

**WOMEN'S STORIES OF ACCESS:
SEXUAL HEALTH EDUCATION AND SERVICES IN YUKON**

by

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Abstract

This research explored five women's life stories of access to sexual health education and services in Yukon using a narrative approach. The narratives represented the experiences of the women and the meaning they derived from their experiences. The primary research question was: What are women's stories of sexual health education and services and how have these stories affected their sexual health and overall well-being? The themes were organized into three main categories: Sexual health education in Yukon schools and sexual health services and supports in the community; challenges associated with limited access to sexual health education and services in the schools and community; and dreams for the next generation. Three metathemes were interpreted from the narratives: Trust, Accessible Sexual Health Education and Services, and Desire for Positive Change.

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Chapter One: Introduction

Research Significance

Women in Canada often struggle to have their reproductive rights honored and upheld. Many women in Yukon do not have accessible sexual health education and are therefore not able to be successful health advocates. How do we create accessible sexual health education for women in Yukon? What does ‘accessible’ mean in the context of this study?

This study addresses the dichotomy that exists between sexual health curriculum and services and the ‘northern female student and client.’ When I use the word “accessible” sexual health education and services, I am suggesting that sexual health education and services should be culturally safe, non-judgmental and non-discriminatory (Public Health Agency of Canada, 2008). In order for sexual health education and services to be accessible, the educator, student, and healthcare provider should ideally receive comprehensive training. In this research study, I have conducted narrative research, with the goal of contributing to the development of accessible, culturally safe, non-judgmental and non-discriminatory sexual health education and services in Yukon.

Based on the research completed in other provinces and from my own front-line work, there appears to be a need to better understand the barriers northern women face when accessing sexual health education, specifically addressing the negative side effects faced by northern women as a result of limited accessibility. Although studies have been conducted on similar topics in northern communities in northern British Columbia (Browne, Fiske & Thomas, 2000), there is little research about the effects of women’s limited accessibility to sexual health education in Yukon.

From my experience as a former sexual health educator in Yukon, it is clear that there are many barriers for women in Yukon, which impede their ability to access sexual health education and services. Some barriers include; culturally irrelevant/insensitive education materials; imported knowledge to small rural communities from urban centers in the south which have led to sensitivity issues; health-illiteracy; limited follow-up after presentations and workshops by sexual health educators and sexual health service providers; breaches of confidentiality by local healthcare workers; and limited anonymity for students and clients. Often sexual health educators and service providers arrive from another community and workshop participants and students do not ask important questions because there is little trust or comfort with the outsider who is presenting. Without trust and comfort, there is little to no knowledge sharing between the educators and the learners, which limits the overall success rate of preventative care.

Purpose of the Study and Research Questions

The purpose of this narrative study was to better understand the situation and experiences of women accessing sexual health education and services in Yukon. Accessibility to sexual health education and services was generally defined as the barriers that currently exist, which limit women's ability to access sexual health education and services.

The barriers, which have created perceived accessibility issues, have in turn lead to a gap in knowledge and knowledge sharing. This research begins to address the gaps in knowledge by using a narrative approach, exploring the stories of women's life experiences within the context of their ability to access sexual health education and services in their communities and in schools. The research question guiding this study was: What are women's stories of sexual health education and services and how have these stories affected their sexual health

and overall well-being? Secondary questions included: How do women describe culturally safe, non-judgmental and non-discriminatory sexual health education and services? What would women want to see implemented in current sexual health education and services to improve overall well-being and quality of life for women in Yukon?

Researcher Context

My interest in this topic stems from my previous experience working as a Human Immunodeficiency Virus (HIV) and Hepatitis C (HCV) community health promotion worker for a local non-government organization. I was responsible for presenting sexual health education workshops in all Yukon communities. I presented workshops in schools, First Nations' government offices, and community centers across Yukon. It was during this time that I began to see accessibility issues in the way that the services were delivered and I became concerned with the limited accessibility First Nation and rural students, specifically women, had to sexual health education. I wanted to hear the stories of women who have been educated in Yukon. How did their sexual health education contribute to the lives they are living today? Did the information received in school prepare them and empower them to make responsible choices about their reproductive health? How can we improve the delivery of this information?

Theoretical Lens

Feminist Theory. Feminist theory's primary focus is to understand gender inequality, valuing the lived experiences of women and their stories of oppression in the social, political, economic, private and public spheres. Women's experiences are not universal and many women have different experiences and diverging understandings of oppression (Miles, Rezaei-Rashti & Rundle, 2001). "Feminist theory cannot explain the world for all women at all

times” (Miles, et al., 2001, p. 3). Feminist theory has moved away from universal claims and has moved towards the local and specific experiences of women, but encourages collaboration by collectively speaking out against inequality. I use feminist theory to examine the inequalities faced by women in relation to their experience of access to sexual health education and services, recognizing that women are more likely to experience subordination and oppression because of their gender (Elliot & Mandell, 2001). Women who are marginalized as a result of their class and race often face even greater barriers.

Feminism. It is difficult to define feminism as it takes on different meanings for many women. “A central problem within feminist discourse has been our inability to either arrive at a consensus of opinion about what feminism is or accept definition(s) that could serve as points of unification” (hooks, 1984, p. 25). In many ways, feminism is mobile, diverse, and unrestricted addressing issues such as sexuality, body image, violence against women, racism and classism (Miles, et al., 2001). hooks (1984) attempted to define feminism by stating,

Feminism is the struggle to end sexist oppression. Its aim is not to benefit solely any specific group of women, any particular race or class of women. It does not privilege women over men. It has the power to transform in a meaningful way all our lives. Most importantly, feminism is neither a lifestyle nor a ready-made identity or role one can step into (p. 18).

Feminism can be viewed as a cluster of theories, which attempt to see the world from an equality seeking, women’s perspective (Miles et al., 2001). More broadly feminists agree that women’s oppression is the most widespread and deepest form of oppression, along with being the hardest to eradicate (Elliot & Mandell, 2001). Feminism suggests that inequality and oppression stems from patriarchy. Patriarchy keeps women in subordinated and exploited

positions in the economic, social and political spheres. Feminism encourages collaborative and innovate ways of transforming society through awareness, self-knowledge, courage, commitment, and transparency, placing value on personal experiences, talents and skills. Largely feminism is about, “joining together in support of each other to make our voices and the voices of those who have been silenced heard” (Miles et al. 2001, p. 2).

Indigenous Feminism. Indigenous Feminism is not an offshoot of Feminism, but has been a part of many Indigenous cultures far before western feminism was introduced. It is important for me to define Indigenous Feminism, as some of the participants describe themselves as Indigenous Feminists, making it essential that I introduce this concept. I am not Indigenous therefore I cannot use Indigenous Feminism as my lens, but it has nevertheless shaped this study through my sensitivity to an Indigenous perspective. It is essential that we have culturally relevant education in the North. In order for this to happen, there must first be space for meaningful discussion. Therefore, I could not overlook the Indigenous Feminist lens to better position myself as a non-Indigenous researcher conducting research with northern women, some of whom have First Nations heritage.

“When a bunch of white women sit around decrying racism in a space where there are, suspiciously, no women of colour around to lead and shape that dialogue, it quickly becomes clear who the space is geared towards” (Klein, 2011, p. 175). The process of defining Indigenous Feminism remains controversial as Indigenous women and women of colour view feminism as a ‘political and academic movement,’ which addresses problems of the white middle class woman, not the Indigenous or coloured woman (Suzack & Huhndorf, 2010.) There has been active involvement in the second and third wave feminist movement

by Indigenous women and women of colour, however academia still remains largely white-centered.

Klein (2011), an academic, expressed her frustration about the gap between women who are out on the streets trying to survive and the academics that theorize about the state of those on the street. Klein recognized this dichotomy when she found herself in the presence of a woman who was not an academic. Klein found that she was unable to communicate with her companion because she felt that anything she said would be academic jargon and not understood. She was very frustrated with herself. Could she no longer communicate with those outside the academy?

All I can hope for in the work that I do is to attempt to kick a couple of stones into that gap between the academy and the community and listen to them rattle around until they hit the bottom, hopefully contributing just a little bit to filling the gap. (Klein, 2011, p. 176)

Many Indigenous women find fault in the feminist movement because during colonization, Indigenous women were forced to acquire western gender roles and patriarchal structures. Those who struggle for gender equality in Indigenous communities are sometimes criticized for going against traditional norms. “Consequently, feminist research and politics often appear to be irrelevant to the concerns of Indigenous communities and may even seem to be implicated in ongoing colonial practices” (Suzack & Huhndorf, 2010, p. 15). LaRocque (1996) an Indigenous Feminist, responds to this dilemma of feminism going against traditional norms by stating, “although traditions help us retain our identities as Aboriginal people, as women we must be circumspect in our recall of tradition. We must ask ourselves whether and to what extent tradition is liberating to us as women” (p. 14).

And then I learned about the history of Europe—that as Christianity moved north, midwives, nurses, and so called “witches” were sought after in a campaign of genocide—about four million women were killed by European leaders. So the reason that European men could do this to our people is because they had already cut the umbilical cord in their homeland. (Yee, 2011, p. 17)

It is apparent that there are many diverging perspectives on Indigenous Feminism even within the Indigenous Feminist movement. It is impossible to provide one definition of Indigenous Feminism because Indigenous women’s experiences vary from community to community due to their distinct histories and cultures.

Patriarchy is so ingrained in our communities that it is now seen as a ‘traditional trait,’ and a key to Indigenous Feminism must therefore be to make visible the ‘internal oppression’ against women within our communities as well as in the dominant society. (Blaney, 2003, p. 153)

Indigenous women have a similar colonial history and Indigenous Feminism, which “centers on the fact that the imposition of patriarchy has transformed Indigenous societies by diminishing Indigenous women’s power, status, and material circumstances” (Suzack & Huhndorf, 2010, p. 10). It is important to recognize the importance of community in Indigenous Feminist movement.

While feminists are concerned with the situation of women, Indigenous Feminists are concerned with the situation of an entire community. Most, if not all, Indigenous Feminists share the common goal of restoration... of language, culture, traditional roles, balance amongst the sexes and balance amongst the generations... restoration with the intention of moving forwards. (Formsma, 2011, p. 151)

Ashling Ligate is a non-First Nations person who was raised on the lands of the Six Nations of Grand River Territory, and Krysta Williams is an Indigenous Feminist and member of the Turtle clan from Moravian of the Thames First Nation. They have learned a lot from each other and were able to create a safe and trusting environment for learning in the academy. The research suggestions Ligate and Williams (2011) made helped guide me through this research. The challenge of translating my academic theory into personal lived experiences, made the research process real. Ligate and Williams (2011) state that the researcher should never tell the participant that their story is “interesting,” but suggest honouring their stories by researching and learning about their community (p.159). I tried to acknowledge that every story was someone’s lived experience and I opened myself up to empathize with the participants’ pain and struggles, always understanding that feminist education and learning about oppression is a life long journey. Ligate and Williams (2001) emphasize that researchers should recognize that “despite everything, communities that are labeled as ‘oppressed’ are still vibrant, alive and thriving in whatever way they can” (p.161-162). Finally, they suggest that we need to honour the lived experiences of our participants, acknowledging that their “stories are real and they live them every day” (Ligate & Williams, 2001, p.163). By keeping the above information in mind throughout the research process I was able to conduct meaningful research that promoted trust between the participant and myself as researcher, which in turn allowed the study to live.

Cultural Safety. This concept refers to cultural safety as it pertains to Indigenous people. This lens comes from New Zealand and was implemented into nursing curriculum and practice in 1992 when a national study revealed the direct relationship of poor health

outcomes of the Maori patients and cultural inappropriateness and insensitivity of their health care providers (Smylie, Josewski, & Kendall, 2010).

Cultural safety focuses on the social, structural and power inequalities within the formal education, healthcare, policy and research models that affect the health and experience of Indigenous people when they interact with mainstream institutions. A central component of this lens involves shifting the power of the health care provider to the Indigenous client allowing them to decide what is culturally safe and unsafe (Smylie et al., 2010).

Aboriginal women often face racialized gender stereotyping and discrimination during regular healthcare checkups. An example of this is a client that may have mental health issues and yet is labeled as drunk (Smylie et al., 2010). Often the mental health concerns of Aboriginal people can be directly linked to trauma and intergenerational trauma¹ of the residential school experience. The residential school experience has left those affected with feelings of mistrust, alienation, and loss of identify. Western institutions and healthcare practices often re-traumatize Aboriginal people creating extremely unsafe conditions. That being said, there are key elements that healthcare providers can do to achieve cultural safety (Smylie et al., 2010).

Key elements of achieving cultural safety are ensuring the researcher, healthcare provider, policy analyst and educator have a strong understanding of the colonization of Aboriginal people, particularly the relationship between the residential school experience and (intergenerational) trauma. There must also be an understanding of how government practices have continued to perpetuate health disparities and inequalities for Aboriginal people. Mainstream institutions need to focus on relationship building with Aboriginal

¹ Trauma from residential schools was often unconsciously passed down from parent to child. Therefore, children of residential schools often experience very similar mental health issues as their parents.

community leaders such as Elders and healers, along with respecting the diversity of Aboriginal people such as their unique cultures, languages and history. Finally, service providers and educators need to communicate in culturally safe ways, by limiting technical jargon, which only increases the distance between clients and providers (Smylie et al., 2010). Cultural safety occurs when healthcare providers, educators, policy analysts and researchers are trusting, understanding, respectful, honest and empathic and when Aboriginal clients are given the opportunity and space to decide what a culturally safe practice is.

Summary

The researcher has a responsibility to bring about awareness towards community-level stories that do not always find a home in the academic sphere (Denzin & Lincoln, 2008). As I collected the narratives, I attempted to negotiate smooth transitions from question to question and provide ways to be useful to participants. A goal will be to determine how this research will benefit others and how sexual health education for women in Yukon can be improved. My role as a researcher was to observe, spend time, with and collaborate with participants in a non-exploitive, culturally safe, respectful manner. I am reminded of Elder Angela Sidney's words, "I have no money to leave to my grandchildren. My stories are my wealth" (Cruikshank, Sidney, Smith & Ned, 1990, p. 36). Sidney's words remind me to ask for permission before embarking on an extensive study ensuring not to exploit another people's history, traditions and way of life. Creswell (2007) suggests that the following questions be asked: "Who owns the story? Who can tell it? Who can change it? What happens when narratives compete? As a community, what do stories do among us?" (p. 57).

Chapter Two: Literature Review

The struggles that Yukon women face in relation to accessible sexual health education and services are multifaceted. First, this chapter introduces literature that broadly defines overarching concepts such as health, sexual health, sexual rights, sexual health education, and guidelines for sexual health education. Second, sexual health issues specific to Yukon are highlighted, such as accessibility to contraception, abortions, sexual health education and services, violence against women, and the residential school experience.

Women's Empowerment and Gender Equality

Wellness is directly connected to empowerment. If a woman is in poor health she may feel disempowered, likewise if a woman is disempowered, her overall health and well-being is at risk. "Twenty percent of the global burden of women's health is related to sexual and reproductive health problems" (Black, Bucio, Butt, Crangle, Lalonde, & Dupuis-Leon, 2011, p. 4). Empowered women are those that have equal access to education, healthcare, financial options, and employment. All too often women worldwide are limited by discrimination, power imbalance and systemic inequality (Black, et al., 2011).

Woman experience disempowerment as it pertains to reproductive rights and access domestically and internationally. Many women struggle with unwanted or ill-timed pregnancies and struggle to access family planning. Young women across the globe have disproportionately higher levels of HIV and STIs and represent 62% of youth ages 15 to 24 living with HIV/AIDS (Black, et al., 2011). Women face higher levels of violence and exploitation including domestic violence and sexual violence. They also experience a lack of appropriate reproductive health services and education, which is done directly and indirectly by withholding valuable information as it relates to sexual health (Black, et al., 2011).

