 50% of grade 9 students were not aware that there is no cure for HIV/AIDS. Other examples in the gap in sexual knowledge were also noted in the CAAH study in 2006. These gaps included: 17% of youth were unaware that STIs could be transmitted through oral sex; many demonstrated a limited understanding of the consequences of STIs (20% being aware that HPV can cause cervical cancer and 37% were aware that infertility was a possible consequence of chlamydia); many were misinformed regarding how STIs are acquired (23% of adolescents surveyed believed that public toilets and poor hygiene are sources); and, 25% of adolescents surveyed reported that oral sex was compatible with abstinence. Both the 1989 and 2002 studies reported that condom use decreases with age which was also a finding of the *2003 and 2005 Canadian Community Health Surveys* (Rotermann, 2005; Rotermann, 2008). In the CYSSHAS study, the grade 11 female adolescents reported that this decrease in the use of condoms was due to choosing another form of birth control (38%) or due to having a partner who was “faithful”. Adolescent females were more likely to cite a faithful partner than males, while males were more likely to cite excessive alcohol and drug use as the reason for not using a condom.

Local PEI context. Prior to discussion of adolescent sexuality in PEI, it is important to briefly refer to the age of consent. The age of consent for sexual activity has changed from age 14 to age 16. This change is based on recent changes that have occurred in the Criminal Code of Canada in 2008. Sexual activity refers to a range of behaviours from touching for sexual reasons such as kissing to sexual intercourse. This age of consent identifies that people 18 or older cannot have sex with people under 16 years of age so as to protect youth from people in authority. Exceptions to the age of consent include the following: a) it is not a criminal offence for a person aged 14-15 to consent to sexual activity when the other person is less than five years older; and, b) it is not a criminal offence for a person aged 12-13 to consent to sexual activity when the other person is less than two years older. Finally, it is important to acknowledge that a person less than 12 years of age cannot consent to sexual activity (Community Legal Information Association of PEI, 2009).

This age of consent, being based on the Criminal Code of Canada, is consistent throughout Canada. However, the findings of the national surveys regarding adolescent sexual health behaviour can vary throughout regions and can be used to “inform policy development and clinical/educational practice” (McKay, 2004, p.67). However, it is important to acknowledge that there is diversity amongst the adolescent population that should be taken into account and may be missed by these national data sets (McKay). It is therefore important to address the regional surveys that have been conducted in PEI, where this study was carried out.

The promotion of healthy sexuality of adolescents in this province is an issue; this is especially true as one considers statistics with respect to sexual activity, sexual behaviour, and the resulting negative consequences, such as unintended adolescent pregnancies and STIs. A recent *PEI Student Drug Survey 2007* reported that 13% of grade 9 and 53% of grade 12 students

were sexually active. This rate remains consistent with results that were reported in the *PEI Student Drug Survey 2002*. When asked about their behaviour during sexual intercourse, 33% of students in grade 9, 10 and 12 reported having unplanned sex after using drugs or alcohol and 39% reported not using condoms in their most recent sexual activity (Van Til & Poulin, 2007).

It has also been reported that PEI adolescents have been participating in some concerning sexual behaviour. For example, it was reported that some young girls (12-13 years old) are providing sexual favors to older male adolescents (17-18 year olds) usually in the form of oral sex performed in schoolyards, cars, and private homes. It has also been reported that PEI adolescents are participating in risk oriented sexual experimentation such as “hooking up” and “rainbow parties”. Hooking up refers to casual sexual encounters with no strings attached and often occur at parties in private homes. Rainbow parties refer to girls wearing a different color lipstick and providing oral sex to more than one male while the males display their “rainbows” as sexual conquests (PEI Caucus on Youth Sexual Health, 2005).

These PEI behavioural patterns are similar to Canadian youth in the general population (PEI Caucus on Youth Sexual Health, 2005). However, the adolescent pregnancy rate on PEI is lower than the national rate (19.3 versus 29.2 per 1000 pregnancies) (Statistics Canada, 2008a) as is the PEI chlamydia rate in the 15-19 age group (414.66 versus 822.66 per 100,000 population) with the chlamydia rate of females aged 15-19 being greater than that of males aged 15-19 (666.67 versus 170.70 per 100,000 population) (PHAC, 2010).

Even though the PEI rates of adolescent chlamydia and adolescent pregnancy are lower than the national rates, the sexual health of PEI adolescents is of concern particularly because chlamydia is an important index infection marking the extent of risk behaviour that exists in the adolescent population (McKay, 2004). It provides important information regarding the actual use

or nonuse of condoms with respect to the prevention of STIs. This is especially true as laboratory studies have confirmed that latex condoms are impermeable to the chlamydia infection (Morris, 1993) and prevalence research suggests that 100% use of condoms does decrease the rates of chlamydia (Shlay, McClung, Patnaik, & Douglas, 2004). The lower chlamydia rates in PEI, may be misleading. This may be due to the fact that it has been estimated that approximately 50% of male and 70% of female cases are asymptomatic and therefore may account for adolescents not seeking health care and the eventual lack of diagnosis (PHAC,2006b). This is a characteristic of chlamydia that affects all Canadian adolescents and is not unique to PEI.

What is unique to PEI is that adolescents have limited accessibility to sexual health related services: the province having the least sexual health services in the Atlantic Provinces with no recognizable youth sexual health education and resources (Campbell, 1999). At this time, there are no Planned Parenthood organizations, family planning clinics, STI clinics, school health nurses in high schools or sexual health nurses. During the past two years the Four Neighborhoods Family Health Centre in Charlottetown, PEI has been trying to develop a youth health clinic. There has been difficulty, however, with a large turnover of physicians due to moving, changing professional focus and maternity leaves. The clinic has been available for a limited number of hours per week and has always been run by one physician. At this time, the youth health clinic is closed (personal communication, Lisa Sheaffer, Manager Four Neighborhoods Health Centre, Sept. 15, 2009). The other opportunities for sexual health services exist within the traditional physician and hospital-based services and with public health nurses being periodically “invited” by schools to provide individual counselling or to present sexual health curriculum developed by the PEI Department of Education.

What is also unique to PEI is that it is the only province in Canada where abortion services are not available. The PEI government will only financially support induced abortions if women obtain a written medical pre-authorization from two physicians and if they have the procedure in a hospital. Some women choose to bypass the physician referral process and choose to pay for abortion services at a private clinic outside PEI. As the cost for private clinics are not covered it is difficult to track actual induced abortion rates (personal communication, Joy Coffin, PEI Victim Services, September, 15, 2009).

The limited accessibility to sexual health services is further reinforced in a report *Perceptions and Attitudes of PEI Youth, Parents and Professionals About Sexuality* (2005). The goal of the report was to better understand the current state of youth sexual health in PEI and to advocate that the knowledge that was developed will be used to effect policy to enhance the promotion of healthy sexuality of PEI youth. The youth in this study reported that without a family planning clinic or sexual resource center they are unsure of where to go for sexual health care. This also becomes a greater issue as many youth report anxiety over confidentiality due to familiarity with physicians, educators and nurses and the hours of operation of the limited services available conflict with the schedules of youth. These youth also reported that they “feel alienated in the adult world” as they just “don’t talk about sex with fear of being judged or disapproved of” (PEI Caucus on Youth Sexual Health, 2005, p.13).

Besides limited accessibility to services this report also identified limited access to up-to-date information on prevention and behavioural skills approaches consistent with the current *Canadian Guidelines for Sexual Health Education*. This is of concern as these guidelines, which were initially developed by Health and Welfare Canada in 1994 and updated in 2003 and 2008 by the PHAC, were established to guide the development and delivery of sexual health education

in Canada. However, since health and education are within the provincial jurisdiction, it is up to the discretion of each province and territory to determine how these guidelines will be implemented. Currently, the PEI Department of Education and Early Childhood Development and the PEI Department of Health and Wellness are the primary systems responsible for offering sexual health education and sexual health services. Within the educational system, the promotion of healthy sexuality is included in the health curriculum from grade one to grade nine in an age appropriate presentation of content. However, in grades 10-12, there is no promotion of healthy sexuality content presented unless a student chooses to take a family life course. The existing school health curriculum was updated in 2006 with the initial implementation occurring for Grades 1-3 in 2006, Grades 7-9 in 2007 and Grades 4-6 in 2008; there are plans to update the family life 1996 curriculum in the high schools (Lori MacPherson, Health and Physical Education Curriculum Specialist of the PEI Department of Education, personal communication, September, 15, 2009).

Interventions Designed to Have an Impact on Sexual Health

There are numerous educational programs that are aimed at reducing adolescent pregnancy and/or STIs including HIV/AIDS. Most behavioural research in this area has been focused on describing relationships between individual characteristics of the adolescent and potentially modifiable factors such as knowledge, attitudes and behaviour (Kirby, 2007a; Shoveller & Piertsma, 2002; Shoveller et al., 2006). There have been mixed reviews around the success of these programs. Many of the studies I reviewed have identified areas for future program development including the need for (a) including youth, (b) ensuring programs are supported within communities, and, (c) examining social determinants of health when addressing factors that lead to risky sexual behaviour.

For example, DiCenso (1995) conducted a systematic review and a meta-analysis of randomized controlled trials (RCTs) designed to evaluate adolescent pregnancy prevention programs (DiCenso & Dover, 2000). The programs evaluated included school-based sex education, abstinence programs, multifaceted community-wide programs and planning provided by family planning clinics. The three behavioural outcomes studied were: consistent use of birth control (13 RCTs), initiation of sexual intercourse (12 RCTs) and pregnancy (10 RCTs). This involved 35 RCTs to evaluate interventions. All of these studies were conducted in the United States except for one Canadian study. From all the RCTs reviewed, one found an improvement in the use of birth control, one found a reduction of sexual initiation by males, while none of the studies found a reduction in pregnancies. The study that reported a reduction in the initiation of sexual contact by males included four components: involving factual information, group discussion of the factual information, group discussion of decision making, and personal responsibility for behaviour. The study which demonstrated an improvement in birth control focused on contraceptive information, problem solving, and communication skills. According to DiCenso and Dover (2000), many of the pregnancy prevention programs have not been found to be effective due to the following reasons: (a) youth are rarely involved in providing feedback to programs; (b) programs do not offer reinforcement of learning; (c) programs being evaluated are being compared to conventional programs as opposed to no programs at all; and, (d) there have been no evaluations of multi-component programs which include sex education and clinic services that are accessible, affordable, and confidential. There were also questions raised regarding the methodological rigor of the RCTs that were analyzed with respect to the size of the samples used, the wide variation in the length of time the participants were followed, and how the content was delivered.

Another systematic review, carried out by DiCenso et al. (2002), concluded that no primary prevention strategies delayed initiation of sexual intercourse or improved contraceptive use in adolescent women and men or reduced the adolescent pregnancy rate. This systematic review analyzed data from 26 RCTs from 22 published and unpublished studies and had clear inclusion criteria. Statistical meta-analysis was conducted examining the study findings and of findings of sub-groups to be affected by interventions involving prevention programs aimed at delaying initiation of sexual intercourse, use of birth control, or unintended pregnancy. The prevention programs that were included involved sex education in classes, school based clinics family planning clinics, and community based programs for adolescents. According to DiCenso et al., poor methodological quality is often associated with the overestimation of treatment effects but other factors must be taken into account as well to account for the failure of the interventions to influence the outcomes measured. For example, most of the participants in the studies examined were African-American or Hispanic, therefore revealing an over-representation of lower socio-economic groups. So essentially, the interventions may be more effective in other populations. Also of significance, the control groups continued to receive the conventional sexual education which may be indicative that the programs being assessed are not strong enough to exceed this effect.

Subsequent to this review, DiCenso et al. (2002) identified directions for future research including the need to : (a) investigate the social determinants of unintended adolescent pregnancy; (b) examine countries which have low adolescent pregnancy rates; (c) examine effective programs that have been used for other high risk behaviours in adolescence; and, (d) encourage adolescent input regarding interventions as there are few studies which have implemented this strategy.

Another systematic review conducted by Scher, Maynard, and Stagner (2006) synthesized the evidence of the effectiveness of 31 studies that reported on 38 RCTs of interventions aimed at reducing risky sexual behaviour of adolescents and adolescent pregnancy. The review concluded that “no consistent evidence that the types of pregnancy prevention programs evaluated rigorously to date will alter in intended ways the sexual activity or pregnancy risks of youth” (Scher et al., p. 3). This systematic review focused specifically on four types of interventions and made conclusions about each. First, regarding the intervention with respect to one-time consultations, the authors concluded that there was too little evidence to make specific judgments. Second, due to limited evidence regarding sex education with an abstinence focus, the studies evaluated are not truly representative of abstinence-only programs and it is therefore difficult to generalize to abstinence-only interventions. Third, there was no consistent evidence that the interventions that were aimed at providing sex education with a contraceptive component delayed the initiation of sex or affected risky sexual behaviour or pregnancy. However, there was a high degree of variability within this set of interventions with respect to size, direction, and statistical significance. Some of these studies were found to be effective especially when contraceptive use was emphasized. Finally, the multi-component youth development programs were found to be the most effective programs. However there “is a paucity of rigorous evaluations of such programs, and further replication and evaluation is warranted” (Scher et al., p. 3).

Furthermore, Scher et al. (2006) acknowledge that there has been an increasing body of knowledge with respect to addressing the sexual health risks of adolescents. However, they also acknowledge that there remains “a dearth of evidence to judge the overall effectiveness of particular intervention strategies” (p. 37). They advocate for further research and evaluation to

more rigorously evaluate interventions, especially those that have not yet been rigorously studied and those that are being applied to new populations. They suggest that this new information will enable researchers to “make more concrete conclusions regarding program efficacy” and this “solid information about whether particular types of interventions are effective, as well as information regarding for whom programs are effective and not effective, will help policy makers and practitioners better address the sexual health risks of youth” (p. 37). This study, like many others, reaffirms the need to better understand the target population within their existing communities in order to develop more effective interventions to address the risky sexual behaviour of adolescents.

There has also been 30 years of research done on adolescent sexuality by Douglas Kirby, a Senior Research Scientist at Education, Training and Research Associates in Scott’s Valley, California. This research involved “adolescent sexual behaviour, abstinence programs, sexuality and STI/HIV education programs, school-based clinics, school condom-availability programs and youth programs and youth development programs” (Kirby, 2007a, p.1). He co-authored research on curriculum that positively affected adolescent sexual behaviour including *Reducing the Risk*, *Safer Choices*, *Draw the Line* and *All 4 You!* This research has been credited for positively affecting adolescent sexual behaviour either by delaying the initiation of sex, reducing the number of sexual partners, increasing the use of contraceptives, and specifically increasing condom use.

Kirby also authored the *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*, which is a report that is a comprehensive review of research findings with respect to the effectiveness of programs to reduce teen pregnancy and STIs. This report updates two landmark reviews conducted in 1997 (*No Easy*

Answers: Research Findings on Programs to Reduce Teen Pregnancy) and 2001 (*Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy*). This study acknowledges that there is no evidence to support abstinence- only programs. It has been found in this methodologically rigorous study that “there does not exist any strong evidence that any abstinence program delays the initiation of sex, hastens the return to abstinence, or reduces the number of sexual partners” (Kirby, p.15). This study is also important because it dispels many of the myths that are perpetuated by abstinence-only advocates regarding comprehensive sex education promoting promiscuity and sending a confusing message.

These findings about abstinence-only programs were also found in another recent systematic review. Underhill et al. (2007) carried out a systematic review of 13 randomized and quasi-randomized controlled trials comparing abstinence only programs to control groups (usual care and no intervention) in high income countries. The programs that were reviewed were focused on preventing HIV only or both pregnancy and HIV with all trials evaluating biological or behavioural outcomes. The authors concluded that the effects of sexual abstinence-only programs for HIV prevention for participants do not affect the risk of infection as measured by self reported biological and behavioural outcomes. However, these same researchers completed another systematic review of 39 randomized and quasi-randomized controlled trials comparing abstinence-plus programs to control groups (usual care and no interventions) in high income countries. The programs that were reviewed were focused on preventing HIV with all trials evaluating biological, behavioural, and HIV knowledge. The difference between an abstinence-plus program and an abstinence-only program is that the abstinence-plus program encourages abstinence as well as condom use and safe sex strategies while abstinence-only programs promote abstinence exclusively. Of the programs that were reviewed, 24 revealed a significant

effect on at least one biological or behavioural outcome at short, medium or long intervals; eight found no evidence that the programs affect self-reported STIs and limited evidence that there was an effect on the pregnancy incidence; and, results were inconsistent regarding behavioural studies.

Besides discussing issues relating to abstinence programs, Kirby (2007a) reported that “the quality and quantity of evaluation research in this field has improved dramatically and there is now more persuasive evidence than ever before that a limited number of programs can delay sexual activity, improve contraceptive use among sexually active teens, and/or prevent teen pregnancy” (p. 4). In this report Kirby (2007a) reviewed 56 studies of curriculum-based programs with 8 focused on reducing teen pregnancy, 25 focused on preventing STIs/HIV, and 23 focused on preventing both. Two thirds of the programs that supported both abstinence and the use of condoms and other contraceptives were successful with respect to affecting one aspect of sexual behaviour or with lowering the rates of pregnancy or STIs. Forty eight comprehensive sex and STI/HIV education programs were studied with 15 of 32 programs delaying the initiation of sex, 6 of 21 reducing the frequency of sex, and 11 of 24 reducing the number of sexual partners. None of the programs hastened the initiation of sex and 15 of 32 of the programs increased condom use, 4 of 9 increased the use of other contraceptives, and 15 of 24 reduced sexual risk behaviour. However, even the effective programs did not dramatically reduce the risky sexual behaviour or the rates of pregnancy or STIs with the most effective programs reducing the risky sexual behaviour by only one third.

Kirby’s (2007a) study identified four areas that contributed to the shortcomings of the research. First, many approaches were not sufficiently researched. Second, only a few of the

evaluations of the programs have been replicated. Third, methodological problems or constraints limited the studies. Finally, some of the results of the studies were inconsistent.

Besides acknowledging the shortcomings of the research, Kirby (2007a) recognized that the purpose of most programs is to decrease the risky sexual behaviour of adolescents. Kirby summarized the results of about 450 studies of risk and protective factors. The studies revealed that more than 500 factors affect the sexual behaviour of adolescents with risk factors encouraging risky sexual behaviour that may lead to pregnancy and/or STIs and protective factors discouraging the behaviour and therefore avoiding these negative outcomes. These “risk and protective factors are rooted in communities (e.g., exposure to violence and substance abuse); families (e.g., the presence of both biological parents, parents who express and model responsible values about sex and contraception, a close relationship with parents; friends and peers (e.g., poor performance in school, drug use, permissive and unprotected sex); romantic partners (e.g., an older boyfriend); teens themselves (e.g., values, attitudes, perceptions of peer norms, self-efficacy, and intentions about sex or the use of contraception” (p.52). According to Kirby, the key is to decrease the risk factors while increasing the protective factors. Kirby advocates focusing on several important factors that are pertinent to the adolescent population that is being targeted. He also noted that many of the programs that were studied focused primarily on abstinence and condoms and to a lesser extent STIs. He reports that “too little emphasis is put on limiting the number of sexual behaviours, reducing the occurrence of concurrent partners, and other methods of reducing STD risk” (p 38).

Furthermore, Kirby (2007a) identified three strategies for improving the chances that programs will decrease risky sexual behaviour in adolescents. First, implement programs that have been effective with similar populations. Second, select or design interventions of programs

that have been effective with similar populations. Third, complete the following five activities that were evident in the most effective programs: (a) include individuals and groups with expertise in different aspects of the design of the program; (b) assess the adolescent population being targeted with respect to their specific assets and needs; (c) use a logic model approach to learning; (d) ensure activities that are designed are consistent with community values and resources; and, (e) test the program with pilot projects.

Many of the results that were found with the *Emerging Answers 2007* by Kirby (2007a) were also found in another review carried out by Kirby (2007b). This review was carried out with 83 studies that measured the impact of curriculum-based sex and HIV education programs for youth under 25 years of age in both developed and developing countries around the world. Two thirds of the programs significantly improved one or more sexual behaviours with many delaying or reducing sexual activity or increasing the use of condoms and/or contraceptives. However, Kirby (2007b) reported that many of the studies had significant limitations. Some of the limitations that were identified include: (a) few described the programs adequately; (b) some had problems with implementation; (c) a few had weak quasi-experimental designs; (d) most did not test for multiple tests of significance; (e) some had measurement problems; (f) many were statistically underpowered; and, (g) few measured the impact on STIs and pregnancy rates.

Despite the limitations of the research, Kirby (2007b) identified characteristics that may have contributed to the effectiveness of the more successful programs. These characteristics were divided into three categories: the development of the curricula, the overall design of the program, and the implementation of the curricula. With respect to the programmatic conclusions, Kirby has recognized several important strategies including assessing the relevant needs and assets of

the target population, providing educational programs within more comprehensive community initiatives, and designing programs that are consistent with community values.

Challenges to overcome with respect to interventions. Upon review of the studies, presented there is a recurring theme that there is a need for the completion of more rigorous studies. This theme was further reinforced in an article by Shoveller and Pietersma (2002) in which the purpose of the article was to evaluate the quality of published studies in North America that were focused on behaviour changes of 12-24 year olds to prevent HIV/AIDS. The authors concluded that of the 20 eligible studies, ten studies were rated as strong, six were rated as moderate and four were rated as weak. They further concluded that “the quality of intervention evaluations related HIV/AIDS prevention among young people appears to be improving, although recruitment of probability samples, use of standardized outcomes, and attrition rates remain as challenges” (p.123). They also identified the need for consistency for the measurement of behavioural outcomes.

This need for measurement consistency of behavioural outcomes was also identified in other studies. For example, Fishbein and Pequegnat (2000) recognized that behavioural and biological measures are important outcomes for studying the efficacy and effectiveness of behaviour change interventions but they cannot be substituted for one another and they cannot be truly representative for HIV/STI prevalence or incidence. They advocate for a better understanding of the relationship among STIs, HIV and self-reported condom use as well as identifying more precise methods of measuring correct and consistent condom use. This is significant as the ultimate goal of a behavioural intervention is to prevent the spread of HIV and STIs and it is not always feasible to obtain these physiological measurements. We often rely on the validity of behavioural reports which can be inaccurate and inconsistent. The various methods used to

evaluate condom use may mean different things with respect to the possibility to spread STI's. Condom use is often reported with respect to how many times a condom is used during a specified period of time and the reported number of sexual encounters. However, these results will vary depending on the time frame, the number of partners, type of partner and type of sexual activity. Using a condom 90% of the time means something very different for someone who has sexual intercourse 10 times in the time period assessed as opposed to someone who has sexual intercourse 1000 times. Other questions also arise regarding the technique with which the condom was used, the consistency of use, the number of sexual partners, the population being evaluated, the presence of STIs within that population, and the truthfulness of the report. All of these factors will impact on the degree to which STIs can be transmitted.

Noar (2008) reinforced concerns regarding behavioural interventions to reduce HIV related sexual risk behaviour. The purpose of the study “was to synthesize what is known about such interventions by systematically reviewing and synthesizing extant meta-analyses of the literature” (p. 335). Of the 18 met-analyses that were analyzed, it was concluded that the behavioural interventions were efficacious. Being efficacious, however, is very different from being effective. The studies were efficacious in “increasing condom use, reducing unprotected sex, and reducing STI incidence and perhaps HIV” (p. 353). However, strict interventions were applied in ideal conditions with plenty of resources so Noar questions the actual effectiveness of such programs in the “real world”. He specifically advocates for more “effectiveness trials of interventions that have demonstrated high efficacy and are targeted to key at-risk populations” (p. 351). He recommends further research regarding the translation of evidence-based interventions to increase the ability of the interventions to be adaptable to local circumstances while maintaining the “fidelity of core elements of the programs” (p. 351). This recommendation

is consistent with what other studies have recommended regarding the need to adhere to the values of communities and the need to assess the specific assets and needs of the adolescent population being targeted when designing effective programs.

Shoveller et al. (2004) further challenge the traditional approaches to understanding the sexual behaviour of youth. They recognize that having this traditional epidemiological approach of focusing exclusively on reducing adolescent risky sexual behaviour “enhances the likelihood that our understanding” of adolescent risky sexual behaviour is “denuded of social meaning” (p. 474). According to Williams (2003), “risk factor epidemiology tends to assume a freedom to make healthy choices that is out of line with what many lay people experience as real possibilities in their lives” (p. 147 as cited in Shoveller et al., p.474). Shoveller et al., suggest we move away from this epidemiological approach towards a more socio-ecological one to better understand the relationship of the sexual behaviour of youth within their social context. This is a recognized approach (Frohlich et al., 2002; Pavis, Cunningham-Burley, & Amos, 1998).

This socio-ecological approach was assessed in a study carried out by Shoveller et al. (2006). They “assessed the degree to which socio-ecological approaches were integrated into empirical research regarding interventions to prevent sexually transmitted infections among adolescents” (Shoveller et al., p.163). They reported that most of the interventions targeted at adolescent risk behaviour failed to “yield encouraging results in terms of behaviour change or reducing disease burden in this population” (Shoveller et al., p.163). Additionally, they reported that most studies focused on individual knowledge and attitudes (micro-level issues), some studies addressed the impact of relationships with groups (meso-level issues) and no studies addressed socio-cultural influences (macro-level issues). They strongly advocated for more research regarding socio-ecological approaches but recognized that socio-ecological approaches are not new to health

promotion (McLeroy et al., 1988; Green, Richard, & Potvin, 1996). According to Bay-Cheng (2003), “the assumptions of traditional approaches need to be unpacked in terms of the suppositions about gender, sexuality, class and race that are embedded in most STI prevention interventions” (Shoveller et al., p. 174). To better understand the socio-ecological approach to promotion of healthy sexuality of youth, Shoveller et al. recommend that as the complexities of socio-ecological theory involve a multi-component approach new methods of research must be developed. This is especially true with respect to the meso-level and macro-level issues. Meso-level issues examine the relationships that exist among groups to affect the risk taking behaviour of adolescents (peers, parent etc.), while macro level issues involve the socio-cultural systemic and policy level influences. The micro-level issues are an important component of promotion of healthy sexuality of adolescents as they examine “the individual characteristics, activities, roles and interpersonal relationships in a given setting” (Shoveller et al., p.165) which have been addressed in the primary prevention interventions with respect to the traditional epidemiological approach. Developing socio-ecological approaches requires input from youth regarding the everyday experiences of their lives that shape their sexual development and behaviour.

Upon review of the discussions regarding the interventions designed to have a positive impact on adolescent sexual health and the challenges associated with these interventions, it is clear that there is need for a greater understanding of the context of the lives of youth. It has been established that this greater understanding will have a much more positive impact on the sexual health of adolescents. The next few sections of this review will address both the need to include youth and the need to better understand the broader context of adolescents’ lived experiences.

Youth Participation

Upon review of many of the studies described above, it is evident that the need to include youth in the promotion of healthy sexuality is garnering an increased profile in research. Most experts and organizations active in the promotion of healthy sexuality of adolescents recognize that “involving youth in program decisions and operations is fundamental to sound programming” (Koontz & Conly, 1994; Marie Stopes International, 1995; McCauley, & Salter, 1995; Weiss, Whelan, & Gupta, 1996; Unicef, 1996 as cited in Senderowitz, 1998, p.7). The need to include youth was also suggested with several of the studies discussed earlier as it enables interventions to be developed that better suit the adolescent populations that are being addressed and therefore increases the probability of compliance and ultimately, success (DiCenso, 1995 as cited in DiCenso & Dover, 2000; DiCenso et al., 2002; Kirby, 2007a; Langille et al. 2004; Langille et al. 2010; Noar, 2008; Scher et al., 2006; Shoveller et al., 2004; Shoveller et al., 2006). Many organizations, such as International Planned Parenthood Federation (IPPF), United Nations Children’s Fund, United Nations Population Fund and WHO have identified that including youth in this manner is an essential guiding principle (Senderowitz, 1998). For example, the IPPF Task Force on Youth advocates that youth be actively involved in a meaningful way as opposed to mere tokenism (IPPF, 1995). The WHO strongly urges the inclusion of youth as “youth involvement ensures project relevance, acceptability, dedication to project objectives, long term effectiveness, and personal development of young participants” (WHO, 1997; WHO/UNFPA/UNICEF, 1995 as cited in Senderowitz, 1998, p. 7). The International Justice Network Convention on the Rights of The Child emphasizes a child’s “right to be consulted and have his or her views taken into account in decision making” (Campbell & Aggleton, 1999, p.255). The Ottawa Charter for Health Promotion and the Jakarta

Principles also reinforce how essential it is to ensure community consultation and participation “to meet the needs of the user’s rather than the demands of bureaucracy or the convenience of health professionals” (Campbell & Aggleton, p.256). The necessity of ensuring community consultation and participation is beginning to be acknowledged in the promotion of sexuality of adolescents programs and research. Researchers have recognized the need for input from adolescents in research and program design (Maticka- Tindale, 2001; Milburn, 1995). However, much of the participation of youth is to inform those involved with program development with the direct involvement of adolescents in actual program planning being rare (Hampton, Fahlman, Goertzen, & Jeffrey, 2005). However, youth have become involved in peer education where their role involved the delivery of the program as opposed to its development. This peer education was developed as a means to promote the perspectives of adolescents regarding the consequences of participating in risky sexual behaviour (WHO, 1991). The advantage of involving adolescents to lead the discussions was that they could relate better with other adolescents about the dangers of risky sexual behaviour. These peer- based strategies “helped to shape messages that were designed for young people and others who were in touch with (and identified with) youths’ popular culture” (Shoveller & Johnson, 2006, p.52). This approach, however, was not considered to be as empowering as it was intended with some people identifying it was representative of only “token” participation of youth as the content was developed by adults. With that said, however, it is important to acknowledge that evaluation of these peer-led programs reflected that they are equally as effective as adult-led programs (Dunn, Ross, Caines, & Howorth, 1998; Jemmott, & Jemmott, 2000).

