

GOALS AND OBJECTIVES

The Toronto Teen Survey (TTS) is a collaboration between community-based organizations, academic researchers and policy-makers that has an overall goal of developing a sexual health strategy for diverse youth in Toronto. In Phase I of the project, 1,216 youth were surveyed and approximately 100 service providers consulted about quality and access issues in community-based sexual health education and care services in Toronto (Appendix 1A: TTS Background, Appendix 1B TTS Survey Booklet). This current proposal seeks funding to support phase two of the project. Our plan is to employ a qualitative methodology (focus groups) with targeted youth populations to further investigate significant findings from the survey data, set a future research agenda, and explore community relevant ways to incorporate study findings into sexual health programming. Specific objectives of this study are to:

1. conduct more nuanced analyses of select quantitative survey findings by exploring the lived experiences of youth attempting to access sexual health services from specific sub-populations;
2. synthesize (in greater depth) results relevant to specific sub-populations of youth that experience increased and/or unique barriers to sexual health services and/or higher burdens of sexually transmitted infections (e.g. sexually diverse youth, immigrant and newcomer youth, and ethno-racially diverse youth);
3. understand variations within the sub-populations of interest by gender, age, ethnicity, and sexual orientation;
4. explore issues of equity and inclusion, and the unique barriers faced by specific sub-populations of youth in accessing sexual health services;
5. develop participatory, community-specific policy and program strategies that attend to the unique vulnerabilities and sexual health needs of youth from diverse communities;

HYPOTHESES

As anticipated, the analysis of our survey data from Phase I confirms that sexual health needs and access barriers differ across diverse groups of youth in Toronto, but with surprising differences within and between communities of youth. In conducting focus groups to explore the reasons for these differences, we hypothesize that there are systemic and structural barriers to adolescent access and uptake of sexual health services and interventions. Specifically, these barriers:

- are experienced differently by different sub-communities of youth (varying by age, gender, language, race and ethnicity, sexual orientation, immigrant/refugee status, and socioeconomic status). These constructions likely account for divergent access between and within youth populations;
- require community-specific discussion and understanding in order to arrive at preferred solutions;
- are highly amenable to program and policy interventions.

The overall goal of Phase II (the current project) is to gather information necessary to create a city-wide sexual health strategy including the development of concrete community programs and services. This component of the research will allow us to identify community-specific strategy recommendations that are flexible enough to meet the needs of diverse populations of youth in Toronto. There is no assessment of access barriers to sexual health services for youth in the city of Toronto which means that our findings can lead to practical policy and programming changes in Toronto, Canada's largest and most diverse urban environment. However, given our unique research approach, there is also

significant potential to inform research and models of investigation in other Canadian urban centres. The Toronto Teen Survey has employed a unique *university-community-policy partnership* approach from the beginning, ensuring that all relevant stakeholders are at the table and increasing the likelihood that data are unlikely to ‘sit on the shelf’ and more likely to be translated into policy and programming solutions. Our mandate is to use the information collected to directly affect programming and policy, thereby improving youth sexual health services. We firmly believe that this will lead to strong improvement in adolescent sexual health outcomes.

STEPS TO DATE

Groundwork laid, youth committed. The TTS is a community-based research (CBR) project committed to equitably involving young people and community partners in all phases of research while ensuring that the data collected is used to affect change. CBR initiatives are characterized by: ensuring the relevance of research questions to communities; engaging members of the community as active research partners; building capacities and skills among research partners; and attending to social change by ensuring that data are used to affect positive change.^{1,2} In 2005, TTS secured funding from The Ontario HIV Treatment Network to survey 1,200 ethno-racially diverse youth (aged 13-17) and consult 100 service-providers in community settings. Between November 2006 and July 2007, 1,216 surveys were collected from youth in over 90 different community-based settings across Toronto by youth peer researchers. Survey sessions were conducted through youth-serving agencies (e.g. after school programs, youth shelters, community health centres, recreation centres, employment programs, etc) that have partnered on sexual health initiatives with Planned Parenthood Toronto (see Appendix 1C: TTS Survey Hosts). Our collective experience working with youth demonstrates that they are more likely to engage in open and honest communications about sexuality in their familiar community-based settings (rather than in their home or school environments). This targeted sampling strategy was also used to ensure that we heard from youth who are traditionally invisible or excluded in existing youth research (e.g. gay, lesbian, bisexual and transgendered youth; newcomer youth, etc).

In keeping with our CBR approach, we have recruited a talented Youth Advisory Committee (YAC) that assisted us with the development of the survey tool and administered the survey throughout the city.³ YAC’s diversity, with respect to gender, race, sexual orientation, socio-economic status, religion, and immigration status, reflects the diversity of youth in Toronto and those we have surveyed to date. We intend to continue this innovative and highly successful community-based approach, and YAC members will continue to be integral members of the research data collection, analysis, and dissemination team.