Improving sexual and reproductive health through women's empowerment and gender equality entails defending and upholding sexual and reproductive rights. This can be accomplished by improving access to sexual health education and services; improving access to health information and care; limiting discriminatory practices as it pertains to women and sexual health, and promoting culturally safe environments for minority populations; encouraging men's engagement in tackling inequalities faced by women; implementing legal and policy changes to promote sexual health education and access; encouraging zero tolerance of violence against women (Black, et al., 2011).

Women's empowerment and reproductive rights can be effectively implemented into the work of health professionals. This can be accomplished by insisting health professionals become familiar with underlying social, economic and cultural factors that have caused poor sexual health outcomes; ensure all women have equal access to services, which treat everyone with respect, despite their cultural background, religion, age, disability, and socioeconomic status; develop culturally sensitive and safe environments; provide community based sexual health education for those who are no longer in the formal school system; recognize and provide appropriate referrals for situations of violence against women; change attitudes to develop greater respect and empathy for women (Black, et al., 2011).

The Right to Health

The World Health Organization (WHO) defines health as, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1946). Sexual health is integral to someone's overall well-being; however, this is often overlooked and seen as a separate component to health. Anishnabe teachings state, "Good health is a gift from the creator and it comes with responsibility to care for it...Good health is

a balance of the physical, mental, emotional and spiritual elements. If we neglect one we are out of balance and our health suffers (Deiter & Otway, 2001, p. 10). The Anishnabe teachings propose that sexual health is multidimensional.

The right to health suggests that individuals should have access to basic health, preventative care, treatment, and access to medication (Black et al., 2011). Sadly some people are not in a position to exercise their right to health, specifically those who face poverty and discrimination.

Sexual Health

Similar to the definition of “health”, the Canadian Guidelines for Sexual Health Education defines “Sexual Health” as,

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality...Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. (Public Health Agency of Canada, 2008, p. 5)

A wide range of factors, such as sexual behaviour, societal attitudes, and genetic predispositions influences sexual health. In addition, sexual health is influenced by physical illness, mental health, and violence (Public Health Agency of Canada, 2008). Sexual health can only be maintained when the sexual rights of the person are respected and upheld, meaning they have equal access to sexual health education and services and do not face discrimination or dangerous practices.

Sexual health issues were identified by Aboriginal women in a handbook put out by the Aboriginal Nurses Association of Canada suggesting that living in small communities,

racism, and cultural insensitivity create barriers for women and as a result women do not get the sexual health care needed (Kinnon, Swanson, Wilman, Belcourt, Manitowabi, Foreman, Norris & Harrison, 2002). The handbook goes on to say that women who are marginalized and poor feel like they have little say in their sexual health and well-being (Kinnon et al., 2002).

Suggested ways to support Aboriginal women in becoming more sexually healthy are recognizing and honouring women's traditional leadership roles; valuing motherhood; develop culturally sensitive sexual health curriculum that values local traditions and culture; use healing circles as ways of supporting Aboriginal women; expand services to include rural and remote areas; and ensuring that Aboriginal women have access to information about birth control, abortions and birth (Kinnon, et al., 2002).

Sexual Rights

Sexual rights are closely connected to human rights and should be upheld by national and international human rights procedures. Sexual rights suggest that all people have the right to a high standard of sexual health, which includes access to sexual health care services; access to sexual health education; consensual sexual relations; ability to pursue a safe and pleasurable sexual life; and an ability to decide to be sexually active or not (Public Health Agency of Canada, 2008).

Sexual Health Education

Sexual health education should equip individuals, families and communities with accessible information and skills to enhance sexual health (Public Health Agency of Canada, 2008). A person's ability to make safe and informed sexual and reproductive health decision depends in large part on access to education. Lack of access to education can prevent people

from seeking safe and healthy options. If women are not told about various forms of birth control they may not ask their doctor about the appropriate one for them; if people do not know about confidential STI testing they may not seek out clinics that can administer the tests; if women do not know about prenatal care they may not seek out these services (Black, et al., 2011).

Sexual health education should be a community-supported initiative involving individuals, families, teachers, health professionals, social workers, justice system, etc. Local social and cultural values should also be taken into account in the delivery of these services. Effective sexual health education allows for nondiscriminatory dialogue, which respects individual's beliefs and should not exclude anyone based on "age, race, gender identity, sexual orientation, socioeconomic background, and physical/ cognitive abilities" (Public Health Agency of Canada, 2008, p.5).

Sexual health education is a sensitive topic to teach, especially if you are a visiting professional to a community that is not your own. The following are some barriers Aboriginal people face in relation to sexual health: lack of respect between the client and the health professional; lack of trust between client and health professional; inaccessible language along with complicated handouts; programs that only deal with one issue such as HIV instead of taking a multidisciplinary approach; and programs or workshops that miss crucial contextual information (Kinnon et al., 2002). An example would be a pregnant teen who does not have a place to live, let alone make critical decisions around sexual health (Kinnon et al., 2002).

It is very important to foster a respectful, trusting environment before delivering sexual health education. This can be accomplished by learning about the community from Elders

and community leaders; keeping an open mind; becoming a resource to the community and allowing them to make educated decisions, and by working with the community to improve knowledge and skills. Often people are hesitant about seeking advice about sexual health; as a result it is important to ensure to keep workshops and teaching broad. Awareness of the effects of residential school on the community is a crucial element. It is also important to consider that change happens over time; that communities identify their needs, not people from the outside; and that the use of a “culturally safe” approach that has been approved by community members first, remembering that each Aboriginal community is different (Kinnon, et al., 2002).

The Right to Privacy

Sexual health can be very personal and sexual health issues are often stigmatized. When clients feel afraid that their information may be shared, they may delay or avoid seeking medical advice. Clients need to feel safe and secure when accessing health services. This can be challenging in a small community where health professionals may be doing their best to ensure services are secure, but clients may know the health professionals in the clinic and be deterred to access care for fear of being judged (Black, et al., 2011).

The Right to be Free from Discrimination

Women are subject to discrimination because of their gender and are more vulnerable to harm from additional forms of discrimination. “The discrimination that women endure becomes even more compounded when other factors, such as poverty, race, ethnicity, marital status, sexual orientation, or religion play into the equation as well” (Black, et al., 2011, p. 14). Women know their bodies and their situation better than anyone else and should feel empowered to have a say in decisions about their health. Discrimination takes away women’s

ability to make decisions about their health and instead places this power into the hands of the health professional who does not necessarily have an understanding of the difficulties their client is facing. “No one – husband, leader, relative, or doctor has the right to discriminate against women and decide what is best for them” (Black, et al., 2011, p.14).

In May 2009 the United Nations Declaration on the Rights of the Indigenous Peoples formally recommended “...to fully incorporate a cultural perspective into health policies, programmes and reproductive health services aimed at providing indigenous women with quality health care...and ensure State access to reproductive health services” (UN Economic and Social Council, 2009, p. 4-5). The UN is therefore placing responsibility on countries to ensure that sexual health services are accessible to Indigenous women. This Convention is not legally binding, however since Canada has recently ratified this Convention it has a responsibility to report progress made in this area to the UN.

Canadian Guidelines for Sexual Health Education

The Canadian Guidelines for Sexual Health Education was first published in 1994, revised and republished in 2003 and again in 2008. It was established with three goals in mind. First, to assist professionals with the development and implementation of programs that support sexual health and personal well-being. Second, to provide a framework that evaluates sexual health services in Canada. Last, to offer educators and administrators guidelines to help them better understand the goals and objectives of sexual health education (Public Health Agency of Canada, 2008).

These guidelines suggest that sexual health education should be delivered in a safe environment, and should be non-judgmental and non-discriminatory. The guiding principles of this document suggest that sexual health education should be accessible to everyone

despite their background and should be responsive to age, race, ethnicity, gender, sexual orientation, socioeconomic background, and abilities. "...youth, seniors, sexual minorities, First Nations...individuals who live in geographically isolated areas...require improved and nonjudgmental access to sexual health education" (Public Health Agency of Canada, 2008, p. 19). The guidelines go on to suggest that since formal education systems such as public schools are the only institutions that have mandatory contact with youth, and that accessible sexual health education is essential to their students (Public Health Agency of Canada, 2008).

Sexual health education should also be comprehensive, address diversity, and engage schools, organization and governments. Sexual health education should have effective educational approaches and methods, creating environments that are appropriate for sexual education. In addition, sexual health education should provide training and administrative support, ensuring that professionals have up-to-date knowledge about sexual health and can effectively deliver the material. Finally, sexual health education should incorporate planning, evaluation, updating and social development, which will allow for appropriate changes to occur if needed (Public Health Agency of Canada, 2008).

The guidelines recommend that sexual health education be made available to all citizens, as sexual health is a key component to healthy living. The goals of sexual health education are to help people achieve self-esteem, non-exploitive relationships, self-respect and make informed choices. The guidelines stress the importance of providing effective, diverse, accessible, non-judgmental, and non-discriminatory, far reaching sexual health educations to everyone to ensure that individuals have the skills and resources to be successful health advocates (Public Health Agency of Canada, 2008).

Northern Context

Sexual Health Education in Yukon

According to the Canadian Guidelines for Sexual Health “effective sexual health education should be provided in an age-appropriate, culturally sensitive manner that is respectful of individual sexual diversity, abilities and choices” (Public Health Agency of Canada, 2008, p.18-19). The document is inclusive and very progressive, however how do the guidelines translate in practice? Who uses them and who holds public institutions accountable if the guidelines are not enforced? The above guidelines have not yet been implemented in the formal education system in Yukon (Public Health Agency of Canada, 2008).

The Canadian Guidelines for Sexual Health Education emphasizes the importance of ensuring that accessible education and services are available to persons with disabilities, youth, seniors, sexual minorities, Aboriginal populations and other individuals who live in geographically isolated areas; however, I have yet to see curriculum in the formal school system that reflects the above outlined guidelines. More specifically, the document highlights five principles that characterize effective sexual health education programming. These principles are: accessibility, comprehensiveness, effectiveness of educational approaches and methods, training and administrative support, and finally planning, evaluation, updating and social development (Public Health Agency of Canada, 2008). In my work as a health promotion worker, I witnessed the barriers to sexual health education from the inside. The above principles are far from being met in Yukon, especially in the communities. I cannot speak to community-based knowledge that may have been passed

down from Elders and community leaders, but I can speak to the formal delivery of sexual health education in Yukon schools.

During my time working as a sexual health worker, I was expected to present awareness-based sexual health education to high schools, community organizations and all 14 Yukon communities. It was very difficult to get into Yukon high schools and community schools, requiring permission from the principal of the school, the classroom teacher, and the parents. The parents had to decide whether the information being presented was appropriate for their child. By the time I got into the schools, there were very few students present for the workshops. Sometimes the teachers would sit in on the presentation, which created an uncomfortable dynamic for some students, especially if the teacher interjected with ‘abstinence first’ and ‘pro-life’ philosophies. These interjections were especially distracting and counterproductive when promoting a healthy sexuality/sex positive lens.

Often resources and time are limited and instructors are unable to spend more than one to three days in a rural community at a time, and as a result it is difficult to establish trust and respect. Generally, there is not enough time for community students to develop a sense of trust in order to ask the sensitive questions they may have. I am not aware of any train-the-trainer models developed to educate educators in the community allowing for the knowledge to stay in the community.

As noted in the above guidelines, it is important to provide accessible and comprehensive sexual health education. Yukon has a long way to go in this area and much work must be done to ensure everyone has equal access to accessible, inclusive sexual health education. With any program we need to see resource allocation so program improvement so development can occur.

Sexual health education is multifaceted and services in the community must also provide accessible, comprehensive sexual healthcare. It is not simply the formal education system that is failing to provide sexual health education. Government departments and hospitals also need to be held responsible for barriers to care and access. This is a multifaceted community issue, which requires support of all sectors of the community. Health clinics, nursing stations, and hospitals need to have appropriate services, which contribute to the overall reproductive health of the community. The following sections examine the gaps in services, which have contributed to potentially negative health outcomes and barriers to education in Yukon.

Access to Contraception

“...reproduction has always been a place where racial inequalities have been institutionalized, where the control of women by men has been constantly reaffirmed, and where the wealthy have been valued over the poor” (Eldridge, 2010, p. 6). Birth control is expensive and many women, especially young and low-income women cannot afford it. The government has no policies in place to subsidize birth control. Where does this leave women? Where does this leave women in the Yukon who have limited abortion services? Women’s reproductive health rights are not always being met. Who is to be held accountable?

Inaccessible birth control is not unique to Yukon. “The WHO estimates that around 123 million women want birth control and don’t have access to it” (Eldridge, 2010, p. 306). Women around the world struggle to educate themselves on birth control options. They then struggle to access the birth control option they desire. For example will their doctor prescribe it to them? Can they afford it? “Building reproductive freedom, including the ability to make contraceptive decisions, means working to give women the right to make individual choices

about pregnancy” (Eldridge, 2010, p. 6). Many advocates argue that women should be allowed to make informed decisions about birth control, but many health professionals and health care institutions are resistant. Seeking out birth control options is no easy task, “It can mean dealing with painful cultural histories, standing up to doctors you respect, partners you love, and a culture that can make us feel like we aren’t in charge” (Eldridge, 2010, p. 8).

Yukon has the highest abortions rates in the country, suggesting that Yukon would benefit from improved access to diverse, subsidized, contraceptive options.

Abortion Services in Yukon

To claim one’s sexual agency any woman has to believe that she can be responsible to herself and to her body in ways that both enhance her capacity to experience sexual fulfillment and her ability to be protective so as to diminish the likelihood that she will ever be sexually victimized. (hooks, 2003, p. 143)

Yukon has some of the highest abortion rates in the country, yet does not have an abortion clinic or sexual health clinic (Johnston, 2008). Yukon has one abortion doctor for all Yukon clients. Yukon has 14 communities and as a result women from the communities experience geographic disadvantages. Yukon does not have a self-referral process and at times women run the risk of asking a pro-life doctor for a referral that may lead to bias counselling. The process is extremely time-consuming compared to other jurisdictions. “The whole process takes about four days, including pre and post-op care” (Yukon Government, *Yukon Health Guide*, 2005, “Information about abortions,” para 1-5).

Abortions are performed in the O.R. at the hospital and the room can only be booked on certain days and in certain time slots. This leaves little time for counselling. If a woman has difficulty getting to the clinic from one of the communities and misses her appointment it

may be difficult to rebook. The Northwest Territories does have a women's health clinic where pro-choice doctors perform abortions. Women can contact the clinic directly to make an appointment without going through their family doctor. Medical and surgical abortions are performed in the clinic. Women can also receive counselling before and after the procedure. Finally, women have access to birth control counselling and access to birth control at the clinic. I would like to quote directly from the clinic website as it demonstrates the inclusive nature of the clinic.

Northern Options for Women (NOW) is a program dedicated to making reproductive choice and abortion services available to women in the Northwest Territories and Kitikmeot region of Nunavut. Our mission is to provide accessible, patient centered, non-judgmental, evidenced based, safe abortion care. We are a team of committed, trained, and experienced doctors, nurses, nurse practitioners and support staff who believe in a woman's right to reproductive choice in a compassionate and confidential environment. Our staff all have specific training and experience in abortion care and counselling, and are dedicated to providing these services in an atmosphere of respect and support. We welcome all women, regardless of age, religion, ethnicity, sexual orientation, national origin, marital status, family status, and mental or physical disability. (Northern Options for Women, 2013, "Welcome," para. 1-4)

Yukon would benefit from having a sexual health clinic where women could access abortions and reproductive health related services. Considering Yukon has high abortion rates, a clinic seems necessary in order to meet the basic needs of clients. Effective preventative measures such as non-judgmental, non-discriminatory sexual health education

delivered in a culturally safe environment may also be an effective way of reducing high abortion rates in Yukon.

