

YOUNG WOMEN AND SEXUALLY TRANSMITTED INFECTION TESTING:  
INVESTIGATING THE IMPACT OF CLINICAL EXPERIENCES AND SOCIAL  
CONTEXT ON SEXUAL HEALTH DECISION-MAKING

by

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## **ABSTRACT**

The study investigated how young women's clinical experiences and social context affect their participation in testing for sexually transmitted infections (STIs) and their subsequent sexual behaviour. This qualitative study used a grounded theory approach to address: (i) the use of STI testing among youth; (ii) factors within the health care system and social context young women perceive as affecting their health outcomes and decision-making; (iii) and the impact of testing on young women's subsequent sexual behaviour. In-depth interview data were collected from 18 female participants between the ages of 19 and 24 years within two weeks of being tested for STIs in Vancouver, Canada. Follow-up interviews were conducted 3 months after the initial interviews. Interview data were analysed to develop theoretical descriptions of key concepts, themes, and processes by which the health care system, social milieu, as well as broader structural forces affect the experiences of young women as they engage in testing for STIs. The findings provide screening program planners, clinicians and other community health service providers with helpful insights when responding to youth sexual health needs.

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*There are no magic answers, no miraculous methods to overcome the problems we face, just the familiar ones: honest search for understanding, education, organization, action...and the kind of commitment that will persist despite the temptations of disillusionment, despite many failures and only limited successes, inspired by the hope of a brighter future.*

*-- Noam Chomsky*

## **Chapter 1: INTRODUCTION**

The public health impetus to conduct testing for sexually transmitted infections (STIs) other than HIV/AIDS<sup>1</sup> is strong due to consistently high incidence rates among BC youth over the past 10 years<sup>[1-10]</sup>, and the effectiveness of the currently available treatments<sup>[11-13]</sup>. Recent surveillance evidence indicates that rates of STIs among young people are increasing and continue to pose risks to the health of young British Columbians<sup>[14-16]</sup>. The number of reported cases of STIs may under-represent the actual cases as many infections go unreported. Furthermore human papillomavirus (HPV) and herpes simplex virus (HSV), the most common STIs, are not legally reportable to public health authorities<sup>[17]</sup>. Approximately 30% of sexually active adolescent females have had chlamydia<sup>[18]</sup>. In BC, young women between the ages of 15 and 24 years have the highest rates of chlamydia (females 1210.9 per 100,000 aged 15-24 years; males 550 per 100,000 aged 15-24 years), the most common bacterial STI among youth<sup>[10]</sup>. These rates are developed through the reporting of all laboratories performing chlamydia testing<sup>[10]</sup>. Rates may include repeat testers as anonymity (e.g., use of false names) is a common policy for clinics.

Some researchers have postulated that the high rates among young women may be due to females using STI tests for the purpose of screening, whereas men tend to delay testing until symptoms appear or have contact with an individual who can transmit disease (e.g., asymptomatic and has disease, tested positive for an STI)<sup>[8]</sup>. Conversely, it also has been suggested that this trend may reflect a true increased risk for females because they are more likely to be asymptomatic and less likely to seek treatment for chlamydia<sup>[8]</sup>. However, data from the Vancouver STD Clinic indicate that males and females who have similar screening participation rates also have similar infectious rates<sup>[5]</sup>.

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<sup>1</sup> The use of the term "STI testing" excludes testing for HIV, unless otherwise specified.



Regardless of the similarities between young women and men regarding the frequency of STI cases, it is young women who are most vulnerable to the negative impact of STIs. They are physically more vulnerable to STIs because their immature cervical linings provide a poor barrier against infection<sup>[19]</sup>. Power relations in our society also enhance the sexual vulnerability of young women, particularly among teenage girls, whose first sex partner is often an older teenage boy or young male adult<sup>[20-22]</sup>.

The impact of STIs extends past the short-term consequences of re-infection and disease spread. If not treated, infection can lead to severe, long-term health consequences, such as pelvic inflammatory disease, ectopic pregnancy, and infertility in women<sup>[4;23;24]</sup>. Prevention, screening and early treatment for STIs are relatively cost effective in comparison to the cost of addressing their sequelae within the tertiary health-care system<sup>[24;25]</sup>. Furthermore, STIs have social implications that shape our conceptualizations of health, current and future interpersonal relationships, and characterize targets of stigmatization.

Developments in diagnostics have led many screening programs to adopt alternative screening technologies, such as ligase chain reaction (LCR) and polymerase chain reaction (PCR) urine tests. Theoretically these tests would allow for the provision of screening in settings where such services have not been traditionally provided (e.g., schools, at home)<sup>[26]</sup>. However the bulk of screening for STIs currently takes place at clinics and physicians' offices. While testing occurs relatively frequently in these health care settings, very little is known about its: (i) financial, physical, and psychological costs to individuals, (ii) impact on personal conceptualizations of health and disease<sup>[27]</sup>, and (iii) influence on health behaviour. Moreover, there is a lack of research investigating young women's experiences with STI testing. The current study aims to address these gaps in the literature.

### ***Purpose of the Proposed Study***

The purpose of the study is to investigate how clinical experiences and social context impact young women's participation in testing for STIs and their subsequent sexual health decision-making. The study adopts a more youth-centered approach than many previous studies of STI testing in that it takes youth's perspectives into account by using qualitative interviewing as a means to access youth's perspectives, particularly the social contexts within which they make their decisions. Therefore, the research objectives of this study are to:

1. Identify factors within the health care system and the broader social context that young women perceive to affect their decisions to participate in STI testing.
2. Describe young women's experiences of participating in STI testing at the BCCDC STD Clinic and Pine Free Youth Clinic.
3. Investigate how these young women perceive their experience of having participated in STI testing to influence their subsequent sexual health behaviour and/or decision-making.

### ***Study Setting***

All interviews were conducted in Vancouver, B.C. The study was conducted with a sample of young women who have engaged in STI testing at two Vancouver STI clinics. One clinic recruitment site is the largest STI clinic in the Lower Mainland and the other is the most accessible (e.g., with respect to hours of operation) youth clinic in the Lower Mainland. At the time this research was conducted, there were 17 youth-specific clinics available to youth for STI testing in the region.

### ***Organisation of the Thesis***

In Chapter 2, a review of the literature is presented. A process-oriented framework that describes the STI testing process as well as structural issues that influence youth's engagement

in STI testing is used as a heuristic tool to organize the literature review. In Chapter 3, Methods, a detailed description of the research protocol is presented as well as examples of the analytic decision-making involved in data collection and analysis. Chapter 4 presents both descriptive and theoretical findings of the research. The descriptive findings are organized with respect to the three phases of the STI testing process (and three research objectives of the study). The theoretical findings are presented as the core categories and themes that group the descriptive data into more meaningful aspects of the emerging theoretical description. In the fifth and final chapter, Discussion, the highly theoretical conceptual finding entitled the “Fallacy of Emancipation through Personal Responsibility” is presented and explained in terms of its linkages to the themes that ran throughout the study findings (e.g., purity and personal responsibility). By learning more about young women’s participation in STI testing and the influence this exerts on their subsequent sexual health behaviour and/or decision-making, this study provides an opportunity to gather potentially useful information that could inform the provision of STI testing services for young women.

## **Chapter 2: REVIEW OF THE LITERATURE**

Most STI clinic programmes also offer voluntary testing for human immunodeficiency virus (HIV)<sup>[28]</sup>. Hepatitis B testing and immunization also are offered to vulnerable clients in BC. Traditionally, public health clinical services for STI control have had two goals: (i) to provide “immediate antimicrobial therapy for individuals known to be infected or at high epidemiologic risk for infection (e.g., sexual contact of a known infected case), and (ii) to screen for asymptomatic but transmissible disease<sup>[28]</sup>. Advances in technology, greater understanding of disease etiology, and development of treatments have contributed to the increased use of testing in health care. Much of the literature reviewed in this chapter focuses at least in part on HIV testing. Although the current study excludes those individuals who test positive for HIV, much can be learned about testing behaviour in general by reviewing the HIV testing literature.

### ***Testing Terminology***

Although testing and screening have been “hot” topics of research (e.g., the use of testing in genomic medicine and testing for HIV), there is little consensus on terminology. The terms “screening” and “testing” frequently are used interchangeably, despite differences in their purpose and practice. The term “testing” in this literature review will be an umbrella term for “screening<sup>2</sup>”, “case-finding and diagnostic testing<sup>3</sup>”. In effect, the term “testing” will refer to:

“Any method of producing evidence from a patient at any stage in the clinical process, based on which a different clinical course will be taken depending on the different possible test outcomes (e.g., positive or negative, normal or abnormal, present or absent, high or low)”<sup>[29]</sup>.

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<sup>2</sup> Screening involves systematic, organized efforts to identify pre-symptomatic individuals in a population who are deemed to be at sufficient risk of a specific disorder to warrant further investigation <sup>[133;134]</sup>. The purpose of screening is to benefit the individuals being screened; thus mass testing activities such as surveillance of HIV infection or pre-employment fitness examinations would not be accurately classified as medical screening<sup>[134]</sup>.

<sup>3</sup> Diagnostic testing involves the use of a test in the clinical environment on individuals with clinical signs or other clinical information consistent with the presence of the condition<sup>[29]</sup>. Diagnostic testing is identical to case-finding in that it is the testing of patients for diseases or risk factors to confirm or exclude a diagnosis (Feinstein AR, 1975 as cited in<sup>[135]</sup>.

## ***Factors Affecting Engagement in Testing, Re-Testing, & Treatment***

Testing is a process that involves several elements including: (i) deciding to get tested, (ii) accessing testing services, (iii) test counseling, and (iv) waiting for the test result[30]. There are many factors that influence participation in testing for STI. These factors can be psychological (e.g., fear and anxiety), sociological (e.g., stigma of STIs, social norms), and/or related to the health care system (e.g., delivery of service, geographic location). There is a trend in the literature to dissect the testing process into discrete elements and present these 'participation' factors as pertaining only to a single aspect of the testing process. I argue that in order to better understand participation in STI testing we must view these factors as interactive, multi-level, dynamic forces that shape the testing process as a whole.

Figure 1 is provided as a heuristic tool for the advanced organization of this literature review. The literature review is organized according to the three major phases of the testing experience: (i) the pre-test phase (which includes decision-making to engage in STI testing); (ii) the STI test experience; and (iii) the post-test phase (which includes subsequent sexual health behaviour and decision-making, such as re-testing and treatment). Furthermore, the tool shows that structural<sup>4</sup> forces, such as gender, stigma of STIs, and the health care system, impact the STI testing process.

### ***Pre-Test Phase***

Several factors have presented themselves as influencing the pre-test phase of the STI testing process. The majority of these factors are involved with the decision to get tested for STIs and include knowledge, perceived risk, attitudes, interpersonal relations, and confidentiality.

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<sup>4</sup> Structural or macro-level forces are part of the ecological perspective of health behaviour which posits that multiple levels of social, cultural, psychological, and physical variables are important for understanding and changing health behaviour<sup>[136;137]</sup>. Structural level factors are the broadest level of forces that guide the interactions among other subsystems of an environment (e.g., culture, social norms, and health care policies)<sup>[138]</sup>.

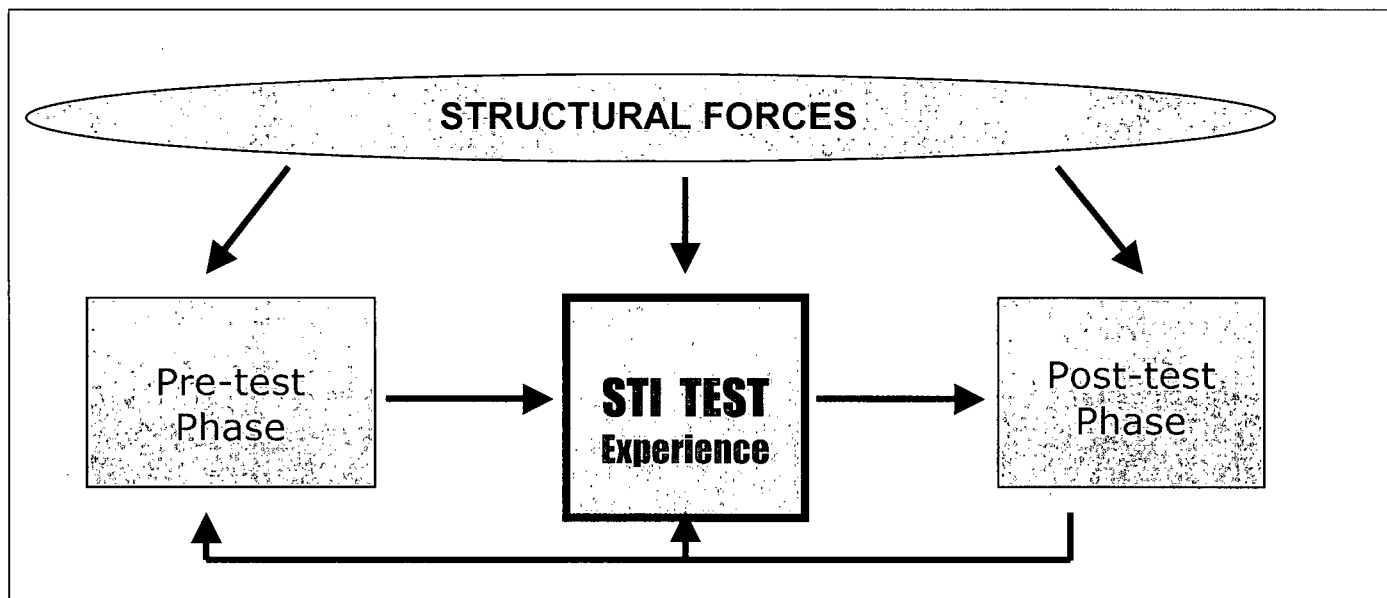


Figure 1. The STI Testing Process

### (i) Knowledge

Knowledge plays a large role in the decision to get tested for STIs. The majority of behavioural research on STI testing has focused on knowledge, and has stressed the need for informed consent<sup>[31;32]</sup> as well as increased education about STIs<sup>[33]</sup> in order to reduce misconceptions of the abilities and purposes of testing<sup>[34;35]</sup>. The findings of Stein and Nyamathi (2000) support other research showing that greater knowledge about AIDS and awareness of testing (e.g., methods, where and how to access testing) is predictive of HIV testing<sup>[36;37]</sup>. It has been suggested that this is due to the high public profile HIV has received through the media and health care providers<sup>[38;39]</sup>. However, knowledge about STIs is much lower than one would expect in light of their prevalence<sup>[33]</sup>.

Despite enormous public health outreach efforts to increase education about STIs, there is a considerable range of knowledge and misinformation about transmission routes, the testing process<sup>[36;40]</sup>, and disease presentation. The appearance of symptoms is a trigger for test seeking behaviour<sup>[41]</sup> and associated with frequency of testing for HIV<sup>[42]</sup>. However many STIs are asymptomatic thus youth are at increased likelihood of developing serious STI sequelae<sup>[10]</sup>,

becoming re-infected, and further transmitting the infection. Furthermore, a lack of knowledge about the location of “youth-friendly” testing facilities<sup>[43]</sup> creates both personal and structural level barriers to testing (e.g., knowledge of services, delivery or accessibility of services) because such health care facilities are difficult to find or are non-existent in some communities. Thus, even the most diligent prevention efforts face significant structural barriers, which implies that knowledge and education need to be supplemented by other strategies.

It has been suggested that acceptance for HIV testing is higher among those who are most likely to acquire and transmit HIV and acknowledge their sexual behaviour<sup>[44;45]</sup>. One study<sup>[42]</sup> found that HIV testing was more common among youth who had more than one male sex partner or who were men who had sex with men (MSM). Being a marijuana user and being White also were associated with higher rates of HIV testing<sup>[42]</sup>. It may be tempting to conceptualize a direct relationship between personal characteristics and engagement in testing. However these kinds of analyses do not incorporate the moderating influences of perceived risk for STIs, which has been shown to be a better predictor of testing<sup>[36;37;46;47]</sup>.

## **(ii) Perceived Risk/Susceptibility**

Risk perception has been a cornerstone of many theories concerned with preventive health behaviour and has been an important component of several models specifically adapted for AIDS<sup>[48]</sup>. Risk perception or a sense of vulnerability to a threat is assumed to motivate self-protective behaviours which include testing, returning for the results, and ‘risk’ behaviour such as condom use and number of partners<sup>[36;37;46;47;49]</sup>. Many youth have a diminished sense of risk if they do not personally know anyone ‘their age’ who is HIV-positive, despite knowing someone in their neighbourhood who is HIV positive or who has died from AIDS<sup>[43]</sup>. Being highly motivated and knowledgeable is no guarantee for the reliable translation of knowledge into action<sup>[50]</sup>. It also may be the case that self-efficacy moderates the relationship between

perceived susceptibility and testing behaviour or the maintenance of behavioural changes following STI testing<sup>[49]</sup>.

### **(iii) Attitude**

The reasons most frequent cited by symptomatic patients who delayed seeking care at clinics for STIs were related to ill-founded hopes that the symptoms would go away or that the symptoms were not enough of a priority to prompt them to go to the clinic sooner<sup>[40]</sup>. Often these reasons are manifestations of denial, as cited in other research as another mode of coping with the anxiety of STI testing<sup>[36]</sup>. The reluctance to engage in STI testing is understandable considering the difficulties in “admitting mistakes” or “incorrect” behaviour<sup>[43]</sup>. Underlying all of these attitudinal factors is the stigma associated with having an STI and the taboos of “sexual” behaviour<sup>[51]</sup>. The relationship between stigma and STI testing is described in more detail in the “structural forces” section of this literature review.

### **(iv) Interpersonal Relations**

Several studies<sup>[42;52-54]</sup> have found that the main reason individuals seek testing is due to concern about the possibility that they may have contracted HIV through sexual behaviour. Testing also has been used as a “health check” before entering new sexual relationships<sup>[55;56]</sup>. Among adults, women are more likely than men to seek testing out of concerns related to family and significant others, especially during pregnancy<sup>[46;47;57]</sup>. One study explored women’s attitudes toward human papilloma virus (HPV) testing and found that women of various ethnic groups expressed concern that distrust may be conveyed to their partner simply by attending screening<sup>[58]</sup>. The same study found that women of Indian and Pakistani ethnicity mentioned the use of testing as a “check” of their husband’s fidelity and an indicator of how much their partners cared about them<sup>[58]</sup>. Additional motivators for testing among youth include



recommendations by parents, partners or peers<sup>[43]</sup>. In particular, heterosexual women identified the influence of friends as a strong motivator for testing<sup>[59]</sup>.

It is important to note that interpersonal relationships also may represent barriers to testing. For example, anticipated partner discord has been identified to deter individuals from testing<sup>[60;61]</sup> or openly discussing sexual health issues<sup>[18;62;63]</sup>. These challenges work against partner notification and sexual network strategies that encourage infected sex partners or needle-sharing partners to seek medical attention<sup>[64-66]</sup>.

#### **(v) Confidentiality**

Physicians have a legal and ethical obligation to keep all patient information confidential. This is true particularly for information surrounding HIV<sup>[67;68]</sup>, in light of the social stigma of HIV and other STIs. Access to confidential, convenient, caring, and youth centred health care has been cited as motivators for testing<sup>[43;57]</sup>. However, many youth have difficulty in finding and using what they perceive to be trustworthy and accessible health care for detection and treatment of STIs. Common misconceptions about the testing process, specifically HIV, include skepticism regarding confidentiality of results and automatic notification of partners by the testers if results are positive<sup>[69;70]</sup>. Encouraging voluntary testing and counseling is important to individual and public health promotion; therefore, problems and misperceptions regarding confidentiality need to be addressed<sup>[69]</sup>.

#### **(vi) Physician Referral**

The majority of testing at clinics result from physician referral. Perceptions of clinician recommendations strongly influence testing<sup>[44;46]</sup>. However, the patient-physician relationships also can serve as a deterrent to testing. Many youth do not trust health care professionals<sup>[71]</sup> and some individuals may not wish to disclose their sexuality to their family physician<sup>[43;54]</sup>. Furthermore, a discrepancy between health care professional's and youth's perspectives exists

with respect to the degree to which youth are comfortable sharing personal health information, such as STI diagnoses and HIV testing with peers<sup>[43]</sup>.

“Some professionals asserted that teens attach little stigma to having a sexually transmitted disease (STD), that an STD might even be considered a ‘badge of pride’ or ‘rite of passage’. In interviews, however, teens were clearly appalled at such a notion. They say STDs label teens as being ‘not clean’ and that having HIV means rejection and isolation”<sup>[43]</sup>.

### **STI Test Experience**

The next phase of the STI testing process is the STI test experience. Generally, STI testing experiences occur within a clinical environment despite our increased ability to test in non-traditional environments (e.g., schools, home)<sup>[72]</sup>. Factors described as important aspects of the STI testing experience include interactions with clinical staff and the service provision environment.

#### **(i) Interactions with Clinical Staff**

Estimates of screening for STIs and offers for HIV testing are well below suggested guidelines and not typically part of routine clinical practice<sup>[37;73-78]</sup>. Complete clinical STI assessment requires that a practitioner be comfortable with their own sexuality as well as that of their patient<sup>[74;75]</sup>. Added pressures that influence clinical interactions include: (i) the sensitive nature of sexually-related health issues, (ii) time constraints to conduct a full assessment (including tracing sexual contacts), uncertainty regarding the sufficiency of STI assessment tools, decreased gratitude from the patient, and avoidance of the problem by the patient, even those presenting with symptoms<sup>[75;79;80]</sup>. Some health care providers perceive STIs (except HIV/AIDS) to be less of a priority compared to other health problems such as injury, cardiovascular disease, or substance abuse<sup>[75;76]</sup>.

