Addressing Rural Adolescents Access to Sexual and Reproductive Health Services

by

Melanie Hawranik Sobering

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University of Manitoba
Winnipeg

ABSTRACT

The purpose of this qualitative exploratory descriptive study was to arrive at an increased understanding of the factors influencing access to sexual and reproductive health services by rural Manitoban adolescents. Focus groups and individual interviews were held with 23 health care providers who provide sexual and reproductive health services to adolescents. The descriptive findings of this study revealed that a number of barriers for adolescents exist, which include: transportation difficulties, system barriers, and fear of lack of confidentiality. Recommendations included: creating health services that are adolescent-friendly: evening hours, remaining open during lunch-hour, and locating a clinic near a high school; increasing nurses scope of practice; encouraging multi-disciplinary referrals; improving relationships between public health nurses and the school division; and advocacy for adolescents' to receive comprehensive sexual health information in school.

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CHAPTER I: INTRODUCTION

Statement of the Problem

Sexually transmitted infections (STIs) in adolescents have risen dramatically over the past 10 years in spite of the number of health education initiatives available focusing on sexual risk-taking activity. In particular, the 15 to 24 year old age group displays the highest rates of chlamydia and gonorrhea cases of all age groups in Manitoba (Communicable Disease Control, 2008). Moreover, females aged 15 to 19 years and males aged 20 to 24 years are reported to have the highest incidence of chlamydia of all age groups (Communicable Disease Control). The high-risk behaviors practiced by adolescents' places them in a high-risk category for STI incidence. Research suggests that such behaviors include unprotected sexual intercourse, and having multiple sex partners (Sieving, et al., 2011). The health care system in North America has responded to the high risk behaviors with the resultant high rates of STIs by offering a variety of services, such as condom availability programs through schools, public health nurses in community clinics offering reproductive health programs, and the occasional Teen Clinic available in schools or community sites. The 2009 Youth Risk Behavior Surveillance System is a school-based youth risk behavior survey of American high school students in grades 9 to 12. This survey reported that 46% of these students had sexual intercourse, with 5.9% having initiated sexual behavior before 13 years of age. Of all the students surveyed, 13.8% already had four or more sexual partners, only 61% reported that their partner had used a condom during the last sexual encounter, and 12.7% had been tested for HIV (Eaton, et al., 2009).

The literature indicates that health care providers have found that adolescents do not seek health care for the following reasons: concerns about confidentiality, lack of trust in health care providers, embarrassment, lack of awareness and knowledge of services, and lack of knowing how to access services (Jarrett, Dadich, Robards, & Bennett, 2011). Other influencing factors to adolescent's access were inadequate time with the health care provider, service availability flexibility, and poor linkages with other pertinent services, according to the health care providers (Kang, et al., 2003). The majority of the literature indicates that health education is an essential step in enabling adolescents to practice safe sexual health education (Banister, Begoray, & Daly, 2011). Studies also indicate that when a nurse is present in the school setting, adolescents' ability to access services improves, the adolescents' health education level increases, and sexually transmitted infection rates and adolescent pregnancy rates decrease (McCall & McKay, 2004; Sannisto & Kosunen, 2009).

The literature indicates that adolescents suspect a lack of confidentiality and anonymity when they are seeking any health services. (Berlan, & Bravender, 2009; Britto, Tivorsak, & Slap, 2010; McCann, Donnelly, Quinn, & McAnerney, 2008). Adolescents may decline needed care when the risk of lack of confidentiality and anonymity exists (Berlan & Bravender). The authors also assert that adolescents need information about sexual health and sexual health services targeted to their particular needs (Ott, Rouse, Resseguie, Smith, & Woodcox, 2010a).

Compounding the problems of high-risk behaviors and high STI rates is that adolescents have one of the lowest rates of primary health care use and health care access than any other age group (Blank, Baxter, Payne, Guillaume, & Pilgrim, 2010; McCann, Donnelly, Quinn, & McAnerney, 2008). One American study recognized that adolescents who did not receive care were less knowledgeable about sources of adolescent health care and therefore less likely to express intention to seek care (Booth, et al., 2004; Selkie, Benson, & Moreno, 2011). This low usage appeared to be related to negative impressions of health care providers and lack of information received regarding their health. Further, research has shown that people living in rural areas have poorer health and more limited access to health services than those living in urban areas (Barnes, Walsh, Courtney, & Dowd, 2004; Pong, et al., 2012). McCann and associates notes gaps in service provision geographically. Research has reported that young people require information about sexual health and sexual and reproductive health services targeted to their particular needs but minimal research has identified whether this is the reason for their risk-taking behavior and low use of sexual & reproductive health services (McCann, Donnelly, Quinn, & McAnerney). In general, there is also a lack of evaluations on adolescent pregnancy prevention programs (Blank, et al., 2010).

Overall, additional research is needed to identify perceived barriers and provide recommendations for services that HCPs identify as important in influencing the use of reproductive and sexual health services in order to prevent the spread of STIs and occurrence of pregnancy.

The Study Setting

This study targeted a rural community 320km north of the large urban center in Manitoba. This community is the largest community in the Regional Health Authority being studied. Agriculture and business are the predominant industries in this area. This geographic area has a number of characteristics that place the teens at high risk for STI’s and adolescent pregnancies. These risk factors include: high unemployment rates, low-income families, and individuals with decreased educational status (Community Health Assessment, 2009). Chlamydia rates for adolescents continue to rise within this RHA and exceed the Provincial average (Strategic Plan, 2010).

Purpose

The overall purpose of this qualitative study was to arrive at an increased understanding of rural Manitoban HCPs perspectives of the barriers rural adolescents encounter when accessing and using sexual and reproductive health services. This study was warranted considering minimal research exists examining sexual and reproductive health services in Manitoba, including rural Manitoba. Further, there have been no formal evaluations conducted of the services that currently exist in Manitoba (SERC, 2008). This study provided HCPs with the opportunity to articulate the barriers adolescents encounter accessing sexual and reproductive health services and provide recommendations on how to improve accessibility and utilization.

Research Questions / Objectives

The research objectives included:

1. To identify and describe, from the perspective of the Health Care Provider:
    a. The conditions that facilitate rural adolescents in accessing and using sexual and reproductive health services,
    b. The conditions that prevent or affect the use of sexual and reproductive health services by rural adolescents.
2. To obtain recommendations from the Health Care Provider’s that would improve rural adolescents’ access and use of sexual and reproductive health services.

Definitions

For the purpose of this study the following terms were defined: rural, adolescence, and sexual and reproductive health services.

1. Rural refers to populations living in towns and municipalities outside the commuting zone of larger urban centers of 10,000 people or more (Statistics Canada, 2006).

2. Adolescence is a critical developmental period in one's lifecycle. Major changes biologically, cognitively, psychologically, socially and environmentally take place. Exploratory behavior and experimentation with a wide range of behaviors is often essential for normal adolescent development (Irwin, 1993). For this study, HCPs will be asked to discuss the use of services by adolescents between 15 and 19 years of age. This definition is used by Statistics Canada and Communicable Disease Control when reporting statistics on adolescents.

3. Sexual and Reproductive Health Services are intended to address STIs and maternal mortality (AbouZahr & Vaughan, 2000). The World Health Organization identifies five major components of sexual and reproductive health services: maternal and newborn health, family planning, prevention of unsafe abortion, management of reproductive tract infections and sexually transmitted infections, as well as the promotion of sexual health (WHO, 2006). Further to this definition, the researcher included accessibility and comprehensiveness of programming for STI education and knowledge, and reproductive and contraceptive education and knowledge for this study.

Guiding Assumptions

My interest in this area began through my clinical practice as a PHN. I have seen many adolescents' who have been diagnosed with a STI, or are seeking birth control pills who have expressed to me that they have difficulty accessing health professionals. Often adolescents have to make several appointments with the physician, laboratory, and PHN during school-hours before their infection is treated. They must leave school and find transportation to the clinic, hospital or community health building. Teachers and peers note the adolescent's absence. The school notifies the student's parents of their absence. For an adolescent to arrange and attend several appointments in different locations poses problems for school attendance, efficiency and anonymity. For adolescents living in rural areas, this is complicated by lack of transportation and lack of anonymity within their communities. The literature that exists provides limited data outlining some of the difficulties adolescents experience in accessing these services in both rural and urban areas. I wanted to determine how we as HCPs can address these access issues.

The following assumptions of the researcher guided this study:

1. Health care providers believe that adolescents are capable beings. They are capable of making responsible and informed decisions about their health. With access to a system that has their best interest in mind, they will seek services for medical reasons.
2. Rural adolescents have a low use of health services, similar to the overall rural population.
3. Rural adolescents have difficulty accessing sexual and reproductive health services in the community in which they reside.

4. Adolescents are reluctant to ask for information on sexual and reproductive health services from adults and therefore will rely on information from their peers who will tend to be unreliable sources of this information.

Significance of the Study

There has been minimal research outlining the reluctance by adolescents to use sexual and reproductive health services. The findings from this study add to the existing literature on what barriers adolescents encounter when accessing sexual and reproductive health services from the HCP perspective. The findings from this study may help to guide HCPs who provide sexual and reproductive health services to rural adolescents.

Chapter Summary

The use of sexual and reproductive health services by rural adolescents is an under studied issue from the perspectives of HCPs. There is a lack of understanding of the factors that influence the low use of such services by rural adolescents. This study examined the barriers and the conditions that affected the use of such services from the perspective of the HCP. The following chapter will review the current literature on the challenges that exist regarding rural adolescents and sexual and reproductive health service use.

CHAPTER II – REVIEW OF RELATED LITERATURE

Introduction

This section will provide a review and analysis of the published literature on adolescent development, health care decision making by adolescents, STIs and adolescents, rural health, and the health care provider perspectives of adolescents. Also highlighted, are the types of sexual and reproductive health services that are available, and the factors that can influence the use of services.

A number of search engines were used to examine the published literature: CINAHL, PubMed, PsychLit, Social Sciences and Google Scholar. The search terms that were used included: teens, adolescents, youth, reproductive health services, sexually transmitted infections, health care use, barriers, access, rural, non-urban, urban, rural and health services, sexual and reproductive health services, use of health services, and adolescents and health services. Published articles, in the English language, from 1999 to May 2012 were retrieved. Government documents from Statistics Canada, Manitoba Health, and the rural community's Regional Health Authority's (RHA) Community Health Assessments and Strategic Plans were all reviewed.

Adolescent Development.

Adolescence is a time of numerous significant psychological, cognitive, physical and social changes. For most adolescents, this developmental period is marked by relatively good health and few visits to a health care provider. This section will describe the physical, cognitive, psycho-social and sexual developmental milestones that are marked by adolescence.

Physical Development. Adolescence usually begins with a rapid physical growth spurt leading to sexual maturity. Puberty timing differs substantially across individuals, and occurs on average one to two years later for boys than girls (Dixon-Mueller, 2008). Girls experience menarchy on average by 12-13 years of age (Dixon-Mueller). Marked increases in height and weight, the development of the pelvis, breasts, and uterus occur after menstruation begins. Males experience puberty slightly differently. Increased muscle mass, broadening of the shoulders, increases in height and weight, the presence of facial and body hair, and penile development mark puberty for males. The process of bodily growth along with sexual and reproductive maturation that is associated with puberty are accompanied by emotional, cognitive, and behavioral transformations (Dixon-Mueller).

Cognitive Development. Remarkable behavior and cognitive changes also occur during this time (Shafii & Burnstein, 2009). Adolescence is marked by an uneven progression in the development of brain structures and mental processes. These processes are associated with emotions, interpersonal relationships, and logical and critical thought. Adolescents develop the capabilities for abstract thinking and conceptualization, yet their ability to carry out this behavior is limited (Shafii & Burstein). Formal thought evolves to become adult-like. By the end of adolescence, many are capable of reasoning abstractly, making hypothetical deductions and postulating the idea of relativity (Shafii & Burstein). However, during times of stress, adolescents may still revert back to concrete thinking, which adds to their susceptibility to high-risk behaviors such as sexual activity (Shafii & Burnstein). Thought processes move from concrete thinking to abstract thought (Shafii & Burnstein). Adolescents often presume that "nothing bad will happen to me... those things only happen to other people" (Shafii & Burnstein, p.103). Due to this reasoning, their limited judgment fails to identify and acknowledge potentially dangerous situations.

Sexuality is often realized during this time, and can become a central focus for many adolescents. The overactive hormonal surges are linked to severe mood swings (Shafii & Burnstein, 2009). The attitudes and behaviors developed during adolescence often determine the lifestyle and health habits they adopt during adulthood (Masatu, Klepp, & Kvale, 2001; Shafii & Burnstein).

Psycho-Social Development. Developmentally, adolescents are attempting to establish their independence from their family of origin, make significant connections within peer groups and struggle to find their own identities. They are defining and redefining concepts of evolving capacities that weigh parental rights and obligations against their rights and their peers to make their own decisions.

Risky behaviors are often characterized by the adolescent years. Teenagers seek out risk-taking behaviors because the brain systems involved in decision-making mature at different times (Boyles, 2007). The section of the brain most involved in emotion and social interaction becomes very active during adolescence, while the section most critical for regulating behavior is still maturing into early adulthood (Boyles). In instances when alcohol is consumed, adolescents have been shown to more frequently fail to use contraception, engage in sex with casual partners, and have multiple sex partners (Kotchick, Shaffer, Forehand, & Miller, 2001). Cigarette smoking, drug usage, and sexual intercourse often start at this age. There is also a general increase in risk taking behaviors (Shafii & Burnstein, 2009). Access to health services during adolescence has been found to modify risky behaviors, promote healthy habits, and improve adolescents' health (Masatu, Klepp, & Kvale, 2001).

As psychosocial maturity increases, "teenagers gain more impulse control, responsibility, and self-awareness over the course of adolescence" (Weinberger, 1997). In contrast, another study found that age and maturity were not found to be tightly associated during adolescence (Sumter, Bokhorst, Steinberg, & Westenberg, 2008). There are individual differences in the timing and speed of maturity that may be less pronounced with the age of the adolescent.

Factors that influenced health care decision-making were found to include: age, psychological maturity, peer pressure and religion. Limited research was found discussing peer pressure and adolescence. One study reported that older adolescents self-reported more resistance to peer pressure (Sumter, et al., 2008). These studies also suggested that over time adolescents gain more autonomy from their peers and were able to defend their own opinions (Sumter, et al.). Girls displayed greater resistance during their mid-adolescent period than boys (Sumter, et al.). Resistance to peer pressure occurred earlier for girls than for boys.

Several studies reported that psychosocial development during the adolescent years have found that girls mature more quickly than boys during mid-adolescence, and that boys typically catch-up with the girls during late adolescence (Moffit & Caspi, 2001; Sumter, et al., 2008).

Health Care Decision Making by Adolescents.

The developmental changes that occur in adolescence influence their decision making in regards to seeking health services, and making informed health care decisions.

Various studies have found that adolescents' main reason for seeking health services were for illness-related symptoms, such as respiratory, dermatological, and musculoskeletal complaints (Marcell & Halpern-Felsher, 2005; Masatu, Klepp, & Kvale, 2001). During clinic visits, only a small proportion of adolescents discussed STI's, pregnancy and substance use (Masatu, Klepp, & Kvale). Marcell and Halpern-Felsher reported that adolescents may not be adequately socialized into the health care system, and may have incorrect beliefs about the system and the role of the physician. These authors believed that a contributing factor to adolescent's low use of health care services is their inability to identify health problems and comprehend the physician's role in managing the health problems (Marcell & Halpern-Felsher). Sexual and reproductive health issues are not always seen as a concern a physician can resolve.

Adolescents' perceptions of provider characteristics were among the most common issues when making decisions to seek health services (Marcell & Halpern-Felsher, 2005). Also influencing adolescents' decisions was the general competence of the health care provider, previous quality of provider and patient interactions, cleanliness of the site and the physician, as well as the perception of information discussed remaining confidential (Elliott & Larson, 2004). The adolescents who reported not seeking health care or reported being less knowledgeable about available health care services, had negative attitudes toward health care, and were less likely to plan to seek health-care in the future (Selkie, Benson, & Moreno, 2011).

Health Service Use by Adolescents.

Adolescents who seek professional attention do so only after a problem has been present for some time, or when their parent realizes that their adolescent needs to be seen by a health care professional (Kang, et al., 2003; Sears, 2004). A number of factors have been identified in the literature as influencing adolescent's health service use. These include: lack of education about their own health, lack of knowledge regarding where to receive treatment or testing, transportation access, fear of medical examinations, concern for confidentiality, fear of embarrassment, poor motivation to see a provider, fear of the health care provider informing their parents, lack of understanding of the physicians' role in managing health problems, the physician's neglect in assessing risk behaviors, mental health issues, or physical accessibility (Elliott & Larson, 2004; Marcell, & Halpern-Felsher, 2005).

A study that examined health care provider opinions of adolescents use of primary care services in Australia found that adolescents often did not keep appointment times, were not consistent with what treatment was agreed upon at the visit, and do not attend the necessary follow-up appointments recommended by the health care provider (Kang, et al., 2003). Another study found that adolescents' educational levels regarding health and access to health was limited (Blank, et al., 2010; Jacobson, Richardson, Parry-Langdon, & Donovan, 2001). Physicians agreed that adolescents needed more "information and education about aspects of general practice services, such as patient rights, basic health, and confidentiality" (Jacobson, et al., p. 815). It was also reported that adolescents were unaware of the range of health services available to them and the range of health care provider skills that may be relevant to their health needs (Booth, Bernard, Quine, Kang, Usherwood, Alperstein, & Bennett, 2004).

Several American studies highlighted the association between religious affiliation with sexual and reproductive behaviors. The target populations for these studies were women aged 15 to 24 years of age. Several of these studies consistently found that more frequent religious attendance during adolescence was associated with later initiation of sexual intercourse (Wilcox, Rostosky, Randall, & Wright 2001; Billy, Brewster & Grady, 1994). However, the regular attendance of religious services, was not a predictor of adolescent pregnancy, contraception use, timing of first family planning visit, or having more than one sexual partner in the last year (Jones, Darroch & Singh, 2005). These descriptive studies failed to mention the specific religions of the adolescents studied or the extent to which religious practices were incorporated into their daily life. There was also no mention of an association between culture and religion or between culture and sexual and reproductive behaviors.

Health care providers also need to remain aware that adolescents and their parents may hold differing religious beliefs (Dickens & Cook, 2005). This can be particularly relevant for adolescents living in a rural community, where the health care provider may know the adolescent and their family and make assumptions about their religious or cultural beliefs. Other factors, such as the adolescents' academic performance in school and gender were not considered by any study found.

Sexually Transmitted Infections and Adolescents.

Research has shown that STI's are increasing dramatically in Canada and particularly within Manitoba. Currently, Manitoba has the second highest rates of chlamydia and gonorrhea among 15 to 24 year olds among the provinces in Canada (PHAC, 2011). Canadian, including Manitoban Chlamydia rates have steadily increased since 1997 (PHAC, 2008). STI's disproportionately affect adolescents and young adults under the age of 25 years (Maticka-Tyndale, Barrett, & McKay, 2000). Chlamydia, the most common of the reportable STI’s is high among the 15-24 year old age group, only to be slightly exceeded by 20 to 24 year olds (PHAC, 2011). Adolescent males and females account for more than 70% of all chlamydia cases and more than 60% of all gonorrhea cases in Manitoba (Manitoba Health, 2004).

The majority of chlamydia infections present asymptomatically; as a result, the infected individuals are less likely to be diagnosed and treated (PHAC, 2008). Untreated chlamydia can lead to a number of devastating health concerns and long-term consequences for both men and women. Males may experience infertility, Reiter’s syndrome and epididymitis (PHAC, 2008). A chlamydia infection in females can be more devastating and include: ectopic pregnancy, pelvic inflammatory disease (PID), chronic pelvic pain, and ulceration causing the infected to be at increased risk of contracting HIV (PHAC, 2008). If the woman is infected with chlamydia during the vaginal delivery of an infant, pneumonic infection of the newborn can occur (PHAC, 2008).

Gonorrhea rates among Manitoban adolescents are also high. In adolescent females aged 15 to 19 years the gonorrhea rate increased from 79.5 per 100,000 in 1999 to 186.6 per 100,000 in 2008, which is the greatest absolute increase of all age groups (PHAC, 2011). Similar to chlamydia, gonorrhea is asymptomatic in the majority of cases (PHAC, 2008). Consequences of untreated gonorrhea are numerous. For males, these include: chronic urethritis, epididymitis, and gonococcal arthritis. In females, PID, ectopic pregnancy and infertility may occur. If a woman delivers a baby while infected, the newborn may acquire conjunctivitis and become permanently blind if not treated immediately (PHAC, 2008). Recent evidence has reported that quinilone resistance has increased in the recent years, resulting in an increase in the antibiotic dosage required to treat the bacterial infection (PHAC, 2008). The increasing rates of STI's are particularly problematic due to their asymptomatic nature and the difficulty in detecting them resulting in a greater likelihood of serious long-term health consequences.

When the infections of chlamydia and gonorrhea are symptomatic, common symptoms females experience can include: vaginal discharge, shaking and chills, fever, postcoital bleeding, lower abdominal pain, and vaginal bleeding (CDC, 2008). Common symptoms males can experience are: fever, urethral itch, urethral discharge, dysuria, and chills (CDC, 2008). These infections can be treated and cured by prescription antibiotic.

The elimination of gonorrhea and a significant reduction in the incidence of chlamydia were listed as national goals by the Canadian government to be achieved by the year 2010 (Health Canada, 1997). This date has now passed, and these infections remain on the rise, however decreasing these rates remains a goal across Canada. It is evident that a greater understanding of the population at greatest risk, the behaviors and/or circumstances that put adolescents at risk, an understanding of the needed appropriate services and the prevention efforts that may impact the epidemiology of STI's is necessary.

In Manitoba, the individuals with the highest rates of STI's live in the downtown core area of Winnipeg and in the northern rural sections of the province (Manitoba Health, 2001). Both of these locations are characterized by: high unemployment and poverty rates, racial, ethnic and cultural diversity, language barriers, increased migration rates, a disproportionate population of young people aged 25 years of age and younger, a disproportionate population of Aboriginal people, and a large number of single-parent families (Manitoba Health). Aboriginal people tend to have the highest rates of STI's of any ethnicity in Manitoba (Communicable Disease Control, 2005). The Canadian literature does not identify more specific characteristics of this latter population that place them at high risk for STIs. Overall the evidence indicates that STI's are increasing and that adolescents are one of the high risk groups.

