A B S T R A C T

This qualitative study was conducted to learn adolescents' opinions about sexual health services and strategies to improve their delivery. Sixteen 1.5-hour, same-sex focus groups were conducted in one rural and one urban high school in each of two Ontario regions. In total, 83 students (49 females and 34 males) participated in the study. Topics were: sources and quality of sexual health information, knowledge and use of sexual health services, gender differences, factors that influence sexual behaviour, and suggestions for improving sexual health services. The adolescents reported that sex education focussed too much on "plumbing" and was often provided by teachers with whom they felt uncomfortable discussing sexual issues. Peers and media were their main sources of information although they acknowledged that these were not always accurate. The participants had limited knowledge of the services available. Many of their comments reflected traditional gender differences. Peers, and for females, partners and parents influenced sexual decision-making. The participants made numerous suggestions for improving sexual health services.

A B R É G É

Notre étude qualitative visait à sonder l'opinion d'adolescents au sujet des services de santé-sexualité et des stratégies pour en améliorer la prestation. Nous avons organisé 16 groupes de concertation d'une heure et demie entre adolescents du même sexe dans deux écoles secondaires (l'une urbaine, l'autre rurale) dans chacune de deux régions de l'Ontario. En tout, 83 élèves (49 filles, 34 garçons) y ont participé. Ils ont discuté des sources et de la qualité de l'information sur la santé-sexualité, de la connaissance et de l'utilisation des services à cet égard, des différences entre les sexes, des facteurs qui influencent le comportement sexuel, puis suggéré des améliorations aux services de santé-sexualité. Les participants ont déclaré que les cours d'éducation sexuelle étaient trop axés sur la « tuyauterie » et souvent dispensés par des enseignants avec qui ils ne se sentaient pas à l'aise pour parler de sexualité. Les pairs et les médias étaient les principales sources d'information des adolescents, qui en reconnaissaient cependant les lacunes. Les participants n'avaient qu'une connaissance limitée des services disponibles. Beaucoup de leurs remarques reflétaient les différences traditionnelles entre les sexes. Les pairs et (chez les filles) les partenaires et les parents exerçaient une influence sur leurs décisions en matière de sexualité. Les participants ont formulé de nombreuses suggestions pour améliorer les services de santé-sexualité.

Completing the Picture: Adolescents Talk About What's Missing in Sexual Health Services

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Despite the availability of sexual health services, rates of pregnancy and sexually transmitted diseases (STDs) among adolescents in Canada continue to rise. The rate of teenage pregnancy in Canada has risen by more than 20% since 1987. In 1994, the most recent year for which Statistics Canada figures are available, there were 48.8 pregnancies per 1,000 Canadian females aged 15 to 19. This translates into 44,700 teen pregnancies.¹ A systematic review of randomized controlled trials evaluating primary prevention interventions failed to find a reduction in teen pregnancies.² In Canada, adolescent females aged 15 to 19 have the highest rates of chlamydia and gonorrhea among all age groups.^{3,4}

The purpose of this study was to gain a deeper understanding of the reasons teenage pregnancies and STDs continue to increase despite the availability of sexual health services. Sexual health services include health promotion, health education, counselling and birth control clinic services and are designed to enhance sexual health and to promote personal responsibility in decision making regarding sexual

choices and relationships. While clinic attenders are tested for STDs, those with positive tests are referred to STD clinics or to their physicians. The goal of this project was to develop recommendations for delivery of sexual health programs. The specific study objectives were to provide adolescents with an opportunity to voice their opinions about sexual health services and to identify strategies to improve their delivery.

METHODS

Focus groups were used to collect information from the adolescents. All students in grade 9 or 11 at one rural and one urban high school in each of the Haldimand-Norfolk and Niagara regions were potential participants. Randomly selected students were identified and consent letters were sent to their parents explaining the project. Sixteen 1.5-hour, same-sex focus groups were conducted. At each school, 4 focus groups were conducted with grade 9 females, grade 9 males, grade 11 females and grade 11 males, respectively. During the focus group, each student completed an anonymous and confidential demographic questionnaire. All focus groups were led by the same female facilitator who was experienced in leading focus groups, was not a nurse, and was not affiliated with a public health department or school. The focus groups were held in the schools during school hours; staff members were not present. A question guide was developed by the research team outlining specific issues to be explored in the focus groups. The questions were pilot tested with a separate group of males. The main topic areas included: sources and quality of sexual health information, knowledge and use of sexual health

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services, gender differences, factors that influence sexual behaviour, and suggestions for improving sexual health services.