#### **(ii) The Clinical Environment**

Youth have cited the need for teen friendly STI facilities. These are characterized by: (a) respect for teens who are sexually active; (b) free testing; (c) a medical environment; (d) a broad

range of health services; (e) confidentiality; (f) options for oral or blood-drawn HIV testing; (g) convenient access to public transportation or locations within walking distance to schools; (h) fewer questions and paperwork<sup>[43]</sup>. Other factors cited as making STI health clinics less uncomfortable are the ease of obtaining a convenient appointment time (which could also be a factor influencing the pre-test phase), knowing the gender of the physician, the size of the waiting room, methods used to call a patient into the examination room (e.g., call name over loudspeaker), and a clinic environment where one was able to feel less conspicuous (e.g., television in waiting room)<sup>[81;82]</sup>.

### ***Post-test Phase***

Most previous research regarding behaviour subsequent to STI testing has focused on HIV testing. Therefore, in this section of the literature review, I have drawn heavily on the HIV literature and found little research that has specifically focused on subsequent sexual behaviour following testing for other STIs. The research reviewed in this section also includes studies on re-testing behaviour.

#### **(i) Sexual Health Behaviour Subsequent to STI Testing**

The majority of literature reviewed has shown testing to have little impact on subsequent sexual behaviour among women attending a community health clinic<sup>[83]</sup>, pregnant clinic patients<sup>[49]</sup>, and youth<sup>[43]</sup>.

“When HIV tested teens were asked what emotions were experienced upon hearing their test results, most exclaimed ‘Relief!’ Then, as if being sworn in for testimony, they held up their hands and told us, ‘I made a promise to myself never again to have sex without a condom.’ When asked how long that promise lasted, some young people confessed ‘not long;’ one young man said, ‘I think I broke my promise the next day.’”<sup>[43]</sup>

It has been posited that individuals who test negative for HIV are less likely than those who are HIV positive to exhibit behaviour change<sup>[84-86]</sup>. Other investigations support these findings among a variety of populations<sup>[87]</sup>, including heterosexual university students<sup>[88]</sup>. The lack of

observable changes after a testing experience may also be related to methodological issues. Researchers may fail to detect behaviour change due to the type of outcomes measured, the appropriateness of the measures used, and the timing of the follow-up measure.

In response to these limiting factors, Ickovics et al.<sup>[83]</sup> based their research on the premise that lasting risk reduction is best predicted by patterns of long-term behavioural change and conducted a series of interviews with women during the HIV testing and counseling process at community health clinics. They found no behavioural or psychological consequences of testing after an 18 month post-test (HIV) follow-up period, regardless of changes in perceived risk, anxiety levels, or intrusive thoughts about AIDS following the testing and counseling process. However, they did find that abstinence was highest among the HIV-tested group at the second interview, suggesting that many engaged in no sexual activities until they received test results. It was observed that tested women were more likely than untested women to report having had more intrusive thoughts about AIDS, greater anxiety, and depression at baseline, despite equivalent “risk” factors<sup>[83]</sup>.

Failure to return to the genitourinary (GUM) clinic for deferred HIV testing was disappointingly high among individuals who attended the clinic within 3-months following a “risk episode”<sup>[54]</sup>. It appears that attendance at the clinic is fuelled by concern, which is then diffused with counseling and the passage of time<sup>[54;83]</sup>. It seems that once specimens for the testing procedures (e.g., blood) are collected, very few people returned for their results<sup>[54]</sup>. Some research suggests that individuals are deterred from returning for results or treatment because of inaccurate perceptions of risk or out of fears of the psychological impact of a positive test result<sup>[36;89]</sup>.

## **(ii) Repeat Testing**

Repeat testing for STIs and HIV represents a paradigmatic shift towards the use of testing as a general personal “hygiene” strategy<sup>[55;56;59;90]</sup>. The term “repeat testing” refers both to

patterns of regular testing and continued HIV testing at irregular intervals<sup>[91]</sup>. A study focusing on the HIV testing patterns of low-income drug users provided participants with the opportunity to identify four main themes related to their HIV testing behaviour<sup>[91]</sup>. Study participants described their use of repeat testing as being influenced by: (i) the anticipation of positive results, (ii) the belief in a 10-year period during which the virus is undetectable, (iii) regular HIV testing as part of self-care, and (iv) the HIV test as a means of control in their lives<sup>[91]</sup>. The participants viewed HIV testing more as a screening tool, rather than a diagnostic test, and often were skeptical of negative test results despite recent behaviour<sup>[43; 91]</sup>. The high levels of anxiety and anticipation reported in this study are understandable given the context in which the study participants lived<sup>[91]</sup>. Vernon suggests that structural-level forces, such as the community experience of HIV, are more influential on testing patterns than are personal risk behaviours<sup>[91]</sup>. Thus, there is a need to conduct research that focuses on identifying the structural-level factors that moderate the testing process and aid in the development of strategies to circumvent the psychosocial and institutional barriers to testing.

### ***Structural Forces***

The following section will discuss the structural forces that serve as a backdrop for the STI testing process. These structural forces operate at a social level and impact each phase of the STI testing process: (i) pre-test phase, (ii) the STI testing experience, and (iii) post-test phase. Examples of structural factors described previously in the literature include: setting/place, screening priorities, the media, and stigma.

#### ***(i) Setting/Place***

Social setting is an influential factor in the impetus to engage in STI testing. Research has shown high compliance for testing in jails, hospitals, drug rehabilitation programmes, schools, and the military<sup>[47;92;93]</sup>. However, it is questionable if these compliance rates would be

maintained in less strict and enforcement-oriented environments. In a study of adolescent sexual behaviour, neighbourhood context was found to be a more important determinant of adolescent female sexual behaviour than direct incentives created through government policies<sup>[94]</sup>. For example, family planning availability was found to be significantly associated with contraceptive use among sexually active female adolescents<sup>[94]</sup>. In another study, by considering and incorporating key aspects of setting and place into their intervention design, the ACCESS project was able to increase the number of youth seeking counseling and testing for HIV by using Hip-hop language and music in their radio and television advertisements for testing services<sup>[37]</sup>.

### **(ii) Screening Priorities**

Most screening programmes for chlamydia trachomatis (CT) target young women in genitourinary, STI, or family planning clinics in order to take advantage of the opportunity to obtain diagnostic tests in the context of other health services<sup>[60;95-97]</sup>. However, sexually active young women are not regularly screened within their local health care systems<sup>[98]</sup>. Screening also is rationed based on cost, tending to exclude male patients<sup>[72]</sup> and leaving a reservoir of unrecognized infection<sup>[98]</sup>.

### **(iii) Media**

It has been asserted that mass media provides youth with a substantial amount of sexual health information<sup>[99;100]</sup>. Youth often use popular cultural forms as a resource and framework for discussing issues of sexuality, and a form onto which they can juxtapose their own personal experiences<sup>[101]</sup>. Health advocates have recognized the power of media and attempted to use them to their advantage (e.g., mass media campaigns, media advocacy, embedded messages, media literacy, and internet interventions)<sup>[99]</sup>. However, media messages that target adults often miss youth, while those that do focus on youth are frequently limited by political and moralistic rules that do not adequately address the realities of sexually active youth's lives<sup>[37]</sup>.

Furthermore, the media differentially affects subgroups of youth. All youth do not see the same set of sexual messages because some see more than others, some seek out specific sexual content, and some will avoid media exposure<sup>[102]</sup>. There also are differences amongst youth in their interpretation and evaluation of media images compared to their personal sexual behaviour<sup>[102]</sup>.

#### **(iv) Stigmatisation**

Stigmatisation is a multi-level force that influences testing behaviour. There is consensus in the literature describing stigma as a process through which individuals are made to experience isolation and reduced opportunities in life due to a possession of “crediting” or “discrediting” attributes, and that deviation from such socially-constructed expectations can lead to the legitimization of discriminatory practices<sup>[103]</sup>. However, both negative and positive implications of stigma serve social functions, such as providing a basis for comparison between perceptions of individual and collective differences<sup>[104]</sup>. Perceived and actual stigmatization is an important barrier to participation in STI testing<sup>[58;105]</sup>. Stigma functions independently from other factors that may affect testing, such as age, sex, and suspicion of having an STI<sup>[51]</sup>. The power of stigma on the STI testing process should not be surprising in light of the historical association between the institutionalized isolation of individuals known to have STIs, the link between STIs and sexual behaviour, and the political, religious, and cultural norms related to sexual behaviour<sup>[106;107]</sup>.

#### **(v) Gender**

Women in particular face additional barriers related to stigmatisation and STI testing. In addition to factors such as low socio-economic status and a lack of insurance<sup>[46;71]</sup>, other factors make youth and women more vulnerable to the negative impacts of STIs and HIV. Sexual relations between men and women remain unequal despite changing gender roles<sup>[106;108]</sup>.

Although both young men and women acknowledge that having an STI can lead to a “bad reputation” (e.g., being dirty, being promiscuous), these negative labels are more frequently applied to young women than men. The frequency with which young women are negatively labeled may contribute to the severity of the meaning of these labels and may contribute to a more hostile overall environment for young women<sup>[43]</sup>. Many women have declined testing, and discussion of sexual health issues in general<sup>[62]</sup>, for fear of rejection or blame from their partners, families, or health care providers<sup>[57;109]</sup>. This fear may stem from the lack of economic and social power of women, or cultural norms regarding virginity<sup>[109]</sup> and promiscuity<sup>[58]</sup>.

### ***Summary of Previous Research and Rationale for Proposed Study***

Previous studies have identified several important risk factors associated with STI testing. These include various socio-demographic characteristics, lack of condom use, drug use, and high numbers of sexual partners. In addition, the importance of structural forces on youth's sexual experiences has been alluded to in previous studies. However, based on previous research we know little about the psychosocial factors adding to the complexities of the STI testing process. We know even less about the interacting effects of social context<sup>[30]</sup>. As well, rather than examining the entire testing process, researchers have focused on discrete fragments of the process. While this has allowed for detailed examinations of individual factors (e.g., knowledge, attitudes) and their associations with testing behaviour, the influence of context on testing has been neglected. Moreover, there is a profound lack of information specific to young women regarding these issues.



### **Chapter 3: METHODS**

#### ***Rationale: Qualitative Approach***

The health care system has an important role in supporting youth and their sexual health decision-making. Little is known about the impact of clinical experiences and social context on STI testing and subsequent sexual health decision-making. This is an important issue in light of recent disease surveillance evidence that demonstrates elevated rates of some STIs among youth. Contracting an STI may have serious implications for the current health and social status of young people as well as their future sexual and reproductive health. To understand the experience of STI testing among youth it is also imperative to examine the broader social context in which these services are presented and accessed. Qualitative research approaches can provide sufficient flexibility to investigate individuals' perceptions, everyday experiences, and issues of meaning and experience and are particularly useful when undertaking investigations in substantive areas that are under-explored.

#### ***Rationale: Grounded Theory Method***

Grounded theory is a qualitative method rooted in the social psychological theory of symbolic interactionism. Symbolic interactionism is an interpretive science that focuses on portraying and understanding the process of meaning making<sup>[110]</sup>. In the context of this thesis, meaning making refers to the kinds of meanings that are attached to testing for STIs among young women and how these meanings develop. A promising style of symbolic interactionism, "mesoanalysis"<sup>[111]</sup>, appears well suited for the proposed research because its analytical focus is on the interaction between mesostructures (e.g., societal and institutional forces) and human activity<sup>[112]</sup>. The interaction between the health care system and young women that is being investigated in the current study represents such an interaction.

Grounded theory procedures help researchers inductively develop concepts from the raw data, rather than imposing preconceived conceptual frameworks upon the data. Deductive

processes also help guide theorizing about how concepts could be linked, but hypotheses are based on the findings as they are found in the data and not on a set of a priori propositions. The purpose of grounded theory is to identify and hypothesise what theory best accounts for the research situation as it is presented in the descriptions (e.g., the data) of everyday lived experience<sup>[113]</sup>. Grounded theory includes theoretical categories that are closely linked with raw data that have been collected from respondents themselves<sup>[114;115]</sup>. Grounded theory recognizes the co-construction of reality, that individuals make decisions according to their perceptions<sup>[116]</sup>, and that there is meaning in perceived realities, even when those realities are in conflict<sup>[110]</sup>. Hence, a grounded theory study includes a variety of perspectives and accounts and examines both social and psychological influences.

### **Recruitment**

Nineteen participants were recruited to participate in this study, which provides sufficient data for development of the model and was feasible with available resources<sup>[117]</sup>. Women aged 19-24 years, who have undergone screening for sexually transmitted infections from the BC CDC Sexually Transmitted Diseases Clinic and Pine Free Youth Clinic in Vancouver, were invited to participate. I focused on this particular sub-group of youth because I wanted to interview participants capable of providing reflective and in-depth information regarding the STI testing experience. Inclusion criteria included: individuals who have undergone STI testing at the clinic (regardless of the test results); have had heterosexual experiences; are English speaking; do not need further assistance with the consent process (e.g., consent forms in Braille); and have not had a positive HIV diagnosis. This study did not include young women with positive HIV diagnoses because it was felt that HIV is sufficiently stigmatized that a positive diagnosis represents something distinct and unique from other STIs. Inclusion was not limited to those who live in the Lower Mainland; however, participants must have been available to meet

and be interviewed at a location in Vancouver, acceptable to both study participant and myself to ensure confidentiality and safety.

### **Sampling**

Sampling in grounded theory is based on theoretical sampling which involves the purposive selection of study participants who have the potential to provide in-depth descriptions of their experiences and to inform the emerging findings<sup>[118]</sup>. Theoretical sampling is the process of data collection for generating concepts, where the researcher jointly collects, codes, and analyzes the data<sup>[119]</sup>. Based on the emerging findings, the researcher decides what data to collect next, and from what sources, in order to further develop the theoretical description. Theoretical sampling is purposive, flexible, and adapts to the emerging findings<sup>[118]</sup>. To begin, sampling decisions were based on a preconceived set of assumptions about the general, theoretical needs of the study. For example, in this study of young women's experiences with STI testing, the initial sampling decisions helped to identify young women who had come to the clinic for the first time as well as repeat users of the clinic. This initial sampling decision was based on information gathered for the literature review of this study surrounding motivations for engaging in testing. As the analysis continued and the findings began to be identified, subsequent sampling decisions were pursued as a means to select respondents who were thought to be able to provide information about particular concepts (e.g., avoiding screening until symptoms appear)<sup>[118]</sup>.

Sample selection relies on the comparison of concepts and experiences rather than selection based on other factors more commonly associated with traditional, representative sampling strategies (e.g., demographics, location, sex, age, SES)<sup>[118;120]</sup>. The reasoning behind this is that selecting for representational characteristics does not guarantee that respondents would be able to provide insights regarding important and emergent concepts. However, such background information can be useful as a proxy of the likelihood that a particular individual

with such characteristics would be able to provide insights about a specific experience within the emerging theory<sup>[118]</sup>. For example, “older” women in the study (i.e., 24 years of age), were more likely to have engaged in testing while they were in a monogamous and long-term relationship (e.g., married), in comparison to the “younger” women in the study (i.e., 19 years), who were in less stable relationships. Thus, it was logical to theoretically sample women in this study based on age (which served as a proxy for their cumulative life experiences and development), in order to compare their experiences of STI testing.

Selecting participants according to their potential to add to the conceptual variation is important<sup>[118]</sup> because it allows for deeper understanding of the dimensions and properties of the concepts identified in the data. For example, in this study I observed a difference among women who had been motivated to engage in STI testing as a part of their regular health routine (e.g., annual Pap) and those who were motivated by symptoms (e.g., pain in the vulval area). Thus, I decided to theoretically sample women who specifically engaged in testing because of symptoms. Dey<sup>[118]</sup> suggests using more focused methods of observation (e.g., selecting participants that would provide appropriate comparable data to extend and deepen emerging concepts), and looking for a variety of data sources (e.g., selecting participants that represent a variety of constructed realities). In addition to actively screening theoretically contributive women as they called me on the phone to inquire about the study, I also added items to the interview guide that were specific to the concepts that I was interested in further developing (e.g., Have you ever gone for testing when you did not have symptoms?). Sample selection and analysis are iterative processes in grounded theory approach.

### ***Data Collection***

Nineteen (N=19) 19-24 year old women were recruited from the Pine Free Youth clinic and BC CDC STD Clinic. This research project relied on third party recruitment. Posters and informational pamphlets containing the researcher's contact information were made available at

the recruitment sites (see Appendix 1). Clinic clients interested in participating in the study had the opportunity to contact the researcher by telephone. In all cases, I re-confirmed respondents' eligibility for the study before making interview appointments. This also helped to ensure that individuals were selected from the pool of applicants who best met the theoretical needs of the study.

Development of the interview guide was informed by a comprehensive review of the literature related to STI testing (e.g., psychosocial impact of testing, decision-making around sexually transmitted infections). Experts in the field were asked to review a draft of the interview guide (see Appendix 2-3). Interview questions were pilot-tested with three women aged 19 to 24 years. This served the purpose of checking the appropriateness (e.g., content, ease of responding, flow) of the interview questions. Items were added or removed from the interview guide, as indicated by the responses of the participants. As the study progressed, the interview guide was additionally revised according to subsequent analyses, in order to focus on emerging concepts and further develop theory. I documented changes to the interview guide and consulted with my supervisory committee about such changes.

Follow-up interviews were conducted with 9 of the 19 study participants. Both initial and follow-up interviews each lasted between 1.5-2.5 hours. Initial interviews were conducted within two weeks of each of the participant's STI test and focused on young women's motivations for coming to the clinic for testing and their expectations about the testing experience. During the initial interviews, participants also were asked to describe their clinic experiences and to identify aspects of the health care system (e.g., anonymity of testing, interactions with clinic providers) and social context (e.g., interactions with peers, family and sexual partners) that they perceive to have facilitated or created barriers to their participation in STI testing. Each participant was invited to complete a subsequent interview within 3 months of testing.

The follow-up interview provided an opportunity to elaborate on key concepts identified during the first interview (e.g., disclosure of results to sexual partners; compliance with treatment). Furthermore, the second interview provided an opportunity to investigate how young women perceived that their participation in STI testing affected their subsequent sexual behaviour and decision-making. Field notes were taken during and after each of the interviews to capture important reflections about the interviews' substance and process. Interviews were tape-recorded and transcribed verbatim; transcripts were checked for accuracy. All transcripts had identifying information removed. Each study participant received a \$25 honorarium for completing each interview.

### ***Analytical Procedures***

A key feature of grounded theory is the constant comparative method. This analytic procedure involves joint coding and analysis to generate theory in a systematic way<sup>[119]</sup>. This method involves a series of "double back" steps and comparisons between the data and codes in order to find patterns and ensure that study findings remain closely grounded in the experiences of participants<sup>[121]</sup>. The constant comparative method provides explicit principles to guide analysis, incorporates methods of achieving specificity and rigor, and involves a system of checks and balances<sup>[118]</sup>.

I used this method to compare codes from initial interviews to those that presented themselves in subsequent interviews. Comparison and subsequent sampling decisions proceeded in terms of the potential theoretical value of participants (e.g., how their stories add to the analysis), rather than their representational value (e.g., how well do they represent the general population)<sup>[118]</sup>. This method makes no attempt to ensure the universality (generalizability) of the emergent theory. The dynamic interplay between theoretical sampling and the constant comparative process in developing categories is characteristic of grounded theory<sup>[122]</sup>.

There are four parallel processes that occur when the researcher employs the constant comparative method to analyze data<sup>[118;119]</sup>: (1) categorical generation (2) integration (3) development of the initial written theoretical findings (4) refinement of findings.

### **1. Categorical Generation**

The same analytical approach was applied to data gathered during the initial and follow-up interviews. I began by checking my notes against the transcribed interview and tape recording. Each line of text in the transcripts was read for discrete elements pertaining to the process of engaging in STI testing. I assigned codes to these discrete elements. In order to identify these elements I asked the following analytical questions: “What process is occurring in this situation?”, “How is the individual managing the situation?”<sup>[113]</sup>. By asking these questions, I generated codes that moved beyond descriptive labels for various aspects of the situation and moved towards more abstract and analytically sophisticated conceptualizations of its elements<sup>[119]</sup>. I also maintained an inventory of my codes and their definitions that are linked with text from the raw data that represent them<sup>[115]</sup>. The use of the qualitative data management software, *NVivo*, facilitated the maintenance of my inventory of codes, their definitions, and linkages to the raw data.

As the analytic process progressed, the need arose to organise codes according to general categories. General categories are composed of codes that represent abstractions of particular examples of actions, social relations, social outcomes and institutions that are described in the raw data<sup>[115]</sup>. As specific codes were identified during analysis of initial interviews, I began to organize the codes into groups that represent more abstract and encompassing aspects of the process of engaging in STI testing<sup>[123]</sup>. For example, I saw that friends, family, and partners were influential in the decision to engage in STI testing; thus I grouped them together under the same category of interpersonal relations.

The basic defining rule for the constant comparative method is to compare each coded unit of data (sometimes called “chunks” of data) with previously coded units<sup>[119]</sup>. Initially, the comparisons occurred between data units. Raw data are usually, but not always, at a lower level of abstraction than a code<sup>[118]</sup>. As the coding process progressed, the comparison process began to shift and focus more on comparisons between codes and specific groupings of codes, called properties. Properties are usually at a higher level of abstraction and integration than codes, but at a lower level than categories<sup>[118;119]</sup>. A property is a conceptual aspect or characteristic of a category<sup>[118;119]</sup>. These categorical characteristics (theoretical properties) vary along a range or continuum.