Summary: Community-based organizations need increased support to provide relevant, inclusive, and culturally-appropriate programming aimed at enhancing sexual health outcomes for diverse groups of youth. The increase in youth HIV and STI rates, the reduction in sexual health knowledge among youth, the rapid diversification of Canada’s urban centres, and the needs of Toronto’s diverse youth communities demonstrate an urgent need to change the current state of youth sexual health services. **We are proposing a TTS Phase II qualitative study that will examine *how* marginalized youth access sexual health services, *how* they navigate gaps and barriers (to and within) services, and *how* researchers and service providers can better understand the access barriers they encounter.** Overall, this research will help illuminate and deepen our understanding of the unique needs of youth in relation to sexual health information and access to services. As part of the larger Toronto Teen Survey (TTS) program of research, this qualitative study will leverage resources by building on the existing TTS infrastructure and partnership.

BACKGROUND & FINDINGS

Resurgence of sexually transmitted infections (STIs) among youth: Due to a number of biological, social, developmental, and behavioural factors, STIs disproportionately affect adolescents.⁴ Recent data indicate a resurgence of STIs in this population,⁵ along with an increase in the reported number of HIV infections.⁶ Rates for chlamydia, gonorrhoea, and syphilis have increased steadily among Toronto youth since 2001;⁷ and are highest among those aged 15 to 19 in Canada.⁸ In fact, Toronto reports higher rates of STIs compared to the rest of Canada. An increase in youth HIV infection rates, especially in adolescent females, coupled with this recent surge in STIs are signs of the potential for the spread of HIV among Canadian youth.⁹

Gaps in sexual health knowledge of youth: Research indicates an alarming gap in the sexual health knowledge of youth,¹⁰ particularly younger teenagers.¹¹ Canadian youth lack comprehensive knowledge of the risk factors associated with unprotected sexual activity and the necessary skills required to ensure the protection of their sexual health.¹² Canadian youth do not consider themselves to be at risk for HIV/AIDS and their overall knowledge base about the disease has declined since 1989.¹⁰ Recent findings from the Gendering Adolescent AIDS Prevention (GAAP) project¹³ revealed several common myths held by Ontario youth about the origin and transmission of HIV/AIDS, including: HIV came from monkeys; urine and saliva can transmit HIV; and you can ‘catch’ HIV from toilet seats. Paul Cappon, Director-General of the Council of Ministers of Education, has described this situation as “alarming.”¹⁴

Our Phase I survey results provide additional evidence that youth have inadequate sexual health knowledge: 7% of TTS respondents claimed to have received no sexual health education at all and over 50% reported that they consult friends on questions related to sex. Given that the sexual health knowledge of youth has declined since 1989¹⁰, coupled with the worrying rise in STI rates, it is doubtful that the information youth obtain from their peers is accurate. Although 62% of respondents claimed to have received sexual health education in both elementary and high school, there was an inverse relationship between the information youth were receiving and what they wanted to know. For example, only 28% of LGBT identified youth wanted to learn more about HIV/AIDS, whereas 45% wanted to learn more about “healthy relationships”. Results like these suggest education differs across groups, but in ways based more on assumptions and stereotypes than the actual needs of youth. It may be that LGBT youth (especially young gay men) have more HIV/AIDS information targeted at them than heterosexual youth (considered to be a “high risk” group), but that some of their “risk” may be the consequence of difficulties negotiating safer sex practices within relationships. This may also have consequences for other groups of youth, who may continue to understand HIV/AIDS as a problem only affecting the LGBT community, with consequences to their own perceptions of vulnerability and subsequent risk taking. We intend to investigate this, and other findings, in more depth in the focus groups and determine what information would be most relevant to different youth populations, and how to integrate various issues (e.g., healthy relationships and negotiating safer sex).

Early intervention: The early teen years are a critical time to provide youth with accessible sexual health education and prevention services. This is the period where first sexual experiences often occur,¹⁵ and where behavioural risk for HIV or STIs occurs. In the TTS survey 5% of 13 year olds reported high risk sexual activity, increasing to 10% for 14 year olds, and again to 22% for 15 year olds (this increased to 72% for LGBT youth). Youth also face conflicting messages about their sexuality. Despite seeing their sexuality used (and even exploited), in advertisements, music videos, television

shows, and movies, youth are often solely provided abstinence messages. In the TTS, 19.9% wanted to learn more about communicating about sex, and 25.4% of respondents wanted to learn more about healthy relationships (including how to negotiate safer sex, when to initiate sexual relations, and what is “acceptable” behaviour within relationships). Access to accurate information regarding STIs, HIV, pregnancy, and sexual health services is crucial for healthy sexual development in youth. For TTS survey respondents, only 62% had learned about HIV/AIDS in any forum, and only 56% about sexually transmitted infections; 23% and 19% (respectively) indicate that these topics are among the top 3 things they want to learn more about.

