A PROGRAM ASSESSMENT:

BARRIERS AND FACILITATORS TO THE IMPLEMENTATION OF THE TEEN TALK PEER SUPPORT TRAINING PROGRAM AND THE IMPACT OF THE PEER SUPPORT TRAINING ON PARTICIPANTS IN RURAL AND NORTHERN MANITOBA

By

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Abstract

Manitoban and specifically Aboriginal youth have higher rates of sexually transmitted infections (STI) and HIV than the general population, and various contributing factors have been documented. One response by the Manitoba Government to the growing concern of STI/HIV rates among its youth has been the funding and support of a Youth Health Education Service named Teen Talk. Over the past 12 years Teen Talk has developed two programs, the Workshops for Youth Program and the Peer Support Program, to address STI risk with youth. The Peer Support Program (PS) has developed an in-city training program that teaches youth how to support their peers on sexual and mental health related topics. Upon completion of the training, PS volunteers can join post-training outreach activities to educate their peers. Since 2006, the PS has prioritized providing service to Manitoba's rural and northern youth and this aspect of the PS had yet to be examined.

In this mixed methods research study the barriers and facilitators to implementing the program beyond the limits of the City of Winnipeg and the impact of the PS training on its participants were documented. Using grounded theory, semi-structured qualitative interviews were conducted with seven key individuals to record the barriers and facilitators to instituting the PS training and the post-training outreach component in rural and northern areas.

The results were organized into categories and diagrams were created. The barriers to the PS training were organized into the following seven categories: 1) Training Coordination Barriers, 2) Barriers to Participation, 3) Program Related Issues 4) Program Resource Limitations 5) Negative Community and Parent Reaction 6) Participant Related

Themes and, 7) Secondary Results. Facilitators to establishing the PS trainings were 1) Various Levels of Support, 2) Group Attendance, 3) Guidance Counsellor Presence and 4) an Adequate Training Facility. The benefits to the PS training were also recorded. The challenges, 1) Guidance Counsellor Challenges, 2) Youth Challenges, and 3) Limited Teen Talk Support, in creating the post-training outreach component were noted. The benefits, the positive impact of the outreach component on the school and the PS volunteers, were also documented.

Using the Theory of Planned Behaviour the impact of the training was measured with a series of questionnaires by surveying the PS training participants' knowledge, attitudes, and self-esteem relating to STI, HIV, and condoms, with a series of questionnaires. The questionnaires were analyzed using Paired T Tests and the Wilcoxon Signed Rank test. Significance was found both post intervention and in the six months follow up on the HIV/AIDS Knowledge Test. The Condom Attitude Scale and the Self-Esteem Scale however, did not show significance. Therefore, it was concluded that the PS training participants' knowledge of HIV increased but that the PS training affected neither their attitude towards condoms nor their self-esteem.

These results provided Teen Talk with valuable information to establishing a PS training beyond the City of Winnipeg. It was concluded that in order for the PS training to best meet the needs of its rural and northern participants, Teen Talk needs to become a part of larger community wide initiatives. Within Teen Talk a paradigm shift needs to occur, in order for the rural and northern training sessions to be acknowledged as their own entity rather than an extension of the in-city programming that already exists, and appropriate financial and human resources would need to be allocated.

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Chapter One

Introduction, Study Purpose and Objectives

1.0 Introduction: A Profile of STI and HIV Risk among Manitoban Youth

In Canada, it has been reported that sexually transmitted infections (STI) cases have been on the rise since 1997 (Public Health Agency of Canada (PHAC), 2006). By 2007 the number of chlamydia cases in Canada had increased to 73 770 - an overall increase of 73.6% over what was reported in 1998 (PHAC, 2007). The Province of Manitoba has one of the highest rates of chlamydia, 471 cases per 100 000, i.e., 5621 cases, more than double the national rate of 224 cases per 100 000 in 2007.

In addition, it is confirmed annually that Manitoban youth have one of the highest rates of sexually transmitted infections (PHAC, 2007). In 2002, 40% of the reported 32 869 chlamydia cases were among women aged 15-19 (Health Canada, 2002a). This rate is nine times the national rate across all age categories (Health Canada, 2002a). Similarly, 41% of the gonorrhoea cases in Manitoba were reported by females aged 15-19 in 2002 (Health Canada, 2002a). In 2007, the gonorrhoea rate for this group was four times the overall national rate (PHAC, 2007). Although HIV rates have typically been low among young women, a noteworthy trend from 1996 to 2006 was that women accounted for the majority of HIV positive test reports within the 15-19 age category - 56.4% in 2006 for example (PHAC, 2007).

Among young people in Canada, Aboriginal youth have the highest rates of STI, chlamydia and gonorrhoea specifically (PHAC, 2007). In addition while globally young

people are at greater risk of contracting HIV than the general population, Aboriginal youth, including First Nations, Inuit, and Metis people of Canada, are disproportionately vulnerable to HIV/AIDS. Among Canadian youth, Aboriginal youth are overrepresented in Canadian statistics (PHAC, 2006). In 2005, Aboriginal peoples represented three percent of the population, yet accounted for almost nine percent of all new HIV infections and accounted for seven and a half percent of persons living with HIV (PHAC, 2006). More significantly, it has been documented that generally Aboriginal people contract HIV ten years younger then non-Aboriginal people; 30 percent of Aboriginal HIV infections are among youth 20-29 years compared with 20 percent of non-Aboriginal population (Isaac-Mann cited in Flicker et al, 2008). It follows to reason that HIV rates will begin to reach epidemic proportions within these groups as HIV prevalence grows unless sexual activity decreases and/or condom use increases.

These statistics are alarming because chlamydia and gonorrhoea are often asymptomatic. This may cause them to go untreated for a more extended period of time as there are often no signs to indicate to an individual that s/he has an infection, need to get tested and cured. If left untreated both chlamydia and gonorrhoea have long term consequences causing reproductive complications such as pelvic inflammatory disease, which can lead to chronic pelvic pain, ectopic pregnancy, and infertility in women (PHAC, 2007). HIV has an asymptomatic period and a delay in HIV testing similarly results in a delay in HIV treatment and care, negatively impacting the HIV-positive individual's health.

1.0.1 Research on Youth Sexual Behaviour and Condom Usage

While some of the highest STI rates are among youth aged 14 to 19, the corresponding research of their sexual behaviour is limited. In the last 20 years four national studies have focused on the sexual health behaviour of mainstream Canadian youth: *The Canada Youth and AIDS Study* (CYAS) (King et al., 1989), *The Canadian Youth, Sexual Health and HIV/AIDS Study* (CYSHHAS) (Boyce et al., 2003), *The Canadian National Population Health Survey* (NPHS) (Boyce, 2004), and the *Sexual Knowledge, Attitudes and Behaviour of Canadian Teenagers and Mothers of Teens Survey* (The Canadian Association for Adolescent Health (CAAH), 2006).

The research confirms what youth STI rates indicate: that many youth are engaging in sexual activity and either do not use condoms or use them incorrectly. The CYSHHAS found that sexual activity increased with school grade and, in comparison with the 1989 CYAS, the student proportions engaged in sexual activity in 2003 were similar to those in 1989 (Boyce et al., 2003). According to Boyce et al., 23% of male and 19% of female 9th graders, and 40% and 46% of respective 11th graders have engaged in sexual intercourse at least once. These findings were consistent with the 2004 NPHS survey and the 2006 CAAH study which utilized the Ipsos-Reid Canadian Consumer Online Panel. In terms of condom usage, it was reported that a substantial number of youth are engaging in sexual risk-taking behaviour i.e. behaviour that includes the risk of unwanted pregnancy and STI/HIV infection (Boyce et al., 2003, CAAH, 2006). Boyce et al. (2003) found students who used condoms during their most recent sexual intercourse included 56% of male and 50% of female 9th graders, and 47% of male and 34% of female 11th graders. The CAAH (2006) however, documented that 80% of 15 year olds

and 72% of 17 year olds reported condom usage during their most recent sexual intercourse, a much greater amount than reported by Boyce et al. (2003). Regardless, it follows that an estimated 25% of youth were not using STI protection the last time they had sex which still translates into 100 000 youth having unprotected sex in Canada (CAAH, 2006). In addition, due to the discrepancy in findings and underreporting, 100 000 may actually significantly underestimate the magnitude of STI/HIV risk and the number of diagnoses among young people - young women and young Aboriginal people specifically (PHAC, 2007).

1.0.2 The Rationale for Sexual Risk-Taking Behaviour

In order to shed light on the rationale for youth's sexual risk-taking behaviour, the underlying factors are documented here. These specific underlying factors need to be understood in order for sexual health programming to address these specific issues and use an effective approach when trying to elicit behaviour change i.e. increase condom usage among youth. Regarding youth's attitudes toward using condoms, the CYSHHAS (Boyce et al., 2003) reported that 18% of male and 26% of female 9th graders, and 13% and 21% of respective 11th graders were too embarrassed to buy condoms. This study also reported that 30% of male and 22% of female 9th graders, and 32% and 23% of respective 11th graders would not request for their partner to use a condom. These statistics demonstrate that negative attitudes towards condom use are prevalent barriers to condom use, and must be taken into consideration by any health program if lower STI rates are to be achieved.

In the study by Boyce et al., youth were asked why a condom was not worn at last intercourse. Use of an alternative method of birth control was documented as the primary

reason provided by 22% of male and 18% of female 9th graders and 36% and 38% of respective 11th graders (Boyce et al., 2003). These responses, also documented by Shaw (2003) and PHAC (2008), illustrate that pregnancy prevention is more of a concern with youth than STI/HIV prevention. Therefore, youth's knowledge and awareness of STI should be assessed and STI risk-taking behaviour addressed in programming.

1.1 Addressing STI Risk among Manitoban Youth using a Peer Education Approach

In most established Manitoban peer education programs, addressing the issue of STI among youth is not a common mandate. While in the urban centers such as Regina, Toronto and Vancouver these types of programs exist, many have not been researched. A process evaluation of The Youth Educating About Health (YEAH) program in Regina was published in the *Canadian Journal of Human Sexuality.* Its goal was youth-driven education and awareness of sexual health. The goal of the education was to raise peer awareness of the risks involved in having sex and the risks involved in combining substance use and sex (Hampton et al, 2005). Rural and northern Manitoban regions in particular have no such education available to their youth. Teen Talk (see www.teen-talk.ca for more details), a youth health education service located in Winnipeg, Manitoba, developed a Peer Support Program as a secondary component to its Workshops for Youth Program in 1998. This program is described in more detail in section 3.1.

Since 2006, Teen Talk had expanded its peer support training component to reach more youth in rural and northern regions of the province. The goal of the peer support training was for its participants, the youth, to become formally trained volunteers. These volunteers would encourage positive sexual health behaviour amongst their peers through

the post PS training outreach component. It is theorized that this peer education and support will ultimately have a positive impact the STI rates among youth.

1.2 Study Purpose and Objectives

This research project has two objectives, as follows:

1) To explore, then describe, the barriers and facilitators found in the process of implementing the PS training and in developing the post PS training outreach component of the program in northern and rural regions.

2) To assess the impact of the PS training on PS training participants' knowledge of, attitude toward, and self-esteem relating to STI, HIV, and condom usage.

This study both qualitatively and quantitatively examines issues surrounding the northern and rural PS training and the resulting impact on participants. Interviews were conducted with youth, guidance counsellors and school administrators in order to understand thoroughly the unique dynamics of implementing PS training in northern and rural regions. The intention was to shed light on issues that arise from establishing this type of training in this non-urban context. A series of questionnaires was completed by the youth who were taking part in the training (the PS training participants) to assess the impact of the training on their knowledge of, attitude toward and self-esteem relating to STI, HIV, and condom usage.

Chapter Two

Background and Literature Review

This section provides an overview of the topics beyond youth STI rates that influenced the development of Teen Talk. These topics are: the government's role in sex education, gaps in sex education in schools, a critique of health education programming, and peer education.

Peer education is only touched upon because the current research focuses mainly on the establishment of a peer training session - the first step in the development of a peer education program - and whether the training has a positive impact on the participants.

2.0 Government Role in Sex Education

In Canada, health education is under the jurisdiction of the provincial government. There are no national guidelines that mandate the teaching of sexuality in schools. There are, however, voluntary guidelines: the *Canadian Guidelines for Sexual Health Education,* (PHAC, 2008). The impact of these guidelines put forth by PHAC has not yet been formally evaluated; nevertheless, Canada's national report on Teenage Sexual and Reproductive Behaviour has cited substantial evidence of the benefits for developing and improving sex education programs for adolescents (Maticka-Tyndale et al., 2001).

At a provincial level, once youth reach high school there are gaps in the school curriculum as there is no mandatory sex education after grade 10. This omission in the curriculum has serious consequences because youth are not receiving preventative information at the age when it is most relevant and critical for the majority of youth. The

"Safer Choices" intervention has demonstrated that safer sex education and practices has had a greater impact on those who are currently or were engaging in sexual risk-taking behaviour during the intervention (Kirby et al., 2004). This would imply that the majority of youth would benefit greatly from sex education in the latter high school years when they are most sexually active. The gaps in STI knowledge and the sexual risk taking behaviours of many teens partially explain the prevalence of STI in Canadian youth. Although there is no direct link between safer sex - sex using a 'barrier method,' like a condom or a dental dam - and accurate sexual health knowledge, efforts should be made to improve sexual health knowledge in Canadian youth (CAAH, 2006). The CAAH also stated that governments through their health or education departments and public health authorities "have an important role to play in order to make sexual health information accessible, diverse, and repeated and overall adapted to the reality of adolescents."

2.1 Gaps in Sex Education in Canadian Schools

An overview of sex education programs in Canadian schools indicated that the majority of youth have access to some form of sexuality education particularly during grades 7 to 9 through school-based programs (Maticka-Tyndale et al., 2001). In 2004, four in five youth reported getting sexual education in school (CAAH, 2006). However, in the CAAH (2006) study, only one in four youth reportedly thought the sex education provided was very useful; less than one third reported no perceived gaps in their sexual health education (CAAH, 2006). Sixty-nine percent of teens reported perceived gaps which most often fell into two categories: 1) dating violence, including physical and psychological violence between partners as well as date rape; 2) emotional aspects of sexuality and of communication between partners and between teens and their parents.

This included "how to know if I am ready," and "how to talk with my parents and my partner about sex, love, emotions." When asked in the CAAH study what were obstacles in obtaining answers to questions about sex and sexual health, 38% of youth reported no obstacles, 31% were reportedly uncomfortable talking about or learning about sexual health information, 20% feared their parents would find out, and 14% claimed it was difficult to find sexual health information that matched their values (CAAH, 2006). According to student respondents in a Nova Scotia study (Langille, 2000), their school sexual health education component was less than "ideal." Langille (2000) documented that these students found the curriculum 1) repetitive 2) not relevant to them and 3) not presented in a comfortable manner by teachers. These responses indicate that despite reporting gaps by their main source for sex and birth control information (CAAH, 2006; King et al., 1988), a large proportion of youth were sexually active without being informed or comfortable.

2.3 A Critique of Health Education Programming

In the past few decades, while health education programs have grown in popularity, their assumptions have come under scrutiny and have been heavily critiqued. Early research in the 1960's in family planning emphasized primarily knowledge and attitudes as the key determinants of an individual's behaviour (Hermalin et al., 1985). This emphasis resulted in the primary objective for health education initiatives being knowledge transmission. The assumption then made by health education initiatives was that imparting information from one person to another is a positive notion because it enabled individuals to make healthy choices by changing their corresponding behaviour. When working in the field with youth, the goal is to pass on as much information as

possible, in order to enable them to make the most informed decisions they can for themselves. This corresponds with the belief that acquiring knowledge is inherently good, i.e., it makes individuals smarter, gives them more choices, and results in them being better able to take care of their sexual health. Many health care professionals work to deliver sexual health information that they wholeheartedly believe will empower youth, prevent disease and promote health, never questioning the validity of its assumptions.

What if health education does not empower youth and enable them to make better choices? Can it prevent disease or promote sexually-healthy behavioural changes? Furthermore, does increased knowledge lead to behavioural changes and improved health? What contributes to our health status, disease and illness beyond our behaviour? The area of study known as the field of Critical Public Health challenges these assumptions. It involves examining that which the health educator believes as being 'good', 'right', and 'proper' and seeing it as part of the issue and not the solution (Gastaldo, 1997).

Critical public health emphasises the impact of structural barriers and resources. It contends that without recognizing and integrating information surrounding these barriers, victim blaming occurs, i.e., blaming the recipient of the intervention. Tones (1990) wrote that even attempts to empower individuals and remove some of the barriers to choice are to be condemned as victim blaming due to their focus on the individual. Incidentally, Tones (1990) also commented on the fact that in effort to change the social structure, some health professionals neglect an individual's freedom of choice through making the healthy choice the easy choice or, more accurately, the only choice.

In the early 1990's, as a result of economic recession in Western countries, the policy focus in health shifted from curative medicine to prevention. The focus of prevention education was individual behaviours, counter to the notions of critical public health laid out in the previous paragraph. In his article, "Economic Rationalism, Healthism, and School Health Education," Colquhoun (1990) suggested that school health education was affected by fiscal restraints. The individualistic notion of health education, i.e., that we are each responsible for our own health, was strengthened in school programs (Colquhoun, 1990). The underlying message was that if individuals adhere to prescribed health habits such as consistent condom use to prevent unplanned pregnancy and STI, the result would be a substantial financial gain for society. This was evident in any message from health educators regarding the economic burden of infections and ill health that indicated the dollars saved by government if regimes were followed. This led to excessive pressure on a person to adopt these healthy habits or be portrayed as a failure, morally and socially (Coluqhoun, 1990; Nettleton in Petersen and Bunton, 1997; Petersen and Lupton, 1996).

The fixation with individually-determined 'health' has led to the coining of a term called 'healthism'. Healthism is "the preoccupation with personal health as a primary focus for the definition and achievement of well-being – a goal which is to be attained primarily through the modification of lifestyles" (Crawford cited in Tones 1990, p. 5). It is in direct contrast to goals emphasising empowerment because it prescribes "the right choice." It places doctors "above the rest of society" for it is they who determine what 'is best' and what is required to be healthy (Fox, 1994; Petersen and Lupton, 1996). Furthermore, fundamental determinants of health such as poverty, a polluted

environment, or societal discrimination are not associated with this notion of health. The effect healthism had on health education was substantial. Healthism had become a 'natural' and 'given' belief that individuals should take responsibility for their own health (Colquhoun, 1990; Petersen & Lupton, 1996; Tones, 1990).

It is the belief of some health providers that health education must be political and radical in order to make a difference and challenge this stronghold that healthism has over society. Tones (1990) stressed the need in radical health education programs for emphasis to be placed on raising critical consciousness in order to challenge the socio-political system that is associated with inequalities and ill health. Colquhoun (1990) agreed that traditional health education models reinforce healthism, legitimizing the medical model that places itself at the pinnacle of health. He has coined the term 'emancipatory health education,' which focuses on overcoming structural barriers to an individual's health and therefore includes not only behavioural factors but also social, economic, environmental, and political factors which place heath education in the political arena. Within the school system, Colquhoun (1990), like Tones (1990), believed this involved discussing the neglected areas of health, challenging the dominant ideology and encouraging social change. The distinction made by Gastaldo (in Petersen and Bunton, 1997) was that 'radical health education' programs focus on empowering individuals to control their own health and 'traditional health education' programs focus on the individual's responsibility for health and disease.

Health education may enable youth to make better choices in the sense that it will enable them to make the choices they want to make. This may or may not make them healthier, however health is about much more than behaviour and addressing that point is

essential. This new form of education may instil in youth the beginnings of the critical skills required to challenge health 'propaganda' which people are subjected to daily.

2.4 Peer Education

Peer education is a process whereby individuals who are motivated and well-trained to undertake informal or formal educational activities with those similar to him/her in age, interest, experience, status or social and cultural background (Strange et al., 2002). The assumption is that youth have a strong influence on each other particularly with taboo subjects. In fact it was documented that by the time they reached grade 11, 38% of Canadian adolescents cited friends as their main source of information for sex, and 30% cited friends as their primary source of information for birth control (King et al., 1988). This heavy reliance by youth on friends and school for sexual health information is the rationale behind the development of peer education: since youth talk to youth, they can inform and support their peers using their peer influence positively.

The intention of peer education programs is to reinforce positive behaviours, to develop new recommended behaviours, or to change risky behaviours within a specific group using peer influence. Numerous theories have been cited as applicable to peer education. Two theories that were most often cited as a theoretical grounding for peer education are Bandura's social learning theory and the information, motivation, behavioural skills, and resources model both of which are foundations to the Teen Talk program and elaborated on in chapter three. As noted by Turner and Shepherd, (1999) peer education literature seldom made references to theories in their rationale. They concluded that there is little empirical evidence in health promotion practice to support these theories.

Numerous claims are nonetheless often made for the use of peer education (Turner and Shepherd, 1999). Turner and Shepherd (1999), in their extensive review of peer education literature, documented the ten most frequently cited rationale for adopting peer education. They were:

1. It is more cost-effective that other methods.
2. Peers are credible sources of information.
3. Peer education is empowering for those involved.
4. It utilizes a previously-established means of sharing information and guidance.
5. Youth are seen as more successful than professionals in passing on information because they identify with their peers.
6. Peer educators act as positive role models.
7. Peer education is beneficial to those involved in providing it.
8. Peer presented education may be acceptable when other education is not.
9. Peer education can be used to educate those who are hard to reach though conventional methods.
10. Peers can reinforce learning through ongoing contact (see Turner & Shepard, 1999 for more details).