Besides peer education, youth are also becoming involved in the development of the programs but under the direction of adults. Some of these programs include: the *Raising the Roof*

program in Cape Breton, Nova Scotia (Cape Breton Wellness Centre, 1999). However, some programs are trying to include youth to a greater degree such as *The Youth Educating About Health* program which was directly designed and implemented by youth in Saskatchewan (Hampton et al., 2005). Sexual health programs involving youth in this way are becoming popular. Recently a youth- centered approach was applied with Nova Scotia youth with respect to the development of the *Framework for Action: Youth Sexual Health*. In the development of this program youth were included in the discussions and decisions that were made. It is also expected that they continue to participate in programs across the province with respect to the decisions being made for program development.

Perceptions of youth regarding barriers and facilitators. Including youth, as discussed earlier in this review, is an important component of program development so as to develop more successful adolescent sexual health programs. There have been a number of studies that have been assessing the perceptions of youth regarding the barriers and facilitators of their healthy sexual development. It is becoming more recognized that adolescent perceptions of what is needed to promote health is a valuable component of program planning. The Canadian Association of Adolescent Health carried out a national survey with online interviews with respect to better understanding 14-17 year olds' perceptions of barriers to sexual education and services. A number of obstacles and gaps were identified. It was reported that although 79% of these youth obtain sexual education within the school programs only 23% report that it is useful. Gaps identified by 69% of adolescents were a lack of education regarding violence in relationships, date rape, communication issues and how to deal with emotions. There were also barriers identified with respect to accessing health services. About 62% of these adolescents identified barriers such as being uncomfortable talking or learning about sexuality issues (31%)

and fearing that parents will find out they are seeking sexual health information 20%) (Canadian Association of Adolescent Health, 2006).

Another national survey, the *Canadian Youth, Sexual Health and HIV/AIDS Study* (2003) surveyed students in grades 7, 9, and 11 from all provinces and territories by using questionnaires with mostly closed ended questions (Boyce et al., 2003). The questionnaire was based on three components: psycho-social-environmental health determinants, sexuality variables, and, sexual health. Some of the barriers that were identified with respect to sexual health education and services were of concern. For example only 17% of girls reported that they would go to their family physician if they thought they had an STI. Less than 3% of girls and 1% of boys were assessed for STI's within the last 12 months. Furthermore, some adolescents did not know where to go to obtain condoms (12% of boys and 16% of girls in Grade 11). With respect to education, many of the students disturbingly reported that they had not received any instruction about HIV/AIDS over the last two years (27% of Grade 7 students; 14% of Grade 9 and 11 students). Also of significance is that some of the students reported that they did not receive any information in school regarding sexuality (17% of Grade 7 students; 8% of Grade 9 students; and, 11% of grade 11 students).

Besides these national surveys there have also been some regional studies that were carried out to better understand adolescents' perceptions of sexual education and services. For example DiCenso et al., (2001) carried out a study in Ontario to learn about the perceptions of adolescents regarding sexual health education and services. The study was a qualitative one in which the data was gathered by using focus groups of male and female students in grade 9 and 11 in both rural and urban high schools in the Haldimand- Norfolk and Niagara regions. The adolescents reported that there was too much emphasis on the "plumbing" and it was often provided by teachers who

were obviously uncomfortable with teaching about sexuality. They also identified suggestions for improvement of education by adding the following topics: “ how STIs are transmitted and prevented, accurate information about AIDS, sexual activity options other than abstinence and intercourse, pregnancy and birth control options, emotional aspects of sexuality, relationship issues, communication with partners, and gender differences” (DiCenso et al., p. 37). They identified traits in educators that they believed to be effective: dynamic, non-judgmental, relaxed, and humorous. They also identified the need to better inform adolescents about the availability of sexual health services and to improve the times with which the services were accessible.

The findings of this study were compatible with another qualitative study carried out by Planned Parenthood Nova Scotia (1996), *Just Loosen Up and Start Talking*, in which 17 youth were trained to carry out 220 face-to-face interviews following a prescribed set of questions to youth aged 14-24 years of age from diverse population. The study identified barriers including: (a) limited availability of services, (b) lack of confidentiality; lack of privacy; (c) teachers being overly judgmental, negative, and (d) often uncomfortable with the subject matter; and, (e) information being too narrow in focus. Some of the suggestions made by these students included: (a) making the courses more comprehensive; (b) providing better training to teachers to improve their comfort; (c) providing education sooner; (d) use more stimulating complete and updated resources; and, (e) providing more thorough information about preventing STIs. Some of the suggestions for improvement of services included: (a) improving accessibility and confidentiality of services; (b) normalizing sexuality to eliminate it as a source of shame; and, (c) recognizing that adolescents can be sexually active and address it as such (Planned Parenthood Nova Scotia, 1996).

Langille, MacKinnon, Marshall, and Graham (2001) conducted another study in Nova Scotia. They conducted research with young women to better understand their perception of barriers to sexual health education in schools in Amherst, Nova Scotia through a qualitative descriptive inquiry with in-depth interviews which were based on interview guides. Twenty eight high school women aged 15-18 from diverse populations participated in the study. Important findings regarding the adolescents` perceptions of barriers to sexual education included: (a) teachers placed sexual education as a low priority within the school system; (b) there was a disconnect between what is taught in the schools and what the young women are experiencing in their everyday lives with respect to a temporal perspective; (c) young men in the classes is of concern as they interfered with the learning through their disruptive behaviour; (d) teachers were often uncomfortable with the content; and, (e) some teachers were judgmental.

Yet another project that was conducted in Nova Scotia was *Raising the Roof* that was completed by the Cape Breton Wellness Centre (1999). During the needs assessment phase of this project, which was carried out at the Whitney Pier Youth Club in Sydney, Nova Scotia, a group of 20-35 adolescents between the ages of 14 to 18 were consulted through informal meetings. Participants identified the following barriers to sexual health: (a) lack of finances interfered with the adolescents purchasing condoms; (b) lack of privacy also interfered with purchasing condoms; (c) having no booked appointments in the community medical clinic forced adolescents to wait in a waiting room which they vocalized as interfering with their privacy; and, (d) lack of knowledge regarding available sexual health services.

In PEI, where this study took place, there was one survey that was completed that identified the perceptions of youth regarding barriers to sexual health education and services. This project was conducted by the PEI Caucus on Youth Sexual Health and was completed in 2005. During

this project 150 youth (aged 13-21) were consulted through informal small group discussions or larger public health events. Within this process, information regarding the barriers to sexual health education and services were identified. The youth in this project identified the following barriers: (a) lack of identifiable sexual health resources; (b) lack of confidentiality when accessing family physicians, public health nurses and/or teachers; (c) difficulty accessing transportation to access services; (d) unclear of whether they can seek sexual advices without parental permission; (e) health services available are not accessible with their schedules; and, (f) feelings of “alienation” in the adult world interfering with seeking support.

Upon review of the sources discussed regarding youths’ perception of the facilitators and barriers to sexual health education and services, it has been identified that the styles of obtaining the information varied from formal questions developed and carried out with each participant or focus group to informal discussions with loose boundaries. The studies carried out by DiCenso et al., 2001, Langille et al., 2001, Canadian Youth, Sexual Health and HIV/AIDS Study, 2003, and the Canadian Association of Adolescent Health study, 2006 were formal academic research studies. The other projects were less structured and formal in nature. It was also noted that the study conducted by Canadian Youth, Sexual Health and HIV/AIDS Study is the only one that used a framework with which to guide the development of questions. They specifically acknowledged that the social determinants of health were of importance to adolescent sexual development and should therefore be taken into account.

These social determinants of health were also taken into account in this study to better understand adolescents’ perceptions of facilitators and barriers to sexual health education and services in PEI. According to Shoveller and Johnson (2006), “there is a paucity of research regarding the processes by which youth sexual health outcomes are shaped by social contexts

and structures” (p.56). They advocate for researchers to adopt new directions for public health research that “moves us away from risk-factored models and towards approaches that consider, respond to, and potentially transform youths’ social contexts and structures” (p.56). According to MacIntyre & Ellaway, 2000 “considerable theoretical and empirical work needs to be conducted in order to come to terms with the ‘upstream’ structural-level forces” (as cited in Shoveller et al., 2006, p.174).

Social Determinants of Health

In 1999, the *Report from Consultations on a Framework for Sexual and Reproductive Health*, which was developed by Health Canada, recognized the need for the integration of these social determinants of health in the promotion of healthy sexuality programs and services. This framework was developed in collaboration with other federal departments, provincial and territorial governments and national and non-governmental organizations in an effort to establish strategic directions for the maintenance, protection and promotion of sexual reproductive health in Canada. The document developed goals to address the social determinants of sexual and reproductive health (SRH), however, the initiatives that were called for were never developed and a national strategy to address SRH was never developed (Canadian Federation for Sexual Health, 2007).

The social determinants of SRH that were developed in this framework were adapted by the document *Strategies for Population Health: Investing in the Health of Canadians* (1994). These social determinants include: (a) social and economic environment (including income, social status, social supports, education, employment and working conditions); (b) physical environment (including natural and human built environments); (c) individual capacities, coping skills, and health practices (including health choices, psychological attributes, biological

characteristics); and, (d) health services. This framework also acknowledges gender and culture as important social determinants of health; these are not usually identified as specific social determinants of health. For the purpose of this study, all of the social determinants that have been recognized in the framework will be integrated into the research process.

Although Canada has not been successful in developing a national strategy with which to integrate the social determinants of health into sexual health services, education and support programs, there has been an acknowledgement of its importance in recent research, as discussed earlier. There has also been an increasing body of literature with respect to how these social determinants impact on adolescents' sexual health. A number of these recent studies will be addressed in the context of specific social determinants of health.

For example, a systematic review was carried out by Marston and King (2006) in which 268 qualitative studies were evaluated to identify key themes with respect to social and cultural forces that shape adolescent sexual behaviour. Seven key themes were identified. First, adolescents assess potential partners as being 'clean' or 'unclean' with respect to the risk of getting a disease. Second, adolescent sexual activity is influenced by their partners as a way to keep a boyfriend, or to avoid violence, for example. Third, the use of condoms can be associated with a lack of trust and stigmatization and therefore interferes with the actual use of condoms. Fourth, prevailing gender stereotyping is integral in the determination of social expectations and behaviour. Fifth, there are penalties and rewards within the broader social context for participating in sexual activity. Sixth, reputations and displays of sexual activity or inactivity influence adolescent sexual activity. Finally, social expectations interfere with open communication about sexual activity. Researchers concluded that understanding the broader context of the "why" of adolescent sexual behaviour can better inform policy makers when

designing sexual health programs. Marston and King also identify that the “challenge now is to design locally tailored programs that take seven themes into account and address the important factors for each setting” (p. 1584). They also suggest that there is a need for future research with which to broaden this understanding of adolescent sexual behaviour.

Another systematic review conducted by Gerressu and Stephenson (2008) addressed the impact of gender on sexual behaviour. The purpose of this review was to analyze research findings from 2006-2007 regarding adolescent sexual health behaviour. This study reported that “powerful and consistent forces sustain gender differences in sexual behaviour” (p. 37) and these differences should be taken into account when designing sexual health programs.

Gahagan, Rehman, Barbour and McWilliam (2007) also acknowledged the need to integrate gender differences when providing programs and education to adolescents regarding the promotion of healthy sexuality. This study revealed that “heterosexual males remain glaringly absent from HIV prevention programming in Nova Scotia” (p. 136). These results were determined from six focus groups that were carried out with 50 heterosexual males aged 15-23 years of age. The focus groups were conducted in both rural and urban communities throughout Nova Scotia. A number of themes have emerged from this study to identify the current disconnect between the actual sexual health education and the needs of these heterosexual males: (a) perceptions of males as knowledgeable about sex; (b) peer norms; (c) structural and attitudinal barriers to accessing information; and, (d) confidentiality. This study advocated that programs directed at preventing HIV and healthy sexuality must take into account “how male sexuality is socially constructed, regulated, and enforced through practices such as gender-based sexual risk taking behaviours and the sexual double standard” (p. 150).

Buhi and Goodson (2005) acknowledged the significance of the context of adolescents being predictive of sexual activity. In the systematic review, these researchers synthesized quantitative studies published 1996-2005 to examine predictors of initiation of adolescent sexual behaviour. In the 69 studies that were reviewed, three themes emerged as stable predictors of sexual behaviour: intention to have sex (or conversely intention to remain abstinent), perceived norms, and time home alone (p. 18). The researchers therefore advocated for program interventions to target these three variables to promote healthy sexuality.

Huebner and Howell (2003) examined the influence of adolescents' context on predicting sexual behaviour. Specifically, this study examined the relationship between adolescent risky sexual behaviour and adolescents' perceptions of parental monitoring, parent-adolescent communication, and parenting styles. This was a quantitative study in which surveys were collected from 2701 adolescents from grade 7 through 12 in rural communities in a Southeastern state. They concluded that adolescents' perception of parental monitoring, parent-adolescent communication and parenting styles were all important variables to consider when addressing adolescent sexual behaviour.

Other studies have also reinforced that social determinants of health do influence adolescent sexual activity. For example, a study carried out by Cowley (2001), recognized that adolescent female attitudes towards pregnancy are influenced by what the boyfriend wants. In this study a total of 202 girls aged 13-18 years were interviewed about their desire for pregnancy. It was found that the girls who were unsure about their desires were not different from the girls who desired pregnancy. Specifically, it was found that the best predictor of adolescent females' attitudes toward pregnancy was the perception that the boyfriend had towards pregnancy because this perception influenced the female adolescent if they were ambivalent about pregnancy.

Therefore, it was concluded that those adolescents who were ambivalent about pregnancy should be considered just as high risk as those who desire to be pregnant.

The contexts of the environment with which adolescents are seeking health care are important factors to consider. For example, a study carried out by Ford, Millstein, Halpern-Felsher and Irwin (1997) revealed that adolescents are more willing to disclose information and seek health care from physicians who assure confidentiality. This study was conducted with 562 students with a mean age of 14.9 years. It was also concluded from this study that further investigation is required to identify legal issues in this area so as not to deter adolescents from seeking assistance.

Summary of Issues and Gaps in the Literature

This discussion of literature has explored the factors influencing the promotion of healthy sexuality of adolescents, adolescent sexual activity, interventions designed to have an impact on sexual health, youth participation in sexual health programs, and the social determinants of health. What is apparent from the literature reviewed is that there needs to be more research conducted on the perceptions of adolescents regarding the facilitators and barriers towards the promotion of the healthy sexuality of youth within a socio-ecological framework.

To summarize, while there have been improvements with respect to adolescent sexual health behaviour there are concerns including adolescents' limited knowledge of sexual health issues and high rates of STI's. It has also been quite evident that within PEI there are limited resources with respect to the promotion of the healthy sexuality of adolescents. There is also limited accessibility to up-to-date information on prevention and behavioural skills approaches consistent with the *Canadian Guidelines for Sexual health Education* and there is a lack of consistency regarding what is actually taught in the classrooms in PEI.

Upon review of the interventions designed to have an impact on sexual health, it was identified that many of the programs are ineffective. Most behavioural research in this area has been focused on describing relationships with individual characteristics of the adolescent and potentially modifiable factors such as knowledge, attitudes, and behaviour. Many of the studies reviewed identified areas for future development including the need to: (a) include youth in program development, (b) ensure programs are supported within the community, (c) examine the social determinants of health when addressing factors that lead to risky sexual behaviour, (d) improve methodological rigor of studies evaluating the effectiveness of programs, (e) increase research of the effectiveness of multi-component programs, and, (f) implement programs that have been proven to be effective with similar populations.

Furthermore, according to Shoveller et al. (2004), there is a need to challenge the traditional approach of understanding the sexual behaviour of adolescents. As discussed earlier in the chapter, the traditional epidemiological approach of focusing exclusively on reducing adolescent sexual activity, assumes that adolescents have the options to make healthy choices. Shoveller et al. suggests that we move away from this epidemiological approach towards a more socio-ecological one to better understand the relationship of the behaviour of adolescents within their social context. Additionally, in a study carried out by Shoveller et al. (2006), upon assessing the degree with which socio-ecological approaches were integrated into empirical research, it was revealed that most studies focused on micro-level issues being focused on individual knowledge and attitudes while some studies addressed the impact of relationships with groups (meso-level issues) and no studies addressed socio-cultural influences. Therefore, they strongly advocated for the need for more research regarding socio-ecological approaches.

Within the development of this socio-ecological approach there is a need to include adolescents and to explore the everyday experiences of their lives that shape their sexual development. Most experts and organizations active in the promotion of healthy sexuality of adolescents recognize that involving youth is necessary to sound program development. This is a concept that is beginning to be recognized in adolescent programs.

There has been an increasing body of literature that explores how the specific social determinants of health impact on adolescents' sexual health. However little is known about the social contexts and structures that shape adolescent sexual health. This literature review has provided extensive rationale to support this study which is focused on identifying adolescents' perceptions of the facilitators and barriers towards the promotion of the healthy sexuality of adolescents living in PEI. In the following chapter, the methods used to conduct this study are discussed

Chapter Three: Methodology and Method

The purpose of this chapter is to describe the qualitative descriptive methodology used in this exploratory study informed by a CST perspective and a socio-ecological model. Methodology is defined as “a theory and analysis of how research does or should proceed” (Harding, 1987, p.2). According to Allen, Benner and Diekelmann (1986), for a study to successfully address its research question it must be grounded within a methodological approach. This methodological approach is integral to “best research practice” when selecting the method with which to carry out the research (Maggs-Rapport, 2001). Methods in turn can be defined as “a technique for (or way of proceeding in) gathering evidence” (Harding, 1987, p.2). According to Harding (1987), all methods fall into one of three categories: a) listening to informants; b) observing behaviour; or, c) examining historical traces and records. The qualitative descriptive approach, CST, and the socio-ecological framework will be discussed as well as study setting, participation selection, data collection procedures, data analysis, establishing trustworthiness and rigor, and ethical considerations.

Qualitative Descriptive Methodology

According to Sandelowski (2000) a qualitative descriptive design is an appropriate approach when “straight descriptions of phenomena” (p. 339) are the focus of research. This approach will enable researchers to be “close to their data and to the surface of words and events” (p. 334) to develop a comprehensive summary of events in the everyday lives of the participants. It is one that recognizes that there are multiple interpretations of reality embedded in the contextualized lives of the participants (Polit & Beck, 2008). This qualitative design was chosen to explore the field and gain a reasonable coverage of the adolescents’ perceptions of the facilitators and barriers to the promotion of healthy sexuality of adolescents living in PEI. The approach is

enhanced with a CST empowerment perspective that allows the researcher to explore the participants perceptions within a sociopolitical perspective.

Critical Social Theory

There are a number of paradigms or worldviews that have influenced the development of knowledge. The emancipatory paradigm, CST, has been identified as an appropriate approach to inform this study to explore the lived experiences of adolescents. As CST is being increasingly recognized by researchers with respect to addressing the social, political, economic, and historical conditions in which one lives, it is one that was beneficial in exploring adolescents' perceptions of the facilitators and barriers that promote healthy sexuality of adolescents within a socio-ecological framework. A number of researchers have identified this theory as being a "valuable lens for viewing phenomena within their sociopolitical contexts" (Ekstrom & Sigurdsson, 2002, p. 289). According to Forbes et al. (1999), "authors in nursing, such as Wuest (1997), Rafael (1996), Drevdahl, (1995), Stevens, (1992), Butterfield (1990), and Allen (1985) advocate for the "application of critical approaches to reveal and examine the socio-environmental conditions which contribute to lifestyle behaviours, recognizing the interplay between individual choice and available options" (p. 375).

Relevance of critical social theory. CST is a "theory which builds upon our understandings of sociopolitical systems and oppression" (Pearrow, 2008, p. 509) and "advocates for a type of consciousness that regards how these structures operate to oppress some members of society while systematically privileging others" (Mohammed, 2006, p. 68). It is being increasingly recognized as a methodology that can inform research that is carried out to better understand the basic causes of social injustices and disparities in health. It can be used as a methodology in research to guide the "identification of environmental conditions that constrain health and those

that potentiate health” to move towards “human liberation from oppressive constraints that inhibit health and human potential” (p. 66). It is also consistent with a socio-ecological framework.

For example, Mohammed (2006) advocated for the use of CST as a framework to explore “the fundamental causes of health disparities and social justices” (p. 70). She specifically referred to a research project which successfully implemented CST as the framework to inform her unpublished dissertation in 2004. Mohammed acknowledged that she used CST in this dissertation to explore how “urban American Indians described diabetes” (p. 69). This study revealed that the participants’ descriptions of diabetes “went beyond the biomedical model to define diabetes and demonstrated how systematic racism and economic oppression affected their access to healthcare services and their ability to manage diabetes” (p. 69), which ultimately affected their health status.

Dickinson (1999) also advocated for the use of CST, specifically for adolescents with diabetes, as healthcare can often be delivered in a paternalistic manner, particularly to adolescents. She suggested that by using CST as a framework to work with adolescents, healthcare workers can move away from being the experts and making judgments about such concepts as compliance towards enabling and empowering the adolescents so that “they can determine what works and what doesn’t” (p. 151). Such a strategy will promote positive relationships that will “result in happier adolescents and ultimately healthier adults with diabetes” (p. 151).

Other authors have also used CST for the promotion of health of adolescents. Jennings, Parra-Medina, Messias and McLoughlin (2006) presented an article with their purpose being to “contribute toward the development of a critical social theory of youth empowerment” (p. 32).

They used CST to synthesize the analysis of four youth empowerment models and findings from a participatory study to identify six key dimensions of critical youth empowerment. These dimensions include: (a) a welcoming and safe environment; (b) meaningful participation; (c) equitable power-sharing between youth and adults; (d) engagement in critical reflection on interpersonal and sociopolitical processes; (e) participation in sociopolitical processes to affect change; and, (f) integrated individual and community level empowerment (p. 41). These dimensions have been further recognized by Pearrow (2008) as a framework to provide a lens with which to analyse the Teen Empowerment Program, as implemented with high-risk youths in urban communities. This research, carried out by Pearrow, resulted in the creation of a model for “how to critically examine youth empowerment programs using this framework” (p. 510).

Adolescents living in oppressive circumstances. As discussed above, the application of CST is relevant to be used with adolescents for the promotion of health. It can also be considered to be quite relevant to this specific adolescent population as adolescents are often referred to as a vulnerable group that are subject to oppressive circumstances. As CST is an emancipatory paradigm, it can prove to be quite beneficial towards enabling and empowering the voices of this vulnerable group to be heard. As oppression is defined as one group exerting power over another group, oppression of adolescents is evident in our society as it is acceptable for adults to exert power over adolescents. The term adultism is a recent concept which refers to “behaviours and attitudes based on the assumption that adults are better than young people, and entitled to act upon young people without their agreement” and is “reinforced by social, institutions, laws, customs, and attitudes” (Bell, 2000). It is a concept that can be considered to be equally as negative as concepts such as sexism and racism, yet, it is not as widely recognized and is more accurately identified as the “overlooked-ism” (Tate & Copas, 2003, p. 41). It can be

characterized by the “disrespect the adult world shows toward the intelligence, needs and potential of children” and therefore adults “unwittingly impede the growth and development of children by excluding them from opportunities to develop creative solutions to the issues that influence their lives” (Tate & Copas, p. 41).

Oppression of adolescents is evident with respect to the promotion of healthy sexuality of adolescents. This was clearly evident in the discussion regarding youth participation in the literature review chapter. Although most experts and organizations active in the promotion of healthy sexuality of adolescents recognize that “involving youth in program decisions and operations is fundamental to sound programming” (Senderowitz, 1998, p.7) it is rarely seen (Hampton, Fahlman, Goertzen, & Jeffrey, 2005). Including youth enables interventions to be developed that better suit the adolescent populations that are being addressed and therefore increases the probability of success (DiCenso, 1995 as cited in DiCenso & Van Dover, 2000; DiCenso et al., 2002; Kirby, 2007a; Langille et al., 2010; Scher et al., 2006; Shoveller et al., 2004; Shoveller et al., 2006). Historically the programs and support that have been developed have been based on what adults have considered to be relevant to the promotion of healthy sexuality of youth. However, as discussed in the literature review chapter, there has been some involvement of youth with respect to peer education and seeking input from adolescents regarding adult- led programs but this involvement has often been speculated as being mere tokenism.

Overview of critical social theory. Critical social theory originated in the Frankfurt School in Germany in the 1920s and 1930s. It started with the establishment of the Institute for Social Research as left wing intellectuals felt a need to reappraise Marxist theory and move the notion of domination and oppression beyond economic and class struggle (Kim & Holter, 1995). Under

Max Horkheimer's influence, the Institute developed as a program of interdisciplinary research involving the disciplines of philosophy, sociology, economics, history, and psychology. The other critical theorists included Theodor Adorno, Frederick Pollock, Erich Fromm, Franz Neumann, Herbert Marcuse, and Leo Lewenthal. Their basic belief was that a social phenomena is understood only as it relates to its historical and structural context within which it is situated. Horkheimer (1972) summarized the process of CST to include exposing the dominating system that prevails in society, identifying contradictions that are integrated in the domination, assessing society's capacity for emancipatory change, and criticizing the dominating system within society to create change (Kim & Holter, 1995).

In the late 1960s CST was rejuvenated by a second generation of German theorists with Jurgen Habermas being the most prominent and prolific. Habermas was responsible for emphasizing the importance of communication as well as the coordination of social action (Stevens, 1989). His primary task was to understand how people communicated in order to uncover the "distortions and constraints that impede uncoerced participation in society" (Stevens, 1989, p. 58).

Although CST has gained recognition, it is not considered to be a single theory. According to Stevens (1992), overarching critical theories have evolved which include many perspectives such as the German Frankfurt School, feminist theory, American liberation scholarship involving scholars, such as Paulo Friere, and lesbian and gay liberation studies.

Over the past 20 years there has been an increased interest in CST amongst nursing scholars as they question the validity of the development of knowledge being based primarily in empiricism. As a result, nursing scholars have begun to include an epistemological shift "from the act of knowing to the social world" to recognizing that "critical theory discloses the coercive

and repressive aspects of the circumstances and then asks the question: How has this come about?" (Marcellus, 2003, p. 442). By using CST, one is able to look past existing ideologies toward meaningful analysis which leads to the creation of knowledge that can ultimately be used to improve lives. With respect to this study, I am most interested in the creation of knowledge that can be used to promote the healthy sexuality of adolescents.

For the purposes of this study, I drew primarily on Habermas' CST to inform the research as I specifically adhered to the basic assumptions and central tenets which were outlined by Browne (2000). These assumptions and central tenets include:

(a) there is no ahistorical, value neutral, or foundational knowledge that can be known outside of human consciousness; (b) all knowledge is fundamentally mediated by socially and historically mediated power relations; (c) every form of social order entails some form of domination and power; (d) language is central to the creation of knowledge and formation of meaning; (e) mainstream research generally maintains and reproduces (albeit unwittingly) systems of race, class, and gender oppression; (f) facts (or "truth claims") can never be separated from the domain of values or forms of ideological inscriptions; (g) by explaining and critiquing the social order, critical social science serves as a catalyst for enlightenment, empowerment, emancipation, and social transformation; and, (h) critically oriented knowledge should offer social or cultural critiques with a view to transforming normative foundations that maintain the status quo (Browne, 2000, p. 39).

Integrated within these tenets is the awareness of the pervasiveness of the power hierarchies that exist in society with the ultimate goal of CST being to facilitate change that seeks liberation from

constraints and domination which arise from social, political, economic, and ideologic circumstances (Stevens, 1989).