Community Nursing Stations

Women who are in need of sexual health and reproductive care do not always feel comfortable accessing their local health centre or nursing station. Although the health centers and nursing stations must uphold a high standard of confidentiality, those who are employed at the nursing stations and health centers are usually community members who may be relatives or close friends of the client who may be seeking care. Nurses who are hired from outside are sometimes better able to address the need for anonymity, however they could be perceived as an “outsider” so a different barrier is presented in terms of community trust. Questions asked include: “Who is this person? Are they First Nations? Will they judge me and my culture?”

Violence Against Women in Yukon

No matter how young or old, most of us know, or learn the hard way that our true stories of rape and sexual harassment tend either not to be believed or deemed unworthy of serious attention, especially if the culprit is someone close, a family member, a boyfriend, or just the man next door. (hooks, 2003, pp. 40-46)

One in three women worldwide is a victim of violence (beatings, rape, torture or attack). When female victims of violence are under the control of their partner, they are sometimes unable to make decisions about their sexual and reproductive health and well-being and as a result are at increased risk of poor sexual and reproductive health (Black et al., 2011).

Violence is often invisible and can be inflicted on victims in less obvious ways, such as by a medical professional or in any situation when a person has power over another. People place

enormous amounts of trust in health professionals, which can place the client in very vulnerable situations. Health professionals should "...take extra care in learning to recognize the signs of violence, as well as to familiarize themselves with the resources available in the area, in order to facilitate referrals to service providers who can offer the woman assistance and or shelter from such abuse" (Black, et al., 2011, p. 17).

Violence against women is particularly problematic in Yukon. The Yukon Health Status Report (Yukon Government, 2009), states that sexualized assault and male-violence against women is two to three times higher in Yukon than any of the provinces (p. 23). In 2003/04, at least 388 women and 219 children used shelters for abused women in the Yukon, and shelter use on a single day was between three to ten times higher in the territories than elsewhere in Canada. Acts of spousal assault against women are more likely to result in physical consequences for victims than assaults against men (Yukon Government, 2009). A violent community is an unhealthy community. Healthy relationship training, violence prevention workshops, sexual health education delivered in a culturally safe environment for both men and women may improve the overall health and wellness of those living in Yukon.

The Residential School Experience

It would be neglectful to overlook the devastating effects of residential school on the First Nation people of Yukon. Many First Nations children that attended residential schools experienced physical, emotional and sexual abuse, which affected their physical, emotional, mental, and spiritual well-being and the well-being of their children and grandchildren.

When Europeans arrived in Yukon, they decided that the First Nations people of the north needed to become "civilized." They completely overlooked the sophisticated systems that already existed, which allowed First Nations to govern, educate and live peacefully with each

other. In 1911 Choulta Residential School was opened in Carcross, followed by the Baptist Mission School in Whitehorse, the Lower Post Indian Residential School near Watson Lake, and the Catholic and Anglican Hostels in Whitehorse. In 1920 it became mandatory that all Status First Nations attend these residential schools (Clarke, 2009).

The students that attended these schools lived in appalling, inhumane conditions and were denied regular contact with their families, were given limited education, and few life skills. They were taught that their culture, language and traditions were inferior to white Europeans. Many children in residential school forgot the language and customs of their parents. When they left the school and returned home, they could no longer communicate with their parents. Many suffered from low self-esteem and posttraumatic stress disorder (PTSD) and were confused and ashamed of their culture and identities. Many felt they did not belong in their community or in the dominant white community leaving them without a home. “You feel lost when you come back, you know. You don’t know Indian way or white man way; just stuck in the middle” (Clarke, 2009, p. 82). Without the youth, First Nations communities began to fall apart and the trauma of residential school has been passed down from generation to generation. Residential school has had a direct impact on First Nations overall health, and sexual health in particular (Kinnon, 2002).

[At the] Yukon Arts Centre a year ago...We came around the corner not thinking anything of it, and both of us saw white nighties hanging there in the air and a pile of dirt underneath...Both of us stopped dead, we couldn’t even breathe for about...60 seconds – we both stopped dead. We, we saw this thing...because white nightie to us is not a good thing. (Clarke, 2009, p.90)

The sexual violence and abuse inflicted on children in residential school remained and for some still remains an untouchable subject. For many, healthy sexuality and parenting skills were lost at residential school. Women, men, parents, grandparents and children find it hard to talk about sexual issues because of embarrassment and painful memories; many parents have not had access to sexual health education and cannot pass these teachings down to their children. It is difficult for members of many generations of First Nations people to make informed decisions about sexual health because there are few positive role models or resources available in their communities (Kinnon, 2002). It is essential that sexual health educators and service providers are aware of the residential school experience and the negatives effects it has had on generations of Yukon First Nations.

Summary

Yukon women have limited access to sexual health education and services compared to women in other jurisdictions. There are many barriers to access such as limited rural community sexual health education outreach; issues of anonymity, especially in smaller communities; access to birth control, and access abortion services. The Canadian Guidelines for Sexual Health Education highly recommend that sexual health education should be accessible, comprehensive and culturally appropriate. Yukon's sexual health education does not uphold the recommendations outlined in the Canadian Guidelines for Sexual Health Education. What does this mean for Yukon women? The combination of limited educational outreach and limited sexual health services leaves Yukon women in a highly vulnerable situation.

Chapter Three: Methodology

Introduction

“We are the storytelling species. Storytelling is in our blood. We think in story form, speak in story form, and bring meaning to our lives through story” (Atkinson, 2007, p. 224). Statistical data provides a general numerical analysis; however, the voices and stories behind those numbers often go untold. In Yukon, most of the information and knowledge is limited to statistical based analysis; this research project focused on the stories of the women and their encounters with sexual health education and services in their community. This chapter explores qualitative research, narrative analysis, the interview, restorying and the evaluation process.

Qualitative Research

Stories give us insight into the lives of others; they allow us to connect on a more human level. We do not have this luxury with numbers. Qualitative methodology was chosen in order to generate descriptive information through personal stories. I wanted to move beyond numbers and graphs and hear the lived experiences of women in our community. Stories are our lifeline. Stories connect us to the rest of the world, allowing us to be a part of something larger than our individual lives. Qualitative research seeks to understand a research topic through the perspectives of the local population it involves. Additionally, it is effective in obtaining insight into participants’ attitudes, opinions, behaviors, value systems, concerns, motivations, aspirations, culture, and lifestyles (Elliot, 2005). The strength of this form of research is its ability to provide written descriptions of how people experience the given research issue. It provides valuable information about the “human” side of the topic.

“Qualitative methods are also effective in identifying intangible factors, such as social norms,

socioeconomic status, gender roles, ethnicity, and religion, whose role in the research issue may not be readily apparent” (Elliott, 2005, p.1). Qualitative research is inherently multimethod in focus, using multiple voices, perspectives, points of view and angles, moving the text from the “personal to the political, from the local to the historical and cultural” (Denzin & Lincoln, 2008, p.7). By integrating multiple voices, experiences, perspectives and practices into the research analysis, the researcher is able to get a better understanding of the subject matter.

Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world.

This means that qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them.

(Denzin & Lincoln, 2000, p. 3)

Both qualitative and quantitative researchers are concerned with the individuals’/participants’ point of view; however, the qualitative researcher is able to get closer to the individual through detailed interviewing and observation. Qualitative researchers pay close attention to the everyday social world, whereas the goal of quantitative researchers is to generalize information from the world, seldom studying individual stories. “They seek a nomothetic or etic science based on probabilities derived from the study of large numbers of randomly selected cases... Qualitative researchers use ethnographic prose, historical narratives, first-

person accounts, still photographs, life histories, fictionalized facts and biographical material, among others” (Denzin & Lincoln, 2003, p. 17).

Narrative study allows the researcher to move from the individual to the communal in a few pages. Narrative research has typically been appealing to life history researchers because people compose stories to understand their lives. “Narrative research requires work from a reflective stance; it focuses on holistic aspects of participants’ biographies and utilizes the capacity to meld observation and theory in meaningful ways” (Josselson, 2011, p.64).

Narrative researchers believe that people understand their lives in story form, with a beginning, middle and end. Narrative truth involves a constructed account of the participant’s experience, not a factual record of what “really” happened. The focus of narrative research is on how events are understood and organized according to the participant (Denzin & Lincoln, 2008).

The construction of a story is rooted in the internal world of the participant and aspects of the external social world where the participant lives. The researcher tries to understand the two worlds as a whole. The participant has multiple voices and realities throughout the telling of their story. “The self is regarded as a ‘multiple’ as different voices in dialogue with one another... some of these selves may be strongly developed, whereas others may be suppressed or even dissociated” (Josselson, 2011,p.227). The role of the researcher is to piece together data, deciding what is significant and insignificant, and making the invisible visible. “The researcher pays close attention to both the content of the narration (“the told”) and the structure of the narration (“the telling”)” (Josselson, 2011,p.227).

Narrative and Life Story

Oral histories and stories are the traditional forms of communicating and sharing knowledge for the First Nations people in Yukon. “Stories told from generation to generation carried timeless elements, enduring values, and lessons about life lived deeply” (Atkinson, 2007, p. 231). I wanted to hear the life stories and narratives of women in Yukon using narrative inquiry as it is a research approach that allows the researcher to gather needed information directly from the person.

Atkinson (2007) suggests that life stories take on their own unique form that is impossible to predict. The researcher and participant enter a partnership that may be mutually beneficial. The participant’s story is recorded and interpreted allowing the story to reach a greater audience. Life stories highlight the experiences, emotions and thoughts of participants to find out the impact of past events on their lives. In narrative inquiry, the researcher learns from the participant and both participant and researcher guide the study together with the resulting work being co-constructed. After the life story of the participant has been recorded and analyzed by the researcher it is essential to have the participant check over transcribed information to ensure it has been recorded and interpreted exactly the way the participant intended (Atkinson, 2007).

In essence, we need to acknowledge the value of multiple realities, where the role of the researcher, whether Indigenous or non-Indigenous, is as kumu (teacher). That is to say the kumu explicitly and intentionally presents a set of critical accounts that creates space for multiple audiences, convenes conversations that critique the approach within local and global contexts, and directs learning and inquiry toward community empowerment. Hence, conversation regarding the ontology and epistemology of a cultural group brings

to the surface multiple realities, defined over time, in a manner that benefits (does no harm to) Indigenous communities (Benham, 2007, p. 513).

Inquiry Process

Recruitment. I am a board member of a small non-profit (NGO) which is an advocacy and awareness group for women's equality. Our office is located in a women's centre and as a result I have contact with many women. Our office is separate from the women's centre; therefore, the women I meet are not my clients. The women's centre provides services to women from rural communities when they are in town. For this reason, we get many different women in the centre daily. It was through the centre that I was able to gather information from women and assess their needs. Several women expressed a need for this type of study on the topic of accessibility to sexual health education and services in Yukon. I decided to follow through with their requests by conducting this study. Posters outlining the study and requirement criteria of participants were posted in women's centers and shelters.

Participants. I recruited five female participants who went to public school in Yukon, and who were between the ages of twenty and thirty. Three women identified as Caucasian. One woman self-identified as a woman from a visible minority, and another woman self-identified as First Nations. In the interview, participants were asked to talk about their experience with sexual health education in their community and school and how this experience affected their lives. Participants were not expected to tell painful stories, but counselling support information was provided to everyone. Participants' names were changed and all identifying information was removed from the analysis and overall research project. Participants took part in one interview each that lasted approximately one hour. Participants were compensated for their time and travel with a \$40 gift certificate. Once the

interviews were re-storied, participants were asked to attend one additional half hour session to ensure information had been re-storied in a way that was true to their life experience.

Participants received an additional \$20 gift certificate to compensate them for their time and travel.

Data Collection. All participants completed their interviews; however, they were informed that they could terminate the interview at any time and that all data collected up to the point of termination would not to be used in the study. If the participant had not felt comfortable with the information collected, the data would have been destroyed as described in the letter of consent (Appendix B). I ensured that the participants were aware that they should only disclose information that they felt comfortable with disclosing. I referred participants to women's support services if they needed additional counselling or support (Appendix G). The interviews were conducted in a vacant room in the women's centre when the centre was officially closed to the public and there were no interruptions from the public during the interview. Confidentiality was ensured by asking the participants to choose a pseudonym, and all names of people were omitted and the names of places were changed or omitted.

Narrative Interview. The narrative interview is a conversation between researcher and participant. Both the researcher and participant monitor and influence one another in the conversation. The life story approach allows the participants to tell the story of their life and well-being prompted by guiding research questions. This approach allowed me to better understand the whole participant and the story of their life within the context of the greater research question. The overarching goal of the interview was to discover the participant's subjective truth. This was done effectively by focusing on the stated and unstated, the voices

within the narrative, attending to the layering of voices (subject positions), and to both the content of the narrative (“the told”) and the structure of the narrative (“the telling”) (Josselson, 2011). The interview was structured to allow for the multiple voices and realities of the participants’ stories to be revealed. My role was to actively listen, which allowed the participant to talk openly about their experiences. At times, some participants needed prompting at which point I referred to the research questions (Appendix A). The participant had the power to decide what was told, which meant at times I had to draw out details by asking the participants to describe events in detail. Meaning was negotiated as the interview unfolded. Narrative interviews often result in the rediscovery of an untold truth or lost voice, which can be very healing for the participant (Josselson, 2011).

The following is an excerpt from my reflective journal, which outlines my thoughts on the interview process with each participant. I used the journal to record my thoughts on the interview as well as the atmosphere of the interview space, the reaction of the participant to the interview at large, their tone, expression, and emotions before the interview started, during the interview and at the end of the interview. I have selected an excerpt from the middle of Vivian’s Story, where it became apparent to me that she was reliving some of her past experiences as she told her story about her friend’s assault. I recorded the below reflections after the interview.

She closed her eyes for a second to recall what had happened that day. She took a deep breath and began. The story started to flow out of her, she appeared calm, but her hands were shaking and her breathing was shallow. At one point she stopped the story to point out that she had never really told this story from beginning to end before, also stating that she hadn’t thought about it in years and as a result never had time to process it. I could tell

she wanted to tell her story; there was no hesitation or shame as she proceeded. There was a combination of anger and sadness in her voice, but all of this was overshadowed by an overwhelming sense of resilience and strength. After this segment of the story was complete she took another deep breath, looked out the window and commented on how beautiful it was outside; taking a sip of water she continued.

I was amazed at the speed in which she told her story. Her story was told with so much expression and emotion I felt like I was there with her through all of those difficult transitions. It will be very difficult for me to shorten this interview as it feels like every point of this interview was an important one. I do not think I will need to give it a beginning, middle and end as she already did this so well. She went on very few tangents. I feel so honoured that she let me hear about some of her most intimate moments as an adolescent.

The reflective journal brought strength to the re-storying process. I was able to re-read my journal and gain insight into how to determine a beginning, middle and end for each narrative. It reminded me about the emotions and physical reactions the participants had to their own story. I was able to paint the true voice of the participant into the narrative, by recalling the tone of the participant. I was also able to detect my own personal biases. For example, during one interview I had hoped that the participant would discuss cultural safety at more length because she had self-identified as First Nations, however she was quick to dismiss this discussion and I in turn recognized my own personal research biases and honoured her dismissal of the subject. The reflective journals were also a place for me to remind myself to ask questions of clarification to the participant during the check in process, which strengthened the final product.

Narrative Analysis

This qualitative study followed a life-story narrative research approach. My aim was to view the whole story of the participant. “Narrative inquiry is about eliciting from life stories the insight, essence and resonance that accompany our philosophical and cultural expressions and our desire for them to be recognized” (Barton, 2004, p. 519). Analysis of this form required integration of the life experiences of the individuals, which strengthened the social context of the study. I used reflective journals of the interview process, along with the audio digital recordings and transcripts of the interview in my analysis.

Although narrative researchers hold narrative authority in the interpretive nature of this work, I wanted to offer the participants an active role in all stages of the process. I collaborated with the participants, asking them how they wanted to be represented in the study and ensuring that both researcher and participants’ goals were met throughout the study. The participants played an active role in the process. One of my research questions is, “What changes would you like to see in sexual health education and services in Yukon for the next generation of women?” Participants had a chance to reflect on positive solutions. “As researchers collect stories, they negotiate relationships, smooth transitions, and provide ways to be useful to the participants” (Creswell, 2007, p. 55).