Rural Health.

Definitions. Rural is a concept that has not been consistently defined. Numerous definitions are found within the literature. In the Statistics Canada 2011 census provides a new definition of 'rural' and 'urban'. Population centre is the term now used to categorize rural and urban areas as small, and medium population centers, and large urban population centers. A small population centre is defined as a population of 1,000 to 29,000 (Statistics Canada, 2011). The community examined in this study fits into the small population center category. 'Census-rural' is another definition which refers to individuals living outside of centers of 1,000 or more in population. Rural and Small Town (RST) is another frequently used definition among rural health researchers. RST refers to residents in towns or municipalities who are "outside the main commuting zone of 10,000 or more" (Bollman, & Clemenson, 2008, p. 9). Another definition refers predominantly to rural regions. Predominantly, Rural Regions refer to communities with a population density of less than 150 persons/km^2 (OECD, 1994; Kulig & Williams, 2012). There has been a longstanding debate on whether rural is a geographical concept, a location with boundaries on a map, or a social representation of a community of interest, culture, or way of life (Statistics Canada, 2001).

The size of Canada's rural population differs according to the rural definition that is chosen. Statistics Canada reports that the number of Canadians who live in rural populations is decreasing. Currently 18.9% of Canada's population live rurally (Statistics Canada, 2011). Manitoba's rural population would total 28.5 percent (Statistics Canada, 2012).

Unique challenges. Canadian rural health research has focused on accessibility to health services because of the long distances and low population density. There is evidence suggesting that rural populations may have specific health vulnerabilities, poorer health status, lower family incomes, higher transportation costs, lower life expectancy and higher accident and injury rates than urban areas (CIHI, 2006; Kirby & LeBreton, 2002; Kulig & Williams, 2012). Evidence indicates that rural communities have unique characteristics with respect to health determinants, demography, and economic, social, and physical environmental factors (CIHI; Kulig & Williams). According to Curtis and colleagues (2011), rural adolescents may be at greater risk for poor health outcomes related to lack of accessible community resources. Access to services in rural areas are far more limited than in urban areas (Atkinson, Schattner, & Margolis, 2003; Curtis, Waters, & Brindis). Many services are simply not available in rural and northern communities due to the low population density. Rural individuals and families often have to travel great distances to access necessary services (Pong, et al., 2012).

Another factor affecting health service use is one's definition of health. A study conducted in Australia found that people in rural areas commonly described health as the absence of disease (CIHI, 2006). Curative treatment is the focus of the community and health care system, therefore placing more of the demand on acute care services as opposed to primary care, health promotion and prevention. In addition, many adolescents who seek professional attention do so only after a problem has been a problem for some time (Laitinen-Krispijn, van der Ende, Wierdsma, & Verhulst, 1999; Sears, 2004).

Rural communities face a number of challenges. Aging populations, economic difficulties, and geographic isolation are among the many factors that can contribute to specific health vulnerabilities in rural areas (CIHI, 2006; Kulig & Williams, 2012). Rural areas tend to have low youth populations. This is associated with rural youth migrating to urban centers for further education and employment opportunities (CIHI). Rural populations tend to be less highly educated, have higher unemployment rates and have lower incomes than urban populations and the average Canadian (CIHI; Curtis, Waters, & Brindis, 2011; Statistics Canada, 2006). Geographic isolation and problems associated with access to and shortage of providers and services pose significant barriers for rural residents. In addition, economic circumstances, traveling time to the city and the lack of car ownership can affect access to and demand for health services (CIHI; Curtis, Waters, & Brindis; Elliott & Larson, 2004; Humphreys, Matthews-Cowey, & Weinand, 1997; Stewart, & Rosenthal, 1997; Kulig & Williams, 2012).

Rural adolescents. The literature on rural health identifies known gaps in service provision for various target groups and those that live rurally (McCann, Donnelly, Quinn, & McAnerney, 2008; Curtis, Waters, & Brindis, 2011). Rural adolescents need information about sexual health and the services available to them targeted at their specific needs. Rural areas pose distinct barriers for adolescents. These barriers can include transportation and lack of confidentiality and anonymity (Curtis, Waters, & Brindis, 2011; Kulig & Williams, 2012; McCann, Donnelly, Quinn, & McAnerney;

Shoveller, et al., 2009). Additional research is needed to identify the barriers rural adolescents encounter when seeking health services.

Types of Sexual and Reproductive Health Services Available.

Much of the literature described school-based programs providing health care services for STI and reproductive health related services (Blank, et al., 2010; Braeken, Otoo-Oyortey, & Serour, 2007; Crespo & Shaler, 2000; Eisenberg, Bernat, Bearinger, & Resnick, 2009; Harrison, Beebe, Park & Rancone, 2003; Hobcraft & Baker, 2006; Kirby & Brown, 1996; Lambke & Kavanaugh, 1999; Nwokolo, McOwan, Hennebry, Chislett, & Mandalia, 2002; Peckham & Carlson, 2003; Shoveller, et al., 2009). The literature described programming targeted to adolescents who attended school, however, the minority of adolescents who do not attend school may be at higher risk for STIs (Zimmerman, et al., 2008). Therefore, programs or interventions should attempt to target these adolescents as well.

Condom availability. Several American studies specifically discussed condom availability. Utilizing contemporary models of health behavior, researchers and practitioners assumed that school condom availability programs would increase condom usage, improve the negative perceptions of condoms, and eventually remove barriers for teens to obtain condoms, creating an environment that facilitates and reinforces condom usage (DiClemente & Peterson, 1994; Eisenberg, Bernat, Bearinger, & Resnick, 2009; Kirby & Brown, 1996). To create this type of environment, school nurses and select teachers participated in a study in which condoms were provided to students (Kirby & Brown). Kirby and Brown found that after the program was implemented, the pregnancy rate for adolescents aged 14 to 17 years of age declined significantly for several years.

Once the program had concluded, pregnancy rates “returned to pre-program levels” (Kirby & Brown). There was no discussion of other factors that could have influenced this change in pregnancy rates in addition to the condom availability program.

Another study described an intervention that allowed condoms to be distributed in the school to adolescents (Eisenberg, et al., 2009). This study found that parents of adolescents supported condom distribution programs and education in high school (Eisenberg, et al.). When comprehensive sexuality education programs were in place and included information on condom use and other contraceptive methods, adolescents were shown to delay sexual activity, use condoms and contraceptives appropriately (Kirby, 2001; Manlove, Romano-Papillo, & Ikramullah, 2004). Thus far, a minimal number of studies have been published on the impact of condom availability programs on adolescent’s sexual behavior or condom use (Kirby & Brown, 1996).

School clinics. A survey conducted by Kennedy and MacPhee found that many cities and towns within the Maritimes in Canada had school-based ‘youth health centers’ (2006). These clinics were offered in both rural and urban schools, and offered an array of health services that adolescents could access without parental consent. A large component of these clinics focused on sexual health services, which included information on: birth control, sex, pregnancy, STIs, relationships, abortion information and sexual bullying. These clinics were directed toward students predominantly aged 13-16 years, and were generally utilized well (Kennedy & MacPhee).

Community programs. One study in particular, examined the types of reproductive health counseling that five registered nurses working within an urban community setting provided to adolescent females. The nurses, all with over ten years of experience, described the reproductive health counseling they conducted. It included providing information about contraceptive methods, condom usage, and disease risks of sexual intercourse (Lambke & Kavanaugh, 1999). Adolescent females were the main users of the information. The methods used to deliver the information to the girls varied by the individual nurse. One nurse provided an abundance of information around STI prevention; another nurse concentrated on barrier methods for her clients, while a third nurse stressed abstinence (Lambke & Kavanaugh). Even though each nurse had a slightly different focus, they felt the education they were providing was the same (Lambke & Kavanaugh). However, no formal evaluation was conducted to determine the impact on sexual behavior, incidence of STIs, or pregnancy.

Education curricula. The literature has raised criticisms about the extent and adequacy of sexual and reproductive health education in the school system. Several studies concluded that formal instruction about sexual and reproductive health, needed to be improved (Banister, Begoray, & Daly, 2011; Blake, 2001; DiCenso, 2001; Mevsim, Guldal, Gunvar, Saygin, & Kuruoglu, 2009; Omar, McElderry, & Zakharia, 2003; Phillips & Martinez, 2010; Romero-de-Castilla-Gil, Lora-Lerenzo, & Canete-Estrada, 2001). Many schools were not fully implementing their reproductive health education curricula or utilizing PHNs to their full potential (McCall & McKay, 2004). However, Mcall and McKay add that PHNs do not have the resources, support or coordination to provide formal educational instruction in the schools (McCall & McKay). This same study reported that students typically receive three to eight hours of education on sexual health issues per year. Depending on the school and school division, the content of the sexual and reproductive health topics may vary. There is an emphasis on abstinence-only education and reluctance for open discussion on the topic (McElderry, & Omar, 2003; Phillips & Martinez, 2010). McElderry and Omar conducted a review of 30 studies that analyzed sexuality and HIV education in schools, and learned that comprehensive sexual education programs did not increase any measure of sexual activity, but in fact reduced the amount of sexual risk-taking behavior, decreased sexual behavior, and increased condom use.

Adolescents reported feeling uncomfortable when taught about sexual issues by their teachers (DiCenso, 2001). Successful curricula were described as providing "interventions that were able to attract and hold the attention of target audiences at particularly high risk" (Zimmerman, et al., 2008). HCPs were seen as a reliable source of sexual and health information (Ginsburg, Forke, Cnaan, & Slap, 2002). Research that has evaluated school-based or linked clinics has shown that by making adolescent health services convenient and youth-friendly, adolescent's access and use of those services increased and their health improved (McCall, & McKay, 2004).

Despite these programs, Shaw reports (2009, p. 135) that "no single program is likely to be able to serve the needs of all young people", meaning that their reproductive health issues need to be addressed and the services that are offered need to be youth-friendly. Shaw recommended that the services be based on the adolescent's input, on their lives, and their health. Shaw also suggested that this may be accomplished by working with local politicians, religious leaders, and the community to increase awareness of sexual and reproductive health issues affecting adolescents today.

Current Services Available.

Currently, there are limited services for adolescents that specifically address sexual and reproductive health in Manitoba. Only a handful of rural Regional Health Authorities in Manitoba offer Teen Health Clinics (Manitoba Government, 2009). As this study was being conducted, one Teen Health Clinic opened in the Health Region being studied.

A Public Health Nurse (PHN) or Nurse Practitioner (NP) offered Teen Health Clinics in local schools around the province, and offered the clinics during school hours. These clinics tended to be open two to six days a month for a limited number of hours. The services consisted of secondary prevention rather than primary prevention activities. They were also limited by the nurse's scope of practice. PHN's would not order or conduct urine testing for STIs, treat STIs, order or conduct blood tests for STI screening and pregnancy, distribute pregnancy tests, or provide birth control pills without a prescription. Therefore, after the adolescent sees the PHN, they must also make appointments to see a physician and lab technician for the needed services.

The clinics offered within the RHA being studied were not adolescent-driven. The services that young people required were often not available where and when they wanted them or provided in a manner that they found appropriate to their needs (McCann, Donnelly, Quinn, & McAnerney, 2008). Some regions had health services specifically designed to meet the needs of adolescents, while most regions offered only the mainstream health services. School based clinics are often ineffective at attracting adolescents (Atkinson, Schattner, & Margolis, 2003). Drop-in centers can be effective, but are too costly to offer in rural communities. The primary reasons being: funding and staff resources (M. Zamrykut, personal communication, December 20, 2010). However, if tackling rising rates of STIs and reducing current levels of teenage pregnancy are to be addressed in line with the targets set by regional strategies, then providing services appropriate to the needs of adolescents which they can and will use should be seriously considered (Zamrykut). In addition, the educational needs of those providing such services in terms of continuing professional development and training must be addressed (Zamrykut).

Within the urban centers of Manitoba, there were significantly more services available to adolescents. There were a few private agencies within the urban centers that offered convenient locations and hours for adolescents to access services. Private clinics and organizations existed, in addition to the medical and public health offices addressed the sexual and reproductive health needs of adolescents. These clinics provided adolescents with education, counseling, free condoms and birth control pills. They had multidisciplinary staffing to meet the demands of the urban communities. These organizations also provided outreach in the form of education and support to individuals and groups in areas of the city and schools that were unable to access the clinics readily.

An urban health region in the same province employed Street Nurses. These nurses targeted the health needs of adolescents and adults who were living in the inner-city, were homeless, or had difficulty accessing mainstream health services.

Across Canada, similar services to those described above, were provided to adolescents in all Provinces. Teen Clinics held within schools by PHNs tended to provide similar services and hours to those provided within Manitoba. Youth clinics were primarily government funded and managed by PHNs aimed to all individuals younger than 24 years of age (BC Center for Disease Control, 2009). The use of NPs in Teen Health Clinics was a relatively new approach. NPs had an expanded scope of practice compared to PHNs, and could therefore provide a broader range of intervention strategies than the PHNs. Teen Health Clinics were typically available one to two times/week within regular office hour times. The privately managed youth clinics had occasional evening hours. The majority of the clinics offered walk-in services to adolescents.

Factors That Influence Use of Sexual and Reproductive Health Services.

Young adults between the ages of 13 and 24 years of age have the lowest number of healthcare visits per year, compared to all other age groups (Blank, et al., 2010; Ma, Wang & Stafford, 2005). Adolescent males, older adolescents, and runaway homeless youth use health services less often than other adolescents (Marcell & Halpern-Felsher, 2005). A British study of 250 adolescents between the ages of 13-18 years found that mainstream contraception and sexual-health services were difficult to access (Hayter, 2005). A number of barriers have been identified in the literature that prevented adolescents from using sexual and reproductive health. Judgmental attitudes from service providers, concerns about confidentiality, and transportation difficulties were identified by the adolescents as barriers to seeking care (Barrett & Harper, 2000; Brindis, 2010; Elliott & Larson, 2004; Fitzpatrick & Walton-Moss, 2011; Fothergill & Feijoo, 2000; Kang, et al., 2003; McCann, Donnelly, Quinn, & McAnerney, 2008).

Health care providers. A small qualitative Australian study examined rural and urban health care providers perceived barriers to youth service provision (Kang et al., 2003). The health care providers included: general practitioners, youth health workers, youth health coordinators, and community health centre staff. Utilizing focus groups and interviews, several barriers were identified. The physician’s lack of available time to spend with the adolescent was one barrier. The physicians reported that they could not “really afford the time to spend with them… financial pressures and time pressures” (Kang, et al., p. 949). Several other studies found similar findings (Sannisto & Kosunen, 2009; van der Meulen, Oliver, Flicker, & Travers, 2010). Long wait-times to see a physician, rushed office appointments and delays in securing an appointment were barriers that adolescents encountered and prevented them from seeking sexual and reproductive health services (Sannisto & Kosunen).

A British study examined how adolescents and primary health care providers perceived each other in the clinic. Twenty one percent of the adolescents reported that their appointments were ten minutes or less, which they considered was not enough time to discuss their health concerns (Jacobson, Richardson, Parry-Langdon, & Donovan, 2001). Physicians in the Kang and associates (2003) article reported deliberately not asking the adolescent questions for fear of what the discussion would lead to in regards to the amount of time the discussion would take, and the possibility of the discussion being uncomfortable for the health care provider. Jacobson and associates reported that a common theme expressed by the adolescents was that they did not feel as respected as clients of other ages and were often treated as children. The general practitioners interviewed by Kang and colleagues expressed difficulty understanding adolescents health concerns, as they were “very non-verbal at that age” (p. 949). While adolescent’s reported that “doctors treat teenagers as if we’re not capable of knowing what’s wrong with us” (Kang, et al., p. 812).

Adolescents are often required to encounter several health care providers to solve one health issue. An American study found that adolescents who interacted with medical residents and fellows in addition to their primary physician felt as though the presence of the multiple providers was unnecessary (Britto, Tivorsak, & Slap, 2010). The adolescents in this study also reported that they were not comfortable with information-sharing among health care providers for the purpose of client care (Britto, Tivorsak, & Slap). The adolescents' concerns were primarily surrounding nonclinical staff having access to their personal medical records. Beresford and associates revealed that adolescents preferred to see their own physician only, and not a medical student, as they felt the students presence interfered with the open communication between the physician and themselves (2003).

Gender preference among health care providers was discussed in the literature. Many adolescents reported preferring a female or same-sex health care provider (Britto, Tivorsak, & Slap, 2010; Turrow & Sterling, 2004; van Ness & Lynch, 2000). Britto and colleagues reported that adolescents were uncomfortable having a physical examination performed by a male health care provider for fear of being touched inappropriately. Embarrassment was also identified as being an issue in wanting a same-sex health care provider (Turrow & Sterling). Female health care providers were found to be more likely to discuss emotions and non-medical information, and communicate in a manor that elicits a partnership with the adolescent (Brown & Wissow, 2009).

Difficulty with multi-disciplinary partnerships was identified by Kang and associates (2003). A complicating factor for these partnerships among rural service providers was job turnover and therefore the lack of a long-term working relationship with the support services. Both the physicians and other health care providers in this study agreed that initiating and maintaining a presence in the school setting would be ideal to adolescent care and foster multi-disciplinary partnerships among health care providers and school staff.

Parental presence. Adequate exploration of health issues became complicated when the adolescent's parent attended the appointment with them (Kang et al., 2003). When the adolescent was accompanied by their parent and appeared not to know why they were seeing the physician, this created an uncomfortable atmosphere for both the physician and the adolescent. In situations similar to this, Kang and associates explained that the physician did not direct the conversation to the adolescent, but to the parent in order to prevent the parent from becoming upset and possibly losing them as a patient.

Health care providers were found to prefer meeting with adolescents solo, rather than with a parent. Adolescent's honesty regarding sensitive issues could be impeded by the presence of the parent (Bitar, Springer, Gee, Graff, & Schydlower, 2009). Shafii and Burnstein (2009) recommend that health care providers interview the adolescent separately from their parent. The reasons they cited for this separation were to empower the adolescent to be responsible for his or her own health, to create a therapeutic alliance between the health care provider and the adolescent, and to provide the opportunity for a confidential assessment of his or her sexual history and risk-taking behaviors (Shafii & Burnstein). Adolescents stated that health issues related to contraception and sexual behavior were confidential and should remain private from their parents (Carlisle, Shickle, Cork, & McDonagh, 2006). Despite health care providers preference to meet with adolescents individually, they reported always encouraging adolescents to involve and inform their parent or a trusted adult in their health care as much as possible (Helitzer, et al, 2010; Ott, et al., 2011b; Shafii & Burstein, 2009).

Confidentiality. Confidentiality was highlighted as the number one barrier to accessing sexual and reproductive health services by adolescents (Barrett & Harper, 2000; Bradley-Stevenson & Mumford, 2007; Britto, Tivorsak, & Slap, 2010; Brindis, 2011; Elliott & Larson, 2004; Fitzpatrick & Walton-Moss, 2011; Klein, Nulty & Flatau, 1998; Lambke & Kavanaugh, 1999; Shoveller, et al., 2009). Of particular concern for both male and female adolescents, was fear of the physician breeching confidential information to parents (Kennedy & MacPhee, 2006; Shoveller, et al.). As a result of this fear, physician services were not accessed. Adolescents strongly emphasized that "private sexual issues and concerns would not be disclosed to parents" (Kennedy & MacPhee, p.4).

An American study attempted to predict urban adolescent girls' initiation of gynecologic care (McKee, Fletcher, & Schechter, 2006). This study noted that parental awareness of girls' health needs is low; therefore this can result in girls missing or delaying needed gynecologic health care (McKee, Fletcher, & Schechter). As girls gradually became more sexually active, confidentiality concerns influenced their decisions to seek a health care provider. The authors did not mention confidentiality concerns specifically directed to Public Health Nurses or Nurse Practitioners. The authors expressed that students may feel more secure that their visit will remain confidential in a school-based program rather than an urban community clinic.

A recent American study examined adolescents' need for health care privacy (Britto, Tivorsak, & Slap, 2010). The authors found adolescents want informational, psychological, social, and physical privacy. Adolescents did not want the health information they considered confidential to be shared with their parents, other clients or other health care providers (Britto, Tivorsak, & Slap). Psychological privacy involved adolescent clients being comfortable with their health care provider. The adolescent was only willing to discuss their involvement in risk behaviors if they felt that their behavior was acceptable by the health care provider (Britto, Tivorsak, & Slap). Social privacy involved establishing a relationship with the health care provider; adolescents expressed wanting to see one health care provider for health related issues and not be exposed to many different health care providers (Britto, Tivorsak, & Slap). Physical privacy referred to health care provider violations of the adolescents physical privacy and who should have physical access to the adolescent. Many of the female adolescent participants preferred a female health care provider for physical examinations and assessments.

Another study examined Australian adolescents' access to health care (Booth, et al., 2004). One of the findings from this study was that many adolescents did not seek health services when they encountered a health issue. Only a small proportion of adolescents sought help from a health care provider. The adolescents who did seek services from a health care provider, did so only because they had formed a positive relationship with the provider previously (Booth, et al.). The authors found that adolescents may not access services if they were unaware of the range of services available to them and the range of skills that providers have (Booth, et al.). Other factors for not seeking sexual and reproductive health services were long wait times, not wanting to 'waste' the physician's time, and not being able to see a female physician (Booth, et al.).

An American study interviewed 18 urban male adolescents and found that young men aged 15-18 years did not want to seek health information in a clinic due to being recognized by someone (Lindberg, Lewis-Spruill & Crownover, 2006). A group of female adolescents in one study stated that they worried about being seen by a friend, family member or a friend of their parents when seeking primary health care (Jacobson, Richardson, Parry-Langdon, & Donovan, 2001). This lack of anonymity deterred some adolescents from seeking services. Rural areas have smaller populations and are closer-knit communities (Lishner, Richardson, Levine & Patrick, 1996). Rural adolescents could potentially face this same barrier.

The internet. The internet is a common source for adolescents to seek information about sexual and reproductive health. Ninety three percent of adolescents use the internet. Approximately 75% of American youth have home internet access, 77% of adolescents have classroom access, and most adolescents report daily use (Gilbert, Temby, & Rogers, 2004; Jones & Biddlecom, 2011; Moreno, Ralston, & Grossman, 2009). Jones and Biddlecom report that 72% have searched for health related information on-line. Borzekowski, and colleagues found that the internet was chosen by one third of students as their primary method to obtain sexual health information (2006; Harrison et al., 2003). The internet was sited as the most common source of information for birth control and sex (Jones & Biddlecom).