Dimensions refer to the full range of conditions, consequences, and characteristics of a category. For example, one dimension of a particular category might describe the set of conditions under which that category is more evident or less obvious. Other examples of dimensions could include a category’s major consequences, an identification of its relation to other categories, and/or its relationships with particular properties of the category<sup>[119]</sup>. A dimension can also represent a characteristic of a category, and those characteristics can range along a continuum<sup>[123]</sup>. It is important to develop categories inductively based on dimensions before applying deductive logic to further differentiate each category by breaking it down into subcategories that explain the conditions (e.g., when, where, why, how) under which the phenomena are likely to exist<sup>[123]</sup>. These subcategories also must account for consequences and characteristics. Like most aspects of the grounded theory analytical process, the use of induction and deduction to create categories is highly iterative.

Categories and properties share two main characteristics. First, they are “analytic”, meaning that they are concepts inductively derived from the data rather than mere labels for anything existing in the data. They vary in their degree of abstraction from low to high. According to Glaser and Strauss<sup>[119]</sup>, lower level concepts will be identified quickly from data



collection. In contrast, higher-level concepts and their characterizing properties will be identified later on in the analytical process because they are more abstract and integrate lower level concepts and properties<sup>[119]</sup>.

## **2. Integration**

The generation of theoretical findings should aim at achieving as much diversity in emergent categories (at as many conceptual levels as possible) in order to clearly illustrate the connections between categories and properties<sup>[119]</sup>. Theoretical or axial coding is the process of relating conceptual elements (codes, categories, and properties) to each other through a combination of inductive and deductive thinking<sup>[115;121;123]</sup>. At this point of analysis and data collection, I organized the products from open coding into a theoretical framework and develop integrative hypotheses about the relations between categories and their properties<sup>[118]</sup>. I was looking specifically for causal relationships that help to explain human behaviour and behaviour patterns<sup>[115]</sup>.

At this point in the analysis, the diverse range of properties also become more integrated and more linkages amongst the properties themselves were identified<sup>[119]</sup>. Previously unidentified abstract and integrated concepts were also inductively developed at this point, as I was searching for patterns in the data that revealed similarities and differences within and between categories<sup>[118]</sup>.

## **3. Developing the Initial Written Theory**

Throughout the constant comparative process, I recorded my ideas about a variety of aspects of the emergent theory<sup>[119]</sup>. Memos are short documents in which I recorded theoretical notions as I completed the analysis. Unlike some forms of quantitative analysis, the development of theory using grounded theory method requires that the writing begins and continues throughout the data collection and analysis process. Initially, memos included conceptual

definitions that described the meaning of each code and its various dimensions<sup>[115;123]</sup> or explain linkages between codes (and includes examples from the raw data to demonstrate such linkages). As the analysis and writing progressed, the memos began to include hypotheses about the nature or strength of relationships between the codes, described how specific sampling strategies might help fill in a category, or discussed the analytical process and key ideas associated with a refinement of the emergent theory<sup>[123]</sup>. Memos also explained the procedures followed to demonstrate the use of the constant comparative method or provided discussions of particular aspects of specific study participants that may have bearing on the theoretical findings. As the analysis progressed and the final theoretical description was prepared, the memos became increasingly integrated and ultimately formed the body of the final description of the findings. Memos are sometimes referred to as an “audit” trail.

As the analysis continued, the codes were organized into a framework that illustrated the links among the emerging codes and identified how these codes relate to the process of testing for sexually transmitted infections. This process of integration (linking categories, properties and codes) allows a central theoretical framework to develop around a “core” category (e.g. the main “story line” of the study)<sup>[118]</sup>. The theoretical framework is similar to the structure of a cobweb, with the core category as the central structure. Like the threads that are woven around the cobweb’s framework, the other categories are related to the core category. In this way, the core category accounts for much of the variation in the data, is a stable pattern that repeats itself in the data, and is at a higher level of abstraction or more complex<sup>[121]</sup>. The core category is highly variable in that it is sensitive to a variety of conditions (e.g., degree, dimension, type) and powerful in explaining the data by helping the analyst to draw a conclusion (e.g., influences the overall shape of the cobweb)<sup>[121]</sup>.

In this study, “Ascribing meaning” (to the test) is the label I gave to the category most prominent in the findings to date. This highly theoretical category encompasses a set of more

abstract concepts that emerged when I was identifying the key processes associated with STI testing. I consider 'Ascribing meaning' as the core category of the findings at this final point of analysis and data collection because it helped to explain the young women's use of testing (e.g., motivations to test, choice of clinic), with respect to their personal circumstances (e.g., type of relationship, symptoms) and linked these to the broader themes of purity, personal responsibility, and empowerment that were analytically developed from the raw data and used to describe the overall phenomenon.

As the methodological literature cautions, it was the case in the current study that two central categories (core categories) were identified during the analysis. Strauss and Corbin<sup>[123]</sup> suggest choosing one and selectively coding in order to maximize the depth and understanding of it. The reasoning for this is that any other core category can be analyzed and developed later on<sup>[118;123]</sup>. In contrast, Glaser argues that a core category must earn its position by being able to account for most of the variation in a pattern of behaviour<sup>[118;121]</sup>. Clearly, there is the potential for multiple core categories to be identified and the onus remains on the analyst to choose them, but not prematurely, and further develop them<sup>[118]</sup>. Due to the limited resources for conducting this study (extra resources may have allowed me to fully develop and identify one "dominant" core category as described by Glaser), I have followed the strategy suggested by Strauss and Corbin in focusing on developing as fully as possible one category (Ascribing Meaning).

#### **4. Refinement**

After identifying a theme (Embodying the Ideal of Purity), I continued to focus on integrating (by systematically relating additional categories and their properties), refining the theoretical description (by filling in categories that need further development and excluding categories not related to the core category)<sup>[118]</sup>, and validating relationships between concepts and my central theme<sup>[118;123]</sup>. I aimed to gather data tailored to filling in the properties and dimensions of my core category (Ascribing Meaning) and focused my analysis on the aspects of

the findings that remained underdeveloped. I also selectively searched for and coded for new evidence that supported or refuted my emergent findings in subsequent interviews. I also went back to previous interviews to review the evidence in support of (or refuting) my emergent findings. This process is called selective coding (delimiting or refining the theory) and its main purpose is to develop the central idea (core category) around which all other conceptual elements branch from.

### ***Completion***

An indication for stopping data collection is theoretical saturation. According to Glaser and Strauss<sup>[119]</sup> this point refers to the non-emergence of new properties, categories, or relationships. Perhaps less explicit in this definition is that theoretical saturation refers to concepts, and not data, and identifies a point where no further conceptualization of the data is required<sup>[118]</sup>. For example, as the analytic process continued, I eventually began to repeatedly code incidents for the same category, which did not add new aspects to the findings. If an incident did make a new contribution, then I coded it and compared it to other existing codes organized under the category<sup>[119]</sup>. If not, then it incorporated into the existing findings. As the analysis continued, I found no new concepts then I began to suspect saturation. However, full saturation was unlikely to have been reached in my thesis because of my resource constraints, which limited my ability to sample a broad range of experiences (e.g., diversity of stories describing symptoms and/or positive diagnoses). In spite of the likelihood of not reaching saturation, I did reach a point of diminishing returns and repetition when comparing more fully developed concepts with those assigned during earlier stages of the analysis.

### ***Issues of Rigor***

It is important to consider the assumptions underlying a research method in order to address the trustworthiness of its products<sup>[122]</sup>. Grounded theory has its own methods of judging

rigor. For example, the constant comparative feature of grounded theory automatically searches for disconfirming evidence on a continuous basis<sup>[122]</sup>. The constant comparisons drive the emergent findings into a final form that should be a good fit to the data<sup>[113]</sup>. Furthermore, categories generated by the constant comparative method are indicated by the data rather than imposed on the data<sup>[119]</sup>. This focus on the inductive development of theory improves the fit, relevance, and richness of categories to the data<sup>[119]</sup>. Therefore, it is inappropriate to apply criteria developed for a different research approach, such as deductive, hypothesis testing research<sup>[113]</sup>, in order to establish the rigor of a qualitative and inductive grounded theory product.

Glaser suggests two main criteria<sup>[121]</sup> for judging the adequacy of the emerging theory. The first is that it fits the situation and the second is that it works (e.g., that it helps the people in the situation to make sense of their experience and to manage the situation better)<sup>[113]</sup>. While Glaser's criteria are intuitively appealing, this study will utilize additional criteria for rigor commonly used in qualitative research<sup>[124;125]</sup> including the: (i) establishment of an audit trail that provides detailed documentation of analytic procedures; (ii) use of member checks in order to solicit study participants' feedback on the interpretations of their interviews; and (iii) use of data management software, *NVivo*, to systematically compare and contrast data from various participants and to contextualize individual perceptions into a larger, macro-level perspective regarding the influences of broad social norms and system level factors in the health care system. This strategy helped to move the analysis beyond basic description of individual or group behaviour and encouraged a more theoretical and structural approach to my analysis. I also discussed theoretical notions with my supervisory committee members at key points during my analysis. This allowed me to cross check ideas, help to identify and uncover new ideas, as well as to provide another way to test and challenge my analytical interpretations<sup>[119]</sup>.

## ***Ethical Considerations***

A third party recruitment process was used to recruit participants. Individuals interested in participating in the study received an informational pamphlet and my contact information from the clinics (e.g., posters, pamphlet racks). Interested individuals contacted me by telephone in order to learn more about the study. This provided the opportunity to reconfirm eligibility for the study before making an interview appointment. The consent form and socio-demographic survey was explained in detail with each participant before beginning the interview (see Appendix 4-5). Study participants were able to refuse to respond to interview questions, stop the interview at any time, and review their interview transcripts. If participants had any questions about the study, they were able to contact myself, or my thesis supervisor, Dr. Shoveller. They also were given the contact information of the director of research services at UBC if they have any questions regarding their rights and treatment as a research participant.

The specific location for interviewing was decided upon by both the study participant and myself to ensure confidentiality and safety. Most interviews were conducted at Dr. Shoveller's UBC-based project office. All identifying information was removed from the transcripts and all tape recordings and interview transcripts were locked and filed in a secure and private office. Because the participants were asked to provide personal information that is confidential, the researcher anticipated that some would recall experiences that would cause psychological and/or emotional discomfort. Each study participant was provided with contact information for sexual health services and counseling resources. A list of locally available resources accessible to study participants was provided (Appendix 6) after the explanation of the informed consent form. Although I was unable to control the speed of access to resources, I did contact each of the sites to advise them of the nature of the study and the possibility of participants approaching them. An application to the UBC Ethics Review Committee was submitted and approved in August 2003.

## **Chapter 4: FINDINGS**

### ***Overview of Chapter***

The first section of the findings chapter describes the characteristics and backgrounds of the study participants (see Appendix 7) and provides a brief description of the interview process. The second section provides a description of these young women's experiences of participating in STI testing at two clinics in Vancouver, British Columbia. These descriptive findings, organized around the three phases of the STI testing process (and the three research objectives of the study), provide empirical evidence and context for the study's more theoretical insights. The section entitled *Ascribing Meaning* presents a set of abstract concepts that emerged as the analysis identified the key psychosocial processes associated with STI testing. A theme, *Embodying the Ideal of Purity*, which extends throughout the findings, is described in the final section of this chapter.

### ***Study Participants***

Nineteen women participated in initial interviews and nine of these women returned for follow-up interviews. Study participants' ages ranged from 19 to 24 years (with a mean age of 21 years). Six women identified their ethnicity as Caucasian or White, three as Chinese-Canadian, one as Iranian-Canadian, one as German-Chinese, one as European-Canadian, two as Filipino-Canadian, one as Latina-White, one as South Asian, one as Greek-Canadian, one as Welsh-Canadian, and one as Alaskan Eskimo. Fifteen participants were enrolled in post-secondary education (e.g., college, university, technical school). Eleven study participants were employed (full or part-time) at the time of the interview. Ten participants reported being in heterosexual sexual relationships at the time of the interview (two were involved in sexual relationships with more than one man) and the remainder of participants were not currently involved in a sexual relationship.

Each interview took 1.5 – 2.5 hours to complete, including the informed consent process. Each interview began by asking the women to describe how they came to the point of getting tested for STIs. Seven study participants were recruited from the CDC STD Clinic and twelve were recruited from the Pine Free Youth Clinic. Six women sought testing for STIs because of symptoms. Thirteen study participants were asymptomatic. Of those participants who were asymptomatic, nine women experienced STI testing as part of their regular health care (e.g., annual Pap and “overall” check-up), one sought STI testing in order to determine her STI status before ending a long-term relationship, one woman sought testing after a sexual assault<sup>5</sup>, one engaged in testing in order to comply with requirements for the adult entertainment industry, and another received testing as part of a pre-natal check up.

Although the study participants were not required to disclose their test results during the interviews, six study participants voluntarily reported that they had been previously diagnosed with chlamydia, which was the most common STI reported by study participants. Two other study participants reported having been diagnosed with genital warts and two had experienced herpes. Two study participants reported co-infections with non-sexually transmitted infections (chlamydia with bacterial vaginosis and bacterial vaginosis with herpes).

### ***Describing the STI Testing Process***

The description of the study participants’ experiences with the STI testing process is organized according to three phases: (1) Pre-Test Phase; (2) STI Test Experience; and (3) Post-Test Phase. Figure 2 illustrates the phases of the testing process and the corresponding research objectives of the study. Quotes from the raw interview data are included to provide illustrations of the major descriptive codes. The descriptive codes provide the basic “building blocks” for the

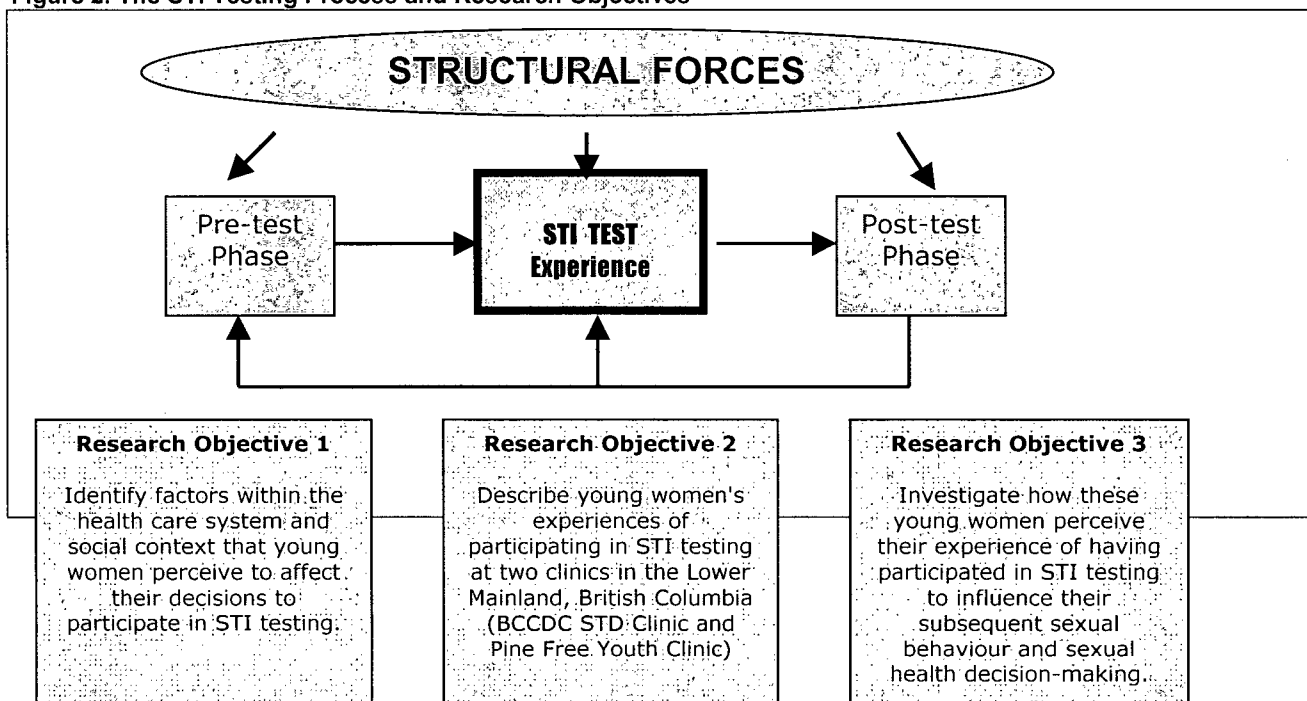
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<sup>5</sup> While most study participants described consensual sexual experiences within the context of relationships, it is important to acknowledge that this participant’s experience with STI testing was instigated by sexual assault.



chapter. The theoretical insights described here provide a foundation upon which to develop a more advanced and complete theoretical framework in subsequent studies.

**Figure 2. The STI Testing Process and Research Objectives**



### ***Pre-Test Phase***

At the outset of each interview, study participants were invited to tell the story of how they came to the point of engaging in STI testing. For some study participants, engaging in STI testing was a deliberate, self-initiated decision and action (e.g., urgent response to symptoms), while for others their engagement in STI testing was less urgent (e.g., as a part of their annual check up). Study participants who actively sought STI testing cited multiple reasons for deciding to engage in STI testing, rather than identifying one specific reason for engaging in testing. These reasons included: having symptoms (e.g., pain, odor, discharge, vaginal itch, bumps) and protecting their personal health.

Having symptoms was the primary motivator for engaging in STI testing for six study participants. Study participants who experienced symptoms focused their stories about deciding

to go for testing by describing their physical discomfort (e.g., pain, itching, discharge, odor) or how they responded to visual cues (e.g., bumps on genitalia). Typically, study participants associated their experiences of symptoms with a perceived lack of cleanliness, particularly once a positive diagnosis had been confirmed. As one young woman said:

*You got symptoms that weren't normal, like a normal discharge, or odor, or, when you're urinating, if it was burning or anything, or hurting. That would not be considered normal. It's not your normal state to be painful. You know, having weird discharge. I think that would be, considered not clean. It doesn't mean you're dirty, yet. I think dirty would be more like **having** a disease.*

*("Susan", age 19 years, Pine Free)*

Most study participants identified feeling dirty as being directly linked with socially unacceptable sexual behaviour, particularly promiscuity. It is interesting that study participants used the language of "clean" or "dirty" when describing their sexual health status in light of alternative connotations associated with these terms (e.g., being clean is often used as a metaphor for being drug-free, hygienic, and healthful). Women who described these experiences expressed a strong desire to resist being labeled negatively, as the following quote illustrates:

*If you're married and you're faithful then you don't have to go to clinics. Promiscuous people go to STD clinics...I mean I went there [to the STD Clinic] but, I'm not promiscuous. I went there because my partner was promiscuous....And, I wanted to wear a sign that says: 'It's his fault.'*

*("Zula", age 24 years, CDC)*

As the previous quote demonstrates, the overwhelming perception amongst study participants was that monogamous relationships should preclude the need to engage in testing (i.e., fidelity was viewed to be sufficiently protective). Across the interviews, deciding to engage in STI testing within monogamous relationships was perceived to be a potential insult to one's sexual partner, as the following quote illustrates:

*I think I insulted him. He was hurt. He asked, 'Does that mean I have something? Are you saying that you gave **me** something? Are you saying that I gave **you** something and you gave it back to me?'...His response wasn't very, positive.*

*("Susan", age 19 years, Pine Free)*

However, some study participants who regularly engaged in sexual relations with multiple partners and who tended to identify sex as a facet of their physical pleasure (rather than a source of emotional intimacy) were less likely to associate the idea of being dirty with the process of deciding to go for an STI test. The stories that these study participants presented were more likely to be stories about casual sexual encounters than long-term sexual relationships. For example, one young woman hypothesized that she had had “less drama and heartache than other girls her age that are going through the same kinds of things” (“Sarah”, age 20 years, Pine Free), which she argued stemmed from her ability to separate physical sex from emotional experiences. This separation may have helped her to dissociate a sense of stigma from the STI testing process. She likened her regular use of STI testing to other reproductive health routines (e.g., watching her cycle carefully and her taking oral contraceptives everyday), which she suggested helped to make her feel more comfortable with her body and with her sexual decision making:

*It's made me more methodical about the whole thing [sexual activity] ...I'm not like: 'Oh well, it happens when it happens.' – I **plan** it [sex]. I plan when I want it to happen, and with who, and how and all that kind of stuff and how it's going to go. I'm really comfortable with that. It's made me a lot more comfortable with my body because I've gotten all this information about how everything works and just having gone through it [testing] so many times...I'm a lot more comfortable – definitely.*

*(“Sarah”, age 20 years, Pine Free)*

During the interviews, study participants also were asked to describe how long they usually waited to go for testing after they had first noticed their symptoms. Study participants who noticed having symptoms usually pursued testing as soon as possible. One young woman described how she was desperate to deal with her symptoms. She accessed the first available clinic (on a weekend) and agreed to be seen by a male doctor (something she would have normally avoided). The urgency of her need to address her symptoms is illustrated in the following quote:

*I need to go check it out. It...it hurts. It doesn't feel right. It just... it scared me, a lot. (“Susan”, age 19 years, Pine Free)*

In a few cases, study participants attempted to explain away their symptoms by hypothesizing that the symptoms were caused by rough sexual play or pre-existing non-sexual conditions (e.g., warts on their hands). One study participant who went for testing (and had not yet received her diagnosis) subsequently experienced relief from her symptoms (without any treatment). She described feeling “cleaner” simply because she had undergone the testing experience. This participant subsequently tested negative for an STI.

Even in the absence of symptoms, some study participants engaged in STI testing on a regular basis, particularly to determine their STI status during the interim between former and future sexual relationships. As one young woman said when asked about her reasons for attending the clinic, “I just kind of broke up with someone and I just want to make sure that everything is OK, and so I just want to have an STD check.” (“Kimberly”, age 20 years, Pine Free). Study participants who regularly engaged in STI testing described the importance of STI testing as part of their overall regimen to protect their personal health. These study participants frequently associated testing with an enhanced sense of maturity and characterized STI testing as a method for taking responsibility for one’s personal sexual welfare. As one young woman noted:

*I feel more adult and more mature. Now I need to get tested before sleeping together. It's the healthy thing to do.*  
(“Kate”, age 23 years, CDC)

Many women who decided to undergo STI testing regularly said that they did so in order to receive a confirmation of their good health (i.e., “just to make sure”). Overwhelmingly, women in the study who regularly underwent STI testing described it as a proactive and healthy thing to do. While most regular testers talked about their short-term health, two women also cited longer-term health concerns when describing their motivations to participate in STI testing.