Many of these claims have been validated however, inconsistently, and it is yet to be determined if the issue is with the claim or the peer project it studied.

Lindsey (1997) critiqued three assumptions made in peer education: Did peer education really expand outreach? Was it cheaper? Was it more effective than adult-led education? Lindsey (1997) found that peer educators could only reach more individuals because staff and facilitators spent the majority of their time recruiting, training, and organizing their peers. She demonstrated that if that same amount of staff time were spent on outreach, the paid staff would reach more youth and as a result be more cost effective. She also questioned the legitimacy of replacing paid professional staff members with peer educators. The attractiveness of the relatively low cost of peer educators to paid adults and professionally-trained staff cannot be ignored as it could be an underlying factor for

how information is disseminated (Ebreo et al., 2002; Fennell, 2003; Lindsey, 1997). Thirdly, she challenged the notion that peers were perceived to be the only credible sources of health information among youth. Lindsey documented a number of studies which show that youth mentioned that medical service providers, professional health educators and medical media sources were preferred sources of health information, as opposed to their peers (1997). In sum, it is important when presented with the rationale for a peer program to critically examine if it in fact does support its underlying claims.

2.4.1 Peer Education a Tool in Health Education and Health Promotion

In the 1980's peer education was used in health programs aiming to reduce smoking in youth. This was followed by peer programming focused on youth substance use. Since the 1990's peer education has been used in STI/HIV prevention and sexual health promotion. Peer education has gained such global popularity in STI/HIV prevention programs that in countries like the UK, the government has recommended a peer-led approach to delivering sex education in schools (Strange et al, 2002). Concurrently, the United Nations Populations Fund (UNFPA) and the Family Health Institute (FHI)/YouthNet developed the Youth Peer Education Network (Y-PEER Program). Since then Y-PEER has worked with country partners to build their capacity to implement, supervise, monitor, and evaluate HIV prevention and sexual health peer education programs. It is a network of over 200 organizations and institutions and has been launched in 27 countries of Eastern Europe and Central Asia. They advocate for dissemination of information and knowledge of adolescent sexual and reproductive health and shared lessons learned across borders and among cultures. Most applicable for this

research they have developed standards for peer education programs, a performance improvement tool and published a Youth Peer Education Toolkit.

Some key components documented by Puentes et al. (2003), as essential to the success of peer health education activities included the following:

1. Peer educators active involvement the design, and delivery of the program.
2. Adult allies active involvement in providing support and resources to the peer educators.
3. Curriculum designed to respond to multiple biopsychosocial factors that contribute to health risk behaviours.
4. A commitment of resources required to sustain the effort.

In response to the range of quality of peer health education programs, and the request for standards in peer education, FHI and Youth/Net hosted a 3 day conference with 45 participants from 22 countries. They developed the minimal standards for peer education programs under the following headings 1) planning, 2) recruitment and retention, 3) training and supervision, 4) management and oversight and, 5) monitoring and evaluation (for more details see the Youth Peer Education Toolkit).

2.4.1.1 Using the Peer Approach to Sex Education with Aboriginal Youth

The notion that utilizing the peer approach is found to be an effective method of educating Aboriginal youth on sexual health topics is significant. Research has shown that mainstream sex education and the pan-Aboriginal approach have been unsuccessful (Ricci et al. 2009). Ricci et al. (2009) documented that in the field of HIV prevention education using peer educators as part of an intervention strategy can have both positive impacts on the peer educators and the youth they are targeting. This could build capacity and increase the chances of initiatives being sustained (Prentice, 2004). The Ontario Federation of Indian Friendship Centers (OFIFC) (2002) study, *Tenuous Connections:*

Urban Aboriginal Youth Sexual Health & Pregnancy, also found that peer based education was mentioned as potentially being 'extremely' beneficial to prevent teen pregnancy by 35% of the interviewees.

Chapter Three

Program Background and Theoretical Models

This section provides a comprehensive overview of the Teen Talk Program, its Peer Support Program specifically, and the theoretical models utilized by Teen Talk and this study.

3.0 A Provincial Response to STI Rates in Manitoban Youth

In 1996 the Manitoba government recognized that adolescent STI and pregnancy rates were among the highest in the country (Health Canada, 2002a); It was also recognized that Manitoban youth often face barriers in trying to access information about sexual, and mental health, and abuse in relationships. That year a needs assessment called *Dialogue with Youth* (Davis & Wright, 1996) was granted government funding. It surveyed 354 youth across Manitoba and set up focus groups through school and youth service organizations. The following is a summary of the main findings:

1) identified issues – distrust of guidance counsellors, distrust of service providers, and fears of violence and gangs;
2) identified needs – healthy sexuality, communication skills, and peer education;
3) potential strengths – other youth, **peer education**, teen theatre, schools, and drop-in centers.

Peer education was highlighted in 3) above because youth stated they were:

1) more comfortable with their peers,
2) more apt to listen to peers,
3) more trusting of their peers,
4) able to respond better to their peers.

Davis & Wright (1996) also determined that youth were four times more likely to speak to a peer in regards to relationships, sexual decision making, drug abuse, suicidal thoughts and body weight.

These documented findings relating to peer education are comparable to those documented by Posavac et al., (1999) and Stephenson et al., (2004). They form the rationale that has lead to the popularity and increasing role of peer education in the delivery of a variety of health topics to other youth (Ebreo et al., 2002). They also replicated the findings of Lindsey (1997), specifically the beliefs that: youth rely on peers for information; peer education volunteers act as role models; and peer education volunteers have the opportunity to experience personal growth and career development (Ebreo et al., 2002).

3.1 A Youth Health Education Program: Teen Talk

The result of the *Dialogue with Youth* needs assessment findings has been a health education service called The Teen Talk Project. It has been developed as a Youth Services Canada Project in Winnipeg led by Kristine Barr, Trina Larsen, and Pam Zorn. It became a program at Klinic Community Health Center in 1996. Like many pilot programs, long term funding has been an issue and took several years to be secured.

3.1.1 Teen Talk's Vision, Mission and Goals

Teen Talk's vision has been "an equal and diverse society, where youth are empowered to make informed decisions about their health and well-being." Its mission statement has been "to promote the health and well-being of Manitoba youth by sharing accurate, non-judgmental information in an interactive, youth-friendly manner" (Buehlmann, 2005). Its goals have been: "1) to provide youth with comprehensive, non-judgmental information on options and resources available, 2) to provide this education in an interactive, accessible and youth-friendly manner, 3) to work with youth and at-risk

youth, and to network with youth and service providers to ensure that their needs are being met" (Buehlmann, 2005).

The ultimate desired impacts of the Teen Talk Program are listed as follows: 1) To help youth understand the consequences of their actions regarding their sexual and mental health and overall well being, 2) To encourage youth to empower themselves through the promotion of self-esteem and communication skills, 3) To enhance decision-making skills regarding their sexual and mental health, and 4) To reduce Manitoba's unplanned pregnancy and STI rates. Teen Talk has adhered to the following operating principles:

- harm reduction,
- sex positive,
- youth oriented,
- empowerment,
- pro-choice,
- feminist perspective,
- addressing oppression,
- capacity-building, and
- Lesbian Gay Bisexual Transgender Two-Spirited Queer** positive (See Appendix A for more details in the provided Teen Talk program document.)

Teen Talk had utilized a comprehensive community-based approach to sexual education. Comprehensive was demonstrated by Teen Talk offering more sexual health information such as, "how to negotiate condom use," going beyond the anatomy and the biology of sex. Community-based was demonstrated by Teen Talk linking youth to local, youth-friendly resources and information.

3.1.2 Teen Talk's Connection with the Canadian Guidelines for Sexual Health Education

Concerning sexual health education, Teen Talk has adhered to the Public Health Agency of Canada's philosophy, guidelines and models that have given rise to effective sexual health education (PHAC, 2008). Its philosophy has placed an emphasis on positive sexual health and healthy sexuality by providing information that is age-appropriate, and respectful of individual choices.

3.1.3 Teen Talk's Strategies for Working with Youth

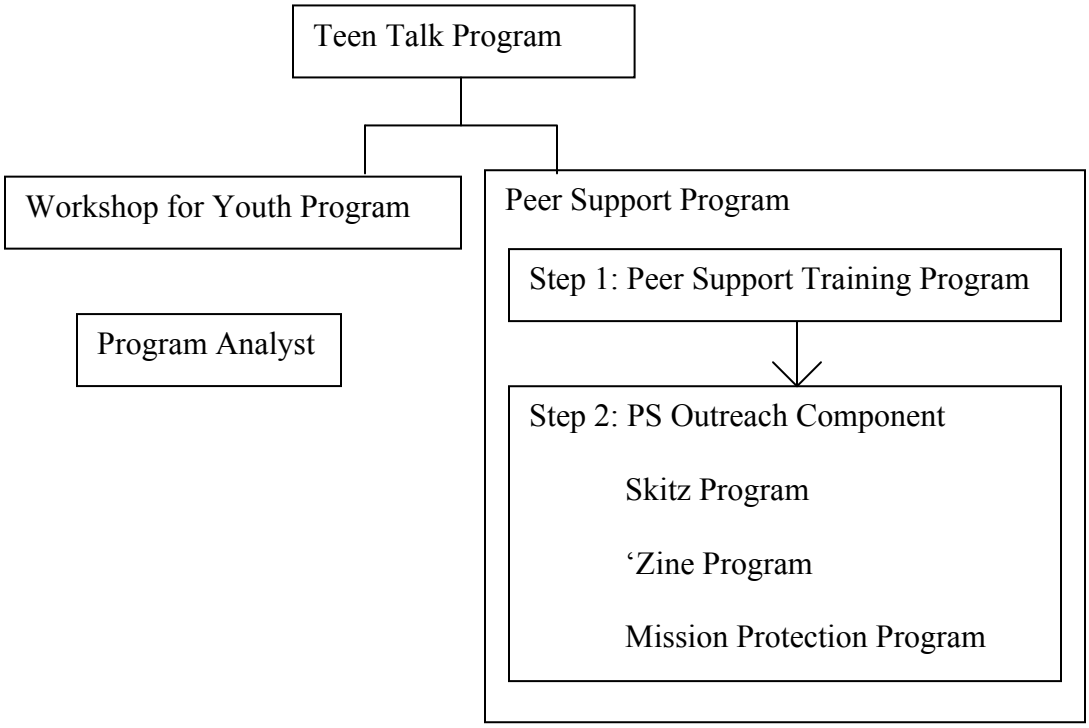
Teen Talk has utilized several key strategies and learning approaches to interact with youth. Its key strategies have required specific skills and techniques of its facilitators. They have been required 1) to be youth oriented in attitude, language, and awareness, 2) to be comfortable with the topic, 3) to be humorous, 4) to be flexible to the needs of the group, and 5) to provide relevant information. Teen Talk has also established ground rules and professional relationships with youth to gain their respect. In order to engage youth, Teen Talk has utilized various learning approaches such as 1) interactive classroom discussions, 2) visual and hands on demonstrations, 3) games and activities, 4) presentations by dynamic speakers, and 5) humour to capture and maintain the attention of youth. The Teen Talk Program has adhered to DiCensto et al.'s, (2001) documented recommendations deemed necessary for effective delivery of adolescent sexual education. Research and Teen Talk experience have demonstrated that these strategies and approaches were seen by youth as integral for delivering youth sexual health education (DiCensto et al., 2001; Maticka-Tyndale, 2001).

3.1.4 Programs of Teen Talk: Workshops for Youth and Peer Support

Since 1996, Teen Talk has developed two program areas: the Workshops for Youth Program (WFY) and the Peer Support Program (PS). The WFY was developed first, followed two years later by the PS. Teen Talk has had three PS outreach programs to offer youth once they have completed the training as is shown in Figure 1 below.

Figure 1

Teen Talk Program Components



The Teen Talk Program has consisted of 11 facilitators called Youth Health Educators, (YHE) three of whom have also been called Peer Support Program Facilitators. The YHE have been developing, delivering and adapting 11 interactive workshops and training modules for youth aged 14-19.

3.1.4.1 Workshops for Youth Program (WFY)

The foundation of the WFY originated from the Canadian Federation for Sexual Health's book titled *Beyond the Basics: A Sourcebook on Sexual and Reproductive Health Education* (2001). See Appendix B for the provided Teen Talk resource document describing workshops. All workshops have been tied to sexual health and certain program activities focused on the following eight factors relating to sexual risk-taking behaviour: 1) knowledge and myths about STI and HIV, 2) youths' self-efficacy to refuse sex or unprotected sex, 3) attitudes about sexual behaviour and condom use, 4) perceived barriers of condom use, 5) perceived peer norms regarding sexual behaviour and condom use, 6) perceived risk of becoming infected with STI/HIV, 7) personal negotiation skills regarding condom use, 8) protection against pregnancy and STI, and condom use. At the request of educators, teachers, guidance counsellors, and program staff, three teams of YHE have been working in pairs in order to facilitate these interactive workshops for youth throughout Manitoba. The workshops that have been developed pertain to issues requested by youth such as substance use, abusive relationships, mental health, and sexual health. While the majority of the workshops are presented in schools, they have also been delivered at youth drop-in centers, after school programs, and other alternative programs.

3.1.4.2 Peer Support Program (PS)

In 1998, due to Manitoba's high teen pregnancy rates and a request from youth to gain more knowledge to support each other, the Teen Talk PS was created. The PS has developed a volunteer opportunity for youth composed of a 25-40 hour facilitated training program that educates youth aged 14-19. The PS grew out of the WFY; this

program has adapted the material from the WFY curriculum by providing more in-depth curriculum and adding additional information on suicide awareness. The intention has been for the PS training participants to become aware of the youth-friendly resources available. The training sessions have taken place in a variety of settings and locations such as in-house at the Teen Talk's site at Klinic on Broadway, camps, drop-in centers or schools. The training sessions have been tailored to meet the needs of the particular group. The topics have been facilitated by two Teen Talk YHE and group discussion has been encouraged. A user's manual has been provided and the interwoven theme throughout the training has been 'supporting their peers.' In addition, activities to enhance team building and group interaction have been included.

Upon completion of the training, the now officially titled PS volunteers have been prepared and encouraged to act as a link between their peers and community resources. For example, if a youth talks to a PS volunteer about needing a pregnancy test, the volunteer has been trained to listen non-judgmentally and direct her/him to the closest youth-friendly clinic. In Winnipeg, the PS volunteers have been supported in their post-training outreach activities by the Teen Talk PS facilitators if they continue their involvement in the program beyond the training. Some PS volunteers have initiated activities in their schools such as resource lockers, anonymous question pages, skit presentations, and other educational events (see www.teen-talk.ca for more details). Furthermore, they have had the opportunity to join one of the three programs in the PS outreach component: Skitz, 'Zine, and Mission Protection.

The Skitz program has created and delivered a type of forum theatre to youth in junior high schools. The Skitz program has had ten PS volunteers involved in the

program partaking in its weekly meetings and biweekly presentations. The most common Skitz topics have been drinking and sexual decision-making, violence in relationships and cyber-bullying. Key themes of other related issues such as STI and body image have been interwoven into the skits. Over the past six years this program has become very popular and has been booked for the entire school year by the end of September (see www.teen-talk.ca for more details).

The 'Zine and Mission Protection programs have been created with ad hoc groups when there has been a demand for their product or service, respectively. The 'Zine program has created youth friendly 'magazines' on the topics of mental health, relationships, birth control and STI. The 'Zines have been distributed to high schools that Teen Talk has visited throughout Manitoba. The third outreach program called the Mission Protection program has been educating youth on the myths and facts surrounding condoms. This has been done in an interactive format known as the condom obstacle course; an activity where youth gain hands on experience getting comfortable with condoms. In the past the PS volunteers in the Mission Protection program have facilitated to groups of youth in a variety of settings on a monthly basis.

3.1.5 Program Evaluation: Teen Talk

Pertaining to program evaluation, five categories of Teen Talk evaluations have been conducted by the Teen Talk Program Analyst: 1) the workshops for youth feedback forms, 2) the peer support training final evaluations, 3) the post-training monthly collection sheets, 4) the Skitz feedback forms and 5) a report on the impact of the PS on volunteers. Below each of the aforementioned are discussed.

3.1.5.1 Program Evaluation: Workshops for Youth

In order to evaluate the WFY, statistics have been collected to document how many youth attended workshops, how youth rated the workshops and which workshops were requested most frequently. Over 12 517 youth attended a workshop in 2001-2002 and over 15 680 youth attended workshops in the 2002-2003 school year (Shaw, 2004). Following each workshop, students have been asked to fill out a half page anonymous feedback sheet. In the past the form asked youth 1) to rate the workshop, 2) if it would change their behaviour, 3) what the behaviour change would be, 4) what if any questions they may have and 4) what if any comments they may have (Barr et al., 1999; Shaw, 2004). Overall, these evaluations have found that over 80% of the students rated workshops from 1999-2003 as good or excellent (Shaw, 2004). In 2006, the feedback form was changed although the youth have still been asked to rate the overall workshop and whether they had any questions or comments. They have also been asked what they would add or change about the workshop in addition to how they would rate the information and the presenters.

3.1.5.2 Program Evaluation: Peer Support Trainings

Another type of evaluation occurred in 2004 when the PS training participants were surveyed pre- and post-training on their attitudes and knowledge of the PS training information. The former Teen Talk Program Analyst, Souradet Shaw, developed evaluation measures known as the Youth Behavioural/Attitudinal Survey (YBAS) and the Knowledge Test. He found that following the training, youth were more knowledgeable, with a 35% increase on the topic of sexuality (Shaw, 2004). Furthermore, post training, these youth stated they were more likely to use contraceptives and less likely to believe

the myths surrounding STI (Shaw, 2004). Some of the qualitative responses to the training program documented by Shaw (2004), were:

> "I feel I can answer my friends questions better because I'm more educated. I like knowing all this stuff and not feeling helpless." Peer Supporter
>
> "I got so much out of this-great info, ideas, friends, contacts, feeling of security...I wish it were longer!" 16 year old Peer Supporter
>
> "I think these trainings are so important for today's youth. It is so important for teens today to be aware of all these things and to be informed. I really think there should be even more trainings around the province so as many people as possible will be able to do the training!" Peer Supporter, Grade 9

3.1.5.3 Program Evaluation: PS Outreach Component

The PS volunteer monthly statistics form was developed in order for the PS volunteers to document their formal or informal outreach activities in schools and communities (see Appendix C for form). Statistics have been collected monthly on the number of hours the PS volunteers have been engaged in Teen Talk related activities. The number of youth involved, the number of youth reached and the hours youth spent working on the formal activities such as a Skitz presentation have been kept track of by the Teen Talk staff. The concern however, has been with the underreporting of the informal activities. The informal activities have included tasks such as supporting a peer in crisis, handing out condoms or doing an informal condom demonstration. An average of 8-20 PS volunteers have filled out the form regularly, even though the program has had triple the number of volunteers. It has been difficult to gather accurate statistics with such low reporting. The problem has been that the responsibility lies with each individual volunteer who is required to track his/her own activities and hours on the form and return it to Teen Talk

The Skitz program has utilized feedback forms to evaluate its program and its group. After each presentation, PS volunteers have been handing out forms to the junior high students that are comparable to the feedback form the WFY had been using. The junior high youth has provided the PS volunteers with valuable feedback on their performance. From 1999-2003, the Skitz youth have received an overall rating of good/excellent by 82% of the participants.

3.1.5.4 Program Evaluation: Peer Support Impact on Volunteers

To study the long term impact that the PS has had on its volunteers, interviews were conducted in 2005. Shaw (2005) found that the program 1) was viewed positively by the volunteers, 2) exposed them to different viewpoints and advocacy issues, and 3) helped them develop their inherent 'helping' and 'supporting' qualities. It also found that having a supportive home and a steady rapport with a PS facilitator were common features of youth who were very involved in the PS Outreach Component (Shaw, 2005). These findings, the role family support and the rapport with the PS facilitator play in how involved a youth is, were comparable with other documented research in the field of peer education (Song et al., 2000; Strange et al., 2002).

3.1.6 Program Limitations: Peer Support

The Teen Talk PS has recognized its numerous challenges and limitations, as described below.

3.1.6.1 Profile of Participants

A significant limitation of the PS program has been the homogenous demographic of the participants: the majority of PS volunteers identify as Caucasian and female. This

was also a concern expressed by past PS volunteers themselves as documented by Shaw (2005). Strange et al. (2002) and Phelps et al.'s research (1994) found similar profiles of peer educators. This homogeneity has challenged the emphasis placed on the importance of similarity between peer educators and their peers for peer education. This lack of gender and ethnic diversity has created social distance that may be seen as limiting the program's ability to reach a broad spectrum of youth through the outreach program (Reeder et al., 1997). However, other research has demonstrated that 'perceived demographic similarity' is less important than 'positive regard' for peer educators (Ozer et al., 1997). Greater positive regard was reported by Ozer et al. (1997) for highly individuated and less shy peer educators that were then linked with lower HIV/AIDS risk. Therefore, an individual's personality was seen as more important than their appearance, ethnicity, and gender. Another limitation identified was that peer programs often attract youth who have been economically privileged, academically strong and engaged in numerous extracurricular activities (Stephenson et al., 2004; Strange et al., 2002). This raises the concern of whether peer education has been reaching all youth, especially those in the most need. The increased sexual knowledge and skills gained by PS volunteers may not be benefiting those who are educationally disadvantaged. Consideration needs to be given to reach and recruit those abovementioned youth in order to provide them with an equal opportunity to join the program. Moreover, it should be recognized that youth who are educationally disadvantaged have been at greater risk of negative sexual health outcomes and should be targeted when recruiting (Ozer et al., 1997).