Need to ensure sexual health services meet diverse needs: Health professionals need to find innovative and effective ways of educating young people about sexual health.¹⁶ Toronto is home to more than 80 ethnic groups, speaking over 100 different languages. Nearly a quarter of Toronto youth are living at or below the poverty line¹⁷ and racialized groups are disproportionately poor.¹⁸ Local, as well as global research, indicates that HIV follows patterns of inequity^{19,20} with marginalized groups most at risk. Newcomers from HIV endemic countries face numerous health-related stressors and remain at increased risk of HIV infection in Canada.²¹ In the context of such diverse populations, ‘one size fits all’ STI and HIV/AIDS prevention strategies have proven ineffective in increasing knowledge and changing behaviour among youth.²² As Toronto’s population continues to rapidly grow and diversify, its youth communities will continue to face challenges; consequently, addressing risk factors will become more complex and challenging. The TTS represents the most diverse sample of Canadian youth ever surveyed in a sexual health research initiative; 85.% identify as non-white, 34% are born outside of Canada, 7% identified as LGBT or questioning their sexuality, and 10% Muslim (all of these groups were identified in service provider consultations as a critically under-researched/served youth population). Our focus groups, drawn from this sample, will provide important insights for diversifying sexual health services.

Generic STI and HIV/AIDS prevention programs targeted at youth, but focussed solely on behavioural change, are often unsuccessful because youth in different communities approach their health differently²³ and broader social determinants of health (such as poverty, racism,²⁴ sexism^{9,25,26} and homophobia^{27,28}) shape risk. While service providers and youth identify many of the same sexual health issues, they often differ in what they consider ideal approaches to these concerns.¹³ As a result, the strategies used by health promoters in public health and community-based organizations need to be adapted in order to provide culturally effective health promotion and prevention services.²⁹ Fortunately, the TTS survey data can help to guide these developments, they will be considerably strengthened (and therefore more useful)_ through more nuanced qualitative exploration.

Inequitable access. Many youth find it difficult to access appropriate sexual health resources. Rates of STIs (including HIV) are higher among street-involved youth,^{30,31} youth in care (criminal justice system and state wards),^{32,33} young men who have sex with men,^{34,35} Aboriginal youth,³⁶⁻³⁸ and young injection drug users,^{39,40}. This is likely due to a combination of systemic factors that shape individual risk and increase barriers to accessing appropriate services and prevention resources. In addition, newcomer youth, racialized youth, and young people with disabilities⁴¹⁻⁴⁴ also report increased barriers to accessing appropriate medical care and sexual health advice. Regarding access to sexual health professionals, worrisome trends emerged in the TTS survey data. First, only 35% of teens aged 13 – 17 currently have access to supportive and relevant sexual health professionals, indicating that access is an overall concern for young people. Moreover, more marginalized groups of youth (newcomers, youth living with disabilities, racialized youth, and sexually diverse youth) indicated the strongest desire and

need for increased access to sexual health professionals. Despite the urgent need to develop focused strategies that attend to these unique vulnerabilities, there is little in the published literature that attends to these diverse needs. Our decision to explore the unique vulnerabilities of under-served groups stems from the dearth of information in the literature attending to their needs and in our interest in finding inclusive strategies. Should there be commonalities across these groups, there is an excellent chance that adopting recommended tactics will also encourage more widespread uptake of sexual health resources.

PARTNERSHIP

For a detailed description of the investigator team and research partners, see (Appendix 1D: Partnership Outline).

METHODOLOGY OVERVIEW

We will use a community-based research approach and work directly with diverse communities of youth aged 13-17. We will bring them together in focus groups to help them identify, assess, and ultimately address their concerns about community-based sexual health services. During these focus groups, we will (a) provide youth with opportunities to reflect on issues emerging from the quantitative survey data; (b) generate community-specific qualitative data that will allow for a more in-depth understanding of emergent themes and trends from the survey data; and (c) solicit general and population-based ideas for program and policy development .