These basic assumptions directly influence the knowledge that is created in research informed by CST as do the philosophical underpinnings regarding the ontology and the epistemology of CST. The ontology is concerned with understanding existence, the nature of being, and the structures of reality while the epistemology is defined as claims about who is the knower, what constitutes legitimate knowledge, what can be known, and what are the legitimate ways of knowing (Harding, 1987).

Ontology. According to Habermas (1971), individuals who are oppressed within a society have a conscious and subconscious awareness of their reality. This is referred to as a “false consciousness”. It is through this process of reflection, critique and dialogue, as discussed earlier, that the oppressed become aware of their true existence. This awareness of their true existence is what is referred to as being “conscientized”. Once conscientized, an individual is able to create possibilities.

According to Morrow and Brown (1994), the ontology of CST is one of critical realism. This is a philosophical stance that “rejects the basic polarization between positivism and post modern relativism” (p.71). Positivism, being empirical, reflects a realist ontological position with a single objective reality which exists outside of our consciousness. On the other hand, the post modern relativism ontology acknowledges the existence of multiple realities that are equally relevant being based on inter-subjective understandings. The critical realist ontology that is characteristic of CST goes beyond the objective and subjective realities to a “dialectical relationship between the two philosophical traditions in an effort to address and alter relations of power that shape social reality” (Browne, 2000, p. 41).

Epistemology. Habermas (1971) places CST within a framework of scientific knowledge. He claims that there are three types of knowledge: technical, practical, and emancipatory. Technical knowledge focuses on technical control of the environment with an emphasis on practical reasoning and objectivity, placing it within the empirical-analytical sciences. Practical knowledge focuses on understanding an individual's subjective experiences with an emphasis on reflective judgment and interpretation, placing it within the historical-hermeneutic sciences. The emancipatory knowledge focuses on liberating individuals from constraints and domination, with an emphasis on critique and self-reflection for mutual understanding, placing it within CST.

Habermas acknowledges the value of these three different epistemological traditions. He considers that both the empirical-analytical and the historical-hermeneutical epistemologies are necessary but not sufficient to completely comprehend social phenomena (Kim & Holter, 1995). He demands that "they realign their self perceptions in relation to each other and to critique domination" (Stevens, 1989). He views the empirical-analytical as developing knowledge that is objective in nature while that of the historical-hermeneutical tradition is subjective in nature. Habermas (1971) further acknowledges that CST has the capacity to move beyond the subjective and objective knowledge theory in a process of reflection and critique.

According to Habermas, CST should produce emancipatory knowledge that promotes social change towards a more just society (Morrow & Brown, 1994). This knowledge is developed through the reflection and critique of social, economic, political, historical and cultural structures that produce ideologies such as sexism, racism, ageism, and classism. These ideologies serve to constrain people and interfere with their ability to develop to their full potential.

For a social critique to be truly liberating, it is essential that the hidden relations of domination and power hierarchies be revealed. According to Habermas (1979), his theory of

communicative action forms the foundation for achieving this goal through a process of enlightenment, empowerment, emancipation and social transformation (Browne, 2000). Through communication, with “language being central to the creation of knowledge and the formation of meaning”, (Browne, 2000, p. 39) CST initiates a process of self-enlightenment of socialized individuals about “what is” to “what could be”. It is also important to note that this “liberation process can be conceptualized as dialectical, in that action promotes further reflection and dialogue, which in turn generates renewed action” (Stevens, 1989, p. 60).

Application in research. When developing a discussion regarding how a philosophical orientation influences research, it is important to clarify the following terms in relation to one another: ontology, epistemology, methodology, and methods. As discussed earlier, ontology is concerned with understanding existence, the nature of being and the structure of reality while epistemology can be defined as justificatory claims about who is the knower, what constitutes legitimate knowledge, what can be known and what are the legitimate ways of knowing (Harding, 1987). It is considered to be a theory of knowledge which guides the methodology based on its particular concepts and assumptions.

According to the epistemological discussion carried out earlier, CST requires an interaction of at least two persons who seek to achieve a mutual understanding and agreement about the situation as a means to coordinate their plans of action. The purpose of the interaction is to liberate the person through a process of reflection, critique and dialogue. These epistemological statements can be used to make assumptions about the methodology which is used in CST. For instance, mutual understanding and agreement about meaning implies that the researcher and the participant form a partnership. In this partnership the researcher and the participant are considered to be of equal status and both consent to participation and are changed as a result of

the interaction. This relationship is very different from those that are established by the empirical and post modern epistemological traditions. In the empirical realm, the researcher observes the “subject” and keeps an objective distance with which to discover knowledge. In the post modern tradition, the researcher concentrates on the “informants’” personal meaning developing an inter-subjective relationship (Allen et al., 1986).

Besides having implications on the relationship established by the researcher and the participant, the epistemology also guides how knowledge is developed. In CST, knowledge is created with its creation and interpretation being grounded in language (Allen, et al., 1986). This is different from the empirical in which knowledge is discovered. Initially CST sounds similar to the subjective knowledge that is developed in the post modern tradition but it is quite different. In the post modern tradition, the researcher focuses on the participant’s personal meanings. In CST interviews occur in the form of dialogue where the researcher and the participant reflect and critique social structures to negotiate and decide on a meaning that evolves from both the researcher and the participant (Campbell & Bunting, 1991). When considering the dialectic of doing and knowing that is characteristic of the epistemology of CST, it is also important to acknowledge that knowledge created within CST research coincides with liberation (Stevens, 1989).

A number of research methods can be used to create knowledge using CST. As long as the method that is used is consistent with the concepts and assumptions of CST, it is considered to be valid. It is not the mechanical application of the method that is important but rather the use of the methodology that is consistent with the philosophy of CST (Harding, 1987). This philosophy’s aim of inquiry is to raise the consciousness of participants to become enlightened and empowered to take action towards liberation.

Upon reflection on the discussion of the ontology and the epistemology of CST, it is clearly evident that CST was an appropriate philosophy with which to inform this study. CST can serve to address the gap regarding the social determinants of health and the ideologies that interfere with the promotion of healthy sexuality of adolescents. In particular, it can be used to uncover the hidden relations that exist within the social determinants of health and how they play a role in creating the lived experiences of these adolescents.

Socio-ecological Framework

The specific framework that was used to address the social determinants of health is a socio-ecological framework. A socio-ecological approach of health promotion is one that “focuses attention on both individual and environmental factors as targets for health promotion interventions” (McLeroy, et al., p.351). It addresses “health promotion from a multi-component approach in which interventions are directed at changing the intrapersonal, interpersonal, organizational, community and public policy, factors which support and maintain unhealthy behaviours” (McLeroy et al., p.351). According to Bay-Cheng, (2003), “the assumptions of traditional approaches need to be unpacked in terms of the suppositions about gender, sexuality, class and race” that are embedded within most health promotion programs (cited in Shoveller et al., 2006, p. 174). To better understand the socio-ecological approach to promotion of healthy sexuality of youth, Shoveller et al. recommend that as the complexities of socio-ecological theory involve a multi-component approach, new methods of research must be developed. This is especially true with respect to the meso-level and macro-level issues. Meso-level issues examine the relationships that exist among groups to affect the risk taking behaviour of adolescents (peers, parent etc.) while macro level issues involve the socio-cultural, systemic, and policy level influences. The micro-level issues are an important component of promotion of healthy sexuality

of adolescents as they examine “the individual characteristics, activities, roles, and interpersonal relationships in a given setting” (Shoveller et al., p.165), which have been addressed in the primary prevention interventions with respect to the traditional epidemiological approach. Developing socio-ecological approaches require input from youth regarding their everyday experiences which shape their sexual development and behaviour.

This qualitative descriptive exploratory study was informed by CST and a socio-ecological model through qualitative methods. I ensured that it was informed by the assumptions and central tenets as outlined earlier with respect to knowledge being historical, value laden, hierarchical, and reflexive in nature with an emancipatory potential. The qualitative methods of semi-structured interviews, reflective interviewing and critical reflective journaling and field notes were used to gather data.

Study Setting

This study took place in the province of PEI, which is the smallest province in both geographic size and population in Canada. It is located in the Gulf of St. Lawrence of Canada’s East Coast and is separated from mainland Canada by the Northumberland Strait being connected to Nova Scotia through the Northumberland Ferry Limited and to New Brunswick by the Confederation Bridge. It is known for its quiet and traditional lifestyle with a strong religious foundation. It has a population of approximately 142, 266 of which 56% live in rural communities. The major industries in the province are agriculture, tourism, fishing and manufacturing with the unemployment rate being 11.1 as compared to the national unemployment rate of 6.6 (PEI Statistics Bureau Department of Finance and Municipal Affairs, 2011).

The adolescent participants were recruited from a high school located in the city of Charlottetown, the largest city in the province, (population of 58, 625) and has students from both rural and urban communities. The school has a population of about 950 students and is one of six high schools that is part of the Eastern School District (PEI Statistics Canada, 2011).

I chose to work with the Eastern School District because I was familiar with it, having worked in schools carrying out clinical instruction with third and fourth year university nursing students. I have facilitated health promotional activities on an invitational basis including group educational presentations, individual counselling, and school health fairs. Although there has been a wide range of topics that have been covered in these activities, the promotion of the healthy sexuality of youth has been one topic that was recognized as needing much more development as many of the students requested information when the nursing students carried out needs assessments in the high schools. There is no mandatory sexual health curriculum in the high schools and no specific public health nursing programming in the high schools. Public health nurses attend high schools if requested by the staff to become involved in situations such as adolescent pregnancy, STI follow up, and relationship issues, as well as other adolescent health-related issues. The public health nurses may also attend schools, if invited, to carry out presentations regarding the promotion of healthy sexuality of adolescents for the optional Family Life Course.

Participant Selection

The technique of purposeful sampling was used to recruit participants who self-selected based on their first hand knowledge and expertise with the phenomenon being studied (Patton, 2002). The purpose of this type of sampling is to select “information-rich cases whose study will illuminate the questions under study” (Patton, 2002, p.230). The objective was to access

adolescents whose experience with the promotion of healthy sexuality within PEI would provide a rich source of information for this study.

The participants were recruited to participate in semi-structured interviews to address the research questions. Specific inclusion criteria included: (a) be between the ages of 16-18; (b) be a grade 10-12 student in the high school in the Eastern School District; (c) be willing and able to sign the consent form; (d) have a signed consent form from a parent or legal guardian (if participant is under 18 years of age); (e) have a good understanding of the English language; and, (f) consent to the audio recording of the two interviews.

Recruitment of participants. Before selecting participants and gathering data, ethical approval was obtained from the Dalhousie Health Sciences Research Ethics Board (January 17, 2011). Ethical approval was also obtained from the Eastern School District within PEI (February, 9, 2011). Once the appropriate forms of approvals were obtained, a meeting was set up with the principal of the high school to discuss the study and gain approval for recruitment of students. During this meeting, a Letter of Information for the Principal and Teachers (Appendix A) was reviewed including a brief overview of the study, details about participation, the maximum number of participants required, issues of confidentiality, potential risks/benefits, and reassurance that participation was voluntary and that students could withdraw at any point prior to the completed analysis of data and, the teachers' role in the study. Time was also allotted for any questions to ensure that the principal was comfortable with providing permission for the researcher to recruit students in the high school. Copies of the Letter of Information for the Principal and Teachers (Appendix A) were also provided to the principal for distribution to the teachers whereby the teachers who were instructed by the principal to contact the researcher directly to request recruitment presentations to their classes. In a four week period 15, 10-15

minute recruitment presentations were made to grade 10, 11 and 12 classes. During each presentation, a Letter of Invitation for the Student (Appendix B) was provided to each student addressing an overview of the study, details about participation, the maximum number of participants required, issues of confidentiality, potential risks/benefits, reassurance that participation was voluntary and that students could withdraw prior to analysis of data and, students' role in the study. This Letter of Invitation for the Student was also reviewed with each class with time allotted for questions. The students were instructed to contact the researcher directly, by phone or email, if they were interested in participating in this study. The researcher's contact information was available on the Letter of Invitation to the Student.

Once contacted, the researcher set up an appointment for a face-to-face meeting with the student (and their parent if under the age of 18) at their convenience to review the study in more detail and answer all questions and complete an informed Consent Form (Appendix C). As it is a policy by the Eastern School District that all students under the age 18 are required to have parental consent to participate in research, no student under the age of 18 participated in the study if there was no written parental consent. If the student agreed to participate, and signed the Consent Form (and parent of student less than 18 years of age signed the consent form), the first appointment for the semi-structured interview was set up. Copies of the signed consent form were provided to each participant. At the beginning of the first and second interviews the Consent Form (Appendix C) was reviewed with the student again to ensure that the student had a good understanding of the study. Time was also allotted to questions that the student had.

Sample size. A descriptive exploratory qualitative research design (Sandelowski, 2000) was used. This design was appropriate to gain authentic insight into areas where there is minimal theoretical or factual knowledge (Cormack, 1996; Sandelowski). This qualitative design was

chosen in order to explore the field and gain a reasonable coverage of the perception of these adolescents with respect to their perceptions of the facilitators and barriers to the promotion of healthy sexuality of adolescents living in PEI. The ultimate goal was to select information-rich cases who would provide the information that would answer the question of this study (Patton, 2002, Sandelowski, 2000): What are adolescents' perceptions of the facilitators and barriers to the promotion of healthy sexuality of adolescents living in PEI?

The sample size for this descriptive exploratory qualitative study was designed for 6-8 participants. This number is consistent with other studies that have used this design (Glacken, Kernohan & Coates, 2001; Profetto-McGrath, Smith, Hugo, Taylor, El-Hajj, 2007; Mavundla, Toth & Mphelane, 2009; Gleeson & Higgins, 2009). According to Patton (2002), qualitative designs specify minimum samples based on expected reasonable coverage of the phenomenon given the purpose of the study.

There were six students who volunteered to participate in this study. All six of the participants were female. No males volunteered despite repeated recruitment attempts. Two of the students were in grade 10 and were 16 and 17 years of age; one of the students was in grade 11 and was 18 years of age; and, three of the students were in grade 12 two of which were 17 and one 18 years of age. All of these students lived in an urban area. Given that five of the six participants participated in two interviews, "information rich cases" were obtained (one participant withdrew for personal reasons after the first interview). Meetings were held with the thesis supervisors throughout the data gathering process to verify reasonable coverage of the study question and that the sample size was adequate.

Data Collection Procedures

Each participant completed an initial face-to-face, semi-structured interview (45-60 minutes in length) followed by a second face-to-face follow up interview reflecting on the first interview (20-30 minutes in length). This second interview occurred about two weeks after the first interview. The two interviews were audio-taped and transcribed verbatim. Each participant was also asked to complete a brief form requesting demographic information including age, sex, grade level and location of home (urban or rural). (Appendix D). It was completely voluntary. The purpose of this form was to describe the population who took part in the study. The researcher also kept a reflective journal and took field notes.

The students were provided with two options for the location of the interviews: the Capital Area Recreation Incorporation (a recreational facility that is a 10 minute walk from the high school) or the Royalty Centre (an educational and community institution about a 10 minute walk from the high school). The interviews took place either before school, at lunch or at the end of the school day. The student and the researcher chose a mutually agreed upon date, time, and place for the interviews.

Interviews. According to Rubin and Rubin (1995, p. 1), “qualitative interviewing is a way of finding out what others feel and think about their worlds”. It is a “tool of research” that is “guided by the researcher, who intentionally introduces a limited number of questions and requests to explore these questions in depth” (Rubin & Rubin, 1995, p. 2). The interviews were set up as an interaction between the researcher and the participant in which the interview was informal and guided by broad topics rather than detailed questions. This style contributed to the open exchange of ideas typical in most qualitative research (Ulin, Robinson & Tolley, 2005).

Since the study was grounded in CST, the interviews were based on the assumptions and central tenets of CST. CST was applied to the interviews as a basis with which to develop questions and strategies to explore the social determinants of health and therefore uncover the hidden power hierarchies that maintain the status quo with respect to the promotion of healthy sexuality of adolescents living in PEI. During this process, the theory of communicative action was used, as developed by Habermas, in which language was “central to the creation of knowledge and the formation of meaning” (Browne, 2000, p.39) as it “initiates a process of self enlightenment of socialized individuals about what they would want if they knew what they could want” (Habermas as cited in Kim and Holter, 1995, p.210). The purpose of the interviews was to dissect and unravel the adolescents’ everyday experiences so as to better understand their lives within structures they had not necessarily chosen for themselves.

During the interviews, a non-hierarchical partnership was developed between the researcher and the participant that promoted sharing and reciprocity to aid in the development of the dialogue and critical reflection that led to enlightenment for both the participant and the researcher. While carrying out the interviews the researcher used communication strategies to facilitate discussion including active listening, clarification, reflection, facilitation, and summarizing as well as conveying empathy, respect, warmth and genuineness. Other strategies that were used to facilitate discussions included: (a) creating a comfortable environment with respect to lighting, temperature and distance between researcher and participant; (b) encouraging conversational competence by starting new topics with broad questions in a non-threatening manner and probing for further information only if necessary for the study and the participant was comfortable with the topic; (c) being cognizant of the degree of comfort of the participant by observing verbal and non-verbal behaviour to ensure the participant was comfortable and the

messages were congruent; and (d) changing the topic of discussion if the participant was uncomfortable with continuing (Balzier-Riley, 2008; Rubin & Rubin, 1995). The researcher also used several strategies to develop trust and comfort with the participants: (a) met with the participants in a familiar environment such as the community recreational facility; (b) wore non-threatening age appropriate clothing (jeans, sneakers and tee shirt); (c) provided reassurance that there were no right or wrong answers prior to each interview; (d) provided reassurance of confidentiality prior to each interview; and, (d) designed the interview guide so that all questions asked were more reflective of adolescents perspectives in general rather than about the participants themselves.

Semi-structured interview. The initial face-to-face semi-structured interview took about 45-60 minutes in length to complete. The semi-structured interview guide (Appendix E) was developed using a socio-ecological framework to address the multi-component level of the lives of these adolescents. This interview guide was developed by the researcher in collaboration with her thesis committee. The guide was set up in such a manner to address the influences that the determinants of health had on the promotion of health of adolescents. The determinants of health that were specifically addressed included socio-economic status, culture, gender, social and physical environment, health services, social supports, education, employment and working conditions, individual capacity and coping skills, and health practices (Health Canada, 1999). A socio-ecological framework was used to structure the questions to capture the multi-component nature of the adolescents' lives with respect to these determinants of health. The socio-ecological framework itself involved the following interrelated levels of influence: intrapersonal, interpersonal, organizational, community/cultural and policy levels (McLeroy, et al.,1988).

The semi-structured interview guide (Appendix E) that was used for this study followed the format that incorporated three types of questions: main broad questions, follow up questions, and probes (Rubin & Rubin, 1995; Patton, 2002). This pattern of questioning provided the structure which enabled participants to share rich information regarding the focus of the study. Each broad question was used to introduce a specific theme of the topic. The follow up question encouraged the participant to share information at a deeper level by asking for more detail while a probe question took the interview into an even deeper level. This pattern of questioning adapted well to the semi-structured interview as the researcher “typically used a written set of flexibly worded topics or questions that kept the conversation guided and on track but without imposing boundaries on the participant’s style and expression” (Ulin et al., 2005, p. 85).

Reflective interview. Two weeks after the first interview, each participant took part in a second reflective interview that was about 20-30 minutes in length. The purpose of this interview was to review what was covered in the initial interview, ensure accuracy of the researcher’s interpretation of the initial interview, and to provide each participant with the opportunity to elaborate on experiences and perceptions. This second interview was important as reflection is an integral process in CST. It provided the participants an opportunity for elaboration to ensure a “thickness” of the description of their experiences and perceptions. The “thickness” of the description relates to “the multiple layers of culture and context in which the experiences are embedded” (Morrow, 2005, p. 252). This follow up interview occurred after the data obtained in the first interview was analyzed. In the second interview, the researcher also sought clarification and elaboration of themes that emerged during the first interview.

Reflective journal. Besides conducting interviews, the researcher kept a reflective journal of the study. The researcher submitted entries at the beginning of the process, prior to starting the

interviews, after each interview, and during the analysis process of the study. As self reflection is such an integral process of CST, these journals were a beneficial exercise. The reflective journaling helped the researcher become more aware of personal biases, values and prejudices and how they were affecting the research process.

Field notes. The researcher also recorded field notes during each interview. According to Lofland (1971), field notes are “the most important determinant of later bringing off a qualitative analysis. Field notes provide the observer’s *raison d’etre*. If he is not doing them, he might as well not be in the setting” (as cited in Patton, 2002, p. 302). The field notes took a descriptive narrative form describing who was present, the physical setting, and interactions that occurred during each interview to “permit the observer to return to that observation later during analysis and eventually permit the reader of the study findings to experience the activity observed through the research report” (Patton, 2002, p. 303).

Data Analysis

According to Sandelowski (1995), “probably the most daunting challenge confronting anyone conducting qualitative research is what to do with the data that has been collected” (p. 371). It is “the final stage of listening to hear the meaning of what is said” (Rubin & Rubin, 1995, p. 226). For the purpose of this study, thematic analysis was used to analyze the data obtained. CST was used as a lens with which to analyze the data. Analysis was ongoing during and following data collection as the researcher read and reread the data obtained through the two interviews per participant, the field notes, and the reflective journal.

The researcher set up a process to prevent errors of analysis such as “premature analytic closure” and having a “commitment to some a priori view of the phenomena under investigation” (Sandelowski, 1995, p.371) and to ensure that the analysis was in-depth and took the researcher

“a further step to show what meaning lies beyond the themes” (Caelli, Rat, & Mill, p.5). This process included the use of reflective journaling, member checking at the time of the second interview, and a systematic thematic analysis (Sandelowski). The researcher also met her thesis supervisors throughout the data analysis process to verify the coding/thematic structure development.

During the data gathering phase of the research study, the researcher carried out reflective journaling and ongoing analysis of the data. This ongoing analysis of the data from each interview affected the data collection process. As themes emerged they were probed in subsequent interviews. Reflective journaling also provided the researcher with a means to record observations, perceptions, and interpretations during the data gathering and analysis. The researcher was specifically trying to be aware of personal biases, values and prejudices and how they may be affecting the research process (Ulin et al., 2005).

Member checking was carried out during the second interview. The analysis of the first interview of each participant formed the basis for the second interview for each client. The questions that were asked were designed in such a manner so as to identify particular themes in the first interview and to seek clarification and more depth in the second interview.

It was also important for the researcher to demonstrate the application of the basic assumptions and central tenets of CST during the analysis. The researcher did this by explicitly identifying competing interpretations as well as issues of power with respect to “ whose perspective is privileged, what is left out of the account of how this is negotiated” (Caelli et al., 2003, p.5). These are presented throughout the *Findings and Interpretation* chapter of this thesis.

Thematic analysis. For the purpose of this study, a process as advocated by Sandelowski (1995) was used as a framework to inform the analysis for this study. Data collection,

preparation of data, analysis of raw data, and interpretation are all considered to be aspects of the research that overlap conceptually. According to Sandelowski, the analysis begins when the first “units of data are collected” (p.372) with the analysis and interpretation flowing back and forth until the analysis has become the means with which to accomplish the interpretation of the data.

The data was prepared by the transcription of the audiotapes verbatim by a trained transcriptionist. The researcher personally proofread each interview once it was transcribed to become immersed in the data. The two main aspects of analysis included getting a sense of the whole and developing a system. Getting a sense of the whole required the researcher to first get a sense of each interview prior to developing any comparisons between interviews. The researcher did this by first reading each interview along with the field notes and the reflective journal as many times as needed to develop a sense of each interview. The researcher wrote a brief summary about the key concepts that emerged as a first impression of each interview. It was important that the researcher did not focus on each word or sentence and remained creative and open so as not to “shape the summaries according to any preset criteria or to remain in any one domain of abstraction” (Sandelowski, 1995, p.373).

After getting some sense of the whole, the researcher developed a system to analyze the data. This system involved extracting the facts, identifying storylines, and dimensionalizing their informational content, and using frameworks to reduce the data (Sandelowski, 1995). Extracting the facts involved the identification of the factual information with respect to the interviews. These facts “allow researchers to look at their data and, therefore, to see suggestive patterns or relationships both within and across cases” (Sandelowski, p. 374). Identifying storylines was the next step to approaching the data systematically. Once these storylines were identified the researcher went back to them to “further dimensionalize their informational content”

(Sandelowski, p. 374). The final step towards systematically analyzing data involved using a coding framework with which to organize the data and enable the researcher to see the data in a new way.

To assist with the coding for this study, a coding process as recommended by Myles and Huberman (1994) was used. The codes that were developed for this study were based on the socio-ecological framework that has been used throughout this study (McLeroy, 1988). This socio-ecological framework involved the following interrelated levels of influence: intrapersonal, interpersonal, organizational, community/cultural and policy levels. Using these levels of influence, as the framework for the coding process, proved to be beneficial in capturing the multi-component nature of the adolescents' lives. Upon reading and rereading the transcripts first individually' and then as a whole, new codes were created and added to the framework that served as a lens with which to interpret and give meaning to the interview data.

The researcher further analyzed the data to group it into themes to develop further interpretation and meaning (Myles & Huberman, 1994). The purpose of this data analysis was to identify the "the patterns, themes, and categories that emerged out of the data collection and analysis" (Patton, 2002, p.494). According to Desantis and Ugarriza (2000), "the term emerge does not mean that they spontaneously fall out or suddenly appear" (p. 355) but rather that they are "extracted by a careful mental process of logical analysis of content from all data sources" (Germain, 1986 as cited in Desantis & Ugarriza, p.355). Ultimately the interview data for this study was reconstructed into various themes that grabbed the essence of the phenomenon under investigation: adolescents' perceptions of the facilitators and barriers to the promotion of healthy sexuality of adolescents in PEI. These themes are discussed in the next chapter.

To summarize, analysis occurred through thematic analysis in which the transcripts, field notes, and reflective journals were read, reread and analyzed in a systematic approach. Regular meetings were carried out with the researcher's thesis supervisors throughout the data analysis process to verify the coding/thematic structure development. Special attention was paid to the development of the themes that emerged within and across categories to establish meaning to what was being heard with respect to the perspectives of adolescents regarding the promotion of healthy sexuality.

Establishing Trustworthiness and Rigor

When establishing trustworthiness in qualitative research the “research procedures utilized by qualitative researchers to establish rigor are an important way to increase our confidence that the voice of the participant is heard” (Lietz, Langer, & Furman, 2006, p. 441). This is especially important “in a practice oriented discipline such as nursing”...“to achieve the fuller knowing that advances knowledge and influences practice” (Sandelowski, 1986, p.3). Over the past 25 years, however, there is controversy regarding how the researcher establishes this rigor to hear the voice. Sandelowski and Barroso (2002) have acknowledged that “scholars across the practice and social science disciplines have sought to define what a good, valid, and/or trustworthy qualitative study is”...and that...“we seem to be no closer to establishing a consensus on quality criteria, or even on whether it is appropriate to try to establish such a consensus” (p. 2). Morse, Barret, Mayan, Olson, and Spiers (2002) also reached the same conclusion stating that “the literature on validity has become muddled to the point of making it unrecognizable” (p. 2). Throughout this debate there has been an “evolution of thought as notions of rigor mature” (Caelli et al., 2003, p.4). This evolution of thought is evident amongst some prominent authors such as Lincoln and Guba (1985), Denzin and Lincoln, (2000) and Sandelowski (1986, 1993,

2000, 2002). What has been common among these authors is the need to establish criteria for qualitative research that are different than the criteria established for quantitative research, as the two types of research are fundamentally different. However, as there are numerous paradigms that fall under the umbrella of qualitative research, some researchers acknowledge that it would be futile to develop one set of criteria that would apply to all types of qualitative research. It has also been acknowledged that the approach to rigor that is used should reflect the ontological and epistemological underpinnings of the methodology that is being used to guide the research. In other words, the procedures employed to establish rigor need to emerge from the nature of the inquiry including the question and underlying beliefs and assumptions that are guiding the inquiry (Maggs-Rapport, 2001; Allen et al., 1986; Sandelowski, 1986; Mill & Oglivie, 2003). However, according to Sandelowski (1993), it is also important not to “remain in danger of succumbing to the illusion of technique: of making a fetish of it, at the expense of perfecting a craft and making rigor an unyielding end in itself” (p. 1) but rather advocating that rigor be “less about adherence to the letter of rules and procedures than it is about fidelity to the spirit of qualitative work” (p.3). Sandelowski further argues that “validation is less a technical problem than a deeply theoretical one” ...and one “that is a matter of judgment” (p.2) and that validation is “viewed as a culturally and historically situated process” whereby “trustworthiness becomes a matter of persuasion” when the researcher makes “good science” visible and therefore auditable (p.2). In an earlier paper Sandelowski (1986) referred to this process of auditability as “leaving a trail” so that the reader would be able to track and verify the research process. Sandelowski and Barroso (2002) take this stance further advocating that the actual research report “is more usefully treated as a literary technology that is designed to persuade readers of the merits of the

study” ... in which...“readers make meaning from texts rather than the rigid application of standards and criteria” (p.2).