3.1.6.2 Recruitment and Promotion Challenges

PS recruiting and program promotion have been a challenge. A considerable amount of time and energy has been allocated by the Teen Talk staff for recruitment. In the past it appeared that youth who joined the PS program either heard about it from their friends or a teacher/guidance counsellor, even though the YHE promoted it in schools verbally and by distributing posters and pamphlets. It appeared to Teen Talk staff that in order for youth to decide to partake in the program it required the endorsement of someone they know.

3.1.6.3 Terminology

The language of the Teen Talk curriculum has been fairly complex. In PS training there are three hours allocated to each topic, so the facilitators have been able to explain concepts in more detail than during the workshops where each session has been an hour. However, language level and terminology have been issues that Teen Talk acknowledges and have been a barrier that the program works on conscientiously and continuously. Because youth are all at different stages of development, for some, the information has been beyond their level of development; some youth are still very concrete thinkers and have yet to comprehend that social issues have many facets to consider and there often is not a clear cut answer. Finding a balance to educate the varying degrees of understanding has been expressed as a challenge by the Teen Talk staff. They also recognize that social change is a process and some youth are farther along the continuum than others. Some youth are indifferent to the topic or find it irrelevant and this makes it difficult to educate an entire class. Because Teen Talk challenges some of the values held by mass media and

mainstream society, it often has to make a strong argument to get its message across. For some youth, Teen Talk has been introducing an entirely new way of looking at mental, sexual, and social issues. As a result, it has left little room to recognize and acknowledge all the layers that exist in most life situations. For example, when discussing pro-choice and a woman's right to choose in a pregnancy options session, there has been not enough time and comprehension, in some cases, to discuss the situations that complicate a woman's right choice to continue a pregnancy such as living in poverty, having no support or being abused by their partner. A woman may strongly want to parent but decides to have an abortion because her situation would make it impossible for her to continue with the pregnancy.

3.1.6.4 Post Training Connection

An issue specific to the PS program has been the ability of the PS staff to support their youth in the post training outreach initiatives. There has been simply not enough capacity with only three PS facilitators and over 60 youth. The PS program has experienced drop off; some have chosen not to participate in the outreach activities and end their involvement with Teen Talk once they have completed the training. Many youth however, have remained involved and connected to the program, even though the PS staff has not had enough time to fully support them in their initiatives at school. Most of the PS volunteers have been involved in many activities outside of the PS program. Likewise, it has been difficult when youth want to take part but have overloaded themselves with too many activities. For some youth the PS staff's support has been very much needed in order for the youth to be able to feel confident enough to develop initiatives in his/her school.

3.2 Theoretical Models of Teen Talk

Teen Talk relies on theoretical frameworks that are endorsed by *The Canadian Guidelines for Sexual Health Education* (2008). These models are evidence based, well tested and empirically supported and thus PHAC encourages program planners and policy planners to use these models as a foundation for sound sexual health program development. The Information, Motivation, and Behavioural Skills Model, and the Social Cognitive Theory are utilized by Teen Talk and many other sexual health promotion interventions. Each is discussed below.

3.2.1 Information, Motivation, and Behavioural Skills (IMB) Model

A theoretical model utilized by Teen Talk is the Information, Motivation, and Behavioural Skills Model (IMB) (PHAC, 2008). According to PHAC, this model is empirically supported by research, demonstrating its efficacy as the framework for behaviourally effective sexual health promotion interventions. The IMB chart theorizes that these ideas will 1) help individuals to be better informed, 2) motivate individuals to use their knowledge to change negative risk behaviour and maintain consistent, healthy practices, and 3) help individuals acquire the relevant behavioural skills that will likely reduce negative outcomes and enhance sexual health. (See Appendix D for chart.)

PHAC (2008) has found that this theoretical model is easily understood by educators and program planners and thus easily put into practice (PHAC, 2008).

To demonstrate this, examples taken from the Teen Talk curriculum for each sexual and reproductive health behaviour component-information, motivation and behaviour skills-are as follows. 1) The information component ('the what') includes acquiring information about how specific forms of birth control such as condoms work and are used effectively,

or distributing a local directory/resource sheet of easily accessible sexual and reproductive health centers. This information can lead to youth using condoms more effectively or visiting the clinics for condoms and STI testing more frequently. 2) The motivation component ('the why') includes the subsequent three types of motivation which Teen Talk approaches with information and an attitude that demonstrates a humorous positive regard for sexuality. For example how to make condoms fun and acceptable through a theatre piece called Mission Protection. a) Emotional motivation, a youth's emotional responses to sexuality such as a youth's degree of comfort with sex and sexual health. If a youth views sexuality positively s/he would be more likely to benefit from education regarding condoms and STI testing. b) Personal motivation, a youth's attitudes and beliefs in relation to specific sexual and reproductive health behaviour such as a youth's positive attitude towards condoms because s/he like the security s/he feel and as a result is more likely to use them. c) Social motivation, the social norms or perceptions of support pertaining to pertinent sexual and reproductive social information, for example, if a youth thinks condoms are used by his/her friends and partner and they would look upon him/her favourably for suggesting them then s/he would be more likely to raise the topic. 3) The behavioural skills component ('the how') involves skills that are required to adopt and perform sexual health behaviours, i.e., the practical skills for performing the behaviour and the belief in his/her ability to do so. For example, youth are encouraged to practice putting on a condom with 'condom races' and made to feel confident that s/he will be able to do it properly when the time comes. A fourth component is often included in this model; the resources ('the where'). The concept of resources is important because if a youth does not have access to resources

such as condoms then s/he cannot engage in safer behaviour even if s/he has the desire to do so. In summary these four components make up the IMB-R model and the examples demonstrated how this theory is put into practice in the Teen Talk program curriculum.

3.2.2 Social Learning Theory

Bandura's Social Learning Theory (SLT) or Social Cognitive Theory is the most cited theoretical foundation of peer approaches (Turner & Shepherd, 1999). SLT explains human behaviour "in terms of a continuous reciprocal interaction between cognitive, behavioural and environmental determinants" (PHAC, 2008). The three factors have many components: 1) cognitive factors (also called personal factors) include knowledge, expectations, and attitudes; 2) environmental factors include social norms, access to resources in community, and influence on others; and 3) behavioural factors include skills practice and self-efficacy. The following are some of the aspects of applying SLT:

- to observe and imitate the behaviours of others,
- to observe positive behaviours modeled and practice,
- to increase one's own capacity and confidence to implement new skills,
- to gain positive attitudes about implementing new skills and
- to experience support from their environment in order to use their new skills.

STL is a framework utilized by health educators to help youth gain new health supporting skills such as putting on condoms or negotiating condom use. Research has demonstrated that the STL framework has helped modify individual behaviour in the area of STI/HIV prevention programming (PHAC, 2008). It is most applicable to peer education programs like the Teen Talk PS program in terms of credibility, youth empowerment, role modeling, and reinforcement. For example, the educators have to be seen as credible with their peers on order to be influential. Their peers have to observe

them practising the desired health behaviour. The peers need to then be able to practice it themselves and obtain positive reinforcement. If they are successful in doing so they would feel empowered by their new skill. It also applies to the PS program because it focuses on educating youth on how to support and inform their peers (see Turner & Shepherd, 1999 for more details).

3.3 Summary

In this chapter, the Teen Talk program was described, as well as the underlying theoretical models applicable to the program. The Information, Motivation and Behaviour Models and Social Learning Theory were used by the Teen Talk program and highlighted by PHAC as effective models for sexual health programming.

Chapter Four

Research Design and Methodology

4.0 Research Design

This was a mixed methods study using both a qualitative and quantitative research design. In order to describe some of the barriers and facilitators of implementing the PS training and to developing the post PS training outreach component, semi-structured qualitative interviews were conducted by the researcher. The PS training participants' knowledge, attitudes, and self-esteem relating to STI, HIV and condoms, were surveyed with a series of questionnaires. The methodology of the qualitative study is presented first, followed by the quantitative study below.

4.0.1 Qualitative Study

This section describes the qualitative study's methodology used, including its participants, measures, procedure and data analysis.

4.0.1.1 Qualitative Study Interviewees

The foci of the qualitative study were the barriers and facilitators to holding training beyond the City of Winnipeg. A purposive sample of participants was selected from all those involved in the rural and northern PS training, based on their role in the training. The first interviewees were the coordinators of the training; the interviews were held with two administrators who had organized the training - one from the Interlake Regional Health Authority and one from Frontier School Division. The subsequent interviewees were four Guidance Counsellors - two from each area, and two PS

volunteers who attended schools in the Interlake. A total of seven interviews took place. One interview was with two guidance counsellors.

4.0.1.1.1 Rationale to Purposive Sampling for Qualitative Research

These regions and schools were selected for interviews to provide as much detail as possible because they underscored some of the common issues of implementing this type of program. Furthermore, the schools in the rural area known as the Southern Interlake had an established relationship with Teen Talk and have had PS trained youth in their schools for over 8 years. The administrators who organized the training were selected because they had a good understanding of the program and saw its potential for developing youth leaders in their area. The two selected PS volunteers were chosen because they were outgoing youth who had strong leadership skills, and could provide insight into the impact of the program.

Signed consent forms were obtained from all the participants prior to the interviews; assent forms were obtained from the two youth as well as corresponding consent forms from their parents. (See appendix E for assent and consent forms.)

4.0.1.2 Qualitative Measures

The semi-structured interview style utilized in this study consisted of closed and open ended questions. These questions pertained to the barriers and facilitators to the PS training program and its outreach component. (See appendix F for the interview questions.) The interview questions had previously been determined by Teen Talk staff at a team meeting. The researcher had facilitated this meeting in which she provided the staff with background information on the thesis and what she wanted to learn about the

trainings. The group then brainstormed together for a list of potential questions; the researcher selected the final questions from the list. In summary, interviews were conducted with four guidance counsellors, two administrators who organized the training, and two PS volunteers from the Southern Interlake region of Manitoba.

4.0.1.3 Qualitative Study Procedure

The interviews conducted by the researcher with the administrators were held in their place of work. The interviews with the guidance counsellors were held over the phone as well as in person. The interviews conducted with the youth were completed over the telephone. A semi-structured interview guide was used to obtain the youth's opinions regarding the PS training and outreach component of this program in their schools. The in-person interviews were audio-recorded, and the phone interviews were manually recorded by hand-written notes. Documented interview notes were shared with respective individuals whose feedback was requested to confirm response accuracy. For the adult interviewees, documentation was mailed by post to obtain confirmation. Youth confirmation was obtained via Facebook as it was deemed the most convenient way of contacting them.

4.0.1.4 Qualitative Study Theory and Data Analysis

The interviews were then thematically analyzed using grounded theory. This theory was developed by Glaser and Strauss in the 1960s. It is rooted in observation and examines data for patterns through common responses and themes (Trochim, 2006). It recognizes that data collection and analysis occur concurrently. There are core theoretical concepts that are derived from the interviews and observations by comparing data from

one interviewee to another incorporating the researcher's observations (Trochim, 2006). The literature review on the relevant topics was completed prior to the interview analysis to gain a thorough understanding of the subject (see chapter two for more details). Many informal conversations were held by the researcher and the Teen Talk facilitators prior, during and post interviewing. Discussions were also held less frequently by the researcher with many of the interviewees.

4.0.2 Quantitative Study

This section details all aspects of the quantitative study - the theory, participants, measures, procedure and data analysis.

4.0.2.1 Quantitative Study Theoretical Model

The theoretical model drawn from for the quantitative study was the Theory of Planned Behaviour (TPB). The TPB deals with a person's intention to act a certain way (Ajzen cited in Stroebe & Stroebe, 1995). According to the theory, behaviour intention is determined by a person's attitude, subjective norms, and perceived behavioural control. See appendix G for a comprehensive diagram. In this study, one objective is to determine whether this program has an impact on a person's attitude surrounding condom use. Attitudes are determined by a person's beliefs and evaluation of those beliefs pertaining to a specific outcome of his/her behaviour. According to the theory, there must be positive influence on the attitudes toward condom use in order to affect a person's intention to use condoms. Therefore, it stands to reason that influencing the PS training participants' beliefs about condoms and about their health is vital. For this research project the PS training participants' attitudes regarding condoms were measured using a

Likert type scale ranging from 1 to 4; 1 being strongly disagree, and 4 being strongly agree.

The second determinant of the TPB is subjective norms, that is, beliefs about how people close to the individual expect them to behave. Subjective norms are made up of normative beliefs and motivation to comply. Normative beliefs involve peers, partners, parents, educators, and what it is assumed that they think the individual should do. In this case, it is assumed by youth that their peers, aka the PS volunteers, would like them to reduce sexual risk-taking behaviour by using condoms if they are engaging in sexual activity. Motivation to comply involves the extent to which an individual is influenced by other's advice. How motivated is a youth to what others tell them to do? The final component of this theory is perceived control, which includes control beliefs and how much power an individual feels they have in a situation. In this study it would be how much control does a youth feel they have in using a condom.

More than a dozen tests have supported the predictions of the TPB model (Stroebe & Stroebe, 1995). The TPB's average multiple correlation is 0.71 for the predictions of intentions to perform a behaviour and 0.51 for actual behaviour (Stroebe & Stroebe, 1995). However, it is assumed that behaviour is a function of the intention to perform that behaviour, therefore, planning must be involved. Moreover, it is recognized that intention is only one determinant of behaviour. Execution of behaviour will depend on many other factors such as ability, skills, information, opportunity, and will power (Stroebe & Stroebe, 1995). For this reason actual condom use is difficult to impact because it involves much more than the intention to use condoms.

4.0.2.2 Quantitative Participants

During the proposal development stage of this project, the researcher assumed that the potential PS training participants involved in two of the training sessions would be a total of 50 youth; therefore, the researcher prepared for 40 PS training participants. During the recruitment phase of the study, the researcher asked all youth who were taking part in the PS training sessions outside of Winnipeg to participate. Because of the large number of PS training participants, quantitative data was collected on 67 youth for this project. However, of the 67 participants, 12 did not complete the consent forms even though they were given a chance to do so after training. As a result their data could not be used. Of the 12 youth without consent forms, 6 were from the same community. One person did not complete the training and so her pre-intervention survey was not included. Therefore, a total of 54 participants' were included in the quantitative part of the study. Of those participants, 2 were not present on the final day of training to complete the post training surveys and 24 participants did not complete the 6 month follow-up surveys; 11 of those belonged to two communities that did not return any follow-up surveys. Thirty one youth completed a 6 month follow-up survey and 30 participants completed the 3 sets of surveys - pre, post and 6 month follow up.

4.0.2.2.1 Acquiring Consent and Assent for the Quantitative Research

Since it was not possible for the researcher to travel to these communities prior to a PS training session to obtain parental consent forms, a staff member at the involved schools was contacted for assistance; in most cases this was the guidance counsellor. The researcher provided school personnel with the background information and details in relation to the study which they passed on to the youth and their parents. It was made

clear that participation was voluntary and not tied to the youth becoming involved in the program. The guidance counsellors explained and distributed the study consent form to the parents of the participants or the participants themselves. The youth then took home the forms and returned them either prior to or on the day of the training. The researcher administered the assent forms to both the youth who had returned a signed consent form the first day of the training session and to those who were interested in taking part but had yet to return the consent forms. The researcher made it clear to the youth that this was also voluntary but separate from the PS training itself. Consent was obtained from the guidance counsellors and administrators prior to their interviews.

4.0.2.3 Quantitative Measures

Three questionnaires/tests were administered pre and post training and again six months post intervention to the PS training participants. The rationale for the selected tests and scales is given in the theory presented above. (See section 4.0.2.1). In addition, a self-esteem questionnaire had also been included because this program previously demonstrated an ability to increase self-esteem (Shaw, 2004). The test and two scales administered are described as follows:

1 . HIV/AIDS Knowledge Test (see appendix H). Eighteen true-false items were used to assess the PS training participants' level of STI and HIV/AIDS knowledge. This is the same test which had been administered in the CYSHHAS and the CYAS. It was previously validated and used with this age group (Boyce et al., 2003).

2. Condom Attitude Scale – A (see appendix I). Twenty-three items were used to assess the students' overall attitude towards condoms use. The score for the entire test was the only number used although there were eight subscales to assess the following attitudes

relevant to condom use: Interpersonal Impact, Effect on Sexual Experience, Self-Control, Global Attitude, Perceived Risk, Inhibition, Promiscuity, and Relationship Safety. A higher score reflected more positive attitudes towards condoms with responses ranging from (1) strongly disagree to (4) strongly agree. This measure demonstrated an acceptable internal consistency (alpha = .80), and has been cross-validated (St. Lawrence et al., 1994). It has also demonstrated significant correlations between the following: 1) adolescents' self-reported condom use, 2) frequency of unprotected intercourse, 3) rates of STI health beliefs, 4) AIDS knowledge, and attitudes toward prevention (St. Lawrence et al., 1994).

3.The Rosenburg Self-Esteem Scale (see appendix J). The ten items from Rosenberg's Self-Esteem Scale (1965) consist of statements whose responses reflect a youth's feelings of self-worth. Self-revealing responses ranged from (1) strongly disagree to (4) strongly agree (see appendix J for an example). Results from this self-esteem measure demonstrated statistically acceptable internal consistency (alpha = .78).

4.0.2.4 Quantitative Study Procedure

The quantitative questionnaires were administered three times as mentioned beforehand and shown in the box below.

Sequence of Administration of Questionnaires		
1	2	3
Pre Training	Post Training	6 Months Later

The three questionnaires/tests consisted of 51 questions which were administered by the researcher at the beginning and end of the PS training. The series of questionnaires was anonymous in nature, and the data was linked to the individual using a confidential identification number. These confidential identification numbers were used to make baseline, post intervention, and six month post comparisons. It ensured that the researcher could link the surveys without using names. It was necessary to keep the identification number on file in case participants forgot their number.

The six month post training data was collected by the guidance counsellor in a PS follow-up gathering at the school. The guidance counsellors were given clear instructions on the importance of confidentiality. In an envelope that contained the follow-up questionnaires there was also a sheet containing the identification number of the PS volunteers in their school. The guidance counsellors were asked to provide the number to their PS volunteers, tear up the sheet once everyone had their number, then leave the room and seal the return-addressed prepaid envelope once all the students had handed in their forms. All envelopes except for two were successfully returned. Although the two respective schools were given reminder telephone calls just before the end of the school year, they did not return any of the 6 month post training tests.

4.0.2.5 Quantitative Study Data Analysis

The quantitative data was analyzed using both parametric and non-parametric statistical methods. The paired-sample T-tests in SPSS were used, as well as the Wilcoxon matched-pairs signed-rank test. Missing data was replaced with the mean score for the respective item. In the HIV/AIDS Knowledge Test, questions 9 and 18 (see appendix H) were excluded because the information was not addressed in the Teen Talk

curriculum. Ninety-five percent confidence intervals were used to determine significance. Rejecting the null hypothesis implied the intervention did have an impact on the participants.

4.1 Methodological Issues

Several methodological issues regarding the researcher's role were observed, as noted below.

4.1.1 Researcher Role

Due to the qualitative nature of this study, the researcher invariably became part of the research process. As a result it was imperative that her background and connection to the program was understood. The researcher has worked for Klinic in the Teen Talk program for over eight years, two of which were in the Workshop for Youth program (WFY) - one year as acting coordinator and three years in the Peer Support program (PS). In these seven years, she was able to travel throughout the province of Manitoba several times during a semester to interact with a large range of youth and adults. She felt her approachable, non judgmental attitude and rural upbringing made it easier for her to be accepted and treated as an insider by the communities she visited. While holding the role of researcher, she was employed by Teen Talk throughout the process, and she facilitated the PS training sessions to this study's participants; the PS training participants. Resulting methodological issues related to these roles she filled are noted below.

4.1.2 Dual Role: Researcher and Teen Talk Employee

The dual role the researcher played in this study should be noted. Because the researcher worked for the Teen Talk PS, there was a concern that the participants who

interacted with her would be unable to distinguish between the two roles, and therefore would not be as open and candid as was necessary to gain a broader perspective. The researcher reinforced the different roles that she filled. She made it clear to both the youth and the staff that her role as a researcher was independent from her role as a PS training facilitator. She found that because it was common in many smaller communities for individuals to play different roles, the youth did not appear to be concerned.

4.1.3 Dual Role: Researcher and Training Facilitator

Originally it was the intention of the researcher to be an observer, without simultaneously participating as a facilitator at the trainings. For primarily logistical reasons, it was not feasible to have another team member carry out observation. The Teen Talk program was fully booked and the researcher did not want to compromise service delivery, therefore, it was determined that it would be best if she facilitated the training sessions. The benefit of this was that she was able to give unique insight into the program. The drawbacks were 1) at times it was difficult for the researcher who was so involved to have an outsider's perspective, 2) the training days were intense and 3) the influence she had as a trainer potentially impacted the relationship with the participants and adults involved.