An American study reported that urban adolescents were using the internet to find information for health and medical information 72% of the time (Jones & Biddlecom, 2011). Despite their preference for the internet, adolescents did question the quality of the information they obtained; this did not however influence their use. However, friends and parents were still identified as a more valuable and reliable source of this information (Jones & Biddlecom). Other sources of information consisted of bulletin boards on the World Wide Web as well as instant messaging with their friends (Skinner et al., 2003). Despite the adolescents questioning of the validity of the information, it was perceived as providing valuable health information due to the anonymity and unbiased method in learning about sensitive health concerns, such as sexual and reproductive health (Buhi, Daley, Oberne, Smith, Schneider, & Fuhrmann, 2010; Selkie, Benson, & Moreno, 2011).

Adolescents reported that the availability of internet access and the privacy it afforded were major reasons for its preferred use (Buhi, et al., 2010; Skinner et al., 2003). Most reported that they would rather have slightly inaccurate information than risk a breech of confidentiality or someone they know seeing them at a clinic (Borzekowski, Fobil & Asante, 2006; Skinner et al.). Adolescents in one study were particularly concerned with the reliability of internet sites and the popularity of social networking and "it's platform for advertising and the openness that allows so many people to create and upload content of a wide-ranging nature" (Jones & Biddlecom, 2011, p. 119). The adolescents accessed the internet to gain information about sexually transmitted infections, sexual activities, sexual abuse, nutrition, and fitness (Borzekowski, Fobil, & Asante; Skinner et al.). Adolescents recommended that a URL or website with accurate information should be made available to them. A number of studies highlighted the difficulty that adolescents experienced when searching for sexual and reproductive health material online (Jones & Biddlecom, 2011; Keller, Labelle, Karimi, & Gupta, 2002). Jones and Biddlecom also found that most adolescents who searched for information on the internet reported no or limited exposure to contraceptive information. In the instances that contraceptive information was found, the adolescents reported that they "knew the information was there if they needed it, but they were not motivated to look it up or click on it" (Jones & Biddlecom, p. 116).

Social media is a relatively new phenomenon to health education. The use of social media in public health practice and health administration has dramatically increased in recent years (Kapp, LeMaster, Lyon, Zhang, & Hosokawa, 2009). YouTube, the use of social networking sites, and connecting with clients by text message are all social media venues that target the adolescent population. It was found that adolescents appreciated the anonymity and nonjudgmental, confidential information they received when utilizing these outlets (Selkie, Benson, & Moreno, 2011).

Health Care Provider Perspectives of Adolescents.

Developmentally adolescents require different care from their HCP than an adult would. Adolescents do not have an abundance of life experiences to base their decision making or consequential behavior upon. One physician described adolescents as having difficulty keeping appointment times, noticing inconsistencies with what was agreed to at appointments, and follow-up appointments (Kang, et al., 2003). Kang and associates also reported that adolescents did not typically present when they noticed a health problem, but when their parent noticed a deviation from their health and brought them to see a HCP.

In the United Kingdom, Jacobson and colleagues conducted a study to assess how adolescents and HCPs viewed each other (2001). Nurses reported that when interacting with adolescents, they required specific communication skills, the requirement to "read between the lines to find out what they (adolescents) really want(ed) and need(ed)"

(Jacobson, et al., p. 814). Physicians reported that communicating with adolescents required both time and encouragement to solicit the adolescent to express themselves in a meaningful way (Jacobson, et al., 2001). They also recognized that the nature of a clinic setting militates against effective communication (Jacobson, et al., 2001). This was exemplified by the limited time the adolescent was in contact with the physician and the long wait to meet with the physician. Another study found adolescents to be "uncommunicative" (Jarrett, Dadich, Robards, & Bennett, 2011, p. 56). Health care provider's reported that they often received one-word answers and that adolescents appeared to be very impatient when waiting to see a HCP (Jarrett, et al.).

Some HCPs described how "working with young people is hard" (Jarrett, et al., 2011, p. 56). Health care providers described their interactions when being with an adolescent as intimidating or daunting (Jarrett, et al.). Kang and associates reported that adolescents needed to feel in control of their health and life situations (2003).

Some HCPs admitted that they prefer to not work with adolescent clients due to the comfort levels of the HCPs. The literature suggested that HCPs should attend specific training to become adolescent-designated workers (Kang, et al., 2003). This would allow the HCP to provide better adolescent-friendly care that is catered to the needs of the adolescent.

Summary

Limited studies were available describing adolescents barriers when accessing sexual and reproductive health services from the perspectives of the HCP. Previous studies have identified some barriers, such as confidentiality, transportation, and parental involvement. The perspective of the HCP is necessary due to the influence that HCPs have over programming and service availability for adolescents. However, more research is warranted to inform HCPs on the barriers other HCPs find that adolescents encounter, as well as the adolescents themselves in rural areas experience when accessing sexual and reproductive health services. The following chapter outlines the methodology used to conduct this study.

CHAPTER III - METHODOLOGY

Introduction

This chapter describes the research methodology used for this study. The research design, which includes the sample, setting, data collection methods, data analysis and ethical considerations are presented.

Based on the literature, Health Care Provider (HCP) perspectives were sought to identify areas that challenged or facilitated adolescents to access sexual and reproductive health services, therefore a qualitative methodology was used. Qualitative methodologies attempt to capture the human experience in its entirety: through subjective meaning within the context in which it occurs from those who live the experience. Creswell (2007) indicates that qualitative research is used to explore topics to understand the complex and detailed issues being studied. The detail extracted from qualitative research is only achieved by talking to people, seeing them and interacting with them (Creswell). Quantitative measures would provide limited information on the HCPs perspectives on what barriers rural adolescents encountered and the experiences when accessing sexual and reproductive services, and therefore were not considered for this study. Nurse researchers choose their approach based on their worldview and the nature of their research question (LoBiondo-Wood & Haber, 2005).

This chapter describes the study and is followed by the methodology for the recruitment and data collection. Subsequently, the methods to ensure methodological rigor are described in the latter part of this chapter.

Study Design

An exploratory qualitative research design was deemed the most appropriate for this study due to the lack of specific knowledge regarding HCP perspectives on adolescent use of sexual and reproductive health services. Qualitative research stresses the ability of "humans to shape and create their own experiences, and the idea that truth is a composite of realities" (Loiselle, Mc-Grath, Polit, & Beck, 2007, p. 17).

Exploratory studies incorporate multiple methods of data collection. This approach seeks to identify and explore the characteristics, patterns, and subjective perceptions that help to inform clinical understanding (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004). Studies with relatively small samples are ideal for exploratory description (Thorne, Reimer Kirkham, & O'Flynn-Magee). This approach was selected because there has been limited research examining HCPs perspectives of rural adolescents' access to sexual and reproductive health services in Canada. This section will describe the procedures used for sample recruitment and data collection.

Participant Access.

Ethical approval from the Education Nursing Research Ethics Board (ENREB) at the University of Manitoba was obtained. ENREB follows ethical policy according to the Tri-Council Policy Statement: Ethical Conduct for Research Involving Human Subjects. After the approval from the University of Manitoba (Appendix A), the researcher then proceeded to seek approval from the Regional Health Authority Ethics Board. The researcher submitted the thesis proposal to the Regional Health Authority's Board of Directors and their Executive committee. They in turn, distributed the proposal to the Regional Health Authority's Ethics Board for review. The Ethics Board approved the thesis proposal (Appendix B). Participant access was granted after approval was obtained from both REBs. In addition to being the principal researcher of this study, the researcher is also a Registered Nurse following the Canadian Nurses Association Code of Ethics for Registered Nurses. The researcher has also signed a Privacy Health Information Agreement (PHIA) with the Health Authority.

Procedure.

The researcher conducted all recruitment, data collection and analysis under the supervision and guidance of her thesis advisor. Focus groups comprised the main form of data collection.

Sample and Sampling Technique.

Qualitative research sampling is guided by two principles: appropriateness and adequacy (Morse & Field, 1995). Appropriateness is the result of identifying and using the participants who can best inform the research according to the theoretical requirements of the study (Morse & Field). Adequacy refers to recording a sufficient amount of data to allow fullness and rich description of the phenomena (Morse & Field). The authors stress that without meeting these two criteria, qualitative results will be thin, and the reliability and validity of the studies could possibly be threatened (Morse & Field). Convenience sampling was utilized. This sampling method is used when the researcher needs participants to come forward to identify themselves (Loiselle, Profetto-McGrath, Polit & Beck 2007). This method is efficient but not a preferred method of sampling due to the risk of bias (Loiselle, Profetto-McGrath, Polit & Beck). Due to the risk of bias, caution must be used when interpreting the findings and generalizing results (Loiselle, Profetto-McGrath, Polit & Beck). HCPs met the criteria for the study if they practiced as a Public Health Nurse, Community Health Nurse, Nurse Practitioner, Medical Resident, or Family Medicine Physician in the rural community or surrounding area being studied and signed a consent form indicating they were willing to participate.

Sample Recruitment.

A letter written by the researcher invited all of the HCPs practicing in the rural community being studied to participate in the study (Appendix C). PHNs who worked in the same office as the researcher (three PHNs) were excluded to prevent any conflict of interest and undue influence by the researcher. Ten letters were distributed to Public Health Nurses / Community Health Nurses, 4 letters to Nurse Practitioners, 29 letters to Family Medicine Physicians, and 13 letters were sent to the Family Medicine Residents who were placed in the rural community being studied by the University of Manitoba Family Medicine Residency Unit. A total of 56 letters were sent.

The letter described the study's purpose and objectives, procedures, ethical considerations, and the sample selection process. The HCPs were given three weeks to respond to the letter, ask any questions, and indicate their interest to participate. Each HCP who was interested in participating contacted the researcher by telephone or email. The telephone conversation allowed them to ask questions, seek clarification, and confirm their participation if interested. The HCPs were able to identify whether they were willing to attend a focus group or an individual interview. Prior to commencing the focus group or individual interview, a formal consent form (Appendix D) and confidentiality form (Appendix E) were signed. The participants were assured of confidentiality. They were informed that participation was voluntary and that they could leave the interview at any time and refuse to answer any question. The focus groups and individual interviews were conducted in the evening at the Community Health Services Building in the rural community being studied.

Sample Size.

According to Loiselle and associates (2007), there is no method to determine how large a sample is needed. Final sample size is dependant on the saturation of responses from the participants (Berg, 2004). Four focus groups were held with HCPs, which consisted of: nine Family Medicine Residents, four Family Medicine Physicians, two Nurse Practitioners, and seven Public Health Nurse / Community Health Nurses. One individual interview was held with a Family Medicine Physician. Therefore, 23 HCPs participated in the study. The sample recruitment occurred over five months.

Data Collection Methods.

Data was collected through a variety of methods. This study collected data from focus groups, individual interviews, a demographic form (Appendix F), and the researchers' own personal field notes. Focus groups comprised the main form of data collection with the HCPs.

Focus Groups. Focus groups are a method of data collection that is characterized by moderated group discussion based on the participant's experience and perceptions (Carlsen & Glenton, 2011). Emphasis is placed on interaction between the participants, and focuses on the participant's experiences and attitudes (Carlsen & Glenton). The researcher tried to elicit the participants to speak freely and generate discussion on the research topic (Loiselle, McGrath, Polit, & Beck, 2007). The general purpose of the focus groups was to explore common experiences, opinions, and reactions (Horowitz, Vessey, Carlson, Bradley, Montoya, & McCullough, 2003).

Recommended focus group size generally consists of a minimum of 4 and a maximum of 12 participants per focus group (Kruegher & Casey, 2009; Stewart, Shamdasani, & Rook, 2007). Some literature states that there is no existing guideline for deciding the number of focus groups the researcher conducts (Stewart, Shamdasani, & Rook). Sandelowski stresses that too many and not enough focus groups can lower the quality of focus group data (2005). The number and size of the focus groups depended upon the availability of the HCPs. For this study, the size of the focus groups ranged from three to seven participants. Four focus groups were conducted in addition to one individual interview.

The focus groups consisted of open-ended questions to encourage discussion and allow the participants to raise issues and comments freely without being restricted by specific close-ended questions (Loiselle & Profetto-McGrath, 2007). The focus groups followed a semi-structured interview process. The semi-structured interview is used when the researcher "knows most of the questions to ask but cannot predict the answers" (Morse & Field, 1995, p. 94). Probes were utilized to encourage the participants to elaborate and clarify their responses. Questions were developed by the researcher with the assistance of her thesis advisor, and guided by her assumptions and the literature review (Appendix G). The questions asked the HCPs to explore their opinions and experiences in assisting adolescents with their reproductive health concerns, such as: how comfortable they thought the adolescents were when discussing issues relating to their sexual health and what barriers or facilitators they thought adolescents encountered when accessing these services. The meanings adolescents attributed to sexual health, testing, and education were also explored to learn if these may have had any influence on the use of sexual and reproductive health services, again from the perspective of the HCP.

Gaining respect and mutual trust between the researcher and the participant allows for a successful interview and the ability to access personal information (Speziale & Carpenter, 2007). Refreshments and snacks were served prior to the focus groups and individual interview.

At the commencement of the focus group, ground rules were established by the researcher, stressing confidentiality, respect for the views of others, and the importance of honesty (Hyde, Howlett, Brady, & Drennan, 2005). The participants were also made aware that they could leave the focus group at any time and refuse to answer any question. During the time period of the data collection the researcher, who was employed by the RHA in the community being studied as a PHN, was on a one-year maternity leave, and therefore was not working directly with the participants at that time. However, the researcher emphasized that confidentiality, anonymity and independence would be respected and followed. All participants prior to the focus group discussions signed a Form of Confidentiality (Appendix E). The researcher was the only person, besides the participants who attended the focus groups.

Focus groups were held on days and times convenient to those who had expressed an interest in participating. Focus Groups occurred after office hours in the boardroom of the Community Health Services Building in the rural community being studied. This allowed the participating HCPs to remain anonymous as participants and did not interfere with their workday. All focus groups were audio-taped in order to ensure an accurate recording of events. By using an audio-tape, the researcher was able to replay the discussions, note voice inflections and dialogue accurately. Field notes were also taken during the interviews to include any observations that could not be captured by audio-tape. The focus group sessions lasted approximately 50-100 minutes in length. Those who attended the focus groups were also given the opportunity to be interviewed individually to provide more detailed information or clarify statements or perspectives. No HCP indicated interest in following up with an individual interview.

Individual Interviews. Interviewing is a method of discovering the participants experences, meanings, feelings and personal theories (Ovretveit, 2008). The use of semi-structured questions are useful in discovering the participants' views and the reasons they have for their views (Ovretveit). Due to the nature of this study, the researcher acknowledged that some participants may feel uncomfortable expressing their views in front of a group. For this reason, the participants had the choice to participate in a focus group or individual interview. Participants who wished to expand on what was said during the focus groups also had the opportunity to take part in a follow-up individual interview. No health care provider participated in a follow-up individual interview. Only one health care provider was unable to attend a focus group and therefore was interviewed individually. Individual interviews are best held in a quiet, distraction-free location (Creswell, 2007). This interview was conducted in a small office in the Community Health Services Building in the rural community being studied after office hours. All questions followed the same interview guide as used during the focus groups using open-ended questions. The individual interview participant was also required to sign a Form of Confidentiality; confidentiality was stressed, as was voluntary participation and the right to refuse to answer specific questions.

Demographic Questionnaire. This method of data collection allows the participants to answer general questions in a narrative fashion (Loiselle, McGrath, Polit, & Beck, 2007). The demographic questionnaire developed for this study was used as a tool to obtain the personal and professional characteristics of the participants (Appendix F). The HCPs were asked to fill out this self-reporting questionnaire at the beginning of the focus group or individual interview. The questions included: age, years/months work experience, gender, highest level of education achieved, and length of employment in the health region. The form took approximately five minutes to complete.

Field notes. Field notes were gathered after each focus group and individual interview as an added source of data collection. These notes were necessary for this study to supplement the other forms of data collection. Field notes were used to identify relationships within the data, which may not have been conveyed through audio-tape (Bogdan & Biklen, 1982). Descriptions of the interview location, interactions between the participant(s) and the researcher, the researchers' own thoughts about what was being said, and other information the researcher deemed important were incorporated into the field notes.

Data Analysis

Data analysis and collection took place concurrently, beginning after the first method of data collection was conducted. The goal of data analysis is to strive for a thick description of data. Analysis was done by providing detailed accounts of the domains of meaning relevant to the HCPs' perspectives of how sexual and reproductive health services were accessed by rural adolescents.

The researcher transcribed all audio-tapes and data from the interviews immediately after the focus groups and individual interviews. Following the transcription of each interview, the researcher would re-listen to the audio-tape and re-read the transcribed transcript to ensure accuracy and think of alternative probes that could be used for enhanced data extraction.

Data analysis was done by content analysis. Content analysis is the "analysis of data to identify prominent themes and patterns among the themes" (Loiselle, Profetto-McGrath, Polit, & Beck, 2007, p. 395). Content analysis provides a systematic, replicable technique for compressing many words into main categories based on the rules of coding (Krippendorff, 1980), or in the case of this study, the main descriptive findings.

As this study is part of a Master of Nursing thesis, collaborative analysis was also used whereby the researcher's thesis advisor provided recommendations about the descriptive findings, and offered clarification and re-examination. Not only did this impart the student with guidance and experience in the analysis, but it was a method of ensuring that the analysis of the material was an appropriate representation of what the participants shared. Only the researcher and thesis advisor read the interviews and had access to the data that was identifiable to each participant.

Methods to Enhance Methodological Rigor

To demonstrate how credible, valuable, trustworthy and justifiable the research is, it is essential to establish rigor (Sandelowski, 1993). Rigor is often associated with the quantitative terms of reliability and validity. Lincoln and Guba (1985) coined the term "trustworthiness" in qualitative research as a synonymous term for "rigor", which is used in qualitative research. The criteria to ensure "trustworthiness" of the data are: credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). This section will describe the trustworthiness of the data in this thesis study.

Credibility.

Credibility is when the results are credible or believable from the perspective of the participant in the research (Trochim, 2006). The researcher acknowledged and reported the perspectives of the informants as clearly as possible and recognized that participants have multiple realities (Morse & Field, 1995). Credibility was enhanced by various participants agreeing with each other's comments and nodding when they heard another participant saying something they also felt was true or relevant in the focus groups. It was also exemplified by when the researcher reached saturation.

Transferability.

Transferability refers to the "degree to which the results of qualitative research can be generalized or transferred to other contexts or settings" (Trochim, 2006). Transferability was addressed by providing detailed descriptions of the process the researcher used: the time, place and context of all interviews and focus groups so that the study could be repeated by another researcher. Therefore, it was the responsibility of the researcher to provide sufficient data so that the study findings could be replicated in similar settings. Comparison of the descriptive findings with previously published studies occurred to detect similarities and differences in findings.

Dependability.

The researcher acknowledges that the results can be subject to change and instability (Creswell, 2007). To assess dependability, the researcher had her thesis advisor examine the research data and all supporting documents.

Confirmability.

Confirmability refers to the “degree to which the results could be confirmed or corroborated by others” (Trochim, 2006). To enhance confirmability, field notes were kept to verify the assumptions of the researcher during data collection, and direct quotes were used when writing the descriptive findings. After all interviews participants would remain with the researcher for a short period of time and continue talking about the discussion and validating comments made by themselves or others.

Ethical Considerations

Ethical issues surrounding informed consent, anonymity, confidentiality, data generation, publication and researcher-participant relationships must be acknowledged (Speziale, & Carpenter, 2007). In order to comply with the ethical standards Registered Nurses follow, the ethical principles of autonomy, justice, non-maleficence and beneficence were implemented and are discussed.

Process.

The names of the HCPs were recorded for clarification purposes on a list that was kept separate from the data. Only the researcher and thesis advisor have seen the raw data.

Entry into the community was granted by contact with the RHA and individual HCPs. The researcher demonstrated trustworthiness, approachability, and genuine interest in the community’s concerns, questions, and daily lives. All participants selected were aware of the objectives of the research study and the role of the researcher who was also a PHN in the region. The only information that was obtained was from the participants.

The HCPs who participated signed a consent form. Consent forms were written by the researcher with the assistance of the thesis advisor. All consent forms were returned to the researcher directly. Health care providers were made aware that no other HCP would be aware of their decision to participate or not to participate. If a study participant wanted to speak to the researcher privately or expand on the discussion from the focus group, they were given the opportunity to speak individually with the researcher either after or before the focus group, over the phone or by e-mail. Voluntary participation was emphasized throughout the data collection process.

Autonomy.

To respect the participant's autonomy, the researcher must acknowledge the participant's right to choose to participate and continue with the study voluntarily (Polit & Beck, 2008). All HCP participants signed a consent form to confirm that they were willing to participate in the study and that they understood their role and the purpose of the study.

Written informed consent was obtained for all participants. Informed consent is a means to educate participants about the research study. Participants are then capable of comprehending the study information and have the power to choose whether or not they wish to participate (Speziale, & Carpenter, 2007). Informed consent was an ongoing process throughout the study. All of the participants were given the opportunity to remain or withdraw from the study at any time.

Non-maleficence.

Ensuring that the researcher and the research do not do any harm to the participant is the principal of non-maleficence (Polit, & Beck, 2008). The researcher remained cognizant of the feelings and emotions experienced by the HCPs at all times. The researcher was sensitive to all participants when discussing the topic of sexual and reproductive health services, and remained professional, caring and understanding during their responses. If a participant did not wish to discuss personal experiences or a certain topic, the researcher respected the participants' decision and continued to another question. Participation was not forced by the researcher.

Beneficence.

Beneficence is to do good or prevent harm while providing confidentiality and anonymity to all research participants (Speziale & Caprenter, 2007). This is maintained by guaranteeing that the research being conducted is of maximum benefit to the participants, while minimizing harm (Polit & Beck, 2008). All participants were assured that confidentiality and anonymity would be maintained and respected. Participants were provided with sufficient knowledge to make informed, autonomous choices during the research process. Written and verbal information were provided to all participants regarding this study and the risks and benefits it may pose. All participants were encouraged to ask questions and seek clarification during the duration of the study.

Justice.

Justice refers to the participants' right to fair treatment, their right to privacy and the treatment of each person in accordance with what is morally right (Polit & Beck, 2008). This principle requires that the researcher does not neglect or discriminate against individuals or groups who may benefit from advances in research (Polit & Beck). The researcher allowed all individuals, who met the sample eligibility criteria to participate in the study. The researcher made every attempt to include a variety of disciplines of HCPs.