Lincoln and Guba (1985) identify trustworthiness as the fundamental criterion for qualitative research. Establishing trustworthiness will ensure that “the findings of an inquiry are worth paying attention to, worth taking account of” (Lincoln & Guba, p.290) and it is established when the findings of the study closely reflect that which the participants describe as their lived experiences. To ensure the trustworthiness of this study several strategies have been utilized: (a) ensuring that all aspects of the study including the research question, data collection, data analysis interpretation, and presentation of the report are embedded within the epistemological and ontological underpinnings of CST; (b) ensuring that there was an explicit trail of the decisions that were made throughout the research process documented within the research report as well as the evidence of the research process (field notes, reflective journal, and records of analysis process); and, (c) using several criteria with which to evaluate the trustworthiness of this study: credibility, dependability, transferability, and confirmability.

Credibility. According to Lincoln and Guba (1985), credibility is an evaluation of whether or not the research findings represent a credible interpretation of the participants’ description of the phenomenon being studied. It is associated with testing findings and interpretations with participants. It focuses on the truth of findings such that the findings demonstrate a logical relationship to each other and the interpretations are true representations of the intent of the participants. Carrying out member checking as advocated by Lincoln and Guba (1985) is a way to ensure the credibility of findings. Member checking was implemented in this study during the reflective interview which provided participants the opportunity for elaboration to ensure a “thickness” of a description of their perspectives. The “thickness” of the description” relates to

the multiple layers of culture and context in which the experiences are embedded” (Morrow, 2005, p.252). This “thickness” is especially important in this study that is being informed by CST as the data that were obtained reflected the historically situated basis of knowledge (Morrow, 2005).

According to Rubin and Rubin (2005) the credibility of a study can be judged by its transparency, consistency-coherence, and communicability. There are several strategies to achieve this. First, transparency “means that a reader of a qualitative research report is able to see the basic processes of data collection” (Rubin and Rubin, p.85). This was carried out in this study through the process of reflective journaling and use of field notes, keeping transcripts of interviews, and keeping records of how they were analyzed. The reflective journal was especially useful because it is a record of how decisions were made throughout the research process. Second, ensuring consistency refers to the researcher checking out “ideas and responses that appeared to be inconsistent” (Rubin & Rubin, p.87). These inconsistencies may be within or across cases. The goal here is not to eliminate inconsistencies but to demonstrate why they occurred. During the analysis of the data multiple inconsistencies were found. The researcher accounted for these inconsistencies by referring to past and recent research to help give meaning to the findings. Finally, communicability refers to ensuring that the research report that is presented “feels real to the participants and the readers” of the report (Rubin & Rubin, p.91). This was accomplished by including “richness of detail, abundance of evidence, and vividness of the text” (Rubin & Rubin, p. 91). Many examples were provided in the findings of the report that represented the participants’ direct words to demonstrate the realness of the study.

Dependability. Dependability refers to the way in which a study is conducted such that it is consistent across time, researchers, and analysis (Morrow, 2005). To ensure dependability an

explicit audit trail was kept that was detailed with respect to the “chronology of research activities and processes; influences on the data collection and analysis; emerging themes, categories, or models; and, analytic memos” (Morrow, 2005, p. 252). Rationalizing decisions that were made throughout the research process has also increased strength of the dependability of the study. An audit trail was kept through a reflective journal, field notes, copies of transcripts and records of analysis. The goal was to ensure that the results are dependable not necessarily repeatable.

Transferability. Transferability is the qualitative analogous term to the quantitative term of generalizability. Whereas the “generalizability of the findings to a wider population is a goal of most quantitative studies” (Ulin et al., 2005, p. 26) according to Denzin and Lincoln (1998), the goal of transferability is “to produce data that is conceptually, not statistically, representative of people in a specific context” (Ulin et al., p.27). Several strategies were utilized in this study to ensure transferability was achieved. First, all the themes and conclusions that were established from the study were well supported by the data. Second, contextual factors were accounted for by developing explicit descriptions so that the readers can decide how transferable the results are.

Confirmability. Confirmability refers to the acknowledgement that the researcher is never objective. What is most important here is that the results should represent the phenomenon being studied rather than the beliefs, values, interests, or biases of the researcher (Ulin et al., 2005). It is the researcher’s responsibility to ensure that “the integrity of the findings lies in the data, analytic processes, and findings in such a way that the reader is able to confirm the adequacy of the findings” (Morrow, 2005, p.252). Confirmability therefore requires an audit trail like dependability but also requires the management of the subjective nature of the research. This is

especially true as one considers that CST was used to inform this research project whereby both the researcher and the participant are considered to change as a result of the research process. A reflective journal was therefore used to record the researcher's thoughts and beliefs prior to, during, and upon completion of the research process. The goal was for the researcher to be aware of personal beliefs, biases, and prejudices so as to not interfere with the research process, findings and conclusions of the research.

Ethical Considerations

When carrying out this research there were certain ethical actions taken to ensure the protection of the participants. These included obtaining informed consent, informing participants of their right to withdraw, taking steps to ensure confidentiality, and identifying the potential risks and benefits.

Informed consent. According to the policy of the Eastern School District, the age of consent to participate in any research study that is affiliated with the Eastern School District is 18. This is consistent with the age of consent in PEI. Therefore all students who chose to participate in this study and were under the age of 18 were required to have parental consent to participate in this study.

Once each participant indicated an interest in taking part in the study via an email or by phone, an appointment was set up to have a face-to-face meeting with the student (and parent if the student was under 18 years of age). During the meeting specific aspects of the study were reviewed including the purpose of study, study design, who could participate, maximum number of participants, participants' role, possible benefits or risks, compensation and confidentiality. Time was allotted for any questions the student or parent may have had.

Students (and parent if the student was under 18 years of age) were informed that participation was voluntary and that they could withdraw from the study at any time but it was not possible to withdraw the data they have provided once the thematic analysis for the study was completed. They were also informed that those participants under the age of 18 could withdraw from the study without the parent's consent. Participants could withdraw from the study by informing the researcher by phone or email or by simply not showing up. The Consent Form (Appendix C) also acknowledged that the student (and parent of a student under 18 years of age) could withdraw the use of quotes up until the completion of the thesis. They may make a request to have data withdrawn through email, phone or in person.

If the student agreed to take part in the study, and signed the consent, (and the parent for a student under 18 years of age) an appointment time for the first interview was established. On the Signature Page of the Consent Form there was a separate section for each participant (and parent if the student was under 18 years of age) to sign to consent to each of the two interviews being audio recorded. There was also a separate section for each participant (and parent if the student was under 18 years of age) to sign to consent to direct quotes being used in the final report (with the use of pseudonyms). This signature was obtained once the interviews were completed so that the participants were aware of what they were consenting to.

The signing of the consent form was voluntary. Copies of the consent form were provided to each participant. At the beginning of the first and second interviews the consent form was reviewed with the students again to ensure that each student had a good understanding of the study. Time was also allotted to answer any questions or concerns that the student(s) had.

Confidentiality. To ensure confidentiality each participant was assigned a pseudonym at the time of the first interview. Only the principal investigator, co-supervisors, and the transcriptionist

(only during transcription) had access to the data. All data collected was kept in a locked cabinet and electronic data was password protected. The transcriptionist was required to sign a Confidentiality Agreement (Appendix F) prior to transcribing audiotapes. If the participants introduced names during the interview process, pseudonyms were assigned to each name so as to protect the identity of the participants and those named. At the time of obtaining informed consent, each participant was informed of these processes.

The consent forms, the audio tapes, and transcripts were stored in a locked cabinet in the researcher's office (which is always locked when not in use) at the UPEI School of Nursing which has a security system. The computer that was used was a personal computer that was only used for work (part-time clinical nursing instructor) and graduate studies. The computer was password protected. There was no permanent or even a temporary record of the electronic transcripts on the computer hard drive as the computer is mobile and could be lost, stolen, or corrupted. Data were stored on two jump drives. One jump drive was stored in the locked filing cabinet in the researcher's office as discussed above. The other jump drive was stored in the researcher's locked filing cabinet at the researcher's home in an office. The home was always locked if no one was present. The jump drives were always in a locked filing cabinet when not in use. The information on the jump drives was also password protected. The audio tapes were destroyed after they were transcribed and analyzed to enhance confidentiality of the participants.

Potential risks and benefits. There were several social/sexual and safety considerations for this study. The researcher anticipated that: (a) participants may feel uncomfortable due to their developmental stage of being an adolescent and the awkwardness that may occur when discussing sexuality during the interview; (b) participants may request resources for support and education regarding the promotion of sexual health; (c) the interviews may cause participants to

reflect on previous sexual abuse or trauma; and, (d) participants may disclose abuse (sexual or physical) or neglect of a child. There were steps taken to mitigate the risks for participants regarding aforementioned social/sexual and safety considerations. There were no direct questions regarding the participants' personal sexuality or sexual history. The participants were informed during the informed consent that they could refuse to answer any question during the interviews. They were also informed that they could withdraw from the study prior to the thematic analysis of the second interview. The researcher observed the participants for verbal and non-verbal signs of discomfort and acknowledged such with the participants and sought permission to continue with the questioning if needed. The researcher did not explore any areas that were not relevant to the purpose of the research study. The researcher developed a list of educational and support services that were available in PEI and distributed to participants at the time of the first interview. The researcher gave each participant the name of a physician and counsellor who volunteered their services if further follow up was required for a participant with a past history of sexual abuse or trauma. These names were given at the time of the first interview. It was up to the participant to choose to contact the physician and/counsellor on their own or seek the researcher's assistance with setting up an appointment. The participants were informed, during the informed consent, of the researcher's duty to disclose abuse (sexual or physical) or neglect of a child to the Intake Unit of the Child and Family Services Division of the Department of Community Services, Seniors and Labor in PEI. As per law in PEI, this is to be reported for all participants that are under the age of 18.

There were no direct benefits for the participants who chose to take part in this study. However, the participants were informed that the knowledge created as a result of the study may be used to inform educational programs, services, supports and policies regarding the promotion

of healthy sexuality of adolescents. They were also informed that, as a result of this study they may become more aware of the facilitators and barriers that affect the promotion of healthy sexuality of adolescents living in PEI. As this study was developed within a socio-ecological framework these adolescents may also develop a greater understanding of their lived experiences as to “what is” and “what can be” with respect to the promotion of healthy sexuality in PEI.

Chapter Four: Findings and Interpretation

The purpose of this qualitative descriptive exploratory study informed by CST and a socio-ecological framework was to identify adolescents' perceptions of the facilitators and barriers to the promotion of healthy sexuality for adolescents living in PEI. CST is recognized as being a "valuable lens for viewing phenomena within their sociopolitical contexts" (Ekstrom & Sigurdsson, 2002, p.289). It is also an approach that is able to "reveal and examine the socio-environmental conditions which contribute to lifestyle behaviours, recognizing the interplay between individual choices and available options" (Forbes et al., 1999, p. 375) and to look past existing ideologies toward meaningful analysis which leads to the creation of knowledge that can be used to improve lives.

A socio-ecological framework enhanced the application of CST. According to McLeroy et al. (1988) the use of such a framework "focuses attention on both individual and environmental factors as targets for health promotion interventions" as well as addressing "health promotion from a multi-component approach in which interventions are directed at changing the intrapersonal, interpersonal, organizational, community/cultural and public policy, factors which support and maintain unhealthy behaviours" (McLeroy et al., p.351). Specifically, it addresses the social determinants of health at multiple levels: (a) the intrapersonal factors look at the characteristics of the individual; (b) the interpersonal factors look at the formal and informal relationships; (c) the organizational factors look at the social institutions with organizational characteristics; (d) the community factors look at the relationships among institutions and organizations; and, (e) the public policy level looks at the local, provincial, and national policies and laws.

A qualitative descriptive exploratory design informed by CST and a socio-ecological framework worked well with the six students who participated from the High School in Charlottetown, PEI. All participants participated in a first face-to-face, audio-recorded, semi-structured interview during which time their perceptions of the facilitators and barriers to the promotion of healthy sexuality were discussed. All but one also participated in a second face-to-face, audio-recorded, semi-structured reflective interview in which the content of the first interview was reviewed for the purpose of verification, clarification, and/or elaboration of previously collected data.

Seven themes emerged within a socio-ecological framework (intrapersonal, interpersonal, organizational, and community factors). The themes that have emerged for the intrapersonal factors include: *The Illusion of Accessibility* and *Risky Behaviours*. The themes that emerged for interpersonal factors were *Peer Pressure: Alive and Well in High School*; *Cyberbullying*; and, *Parental Influence on Adolescent Decision Making*. The theme that emerged for organizational factors was *Insufficient and Underutilized School Health Resources*. The theme that emerged for the community factors was *Insufficient and Underutilized Community Health Resources*. As the category of policy factors was not directly discussed with the adolescents during the interviews, it is more appropriate to address it in the *Research, Conclusions and Future Implications* chapter of this study.

Intrapersonal Factors

Illusion of accessibility of resources. Upon analysis of the interview data, it became clear that all of the participants were well aware of a number of factors that interfered with the accessibility of the supports and services towards the promotion of healthy sexuality of adolescents. Even though the students named various supports and services that were available

within the schools and communities, they also identified a number of barriers to accessing them. Some of the supports and services they identified were school counsellors, teachers, school administrators, physicians, walk-in clinics, emergency rooms, pharmacists, psychologists, and family physicians. Some of the prevailing barriers they reported to accessing these resources were: feeling uncomfortable; lack of trust; lack of confidentiality; unclear role of supports at school; lack of knowledge of resources; and, limited resource availability.

Feeling uncomfortable. All six of the participants identified the degree of comfort as an integral factor to consider regarding whether they would access a service or a support. The following quotes from three of the youth participants illustrate the depth of the importance of youth feeling comfortable prior to accessing a service or a support. One participant reported:

There are a lot of places where you might think it would be nice and open, like teachers. You're always worried about creating a relationship that you don't want there. There is an awkwardness. So I think that if you had a really good, good rapport with a teacher, you could approach them about that. I don't. I am uncomfortable with that sort of thing.

A second participant described the feeling of being uncomfortable as a barrier to services provided by the school counsellor by stating:

The only thing that is unfortunate about that is that they don't make it feel welcoming, kind of so, it could be really awkward, and intimidating, kind of. Like I know if I would have a question, I probably wouldn't go there because they're not like. They don't really promote it or anything. No, no. You just don't feel comfortable. It's just weird, like.

A third participant further described her discomfort in discussing sexually related issues with her parents:

I don't know. I guess, I don't know because I love my parents. I can talk to them about anything else. I think that's so weird. I think they'd be really disappointed if they found out that I was doing anything. And I don't like them being mad or disappointed in me. So I don't talk to my parents at all about sexual things. I don't think- like- they may want to bring up a topic but I feel really uncomfortable talking to my parents...I don't

think teenagers would go to their parents. That wouldn't be their first choice, any unless they were in deep trouble or pregnancy or something, then yeah...

Lack of trust. Another relevant concept with respect to being a barrier to accessing potential supports and services is the lack of trust that may be perceived by adolescents. Three of the participants have referred to this. One participant spoke about this lack of trust when referring to not accessing walk-in clinics or emergency rooms:

I would never go to the walk-in clinic or an emergency room. You don't have that trust built up. You don't know who you are going to see. I have never heard of anyone using them. Maybe others [do], but I wouldn't personally.

Another participant reported concerns regarding accessing teachers because of her lack of trust for fear of being judged and ultimately affecting her performance in school:

I don't trust teachers. A lot of teachers are really judgmental. They're just- I feel that if you tell a teacher that you're having sex, they'll think less of you. They will think really less of you in certain-they'll treat you different.

A third participant commented on the lack of trust interfering with students accessing teachers as sources of support for sexual health issues:

You would have to, again have that trust issue. And maybe [feel] comfortable? Some teachers are not comfortable about that subject. They would probably tell you to go to the guidance counsellor. Some are more open.

Lack of confidentiality. All of the participants referred to the potential lack of confidentiality as a strong barrier to not choosing to access a support or service. The concept of confidentiality is an important one to all of these participants, who reported that they themselves and adolescents in general would forgo health care or support regarding sexual health if confidentiality was at risk. Four quotes that capture adolescents' concern for confidentiality will

be presented. The first quote is from a participant who had a concern about her family physician informing her parents about her personal business:

Everybody needs to go to a family doctor- if you're comfortable. I would not feel comfortable talking to mine because my mom usually comes in with me. So I would love to tell her to go away, but, um. Maybe if he's a long time family doctor. Maybe if you'd known him since you were little. I haven't gone to mine.

A second participant discussed confidentiality with respect to not accessing pharmacists for information regarding the promotion of healthy sexuality for fear of people hearing their conversation:

It's not a place you would generally choose... yeah. I think it would be a really good place, because that's where all the sex, um, like safe sex things are located. And it's good to get information, or if you need medication... That's some place you should be able to go to. But, because the only pharmacies that I know of are drug store atmospheres, even the one that is located near a doctor's office, is...there's no little room that you go into to pick up your medicines or a place that you can easily say, 'I need to talk to you about something'. Everyone will hear you.

A third participant commented on the importance of confidentiality in general with respect to students accessing supports and services:

Yeah, but because there's the whole thing about being judged in high school. You don't want to be judged, so you lean more towards the side that's more confidential than just Open about it.

A fourth student commented on concerns for privacy when seeing the school counsellor during school hours:

The counsellors I don't think they operate after school, and so they are basically only operating during school hours. So you can get out of class to talk to the counsellor but because of that it sort of lacks privacy.

A fifth participant discussed the concept of confidentiality using a hypothetical scenario:

Well let's say they have an STI, they might not be comfortable enough about wanting anyone else to know, about going to see their doctor because then people might know. But what they need is someplace they can go to talk about stuff. Mentally, they might feel more comfortable just talking it over with someone incognito like a counsellor or something like that.

This same participant referred to concerns about confidentiality preventing with a student from accessing school counselling services:

I don't know. I mean they all have their own merits and all have their own sort of problems that anyone might feel uncomfortable with. Um, I would think probably like, they might not, I don't know, they might go to a school counsellor because they'd [be] more useful but they might feel more uncomfortable going to a school counsellor because it would be like someone might hear, or...one of their friends might have seen them going in and like ask like why did you go there?

Unclear role of supports in school. Participants consistently reported that many students were not clear on the roles and responsibilities of potential supports at school.

This theme was evident in some of the quotes that are presented. One participant reported:

I don't think it is very good thing, because it's not welcoming. I...like, I don't know anyone who's gone and talked about that specific kind of thing. Like, you don't like when you think of them [school counsellor], they come to mind as people that you go to if you need a course change or something. It's not somebody you want to go to for a personal question.

The following comments made by two participants, further supports that students are unclear about the roles and responsibilities of the school counsellor and administrators:

Well if it was me personally, I don't think I would want to just, like I'd feel like kind of, like random, like...just like I dunno, I feel like that's not their job, so I don't wanna make them feel uncomfortable, too, and- just avoiding an uncomfortable situation, I guess.

With school counsellors, especially in high school, I find they're much more focused on the academic part and so a lot of people don't feel comfortable about approaching counsellors about, sort of, emotional issues in high schools....In junior high I was quite comfortable with my counsellors because they seemed very much dedicated to the

emotional part, but in high school it's all sort of, you have these academic things to do and we're here for academic reasons. That's mostly what they come off as...The administration. Um, I have never heard of someone approaching the principal or anyone in the administration about that. They are very much seen as administration, and in my mind, 'cause I always see the principal, or the vice principal for assemblies doing introductory speeches, and while, they could be quite friendly people, you don't get to be in contact with them that much...I wouldn't feel comfortable at all approaching the principal or the vice principal.

Lack of knowledge of available resources. All of the students reported concern about being unaware of available resources in the school or the community. When questioned about the possible sources of support many of them responded in a hesitant manner and commented that they were something that might be of use for adolescents. Some of the comments made by the students regarding this theme will be presented. One student responding to a question regarding the possibility of using a pharmacist as a resource stated: "No, I-uh, we-I don't know well, if they can't tell your information to anybody? I don't think that'd be such a bad idea if you really needed to ask a question and you need, like, a sure thing, 'cause they know what they are doing". A second student responded with hesitancy regarding seeking support from her family physician: "Because they just don't wanna, like they feel like they're bothering the doctor, like, just to be there for a question, you know what I mean?" Another student, who was having difficulty trying to figure out potential resources in the first interview, reported using the internet to find out what resources were possible when she went home. During her second interview she reported:

I was curious about you know what sort of services we did have in PEI and I googled it and I didn't find a whole lot...Basically, I didn't do it narrowed, narrowed down. I was curious to see if I did a bag search what would I get. And I pretty much got little to nothing.

Limited availability of resources. All the students also reported that there were limited sexual

health resources available for adolescents in PEI. In this study, all of the participants reported that they had never seen a nurse within the school and were unaware of anybody actually using one at school. However, they reported that you could access a nurse at the hospital or at a doctor's office but they were unaware of such a consultation as one participant reported "it is possible". Although a few students reported that they "heard" of students phoning a nurse "somewhere" so they could be anonymous and get information. Every participant also reported that they were not aware of any health or youth clinic in school or within the community that specialized in providing health care support or services to the adolescent population.

Some of the data that further illustrates the students concerns regarding the lack of resources will be provided. One participant commented with great conviction that the only resource that is a possibility in the school is a school counsellor whom she has never gone to and has never heard of anyone going to commented:

Okay, so basically, like I said, we have those counsellors that you can go to for either your university, or school, classes, anything. And you can go to them for other types of questions that you have. And that's basically all that's there, and that's all I know.

This same participant also reported frustration regarding not knowing what is actually available and not being informed even in a Family Life Course in high school:

Even when they mention going to the doctor or going to your parents it's more in passing sort of you know, or common sense really. But they don't really tell you other places that you could get help. And I'm not sure if that's even there, maybe there isn't enough places that they know of... that could help. Like...tell the students where they could get help.

In summary, all participants identified many barriers to accessing supports and services towards the promotion of healthy sexuality of adolescents. Some of these barriers include feeling uncomfortable; lack of trust; lack of confidentiality; unclear role of supports at school; lack of

knowledge of resources; and limited availability of resources. These barriers are not new, as many studies report barriers for adolescents accessing sexual health resources (Boyce et al., 2003; Boyce, Gallupe, & Stevenson, 2008; CAAH, 2006; Cape Breton Wellness Centre, 1999; Di Censo et al., 2001; Langille et al., 1999; Langille et al. 2001; Langille, Rigby, Bartlett, Barbour, & Allen, 2007; Langille et al., 2009; Langille et al., 2010; PEI Caucus on Youth Sexual Health, 2005; Planned Parenthood, 1996). These barriers place adolescents at risk if they are not accessing needed sexual health supports and services. This is of concern as this adolescent population has unacceptable STI and pregnancy rates which can have a tremendous impact on the adolescent, her partner, her children, and society in general.

A number of the above studies specifically referred to the barriers that these participants identified. The barrier of feeling uncomfortable was identified in a number of research reports (Boyce et al., 2003; CAAH, 2006; DiCenso et al., 2001; Langille et al., 2010; PEI Caucus on Youth Sexual Health, 2005; Planned Parenthood, 1996). For example, in a national study, carried out by the CAAH, it was reported that many of the students, aged 14-17 years of age, were uncomfortable talking about sex. It was specifically reported that: 49% were uncomfortable talking with their mother; 72% were uncomfortable talking with their father or school counsellor; 45% were uncomfortable talking with their family physician; and, 51% were uncomfortable talking with a nurse. As a result, this feeling of discomfort places adolescents at risk as they choose to forgo health care and support even when they need it.

Another relevant concept with respect to being a barrier to accessing potential supports and services is the lack of trust that may be perceived by adolescents (CAAH, 2006; Langille et al., 1999; Langille et al., 2001; PEI Caucus on Youth Sexual Health, 2005; Planned Parenthood, 1996). This lack of trust can impede adolescents from accessing needed support and services. For

example, Langille et al., (1999) reported that difficulty with trusting in the physician/patient relationships was a barrier that was identified for adolescent females aged 15-18 years of age. The adolescents reported concerns about the difficulty of achieving a balance between knowing the physician well enough to confide in or knowing the physician too well and therefore risking confidentiality and their parents finding out.

Confidentiality is an issue that has been repeatedly identified in many studies regarding the accessibility of adolescent sexual health resources (CAAH, 2006; DiCenso et al., 2001; Langille et al., 2001; Langille et al., 2009; Langille et al., 2010; PEI Caucus on Youth Sexual Health, 2005; Planned Parenthood, 1996). According to a study carried out by DiCenso et al. (2001), confidentiality was a key concern upon using a sexual health service. Many of the students expressed concern about being seen using the local drug store or health clinic. In a national study carried out by the CAAH (2006), adolescents also identified confidentiality as a barrier to using sexual health resources; they reported the fear of parents finding out as a reason to not seek sexual health service or support. In another report, *Perceptions and Attitudes of PEI Youth, Parents and Professionals about Sexuality*, confidentiality was also identified as one of the barriers to sexual health resources in PEI. The adolescents in this study identified anxiety over confidentiality due to familiarity with physicians, educators, and nurses they have known for a long time as a reason to forgo support and services in an adult world that they just “don’t talk about sex with fear of being judged or disapproved of” (PEI Caucus on Youth Sexual Health, 2005, p.13).

As it is clear within the data that is presented from this study and the studies discussed above, confidentiality is a major concern to consider with respect to adolescents’ accessing sexual health services and supports. This concern is often referred to as a most prominent barrier for

those who are working with adolescents as it can interfere with them accessing needed health care (Ford, Bearman, & Moody, 1999; Ford, et al., 1997; Langille et al., 2009). Parents finding out is a great concern for adolescents when they are choosing to use health care services and supports for issues relating to sexuality (Jones, Purcell, Singh, & Finer, 2005; Reddy, Fleming, & Swain, 2002) as well as the fear of being judged when disclosing sensitive information about their sexuality (Ford et al., 1997; Kennedy & MacPhee, 2006). In a recent study carried out in Nova Scotia, where it was revealed that many of the adolescents were unaware of their actual rights to confidentiality, it was suggested that education regarding confidentiality be implemented in sexual health education curriculum (Langille et al.). Other studies have also identified the need to provide adolescents with the reassurance of confidentiality for health services and supports as it may lead to the disclosure of more sensitive information about their sexuality and thereby improve their health (Ford et al., 1997; Kennedy & MacPhee, 2006).

The lack of knowledge of resources that was identified, as yet another barrier, by the participants of this study, was also identified in other studies (Boyce et al., 2003; CAAH, 2006; Cape Breton Wellness Centre, 1999; DiCenso et al., 2001; PEI Caucus on Youth Sexual Health, 2005; Planned Parenthood, 1996). For example, in the study carried out by DiCenso et al., it was reported by the adolescent participants that there needs to be much more information provided to the students regarding what is actually available as resources and specifics about locations and hours of operation. They specifically identified that better marketing of resources was needed both within the schools and the community.

The barrier of limited availability of resources that was identified as a barrier by all of the participants of this study was also identified as a barrier by other studies (Boyce et al., 2003; CAAH, 2006; Cape Breton Wellness Centre, 1999; Di Censo et al., 2001; PEI Caucus on Youth

Sexual Health, 2005; Langille et al. 1999; Langille et al., 2001; Langille et al., 2010; Planned Parenthood, 1996). This concern was also reported in the Environmental Scan of Sexual and Reproductive Health in the Atlantic Provinces whereby it was identified that adolescents in PEI have the least sexual health services in the Atlantic Provinces with no recognizable youth sexual health education and resources (Campbell, 1999). Another provincial report, *Perceptions and Attitudes of PEI Youth, Parents and Professionals about Sexuality* also reported that without a family planning clinic or sexual resource centers in PEI the youth were unsure of where to go for sexual health care (PEI Caucus on Youth Sexual Health, 2005). This limited availability of sexual health services and supports has been identified as the most prominent barrier with respect to the participants in this study.

At the time of this study, the adolescent sexual health resources in PEI were quite limited. There were no recognizable health clinics in the school or community that were specialized for adolescent sexual health or adolescent health in general. There were no regular public health nurses practicing within the high school unless there were special requests made by school staff for the public health nurses to come in for presentations, counselling or health care follow up. There was also no mandatory sexual health curriculum or programming for students in this high school. However, students could choose to take a Family Life Course that had a portion of the content dedicated to the promotion of healthy sexuality for adolescents.