4.2 Retrospective Interviews

The follow-up interviews were held a year or more after the PS training sessions took place. This lapse of time creates concerns for recall biases - a loss of clarity regarding events which had occurred.

4.3 Ethical Considerations

The following are the several ethical considerations to be highlighted and addressed.

4.3.1 Research Consent Issues

There were issues related to consent that are covered in the following sections.

4.3.1.1 Guidance Counsellor Role

Not only were the guidance counsellors responsible for recruitment and selection of students, they were also responsible for insuring completion of parental consent forms necessary for youth participation in the training. The researcher did not contact parents because she was not available in the community beforehand and she often did not know who was expected until the day before the training sessions. Because the guidance counsellors in these communities had a connection and relationship with the families, the researcher felt that this community link made it more appropriate for them to obtain consent.

4.3.1.2 Acquiring Parental Consent

The overall sample size was less than half of the initial sample of potential participants. There were several reasons why the participation rates were low: 1) Dual requirement for written parental consent and consent from the youth was a barrier to some youth taking part. One guidance counsellor mentioned that she had not distributed the consent forms because she felt the parents would have prevented their youth from participating had they seen such personal surveys (Personal communication, October 20 2006). 2) The guidance counsellors' hectic schedules stopped them from tracking down

students who had forgotten their forms. 3) Some guidance counsellors mentioned that the length and the complexity of the forms were reasons why the forms may not have been returned, even though some counsellors called the parents to verbally explain the consent forms. The guidance counsellors did this because they realized it would be a challenge for some parents to understand the form for a number of reasons ranging from literacy to comprehension issues (Personal communication, April 27, 2006). 4) Another reason why such a small number participated as provided by youth was that some parents or youth were not interested in the study. The researcher was thus convinced that had parental consent forms not been required, the sample size would have easily doubled.

4.3.2 Stigmatized Nature of Topic

One of the ethical considerations involved the sensitive nature of the subject matter; talking about sexuality in general may be considered taboo. Research has demonstrated that youth sexuality is even more controversial and complex: our society tends not to accept youth as sexual beings (Nova Scotia Roundtable on Youth Sexual Health, 1999). Furthermore, our society tends not to accept that youth are sexually active even though almost 50% will have had sexual intercourse by the time they graduate and 70% will have had sexual intercourse by the time they are 20 (Alan Guttmacher Institute, 2002; Maticka-Tyndale, 2001). Denial, fear and ignorance cause sexual health communication to be very limited. Guttmacher (2002) states the public assumption is that talking about safer sex will lead to increases in sexual activity or accelerate sexual debut. However, it has been found repeatedly that this is not the case (Alan Guttmacher Institute, 2002; Guttmacher et al., 1997; Kirby et al., 1999). In fact, it has been demonstrated that the levels of sexual activity and the age at which teenagers become

sexually active do not vary across comparable developed countries, even though there are large variations in sexual health programming (Alan Guttmacher Institute, 2002; Maticka-Tyndale, 2001). Countries with low levels of adolescent pregnancy, child bearing and STI are characterized by 1) societal acceptance of adolescent sexual relationships, 2) comprehensive and balanced information about sexuality and 3) clear expectations about commitment and prevention of pregnancy and STI within these relationships (Alan Guttmacher Institute, 2002; Lottes, 2002; Maticka-Tyndale, 2001). In addition, easy access to contraceptives and other reproductive health services contributes to better contraceptive use and, in turn lower teenage pregnancy and STI rates (Alan Guttmacher Institute, 2002; Lottes, 2002; Maticka-Tyndale, 2001). Teen Talk recognizes this and thus has incorporated some of these aspects into its programs. In addition, it has been Teen Talk's experience that under the umbrella of peer education, sensitive health information appears to be seen as less threatening by some parents because it involves providing information to youth to help others; the idea that the PS information was for helping others and not specifically targeting the behaviours that their child may be engaging in may be easier for some parents to accept.

4.3.3 Youth as a Vulnerable Population

Another consideration was that this study involved youth; a vulnerable population due to their age. The power dynamics between youth and adults can also make this type of research more difficult. The experience this study's researcher has had working to empower youth helped minimize the effects of this dynamic. Furthermore, Teen Talk staff is sensitive and aware of the issues that arise with power and as a result use the philosophy of empowerment and strategies such as being youth-orientated to mitigate

that dynamic. The researcher has shared these results not only with Teen Talk program staff but also with those who participated in the study.

4.3.4 Youth and Consent

Consent issues relating to youth was another consideration. In Canada, the age at which informed personal consent must be obtained for research purposes is 16 years; in order to study youth under the age of 16 years, parental consent is required. This can inadvertently create a barrier for many youth involved in research - sexual health research in particular. This is a significant obstacle to sex research with teens; in 2008, Toronto Teen Survey actively did not seek parental consent because of this reason (Flicker & Guta, 2008). Consent was difficult to obtain in this study for various reasons that may have involved values, logistics, or interest as is discussed in a following section.

4.3.5 Feasibility Issues

A fourth consideration was tied into the feasibility issue. In 2003 the federal government implemented the CYSHHAS study and difficulties in obtaining school consent were documented. The researcher's study was much smaller than the CYSHHAS study, and required greater personal involvement of the guidance counsellors. Because there was a relationship between the program and some of the staff, it helped obtain participation. Furthermore, it was made clear that everyone would remain anonymous and the intention was not to represent a school poorly but to obtain information specifically about the Teen Talk PS program. In addition, once the interviews were completed, there was an opportunity for the youth to review their comments with corresponding guidance counsellors and confirm their correctness.

4.3.6 Confidentiality Issues

The use of identification numbers for data linkage was an ethical issue. Assigning the PS training participants a personal number to match their results did not give them total anonymity. A participant's information could still be revealed if the number sheet with his/her name was matched with his/her questionnaires and tests. This was a concern because the questions were personal in nature asking the youth how they feel about themselves and condoms. The numbers were necessary because many of the youth did not remember their number for the post training and 6 month post training questionnaires. It was the researcher's task to make sure the documents were locked in a filing cabinet, kept separate and destroyed when the study was completed. All study electronic files were stored on the researcher's password-protected computer. As noted above, the guidance counsellors had access to their volunteer numbers in order to administer the 6 month post training questionnaires; they were instructed on the importance of confidentiality.

4.4 Adjustments to Methodological Design: Outcomes of the Research Process

There were several adjustments made once the study was underway. It was the researcher's intention to study only the outreach component of the PS program. However, in the process of delivering the PS training program, it became clear that this first step of delivering the training component beyond the city limits needed to be examined because in trying to establish them, it was not as straightforward as the researcher had anticipated. Therefore, it was decided by the researcher and her advisor that the focus of the thesis

would be the barriers and facilitators to expanding the training program in rural and northern areas of Manitoba. Furthermore, because the Interlake has been involved with the program since 2001, they could provide some valuable insight to their Northern counterparts who were just beginning to integrate the PS into their schools.

In January 2007 after having studied some of the results of the quantitative data, the researcher recognized the need for more descriptive data beyond the interviews. Then some of the information was documented from the informal interactions with participants and events which occurred at the training sessions. As the study evolved it was discovered that additional documentation should have taken place during the training in order to fill empty gaps.

4.5 Effects of Research on the Researcher

Overwhelming would be the word which best describes the impact of this research and the training sessions on the researcher. Simultaneously facilitating and organizing this study was difficult with the study taking second place to providing support to the PS participants. The needs of many northern youth for support, attention, education and care were high in comparison to their southern counterparts. Prior to examining the northern participants' data, the lack of health information available coupled with extensive risk taking behaviour was apparent. There were times when the researcher felt the training and research was irrelevant and much greater issues needed to be addressed such as the significant amounts of violence and high rates of suicide occurring in these communities. The following journal entry from her notes was written after a particularly challenging day:

> "Today I felt as if I was paying lip service to the concepts of choice and empowerment. It was quite obvious that the structural barriers for these youth were significant and 'making it through the day' was more of a concern. I feel frustrated and somewhat paralyzed as a youth health educator. I feel like my efforts to educate on STI and condom use is a form of tokenism. I question what it really means to better inform and support these youth (Notes, October 2006)."

She often felt inappropriate requesting time from such overtaxed individuals such as the guidance counsellors. Many tasks fell on the shoulders of these people because there were so few community resources available. She described some of these communities as neglected, as there were very limited services such as a sole nurse travelling to the community from afar to provide medical care.

Chapter Five

Participants

5.0 Participating Communities and Regional Health Authorities

Youth involved in PS training sessions outside of the City of Winnipeg were asked to participate in the quantitative section of this research by filling out surveys. Youth from the Southern Interlake communities and Northern communities took part in this study. The Southern Interlake training was held through the Interlake Regional Health Authority. The training sessions in Wabowden, Snow Lake, Leaf Rapids and Cranberry-Portage were all held through Frontier School Division. See appendix K for locations on a map of Manitoba. The youth were between the ages of 13 and 19 and attending school at the time of the study. The Teen Talk intake forms were used to gather the demographic data of each youth: his/her gender, age, and home address. It also provided the total number of youth involved in the training session.

5.0.1 Southern Interlake Training Demographics

The majority of these youth lived under 100 km from downtown Winnipeg, some with parents who worked in the City of Winnipeg. While some of the towns were seen as an extension of Winnipeg, other towns/villages a bit farther from Winnipeg were predominantly farming communities. Most Interlake peer support youth were Caucasian and a few were Aboriginal, the general majority identifying as female. The youth ranged from 14-17 years of age, with most of the junior high youth being 14 and the high school youth being 17 years old. For this training session that took place at the beginning of

October in 2006, the 28 youth were mixed with both younger and older teens in each group originating from Selkirk, Lockport, Warren and Stonewall.

5.0.2 Frontier School Division Trainings

The Teen Talk PS training has been endorsed by Frontier School Division and it has created a strategy of how to best utilize this program in their schools. Its plan was to have youth trained first in all the divisional areas. Its second step was to have these youth work alongside the guidance counsellors in their respective schools, passing on the information through formal activities and being a support to their friends and peers. The four different geographical area trainings completed during data collection were held in Wabowden in April 2006, Snow Lake in October 2006, Leaf Rapids in November 2006, and Cranberry-Portage in February 2007.

5.0.2.1 Area 1 - Wabowden Training Demographics

During the time of this study, two PS training sessions were held in Area 1. The first one was held in Wabowden, a town approximately 640 kilometres north on the #6 highway to Thompson from Winnipeg. For the first Area 1 training, there were a total of 29 youth with 5 youth from Gilliam, 4 from Leaf Rapids, 2 from Brochet, 11 from Wabowden, and 7 from South Indian Lake. These PS training participants identified as Aboriginal, Mixed, or Caucasian. The youth ranged from 12-18 years of age with the average age between 15 and 16 years. According to the Teen Talk staff this is considered the ideal age to run a peer support group. The youth were predominantly older than 14 years of age with thirty percent identifying as male. This was not typical in a peer support training where the male-female ratio was often 1:10 for the in-house training sessions.

5.0.2.2 Area 3 - Snow Lake Training Demographics

Twenty nine youth with 8 from Snow Lake, 8 from Cormorant, and 11 from Moose Lake participated in the Snow Lake PS training. The host community was a long-time mining community and the other two communities were reservations. There was a clear ethnic divide between the groups; the majority of youth from Moose Lake and Cormorant identified as Cree and those youth from Snow Lake identified as Caucasian. Furthermore, this was the only training where the largest group of participants did not come from the hosting community. In the Wabowden training, the youth from the home community made up half the participants where as in Snow Lake, they only made up a third. This training again consisted of a significant number of males - nine in total, a ratio of 1:3 male to female. The average age was 13 to 14 years with only one 16 year old youth participating.

5.0.2.3 Area 1 - Leaf Rapids Training Demographics

The second Area 1 training comprised a much smaller group of youth than the first Area 1 training. There were 10 youth from Leaf Rapids, 4 from Wabowden, 2 from Lynn Lake, and 4 from Brochet. Leaf Rapids, a former mining town, was the hosting community for this Area 1 training. Most of these peer support youth would identify as Aboriginal, Mixed or Caucasian. The youth ranged from 13 to 16 years of age, with the average age being 13 to 14 years. Again there were five males, a ratio of 1:4 male to female, which appeared to be the norm for northern Teen Talk PS training sessions.

5.0.2.4 Area 3 - Cranberry Portage Training Demographics

In this Teen Talk training there were a total of 19 students from Moose Lake, God's Lake, Brochet, South Indian Lake, Barrows, Pukatawagan, and Cranberry-Portage. Cranberry Portage was a town primarily of youth who moved there from smaller northern communities, and lived in the residence to gain a high school education. In the eyes of the researcher, the participating youth, all female with the exception of one male, appeared comfortable with each other considering most of them had been complete strangers the previous week; many had just moved to Cranberry-Portage and begun second semester at the school. The average age at this training session was 15 to 16 years, with the youth ranging from 15 to18 years of age.

Chapter Six

Taking It Beyond the Perimeter:

The Results of the PS Training and the Post Training Outreach Component in Rural/Northern Manitoba

Numerous barriers and facilitators to establishing the rural and northern training sessions have been documented qualitatively below. The benefits of the PS training are then discussed. This is followed by the barriers and benefits to the post training outreach component. The second section includes the quantitative results of the scales used to measure the knowledge, attitude, and self-esteem of the PS volunteers at three different points in time.

6.0 Qualitative Results

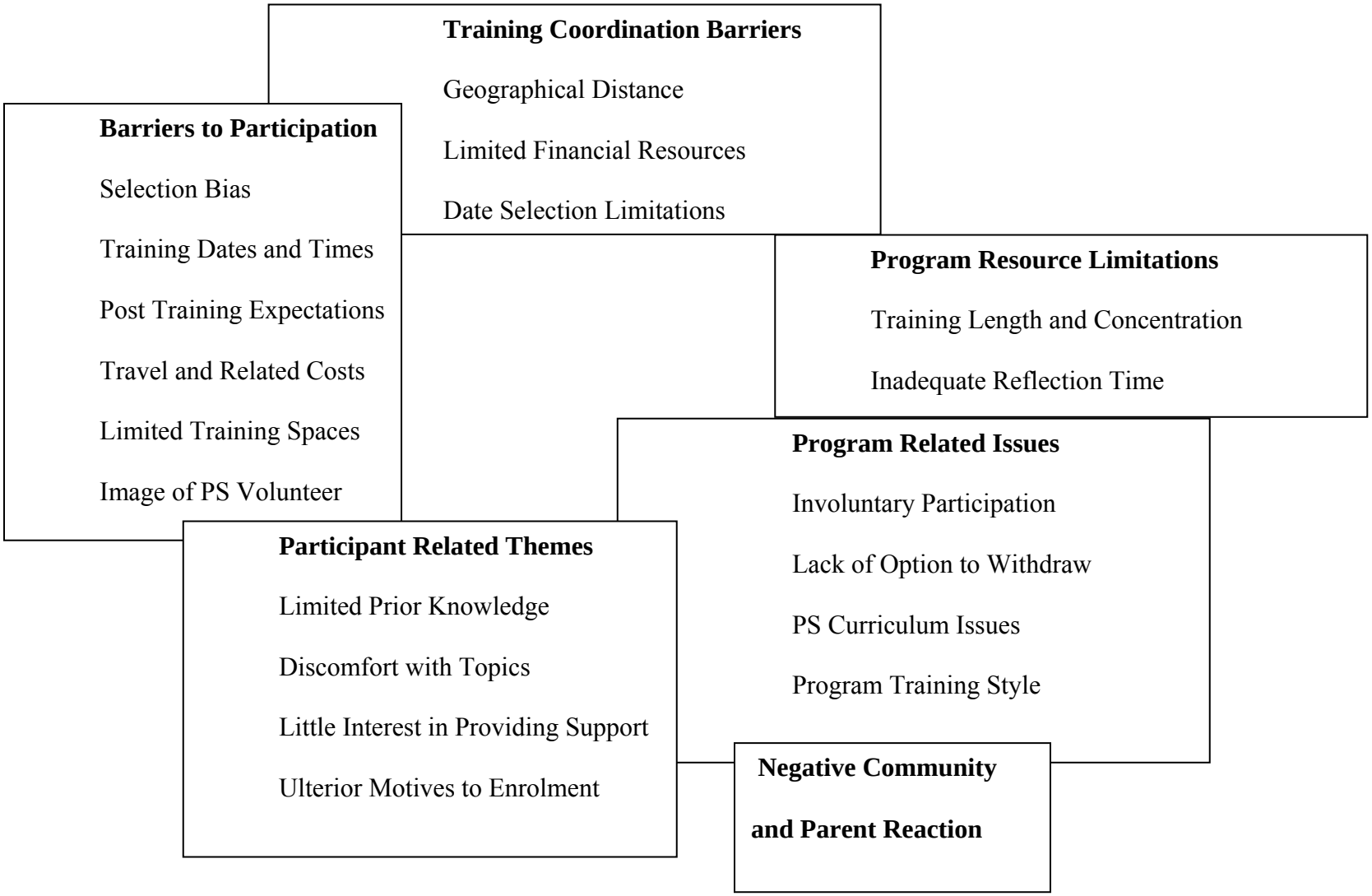
This section includes the feedback of the seven people interviewed on the issues of establishing the PS training and post training outreach components in their communities.

6.0.1 Barriers to the Trainings

The barriers to the trainings were reported and organized into figure 2 on the subsequent page. Each heading has been constructed and is not mutually exclusive; some of these affect more than one topic hence the connectedness of the boxes in the figure. The categories are then elaborated on below the figure. These categories and barriers are significant because they are specific to expanding the program beyond the City of Winnipeg.

Figure 2

PS Training Barriers



6.0.1.1 Training Coordination Barriers

The following are reported barriers that made coordinating the PS training more challenging outside of Winnipeg. Comparisons are made between these new training sessions in rural and northern areas of Manitoba and what the general protocol has been to organizing PS in-house and in-city training sessions.

6.0.1.1.1 Geographical Distance

All the adults interviewed, that is, the guidance counsellors and training organizers, stated geographical distance within their area as a major barrier to organizing PS trainings in their area. The vast distances within Manitoba's North made trips very time consuming and costly. Frontier School Division covers substantial distances, thus northern participants and their guidance counsellors often had to travel between 300 and 600 km to attend trainings in their respective school areas. Those from fly-in communities, communities that are not accessible by land, had to stay overnight in Thompson in order to participate in their training sessions the following morning. In the Interlake region, with the exception of Lord Selkirk School Division, the majority of the youth traveled 50 km or more by car to the hosting community.

Geographical distance was not an issue for trainings within the City of Winnipeg. For the in-city training sessions, Teen Talk gave the youth bus tickets to be able to access public transportation for the in-house training. Alternatively if the training sessions were not held in-house (downtown at Klinic on Broadway), the youth attended the PS training program at their school, neighbourhood or another school in close proximity.

6.0.1.1.2 Limited Financial Resources

The organizers informed the researcher that cost was a major barrier in organizing the Teen Talk PS rural/northern training (Interviews 10/07;12/07). Additional costs not incurred in in-city trainings included meals, transportation, per diems, and accommodation. For a team of four facilitators, the average additional cost for a northern training was $4000 for a three-day training session.[1] This cost was shared by the program and the host organization and did not include transportation or meal costs of the 30 youth and chaperones. In addition to these costs, the guidance counsellors' and other supervising adults' time was paid by the division. The Interlake youth traveled shorter distances and returned home in the evenings. As a result these training sessions did not incur as many additional costs as the northern training sessions - only transportation and lunch.

Frontier School Division used monies from multiple existing budgets to pay for the training sessions because they did not have a peer helper budget. The division often did not have their funding confirmed until the week of the training session (Interview, 12/07). Conversely, the Interlake Regional Health Authority had a Teen Talk budget. They had begun allocating resources in their budget specifically for the training a few years prior (Interview, 10/07).

6.0.1.1.3 Date Selection Limitations

Some guidance counsellors stated that the busy high school calendar was a barrier to arranging training sessions (Interviews, 10/07; 10/07; 12/07). It was difficult to find dates for training that would not conflict with other school events. One administrator stated: "there are so many things going on in a school... for example the provincial sports

schedule does not have much flexibility… whenever you do something over multiple days you're always conflicting with sports" (Interview, 10/07). As one interviewee noted, almost every weekend there was a sporting event taking place, and as a result there was little room left for any other type of programming such as peer support. Such a tight schedule also made it difficult to arrange transportation and supervision for the training as there were only a limited number of divisional vehicles and staff available at each school (Interviews, 10/07; 10/07; 12/07). In the in-house training the sessions were only held for three hours once a week. The training was offered three times a year so there were more opportunities for urban youth to join. For example, if a youth had a busy fall semester they could have taken the training the following spring or summer.

6.0.1.2 Limited Opportunities for Rural/Northern Youth: Barriers to Participation

In rural and northern trainings, the numerous reasons why some youth may or did not participate are explored below.

