Community Readiness Assessment: Adolescent Sexual Health Education in Abbotsford

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RESEARCH ABSTRACT

INTRODUCTION: Currently, Abbotsford mandates an abstinence-based approach to adolescent sexual health education. Data from the Abbotsford Youth Health Clinic (AYHC) has identified a group of youth displaying high-risk sexual behavior in our community. A review of the literature suggests that providing comprehensive sexual health education is a means to reduce negative sexual health outcomes for adolescents. Furthermore, it has been documented that community interventions are more successful if they are tailored towards the communities' current readiness to accept change regarding an issue. **OBJECTIVE**: To determine how ready the community of Abbotsford is to accept change regarding adolescent sexual health education. **DESIGN:** We used the Community Readiness Assessment tool created by the Tri-Ethnic Center Prevention Research at Colorado State University. This tool provides a framework for assessing community perceptions and determining readiness to accept change for a given issue. **METHODS:** Telephone interviews were conducted using a scripted list of open-ended questions and were scored using an anchor weighted scoring system to illicit the stage of readiness for change in the community surrounding adolescent sexual health education. **PARTICIPANTS:** Various stakeholders from the community were interviewed including members of city council, local religious organizations, general public and health care professionals. **HYPOTHESIS**: Due to the conservative nature of this community, we hypothesized that Abbotsford would be in a lower level of readiness for change based on the current values of the community. **FINDINGS:** Our results support this hypothesis and indicate that Abbotsford is in the "denial/resistance" stage with regards to sexual health education in teens. This suggests that some people acknowledge that it is a concern, but most do not appreciate it is occurring locally. **CONLCUSIONS:** Future projects developed to improve sexual health education should acknowledge this current stage of readiness and tailor programs towards raising awareness that the problem is occurring locally.

INTRODUCTION

Sexual health education has been extensively analyzed in the literature and is an important contributor to overall health and wellbeing of our youth[1]. Sexual health education is defined by the World Health Organization as "the process of equipping individuals, couples, families and communities with the information, motivation and behavioral skills needed to enhance sexual health and avoid negative sexual health outcomes"[2]. The Canadian Guidelines for Sexual Health Education also use this definition and outline five principles that should guide effective sexual health education programming: accessibility, comprehensiveness, effective educational approaches and methods, training and administrative support, and planning, evaluation, updating and social development[3]. The current body of literature supports the concept that comprehensive sexual health education has positive effects on sexual behavior including delaying first intercourse, increasing contraception use, decreasing numbers of unplanned pregnancies and decreased rates of sexually transmitted infections (STI)[4,5,6,7].

Importantly, providing comprehensive sexual health education programs do not hasten or increase sexual behaviors[4,5,8], which is a common fear amongst educators, parents and some members of the general public.

Abbotsford has a collection of public, private and faith based schools, which likely have slightly different approaches for providing this type of education. For the purposes of this project we have chosen to focus on the public system. The public division publishes a curriculum guideline, as determined by the Board of School Trustees of School Division No. 34 (SD #34), which is available online[9]. At present, the Board mandates an abstinence-based approach to sexual health education. All teachers and outside speakers (including public health) are to address contraceptives in the context of "saving sex" instead of "safer sex" [9]. Discussions about pregnancy and sexually transmitted infections (STIs) "must focus on encouraging students to make the responsible choice of not engaging in sexual activity" [9]. Although students are instructed on contraceptives, the "how to" is not taught in the classroom setting. Furthermore, all students require parental permission to participate in the personal development (human sexuality) curriculum and are entitled to withdraw their children from such and provide the education at home. While the abstinence-based approach likely benefits many teens in the community, there is more evidence in the literature supporting comprehensive sexual education policy in terms of harm reduction for negative sexual health outcomes[7].

In November 2010, the Abbotsford Youth Health Clinic (AYHC) was opened to service high-risk and under-serviced youth in the semi-urban community of Abbotsford, British Columbia. At the 1-year mark of the clinic opening, statistics were calculated based on intake questionnaires given to all clients and yielded alarming results. Of the youth being seen in the clinic, 66% were sexually active, 36% said their sexual activity resulted in pregnancy, 19% had been treated for STIs, and 22% never or rarely use protection to avoid pregnancy and STIs[10]. These results are showing much higher rates of risky sexual behavior than the regional and provincial statistics as determined by the McCreary Centre Society[11,12]. This report is limited as Abbotsford School district (SD #34) opted out of data collection, however we would expect the results to be similar to the surrounding communities and provincial averages. The most recent McCreary report quotes 20% of youth had sexual intercourse, 60% used condoms and 4% of those who were sexually active had been diagnosed with an STI[12]. It is likely that the AYHC has a selection bias for seeing high-risk and at-risk youth as referral largely comes from youth workers, which would explain the higher rates of risky sexual behavior. Although overall rates of sexual activity are declining on a provincial level[11], there is still a subset of youth that may not be captured in large-scale surveys displaying high-risk behavior and suffering emotional and health consequence as a result.