Risky behaviours. Adolescence is a period of growth and development that is characterized by impulsivity making them quite vulnerable to participating in risky behaviours. During adolescence higher level abilities such as controlling impulses, planning, and making decisions are still maturing. Recent research has now acknowledged that the areas in the brain (pre-frontal cortex) that are responsible for these executive functions are still developing and this maturation

process extends past adolescence until the mid 20's (Weinberger, Elvevag, Giedd, 2005). As a result, there are a number of risky behaviours that adolescents are known to take part in that can interfere with the promotion of a healthy sexuality and may have immediate and long term consequences on the health and well being of adolescents (Pickett et al., 2006; Simpson, Janssen, Boyce, & Pickett, 2006). They have the potential to escalate into larger problems whereby the risk taking behaviours become an actual risk taking lifestyle which can extend into adulthood (PHAC, 2008c). The behaviours reported by the participants in this current study included: (a) alcohol use; (b) drug use; (c) watching pornography; and, (d) having casual sex.

Alcohol use. All of the participants reported that the majority of adolescents in high school are taking part in alcohol use. They identified that alcohol is easily accessible for adolescents and that unplanned sexual activity is the main consequence of the excessive use of alcohol. One participant commented: "Yes, usually when you're drunk, you don't really care who you're with, or what you're doing- so people do have sex when they're drunk". When asked how easy it is for high school students to access alcohol, this same participant responded:

Ah, very easy...well there's people always around the neighbourhood, around the school that can easily buy it. Yeah they go to an older person, they say they'll get you in a half hour...meet you here in half an hour. And then you pay him for it.

Another participant commented on how alcohol can impact on girls having sex, not just because they are drunk but because the "guy is drunk". She explained that girls feel pressured "because, sometimes guys are more, like, forceful...especially if they are drinking". This same participant also referred to the practice of adolescents drinking for the purpose of binge drinking and its consequences:

Because people tend to overuse it, on purpose. And because of this basically they don't even have to make a decision because someone could take advantage of them and they wouldn't really notice because they've had so much alcohol in their system.

A third participant referred to the use of alcohol as a coping strategy saying: “Okay, I’m gonna try and get away from all this stuff and I can drink with my friends and I can forget for now”. This same participant, talking about some girls that she knows who drink a lot, reflected: “It is really sad to watch because I know girls, who basically, if the party starts Friday, then they’re not sober again until Monday evening, because they’re either drunk or hung over”. A fourth participant commented on the regrets that students have regarding the choices they make when they are drinking alcohol:

Cause you don’t really know, you don’t really fully know what you’re doing when you’re under the use of alcohol. It might be a mistake- the next morning. You might’ve really wanted it at the time, but then you might not, like you might not feel the same way in the morning when you wake up. You know you’ve done that and you’re like no! Like why did I do that? That’s so stupid. I never would’ve done that if I wasn’t under the influence of alcohol.

When asked about how many students are actually using alcohol, the responses included: “everybody is doing it”, “like 85%, probably even higher”, and “lots of kids that I know use alcohol”. Recent studies regarding the use of alcohol among high school students reflect a rate that is similar to what these students have reported. According to a recent national survey that was administered to grade 9 and 10 students, 70% reported trying alcohol by the time they were 16 years of age (PHAC, 2008c). It was also reported that over half of these students reported trying alcohol for the first time by the time they were 15 years of age. This rate of alcohol use correlates with findings in another national survey that also reported high rates of alcohol use amongst adolescents; 82% of grade 11 students reported trying alcohol and more than half of these students reported being intoxicated for the first time between the ages of 12 and 15. It was also reported that the use of alcohol was different in males than females with 24% of grade 11

boys drinking once a week in comparison to 18% of girls (Boyce et al., 2003). These findings were also consistent with a study carried out in Nova Scotia in which 85.7% of all students aged 15 -19, reported using alcohol at least once and 30.1% had engaged in binge drinking two or more times within the last month, with males (37%) using more alcohol than females (24%) (Langille et al., 2010). Similar high rates of alcohol use were reported in a study carried out within PEI; 46% of students surveyed (grade 7-12) reported the use of alcohol at least once during the past year and 77% of grade 12 students reported using alcohol at least once in the past year (Van Til & Poulin, 2007).

Although there is some variance reported in the rates of alcohol use, it remains consistent throughout all of these studies, that the rate of alcohol use within the adolescent population is unacceptably high. This is a public health concern because use of alcohol is known to impair judgement and as a result can lead to unplanned and often unprotected sexual activity and threaten adolescents' health and well being both in their adolescence and impending adulthood (Boyce et al., 2003; Langille et al., 2010; PEI Caucus on Youth Sexual Health, 2005; Saewyc et al., 2008).

Drug use. All participants have referred to the use of drugs in the adolescent population as well. However, they reported that drug use is not as common as alcohol use and that the use of drugs has less of an effect on how adolescents think and feel about sexuality. They reported that these drugs are being used by a minority of the adolescent population. Many of the participants indicated this decreased effect was because fewer adolescents take part in drug use, and for those who do take part, they do not overuse drugs like adolescents do with alcohol.

One participant reported that the use of drugs can affect how someone interacts in a relationship:

Um I know people who were heavy users of drugs...they were very sexual people. They had lots of relationships that didn't last long... Yeah just making unhealthy choices about safe sex and things like that... they definitely don't come into play when you're heavily stoned.

A second participant commented: "And drugs, I don't think are as bad as alcohol, because, for the most part, drugs that I see around, like, if I go to a party or something, they're not, like the more intense drugs". This same student further commented that the drugs she has witnessed at parties are "ecstasy, marijuana, and mushrooms...usually marijuana, those who do harder drugs, they're usually not around, they have their own parties". A third participant reported that "I know there are people who do drugs. I don't see it... not like drinking".

Five of the students indicated that it was easy to access drugs if you were interested. When questioned, one participant reported on how easy it was to access drugs in high school:

Yeah, people are usually outside of the school. Not many people sell it in school. But there are a lot of people outside the school that do. Like literally just outside the school, like right across the street behind a tree. [what is available?]. Poison is one of them. Cocaine rocks is one of them. Weed is definitely one of them.

The perspectives of participants in the current study about the use of drugs in the adolescent population is consistent with what is reported in the literature. In a recent national survey of grade 9 and 10 students, it was revealed that just under two fifths of males and females have tried marijuana and those who use marijuana on a monthly basis is quite low. The actual use of so called "harder" drugs was low as well with cocaine use being 3% of students in grade 9 and 4% of students in Grade 10, while another class of hard drugs including heroin, opium, and morphine was 2% in grade 9 and 3% in grade 10 (PHAC, 2008c). Another national survey also reported the low use of drugs as compared to alcohol within the adolescent population. This survey specifically reported that the use of marijuana and hashish was more prevalent than the more

addictive drugs. For example 27% of grade 11 students reported the use of marijuana or hashish once per month whereas the use of cocaine and ecstasy were much lower at 1.7% and 1.6% respectively for the grade 11 students (Boyce et al., 2003). A third study, based out of Nova Scotia, reported that overall, 48.7% of students between the ages of 15-19 have used marijuana at least once with males (56.4%) using more than females (41.9%). This trend was also evident in a recent study in PEI in which the use of marijuana was about 25% in those surveyed (grades 7-12) with the rate of use increasing with age with 37% of grade 12 students reporting having used marijuana in the past year (Van Til & Poulin, 2007). Many studies that have addressed adolescent sexual health have discussed how drugs have a negative impact on the promotion of a healthy sexuality for adolescents as they can impair judgement and lead to poor decision making leading to unplanned and often unprotected sexual activity (Boyce et al., 2003; Boyce et al., 2008; Langille et al., 2010; PEI Caucus on Youth Sexual Health, 2005; Saewyc et al., 2008; PHAC; Van Til & Poulin). Furthermore, drug use, like alcohol use within the adolescent population, is a public health concern as it can significantly interfere with the promotion of healthy sexuality of adolescents and threaten adolescents' health and well being (Boyce et al.; Langille et al.; PHAC; Van Til & Poulin).

Watching pornography. All but one of the participants of this study reported that watching pornography is a risky behaviour that many adolescents are taking part in. It can be accessed through video rentals, movie channels, and on-line. They reported that the majority of adolescents are accessing this material on-line, both at school and at home. They also reported that not all adolescents who are watching pornography have done it purposively as there are many pop ups that lure the adolescents onto sites when it is not even their intention when they initially go on the computer. According to many of the participants, these pop ups are how many

adolescents are first introduced to internet pornography. As a result, however, some of these adolescents become quite engaged in this activity; some on a daily basis. It has also been reported that some students are even becoming involved with making videos of themselves and their partner having sexual intercourse to “imitate” the pornography they have viewed.

Many participants commented on the prevalence of watching pornography saying: “It’s just something that you know that most people do” and “I hear that quite a few people do”. Many participants commented on how easy it is to access on-line pornographic sites: “Everybody goes on the internet...like Facebook...there’s pop ups, like girls with just bikinis on, like come join this site”, “it’s so open anyone can access it...anytime”; “people can just take their ipod and go on the internet and find it there”; and, “It’s easy to access, very easy. You can even access it in schools.”

One participant commented on how internet pornography is much more popular than video rentals:

Like it is easy to access. They don’t need to go to the video store to get some. They probably don’t even know where it is sold. They’re always on the internet doing it, anyway. It’s free.

Participants also commented on how easy it is for adolescents to bypass the blocks that are set up to prevent access to pornographic sites:

I know there’s a lot of people who go on and they find ways around school blocks. You can find lots of stuff on the internet, even at school. Yeah, there’s a couple of guys that got caught a couple of times, during class time. But there are some guys who know how to go around it.

Another participant remarked how students can watch “porn” at school without consequences “as long as the teacher isn’t watching”:

The person doesn’t get into trouble because it is a free world and no one really knows who is on it. But what they actually do is the more people who go on the site...I think if they reach...I think it’s like a hundred or two hundred people who go on that site, that it gets blocked by the school. But there’s always more sites. There’s always more. They

cannot block everything. There's always gonna be porn.

Many of the participants discussed how watching pornography can interfere with the development of the healthy sexuality of adolescents. One participant commented: "The more porn you see, the more you want to do it [sex]. If you see a lot of porn, 80% of the time, you're gonna have sex." A second participant reinforced this effect of pornography by commenting on how pornography influences how adolescents internalize so called "normal" sexual behaviour:

I think that's a bad thing in a lot of cases, because it, sort of, for people who don't know better, or who sort of, don't accept the fact that that's not a normal situation, they become much more open to sexual relationships which I think is a bad thing, personally.

This same participant further reported how pornography can affect the decisions that adolescents are making about sex:

I know people who just [say] 'I like sex, I'm going to go out this Saturday night, and whether it's my boyfriend or someone else, I'm going to have sex cause I like it. They get that sort of image from the internet.

Another participant further commented on how the exposure to pornography coupled with the recent celebrity trend to make sex videos has affected adolescents in PEI:

Because of pornography and all that stuff, people I guess, like people watch that and people wanna imitate it, like it's the same thing. I think it has a really negative effect on teenagers because it's really kind of gross and offensive and people get really into it and they just wanna imitate it. That's where the whole, like, sex video comes into play too. It just kinda influences everyone in a bad way.

She further reported:

Like, sometimes you hear about, like, celebrities, like, making sex tapes and stuff. And that can encourage some people to do the same. I've heard about that before [making sex tapes]. Yeah they think it's funny, or something.

The practice of adolescents watching pornography is increasingly being recognized as a risky behaviour that impacts on the promotion of the healthy sexuality of adolescents that requires

much more investigation with respect to risk factors and how it impacts on youth (Braun-Courville & Rojas, 2009; Brown & Witherspoon, 2002; Carson, Pickett, & Janssen, 2011; Flood, 2009; Svedin, Akerman, & Priebe, 2011; Wolak, Mitchell, & Finkehor, 2011). However, it is a risky behaviour that is addressed less frequently in research than the risky behaviours of drugs, alcohol and casual sex. For example, many of the studies that have focused on the status of adolescent sexual health have not included this watching of pornography as a risky behaviour to consider (Boyce et al., 2003; Boyce et al. 2008; CAAH, 2006; Langille et al., 2010; PEI Caucus on Youth Sexual Health, 2005; Saewyc, Taylor, Homma, & Ogilvie, 2008).

As demonstrated in the presentation of the above interview data, the watching of pornography is a risky behaviour that participants perceived many adolescents in PEI are taking part in. This is also demonstrated in some studies that were focused on the actual prevalence of this behaviour in the adolescent population. For example a study in the United States recently reported that nearly 75% of households have internet access with 93% of adolescents (12-17 years of age) being on-line at least 4 days a week (Horrigan, 2008). Much of this online activity is not monitored, placing these adolescents at risk for pornographic exposure. A recent study reported that 42% of the adolescents between 10-17 years of age were exposed to pornography with 66% reporting that the exposure was unwanted (Wolak et al., 2007).

Casual sex. Many of the participants in this study reported casual sex encounters amongst the adolescent population, often as a result of alcohol and drug use, being “dumped”, and peer pressure. This risky behaviour is one that places adolescents at risk for STIs and adolescent pregnancy (Boyce et al., 2003; Langille, 2010; PEI Caucus of Youth Sexual Health, 2005; PHAC, 2008c; Rotermann, 2008).

All but one of the participants in this study commented on the risky behaviour of casual sex

amongst the adolescent population in PEI. Some of the comments made by participants will be presented to illustrate their perceptions of the depth and causes of the problem. One participant commented on the influence of alcohol and casual sex: “But I hear a lot of stories when people like, fool around and stuff, and then they’re like, oh I would never do that with that person? Why would I do that? I did that!”

Two participants commented on how some girls react to a break-up with a boyfriend:

Um, it depends on the relationship...if the guy broke up with the girl, and that girl happens to really like that guy, yes. The first thing that they really think about is, they try to deal with it. And the best way to deal with it, is usually turning to drugs. And while you are on drugs, it usually ends having sex. Or drinking, really ends up to sex. Yeah, it’s an easy way to pick up a new relationship...That is very common. Very. Very. (Laughter).

Like they just broke up with their boyfriend and they just kinda, like they wanna go out and have sex with a random person? Just to kinda, I dunno, maybe it’s to help them get over the other person, but it obviously never works... [Is that very common?]. Oh yeah! Definitely! It’s pretty gross sometimes. At parties, just like, you see them uh, you can tell that it’s gonna happen. They leave-they go to a different room or leave. Then you don’t hear from them for the rest of the night, and then the next morning, they’re all upset about it again, so. It’s poor decision making, but that’s what people do.

This same participant reported how students choose to drink alcohol knowing they may do something that they know that they shouldn’t, such as having casual sex at a party:

And in their mind, they don’t want to, but they just, like, get all the alcohol in them, and know that once the alcohol is in their system, that it won’t matter anymore. Like morals don’t matter, because you’re not really aware because you’re under the influence, so. That’s why people overuse it, because they don’t want to think about right and wrong. They just wanna do.

She elaborated further describing how the need to be popular can impact on an adolescents’ decision to have a one night stand at a party:

Whenever there is a party there will be a one night stand, for sure...they will go somewhere else, but there will be that odd, that odd two people that’ll just do whatever

they wanna do just right there. But for the most part, people do leave and whatever, but then they make sure that the rest of the school hears about it...[They want people to know?]. Oh yeah. Most people do. Like, especially guys for some reason. They, a lot of them, it's like they keep a list or something. Uh, yeah, um guys are definitely worse than girls, but that's my opinion. It's just, I feel like it's kind of gross, and just like, some people get really carried away with it, and then, carrying away puts more pressure on other people. It's just a big mess.

This pattern of casual sex is of concern as it can interfere with the promotion of healthy sexuality of the adolescent population. The data reported by the participants is consistent with data reported by many research studies. For example this pattern of having unplanned sex while under the influence of drugs or alcohol is a pattern that was reported been reported in a number of studies. A recent Canadian survey indicated that adolescents are reporting the use of alcohol and drugs as having an impact on sexual activity. In this survey, 38% of grade 11 males and 21% of grade 11 females reported the use of alcohol or drugs at the time of their last sexual intercourse. This was also evident in grade 9 students whereby 39% of males and 28% of females reported the use of alcohol at the time of their last sexual intercourse (Boyce et al., 2003). In a recent regional study in PEI, it was reported that the most common consequence of grade 9-12 students use of alcohol or drugs was unplanned sexual intercourse (Van Til & Poulin, 2007). In another national survey, 38% aged 14-17 reported engaging in casual sex with males (44%) reporting more casual sexual experiences than females (32%) (CAAH, 2006). This behaviour is concerning as it places these adolescents at risk for adolescent pregnancy and STIs especially for those who are under the influence of drugs and alcohol as they are less likely to use protection (Boyce et al.).

Interpersonal Factors

Peer pressure alive and well in high school. All participants discussed the impact of peers on the promotion of healthy sexuality of youth. They specifically described situations where peer

pressure has influenced student behaviour with respect to using alcohol and drugs, watching pornography, and participating in casual sex. They reported that there is a tremendous amount of pressure that exists within the school and community for students to conform to the rules established by those known in the school as the “popular crowd”. Most students are affected by this popularity hierarchy and the influence it exerts to purposively make poor choices simply to belong. They also reported that there is a minority of students who are content with being “lower” than the “higher up” people and do not make decisions based on what others expect of them. They would rather make good decisions based on what they think is “moral”. Having a group of “good” friends can help with this decision making.

Many of the comments made by participants will be presented as they illustrate their perception the extent of this problem in the adolescent population. Many of the participants referred to the students in the “popular crowd” as being the “higher ups” or those who are “superior”. One participant described this power that these students have:

I just think that everyone is influenced by the people who are, like superior. They’re not actually superior, but they think they are. And they appear that way, because the school is basically [made up of] divisions. There are groups everywhere, and I just think they’re influenced by the more popular ones.

A second participant reinforced this control that the more “popular” people have by describing how the “popular” people have a strong presence and this gives them more power:

Well the people who have the most influence on you are the people that you have to deal with every single day at school...These are the ones that make the rules that we all have to follow.

A third participant added:

With one night stands. Everyone knows that the popular kids do it. And then other people are like they’re cool. Maybe that’s why they are cool. That’s what I mean, like the popular ones set the rules, and whatever they do is okay. So if you do it [one night stand] you think it is okay too. Like people just forget their morals, I think, and just

strive to be popular and up there. And they'll do, like, a lot of people, just do whatever it takes to become a known person. Like they just wanna be talked about.

This same participant went on to describe in more detail the power granted to this “popular crowd” with respect to one night stands, partying, and the use of alcohol:

A lot of people are looked down on if they have morals and they don't do the whole one night stand thing or anything like that. They are looked down on, like, “like what are you doing?” Or just like “I don't want to be friends with you”. It's really horrible, but that is really how high school is. People pick friends based on what people do or don't do, depending on what's cooler. It all has to do with parties. Even at parties, certain people aren't invited because they won't drink, they won't have sex with whoever wants to have sex. It's really bad.

She elaborated on the structure of the cafeteria seating arrangements that reinforce the power that the popular students have that she was well aware of when she began high school:

All schools have a place where the popular people sit. And then all the non-popular people sit around them or elsewhere. Our cafeteria is divided into groups of people. The popular kids from grade 12 are called bleacher kids and they sit near the bleachers. And we have picnic tables for our lunch tables and they're just lined up, and at the end closest to the door, is where the popular people sit at each table. So there's the popular kids of grade 12, the popular kids of grade 11 and then the popular kids of grade 10. And all the rest are scattered to the right of the cafeteria. So it has all happened before grade 10 and everyone knows where they fit in.

Although participants provided more examples regarding the influencing power of the “popular crowd” they also described that a minority of the student population are unaffected by it and do “what they want to”. The following quote captures the essence of this perspective:

If you have close friends and you don't mind being at the bottom, then they won't change who they are...I see people who are really happy with who they are. Even I would think maybe they were probably lower than me, that's really rude.

Besides popular people having the power to influence students in the school, others have this power as well. Sometimes it is others, who may not be popular, who have the ability to cause pressure on others to take part in activities that they may otherwise not have. Many participants reported that students' friends may be responsible for this pressure. This can include pressuring

others to have casual sex. Participants indicated many male students keep a list of how many people they have slept with and use it to pressure others to do the same. Pressure may also be applied in the guise of “teasing” or playing a joke as illustrated in the following quote:

Like some of my friends, as a joke, they tricked another friend to go on this porn site and afterwards, even from that one event, it made her much more inclined to sort of joke along with the sort of sex jokes, and that sort of thing.

All participants talked about the double standard that exists for males and females when it comes to adolescent sexual activity. One participant described this as:

For the most part, the topic of conversation for guys is usually how many girls they can get. And to them, I guess, that is an accomplishment more than, like their morals. It doesn't matter, they just need to beat their friends with how many girls they can have sex with. And that pressure, girls feel, obviously, because boys are more forceful...especially if they are drinking. Some girls have no problem with it, and they will do whatever, but there are girls that are kind of like, their morals are there...But if a girl has multiple sex partners it is looked down on. It's okay for guys, it's cool...Yeah, like if you're a girl and you have lots of sex partners, people are gonna call you a slut. People are gonna call you a whore. People do this to their face and behind their back...But people don't seem to react negatively. They'll just be, like, that sucks that they think that of me. They're not hurt by it. I think it could be that they want attention, if that's the only kind of attention they can get, then fine. But other people it could just be, like, they might think that everyone's like that, so it doesn't matter, but I don't know, I think it depends on the person.

This same participant described how adolescent females experience pressure to take part in cell phone pornographic pictures, which often end up being sent out to many people:

And then there's pressure, to like, a lot of girls feel pressure, to like send their boyfriend pictures, or even, just, not a friend, but someone they're seeing maybe. Like they just feel like they have to do it to keep their attention.

Although many participants provided examples of how friends can negatively influence one another, they also provided examples of how they can support each other to make healthy choices. All participants commented on how supportive friends can be of help to resist or cope with the pressures:

Friends they're in every group, there's always some friends that are all about the craziness, and there's some that try to keep the other ones more down to earth, kind of thing. So there's always gonna be that friend that's looking out for you, but there's always gonna be that other friend taunting you to do other things, so it's really about yourself. If you're strong enough to say no, or just do whatever you're comfortable doing. But again it depends on the person, so.

Another participant described a situation where someone may have felt left out due to a lack of sexual experience and how friends were supportive:

Some of my friends, like, some of them haven't even had their first kiss yet and they're in grade 12. They must feel so out of place, because they hear other stories, like oh, I've already had sex and stuff and I haven't even been kissed yet.

Some of your friends will pat you on the back and say don't worry about it you'll get a girlfriend/boyfriend when you're ready. You do whatever you want. Some groups may be like, wow you haven't had a girlfriend yet. You're a loser or whatever, but, it depends who your friends are.

This same participant provided another example demonstrating how adolescents can be supportive when a friend has experienced a recent break up:

Like our friends, we'd have a big sleepover to talk about it...If they were sexually active. We would calm them down for a bit, saying like, you had a really good connection but you broke up and it hurt a lot.

Another participant described the importance of friends by making a distinction between peers and friends: "Well they're like peers because if you have to change for them, they aren't actually friends".

All of the participants referred to the pressure that they either feel themselves or see others experiencing. They describe this pressure as a struggle between fitting in and being themselves. These next two quotes, by one of the participants, illustrate the depth of the struggle that the participants have referred to:

With all the pressure and everything, I think it makes it really hard because if you

follow your morals and everything, you're not considered cool. You're not really noticed, I guess. So if you wanna have friends, if you wanna have a good high school experience, you have to do certain things. You have to sacrifice certain things.

I think the pressure is the hard part. You just have to get by it. And most people can't get by it, so it kind of just takes over their life. Like they just can't stand up for what they believe in, kind of thing. So they can't keep their morals, so they just kind of say like, whatever. I'll just conform to whatever they're doing, and be well liked, and get out of here and be myself hopefully. So it's just kind of like pretending to be someone for three years, and then, leaving and hoping it didn't change you for good.

Upon analysis of the interview data, it is clear that the participants in this study perceive that the majority of students in high school experience pressure to participate in risky behaviours such as alcohol use, drug use, casual sex and watching pornography. According to a national survey that was carried out with grade 9 and grade 11 students, significant numbers of youth reported engaging in these risk taking behaviours as ways to become popular, which is of great importance to many adolescents (Boyce et al., 2003). Another national study, that was carried out with grade 9 and 11 students, addressing the characteristics of youth reporting an early sexual debut, reported that a number of factors came into play: (a) pressure to have unwanted sex; (b) having used drugs, and, (c) believing that rebellious behaviour will lead to popularity (Boyce, Gallupe, & Fergus, 2008).

Many of the studies that have addressed peer pressure support what the participants in this current study have reported. For example in a study carried out by Shoveller et al. (2004), it was reported that adolescents aged 18-24 years described a need to conform to sexual norms within their communities for fear of being ostracized by their peers. Overall, their decisions about sex were strongly influenced by wider peer expectations and perceived judgements than by the norms established by their individual friendship groups. In a second study carried out by Laflin, Wang, and Barry (2008), it was reported that greater levels of peer pressure to have sex have

been associated with an increased level of adolescent sexual activity, especially for those under the age of 15. In a third study carried out by Marston and King (2006), it was reported that partner influence and social expectations accounted for adolescents' sexual activity in all settings. Some of the partner influences that were noted in the study with respect to females "choosing" to have sexual intercourse included not wanting to upset the partner and the desire to maintain the relationship. The study also identified that the influence of social expectations on sexual behaviour was contingent on chastity for females and sexual prowess for males. In a fourth study carried out by Gallupe, Boyce and Fergus (2009), it was noted that when girls felt pressure to have sex, it was often associated with not using condoms for protection. This is a concern, as this practice places these young women and their partners at risk with respect to STI's and pregnancy.

The concept of peer pressure is very complex as there are a multitude of factors that contribute to adolescent sexual decision making. According to a paper, that examined the complexities of peer pressure and how it relates to adolescent sexual decision making, it was suggested that more research be done to gain a "more sophisticated understanding of how peer pressure might operate" within "contextualized" environments (Maxwell & Chase, 2008, p. 303).

Cyberbullying. All of the participants of this study reported the increasing use of electronic devices to bully adolescents. This type of bullying is called cyberbullying, which can be defined as "sending or posting harmful or cruel text or images using the internet or other digital communicating devices" (Willard, 2004, p.4). The participants reported that Facebook and cell phones were the main devices for this type of bullying to occur. Some of the quotes that illustrate the depth of this problem and how it impacts the promotion of adolescent healthy sexuality will be presented.

One student reported an incident where Facebook was used by a student to influence other students not to participate in an event that would support those students in the school who were homosexuals:

I have come in contact with very anti-homosexual people. Earlier this year, there was a wear purple day because of the shootings, the killings and suicides that were going on. And there was a boy who had been saying, 'my school wanted to do this but I blocked it' [on Facebook]. He was either vice president, or president of the school council, He thought it was wrong to support this sort of homosexual lifestyle. And I thought that was completely wrong, because even if you aren't homosexual, and even if you disapprove of the sin, like love the sinner, hate the sin. Christianity is all about loving people and embracing people...And I think it was very anti-Christian of him, but he had seen it as a pro-Christian to do that.

This participant proudly reported what happened on the day that the students wore purple:

He did not wear purple. But there were lots of people who were wearing purple, because again, while not all of us may be homosexual, we are very supportive. Because we tend to know, at least, one or two people who are [homosexual] and we know that they face a lot of persecution in, just the general population. And so we really wanted to show our support for that. Again, while we might not be that way, we're more liberal-minded when it comes to this topic, because we know that it's not a choice to be homosexual.

Another participant reported how pictures on cell phones can be used to bully other female adolescents:

Because a lot of people send pictures, revealing pictures and stuff. And that's just bad because it always ends up going around and causes embarrassment. And then there's pressure, to like, a lot of girls feel pressure, to like send their boyfriend pictures, or even, just a friend, but someone they're seeing, maybe. Like they just feel like they have to do it to keep their attention. It's sad as these pictures often get sent to other people. Like you hear, almost monthly that, like, 'oh, like a naked picture is going around'. People, like everyone gets it. If someone gets one picture, they'll send it to all their contacts. And they could have, like 200 contacts, like you don't know. So it's really horrible and it happens really often. Really often. It happens during school. Like people get them in class and they'll start laughing and show their friends. It's just awful.

This same participant described the possible consequences for both the females and the males when this 'sharing' of naked pictures occurs:

Some girls just take it as a positive thing, and walk around the school, and feel confident. But there's the odd one that's really embarrassed. Some even change schools after that happens cause, I mean, I could imagine that could be really embarrassing, being uncomfortable. Walking around the halls knowing that everyone's seen the picture. Cause this year it happened in a matter of, like, twenty minutes, I think, everyone who owns a cell phone at the school received the picture. Guys and girls. It just got sent. Everyone would set up a group message. It's a joke to people, I guess.

There are no consequences for the guy who sends it around. Well, maybe the girl will get mad at him, but since he actually sent the picture to other people, he probably doesn't care about that girl very much, so if she gets mad at him, he probably won't-it won't affect him very much...All the consequences are on the girl, always, in that situation.