6.0.1.2.1 Selection Bias

The selection bias of the guidance counsellors could have prevented certain youth from participating. Many of the youth in these northern areas were given the opportunity to self-select when the training was presented to them in class but in the end their guidance counsellors made the final decision as to who could attend. The reasons the guidance counsellors gave for selecting specific youth were: they were seen by school staff as 1) mature, 2) outgoing, and 3) motivated (Interviews, 10/07; 12/08; 12/08); they were seen as 'chaperonable' which could be interpreted as being well behaved, and could be trusted to represent their communities positively (Interview, 12/08). In the Interlake

region, some youth were selected because the guidance counsellor foresaw their ability to assist in teaching a sexual health curriculum (Interviews, 10/07; 02/09). Some interviewees verbalized that certain youth were selected because Teen Talk administrators had requested a cross section of youth: this was important because the intention was to develop a support person in each peer group. (Interviews, 10/07; 12/08; 12/08). As stated by one administrator, "Teen Talk puts out the guidelines as to the students they want across the peer groups and a certain level of maturity,… that's the criteria that the counsellors are given (Interview, 12/07)." The urban PS training participants were most often informed of the training and recommended to attend by their guidance counsellor or friend. They were more self-selected than the rural and northern youth because they ultimately had to make the decision to partake by signing up and finding their own transportation to the in-house training site downtown at Klinic on Broadway.

6.0.1.2.2 Training Dates and Times

Many interviewees stated not wanting to miss classes, work or a sporting event as reasons certain youth chose not to participate in the training sessions (Interviews, 12/09;12/09; 02/08). The majority of the training sessions were held during school hours causing the PS training participants, to miss a substantial amount of class time. This led some participants to fall behind in their coursework which affected their grades. The length of the training and the amount of class time missed was an issue mentioned by both coordinators (Interviews, 10/07, 12/07). The Interlake coordinator had requested Teen Talk shorten its curriculum by removing sessions (Interview, 10/07). The Frontier

coordinator was interested in the guidance counsellors completing some of the preliminary work with the participants in order to shorten the training (Interview 12/07). Because the training in Winnipeg was offered year round in the evenings, urban youth had less issue with the training dates and times. They had many more dates to select from and missing class was not an issue.

6.0.1.2.3 Post Training Expectations

Outside the City of Winnipeg there were pressure and post-training expectations placed on the participating youth to share the information by the guidance counsellors, coordinators, and Teen Talk staff. This prevented youth from enrolling if they were not interested in sharing the information. The expectation was that these youth take what they had learned back to their communities to inform and support their peers. For example in the Southern Interlake, the PS volunteers worked with the public health nurse to deliver some of the sexual and reproductive health educational material to their classmates. This was the only area in Manitoba which had PS volunteers collaborating with the Regional Health Authority to educate their peers (Interviews, 10/07; 02/09). The coordinator of the Frontier training session requested that the counsellors select "the students that have the potential to take on the responsibility after they've been trained" (Interview 12/07). In in-city trainings there was no obligation to engage in post-training activities, although it was strongly encouraged and many of the youth do volunteer their time once they have completed the training program. If an urban youth wanted to partake in a training session simply for personal interest, s/he was able to do so as there was no connection between their school and Teen Talk.

6.0.1.2.4 Travel and Related Costs

Travel and related costs were issues that prevented youth from partaking in a training session. For example, youth from northern fly-in communities attending a training session required one or two expensive airplane rides; over $300. Understandably, in these situations only a few youth could then participate from those regions due to the significant inherent cost per youth (Interview, 12/07). Youth commuting from outside communities were limited by the number of seats available in the transportation used not only by youth, but also by their chaperones. As noted by one interviewee, some youth were reluctant to leave their community for several days. “You know we struggle with this in other programs too...kids suddenly realize that they’re going to be away from home for a few days and they don’t want to be” (Interview, 12/07). The urban PS training participants could reach the training site by public transportation.

6.0.1.2.5 Limited Training Spaces

In rural and northern training sessions, because there were many schools participating, each school was limited by the number of spaces available in a training session. The in-house PS trainings had no limit to the number of youth from one school that could participate because the training sessions rarely booked full. For Teen Talk the ideal group size for a training session was between sixteen and twenty, so if five schools were participating then each could only bring four participants. If a youth wanted to attend and the session was full, they would have to wait until Teen Talk was in the area again. In Cranberry Portage for example, the researcher noticed that the training session was so popular that non-participating youth would try and sneak in or stand by the door and listen. In fact, the researcher and her co-facilitator during a training session were

approached by several youth whom wanted to guarantee themselves a spot at the subsequent training (Personal communication, February 27, 2007).

6.0.1.2.6 Image of PS Volunteer

The assumptions rural and northern youth made of the image of a PS volunteer was reported as being a barrier to youth enrolling (Interview, 10/07). "A youth may not sign up for such an event because they are trying to protect their image as it is not seen as 'cool' to be involved in school activities (Interview, 10/07)." For some youth, peer support may not be perceived as 'cool' in comparison to other activities. As noted by a couple of interviewees, (10/07; 10/07) "with there being many sporting events... peer training does not necessarily have that appeal." Some may not have become involved because they felt they were not outgoing enough and would not have felt comfortable attending the sessions (Interviews, 12/09;12/09; 02/08). Some youth also claimed they would not be interested in the curriculum presented (Interviews, 02/09; 12/08). It was assumed by the researcher and the Teen Talk staff that urban youth may have had similar issues surrounding the image of the PS volunteer although this had not been confirmed.

6.0.1.3 Program Related Issues

Subsequent issues related to the PS program specifically increased the difficulty found in the training sessions: involuntary participation, lack of options to withdraw, PS curriculum issues, and program training style.

6.0.1.3.1 Involuntary Participation

Involuntary participation of youth was a barrier in delivering trainings. The only stipulation Teen Talk had for any youth to partake in the program was that the youth had

to have a strong interest in taking part; hence, that their participation was voluntary.[1] At numerous training sessions after several youth appeared reluctant to be involved, the researcher questioned their intentions. When asked why they joined, several youth mentioned that an adult had instructed them to sign up for the training. When asked why they had told these youth to attend, the guidance counsellors said they felt "these youth needed it and it was good for them" (Personal communication, November 29, 2006). This challenged the notion of voluntary youth participation. While Teen Talk often suggested motivating and encouraging youth to attend, no one should have felt forced to join regardless of how vital the corresponding adult felt the information may have been for him/her. This issue was not observed for the in-house trainings because the youth had to take his/her initiative to attend each weekly evening session.

6.0.1.3.2 Lack of Option to Withdraw

The fact that rural and northern youth did not have the option to withdraw once they arrived in the hosting community was another barrier. Typically, if a youth decided after the first session that s/he was not interested in continuing with the training, s/he had the option to withdraw. This was the case in Winnipeg and in training sessions that took place in a participant's hometown. The other participating youth did not have this choice. For many of the northern youth, especially those who had traveled a long distance to attend, their only alternate option to taking part was to independently pass the time in another classroom or library. This was not an attractive alternative and resulted in some youth continuing with the training session despite not being interested in the program.

[1] In Winnipeg the facilitators have found that the youth who are forced by adults or workers to attend do not often complete or continue with the training. In addition, they could also distract others and make it difficult for others to take part and learn.

6.0.1.3.3 PS Curriculum Issues

It is important to note that there were issues with the curriculum which arose while the training sessions were being delivered. The content, depth, and approach of the PS training sessions were not originally developed or adapted for rural/northern youth. The training was initially created and tailored for self-selected urban youth who voluntarily attended the Wednesday night sessions at Klinic on Broadway in Winnipeg. From the experience of this program, participating youth often already held the values that Klinic and Teen Talk embraced. Generally these youth had a strong sexual and mental health knowledge base, interest in these issues, and a substantial level of comfort in discussing these topics. As a result, the Teen Talk facilitators were then able to engage in more detailed discussion with the group and take them a step further than a group of youth that were less aware of the issue discussed. With the in-house advanced groups the facilitators could explore the nuances of the topics and in many cases developed detailed action plans as to what they could do as youth to raise awareness on the subject. An example of how the Teen Talk facilitators were able to engage the in-house group is, in the session on teen dating violence, the details of the cycle of violence and what makes it difficult for a person experiencing abuse to leave an abusive situation were discussed. With a group that has for the first time begun discussing such a topic, like some rural and northern youth, more time was spent by facilitators discussing the definition of and the different types of abuse.

6.0.1.3.4 Program Training Style

The academic training style combined with the long training days made the sessions more difficult. The sessions involved discussion-style presentations, use of

flipcharts, small group brainstorming, large group discussions, and role playing; these teaching methods worked well with many of the in-house groups who partake in three hour sessions. The vocabulary used by the Teen Talk facilitators was too difficult for many rural/northern youth to understand; words like erection, negotiating, transmission, sexual intercourse, etc. When presenting four topics in one day, this teaching style was quite gruelling for the average learner's attention span. The approach taken to deliver the information was not very hands-on, i.e., not an experiential type of learning, which made it difficult for hands-on learners.

6.0.1.4 Program Resource Limitations

The Teen Talk program had the following limitations that were reported as training barriers by the interviewees.

6.0.1.4.1 Training Length and Concentration

The length of and concentration involved in a ten hour training day was a major issue citied by all interviewees. The rural and northern trainings were set up differently from the in-house and in-city trainings. Due to geographical logistics the rural/northern trainings were set up to cover all ten Teen Talk topics over three or four days. It appeared to the facilitators there was too much information for many youth to grasp. (See program documents for more details.) At the in-house trainings one or two topics were covered with sessions running for nine or ten weeks, meanwhile, the trainings were spread out over a minimum of four weeks in-city area trainings, while covering five topics in two weeks. This considerable difference in time frame had a significant impact on the delivery of the training program and how it was received.

6.0.1.4.2 Inadequate Reflection Time

The lack of reflection time in a rural and northern training was a concern. With this type of relevant information, there needed to be time for processing, reflecting, and even distraction. There was little time at the end of the training day and, as a result, some youth felt overwhelmed with all the information (Personal communication, October 20, 2006). As noted by the researcher, the final day of the training was difficult because many youth had lost their focus by then. It often appeared to the facilitators that the youth had reached their "saturation point" - another reason that the administrators requested shorter training days. Having inadequate reflection time also resulted in the guidance counsellors being more relied upon for support once the youth returned to their hometown schools and processed the information.

6.0.1.5 Negative Community and Parent Reactions

While all the adults interviewed understood that these issues were relevant to the lives of the youth in their community, they discussed the concerns some adults, parents in particular, had around sex education.

> "There is always concerned parents and when we go into some communities it's a real challenge to do this kind of training…This is the first time we didn't have any angry parent like we did the last few times and every training we do we have one or two parent(s) who are irate and each time we've informed them about what we're going to do" (Interview, 12/07).

While it was acknowledged that "for the most part parents were fine," (Interview, 12/07) the significant impact a few disapproving individuals can have in a small community should not be ignored (Interviews, 12/07; 12/08). One northern counsellor and the administrator mentioned the issues that they experienced with a parent committee that did

not approve of the material presented. These individuals even took it upon themselves to secretly 'edit' the handouts and booklets that Teen Talk had left with the youth and guidance counsellor (Interviews, 12/07; 12/08).

> "The info taken home (the manual and the zines) got to school committee. They did not respond positively; the chairperson said, "had I known that this is the type of info the youth would be receiving then I would not have allowed it into the school." The pamphlets were then gone through by the parent committee and things were taken out that were deemed inappropriate. This was all done behind my back" (Interviews, 12/07; 12/08).

Teen Talk had to be invited into a community, which in some cases meant it had to gain the permission of the school's parent committee, since the training was being brought in by the school division. When parents of youth in the in-city or in-house training sessions had concerns of the Teen Talk material presented, they had the option to withdraw their son/daughter from the program. With Teen Talk being situated in Winnipeg, the additional issue of requiring permission to enter an urban community was not a factor.

6.0.1.6 Participant Related Themes

There were several participant-related themes that presented challenges to the training sessions.

6.0.1.6.1 Limited Prior Knowledge

Some rural and northern youth had limited prior knowledge or exposure to the health topics in the PS curriculum. In fact the Teen Talk pre-test found that northern youth had the least prior knowledge. This was followed by rural youth and lastly by their in-city counterparts. (See program documents for details.)

6.0.1.6.2 Discomfort with Topics

The fact that many youth were uncomfortable with certain topics presented was another training issue. Many youth were surprised the facilitators discussed such stigmatized topics so openly (Personal communication, October 20, 2006). The researcher noticed that the youth were often very quiet and reluctant to speak, making the facilitators' task of creating discussion more difficult.

6.0.1.6.3 Little Interest in Providing Support

It was apparent to the researcher at some of the training sessions that a number of youth did not appear interested in supporting their peers, which presented a challenge. It made the facilitators' work more difficult, because a key component for a voluntary peer program was an interest in supporting their peers by learning the information. Little interest in supporting others made it difficult to have discussions around that particular topic. While in most cases there appeared to be an interest especially in the sexual health information, the researcher noticed that some of the other health topics did not appear to be drawing their attention.

6.0.1.6.4 Ulterior Motives to Enrolment

A number of ulterior motives stated by some uninterested youth presented challenges when delivering the training. When the researcher asked these uninterested youth why they chose to participate, the following reasons were mentioned; to get free condoms, to get out of their community for a few days, to miss school, or to get out of home.

6.0.1.7 Secondary Results

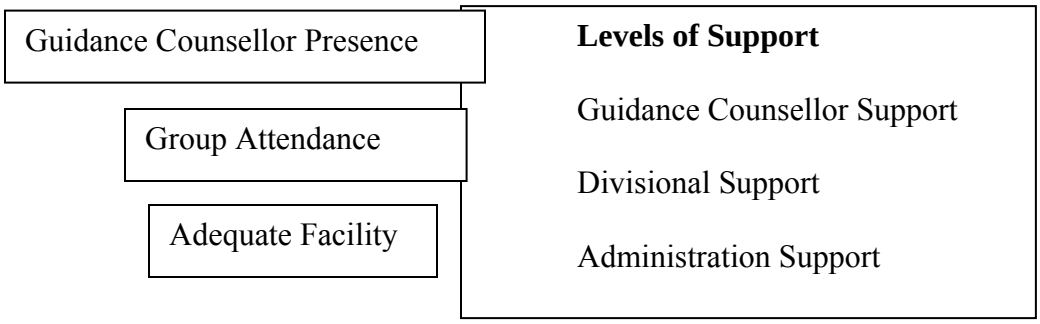
In Winnipeg, condoms were more accessible than beyond the city limits as they were available free of charge in the washrooms or in the waiting room at all the teen clinics. Condoms could also be purchased from a large variety of stores ranging from grocery, drug to convenience stores for a relatively low cost. This was not the case in the rural and northern areas where condoms were a scarcity. In many rural/northern communities condoms were available free of charge only at the nursing station or the health center when requested. The single store in town was often the only place to buy condoms that in some cases were kept behind the check out in individually wrapped packages. Because of the scarcity of condoms, a northern youth told the researcher that a single condom could be sold for a dollar at parties; double the price of a condom in Winnipeg.

6.0.2 Training Supports

While many of the challenges of adapting the training program for the rural and northern areas have been acknowledged, it is important to discuss the supports and benefits to this type of training. In this section both of these will be covered. The following headings were all identified in figure 3 as training supports.

Figure 3

PS Training Supports



6.0.2.1 Levels of Support

Various levels of support were mentioned as the greatest facilitators to the training by all individuals interviewed. Support given by the guidance counsellors, the division, the administration, and teachers helped organize the training session.

6.0.2.1.1. Guidance Counsellor Support

Support from the guidance counsellor(s) was cited by all individuals as key in establishing PS trainings. Both youth in particular stressed how vital guidance counsellor support was. They stated that the guidance counsellors needed to be 'hands on' because youth looked to them to organize the training, provide the transportation etc. They also talked about how difficult it was for youth to attend a training session when there was little support from the guidance counsellors.

> "She wasn't supportive. She wouldn't pick us up or arrange rides or tell us what homework we missed. She didn't talk to the teachers. It was a hassle in the eyes of the school. The parents called and asked her to get us our homework and excused absences and that didn't happen. We were on our own" (Interview, 02/09).

The administrators talked about the importance of a good relationship with the guidance counsellors and of how key their involvement was. "Where it's worked well is where there's good contact with the school with guidance counsellors that can reach out to the students and invite their participation" (Interview, 10/07). The guidance counsellors also mentioned having the other counsellors there for support as being beneficial (Interviews, 12/08; 12/08).

6.0.2.1.2 Divisional Support

Having the support from the division was vital in putting together the training session, as stated by both northern guidance counsellors. “Having the assistant superintendent attend and put in 110%; his support and him setting it up (was a facilitator)” (Interview, 12/08). It was acknowledged by one administrator that in order to establish this type of program, the assistant superintendent and superintendent needed to be involved. “They needed to get on board because we know that was the best way for communication” (Interview, 10/07). Beginning centrally was Frontier School Division’s initial strategy to integrating this program into their division.

6.0.2.1.3 Administration Support

All those interviewed with the exception of one individual felt their administration was supportive of the program. Their support was shown a number of ways: they “did not put up any roadblocks,” they dealt with the school parent committee, they referred youth they felt would benefit from the training, and they allowed class time for peer activities. Some suggested that the organizing of the program be taken over by the school (Interview, 12/08) while others were clear they did not want this responsibility given to the administration in fear that it would be forgotten or lost: they were not sure “if the administration’d see it as much as a priority as we see it and if things in one month are starting to get very busy I could see them say we don’t need to do that anymore” (Interview, 10/07).

6.0.2.2 Guidance Counsellor Presence

Having the guidance counsellor present during the entire training session was cited by both administrators as being integral for trainings for several reasons. “By hearing what was happening in the sessions, the adults better prepared themselves to deal with any issues that could arise with their youth following a training session” (Interview, 12/07). Their presence also meant they could also address any concerns that the parents/guardians may have had following a training session (Interview, 12/07). The guidance counsellors were able to support the Teen Talk facilitators because they really knew the youth, their families, and their history. This was important for the Teen Talk staff. It was the program’s policy that the guidance counsellors were present but not involved during the training sessions for two other reasons - role modeling healthy attitudes and session management, should it be required.

6.0.2.3 Group Attendance

Both youth identified feeling more comfortable attending as a group as being a facilitator to joining the training. “Coming in a group made it easier. It made it more comfortable. The first time we went there were more older people and so you could just ask your friends if you didn’t know something when you felt uncomfortable” (Interview, 02/09).

6.0.2.4 Adequate Facility

An adequate facility or training site was mentioned by a few of the interviewees as being important (Interviews, 10/07; 12/07; 12/08). “The facility makes a bit of a difference. Some of the places are more awkward, many had uncomfortable chairs, while

some places are more comfortable, for us to observe" (Interview, 10/07). Some adults discussed experiencing a training session in less than ideal conditions. The researcher recalled a training session in a community where the facility was in very close proximity to a shopping area which included a coffee shop. As a result the youth were often found in the coffee shop and the facilitators and chaperones spent a considerable amount of time gathering the youth when the sessions were to reconvene; this setup was obviously not very conducive to learning.

6.0.3 Benefits of PS Training

The interviewees mentioned several benefits to the PS training. They felt it had 1) impacted the youth, 2) built community, 3) enhanced relationships and 4) provided resources. These comments are all elaborated on below.

6.0.3.1 Impact on Youth

All individuals interviewed mentioned the relevance of the information that was shared at the training sessions. They all felt it had a positive impact on the youth; it caused them to be better able to take care of themselves, to provide one-on-one support for and to educate other youth. One organizer stated:

> "It's not just about information. We are doing some skill building, self-esteem development, there's the benefits of public speaking that kids always need practice in. And that's one of strengths is to have that opportunity in a safe environment to speak about these things and it's hard because they're difficult issues and some adults don't want to talk about this and it's certainly opened my eyes as to how they see these kinds of issues" (Interview, 12/07).

One youth stated that the sessions helped her educate others through school presentations. She talked about giving presentations at school because she felt that they, as youth, made

the topics more comfortable. She felt it was easier for other youth to ask questions and be educated because they "put it in a way that people understand, not presenting all scientific and complicated, because then people stop listening and caring" (Interview, 02/09).

For some youth the training had more than just a positive impact; it was a life changing experience. One youth said, "I think the Teen Talk has impacted me so much. It helped me decide what to do with the rest of my life and makes me excited to volunteer. It has really opened my eyes" (Interview, 02/09). Guidance counsellors also mentioned a youth who they have seen blossom and said things such as,

> "We have student who teachers think are a pain in the butt and we see that student do some really wonderful things…He liked it and was really passionate about it and in a way that he certainly wasn't into any of his courses. He would get the chairs organized, he would help us with things, and get people calmed down…at the beginning it seems he had the certain image and then he became the biggest poster child (for the program)" (Interview, 10/07).

6.0.3.2 Built Community

A benefit of the PS training was that the area training sessions built community: they brought young people and adults from different communities together. They gave the youth and the guidance counsellors a chance to connect and share ideas. This was significant because it did not happen frequently due to the distance and isolation between the communities. Seeing and interacting with other rural/northern youth in a collaborative manner helped young people open their minds to new ideas or suggestions. Furthermore, it provided youth with support from outside their community and validated their rural/northern reality (Interview, 12/08).

6.0.3.3 Enhanced Relationships

Enhancing the connections between the youth and the guidance counsellors was another benefit of the training. This was accomplished by having the adults involved at different levels such as traveling with the youth, preparing their meals, listening in on sessions, and taking part in the evening activities. The researcher thought this helped the youth and adults feel more comfortable around each other and sent the message to the youth that these adults supported them. The program was seen as a link; "a bridge for youth to be working with adults and I think that some of our early evaluations showed that," as one administrator revealed (Interview, 10/07).