The researcher remained sensitive to all beliefs, habits, lifestyles, and personal opinions of all individuals.

Confidentiality.

The issues of privacy, confidentiality and anonymity were all discussed during the informed consent process. The researcher made every effort to stress and maintain confidentiality during the focus groups. All participants were required to sign a Form of Confidentiality prior to the focus groups and individual interviews. No names or locations were specified during the transcription of the focus groups or individual interview recordings; instead code numbers were assigned to each participant. All paper forms and audiotapes were kept in a locked filing cabinet while all electronic material was password protected and stored on the computer in the researcher's home. All data collected will be destroyed after the completion of the study and the oral defense has been conducted. All data and transcripts will be cross-cut shredded by the researcher at that time.

The researcher and the thesis advisor were the only people who had access to the audiotapes. No reference to the geographic location of the study will be provided in future publications or presentations.

Honorarium.

The researcher provided refreshments consisting of juice/pop, sandwiches and cookies to the participants of the focus groups and interviews. All participants received a $5 Tim Horton's gift card for participating. They were given this gift card after the focus group or individual interview was completed. They were aware of this incentive prior to taking part in the study.

Risks and Benefits.

Risks to the participants may be hearing about other participants' health practices or health issues. A second risk may be the participants feeling embarrassed by the discussion. The sharing of ideas or practices that others deem inappropriate, unethical, or incorrect, resulting in criticism of each other's practices. The researcher observed that the participants spoke freely about their personal practices and encounters with clients. Respect, caution, and sensitivity were exercised when interviewing participants in order to prevent the possibility of any undue stress. This included attending to participants' vulnerability and sensitivity in response to the interview questions and assessing for signs of increased stress. Confidentiality was stressed, as was voluntary participation.

Participants were given the opportunity to express their frustrations with adolescent behavior and identify strategies to improve health care services for this age group. Another benefit for the participants was that they were able to articulate their professional limitation and express their opinions of the same in a safe, supportive environment.

Summary

This chapter described the study design used for the study. Sample recruitment, data collection, and data analysis were discussed. Methodological rigor and ethical considerations were highlighted with specific consideration being made to the principles of informed consent, anonymity and confidentiality.

CHAPTER IV: FINDINGS OF THE STUDY

Introduction

This chapter addressed the following research questions: (1) to identify and describe, from the perspective of the Health Care Provider (HCP) (a) the conditions that facilitate rural adolescents in accessing and using sexual and reproductive health services and (b) the conditions that prevent or affect the use of sexual and reproductive health services by rural adolescents; and (2) to obtain the recommendations, provided by the HCPs that would improve rural adolescents' access and use of sexual and reproductive health services.

The first question was intended to assist the HCPs in identifying the conditions that facilitate access and use of sexual and reproductive health services by rural adolescents. The researcher also wanted to elicit from the HCPs their perceptions on the nature of the conditions that prevent rural adolescents from using sexual and reproductive health services. The second research question was to provide the HCPs with the opportunity to identify recommendations that may address the barriers and would improve rural adolescents' access and use of sexual and reproductive health services.

The first section of this chapter outlines the five descriptive findings derived from the interviews and focus groups: trust, confidentiality, support, barriers, and conditions that facilitate access to sexual and reproductive health services. The second section details the factors and issues, identified by the HCPs, which influenced the use of sexual and reproductive health services by rural adolescents, including: personal factors, geographical features and social influences.

Description of Health Care Providers

Twenty-three HCPs who delivered community health services in the RHA being studied, participated in the study (Table 1). The sample participants included nine Medical Residents, five Family Medicine Physicians, seven Public Health Nurses/Community Health Nurses and two Nurse Practitioners. All of the participants worked in the rural community being studied and in neighboring rural communities. Seventeen of the participants were female, and six were male. The ages of the participants ranged from 23 years to 54 years of age. The majority of these professionals (83%) worked full-time. The length of time that each participant had been employed in the health region ranged from less than six months to 25 years at the time of the study. The mean years worked was 5.1 years. Two participants had graduate degrees, while the remainder had undergraduate degrees in either nursing or medicine.

Descriptive Findings

Trust.

The development of 'trust' was reported to be an essential component of establishing positive rapport with the adolescent. The adolescent's ability to feel comfortable and be open and honest with the HCP was integral to the establishment of trust. However, this task was not straightforward, as the majority of the HCP participants described a variety of emotions displayed by the adolescents at their visits, "I've seen everything from excited to scared to tearful to happy, you know. It's and sometimes it's mixed emotions as well" (S2, l: 158). One HCP reported that they "don't see many that are anxious" (S3, l: 107). Conversely, other HCPs said that a number of adolescents "start crying" (S2, l: 182), and that they see "a lot that are guarded" (S2, l: 162) and "normally anxious" (S4, l: 213). One HCP stated that occasionally there is "the odd one that (is) quite shy" (S3, l: 109)… these are sometimes the adolescents "asking for the condoms" (S3, l: 111).

Nevertheless, the adolescents' comfort level directly impacted the quality of the visit between the adolescent and the HCP. The more at-ease or comfortable the adolescent was with the HCP, the more information the HCP was able to collect. By establishing this rapport and trust, the adolescent and the HCP were able to engage in a positive information-sharing relationship. Once a positive rapport was established, the adolescent became increasingly open and honest about his/her current health situation and concerns. Many participants agreed that one of their goals was to establish this trust at the first visit which they thought was influenced by: communication style, gender, and familiarity with the HCP.

Communication and Trust. The HCP attempted to achieve rapport and trust by talking informally to the adolescent about topics they thought were of interest to the adolescent. The dialogue would include asking the adolescent about various topics intended to relax the adolescents, such as, school, family and sports. This preliminary discussion was not lengthy, only a minute or two and lasted until the adolescent appeared more comfortable. At this point the HCP would begin discussing health related concerns.

When interacting with adolescents, a few HCPs mentioned the extent to which an adolescent's comfort level and trust with the HCP can be influenced by the communication the HCP uses with the adolescent, as well as the way the HCP interacts with the adolescent. It "all boils down to their communication level" (S5, l: 2055). A negative relationship is established when an adult talks "over them or treats them as kids, they're going to lose a lot of buy-in from the patient" (S5, l: 2060). This HCP suggested talking 'to' the adolescent instead of speaking 'over' them.

Gender and Trust. Several of the participants discussed the role that the gender of the HCP played in the adolescents' comfort level toward the HCP. The participants felt that gender influenced the comfort level of the adolescent and influenced the visit. For example, a male participant stated that,

> (She came in with what) She thought was a UTI but when you dig more and more her actually true concern was STDs and she was just afraid, I think, with me being a male maybe doing all the swabbing and stuff. She might have felt a little uncomfortable. Probably would have felt more comfortable with a female. Again, I had to dig. I would have never known. (S2, l: 190).

Another male participant reported that sometimes he sensed that the adolescent girls would prefer a female HCP for sexual and reproductive health related issues. When female adolescents saw him in the clinic, he found that they tended to be more shy and reserved than they would have been if they had seen a female HCP. Another HCP reported that while practicing in a rural community, adolescents are often limited by the HCP available in their community. This participant explained that, "in our community there's only one older male doctor and people don't maybe feel comfortable going to him all the time" (S3, l: 677-678). To overcome these feelings and to create a more comfortable atmosphere for the adolescent client, one male HCP reported that he often "get(s) one of the nurses… to come in" (S5, l: 645) with him.

In contrast, a HCP cited an example of a male adolescent who did not want a male HCP, but preferred a female:

> (An adolescent male patient had a) Wart on his penis and he came to have liquid nitrogen therapy. When I went in, he was like, uh, I don't want to see you. I'd feel it would be easier with Dr (name of female MD)". (S2, l: 230).

A number of other male participants reported that female adolescents were comfortable with a male HCP performing pelvic and breast examination on them. Therefore, the participants concluded that the effects of gender on the adolescents' comfort level may not be an influencing factor for all adolescents. Providing a non-threatening approach and allowing the adolescent some time to relax at the appointment were some approaches both male and female HCPs thought helped to increase the comfort level of the adolescent.

Familiarity and Trust Building. A PHN reported that living in a rural community also facilitated clients to be more comfortable when coming to see her. This nurse had also found that the adolescents who knew her had an increased comfort level with her and were able to confide in her more easily than adolescents who did not know her personally. One HCP gave the example of how a female client presented to her for a physical issue, but after the client became comfortable with the HCP, this client expanded her questions to her anxiety about her relationship with their partner:

> They (come because they) have a weird discharge, but you end up speaking or talking so much about their relationship (with their partner), because it's all like "is he cheating on me?" and it's that whole emotional part that you spend most of your time dealing with (S1, l: 227).

Other HCPs found that adolescents were more at ease with them when the adolescent saw the HCP for health related reasons on more than one occasion.

Personal feelings, insecurities, and emotional questions surface as the adolescent becomes increasingly familiar and comfortable with the HCP. The adolescent is able to confide in the HCP, trusting that the information they tell the HCP will remain confidential and non-judgmental. A participant stated that if “the trust isn’t there” the adolescent is more likely to not disclose whether or not they have been sexually active on their first visit (S1, l: 164). It may take multiple visits to the same HCP for this trust to be established, and adolescents have a difficult time attending multiple or regular appointments. Therefore, making the adolescent feel comfortable, and establishing trust at the first visit is crucial in the development of the relationship with the HCP for the adolescent to seek sexual and reproductive health services.

Once trust was achieved, the HCPs stated that they noticed the visits with the adolescent became more frequent and that the adolescents were more likely to visit them for other health related concerns. The adolescent may have initially presented for an injury or acute illness, and over time as the adolescent became familiar with the HCP, this client began presenting for more sensitive issues related to sexual and reproductive health. Other HCPs found that seeing clients over time allowed the adolescent to become increasingly open when verbalizing their health information, especially when the parent was absent and the adolescent presented by him or herself.

Confidentiality.

Confidentiality was an important factor identified by the HCPs in their contacts with the adolescents. HCPs explained their policy on confidentiality to the adolescents at the first appointment. Confidentiality was described as not sharing client information with anyone, which included keeping the client’s identity confidential as well.

Confidentiality was influenced by: living in a rural community, and nursing or health care office processes.

Living in a rural community. The HCPs described the limitations that living in a rural community can impose on confidentiality: “everyone knows each other” (S5, l: 1177). Another participant stated that “just being in a small town, you can’t guarantee anybody’s confidentiality!” (S5, l: 1376). Presenting to a doctor’s office, school clinic or public health office, “people see you walk in into the clinic” (S3, l: 460) and that physical presence can be “interpreted as a sign they are sexually active” (S6, l: 194).

HCPs identified and reported that rural adolescents were believed to be worried about who may know them or whom they may encounter near the time of their visit with the HCP. Some adolescents would request to see a specific HCP and no one else at their visit. More specifically, “they are worried that word gets around” (S1, l: 326) when they are seen by other staff or clients in the clinic as well as whether someone else will come in contact with their chart and learn of their reasons for presenting to the HCP. On the other hand, some of the adolescents would cancel their appointments or deliberately make appointments with a different HCP for each health problem in order to avoid being identified as a repeat client or have someone recognize them.

Adolescents attended appointments “solo (because) they want to make sure that their parent won’t know that they have come to the clinic” (S1, l: 238). The participants attempted to normalize this fear by saying to the adolescents: “(you) can’t avoid people seeing you in the waiting room… just being at the doctor’s office” (S6, l: 242), meaning that people would see them at the appointment, for there is no hiding their presence. One HCP reported that an adolescent client once told her that she feared a staff member would inform her mother of her visit. Another example was an adolescent who was worried that a neighbor or another family member may see her at the clinic and learn the purpose of her visit. Another HCP reported:

> They won't go see their family doctor because they go to church with them, or they are friends with them, or you know, they know them in some other aspect, so I think that helps our walk-in service and we can be anonymous to some people (S1, l: 288).

Several HCPs pointed out that adolescents deliberately did not see them when the adolescent knew the HCP personally, or the adolescent declined certain investigations because they did not want the HCP to find out about his or her medical situation. HCPs realized that adolescents who may know certain clinic employees may not attend that clinic for their health related concerns.

Nursing or health care office processes. One HCP informed her clients that the information collected is "confidential within our office… within public health. Like I may not be here the next time you come so you will, you could get another public health nurse" (S4, l: 475). Several HCPs voiced that the process that an adolescent must go through to see a HCP poses difficulty for the adolescent and for maintaining confidentiality. One HCP reported that, "I wouldn't want to go see 3 to 4 different people for one thing! Especially a STI! The more people that know… that brings back confidentiality" (S4, l: 924).

Several HCPs admitted that it is difficult to maintain an exclusive one-on-one long term client-provider relationship. Workplace policies, job turnover, part-time employment, staffing at a walk-in clinic, workload, or staff vacations influenced the possibility of long-term relationships. The implications of this lack of continuity were that the HCPs were unable to obtain a full history of the adolescent or to provide adequate counseling for the adolescent's needs besides his or her primary issue.

The structure of the offices and storage of medical records enabled all HCPs in that clinic to have access to the files. Another HCP reported that occasionally adolescents have asked her if other employees in the clinic are able to access client medical information. Realizing that privacy is a concern for adolescents, HCPs are cognizant that confidentiality of information is an issue, and emphasize this with clinic staff. Yearly, all staff who are employed by the medical clinic are required to attend a PHIA session to remind them of the importance of confidentiality. One physician noted that his or her staff are not legally allowed to discuss any result or any client name with anyone else. One HCP reported respecting the adolescent by not phoning with health results because the number would appear on the home phone's call-display. Adolescents do not want their parents to know about the call, therefore, several adolescents requested not to be phoned at home. Another HCP reported:

> I've seen patients around town. I usually don't say 'hi' to them… (Because) then (their parents or whoever they are with will ask) 'do you know Dr (name)? Have (you) seen him about, uh, do you have Chlamydia?' (S5, l: 1236).

Support.

Support was defined as any physical, emotional, or other type of assistance the adolescent received that enabled them to seek a HCP for sexual and reproductive health services. Parents and peers were identified as the adolescents' primary sources of support.

Parental support. Parental support was defined by the HCPs as any type of parental support that had a positive consequence on the adolescent's use of services. The presence of a parent during appointments and the effects of their participation during the interview were frequently mentioned. The HCPs noted that it was uncommon for adolescents who were accompanied by their parent to say "I've talked to my parents about this (being on birth control or being sexually active), it's fine, they can stay" (S1, l: 431) for the duration of the visit. In situations in which the parent was aware of the adolescent's use of birth control, the HCP found the parent to be very supportive of the adolescent being on a birth control pill or seeing a HCP for sexual or reproductive health services. One HCP stated that a parent came into the clinic with his/her adolescent and said:

> Now my daughter is having sex and this is her boyfriend and this is the deal and we talked about it and I'm not happy but what can you do and we just want to make sure that we're keeping informed and on top of things (S6, l: 166).

Several HCP participants reported they were informed by the adolescent client that one of his or her parents knew that he or she was sexually active, "a lot of them are pretty open with their parents" (S5, l: 781). The HCPs also noted that it was most often mothers who knew of their adolescent's sexual activity and who attended the appointments with them. For instance, "in family practice a lot of parents will bring their teenagers in and so it's acceptable for them to be on the pill" (S1, l: 146) reported one HCP, emphasizing that the parent was taking a proactive approach to his or her adolescent's decisions and promoting prevention. By confiding in their parent(s), adolescents were more likely to seek health services. The HCPs found that if the parent was involved, they were more likely to encourage the adolescent's appointment, support their son or daughter in physically getting there, and assist in making treatment or medical decisions.

The support adolescents received from their parents was not solely by accompanying them to appointments as a physical presence. They were also found to assist the adolescent in acting responsibly and making responsible decisions. This scenario was exemplified by several participants who reported "a lot of times the parents are making the appointments for the teens" (S1, l: 150). It is often the adolescents' who bring their parents who "are the ones that always get the best follow-up possible" (S6, l: 374).

The HCPs described how some parents also displayed respect when accompanying their adolescent to medical appointments. One participant reported how a parent came into the clinic and stated that his or her adolescent should receive "birth control and then (the parent) walk(ed) out of the room. They'll leave it open for you to talk to them about it" (S5, l: 300) with the adolescent.

Parental support and need for privacy. While the HCPs appreciated the parents being involved and knowledgeable about their adolescents' use of sexual and reproductive health services, all of the HCPs interviewed stated that they preferred to see the adolescent alone for his or her presenting issue rather than have the parent in the room during the entire interview. The HCPs explained that they often found the visit awkward, particularly in cases where a 14 or 15 year old was reporting that he or she had had more than one sexual partner. The adolescent was reported to feel embarrassed and judged by his or her parent who was present. The presence of the parents changed the atmosphere: "sometimes when their parents are there, they (the adolescent) tend to be a little more quiet and subdued and tend to defer to their parents a bit" (S5, l: 225). One HCP reported that the dynamic between the HCP and the adolescent, as well as the information given to the HCP changed when the parent was present. The adolescents were much more open and forthcoming, especially if their parent was not aware of the purpose of their visit. For example, an adolescent client presented requesting birth control, and once the parent left the clinic room, "she (the adolescent) tells you she's having unprotected sex, so more of the story comes out" (S1, l: 222).

The HCPs stated that if a parent accompanied the adolescent, the adolescent usually "make(s) a point of asking the parent to leave the room" (S2, l: 498) during the appointment, "your child is at an age where he or she can make a few of his own decisions… would it be possible to have a couple of words alone" (S2, l: 521). In addition:

> It sounds like you have a pretty good relationship and there wouldn't be any secrets but I think that I'd like to just talk to the child just to make sure that (I know) everything about them (S2, l: 527).

Once the HCP requests that the parent leave:

> Sometimes they (the parent) get a little bit irritated (when asked to leave). But I just say to them, you know what, your child needs to be able to express themselves freely. And you being here might stop that from happening in which case you will be stopping them from accessing health care. (S6, l: 500).

Once the HCP requests that a parent leaves the room, "you can definitely sense an appreciation from their part (the adolescents') that they don't need to tell their parents" (S2, l: 546). Another HCP also reported that when the parent leaves, the adolescent typically became more relaxed and at-ease. When the adolescent was alone with the HCP he or she became more of an individual and discussed his or her concerns similarly to speaking with friends.

Despite wanting the parents of the adolescents' excluded from the appointments, the HCPs definitely did not want the adolescents' parents to be unaware of the adolescents' lifestyle and lifestyle choices. All of the HCPs reported encouraging the adolescents to discuss all related matters with their parents. A few of the HCPs offered to act as a liaison or informer for the adolescent. The PHNs in particular, reported that they would discuss the adolescent's questions and concerns with the parent and adolescent present at the adolescents' request.

Peers as support. The HCPs identified the role of peers as important in the adolescent seeking or not seeking health care services. Peers were found to provide education, information, physical and emotional support to their adolescent friends. Occasionally it was found that adolescents needed "support getting into the building" (S4, l: 593), and peers provided them with encouragement and accompanied them to their appointments. The adolescents were anxious and wanted their friend to comfort and support them during their visit. The accompanying peer was often someone who was "already on the (reproductive health) program" (S4, l: 598), therefore knew what to expect and was able to prepare their friend for what they would experience during the visit. Many of the participants acknowledged that "peers are the best support for them" (S2, l: 583) if the parent(s) were unable to provide support to their adolescents.

Several HCPs reported that peers act as sources of information for each other. They "take care of each other. You know, if they know that somebody's sexually active, then they are dragging them in" (S4, l: 1509) to see the HCP to make sure they are engaging in safe sexual intercourse.

Limitations to peers being a support. The HCPs described the role of the peer as being helpful to the adolescent but also as having its disadvantages. Several HCPs reported that they found adolescents more honest when they attended the visit by themselves. In other cases the friend's presence at the visit with the adolescent was distracting. The adolescent's attitude "lots of times with the friend, there's like a little bit more what I assume to be kind of false like… bravado or something… they're trying to impress their friend" (S5, l: 681). The majority of the HCPs would request that the peer leave the room during the interview and assessment. The adolescent client was found to be hesitant if his or her peer was requested to leave the room. Occasionally some adolescents returned to see the HCP after the appointment ended to discuss a situation with the HCP while leaving their friend in the waiting room. Therefore, the friend did not have to be asked to leave the room in the presence of the adolescent.

Barriers Identified by HCPs.

Barriers were described as any hindrance or obstacle an adolescent faced when accessing sexual and reproductive health services. These included barriers that prevented adolescents' from accessing services, or that limited their use of these services. HCP participants identified five barriers: maturity level, rural transportation, financial barriers, system barriers, fear of being judged, and lack of education.

Maturity level. A major focus of discussion among the participants was the adolescents' maturity level. The majority of HCP participants stated that adolescents were "not mature enough to handle" (S2, l: 689) decisions that affect their sexual and reproductive health. Several participants agreed that adolescents do not think about their long-term health. The HCPs described adolescents as living ‘in the moment’, and not having any awareness or thoughts on how their current behavior will influence their future. Several participants agreed that adolescents are not self-aware and do not see the importance in prevention and lack long term capacity. A major factor is the “development of their ability to understand these things but if at that age they… can’t really fathom the consequences of those things” (S5, l: 1022). This participant was referring to the lack of understanding by adolescents of prevention strategies, and planning for health in the future. Another HCP reported that maturity, self-awareness and the development of a sense of responsibility affects adolescents’ point of view. Lack of maturity can be associated with lack of competency and disinterest in their own health and health status, as reported by several HCPs. Factors that contributed to the adolescents’ maturity level included: their level of insight and sense of responsibility.

Maturity and insight. Another obstacle, the HCPs identified was the adolescents’ lack of insight into the need to see a HCP. Some participants noted that many adolescents do not possess insight into how to interpret signs that they may need to see a HCP. Other HCPs have found that “some (adolescents) are too shy, (or) some can’t get to the clinic, (or) some just don’t view it as a priority” (S1, l: 374). When adolescents do see a HCP, it is usually at a walk-in clinic or when they attend without an appointment at a Public Health Clinic. Rarely do adolescents’ make appointments with HCPs. Due to the adolescents’ spontaneous nature; they want an immediate appointment with instantaneous results. Another participant reported that adolescents are poor at maintaining their sexual health; they only present when they have a problem. Adolescents not only show their lack of planning by making “last minute” appointments, but HCPs have also noticed that they make decisions without completely thinking them through. This was evidenced by a HCP reporting: “when they’re (adolescent) thinking about becoming sexually active, you have to actually make the decision before you engage in it as opposed to like deciding on the spur-of-the-moment impulsively” (S6, l: 27). This spontaneity and lack of maturity can influence the adolescents’ health outcomes as well. One HCP reported:

> They just really don’t really think about what the consequences are. At 16 or 17 they, like as a young girl, does it, do you really think about whether if you have, you know, scarring to your fallopian tubes that’s giving you an idea (problem) down the road (S5, l: 1035).