In general, Abbotsford is regarded as being a conservative-minded community. As such, making changes to the current model of sexual health education is likely to be met with resistance as it may be seen as a challenge to peoples' belief systems. Any programs implemented in the community may be rejected if they are not consistent with its current beliefs and values. As such, the idea of "community readiness" has been developed as a means of determining how ready the community is to accept change regarding a local

community issue[13]. The Tri-Ethnic Center for Prevention Research at Colorado State University has developed a tool that can be used to gain an understanding of how community dynamics relate to perceptions around certain issues and can be used to assess a community for its stage of readiness for change[14].

The goal of this study is to determine the current perceptions of adolescent sexual health education and readiness to accept change for instituting a more comprehensive curriculum. Based on the current level of readiness we are then able to make recommendations toward improving sexual health education compatible with the communities' values and beliefs thereby having a better chance of being accepted and thus implemented.

METHODS

We surveyed the literature for different tools available to conduct a community readiness assessment. Based on ease of application, availability and training requirements we selected a community readiness model created by the Tri-ethnic Center for Prevention Research at Colorado State University. A detailed guide has been published by this group and is available to the public.

A focus group was held with members of the AYHC executive committee to identify members of the community of Abbotsford who have vested interest with youth and are knowledgeable about current challenges within this community. These included stakeholders from various organizations, such as; community family physicians, public health, youth organizations, religious groups, the City of Abbotsford, youth ministry, etc. Specific organizations and titles will not be listed to protect the confidentiality of interviewees. Once identified, invitation letters were sent out to the stakeholders by email that outlining details of the study. Interested parties replied back to the researchers and consent was obtained for participation. Once informed consent was obtained, a research assistant contacted the potential interviewees to arrange for a telephone interview to be conducted.

Design:

A generic interview script was used from the Tri-ethnic Center's model. The interview script consists of 37 open-ended questions regarding the issue and the community. The questions are split into six dimensions; community efforts (programs, activities, policies, etc), knowledge of community efforts, leadership, community climate, knowledge about the issue and resources for prevention efforts. The questions were tailored to our study with the issue being defined as "adolescent sexual health education in Abbotsford". Interviews were conducted by telephone, recorded and transcribed verbatim by our research assistant. Transcriptions were encoded with a letter and names and identifying information was removed to ensure confidentiality.

The primary researchers scored each interview script independently. First, each interview was read through in its entirety to gain an overall impression. Each dimension was then scored on a scale of 1 to 9 using an anchored weighted scoring system as outlined by the

Tri-Ethnic Center's guidelines. In order to receive a score at a certain stage, all previous levels must have been met first. After independent scoring, the researchers discussed scoring and came to a consensus for each dimension in every interview. Combined scores were then averaged across interviews for each dimension. The final score was determined by taking the average score of all the dimensions and was rounded down as per protocol. This final score was used to determine the overall stage of readiness for change within the community.

Participants:
The guide suggests interviewing between 4 and 6 members of the community to accurately reflect perceptions around the issue while avoiding redundancy. A total of 12 community stakeholders were contacted with an interview invitation letter and 6 responded and completed the interview. Interviewees included members of the general public, health care providers, youth groups, and the City of Abbotsford. Participants were eligible if they were over age 18, able to communicate effectively in English and were current residents of Abbotsford.

Ethics approval for this study was obtained from both the University of British Columbia Research Ethics Board and the Fraser Health Research Ethics Board and each participant signed an informed consent prior to being enrolled in the study.

FINDINGS

The interviews yielded a score of 2.97, which was rounded down to 2 as per protocol. This correlates to the "denial/resistance" stage of community readiness to accept change. Individual scores from each interview are represented in Table 1. The combined scores and calculated overall readiness level score are shown in Table 2.

DISCUSSION

The purpose of this study was to gain an understanding of how community dynamics relate to perceptions around adolescent sexual health education as well as the current stage of community readiness to address the issue. There are nine different stages of readiness described by the Community Readiness Model. These stages range from one (no awareness) to nine (high level of community ownership). The results indicate that the community of Abbotsford is at stage 2 with regards to adolescent sexual health education, correlating with denial and resistance of the issue. This suggests that some community members recognize a concern but there is little recognition of the extent of the problem occurring locally. Once the readiness level of a community has been assessed, different types of community interventions can be implemented depending on the level of readiness, thus effectively using resources for maximal impact within the community[15,16].

Based on interviewee responses it is clear that this a controversial topic and there is a division within the community around how much of a problems this is and whether it even needs addressing. On one hand, there is a group within Abbotsford that tends to be

more conservative in their perspectives on adolescent sexual health education. This group advocates for the current system of education and tends not to view the issues around adolescent sexual health as a local problem. On the other hand, there are pockets within the community that view the current system as inadequate and recognize that despite encouraging abstinence there is still risky sexual behavior occurring amongst youth. Abbotsford in general is a conservative city with a strong religious community. There was a sense from the interview responses that this is not a topic that all people are comfortable talking about openly and felt that some of the interviewees may have been slightly hesitant to speak openly. This is an important dynamic not only for influencing community perceptions of this issue, but is also important to consider when trying to create strategies that are respectful to all potential stakeholders.