The focus groups were taped and transcribed verbatim. The transcripts were analyzed using content analysis for common themes. In order to ensure consistent interpretation of the data, guidelines to categorize the data were established by the research team and one transcript was independently reviewed by all team members and discussed in depth. Each transcript was then independently analyzed by the facilitator and one member of the research team.

RESULTS

Of 1,190 eligible students in the 4 schools, 442 students (37%) were randomly selected to receive invitations to participate. Of the 442, 325 (74%) consents were not returned. Of the 117 consents that were returned, 66 (56%) agreed to participate. To recruit additional participants, telephone calls were made by the public health nurses on the research team or the school principals or guidance counsellors. In one school where they had difficulty recruiting male participants, the principal invited Grade 12 boys who were old enough to participate without parental consent. Of the 91 students contacted, 17 (19%) agreed to participate.

In total, 83 students (49 females and 34 males) participated in the study. Approximately half of the students were from each region. Their ages ranged from 13 to 19 years with a mean age of 15.4 years. Approximately half the students were in grade 9 and the remainder were in higher grades. Approximately one third of both mothers and fathers had completed a university or college education. Just under 80% of the participants had achieved grades of 70% and over in their last semester and over 80% were planning to pursue post-secondary education. Two thirds of the participants lived with both natural parents. Almost all participants reported having had sex education in elementary school and two thirds had had sex education in high school. Approximately 44% of the males and 37% of the females reported having had vaginal intercourse and of these, 27% of males and 44% of females had not used contraception.

The majority of focus groups included 4 to 8 participants. The results were categorized into five main areas: formal sources of sexual health information, informal sources of sexual health information, knowledge and use of services, gender differences, and student suggestions. A detailed report of the findings including quotes from the participants is available from the authors.

Formal sources of sexual health information

All the students had some exposure to formal sex education. However, they agreed that little was taught beyond the basic "plumbing" of sexual health and that the focus was on the negative consequences of unhealthy sexual decisions. Although the teens thought that school was a good place to receive sex-related information, teachers were not considered to be the best sex educators. Teens feared that teachers would tell their parents or give them poor grades if they learned they were sexually active.

All schools involved in the study had public health nurses. If students had been exposed to nurses in sex education classes, the public health nurses were identified as good sources of information. However, with the exception of Grade 11 females, most of the participants did not identify public health nurses or sexual health clinics as sources of sexual health information.

Informal sources of sexual health information

Friends, siblings, television, radio and magazines were the most common sources of sexual health information. Most participants noted that the type of information received from these sources (feelings, decisions and experiences) was not available through formal channels. Students thought that sex education classes offered the technical information and informal sources filled in the gaps or "the important stuff". The type and accuracy of information gained through these sources varied; however it was clear that students found this a useful way of getting information.

Most students noted that perceived parental discomfort, as well as their own, limited conversations about sexual health issues. There seemed to be an assumption that parents "just can't handle" a conversa-

tion on sex. They noted that parents would change the subject, be embarrassed, remain silent or reinforce sex-negative messages. Both male and female adolescents said they would like to be able to talk to their parents about sex. When adolescents did feel strong parental support, they saw parents as valuable and trusted sources of information.

Knowledge and use of services

All the schools in the study had mandatory grade 9 sex education classes and all had public health nurses. Each community had a sexual health clinic. However, most males were not aware of the presence of a public health nurse at the school, her role, or the existence of sexual health clinics in their community. In many cases, males did not identify sexual health services as something they would use. Female students, especially those in grade 11, had a good understanding of the sexual health services available and many had used these services.

Students had little awareness of the scope of services available and how to access them. In some cases the participants noted that services may be available, yet they were unclear about where the services were and who they might approach about them. All groups described sexual health services as services to assist with the physical concerns associated with sexuality such as regular check ups or birth control. None of the groups identified the services as a source of support for relationship or emotional concerns.

Students talked about difficulty accessing sexual health services. Both males and females indicated barriers such as clinic location, hours of operation or insufficient time for appointments. In rural communities, the issue of location provided additional challenges. Transportation to and from clinics was a barrier, given that many students had no access to a car or public transportation. Some support staff lacked the sensitivity to deal with the adolescents' embarrassment and need for confidentiality.