6.0.3.4 Provided Resources

One important benefit was that the training involved empowering youth through the knowledge of and access to resources as stated by both administrators: it provided youth with opportunity. As one organizer stated, "even though sometimes people's fears around building PS and youth was that we're going to expect too much from our youth. It was really enabling the youth to realize their supportive resources and helping them reach out to others. And I think that's been reflected over the years" (Interview, 12/07).

The Teen Talk facilitators brought material resources such as condoms and raised awareness about local resource people such as the public health nurses. In their training completion packages each youth was given a half a box of condoms, water-based lubricant, condom key chains, and printed informative material to distribute. Each youth was given local youth resource sheets created by Teen Talk staff which listed all the places they could go for help and information in their community. The intention of this

sheet was to raise awareness of what was available in each community and to help connect the youth to vital services such as STI testing or a counsellor.

6.0.4 PS Outreach Component: Barriers and Benefits

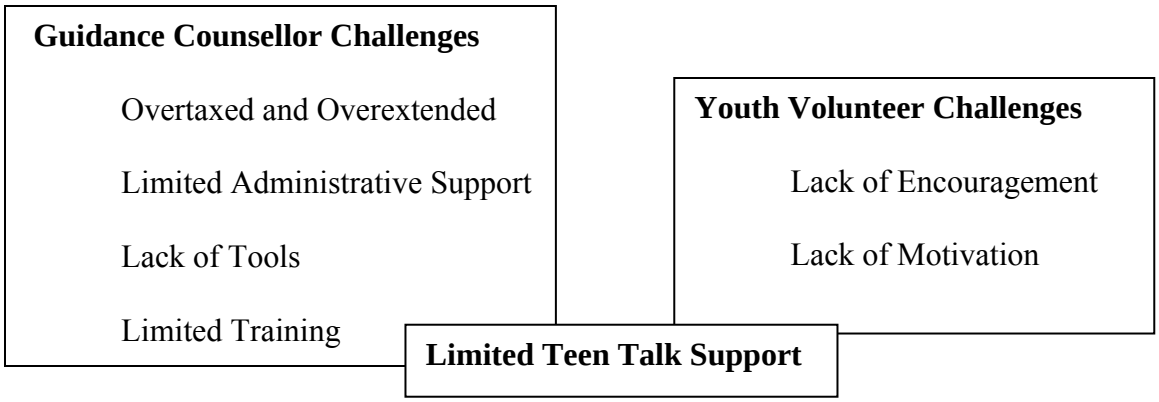
Once the youth had completed the training, they required encouragement to 'take it to the next level' of educating and supporting their peers. While the informal activities, i.e., the one-on-one support, occurred organically, this was not the case with the formal activities. The northern guidance counsellors acknowledged that there was more that needed to be done in that area; the formalized PS outreach component has yet to be established in the northern communities (Interviews, 12/08). In the Interlake the formalized PS outreach component was entrenched in their schools. The challenges and suggestions given by the Interlake interviewees to building this piece of the program are noted below. The benefits they have experienced from having this program in their schools are also noted.

6.0.4.1 PS Outreach Component Barriers

The reported barriers to establishing a PS outreach component (see figure 4) are discussed on the next page.

Figure 4

PS Outreach Component Barriers



6.0.4.1.1 Guidance Counsellor Challenges

There were several barriers to the guidance counsellor role in developing an outreach component. They were limited administrative support, time and training, and lack of educational tools.

6.0.4.1.1.1 Overtaxed and Overextended

The fact that guidance counsellors were often limited for time and overstretched was mentioned by all those interviewed as a barrier to establishing post training activities. "The problem comes with our time as guidance counsellors. We try to meet with them once a month but some months are better than others. Some years you just barely get done what you have to" (Interview, 10/07). It was the case that guidance counsellors in smaller areas are often 'wearing many hats' due to scarcity of human resources. As mentioned by one administrator, "communities are limited in terms of any type of support, in terms of guidance education, or mental health. It's a real challenge often the case is the guidance counsellor is this person who does a lot with the crises that happens"

(Interview, 12/07). Some guidance counsellors were required to teach classes as well as tend to all their counsellor duties. Moreover, many were at times having difficulties trying to meet the needs of the youth when there were very limited services available to refer them to i.e. in some communities the nursing station was the only place someone could access health services and s/he may have to travel to a larger community for additional services.

6.0.4.1.1.2 Limited Administrative Support

The northern guidance counsellors expressed their need for more support from their colleagues and administration. They required this support so they would be better able to encourage and work with the youth following a training session. These counsellors often felt isolated and undervalued.

> "We need more support…but I feel I'm the only one; like it's the guidance counsellor against teachers. It's like these issues are not seen as important…" (Interview, 12/08). "There's a big line here; a divide. There is a barrier between teachers and guidance when we need to work together. The teachers don't think this is as important and we're trying to work on changing that…We need to get teachers on board and on their side" (Interview, 12/08).

The organizers also acknowledged the scarcity of human resources, and the taxing role the guidance counsellor has (Interviews, 10/07; 12/07).

6.0.4.1.1.3 Lack of Tools

One guidance counsellor mentioned her lack of educational tools to organize post training activities. She was not sure what to do with the youth once they were trained, so she approached Teen Talk for some ideas and activities. (Interview, 12/08). One organizer discussed the need and impact of the toolkit.

> "I know this time around the guidance counsellors got a partially developed toolkit to help counsellors move into their schools and it's important so they have some tools to do that and for them to have understanding of that's the thing to do. And for this group they have already met with their students to plan how they're going to get some of the info into the classes." (Interview, 12/07).

6.0.4.1.1.4 Limited Training

One administrator discussed the limited comfort levels among school staff with the health curriculum as a variable. "Teachers are not necessarily comfortable teaching and don't know how to deliver and they often get the RHA or they get the guidance counsellor" (Interview, 12/07). One guidance counsellor mentioned the usefulness of a program that would teach adults how to do these types of presentations (Interview, 12/08). She expressed the need for the school staff to be provided with more training on such sensitive subjects.

6.0.4.2 Youth Challenges

The two documented issues related to the PS volunteers engaging in post training activities were lack of encouragement and lack of motivation.

6.0.4.2.1 Lack of Encouragement

The guidance counsellors all acknowledged that their youth need more encouragement and follow up to establish PS outreach activities. Youth have to have emotional support in order to turn their ideas into reality. In the case of the PS volunteers some acquired knowledge and comfort with the health topics and were interested in initiating activities, but hesitated. For example, some wanted to educate others by running a condom obstacle course in their school; however, they were worried about potential

negative reactions from students. They needed to be encouraged in order to follow through with their plans. This encouragement was not always given. One youth even discussed a situation where they were passively discouraged by the guidance counsellor in their school.

> "We just have Bathroom Betty and Johnny (a question and answer sheet) and that was a struggle to get and it's only in two washrooms. We're on our own. The guidance counsellor doesn't help us and the Public Health Nurse is only there one morning a week. After last year we wanted to do things, we got no response from the school. We had to book an appointment with PHN two weeks in advance because she's so busy" (Interview, 02/09).

6.0.4.2.2 Lack of Motivation

Lack of motivation was cited as a barrier to establishing the PS outreach component. Two guidance counsellors mentioned the challenge of youth not being proactive and waiting for the counsellors because the youth "were not sure what they were to do" (Interview, 10/07). Motivation was stated as imperative for the outreach activities to take form, however, as one youth acknowledged it was often difficult to sustain the momentum once the initial excitement died down (Interview, 02/09).

> "At first we were running around the school telling people what we learned, but we didn't do our presentation like we wanted because we got caught back up in our old routine…We could have taken into our own hands instead of waited for the teachers. We needed motivation and should have gotten together. There was a lack of planning and organizing" (Interview, 02/09).

6.0.4.3 Limited Teen Talk Support

One significant variable was the inability of TT facilitators to provide northern youth and guidance counsellors with the support they required to develop the PS post training outreach component. Once the training sessions were completed, the facilitators returned to Winnipeg. They did not have the resources to intermittently visit these

communities. Being based in Winnipeg made it difficult to keep connected after the training. It was expected that the guidance counsellors, often on their own, take on the coordinating role of the post training support and activities. This was particularly challenging when the guidance counsellors were not quite sure what activities to organize with their youth.

6.0.5 Benefits of the Outreach Component: Positive Impact on School and the PS Volunteers

In the Interlake, the impact of the post training component has been favourable and encouraging. The interviewees discussed the positive impact of the program on the school and the PS volunteers themselves. One guidance counsellor discussed how it broadened the perspective of some youth and developed their inherent skills. She stated that,

> "it's positive (impact on the school and the PS volunteers) and I can only see it becoming more so. I've seen it come a long ways... I know that there's kids talking to the students who have done the training. I think it's a big success. I think it's wonderful for the kids in it...it gives them new contacts and things to think about. I see it as positive. And I see it open up opportunities and get involved in things they're passionate about. And the other thing is really good is that the ones who are separate from a circle of friends. Those who are really marginalized and that population can be hanging out with anyone. And it's those connections that they make that are really powerful. And we give the peer helpers homework to talk to people that they've never talked to before. To make it a better place for everyone. And for the kids who nobody even focuses on and they're so on the outs and I think it's really good. And some kids have no one ever to do things with in the evening and some of these kids do social things on their own. It's a powerful thing even though it's hard to measure" (Interview, 10/07).

The Interlake administrator discussed the community leadership roles that the youth took on post training. She felt the youth had become more comfortable interacting with adults because of this training. She said,

> "Also really important is that…the youth have worked along with other community initiatives as youth leaders because they seem to have gained this openness to working with adults" (Interview, 12/07).

Neither northern guidance counsellor reported having a PS outreach component established in their schools. Both did express an interest in developing one in the future. (Interviews, 12/08).

6.0.6 Summary

The results from the interviews have been noted and the implications are documented in the subsequent discussion chapter.

6.1 Quantitative Results

Once the data was entered into SPSS, histograms were created to determine whether the data met the requirements for a parametric test. The results found the assumption of normalcy was not entirely confirmed; although the frequency distribution was not skewed, it was shaped in leptokurtotic fashion. Therefore, both the paired T test and the Wilcoxon's matched-pairs signed-ranks test were run. The tests were run on the HIV/AIDS Knowledge Test, the Condom Attitude Scale-A, and the Rosenburg Self-Esteem Scale. For the paired T test, all three data sets, the post intervention and the 6 month follow up intervention scales and tests were compared with their corresponding pre-intervention pair. This caused the sample size to decrease from the original 54

participants: because two participants did not complete the post test, the sample size for Comparison 1, the pre and post intervention pairs, was reduced to 52. Because of the poor response rate for Comparison 2, the pre and 6 month follow up intervention pairs, the largest N could be 31. The significance level was set at .05, with a two tailed test, and our hypotheses were:

Ho:u1 ≤ u0	Ho:u2≤u0
H1:u1>u0	H1:u2>u0

6.1.1 HIV/AIDS Knowledge Test

For the HIV/AIDS Knowledge Test, the largest sample sizes were used; an N of 52 for Comparison 1 between the pre and post intervention scores and an N of 31 for Comparison 2 between pre and 6 month follow-up intervention scores. In order to reject the first null hypothesis the researcher had to demonstrate that the participants had a significant increase in their knowledge scores post intervention in comparison to their pre intervention scores. To reject the second hypothesis the participants had to retain the information six months later; this was compared to the pre intervention scores. The table below shows the *p*-value of $p<.000$ for Comparison 1 and for Comparison 2 which implies that both t-tests were significant therefore both null hypotheses could be rejected. In summary, these quantitative results indicate that the PS training did increase the participants' knowledge on the topic of HIV immediately after and 6 months post training. See Table 1 below for a summary of these results.

Table 1

HIV/AIDS Knowledge Test – Paired Samples T Test								
		Paired Differences						
	N	Mean	Std. Deviation	95% Confidence Interval Lower	Upper	t	df	Sig. (2–tailed)
Comparison 1 Pre-Post Intervention	52	-.16269	.17608	-.21171	-.11367	-6.663	51	.000
Comparison 2 Pre-Six Month Post Intervention	31	-.14978	.15444	-.20643	-.09313	-5.400	30	.000

According to the nonparametric test, the Wilcoxon matched-pairs signed-ranks test, comparable results were found to the paired t-tests. The Knowledge Test obtained significance as is noted below in Table 2.

Table 2

HIV/AIDS Knowledge Test - Wilcoxon's matched-pairs signed-ranks test					
	N	Mean Rank	Sum Ranks	Z	A symp. Sig. (2-tailed).
Comparison One t2-t1				5.112	.000
Negative Ranks	8	14.94	119.50		
Positive Ranks	43	28.06	1206.50		
Ties	1				
Total	52				
Comparison Two t2-t1				3.943	.000
Negative Ranks	2	12.75	25.50		
Positive Ranks	25	14.10	352.50		
Ties	4				
Total	31				

6.1.2 Condom Attitude Scale-A

For Comparison 1 on the Condom Attitude Scale-A, 48 participants' data were used; four (excluded) youth did not complete over half of this survey after the intervention. For Comparison 2 there were 30 of 31 potential pairs as one person did not complete this section of his/her 6 month follow up test. The hypothesis that post intervention the participants would have gained a more favourable attitude towards condoms than they had prior to the training was tested. In addition, it was hypothesised that these participants would have retained this positive outlook 6 months later. The table below shows that neither test was significant (i.e., $p>.05$) indicating that the PS training had no impact on the participants' attitudes towards condoms. See Table 3 for more details.

Table 3

Condom Attitude Scale - A – Paired Samples T Test								
		Paired Differences						
	N	Mean	Std. Deviation	95% Confidence Interval Lower	Upper	t	df	Sig. (2–tailed)
Comparison 1 Pre-Post Intervention	48	-1.40625	6.57847	-3.31644	.50394	-1.481	47	.145
Comparison 2 Pre-Six Month Post Intervention	30	-.85000	6.02533	-3.09990	1.39990	-.773	29	.446

The Condom Attitude Scale-A did not obtain significance as is noted below in Table 4.

Table 4

Condom Attitude Scale - Wilcoxon's matched-pairs signed-ranks test					
	N	Mean Rank	Sum Ranks	Z	A symp. Sig. (2-tailed).
Comparison One t2-t1				1.717	-.757
Negative Ranks	17	21.50	365.50		
Positive Ranks	28	23.91	669.50		
Ties	3				
Total	48				
Comparison Two t2-t1				.086	.449
Negative Ranks	9	17.50	157.50		
Positive Ranks	18	12.25	220.50		
Ties	3				
Total	30				

6.1.3 Rosenburg Self-Esteem Scale

The sample size for Comparison 1 of the Rosenburg Self-Esteem Scale was 51 as one person did not complete the pre survey. There were 30 participants in Comparison 2 because one person did not complete this section of the 6 month follow up survey and one person did not complete the pre survey. The hypotheses that post intervention the participants would have gained a higher self-esteem score than they had beforehand was tested. In addition, that six months later they would have retained this positive self-esteem score was tested. The table below shows that neither test was significant (i.e., $p>.05$), indicating that the intervention, the PS training, had no impact on the participants' self-esteem. See Table 5 for details.

Table 5

The Rosenburg Self-Esteem Scale – Paired Samples T Test								
		Paired Differences						
	N	Mean	Std. Deviation	95% Confidence Interval Lower	Upper	t	df	Sig. (2–tailed)
Comparison 1 Pre-Post Intervention	51	-.43137	2.48399	-1.13001	.26726	-1.240	50	.221
Comparison 2 Pre-Six Month Post Intervention	30	.8333	3.10820	-.32729	1.99396	1.468	29	.153

The Rosenburg Self-Esteem Scale did not obtain significance either see Table 6.

Table 6

The Rosenburg Self-Esteem Scale - Wilcoxon's matched-pairs signed-ranks test					
	N	Mean Rank	Sum Ranks	Z	A symp. Sig. (2-tailed).
Comparison One t2-t1				.957	.339
Negative Ranks	22	17.09	376.00		
Positive Ranks	20	26.35	527.00		
Ties	9				
Total	51				
Comparison Two t3-t1				1.560	.119
Negative Ranks	16	13.72	219.50		
Positive Ranks	9	11.72	105.50		
Ties	5				
Total	30				

Chapter Seven

Discussion and Conclusions

7.0 Implications of the Qualitative Results

7.0.1 The Great Impact of Geographical Distance

Due to the great surface area that Manitoba's rural and northern school divisions cover, geographical distance has always been an issue that needed to be factored into any programming brought into the communities. The geographical distance has had a far reaching impact on the establishment of PS in its original form. As documented by the qualitative results in section 6.0, it has brought challenges to all facets of the PS trainings and post training outreach components; its coordination, its layout, its enrolment, its curriculum and its post training outreach activities and expectations. Therefore many aspects of the program had to have been modified.

For example, pertaining to the layout and curriculum, the sessions have been shortened in order to incorporate all the topics into the three/four day training. The only other option in northern areas would have been to cut out entire topics from the training. The Teen Talk facilitators have refused to do this because they felt all the information was vital and each youth had different topics that were most relevant to them. As a result, the training days were very long.

Training recruitment, another example, has been greatly affected by distance in that only a few selected youth, expected to engage in post training outreach activities have been given the privilege of attending. This has excluded potentially many youth who may have had an interest in participating had there been no post training expectations. In addition, the in-person support Teen Talk could provide to urban schools

and guidance counsellors has simply not been available to those beyond Winnipeg. In the city, Teen Talk staff has been able to visit schools to promote the training, to meet with the in-school Peer Support group and to discuss their post training outreach activities such as awareness events and resource lockers. This type of support has not been feasible to provide to those schools farther away, as Teen Talk has had neither the human nor financial resources.

7.0.2 The Financial Cost of Distance

Additional time and financial resources were needed to bring together youth from different communities. Due to the fact that school divisions are often short of time and financial resources, 'thinking outside the box' for alternative approaches to delivering education to numerous sites is key. Interactive television, video conference calls, and instant messaging are examples of tools used to educate individuals at several sites without physically being present. These tools should perhaps be explored for future training sessions because of their less costly and less time consuming nature. In the end it should be noted that financially the training session, however substantial, in comparison to urban trainings, was nevertheless quite cost-effective. This was due to the fact that everyone with the exception of the facilitators was using the school for meals and accommodation by sleeping on the classroom floors and preparing the meals in the cafeterias - a norm for Northern gatherings but rarely ever seen in city gatherings.

7.0.3. Relevant Curriculum

When an education program is taken beyond its intended scope, its assumptions need to be taken into consideration and the curriculum adapted to meet the needs of its

new population. Although all interviewees had seen the sessions, none mentioned the lack of culturally-appropriate curriculum, particularly in regard to Aboriginal communities. As noted by the Aboriginal Nurses Association of Canada (ANAC), in *Finding Our Way: A Sexual and Reproductive Health Sourcebook for Aboriginal Communities,* (2002), Aboriginal health programs need to be culturally-appropriate. In a global review of 38 peer-reviewed articles and 14 community reports on HIV prevention with Aboriginal youth, the authors (Ricci et al., 2009), summarized lessons learned into emerging 'wise' practices. They found 13 articles that called for culturally-relevant HIV prevention education. They reported that taking a pan-Aboriginal approach would likely be unsuccessful and the messages need to be tailored specifically to the environment in which the youth live.

Developing a culturally-relevant curriculum would make the PS program more effective. As illustrated by the OFIFC study, participants who identified with Native spirituality were less likely to have had a pregnancy by 11 percentage points than those who identified with Christian and non spiritual ways (OFIFC, 2002). For the Teen Talk curriculum to become culturally appropriate it would need to incorporate characteristics such as 1) Elders and various members of the community, 2) strong sense of community and shared responsibility among members, and 3) local culture into programming (ANAC, 2002; OFIFC, 2002; Ricci et al., 2009, Thomas, 2007). These suggestions are only a beginning to developing a culturally appropriate program. For example, in the general introduction at the beginning of a session or workshop the Teen Talk facilitator could recognize and pay respect to the territories that the training is being held on. A step further would be that the training would be part of a larger initiative. For example it could

be incorporated into a community wellness week where the youth engage in a variety of activities such as drum ceremonies, tepee raising and sharing circles. All these events could be delivering the same message of self-respect, and respect for others i.e. the message that my partner and I are worth protecting and using a condom for.

7.0.3.1 Participant and Community Reactions: Culture and Religion

Aboriginal cultures and religious values were often mentioned informally as reasons that sexuality was not discussed by some adults and youth involved. The researcher often heard comments comparable to what one youth stated in the OFIFC document "In a traditional home you don't talk about sex." (OFIFC, 2002, p.48). Research has documented that it has become a cultural norm for Aboriginal people to not discuss sexuality openly (ANAC, 2002; Thomas, 2007).

Sexuality was not always seen as shameful in Aboriginal communities; traditionally in Aboriginal cultures sexuality was seen as a gift and a source of great pleasure (ANAC, 2002; Thomas, 2007). Community adults openly taught children about their bodies, the moon time, and other sexual and reproductive passages. The *Kokums*, Grandmothers, were the keepers of the knowledge of herbal medicines for, among other things, birth control. This perspective was lost with the influence of the church and residential schools. The impact of the church-run schools, what the schools taught about sex, and the sexual abuse experienced there has made talking about sex for many Aboriginal people taboo (ANAC, 2002; Thomas 2007). "They say in the old days there was a way to talk about this sex business. But I don't remember anyone showing me. The mission school just told us sex was bad" (ANAC, 2002). "My mother was taught that

they can't talk about sex because they would be punished by God" (Thomas, 2007, P. 21). Over a hundred years of residential schooling has taken its toll.