According to the Tri-ethnic Community readiness handbook, at this level the goal should be towards increasing the awareness that this issue is occurring on a local level. Examples of strategies that could be implemented include presenting information to local related community groups, engaging local educational and health outreach programs, and discussing local incidence rates related to the issue. More specifically, this could involve publishing statistics about sexual behaviors, as obtained from the AYHC, in handouts or posters that are distributed throughout the community in areas that would be accessed by youth and policy makers. Another approach could be to provide more information to the community and it's leaders about the current curriculum as well as data supporting a more comprehensive approach. As there is very little awareness of the issue, any such media interventions would need to be of low intensity in order to not be completely rejected by the community.

Another area we have identified for improvement is to increase public knowledge around current community resources. We have identified at least six different organizations within Abbotsford providing information around sexual health, however the overall awareness of these resources and the services they offer is lacking. In order to address this, initiatives should also include utilizing media to increase awareness of what already exists and to clarify and provide accurate information as to what each of the organizations offer. This may include putting up bulletins in local community centers, churches and/or publishing newspaper articles so that youth in Abbotsford are aware of their options to access sexual health information outside of the current school curriculum.

While the community readiness assessment tool has provided a meaningful way to quantify where our community stands in terms of readiness for change, there were several limitations. The Community Readiness Model is a subjective tool used to assess a particular issue within a community at a given point in time. As both the community and issue change with each application of the tool, scientific validation is difficult to assess[14]. The authors of the assessment tool argue that it is a "broad scale theory" meaning that it encompasses many different phenomena such as facts or opinions and looks at the possible relationships that exist among these phenomena. Construct validity is established by verifying accuracy of hypotheses – if accurate then the underlying theory and instrument used to assess the theory are likely to be valid[14]. Lending support to its credibility is the fact that this tool has been adopted to successfully address a wide range

of health, social, and environmental issues internationally[16,17,18]. Despite the fact that the nature of this tool and study is extremely subjective and difficult to validate, the results yield important information about the current community climate and dynamics playing into the issue at hand providing guidance for future directives.

Another major limitation centers around the inclusiveness of the study. Unfortunately there is no representation from the Indo-Canadian community in the study owing partly to reluctance from some to participate, as well as time constraints of the project. Therefore, our findings may not represent this particular community. Further, youth have not been directly involved in the interview process as they are considered a vulnerable population by the UBC Ethics Board and as such were excluded. To try and compensate for this one of our interviewees is a young adult who recently completed her primary education in Abbotsford. It is possible that the overall result may have yielded a higher level of community readiness if youth had been involved assuming they are more aware of the issues at hand and current community resources.

CONCLUSION

The purpose of this study was to gain an understanding of community dynamics and perceptions around adolescent sexual health education in Abbotsford and use this data to assess readiness for change. The results indicate that there is a denial and resistance of the need for change. This implies that there is several members of the community that realize a problem may exist but are not aware of the significance locally. With this information in mind, community programming can be tailored towards improving awareness of the issue and will thus having higher chances of acceptance and success. While there are certainly limitations to this study, it is an important first step in addressing the issue of adolescent sexual health education in Abbotsford, and may serve as a framework for future initiatives. Ultimately, comprehensive sexual health education such as that suggested by the Canadian Sexual Health Education Guidelines is likely to be more effective at reducing negative consequences of risky sexual behavior thereby improving the overall health and wellbeing of our youth.

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ADDENDUM

Table 1: Individual Scores for Community Readiness Assessment

Interview	#1		#2		#3		#4		#5		#6	
Scorers	**1**	**2**	**1**	**2**	**1**	**2**	**1**	**2**	**1**	**2**	**1**	**2**
Dimension A	3	6	4	6	4	6	2	4	1	5	3	6
Dimension B	3	4	4	3	3	3	1	3	1	2	2	3
Dimension C	3	3	2	1	1	1	2	2.5	2	2.5	2	2.5
Dimension D	2	3	3	3	1	3	2	2	2	2	2	2
Dimension E	3	4	3	3	2	3	3	2.5	1	2.5	1	1
Dimension F	3	5.5	5	3	3	5	2	2	1	2	2	4

Table 2: Combined Scores and Average Score for Community Readiness Assessment

Interviews	#1	#2	#3	#4	#5	#6	Total	Stage Score
Dimension A	4.5	5	5.5	3	5	6	29	4.83
Dimension B	3.5	3.5	3	2	2	3	17	2.83
Dimension C	3	2	1	2.5	2.5	2.5	13.5	2.25
Dimension D	3	3	1.5	2	2	2	13.5	2.25
Dimension E	3	3	2.5	3.5	2.5	1	15.5	2.58
Dimension F	4.5	3	3	2	2	4	18.5	3.08
Average Overall Community Readiness Score = 2.97								

AUTHORSHIP

The order of authorship was based purely on alphabetical order of the residents' last names. Both residents participated equally in the research process. Each was involved in conducting the initial focus group, identifying potential stakeholders and choosing the research tool used. The interview script was adapted collaboratively as well. Interviews were scored by each resident independantly and then a consensus was reached together. Dr. Meloche initiated the literature search and wrote the majority of the "background" and "methods" section. Dr. Aiton focused on writing the "findings" and "discussion" sections.

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