A few HCPs provided examples where they had encountered adolescents that seemed oblivious and unconcerned about their health. A few HCPs shared that they have informed adolescent girls that they were pregnant, and received the unanticipated reaction of passiveness and acceptance, leading the HCP to believe the adolescent was unconcerned with the diagnosis. Another participant shared that he had examined three adolescent girls at the same appointment, who had all had sexual intercourse with the same male adolescent days earlier. They had all presented to him to be tested for chlamydia because they had heard that the adolescent boy they slept with had been diagnosed with chlamydia. Their reaction shocked this physician: “(they were all) high fiving and chatting and going ‘woo!” (S5, l: 712), congratulating each other on all sleeping with the same adolescent boy who had chlamydia. Adolescents were perceived as lacking the insight to understand the consequences of their behaviors.

Maturity and responsibility. As part of accepting responsibility, the HCPs recognized that adolescents may not be of the age and maturity to accept their health as their own responsibility. One HCP admitted that “you have to believe that you’re going to achieve health and wellbeing to start” (S6, l: 721); and that as a HCP you “can’t force them to do any treatment or get any help if they’re not really willing to get there” (S6, l: 148). The same HCP reported that if the adolescents had a desire to learn about their health, they would find out, but they must come to that realization first. One HCP stated that what they see as a problem may not be seen as a problem by the adolescent. Realizing that each individual matures at different rates, HCPs confessed they must learn to accept the adolescent’s developmental level.

As adolescents grow older, HCPs noted they become increasingly self-aware, and therefore more likely to learn about their health, realize they have an issue, and act on it appropriately. The HCPs tended to assume that the adolescent would take responsibility for his or her own health. When the adolescent presented to a HCP on that individuals own initiative, it demonstrated that he or she reached a level of maturity and was taking some responsibility for his or her own health.

Rural Transportation. This descriptive finding included the perceived physical barriers the HCPs thought affected the use of sexual and reproductive health services by rural adolescents, such as geographic factors and lack of transportation. Living in a rural community and being an adolescent poses certain obstacles. The adolescents in this study either lived in a town or in a rural area, miles from the nearest town. The majority of the HCPs identified transportation as a major issue. The medical clinics and community clinics are located a distance from the high schools. There is no public transportation system in the health region. The majority of the adolescents do not have access to a car during school hours. The availability of a car also may not be available when the adolescent needs access to a vehicle. One participant stated that the adolescent “might only have this one trip to town today but you can’t get an appointment today. You can only get one tomorrow and some people don’t have the accessibility of transportation every day!” (S4, l: 961).

Many adolescents who attend high school also live rurally and rely on the school bus as a means to get to and from school. The HCPs viewed this mode of transportation as a significant barrier for the adolescents to access sexual and reproductive health services: “the bus kids… have no way of getting… to the community health building or clinic to get their pills” (S1, l: 491). “Right at 3:30 they have to be on the bus and they are gone! So if they want a ride home, they have to be on the bus” (S3, l: 495), therefore unable to access health services after school. The HCPs also recognized that “if they (adolescents) had to take a bus after school home if they wanted to come without a parent that could be a barrier” (S5, l: 882).

Financial Barriers. In addition to transportation, finances were identified by the participants as being another major barrier to adolescents accessing sexual and reproductive health services. Financial barriers were defined as financial obstacles encountered by adolescents when attempting to or while accessing sexual and reproductive health services. These barriers included: no income, inability to secure funds to purchase sexual and reproductive health supplies, or social assistance challenges. HCPs reported that adolescents “need money to get anywhere” (S6, l: 525), therefore finances influence how they got to the clinic and how they would pay for any medications or supplies such as condoms. Another HCP added, “if you don’t drive, and you don’t have money, how are you going to get there!” (S1, l: 826). “Not everything’s free. Like for example, the Nuva ring or the Evra patch, IUDs” (S6, l: 529). Depending on the family’s medication plan coverage, there may be a cost to the adolescent or their family. If the adolescent’s family is on social assistance, they are automatically covered for the birth control pill prescription. Adolescents may also be covered under their parents health plan; however, if the adolescent chooses not to inform his or her parent(s) that they are on a form of birth control, the adolescent would have to pay for the prescription.

System barriers. System barriers were defined as factors that complicated or restricted the adolescent’s ability to access sexual and reproductive health services. These barriers included factors that were not under the control of the adolescents, for example: the clinic operation, efficiency of the health care system, lack of services, staffing, and interdisciplinary practice.

System barriers and the clinic operation. The limited availability of health care services was raised by the HCPs. The medical clinic walk-in hours were Monday to Friday from 0900 – 1630 and on Saturday’s from 0900-1200; the scheduled medical clinic was open Monday to Friday from 0900 – 1630; the public health clinic was open Monday to Friday from 0900-1600, and was often closed during lunch hour. School hours were very similar to the clinic hours; there were no evening clinics offered in any of the communities in this health region. Many of the HCPs realized that adolescents were “in school or in sports or doing other things during those hours (clinic hours)” (S6, l: 514), and it was very difficult for them to “get time away from… what they usually do”

(S6, l: 512). Realizing that adolescents often needed to navigate going to the clinic during school hours, adolescents may find it "hard to get an excuse to get a ride down here (to the clinic), or work around their, you know, trying to hide their appointment" (S1, l: 475). Several PHNs reported that an obstacle to adolescents only being able to access the clinic during lunch was that they were not able to attend appointments or drop-in to the clinic because the office was closed. Another HCP stated that adolescents find the emergency department rather than the clinic more convenient because of its hours. Adolescents do not want to wait until Saturday morning to attend the walk-in clinic or wait in the walk-in clinic during school hours.

Working in a walk-in clinic setting poses unique barriers to the HCP as well as the adolescent seeking sexual and reproductive health services. One HCP reported that when working in the walk-in setting, they are pressured to see as many people as quickly as possible due to the amount of people waiting to see them. Therefore, there is limited time to provide adequate education or discuss other related issues with the client. Another HCP informed the researcher that:

> These kids come in and you are so focused on like their physical, like what their physical symptoms (are) that they bring up, that I find that I don't have much time to even build the trust to get into the 'are you in a healthy relationship' (issue) which I think is a huge thing (S1, l: 583).

Many of the smaller communities that are located near the town being studied either do not have a health clinic or have irregular health care delivery. The HCPs provide services not only to residents of the rural community being studies, but to communities that are 15 – 120 minutes driving distance from this community's health facilities. Many of the rural communities do not have a HCP providing services at all; while other rural communities may only have one or few HCPs providing services once a week or once every two weeks. Other clinics exist where “there is only one physician there once a week for a few hours” (S1, l: 778). Participants viewed this as a major factor, which resulted in limited availability for rural residents to seek and use health services. This lack of availability posed a significant barrier for the general public, let alone adolescents who attended school.

System barriers and efficiency. Another barrier identified, was the number of HCPs who become involved in one case and the number of appointments that are required when an adolescent seeks sexual and reproductive health services. Several HCPs reported that the consequence of this is a system that is non-supportive of adolescent lifestyles and a decrease in the adolescents’ ability to remain anonymous. Currently, if an adolescent is diagnosed with a sexually transmitted infection, they see three to four HCPs:

> When we (Public Health Nurse) get the contact name and we notify them and then they go to the doctor here. And they get tested and treated… at the doctor’s office… then for the blood work they have to go to the lab… we’re just really following up and making sure that they’ve got everything done and the teaching (and contact tracing) (S4, l: 884).

Despite the PHNs being able to give out free birth control to qualifying adolescents, the adolescent must still see a NP or physician to obtain a prescription. Adolescents also often request pregnancy tests when seeing the PHN; however, the PHN cannot provide this service, therefore a return appointment with their physician or NP is necessary. These situations illustrate the inefficiency of the health care system, forcing the adolescent to find transportation, and make additional appointments for one health issue. Making multiple appointments with multiple HCPs can be a difficult task for adolescents in terms of their compliance rates. Their ability to get to these appointments, and determine how they will keep each appointment becomes a challenge. The participants also reported that the process becomes increasingly complicated when the adolescent needs to be seen by a specialist or have a termination of pregnancy:

> We're going set up an appointment for you to see somebody in Winnipeg. Now we've multiplied this by (interrupted)… they have to show up at the hospital one day and… get a termination… go to Winnipeg for Tuesday… get transported there from here… find a place to stay overnight and then they do the procedure the next morning. And you need somebody there to pick you up and take you home… two full days of stuff (S5, l: 1927).

The majority of HCPs felt that all of these steps were cumbersome and unnecessary. They stressed the importance of an adolescent seeing only one HCP rather than several for the one issue. However, in contrast, one PHN observed that the adolescents do not appear to perceive these multiple contacts as a problem:

> I don't think they would know the difference. They would just think this is status quo… the first time it's ever happened to you, would you know the difference like if you had to see four people? (S4, l: 842).

The adolescent's lack of knowledge and experience on how to "navigate the system" (S1, l: 698) was reported by all HCPs. One HCP suggested that it may be the adolescents' lack of exposure to the health care system, as well as his or her knowledge on how the system is organized. The HCPs described the exposure to the health care system as being an overwhelming process and experience for adolescents. HCPs reported that adolescents often weren’t aware or did not realize that they needed to come back for test results or more education, and therefore frequently “get lost in the follow-up” (S1, l: 693).

System barriers and lack of services. Many of the physicians interviewed indicated that the size of their practice was a barrier for adolescents. Most of the physicians reported that they were not accepting new clients into their practices, but instead were referring clients to the walk-in service. The availability of obtaining care continues to present a problem because the client may have to wait up to two hours to see a physician. In addition, if the adolescent does have a physician, they may have to wait two or more months for an appointment.

The lack of therapeutic abortion services offered in the region was identified as a barrier. Many of the HCP participants agreed that “there’s nowhere for someone to get a therapeutic abortion in our region and that raises significant barriers” (S5, l: 1847). Medical and surgical abortions are not offered in this health region. All of the HCPs agreed that there are “circumstances where people would benefit from the ability to terminate a pregnancy” (S5, l: 1868) therapeutically. Many circumstances, as told by one HCP have occurred, where an adolescent could have received a medical rather than a surgical abortion, but the hospital did not have the capability to perform and staff this treatment or procedure.

System barriers and staffing. Staffing was another barrier that was identified. Some areas of the health region do not have full-time nurses. Nurses have had to reduce their commitment to certain programs and prioritize the programs they deliver and the nature of the clients they serve. A PHN may staff an itinerant clinic in an outlying community once a week; but depending on staffing and other priorities, may not hold the clinic every week' making their visits to that community sporadic, unpredictable, and unreliable. Other towns are not staffed "so there is no Public Health Nurse there. Ever." (S4, l: 1299). Another identified problem was that during "holidays and… long weekends… we're not very accommodating" (S4, l: 1082).

System barriers and interdisciplinary practice. Another barrier identified by the NP and PHN participants, was the lack of adolescent referrals from physicians. Physicians do not typically write referrals to PHNs or NPs who may be able to address some of the adolescents' health needs better than the physician can, or spend more time with the adolescent counseling them. A referral may be made to a PHN for pregnancy counseling, or to a NP for uncomplicated reproductive health care which would comprise oral contraceptive prescriptions and pelvic examinations. Medical residents provided interesting insight into why they tend not to make referrals, specifically interdisciplinary referrals. New physicians and medical residents are not familiar with the resources within a community. Medical residents are new to the community every few months and therefore not aware of the services offered within the community they are working in. One medical resident reported making himself aware of some resources by reading posters that are on display in the clinic. The remainder of the resident or physician participants did not report learning about the resources in their communities. Most of the HCPs interviewed reported that there was definitely a need for greater interdisciplinary collaboration.

Fear of Being Judged. Adolescents can be fearful or worried about adults assuming or finding out why they are seeing a HCP. Judgments by HCPs or other adults regarding decision-making or behaviors of the adolescents were seen as a barrier. Adolescents were thought to be most fearful of others finding out that they accessed a physician or a nurse. Several HCPs agreed that adolescents felt judged by others simply by attending the clinic. HCPs reported that adolescents felt as though people would ask him or her why he or she was at the clinic; the adolescents were also afraid of people telling their parents they were at the HCPs office and consequently having to provide an explanation to their parent.

One medical resident reported that adolescents were afraid that the HCP would tell him or her something they do not want to hear. Perhaps diagnostic information, an opinion about their relationship with their partner or that “they’re maybe not making the right choice and that we’re going to judge them” (S4, l: 233). Adolescents feel that “talking about sex is taboo” (S4, l: 233), therefore if they are doing it or are talking about it, someone will negatively judge them.

Lack of Education. Adolescents appear to have a lack of knowledge about their health, health services, sexuality and reproductive health. The HCPs found that adolescents “are clueless when they come in. They just have no idea. Like ‘oh I don’t want to get pregnant but I’m not using any form of contraception’” (S2, l: 1301). One HCP reported that she spends a great amount of time educating adolescents on basic anatomy and biology. The same HCP reported that adolescent’s lack of information and education surrounding these topics was evident in their risk-taking, questions, and comments during sexual and reproductive health related visits. Several HCPs questioned the school health education curriculum as well as the nature and extent of the content on sexual and reproductive health. Another HCP stated, “the education isn’t being provided or is it that it is not adequate that what is being provided or that it’s not effective” (S5, l: 1836). This issue was evidenced by the questions the adolescents’ asked HCPs, as well as the adolescents’ behaviors and lack of consequential knowledge. Being aware of this lack of education, HCPs realized that “being a teen is tough” (S1, l: 515) and even “when you have the best supports and everything going on, you know it’s just such a tough, tough couple of years” (S1, l: 514), and adolescents tend not to put their health, particularly their sexual or reproductive health “on the top of their list” (S3, l: 566).

Another HCP stressed that if adolescents had access to health promotion initiatives, their awareness of their own bodies and health status may improve:

> Having more access to health promotion and to just general health education, like not being sick, you know, just that anticipatory guidance on what they are going to expect with their bodies changing, when things are going to be happening, that kind of stuff. I think there’s a real gap for that kind of stuff (S1, l: 519).

Therefore, not having their health as a priority results in the adolescents’ lack of knowledge about their sexuality. One HCP noted that there was also a general lack of information about what services are available; thereby increasing their difficulty in understanding and navigating the health system.

Conditions That Facilitate Access to Sexual and Reproductive Health Services.

Situations or resources that facilitate or assist the adolescent's access to sexual and reproductive health services included: word of mouth, services offered, internet usage, HCP roles and responsibilities, and school adolescent clinic.

Word of mouth. One way that adolescents learned about the health services that are available, was by word of mouth. A number of HCPs reported being told by adolescents:

> "My friend told me that I, I can get birth control here'. So, then… it's almost like a free advertising because it's word of mouth. Because then they'll be like (to other friends), 'oh yea, just go to public health and see them there' (S3, l: 146).

HCPs have noticed adolescents often tell each other about services they have accessed. A medical resident stated, "if their experience isn't horrid, then maybe they'll tell their friends that it's not so bad" (S2, l: 865). In addition to telling their friends about health services they have utilized, they also educate their peers about their own health experiences. If one adolescent has a sexually transmitted infection, they will tend to tell their friends and share their knowledge and experience. Some HCPs found that adolescents learn best from lived experiences: either from friends or other peers, meaning that adolescents don't learn by a HCP informing them about disease processes, but by relatable examples provided by people known to them, particularly, their peers.

Services Offered. The types of sexual and reproductive health services, the accessibility o the services and the adolescent's availability are described. Service availability included: flexible hours, visits to the adolescent themselves, the nature of the HCPs practice, going beyond their role, and the distance the adolescent needed to travel to the clinic. Among the services available, walk-in clinics were the services discussed most often. Several HCPs stressed the importance of having this walk-in service in the larger community being studied. The HCPs felt that there was not “a lack of physicians because walk-ins’ everyday and like there’s always someone available” (S5, l: 796). The majority of physicians interviewed did not see physician accessibility as a barrier. During the week, the walk-in service is open from 0900 – 1630 and on Saturdays the hours are from 0900 – 1200. The majority of HCPs interviewed, felt these hours were limiting, and thought that perhaps “evenings and weekends (should be) available (and) that would absolutely improve access to services” (S6, l: 517). It was felt by one participant that “anything after hours (be open)… because (rural community name) is a city like, and there’s tons of outlying communities and stuff like that… if they could do stuff at a really, really local level” (S6, l: 651). Another suggestion was to “start our walk-in at 7:30 am and we should go until 7:00 at night” (S5, l: 1407).

Flexible hours and services offered. The hours that the PHNs were available were even more restricted than the medical clinic’s because they were not open on evenings or weekends. Further, most clinics offered by PHNs were closed during the lunch hour. However, a few participants reported making themselves “available through the lunch hour” (S3, l: 249), if they were aware an adolescent was coming or had made an appointment. This flexibility and willingness to increase their availability to adolescents was described by several of the HCPs. Another HCP limited their access over the lunch hour to being open only to those seeking condoms. An additional HCP added “in our smaller communities that we go out to, we definitely are there over lunch hours… just (do not remain open over lunch) not in our home base” (S3, l: 304). The smaller communities that this HCP referred to were only staffed once per week or once per month. A couple of HCPs reported telling their patients that, “if you can’t make it just call me and I’ll fit you in wherever I can. Like even if you just show up. I will make it a priority to see (you)” (S6, l: 618). The majority of PHNs reported that they should advertise and accept walk-in, non-appointment clients over the lunch hour.

Public health nurses and services offered. Public health nurses in the community being studied offer a reproductive health program. This program provides birth control pills to qualifying adolescents at no charge. Qualifying adolescents would be those who do not have a health plan or cannot afford oral contraceptives. A few HCPs reported that providing free birth control was very valuable to the adolescents’ attendance and continued membership to their reproductive health program. One HCP stated that if “they (the adolescent) know they can access some sort of birth control from you, they’re more likely to come” (S3, l: 160).

Another service offered by the PHNs, is condom access. Condoms are made available in both the male and female bathrooms free of charge. PHNs suggested that it is important to place condoms in easily accessible locations.

> Having condoms in place(s), like the emergency room, you know like in places where people are accessing these services at all hours of the day. Having them in the bathrooms… Walmart or the mall! Where people are going all the time (S1, l: 951).

This strategy would not only improve accessibility to supplies, but also be an intervention that adolescents could utilize in private, without any perceived judgment.

Teen clinic and services offered. A new program offered in the local high school, was the Teen Clinic initiated by the RHA with a NP as the sole health provider. The clinic was offered at the school, one day per week during school hours. At the clinic, Pap smears were conducted, oral contraceptive medications were prescribed and provided, STI testing was done, and adolescents' health related questions were answered. It was felt that the students had appreciated these health services being offered at their school. One HCP reported that:

> Some (adolescents) don't have to, or aren't ready to have that discussion (about sexual intercourse) with their parents but who are in need of birth control, they appreciate that they can come to the school and get that taken care of (S1, l: 731).

A NP reported that an advantage of her services was that she was able to see only adolescent clients, and have an office in the rural community's high school. She also had office hours in the same building as the PHNs in the rural community being studied.

Internet Usage. Internet usage referred to the use of education and technology utilized by rural adolescents to access sexual and reproductive health services. Health seeking information was frequently obtained from the internet by adolescents. All of the HCPs informed the researcher that their clients were able to access the internet whether at home or at school. "I find… a lot of teenagers spend a lot of time on the computer" (S3, l: 746), referring specifically to the internet. Another HCP acknowledged that adolescents with low socio-economic status may not have a computer or internet at home, but "somehow get on the internet… you see them on Facebook all the time" (S6, l: 700). The information sought was not solely on general health issues but also included sexual and reproductive health issues.

Despite the HCPs knowledge of adolescents using this source to gather information: “they’re (adolescents) all there like searching whatever is going on down there on the internet Googling it” (S3, l: 751). The HCPs reported being unsure what sites adolescents were accessing; and only reported being aware that adolescents were accessing information on the internet.

The majority of HCPs interviewed did not recommend specific sites for adolescents. Only a few HCPs, specifically the medical residents, were aware of reliable sites, stating there “are some great websites and teens are all about accessing websites and learning information, so as long as they are from valid resources” (S1, l: 884), they may find the information they are looking for. One of these sites allowed the adolescent to “send an email and you would get an answer back” (S1, l: 879). This interactivity was considered a valuable tool for adolescents to access. The HCPs all acknowledged that adolescents were using both refutable and non-refutable sites to seek information about sexual and reproductive health services. A few HCPs commented that they discuss with the adolescent how to determine which sites provide accurate information, while other HCPs did not refer their clients to the internet due to concerns regarding “quality control” (S1, l: 904).

Acknowledging that adolescents frequently utilize technology and refer to the internet for questions, several of the HCP participants felt the creation of a virtual forum for local adolescents would be of value, for example creating a weblink to the RHA’s website or on Facebook. HCPs suggested that the RHA’s website could contain a question and answer forum, as well as a section where referral forms could be found for HCPs to refer clients to Public Health, Mental Health, as well as other disciplines or agencies. The participants also suggested using a social media outlet such as Facebook: “something they could like ‘favorite’… on Facebook how you ‘like’ that page and you get a reminder that it exists and that something changed on the page or was updated” (S3, l: 835). HCPs could update information pertinent to adolescents or display a question and answer forum utilizing this form of media. Having information displayed this way was seen as a local intervention by one participant and therefore more likely to be successful in education and awareness.

HCP Roles and Responsibilities. The participants described how their roles and responsibilities influenced the sexual and reproductive health of rural adolescents. The HCPs responses regarding working collaboratively varied. The PHNs and NPs reported frequently providing referrals to each other as well as to physicians; PHNs and NPs also conducted referrals to other professionals, such as: guidance counselors in the schools and Mental Health workers. Several PHNs who worked in smaller clinics outside of Dauphin reported referring adolescents “right next door to the physician” (S4, l: 103) in the community they worked where the physician and the PHN operated in the same building. Referrals were often for birth control prescriptions, STI testing, and antenatal appointments.