For these women, testing provided a way to protect their desires to have children in the future, as the following quote illustrates:

*I just thought, like oh, what if? What if I had something, you know, then you know, it could be festering in me, and, that can affect getting pregnant one day. Or, you know, something bad, so...I've just always wanted kids, like a lot of women do um. And, unlike a lot of my friends who are in university and very wanting careers and stuff, I'm kind of more, like, I should have been a housewife in the fifties. Like I really just want to be a mom and a wife. So yeah it's [STI testing] important to me."*

*("Kimberly", age 20 years, Pine Free)*

Women that regularly engaged in STI testing tended to describe following specific, pre-planned schedules for undergoing each test. They described how the schedule of testing was dictated both by their knowledge about particular STIs (e.g., the "window period" when HIV antibodies become detectable) and by the state of their current sexual relationships (e.g., planning to engage in sexual intercourse with new partners). As one young woman's story illustrates, a combination of STI knowledge and relationship status affected her decisions to engage in STI testing regularly:

*The next time I go for testing will be in 3 months for a follow-up so I can fulfill the 6 month window period... Or, if I have a new partner, I'll get tested...I'll do it just so I know, to be careful. It's about making healthy decisions and maintaining my health, and to increase awareness of what's happening with my body.*

*("Kate", age 23 years, CDC)*

Throughout the interviews, most study participants focused their descriptions of deciding to go for testing on issues that related directly to their own health. They described either responding to symptoms or regularly scheduling tests in order to proactively protect their health. However, as the course of the interviews progressed, most study participants also described the important role that STI testing can play in terms of protecting the health of others. While protecting the health of others did not figure as a prominent motivator for women in this study to

engage in STI testing, they acknowledged the social and public health benefits of protecting their sexual partner(s). As one young woman said:

*Testing is important because there are crazy people like me out there. People who are going to get screwed over by their partners, like I did to him [her boyfriend]. Even if you're in a monogamous relationship you can get screwed over.*

*("Ellie", age 22 years, CDC)*

Study participants talked about the idea of feeling dirty when making a decision to go for STI testing. They described how they felt dirty by the time they realized they needed to go for testing and how the physical clinic environment in which they sought testing sometimes enhanced their negative self-perceptions. While not every study participant expressed negative reactions to the clinic settings, the following two excerpts from transcripts illustrate how physical setting can exacerbate some women's negative self-perceptions. The first story stems from a woman who had visited the Pine Free Youth Clinic in order to be tested for STIs also described a situation where the clinic's physical setting affected her self-perception:

*I guess it's kind of a personal thing – you're going in for STD testing. You're already not feeling like the cleanest, purest person in the world ... And then, you walk into a place like that – it kind of has that Downtown East Side ghetto feel to it. And it almost makes you feel a little bit worse. It's like: 'Wow, not only have I put myself in a situation where I have to get tested, but I've ended up in a place that looks like this.' ...I already had a little bit of guilt and I didn't really want to be there, and I asked: 'How did I get myself into this?' ...It looks like a place for troubled teens and I've always considered myself as fairly together.*

*("Sarah", age 20 years, Pine Free)*

The next story describes one woman's first impressions of the BC CDC STD Clinic:

*When I was walking to the STD Clinic, it's kind of uncomfortable because all of the cars are driving by and they know that you're walking into the STD Clinic...I guess there's no way around it because if the sign's not there, then how do you know it's the STD Clinic? ...But, it made me feel kind of uncomfortable because I just think that generally people don't go to the STD Clinic just because they want to be careful... Generally they go down there if they think they have an STD. So, I think, just in virtue of that – it made me feel sort of uncomfortable about walking into the "STD Clinic."*

*("Kate", age 23 years, CDC)*

While some study participants reacted negatively to the physical features of some health care settings, not every study participant had a negative reaction to their interactions with physical environments of the clinics. One study participant took comfort in what she described as the “hospital-like” atmosphere of the BC CDC STD Clinic, which she described as being “the Mecca of all STD buildings” (“Luisa”, age 21 years, CDC), where she perceived that she had access to a wealth of health experts, medical equipment and supplies, as well as specialists in the topic of STIs.

Although all the study participants were recruited as a result of having undergone STI testing, some study participants indicated that they had previously been tested for STIs as a result of having their annual Pap tests. It was common for study participants to indicate that they assumed that they would also be tested for STIs when they received a Pap test. The provision of STI testing concomitantly with Pap testing also provided a way for young women to avoid having to ask specifically for an STI test in often crowded reception and waiting areas, as the following quote illustrates:

*When I asked for the Pap smear on the paper, they said, ‘Oh we do STDs as well.’ So, [from now on] I’ll just say I’m going for a Pap smear, [chuckle] and then I’ll do the STD test too.*

*(“Susan”, age 19 years, Pine Free)*

Most study participants provided positive comments about the experience of being routinely “screened” for STIs as part of their overall reproductive health regimen. Overall, study participants appreciated the opportunity to have all their sexual health care needs met during one visit to youth clinics without having to travel to numerous health care providers. As the following quote demonstrates, it was important to study participants to be able to access multiple services in one location when they needed to address their sexual and reproductive health needs:

*I think I was like fifteen, so I think I was a little shy, but, um. It was fine, like, they, they’re nice and informative. I keep going back there for like, my feminine sort of things...A Pap smear. Um, birth control, yeah, that’s about it. That sort*

*of stuff...It's just good to check everything out... Yeah, I just like to be on top of things and just know that I'm okay...."*

*("Kimberly", age 20 years, Pine Free)*

Many study participants also described feeling more comfortable accessing STI testing services within a clinic setting than through their regular family doctor. Most study participants described how the confidentiality and anonymity at STI clinics added to their sense of comfort and "safety" in comparison with their family doctor, who was often perceived to be more likely to reveal a confidence to family members, particularly parents:

*I think the first time I went to Pine Free I was in grade ten. I just started going there because I didn't want to go to my family doctor, cause I didn't want... you know, I was paranoid about him telling my parents what I was up to and stuff. You know what I mean?*

*("Kimberly", age 20 years, Pine Free)*

In general, study participants described youth clinics as being non-judgmental, safe places where they could feel comfortable accessing potentially "embarrassing" services in a manner more confidential than that of the family physician's office:

*It's just more comfy at the youth clinics...because, I don't know, I think that general practitioners tend to keep in touch with other general practitioners - that's just kind of how I feel...They [clinics] deal with these things like STDs, pregnancy tests, and things like that and they're really used to it, and they make you feel just like "at home" - it's like there's nothing wrong. It's like this is part of growing up and going through these sexual experiences. It's just like part of their routine and I'm just really comfy with it.*

*("Luisa", age 21 years, CDC)*

While all of the participants in this study had engaged in STI testing, they also were asked to describe reasons for either delaying or forgoing STI testing. For some study participants, avoiding the family doctor was cited as a reason to delay or avoid engaging in STI testing. Study participants described how they have a long-term relationship with their family physician that has created the perception that the physician's role resembles that of a parent. Thus, women in this study anticipated negative judgments from their family doctors with respect to their sexual behaviours and relationships. In addition, women feared that family physicians



would not keep their medical histories confidential (e.g., telling their parents and other physicians), which created further barriers to young women seeking STI testing from their family physicians. Because they did not want to seek help from their family physicians and wanted to protect their confidentiality, young women described how they would access sexual health care in neighbourhoods not regularly frequented by people they know. Clinics were also perceived to be more convenient places to access STI testing services (e.g., one-stop-shopping) because diagnoses, referrals, and actual testing procedures can be done in one location within a relatively short period of time (e.g., one day).

Other study participants said that youth sometimes avoid testing because they feel fearful about the testing procedures. They described feeling embarrassed because they did not know what test to ask for (e.g., they would ask for a Pap test hoping to get comprehensive STI testing). In other cases women in this study described that they lacked awareness about the procedures that are included in testing. Study participants described feeling ignorant about what to expect in terms of the physical sensations associated with the procedures involved in testing. A lack of awareness often contributed to delays in women seeking testing in that they tended to focus on the hypothetical negative aspects which they anticipated to be associated with the clinical experience (although many also described how the actual experience was much less negative than the anticipated experience). It is possible that stories about peers' negative experiences with STI testing exacerbated young women's negative expectations, as they often told stories about how their friends had negative experiences when accessing sexual health services.

Some women also described having a poor understanding of where to access STI testing services. In an extreme example, one study participant who was a student at UBC delayed testing for STIs for one year because she did not know that she could be tested at UBC's Student Health Services clinic. Participants talked about the importance of knowing about conveniently located and accessible services in order to facilitate their timely access to STI testing.

Participants also often described general embarrassment about sexual health issues as being an important barrier to accessing STI testing, as the following quote illustrates:

*I meet a lot of, like tons, of my girl friends; they never get blood tests [for STIs]. I think some of the girls get Paps and swabs. But I mean I know some girls that never even get Pap smears, they're so shy you know. Which is bad... They're shy.... I think it's really awkward... Young girls are pretty shy too, um, and I think a lot of people are un-knowledgeable about that.*

*(“Kimberly”, age 20 years, Pine Free)*

Embarrassment about sexual issues was a dominant concern across the interviews. Even those participants who were more confident in accessing and undergoing STI testing expressed their embarrassment about engaging in sex when they described the reasons why they were hesitant to discuss their STI testing experiences with their sexual partners, peers, and/or family. Not surprisingly, women's embarrassment manifested in their hesitation to engage in open dialogue with others.

Feeling comfortable when accessing STI testing services was described as being an important feature of both clinics. However, some study participants delayed STI testing because they felt uncomfortable seeking help from their family doctor, were afraid of the testing procedures, or lacked an understanding of where to access STI testing services. The social context within which young women make decisions about engaging in STI testing is influenced by idealized notions of femininity that connote cleanliness and purity. Deciding to engage in testing puts one at risk of being labeled as “unclean” or “dirty”. This problematic association can also present as a barrier to engaging in the testing process.

In summary, most study participants described their decisions to engage in STI testing as being motivated by their symptoms and their concerns for their personal health. In addition, women in this study sought testing as a means to monitor their sexual suitability (e.g., feeling clean or dirty), and to regulate their relationships. In general study participants perceived STI testing to be a responsible and healthy action to engage in. Furthermore, the social construction

of purity as it relates to female sexuality establishes an ideal and standard which women are encouraged to aspire. Therefore, women may have an emotional stake in aspiring to this social standard.

### **STI Test Experience**

Most study participants provided brief, cursory accounts when asked to describe the actual experience of undergoing STI testing. In general, their descriptions were not detailed and their stories about the STI testing experience typically only included a few sentences about some of the key aspects of the testing experience, including being in the waiting room, interacting with the staff, and undergoing the procedures.

Study participants described feeling extremely awkward when they were waiting in the reception area prior to undergoing their STI test. They reported that they judged others in the waiting area. Simultaneously, they felt judged by other patients who were waiting for service. Study participants typically attempted to cope with these feelings of judgment by trying to ignore their sense of awkwardness, although a few participants mused about the irony of feeling judged and engaging in judgments:

*It's kind of funny. You just sit with your friend and talk quietly and giggle about things. And then, you stare at each other. But, it's like the bus. You stare at each other, but you try not to get caught staring at each other. And then you just sort of size everybody up, going: 'Oh, look at that person.' And you gossip about each other, like: 'Look, she's so slutty. Of course, she's here.' And meanwhile, you're laughing at yourself because you're like: 'Hey, look. I'm in the same position.' ...I've had random conversations with people in waiting rooms. Pretty nice people go [to clinics]. It's kind of awkward, but funny at the same time. You laugh about it because it's like: 'I'm meeting you at the VD clinic – how fun [spoken sarcastically].' ...*

*(“Alice”, age 19 years, Pine Free )*

Although the interview guide contained prompts to ask women to describe their interactions with clinic staff, few study participants elaborated on their experiences with staff members. Most study participants simply acknowledged that the staff was helpful and non-

judgmental. Most study participants described feeling reassured by the clinic staff. This reassurance was perceived to have been helpful in coping with the testing procedures.

In a few cases, study participants either told stories about their interactions that were either exceedingly positive or revealed their disappointments at experiencing negative interactions with some staff. For example, one study participant described experiencing a very helpful educational intervention from one of the nursing staff at the BC CDC STD Clinic. The study participant described how the nurse's approach was both educational and humorous. Conversely, another study participant described a situation where she perceived that a male physician who was attempting to draw blood did not treat her with respect. In this situation, the young woman ultimately lodged a complaint against the physician as a result of this interaction. Another example of a negative interaction involved a study participant feeling like she needed to defend her partner during the process of having her sexual history recorded, as described below:

*I told him [the doctor] about the story about how my boyfriend came into town and after he left, I got something...you know, I think I have something. And the doctor was like asking me about my sexual history. He was asking me about my boyfriend's history and I said he's clean. So the doctor's like: 'I'm not saying I don't believe your boyfriend, but...' It felt like the doctor was accusing my boyfriend...saying that something could have happened...It seems like he was accusing...I felt like saying: 'How would you know?' I was defending. I was offended actually. And, I started defending my boyfriend. I was like: 'No, no, no, I do believe him. That's why I'm here. Just to get it checked out for sure.' I was offended because the doctor was like saying it as if my boyfriend did have something and then, therefore, I had something.*

*("Susan", age 19 years, Pine Free)*

Interestingly, this study participant sought testing because she was having symptoms after a sexual encounter with her long-distance boyfriend. Despite having symptoms, this study participant appeared to be in denial of her boyfriend's potential infidelity. This example points to the sensitive and complex nature of the interactions that occur in clinical settings and reflect the emotionally loaded circumstances under which these women access testing.

The interviews also included questions about the clinical details pertaining to the testing procedures. The standardized approach to providing the basic clinical aspects of STI testing services appeared to meet most of the expectations of young women. While all of the study participants described the actual technical mechanics of physically undergoing testing as an unpleasant experience, they expressed a degree of resignation about the necessary (but undesirable) steps to collecting a specimen and completing a thorough pelvic examination. Most study participants did not provide a great deal of detail in response to these probing questions; however, one young woman provided the following account, which describes some of her perceptions about the testing experience:

*Well, basically you have to take your pants and panties off and sit in that awkward chair with your legs in the air. It's not very lady like. But, you know, that's why I go there [the clinic], because I wouldn't want my male doctor [her GP] to do it... Then they take this weird thing... Spec... whatever [INTERVIEWER: A speculum.] Yeah, ...which I hate because it clunks and it hurts kind of. And, I guess she just looks at the cervix, makes sure everything looks healthy, and takes like a swab of cells or whatever. And then it doesn't take too long. She pushes on your stomach, just to make sure that everything's OK with the ovaries. And it takes a couple of minutes and then you're done. And then, a week later, which is today, you call just to make sure that everything's OK.*  
(“Kimberly”, age 20 years, Pine Free)

In all but one of the interviews, the women, rather than their male sexual partners, initiated STI testing. Of those women who were still in contact with their male sexual partners, one male partner refused to go for testing (despite the woman having symptoms) and another male decided to wait to hear about the woman's test results before making a decision about going for testing. Study participants noted that they perceived that most of their male sexual partners tended to view STI testing as the woman's responsibility. The kinds of reasoning that male sexual partners would provide for refusing to take responsibility for STI testing was generally perceived to be weak. For example, in rare cases where women suggested that both sexual partners get tested for STIs, the male partner often responded by saying things like:

*'It's less uncomfortable for you to get a test.' And, I'm like: "No, it's not! I have their entire hand shoved up my, you know, and this is all you have – a cotton swab. That's not so bad. And, I know it's uncomfortable and it tickles you and you feel floppy, but..." They just think it's the girl's responsibility.*  
(*"Alice", age 19 years, Pine Free*)

In summary, the study participants' overall descriptions of experiences of testing reflect a positive assessment of the services currently being provided at the two participating clinics. Feelings of awkwardness were common when study participants describe how they felt during the STI testing experience. This awkwardness was in most cases alleviated by the young women's interactions with helpful and non-judgmental clinic staff. In terms of their physical reactions to the specimen collection and examination procedures, most study participants described that they tended to endure and tolerate the clinical encounter. Women in this study voiced their perception that it is women's bodies that are usually viewed as suspect (requiring inspection through testing), rather than those of their male sexual partners. Although most descriptions of the testing experiences were presented in terms that lacked variation (and, in fact, seemed to be almost standardized accounts of routine testing procedures), study participants' descriptions of their post-test experiences were more varied.

### **Post-Test Phase**

During the interviews, study participants were asked to describe the ways in which their experiences of having participated in STI testing had influenced their subsequent sexual health behaviour and sexual health decision-making. In describing how their experiences with STI testing had affected the ways they thought about sex and their own sexuality, many study participants described engaging in a process of making resolutions. For some women in this study, resolutions focused on two types of actions: (1) taking "better care" of themselves (e.g., getting fit, saving money, going back to school), and (2) resolving to alter their sexual behaviour patterns (e.g., no more sleeping around, only having sex with particular types of people).

Young women in this study who resolved to “take better care” of themselves sometimes described their experiences with STI testing as a marker for a transition in their overall lives, which led them to engage in a set of self-improvement strategies. During these transitions, the women often described focusing on improving their personal standards regarding their approach to living. As part of their efforts to make transitions to “higher personal standards”, many study participants described how they had also resolved to focus on school, save money, quitting smoking, and increase their physical activity levels after having experienced a STI test. While the experience of testing was not perceived to be “life changing”, study participants suggested that an STI test could facilitate a lifestyle transition if they were ready to experience such a shift. As one young woman observed:

*Sounds like they want to go through a re-evaluation period in their life. Testing was an opportunity to re-evaluate the past, think from an objective point of view. It's a wake-up call. You don't get serious about STDs until it's a reality.*  
(“Kate”, age 23 years, CDC)

Making resolutions to change one’s sexual behaviour and relationship patterns was the most common theme across study participants’ stories about the post-test phase. Typically, these resolutions referred to abstaining from sex and/or waiting for the “right” kind of sexual partner before re-engaging in a sexual relationship:

*I have just decided that I kinda, I just want to kind of be, abstinent for a while...you know, I don't even want to have any more, 'fling kind of guys'. I don't. I kind of just want to wait, 'til I meet someone really serious. And, you know, cause, when you're young, there's a lot of guys, who, are just in for one thing.*  
(“Kimberly”, age 20 years, Pine Free)

In describing the characteristics of the so-called “right kind of guy”, many study participants suggested that they would recognize this type of person by using a set of subjective criteria. Typically, study participants described the right kind of guy as someone that they could envision having a long-term relationship with (possibly marriage). They also described the right kind of guy as someone who was career oriented and who was perceived to be “careful”

about choosing his sexual partners. Study participants also said that it would be important to find a sexual partner with whom they could openly communicate about sex, including frank discussions about STI testing, symptoms and diagnoses.

To summarize, the post-test phase was primarily a period of reflection. During the post-test phase, study participants had the opportunity to reflect on their pre-test and testing experiences as well as their preconceived ideas about STI testing. Study participants' efforts to reflect on their personal experiences led them to develop deeper understandings of the meanings of their conceptualizations of STI testing and sexual health in general. While I had originally hypothesized that the post-test experience would vary according to test results, the bulk of the follow-up interviews were with women who had negative test results. Thus, there is insufficient data to fully explore this comparison. However, based on the available data, I would be inclined to suggest that women's post-test experiences are more influenced by their motivations for seeking testing. All study participants received their test results and expected to be informed of a positive test result by health care providers. Two study participants actively sought their test results after their clinical experiences (i.e., one via phone call and one via follow-up visit). Both participants received negative test results.

For those women who felt empowered enough to engage in STI testing on a regular basis, the post-test phase did not typically include resolutions or strategies to change their lives. In contrast, women who were motivated to test due to negative experiences in their sexual relationships were more likely to describe the post-test phase in dramatic terms, often focusing on their plans to undertake self-improvement strategies. In these ways the meanings that these young women ascribe to their STI testing experiences are affected by their motivations for seeking testing.



### ***Ascribing Meaning***

Throughout the analysis, it was important to attend to the processes by which women in this study appeared to internalize their STI testing experiences. Study participants often struggled to understand and make meaning of both the STI test experience and the circumstances that led them to engage in testing. In addition, the women described how they had reflected on the ways their experiences had affected how they felt about themselves and their relationships with others (including past, current, and future sexual partners). The meanings that study participants ascribed to their STI experiences were influenced by several factors: (1) gender-based power dynamics; (2) the results of the test (being clean or dirty); (3) the curability of the disease; and (4) the type of relationships in which they were engaged (monogamous vs. multiple partners). Study participants also described how they attempted to normalize their experiences in an effort to dissociate themselves from negative meanings of STI testing.

In part, the meanings that women ascribed to their STI testing experiences depended upon their experiences with gender-based power dynamics. Study participants described how such power dynamics permeated across their sexual relationships, their interactions with health care service providers, and the overall social milieu. In describing how some of these power dynamics were operationalised, study participants referred to numerous situations where they had observed/experienced women being blamed and shamed as being the “source” of an infection (regardless of whether this was true), and hence feeling responsible for initiating testing procedures in order to maintain their relationships and sexual attractiveness.

Study participants appeared to use the meanings that they ascribed to their STI testing experiences in order to shape their ideas about how their futures would unfold. By internalizing messages about “passing” or “failing” the test, women in this study described how they had learned to make judgments about their personal worth (as well as the worth of others). The young women tended to describe engaging in a multi-step process that helped them to make

meaning of their STI testing experiences. This meaning-making process began with either “passing or failing” the STI test. One young woman likened this experience to a car either passing or failing an emissions test: “It’s like AirCare for your health. I passed, I’m happy.” (“Ellie”, age 22 years, CDC).