Confidentiality was of prime concern to all students. In rural communities both male and female students expressed concern about confidentiality when using any of the sexual health services given the high risk of being seen in the local drug store or sexual health clinic.

Gender differences

Student comments indicated that males and females continue to be governed by different expectations and codes of behaviour. They noted for example, that females, but not males, gained "bad reputations for sleeping around." Both genders indicated that males and females had different sexual health needs because of their biological differences. As a result, young women received a message that their sexual desires were mild compared to those of males, that they needed to be level headed and to control their urges as well as the urges of males.

Segregating males and females for sexuality education reinforced traditional gender stereotyping. Little explanation was provided to the students about why classes were segregated.

Both male and female teens noted the injustice in the sexist value system. When asked who was responsible for birth control, the majority of male participants stated that both parties were responsible. Many males expressed frustration at being cast in the role of a sex-starved individual who had little desire for solid relationships.

Female adolescents identified many sources of pressure influencing their sexual decision making. A frequent source was male partners and in a few cases, friends had encouraged them to engage in sexual activity. Females also discussed experiences of feeling pressure not to engage in sexual intercourse. They identified parental pressure to refrain from becoming sexually active as a key force influencing their sexual decision making. There were no similar stories in the male groups. Most of the male teens noted that they experienced pressure from a single source which was friends. A few of the participants noted the tendency among some males to view sex as a "game" and to pressure each other to compete.

Student suggestions

Students explained that sex education classes did not provide them with information they found useful. They suggested the following topics be added to the classes: how STDs 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. Although most students had been taught the various forms of birth control, very few could identify forms of birth control other than the pill and condoms. The issue of homosexuality was approached in the groups and many students reacted in a hostile and intolerant manner.

Adolescents expressed a preference for sex educators who used everyday language; were specially trained in teaching sexual health and provided accurate information; were dynamic, non-judgemental, relaxed, respectful, and sex-positive (providing individuals with knowledge specific to their own sexual health concerns while respecting different individual values and social customs relating to sexuality⁵); used humour; shared information in ways that increased student comfort and decreased their embarrassment and fear in voicing their concerns and asking questions; and used demonstrations where appropriate (e.g., how to put on a condom). They recommended that a combination of same-sex and co-ed classes be used and that sex education begin earlier than grade 6 and continue until students leave high school. This would permit gradual transmission of information to correspond with sexual development and more detailed discussion of facts and issues.

Teens indicated that some teaching strategies were outdated (e.g., films, booklets) and unrealistic (e.g., expecting that everyone in the class would remain abstinent until marriage). Many participants expressed frustration over teachers' use of scare tactics. While they appreciated age-specific, thorough and up-to-date pamphlets, they preferred "real images" in audiovisual aids rather than animated ones (i.e., cartoons).

The teens had a number of suggestions for improving confidentiality when making appointments to see the public health nurse in the school. These included: advertising the days and times the public health nurse was in the school, having the nurses collect appointment requests directly rather than through the office secretary, having appointment request boxes in discreet locations such as the women's washroom, not designating the purpose of the appointment on the appointment slip distributed in homeroom, providing sensitivity training for

office staff about issues related to adolescent sexual health, and having the nurse's office in a private, low traffic area of the school. Many males indicated their preference for condom machines in school washrooms with condoms available at a nominal cost.

Both male and female participants stressed their need to be more informed about sexual health services in the community. Although most could recall having been told about the services, few could remember the specific details. They suggested better marketing of the services by including information in weekly announcements and school newspapers, posting notices in the school, listing services in annual school planners, distributing cards listing methods and prices of birth control methods available at the clinic, providing regular home room reminders, and inviting the public health nurse to home rooms once a semester at each grade level. With respect to service provision, the students recommended a location easily accessible from the school for which transportation was not necessary, convenient hours of operation (e.g., during lunch hours), inexpensive birth control, a safe and comfortable environment, a sex-positive approach and confidential services.

DISCUSSION

Our study findings are consistent with the results of two recent Canadian qualitative studies. In one study, students identified the barriers to making healthy decisions about sex as lack of a safe environment to talk about sex in the schools, peer pressure, lack of parent-student communication, gender stereotypes, and limited school resources including teachers who were uncomfortable teaching the subject.⁶ In a second study, adolescents identified the following barriers: limited service availability; lack of confidentiality; lack of privacy; judgemental, directive or negative staff; unreliable or narrowly focussed information; and staff who were uncomfortable with adolescent sexual behaviour.⁷

Three main themes dominated the focus group participants' experiences and thoughts about the current sexual health system: limited and insufficient availability of sexual health information, lack of

knowledge about the existence of services, and lack of societal environment conducive to healthy sexual decision making. The schools used in this research are not atypical of schools in Ontario. They have sex education classes, school-based services, public health nurses and local sexual health clinics. The concerns presented by the adolescents in the group can provide insight for sexual health educators across the province.