As a result important conversations on STI and HIV and harm reduction by using condoms for example are few or nonexistent in some Aboriginal communities. There is limited discussion of the different scenarios in which people engage in sex and how to protect themselves from STI and HIV. There are serious implications to the lack of action especially since Aboriginal youth have significantly higher rates of STI including HIV (Boulos et al., 2005). Additional factors to consider are that the higher rates of HIV among the Aboriginal population are attributed to 1) more travel between reserves and urban communities; 2) the residential school experience-the sexual abuse and sexual violence in the communities; 3) a breakdown of the family and stress and relationships; 4) poor access to health services; 5) a loss of parental guidance and support; and 6) poverty (ANAC, 2002). These factors must be considered in any health programming designed for an Aboriginal population.

7.0.3.2 Addressing the Impact of Colonization in Programming

Ricci et al. (2009) found that 'wise' practices addressed the socioeconomic and systemic factors that place Aboriginal youth at risk in HIV prevention programming. These programs examined root causes such as racism, assimilation, residential school system legacies, and isolation. Colonization and over a century of government policy removing Aboriginal children from their families and forcing them to become assimilated and subjected to sexual and physical abuse at church run residential schools undeniably affects the well being of today's Aboriginal youth.

The impact this history has on Aboriginal sexual health and well being are: 1) Families and communities are not as open and trusting as they could be, so it is hard to address people's needs. 2) Women, men, parents, grandparents, and children find it difficult to talk about sexual issues because of embarrassment and painful memories. 3) Many parents did not have a healthy sexual education so they cannot teach their children. 4) Parents and grandparents may not have good relationships so they cannot be good role models. 5) It is hard for all generations to make good decisions about sexual health because no one learned to make decisions at all (ANAC, 2002). These historical and current perspectives are important to consider when working with Aboriginal youth. A current Teen Talk illustration of this impact was a conversation an Aboriginal Public Health Nurse had with Teen Talk staff. She acknowledged her discomfort discussing sexual health topics explaining that she was taught not to talk about sex but is required by her profession to bring such important information to her community and asked for assistance in overcoming this barrier (Personal communication, May 28, 2009).

7.0.4 The Value of Support

While many of the challenges and concerns are noted, adult support and involvement was a key ingredient to organizing a successful PS training and outreach program. The guidance counsellors had a very significant role which should not to be understated. Their support throughout the organization of the training and establishment of the outreach program within the high school setting was vital. However, in order for the guidance counsellors to provide the required support, the backing by the school administration was necessary. There appeared to be a chain reaction; where the more support the administration provided, the easier it was for the guidance department to

provide support for their youth. In circumstances where there was little support, it made organizing a training session much more challenging. As one youth mentioned, had they "had more support from the school and guidance counsellor, it (attend the training) would have been a lot easier" (Interview, 02/09).

As many guidance counsellors were overtaxed, this program was another undertaking that could be seen as being added to their overwhelming schedules. More collaboration and sharing of workloads would be required among school staff to best meet the needs of their students. One administrator spoke of a paradigm shift that needed to occur within the school system order for such a program to reach its full potential. He said that,

> "In the beginning it is alright to start with the guidance counsellor, but then to move into the school as a whole, so that all the teachers understand what needs to be done and not just something that is seen as the guidance's role or realm. It's trying to change the mindset of how a lot of this programming is done in the schools. That student is now everyone's responsibility and that school needs to work together as a whole to support that student." (Interview, 12/07).

Changing the approach some school staff have towards alternative forms of education and to their students is a grand task, and one which this researcher is sceptical of occurring easily.

The support role, while a main component to the success of this program, does not necessarily have to come from the guidance counsellor. Any school staff or individual essentially could contribute substantially to establishing such a program because no technical or specialized skill is necessary - just the intrinsic ability to support. However, without that adult support or ally as was mentioned by numerous interviewees, the program would not be launched or continued.

7.1 Implications of the Quantitative Results

7.1.1 The Theory of Planned Behaviour and The Unplanned Nature of Youth Sexual Activity

The theory of planned behaviour was used as the rationale for the quantitative study because it has been found to be an effective theoretical foundation for STI/HIV interventions and condom use (Ajzen cited in Stroebe & Stroebe, 1995). It should be taken into consideration however, that sexual activity amongst teens is not often planned, as demonstrated in the CYSHHAS study (2003): 28% of male and 36% of female 9th graders and 28% of male and 21% of female 11th graders indicated that the reason they did not use a condom at last intercourse was because they did not expect to have sex.. Research has documented that use of drugs and alcohol is associated with sexual activity and sexual risk-taking behaviour among youth (Biglan et al., 1990; Boyce, 2004; Boyce et al., 2003; Fortenberry et al, 1997, OFIFC, 2002.) In the 2002 OFIFC study, "youth talked about how sex typically happens when there is partying and that people were more likely to lose their inhibitions about sex when under the influence of alcohol or drugs" (OFIFC, 2002). The CYSHHAS (Boyce et al., 2003) documented that youth reported the influence of drugs and alcohol as the third reason cited for first sexual intercourse. The same study reported that between 20% and 40% of youth used alcohol and drugs before engaging in sexual intercourse (Boyce et al., 2003). These statistics have serious implications because youth under the influence of drugs and alcohol were reportedly less likely to use protection, thus placing themselves at a greater risk of STI and HIV (Godin & Michaud, 1996; OFIFC, 2002). Consequently this issue questions the legitimacy of this theory being part of the quantitative study. In future research, more emphasis needs to be

placed on situational factors and uncontrollable circumstances; therefore a more suitable theory would be required.

7.1.2 Possible Reasons for No Impact on Condom Attitude Scale

The training sessions did not have a significant impact on the attitudes the youth had towards condoms; the age of the participants needs to be taken into consideration. Many youth were 14 or 15, thus many of the PS training participants may not yet have had a sexual partner or been in a sexual relationship. It has been found that less than 50% of students by Grade 11, age 16 or 17, have had engaged in sexual intercourse at least once (Boyce et al., 2003). Therefore it would stand to reason that many PS training participants may not have had any experiences to draw from. As a result many of their quantitative responses toward condoms would have been speculative - what they *would* do in that situation or how they *would* feel. Again because these situations are dealing with the hypothetical, it is questionable as to how much this impacts that individual's actual behavior. One theory the researcher has as to why the scores on the Condom Attitude Scale - A were not significant is that their post training responses were more accurate and realistic. It is reasoned that without prior knowledge and experience, youth would speculate what they would do. For example, "of course I would always use a condom." However, once many of the factors and challenges related to condom use or personal experience were introduced, their self reporting may have become more representative of what they would actually do.

Another theory is that the contact the youth had with Teen Talk and the safer sex messages was too short. If the PS training participants had been able to remain more connected with the PS, they would have been more exposed to 'positive peer pressure'.

Once they would have become PS volunteers and engaged in outreach activities as a group the researcher feels they would have internalized the safer sex messages more; they would have been encouraged by each other and the Teen Talk staff. It would be interesting to administer this scale to the in-city PS training participants, who do have more Teen Talk support, to determine if the program has a positive impact on their condom attitudes when the additional support is present. However, it should be noted that the program did have a significant impact on the participants' knowledge post intervention and on the follow up. They did gain a greater understanding of HIV even six months later.

7.1.3 Possible Reasons for No Impact on Self-Esteem Scale

It is also believed that there was no significant impact of the Self-Esteem Scale because the support and contact that the study participants had with Teen Talk was limited. Again, it would be interesting to administer this scale to the in-city PS training participants to determine if the training has a positive impact on their self-esteem. It is hypothesized that PS volunteers would gain self-esteem by engaging in outreach activities. Again, it would be interesting to confirm this hypothesis in the future.

Another theory is that this scale was not culturally appropriate for the population it was administered to. It is very individualistic in terms of how self-esteem is assessed. Perhaps a scale that is more specific to Aboriginal cultures would have found different results.

7.2 Summary

The most significant aspect of this study is that it described the supports and barriers to expanding and delivering such a health education program beyond its normal scope. With the program being implemented in rural and northern Manitoba, it gave Teen Talk a snapshot of how the Teen Talk PS program has been perceived and received in these areas. This is particularly beneficial information for the program because it helped shed some light into additional issues that need to be taken into consideration to better meet the needs of these youth and their communities.

7.3 Research Methodology Issues

7.3.1 Study Limitations: Descriptive

The greatest limitation is that this is simply a descriptive piece so it does not have any evaluative results. However, it can help others who are expanding similar programs or who are encountering comparable issues by providing them with some guidelines, or validating their concerns. In addition, it provides Teen Talk with some documentation on issues to consider when further developing the program.

7.3.2 Sampling Method Issues

The researcher used a purposive rather than a random sampling process for the qualitative component of this study. As this was intended to be a descriptive overview of the extension of Teen Talk PS training program, this sampling method was appropriate. The depth and insight of the responses given by the chosen participants was felt to be more important than the representativeness of the sample.

7.3.3 Sample Size Limitations

The sample size of the quantitative data was small and thus provided limited power and statistical precision. These two issues (sampling method and sample size) limited the ability of the results being applied elsewhere.

7.3.4 Sample Limitations

It is also important to note that the quantitative data cannot be generalized due to the low statistical power of small sample size. When interpreting the results for sexual risk-taking behaviour, caution must be used. Moreover, the findings are limited by the validity of the self-reported measures; this study relies on self-reported measures and not observed behaviour changes. The youth provided self-reported sexual behaviour and as a result the young people may have been hesitant to reveal information on the topic of sexual health and may have leaned toward socially accepted responses.

7.4 Implications and Directions for Future Trainings

Essentially what is conveyed is that these northern and rural training sessions became their own entity rather than an extension of the in-city trainings. This is noteworthy because it implies a paradigm shift i.e., it requires the Teen Talk staff to see this as its own program and to not think of it as a modified version of the in-city peer support. More time should be taken by Teen Talk to research the history, culture and traditions of a community prior to entering and build relationships with the community. The curriculum and the facilitators need to be more flexible; the curriculum needs to engage the rural and northern youth at their level. It reaffirms the notion that youth sexual health education needs to have a comprehensive focus. It must extend beyond exploring

knowledge, attitudes and behaviour to understanding the motivational factors, context, and action-prompting in which youth engage in sexual activities that inform not only unsafe sexual behaviour but varying degrees of safer behaviour as well (Boyce et al., 2003). For example, what are the unplanned circumstances in which youth find themselves when they do have sex? How are parties and peer pressure involved? Are they having sex to "keep their partners" or just to "get it over with?" From where are youth getting their messages about sex? These issues need to be addressed and applied in the local context to reduce the transmission of STI and HIV.

Consequently, if a paradigm shift does occur, the logical next step would be to allocate the time and resources, both financial, and human, required to adequately develop such a new program to make it most relevant to rural and northern youth, specifically Aboriginal youth.

In the north, the goal was to mandate the schools to organize the peer trainings on a rotating basis, and for this to occur there needs to be divisional support.

> "We have a model within the organization where schools do organize large events like the Frontier Games which runs across our school division and through multiple venues…The mandate has been given to the school by the division and the program has been running for 20 plus years. Everyone knows their responsibilities once it happens. That's the best way to do it because it gives a focus and task to a specific body" (Interview, 12/07).

They have had much success with this approach and feel in the future the schools will take more ownership of the programming that way. The next logical step to reaching this goal would be to demonstrate the impact and effectiveness of this program to the administration and school staff in order to obtain their approval to integrate it into the

school calendar. It is hoped by the researcher that this thesis will help them obtain that approval.

The Interlake guidance counsellors prefer having the IRHA involved in the trainings. They expressed concerns that they would have if it was organized and run divisionally.

> "I think that it's as effective as it is because coming from outside and it's delivered by you. I think we could help organize but with different schools… we can find it difficult to organize with another school and we are trying to coordinate and it can be challenging. So to have it come from someone else is a good thing and we try to support the RHA so that the trainings work well. But it's good to have it done by something else. Connections too are important; as are training people from different agencies coming in and I think it's good for the peer supporters to see and I think they get the idea that there's lots of places where they can go for assistance" (Interview, 10/07).

They feel that the current set up is ideal for their area.

Interestingly as is demonstrated, there is no standard approach to what type of set up this program should have. Adequate resources and flexibility within Teen Talk are necessary in order to best meet the needs of an area by tailoring a PS training session specifically for that community. In order to be more effective the PS program has to be one component of a comprehensive approach and community wide effort. As noted in chapter two and found in the present research, one-shot interventions do not provide the resources necessary for this type of program to be effective or self-sustaining (Puentes et al., 2003). There needs to be a greater commitment from the school/community; a group of adult allies must be assigned to develop and maintain the program. As found by Puentes et al., 2003, and confirmed by the current research, school financial constraints, lack of involvement by adult allies, and lack of support by the administration all hinder

the success of peer initiatives. In the future, more time and attention need to be taken by the Teen Talk staff to build relationships with communities and to take a wider approach in best meet the needs of specific youth. It cannot be building connections only with the youth participants. Teen Talk staff must continuously connect and engage and work with the adult allies and community members in order to ensure sustainability. In addition, the entire community must be committed and Teen Talk should only be complementing pre-existing programming and not be the entire program. As concluded in the Y-PEER Trainer's Manual peer education is and can only be one piece of the puzzle; one part of the complex puzzle of improving young people's sexual and reproductive health by preventing STI/HIV.

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Appendix A: Teen Talk's Operating Principles

*The following definitions are intended to:

- Broadly define and describe our principles;
- Provide an ideal or direction towards which we aspire;
- Establish a common language; and
- Serve as a reference point for the development of services and documents.

These principles are meant to be fundamental and relevant across our program and organization as a whole. It is acknowledged that these guidelines represent the ideal and, as such, may not be achievable due to internal and/or external factors. However, because Teen Talk recognizes youth as a vulnerable population, these principles describe what we hold to be core to our program and our service philosophy. Teen Talk recognizes that these principles are fluid and may overlap from one category to the next. This is meant to be a "living document" and as such, some terms are subject to change.

*Excerpted and paraphrased from Klinic CHC Directional Guidelines found in Klinic Policy Manual.

Harm Reduction: A set of strategies and tactics that encourages people to reduce harm to themselves and their communities, through the sharing of relevant information, facts and practical material tools, that will allow them to make informed and educated decisions (Manitoba Harm Reduction Network – **www.harmreductionnetwork.mb.ca**).

For Teen Talk, Harm Reduction strategies are encompassed by an Abstinence Plus perspective that focuses on meeting youth "where they are at" and is frank as well as non-judgmental. Meeting youth where they are at reminds us that youth are not a homogenous group and that it is important to validate the experiences of all youth – those who are achieving abstinence as well as those who are engaging in risk-taking behavior.

Sex Positive: This refers to the principle that sexual health is a basic human right throughout the lifespan; that the definition of sexuality be broad and comprehensive; and focuses on the life-enhancing aspects of sexuality as well as attention to any potential harm.

Youth Oriented: This refers to a set of tools and strategies that are used to bring youth information in a way that is relevant to them. Such tools include being developmentally appropriate, using language that is accessible (free of jargon), using humor, and adapting to the needs of each group.

***Empowerment**: This model promotes participation of people, organizations, and communities towards goals of individual and community control, improved quality of life, and social justice. It recognizes that every person has the right to accurate

information and the choice to make decisions that impact their personal health and well-being. This approach shares tools with people to make informed choices for themselves.

Pro-Choice: Supporting the legal right of women and girls to choose whether or not to continue a pregnancy to term.

Feminist Perspective: This is the commitment to gender equality and social justice for all. This perspective advocates for awareness, education, activism, and empowerment (including the elimination of stigma). This perspective recognizes power imbalances that exist in society and strives to eliminate all forms of oppression.

Addressing Oppression: This is a commitment to recognize, address and challenge all forms of discrimination. This includes actively working toward the goal of full and equal inclusion of all the youth that we serve as well as the members of our organization and society as a whole.

Capacity-Building: The development of sustainable skills, organizational structures, resources and commitment to health improvement in youth and communities; to prolong and multiply health gains many times over. For example, Peer Support Program, Teen Talk North.

LGBTTQ Positive:** This is the commitment to promote healthy sexuality for LGBTTQ** youth by challenging homophobia, heterosexism, and gender stereotyping, as well as ensuring safe space on Klinic premises for staff and volunteers of Teen Talk.

Appendix B: Teen Talk's Workshop For Youth Descriptions

Youth Sexuality: What is sexuality? In this workshop we attempt to answer this question as well as facilitate discussion on youth sexuality by examining the factors that affect sexuality including our values, laws, gender identity, sexual orientation, body, and mind. Students will have a chance to explore choices regarding their sexuality through discussions and small group work.

Teen Dating Violence 1: A video and discussion will be used to help participants identify various forms of abuse that occur in teen dating relationships. The cycle of abuse, typical warning signs of abuse, and safety plans will be discussed with participants and appropriate community resources will be provided. Qualities of a healthy relationship will be explored at the end of the workshop.

Birth Control 1: Participants will have the opportunity to discuss things to consider before sex, and excuses and responses to condom use. They will gain direct knowledge of anatomy and the most common forms of birth control ranging from abstinence to condom use. Information on the effectiveness, the availability, and proper usage of various methods of birth control will be covered.

STI (Sexually Transmitted Infections)/HIV: This workshop will introduce students to the most common STIs - highlighting the key symptoms, unsafe behaviors, and important measures including abstinence, condom use, and STI testing. Additional emphasis will be given to the importance of responsible decision-making, regular medical testing, and open dialogue with sexual partners.

Appreciating Diversity 1: The purpose of this workshop is to examine the destructiveness of discrimination in society and to identify the linkages existing between different forms of discrimination (sexism, racism, homophobia, etc.). We aim to create/facilitate discussion on the many ways their diversity is not appreciated in order for youth to provide their own answers and workable solutions.

Mental Health: This workshop helps youth understand mental health and recognize symptoms of various mental illnesses and issues through stories. We address myths associated with mental health and suicide, explore feelings during a hard time, support, treatment options, coping strategies, and where to go for help in an interactive manner.

Communication Skills: This workshop looks at effective communication skills with a focus on passive, aggressive, and assertive styles of communication in relationships. The harmful effects of rumors are also discussed as well as a look at how media and gender roles can influence the ways that we communicate. Emphasis is placed on issues of consent, sexual decision-making and negotiating safer sex.

Body Image: This workshop helps youth look at ways to prevent/deal with negative body image by examining harmful messages presented in the media and common attitudes and myths in society at large. We also explore the link between negative body

image, unhealthy behaviors (such as disordered eating and over-exercising, sexual risk taking, and low self-esteem) and depression. A group brainstorm provides ways to feel good about their bodies and themselves.

Substance Use Awareness: An interactive workshop that provides youth with information on the effects of different substances, examines the reasons why youth make the choices they do about alcohol and other drugs and provides harm reduction information.

Pregnancy Options: Participants will be given a presentation that outlines all three legal options (adoption, abortion, and parenting) available to youth in Manitoba after a pregnancy has occurred. The workshop is designed to give youth a realistic picture of all choices and resources available to them. Students will also participate in a game that focuses on the realities of teen parenting.

HIV/AIDS Awareness: The HIV/AIDS workshop is designed to give participants accurate information on HIV/AIDS including how the virus is transmitted, how it compromises the immune system, and where to go for testing though interactive storytelling. Activities include an interactive game on risky behaviors and prevention.

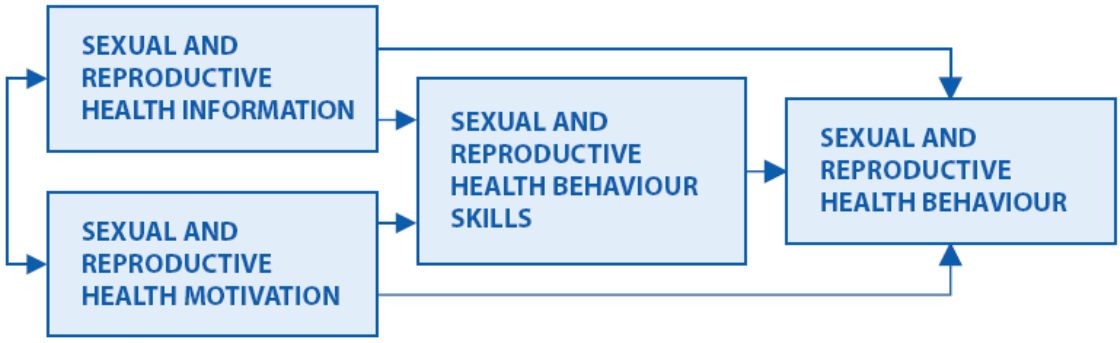
Appendix C - Teen Talk PS Volunteer Monthly Statistics Form

Month _____ **School** _____

Name _____ **Number** _____

	Hours	Number of People	Other
Peer Support Training	☐		
Peer Support Presentations			
Skits and/or Mission Protection			
Rehearsal/Preparation Time	☐		
Presentation Time	☐	☐	
Promotional/Info Presentations			
Rehearsal/Preparation Time	☐		
Presentation Time	☐	☐	
Peer Support Information			
Create 'Zine/Rural Newsletter	☐		
Give out 'Zines		☐	
Peer Support School-Based Activities			
Bathroom Betty and Johnny	☐		
Organize TT School Events	☐		
Acting as a Resource to Peers		☐	
Signing Up Youth for Training		☐	
Talking to Classes	☐	☐	
Talking to School Administrators		☐	
Giving Condoms (how many)			☐
Performing Condom Demos		☐	
Doin' your own thing			
(e.g.) _____	☐	☐	☐
Monthly Meetings	☐		
Community Activism/Awareness Raising Events/Representing Teen Talk (e.g. Participating in Marches/Fast Action)	☐		
Referring to Manual (how often)			☐

Appendix D: Information, Motivation, Behavioural Skills Model



Note: Adapted from Fisher, W.A., & Fisher, J.D. (1998). Understanding and promoting sexual and reproductive health behaviour: theory and method. Annual Review of Sex Research, 9, 39-76.