Participants’ personal narratives were not fixed in time because of each person’s multiple realities and voices. “The self is regarded as ‘multiple,’ with different voices in dialogue with one another. The narrative is conceived as a multiplicity of “*I*” positions where each “*I*” is an author with its own story to tell in relation to the other “*I*” (Josselson, 2011, p.226). It was my responsibility to interpret and analyze the narrative. This was done effectively by focusing on the said and unsaid, the voices within the narrative, attending to the layering of voices

(subject positions), and to both the content of the narrative (“the told”) and the structure of the narrative (“the telling”) (Josselson, 2011). Finally, it is important to note that narrative analysis does not see participants as “entities” fixed in time and stories have a tendency to change overtime and revisions are a part of the process (Josselson, 2011).

Re-storying

Participants voluntarily took part in a private one-on-one interview that lasted an hour. Each participant was asked to share her experiences with sexual health education and services in Yukon throughout her lifetime. Many participants experienced barriers to accessing these services and they describe this in detail. Finally, participants were asked to provide ideas on changes that could be made to affect positive change for women in terms of sexual health education in Yukon. The interviews were audio digitally recorded so I was able to analyze the material after the interview.

After the interviews, I transcribed and analyzed the digital data. I conducted a layered analysis that included my own reflective journal. I used a list of interview probes to assist my focus on the research questions (Appendix A). I also took notes during the interview process.

I then began to re-story the data collected from the audio digital recordings. Re-storying provides the research with a coherent beginning, middle and end. Re-storying consists of gathering stories and information and analyzing them for key elements such as the time, place, plot and scene along with presenting past, present and future ideas (Creswell, 2007, p. 56). The story-line included a three-dimensional narrative inquiry space, “the personal and social (the interaction); the past, present and future (continuity); and the place (situation) (Creswell, 2007, p. 56).”

Analysis and re-storying provides a coherent beginning, middle and end to narratives, allowing the reader to better understand and connect with the narrative of the participant. I worked with the following re-storying guidelines to represent the participants' narratives: a summary of the substance of the narrative; orienting the reader to the time, place, and situation; the sequence of the events that were being represented; the significance and meaning of the events expressed through the attitude of the story-teller; resolution of the story; how the narrator returns to the present time (Riessman, 1993).

I started the process by reading the interview transcripts and the corresponding journal entries and created a summary of each narrative. Each participant started their interview with their first memory of sexual health class, which fell around grade five for almost all participants. Each participant moved from childhood to youth then to adulthood. Participants gave examples of their exposure to sexual health education first and moved to their experience with sexual health services second. When I restoried their narratives, I placed participants' stories of sexual health education and access to community services in chronological order moving from childhood to youth then to adulthood. I returned to present time by emphasizing each participant's desire for change for the next generation of women first by highlighting service gaps emphasized by participants and then providing participants' solutions.

Once the interviews were analyzed and re-storied, the participants were asked to help check the results. This involved a short meeting lasting about 30 minutes, or email check-in for participants who had requested to have their restoried narrative sent to them over email. Participants went through their narrative and then sent me feedback about any changes they wanted to see. Changes were made and the narratives were sent back to them with the edits

for final approval. The participants were able to add any information and let me know if the results made sense to them. The participants negotiated the meaning of the story, adding and validating the findings to ensure the story did not lose its initial meaning in the re-storying process.

In my reflective journal, I noted that one participant felt that I had made one of her brother's stories sound like it was her story. We discussed how it could be rewritten so it read the way it was originally told. I had not even picked up on this so I was grateful for her comments. There was another section that she felt did not sound like her so we reworded it so she felt more comfortable with it. For the most part, the participants were very pleased and had very few comments. When some participants re-read their restored narratives they made small changes, such as adding the exact grade they were in when the event took place and so forth.

After the restored narratives were read and approved by participants, I entered phase two, which is where I conducted a thematic analysis of the narratives. I chose to do a secondary phase of analysis in order to protect my participants' stories and only present the secondary analysis of categories and themes in any future publications or presentations. I did this by reading and rereading the restored narratives and identifying general categories according to the common language and trends shared by participants. I then coded the narrative sections for descriptive elements according to categories and was able to narrow these categories down to three main categories, *Sexual health education in Yukon schools and sexual health services and supports in the community; Challenges associated with limited access to sexual health education and services in the schools and community; and Utopia: Dreams for the next generation*. A category was selected when four or five participants had mentioned the

category in their story. From there, general themes were isolated and placed under the three corresponding categories. There were more themes than categories because I wanted to capture diverging, unique themes from all the stories. Themes included topics such as, *My Changing Body: Mixed Messages*, *What is a Healthy Relationship*, *Sex Positive Education*, etc. Themes were selected when two or more participants had overlapping trends, shared common views and similar language to express that view. This process gave more meaning and understanding to the secondary research questions: How have these barriers affected your life? What changes would you like to see for the next generation of woman?

In phase three, I isolated the metathemes. I did this by going over information collected in phase one and two, and isolating overarching trends that were shared by all participants. The metathemes are the binding, overarching connections of the study and include *Trust*, *Accessible Sexual Health Services*, *Desire for Positive Change*.

Ethical Concerns/ Consideration

Due to the highly sensitive nature of the topic it was essential that the participants felt completely secure with their narratives. For that reason the anonymity and confidentiality of the participants was protected. In order to accomplish this, any identifying characteristics were removed during the analysis. Participants were given pseudonyms to protect their anonymity, and as I did all the interviews, I am the only person who knows the identity of the participants. Furthermore, the community and neighboring communities were not identified due to the nature of small populations in the North. All documents, including consent forms, digitally recorded interviews, and additional researcher notes have been stored in a locked file cabinet in my office. The information will be destroyed two years after the completion of the project.

There is always a potential for an imbalance of power in the researcher-participant relationship. I made sure that it was clear to the participants that they were the experts of their experiences. It was clear to the participants that I was concerned about the well-being of women in the North and examined an imbalance of wealth and service allocation to northern women both in the literature and first hand as a health promotion worker and health researcher. My aim was to listen, learn and hear their life experiences with the goal of breathing descriptive life into the relevant quantitative data that was available through Statistics Canada documents.

It was my role as the researcher to recognize signs of distress and discomfort during the interviews and to be sensitive to the women's vulnerability from sharing personal information (Creswell, 2007, p. 57). Before the interview I talked with the participants and ensured that they were in a safe emotional place to begin. When the interview was finished I ensured once again that the participant was in a safe emotional place before she left.

Evaluative Criteria

Validity. Issues of validity surface in qualitative literature, however a range of criteria has emerged which has contributed to the enhancement of trustworthiness in qualitative research. In narrative inquiry, validity is dependent on the participant. The participant decides if the information collected and analyzed by the researcher is correct and valid. This process is referred to in the literature as, "intersubjective judgment" (Lincoln, 1995). Narrative researchers convey the meaning of participants' experiences by richly describing and reflecting on the participants' stories.

Human experiences and individuals' life stories are complex and therefore are always changing. Often individuals omit and change the meaning of their own story. It was

important for me to tell the told and untold stories of participants by asking important questions, writing thickly through detailed descriptions and member checking once data was collected, analyzed and re-storied.

Reflexivity. The research was monitored by the critical reflection of myself throughout the research process. This was accomplished through note taking, writing thickly and journaling throughout the study. This journal allowed me to reflect on biases, thoughts, ideas, and highlight analysis, interpretation and insight (Lincoln, 1995).

Reciprocity. Reciprocity refers to the quality of relationship between participant and researcher. This was established by developing trust through exchanging and sharing stories of life experiences. Reciprocity was established between the participants and myself through the sharing of stories. I accomplished this by establishing transparency about the intent of the research and sharing professional and personal information when appropriate and necessary.

Triangulation. Triangulation describes the use of multiple forms of data collection, allowing for layered interpretation of results. This was accomplished by note-taking, journaling, audio recording interviews, transcription and analysis of interviews, re-storying, participant member checking and verification, and finally the feedback gathered from my supervisor and committee members.

Summary

Qualitative methodology attempts to move beyond the numerical analysis quantitative methodology provides. It brings the reader and researcher closer to the individual stories of the participants allowing the researcher and reader to see the story behind the numbers. Narrative life stories provide detailed, layered information about a broad subject area within the context of the participants' life experiences. Validity, reflexivity, reciprocity and

triangulation are evaluation tools used to ensure accuracy. After the data is collected it is re-storied and narratives are given a beginning, middle and end. The participant and researcher co-construct the research. This is accomplished by ensuring the participants can contribute to the research throughout the process. Participants read their narratives and navigate validity, making edits were necessary to ensure that it is their story that is being told. The researcher relies on, reflective journals, digital interview data, transcripts, participants' feedback, and narratives to analysis and highlight broader truths within the narratives. The participant-approved life story narratives are then analyzed and multiple categories are coded allowing the researcher to isolate overarching categories and underlying themes common amongst participants. The final phase of research allows the researcher to isolate metathemes, which binds the research. Qualitative research allows the participant, researcher and reader to enter an intimate knowledge sharing experience where together we gain a greater understanding of the subject area. All these steps were undertaken in this study, leading to the following results.

Chapter Four: Women's Voices

This chapter provides the reader with the life story narratives of the five participants. These stories begin to address gaps in service provision and education by using a narrative approach, and exploring the stories of women's life experiences within the context of their ability to access sexual health education and services in their schools and communities. This phase of research started with a one-hour interview, which helped answer the principle research question: What are the women's stories of sexual health education and services and how have these stories affected their sexual health and overall well-being? Each interview was transcribed and multiple readings were conducted. The interviews were restoried and given a beginning, middle and end, providing a cohesive representation of each woman's life story. As part of the narrative analysis co-constructive process, the women were invited to be active participants in the research by reading their restoried narratives and providing feedback.

The participants grew up, attended public school and accessed health services in Yukon. Each participant has experienced barriers to sexual health education and services in Yukon. All participants express a desire to see change in their community for the next generation of women. I was honoured to hear the intimate stories each woman shared. I invite the reader to share in their experiences through their stories.

Vivian's Story

I was sexually active quite young, and I was raised by a nurse, which was really helpful. I remember really only going to the communicable disease clinic to get tested or to get information. I was always a little worried when I would go, and a little uncomfortable about who might see me because it is a small town. Sometimes you would be sitting in the waiting

room and then all of a sudden somebody you know would come in, so that was always uncomfortable. My mom's good friend was working there too, so that was always really weird, and if she was assigned to me as a nurse I would always ask for someone else. She was always really good for asking me if I wanted somebody else, which I always did. But that was kind of the best place to go for STI testing and they were really good about all that stuff.

Birth control wise, I don't know where I would have gotten it if my mother hadn't put me on it. She said she was putting me on it to regulate my period, but I think it was really for birth control. I think she could kind of know I was sexually active, but birth control was definitely a barrier for some of my friends. There were a lot of girls who didn't know how to get birth control. I remember when I started taking birth control I didn't really know what kind to take and who to ask. And I was taking Dian35 because my mom told the doctor they wanted to regulate my period and regulate my skin because I had bad acne. Dian35 was a dermatological, skin medicine that had the same effects as birth control, but was not 100% effective. I thought I was taking regular birth control all the time, but it turned out it wasn't proper birth control. I never really looked into it, I just remember finding out about that later when I switched brands. My girlfriends and I would always sit around and talk about what kind of birth control we were on and what we liked about it and what we didn't like about it, but it was more of us kind of sharing personal stories and information that we had gotten from other people so it was definitely hard figuring out where to get birth control and what would be most effective for our individual needs. The cost of birth control was a barrier. If my mom wasn't paying for it, I don't know who would have paid for it. Some of my

girlfriends who didn't have as much money were always trying to figure out ways to pay for it. I think if you didn't have any money, it would have been harder to get.

I remember when I first started going to the bar when I was 19, it was easy to get free condoms. There were free condoms in all of the drinking establishments, in the bathrooms. But as a teenager I got condoms from my mom because she was a nurse and she just brought big bags of condoms in our house, and was like, "here are condoms, use them." I don't think they offered them in our high school. I don't think they were easy to get. We always had them. I know my girlfriends and I never had trouble getting condoms but when I think back now, where we got them, I can't really remember. I don't know if somebody had some magical stash or maybe it was me giving condoms to my friends that were from my mom. I don't remember having public places to access condoms. People would talk about where to get them and stuff like that, and I imagine they would have had them at the counsellor's office, or something, but you aren't going to go to the counsellor's office and be like "hey, can I have some condoms" because it would be too risky in a small town.

When I was seventeen I got HPV from a guy I was sleeping with and I told my school counsellor. There was a teacher at school whose daughter was dating the guy who gave it to me. And the school counsellor pressured me into telling the mother about it so she could warn her daughter. And then it got all around school and everybody knew about it. I didn't know HPV was really common, and that it wasn't something to be ashamed of. It was all over school that I had gotten this STI from this boy. And the guy who gave it to me said he didn't give it to me. I had gone to that counsellor for support and to have a private confidential talk because I was really upset, but she just pressured me into telling someone else, instead of respecting my privacy. This created a huge barrier, not having counsellors

you could trust, living in such a small community where people fear for their own well-being so they start thinking of their own well-being rather than helping you. After that I never went to a school counsellor ever again and neither did my friends. You are supposed to be able to go to a school counsellor for support and know that they are not going to talk to your parents. It was a really humiliating and disappointing experience for me. This was such a big barrier, not having people to talk to about things like that.

The school counsellor could have given me community resources so I could have been more informed about my STI or a contact for a counsellor, but she didn't give me anything. I went and got tested and they said it looks like HPV and told me to go to my family doctor, but my doctor was my mom's really good friend and we always used to go to her house for dinner and there was no way I was going to talk with her about HPV. And then the symptoms went away and then after that I went and got tested again the tests came back negative so still to this day, I am not really sure what it was or is? My friends and I ended up self-counselling so that ended up being a major resource but of course it is only whatever information we knew when you were 16-17 years old. My friends and I were sexually active quite young, and we talked about that stuff and we were all really super confident young girls at that age. We were kind of the arty-smoker-druggie kind of group maybe it was different for some of my more conservative peers.

I remember my mom always told me that masturbation was really healthy and always talked to us about that stuff. I remember getting in an argument with this girl I went to school with because she thought that no one masturbated because it was disgusting. I remember arguing with her saying, "you are ridiculous, everyone does! You are a liar if you say you don't." I remember having conversations with other girls that were my age and I don't think

they were as sexually active and they got a bit of information from my close friends, but I am not sure if they had much support?

I don't remember having much access to sexual health education. I am sure there must have been a class a year in elementary school? Oh yes, I think it was grade 6 and they split the girls and the boys into separate groups and they talked to us about our periods. I remember, because they had this box where you could ask anonymous questions and I remember writing one, because I didn't know how you knew if you got your period. I thought maybe getting your period might feel like you were peeing so that is what I asked, "When you get your period does it feel like you are peeing?" I remember writing my question and being so embarrassed about it and sticking it in the box and then the lady shook up the box and answered the questions and I think she showed us tampons and pads.

We had something once in grade 8/9/10. We had a sexual health nurse come in to do our Career and Educational Planning and she touched on some minor stuff. When she came in I remember seeing her and she was like this older really kind of tired looking lady. She was sweaty and kind of not kept very well and she was extremely overweight and I know those are judgments I don't want to put on her now, but I remember at that age I looked at her and I was like, "Who is this lady? What could she know about our sex lives?" I couldn't relate to her at all.

I remember she brought candy, she brought a bag of nibs, those little ones. And we were all in the class with the girls and the boys and she gave us all these candies and then she did the horror slide show of the worst STI's that you could possibly get. There were pictures of genital warts that are just inflamed and awful. And I imagine a lot of people had not even seen pictures of regular genitals before that point. And then here they are showing us the

worst ones that you could possibly get and we were horrified with the whole thing. All of us were embarrassed and disgusted and totally grossed out and didn't want to ask any questions and were just hoping to god that we never got them. It was so shocking to see those slides. I remember being upset by it because it was so graphic and they were so gross. If I had an STI I would never tell anybody because all they would think about would be this horrible, nasty vagina they saw in the slide. So it was terrible. It was not helpful in any way. I don't even remember what the STI's were called.