For those who “passed”, the testing experience was internalized as a confirmation of their positive health status and lifestyle choices. Many of the study participants who passed their STI test described how the results had helped them feel more confident about their social worth. For those who “failed” (i.e., were diagnosed with an STI), descriptions of feeling like “damaged goods” were commonplace. While not every study participant believed that having an STI necessarily marked them as damaged, the powerful effects of an STI diagnosis are illustrated in the following quote:

*It’s understandable that people have a concern about not seeming “dirty” or “damaged goods” because they won’t be able to have a relationship, they’re not lovable, or attractive... This is a sad statement because this is a huge judgment on people who do have STDs...[people probably say this] because they lack compassion and are ignorant of STDs. It’s like thinking all cab drivers are on the lower level of the social ladder.*

*(“Kate”, age 23 years, CDC)*

Study participants described how the meanings that they attached to their STI test experiences often affected their decisions about continuing existing sexual relationships as well as starting new relationships. Being certified as “clean” represented a “green light” for continuing in existing sexual relationships or pursuing new relationships. Study participants described how being labeled as “clean” affected their perceived sexual desirability and marketability. In this way, the STI test result becomes incorporated into one’s perceptions regarding how presentable one is to other people. The stigma of being labeled as having an STI was perceived to have negative impacts on the likelihood that these young women would be able to initiate and/or maintain their sexual relationships.

*It's not like I run around telling everybody, 'I went to the clinic last night.' But, if it does come up in conversation with someone that I'm planning on having sex with I think that it's something that makes having sex with me more appealing. The fact that I am careful enough to know for a fact that I'm clean. And, it's not like six months ago and I've slept with five people since then. It's like a month ago [that I got tested] and I haven't slept with anyone since the test. That seems pretty solid. And, like you know, no worries [for either of us], so that if things were to start it's not on the back of your mind, going: 'Is this person dirty? I don't know where they've been.'*

*("Alice", age 19 years, Pine Free)*

Internalizing messages based on a test result can also negatively affect one's self-perception ("I'm dirty"). Study participants' descriptions of these meanings tended to be characterized as barriers to forming trusting and respectful bonds with sexual partners.

The meanings that study participants ascribed to STI experiences also appeared to depend on whether the STI that they were diagnosed with was curable (e.g., chlamydia) or incurable (e.g., herpes). Those who were diagnosed with curable diseases such as chlamydia expressed relief at the fact that they could be treated easily and rapidly. They contrasted this experience with those associated with an incurable STI (e.g., herpes), which they suggested had more potential to negatively impact on one's life over the long term. One study participant described how she felt relieved when she learned that she did not have an incurable STI. As the following quote illustrates, the young woman in this study generally held the perception that if a disease is curable that it would not impact their lives in a chronic and life-altering way:

*On the phone I asked them. She said you have to come in because you tested positive. And I said: 'Well, is it curable?' She said: 'Yes, it's completely curable.' You know, so that was a big relief.*

*("Mary", age 22 years, Pine Free)*

In addition, the meanings that study participants ascribed to STI testing depended on the type of relationship that they were involved in at the time of the test. For those study participants who were involved in monogamous (and usually long-term) relationships, the meaning of going for STI testing was often intertwined with questions about fidelity and trust. By engaging in STI testing within the confines of monogamous relationships, these study

participants and their sexual partners were forced to experience emotional violations of their relationships (e.g., infidelity, deception), in addition to dealing with potential physical invasions of pathogens. Alternatively, those study participants who were involved in non-monogamous relationships ascribed different meanings to the testing experience. For these study participants, testing was interpreted and internalized as a positive health practice, which ultimately helped to make them feel empowered to protect themselves physically and emotionally.

In addition to study participants being able to ascribe certain meanings to the testing experiences, they also attempted to change or detach meanings in their attempts to combat the negative associations with STI testing. The most common strategy to disassociate themselves from the negative connotations of STIs involved normalizing the experience. Study participants described their attempts to normalize their experiences in two primary ways. In some instances, they described how they would draw upon similarities between STIs and other biological infections (e.g., “it’s just like having a cold”). In other cases, study participants sought comfort in the perception that everyone (by virtue of being sexually active) could potentially experience STIs.

*This happens to everyone. Getting an STD is a normal part of being sexual.  
 (“Luisa”, age 21 years, CDC)*

In describing the meanings that they ascribed to their STI testing experiences, many participants expressed a desire to have the social stigma around STI testing reduced (‘Why don’t they look at it like the flu?’ “Ellie”, age 22 years, CDC). During their interviews, a few study participants attempted to de-stigmatize the entire process of STI testing, including the clinical examination (‘It’s like a dental exam.’ “Ellie, age 22 years, CDC), the approach to the way testing is incorporated in their overall health regimens (‘It’s [testing] like taking supplements.’ “Sarah”, age 20 years, Pine Free), and the pathogen itself:

*It’s just like a bronchial infection, but it’s just the way you get it that’s embarrassing. Before I used to think, ‘dirty, whore, slutty, forever dirty, passing*

*disease', and now I think: 'It's just like a cold. It doesn't matter what kind of person you are. ("Alice", age 19 years, Pine Free).*

While some study participants appeared to be able to successfully challenge the institutionalized meanings of STIs<sup>6</sup>, most study participants associated negative meanings to STI testing. Despite having been through the STI testing experience, many women in this study engaged in a process of distancing or detaching themselves from the STI experience. While they described a sense of compassion for *other* people who may have had STIs, some study participants expressed difficulties with accepting or integrating their own experiences with STIs with their expectations about *their* personal lives – STIs might happen to other people, but not to people like them (i.e., knowledgeable people, married people, careful people). In these cases, study participants were more likely to describe feelings of failure to meet expectations as feelings of frustration at having been unjustly burdened with an STI. The following vignette illustrates one woman's experience of internalizing a sense of failure for having contracted an STI. This woman was a volunteer sex educator who worked with high school students to enhance their sexual decision making skills:

*So, I felt like less of a role model. I felt like a failure. Because I'm telling these students about sex and I got it [an STI]. It's ironic. I'm a sex educator and I have an STD.*

*("Claire", age 20 years, Pine Free)*

In the following quote, another woman illustrated how she felt unjustly burdened by her STI experience:

*I didn't sleep around, so I kind of felt like I shouldn't have had to have been there [at the STD Clinic]. ... even just going there, there's this stigma: 'Well you must be sleeping around.' But I'm **not** a ho.*

*("Zula", age 24 years, CDC)*

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<sup>6</sup> Institutionalized meanings refer to the negative connotations of STIs and the general stigma around sex as perpetuated through conservative social norms, which are often generated by powerful institutional level forces, such as religion, hegemonic masculinity, and idealized femininity.

In summary, gender-based power dynamics, the results of the test (being clean or dirty), the curability of the disease, and the type of relationships in which they were engaged (monogamous vs. multiple partners) affect the meanings that study participants ascribed to their STI experiences. Gender based power dynamics manifested in women's descriptions of the meaning of STI testing in a number of ways: (1) women are often blamed as the source of an infection; (2) that those women who are diagnosed with STIs are perceived as "damaged goods"; and (3) that women are expected to take more responsibility for ensuring the sexual health of their relationships. The test's ability to identify specific infections (and by default, "curability" of disease) affected women's perceptions of the extent to which the infection would make an impact on their lives (e.g., acute or chronic condition). The type of relationship young women were involved in also changed the meaning ascribed to the testing experience. As an example, for the young women in monogamous and committed relationships (in contrast to those with multiple partners), the test also meant an evaluation of fidelity and trust in addition to representing a means to measure one's physical health (e.g., infectious state). While some women made attempts to normalize their STI testing experiences, most did not challenge the stereotypes associated with receiving an STI diagnosis.

### ***Embodying the Ideal of Purity***

Ultimately, the ways in which study participants engaged with the experience of STI testing affected their bodily experiences and expressions related to their sexuality. While none of the study participants used the term "embodiment" during their interviews, there was a strong focus on the ways in which women's bodies are intended to portray idealized notions of purity and femininity. While the process of subjecting oneself to regularly scheduled STI testing was described as a way for women to protect their health, it also potentially reflects women's reactions to society's compulsion for them to monitor and/or establish their purity. By establishing their purity (i.e., testing negative for an STI), women in this study also suggested

that they ascertained an elevated sense of eligibility and desirability as a potential sexual partner. Moreover, study participants' reflections on the language that is typically used to describe STIs illustrates their frustration with ingrained expectations and ideals associated with sexual purity among young women:

*Clean – what a terrible word to describe it... Would we call someone who had a non-sexually transmitted disease like pink eye 'dirty'?... Clean means that you were previously a drug user and now you're not... You can't call yourself clean if you've never used drugs before... So, that means you're only clean if you could've been dirty before [by using drugs or having sex]*

*("Kate", age 23 years, CDC)*

Study participants also described how they planned to monitor and regulate their bodies and their sexual relationships in the future. They described how their previous experiences with STIs would help them learn how to avoid contracting an STI in the future. Women in this study suggested that once they were treated for their STI, they would remain "pure" and "clean". They were confident that they would not re-contract STIs because they now possessed the requisite skills and knowledge to protect their health (i.e., they have learned their lesson). In addition to embodying an ideal of purity, study participants also described how they manifested the ideals regarding STI testing as articulated by health officials (i.e., "They [clinic staff] suggest that if you're actually sexual active that you should get it done sort of every six months" ("Suze Q", age 21 years, Pine Free). As the following quote illustrates, some study participants' descriptions of their STI testing experiences appeared to also embody ideals of being careful, cautious, and clean:

*I won't get an STD again because I would take care of myself. I know the measures I need to take to not get one... Like open dialogue, STI testing before becoming sexual, protection, like condoms, being careful about what's going on down there, meaning no penetration. They're [STIs] preventable, so I'm confident I won't get one again.*

*("Kate", age 23 years, CDC)*

This quote also illustrates the difficulties that many of the young women in this study experienced in trying to express themselves with reference to their sexual health. The use of the

phrase “being careful about what’s going on down there” demonstrates both hesitancy and vagueness in the language used to articulate strategies for protecting oneself sexually. This use of coded and veiled language reflects an overall discomfort with (and perhaps a lack of familiarity with) more precise and open ways of describing issues related to sex. In general the young women in this study did not describe engaging in detailed discussions about their STI experience with their partners, their friends, and especially not with their families. Moreover, for many women in this study (including those who had tested many times in the past), the research interview was the first opportunity they had had to freely and openly discuss their experiences.

Thus, testing is perceived as an isolating, shame-based experience. The young women in this study described how by subjecting their bodies to tests, they could establish their purity (as well as their sexual eligibility and desirability). Women’s descriptions of their testing experiences may also reflect their reactions to social pressures that impose unrealistic ideals on female sexuality as well as demanding constant surveillance and regulation (potentially reinforced by public health messages). Although some of the young women in this study reacted negatively to the use of the term “clean”, they all expressed an understanding of the social value of this term and continued to use it in their everyday language.

### ***Summary of Findings***

This chapter provides a description of a group of young women’s experiences with participating in STI testing at two clinics in Vancouver, British Columbia. The chapter provides empirical evidence regarding these women’s experiences during three primary phases of the STI testing process. During the first phase, the pre-test phase, study participants describe their motivations for undergoing testing (symptoms and self-care) as well as barriers to seeking testing. The second phase of the STI test experience included descriptions of standardized approaches to clinical care and a gendered approach to sexual health. The post-test phase focused on women’s experiences with reflection and resolution formation. *Ascribing Meaning* emerged as a pivotal



concept that shaped young women's understandings and applications of STI testing. Finally, a theme, *Embodying the Ideal of Purity*, was identified throughout women's stories, which contributed to the context within which these stories are told.

## **Chapter 5: DISCUSSION**

### ***Overview of Chapter***

This chapter presents an explanation of the central theme of this study, “Embodying the Ideal of Purity” and examines its hypothesized links with notions to personal responsibility. Through an examination of the findings related to young women's use of testing, the bases for the proposed conceptual links between purity and responsibility are unpacked and discussed in relation to a “Fallacy of Emancipation through Personal Responsibility”. This fallacy is proposed as an elemental force that exists within the social context of women’s sexual lives that influences their sexual health decision-making and general development as sexual beings. In discussing the proposed foundations of the fallacy of emancipation through personal responsibility, I also make suggestions regarding implications for the clinical community, public advocacy, and youth action that may improve the context in which young women seek and receive STI testing. Chapter 5 also includes my reflections on the research process, potential implications for public health, and the provision of youth sexual health services.

### ***Purity and Personal Responsibility***

The context in which young women’s decisions to take on personal responsibility for making choices to engage in health-promotive behaviour (such as regular STI testing) is multi-layered and complex. In part, gendered notions of sexuality (e.g., female purity) influence this sense of responsibility. As well, an over-arching social focus on personal responsibility and individual choice contributes to women’s perceptions about the importance of attending to this priority. Women are often expected to bear most of the burden of sexual self-care in order to establish their purity (i.e., an idealized form of femininity), and as a result indirectly protect the sexual health and well-being of others (e.g., their sexual partners). As discussed in the findings chapter, the women in this study tended to take responsibility for reproductive and sexual health consequences, regardless of their relationship status (e.g., long-term, short-term, casual).

Women in this study described how their sexual partners would wait to get tested for STIs until the women received the results of their STI tests, confirming the “status” of the dyad’s infectious state and informing what, if any, actions need to be taken by the male partner. Because it is common for women to come into contact with biomedicine through routine and “chronic” exposures to the health care system (e.g., accessing oral contraception and annual Pap smears), women represent “ideal” targets for STI screening interventions. This responsibility-by-default places women in a position of increased personal responsibility for care (of self and others) in their sexual relationships.

The concomitant care of the self and others contributes to the social context of young women’s sexual development, which provides both a sense of empowerment and responsibility. Analyses of social discourse suggest that subtle aspects of individualism are implied in the concept of “choice”<sup>[126]</sup>. Furthermore, individual choices take place within environments that shape decision-making<sup>[126]</sup>. The women in this study often described how the dynamics of their social relationships (including their intimate sexual relationships) forced them to confront tensions between their perceptions of the ideals associated with individual choice (e.g., personal empowerment) and the situational forces that constrict the realization of these ideals. The discordance between an individual’s sense of agency and their actual ability to exercise decision-making powers within the contexts in which they regularly operate and compose their lives has been previously identified in the social science and public health literatures<sup>[126-128]</sup>.

### ***Female Empowerment***

Because the current study focused on young women, a specific examination of issues related to female empowerment is beneficial. Holland, et al.<sup>[129]</sup> have identified four types of female empowerment as it relates to young women’s sexual decision making: (1) performing power (the “male” model); (2) policing monogamy (context-specific empowerment); (3) the “fragile” integration of intellectual and experiential empowerment; and (4) “effective”

integration of intellectual and experiential empowerment. Performing power refers to women's adoption of behaviour and beliefs associated with hegemonic masculinity<sup>[130]</sup>, such as guilt-free sexual desires and engagement in multiple, short-term sexual relationships. In short, women who perform power become "one of the boys". Policing monogamy refers to a set of relationship-building (and maintenance) practices that monogamous women engage in. These practices include building trust, enacting fidelity, and waiting for appropriate "moments" and contexts in which to express their sexual desires (e.g., in a long and hopefully lasting relationship). For heterosexual women, policing monogamy is about "waiting for Mr. Right".

The "fragile" integration of intellectual and experiential empowerment refers to women's bravery and personal struggles to overcome emotional and physical trauma associated with negative sexual experiences<sup>[131]</sup>. This type of empowerment is perceived to be "fragile" because the "power" to overcome is derived exclusively from the inner strength of the individual who has been negatively affected. An additional problem with this type of empowerment is its dependence on the individual's ability to access a personal support resource network, which may also vary in terms of its availability and quality. Moreover, this "fragile" form of empowerment is practiced only within the private domain; it is not held accountable to public scrutiny or application.

In contrast, the "effective" integration of intellectual and experiential empowerment refers to intrinsic elements of women's power and control that enables them to identify and reflect on the structural level forces that privilege male power<sup>[131]</sup>. This type of empowerment is not context-specific; it is practiced both in the private and public domain. Through her micro-level interactions with others, the "effectively" empowered woman is able to pragmatically challenge and redefine what are considered "normal" and "acceptable" codes of social conduct. Thus, in both the private and public politic, women refuse to be fitted into sexualized, heterosexist roles.

Examples of each of these four types of female empowerment were evident in the young women's stories in the current study. Their stories of performing power (the "male" model) included descriptions of women who take pride in separating the physical and emotional aspects of sex, who have multiple partners, and express no compunction about their "playing the field". Other women's stories focused more on policing monogamy, whereby they described modifying their behaviour in order to adopt specific roles (e.g., the potential good wife who is pure, faithful, loyal, and devoted) in order to enact the rules that monogamy demands of their relationships (e.g., their potential husbands' commitment to fidelity). While stories about "fragile" empowerment were less common in this study, at least two women recounted stories about their attempts to overcome previous negative sexual experiences (and other negative life experiences, such as drug misuse) through their application of individual will power and personal bravery. Only one study participant expressed insights related to "effective" empowerment; however, she had not yet been able to fully enact these insights across the breadth of her social interactions. As a result of engaging in lengthy and deep reflections regarding her previous experiences, this participant was able to articulate how she perceived that macro- and meso-level structures and relations affected her everyday experiences regarding the objectification of women and gender power imbalances.

Although Holland et al.<sup>[129]</sup> drew on examples from interviews regarding the development of sexual relationships, in the current study the interviews focused on STI testing. In the current study, two main forms of female empowerment related to STI testing emerged: policing monogamy and "fragile" empowerment. Study participants' engagement in testing activities for the purposes of policing monogamy helped to establish young women's eligibility as suitable and desirable sexual (and potentially life) partners. A negative STI test represented a "certificate" of health and their eligibility (as well as desirability) to be a suitable sexual partner. In other ways, study participants' uses of STI testing may be viewed as representing their

individual attempts to overcome previous negative sexual experiences (e.g., a boyfriend's or husband's infidelity). All of the study participants described how their engagement in STI testing was focused on informing and/or altering their private actions (e.g., to break up with a boyfriend, to feel safer when having sex with a new partner). Even for those women who described regularly engaging in STI testing and who asserted that they did so in order to be proactively engaged in protecting their own health, confined their practices of empowerment to this personal sphere. None of the study participants had yet enacted "effective" empowerment. Their hushed tones and barely concealed embarrassment when talking about STI testing also lends credence to the hypothesis that "effective" empowerment has yet to be realized in this study group.

Despite some of the young women's best efforts to assert their sexuality in empowered ways, most of their attempts were not effective in that they did not challenge or attempt to deconstruct the structural forces that govern the gendered paradigms of contemporary sexual discourse that privilege heterosexual male power. Although young women in this study alluded to their self-perceived emancipated status (e.g., frequently using STI testing between and within relationships), it appears that they remain regulated by broader structures and institutions. For many of the women in this study, their desire for personal responsibility was greatly influenced by messages from their social world which presented testing for STIs as socially desirable. Hence, participating in testing was indicative of being a responsible and vigilant sexual citizen. Young women in this study may have turned to the health care system with the hope of being sexually emancipated through STI testing, but instead the forms of empowerment gained through their experiences were of a passive, false or impeded nature.

Ironically, although young women who engage in STI testing may be perceived to be engaging in a socially and personally "responsible" behaviour, this act may also potentially present a fallacy of "effective" empowerment. In adopting a philosophy that focuses on personal

responsibility, these young women may conscientiously take on and internalize the duty to ensure that their sexual relationships are healthy. By default, meaningful private reflection and public actions to deconstruct the dominant social paradigm fail to materialize – leaving structural level forces unchallenged. This is the reason why these problematic forms of empowerment ultimately represent false forms of empowerment. Without “effective” empowerment, other forms of empowerment fall short in changing the social contexts within which young women develop as sexual beings.

### ***Fallacy of Emancipation***

Emancipation connotes ideas of freedom and control. In this study, ideas related to emancipation concern both young women’s “freedoms *to*” exert control over their sexual lives as well as their “freedom *from*” disease. Through engagement in STI testing, young women attempt to emancipate (i.e., free) themselves from disease. They seek testing in response to symptoms as well as through more regular, routine “checks” that are not necessarily prompted by symptoms. Those women that receive positive results (i.e., those who are identified as having an STI) seek treatment in order to be free from the disease(s). What testing appears to offer these young women is freedom from an acute episode of a communicable disease. The testing technology addresses only the physiological aspects of STIs and places much emphasis on this uni-dimensional (e.g., physical) construction of sexual health. Arguably, sexual health is constituted in a much broader, multi-dimensional and complex fashion.

In light of this, STI testing has come to mean much more within contemporary youth society than its originally intended diagnostic purpose. This has implications for the ways in which young women conceptualize and live their sexual lives. It also affects young women’s perceptions about the emancipatory benefits of STI testing. The findings of this study clearly point to several ways in which young women perceive that STI testing provides them with “freedoms *to*” improve their overall perceptions of themselves as healthy, sexual beings. For

example, the young women in this study described how they used STI testing to increase their sexual desirability (e.g., purity), regulate and govern their participation in sexual relationships (e.g., monitoring monogamy), and comply with societal expectations of a healthy, responsible person (e.g., public health messages to “get checked” regularly). Through their use of STI testing, young women in this study expected to attain the “freedom *to*” achieve idealized notions of femininity, health, and sexuality. In these ways, young women appear to be striving for emancipation. However, a closer examination of young women’s perceptions about such “freedoms *to*” reveal the emancipatory limitations of STI testing.