Peer-based, participatory approach. The effectiveness of peer researchers has been established in sexual health research and prevention strategies.^{47,48} Peer-based researcher models provide sensitive and culturally appropriate inroads into “hard to reach” communities.⁴⁸ As youth are often the primary source of sexual health information for their peers,⁴⁹ they should be involved in the planning and development of sexual health initiatives and education strategies.⁵⁰ This approach to research has been proven to be particularly effective for health research with adolescents and youth.⁵¹⁻⁵⁶ Our research on engaging youth as partners in CBR initiatives provides an evidence-base for the efficacy of this model.^{3,24,46,57,58} By involving youth as partners in all stages of our research initiative, we expect to increase levels of youth engagement, empowerment, project sustainability and uptake of data.

Youth Advisory Committee (YAC). YAC currently has 18 active members that come from the diverse communities we work with. They will continue to work closely with the project team. YAC members will be mentored in focus group co-facilitation and in participatory data analysis (Appendix 1E: YAC Training Outline). They will co-facilitate focus groups with the members of the Investigators’ Team who have expertise in focus group facilitation.

Compensation. YAC members will receive a \$100 honorarium for the completion of the training, an additional \$20 honorarium for each focus group facilitated and \$20 for each monthly meeting attended. YAC members will work in pairs and will always be supported by a member of the Investigator Team.

FOCUS GROUP ADMINISTRATION

Participant recruitment. PPT has a considerable range and diversity of current outreach and programming. Last year PPT provided services to over 8,000 youth in Toronto and its surroundings and this year conducted survey sessions with 1,216 youth. During the process of distributing our initial TTS survey, we have been able to access a wide cross-section of youth across Toronto. Participating

agencies have spoken positively about the process and expressed a willingness to continue to partner with PPT and the larger TTS team. Most importantly, they indicate an interest in and enthusiasm for the research findings and their ability to drive programming. Given their interest, we will return to community-based organizations that hosted TTS survey sessions (Appendix 1C: TTS Survey Hosts) and solicit the participation of unique sub-populations of youth in focus groups. In particular, we will seek out agencies that serve youth who experience disproportionate social inequality, health services access barriers and/or STI risk. We will ask these agencies to host the focus groups.

The recruitment process: Our Research Coordinator will contact potential host agencies through a letter thanking them again for hosting a survey session in 2006-2007 and outlining the purposes of this next qualitative phase of research. The letter will be followed by a telephone call or meeting to further discuss the project in detail. These agencies work with specific sub-populations of youth, many run youth drop-in programs and other forms of adult-supervised youth programming. The research team will be in discussion with the host agency about addressing participation barriers; funds have been set aside for translation and facilitation (i.e., in languages other than English, or where hearing and visual impairments pose barriers to participation) and for wheelchair accessible spaces. During our survey administration stage we had great success hiring interpreters who provided simultaneous translation in a number of sessions.

The host agency will post a recruitment flier in advance of the session explaining the project, and may organize a small group of interested participants on the day of the focus group (all of the youth will already have likely been accessing the host agencies services in some capacity). The recruitment poster will be designed with input from the YAC using relevant information from the assent forms. On the day of the survey, the YAC members and the researchers will discuss any concerns youth may have related to the focus groups and facilitate informed consent processes.

Sampling Framework:

Youth groups will be purposively sampled to reflect both population specific and issue based needs, which emerged directly from preliminary analysis of Phase I survey data, including:

- populations that experience increased barriers to accessing sexual health services (as indicated by survey findings)
- populations that demonstrated needs that differed from what is currently available within existing sexual health services (as indicated by survey findings)
- issues (not population specific) which require additional investigation (as indicated by survey findings & consultations with service providers)

To be eligible for participation, youth respondents must consent to participate, must currently live in Toronto, and be between 13 and 17 years of age (Appendix 1F: Consent Form). Based on our experiences conducting survey sessions in community-based settings, we anticipate 6-10 participants in each focus group. The matrix below offers a summary of the focus groups and the kinds of issues we will be exploring which include, but are not limited to:

Proposed Sampling Matrix	- Survey Data and Service Provider Consultation (Areas for Further Investigation)
Sexually Diverse Youth	- 72% of LGBT youth have engaged in high sexual risk, as compared with 28% of non LGBT identified youth.
1. Gay and bisexual youth 2. Lesbian and bisexual youth	- 26% of LGBT youth report problems with drugs or alcohol, compared with 6% of heterosexual youth
Living Situation	- Sexual risk behaviours varied significantly between youth living with parents and relatives (25.7%), those in foster or group homes (31.9%), youth living independently (64.9%), and youth living in shelter or hostel (87.5%).
3. Youth in Care 4. Youth Living Independently 5. Youth in Shelter/Hostels	- Youth in different living situations report varying degrees of knowledge about HIV/AIDS: of those living in foster or group homes (26.4%) or independently (23.4%) report having learned about HIV, vs. those living with their parents or relatives (78.6%).
Immigrants, Newcomers & Non-Status Youth	- Newcomer youth identified ‘parents education on healthy sexualities’ as one of their top 5 mechanisms for ‘helping them get services’
6. Immigrants 7. Refugees 8. Non-Status Youth	- Service providers considered refugee and non-status youth a critical priority, but reported difficulty meeting their needs. How do we create effective services for refugees and non-status youth (issues of insurance coverage, confidentiality, and language)?
Youth Living with Disabilities	- Youth living with a disability were more likely to report high sexual risk behaviours, than youth not living with a disability (ranging from 35.8%-63.6%, depending on the nature of their disability vs. 26% for none).
9. Physical 10. Intellectual 11. Addictions	- Youth living with a disability were more likely to report having been pregnant or impregnating someone else (13.2%-20%, vs 5.6%).
Religion	- Muslim youth named “sensitivity to religion” as part of their top five “wants in a clinic” (7.3%), and under “important things to help get services needed” (7.7%).
12. Muslim Youth	- Muslim youth respondents, cited “fear of parents/caregivers” as their top reason for not attending a clinic.
Ethno-Racially Diverse Youth	- While ethno-racially diverse youth indicated lower sexual risk-taking behaviour, they were less likely to have visited a clinic or be aware of available services.
13. Youth of African and Caribbean descent 14. Youth of Middle Eastern descent 15. Youth of Central or South American descent 16. Youth of Asian descent 17. Aboriginal youth	- White youth received the most sexual health education, while 10% of Asian youth reported never having received any sexual health education (with many youth excused from sex-education classes). - Issues arose in respect to cultural sensitivity and representation in sexual health services and programming, which crossed ethno- racial groups, but each having divergent wants and needs in respect to these issues.
Healthy Relationships	- Healthy relationships were an overarching theme for youth and service providers- there exists a need to create dialogue about the cross-cultural meanings of “healthy” and “relationship”.
18. Mixed group	- Question from youth during survey sessions ranged from when to initiate sexual debut, to treating sexual dysfunction, to effective ways of refusing sexual advances.

Focus group sessions. Focus groups will be consistent in their delivery: each will follow the same procedures and will draw upon similar interview guides (see Appendix 1G: Focus Group Questions). Each session will be co-facilitated by a YAC member and an Investigator Team member with

experience in focus group facilitation. A second YAC member will be present at each session as a note-taker. A maximum 18 focus groups will be conducted, during which we hope to reach approximately 150 youth. This means that each YAC member will participate in approximately two focus group sessions.

YAC members will introduce themselves and seek informed consent. They will begin the session by providing an overview of the project and presenting a five to ten minute explanation of the Toronto Teen Survey and its preliminary results. We will develop tailored PowerPoint presentations for each focus group that highlights data relevant and specific to that group. YAC members will have received training in how to present research findings to their peers; their presentations will be highly graphical in nature as well as interactive. For instance, to ‘warm the group up,’ we may include a trivia or guessing game as part of the presentation. As an additional warm-up exercise, youth will be asked to draw/map their neighbourhoods and highlight spaces where sexual health services and information are offered. They can work alone and/or in groups and will be asked to discuss what they think of those services. Group members will introduce themselves and will be invited to briefly share their maps and how it related to what they heard in the presentation. This initial discussion will provide a shared context for the group from which to proceed. The ensuing discussion will focus on what made sense in the presentation, what surprised them, their own (or friends’) personal accounts of accessing services, as well as specific recommendations that could inform program or policy development/change.

While the majority of questions will be the same across focus groups, others will be tailored to explore the unique issues that arise from the quantitative analysis for each population of youth. The goal of the sessions is to highlight and explore the diversity of youth needs in relation to sexual health. Participants will be offered a “condom wallet” containing sexual health information resources should they have any further follow-up questions and a movie pass gift certificate for their time (Appendix 1H: Resource List).

Informed consent. YAC members will receive additional training on informed consent procedures. Participants will be advised that participation is entirely voluntary, that the information they provide will be confidential, and that data will be coded in a manner that ensures anonymity. Participants will be asked to sign an Assent Form indicating that they understand the purpose and goals of the research and how the information they provide in the focus groups will be used. While we will make every effort to encourage participants to treat information presented in the room confidentially, we will also remind participants to be cautious of sharing information that they do not want their peers to know.