The only other thing that I did that sort of relates to sexual health education was the fake baby, parenting thing in Career and Educational Planning class. We had the fake babies, and I remember my fake baby broke, you had to have it for 2 days. It was a pain in the ass to have this fake baby. It was! And you drag it all around and it is embarrassing. Mine malfunctioned and it just kept crying and crying all night long. It was awful and I just kept holding the key and the second I let go of the key it would start crying again and I was up for 9 or 10 hours. I brought her back to school in the morning and my teacher said she felt so bad for me so she gave me an A+. I just remember thinking it was another fear based strategy. Telling us that sex was a bad thing because then we might have a baby and it would be really challenging. I would have been more interested in hearing the parenting story of a young teenager. I think that would have been more real.

And then after those presentations and classes that was it. If I had questions about anything, there wasn't really anywhere to ask and the internet was still pretty new then too. We all had super dial up, and the only computer we had was in our kitchen and so if you ever search anything, if you ever wanted to know about birth control or herpes or whatever, your dial up would make this really loud sound and then it would slowly load. Sometimes my dad

would come in the room and you would have to close it down quickly which was really hard to do because everything was so slow. None of us knew about browser history or anything like that so we didn't know if they could find out so you definitely wouldn't use the internet for information at all because it would be too weird. I mostly relied on family and friends for information and the friend thing was really good because it was supportive, but now that I look back on it as an adult it was really misinformed. We were sharing sexual health information with each other, and some of it was true and some of it was good, but some of it probably wasn't. It would have been good to have more access to sexual health education and services growing up.

If one of us were pregnant, or worried about being pregnant, you would have to do the shameful run to the grocery store at 14 or 15 years old and buy pregnancy tests. And again you are in a super small town; you are sitting in the checkout line holding your pregnancy test at 14. You are either buying for your girlfriend or buying for yourself and you are just waiting, your heart is racing, you are looking around the store and you are like, "Oh my god, what if someone sees me and tells my mom or tells my dad. I am going to have to talk to them about it."

I remember a girlfriend of mine got an abortion when she was like 14, or 15, and we helped her with it. I don't know what we did but I remember we were trying to find information for it and trying to get her where she needed to go. I don't know how she ended up finding out where to go but she got it all set up. I remember my mom was the nurse that was with her when she woke up and that was a big thing because she didn't want anyone to know. I think she was fine with it because my parents and her parents didn't have any connections. That's another barrier for small town people. People know. And my stepmother

is one of the nurses in the emergency room. You have to wait for your abortions in the emergency room and people know it is abortion day. And so even now as an adult I think about that, if I had to access an abortion, even now as an adult I probably would have to tell my stepmother about it because she would ask me what I was doing there? Or other people ask you why you are there and you have to figure out what to say.

My friend got pregnant by this gross guy, he was like this older guy too, really sleazy kind of guy. He didn't want her to have an abortion and he was really pressuring her not to. I think stuff like that might have been a barrier too, with partners who were forceful or abusive in any way. We didn't really know how to deal with him. I remember I went with her to his house when we were going to tell him she didn't want to keep the baby. And we were these confident little teenagers and we went in there and we were yelling and having our little sass fest. This guy was kind of scary. He was at least 18 or 20 years old and we were probably 14 or 15 year old. And he had his own place, and we went alone. Imagine, these two teenagers girls going alone to this older guy's house to confront him about our rights? I remember that being a frightening memory of my childhood, having that happen.

Another one of my girlfriends, got sexually assaulted at a bush party. My girlfriend had her license, and there were four of us that always hung out. And the four of us went to this party and it was getting really late and one of my friends was this really crazy person, she still is to this day, and we couldn't find her. And my friend who was driving us wanted to go home and we were always waiting for this friend at parties and stuff like that. My friends were going to leave and we were her ride so I went to find her, but I couldn't find her and we were sick of waiting for her at all these parties, so we left not thinking anything of it.

Then a few days later we found out she had been raped by this guy. She was this super crazy girl and she was kind of slutty and she did drugs and as a result had this bad reputation, but she was our friend and so she told us what had happened. Again, I don't know where we got this information, but we were like, "You gotta report this, this is ridiculous, you should go to the police." And so we went to the police and reported it. It took a really long time for everything to be processed. I think in the long run they dropped the case because our interviews were done too late after the fact for them to be counted as evidence or something. They said our memories weren't clear enough so that is the reason it didn't go to court, at least that's what I remember.

The guy that assaulted her was this cooler guy and so after he was charged people attacked my friend. People threatened to beat her up; she couldn't go to any parties anymore without girls beating her up. They would scream at her, threaten her. Not small threats either. They would threaten her life and stuff. They told her to drop the charges. This was a lot to handle in grade 10 -11. People assumed that if you slept around you couldn't get raped. People thought she was doing it for attention because in her past she had used really negative ways to get attention, but you could tell, she went through this stuff for years and never retracted and you don't think it would be worth it after all those years.

It was crazy, I remember being in the parking lot of a restaurant and we were arguing with these guys about it and I remember this guy grabbing me by my neck and slamming me up against this van and screaming at me saying my friend was a liar and that I was liar, and telling me and my friends to watch out. It was horrible. And the RCMP, they didn't tell my friend where to go. They didn't tell her what services were available to her. We didn't know

that the threats these guys were making were illegal. We didn't know we could have gone for more protection.

We didn't report the guys and the threats. My friend got beat up a bunch of times and we didn't think to report any of that stuff, we just tried to protect her as much as we could and talk to her as much as we could. It got so bad for us that we had to step away from her for a little while because it was dangerous to be around her. She was totally isolated, cut off from most of her friend group. Even us who would try and support her as much as we could, but it got to a point where we had to look out for ourselves as well, and we had to back away.

She was going through all of this trauma and using a lot of drugs and alcohol to deal with her issues and we didn't know where to go or how to help her. The only place we knew where to go was the police, but that was totally disappointing. I remember going to the courts and there was no court support. We didn't know how the court systems worked. I don't know they explained it to her. We just arrived and made our statements; they didn't even give us copies of our statements, until much after the court dates. Eventually the case got dropped and then she had to deal with the aftermath of everything. I don't think we even processed what happened to her because we were on the defensive for her physical and emotional safety. We didn't tell our parents about it. My mom is a really open person and was someone that I probably could have talked to, looking back on it now, but I think it took a long time. I don't think I started to process anything until I was in college, and was working with a lot of women's organizations. I started processing the trauma and began to realize how much bitterness and resentment I had towards being in a town where it was permissible to treat someone like that. Even now talking about it I can feel myself getting really heated, feeling

that lack of justice of what happened to her. That was years ago now. That was a long time ago and people still come up to me and ask if my friend really got raped.

As I was saying, I didn't start processing everything until I went away to school and I think that was because I had this really supportive community of women there. There was this women's collective, at college, and we all got together once a week to sort of organize events. They were a good diverse group of girls. There was a girl there who was from a small community in Yukon, and someone from Alberta, and somebody from northern BC, and there were actually a couple of girls who grew up in Vancouver. And the two girls who grew up in Vancouver were so savvy. They were so cool and urban and they knew where to get all this stuff, even things like sex toys. Where as in Yukon there was one dodgy sex shop in town. And again you'd never go in there because you would worry about your parents finding out. These young women knew about everything; where to get free birth control; where to go and get an abortion; where to go get support after your abortion; where to go if you were dealing with abusive relationships; where to get free pregnancy tests.

We had totally different lifestyles growing up, but we found a camaraderie because we were such similar women, but their experiences growing up in Vancouver were so different yet similar and they too had dealt with sexual assaults and they dealt with a lot of the same things that we had all dealt, but they just knew so much more and had all of this information and access to services.

Even musically and culturally, they listened to Ani Di Franco, and other songs about the sexual revolution and strong women, along with songs that sung about sexual assaults. Even the fact that they had that information, about sexual confusion and different sexual orientations and partnerships around queer relationships and those kinds of things, it would

have been nice to even have that music here. Even our radio station was kind of a barrier for us because we didn't have other places to access different less mainstream music, this was before we could download music off the internet.

One of my girlfriend's from college was totally obsessed with menstruation. Totally obsessed. She used a diva cup and she knew all about her cycle all the way through. She had these cool posters. She even had this big poster on the back of her bathroom door of all these different vaginas, some with piercings, some were hairy... Just seeing these empowered women was so cool, you know. I would look at these radical young women and again, they were the same age as me, but just had so much more information than us. At college you could go get free birth control just by going and talking to the guidance counsellor. Whereas here I had to get my mother to pay for my birth control for the first few years I was on it.

I remember the urban girls from Vancouver thought my stories of limited access to sexual health education and services was kind of a horror story. I wasn't ashamed at all. They were so surprised by my stories and I was so surprised by their stories and so we would spend a lot of time sharing stories. I definitely didn't feel any shame or guilt. I was raised in a household that was really good about being sexually expressive and asking questions and so it just felt like it was a classic college experience where I was going through these stages that everyone said you would go through when you went to college. You become a different person.

There is a lot of resiliency around women in the north, even though we do have a lot of barriers, and we don't have as much access to service, but we are able to find the strength and time to access things like abortions or STI testing or birth control in creative ways. I think it forces you to think on your toes around these things so in some ways I think our barriers made us more resourceful in a lot of ways because by the time we arrive in a city outside of

Yukon everything is so easy. I think a lot of women who are raised in urban settings would come here, and would find it really, really challenging. I think they would feel a great loss emotionally. That is one of the strengths you get being in a place with barriers.

I definitely wanted to come back here and transplant some of the stuff I learned down south. Especially when it came to gay and lesbian rights. I ended up joining the queer collective there. I had all these friends who were lesbians. It was the first time I knew any lesbians, that were open. So it was a really great experience, and I remember I still feel really emotionally connected to the queer movement. It was so beautiful because Vancouver is really accepting and really celebratory around gay partnerships whereas here it is different. I don't think there was anyone that was openly gay in my high school. People went away and then came out. There were two girls that were accused of being gay at a camp in grade 6 or 7 because they slept in the same tent and people suspected they were fooling around. They were totally targeted and harassed. It didn't feel like a safe place for anyone to come out. I was a really strong independent woman in high school and as a result I was accused of being a lesbian and was really targeted. I couldn't imagine what it would be like for me if I was a lesbian here in high school. It would have been really, really challenging. I think that's why people wait to come out once they have moved away. They probably felt safer coming out away from here. These guys dressed up at Halloween in suits and called themselves the "cunt patrol mafia" and women were really being harassed at school by them. Finally, teachers started to recognize that it was a gang mentality, but nothing was really done about it. I think in a culture like this, where heterosexual women were being harassed and targeted, it was even worse for a lesbian or a gay man, I wouldn't come out. Nobody would do it, it just wouldn't be safe.

I would love to see sexual health education be a part of the regular school system. Not just a one-hour, once a year class. I think it would be good to talk a lot more about sexual orientation, sexual pleasure. So often we talk to kids about how sex is bad and it just leads to pregnancy and STIs. Sex is this incredible thing. I think it is really important to talk to them about their first sexual experience. I think a lot of young women have very disappointing sexual experiences, and they are expecting to have this sex that they see in movies and it doesn't happen. I would love for people to have less frightening more realistic knowledge.

I think about guys as well, and I think teaching both men and women about their reproductive rights is important. You can start super young by talking about bodies and becoming familiar and comfortable about body parts at a really young age so by the time you start talking about sex it is really natural and not as traumatizing and uncomfortable. I think it would also be good to have community supports. I probably would have skipped out on sexual health class and gone to a sexual health centre to learn about things on my own time, but we don't have a space like that here. I think we need a really accepting sexual health clinic where people can go to learn about a whole range of stuff and access many different services such as STIs and pregnancy testing, counselling and abortions. There was this really amazing sexual health clinic in Vancouver. It was right downtown and it was in a building that had a lot of other services, but it was open at night when all the other services were closed. And so you could pop in there and it was really friendly and it had all sorts of nice signs and colours and magazines and things you could read. The doctors were all super hip, even in the way they dressed. You would go in there and feel really welcome. You knew you could ask them questions and because they offered all those things you knew that you could go in there with multiple excuses. I think it is really important to have a space where men and

women can engage in a healthy reproductive rights dialogue. It shouldn't just be a place for women.

If a girl got raped in Vancouver they had a rape nurse so if you ever got sexually assaulted there was a nurse in town who specialized in that and no matter what time of day or night if you got to the hospital and you'd been sexually assaulted they would call her up and she would come and she would be the nurse that would deal with you and she was really skilled. She was this amazing woman, she was so gentle and so sweet and she really explained the process around the rape kit. Even if you had questions around what stuff would be used in court she would take the time to explain everything to you. I think we need to have services like this in Yukon.

Emma's Story

I was lucky; I had a family member who really wanted to talk to me about sexual health, so I got quite a bit of an education from her. There were things that she didn't have information on, like pap smears or HPV. I wanted to know if I should get a vaccine for HPV. I had to seek that information out from other sources, but it was very hard and I am still vague on the information the doctor gave me. Finding a doctor in the first place was hard, and then talking to him about it was awkward and hard for me because he was a male doctor.

Aside from my family member, I didn't have much additional information on sexual health or the services available in the community. Sexual health education was not structured into the school curriculum. My first memory of sexual education in school was when my friend's parents came in to talk with us. They were both nurses so they came in to talk with us about our changing bodies. They sort of insisted on coming in, I don't think they were hired by the school to come. They didn't talk about reproductive rights, they didn't talk about

abortion, and they didn't talk about sexual assault or our rights, in terms of our bodies and our space. They didn't talk about any of that.

They did seem to take into account that we were kids who were being silly and who felt uncomfortable about asking questions so they had this question box. We could put anonymous questions in the box and then they would read them out to the class and we had a chance to have some of our questions answered. I think I learned some stuff then. I remember thinking that they were really aware of comfort levels and they worried about people who might be made fun of so this was a good strategy that allowed for some questions to be addressed.

Another thing that was interesting was that the boys and the girls were split. I didn't know what the boys got to talk about. I didn't know what the heck was going on over there. I wonder whether it was different from our discussion? Who did they talk to and how did they act? I wanted to know just out of curiosity. I still wonder because it is interesting. I wonder how they were acting and what they were talking about and if it was a healthy approach to sexual health education.

I do admit that I felt more comfortable with the class being split into genders, mainly because I think we were too young. I am not sure if I was mature enough to have a discussion about sex with boys in the same room. I still don't want to talk with a guy in the room about my sexual health because it is not his business. I don't know, it is tricky I guess. I think there is definitely room to have discussions with the opposite gender and we certainly have a lot to learn from each other, but we also have to respect our comfort levels.

No one came in to talk about sex again after that in elementary school. It was just that one time. I had more questions that I definitely wanted to ask. I did have one family member I

talked to about this, but asking her was also kind of difficult because my own personal comfort levels just weren't there. For a while I just kind of went without. I remember the Women's Centre came in and talked about sexual violence and violence in relationships but that is the only people who came in afterwards. That is all I can remember from elementary school.

There is nothing that sticks out in high school. It seemed like the teachers considered sexual health to be out of their realm. There were pamphlets, as I recall there were these pink pamphlets that were given to us that talked about the menstrual cycle and I think that happened before high school in grade seven. We could pick up pamphlets as they were made very available, but there wasn't any person that we could talk to about anything. At least I didn't know if there was someone to talk to about them?

My friends and I didn't talk about sex with each other because we weren't comfortable talking about it. I think that is one thing that they probably missed in our few sexual health classes, is that it is totally natural and it is okay to talk about sex. I do remember talking with a friend about how she shouldn't wear white pants, but I couldn't ask her why she shouldn't wear white pants. She wanted to talk about it, she really wanted to engage me in a discussion about periods and your menstrual cycle, but I closed up like a clam because I just wasn't in the right mind-frame. I feel kind of bad for that. She is becoming a doctor now so I guess she has always been curious and inquisitive.