Public health nurse. The participants identified a number of positive aspects about their services. Several PHNs voiced that they typically have more time to spend with clients than a doctor can provide, and are able to “provide more information” (S3, l: 584) to the client during their appointment time. Another PHN reported that their “follow-up is better" (S4, l: 952) than that of a physician. The PHNs viewed their ability to provide free birth control pills to adolescents whose families were not on social assistance, and whose parents did not have a health plan, as well as providing free condoms, as a positive aspect of their role.

It was felt that the limited scope of practice of the PHN influenced how they interacted with other disciplines. PHNs rely on the physicians for testing and treatment of their STI clients. Service delivery specific to PHNs was discussed frequently in the focus groups. The PHN's recommendations primarily focused on their function and scope of practice. The PHNs felt that their knowledge and skill were not being used to the best of their ability, stating that they should be doing "pregnancy testing for sure… Plan B… STI testing… testing the urine, blood and then the treatment" (S4, l: 1099). The PHNs also reported that, "it really would be nice if we could offer Depo (Depo-provera)" (S3, l: 646). Currently, PHNs cannot administer Depo-Provera to any patients.

If adolescents were able to access the PHN solely, services would be "more confidential because there's only one health care provider. So… people are going to trust you a little more" (S4, l: 1202). Several PHNs voiced that if they had an increased scope of practice, they could see more adolescents for sexual and reproductive health services. One PHN discussed the need for RHA management to support a delegation of function to increase the PHN's scope of practice. Two PHNs and a medical resident suggested having two PHNs in the RHA conduct only STI contact tracing, testing, and treatment. However, other HCPs realized this specialty may not be a feasible solution given the size of the RHA and the limited scope that the nurse would then practice.

Physicians. The physicians who participated in the study also discussed the positive aspects of the sexual and reproductive health services they offered. One family medicine resident reported that one benefit of seeing a physician versus a NP would be that the physician is able to provide care to the 'whole' client and not only a few health issues. Another physician agreed, stating that physicians can address all health issues therefore the client would not have to make multiple appointments with multiple health care providers. Another physician also described his role as a "holder of information" (S5, l: 1740), where the physician is the main health care provider for the client and sees the client for all of their health concerns, not solely sexual and reproductive health, thereby resulting in treating "the entire picture rather than a snapshot" (S5, l: 1740). Physicians are also able to provide STI treatment in the clinic, as well as test a client's urine and conduct vaginal and penile swabs.

Going beyond the typical HCP role. The HCPs described various strategies they utilized to improve adolescents' availability and accessibility to health services. To promote treatment compliance and ensure the adolescent is getting the needed follow-up, a physician reported to have occasionally made other appointments, such as blood work for the adolescent. Other HCPs made a list of all the appointments the adolescent will need to assist him or her to receive the best care possible. Another example of a HCP making extra effort to assist the adolescent through a difficult situation, "I've even gone, they've given me money and I've gone to the pharmacy and bought them a pregnancy test because they just felt too nervous about going to the local pharmacy" (S4, l: 109). Another HCP wrote a letter to a drug company and was able to get an intra-uterine device

(IUD) covered by the company for a adolescent patient who could not afford one, and whose best option was an IUD for birth control.

School adolescent clinic. A number of HCPs discussed the importance of being present within the school system, and having a more active role with schools and the students. Being available in the schools to dispense health advice, conduct assessments, write prescriptions, conduct STI testing and provide condoms were valuable services as noted by the HCPs. One HCP suggested displaying posters in the bathroom stalls so that adolescents would not feel judged or self-conscious when reading about STI or pregnancy information. Another suggestion was to have an information forum where adolescents would have the opportunity to discuss certain topics.

Creating a teen clinic. The HCPs recommended the establishment of a modified Teen Clinic to the one that currently exists. Interestingly, the majority of the participants were not aware of the school's policies surrounding condom distribution, or criteria for PHN contact. One PHN reported that she would appreciate finding "out what they (the school) feel their needs are and how much we could do in (the) schools" (S3, l: 687). Due to this lack of knowledge, the establishment of a partnership with the school division was identified as an imperative step.

A suggestion given by a physician was "if you have a lot of teens in your practice then maybe you would take one of your afternoon clinics and make it a teen clinic" (S2, l: 1176). Another physician shared that:

> It would be useful if there was a Teen Health Clinic! Like, like they have in

> the city. Where there are doctors, nurses, it's somewhere easy for everybody to get to. And I don't know, somehow be able to get people in and to see you without it being very obvious what door they are going in and out of (S1, l: 845).

The participants' suggested that the location of the proposed Teen Clinic be in a neutral place, such as in the downtown area of the rural community; a location that is not identified as a medical clinic. The clinic should be somewhere the adolescents "can go in and not be sure of what services they need, but just walk-in… and have access to mental health, nutrition, physician, nurse, just sort of all under one roof" (S1, l: 856). One participant suggested having each adolescent screened and then triaged at the clinic to determine what type of HCP they require. The HCPs suggested offering free birth control, emergency contraception, and condoms.

The participants agreed that the atmosphere of the Teen Clinic should be a social experience: adolescents eating popcorn while watching movies in the waiting room. Having an informal atmosphere would assist with alleviating any anxiety experienced by the adolescents, provide a more acceptable and needed intervention and remove the medically oriented atmosphere, "outside of that whole traditional setting, in a whole team approach" (S1, l: 868).

The HCPs identified a number of issues that affect rural adolescents' access to sexual and reproductive health services. The HCPs were open and discussed factors that they thought influenced the use of services and expressed a number of ideas on ways to improve access for rural adolescents.

Summary

The participants' perceptions of the factors that affect the use of sexual and reproductive health services by adolescents in a rural area were described. The major descriptive findings that emerged from the interview transcripts were identified and discussed along with excerpts from the data in detail. In Chapter four, further exploration of the descriptive findings is provided, as is direction for future nursing research and practice.

CHAPTER V: DISCUSSION

Introduction

Health Care Providers (HCPs) were recruited to provide their perspectives on the barriers that influenced their adolescent clients' use of sexual and reproductive health services. In the first section of this chapter, the major descriptive findings derived from the HCP interviews are discussed in relation to previously published research: trust, confidentiality, support, barriers identified, and the conditions that facilitate rural adolescents' access to sexual and reproductive health services. The strengths and limitations of this study, as well as recommendations and implications for nursing education, practice and research will be discussed.

Discussion of Descriptive Findings

A limited number of research studies were found that explored the issues that affect the use of sexual and reproductive health services by rural adolescents. In the last seven to ten years, research in this area has dramatically increased. However, studies pertaining to rural adolescents and studies that were conducted in Canada were minimal. The major descriptive findings from the interviews conducted for this thesis are discussed.

Trust.

Trust was identified as a significant finding in this study as well as throughout the literature. Establishing a level of trust facilitated the adolescent's comfort level thereby encouraging the client to share information about his or her health. Shafii and Burstein (2009) emphasize that allotting time to build rapport, trust, and ensure confidentiality are imperative steps to enable adolescents to discuss their health concerns.

Communication and trust. The HCPs in this study believed that the quality of their interactions and verbal reassurance would be kept confidential were important when establishing trust with the adolescent. The HCPs reported deliberately making an effort to make the adolescent feel comfortable when meeting with them. Conversely, adolescents in a British study expressed frustration and mistrust of their HCP because they did not feel respected and felt they were treated like children during the appointment with their HCP and in communication with the receptionist (Jacobson, Richardson, Parry-Langdon, & Donovan, 2001). The participants in this study reported that they remained cognizant of communicating in age-appropriate ways with adolescent clients, thereby deliberately attempting to avoid this paternalistic attitude described by Jacobson et al. For instance, the HCPs informed the researcher that they made a point of talking ‘to’ the adolescent instead of speaking ‘over’ them. Creating an environment where adolescents feel safe disclosing health concerns is essential to developing a positive HCP-client rapport (Shafii & Brunstein, 2009). Shafii and Burstein pointed out that this strategy is important in building rapport and trust with adolescent clients. The strategies described by the HCP participants were effective in developing a positive rapport with the adolescent thereby making the adolescent feel comfortable about returning for future appointments.

Gender and trust. The HCP participants in this study reported that the adolescents’ comfort level is influenced at least in part by the gender of the HCP. Male HCP participants had the perception that an adolescent female would prefer a female HCP for a sexual or reproductive health related issue. Therefore, the gender of the practitioner may pose a barrier for female adolescents who may be hesitant about being examined by a male physician (Akinbami, Gandhi, & Cheng, 2003). This finding is supported by numerous studies in the academic literature. For instance, an American study reported that female HCPs were more likely to discuss emotions and non-medical information with adolescents and to communicate in a way that built a partnership and trust with the adolescent client (Brown & Wissow, 2009). Moreover, a Canadian study that examined university athletes' gender preferences for a team physician found that both female and male athletes preferred a female physician for sexual and reproductive health issues because the female physician was thought to be more caring, sympathetic, and have a more nurturing demeanor (Wesner & Vallance, 2005).

Embarrassment has been cited as a factor in adults wanting a same-gendered physician (Turow & Sterling, 2004) and adolescents may feel the same way. They may feel embarrassed of their health concern or question, or they could feel shy about being examined by a physician of the opposite sex.

Familiarity and trust building. In this study, the HCPs stated that if the adolescent had an established relationship as HCP and client, or was familiar with the HCP from the community, then he or she would be more likely to trust the HCP and visit again for a health related concern. Adolescents appeared to find the HCP more approachable when the HCP knew the adolescents' family member(s), or had been in contact with them informally within the community. A number of studies confirmed that adolescents trusted the HCPs with whom they had long and consistent relationships (Ginsburg, Forke, Cnaan, & Slap, 2002; Mauerhofer, Bertchold, Akre, Michaud, & Suris, 2010). Continuity of care with the same HCP was deemed to be very important to adolescent clients and necessary in establishing a physician-client relationship (Mauerhofer, et al.). However, an American study of urban adolescents reported that they would rather not see a HCP whom they were familiar with especially for a serious personal matter, such as an STI related issue (Ginsburg, et al., 2002). However, the reasoning or rationale as to why urban adolescents would not see a HCP for these purposes was not explored in this article. The findings from this thesis study did not agree with Ginsburg and associates but instead indicated that adolescents who knew the HCP would be more comfortable seeing this individual for serious personal health issues.

The HCPs in this study reported that adolescents who they saw repeatedly or with whom they had gained trust confided more information about their health complaint to the HCP. For instance, adolescents who presented with general illness-related complaints were often attempting to address a sexual or reproductive health related issue indirectly. This behavior is consistent in the literature and may be due to the adolescent's level of comfort or trust in the HCP (Shafii & Burstein, 2009). Once trust was established or the adolescent felt comfortable with the HCP, the actual reason for the appointment was conveyed more directly and openly from the start of the appointment.

Confidentiality.

Concern for confidentiality was mentioned throughout the literature and in this study. Published studies reported that confidentiality was the adolescents' primary barrier to accessing sexual and reproductive health services (Barrett & Harper, 2000; Brindis, 2010; Carlisle, Shickle, Cork, & McDonagh, 2006; Cheng, Savageau, Sattler, & DeWitt, 2002; Coker, Sareen, Chung, Kennedy, Weidmer, & Shuster, 2010; Garside, Ayres, Owen, Pearson, & Roizen, 2002; Klein, Nulty & Flatau, 1998; Lambke & Kavanaugh, 1999; Mauerhofer, et al., 2010). Verbal assurance of confidentiality was found to be a critical component for the adolescent to establish a trusting relationship with their HCP

(Brindis, 2010). This assurance of confidentiality has a positive impact on the adolescents' service continuity and increases their likelihood of presenting for repeat visits (Brindis).

Living in a rural community. The HCP participants in this study felt that adolescents were concerned with other staff, clients or other youth noticing or recognizing them and then assuming the reasons for which they were present. It is acknowledged within the literature that confidentiality challenges exist within rural communities: lack of anonymity and stigmatization affect the clients' comfort level when seeking services (Chipp, Johnson, Brems, Warner, & Roberts, 2008). The HCPs in this study acknowledged that adolescents may not attend the clinic to address their health related concerns for fear that they may know clinic employees. Rural towns pose amplified risks of decreased confidentiality or anonymity compared to urban areas. Strategies on how to decrease this fear needs further investigation through additional research, specific to rural populations.

Rural adolescents feared being seen at a medical clinic and having their visit reported to their parents by bystanders out of concern or gossip (Garside, et al., 2002). Similarly, an American study examined the barriers that 18 urban males encountered when attempting to access sexual and reproductive care (Lindberg, Lewis-Spruill, & Crownover, 2006). The adolescent males in the study reported that if they saw another adolescent at a clinic, they would make the assumption that the adolescent was at the clinic for STI services (Lindberg, Lewis-Spruill, & Crownover). The adolescent males made this assumption based on their personal beliefs that adolescents only present to a clinic to be examined or receive treatment for such issues (Lindberg, Lewis-Spruill, & Crownover).

Nursing or health care office processes. Adolescents often inquire or worry about their health information being made known to others who work in the clinic where they are seen fro sexual and reproductive health services. The HCPs in this study expressed that this concern is commonly voiced by their adolescent clients. The participants admitted that they could not guarantee anonymity in a clinic setting. HCPs in rural communities will often take extra steps to ensure that adolescents feel that their privacy is kept confidential and that they are comfortable seeking services (Chipp, et al., 2008). The HCPs who were interviewed were cognizant of how health information could potentially be leaked and therefore practiced preventative strategies. The HCPs in the study emphasized the importance of confidentiality with clinic staff, regular Personal Health Information Act (PHIA) sessions, and discretion by not phoning adolescent clients at their home with test results, for instance.

Support.

The HCPs identified that support is provided by both parents and peers regarding adolescent's access to resources for sexual and reproductive health. Parental involvement was frequently discussed among the HCPs in this study as both a positive source of support and as a limitation to their work with the adolescents. Peers were also recognized as being a positive and sometimes negative or unhelpful form of support to the adolescent.

Parental support. The HCPs found that the involved and informed parent was more likely to assist the adolescent in acting responsibly, making medical decisions, and supporting the adolescent in attending his or her appointment. Parents can have a positive impact on their adolescent's sexual and reproductive health by delaying the age of sexual initiation and positively influencing their health and wellness decisions (Helitzer, Sussman, de Hernandez, & Kong, 2010; Saewyc, Taylor, Homma, & Ogilvie, 2008). Adolescents who discussed sexual and reproductive health issues with their parents were more likely to use condoms or other forms of contraception and were less likely to become pregnant (Lerand, et al., 2007; Saewyc, et al.).

The HCP participants found that the adolescents whose parents were involved tended to receive the best follow-up simply because the parent was involved and demonstrated support to their adolescent. In a qualitative study in which primary care providers were interviewed, parents acknowledged adolescent risk behavior and made the decision to initiate or assist their adolescent in prevention (Helitzer, Sussman, de Hernandez, & Kong, 2011). The researchers reported that this proactive approach was demonstrated by the parents bringing their adolescent to the clinic for oral contraceptives, STI testing, and being present for sexual health education (Helitzer, et al.). The HCPs in this study also found this approach to yield the same or similar results. Several HCPs reported that parents who accompanied their adolescents to appointments, advocated for what the adolescent may require from the HCP, and encouraged and facilitated the adolescent to attend follow-up appointments.

Parental support and need for privacy. Support from parents has been found to be important to the adolescents' health and decision-making. However, HCPs have acknowledged that adolescents must also be independent health care decision-makers and their individual goals and ideas must be respected by HCPs. HCPs in an American study identified barriers and facilitators that adolescents encountered when accessing behavioral and mental health services in a primary care setting (Bitar, Springer, Gee, Graff, & Schydlower, 2009). The HCPs questioned the honesty and validity of the information the adolescents provided when they were assessed with their parent present (Bitar, et al.). More specifically, the adolescents' ability to respond openly about sensitive issues may be impeded with a parent present (Bitar, et al.). The HCP participants of this study reported that adolescents may not have disclosed all of the information required by the HCP to their parents. If the parent is included in the full assessment of the adolescent by the HCP, the adolescent is being put at risk of feeling embarrassed or being judged by the parent. As noted by Helitzer and associates (2011), primary care providers believe that adolescents perceive parental involvement as a threat to the adolescent's privacy and confidentiality. The HCPs in this study found that adolescents felt more comfortable being assessed without the parent in the room, and having their health concerns remain private and confidential from their parents. The HCPs in the literature and in this study reported that they always encourage adolescents to involve and inform their parent or a trusted adult in their health care as much as possible (Helitzer, et al; Ott, et al., 2011b; Shafii & Burstein, 2009).

Peers as support. The HCPs in this study reported that adolescent peers appeared to provide education, information, and emotional support to each other. Many adolescents attended the clinic accompanied by their peer. Peers were thought to provide them with encouragement and comfort at the appointment. In the literature, peers were identified as a strong source of support for adolescents (Bayley, Brown & Wallace, 2009; Ott, et al., 2011b). Peers were recognized as having influence over adolescents' behaviors. If peers do not support risky behaviors, the adolescent is less likely to have sexual intercourse before the age of fourteen or become pregnant as an adolescent (Saewyc, Taylor, Homma, & Ogilvie, 2008). Peers were asked to provide support in circumstances where a parent was unavailable or the adolescent was uncomfortable with their parent being present (Ott, et al.). The situations where the adolescent was reportedly uncomfortable asking their parent(s) to accompany them were situations which involved: sex, contraception, substance use, or relationships (Ott, et al.).

Limitations to peers being a support. The HCPs in this study noted that a peer's presence at the appointment occasionally resulted in the adolescent exaggerating their story. The opposite also occurred with adolescents appearing more shy or distracted during their appointment. In most instances, the HCP requested the peer to step out of the room for the adolescent's assessment and interview. Bayley and colleagues note that peers can and do provide adolescents with conflicting pressure and support (2009). Peers can occasionally act as a source of peer pressure, eliciting a burden of social belongingness in the adolescent (Bayley, Brown, & Wallace, 2009).

Barriers identified by the health care providers.

Studies which included rural participants have reported that geography, transportation, and confidentiality influenced rural adolescents' access to and use of services (McCann, Donnelly, Quinn, & McAnerney, 2008; Schovellor, et al., 2009). A study conducted in Northern Ireland reported that sexual health services should be targeted to the adolescents' specific needs (McCann, et al., 2008). One of these needs was for service providers to acknowledge that rural adolescents have difficulty accessing transportation to access services (McCann, et al.). This barrier aligns with findings from the HCP data. Other barriers that were mentioned in the literature included: age, psychological maturity, peer pressure, and religion (Sumter, Bokhorst, Steinberg, & Westenberg, 2008). Maturity of the adolescent, transportation, financial barriers, system barriers, fear of being judged, and lack of education were discussed among the HCP participants, and will be consequently discussed in this section.

The maturity of the adolescent. The HCP participants in this study commented that the age, maturity and capacity of the adolescent did have an impact on adolescents' health care use. The HCP participants repeatedly mentioned that adolescents were not mature enough to make responsible decisions about their sexual and reproductive health. They described adolescents as spontaneous individuals who lacked insight into the consequences of their behavior. At times, their lack of maturity appeared as disinterest in their health status. The HCP participants also expressed frustration over the adolescents' behaviors; however, the HCPs took the adolescent's concerns seriously and worked with the adolescents to resolve their health complaints. The complaints expressed by the HCPs in this study are similar to those of urban physicians. In a study that included urban physicians, a physician expressed frustration that adolescents do not act responsibly and do not act 'grown-up' (Kang, et al., 2003). Furthermore, the physician noted that adolescents often do not keep their appointment times and are not consistent in following through with what was agreed upon at the medical visit (Kang, et al.). The physician also reported that meeting with adolescent clients is not worthwhile for this reason (Kang, et al). The rate of physical development exceeds the adolescent's rate of cognitive development (Shaffii & Burnstein, 2009). Sumter and colleagues (2008) pointed out that maturity affects decision-making more than age, and that the timing and pace of the adolescent’s development or maturity can vary considerably during adolescence. Unskilled decision-making was evidenced in the immature adolescent, as was the increased rates and risk of STIs (Shaffii & Burnstein). Ott and associates (2011) reported that respect for the adolescent’s evolving capacity to make decisions is imperative. As adolescents become older, they often gain more impulse control, responsibility, and self-awareness (Sumter, et al., 2008). As the adolescent ages and approaches adult-hood, they become more mature, which results in an improved capacity and responsibility to make decisions relating to their health. HCPs have a unique role whereby they are able to respect and support adolescents in promoting good sexual health, despite the adolescents’ developmental dual between judgment and action (Ott, et al., 2011b; Shafii & Burnstein). The presence of the adolescent’s social, cognitive and behavioral competence was found to have a positive influence on sexual and reproductive health, thereby delaying sexual intercourse and more reliable use of a form of contraception (Katz, 2011). Adolescent specific training may benefit HCPs. Workshops on how to interact with adolescents and promote the best care for their health and development may be an appropriate intervention to assist HCPs in caring for adolescents.

Rural transportation. The HCP participants in this thesis study noted that a car may not be available to the adolescents over the age of sixteen every day, thereby making it difficult for the adolescent to plan his or her appointments, resulting in last minute appointments or attending a walk-in service over lunch. The HCPs found that a major obstacle for the adolescents in this study was if the student depended upon the school bus to travel to and from school. Rural adolescents were required to board the school bus immediately after school, and were not able to access sexual and reproductive health services after school as a result. Transportation is consistently identified as a problem for rural residents when seeking health, social, or recreational services (Brems, Johnson, Warner, & Roberts, 2006). Rural communities typically do not have a form of public transportation, such as a bus or subway system. When public transportation does not exist or is inadequate, adolescents are left to rely on their own sources of transportation such as their parents (Fitzpatrick & Walton-Moss, 2011; O'Callaghan, McAllister, & Wilson, 2005; Shoveller, et al., 2009). Several studies have identified that adolescents living in rural areas had fewer opportunities to seek sexual and reproductive health services, due to the lack of public transportation and cost of transportation, as compared to urban adolescents (Bayley, Brown, & Wallace, 2009; Brems, Johnson, Warner, & Roberts, 2006; Fitzpatrick & Walton-Moss; Shoveller, et al., 2009).