Articles 2.6, 2.8, and 5.3 of the Tri-Council of Canada’s ethical guidelines⁵⁹ articulate the importance of involving vulnerable groups who are often deemed ‘incompetent to consent for themselves’ in research; this is very applicable here given the unique social, cultural, and biological realities of adolescence. For many adolescents, parental notification of their use of sexual health services or contraceptives impedes their continuation of use of these programs, leading to potentially adverse sexual health outcomes.^{60,61} As such, we have successfully made the case to both the University of Toronto and York University Human Subjects Research Ethics Boards to allow youth participants to consent for themselves during the survey administration sessions upon which this protocol builds (Appendix 1I: Ethics Approval). We anticipate that this same arrangement can be extended to this proposed study phase as well.⁵⁷ The model we have used for assuring ethical conduct with youth throughout the TTS⁶² has been described as a “lesson in sensitivity and accountability for all

researchers in adolescent medicine”.⁶³ We hope to continue the development, documentation, and dissemination of best-practices in this important area of inquiry.

DATA MANAGEMENT AND ANALYSIS

i) Confidential storage of audio and written data. Given the risk for potential malfunction or human error, focus group sessions will be taped by two independent audio recorders. Moreover, one of the YAC members will act as a note-taker in each session. All focus group data (and related demographic information of participants) will be transported securely to and from the community sites by the TTS Research Coordinator. Only members of the Investigators’ Team, the project’s Research Coordinator, YAC members and student Research Assistants will have access to data and participant demographic information. When not in use, data will remain in a secure, locked location. When stored on the project’s computer, data will be password protected and/or kept on a computer to which only team members will have access. Data will be backed up and stored on a secure (password protected) portion of the server at the home institutions of the Co-Principal Investigators (York University and the OHTN).

ii) Transcription. All audio tapes will be confidentially submitted to a transcription consultant who will be asked to sign a confidentiality agreement and who will transcribe the audio recordings verbatim for the purposes of coding and analysis. The accuracy of transcription will be verified on an ongoing basis by conducting random and periodic checks of the transcripts against the tapes.

iii) Data coding and analysis. All transcripts will be inputted into NVIVO, qualitative data management software. Several of our research team members have been trained in the use of NVIVO. Coding and analysis of data will commence using the constant comparative method outlined by Strauss and Corbin.⁶⁴ A preliminary coding framework of relevant themes garnered from the literature will be developed prior to conducting the focus groups. This way all preconceived notions and assumptions can be documented in the first draft of the framework. After the focus groups take place, the coding framework will be revised to incorporate themes generated through an adaptation of the constant comparison methods used in grounded theory.⁶⁴⁻⁶⁶ This type of coding will involve the development of codes that describe respondent's accounts of participation in their own words. As codes are developed, they will be applied and compared to newly collected data and will be modified as necessary. Descriptive codes will then be combined to develop theoretical or analytical themes. Coded data will be analyzed and explicitly compared in several primary ways:

- according to general codes, themes and sub-themes
- comparisons will be made between members of the same group with special attention to issues of gender, age, race and ethnicity and sexual orientation (intra-group)
- comparisons will also be made between groups of youth (inter-group)
- maps will be used to provide contextual visual data, coded for common themes

In addition, we will take a phenomenological approach to reading the data by drawing on the stories that youth tell. We will encourage them to provide concrete examples of experiences that highlight both their challenges and successes in accessing sexual health services. Together with our YAC, the Investigator’s Team will collaboratively develop the coding scheme and analyze the data. YAC members will contribute to the analysis by attending sessions pertaining to the focus groups they helped facilitate; this participatory approach will ensure youth involvement in all aspects (from collection to analysis). Notes will be taken during each analysis meeting and summary documents will be circulated to project partners for review and feedback.

iv) Quality control. Because there is no one set of pre-prescribed methods, assessing the quality, validity, and reliability of qualitative data requires clear criteria.⁶⁷ Lincoln & Guba⁶⁸ suggest criteria for assessing the “trustworthiness” of qualitative data. They propose that research be assessed for ‘credibility,’ ‘transferability,’ ‘dependability,’ and ‘confirmability’. A number of different methods will be employed to ensure the quality and trustworthiness of our qualitative results:

- 1) *Triangulation*⁶⁷⁻⁷¹: Triangulation is the process of using a variety of data sources and approaches to understand a problem. In this study, we will be able to triangulate the quantitative survey data with the qualitative focus group data and the experiences of the YAC and research team.
- 2) *Thick description*^{67-70,72}: Careful background case notes of the research settings (participating community-based organizations, including their mission, vision and reach) will be incorporated into the analysis.
- 3) *Member checks*,^{67,68,70-73}: The focus groups in and of themselves are a form of quality control for our survey results. YAC members will also be able to reflect on the analysis.
- 4) *Clear audit trail*⁶⁸⁻⁷²: Clear records and field notes will be kept of all data collection and analytic decision-making points.