I remember learning some stuff from biology, but from a very analytical, biological standpoint. We learned about the differences between the male and female and very scientific details about the menstrual cycle, conception and pregnancy. It was interesting to know, but it also kind of raised more questions because it wasn't familiar to me. I remember wondering

if there was something wrong with me because my periods weren't regular. From my understanding according to my biology class you were supposed to get your period once a month. Sometimes I would get really worried and wonder if I had cancer or something like that.

At the time, I was not aware that the school system wasn't meeting my needs. I knew I had questions that weren't being answered, but I didn't necessary know that they could be answered in a sexual health class because it wasn't my experience. I thought this was kind of just part of the education. I thought we were probably lucky because maybe other schools didn't have parents who were nurses who could talk about this kind of thing in the classroom.

As far as education outside of the classroom went it was fairly limited. I couldn't go to the doctor without my mom also being in the room so I didn't feel comfortable asking questions about my sexual health while my mom was in the room. For a while I didn't even have a doctor, which is something that is normal in the Yukon for a lot of people. I kind of just went without. I guess when the Internet came in I looked at that too for answers to my questions. I still had and still have unanswered questions about sexual health. I would have liked to talk to somebody in health about irregularities, but I wasn't able to.

I don't really have great access now. I experience a lot of barriers. My doctor is male and he is not someone I can talk to. He's not someone I feel comfortable getting a pap smear from. I don't like him poking or prodding me; it is very uncomfortable for me. I don't really have anyone I can ask sexual health related questions to unless I call the health line, which is anonymous, but even then I hope it is an understanding woman on the phone.

When I went away to university I began to talk about girlhood experiences in one of my classes and we talked about sexual education and health and what theirs was like and it was

pretty amazing. Some of the people in the class had much more access to sexual health education in the classroom, but some people's stories were actually like mine. I don't think that we got what we needed in Yukon compared to other places. I don't think things have changed much in the Yukon. I know this from working here and learning what is going on in the curriculum now according to sexual health. I think it is kind of the same now as it has always been. It is still vague and they are very reluctant to get into reproductive rights and a more in depth understanding of sex and sexual health.

Most of my sexual health education dealt with changing bodies and the menstrual cycle, but they should be talking about sex and STIs. It sounds like there are nurses going into the schools to talk about STIs, but sometimes those are fear-based forms of education. I know some of the sexual health promotion workers have tried to get into the schools, but they don't always get to go in as much as they might like. People go away scared to have sex. I think there needs to be a more positive sexual education model used. I don't think students are getting that. I think it is still exactly the same format. They talk about changing bodies and the menstrual cycle.

I would really like to see sexual education classes in every grade. I think it would be great if there were counsellors, and nurses available to students at school. I think grade five is a great place to start sexual health education classes. It would be great to have the fundamentals down so you can actually feel comfortable about sex. That way you can start to ask questions and feel like it is okay to talk about sex to others such as your teachers, healthcare providers, friends and partners.

It would be great to have more women health professionals. It would be so awesome if there was a women's healthcare centre, which you could go to and feel like you could talk

about sex, get pap smears, STIs tests, and learn about your reproduction rights. If you wanted to have an abortion there would be a clinic that you could go to and not feel like you have to hide it or feel ashamed or something like that. It would be necessary to have pro-choice, liberal, and open-minded health professionals at the clinic.

If there had been sexual health education and services like the examples I gave above available to me when I was growing up here I think I probably would have been a more confident person overall. I wouldn't feel like I have something to hide, I wouldn't feel ashamed for not knowing. That is something that I do grapple with. I would be healthier. Having access to these services would have affected my life in other ways, relationships-wise, maybe career-wise, I don't know, it would have affected a whole bunch of different things.

It is only very recently that I have been able to talk about sex and sexual health. This is because I have grown up and I have gotten a little bit more mature about things and I am more worried and more aware of my body now. Before, my body was like a separate entity. I wouldn't worry about it, but now I am way more aware and I am more comfortable. My friends are also worried about sexual health and we can talk about it more openly without feeling like we're going to be made fun of or we're going to be put down or something like that. It would have been great to have more services in place, which would have allowed for this to happen early.

Morgan's Story

When I think back to the sexual education in elementary school, I realize it was quite limited. We touched on some aspects of sexual health for the first time in Grade 3 or 4 where they focused on puberty and our changing bodies. They also spoke to us about sexual assault.

For the most part sexual health education really focused on puberty. I remember it being somewhat helpful at the time, but I think we only had one or two classes and they didn't go into a lot of depth. Our Grade 4 teacher taught our first class. I remember they split up the boys and the girls. Some of our parents came in and did a self-esteem workshop. It focused primarily on how to say no to strangers, and what to do if someone touches you inappropriately. We also had a sex education class in grade 5, where they focused on the biology side of things, such as conception.

The next sex education class we had was in Grade 8. Nurses taught it and it focused on STIs and prevention, and how to put on a condom, very basic stuff. Those were the only sex ed classes that I can remember having in elementary school and high school. When I think back on it, I think it was really inadequate. Sexual relationships are some of the most important relationships in our lives and they really didn't do a great job of going into any detail around what the relationship part of it would involve, we focused on the biology side of things. I think that's probably an easier thing to talk about for parents and teachers, so that was the focal point.

We didn't have a lot of information on obtaining consent from a partner. We also didn't have sex positive education. Sex was never explained as being a good thing, something you could enjoy as long as you're safe. It was more of a scare tactic--scaring people with pictures of diseases that you can catch rather than a more realistic approach. We didn't focus on what might happen in a relationship or how to talk to a partner.

I remember people asking questions during the presentations when the nurses came in, but outside of those classes, I don't think there was a lot of support for people. I don't think I went to any adults with questions around sexual health that I can recall. It was more talking

about it with friends or looking information up on the internet, when we finally had the internet. I would seek out the more detailed information on the internet or get it from friends. The information I found myself was information teachers probably felt awkward talking about in school.

There were definitely no condoms in the school. I remember the sexual health nurse brought in tampons and pads, but I am not sure where you could access free condoms, certainly not in the school. I also don't think there were any pamphlets around the school that related to sexual health. There were very few resources available. I imagine you would go to the communicable disease clinic if you had any specific questions? But yeah, if you were under age and couldn't go to the bar to get free condoms I'm not sure where you could go?

Most of my friends had the money to buy condoms if they needed them. So yeah, we'd just buy them. I worked at a store, and a bunch of friends worked at the same store so you could get condoms and it wasn't super-embarrassing to go and buy them because you could get your friend to ring them through for you. I didn't go on birth control until I was a bit older. I never actually really had to ask for birth control from my doctor while I was in the Yukon. I was lucky to never need an abortion or anything like that. I didn't go to my doctor for sexual health questions.

One of my friends had an abortion here when she was younger. I don't think she had trouble accessing abortion services? I know some friends had issues with their doctors because they wanted to go on birth control, but their doctors were a bit judgmental and would say, "Oh, you're too young." I do know one friend who did have an abortion and she got negative comments from the front desk attendant in the clinic, basically saying that she should have an abortion. At that point she was debating whether or not to have one so there

were some problems around attitudes. Health professionals didn't always seem open to young people making their own decisions. I guess there were just more conservative attitudes around young people having sex.

There were also small-town, anonymity issues. My male doctor, for instance, is a family friend of my parents so I wouldn't feel super-comfortable asking him sexual health related stuff. Now I ask for a female doctor if I'm going to get a Pap Test done. Also my mom's a nurse, my sister's a nurse, a couple of my friends' moms are nurses. There's definitely a small-town, anonymity issue that stops a lot of people from going to the doctor to talk about things because they may feel like their family or friends or someone that they know might find out. I wouldn't confide in my family doctor with something that was really personal because I might see him at some family gathering and it would just be really awkward.

When I went away to school, it was great because we had the sexual health clinic at the university. Just knowing that there is a place that specializes in sexual health makes you feel very comfortable. I would wait until I was back in the city at school to get any tests done or birth control—just because I felt weird asking for it from people you know. It's just more comfortable doing it where people have no idea who you are. Luckily, I was going away to school every year for a while so that was a possibility for me. There were more services available, especially at universities, which cater to a young population. At University they had a sexual assault centre and people could go there for help and advice and counselling. It was a really welcoming place and easily accessible as well.

While I was away at school I did my own research on birth control options. I didn't really have a lot of knowledge about different options so that was my own initiative after leaving. I started feeling more comfortable going to the doctor and asking about different options. It

was kind of a combination I guess of some services just being more obviously available and I think the anonymity bit definitely helped a lot.

Again, some major barriers to accessible sexual health education in Yukon are the lack of discussion around consent, and communication around sex and healthy relationships. It would be good to have more detail about sex generally in schools just because I think it's such an important topic and something that's central to many people's lives. It doesn't seem adequate that during my whole time in elementary school and high school there was maybe five or six hours spent on sexual health. That seems pretty bad. I think sexual health education could start really young so that people become more comfortable with their sexuality and that way more educated detailed discussions can occur. If you only have a few hours dedicated to sexual health throughout school it becomes really difficult to have a comfortable conversation about sexual health.

I think we need to address the really high rates of sexual assault in the Territories, which was something that I focused on in law school. We did a sexual assault law course, which was super interesting, but it just makes you think about how to actually address the issue of sexual assault and the really high rates. I think we have to start with prevention education. Why does sexual assault happen in the first place? We need to address attitudes and stereotypes. I would like to see prevention education in schools here.

I think we need a non-judgmental sexual health center. I don't think people feel comfortable going to their family doctors because you might know the person at the front desk, you might know the nurses who are at the hospital... I think it prevents a lot of people from going and asking questions and getting the services they need. We need a space where

people feel safe. We need a welcoming place to go and ask questions and get non-judgmental services.

Some of the unique challenges we face in the north are related to communities being remote and physically isolated. In Whitehorse there are services available to people, but you have to make an effort to seek them out and also you need to feel comfortable especially with the lack of anonymity which can occur here. I would say it is more challenging in the small communities, where there is even more isolation. You need to have a vehicle to get to Whitehorse to access a lot of the sexual health services. It's just more of an effort to do it, compared to other places in the south outside the territory. You know, you can hop on the metro and go find whatever it is that you need.

During university I started doing consent workshops. They trained some of the students and we did workshops in schools. The workshop is based around a story that turns out to be a real case that went through the court system where a woman was sexually assaulted, but the lower courts found that she had consented based on stereotypes around her not screaming and running away, and on what she was wearing. I wanted to do the workshop here because of the high rates of sexual assault and how it impacts people's lives, it's a really horrible thing and I think it's something that really needs to be addressed here. I really like my community and this was a way I can give back to it.

Thinking about my experience in high school and elementary school and basically having no knowledge whatsoever of the law and sexual assault and consent and how to actually obtain it and the definition of it, all of those things. It is so important to address those myths and stereotypes that we place on women. Even discussions that I hear some of my friends having, often male friends, but also female friends and the stereotypes that people hold. You

can just see how these things get perpetuated—suggesting that women ask for it by the way they're dressed. There's often a lot of victim blaming, especially when it comes to a woman and what she wears and whether she was walking late at night. Stuff like that. Or the mixed messages we get from the media where the onus is placed on the person who was sexually assaulted. It just makes no sense. Again, this is why I think we need to address prevention and this is done in part through the consent workshops. It's these types of discussions that I think are really important to have and obviously they need to get addressed at a younger age because by Grade 8 people already hold these stereotypes.

I would like to see more resources for sexual health education in the schools and in the communities, especially the remote communities. I think it is really important to move beyond surface level sexual health education. There is a real need for more in-depth education along with non-judgmental resources within the school and community.

Sam's Story

There are definitely huge barriers for women, especially those that teenagers face when accessing sexual health services in Yukon. At least I certainly experienced barriers growing up as a teenager here. My friends and I wanted to know about things like STIs and pregnancy, but I went to a catholic high school and there was no one we felt safe talking to about sexual health. If someone wanted to know we would all march down to the Communicable Disease Clinic, and we would sit in the waiting room and wait and then we would ask the nurse our questions all awkwardly. I can't remember how we found out about the clinic? I guess it was just common knowledge. That was the only service we knew to go to. Now there is also 811, but I don't know how much better I would feel about that because they ask for your name, even if it is optional, it still doesn't feel comfortable.

We had school counsellors in high school, but I never felt comfortable talking to them and definitely not about sexual health. I was more kind of buddy-buddy with the counsellors, I did not have a therapeutic relationship with them. The counsellors didn't seem to build relationships with many of the students. Also one of the counsellors was a gym teacher and I definitely didn't feel like talking to my gym teacher about sex, "Hey where can I get condoms?" No way. There were no teachers that I felt safe enough to seriously ask them about sexual health. There was one time when we were 17 and wanted to know if you could get crabs from a toilet seat, so we asked this big dumb teacher about it. He told us that we shouldn't use the toilet if it looked like there was pepper on the seat and then he laughed and walked off. That is the only thing I asked. Interestingly, my sister who is six years younger than me asked the same question in the same high school. I asked that question in a joking way and I know I would have never asked a serious question to any of my high school teachers.

I have a pretty good memory and I don't remember any form of sexual health education in elementary school. It was again, the catholic elementary school, nevertheless nothing from K to 4. In grade 8, there was a bit about puberty, and then there was a survey done at the end on things like masturbation, which kind of seemed out of place since we hadn't talk about it up to that point. There were also diagrams and they made you learn the names of body parts, but that was about it. Anyway, the results of the survey about masturbation were put up on a screen and we could see how many times a week our classmates masturbated, but the teacher made a joke of it and said, "Oh you guys are all a bunch of horny bastards." That was the only response to the survey. At the time I remember being disgusted. I didn't think it was right and it seemed really inappropriate. It builds a relationship where there are no feelings of

trust for the sacredness of your answers around something so intimate. I remember one other comment being made about reproduction and how he and his wife were having a hard time conceiving so the doctor told him to stop wearing tight pants and that was about it for grade 8.

In grade 9 we all had to do a presentation to scare the crap out of us about STIs with horrible pictures. Then we never talked about sexual health again. Everything we learned from that point on we learned on the fly. I learned from my friends who were sexually active way before me. My family certainly didn't talk about sex. It is horrible and I know how I am going to parent my kids based on that. I was about to turn 19 and my grandma made a comment to my mom and I about birth control just kind of on the sly and then turned away because she didn't want to talk about it. My mom was pissed off because she thought I was too young and didn't think she needed to talk with me about that, but I had been sexually active for almost a year at that point. Then I told her we didn't need to have "the talk" because I already knew everything. It was just very uncomfortable.

Most of what I knew came from my friends, which was basic information like how you should wear a condom so that you didn't get pregnant. Sometimes when I was in hospital waiting rooms I would grab pamphlets and get some information there, but I would always hide them inside one about blood pressure because you don't want anyone to see you read something about birth control, STIs or pregnancy.

I didn't really know where to get free condoms. I expected the guy to have them, and if he didn't have them I would go ahead and have sex and then I would run to the doctor the next day and get the morning after pill. Then I got a friend who was a bit more liberal and she would always make sure I had condoms, which was great. Sometimes if we were at the

hospital getting blood work we would take them, but we didn't want to go out and buy them because you're judged. Even today, I still feel like I am being judged.

If I needed birth control, I didn't use my family doctor for fear of my parents finding out. I didn't have any strong role models in my family or extended family that I could have consulted with about birth control, like a close friend of my mom's or an aunt. I have never had that, so really the only place that I went was the Communicable Disease Clinic because it was there, and then if they were closed and if someone needed the morning after pill we would use the emergency room to get it. I never felt completely anonymous at the clinic. They take all of your information and people see you in the waiting room. It was just the best thing that we had at the time.