Financial barriers. The adolescents in this study are residents of a province in Canada, and as such, have a provincial health insurance plan through their parent's employer, which covers the majority of the cost of contraceptives. Families on social assistance also receive contraceptives at no cost. However, for an adolescent to receive contraceptives at a reduced or no cost, their parent must be informed and claim their medication to the insurance company. Many adolescents including those in this study, who are on contraceptives do not disclose their use to their parents. Financial barriers were infrequently mentioned within the Canadian literature. The majority of studies that discussed financial barriers were American, and focused on insurance plans, reimbursement models, and individual health care costs. One American editorial briefly stated that adolescents benefit from free or low-cost access to contraceptive methods and did not outline the eligibility criteria or the services that might be available for adolescents (Brindis, 2010).

System barriers. There are minimal studies examining rural health care delivery. Studies examining system characteristics such as health service accessibility and availability, duplication of services, staffing, and interdisciplinary practice were scarce.

System barriers and clinic operation. Characteristics of the health care system were identified as barriers by the HCPs in this study. Physicians and medical residents noted that appointment times were very short, particularly in cases in which adolescents attended the walk-in clinic. Feeling rushed and pressured to see as many people as quickly as possible was how the physicians and medical residents described the walk-in service. The nature of the walk-in clinic represented a hurried atmosphere, and the HCPs felt that they could not provide the adolescent client with the requisite amount of time for the appointment. When the appointment is rushed and the adolescent requires more time, it may be feasible for the physician to utilize a clinic nurse to conduct the initial screening and assessment (Shafii & Burnstein, 2009). These findings replicate the available literature on the time spent with adolescent clients.

Physicians felt that they did not have the time that was required to discuss sexual and reproductive health issues especially with adolescents (Jacobson, et al., 2001; Kang et al., 2003). A study that examined adults access to primary health care services in Canada found that the clients who reported difficulty accessing routine or on-going care, gave the following reasons: waited too long to get an appointment (45%); had difficulty getting an appointment (32%); had difficulty contacting a physician (18%); and waited too long to see a physician (10%) (CIHI, 2009). The physicians in this study also identified wait times as a barrier, which was identified mainly in the walk-in clinic setting. Wait times and difficulty making an appointment to see a HCP can influence or hinder adolescents securing an appointment (Sannisto & Kosunen, 2009). Wait times also have the ability to deter adolescents from seeing a HCP for a health issue.

Hours of clinic operation were viewed as a system barrier among the HCP participants. Several participants acknowledged that the clinic hours and the school hours were similar, which made it difficult for students to attend the clinic either before or after school. Limited clinic hours were mentioned as a barrier in a study examining youth's experiences with STI testing in Canada (Shoveller, et al., 2009). Modifying existing or creating new adolescent clinics was deemed by the literature to be a positive method for increasing adolescents' access to sexual and reproductive health services (van der Meulen, et al., 2010). The HCP participants in this study concurred that modifying their clinic hours would improve adolescent access.

System barriers and efficiency. Meeting with multiple HCPs for one health issue was identified as a system barrier by the HCPs in this study. The efficiency of the health care system is decreased and is an inconvenience to adolescents when they have to see multiple HCPs for one health issue. Interactions with medical residents and medical fellows, in addition to the medical practitioner were viewed as a barrier and perceived to be an unnecessary and unwanted encounter (Britto, Tivorsak, & Slap, 2010). Adolescents viewed the presence of other HCPs negatively, as the presence of another adult or unfamiliar bystander impeded communication with their primary HCP (Britto, Tivorsak, & Slap). The HCPs in this thesis study felt that having to visit multiple HCPs was redundant and unnecessary. Moreover, the arrangement of multiple appointments, transportation, and time away from school was identified as being difficult for the adolescent and further decreased the likelihood of the adolescent attending multiple appointments.

System barriers and lack of services. The HCPs in this study mentioned that the lack of therapeutic abortion services in the region was a barrier for some adolescents. Adolescent clients who request this service, must travel two to four hours to a larger centre and are typically required to stay overnight at a hotel. Brems and associates (2006) identify that travel is a burden for rural healthcare. These authors also state that travel to urban areas is not uncommon for those living in a rural community. Travelling for a service such as a therapeutic abortion, places the adolescent in a compromised position: missing school, finding overnight accommodation, obtaining transportation, coordinating the health appointments, and increasing the risk of their parent(s) learning of their appointment.

System barriers and staffing. The physicians in this study reported that they were no longer accepting new clients but instead referred them to the walk-in service, which means that the client then does not have a physician following their care. The lack of on-going care from a physician contrasts the Canadian Institute of Health Information (CIHI) (2010) which indicates that rural physicians are more likely to be accepting new clients than their urban colleagues and that access to a family physician is essential to ensuring adequate primary health care (CIHI, 2010). The twenty family medicine physicians who are employed in Dauphin work in a group practice. Thirty-eight percent (38%) of rural physicians, who operate in a group practice, indicated that they were open to accepting new clients (CIHI, 2010). However, the physicians interviewed in this thesis study reported that their colleagues' practices were full, and therefore were not accepting new clients. McCann and colleagues (2008) mention in their study that funding and staff resources are among the primary reasons why there are not appropriate health services targeted to adolescents.

System barriers and interdisciplinary practice. The PHNs in this thesis study reported a lack of referrals from physicians. The physicians acknowledged that they did not refer adolescent clients to other health disciplines and community resources as often as they should. The physicians stated that they were able to provide care to the 'whole' client and are able to address all health issues. They also reported that due to their scope of practice and function, clients do not need to see multiple health care providers which may be one reason that interdisciplinary referrals for physicians are rare. Canadian data indicates that, only 27% of adults who have a regular physician reported they saw a nurse in the clinic regularly who was involved with their care, while only 16% of adults reported that other health care professionals, such as dietitians, were involved in their care (CIHI, 2009). The lack of communication between physicians and other HCPs was acknowledged in an Australian study examining adolescent's access to primary care services (Kang, et al., 2003). Kang and associates recommended that this lack of communication between HCPs be addressed in order to share expertise and to optimize the care given to adolescents. The HCPs in this study, the PHNs, NPs, and physicians operate in different clinics. The PHNs and NP have offices across the street from the medical clinic. Not working directly with each other may contribute to the lack of knowledge of each others services, referrals, and co-ordination of services.

Fear of being judged. The fear of being judged by HCPs can have a negative impact on the adolescents' access to sexual and reproductive health. The HCPs in this study found that if they appeared to be judgmental when interacting with the adolescent, the adolescent was less likely to return to the clinic or that HCP. The HCPs in this thesis felt that adolescents were also less likely to discuss sexual and reproductive issues unless the behavior was thought to be acceptable by the HCP. A research study conducted in England also identified judgment, fear and embarrassment as barriers to accessing sexual and reproductive health care (Bayley, Brown, & Wallace, 2009).

Lack of education. The HCP in this study commented that their adolescent clients possessed limited knowledge about sexual and reproductive health which is a consistent finding in the literature. McCall and McKay (2004) pointed out that many sexually active youth do not consistently use condoms, and that the quantity and quality of sexual health education and services targeted to adolescents are inadequate.

All of the HCP participants confirmed that there is a lack of health education opportunities for adolescents in the Regional Health Authority being studied. The HCPs commented that they felt that adolescents do not receive adequate information about basic anatomy, biology, or reproduction. Many schools and school divisions are not fully implementing sexual health education in the current school curricula and that public health systems typically do not have the resources required to provide adequate support and coordination for preventive services (McCall & McKay).

The literature adds that education pertaining to sexual and reproductive health is given insufficient time within the school curriculums, as are discussions around the emotional aspect of sexuality and the services that are available (Martinez & Phillips, 2008; Ott, et al., 2011a; Phillips & Martinez, 2010). It was recommended by several authors, as well as the participants in this study that improved collaboration between public health and the school divisions must exist (McCall & McKay, 2004; McElderry & Omar, 2003; Omar, McElderry, & Zakharia, 2003; Ott, et al., 2011a; Phillips & Martinez, 2010). It is acknowledged throughout the literature that rural settings encounter their own unique challenges regarding sexual education. These challenges include: fewer available sexual and reproductive health services, geographic isolation, transportation challenges, increased poverty and rural values being more likely opposed to sex education (Ott, et al., 2010).

The HCPs in this study acknowledged that the adolescents were not aware of what health services were available for them to use. They added that the students were not familiar with the teen clinic, the hours of the various medical clinics, nor that condoms or contraceptives were provided by HCPs if requested and needed. Booth and colleagues (2004) confirmed that this limited knowledge acts as a barrier to adolescents, resulting in their not seeking the appropriate services.

Adolescent’s limited knowledge regarding available services was also identified as a barrier (Booth et al., 2004). The literature found that adolescents are not receiving the necessary information and education on the types of health and medical services and basic health education (Jacobson, Richardson, Parry-Langdon, & Donovan, 2001).

Conditions that facilitated access.

Despite many barriers being present, the HCPs identified several factors that promote adolescents’ access of sexual and reproductive health services. Including: the services that are offered, internet usage, the HCP roles and responsibilities, and the school adolescent clinic.

Services offered. The Teen Clinic in the community being studied was in its infancy during the recruitment phase of this thesis. Therefore, not many of the adolescents who were interviewed had utilized the service or were familiar the specific services offered. The presence of the Teen Clinic may improve access to adolescents who attend school and are comfortable using this service at the school. Condoms are provided free of charge to those clients who present to the Community Health Services Building during office hours. A reproductive health program is available to adolescents who qualify to receive free birth control pills through the PHNs. The reproductive health program and condom availability help to address the financial barriers that adolescents face.

Internet usage. The internet as a source of information and education about sexual and reproductive health was discussed in this study as well as in the literature. Several studies agreed that the majority of adolescents utilize the internet as one of their primary sources of health information and that the internet is accessible to most youth (Gilbert, Temby, & Rogers, 2004; Jones & Biddlecom, 2011; Shoveller, Knight, Davis, Gilbert, & Ogilvie, 2012). This thesis also indicated that there are websites that provide accurate information and may also offer discussion forums (Gilbert, Temby, & Rogers; Jones & Biddlecom). The HCPs in this study admitted to not referring their clients to any websites for fear of the website not being accurate. They also acknowledged that they had limited knowledge on what websites are appropriate, available, and reliable.

The literature made it clear that adolescents tend to rely primarily on traditional sources for sexual and reproductive health information, such as family and friends, prior to seeking information from the internet (Jones & Biddlecom). Valaitis and Sword (2005) stated that on-line communication was a preferred method to learn about sexual and reproductive health by adolescents. Both the HCPs and the literature, proposed that an online website and discussion forum could be useful to youth (Borzekowski, Fobil & Asante, 2006; Jones & Biddlecom, 2011). Shoveller and associates (2012) conducted a Canadian study that found adolescent clients preferred the anonymity of being online to source information rather than face-to-face with a HCP.

HCP roles and responsibilities. The collaboration between HCPs varies with regards to client care. Referrals and interdisciplinary collaboration may solicit improved practice and care for the adolescent. The following findings describe the roles of the PHN, NP and physician as well as how they work together.

Public health nurse. The desire for an increased scope of practice was voiced frequently by the PHNs interviewed. This increased scope of practice would allow the PHN to test urine, treat STIs with antibiotics, and conduct blood testing for STIs. This expanded role would improve access, system efficiency, and ease of navigation for the adolescent. A recent Finnish study has shown that services provided by nurses, either in the school or clinic setting may improve accessibility and even decrease rates of teenage pregnancy (Sannisto & Kosunen, 2009). In Finland, expansion of the nurses’ scope of practice to prescribe oral contraceptives is being considered (Sannisto & Kosunen).

The PHNs and NPs in this study reported that they typically have better follow-up with clients and have more time to spend with their adolescent clients. The PHNs and

NPs also reported being able to provide a more confidential service since the adolescent would only have to see one HCP. Traditionally, nursing education focuses on providing client centered care, thereby instilling in nurses the importance of addressing the holistic needs of the client (Hitchings, Allotey, & Pittrof, 2010). A study that examined staff perceptions on the quality of service provision of nurse-led STI clinics, found that nurse-led services resulted in more time spent with clients, greater confidentiality, shorter wait-times for clients, and improved job satisfaction for both nurses and physicians (Mindel, Fennema, Christie, & van Leent, 2009).

The NPs in this study were hired to conduct a weekly Teen Clinic in the school, to provide screening, assessment, treatment, and medication prescribing of adolescents. Expansion of the NPs role in the school and the clinic setting, as well as improving the community's knowledge of the NP function will assist with them being better utilized.

Nurse Practitioners are becoming increasingly more common in areas of sexual and reproductive health, and are a cost-effective service for rural communities (Lindeke, Jukkala, & Tanner, 2005; Mindel, Fennema, Christie, & Van Leent, 2009). Nurse Practitioners are able to deliver quality care, order testing, and diagnose health conditions. The NPs presence in the health care system has proven to address staff shortages, reduce client wait times, and improve staff morale (Mindel, Fennema, Christie, & Van Leent).

Physician. The physicians in this thesis viewed their services positively. They are able to test, treat, and diagnose clients for any health condition. The physicians reported that they are the main health care provider who met with the client regularly for any health concern. The data from this study found that adolescents do use physicians as their primary health care provider. This finding may be due to the fact that the NP role is new to the communities being studied, and that the physicians in these communities do not tend to refer adolescents to other HCPs, such as PHNs.

School adolescent clinic. The HCPs in this study thought that having a presence within the school setting would improve adolescent's access to services and facilitate improved care. Research has in fact demonstrated that when health services were offered in the school and clinic setting, adolescent pregnancy rates were lower than in communities that only offered clinic services (McCall & McKay, 2004). Moreover, establishing a positive working relationship and collaborative approach with the Principal of the school was important if they wanted to address adolescent sexual and reproductive health needs in the school.

Creating an adolescent clinic. The HCP participants suggested distributing condoms or having them easily accessible to adolescents in schools or other locations which they frequent. Greater accessibility to condoms increased the likelihood of their use by adolescents who were sexually active (Eisenberg, Bernat, Bearinger, & Resnick, 2009). The HCP participants also discussed having a downtown adolescent-only clinic that would involve a multi-disciplinary team of HCPs in an informal setting. The clinic would incorporate PHNs, NPs, physicians, dietitians, and mental health nurses. This downtown adolescent clinic would improve accessibility and be located in a central and convenient location. In this way, the students would be able to walk to the clinic and not necessarily rely on transportation. Furthermore, the participants emphasized that the clinic would be adolescent-driven, thereby based on the adolescents' needs. It could be open in the evening and during the lunch hour.

Assumptions Guiding the Study

The researcher's personal assumptions for this study were written prior to the data collection. The researcher remained cognizant of her assumptions while developing the questions that were asked of the participants. The personal assumptions described below did not influence the interviews or questions. The personal assumptions were made explicit by the researcher at the beginning of the study and before each interview in the fieldnotes. These assumptions guided this study.

The first assumption was that HCPs view adolescents as capable beings, capable of making responsible and informed decisions about their health. The study confirmed that many adolescents were in fact capable beings, seeking information and asking questions of their peers, parents and HCPs that would guide their decision making. When determining their need to seek health services, the HCPs noticed that the adolescent's parent initiated the contact with a HCP or advised the adolescent to present to a HCP. The decreased insight of when to see a HCP by some of the adolescents may be influenced by their developmental maturity, and lack of knowledge about sexual and reproductive health and the availability of health services. Perhaps adolescents would require less guidance when making sexual and reproductive health decisions if they were adequately educated in this area. The literature determined that adolescents are not educated adequately about their health status, when to visit a HCP for a health concern, and what type of HCP to visit for a particular health issue. Furthermore, these factors could influence this guiding assumption. Maturity, lack of education and lack of resources influence the adolescents' capability of identifying and seeking sexual and reproductive health services.

The second assumption was that rural adolescents would have low use of health services. This assumption was frequently mentioned in the literature on rural populations. The literature indicated that the adolescent population has the lowest number of health care visits per year. This study found that rural adolescents often presented to HCPs when they experienced serious symptoms or their parent noticed a health problem. The low rate of health services use may be due to the adolescents' decreased knowledge of when to seek sexual and reproductive health care.

The third assumption was that rural adolescents would have difficulty accessing sexual and reproductive health services. The HCPs in this study identified a number of barriers, which influenced adolescent's use of services, such as the distance to health services, transportation, concern for lack of confidentiality, and limited availability of services. These barriers were thought to pose significant problems for the adolescents. Therefore this assumption was confirmed.

Lastly, the fourth assumption was that adolescents would be reluctant to ask for information on sexual and reproductive health services from adults and would therefore rely on information obtained from their peers. This assumption was partially correct. The researcher learned from the HCPs that a great deal of the information adolescents received was from their peers, as well as other sources, such as their parents and the internet. It was unclear whether HCPs found adolescents obtained more reliable information from their peers, adults, or the internet. Most of the HCPs were skeptical of the validity of the information on the internet and therefore were reluctant to refer adolescents to websites.

Strengths and Limitations of the Study

A major limitation of the study was the small sample size of the HCP participants. Due to the small sample size, the findings of this study cannot be generalized. The majority of the HCP participants in this study were female, physicians, and in their twenties and thirties. The limited professional experience of the HCPs may have influenced the data. The inclusion of several experienced HCPs added to the richness and greater depth of examples.

The limited depth and richness of the data precluded any conceptual rendering of the data. The researcher was unable to interpretively integrate portions of data, that is, she was not able to do any interpretive analysis.

Recommendations

This study provides the opportunity for a number of recommendations to be made for nursing practice, education and research. Due to the small sample size, further research is needed to support these findings and recommendations. This thesis highlights a number of recommendations, however, before these recommendations can be implemented, further research is required. The results from this study allow for the consideration of future research by nurses to improve the sexual, reproductive, and general health of not only rural adolescents, but adolescents in general.

Nursing Practice

The majority of the PHNs in the study emphasized that their scope of practice needs to be addressed by the regional health authority. They stated that the expanded role should include urine STI testing, blood testing for HIV, syphilis, Hepatitis B and C, as well as antibiotic treatment for positive STI cases. Once this area of practice is addressed, the PHNs will be able to more efficiently assist adolescents. The adolescent would only be required to see one HCP for their full assessment and treatment. This would also assist with the maintenance of confidentiality since only one health professional would be involved.

Changes to improve the availability and accessibility of health services to adolescents need to be addressed. The HCPs from this study presented a number of suggestions. The suggestions included: longer clinic hours, seeing one HCP for STI follow-up, remaining open over lunch-hour, being accessible for and encouraging walk-in appointments, having regular contact with adolescents in the schools, and establishing a strong, positive working-relationship with school administration.

Incorporating the use of technology as a means to provide health education would be an innovative strategy that was raised in the literature and by the thesis participants. This would include utilizing social networking and internet forums to disseminate sexual and reproductive health information. Basing programming on adolescent interests and generational characteristics may produce a more active, engaged and informative audience. Offering accurate and reliable health information in a non-intimidating, confidential manner is important for adolescents and this could be partially achieved by internet technology.

One study discussed the importance of social media in public health practice as a method of teaching and engaging learners (Kapp, LeMaster, Lyon, Zhang, & Hosokawa, 2009). A project involved graduate students who performed and created videos for other students that were launched on the social media outlet, YouTube. This strategy could be implemented by the health region. For example, PHNs could prepare a series of presentations to high school students on various topics, such as body image, STIs, reproductive health, and healthy relationships. The students would then produce several videos on those topics, translating theory and information into real-life scenarios. These videos would be edited and used by public health nurses, the schools and others when placed on YouTube, resulting in accurate and reliable sexual health information being available.

The relationship that HCPs had with the school was frequently mentioned by the PHNs in this study. Establishing a positive relationship and rapport with school principals, teachers, and counselors was considered an imperative step in effectively engaging and accessing adolescents who attend school. A needs assessment should be conducted within the schools to determine the frequency of nursing visits to the school. Meetings between public health managers and the school division could also be held to discuss the role of nursing in the school and ensure consistent and common expectations between the two organizations. PHNs should be encouraged to meet with school principals yearly to discuss what can be provided by the PHNs, as well as any special skills or specialties unique to that PHN that could be offered. A regular presence and positive relationship needs to be established and maintained in order for PHNs to be accepted and available to adolescents in the school.

Special attention needs to be directed towards rural and remote communities that are a greater distance from an urban centre or a larger rural community. Programs, resources and services need to be carefully and creatively delivered so that the adolescent populations' health needs are addressed. This may include programming that is delivered at a clinic near or inside the school and longer hours for the clinic and public health program. Another strategy would be to establish an adolescent health advisory group, consisting of adolescents, parents, and teachers. This group would discuss unique ways for the school and the health region to promote health and illness prevention services to adolescents.

Nursing Education

Adolescents have specific health needs and want to be treated with respect and honesty. Educating other rural HCPs, school staff, families and adolescents who lack knowledge of the sexual and reproductive health services that are offered in their community should be a priority. This education could be provided by nurses in the form of posters, health forums, and presentations to the school staff as well as to other members of the community.

Collaboration between HCPs should also be encouraged. Support of each discipline’s scope of practice is crucial to a multi-disciplinary approach to patient care. Joint educational sessions and interdisciplinary health care rounds could take place. Creating a central location on the RHA website for interdisciplinary referral forms to be accessed would allow HCPs to visually see the types of services that are offered and create a simpler environment to write referrals. Dialogue promoting continuous communication and common patient information should be encouraged and facilitated.

Nursing Research

Future studies are needed to validate the findings from this study. Qualitative studies that explore how HCPs interact with adolescents, and how adolescents interpret their interactions need to occur to determine the effectiveness of communication. Additional research is also needed to assess whether adolescent specific training for

HCPs is effective in reaching and assessing adolescent clients. Additional research also needs to be conducted on rural adolescents with regards to their health service needs. Recruitment of adolescents is a challenge, particularly for the sensitive topic that this thesis focused on. Studies to determine the most appropriate, ethical, and effective methods for recruitment of adolescents for sexual and reproductive health research are needed. Further investigation is needed on the nature and effectiveness of the sexual and reproductive health education that is provided in the school curriculum. Determination of measurable goals and expected outcomes are needed with evaluation assessing the achievement of the goals. Formal program evaluations need to be conducted at regional and provincial levels to determine the effectiveness of the programming on adolescent STI and pregnancy rates.

Conclusion

This chapter presented the discussion of the findings. Health care providers' perspectives of the barriers to accessing sexual and reproductive health services by rural adolescents were explored and discussed. The discussion of the research findings indicated that barriers exist and influence the adolescent's utilization and access to sexual and reproductive health services. Methodological strengths and limitations of the study were discussed. Recommendations for nursing practice, nursing education and nursing research were also presented. The findings from the study validated the current published literature of the barriers adolescents encounter when seeking health services.