Our goal is to collect data that will provide depth and insight into the particular contexts of the youth we are speaking with; it is not to create a representative or random sample. As such, we are not striving for generalizability of our data. By contrast, we want to hear from young people who rarely have a chance to provide input into the services that are meant to reach them (we will be actively seeking out young people who are traditionally marginalized from research, social and health contexts.) As such, our results will provide insights into ‘specificity’ rather than generalizability.

FOCUS GROUPS: STRENGTHS AND LIMITATIONS

Focus groups are moderated discussions to gain insight into people’s shared understandings of phenomena.⁷⁴ They are particularly effective at drawing on collective wisdom because attitudes and perceptions are often developed by our interactions with other people and the environment.⁷⁵ Focus groups allow for group dynamism or a ‘synergistic group effect,’ where group members can draw from one another, build on each others thoughts and experiences,⁷⁶ and re-evaluate their own understandings.⁷⁴ The goal of these facilitated discussions is not necessarily to come to a consensus but rather to allow for a diversity of opinions and experiences to emerge. Interactions are also useful in trying to identify issues that people have difficulty talking about.^{77,78} Our team has used this approach effectively with youth in the past.^{13,24}

In addition, the very process of participating in group discussions can be empowering.^{79,80} Engaging in group discussions can raise the level of consciousness that group members have of themselves and the topic. This can change the group members and the environment in which they interact and can also empower them (especially when dealing with vulnerable populations).⁷⁸ Focus groups have been used as an empowering participatory research strategy in a variety of contexts.⁵⁴ Focus group (FG) methodologies also have their limitations; we highlight them below as well as strategies for addressing them:

FG can sometimes be difficult to organize	We will be organizing the groups through local community settings that work with groups of youth and have already invited us to conduct survey sessions with them.
It is difficult to get a	Our interest is not in getting a representative sample, but a purposively

representative sample	diverse sample with a range of interests and opinions.
Difficult to facilitate particularly when some participants are very quiet and others loud	YAC members will receive training in facilitation and will be accompanied by an experienced member of the research team; during each session, we will also engage in a variety of activities (including drawing and mapping, etc) that will allow for different levels of participation among participants.
FG may silence divergent viewpoints – e.g. group think	We will set very clear ground rules that stipulate our interest and enthusiasm for divergent opinions and will attempt to create a space for youth to feel safe expressing differences of opinions.
FG limit confidentiality	As part of our consent procedures, we will instruct youth to keep our conversations confidential. We will also hand out paper for them to express other thoughts that they did not feel comfortable verbalizing in the group.
FG depend on ability to speak and interact in a dominant language	Funds have been set aside to make accommodations (e.g. hire translators, ASL interpretation, etc) for those that may not traditionally be able to participate. In the past, team members have worked on focus group projects with youth where languages other than English are spoken and where simultaneous translation is provided.

RESEARCH OUTCOMES, DISSEMINATION & ORIGINALITY

Sexual health resources both in Toronto and across Ontario, represent a patchwork of competing policy interests and priorities. There is no singular policy we intend to challenge or alter, but instead propose a broad strategy for improving access to sexual health services for youth. In keeping with our *university-community-policy partnership* approach, and reflective of the complex ways in which sexual health policy is formed- we are taking a “bottom-up” approach to disseminating our research with the intent of affecting sexual health policy.

The process of dissemination has already started as a result of our service provider consultations (recruited from PPTs large referral/partner network), which directly provided front-line staff with preliminary Phase I survey findings. Many of these service providers indicated their intent to take this information back to their home institutions, and to integrate it into practice and organizational policies. PPT is not only our community partner, but provides some of the most innovative sexual health education available (to both youth and service providers from across Toronto) through its training centre that delivers a range of sexual health workshops. PPT is already incorporating findings into its various curricula, and into future organizational priority setting. PPT works directly with Toronto Public Health (TPH) and is formally contracted to provide many of their sexual health workshops (including in high schools). TPH in turn sets the youth sexual health agenda for the city of Toronto, and is in direct communication with other municipal public health units and the Ontario Ministry of Health and Long-term Care. The use of TTS data will improve PPTs curriculum (and the development of future learning modules), with immediate benefits to the Toronto area, and eventually the province and beyond. Furthermore, TPH has been a close partner and contributor in all aspects of this project. A TPH representative is a regular contributor to monthly project meetings and TPH requested multiple meetings with their staff to discuss the findings from our survey and how they can be addressed. The TTS was highlighted in a recent policy briefing to Toronto’s Board of Health, and the research team have meetings planned with senior management in TPH's Policy and Planning Department who oversee sexual health initiatives and set policy direction for the city. This office is directly responsible for 1) providing community health status information and epidemiological services in support of the

planning, monitoring and evaluation of programs, and 2) ensuring that Public Health programs address the diverse health needs of Toronto, are equitable and accessible, and are based on evidence of need, efficiency and effectiveness, and 3) provide policy and technical support to promote optimal health behaviours.