While I had initially identified STI testing as a truly emancipatory experience, I eventually have come to identify this experience more in terms of providing young women with a false sense of security and freedom. In this study, it was rare for a woman to attribute her experiences with STI testing (including the circumstances surrounding her engagement in testing) with anything except for her lack of vigilance and/or her lack of personal responsibility. Few women in my study identified how other forces within their social contexts affected their experiences with STI testing. I would argue that the interactions between gender-power imbalances and contemporary society's regard for medical technology create a set of dynamics that establish an environment where young women *actually* have very limited “freedom *to*” control the more socially-constructed aspects of their sexual lives. While STI testing does offer women opportunities to exercise a “freedom *from*” disease, what is rarely de-constructed is the *context* within which this medical technology operates.

As a result of focusing on the social context of STI testing, I suggest that testing does not in and of itself provide young women with meaningful “freedoms *to*” engage in equitable and healthy heterosexual relationships. Based on the interviews that I conducted, it appears that testing rarely provides the kinds of freedoms that many young women anticipate it will. Rather, STI testing is promoted as a representation of personal responsibility (e.g., those that engage in



testing are perceived as sexually vigilant citizens). Women who take on this responsibility, but who fail to achieve the idealized outcomes (e.g., purity, femininity) promised through an adherence to testing regimens are destined for disappointment, shame and increased emotional burdens. Thus, rather than providing a truly emancipatory experience, STI testing appears to create a fallacy of emancipation among young women.

### ***Social Context***

By examining the social context in which a sample of young women living in Vancouver engage in STI testing, the findings of this study point to some of the challenges young women face in today's society. Within this context, over-reliance on and trust in technology appear to have displaced fundamental social practices (e.g., interpersonal communication and contemplative reflection), which might otherwise produce opportunities for young women and others to engage in social action that would help to develop environments that support effective empowerment. Within such environments, young women would be supported in their attempts to negotiate social expectations while at the same time identifying personal needs and expressing personal agency. For example, within an effectively empowering context, young women and their sexual partners would co-negotiate responsibilities for sexual health. Thus challenging the social expectation that the woman would assume primary or sole responsibility for the sexual health of the relationship.

A variety of messages are embedded in the social context of women's lives and influence their opportunities, decisions, and development as sexual beings. This research helps to draw our attention to the importance of challenging what have been identified as the dominant paradigms and contemporary social norms regarding young people's sexual lives (e.g., hegemonic masculinity, heterosexuality). Currently, ideals of 'purity', 'femininity', and the 'sexual double standard' restrict the ways in which young women and men navigate their sexual lives.

Health care professionals and policy makers are well positioned to challenge the existing social norms and dominant ideologies that currently re-enforce stereotypical sexual values and practices amongst youth. The findings of the current study are intended to increase awareness and sensitivity among clinicians, policy makers, and educators regarding the ways in which these social norms play out in the lives of young women. Although many health professionals may feel constrained by the brevity of their interactions with youth (e.g., a clinic visit), the social distance between themselves and youth (e.g., the generation gap), and/or the expanse between policy development and implementation, the findings of the current study point to a number of actions that health professionals might feasibly engage in both within their clinical practice and public advocacy.

### ***Clinical Communication***

Within clinical practice, health professionals are confronted with managing a fine balance between a didactic (and efficient) presentation of relevant information and the art of engaging in clinical communication that develops young women's sense of comfort in feeling free to openly express their concerns. Opportunities to engage in less didactic clinical communication also might present opportunities to identify important misunderstandings. For example in the current study, study participants often reported misunderstanding the information provided to them about the testing procedures and information associated with the timing of STI tests (e.g., the "window" period). For example, in the case of HIV, there is a minimum 3-month waiting period since an individual's last "risk" episode in order for the diagnostic test to accurately measure antibodies. Several study participants who were expecting to be tested for all infections, including HIV, were told by clinic staff that the HIV test could not be completed until the window period was reached. However, study participants misinterpreted this delay of testing to mean that they did not need the test because they were not at risk of HIV. Furthermore, study participants did not appear to comprehend the concepts of sensitivity and specificity (ergo, the

fallibility) of diagnostic tests. Within the constraints of clinical contexts, health professionals often do not have time to provide effective educational interventions regarding the operating characteristics of STI testing. Similar constraints make it difficult for health professionals to fully characterize and explain the construction of risk estimates. For example, one young woman mistakenly estimated her risk of contracting STIs to be “two percent” because she had only had “two partners” since her previous STI test. Explaining the nuances of STI risk and complexities of STI testing is both time consuming and demands highly sophisticated clinical communication skills. Although health care providers appear to be actively encouraging young women to engage in the testing process, misunderstandings and inappropriate conceptualizations of the relationship between sexual lifestyle and “risk” is a sophisticated message to provide during a brief clinical interaction.

While women’s engagement in STI testing represents a positive action, in its current form it tends to focus on the physiological dimensions of their sexual lives, without extending the scope to address issues related to intimate relationships. While I am not advocating that health professionals attempt to manage or “fix” their patients’ personal lives, the clinical encounter provides an opportunity to challenge youth to translate the information and motivation that they derived from their testing experience into more robust forms of empowerment that could be implemented within their private relationships. As an example, health care professionals could teach youth communication skills that would help them to initiate discussions about sexual practices and/or re-negotiate safer sex behaviour. In this and other ways health professionals can facilitate the process of embedding empowering messages and developing skills that help young women reflect on, deconstruct, and understand their social contexts.

In light of health care professionals’ training and expertise, some messages are particularly well suited to the clinical context (e.g., detailed explanations of the procedures,

discussions related to women's anatomy and physiology, the pathways of disease transmission, and step-by-step instructions about the use of protection). To fully exploit health professionals' collective expertise and to allow for opportunities for meaningful clinical communication, the health care system needs to change. Youth often present in clinical settings related to STI testing at critical moments in their lives (e.g., they are experiencing symptoms of a disease; they are contemplating ending or beginning sexual relationships); the health care system needs to be prepared to respond appropriately. In addition to providing adequate time for meaningful discussions about STIs, the clinical context could be further enhanced through the provision of continuing education opportunities that would focus on developing health care professionals' sexual health communication skills, with a particular emphasis on communicating with youth. Additionally, youth who engage in STI testing should be provided with opportunities to express their perspectives (preferably using an anonymous format) about the care that they have received and to make suggestions that they perceive might improve their experiences during clinical encounters.

### ***Public Awareness and Advocacy***

Because young women need to enact clinical messages within their broader social contexts in order to promote and protect their health (and because clinical messages do not necessarily alter the social context within which women exist), even the most effective and comprehensive clinical communication efforts may be difficult to operationalise in youth's daily lives. There is a need for increased awareness of the sexual health resources available to young people. Advertisements aimed at increasing public awareness need to include information on the location of clinics, eligibility of clients, and the services available.

Health professionals could use their power and status to take up leadership roles in effecting overall changes outside of the clinical context. Health professionals could undertake a number of public advocacy roles including:

1. Acting as change agents within their professional organizations to advocate for youth's rights to access appropriate sexual health care (e.g., developing clinical practice guidelines to tailor services to meet the needs of a wide range of youth);
2. Being active and visible participants in community based organizations dedicated to advancing the sexual well-being of young people (e.g., Options for Sexual Health);
3. Offering their expertise to youth-led organizations that provide peer support and training related to sexual health (e.g., YouthCo, Real Power Youth Society);
4. Increasing their awareness and sensitivity to youth popular culture in order to prevent their engagement in stereotyping and/or stigmatizing youth (e.g., assuming that youth who have multiple sexual partners are indiscriminantly promiscuous); and
5. Engaging in media discourses that promote positive and non-judgmental understandings of the meanings of the sexual lives of youth (e.g., books such as, 'It's Your World – If you don't Like It, CHANGE IT', 'The Male in the Head', 'Safe Teen'; movies like 'Thirteen', 'KIDS'; youth oriented and 'sex positive' radio shows such as 'Primal Radio'; use of fine arts as a vehicle for expression of youth sexuality).

### ***Youth Action***

Up to this point my discussion has focused on actions that adults could take in order to improve the social context in which youth enact their sexual lives. It also is important to consider what actions young people might take as they develop as sexual beings. At a fundamental level, youth need to take advantage of opportunities that allow for them to critically reflect on messages they receive about sex (from their peers, family, media, school). Even if they are not able to fully comprehend and/or articulate their positions on salient issues, adolescence provides the first real

opportunities to begin to exercise and gain experience with the process of critical reflection. This kind of reflective and analytical approach to understanding human sexuality was noticeably absent from the study participants' interviews. While the project of developing critical reflection skills necessitates support and guidance from informed and caring adults, the need for young people to actively engage in this process is paramount. Developing a critical mass of young people who are prepared to actively engage in critical reflection about sexual health should be a priority for adults, particularly those that interact with youth on a regular basis (e.g., health care professionals, teachers, youth group leaders). Other things that youth could do include writing their experiences and reflections, and sharing these with their communities and media productions.

### ***Strengths, Limitations & Reflexivity***

This study provided a unique opportunity to examine the experiences and context of young women's engagement in STI testing. This qualitative study used a grounded theory approach to describe the phenomenon of STI testing among young women in Vancouver. Although the complete phenomenon has not been described due to a lack of variation of stories, particularly those of women who engaged in testing because of symptoms and/or were managing a positive diagnosis, the in-depth, detailed descriptions gathered through the interviews with study participants provide rich insights into the perspectives of young women. This is not something that had been previously well documented in the literature. Moreover, the scope of the study encompassed a more complete exploration of the entire STI testing process (spanning from pre-test phase to post-test phase and including follow-up interviews) than had previously been recorded in the literature. While most previous studies in this area have focused on particular infections (i.e., only focused on chlamydia), the questions articulated in the current study tapped into the social dimensions of engaging in the testing process for many different pathogens.

From a technical standpoint, several strategies were employed throughout the research process in order to address rigor in this study. These include: (1) the development of the audit trail, composed of field notes and conceptual memos, (2) discussions with the supervisory committee members regarding important logistical issues and key analytic concepts, (3) member checks with study participants in order to "double-check" the accuracy and interpretations of the interview data (e.g., follow-up interviews), (4) and the use of data software, *NVivo*, to effectively manage and organize the data.

Because the sample was limited to nineteen participants the reader needs to be cautious about the limited diversity and range of potential experiences related to the phenomenon under study. Furthermore, only the voices of heterosexual young women were heard, although their stories may have helped me gain insights to their male sexual partners' lived experiences. In addition, the study group was composed of women who attended two Vancouver health clinics and therefore their experiences may be reflective of their particular social positions and geographical locations. Additional research is required in order to develop a better understanding of the experiences of members of other groups not included in this thesis, including males, youth who identify as lesbian, gay, trans-gendered, and/or bisexual and those individuals seeking testing and/or treatment for HIV.

It is important for the researcher to critically reflect upon and examine the research process. Engaging in what qualitative researchers refer to as 'reflexivity', provides opportunities to reflect on and examine the study's ontological and epistemological assumptions (i.e., the nature of knowledge and the means by which we develop knowledge). A limitation of this study is that it is impossible to know which factors and/or what combination of factors, both identified and unidentified, provided the women with enough security and comfort to freely share their stories with the researcher. These stories included not only women's experiences of STI testing, but also of their overall sexual health, perceived choices, and developing sexualities.

Furthermore, even when stories are provided, there are challenges in obtaining the most 'accurate' representation of the data as well as producing a written document that is a 'true' reflection and interpretation of what was studied<sup>[132]</sup>. In order to minimize this tension, I tried to be reflexive by increasing my sensitivity and awareness to the social construction of reality and paying particular attention to the way study participants presented their stories and their interpretations.

Because the current study assumed a constructivist approach to understanding the nature of the knowledge generated through this work, it assumes that there are multiple realities and that those realities are created by individuals' interactions with and understanding of their social contexts. Hence, the study focused on young women's interpretations and representations of their experiences. In this way, the study's approach to developing new knowledge in this substantive area relied on a set of "facts" that are composed of young women's perceptions of their realities. It is accepted that these perceptions will vary according to preconceived theories, concepts, values, and ideas.

Reflexivity provides the means by which one can understand how and why such perceptions might vary. Throughout the data collection and analysis process, I attempted to examine and acknowledge my own personal values, beliefs, assumptions, prejudices, and motivations. In addition, as a university based researcher, I am afforded a particular social position and status that allows me to ask highly personal questions within the context of research that might otherwise be considered inappropriate.

Several study participants voiced their feelings of safety and comfort in sharing their stories with me, not only because my position as researcher is associated with being a knowledgeable and 'trustworthy' representative of biomedicine and social science, but also because they felt a kinship with me being a young woman myself. Furthermore, I deliberately avoided technical terms throughout the interview guide and interview in order to engender



relaxed conversation. As a result of these factors, many of the study participants assumed that I shared their perceptions about their social contexts and faced similar situations that helped to imply that I was in a position to empathize and truly understand their stories. Several of the women also commented on my physical appearance and their perceptions about my social status, (e.g., visible minority, graduate student, "academic"). At several points during the research process, study participants told me that they had to confront previously entrenched stereotypes related to my gender, age, and ethnicity. Although I have no way of determining how freely the women in this study shared their stories, many of them commented that both my appearance and my approach to the interviews had put them at ease. Moreover, while some of the participants indicated that their initial motivations for enrolling in the study were related to the twenty-five dollar incentive, these same participants made a point of describing the unanticipated benefits of talking about their experiences in a non-judgmental and safe setting.

The metaphor of a "doorway" may also be useful in order to help orient the reader to understand the researcher's reflexive approach to the empirical data, use of the specified theoretical literature, and development of the theoretical findings. The interviews provided me with a "doorway" through which to enter into the private and often covert world of young women's sexual lives. Passage through this doorway affords both privileges and responsibilities. This set of interviews provided me with the privilege of listening to and being able to draw on the often painful, personal experiences of a group of young women in order to develop a realistic and grounded conceptual representation. In turn, I also am cognizant of the responsibility to be diligent in my analysis and respectful in my presentation of the study's conceptual findings. Because entry into these young women's lives is restricted (only certain groups such as health care providers and researchers tend to have passage through the doorway), these interviews provided a unique opportunity to access rich, holistic, and reflective dialogue surrounding the STI testing clinical experience and related circumstances. However, as a researcher I am

afforded an additional special status (because unlike health care providers) my interactions with these young women occurred in a non-clinical setting and at a point where study participants had had an opportunity to distance themselves from their clinical encounters.

## **Conclusion**

The physical, emotional, and social effects of STIs on young women can be profound. Testing for STIs provides young women with opportunities to exert their personal agency and to undertake efforts to protect their health. By examining the social context in which young women engage in STI testing, this study provided an opportunity to explore and deconstruct the process by which a group of young women made decisions about engaging in STI testing. In addition, the qualitative interviews provided insights regarding young women's perspectives on the factors within the health care system and broader social context that affect their approaches to STI testing. In their interviews, young women in this study also described how participating in STI testing affected their subsequent approaches to decision-making regarding their sexual lives.

Findings of this thesis suggest policy implications through recommendations for clinical communication, public advocacy, and youth action. Clinical communication that is less didactic may provide young women with opportunities to identify gaps in understanding and clarify relevant sexual health information in a style that supports their perspectives and communication styles. The status of health care professionals is such that they are in an ideal position to take visible leadership roles in public advocacy supporting the sexual and reproductive rights of young people, both within and outside of their clinical contexts. Finally, youth can take action to actively question and reflect on messages they receive about sex from society (e.g., the media, peers, family, public health, school) in order to establish and articulate their needs, ultimately to make informed decisions about their developing sexuality.

Although this qualitative study used a grounded theory approach in order to develop a theoretical framework explaining the phenomenon of STI testing among young women

in Vancouver and generate hypotheses for future research, the limited resources of this study constrained the amount of data required to develop a full framework. Furthermore, the phenomenon under study is highly sophisticated and complex, thus further exaggerating the need for more resources to complete the theory. As a result, I have been conservative in providing theoretical connections between the concepts analytically developed from the study findings. However, I have been able to provide a strong theoretical description of the key attributes (and dimensions) underlying the phenomenon of STI testing. In other words I have provided an explanation and deconstruction of the necessary and highly complex foundational elements of the emergent theory.

The findings of this study shed new light on the way we conceptualize and construct our approaches to providing STI testing as well as other sexual and reproductive health services. By challenging the 'Fallacy of Emancipation through Personal Responsibility', the findings of this study cultivate a more sophisticated and complex vision of what it means for young women to engage in STI testing. The purpose of this thesis was to develop insights into the social contexts where young women live and develop as sexual beings. By attending to these insights, it may be possible to cultivate an enhanced sensitivity to young women's perspectives and to develop a social context in which young women can truly be sexually and socially healthy.

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## **APPENDICES**

## Interview Questions for use with Youth

Young Women and Sexually Transmitted Infection Testing (STI): Investigating the Impact of Clinical experiences and Social Context on Sexual Health Decision-Making

### **Review the informed consent and interview structure:**

- ✓ When we spoke on the phone, you told me a, b, c...did you see our pamphlet?
- ✓ Consent forms - we take this very seriously at UBC...
- ✓ This session will be audio-taped and last 1-2 hours.
- ✓ We'll begin our interview by completing a brief questionnaire (5 mins). The information we collect through the survey will be used to describe the characteristics (e.g., age, education, current sexual activity level) of the overall group of study participants.
- ✓ Any questions before we begin?

Now that we have that out of the way, let's focus on the task at hand.

**The purpose of the study** *is to better understand and describe young women's experiences with testing and sexual health decision-making. I hope to produce something that clinicians, programme planners etc. can use to better understand what youth are going through and improve sexual health services.*

### **Before Discussion:**

- ☐ This is more than just about your experiences, it's about your thoughts, feelings, and opinions. So I really want to hear about these today as well.
- ☐ I may be taking a few notes during the interview just for my reference and to help me stay on track...I will review these with you if you like and remember, there is no right or wrong answers. I just want to hear your story. Any questions about how we're going to spend our time today?
- ☐ I'm not judging you or evaluating you. I just want to hear your story.
- ☐ Interview
- ☐ Expense Records

## QUICK CHECK LIST

### Tell me the story....

- How did you feel right before, during, and after the clinic visit?
- Physical procedures...
- Results...
- Telling others...what was it like? (nurses, partner(s), others)

### How would you prepare someone else?

Keeping in mind that the word "SEX" doesn't mean just penetration, it can include all kinds of things like sexual touching, use of sex toys, kissing, phone sex...(9 April 2004)

Emotional difficulties related to STIs...

### Hypothetical Case Scenario:

- (a) You want testing, he doesn't...what happens?
- (b) He wants testing, you don't...what happens? (doesn't work well, elicits socially desirable responding) (9 April 2004)
- (c) What do you think of people who don't get tested? (9 April 2004)

Can you tell me what makes it \_\_\_\_\_?

That's interesting, can you tell me a little more about that?

Keywords

Paraphrase

## **Opening Discussion:**

Please remind me, when did you get tested at the BC CDC/Pine Free Clinic?

*TELL ME THE STORY ABOUT HOW YOU CAME TO GET TESTED.*

Example probes:

- ☐ Start anywhere you want. People start at different places like how they got there, symptoms...
- ☐ Walk me through step-by-step.
- ☐ Was this your first visit to the clinic? Have you ever been tested for STIs before? Where?
- ☐ Why did you choose to come to the clinic and not another one?
- ☐ How would you describe the clinic?
- ☐ How long did it take for you to go to the clinic?
- ☐ Was this your first test?
- ☐ How did you feel: right before, during, and right after leaving the clinic?
- ☐ What was it like telling them at the clinic the reason for your visit?
- ☐ What is it like waiting for the results right now?
- ☐ How did you find out about the results? (You are under no obligation to tell me your results)
- ☐ How would you describe the physical procedures that you underwent at the clinic? What happened?
- ☐ What kinds of questions do you have about getting a specific kind of test? What has the response of the HCPs when you have specific questions testing [the different kinds of tests]? (listen to tape 11 May 2004)
- ☐ How do you think your story would be different if you were a "guy"/male? (9 April 2004)

*HOW WOULD YOU PREPARE SOMEONE ELSE TO GO THROUGH THIS?*

Example probes:

- ☐ If there was something that you could change about the testing process, what would it be?
- ☐ Is there something that you liked about it? Please describe it for me.

*IF THERE'S ANYTHING YOU WANT THEM (CLINIC, STAFF) TO KNOW, WHAT WOULD IT BE?*

Example probes:

- ☐ What would you change if you could?

**SOME PEOPLE EXPERIENCE EMOTIONAL DIFFICULTIES RELATED TO STIs (E.G., MISTRUST; DEPRESSION; BEING LABELLED OR STIGMATIZED)**

Example probes:

- ☐ How has this whole experience influenced your trust of others in intimate relationships?
- ☐ What was it like to tell your partner(s)/others that you got tested?
- ☐ How difficult of a decision was it for you to come for testing?
- ☐ What made you feel worried about coming for testing?
- ☐ Please describe your thoughts on why some people might choose not to come for testing?

**HYPOTHETICAL CASE SCENARIO**

- ☐ You want him to go through testing, he doesn't...what happens?
- ☐ He wants you to test, you don't want to...what happens?

Is it possible that women have a sense that they will be evaluated negatively if they actively confront their partners [about testing]? 16 May 2004

[IG – ask, would you have a sexual relationship with someone who has an STI, if you have an STI?] 16 May 2004

### **HOW DID YOUR EXPERIENCE WITH STI TESTING CHANGE HOW YOU THINK ABOUT SEX AND/OR YOUR SEXUALITY?**

Example probes:

Keeping in mind that the word "SEX" doesn't mean just penetration, it can include all kinds of things like sexual touching, use of sex toys, kissing, phone sex...(9 April 2004)

- ☐ Has your experience with testing changed or influenced your sexual practices (e.g., negotiating safe sex, condom use, types of sexual activity, or choice of partner?)
- ☐ Do you think that certain types of sexual activity makes one more susceptible to STIs than others? How so?
- ☐ How does the fact that you got tested make you feel/think about yourself sexually (e.g., more or less "sexy")? (9 April 2004)
- ☐ If testing wasn't available, what would you do? (9 April 2004)

### **TESTING THE DATA (9 April 2004 whole section)**

Some women have said that the test has a special meaning for them. For example, some talk about it as a "certificate of good health" (e.g., checks if you're "clean").