This study had a number of strengths and limitations. Strengths included recruitment of students from high schools in different regions of Ontario and from rural and urban settings. Sixteen different focus groups were conducted. The adolescents were enthusiastic about sharing their experiences and suggestions to improve sexual health services. The teens supported the separation of focus groups by grade because they believed the older students would inhibit the participation of the younger students. No teachers or school staff were present during the discussion. All data transcripts were independently reviewed by two members of the research team.

Limitations included a poor response rate with 74% of the students not returning the consent form and only 56% of the remaining students providing personal and parental consent to participate. Follow-up calls to parents revealed that some parents had not been given the consent form, did not want their son or daughter to miss class, didn't see the value of such a focus group, worried that their son or daughter would be asked to disclose information about their sexual behaviour, and were uncomfortable with an 'outside' facilitator. Response was particularly poor from male students which may reflect that they or their parents see sexuality as a female issue or that they are less comfortable discussing sexuality issues.

On the basis of the extensive information provided by the adolescents, much of which is confirmed by previous research conducted in Canada, recommendations regarding the delivery of sexual health services to adolescents have been formulated (Table I). It is clear from the escalating adolescent pregnancy and STD rates, and the numerous suggestions made in this study, that there is still a long way to go in delivering optimal sexual health services to adolescents.

TABLE I
Recommendations for the Delivery of Sexual Health Services to Adolescents

1. Health departments should provide training sessions on sexual health issues for educators, parents and community professionals.
 2. Input from adolescents should be sought regularly for the planning and development of sexual health services.
 3. More research is required in the area of adolescent sexual health issues.
 4. A committee should be formed consisting of adolescents, teachers and public health nurses who can look into implementing these recommendations.
- Recommendations Regarding Education**
1. Sexual health education should be more sex positive with less emphasis on the anatomy and scare tactics.
 2. Sexual health education should include assertiveness training, relationships, how to ask for a date, violence and dating, gender differences in sexual relationships, negotiation skills in sexual relationships, sexual activity options and communication.
 3. The sexuality education curriculum should be expanded to include such issues as homophobia, heterosexism, gay/lesbian and sexuality for the physically challenged.
 4. The dated videotapes, long pamphlets and booklets should be replaced and new videotapes should be used in moderation.
 5. Sexual health education should include varied learning approaches (e.g., interactive classroom discussion, use of humour, dynamic speakers, hands-on demonstrations).
 6. Sexual health education should be available to all high school students beyond grade 9.
 7. Public health nurses should be asked to teach sexual health topics since they are perceived by students as comfortable with the material, knowledgeable, open, and separate from the school staff who they see every day.
- Recommendations for Sexual Health Clinic Services**
1. The sexual health clinics should advertise services in areas that teens are likely to frequent (i.e., washrooms in schools, pubs, shopping malls).
 2. Any descriptions of the clinic services should indicate that counselling is also available for relationship/emotional issues.
 3. The clinics should advertise flexibility in the fee schedule for oral contraceptives based on the client's financial situation.
 4. The location and hours of the clinic should be assessed to ensure that the needs of the adolescents are being met.
 5. The clients should be fully informed about the clinic procedures and policies.
- Recommendations Regarding Confidentiality**
1. School staff, school nurses and clinic nurses should be alert to any perceived breach of confidentiality.
 2. Appointment bookings for the public health nurse in the school should be done in a discreet and confidential manner.
 3. The location of the public health nurse in the school should ensure privacy and confidentiality.
 4. The public health nurses should provide sensitivity training and address issues of confidentiality with office staff in the school.
- Recommendations Regarding Public Relations**
1. The public health nurses should introduce themselves to students at the beginning of each semester in student assemblies or in individual classrooms.
 2. Public health nurses should distribute information pamphlets about their services.
 3. Posters should be placed in washrooms to explain the available services and how to access them.
 4. The students and school staff should be offered tours to local sexual health clinics.
 5. The availability of the public health nurse should be increased in terms of amount of time available or by varying the hours in the school.

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