Another form of bullying that was described is that of young women taking part in pornographic videos with their partners trying to "imitate" the pornography that they are watching. Two of the participants refer to videos being sent out to everyone as yet another form of bullying. One participant described this:

A lot of times, they make them [sex videos] and they, could, most people who make them are in a relationship. But that could turn out really bad. Like I heard of people's sex tapes being, like, sent to other people. That just causes a lot of embarrassment, and yeah, it's just I dunno. It's bad.

Another participant commented on why people use cell phones or the internet :

Cause the things you might not have the guts to-like, for example, it's easy to pick up a phone and talk, but it's hard to talk to someone face -to-face. So if you're on the phone, or you're texting it is easier to say something you don't have to say face-to-face. This can be texting or Facebook.

This type of bullying, cyberbullying, that all participants in this study referred to, is increasingly being recognized in many studies as a new phenomenon that results from the advances in new communication technologies (Cassidy, Jackson, & Brown, 2009; Collins, Martino, Elliot, & Rand, 2011; Li, 2006; Li, 2007; Patchin & Hinduja, 2011; Vandebosch & Van Cleemput, 2009; Wade & Beran, 2011). It is an area that is not well researched and therefore

requires much more extensive research with respect to prevalence, causes, consequences, and interventions to deal with it (Cassidy, Jackson, & Brown, 2009; Collins, Martino, Elliot, & Rand, 2011; Li, 2006; Li, 2007; Patchin & Hinduja, 2011; Vandebosch & Van Cleemput, 2009; Wade & Beran, 2011). Much of what was described in this current study has been supported by recent literature. Some of the studies that have addressed this phenomenon will be presented.

According to a study carried out with adolescents aged 12-16 almost 50% of the students reported being bullied, with about 25% of these incidents being the result of cyberbullying. It was also found that the majority of victims and bystanders did not report the incidents and there are significant differences in bullying with respect to males and females. Males were more likely to be the perpetrators while females were more likely to be the victims (Li, 2006). A second study carried out by Wade and Beran (2011) exploring prevalence as well as gender and grade differences demonstrated that a significant number of students from grades 6, 7 10 and 11 are involved in cyberbullying. It was also reported that girls are more likely to be the victims of this abuse while the incidents decrease in high school. A third study carried out by Vandebosch and Cleemput (2009) with primary and secondary students reported a number of findings: victims of cyberbullying are more dependent on the internet, feel less popular, take more internet related risks and the perpetrators were more often victims and bystanders of previous incidents.

Parental influence on adolescent decision making. All participants reported that it was difficult to talk to their parents about sexuality issues because it was awkward and uncomfortable. They reported that the majority of adolescents would choose to approach friends as opposed to parents regarding issues relating to sexuality. However, they also reported that there were a number of factors that enabled parents to influence adolescents with respect to decisions that promote healthy sexuality. Some of these factors include having: (a) strong

relationships with parents; (b) established rules with consequences within the home; (c) parental involvement in an adolescent's life; (d) provision of basic needs within home; (e) a sense of parental acceptance and support; and, (f) established criteria about what is right and wrong regarding risky behaviours.

Some of the quotes that demonstrate the views of participants will be presented. For example, all participants commented on how friends are the people that adolescents talk to about sex. One participant described this as: "Well the ones that most influence you are the people you have to deal with every single day at school. But parents?"

All participants indicated that it is awkward to discuss issues of sexuality with their parents and therefore they often seek out their friends to discuss issues relating to sex. One participant described this awkwardness with these three statements:

Because while you go to your parents at first, for the first few years, and like ask 'what do you think about this?' A lot of teenagers drift away from their parents when they get older, and they're in contact with their friends a lot more, and they're probably more open to their friends about 'I kissed Johnny'.

Because a lot of things with teenagers is we really don't want to get our parents involved. Probably, unless it's a really good relationship, if you're getting into a sexual relationship, even then you probably are really uncomfortable about 'Mom, I need to go to get some birth control pills'. 'But honey, why do you need those?' 'Um because I'm dating a guy, and I really like him, and'... But no one really wants to have that conversation with their parents.

I know a friend of mine who, she's actually quite open about her sexuality with us. Yes her friends. But, she never touches the subject with her parents because they're very conservative when it comes to that, and she's much more liberal, but she doesn't want to have to discuss it with her parents because she doesn't want to create conflict between them

A second participant commented on how uncomfortable it is for adolescents to talk with their parents:

I love my parents. I can talk to them about anything else. I think that's just so weird. I think they'd be really disappointed if they found out that I was doing anything. And I

don't like them being mad at me or disappointed in me.

All participants identified that although parents would not be the first choice adolescents would go to for issues relating to sexuality, and at the same time indicated parents can influence adolescents towards healthy sexual decisions. There are a number of quotes that illustrate why this could occur. For example one participant reported how parents being there for adolescents can deter them from watching pornography:

I think their parents are more in it too. Like they're more proud of them, which makes them have more like, higher self-confidence...If you're in the other group and got caught and your parents don't really care what you're doing. So they don't look at your computer, they don't really care what you are doing at all. So you can kind of do whatever you want, thinking things like, they don't care. But, other parents that are in your life, and like help you out, like you don't want to disappoint them at all. So, you know, you won't go to any of those sites at all.

This same participant further described how parents demonstrated that they care about their adolescent children:

They punish them if they do something. Like I know if I did something wrong, then I would probably be grounded for like a week or two weeks. Some kids can steal, drink, do drugs, and their parents are like oh you shouldn't do that and just forget about it.

Another participant described how the state of the relationship between the parent and adolescent can affect adolescent decision making: "If you have good relationships with your parents, then you're more likely to discuss things with them and make healthier choices."

Several participants commented on how parents' family income can influence adolescent decision making by simply being able to provide for their needs and care for them. One participant made several comments regarding this theme:

Well I'm lucky enough to come from a very good income family. And so I don't have to worry about things. I don't know how to describe it. I just know that people that I know who do have very good incomes, they're more likely to have a good relationship with their parents. And they're more likely to make good choices, cause they're able to talk

about things.

If you're living with your core family, it's the relationship with the parent and child. If they're able to support them and care for them, a teenager can see that there's a relationship there and they don't want to disappoint their parent because they're putting so much effort towards them. And that they really care about them.

When questioned about the potential impact that parental income has on adolescent decision making, a second participant elaborated on the importance of the strength of the adolescent and parent relationship through these two statements:

I don't think so because whether they have a high income or low income, you can still have a strong relationship. And I think that the relationship is the most important thing. More than anything else.

I think it depends on your parents... Maybe, like you don't have a close relationship with your parents, maybe you don't like that they don't teach you as much. Like I know they don't help the moral thing, and they don't help your morals, and maybe you're just more lost than people who have a stronger connection with their parents [who] don't have to talk about sex necessarily, just like in general situations. And they can teach them how to handle things better. So I think it depends on your relationship with your parents.

Several participants made comments about how students having access to money can actually be detrimental to their decision making. One participant elaborated on the potential for harm with respect to this theme:

But for people who have jobs, and their parents sort of say 'okay, you have the credit card, you have your money now. I don't need to keep track of that'. They're much more, sort of, into the alcohol scene, they're into texting, and subsequently, if they do both, bad things happen. So, I think people who do have more access to money, whether it's through their parents giving them a lot of money all the time, like a fixed rate every week you'll get fifty dollars or something like that, or people who have jobs and they're sort of, in control of their own money. I think they are much more likely to get involved with the, what I consider to be a negative scene... Like a lot of people I do know who have money, they're not putting it towards 'okay, I'm saving up my money so I can pay off my first two years of university' It's 'Oh, I have just enough money so that I can grab a Tim's and then I can go out shopping and I can get someone to go and buy me a case of beer for the weekend'.

Several participants indicated that some adolescents try to follow what their parents taught them when it comes to making decisions about sex. For example, one participant commented:

Their parents might not influence it too much, but, there probably are enough [who think] ‘this is what my parents taught me and so I’m gonna try and follow it the best I can’.

Another participant made several comments on the importance of what is taught at home:

I’m lucky enough to have a mother who talks a lot about- or is willing to talk about these sorts of issues. And she had a mother, who talked a lot about that sort of thing and it trickled down to me.

There’s a lot of people who, even though their parents don’t go to church, they’ve been raised with that sort of ‘well the first thing you should consider is abstinence, but if not safe sex’.

For me, my parents have a stronger influence because they’ve taught me my Christian background. And so, I find that I tend to go to them, and I do identify more with their feelings about sexuality and healthy sexuality than my friends’ [parents] because they are much more open.

A third participant also referred to what was taught at home as being significant in healthy adolescent decision making if peer pressure doesn’t interfere:

Like the people whose morals are stronger, and they can, they’re strong enough people to keep them. I think that parents could be a good influence if they, you know, are raised well, and teach you everything, and it just, it depends on the individual, again. But, sometimes the whole popularity thing just tramples all over that and you forget about it [what was taught].

A fourth participant, upon acknowledging the desire for adolescents to use their parents as a source of knowledge and support, commented that parents should be supported to support their children: “Parents are the best teachers for their children... Teach the parents to teach the children”.

Parents, by the nature of their relationship with their children, have the potential to influence adolescent decision making, which can ultimately affect the development of healthy sexuality of adolescents. Much of the data that was presented in this current study has been supported in the literature.

For example, a study carried out with grade 7-12 students, by Huebner and Howell (2003), identified that parental monitoring, parental-adolescent communication and parental style are all variables that should be considered with respect to adolescent risk taking behaviour that affects the development of healthy sexuality.

A second study, carried out by Robert and Sonenstein (2010), acknowledged that fewer female adolescents reported discussions with a parent about STIs or birth control measures and it was therefore recommended that efforts should be taken to encourage parents to talk to their children.

A third study carried out nationally by Frappier et al., (2008), with 14-17 year old adolescents and mothers of adolescents aged 14-17 years of age, reported that 45% of students look up to their parents and consider them to be role models and a source for information. However, parents have underestimated their role with respect to promoting a healthy sexuality with their adolescent teens; 78% of the mothers who participated in the survey believed that their children modeled their friends' behaviour. This study also recognized that parent-child communication and parental knowledge level of sexual issues and resources could be better. It was recommended that parents should be encouraged and supported to obtain further sexual education for themselves to better support and inform their adolescent children.

A fourth study, carried out by Wight, Williamson and Henderson (2006), with adolescent children and their parents addressed the parental influence on adolescent sexual behaviour. This study reported several findings: (a) parental monitoring predicts sexual behaviour for both male and female adolescents; (b) low parental monitoring predicts more sexual partners and less condom use; and, (c) access to a lot of money predicts early sexual behaviour and more sexual partners for males. In a fifth study by Langille et al., 2010, carried out with students aged 15-19

years, it was reported that poor relationships with parents are associated with increased likelihood of sexual activity. It was also reported in this study that students whose parents were perceived as less controlling and more permissive were more likely to be sexually active.

A sixth study carried out by de Graaf, Vanwesenbeeck, Woertman and Meeus (2011), addressed parenting styles and adolescents' sexual development. It was noted in this study that clear and fair demands were related to a delay in first sexual experience and less unwanted sexual experiences. Parental support was correlated with "higher levels of contraceptive and condom use, among sexually active adolescents, more positive feelings regarding sexuality, and higher levels of competence in sexual interactions" (p. 28).

Organizational Factors

Insufficient and underutilized school health resources. All participants commented on the status of the resources available within the school. The resources they identified included school counsellors, teachers, school administrators, and the Family Life course. They elaborated on factors that contributed to positive experiences and factors that interfered with the accessibility of the resources. They also identified areas for improvement for existing resources and recommended the development of specific resources that are required for the promotion of healthy sexuality of adolescents. A summary of the participants' perceptions regarding the status of supports, services, and education at the school will be presented with accompanying quotes where applicable.

All of the participants identified a number of factors that have interfered with the accessibility of resources within the school: (a) feeling uncomfortable; (b) lack of trust; (c) lack of confidentiality; (d) lack of awareness of resources available; (e) unclear roles of supports at school; (f) lack of knowledge of available resources; and, (g) limited availability of resources.

These barriers are discussed in depth in the Illusion of Accessible Resources section of this chapter. All participants also identified that they have never seen a public health nurse in the school and that they are not aware of how they could access a nurse within the school. They also identified that there is no health clinic or referral system to physicians or nurses that they are aware of.

There are a number of resources that participants identified as being useful with respect to the promotion of healthy sexuality of adolescents. All participants identified school counsellors as a potential source of support. They identified that the school counsellors are staff that have helped students with problems such as academic concerns, ongoing counselling once referred by a parent or teacher, and assistance for those who think they may be pregnant. One participant explained a situation where the school counsellor was very helpful:

I went in with a personal friend of mine not too long ago to talk about that [sexuality]. She needed a pregnancy test. They did the test for her and talked with her. It helped...She wasn't pregnant.

I actually have a friend right now who's pregnant. And she's probably due next month. And they helped her so much, the guidance counsellors. They even call her down, even when she's not expecting it, and they're like, we brought someone in to help talk to you, a nutritionist. They get people to come in and gave her a bag full of diapers and everything to help her out. I think the counsellors just want to know if, if you're okay, if you know what you're doing. Cause I know my friend didn't really know what she was doing. She didn't know much about raising a child. So they helped her out a lot.

A second participant described her experience with the counsellor as being helpful even though she was "made to go":

Um, mostly I get a lot of migraines and a lot of doctors worry that it's from stress or I'm getting sick just from stress. So to make sure that's not the cause they wanted me to go to a counsellor and it makes the teachers happy and it makes the parents happy...It helped because I had someone to talk to, someone to talk to without saying stop complaining.

However, the majority of participants reported that few adolescents would actually seek out the school counsellor for support because as one participant stated:

I don't think they really care. They care more about the students that are having, like, problems in school, or something like that. But, I don't think they really care about what you do outside of school.

Another participant commented further regarding the reason counsellors may not be accessed by students:

Like all the counsellors that are in student services, most of the people who go to them, it's for, like, school stuff, like university or whatever. But you can still go talk to them about, like anything. Like, any questions you may have about sexual education or whatever, but, no one really goes because they don't like promote it, they don't make you feel really comfortable about it. I would personally feel awkward to go to talk to them. It's just, weird like...And it's not the people, it's not like they're mean people or anything, it's just weird...They assume that if someone has a problem they'll just go on their own, but I think people are too scared to do that.

All of the participants referred to the teachers and the administrators as a source of support as well. However they indicated that because it has not been "marketed" as their role within the school, very few students would seek them out for support regarding issues relating to sexuality. The participants identified that the strength of the relationship that an individual student had with a teacher or administrator played an important role in whether a student would go to them for support or guidance. They also commented on how this would be difficult to develop as they usually only have a teacher for one semester in three years and hardly see the administrators as they are "very busy". They indicated that teachers were uncomfortable talking about sex and would usually refer them to a counsellor.

All of the participants reported that there were limited educational opportunities regarding sexuality for students within the high school environment. They identified that there was no mandatory education that addressed the promotion of healthy sexuality for adolescents. They reported that there was only one course called the Family Life Course that addressed the

promotion of healthy sexuality and this course is not mandatory; it is a course that a student chooses to take. However only 3 of the 6 participants had previously taken or are currently taking this course. The participants reported that the course is not easily accessible as it can be difficult to fit it into their schedules. One participant described this issue:

I personally have never been able to take the course, even if I wanted it, because of the time constraints and I'm working on a high academic level and I need to take my sciences, I need to take my French and so.

All but one participant reported that they had never attended a presentation that was focused on the promotion of healthy sexuality issues. Only one participant indicated that she attended a few presentations that were presented by experts in a few classes during the Family Life course. This excerpt describes her experience:

I just found them really long and kind of boring actually cause it was stuff that we already went over in class. I kinda didn't listen to them. I was kinda playing with my ipod (Laughter)... Maybe if they came in before and asked us what our questions were and what we wanted to know, and stuff. But they came in with their slide show already set up and stuff.

However, all of the participants reported that the Family Life course was a very good course. This included those who experienced the course and those who just "heard" about the course. They all suggested that this is a course that all students would benefit from taking and suggested that it be made mandatory for all students to take once during their 3 years in high school. One participant who completed the course described the experience in a positive manner:

Oh! Yeah. If you take something like Family Living, there's a whole unit on sexual education, and that goes into detail on STI's and everything. I thought it was great. It was really informative, like it didn't lack in anything. I think I really liked the Family Life class because it went into detail. Like, it talks about STIs and everything. It kinda scares people, but I think that's a good thing because it can maybe, like, it'll make someone think twice about having a one night stand with someone they don't even know. I think it would be good to make it a course you have to take. I think that unit on sexuality really helps.

Three of the participants identified that school psychologists would be a good resource to have available for students. One participant made several comments regarding the usefulness of a school psychologist:

I know that just talking to a lot of my friends, they feel, it makes them feel kind of more comfortable with themselves. I think. That's what I noticed from them after they've talked to their psychologists. But I really think that they're a good help because I see a difference in my friends. Like, the ones that do go to psychologists.

I've seen a difference in my friends who go to psychologists. Just kinda like before they're maybe confused or something. And they just wanna know more or they're lost on something. And afterward they talk about it with confidence. But it helps them in every, like, kind of spot that they need help with. It's just kinda like, another boost kind of thing. And it's like every teenager should be comfortable and stuff like that.

Much of the data that was reported by participants was supported in the literature. Many studies that have addressed the perceptions of adolescents regarding the status of sexual health resources within schools, have identified many of these same gaps, barriers and recommendations (CAAH, 2006; Cape Breton Wellness Centre, 1999; DiCenso et al., 2001; Langille et al., 2001; PEI Caucus of Youth Sexual Health, 2005; Smylie, Maticka-Tindale & Boyd, 2008; Planned Parenthood, 1996). For example, in a study carried out with students in grade 9 and 11 by DiCenso et al. (2001), it was reported by students that too much time was spent on the “plumbing” and teachers were often uncomfortable providing sexual health education. The students made the following suggestions for improvements: (a) provide more comprehensive content on STIs, contraception, relationship issues and sexual activity options., (b) begin sex education earlier (grade 6), (c) update teaching strategies, (d) improve confidentiality, and better prepare the educators and, (e) better inform the students about available resources.

In a study carried out with 14-24 year olds, by Planned Parenthood Nova Scotia (1996), *Just Loosen Up and Start Talking*, the students identified a number of similar barriers and recommendations for improvement. The barriers included: (a) limited availability of services, (b) lack of confidentiality; (c) lack of privacy; (d) teachers being overly judgmental, negative, and often uncomfortable with the subject matter; and, (e) information being too narrow in focus. Suggestions made by these students included: (a) making the courses more comprehensive; (b) providing better training to teachers to improve their comfort; (c) providing education sooner; (d) using more stimulating complete and updated resources; and, (e) providing more thorough information about preventing STIs (Planned Parenthood Nova Scotia, 1996).

In a third study conducted by Langille et al (2001), carried out with female adolescents age 15-18, the students identified concerns regarding sexual education within the school environment. Important findings regarding the adolescents' perceptions of barriers to sexual education included: (a) teachers placed sexual education as a low priority within the school system; (b) there was a disconnect between what is taught in the schools and what the young women are experiencing in their everyday lives with respect to a temporal perspective; (c) young men in the classes are of concern as they interfered with the learning through their disruptive behaviour; (d) teachers were often uncomfortable with the content; and, (e) some teachers were judgmental.

In a fourth study, the CAAH carried out a national survey with online interviews with respect to better understanding 14-17 year olds' perceptions of barriers to sexual education and services. A number of obstacles and gaps were identified. It was reported that although 79% of these youth obtained sexual education within the school programs only 23% reported that it was useful. A number of gaps were identified by 69% of these adolescents involving a lack of

education regarding violence in relationships, date rape, communication issues and how to deal with emotions. There were also barriers identified with respect to accessing health services. About 62% of these adolescents identified barriers such as being uncomfortable talking or learning about sexuality issues and about fearing that parents would find out they are seeking sexual health information (CAAH, 2006).

In another national study, involving students in grades 7, 9, and 11, Boyce et al. (2003) reported barriers with respect to adolescent educational services. Many of the students disturbingly reported that they had not received any instruction about HIV/AIDS over the past two years (27% of grade 7 students; 14% of grade 9 and 11 students) and some reported that they did not receive any information in school regarding sexuality (17% of grade 7 students; 8% of grade 9 students; and, 11% of grade 11 students).

Finally, a study carried out in PEI, where this current study took place, there was one survey that identified the perceptions of youth regarding barriers to sexual health education and services (PEI Caucus on Youth Sexual Health, 2005). During this project, 150 youth (aged 13-21) were consulted through informal small group discussions or larger public health events. Within this process a number of barriers to sexual health education within schools were identified. The youth in this project identified the following barriers: (a) lack of identifiable sexual health resources within the school; (b) lack of confidentiality with teachers, (c) teachers appear uncomfortable with discussing sexuality issues; and, (d) teachers appear judgemental when discussing issues of confidentiality. They recommended to: (a) better prepare the teacher to be more comfortable with the content and to create a more comfortable environment when teaching, (b) create youth sexual health and education centres in schools; and, (c) include decision making skills as part of education.

It is interesting to note, however, that the participants in these previous studies did not identify the need for a school psychologist, as some participants did in this current study. This resource, however, is one that is becoming increasingly recognized as one to consider in a comprehensive school health program. It is specifically being recommended that school psychologists spend less time testing and assessing and spend more time on collaboration with community resources, interventions and prevention (Corkum, French, & Dorey, 2007; Harris & Joy, 2010; Jordan, Hinds, & Saklofske, 2009).

Community Factors

Inefficient and underutilized community health resources. All participants commented on the status of resources within the community. They identified that the most useful resources were the family physicians. They also identified other resources such as physicians in emergency rooms and walk-in clinics, pharmacists, youth groups, and nurses as being potential sources for information and support with respect to the promotion of healthy sexuality of adolescents. They elaborated on factors that contributed to positive experiences and factors that interfered with the accessibility of resources. They also identified areas for improvement for existing resources and recommended the development of specific resources that are required for the promotion of healthy sexuality of adolescents. A summary of the participants' perceptions regarding the status of supports and services within the community will be presented with accompanying quotes where applicable.

All of the students identified a number of factors that interfered with the accessibility of resources. These factors include: (a) feeling uncomfortable, (b) lack of trust, (c) lack of confidentiality, (d) lack of awareness of resources available, and, (e) limited availability of resources. These barriers are discussed in depth in the *Illusion of Accessible Resources* section of

this chapter. These barriers are considered to be significant as they influence adolescent decision making regarding accessing community resources. For example, all participants identified that family physicians would be the resource that would be used most by adolescents regarding issues of sexuality. However, they identified a lack of confidentiality and fear of parents finding out as a barrier. Participants reported that lack of trust was the most recognized barrier with respect to walk-in clinics and emergency room physicians. All of the participants identified a nurse as a potential support for the promotion of healthy sexuality of adolescents. However, the participants were unsure of how to access a nurse, commenting that they may be accessed at the hospital or a doctor's office. One participant commented on the difficulty of accessing a nurse in the community:

Seeking the nurses would be going to the hospital and that's probably even more uncomfortable than to walk-in-clinics to ask for help. Well we don't have a nurse at my family doctor. We don't really have that option.

A lack of confidentiality was the most recognized barrier for accessing the pharmacist as well as one student captured her concern in this quote:

It's not a place you would generally choose... yeah. I think it would be a really good place, because that's where all the sex, um, like safe sex things are located. And it's good to get information, or if you need medication... That's some place you should be able to go to. But, because the only pharmacies that I know of are drug store atmospheres, even the one that is located near a doctor's office, is...there's no little room that you go into to pick up your medicines or a place that you can easily say, 'I need to talk to you about something'. Everyone will hear you.

However, three of the participants identified positive experiences with a pharmacist through the telephone contact or face-to face. One participant indicated that using the phone can be a confidential way to obtain support from a pharmacist: "I have some friends who call

pharmacists. They can be helpful. On the phone they don't know who you are. You can ask whatever questions you want.”

Another participant made several comments to describe her thoughts on a pharmacist being a good support for sexual health issues:

Teenagers would use a pharmacist more than a nurse or a doctor. We have like Shopper's Drug Marts, they're all over the place, so they're more available than a nurse would be... I have used one. I went face-to-face. I think that face-to-face would be more beneficial [than phone] because you can see if they actually care or not.

And the other guy that was working was actually my friend. So I didn't want him to know what I was talking about, so we went to the side and just kind of spoke face-to-face, kind of more quietly. And while she was handing me something, she put it under her coat so that the other guy wouldn't see if I was taking something and she let me go to the other cash so he wouldn't have to ring me in, like she wanted me to. It was really nice.

All but two of the participants reported that adolescents would not consider youth groups within the community to be a source of support as they are affiliated with a church that tells students “Don't do it”, it being sex. Participants reported that these groups don't give a message that's based in the reality of their everyday lives. One participant described that youth groups are more for pre-teens:

I haven't participated in any, but I know that I have a few friends that have gone. But that was early, like pre-teen, like 13, 14 years of age. There's none really for my age. It's more like a pre-teen kind of thing and then you ease out of it.

A second participant described how youth groups are based on what adults expect of adolescents:

I don't think teenagers will get anything out of youth groups. Like, when it comes to having sex and all that stuff, it's usually aimed for adults, not teenagers. Like, don't have sex.

A third participant who attends a youth group and likes it, reported that she would seek out the youth pastor to discuss issues of sexuality individually because “ He's a really open guy, he even

talks about his own problems too, so that you don't have to feel abnormal in any kind of way, like he can relate to what you are saying." However, this same participant further reported that she had "never heard of anyone going to their youth group asking, like, sexual questions" during the group sessions.

Much of the data that was presented by the participants of this current study has been supported by the literature. Many studies that have addressed the perceptions of adolescents regarding the status of sexual health resources within communities, have also identified many of the same gaps, barriers and recommendations (Cape Breton Wellness Centre, 1999; Langille et al., 2001; PEI Caucus of Youth Sexual Health, 2005; Planned Parenthood, 1996). However, the health promotional role of pharmacists was not a gap that was identified in these studies as it was in this current study. In the earlier studies, participants discussed pharmacists with respect to accessing condoms and prescriptions and discussed students concern with lack of privacy and confidentiality. According to participants in this current study, provided with a safe, confidential and non-judgmental environment, pharmacists could play a valuable role with respect to promoting healthy sexuality to adolescents.

A national survey, the Canadian Youth, Sexual Health and HIV/AIDS Study (2003) surveyed students in grades 7, 9, and 11 from all provinces and territories. Some of the barriers that were identified with respect to sexual health education and services were of concern. For example only 17% of girls reported that they would go to their family physician if they thought they had an STI. Less than 3% of girls and 1% of boys were assessed for STI's within the last 12 months. Furthermore, some adolescents did not know where to access condoms (12% of boys and 16% of girls in grade 11) (Boyce et al., 2003).

A second study carried out by Planned Parenthood Nova Scotia (1996) *Just Loosen Up and Start Talking*, with youth aged 14-24 years of age identified a number of barriers with respect to adolescent sexual health services. Some of the barriers included: (a) limited availability of services; (b) lack of confidentiality; and, (c) lack of privacy. Some of the suggestions for improvement of services included: (a) improve accessibility and confidentiality of services; (b) normalize sexuality to eliminate it as a source of shame; and, (c) recognize that adolescents can be sexually active and address it as such.

A third study that was conducted by the Cape Breton Wellness Centre (1999) with adolescents between 14 -18 years of age also identified a number of factors that interfered with adolescents accessing sexual health services. Participants identified the following barriers to sexual health: (a) lack of finances and privacy interfered with the adolescents purchasing condoms; (b) having no booked appointments in the community medical clinic forced adolescents to wait in a waiting room which they vocalized as interfering with their privacy; and (c) lack of knowledge regarding available sexual health services.

In a fourth study that was carried out in PEI, with youth aged 13-21, a number of barriers were also identified by the participants. The participants identified the following barriers: (a) lack of identifiable sexual health resources; (b) lack of confidentiality when accessing family physician and public health nurse; (c) difficulty accessing transportation to access services; (d) unclear of whether they can seek sexual advices without parental permission; (e) health services available are not accessible with their schedules and, (f) feelings of “alienation” in the adult world interfering with seeking support (PEI Caucus on Youth sexual Health, 2005).

In a fifth study carried out by Langille et al. (2010) with students aged 15-19 years, a number of barriers were also identified with respect to adolescents’ accessibility to physician services.

Some of these barriers that the participants identified, in order of significance, included: a) feelings of embarrassment to discuss sexual issues with physician; b) concern with confidentiality with respect to parents finding out about their sexual activity; c) physician being judgmental; d) trouble making an appointment; e) lack access to transportation; and e) physician does not bring up topic of sexuality.