Example Probes:

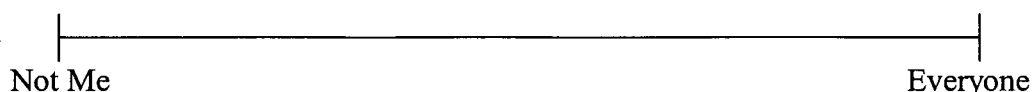
- ☐ Do you think about the test in this way?
- ☐ What do you think about it?
- ☐ Do you know others who use the test this way?

Some women have talked about the test to prove that they're not "damaged goods". Even if there's nothing "wrong" with them and they're healthy.

Example Probes:

- ☐ What do you think about this?
- ☐ Why do you think there is a concern about not seeming "dirty" or "damaged"?

I have heard a lot of stories in the interviews about the connection between the way women see themselves and the way they feel about the test. For example, "This can't happen to me because this only happens to other people" (e.g., sexually promiscuous) while others have said, "Well of course this happened to me because it happens to everyone sexually active."





Example Probes:

- ☐ Where do you think you fit on that continuum?
- ☐ What makes you say that?
- ☐ What kind of experience would it take to make you shift on this continuum (both left and right?)

Making Resolutions: (20 May 2004)

Some women have said that after dealing with the STI (testing) experience that they're only going to date the "right" kind of guy.

- ☐ What makes someone "right"?
- ☐ What makes someone "wrong"?

Others have told us that they've made the decision to abstain (from sexual relations/behaviours) for a while (after this testing experience).

- ☐ What do you think about this idea?
- ☐ How long do you think most people would wait?
- ☐ What do you think it would be like to re-engage in a sexual relationship?
  - ☐ With the previous partner (partner you got it from)
  - ☐ With a new partner?

Lingering Disbelief: (20 May 2004)

In 2-3 cases we've seen stories where women have told us that they just can't understand how this could have happened to them. Like they have a lingering disbelief that they could have contracted this infection from their partner(s) - maybe because they were monogamous, didn't have infections themselves etc...

- ☐ What do you think is going on in these cases?
- ☐ What do you think is the best way for health care providers to provide ongoing support in these kinds of situations?

(20 May 2004)

Lots of people have said that testing is important in order to take care of themselves and protect others.

- ☐ Why do you think it's important for us to take on this personal responsibility in order to protect other people's health?

Follow-up:

- ☐ How do you think men approach this idea of caring for the self in order to protect others?

Meaning-making: (20 May 2004)

For some people, this is a life changing experience and for others it's not such a trauma. Can you help put this test experience into perspective in terms of how it fits with your life?

Follow-up:

- ☐ So for you the test means a way to (e.g., stay healthy). Does it mean anything else?

Other Health Care: (20 May 2004)

You mentioned in your last interview that you were going to see a naturopath for your symptoms.

- ☐ Can you tell me what happened with that?

- ❑ Have you gone to other kinds of health care providers for this?
- ❑ What was that like?
- ❑ Did the symptoms get resolved? How (e.g., what kinds of treatment)?
- ❑ Can you describe for me what they suggested to you with respect to avoiding re-infection? What exactly did they say? How (e.g., offer other support)?
- ❑ Did you have to wait? What was that like?

How can we do a better job of supporting young women after a diagnosis, an STI testing experience? (20 May 2004)

## Interview Questions for use with Youth

### Young Women and Sexually Transmitted Infection Testing (STI): Investigating the Impact of Clinical experiences and Social Context on Sexual Health Decision-Making

#### **Review the informed consent and interview structure:**

- ✓ When we spoke on the phone, you told me a, b, c...did you see our pamphlet?
- ✓ Consent forms - we take this very seriously at UBC...
- ✓ This session will be audio-taped and last 1-2 hours.
- ✓ We'll begin our interview by completing a brief questionnaire (5 mins). The information we collect through the survey will be used to describe the characteristics (e.g., age, education, current sexual activity level) of the overall group of study participants.
- ✓ Any questions before we begin?

Now that we have that out of the way, let's focus on the task at hand.

*The purpose of the study is to better understand and describe young women's experiences with testing and sexual health decision-making. I hope to produce something that clinicians, programme planners etc. can use to better understand what youth are going through and improve sexual health services.*

#### **Before Discussion:**

- ❑ This is more than just about your experiences, it's about your thoughts, feelings, and opinions. So I really want to hear about these today as well.
- ❑ I may be taking a few notes during the interview just for my reference and to help me stay on track...I will review these with you if you like and remember, there is no right or wrong answers. I just want to hear your story. Any questions about how we're going to spend our time today?
- ❑ I'm not judging you or evaluating you. I just want to hear your story.
- ❑ Interview
- ❑ Expense Records

## INTERVIEW GUIDE 2 (within 3 months of STI test)

This follow-up interview will provide an opportunity to elaborate on key concepts identified in the first interview (e.g., disclosure of results to sexual partners) as well as provide an opportunity to investigate how young women perceive their participation in STI testing to have affected their subsequent sexual health behaviour. The follow-up interview will take about 1-2 hours to complete.

- *A general opening statement that reminds the participant about the issues discussed in the first interview:*

“During the first interview, we discussed how you got to the point of testing for STIs at the Pine Free/BC CDC STD Clinic and what it was like to get tested there. I asked you about things such as sexual health information, relationships, telling your partner(s), and the clinic staff. Remember, from my perspective it would be best if you did most of the talking. I’m mostly here to listen. It’s perfectly natural to have pauses in our conversation so feel free to take your time. I’d like you to tell me your story in your own words and in your own way. I will be taking some notes during the interview but they are more for my reference and to help me stay on track. So let’s start ...”

1. In thinking back about your first interview with me, I noticed that you talked a lot about *[insert topic(s), e.g., partner notification]*. I’d be interested in hearing any additional thoughts that you might like to add regarding that topic *[e.g., how did it go when you told your partner(s) about your test results?]* **You don’t have to tell me about your test result if you don’t want to.**

Please tell me your story keeping in mind that the word "SEX" doesn't mean just penetration, it can include all kinds of things like sexual touching, use of sex toys, kissing, phone sex ... (9 April 2004)

### Example Probes:

- ☐ What was it like to tell your partner(s)?
- ☐ What made it challenging for you to talk about it with your partner(s)?

In preparing for today’s interview, I reviewed your transcript in detail. Here’s a list of the words I wrote down during our first interview. Take a moment to look at them. Is there anything you want to discuss in more detail?

### Example Probes:

- ☐ If there’s anything in there you want to talk about please do – or you can think about it and tell me later.

2. Describe for me what it’s been like for you since you got tested at the Clinic up to the moment that you came here to have this interview today. Try starting your story at the point where you left the clinic. **You don’t have to tell me about your test result if you don’t want to.**

### Example Probes:

- ☐ What did you do when you left the clinic that day?
- ☐ How did you find out about your results?
- ☐ How long did you wait for the results?
- ☐ Did you talk with anyone about the results?

- ☐ How did you feel while waiting for your results?
- ☐ When you think back on your test, what kinds of things do you remember about going to the clinic?
- ☐ What kinds of questions do you have about getting a specific kind of test? What has the response of the HCPs when you have specific questions testing [the different kinds of tests]? (listen to tape 11 May 2004)

3. Regardless of your test results, I wondered how you think that your STI testing experience has influenced your subsequent intimate relationship(s)? Really what I'm interested in hearing about are the things that you think about now (after your test experience) when you are involved in intimate sexual relationship(s). (9 April 2004)

Example Probes:

Making Resolutions:

- ☐ Since you had your test, tell me about what it's been like to start or get involved in new relationships, or continue in your existing relationship(s).
- ☐ Why do you think it has been like that?
- ☐ Have you been with anyone since the test? What was that like?
- ☐ Have you been in a relationship since the test? What has that been like?
- ☐ What has it been like to (re)start your relationship after the test?
- ☐ What's it been like to make decisions about having sex (e.g., condom use, types of behaviours), and using protection?
- ☐ What about choosing partners?
- ☐ What about trusting partners?
- ☐ How does the fact that you got tested make you feel/think about yourself sexually (e.g., more or less "sexy")? (9 April 2004)
- ☐ If testing wasn't available, what would you do? (9 April 2004)

4. We've also heard that some people experience changes in their relationships with friends after experiencing a STI test. How has going for a STI test affected your friendship(s), if at all?

5. Have you been back to the clinic since we last met? If so, please describe for me what it's been like to go back there (e.g., treatment, counseling).

Example Probe:

- ☐ Did you recognize any of the clinic staff from your previous visit?
- ☐ What made you remember them?

6. Can you tell me what it's been like to undergo treatment, if you had treatment?

Example Probes:

- ☐ What kind of treatment did you take?
- ☐ Where did you go to get that treatment?
- ☐ How long did you have to be treated for?

7. What kinds of counseling or support did you access after your testing experience?

Example Probes:

- ☐ Where did you go for that support?
- ☐ What was it like?

- ☐ Based on your experience, would you recommend this source of support for another person in a similar situation as yours?
8. Please describe for me the kinds of situations that would make you get tested again for STIs.  
Example Probe:
- ☐ How do you think things might be different next time?
  - ☐ What was the one worst moment in your testing experience? The thing you dreaded the most? Or the thing that you were most dissatisfied with?
10. If you had the chance to change something about the testing experience, what would that be?  
Example Probe:
- ☐ In your opinion, what would have to happen to make your suggested change a "reality"?
11. Describe how your test experience has made you think about your health in general.  
Example Probes:
- ☐ How does the fact that you got tested make you feel/think about yourself sexually (e.g., more or less "sexy")?
  - ☐ If testing wasn't available, what would you do? (9 April 2004)
  - ☐ Sometimes when we think of our health, we think about the short-term, like the next 3-6 months. And then, at other times we think about our health in much longer terms, like 5-10 years from now. How would you say that your STI testing experience has made you think about your short-term health? What about long term health? What about the health of others?
12. How do you think your story would be different if you were a "guy"/male? (9 April 2004)
13. We all know that whether we mean to or not, our interactions can influence us. Have you thought about our last interview and the things we talked about? How do you think that has affected you? (9 April 2004)

### **TESTING THE DATA (9 April 2004 - whole section)**

1. Some women have said that the test has a special meaning for them. For example, some talk about it as a "certificate of good health" (e.g., checks if you're "clean").

Example Probes:

- ☐ Do you think about the test in this way?
- ☐ What do you think about it?
- ☐ Do you know others who use the test this way?

2. Some women have talked about the test to prove that they're not "damaged goods". Even if there's nothing "wrong" with them and they're healthy.

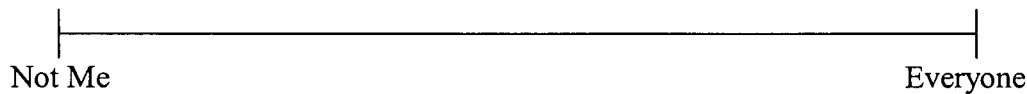
Example Probes:

- ☐ What do you think about this?
- ☐ Why do you think there is a concern about not seeming "dirty" or "damaged"?

3. Is it possible that women have a sense that they will be evaluated negatively if they actively confront their partners [about testing]? 16 May 2004

[IG – ask, would you have a sexual relationship with someone who has an STI, if you have an STI?] 16 May 2004

4. I have heard a lot of stories in the interviews about the connection between the way women see themselves and the way they feel about the test. For example, “This can’t happen to me because this only happens to other people” (e.g., sexually promiscuous) while others have said, “Well of course this happened to me because it happens to everyone sexually active.”



Example Probes:

- ☐ Where do you think you fit on that continuum?
- ☐ What makes you say that?
- ☐ What kind of experience would it take to make you shift on this continuum (both left and right?)

Some women have talked about differences among the different STIs and that some would be “better” to have than others.

Example Probes:

- ☐ What do you think these differences are?
- ☐ What makes some “better” to have than others? Why?
- ☐ What makes some infections more serious than others? Why?
- ☐ What's the difference between chlamydia, syphilis, gonorrhea, and HIV/AIDS? Why?

Making Resolutions: (20 May 2004)

Some women have said that after dealing with the STI (testing) experience that they're only going to date the "right" kind of guy.

- ☐ What makes someone "right"?
- ☐ What makes someone "wrong"?

Others have told us that they've made the decision to abstain (from sexual relations/behaviours) for a while (after this testing experience).

- ☐ What do you think about this idea?
- ☐ How long do you think most people would wait?
- ☐ What do you think it would be like to re-engage in a sexual relationship?
  - ☐ With the previous partner (partner you got it from)
  - ☐ With a new partner?

Lingering Disbelief: (20 May 2004)

In 2-3 cases we've seen stories where women have told us that they just can't understand how this could have happened to them. Like they have a lingering disbelief that they could have contracted this infection from their partner(s) - maybe because they were monogamous, didn't have infections themselves etc...

- ❑ What do you think is going on in these cases?
- ❑ What do you think is the best way for health care providers to provide ongoing support in these kinds of situations?

(20 May 2004)

Lots of people have said that testing is important in order to take care of themselves and protect others.

- ❑ Why do you think it's important for us to take on this personal responsibility in order to protect other people's health?

Follow-up:

- ❑ How do you think men approach this idea of caring for the self in order to protect others?

Meaning-making: (20 May 2004)

For some people, this is a life changing experience and for others it's not such a trauma. Can you help put this test experience into perspective in terms of how it fits with your life?

Follow-up:

- ❑ So for you the test means a way to (e.g., stay healthy). Does it mean anything else?

Other Health Care: (20 May 2004)

You mentioned in your last interview that you were going to see a naturopath for your symptoms.

- ❑ Can you tell me what happened with that?
- ❑ Have you gone to other kinds of health care providers for this?
- ❑ What was that like?
- ❑ Did the symptoms get resolved? How (e.g., what kinds of treatment)?
- ❑ Can you describe for me what they suggested to you with respect to avoiding re-infection? What exactly did they say? How (e.g., offer other support)?
- ❑ Did you have to wait? What was that like?

How can we do a better job of supporting young women after a diagnosis, an STI testing experience? (20 May 2004)

- *A general closing statement that invites the participant to reflect on and add to their interview responses:*

“Would you like to add to any of your responses or change any of them? Is there anything else you would like us to know about STI testing that we haven't talked about in the two interviews?”

Is there anything you think I should know about what young people are going through?

Example Probes:

- ❑ Is there anything that tells the story (your story) of young people? (e.g., movies, books, music)

Thanks for your time and valuable insights. I'll be in touch to send you a summary of the results of the study, as you requested on the consent form. You have my contact information if you have any other questions about your participation.



**KEY PHRASES:**

I hear that a lot...how does that make you feel?

How so you think that will affect you in the future?

Can you give me an example of what a conversation will look like between.....

**Interview 1:** The first interview will take place within 2 weeks of your STI testing experience at the BC CDC STD Clinic. You will be asked questions about your experiences as a young female who has undergone STI testing, your motivations for coming to the clinic, and your expectations about the testing experience. You also will be asked to describe your experiences at the BC CDC STD Clinic and to identify aspects of the health care system that you perceive to have facilitated (or created barriers) to your participation in STI testing. You will be invited to participate in a subsequent interview, within three months of your testing experience.

**Interview 2:** The purpose of the second interview is to follow up on important ideas that you identified during your first interview. The second interview also will give you an opportunity to discuss your interactions with peers, family and sexual partners following your STI test, and to ask you to talk about how you perceive these experiences to influence your subsequent sexual health behaviour. Each interview will take 1-2 hours and you will receive \$25 for each interview that you complete.

Your participation is entirely **voluntary** and you may choose at any time not to answer a question, change responses, withdraw an answer, or stop the interview. Refusal or withdrawal from the study will **in no way affect any treatment, clinical care, or support** that you are currently receiving.

**Confidentiality:** Your identity will be kept strictly confidential. Audio-tapes will be transcribed, identified only by false name, and will be securely locked in a filing cabinet. The tapes will be erased after they are transcribed and checked for accuracy. No names or other unique identifiers will be included in the transcripts or used in any published report. Three individuals will have access to your tapes and transcripts: (1) Ms. Canso, (2) Dr. Jean Shoveller, and (3) the transcriptionist. The transcriptionist will only receive the false name on your audio-tape and will not know your actual identity.

"Your rights to privacy are also protected by the Freedom of Information and Protection of Privacy Act of British Columbia. This Act lays down rules for the collection, protection, and retention of your personal information by public bodies, such as the University of British Columbia and its affiliated teaching hospitals. Further details about this Act are available upon request." (Freedom of Information and Protection of Privacy Act of British Columbia)

If you have any questions about this study at any time, please contact Denise Canso, or Dr. Jean Shoveller, at the phone numbers listed above.

Due to the sensitive nature of this topic, you may experience uncomfortable feelings or memories. If this happens, Ms. Canso can refer you to someone local who can assist you.

If you have any concerns about your treatment or rights as a research subject, please contact the Research Subject Information Line in the UBC Office of Research Services at (604) 822 – 8598.

By signing this consent form, I agree to participate in this study. I understand that my participation in this study is entirely voluntary and that I may refuse to participate or withdraw from the study at any time. I also acknowledge that I have received a copy of this consent form for my own records, and that I may be contacted in the future to receive feedback on the results of the study.

I understand that the interviewer has a legal responsibility to report abuse of minors.

\_\_\_\_\_ I agree to have today's interview audio-taped.

\_\_\_\_\_ I can be contacted at a later date to review the accuracy of transcripts and to participate in an additional interview.

Please contact me at: \_\_\_\_\_

\_\_\_\_\_ I would like to receive a summary of the study findings. Please send them to me at:

E-mail: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Participant Name (please print)

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Name (please print)

My false name is: \_\_\_\_\_

## Appendix 5: Socio-Demographic Survey

***Young Women and Sexually Transmitted Infection Testing:  
Investigating the Impact of Clinical Experiences and Social Context on  
Sexual Health Decision-Making  
Socio-Demographic Survey***

*To be completed by researcher:*

Pseudonym: \_\_\_\_\_  
(False Name)

Date of interview: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Day Month Year

**To be completed by study participant:**

1. How old are you? \_\_\_\_\_ yrs.

2. When is your birthday? \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mo. day year

3. What is the highest level of education that you have completed?

Grade \_\_\_\_\_ OR \_\_\_\_\_ Year(s) of study in university/college/technical school

4. Are you currently enrolled in:

- ☐ High school
- ☐ College, trade school
- ☐ University
- ☐ Other type of post-secondary studies (please write) \_\_\_\_\_

5. Are you currently working for pay?

- ☐ Yes, I work full-time
- ☐ Yes, I work part-time
- ☐ No, I am disabled
- ☐ No, I am unemployed

6. What is your current job? Please write down exactly what you do for work (i.e.,

waiter, salesperson, teacher, etc.) \_\_\_\_\_ OR

- ☐ I'm not working right now

7. How would you best describe your ethnicity? For example, some people describe themselves as Chinese Canadian, others as South Asian.

\_\_\_\_\_

8. Do you own a car (or truck or van) at the present time?

\_\_\_\_\_ Yes

\_\_\_\_\_ Yes, two or more

\_\_\_\_\_ No

9. Whom do you currently live with? Check all that apply.

☐ Female Partner/Spouse

☐ Male Partner/Spouse

☐ Friends

☐ Mother

☐ Father

☐ Step-mother/step-father

☐ Foster parents

☐ Grandparents

☐ I live alone

☐ Other (please specify): \_\_\_\_\_

10. What are the first 3 digits of your current postal code? \_\_\_\_\_

11. How many times have you moved in the past 12 months? \_\_\_\_\_ times

12. Are you currently involved in sexual relationships? (check all that apply)

☐ No, I am not involved in a sexual relationship at this time

☐ Yes, with a woman

☐ Yes, with more than one woman

☐ Yes, with a man

☐ Yes, with more than one man

**Thank-you for participating in this study.**

## **Appendix 6: Resource List**

### **Sexual Assault**

#### **Sexual Assault Service Office**

Emergency medical care for men and women ages 13+ years who have experienced sexual assault within the past seven days; confidential, sensitive care including examination and prophylactic treatment for STDs and pregnancy; forensic evidence can be collected for legal purposes at survivor's request; no referral or adult accompaniment required. Sexual assault survivors can access services 24 hours a day by going to the VGH Emergency Room. Provides information and education to the public, community groups, medical personnel, and professional agencies; training for sexual assault nurse examiners and physicians; information about setting up sexual assault medical services.

4500 Oak Street  
Vancouver, BC  
V6H 3N1  
Coordinator/Counsellor: 604-875-2881  
Nurse Clinician: 604-875-3284

#### **Vancouver Rape Relief and Women's Shelter**

##### **Rape Relief and Women's Shelter**

Free, confidential support services to women who have experienced violence; 24-hour crisis line; rape crisis & women's organizing centre; transition house for battered women and their children; emotional support, information, & education for women's issues; referrals to women through one-to-one work; action groups; legal and medical accompaniment and advocacy; public education program and offers women opportunity to organize with other women to end violence against women; holds confidential, women-only group (open to women who have experienced male violence at any time in their life). Volunteer participation strongly encouraged; non-profit society; feminist collective.