My greatest fear was getting pregnant. I didn't want to get pregnant. That would have been the worst thing. I didn't give any thought to STIs or anything else, which is so bad. If I thought there was any chance, my friends or I was pregnant we got the morning after pill and you paid for it. After a while the walk-in doctor that I would see sometimes would shake his head and say that I should go on birth control, but the conversation never went beyond that comment and he never put me on it. It would have been a nice conversation to have.

I don't think much has changed. I have younger sister and her stories are very similar as far as access goes. When my closest sister was a teenager she had her first boyfriend and they went out and he got her drunk, it was her first time drinking and she just drank to the point where she had no control. She had lied to my mom and said she was at a sleepover, but my mom ended up finding out that she was with her boyfriend. My mom was really freaking out, but she finally found her. My sister was passed out in a bathroom and there was puke all over her and she had wet herself, it was really horrible. We took her to the emergency room at the

hospital and we told the nurse that we thought she needed to have a check done to see if she has been raped and she declined. Anyway, that incident set the stage for her exploration into sex, which was crisis focused. I think if she had more exposure to positive sexual health education this might not have happened.

I would like to see sexual health start as early as grade 1 or 2, just to get students used to it so it is not such a shame-based process. I am pretty comfortable in my skin, but I still have a hard time talking about those kinds of things. It could be as simple as being able to label a penis and a vagina and knowing what a penis and vagina are. Knowing that it is not a hoo-ha and wiener, it is a penis and a vagina. My brother in law, and my husband still don't want to call it a penis, and it is not a vagina, it is a 'down-below.' They have never heard those words from their mom. My mom has started to use those words now because she has younger kids and so she made sure that they know those words and what they are. Naming is an important starting point especially for younger kids so that they are equipped with the words that they need if something bad happens. They can say "someone touched my penis" and people will understand, rather than saying, "Someone touched my teddy."

I have a member of my extended family who was sexually assaulted by a grandparent and they didn't know how to talk about it or ask for help. This grandparent would cut their hair and then would blow it off their penis, but they didn't know how to say that. They just said, "Grandpa would blow the hair off me" which didn't sound bad because the word penis wasn't in there. If they had known the word penis the meaning of the story would have changed and something might have been done.

I think the high incidents of sexual assault that we have in the Yukon should be a huge component of sexual health education addressing things like sexual assault and rape. It

should also address healthy relationships and what they should look like, which also allows people to identify what an unhealthy relationship looks like. That way people are taught that there should be a mutual agreement and consent before having sex.

I think it would be better if there were another kind of drop-in centre where you could get sexual health education and services. A place where you could get information on pregnancy, birth control, STIs and abortions and all of those services. It would also be great if the clinic was open during the day, but also into the evening and on weekends. That way if you had a job or worked you could go after. If there were a lot of different services available at the clinic people wouldn't necessarily know why you went there. For example if you went to the clinic to get an abortion you could say that you went there to look into birth control options or something.

It would be good to see birth control available for youth. There are free condoms in bars, but if you are under 19 you can't go and get them. There are few places in town where youth could go and get free condoms. If something had been readily available to provide me with non-discriminatory, non-judgmental information on birth control, I would have been on it far before I actually was. I could have avoided the morning after pill as a regular form of birth control.

We also have to think about rural Yukon communities. It is really difficult for women in the communities. Teachers are often teaching mixed grades so it is hard to appropriately introduce sexual health when there are children of all different ages. Everyone knows your business to. When you walk to the health clinic people see you and ask why you went there. Also what if your aunty is working at the front desk, what do you do then? I know of several people in the communities who have just had to have kids. They wanted to have an abortion,

but their families won't let them and they had no other way into town to get the abortion. It's kind of pitiful that people don't have access to these things. It is a basic human right, you should have the right to choose not to have a child if you are raped or if you make shitty choices, you should have that choice.

I have reproductive health issues, so I was seeing a gynecologist and I asked if there are any sexual positions that are better for my husband and I to use for conception. He couldn't say sex. He couldn't look me in the eye. He was like, "Well, you can look on the internet and there are some different things that it says about different ways to do it." He was shuffling his papers and he said, "Some people say you can put your legs up, but I don't think that actually works." That's all he said. He couldn't say sex; he couldn't say intercourse, which is funny because he delivers babies. That's a problem, a doctor who specializes in female reproduction, but can't talk about sex. I felt confident enough to ask questions, but when I was younger I wouldn't have, and even if it was something I should have known, I wouldn't have asked. It's sad that I have to do my own research and ask really detailed questions about my health, otherwise the gynecologist doesn't offer any additional information. I often leave there feeling like he poked and prodded me and that's it. I don't go away with any of my questions answered. We really need a safe place in Yukon where women can go to get their reproductive health questions answered.

Clare's Story

I think the decisions around curriculum and the way it's delivered all the way through school is a fucking disaster. I don't remember having any sex ed classes until grade five and then we got split up by gender and the strange thing about that is you don't get to learn what the boys are learning. Maybe they separated us to make people feel more comfortable, but I

really think they should have taught both of the groups the same thing. The girls just learned about puberty and periods and stuff like that, but nothing past that. I already knew most of what was presented to us. I found out from one of my male friends that they learned about wet dreams. A dental hygienist came and told us about dental hygiene, but we didn't have a nurse come in and teach us about sexual health.

I think my mom was my first teacher. I remember we had this book called, "The Child's First Book about Sex." I always called it the Child's First Book about Blank; I was uncomfortable with the word sex when I was a child. The book had these photos of clay figures in it and they were all doing it. It was a fantastic book.

In grade 6 we had a special feature, one-time only, sexual education class. I don't remember much about that class, but I do remember this blushing skinny teacher who was entirely red as he taught. I don't remember the content at all, and all I remember was how embarrassed he was, it was so awkward. The only thing I took in was the awkwardness of it all.

In grade 8 or 9 we had Guidance and there was a whole part about STIs with a lot of graphic pictures in the textbook. We also learned about the clitoris and the penis. I remember in grade 10 in Career and Personal Planning class, a public nurse came in to talk with us about STIs. I remember learning a bit in this class, but there really wasn't sufficient information so I wasn't that impressed. We also played a game where we exchanged pieces of paper and we found out that the paper was an STI at the end. Again, I remember thinking it was really fun to learn about sex in school, but felt that there was insufficient content and wished that there had been more classes dedicated to sexual health.

There was a very consistent message in the few sexual health classes we had. The message was be afraid. Sex is bad and you will probably get pregnant or get an STI if you have sex. When we were divided by gender the girls had to watch a really detailed video of birth and one of the girls said that was disgusting. The nurse said, “You think that's disgusting, but you would let someone put their penis in your vagina?” If you were ever wondering about sexual health education here and wonder if it was sex positive, I would say probably not. Unfortunately, the fear tactic worked. The birthing video was horrible and birth is really going to hurt therefore penises are gross.

I think the last class that could be loosely connected to sexual health education was in grade 11 where we got a robotic doll for the weekend. We had to take care of it. It was kind of annoying to be around, but I also thought it was cool. It was interesting how it kept score of how well you took care of it and you can't just ignore it because it cries and needs its diaper changed and stuff. I think we should have talked a bit more about birth control and all of the different options. That would have been a beneficial addition. I remember looking into all of the different birth control options myself. I looked through the Public Health book, which talked about the effectiveness and rates of all options.

I had a mom who gave me books on sexual health so I could investigate things on my own at my own speed. My dad also made us learn body parts. The thing about public education is that we can't assume that all parents provide that material to their children. We have to assume that they don't so all students have access to the information they need. I feel very lucky that my mom gave us sexual health books, but I know that there were a lot of students that didn't have that and that is not acceptable. Educators can't just decide to not deliver

sexual health education because they don't know how to deliver it or they feel uncomfortable. They really have to get over their own bullshit.

We have high rates of pregnancy and STIs. Terrifying students with videos of pregnancy and pictures of STIs isn't empowering them to take care of their bodies. I don't want to see people have to get wasted so they feel comfortable to having sex. There are certainly ways to structure sexual health education in the classroom that isn't fear based.

As far as my experience with sexual health services in the community, I had a family doctor who I would go to for annual checkups. She was my mom's doctor. I used to be terrified of them because near the end of each appointment she would ask if I was sexually active. I always knew it was coming and I always felt so uncomfortable about that question. I remember distinctly bringing my mom with me to an appointment because I just hated that part, but then she asked my mom to leave and asked me the question anyway. The whole reason I had my mom come into the room was so that she would be there to make me feel more comfortable because I was so awkward. Anyway, I think I stopped going for checkups or maybe she asked me to stop coming unless I was sick I don't remember? I do remember thinking that you can't just start from zero with a question like, "are you sexually active?" It would have been more comfortable if we had established a relationship and built up to those bigger questions. There was no way I was going to start asking questions I had about sex because we didn't have that kind of relationship.

Years later, when I was in my twenties I went to the doctor and asked about birth control. I'd done my research and I wanted an IUD. The doctor said he wasn't going to give me an IUD because I was too young and hadn't had a baby. Instead he gave me the birth control pill. After I got those pills I sat on them for a while because I didn't feel comfortable with

them. I didn't want hormones, I've known that forever that I didn't want hormones. I was independent, aware and educated, and I wanted to be self-determining. Then I go to an expert who claims to know you better than you know yourself, but that's total fiction. Doctors know science and I know my body and what I want.

I left with this option that I didn't want. I eventually took it because it felt like my only option, but then I got migraines. I discontinued the pill after I got migraines. I went to see health professionals at my university and they talked about hormonal birth control again. The doctor actually said, "If you were my daughter I would prescribe you this." Which I was thinking, "Well you aren't my father so..." I think you have to be really firm about what you want, inordinately so.

I don't think I have ever had a conversation with a healthcare professional about informed options where they talk about the side effects of all of the different options. I have never had a conversation where I felt like I was given options to choose from. With every encounter I have had I have to convince health professionals that I am capable of having an option. I find myself getting into arguments about my ability to make decisions about what birth control I want to use. What about the people who go to a health professional who don't have the same resources and who don't feel comfortable confronting a doctor about birth control options? I guess they walkout with whatever they walkout with and that's that.

I have yet to encounter a space where an actual conversation could happen between a healthcare professional and a client where there is a sex positive, woman positive, space. Where they honour and believe what you're saying about your body. This is something that you can access in the south. There's almost always a sexual health space where you can go to find out about different birth control options and free birth control and people are trained to

believe what you're saying about your body and your unique needs. This is a huge obstacle here. I imagine there are even bigger issues of barriers to care and access in the communities.

I think we need to have sexual health curriculum start at an early age, even as early as preschool. Sexuality should be integrated into everything that you're learning so that it isn't separate and imbued with shame. When you're learning about dinosaurs you are also learning about vaginas and you are learning the appropriate words. All through school there is a specific teacher who comes in to teach you French and so forth. I think that there should also be a teacher that specializes in sexual health someone that you develop a relationship with. It is important that there is an open safe space where you can find out what you actually need to know and feel safe and comfortable about your sexuality. Education should not further marginalize queer people, like that's completely pointless. We have to ensure that sexual health education is not just hetero-normative. It must be inclusive. It would also be beneficial to have a referral system. A knowledgeable person could refer you to community clinics and resources if you need that.

That being said we need a dedicated sexual health clinic that would maybe operate after school hours so that more people could access it. It would be safe for young people and safe for women. It would also be a sex positive, feminist space. A space where you are respected for your choices and can make really informed decisions. It wouldn't be a judgmental environment and everyone in the building even the administrative assistance would be welcoming and non-judgmental. There are two components. One is curriculum in schools to allow for students to become informed, and also a space within the community that tests for STIs, pregnancy and performs abortions. I would also like to see funded birth control.

Public Health and public education should play a role in interacting in cycles of violence. We need to think critically about gender roles and healthy relationships because many people have only known unhealthy relationships, but we need to introduce alternatives to what is seen at home and in the community.

Summary

I feel very honoured to have had the privilege of listening to and restorying the five participants' life stories. I heard strength, wisdom, resilience and a strong desire to see change in all of their voices. Although many of the women come from diverse backgrounds they all attended school and accessed services in Yukon and all were between the ages of 20 and 30 years. Their stories are all bound by a common desire to see improvements made for the next generation of women. The following chapter describes the categories, themes and metathemes found in the participants' stories.

Chapter Five: Analysis of Themes and Categories

After the restoried narratives were read and approved by participants, I entered phase two, which is where I conducted a thematic analysis of the narratives. I chose to do a secondary phase of analysis in order to protect my participants' stories and only present the secondary analysis of categories and themes in any future publications or presentations. I did this by reading and rereading the restoried narratives and identifying general categories according to the common language and trends shared by participants. I then descriptively coded the narrative sections according to categories and was able to narrow these categories down to three main categories, *Sexual health education in Yukon schools and sexual health services and supports in the community*; *Challenges associated with limited access to sexual health education and services in the schools and community*; and *Utopia: Dreams for the next generation*.

This process gave more meaning and understanding to the primary research question: What are women's stories of sexual health education and services and how have these stories affected their sexual health and overall well-being? Secondary questions: How do women describe culturally safe, non-judgmental and non-discriminatory health education and services? What would women want to see implemented in current sexual health education and services to improve overall well-being and quality of life? The categories and the corresponding themes are highlighted in the table below. In the third phase, a meta-analysis was used to identify common themes, patterns and connections across all of the participants' stories. The following themes were not identified in the early phases of analysis, but are the binding, overarching metathemes of the study: *Trust, Accessible Sexual Health Education and Services, Desire for Positive Change*.

Table 1

Overview of Categories and Themes

Research Questions	Interview Questions	Categories	Themes
<p>Primary Question: What are women's stories of sexual health education and services and how have these stories affected their sexual health and overall well-being?</p>	<p>Please tell me your story of sexual health education and sexual health services in Yukon?</p>	<p>Sexual health education in Yukon schools and sexual health services and supports in the community</p>	<ul style="list-style-type: none"> • My Changing Body: Mixed Messages • But I have Questions • Embarrassed and Ashamed • Sex is Bad: You might get Pregnant or Become Infectious • Rumors: Lack of Anonymity • Am I in Control? Birth Control, Who knows Best
<p>Secondary questions: How do women describe culturally safe, non-judgmental and non-discriminatory sexual health education and services?</p>	<p>Have you experienced barriers accessing sexual health education and services in Yukon?</p> <p>How have these barriers affected your life?</p>	<p>Challenges associated with limited access in the schools and community</p>	<ul style="list-style-type: none"> • What is a Healthy Relationship? • Gender Stereotypes • Where do I fit? Hetero-normative Sex Ed • Is there anyone I Can Turn to for Support? • Can I Trust You? • Violence Against Women • Wish I had That When I was in High School
<p>What would women want to see implemented in current sexual health education and services to improve overall well-being and quality of life?</p>	<p>What changes would you like to see for the next generation of women?</p>	<p>Utopia: Dreams for the next generation</p>	<ul style="list-style-type: none"> • Start Young: Towards a K-12 Sexual Health Curriculum • Sex Positive Education • Moving Away from Hetero-normative, Whitewashed Sexual Health • Healthy Relationship Training • Safe Space: Sexual Health Centre

Sexual Health Education in Yukon Schools and Sexual Health Services and Supports in the Community

This category highlights the barriers that participants faced in school and the community, specifically as it pertains to the limited exposure they had to sexual health education within the school and availability of safe anonymous sexual health services within the greater community. Participants speak to the detrimental effects this had on them and how it continues to affect their lives such as their abilities to talk about sex with peers, navigate birth control options, and seek anonymous, trusting advice from health professionals.

My Changing Body: Mixed Messages

My first memory of sexual health education in school was when my friend's parents came in to talk with us...They didn't talk about reproductive rights, they didn't talk about abortion, they didn't talk about sexual assault or our rights, in terms of our bodies and our space. They didn't talk about any of that. (Emma's Story)

Participants' shared similar stories about their initial exposure to sexual health in elementary school, stating that it was very limited in scope with little time to develop a trusting relationship with the presenter, process presentation content, and formulate questions. After the initial sexual health presentations in elementary school there were few participants who felt that they had someone to ask about outstanding questions that related to sexual health. Many participants were confused as to why the boys and the girls were split into two different classes, suggesting that it is important for boys and girls to learn together.