Participants' Recommendations

Participants, in this current study, identified recommendations for improvement of resources and suggested resources that should be developed within the school and community environments. In identifying these recommendations, these participants demonstrated that adolescents have potential in contributing to the promotion of healthy sexuality of adolescents. This study was designed to make the voices of adolescents more audible. In doing this, the data was reflective of both the issues that need to be addressed with adolescents as well as the strengths that adolescents hold that can be used to enhance the promotion of healthy sexuality of adolescents. For example, the participants identified that adolescents who are involved in peer support within the school are a source of support that can be very useful for other adolescents. They also identified that adolescents are very knowledgeable about the increasing technology that is being developed. This strength can be used by seeking out adolescents regarding their expertise and how this technology can be used in a positive way to reach out to peers.

The participants made recommendations to improving the accessibility to sexual health resources within the school environment. These were to: (a) develop a youth health clinic in the school; (b) create a position for a public health nurse to work in the school on a regular basis; (c) ensure that the services available within the school and community are accessible, confidential and non-judgmental; and, (d) include a school psychologist as a resource for students.

The participants made recommendations to improve the educational opportunities for students with respect to the promotion of healthy sexuality. These were to: (a) make the Family Life course mandatory for all students; (b) make the Family Life course more comprehensive to include content on how to handle relationships and peer pressure; (c) start sexual education sooner in elementary school and ensure that it continues through high school; (d) ensure teachers are better prepared and more comfortable; (e) increase the use of experts to provide presentations and counselling for students; (f) educate parents so that they can provide better support and guidance to their children; and, (g) inform the students about the availability of the sexual health resources within the school and community.

All participants made recommendations with respect to improving the accessibility to sexual health resources for adolescents within the community. These included: (a) develop a youth health clinic within the community; (b) ensure that the services available within the community are accessible, confidential and non-judgmental; (c) inform the students about the sexual health resources that are available in PEI; (d) develop and distribute advertisements of the sexual health resources that are available for adolescents; (e) create interactive websites that can be used by adolescents to anonymously ask questions regarding adolescent sexual health; and, (f) create a private space within the pharmacies where adolescents can privately access pharmacists.

Summary

In summary, the purpose of this qualitative descriptive exploratory study informed by CST and a socioecological framework was to identify adolescents' perceptions of the facilitators and barriers to the promotion of healthy sexuality for adolescents living in PEI. It was beneficial in exploring the perspectives of the six adolescents who participated in this study within the social, political, economic and historical conditions in which people live. A socio-ecological framework

(McLeroy et al., 1988) was also used in this study, as it enhanced the application of CST and data were analyzed using thematic analysis. The socio-ecological framework includes the following interrelated levels of influence: intrapersonal, interpersonal, organizational, community and policy levels. Using these levels of influence, as the basis for the coding proved to be beneficial in capturing the multi-component nature of participants' perspectives.

Seven themes emerged. The themes that have emerged for the intrapersonal factors included: *The Illusion of Accessibility*; and *Risky Behaviours*. The themes that emerged for interpersonal factors were *Peer Pressure Alive and Well in High School*; *Cyberbullying*; and, *Parental Influence on Adolescent Decision Making*. The theme that emerged for organizational factors was *Insufficient and Underutilized School Health Resources*. The theme that emerged for the community factors was *Insufficient and Underutilized Community Health Resources*. As the category of policy factors was not directly discussed with the participants during the interviews, it is more appropriate to address it in the *Research, Conclusions and Future Implications* chapter of this study.

Within the theme, *The Illusion of Accessible Resources*, the participants identified potential resources for the development of healthy sexuality for adolescents including family physicians, emergency rooms, walk-in clinics, teachers, school counsellors, school administrators, youth groups, and school psychologists. The participants also identified barriers to these resources: (a) feeling uncomfortable; (b) lack of trust; (c) lack of confidentiality; (d) unclear roles of supports at school; (e) lack of knowledge of available resources; and, (f) limited availability of resources. According to participants, these barriers impact on the development of the healthy sexuality of adolescents because many of the barriers cause adolescents to forgo needed health care.

Risky Behaviours, the second theme within the intrapersonal factors, encompasses the multiple risky behaviours that many adolescents are at risk for engaging in. The risky behaviours that participants reported some adolescents are taking part in are alcohol use, drug use, watching pornography, and casual sex. These risky behaviours, which are often interrelated, have been widely recognized in many studies as placing adolescents at risk for unplanned and often unprotected sexual activity which increases the potential for adolescent pregnancy and STIs.

Peer Pressure: Alive and Well in High School, is the first theme within the interpersonal factors. This theme addresses the impact of peers with respect to the promotion of healthy sexuality of youth. Participants identified that peer pressure plays a role in pressuring adolescents to participate in unhealthy risky behaviours such as using alcohol and drugs, watching pornography and participating in casual sex. The participants further reported that there was a tremendous amount of pressure that exists, within the school and community, for students to conform to the rules established by the “popular crowd”. The participants also reported that the majority of students were affected by this hierarchy which causes extreme pressure for some of the adolescents to purposely make poor choices to simply belong. Having a group of good friends and strong parental relationships can help buffer the influence of peer pressure and improve decision making.

Cyberbullying, is the second theme of the interpersonal factors. According to many studies this new type of bullying is becoming an increasing issue for youth. It is different than the traditional form of bullying because it extends beyond the school yard and has the potential to capture an increasing number of bystanders. The participants in this study identified incidents of cyber bullying that have the potential to interfere with the promotion of sexual health of adolescents. They specifically related incidents in which naked pictures, sex tapes, and

derogatory texts and Facebook messages have been posted and sent to peers within the school population. All of the participants described that such cyber bullying can have detrimental effects on the victims causing some students to actually stop attending or transfer schools. On the other hand, it was also reported that some adolescents desperately wanting to be popular appear to enjoy the attention that they receive as a result of the cyber bullying incidents.

The fifth theme, *Parental Influence on Adolescent Decision Making*, addresses the potential influence that parents may have on adolescent decision making. All of the participants reported that it was difficult to talk to their parents about sexuality issues because it was awkward and uncomfortable. They reported that the majority of adolescents would choose to approach friends as opposed to parents regarding issues relating to sexuality. However, they also reported that there were a number of factors that enabled parents to positively influence adolescents with respect to decisions that promote healthy sexuality. These included: (a) strong relationship with parents; (b) established rules with consequences within the home; c) parental involvement in adolescents life; (d) provision of basic needs within home; (e) sense of parental acceptance and support; and, (f) established criteria about what is right and wrong regarding risky behaviours.

Insufficient and Underutilized School Health Resources, is the only theme in the organizational factors. This theme addresses the status of resources within the school that promote the healthy sexuality of adolescents. The potential resources participants identified included school counsellors, teachers, school administrators, and the Family Life course. Some of the participants also identified that a school psychologist could be a source of support for student in school. This was a resource that was not identified in other studies that addressed the evaluation of the status of school health resources. Participants in this study also elaborated on factors that contributed to positive experiences stressing the importance of a confidential,

trusting, and non-judgmental environment. They also identified that the barriers to accessibility that have been identified in the *Illusion of Accessible Resources* section have contributed to fewer students actually utilizing the resources for the promotion of healthy sexuality

Furthermore the participants of the study made several recommendations for improvement of the supports and services within the school: (a) develop a youth health clinic in the school; (b) create a position for a public health nurse to work in the school on a regular basis; (c) ensure that the services available within the school and community are accessible, confidential, and non-judgmental; and, (d) include a school psychologist as a resource for students. They also made some recommendations for increasing the educational opportunities for students with respect to the promotion of healthy sexuality: (a) make the Family Life course mandatory for all students; (b) make the Family Life course more comprehensive to include content on how to handle relationships and peer pressure; (c) start sexual education sooner in elementary school and ensure that it continues through high school; (d) ensure teachers are better prepared and more comfortable; (e) increase the use of experts to provide presentations and counselling for students; (f) educate parents so that they can provide better support and guidance to their children; and, (g) inform the students about the availability of the sexual health resources within the school and community.

The seventh theme, *Insufficient and Underutilized Community Health Resources*, is the only theme for the community factors. This theme addresses the status of resources within the community for the promotion of healthy sexuality of adolescents. Participants identified the following resources as potential sources of information and support: family physicians, physicians in the emergency room and walk-in clinics, pharmacists, youth groups and nurses as potential sources for information and support with respect to the promotion of healthy sexuality

of adolescents. Some participants also identified a pharmacist as a support with respect to providing counselling regarding sexual health issues. This pharmacist role was not identified in other studies that addressed the status of adolescent sexual health resources within communities. They elaborated again on factors that contributed to positive experiences such as a confidential, trusting and non-judgmental environment. They also identified that the barriers to accessibility identified in the *Illusion of Accessible Resources* section have contributed to fewer students actually utilizing the resources for the promotion of healthy sexuality.

Furthermore the participants of the study made some recommendations for improvement of the supports and services within the community: (a) develop a youth health clinic within the community; (b) ensure that the services available within the community are accessible, confidential, and non-judgmental; (c) inform the students about the available sexual health resources; (d) develop and distribute advertisements of the sexual health resources that are available for adolescents; (e) create interactive websites that can be used by adolescents to anonymously ask questions regarding adolescent sexual health issues; and, (f) create a private space within the pharmacies where adolescents can privately access pharmacists.

Chapter Five: Research Conclusions and Future Implications

Research Conclusions

Adolescence is a critical time in an individual's development that represents profound biological, social, and psychological changes and is accompanied by growth and development. It is a time when adolescents are becoming increasingly aware of their sexuality (Benda & Corwyn, 1998, De Graff et al, 2011; Galambos & Tilton-Weaver, 1998). Since the beginning of the 1980s there has been a rise in the proportion of adolescents reporting engaging in sexual intercourse by age 15 (Maticka-Tindale et al., 2000). This places them at risk for unwanted pregnancy and STIs which in turn can have a tremendous impact on them as well as on their children, their partners and society in general. According to several studies, there have been declining adolescent pregnancies, fewer adolescents having more than one sexual partner, and an increasing numbers of adolescents using contraceptives. Notwithstanding these improvements, there are some concerns regarding adolescents' sexual health. These concerns include adolescents' limited knowledge of sexual health issues, high rates of adolescent STIs, and the need to eliminate barriers to adolescent sexual health service (Canadian Federation for Sexual Health, 2007).

Upon review of the interventions that are designed to have an impact on adolescent sexual health, it was identified that many of the programs are ineffective. Most behavioural research in this area has been focused on describing relationships with individual characteristics of the adolescent and potentially modifiable factors such as knowledge, attitudes, and behaviour (Kirby, 2007a; Shoveller & Piertsma, 2004; Shoveller et al., 2006). Many studies have advocated for the inclusion of youth in the evaluation and development of programs and services to increase their effectiveness (Di Censo, 1995 as cited in Dicenso & Dover, 2000; Di Censo et al., 2002; Kirby,

2007a; Langille et al, 2004; Langille et al., 2010; Noar, 2008; Scher et al., 2006; Shoveller et al., 2004; Shoveller et al., 2006).

It has also been acknowledged that there is a need to challenge the traditional approach of understanding the sexual behaviour of adolescents. The traditional epidemiological approach of focusing exclusively on reducing sexual activity, assumes that adolescents have the options to make healthy choices. It has been suggested that we move away from this epidemiological approach towards a more socio-ecological one to better understand the relationship of the behaviour of adolescents within their social context (Shoveller & Piertsma, 2002; Shoveller et al, 2004; Shoveller et al., 2006)

While there has been an increasing body of literature that explores how the specific social determinants of health impact on adolescents' sexual health, less is known about the social contexts and structures that shape adolescent sexual health. New approaches are needed using a socio-ecological approach that includes input from adolescents. Therefore, the current qualitative study informed by CST and a socio-ecological model was conducted to address the question: What are adolescents' perceptions of the facilitators and barriers to the promotion of healthy sexuality of adolescents living in PEI?

Thematic analysis of the study data identified seven themes within a socio-ecological framework. The themes that have emerged for the intrapersonal factors include: *The Illusion of Accessibility*; and *Risky Behaviours*. The themes that emerged for interpersonal factors were *Peer Pressure Alive and Well in High School*; *Cyberbullying*; and, *Parental Influence on Adolescent Decision Making*. The theme that emerged for organizational factors was *Insufficient and Underutilized School Health Resources*. The theme that emerged for the community factors was *Insufficient and Underutilized Community Health Resources*.

The perceptions of the participants who participated in this study played a role in the creation of a body of knowledge that can be used to contribute to the promotion of healthy sexuality of adolescents in PEI. They identified a number of themes that affect the promotion of sexuality of adolescents: (a) barriers to accessing sexual health resources can cause adolescents to forgo needed sexual health support and services; (b) facilitators to accessing sexual health resources can encourage adolescents to seek needed sexual health support and services (c) adolescent risky behaviours can negatively impact adolescent sexual activity, (d) peer pressure can impact on adolescent sexual activity, (e) cyberbullying can interfere with adolescent sexual development, (f) parents have the ability to impact on the sexual decision making of adolescents; (g) school health resources are inefficient and underutilized; and, (h) community health resources are inefficient and underutilized.

Furthermore, the participants of the study made some recommendations for improvement of the supports and services within the school: (a) develop a youth health clinic in the school; (b) create a position for a public health nurse to work in the school on a regular basis; (c) ensure that the services available within the school and community are accessible, confidential and non-judgmental, and, (d) include a school psychologist as a resource for students. They also made some recommendations for increasing the educational opportunities for students with respect to the promotion of healthy sexuality: (a) make the Family Life course mandatory for all students; (b) make the Family Life course more comprehensive to include content on how to handle relationships and peer pressure; (c) start sexual education sooner in elementary school and ensure that it continues through high school; (d) ensure teachers are better prepared and more comfortable; (e) increase the use of experts to provide presentations and counselling for students;

(f) educate parents so that they can provide better support and guidance to their children and, (g) inform the students about the availability of the sexual health resources within the school and community.

The participants also made some recommendations for improvement of the supports and services within the community: (a) develop a youth health clinic within the community; (b) ensure that the services available within the community are accessible, confidential and non-judgmental, (c) inform the students about the available sexual health resources; (d) develop and distribute advertisements of the sexual health resources that are available for adolescents; (e) create interactive websites that can be used by adolescents to anonymously ask questions regarding adolescent sexual health issues and, (f) create a private space within the pharmacies where adolescents can privately access pharmacists.

Additionally, new findings were identified, within this current study, that have not been identified in other studies that have examined the status of sexual health resources in the adolescent population. The participants identified that specific resources such as school psychologists and community pharmacists could positively impact the promotion of health sexuality of adolescents with respect to the educational and counselling opportunities they could offer if structured to ensure confidentiality and privacy. The participants also identified that watching pornography and cyberbullying, are activities that students are increasingly taking part in that could negatively impact on the promotion of healthy sexuality of adolescents. Participants reported that students have easy access to on-line pornography both at home and school whose exposure is negatively affecting adolescent sexuality. For example, according to the perspectives of the participants, some adolescents who are watching pornography are interpreting it as “normal” behaviour with some students making sex videos to imitate it. They also reported that

cyberbullying, which usually occurs through the internet and cell phones, can extend past the schoolyard into adolescents' homes. According to the participants' perspectives some students are sending sex tapes and naked pictures of others to their friends. The participants reported that students are receiving these images during class and at home. This experience has been reported, as being, devastating to the victims causing some students to stop attending or transfer schools.

Limitations of study. This study has been successful in creating comprehensive data with respect to the question that was addressed as the purpose of this study: What are adolescents' perceptions of the facilitators and barriers to the promotion of healthy sexuality of adolescents living in PEI? However, there were some limitations that must be taken into account when interpreting the data and conclusions of the study. As this study addresses a sensitive issue of promotion of sexual health of adolescents the bias of social desirability must be taken into account. Several strategies were developed to prevent this bias: (a) the participants were not asked about their own personal sexual history; (b) all questions were asked to gain the adolescents perspectives of barriers and facilitators of promotion of adolescents in general; (c) all participants were informed that there were no right or wrong answers; (d) the issue of confidentiality was addressed with each participant prior to each interview; and, (e) each participant was informed that they could refuse to answer any question.

There were some limitations of the study. For example the findings of the study have limited transferability due to the nature of the purposeful sample. The sample was small in number and was not adequately representative of adolescents in terms of gender, culture and other demographics (i.e. all participants were female and predominantly Caucasian. For example no males participated in this study despite repeated recruitment attempts. All but one participant was Caucasian preventing any cultural assumptions to be made with respect to the promotion of

healthy sexuality of adolescents. All participants represented one high school located in Charlottetown, PEI.

Implications for Practice

Evidence from this study identifies the need for public health nurses to become more actively engaged in health promotion and prevention activities focused on adolescents in the high school population. At this time, public health nurses on PEI are currently involved in adolescent health promotion, but it is somewhat limited and sporadic. They are assigned to high schools but do not carry out regular contact or programming. When requested by the staff of the high school, the public health nurses provide presentations, health fairs, counselling and follow up of acute and chronic conditions. They may also provide STI contact follow up counselling for those who have been diagnosed with an STI or named as a contact by someone who has been diagnosed with a reportable STI. However, all six participants in this study reported that they have never seen a public health nurse in the school and were not aware of any students consulting a public health nurse. They also reported that they were unaware of how to access a public health nurse within the school. Hospitals and possibly family physicians offices were the only places that participants identified adolescents could access a nurse for services or support.

The study calls into question the adequacy of this type of support and services provided by Public Health Nursing in PEI high schools. The limited role and lack of availability of the public health nurses, coupled with the fact that there are no visible health clinics or centres specialized in health promotion for the adolescent population, is troublesome given that studies have shown adolescents have a limited knowledge of sexual health issues, high rates of adolescent STIs and unacceptable adolescent pregnancy rates (Canadian Federation for Sexual Health, 2007). This current study has also identified a number of issues that place adolescents in PEI at risk with

respect to the promotion of healthy sexuality. There are a number of barriers to the accessibility, efficiency and utilization of existing sexual health resources in the school and community that can cause adolescents to forgo needed sexual health support and services. This is a concern because adolescents are engaging in risky behaviours that put them at risk for unplanned and often unprotected sex.

Considering the current status of the adolescent population and the limited role of the public health nurses in PEI, there is an opportunity for public health nurses to champion the development of comprehensive school health programming in PEI. Comprehensive School Health (CSH) is an internationally recognized framework that refers to “a multifaceted approach that includes teaching health knowledge and skills in the classroom, creating health-enabling social and physical environments, and facilitating links with parents, local agencies and the wider community to support optimal health and learning” (Canadian Association for School Health). This approach to health is one that research indicates can “influence the health-related knowledge, attitudes, and behaviours of students, and alleviate factors that compromise health” (Canadian Association for School Health, p.1).

Promotion of healthy behaviours and well-being of school aged children and adolescents is a developing issue in public health. It is one that is increasingly being recognized by provincial, federal, and international governments. Recent studies on interventions designed to promote health for school aged children support a Comprehensive School Health approach to improve lifestyles and prevent diseases (Deschesnes, Trudeau, & Kebe, 2009). This approach of CSH is congruent with the *Canadian Community Health Nurses Professional Practice Model and Standards of Practice* (2011) and the Canadian Public Health Association’s (CPHA) roles and activities (CPHA, 2010). It has been recognized by both the Community Health Nurses of

Canada (CHNC) and CPHA that there is a role for nurses within the school setting to carry out comprehensive health care with a “capacity building and strength based approach to coordinate or facilitate direct care and link people to community resources” (CCHN, 2011, p.3). Public health nurses are in a unique position to take a leadership role with respect to the implementation of CSH regarding the promotion of healthy sexuality of adolescents. It is a profession that is grounded in health promotion and prevention, empowerment of individuals, groups, and communities, and advocacy for the continuous development of partnerships within the community to enhance the well being of individuals, groups and communities.

Implications for Education

If public health nurses in practice are to meet the existing challenges of promotion of healthy sexuality of adolescents, they need to be adequately prepared through their professional education program. Nurses must be prepared with knowledge and skills to implement CSH. They need to have the theoretical and experiential knowledge and skills to work with individuals, families, groups, communities, and the population within a CSH approach.

As this qualitative study has been grounded in a CST and socio-ecological approach, it has become quite evident that in order to be effective it is essential that interventions within a CSH approach be directed at multiple levels and adopt an empowering approach. Using a socio-ecological framework for addressing the promotion of healthy sexuality of adolescents is increasingly being recognized by a number of researchers (Edwards, Mill, & Kothari, 2004; Frolich, Potvin, Chabot, & Corin, 2002; Langille, Corbett, Wilson, & Schelievert, 2010; Marston & King, 2006; Pavis, Cunningham-Burleu, & Amos, 1998; Shoveller, & Johnson, 2006; Shoveller, Johnson, Langille, & Mitchell, 2004; Shoveller, Johnson, Savoy, & Pietersma, 2006). According to McLeroy et al. (1988) a socio-ecological approach of health promotion is one that

“focuses attention on both individual and environmental factors as targets for health promotion interventions” (p.351). It addresses “health promotion from a multi-component approach in which interventions are directed at changing the intrapersonal, interpersonal, organizational, community and public policy, factors which support and maintain unhealthy behaviours” (McLeroy et al., p.351). Specifically, it addresses the social determinants of health at multiple levels: (a) the intrapersonal factors look at the characteristics of the individual; (b) the interpersonal factors look at the formal and informal relationships; (c) the organizational factors look at the social institutions with organizational characteristics; (d) the community factors look at the relationships among institutions and organizations; and, (e) the public policy level looks at the local, provincial, and national policies and laws.

It is therefore necessary that nursing educational programs enable students to look beyond individuals, groups, and communities and to better understand the contextualizing factors that are contributing to the current status of those individuals, groups, and communities that they will ultimately be practicing nursing with. It is therefore necessary that students be prepared with a multitude of skills to carry out this type of practice. In order for students to be properly prepared to work in this manner they need to have specific knowledge and skills with respect to the following areas: (a) understanding the socio-ecological theory and its multiple levels of interventions; (b) developing the skills to establish partnerships with other health care disciplines and sectors; (c) understanding the significance of and application of epidemiological issues relating to the school aged population; (d) understanding the developmental tasks of school aged children and adolescents; (e) understanding the chronic and acute conditions of school-aged children and adolescents; and, (f) understanding the significance of knowing the socio-political contexts in which we live. It is therefore necessary that educational programs provide this

knowledge and skills both in the classroom and the clinical area. Nursing educational programs need to ensure school health settings are part of the mandatory clinical placements of all of their students. Considering that CSH is increasingly being recognized both on a national and international level, as an approach to health for the school aged population, it is only timely that nursing schools embrace this concept and take the lead in its implementation.

Finally, it is necessary for educational programs to continue to provide research opportunities to students. It is beneficial for nursing students to be aware of various research methodologies and methods in order to incorporate current research into their practice, to identify potential research questions and to actively participate in the research process. Such skills will enable students to be continuously aware of their responsibility to integrate best practice and be the leaders with respect to the development of best practice. As nursing is always changing, depending on the ever increasing body of knowledge and the ever changing needs of the population, research oriented practice is essential. Embracing CSH is one of many examples of how nursing practice is changing today.

Implications for Research

This research was carried out as a qualitative descriptive exploratory study **informed by** CST and a socio-ecological framework. Overall both CST and the socio-ecological framework proved to be beneficial in enabling the researcher to capture the multi-component nature of the perspectives of adolescents about barriers and facilitators to the promotion of healthy sexuality. CST was useful throughout this process as it enabled the researcher to develop a partnership with the participants in that both were considered to be of equal status and both were changed as a result of the interaction. Due to the critical reflection of dialogue, that is advocated in CST, both the researcher and the participant developed a more complex understanding of issues relating to

the promotion of healthy sexuality of adolescents.

The study itself involved adolescents participating in a first semi-structured face-to-face interview and a second face-to face follow up reflective interview. The semi-structured interview guide was developed by the researcher using a socio-ecological framework. This guide was that developed by the researcher, was set up in such a manner to address the influences that the determinants of health had on the promotion of health of these adolescents. The determinants of health that were specifically addressed included: socio-economic status, culture, gender, social and physical environment, health services, social supports, education, employment and working conditions, individual capacity and coping skills, and, health practices (Health Canada, 1999). The socio-ecological framework involves the following interrelated levels of influence: intrapersonal, interpersonal, organizational, community and policy levels (McLeroy,1988). This semi-structured interview guide was useful as it enabled the participants to elaborate on issues with respect to the promotion of healthy sexuality in a comprehensive manner.

The interview guide was designed to enable participants to identify barriers and facilitators that were not anticipated. When identified by a participant, prompts were added in subsequent interviews to ensure a comprehensive exploration of factors affecting the promotion of healthy sexuality of adolescents. Examples of concepts that were added to the semi-structured interview guide included: cyberbullying, cell phone texting and messaging, making of sex videos and Facebook messaging.

The second follow up interview provided participants the opportunity to reflect on the first interview, to ensure accuracy of the researcher's interpretation of the initial interview, and to provide each participant with the opportunity to elaborate on experiences and perceptions. This second interview was important as reflection is an integral process in CST. It provided the

participants with an opportunity for elaboration to ensure a “thickness” of the description of their experiences and perceptions. The ‘thickness’ of the description relates to the multiple layers of culture and context in which the experiences are embedded” (Morrow, 2005, p.252). This follow up interview occurred after the data obtained in the first interview was analyzed. In the second interview the researcher also sought clarification and elaboration of themes that emerged during the first interview. This helped the participants and the researcher come to a better understanding of the issues relating to the promotion of healthy sexuality of adolescents.

As a result of the two interviews, the data that was gathered represented a comprehensive picture of the perspectives of six adolescent participants from one high school in PEI. The use of a qualitative descriptive approach informed by CST and a socio-ecological framework enabled the researcher to answer the research question: What are adolescents’ perceptions of the facilitators and barriers to the promotion of healthy sexuality of adolescents living in PEI? This was accomplished as both the participants and the researcher contributed to the creation of information-rich data enabling authentic insight and new knowledge about a hitherto fore under-researched area, the facilitators and barriers to the promotion of healthy sexuality of adolescents living in PEI.

Using CST along with a socio-ecological framework was challenging particularly organizing the data into one of the five levels of the framework (intrapersonal, interpersonal, organizational, community and organizational). While it was beneficial to present these themes within the framework’s levels of influence as it made it more clear where issues arose and where targets for intervention would be most valuable, it was difficult to do so without being repetitive because of their interrelatedness. It was also challenging to integrate the results from other literature as the findings from studies did not fit neatly into single levels within the framework; most had not

used a socio-ecological framework.

Additionally, there is minimal research regarding the process by which youth sexual health outcomes are shaped by social contexts and structures. It is therefore recommended that the application of CST and socio-ecological frameworks be used to promote new directions of public health research that “moves away from risk-factored models and towards approaches that consider, respond to, and potentially transform youths’ social contexts and structures” (Shoveller & Johnson, 2006, p. 56). Using a socio-ecological framework enables the researcher to cast a wider net in order to capture the intricate complexities of the perspectives of those who are participating in the research. The framework enables researchers to capture unexpected findings arising within the various levels of influence, therefore creating a more complete presentation of the perspectives of participants.

Upon review of this current study a number of other areas have been identified as areas for future research: cyberbullying, peer pressure, and pornography. According to this current study, cyberbullying is an activity that adolescents are taking part in that can have an impact on the promotion of healthy sexuality of adolescents. It is increasingly being recognized as a new phenomenon that results from the advances of new communication technologies (Cassidy, Jackson, & Brown, 2009; Collins, Martino, Elliot, & Rand, 2011; Li, 2006; Li, 2007; Patchin & Hinduja, 2011; Vandebosch & Van Cleemput, 2009; Wade & Beran, 2011). While there is some research beginning to be done with respect to the prevalence and types of bullying that are occurring, there needs to be more research regarding the impact of bullying on youth. This is of significance considering that the participants of this current study have reported that some of the victims of cyberbullying are so affected that they stopped attending or transferred schools. Some empirical studies and some high profile cases have highlighted the link between cyberbullying

and suicide and recommended that more research be done on this link with suicide (Hinduja & Patchin, 2010).

Cyberbullying is a risky behaviour that is addressed less frequently in research than drug and alcohol use and casual sex. Many of the recent studies that have focused on the status of adolescent sexual health have not included cyberbullying as a risky behaviour to consider (Boyce et al., 2003; Boyce et al. 2008; CAAH, 2006; Langille et al., 2010; PEI Caucus on Youth Sexual Health, 2005; Saewyc, Taylor, Homma, & Ogilvie, 2008). It is therefore recommended that cyberbullying be further investigated with respect to its impact on the promotion of healthy sexuality of adolescents.

As shown in this current study, peer pressure is a major influencing factor during adolescence; however, it is very complex and one of several factors that contribute to adolescent sexual decision making. According to a paper, that examined the complexities of peer pressure and how it relates to adolescent sexual decision making, it was suggested that more research be done to gain a “more sophisticated understanding of how peer pressure might operate” within “contextualized” environments (Maxwell & Chase, 2008, p. 303).