PO Box 21562, 1850 Commercial Drive  
Vancouver, BC  
V5N 4A0  
24-hour: 604-872-8212  
Fax: 604-876-8450  
E-mail: [wgacj02@web.net](mailto:wgacj02@web.net)  
Web: [www.rapereliefshelter.bc.ca](http://www.rapereliefshelter.bc.ca)

#### **Women Against Violence Against Women (WAVAW)**

##### **Other names:**

Young Women's Project

WAVAW (Women Against Violence Against Women)

Crisis line offering information, support, counselling, and referral to survivors of rape/sexual violence; support groups, public education through speaking engagements and information fairs, liaison with community and professional groups; offers advocacy, form completion assistance, information and referral; accompaniment to police, hospital, and court appointments; service also provided by an Aboriginal worker. The **Young Women's Project** offers same services, plus free one-to-one counselling regarding rape/sexual violence for young women ages 14 and over.

Webpage ([www.wavaw.ca/ywp.htm](http://www.wavaw.ca/ywp.htm)) offers information about sexual assault (rape myths, memory loss drugs used to rape, laws, medical information, safety tips, and other resources).

PO Box 29084 RPO Delamont  
Vancouver, BC  
V6J 5C2  
WAVAW cont...  
Crisis Line (9am-5pm): 604-255-6344 or 1-877-392-7583  
No drop-ins; women only.  
Suite 102, 1690 W. Broadway  
Business: 604-255-6228  
Fax: 604-255-3579  
E-mail: [wavaw@shaw.ca](mailto:wavaw@shaw.ca)

**Sexual Assault Support Centre**

Caters to university students, however non-UBC students welcome; free and confidential; personal counselling; support groups; victim assistance programme; hospital accompaniment; workshops.

604-827-5180

Rm. 58 Student Union Building, UBC

**Sexual Assault Recovery Anonymous (SARA)** 604-584-2626

**Sexually Transmitted Infections**

**Sexually Transmitted Diseases Clinic**

Walk-ins and appointments. Testing and treatment for sexually transmitted infections.

655 West 12<sup>th</sup>

Tel: 604-660-6161

Mon. 8:30am-7pm

Tue-Thur. 8:30am-3:30pm

Fri. 8:30am-7:00pm

Sat. 9:30am-1pm

**STD/HIV Outreach Nurses - Bute Street Clinic**

Specializes in outreach for gay, lesbian, bisexual, and transgendered community regarding sexually transmitted disease; testing and treatment for sexually transmitted infections; drop-in.

1170 Bute Street

Vancouver, BC V6E 1Z6

604-660-7949

Hours: Mon-Fri. 11am-6:30pm

**STD/HIV Outreach Nurses - Seymour Street Nurses**

Provides outreach regarding HIV and sexually transmitted disease, to high-risk, street-involved youth in the Downtown South area of Vancouver; part of Street Youth Services.

1065 Seymour Street

Vancouver, BC

V6B 5S4

604-660-6776

**Sexual and Relationship Abuse**

**Abusive Relationships (Battered Women's Support Services)**

Women's centre for those abused in peer support, drop-in groups, peer counselling,

Hours: mon-fri 10-5pm

Phone counselling

Wednesday – open till 8

Please call ahead to book appointment.

Confidential address; bus tickets provided

604-687-1867 counselling line



**Vancouver Incest and Sexual Abuse Centre (VISAC)**

Free and confidential personal counselling.

1193 Kingsway,  
Vancouver, BC V5V 3C9  
604-874-2938  
Mon-Thurs. 9am-5pm  
Fri. 9am-4:30pm  
[www.fsgv.ca](http://www.fsgv.ca)

**Salvation Army Family Services**

Individual and family counselling; weekly women's support groups (including a support group for sexual abuse survivors); assistance with food and clothing; free legal services; educational series on psychological and social issues; summer residential camps for children ages seven to 12 and mothers with young children.

Services by donation (suggested \$5). Call to make appointment.

3213 Fraser Street  
Vancouver, BC  
V5V 4B8  
604-872-7676  
Fax: 604-872-7678  
Mon. to Fri. 8:30am-12 noon &  
12:30pm-4 pm.  
Drop-in services:  
Tuesdays 9:30 am-11:30 am

**Act II Society (Counselling)**

Strictly confidential and professional; Free personal and family counselling; must be referred by the Ministry for Children and Family Development

604-937-7776

**Ministry for Children and Family Development**

Call for referral to Act II; only basic information required; strictly confidential and professional.

604-469-7600  
8:30am-4:30pm  
After hours emergency line:  
604-660-8180

**Health Clinics****Planned Parenthood Association of BC**

Supports reproductive choice and healthy sexuality. Offers medical, scientific, and other information on all aspects of sexual and reproductive health through clinics, the Facts of Life Line, and educational materials. Education programs on family planning topics, including audio-visual resources and literature, are available for students, parents, and professionals. Office hours are 9 am to 4:30 pm Monday to Friday. Nonprofit society.

**Provincial Office**

401 Esmond Avenue North  
Burnaby, BC V5C 1S4  
604-731-4252  
Fax: 604-731-4698  
E-mail: [admin@ppabc.org](mailto:admin@ppabc.org)  
Web: [www.plannedparenthoodbc.org](http://www.plannedparenthoodbc.org)

**Burnaby Planned Parenthood Clinic**

BCIT Medical Services Room  
3700 Willingdon Avenue  
Burnaby, BC V5G 3H2  
604-731-4252  
Clinic hours: Tues. 7 pm-9 pm  
Call for appointment.

**Delta Planned Parenthood Clinic - North**

North Delta Public Health Unit  
11245 84th Avenue  
Delta, BC V4C 2L9  
604-731-4252  
Clinic hours: Thurs. 6pm-8pm (drop-in).

**Delta Planned Parenthood Clinic - South**

South Delta Public Health Unit  
4470 Clarence Taylor Crescent  
Delta, BC V4K 3W3  
604-952-3550  
Clinic hours: Thurs. 7pm-9pm. Call for appointment.

**New Westminster Planned Parenthood Clinic**

New Westminster Public Health Services  
537 Carnarvon Street  
New Westminster, BC  
V3L 1C2  
604-731-4252  
Clinic hours: Wed. 7pm-9pm Call for appointment.

**North Shore Planned Parenthood Clinic**

Lions Gate Hospital  
Medical Daycare Centre  
231 East 15th Street  
North Vancouver, BC  
V7L 2L7  
604-731-4252  
Clinic hours: Wed. 7pm- 9 pm  
Call for appointment

**Port Coquitlam Planned Parenthood Clinic**

Simon Fraser Health Unit  
2266 Wilson Avenue  
Port Coquitlam, BC  
V3C 1Z5  
604-731-4252  
Clinic hours: Mon 7pm-9pm.  
Call for appointment

**Surrey Planned Parenthood Clinic**

North Surrey Public Health Unit  
220-10362 King George Highway  
Surrey, BC V3T 2W5  
604-731-4252  
Clinic hours: Tues. 7pm-9pm (drop-in).

Vancouver Planned Parenthood Clinic  
Vancouver General Hospital  
Women's Clinic, Willow Pavilion  
805 West 12th Avenue  
Vancouver, BC V5Z 1M9  
604-731-4252  
Clinic hours: Tue/Wed/Thur 6:15pm-9:30 pm.  
Call for appointment

**Boulevard Youth Clinic**

Free and confidential health counselling, birth control, pregnancy tests and counselling, testing for sexually transmitted diseases, and help with personal/school problems; serves youth and adults 25 years and younger. Drop-in, no appointment necessary.

Pacific Spirit Community Health Centre  
2110 West 43rd Avenue  
Vancouver, BC V6N 2E1  
604-261-6366  
Fax: 604-261-7220  
Hours: Tues. 2:30pm-5:30pm

**Broadway Youth Clinic**

Health clinic for youth under 25 years of age; free and confidential; no appointment necessary; MSP coverage is not required.

691 East Broadway  
Vancouver, BC V5T 1X7  
604-709-5720  
Fax: 604-709-5721  
Hours: Mon 2:30pm-5pm  
Thurs. 2:30pm-5:30pm

**Commercial Drive Youth Clinic**

Free and confidential health counselling, birth control and pregnancy counselling, diagnosis and treatment of sexually transmitted diseases, and help with personal problems; serves youth and adults 25 years and younger. Drop-in, no appointment necessary.

REACH Community Health Centre  
1145 Commercial Drive  
Mailing address: c/o 200-1651 Commercial Drive  
Vancouver, BC V5L 3Y3  
604-253-3575  
Fax: 604-253-2460  
Hours: Thurs. 2:30pm-6pm

**East Youth Clinic/ Youth Clinic East Vancouver**

Free and confidential services for birth control, pregnancy tests and counselling, sexually transmitted disease testing, and help with personal problems; serves youth and adults 23 years and younger. Drop in; no appointment needed.

Evergreen Community Health Centre  
3425 Crowley Drive  
Vancouver, BC V5R 6G3  
604-872-2511  
Fax: 604-872-2368  
Hours:

Tues. 3:30pm-6pm  
Fri. 2pm-4:30pm

**Knight Street Clinic**

Free and confidential health counselling, birth control, pregnancy counselling, and testing and treatment for sexually transmitted diseases; serves youth over 12 years of age, and adults. Drop-in; no appointment necessary.

South Community Health Office  
6405 Knight Street  
Vancouver, BC V5P 2V9  
604-321-6151  
Fax: 604-321-5108  
Hours:  
Mon. 2pm-4:30pm  
Thurs. 5:30pm-8pm

**Mid-Main Youth Clinic**

Free and confidential health counselling, birth control, pregnancy tests, pregnancy counselling, testing for sexually transmitted diseases, and help with personal/school problems; serves youth up to and including age 25, including those without medical coverage. Drop-in; no appointment necessary.

3998 Main Street  
Vancouver, BC V5V 3P2  
604-709-6400 Local 2092  
Fax: 604-872-5223  
Wed. 2:30pm-5pm

**Pine Free Community Health Youth Clinic**

General medical care, birth control, pregnancy counselling, and diagnosis and treatment of sexually transmitted diseases; serves youth and young adults 25 years of age and under, including uninsured people. Uninsured people may only attend the clinic in the mornings on weekdays and all day Wednesday.

1985 West 4th Avenue  
Vancouver, BC V6J 1M7  
604-736-2391  
Fax: 604-731-9479  
Mon/Tues/Thur/Fri. 9-12noon, 2-5pm  
Wed. 9am-12noon, 2:30pm-7:30pm  
Sat. 1pm-4pm  
Every third Wed. 9am-12noon, 4:30pm-7:30pm.

**Three Bridges Youth Services/ Downtown South Community Health Centre Youth Services**

Counselling and treatment for sexually transmitted diseases and other medical concerns, pregnancy testing and birth control; drop-in or appointment basis for individuals under age 26. Clients do not require medical coverage; appointment basis only for personal counselling.

1292 Hornby Street  
Vancouver, BC V6Z 1W2  
604-736-9844  
Fax: 604-734-5918  
Mon-Fri 8:30am-8pm  
Sat. 10am-5pm  
Personal Counselling: 604-633-4220

**Youth Clinic**

Deals with issues related to adolescent sexuality, pregnancy, and parenting; offers free and confidential pregnancy testing, pregnancy counselling, screening for sexually transmitted infections, hepatitis B vaccines, HIV testing and counselling, information on birth control and sexuality, and counselling; serves youth 13-24 years. Social worker on staff. Drop-ins accepted, but appointments preferred.

13750 96th Avenue

Surrey, BC

V3V 1Z2

604-585-5999

Fax: 604-585-5998

E-mail: [sharon.jagich@sfvhr.hnet.bc.ca](mailto:sharon.jagich@sfvhr.hnet.bc.ca)

Mon. 1pm-8pm/Tues. 12noon-6pm/Thurs. 1pm-8pm/Fri. 12noon-5pm

**Emergency/Telephone Services**

**Nurse resource line (BC CDC)** 604-660-6768

**Facts of Life Line**

Toll-free, confidential, non-judgemental telephone service providing information and referral on reproductive health and/or sexuality concerns. Hours are 9 am to 9 pm Monday to Friday, and 10 am to 2 pm Saturdays.

604-731-7803 or 1-800-739-7367

E-mail: [fol@ppabc.org](mailto:fol@ppabc.org)

**Sexual Assault Information Line**

Recorded information 24 hours/day; UBC services 604-822-9090

**Crisis Centre**

24 hour telephone service; strictly confidential 604-872-3311

**STD/HIV Information Line**

Can access nurse Mon.-Fri. 1-3pm 604-872-6652

**Victim Assistance**

provincial; 24-hour telephone referral service 1-800-563-0808

**Ethno-specific Services**

Asian Society for the Intervention of AIDS (ASIA)

604-669-5567

[www.asia.bc.ca](http://www.asia.bc.ca)

Drop-in:

Mon-Fri. 10am-6pm

Sat. 10am-4pm

**Vancouver and Lower Mainland Multicultural Family Support Services Society**

Culturally-sensitive services to immigrant and visible minority women, children, and families experiencing family violence; individual and group counselling by bilingual/bicultural workers; supportive services for interactions with legal and social systems; volunteer training to develop organizational and leadership skills; supportive counselling and referral for women who are victims of sexual assault or adult survivors of childhood sexual abuse.

The **Children Who Witness Abuse Program**, provides individual and group counselling to children ages preschool to 19 who have witnessed violence; provides educational programs to multicultural communities regarding dynamics of family violence and alternative models of treatment; provides consultation and educational programs to professionals.

Confidentiality is strictly maintained. Service is offered in Amharic, Arabic, Cantonese, Czech, Farsi, Gujarati, Hindi, Ilocano, Italian, Japanese, Korean, Mandarin, Polish, Punjabi, Russian, Spanish, Tagalog, Tigrania, Urdu, and Vietnamese. Nonprofit society. Funded by MCAWS, MPSSG, and Health Canada.

5000 Kingsway Plaza - Phase III  
306-4980 Kingsway  
Burnaby, BC V5H 4K7  
604-436-1025  
Fax: 604-436-3267  
E-mail: [againstviolence@vlmfss.ca](mailto:againstviolence@vlmfss.ca)  
Web: [www.vlmfss.ca](http://www.vlmfss.ca)  
Mon-Fri. 9am-5 pm

### **Student Services**

#### **UBC Counselling Services**

Free counselling services to admitted and registered UBC students; services provided by psychologists, professional counsellors, pre-doctoral interns, and masters-level counselor trainees. Please call 604-822-9260 to make appointment.

Brock Hall, Room 1200, 1874 East Mall  
Vancouver, BC V6T 1Z1  
Canada  
Phone: (604) 822-3811 or 9260  
Fax: (604) 822-4957  
Mon/Tues/Thurs/Fri 8am-4pm  
Wed. 9am-4pm  
Website: <http://students.ubc.ca/counselling/>

#### **Student Health Service, UBC**

Available and free to all registered students of UBC; trained in family medicine, sports medicine and primary nursing care; appointments preferred to avoid having to wait "forever" to see the doctor. Same day care if health concern is urgent. Call ahead to book appointment (604 822 7011).

2211 Wesbrook Mall V6T 1Z3  
Tel: 604-822-7011  
Website: [www.students.ubc.ca/health](http://www.students.ubc.ca/health)

#### **Wellness Centre, UBC**

An outreach programme of the Student Health Service; information on variety of health and wellness topics available; wellness assessments(non-medical); talk to a Peer Educator or Coordinator on site; attend a workshop; pick up safer sex products.

Room 56B, SUB  
822-4858  
[wellness.centre@ubc.ca](mailto:wellness.centre@ubc.ca)  
Hours: Mon.-Thurs: 9am-5pm  
Fri.10am-2pm

#### **Nurses in Residence Programme, UBC**

This service is available and free to all students living in a UBC student residence; nurse staffs each UBC Student Residence one day per week during the school term. Visit them in the Commonsblock area of these residences from 4 - 7 pm.

Tues.: Hollie at Totem Park  
Wed.: Debbie at Place Vanier

#### **BCIT (British Columbia Institute of Technology)**

Enrolled BCIT students have priority for appointments; quick response and emergency appointments available; students in crisis seen immediately; counselling Services are free of charge; all information held in strict confidence; no information released to Institute administrators, instructors, outside agencies, or anyone else unless authorized by student or required by law.

3700 Willingdon Avenue, Burnaby, B.C. V5G 3H2  
Tel: 604-432-8608  
Fax: 604-431-7261  
Visit in person: Building SE16, Room 127  
Office hours: Mon-Fri 8:30am-4:30pm (September-May); 8:30am-4:00pm (June-August)

### **Capilano College**

Information shared with a counsellor is strictly confidential and will not be released to anyone inside or outside the College, unless authorized by the student or required by law. Appointment times available Mon-Fri. Drop-in counselling available to accommodate students in crisis or emergency situations, or for short consultations.

Room 267, Birch Building.  
Tel: 604.984.1744

### **Douglas College**

Short term personal counselling is available for students. Individual appointments and drop-in times are scheduled daily. When appropriate, referrals are made to community agencies and services. Students in crisis or emergency situations are encouraged to contact counselling services for assistance.

New Westminster 604-527-5486  
Coquitlam 604-777-6185

### **Langara College**

Counselling is available to help Langara students resolve personal issues that may affect their academic performance or well-being. Issues may include stress management, adjustment to college, interpersonal relationships, communication skills, assertiveness training, and self-esteem. Referrals made for students requiring long-term counselling or therapy.

Tel: 604-323-5221  
Visit in person: 'B' building, Room B111  
Hours: Mon-Thurs. 8:30am 5:30pm  
Fri. 8:30am-4pm  
Website: <http://www.langara.bc.ca/counselling/>

### **Simon Fraser University (SFU)**

Free service to students presently enrolled at SFU taking credit courses, graduate students involved in meeting degree requirements and coop students registered in work terms may access the full range of Personal Counselling services.

Nightline offers crisis intervention, peer counselling, information and referrals, supportive, confidential, non-judgmental environment. An opportunity to explore your situation and options for solving problems

Personal counselling website:  
<http://www.sfu.ca/hccc/pages/psnl-counselling.html>

Tel. 604-291-4615  
Mon-Fri. 9am-4:30pm  
Nightline 604-857-7148.  
4:30 pm to 8:30 am weekdays  
24 hours weekends and holidays

## **Other Sexual Health Services**

### **Sexual Health Service**

Provides continuum of coordinated, interdisciplinary, consumer-driven rehabilitation services to enable people with disabilities to understand and manage potential changes in sexuality; assessment includes clarification and validation of sexual concerns and takes into account personal development issues, including values and beliefs; education includes information provision and skill development; specialized services include sperm retrieval & erection enhancement clinics; treatment available for individual clients, their partners, and/or family members.

4255 Laurel Street  
Vancouver, BC V5Z 2G9  
604-737-6233  
Fax: 604-737-6359

**Appendix 7: Characteristics of Study Participants**

Participant	Age (yrs)	Educ.	Enrolled	Work	Current Job	Ethnicity	Veh.	*Currently Involved Sexually	Sx	Clinic	Type of Testing
1. Sarah♦	20	U/C/T	Yes	PT	Fitness Instructor	Iranian-Canadian	Yes	Multiple Partners	No	Pine Free	Screen
2. Sara	23	U/C/T	Yes	No	-	White	No	Multiple Partners	No	Pine Free	Screen
3. Susan♦	19	Gr. 13	Yes	PT	Tutor	Chinese-Canadian	Yes	Single Partner	Yes	Pine Free	Case-Find
4. Suze Q	21	U/C/T	No	PT	Self-employed	European-Canadian	No	None	No	Pine Free	Screen
5. Luisa♦	21	U/C/T	No	FT	Data Entry	Filipino-Canadian	No	Single Partner	Yes	CDC	Case-Find
6. Kate♦	22	U/C/T	Yes	PT	Fitness Instructor	German-Chinese	Yes	None	Yes	CDC	Case-Find
7. Zula♦	24	U/C/T	Yes	No	Mother	Latina-White	No	None	Yes	CDC	Case-Find
8. Mary	22	U/C/T	Yes	No	-	Caucasian	No	Single Partner	No	Pine Free	Screen
9. Kimberly	20	Gr. 12	Yes	PT	Waitress	Caucasian	No	None	No	Pine Free	Screen

U/C/T = University, College, Tradeschool

Veh. = Owns a vehicle

\*Currently Involved Sexually = refers to sexual relations with male partners at time of interview

♦ Participated in Follow-up interviews

*Note: All responses were self-reported*



### Appendix 7: Characteristics of Study Participants cont...

Participant	Age (yrs)	Educ.	Enrolled	Work	Current Job	Ethnicity	Veh.	*Currently Involved Sexually	Sx	Clinic	Type of Testing
10. Alice ♦	19	Gr. 12	Yes	No	-	White	No	None	No	Pine Free	Case-Find
11. Claire ♦	20	U/C/T	Yes	FT	Volunteer Sex Educator	Chinese-Canadian	No	Single Partner	Yes	Pine Free	Case-Find
12. Ellie ♦	22	U/C/T	No	No	-	Chinese-Canadian	Yes	None	No	CDC	Screen
13. Sandy	24	U/C/T	Yes	No	-	South Asian	No	Single Partner	No	Pine Free	Screen
14. Sarah	19	U/C/T	Yes	No	-	Caucasian	No	Single Partner	No	Pine Free	Screen
15. Gwen	19	U/C/T	Yes	PT	Hostess	Welsh-Canadian	Yes	Single Partner	No	Pine Free	Screen
16. Liz	21	U/C/T	Yes	No	-	Greek-Canadian	Yes	None	No	CDC	Screen
17. Teresa	23	U/C/T	Yes	PT	Tutor	Filipino-Canadian	No	None	No	CDC	Screen
18. Anna ♦	24	U/C/T	Yes	FT	Lifeguard	Caucasian-Canadian	No	None	Yes	CDC	Case-Find
19. Brittany	21	Gr. 12	No	FT	Waitress/ Prep Cook	Alaskan Eskimo	No	Single Partner	No	Pine Free	Screen

U/C/T = University, College, Tradeschool  
Veh = Owns vehicle

\*Currently Involved Sexually = refers to sexual relations with male partners at time of interview  
♦ Participated in Follow-up interviews

*Note: All responses self-reported*