As well, we intend to collaborate with the Toronto District School Board and Ontario Ministry of Education, two important stakeholders we have yet to fully engage with. While bringing together sexual health and mainstream education has traditionally been a difficult task, *we believe the current climate in Toronto schools (increasing gender violence, sexual harassment, and assault) necessitates that educators consider innovative and alternative partnerships and curriculum delivery.*

In addition to contributing to a Toronto-wide sexual health strategy, there exists the potential to set the stage for continued work in other Canadian urban centers. Dr. Flicker and the TTS have been profiled on CBC Radio's "Metro Morning" show in Toronto (original air date February 4th, 2008), and continue to receive strong support through York University and the OHTN. Dr. Flicker is currently implementing lessons learned from the TTS model in Durban, South Africa, through collaboration with the University of KwaZulu-Natal. She is also in the process of forming a Youth Research Interest Group at the CIHR-funded, Centre for Urban Health Initiatives at the University of Toronto, to implement a plan of research with various stakeholders (interdisciplinary academics / students, service providers, and policy makers). This Youth RIG will directly integrate findings from the TTS into future research and policy recommendations. The research team has submitted a Community-University Research Alliance grant through the Social Science and Humanities Research Council, towards implementing the TTS model in five Canadian cities (Montreal, Edmonton, Ottawa, Halifax and Vancouver). The team won the Centre for Urban Health's CBR Award of Merit. Dr. Travers is directly linked to a range of multi-population HIV prevention initiatives across the Province of Ontario, and can share the exceptional knowledge translation models developed by the OHTN- an organization with significant expertise in 'mobilizing knowledge'.

Broadly, our research supports the Canadian government's commitment to ensuring that by 2010 at least 95 % of young men and women are able to reduce their vulnerability to HIV infection⁸¹. The "Leading Together" document, a blueprint for Canada's strategy on HIV/AIDS, identifies "at-risk youth" as prevention priorities. Leading Together recommends prevention programs include age-appropriate information, youth-led initiatives, and directly involving relevant youth serving agencies in the development of HIV prevention/harm reduction resources and interventions⁸². The goal of our research is to develop a model of high-quality, collaborative, practice-oriented research that builds the capacity of youth, researchers, and service-providers to respond more effectively to the needs of youth at risk of STIs and HIV. The implications of this research are broad, and will inform future research and interventions with other "at risk" populations, as well as improve the responsiveness of mainstream services. Our study findings and recommendations will contribute to a body of evidence that will inform youth-based sexual health promotion strategies around the world.

We also propose conducting a roundtable discussion with stakeholders before we produce final 'knowledge products' from TTS data. In these discussions, we will ask stakeholders 'what key messages they would like to see delivered out of our data' (e.g., what's the highest priority, second, third, etc.), 'what forms they would like those messages to take' (e.g., fact sheets, slides, brief reports, etc.), and 'who the credible messengers are that should deliver the messages' (e.g., youth, front-line

service providers, politicians, etc.). From consultation with the OHTN's Director of KTE, we have devised a KTE strategy that includes the following components:

- The Strategy (which will draw upon these data as well as the initial TTS quantitative study) and community reports will be written in accessible language and made available on GAAP and PPT's websites, distributed to members and donors in newsletters and bulletins, and circulated via e-mail on relevant list serves;
- Youth friendly electronic forms of research dissemination that are accessible to youth and in-line with state of the art technology most popular with youth (e.g., facebook);
- Arts-based projects that involve youth in disseminating the research findings through drama, photography and other arts forms popular with youth;
- Results will be disseminated to researchers and health professionals in academic forums and professional conferences, including, but not limited to, the annual meetings of the Canadian Association of HIV Researchers (CAHR); the Canadian Public Health Association (CPHA); and the OHTN Annual Research Conference;
- Manuscript submissions to appropriate peer-reviewed journals for publication;
- YAC members will be encouraged and supported to attend conferences and participate in presentations, especially when presenting the research process or results to other youth;
- A communications plan will also be developed to attract the attention of local print-based media, including newspapers, websites, and teen magazines;
- PPT will develop training modules for service providers on how to improve and target sexual health services for diverse groups of youth.

There is clearly a need for research which focuses on barriers and assets regarding sexual health services for diverse groups of youth. This research will be greatly enhanced by the use of a community-based approach which ensures that the key stakeholders in this research, youth, are involved in a meaningful manner in each step and phase of the project.

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