As was evidenced in the findings of the current study, the practice of adolescents watching pornography can impact the promotion of the healthy sexuality of adolescents. However, it too is a risky behaviour that is addressed less frequently in research than drugs, alcohol use and casual sex. Many of the studies that have focused on the status of adolescent sexual health have not included it (Boyce et al., 2003; Boyce et al. 2008; CAAH, 2006; Langille et al., 2010; PEI Caucus on Youth Sexual Health, 2005; Saewyc, Taylor, Homma, & Ogilvie, 2008). Although it is an area that is beginning to be investigated, it requires much more investigation with respect to risk factors and how it impacts on youth (Braun-Courville & Rojas, 2009; Brown &

Witherspoon, 2002; Carson, Pickett, & Janssen, 2011; Flood, 2009; Svedin, Akerman, & Priebe, 2011; Wolak, Mitchell, & Finkehor, 2011).

As a result of this study, other areas have also been identified as areas for future research: (a) including males to be part of future research regarding adolescents' perceptions of the facilitators and barriers of the promotion of healthy sexuality of adolescents; (b) exploration of the male-female relationships and how this impacts on adolescent sexual decision making; (c) investigation of adolescent self-efficacy and the role it plays in adolescent sexual decision making; and, (d) examination of rural and First Nations' contexts which may produce findings that diverge from those found in this study of adolescents living in urban environments.

Concluding Remarks on Knowledge Translation and Exchange

As a result of carrying out this research, it has become evident that while promotion of healthy sexuality of adolescents is one that is occurring in PEI, more investigation and development is needed with respect to how to better support and provide guidance and education. This research has identified the issues, concerns, and recommendations of the six participants in this study and can make a contribution to future development of the promotion of healthy sexuality of adolescents in PEI.

As a way forward and building on existing initiatives it is therefore recommended that a committee be established to explore options for the further development of the resources for the promotion of healthy sexuality of adolescents in PEI. First and foremost, it is recommended that youth be invited to participate on this committee. Many experts have identified that including youth in the development of programs and services is critical for success. The adolescents who chose to participate in this study expressed interest in contributing to future developments as was evidenced by the many issues and recommendations that they identified with respect to the

promotion of healthy sexuality of adolescents. They also indicated that youth involvement is essential for the successful development of the promotion of healthy sexuality programs and services. It is also recommended that representatives from a variety of disciplines such as Department of Education and Early Childhood Development, Department of Health and Wellness, Comprehensive School Health Research (CSHR) Group, UPEI School of Nursing Faculty as well as teachers, principals, school counsellors, public health nurses, physicians pharmacists, and psychologists be invited to participate in this process. Considering the potential impact that parental influence can have on adolescent decision making, it is also important to invite parent representatives.

The mandate of this committee would be to address the integration of a CSH approach within PEI as it relates to the promotion of healthy sexuality of adolescents. The Comprehensive School Health Research (CSHR) group that is located in UPEI would be a source of support for this committee. The CSHR Group that was established in 2003 is a multidisciplinary group whose goal is to conduct high quality, policy-relevant research that contributes to healthy school environments and promotes the optimum health of youth. It advocates for the use of a socio-ecological approach that addresses the multidimensional levels of influences on school health. At this time, the promotion of healthy sexuality has not been a focus for the CSHR Group. They have been successful in promoting research related to smoking and childhood obesity. Another source of support for this committee would be the UPEI School of Nursing as the school has recently developed a strategic planning committee to ensure the integration of CSH in the BScN program to ensure that nursing students will be prepared for CSH once they graduate. The UPEI committee is currently reviewing the current program to ensure that all students are exposed to theoretical and experiential opportunities to adequately learn and ultimately practice a CSH

approach to nursing within school environments.

It is also recommended that health services specialized in adolescent health be explored by this committee. Taking into account that PEI is the only province or territory that has no recognizable services in the schools or communities, this would prove to be beneficial to the development of the promotion of healthy sexuality of adolescents and their overall well being. Other potential areas for discussion would include: (a) accessibility of internet pornography on school property; (b) cyberbullying on school property; (c) accessibility of drugs and alcohol on and near school property; (d) increasing the role of public health nurses in high schools; (e) increasing the role of the school psychologist towards more health promotional activities; and, (f) advocating for a more health promotional role of pharmacists within the community.

As this is an issue that I have become passionate about, plans have been established with respect to the dissemination of the results of this study to a broader audience in hopes that it will stimulate further development of the promotion of healthy sexuality of adolescents in PEI. I plan to present study findings with the following: (a) faculty of UPEI School of Nursing, b) nursing students of UPEI School of Nursing (b) Health, Family Life and Physical Education Specialist of the Department of Education of PEI, (c) public health nurses of the Charlottetown Public Health Nursing Office, (d) annual meeting of public health nurses in PEI, and, (e) presentations with regional and national academic conferences. I will also submit papers for publication, regarding this study, to scholarly and professional journals. Finally executive summaries of this research will be distributed to the Eastern School District, participating High School principal and staff, and the participants of the study.

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Appendix A

Letter of Information for the Principal and Teachers

Identifying Adolescents' Perceptions of the Facilitators and Barriers to the Promotion of Healthy Sexuality for Adolescents of Prince Edward Island

Dear Principal and Teacher:

My name is Rosanne McQuaid and I am registered nurse completing a Master of Nursing at Dalhousie University, Halifax, Nova Scotia. In order to fulfill the requirements of this program I have chosen to conduct a research study. I am informing you of this study (Identifying Adolescents' Perceptions of the Facilitators and Barriers to the Promotion of Healthy Sexuality of Adolescents in Prince Edward Island) because I hope to obtain the research participants from your school. I am interested in working with 6-8, grade 10-12 students from Colonel Gray High School.

Teacher Role

I would like you to assist me with this study by permitting me to speak to your class to provide an overview of my study and to distribute Letters of Invitation to the students of Colonel Gray High School. This presentation will take about 10 minutes of class time. The students will be informed that participation is voluntary. They will also be informed that if they are interested in this study they should contact me directly through email or phone. The contact information is at the bottom of the Letter of Information for the Principals and Teachers and the Letter of Invitation for the Students.

Purpose of Study

The purpose of the study is to identify factors that may lead to or interfere with the healthy sexuality of teenagers living in Prince Edward Island. This study will consider many different parts of teenagers lives that may make things easier or harder for them to have positive experiences (self esteem, respect for self and others, and non-exploitive sexual relations) and to avoid negative experiences (unintended pregnancy, HIV/AIDS, sexually transmitted infections, forced sexual relations). Taking part in this study will provide the participants with a chance to describe what they think is important about the everyday lives of teenagers and how that can affect the promotion of healthy sexuality of teenagers. The information that is learned from this

study may be useful to help plan programs and services that might help promote healthy sexuality among teenagers.

Study Design

This qualitative descriptive exploratory study will involve 2 face-to-face interviews with the researcher. The first interview will involve a face-face interview with each participant and the researcher. The second interview will involve a face-face follow up interview with the researcher and each participant. This second interview will occur 2 weeks after the first interview. The study will involve 6-8 participants aged 16-18 years of age.

Who Can Participate in the Study

Students who attend Colonel Gray High School and are between the ages of 16-18 can participate in this study. Students will have to sign a consent form to participate and those students who are under the age of 18 will require a written parental consent to participate.

Who will be Conducting the Research

I (Rosanne McQuaid BSc, BScN, RN) will be the researcher for this study as a requirement for the completion of a Master of Nursing Program at Dalhousie University. I have designed the study and created the semi-structured interview guide and will be facilitating all interviews, analysing the data and developing the final write up of the study. This will be done under the supervision of the co-supervisors Dr. Ruth Martin-Misener and Dr. Donna Meagher Stewart.

Participating in this Study

Participating in this study is voluntary. Participants may decide not to answer a question or may decide to withdraw from the study.

Participants will be asked to complete a form about information that will help me describe the people who take part in the study (age, grade level, sex, location of community [rural/urban]).

Each participant will take part in two interviews. The first face-to-face semi-structured interview will take place with the researcher and will take approximately 45-60 minutes. During this interview the participants will be asked questions about what they think can make things easier or harder for teenagers to have positive experiences and to avoid negative experiences which relate to the promotion of the healthy sexuality of teenagers. They will not be asked questions about their personal experiences. About two weeks after the first interview, a face-to-face follow up reflective interview with the researcher will take place. This interview will take about 20-30 minutes in length. It will involve the participants answering questions to make sure that was said

in the first interview was what they wanted to say. It will give them the opportunity to add, remove, elaborate on, or change any of the information they shared in the first interview.

The interviews will take place in rooms booked at community centers such as the Capital Area Recreation Inc. (CARI) or the Royalty Centre. They will occur before school, at lunch or immediately after school. The date, time and place will be mutually agreed by the participant and the researcher.

Possible Benefits

There are no direct benefits for participants participating in this study. However, they may become more aware about what factors, in the everyday lives of teenagers, contribute to positive or negative experiences with respect to the promotion of their healthy sexuality. Their participation may, however, help me to identify factors that may be used to develop educational programs, services or supports that promote the healthy sexuality of teenagers.

Possible Risks

As the purpose of this study is to gain input on the everyday lives of teenagers in general, there will be no direct questions asked about the participants' personal experiences relating to the promotion of healthy sexuality of teenagers. Each participant may decide not to answer any question and may choose to withdraw from the study at any time. However, the information they provide can only be withdrawn prior to the analysis of the data from the second interview. Participants may feel uncomfortable or embarrassed talking about healthy sexuality. If a participant says they are uncomfortable or show signs of discomfort I will seek permission to continue with the topic that is being covered. If the participant does not want to continue, no further questions will be asked and a new topic will be begin. Only if the participant chooses to continue, will the questions continue regarding that topic. Also, if they have had a negative experience with respect to their own sexuality (sexual abuse and/or trauma) this interview may cause them to think about it more and cause them distress. I have arranged for a physician and a counsellor to be available if they decide they need help. I will give each participant the names of the physician and counsellor, who have volunteered to be available if needed, at the time of the first interview. If the participant chooses to seek help, each participant can choose to contact the physician and/or counsellor by themselves or ask the researcher to initiate the contact for them.

If a student discloses sexual or physical abuse or neglect of a child under 18 years, it will be reported to the Child and Family Services of the Department of Community Services, Seniors and Labor of PEI.

Compensation / Reimbursement

There will be no costs for the participants to participate in this study. Each participant will be given movie money (\$10) following the face to face interview and again following the second face to face follow up interview.

Confidentiality

Participants' confidentiality will be fully respected. No information that discloses their identity will be released or published. In the written report of this study, direct quotes from the interviews may be used with the use of pseudonyms to protect their identity. All the information collected from this study will be stored in a locked filing cabinet and will be password protected on the computer. If the participants introduce the names of others during the interview I will ensure their confidentiality by using pseudonyms for each name identified.

Questions

If you wish to ask further questions about the study, please contact the principal investigator, Rosanne McQuaid at (902) 940-7610 or at email mcquaidr@dal.ca. You may also contact the research co-supervisors Dr. Ruth Martin-Misener (902) 494-2250 or at email Ruth.Martin-Misener@dal.ca or Donna Meagher-Stewart (902) 494-2143 at email donna.meagher-stewart@dal.ca.

Problems or Concerns

If you have any difficulties with, or wish to voice concern about any aspect of your participation in this study, you may contact Patricia Lindley, Director of Dalhousie University's Office of Human Research Ethics Administration, for assistance (902) 494-1462, patricia.lindley@dal.ca

Appendix B

Letter of Invitation for the Student

Identifying Adolescents' Perceptions of the Facilitators and Barriers to the Promotion of Healthy Sexuality for Adolescents of Prince Edward Island

Dear Student

My name is Rosanne McQuaid and I am a registered nurse completing the Master of Nursing Program at Dalhousie University, Halifax, Nova Scotia. I invite you to take part in a research study that is being carried out with Colonel Gray High School students as part of my requirements for my degree. Taking part in this study is voluntary. Your participation in this study will not affect your performance in school.

Purpose of Study

The purpose of this study is to identify factors that may lead to or interfere with the healthy sexuality of teenagers living in Prince Edward Island. Healthy sexuality is a part of everyone's health. Teenagers who have a healthy sexuality feel good about themselves and the decisions they make about sex. They do not make decisions about sex that may cause them harm. They enjoy their relationships. I would like to learn from you, as a teenager living in Prince Edward Island. I will be asking you questions about what can be helpful or what can get in the way of teenagers having a healthy sexuality. I will not be asking you any questions about your personal experiences. I will only be asking you questions about what factors in teenagers lives, in general, can makes it easier or harder for teenagers to have a healthy sexuality. Taking part in this study will provide you with a chance to describe what you think is important about the everyday lives of teenagers and how that can affect the promotion of healthy sexuality of teenagers. The information that is learned from this study may be useful to help develop programs, supports, and services that might help promote healthy sexuality among teenagers.

Study Design

This study will involve two interviews. The first interview will involve the researcher and each participant. The second follow up interview will also involve the researcher and each participant. This second interview will occur 2 weeks after the first interview. The study will need 6-8 participants aged 16-18 years of age.

Who Can Participate in the Study

Students who are attending Colonel Gray High School and are between the ages of 16-18 can participate in this study. Students need to sign a consent form to participate. Parents for those students who are under the age of 18 will also need to sign a consent form for a student to participate.

Who will be Conducting the Research

I (Rosanne McQuaid BScN, BSc, RN) will be the researcher of this study. I am doing this research to help me to finish a Master of Nursing Program at Dalhousie University. I developed the study and will be carrying out all of the interviews, the analysis of the interviews and the final write up of the thesis. This will be done under the supervision of my co-supervisors Dr. Ruth Martin-Misener and Dr. Donna Meagher Stewart.

Participating in this Study

Participating in this study is voluntary. You may decide not to answer a question. You may also decide to stop participating in this study. You may withdraw your data prior to the analysis of the second interview.

You will be asked to complete a form about information that will help me describe the people who take part in the study (age, grade level, sex, location of community [rural/urban]).

Participating in this study will involve two interviews with me. The first face-face interview with me will last about 45-60 minutes in length. It will involve you answering questions about issues about the promotion of healthy sexuality of adolescents. You will be asked about what you think can make things easier or harder for teenagers to have a healthy sexuality. You will not be asked questions about your personal experiences. Two weeks following the first interview you will take part in a second face-to-face follow up interview with me. This interview will involve you answering questions to make sure that was said in the first interview was what you wanted to say. It will give you the opportunity to add, remove, elaborate on, or change any of the information you shared in the first interview.

The interviews will take place in a room at the Capital Area Recreation Centre (CARI) or in a room at the Royalty Centre. The interviews will occur before school, at lunch or right after school. You and I will work together to decide the date, time and place of each interview. The interviews will be audio recorded and the researcher will take brief notes during the interview.

Possible Benefits

There are no direct benefits for you for being in this study. However, you may become more aware about what things make it easier or harder for teenagers to have a healthy sexuality. Your participation may, however, help me to identify factors that may be used to develop educational programs, services or supports that may promote the healthy sexuality of teenagers.

Possible Risks

As the purpose of this study is to gain your input on the everyday lives of teenagers in general, there will be no direct questions about your personal experiences. However, you may feel uncomfortable or embarrassed talking about some of the content as it relates to healthy sexuality. If you say you are uncomfortable or show signs of discomfort I will seek permission to continue with the topic that is being covered. If you do not want to continue, no further questions will be

asked and a new topic will be begin. Only if you choose to continue, will I continue with that topic. Also, if you have had a negative experience with respect to your own sexuality (sexual abuse or trauma) this interview may cause you to think about it. This may cause you distress. Therefore, I have arranged for a physician and a counsellor to be available if you decide you need help. I will give you the names of the physician and counsellor at the time of the first interview so that you can contact them yourself if you want to. I will also contact them for you if you want me to.

If a student discloses sexual or physical abuse or neglect of a child under 18 years, it will be reported to the Child and Family Services of the Department of Community Services, Seniors and Labor of PEI.

Compensation / Reimbursement

There will be no costs for you to participate in this study. You will be given movie money (\$10) following the first face to face interview and again following the second face to face follow up interview.

Confidentiality

Your confidentiality will be fully respected. No information that identifies your name will be released or published. In the written report of this study, direct quotes from the interviews may be used with the use of pseudonyms to protect their identity. All the information collected from this study will be stored in a locked filing cabinet and password protected on the computer. If you introduce the names of others during the interview I will ensure their confidentiality as well, by using pseudonyms (made up names).

Questions

If you wish to ask further questions about the study, please contact the principal investigator, Rosanne McQuaid at (902) 940-7610 or at email mcquaidr@dal.ca. You may also contact my co-supervisors Dr. Ruth Martin-Misener (902) 494-2250 at email Ruth.Martin-Misener@dal.ca or Donna Meagher-Stewart (902) 494-2143 at email donna.meagher-stewart@dal.ca.

Problems or Concerns

If you have any difficulties with, or wish to voice concern about any aspect of your participation in this study, you may contact Patricia Lindley, Director of Dalhousie University's Office of Human Research Ethics Administration, for assistance (902) 494-1462, patricia.lindley@dal.ca

Appendix C Consent Form

Identifying Adolescents' Perceptions of the Facilitators and Barriers to the Promotion of Healthy Sexuality for Adolescents of Prince Edward Island

Principal Investigator: Rosanne McQuaid BScN, BSc, RN
Master of Nursing Student
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Invitation to Participate in Research

I am presently a student enrolled in the Master of Nursing Program at Dalhousie University, Halifax, NS. I invite you to take part in a research study being conducted with Colonel Gray High School students as part of the requirements for me to obtain my degree. Taking part in this study is voluntary. Your participation in this study will not affect your performance in school. You may withdraw from this study without any consequences to your performance at school. You can withdraw data up to the analysis of the second interview. The study is described below. This description tells you about the risks, inconvenience, or discomfort that you might experience. Participating in the study might not benefit you, but we might learn things that will benefit others. You should discuss any questions you have about this study with Rosanne McQuaid or the Thesis Co- Supervisors Ruth Martin-Misener or Donna Meagher- Stewart.

Purpose of Study

The purpose of this study is to identify factors that may lead to or interfere with the healthy sexuality of teenagers living in Prince Edward Island. Healthy sexuality is a part of everyone's health. Teenagers who have a healthy sexuality feel good about themselves and the decisions they make about sex. They do not make decisions about sex that may cause them harm. They enjoy their relationships. I would like to learn from you, as a teenager living in Prince Edward Island. I will be asking you questions about what can be helpful or what can get in the way of teenagers having a healthy sexuality. I will not be asking you any questions about your personal experiences. I will only be asking you questions about what factors in teenagers lives, in general, can makes it easier or harder for teenagers to have a healthy sexuality. Taking part in this study will provide you with a chance to describe what you think is important about the everyday lives of teenagers and how that can affect the promotion of healthy sexuality of teenagers. The information that is learned from this study may be useful to help develop programs, supports, and services that might help promote healthy sexuality among teenagers.

Study Design

This study will involve two interviews. The first interview will involve the researcher and each participant. The second follow up interview will also involve the researcher and each participant. This second interview will occur 2 weeks after the first interview. The study will need 6-8 participants aged 16-18 years of age.

Who Can Participate in the Study

In order to participate in the study you must:

1. Be between the ages of 16-18 years of age
2. Be willing and able to sign the consent form
3. Obtain parental (legal guardian) consent (under 18 years of age)
4. Have a good understanding of the English written and spoken language
5. Attend Colonel Gray High School in PEI
6. Be willing to have the two interviews audio recorded

Who will be Conducting the Research

I (Rosanne McQuaid BSc, BScN, RN) will be the principal investigator of this study as a requirement for the completion of a Master of Nursing Program at Dalhousie University. I developed the study and will be carrying out all of the interviews, the analysis of the interviews and the final write up of the thesis. This will be done under the supervision of my co-supervisors Dr. Ruth Martin-Misener and Dr. Donna Meagher Stewart.

Participating in this Study

You will be asked to complete a form about information that will help the researcher describe the people who take part in the study (age, grade level, sex, location of community [rural/urban]).

Participating in this study will involve two interviews with me. The first face-face interview with me will last about 45-60 minutes in length. It will involve you answering questions about issues about the promotion of healthy sexuality of adolescents. You will be asked about what you think can make things easier or harder for teenagers to have a healthy sexuality. You will not be asked questions about your personal experiences. Two weeks following the first interview you will take part in a second face-to-face follow up interview with me. This interview will involve you answering questions to make sure that was said in the first interview was what you wanted to say. It will give you the opportunity to add, remove, elaborate on, or change any of the information you shared in the first interview.

The interviews will take place in a room at the Capital Area Recreation Centre (CARI) or in a room at the Royalty Centre. The interviews will occur before school, at lunch or right after school. You and I will work together to decide the date, time and place of each interview. The interviews will be audio recorded and the researcher will take brief notes during the interview.

Possible Benefits

There are no direct benefits for you for being in this study. However, you may become more aware about what things make it easier or harder for teenagers to have a healthy sexuality. Your participation may, however, help me to identify factors that may be used to develop educational programs, services or supports that may promote the healthy sexuality of teenagers.

Possible Risks

As the purpose of this study is to gain your input on the everyday lives of teenagers in general, there will be no direct questions about your personal experiences. However, you may feel uncomfortable or embarrassed talking about some of the content as it relates to healthy sexuality even though you may refuse to answer any question at any time. If you say you are uncomfortable or show signs of discomfort I will seek permission to continue with the topic that is being covered. If you do not want to continue, no further questions will be asked and a new topic will be begin. Only if you choose to continue, will the questions continue with that topic. Also, if you have had a negative experience with respect to your own sexuality this interview may cause you to think about it more and cause you distress. I have arranged for a physician and a counsellor to be available if you decide you need help. I will give you the names of the physician and counsellor at the time of the first interview so that you can contact them yourself if necessary. I will also contact them for you if you.

If a student under the age of 18 discloses sexual or physical abuse or child neglect it will be reported to the Child and Family Services of the Department of Community Services, Seniors and Labor of PEI.

Compensation / Reimbursement

There will be no costs for you to participate in this study. You will be given movie money (\$10) following the first face to face interview and again following the second face to face follow up interview.

Confidentiality

Your confidentiality will be fully respected. No information that discloses your identity will be released or published. Direct quotes from your interviews may be used with the use of pseudonyms (made up names) to protect your identity. All the information collected from this study will be stored in a locked filing cabinet and password protected on the computer. Your personal information will be identified with a pseudonym (made up name). This name will be assigned at the time of the first interview. You are assured that only the researcher, my co-supervisors from Dalhousie University and typist (person who copies taped interviews to a computer file) will have access to the data. If you introduce the names of others during the interview I will ensure their confidentiality as well, by using pseudonyms (made up names). I will keep a single copy of the names, phone numbers and pseudonyms in a locked cabinet separate from the data and this will be destroyed once you have verified the data. The data (tapes and transcripts) from this study will be kept in a locked cabinet for five years following the report. At the end of this five year period, the data will be destroyed.

If a student under the age of 18 discloses sexual or physical abuse or child neglect it will be reported to the Child and Family Services of the Department of Community Services, Seniors and Labor of PEI.

A copy of this form will be provided to you for your records.

Questions

If you wish to ask further questions about the study, please contact the principal investigator, Rosanne McQuaid at (902) 940-7610 or at email mcquaidr@dal.ca. You may also contact my research co-supervisors Dr. Ruth Martin-Misener (902) 494-2250 at email Ruth.Martin-Misener@dal.ca or Donna Meagher-Stewart (902) 494-2143 at email donna.meagher-stewart@dal.ca.

Problems or Concerns

If you have any difficulties with, or wish to voice concern about any aspect of your participation in this study, you may contact Patricia Lindley, Director of Dalhousie University's Office of Human Research Ethics Administration, for assistance (902) 494-1462, patricia.lindley@dal.ca

Signature Page

Identifying Adolescents' Perceptions of the Facilitators and Barriers to the Promotion of Healthy Sexuality for Adolescents of Prince Edward Island

"I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part (or have my child take part) in this study. However I realize that my participation (or my child's participation) is voluntary and that I am (he/she is) free to withdraw from the study without consequence. I realize that I (he/she) will be unable to withdraw data once it has been analyzed.

Signature of Participant

Signature of Principal Investigator

Date

Date

Signature of Parent
(if participant under 18 years of age)

Date

"I consent to the audio recording of the face-to-face semi-structured interview as well as the face-to face follow up reflective interview for myself (for my child)

Signature of Participant

Signature of Principal Investigator

Date

Date

Signature of Parent
(if participant under 18 years of age)

Date

“As I (he/she) have (has) now completed the face-to-face semi-structured interview and the face-to-face follow up reflective interview, I consent to the use of my (his/her) quotes with the use of pseudonyms in the final report of this study”.

Signature of Participant

Signature of Principal Investigator

Date

Date

Signature of Parent
(if participant under 18 years of age)

Date

Appendix D

Demographic Information

Identifying Adolescents' Perceptions of the Facilitators and Barriers to the Promotion of Healthy Sexuality for Adolescents of Prince Edward Island

The following information will help the researcher describe the people who take part in the study. Please circle the number that is the correct answer and fill in the blanks. You can choose which questions you would like to answer.

1. What is your age? _____ years
2. What is your current grade level? Grade _____
3. What is your sex? a) male
b) female
4. What kind of community do you live in? a) urban (Charlottetown)
b) rural (outside Charlottetown)

Appendix E

Semi-structured Interview Guide

Identifying Adolescents' Perceptions of the Facilitators and Barriers to the Promotion of Healthy Sexuality for Adolescents of Prince Edward Island

I would like to begin this interview by thanking you (name) for participating in this study. Your input is extremely valuable for people who are working with teenagers to promote healthy sexuality among teenagers. When I say healthy sexuality what I mean is that teenagers feel good about themselves and the decisions they make about sex. They enjoy their relationships. They do not make decisions about sex that may cause them harm. I am interested in learning from teenagers living in Prince Edward Island about what is being done now and what should be done to help teenagers develop a healthy sexuality. I will not be asking you any questions about your personal experiences. I will only be asking you questions about what things can make it easier or harder for teenagers to have a healthy sexuality.

1. Tell me about the programs, services or people that are available in your community to help teenagers who have questions or concerns about sexuality.

Probes: Health services; Clinics; Youth groups; Physicians; Nurses; Pharmacists

2. Tell me about the programs, services, or people that are available in your school to help teenagers who have questions or concerns about sexuality.

Probes: Principal; Teachers; Nurses; Counsellors; Courses; Presentations

3. Which of these programs, services or people do you think teenagers use the most and find most helpful?

Probe: Tell me more about why you think each of these resources are used most by teenagers.

4. Which of these programs, services or people do you think teenagers don't use very often and don't find helpful?

Probe: Tell me more about why you think each of these resources are used the least by teenagers.

5. Tell me who the people are that influence how teenagers think and feel about sexuality.

6. Which of these people do you think have the most influence on how teenagers think and feel about sexuality and which have the least?

Probe: Tell me more about why you think these people have the most or least influence.

7. Are there other influences in the lives of teenagers that can affect how they think and feel about sexuality?

Probes: Mass Media, Religion, Culture, Internet, Sex Videos, Porn Sites/Videos?

9. Is there anything about the settings where teenagers live that can affect the decisions they make about sex? Tell me about them.

Probes: Family income, Type of employment of parents; Culture of family

10. Are there things that teenagers have or do that can affect the decisions they make about sex? Tell me about them.

Probes: Coping strategies (use of alcohol, drugs, fighting, promiscuity); Access to money; Type of employment

11. What do you think should be available in Prince Edward Island for teenagers to help them to develop a healthy sexuality?

12. Is there anything you want to add about what you think has helped teenagers in Prince Edward Island to have a healthy sexuality?

Probes: Programs; Educators; Supports; Access to services; Access to resources; Information

13. Is there anything you want to add about what you think has made it harder for teenagers in Prince Edward Island to have a healthy sexuality?

Probes: Programs; Educators; Supports; Access to services; Access to resources; Information

Appendix F
Confidentiality Agreement for Transcription

**Identifying Adolescents' Perceptions the Facilitators and Barriers to the
Promotion of Healthy Sexuality for Adolescents of Prince Edward Island**

“I, agree not to discuss, share, or transmit (ie. electronic files) the information learned as a result of transcribing the interviews with anyone other than the researcher of the study Identifying Adolescent’ Perceptions of the Facilitators and Barriers to the Promotion of Healthy Sexuality for Adolescents of Prince Edward Island. The electronic files of the transcriptions of the interviews will be password protected”.

“The tapes will be returned to the researcher and the electronic file will be deleted from my computer 30 days following providing that file to the researchers”.

“I have been given a copy of this agreement for my records”.

Signature of Transcriptionist

Date

Signature of Principal Investigator

Date