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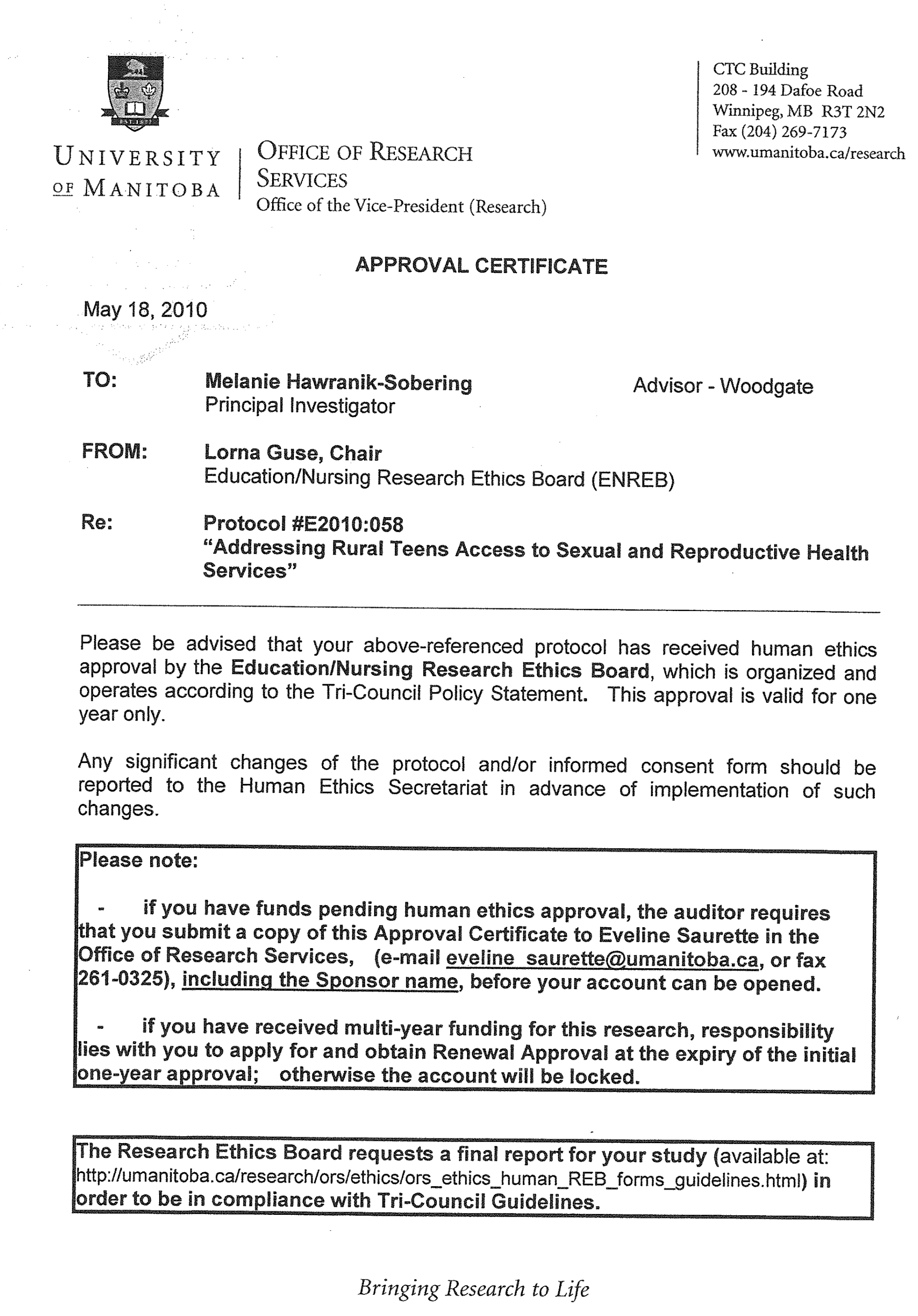
Appendix A



UNIVERSITY
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OFFICE OF RESEARCH
SERVICES
Office of the Vice-President (Research)

CTC Building
208 - 194 Dafoe Road
Winnipeg, MB R3T 2N2
Fax (204) 269-7173
www.umanitoba.ca/research

APPROVAL CERTIFICATE

May 18, 2010

TO: **Melanie Hawranik-Sobering** Advisor - Woodgate
Principal Investigator

FROM: **Lorna Guse, Chair**
Education/Nursing Research Ethics Board (ENREB)

Re: **Protocol #E2010:058**
"Addressing Rural Teens Access to Sexual and Reproductive Health Services"

Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

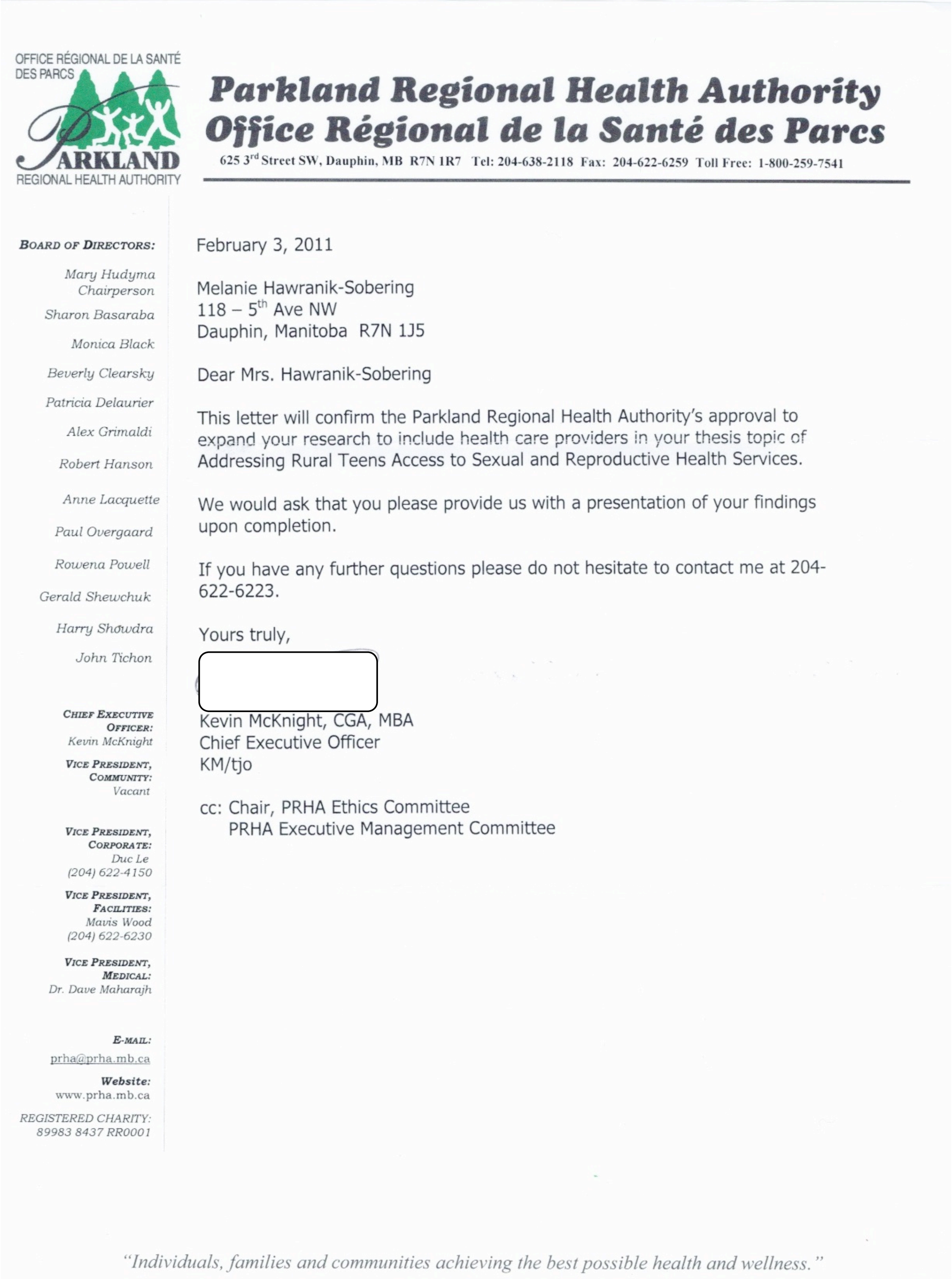
Please note:

- **if you have funds pending human ethics approval, the auditor requires that you submit a copy of this Approval Certificate to Eveline Saurette in the Office of Research Services, (e-mail eveline_saurette@umanitoba.ca, or fax 261-0325), including the Sponsor name, before your account can be opened.**
- **if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.**

The Research Ethics Board requests a final report for your study (available at: http://umanitoba.ca/research/ors/ethics/ors_ethics_human_REB_forms_guidelines.html) **in order to be in compliance with Tri-Council Guidelines.**

Bringing Research to Life

Appendix B



OFFICE RÉGIONAL DE LA SANTÉ DES PARCS
PARKLAND
REGIONAL HEALTH AUTHORITY

Parkland Regional Health Authority
Office Régional de la Santé des Parcs
625 3rd Street SW, Dauphin, MB R7N 1R7 Tel: 204-638-2118 Fax: 204-622-6259 Toll Free: 1-800-259-7541

CHIEF EXECUTIVE OFFICER:
Kevin McKnight
VICE PRESIDENT, COMMUNITY:
Vacant
VICE PRESIDENT, CORPORATE:
Duc Le
(204) 622-4150
VICE PRESIDENT, FACILITIES:
Mavis Wood
(204) 622-6230
VICE PRESIDENT, MEDICAL:
Dr. Dave Maharajh
E-MAIL:
prha@prha.mb.ca
Website:
www.prha.mb.ca
REGISTERED CHARITY:
89983 8437 RR0001

February 3, 2011

Melanie Hawranik-Sobering
118 – 5th Ave NW
Dauphin, Manitoba R7N 1J5

Dear Mrs. Hawranik-Sobering

This letter will confirm the Parkland Regional Health Authority's approval to expand your research to include health care providers in your thesis topic of Addressing Rural Teens Access to Sexual and Reproductive Health Services.

We would ask that you please provide us with a presentation of your findings upon completion.

If you have any further questions please do not hesitate to contact me at 204-622-6223.

Yours truly,

[redacted]

Kevin McKnight, CGA, MBA
Chief Executive Officer
KM/tjo

cc: Chair, PRHA Ethics Committee
PRHA Executive Management Committee

"Individuals, families and communities achieving the best possible health and wellness."

Appendix C

Letter to the Health Care Providers Inviting Participation

University of Manitoba
Faculty of Nursing

Faculty of Nursing
Helen Glass Centre for Nursing
Winnipeg, Manitoba
Canada R3T 2N2
Telephone: (204) 474-7456
Fax: (204) 474-7682

Dear Physician,

You have received this package because you are a Physician who provides sexual and reproductive health services to rural teens. I encourage you to review the information provided to you in this package: the study description and the consent form. This study is being conducted in the Parkland area, and the results will have the potential to influence how services are delivered to youth living in our community!

Participation in this study is completely voluntary and confidential. The schools, school division and RHA will not be aware of who chooses to participate, and who does not choose to participate. If you need any further information or have questions about this study, please contact me. If you decide to participate, please phone me to register and sign the consent form in this package. The consent form can be returned to me in person at the time of the focus group.

I am a Master of Nursing student, and as part of the requirement for my degree, I am conducting my thesis to understand rural teen's experiences in accessing sexual and reproductive health services, determine what types of services they would recommend, and learn what barriers health care providers feel they encounter.

I am sending this letter to all health care providers who see teens for sexual and reproductive health services in the Dauphin / Ste Rose / Roblin areas. I plan on conducting focus groups with Health Care Providers who consent to participate. The health care providers who choose to participate will be asked a variety of questions pertaining to how sexual and reproductive health services are accessed and used.

The focus group will take place at the Community Health Service Office in Dauphin. See the bottom of this letter for the date of the focus group. I will be responsible for conducting the interviews. All sessions will be recorded by audio-tape. My thesis advisor and I will be the only people to see the data.

Confidentiality is assured by the researcher. I will be the only person who will be aware of who chooses to participate in the study. All names will be replaced with code numbers. My thesis advisor, a transcriptionist and myself will be the only people to see all data. All data will be kept in a locked filing cabinet, and will be destroyed shortly after the study is completed.

Results from the study will be available to you upon request. A presentation will be conducted to the Regional Health Authority on the study findings.

If you have any further questions regarding this study, please feel free to contact me at any time. You may also contact my advisor with further questions; her contact information is listed below. If you choose to participate, please sign the consent form on the next page.

Researcher: Melanie Hawranik-Sobering RN BN
Phone number: (removed)
Email address: (removed)

Advisor: Dr. Roberta Woodgate
Phone number: (removed)
Email address: (removed)

Thank-you for your time,

Melanie Hawranik-Sobering

Appendix D

UNIVERSITY OF MANITOBA

Faculty of Nursing

Faculty of Nursing
Helen Glass Centre for Nursing
Winnipeg, Manitoba
Canada R3T 2N2
Telephone: (204) 474-7456
Fax: (204) 474-7682

Health Care Provider Consent Form

Research Study Title: Addressing Rural Teens Access to Sexual and Reproductive Health Services

Study Investigator:
Melanie Hawranik-Sobering, RN BN Nursing Graduate Student, University of Manitoba
Faculty of Nursing Supervisors:
Dr. Roberta Woodgate, Faculty of Nursing, University of Manitoba, Advisor

Dr. Lynn Scruby, Faculty of Nursing, University of Manitoba, Internal Committee Member

Dr. Anna Johnston, Medical Officer of Health, Parkland Regional Health Authority, External Committee Member

This consent form, a copy of which will be left with you for your records is only part of the process of informed consent. This form will give you an idea of what the research study is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please contact me for this information.

I, _________________________ agree to participate in the above study. I have been told that this study is being conducted as part of Melanie Hawranik-Sobering's Master's thesis. I understand that the overall purpose of this study is to understand rural teens experiences in accessing sexual and reproductive health services, determine what type of services they would recommend, and what barriers health care providers feel that these teens' face. I understand that what is learned from this study will be used by professionals who work with rural teens to improve their access to these services.

I understand that if I agree to participate in the study, I will be asked to participate in a focus group. I understand that the Master of Nursing student, Melanie Hawranik-Sobering will be doing the interviewing. I understand that I will be asked questions regarding how these services are accessed and used. The focus group will take one hour and will be tape recorded for further analysis and interpretation. During the focus group, field notes will be recorded to describe the researcher's observations, reflections and arising themes. These notes will be kept confidential except to be shared with the researcher's thesis advisor to aid in the analysis of the data.

I understand that my participation in this study is completely voluntary. I understand that even if I decide to participate, I may withdraw at any time and refrain from answering any questions without prejudice. I may also decide not to participate in the study at any point, and can also decide not to answer all the questions.

I understand that there are no direct benefits for me or my family to participating in the study. However, this study will result in knowledge that may help professionals facilitate improved access for rural teens to sexual and reproductive health services. I will receive a $5 Tim Card in appreciation of participating in this study. I understand that there are no risks to me by taking part in the study.

I understand that findings from this study may be presented at a health or educational conference or published in a professional journal. In all instances, my identity would not be discussed or revealed to anyone. Only Melanie Hawranik-Sobering, the study's researcher will have access to my name. Any personal identifiers or names will be replaced with a code number so that no one will be able to identify me. I understand that only Dr. Woodgate, Melanie Hawranik-Sobering, and a transcriptionist will have access to the focus group. The transcriptionist who will be transcribing the audio-taped data will have signed a pledge of confidentiality.

I understand that confidentiality will be maintained except in situations where it is a legal requirement to disclose identity (ie: abuse situations). If situations such as these arise, I understand that Melanie Hawranik-Sobering is obligated to report these cases to the RCMP. I understand that all data including the audio-tapes, interview transcripts, fieldnotes, and demographic information will be stored in a locked filing cabinet and computer protected by a password known only to Melanie Hawranik-Sobering. All data will be destroyed following completion of the study. A summary of the study findings will be provided to me if requested.

If at any time I wish to withdraw from the study, I will inform Melanie Hawranik-Sobering and all of my information from the focus group will be destroyed.

My signature on this form indicates that I have understood to my satisfaction the information regarding participation in the research project and agree to participate. I understand that my participation and my support of this study should be as informed as my initial consent. In no way does this waive my legal rights nor release the researchers, or involved institutions from their legal and professional responsibilities. I understand that my continued participation should be as informed as my initial consent, so I should feel free to ask for clarification of new information throughout my participation. I understand this research has been approved by the Education/Nursing Research Ethics Board at the University of Manitoba. If I have questions about the study or what is involved, I can contact Melanie Hawranik-Sobering at (phone number). If I have any concerns or complaints about this project I may contact Dr. Woodgate at (phone number) or the Human Ethics Secretariat at (phone number). A copy of this consent form has been given to me to keep for my records and reference.

To have my adolescent participate in this study, I will phone Melanie Hawranik-Sobering at (phone number) to register.

________________________ Please Detach Here

____

I agree to take part in the focus group. Yes _____ No _____

This research as been approved by the University of Manitoba (REB).

Health Care Providers Signature _______________________ Date ______________

Researcher's Signature _____________________________ Date ______________

I would like a summary report of the findings: Yes ___ No ___

Please mail a summary of the report findings to:

Name: ______________________________________
Address: ____________________________________
Postal Code: _________________________________

Appendix E

UNIVERSITY OF MANITOBA

Faculty of Nursing

Faculty of Nursing
Helen Glass Centre for Nursing
Winnipeg, Manitoba
Canada R3T 2N2
Telephone: (204) 474-7456
Fax: (204) 474-7682

Form of Confidentiality

I, ____ understand that everything discussed during this focus group is to be kept confidential, and not spoken about after this group. I agree to respect the rights, and views of the people participating in this research study. The people who are participating, will remain anonymous, therefore I will not discuss who did and who did not participate with anyone outside of this group.

____
My Signature

____
Date

Appendix F

Demographic Questionnaire for Health Care Providers

1. Position / Title: ____
2. Discipline: ____
3. Length of time worked in this region: ___________months OR ____________years
4. Length of time in current position: ___________months OR ____________years
5. Gender: _________male _________female
6. Age category:
   a. 20-29
   b. 30-39
   c. 40-49
   d. 50-59
   e. 60 or over
7. What is the highest level of education you have achieved?
   a. High school
   b. College
   c. Undergraduate degree from a university
   d. Medical degree
   e. Graduate degree (Masters, PhD, etc…)
   f. Other, please specify ______________________________
8. Do you work:
   a. Full-time
   b. Part-time
   c. Casual
   d. Other, please specify _______________________________
9. What area within this region are you responsible for?
   a. Entire region
   b. Specific domain
   c. Other, please specify _______________________________

Appendix G

Interview Guide for Health Care Providers

Introduction to the Interview

Hi everyone! I am a graduate student with the University of Manitoba, Faculty of Nursing, and for my Thesis, I would like to lean more about how rural teens access sexual and reproductive health services and how you as health care providers experience them accessing and using these services. This thesis has two phases: one, to interview teens who use these services, and two, to interview the people who provide the services, and derive recommendations and solutions to health care access from both of these results. For the purpose of this study, I am defining sexual and reproductive health services as any service someone would receive from a: Doctor, PHN, NP, or other health care person who would provide this service. I would appreciate your assistance in learning what facilitates or hinders teens' access, and what they have been using these services for.

Before we get started, let's go around the room and please say your first name, and tell me about a hobby you like to participate in… I'll start…

Note: Probes will be used as necessary to elicit further discussion.

1. Approximately how many teens do you see in your clinic or practice every week or month?
2. What type of health issues are they presenting with?
    a. How many of these are for sexual or reproductive health services?
    b. What forms of sexual and reproductive health services are being accessed? (BCP, EC, STI testing, advice, etc…)
    c. What other reasons do teens come to see you for?
3. What are the teens like who come to see you? Are they nervous?
    a. Are they concerned with confidentiality being in a small community?
    b. How do you ensure them confidentiality will be maintained?
    c. How do you put them at ease?
4. What proportion of teens present with a parent or guardian? Friend?
    a. Do these sources help them access these services?
    b. Do you find that the teens who seek you for these services confide in their parent, guardian or friend regarding what they are discussing with you?
    c. Do you interview the teen with or without the parent, guardian or friend present?
    d. How is interviewing them with and without the parent different for you? How is it different with a friend present?
5. Do you ever have to inform a parent or guardian that their teen has accessed your services? Give me an example of this.
6. What barriers, if any do you feel teens face when accessing your services?

   a. Do they need to take time away from school?
   b. How do they arrive at your clinic?
   c. How do they manage return-appointments or lab appointments?
7. Do you ever make referrals to other health care providers who may provide a similar service based on the teens' accessing needs? For example, have evening hours, less wait time, etc…
   a. How often are these referrals made?
   b. What is the main reason a referral would be made?
8. What is good (positive) about accessing sexual and reproductive health services from you? What is bad (negative) about accessing these services from you?
9. Overall, do you feel that they are sexual and reproductive health services or programs that you feel are needed but are not available?
   a. What types of services would meet there needs best?
   b. What location would work the best for this cohort?
   c. Who is the ideal provider for these services?
   d. Do you feel that an internet site or forum created by the RHA be of interest to you to answer specific questions the teen may have, etc…
10. What suggestions do you have for health care professionals about how they can best support rural teens' access to sexual and reproductive health services?

Table I
Demographic Characteristics of the Health Care Providers (n=23)

Characteristics	Number	Percent (%)
Position/title		
Medical Resident	9	39%
Physician	5	22%
PHN/CHN/NP	9	39%
Other	0	0
Discipline		
Nursing	9	39%
Medicine	14	61%
Gender		
Female	17	74%
Male	6	26%
Age category		
20-29	10	43.5%
30-39	8	35%
40-49	4	17.5%
50+	1	4%
Work Status		
Full Time	19	83%
Part Time	4	17%
Length of time worked in this Region		
1-6 months	6	26%
6-12 months	3	13%
1-5 years	8	35%
5-10 years	3	13%
10+ years	3	13%
Length of time in current position		
1-6 months	5	22%
6-12 months	3	13%
1-5 years	9	39%
5-10 years	3	13%
10+ years	3	13%
Highest education attained		
Undergraduate de.	7	30%
Medical degree	14	61%
Graduate degree	2	9%
Other	0	0
Geographic area responsible for		
Entire region	10	43.5%
Specific Domain	10	43.5%
Other	3	13%