Appendix E: Consent and Assent Forms

Consent Form For Parents of PS Training Participants

RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM

Title of Study: A Program Description: The Effects of the Teen Talk Peer Support Program Barriers and Facilitators to the Outreach Component

Principal Investigator: Eveline Buehlmann, 506 Stiles St., Winnipeg, MB, R3G 3A4, (204) 784-4010

You and your child are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you and your child may have with the researcher. You may take your time to make your decision about participating in this study and you and your child may discuss it with your friends or family before you make your decision. This consent form may contain words that you do not understand. Please call the researcher to explain any words or information that you do not clearly understand.

Purpose of Study

The purpose of this research study is to gain some knowledge and feedback of the impact of the Teen Talk Peer Support Program. (PS) The first objective is to examine some of the barriers and facilitators of the Teen Talk Peer Support program's outreach component through interviews with youth and school staff involved with youth. A second objective is to assess the impact of the PS program on the PS volunteers' knowledge, attitude, self-esteem, self-efficacy and intentions in regards to STI, HIV and condom use.

A total of 50 participants will participate in this study.

Study procedures

All the PS volunteers who sign up for this training will be asked to participate. In addition, other youth and a staff involved with the PS youth in the school setting will be asked to participate.

If you and your child are to take part in this study, you will have the following procedures:

Participant Initials _____

The following battery of tests and scales will be administered to your child confidentially and anonymously pre and post training and 3 months later. The PS Volunteer Outreach Form will be collected on a monthly basis.

- **STI and HIV/AIDS Knowledge Test. Eighteen true-false items will be used to assess the youth's level of STI and HIV/AIDS knowledge.**

- **Condom Attitude Scale - A. Twenty-three items will be used to assess the youth's overall attitudes towards condoms score.**

- **Condom Use Self-Efficacy Scale (CUSES). Thirteen items will be used to assess the perception of the youth's ability to use condoms.**

- **Self-esteem Scale. Ten items of the Rosenberg's (1965) Self-Esteem Scale will be used to assess the youth's self-esteem.**

- **Intentions to Use Condoms. This survey focuses on the youth's intention to use condoms.**

- **Peer Support Volunteer Outreach Form. The Peer Support Volunteer Outreach Form will be administered on a monthly basis. It collects PS volunteers' hours and contacts in regards to peer support initiated formal and informal activities.**

The surveys will take a half an hour to complete.

In addition, interviews will be held with one PS volunteer per training, two youth, and an adult support from the schools of that PS volunteer. The interview consists of questions concerning their perceptions of the Peer Support outreach component's challenges and facilitators in their school. The interviews will take place 3 months post training and will be confidential and no names will be used. The interviews will be audio-taped and last under an hour.

Participation in the study will be for 4 months. You and your child can stop participating at any time. However, if you and your child decide to stop participating in the study, we encourage you to talk to the researcher first.

Participant Initials _____

Benefits

There may or may not be direct benefit to you from participating in this study. We hope the information learned from this study will benefit the Teen Talk Peer Support Program in the future.

Costs

All the procedures, which will be performed as part of this study, are provided at no cost to you and your child.

Payment for participation

You and your child will receive no payment or reimbursement for any expenses related to taking part in this study.

Confidentiality

Information gathered in this research study may be published or presented in public forums, however your name and other identifying information will not be used or revealed. All study related documents will bear only your child's assigned study number. Although confidentiality and anonymity is protected, individuals may be identifiable because of their unique characteristics.

Everything in the interviews will be held in confidence and not be repeated out of interview. The interviews will be transcribed and analyzed for common trends and themes.

The University of Manitoba Health Research Ethics Board may review records related to the study for quality assurance purposes.

All records will be kept in a locked secure area and only the researcher will have access to these records. The data will be stored for two years. No information revealing any personal information such as your name, address or telephone number will leave the University of Manitoba.

Voluntary Participation/Withdrawal from the Study

Your decision to take part in this study is voluntary. You and your child may refuse to participate or you may withdraw from the study at any time. If the researcher feels that it is in your best interest to withdraw you from the study, they will remove you without your consent.

Participant Initials _____

Questions

You and your child are free to ask any questions that you may have about the study and your rights as a research participant. If any questions come up during or after the study contact the researcher at (204) 784-4010 or evelinebue@yahoo.com. You may also contact her advisor, Dr. Elliot at (204) 789-3404 or elliottl@cc.umanitoba.ca.

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389

Do not sign this consent form unless you and your child have had a chance to ask questions and have received satisfactory answers to all of your questions.

Statement of Consent

I have read this consent form. I have had the opportunity to discuss this research study with Eveline Buehlmann if needed. I have had my questions answered by her in language I understand. I believe that I have not been unduly influenced by the researcher to participate in the research study by any statements or implied statements. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board, for quality assurance purposes.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

For Youth

Parent/legal guardian's signature_____Date _____
(day/month/year)

Parent/legal guardian's printed name: _____

Parent/legal guardian's phone number: _____

Youth's signature _____ Date _____
(day/month/year)

Youth's printed name: _____

I, the undersigned, attest that the information in the Participant Information and Consent Form was accurately explained to and apparently understood by the participant or the participant's legally acceptable representative and that consent to participate in this study was freely given by the participant or the participant's legally acceptable representative.

Witness signature_____ Date _____
(day/month/year)

Witness printed name: _____

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent

Printed Name: _____Date _____
(day/month/year)

Signature: _____

Role in the study: _____

Consent Form for the Adults Participating in the Interview

RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM

Title of Study: A Program Description: The Effects of the Teen Talk Peer Support Program Barriers and Facilitators to the Outreach Component

Principal Investigator: Eveline Buehlmann, 506 Stiles St., Winnipeg, MB, R3G 3A4, (204) 784-4010

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with the researcher. You may take your time to make your decision about participating in this study and you may discuss it with your friends or family before you make your decision. This consent form may contain words that you do not understand. Please ask the researcher to explain any words or information that you do not clearly understand.

Purpose of Study

The purpose of this research study is to gain some knowledge and feedback of the impact of the Teen Talk Peer Support Program (PS). The first objective is to examine some of the barriers and facilitators of the Teen Talk Peer Support program's outreach component through interviews with youth and school staff involved with youth. A second objective is to assess the impact of the PS program on the PS volunteers' knowledge, attitude, self-esteem, self-efficacy and intentions in regards to STI, HIV and condom use.

A total of 50 participants will participate in this study.

Study procedures

You as the staff involved with the PS youth in the school setting will be asked to participate.

If you are to take part in this study, you will have the following procedures:

Interviews will be held with you in addition to one PS volunteer, and two youth, from the schools of the PS volunteer. The interview consists of

Participant Initials _____

questions concerning their perceptions of the Peer Support outreach component's challenges and facilitators in their school. The interviews will be confidential and no names will be used. The interviews will be audio-tape and last under an hour.

This is a one time only interview. You can stop participating at any time. However, if you decide to stop participating in the study, we encourage you to talk to the researcher first.

Benefits

There may or may not be direct benefit to you from participating in this study. We hope the information learned from this study will benefit the Teen Talk Peer Support Program in the future.

Costs

All the procedures, which will be performed as part of this study, are provided at no cost to you.

Payment for participation

You will receive no payment or reimbursement for any expenses related to taking part in this study.

Confidentiality

Information gathered in this research study may be published or presented in public forums, however your name and other identifying information will not be used or revealed. All study related documents will bear only your assigned study number. Although confidentiality and anonymity is protected, individuals may be identifiable because of their unique characteristics.

Everything in the interviews will be held in confidence and not be repeated out of interview. The interviews will be transcribed and analyzed for common trends and themes.

The University of Manitoba Health Research Ethics Board may review records related to the study for quality assurance purposes.

All records will be kept in a locked secure area and only the researcher will have access to these records. The data will be stored for two years. No information revealing any personal information such as your name,

Participant Initials _____

address or telephone number will leave the University of Manitoba.

Voluntary Participation/Withdrawal from the Study

Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time. If the researcher feels that it is in your best interest to withdraw you from the study, she will remove you without your consent.

Questions

You are free to ask any questions that you may have about the study and your rights as a research participant. If any questions come up during or after the study contact the researcher at (204) 784-4010 or evelinebue@yahoo.com. You may also contact her advisor, Dr. Elliot at (204) 789-3404 or elliottl@cc.umanitoba.ca.

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389

Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

Statement of Consent

I have read this consent form. I have had the opportunity to discuss this research study with Eveline Buehlmann. I have had my questions answered by them in language I understand. I believe that I have not been unduly influenced by the researcher to participate in the research study by any statements or implied statements. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board, for quality assurance purposes.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

Participant Initials _____

Participant signature_____ **Date** _____
(day/month/year)

Participant printed name: _____

Witness signature_____ **Date** _____
(day/month/year)

Witness printed name: _____

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent

Printed Name: _____**Date** _____
(day/month/year)

Signature: _____

Role in the study: _____

Assent Form For PS Participants Involved in the Study

ASSENT FOR PS VOLUNTEERS

Study title: A Program Description: The Effects of the Teen Talk Peer Support Program Barriers and Facilitators to the Outreach Component

Investigator: Eveline Buehlmann

Why you are here?

The researcher wants to study the barriers and facilitators to the outreach component of Teen Talk Peer Support Program. She wants to see if you would like to participate in this study. This form will provide you with information about the study. If there is anything you do not understand, please ask the researcher, your parent, or your guardian.

Why are they doing this study?

She wants to learn more about how the outreach component of the Teen Talk Peer Support Program is perceived by the youth it has trained, their peers and their adult support. She wants to see what some of the challenges and facilitators are to the outreach component.

What will happen to you?

If you participate in the study this is what will happen:

The study will last about 4 months.

For the PS volunteers

The following battery of tests and scales will be administered to you confidentially and anonymously pre and post training and 3 months later. The PS Volunteer Outreach Form will be collected on a monthly basis.

- STI and HIV/AIDS Knowledge Test. Eighteen true-false items will be used to assess your level of STI and HIV/AIDS knowledge.

- Condom Attitude Scale - A. Twenty-three items will be used to assess your overall attitudes towards condoms score.

- Condom Use Self-Efficacy Scale (CUSES). Thirteen items will be used to assess the perception of your ability to use condoms.

- Self-esteem Scale. Ten items of the Rosenberg's (1965) Self-Esteem Scale will be used to assess your self-esteem.

- Intentions to Use Condoms. This survey focuses on your intention to use condoms.

- Peer Support Volunteer Outreach Statistics Form. The Peer Support Volunteer Outreach Statistics Form will be administered on a monthly basis. It collects PS volunteers' hours and contacts in regards to peer support initiated formal and informal activities.

For one PS volunteer in each region

Interviews will be held with one PS volunteer in the training, two youth and an adult support from the areas of those involved in the training. The interview consists of 5 questions concerning their perceptions of the outreach component's challenges and facilitators. The interviews will be audio-taped, confidential and no names will be used.

What if you have any questions?

You may ask questions throughout the study. You can talk to the researcher, your family or the guidance counselor about your concerns. To contact the researcher, please contact Eveline Buehlmann at (204) 784-4010 or evelinebue@yahoo.com. You may also contact her advisor, Dr. Elliot at (204) 789-3404 or elliottl@cc.umanitoba.ca.

Who will know what I did in the study?

Any information you give to the researcher is confidential. Your name will not be on any of the research materials and no one but the researcher and the other participants may know that you were involved.

Do you have to be in the study?

You are not required to participate in the study. If you do not want to participate simply say so. We will also ask your parents' consent however, even if they give consent and you do not want to participate you

can still say no. Even if you agree to participate now, you are able to change your mind later.

Do you have any questions?
What questions do you have?

Assent

I want to take part in this study. I know I can change my mind at any time.

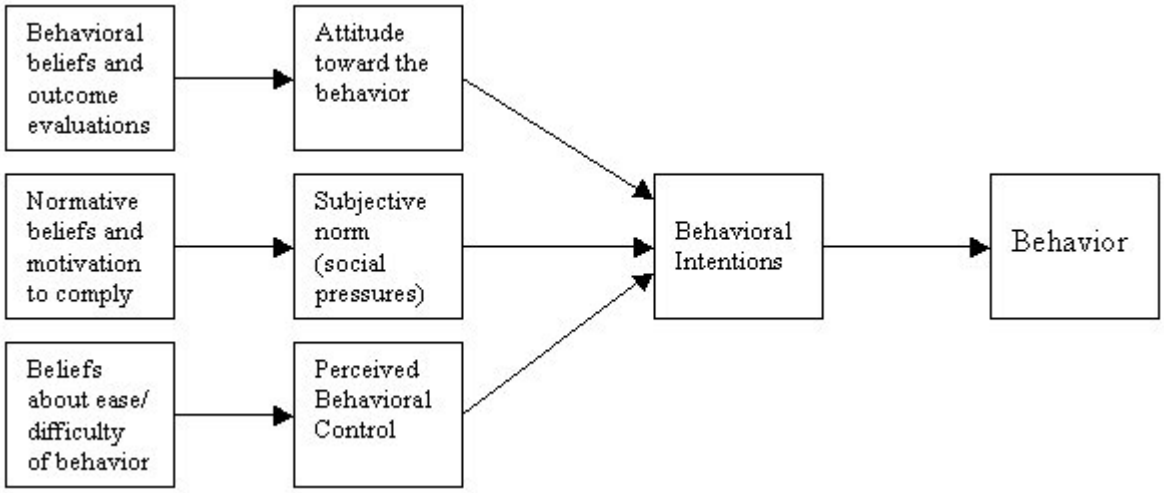
Written assent if the youth chooses to sign the assent.

_____	_____	_____
Signature of Youth	Age	Date

I confirm that I have explained the study to the participant to the extent compatible with the participants understanding, and that the participant has agreed to be in the study.

_____	_____	_____
Printed name of Person obtaining assent	Signature of Person obtaining assent	Date

Appendix F: Theory of Planned Behavior



(Ajzen, I, Attitudes, Personality and Behavior, 1988 cited in Stroebe & Stroebe)

Appendix G: Interview Questions

1. How would you describe your school culture?
2. How do you see your school when it comes to some of the issues discussed at the PS training?
3. How do you select the students that go to the trainings?
4. Why do you think some of the students are not willing to attend?
5. How many trainings have you participated in?
6. What are some of the barriers to having a training; what made them a challenge? (Elaborate)
7. What are some of the facilitators to the training; what made it easier to have a training? (Elaborate)
8. After a training, how do you consider the peer helper program - active/inactive? (Why)
9. If inactive, how do you think they could become more active?
10. What do you consider the most significant aspect for the youth after the training?
11. How do the youth in the school see the program? (Do they know it exists?)
12. How does the administration view the program?
13. Does this program impact your school? How? If not how could it better impact your school?
14. What do you see happen in the future regarding the peer trainings?
15. Anything else you'd like to add or recommend?

Appendix H - HIV/AIDS Knowledge Test

Number _____

Please circle true or false or don't know.

1. When a person shares drug needles, he or she is at risk of catching HIV/AIDS.

   True False Don't know

2. Having more than one sexual partner increases the risk of being infected with HIV/AIDS.

   True False Don't know

3. Condoms give 100% protection from HIV/AIDS

   True False Don't know

4. It is possible to become infected with HIV by having unprotected sex only once.

   True False Don't know

5. The most effective way to avoid being infected with HIV is to not have sex (abstinence).

   True False Don't know

6. Men who have unprotected sex with men increase their risk of getting HIV/AIDS.

   True False Don't know

7. Vaseline is not a good lubricant to use with a condom.

   True False Don't know

8. There are vaccines available to prevent HIV/AIDS.

   True False Don't know

9. The risk of HIV infection is higher with vaginal sex than with anal sex.

True **False** **Don't know**

10. There are drugs available that can cure HIV/AIDS.

True **False** **Don't know**

11. A person can have HIV for ten or more years without developing AIDS,

True **False** **Don't know**

12. HIV/AIDS can be cured if treated early.

True **False** **Don't know**

13. A person can be infected by HIV/AIDS for up to six months before its presence can be detected in the blood.

True **False** **Don't know**

14. If a person has had an STI, he or she cannot catch it again.

True **False** **Don't know**

15. A person can get genital herpes from having oral sex.

True **False** **Don't know**

16. Many people with STIs do not have signs and symptoms.

True **False** **Don't know**

17. Chlamydia, the most common STI, does not lead to serious complications.

True **False** **Don't know**

18. Men and women are equally likely to have serious problems if they catch an STI.

True **False** **Don't know**

Appendix I: Condom Attitude Scale – A

Number _____

Please circle <u>one</u> of the following responses for each question:

1. Using a condom takes the 'excitement' out of sex.

   Strongly agree Agree Disagree Strongly disagree

2. I am concerned about catching AIDS or some other sexually transmitted disease.

   Strongly agree Agree Disagree Strongly disagree

3. A condom is not necessary if you and your partner agree not to have sex with anyone else.

   Strongly agree Agree Disagree Strongly disagree

4. Condoms are messy.

   Strongly agree Agree Disagree Strongly disagree

5. A condom is not necessary if you know your partner.

   Strongly agree Agree Disagree Strongly disagree

6. Using condoms shows my partner that I care about him/her.

   Strongly agree Agree Disagree Strongly disagree

7. A condom is not necessary if you're pretty sure the other person doesn't have a sexually transmitted disease.

   Strongly agree Agree Disagree Strongly disagree

8. If I'm not careful, I could catch a sexually transmitted disease.

   Strongly agree Agree Disagree Strongly disagree

9. I wouldn't use a condom if my partner refused.

   Strongly agree Agree Disagree Strongly disagree

10. People who carry condoms would have sex with anyone.

Strongly agree **Agree** **Disagree** **Strongly disagree**

11. I wouldn't mind if my partner brought up the idea of using a condom.

Strongly agree **Agree** **Disagree** **Strongly disagree**

12. Condoms create a sense of safety.

Strongly agree **Agree** **Disagree** **Strongly disagree**

13. People who use condoms sleep around a lot.

Strongly agree **Agree** **Disagree** **Strongly disagree**

14. If I'm not careful, I could catch AIDS.

Strongly agree **Agree** **Disagree** **Strongly disagree**

15. Condoms take away the pleasure of sex.

Strongly agree **Agree** **Disagree** **Strongly disagree**

16. If my partner suggested using a condom, I would respect him or her.

Strongly agree **Agree** **Disagree** **Strongly disagree**

17. Other people should respect my desire to use a condom.

Strongly agree **Agree** **Disagree** **Strongly disagree**

18. I worry that I could catch a sexually transmitted disease.

Strongly agree **Agree** **Disagree** **Strongly disagree**

19. If my partner suggested using a condom, I would feel relieved.

Strongly agree **Agree** **Disagree** **Strongly disagree**

20. People who carry condoms are just looking for sex.

Strongly agree **Agree** **Disagree** **Strongly disagree**

21. A condom is not necessary when you are with the same partner for a long time.

Strongly agree **Agree** **Disagree** **Strongly disagree**

22. If my partner suggested using a condom, I would think s/he was only being cautious.

Strongly agree **Agree** **Disagree** **Strongly disagree**

23. Condoms protect against sexually transmitted diseases.

Strongly agree **Agree** **Disagree** **Strongly disagree**

Appendix J: The Rosenburg Self-Esteem Scale

Below is a list of Statements dealing with your general feelings about yourself. Please circle <u>one</u> of the following responses for each question:

1. I feel that I'm a person of worth, at least on an equal plane with others.

   Strongly agree **Agree** **Disagree** **Strongly disagree**

2. I feel that I have a number of good qualities.

   Strongly agree **Agree** **Disagree** **Strongly disagree**

3. All in all, I am inclined to feel that I am a failure.

   Strongly agree **Agree** **Disagree** **Strongly disagree**

4. I am able to do things as well as most other people.

   Strongly agree **Agree** **Disagree** **Strongly disagree**

5. I feel I do not have much to be proud of.

   Strongly agree **Agree** **Disagree** **Strongly disagree**

6. I take a positive attitude towards myself.

   Strongly agree **Agree** **Disagree** **Strongly disagree**

7. On the whole, I am satisfied with myself.

   Strongly agree **Agree** **Disagree** **Strongly disagree**

8. I wish I could have more respect for myself.

   Strongly agree **Agree** **Disagree** **Strongly disagree**

9. I certainly feel useless at times.

   Strongly agree **Agree** **Disagree** **Strongly disagree**

10. At times I think I am no good at all.

    Strongly agree **Agree** **Disagree** **Strongly disagree**

Appendix K: Map of Manitoba