I don't remember having any sex ed classes until grade five and then we got split up by gender and the strange thing about that is you don't get to learn what the boys are learning. Maybe they separated us to make people feel more comfortable, but I really think they should have taught both the groups the same thing. The girls just learned about puberty and periods, but nothing past that. I found out from one of my male friends that they learned about wet dreams. (Clare's Story)

After elementary school participants had a handful of sexual health presentations in high school. One participant suggests that, *“It doesn’t seem adequate that during my whole time in elementary school and high school there was maybe five or six hours spent on sexual health. That seems pretty bad”* (Morgan’s Story). This is echoed by another participant who states, *“I think the decisions around curriculum and the way it’s delivered all the way through school is a fucking disaster”* (Clare’s Story). Participants felt that it was difficult to begin to discuss sexual health with their peers and become comfortable with their own changing bodies because they had such limited exposure to this topic. Often parents or nurses were brought in from the outside for an hour to discuss the basics of sexual health. Many felt that they had not developed a trusting relationship with the presenter so often the presentation sparked questions in students, but those questions were never asked.

But I have Questions

No one came in to talk about sex again after that in elementary school. It was just that one time. I had more questions that I definitely wanted to ask. I did have one family member I could talk to about this, but asking her was also kind of difficult because my own comfort levels weren’t there. For a while I just kind of went without. (Emma’s Story)

All participants expressed that the few presentations on sexual health they received left them with more questions and in most cases those questions were never asked because there was not an appropriate, space to ask them nor was there a referral process. Participants stated that there was not a reliable professional referral system within the school. There was a lot of peer-counselling as a means of answering outstanding questions. Vivian expresses her hesitations about this process,

And then after those presentations and classes that was it. If I had questions about anything, there wasn’t really anywhere to ask...I mostly relied on family and friends for information and that friend thing was really good because it was supportive, but now that I look back on it as an adult it was really

misinformed...It would have been good to have had more access to sexual health education and services growing up. (Vivian's Story)

Vivian remarks that peer based education and counselling was often misinformed. Participants used peer education and counselling because there was not anything else for them to use. It was done out of a basic need to address concerns and navigate available services within the community. *"Everything we learned from that point on we learned on the fly. I learned from my friends. I didn't talk to anyone else about it. My family certainly didn't talk about sex"* (Sam's Story). Some participants felt that they did not have the knowledge they needed leading up to sex, but sought it after. Some participants did not know where to get birth control before having sex, but learned how to access emergency birth control after. Many responses to sex were emergency, fear based, and reactive responses. Many participants wished that they had preventative based knowledge and resources to draw on. Sam expresses attempting to engage a teacher in a discussion about STIs.

There were no teachers that I felt safe enough to seriously ask them about sexual health. There was one time when I was 17 and I wanted to know if you could get crabs from the toilet seat so we asked this big dumb teacher about it. He told us that we shouldn't use the toilet if it looked like there was pepper on the seat and then he laughed and walked off. That is the only thing I ever asked. (Sam's Story)

Sam felt safe with this teacher, which is why she asked him a question about STIs. This question could have allowed for a bigger conversation about STIs and sexual health, but the teacher was not comfortable with the question and instead quickly turned the conversation into a light hearted joke. Teachers should not be expected to be experts on sexual health; however, community referrals should take place when important questions need to be addressed.

I remember people asking questions during the presentations when the nurses came in, but outside of those classes, I don't think there was a lot of support

for people. The information I found myself was information teachers probably felt awkward talking about in the school. (Morgan's Story)

Participants shared their observations of a common understanding of their teachers discomfort with the topic of sexual health education. Some teachers were incredibly uncomfortable while teaching sexual health classes. In most cases, the participants sensed this discomfort and in turn became uncomfortable, feeling like it was not appropriate for them to ask questions. Clare expressed her frustration with this common occurrence,

I had a mom who gave me books on sexual health so I could investigate things on my own...The thing about public education is that we can't assume that all parents provide that material to their children. We have to assume that they don't so all students have access to the information they need. I feel very lucky that my mom gave us sexual health books, but I know that there were a lot of students that didn't have that and that is not acceptable. Educators can't just decide not to deliver sexual health education because they don't know how to deliver it or they feel uncomfortable. They really have to get over their own bullshit. (Clare's Story)

Clare was very grateful for the sexual health education her parents provided, however feels incredibly frustrated for those that do not have access to resources or parents with this knowledge and the expectation that gaps will and should be filled at home. Likewise, Emma reveals that information she learned in biology class made her very concerned about the regularity of her menstrual cycle. She was very worried that something was wrong, but felt that she had no one to ask.

I remember learning some stuff in biology...It was interesting to know, but it raised a lot of questions because it wasn't familiar to me. I remember wondering if there was something wrong with me because I wasn't always regular. From my understanding according to my biology class you were supposed to get your period once a month. Sometimes I would get really worried and wonder if I had cancer or something like that...I would have liked to talk to somebody in health about irregularities, but I wasn't able to. (Emma's Story)

Emma states that she was not able to ask questions about her menstrual cycle. It is important to understand what she means by this. She had a family doctor, but did not feel comfortable discussing this with her doctor. Her mom would also attend all of her medical appointments and she did not want to discuss this with her doctor while her mother was in the room. There were no procedures in place to facilitate a safe conversation about her body and her sexual health. It is also fair to assume that her family doctor had no idea she had questions.

Embarrassed and Ashamed

My friends and I didn't talk about sex with each other because we weren't comfortable talking about it. I think that is one thing they probably missed in our few sexual health classes, which is that it is totally natural and it is okay to talk about sex. (Emma's Story)

A theme amongst some participants is that of embarrassment and shame around the topic or discussion of sex. Some participants had a desire to talk and learn from their peers, but had absolutely no comfort around the subject. Emma reflects on specific moments when she had an opportunity to discuss her period with her close friend, but shut the conversation down because she was too embarrassed and uncomfortable with the subject. Clare remembers feeling uncomfortable in class when one of her teachers taught sexual health because the teacher was so uncomfortable with the topic. This discomfort transferred to the students in the class.

...I do remember this blushing skinny teacher who was entirely red as he taught a sexual health class. I don't remember the content at all...all I remember was how embarrassed he was, it was so awkward. (Clare's Story)

If teachers are uncomfortable teaching a sexual health class there is a high probability that the students will feel a sense of discomfort as well. Clare remembers that she did not focus on the content of the information that was being delivered, but was fixated on the complete discomfort of her teacher and simply wanted the lesson to end. This discomfort is not solely

an issue within the school, but is a common theme within services offered in the community. Clare reflects on the discomfort she felt during her early teens when she went for her annual doctor's appointment.

I used to be terrified of them [doctor's appointments] because near the end of each appointment she [the doctor] would ask if I was sexually active...I do remember thinking you can't just start from zero with a question like that. It would have been more comfortable if we had established a relationship and built up to those bigger questions. There was no way I was going to start asking questions I had about sex because we didn't have that kind of relationship. (Clare's Story)

The need to develop trusting relationships with health professionals and educators before being prompted to respond to sensitive questions about sexual status was very important and a theme that was highlighted by most participants. Many participants had questions and a desire to ask these questions, but did not have trusting relationships with an adult, teacher, nurse or doctor and therefore their questions were never asked. Spaces such as sexual health classes, and doctor's offices are places where one would think would be safe spaces to ask questions, especially if you are being prompted to ask them, but trust is key and if it is not present, questions are not asked. Sam reflects on measures she took to get information about birth control, STIs and pregnancy.

Sometimes when I was in hospital waiting rooms I would grab pamphlets...but I would always hide them inside one about blood pressure because you don't want anyone to see you read something about birth control, STIs or pregnancy. (Sam's Story)

Sam's story reminds us of the persistent discomfort youth encounter in places that the greater public might perceive as a safe space to gather information, yet Sam felt the need to hide her pamphlet about sexual health in a pamphlet about blood pressure in an attempt to save herself from embarrassment.

Sex is Bad: You might get Pregnant or Become Infectious

Sex was never explained as being a good thing, something you could enjoy as long as you're safe. It was more of scare tactic—scaring people with pictures of diseases that you can catch rather than a more realistic approach. We didn't focus on what might happen in a relationship or how to talk to a partner. (Morgan's Story)

A common theme participants shared was the terrifying STI presentation they received from public health nurses. Morgan echoes the feelings, which most participants expressed. She felt that although the STI presentation was important, other components of sexual health, such as healthy relationships and navigating consent were not part of the presentation. *“In grade 9 we all had to do presentations to scare the crap out of us about STIs with horrible pictures. Then we never talked about sexual health again”* (Sam's Story). Many participants went away from the presentation feeling far from empowered, and shared feelings of disgust and negatively toward their bodies and sex.

There was a very consistent message in the few sexual health classes we had. The message was be afraid. Sex is bad and you will probably get pregnant or get an STI if you have sex. When we were divided by gender the girls had to watch a really detailed video of birth and one of the girls said that it was disgusting. The nurse said, “You think that's disgusting, but you would let someone put their penis in your vagina?” If you're ever wondering about sexual health education here and wonder if it was sex positive. I would say probably not. Unfortunately, the fear tactic worked. The birthing video was horrible and the common consensus was that birth is really going to hurt therefore penises are gross. (Clare's Story)

Many participants did not feel that the presenters were intentionally trying to promote fear, but rather did not know how to deliver the material with a sex positive lens. Also there was not enough time allotted to the presentations and no follow up presentations were given. The concern amongst many participants was that this fear-based style of educating about

sexual health can cause destructive patterns in youth's lives, contributing to poor body image, unhealthy relationships and a negative perception of sexual organs and sex in general.

And we were all in the class with the girls and the boys and she gave us all these candies and then she did the horror slide show of the worst STI's that you could possibly get. There were pictures of genital warts that are just inflamed and awful. And I imagine a lot of people had not even seen pictures of regular genitals before that point. And then here they are showing us the worst ones that you could possibly get and we were horrified with the whole thing. All of us were embarrassed and disgusted and totally grossed out and didn't want to ask any questions and were just hoping to god that we never got them. (Vivian' Story)

Participants were scared of sex. Some felt like they had to drink to feel comfortable with sex.

This is extremely problematic as sexual assault is easily excused when drinking is involved.

Women are blamed for drinking and the sexual assault is all too often overlooked and excused, despite the fact that legally you cannot consent to sex when you have been drinking.

It is important that we develop healthy life patterns around sex and this is only possible if we start normalizing healthy relationships and giving examples of what this might look like in sexual health class.

Rumors: Lack of Anonymity

We also have to think about rural Yukon communities. It is really difficult for women in the communities...When you walk to the health clinic people all see you and ask why you went there. Also what if your aunty is working at the front desk, what do you do then? I know of several people in the communities who have just had kids. They wanted to have an abortion, but their families wouldn't let them and they had no other way into town to get the abortion. It's kind of pitiful that people don't have access to these things...you should have the right to choose not to have a child... (Sam's Story)

A theme in many smaller settings is lack of anonymity and access. The smaller and more rural a community is, the more challenging it is for people to remain anonymous. Participants noted that some of their peers were unable to access the proper reproductive care they needed

due to a lack of anonymity. Sam mentions that women should have a right to choose not to have a child without being judged by others. This is often accomplished by insuring that anonymity is kept, which can be nearly impossible in a small community.

I remember really only feeling comfortable going to the Communicable Disease Clinic to get tested or to get information. I was always a little scared when I would go, and a little uncomfortable about who might see me because it is a small town. Sometimes you would be sitting in the waiting room and then all of a sudden somebody you know would come in, so that was always uncomfortable. (Vivian's Story)

In some cases participants did not go to access sexual health services such as STI testing because they were too scared of running into someone they knew in the waiting room or at the front desk. Some participants had family doctors who were friends of the family. *"I wouldn't confide in my family doctor with something that was really personal because I might see him at some family gathering and it would just be really awkward"* (Morgan's Story). Vivian expresses her frustration with a school counsellor who broke her trust by breaching confidentiality.

When I was seventeen I got HPV from a guy I was sleeping with and I told my school counsellor. There was a teacher at school whose daughter was dating the guy who gave it to me. And the school counsellor pressured me into telling the mother about it so she could warn her daughter. And then it got all around school and everybody knew about it...I went to that counsellor for support and to have a private confidential talk because I was really upset. (Vivian's Story)

The counsellor in Vivian's story was misinformed about STIs and broke her ethical code of conduct as a counsellor by telling a coworker something that was confidential and only Vivian's to reveal on her terms and her terms only. Vivian felt completely ostracized by her peers and never went to a school counsellor again. She needed to talk to someone and when she did it ended up being a very traumatizing experience for her. Anonymity is very difficult to uphold in very small communities. Clients and professionals can do everything within

their power to keep a client's visits private, but if a relative or a friend sees you in the waiting room and jumps to conclusions there is very little that can be done to uphold anonymity. However professional counsellors, teachers, nurses and doctors are requested to be especially vigilant about never revealing confidential information.

Am I in Control? Birth Control, Who knows Best?

Years later, when I was in my twenties I went to the doctor and asked about birth control. I'd done my research and I wanted an IUD. The doctor said he wasn't going to give me an IUD because I was too young and hadn't had a baby. Instead he gave me the birth control pill. After I got those pills I sat on them for a while because I didn't feel comfortable with them. I didn't want hormones, I've known that forever that I didn't want hormones. I was independent, aware and educated, and I wanted to be self-determining. Then I go to an expert who claims to know you better than you know yourself, but that's total fiction. Doctors know science and I know my body and what I want. (Clare's Story)

Participants such as Clare express their frustration with their inability to have an opinion on birth control. Clare researched her options and went to her doctor with a clear idea of what would work best for her. She had hoped to have a discussion about birth control, but instead was given the oral contraception option and there was little discussed. She did not want hormones, but that is what she went home with. *"I wanted to be self-determining. Then I go to an expert who claims to know my body better than I do, but that's total fiction"* (Clare's Story). Patients should expect to have a discussion with their healthcare professional about their options. This did not occur for most of the participants and many were left with a feeling of limited control over their bodies. Morgan echoes Clare's experience, *"I had some friends who had issues with their doctors because they wanted to go on birth control, but their doctors were a bit judgmental and would say, "oh you're too young"* (Morgan's Story).

I don't think I have ever had a conversation with a healthcare professional about informed options where they talk about the side effects of all of the

different options. I have never had a conversation where I felt like I was given options to choose from. With every encounter I have had to convince health professionals that I am capable of having an option. I find myself getting into arguments about my ability to make decisions about what birth control I want to use. (Clare's Story)

Many participants worry about others with even more limited resources than themselves, “*What about the people who go to a healthcare professional who don't have the same resources and who don't feel comfortable confronting a doctor about birth control options? I guess they walkout with whatever they walkout with and that's that*” (Clare's Story). Clare fears that some women may have blind trust in their doctors, ending up with birth control without a discussion about other options. Paying for birth control is also a barrier and for some it is completely out of reach financially.

The cost of birth control was a barrier. If my mom wasn't paying for it, I don't know who would have paid for it. Some of my girlfriends who didn't have as much money were always trying to figure out ways to pay for it. I think if you didn't have any money, it would have been harder to get. (Vivian's Story)

Vivian suggests that she would not be able to afford the birth control pill if her mom had not offered to pay for it. She echoes the importance of recognizing that not all youth are comfortable telling their parents that they are having sex and then asking their parents to pay for birth control and likewise parents are not always willing to accept their child is having sex and/ or willing or able to pay for birth control. Health promotion does an excellent job of distributing condoms, however if the high school does not allow condoms in the school there are few places where high school aged youth can access condoms. “*If you were under age and couldn't go to the bar to get free condoms I'm not sure where you could go?*” (Morgan's Story) If the healthcare system creates barriers to accessing birth control it is not surprising that there are high numbers of abortions performed in Yukon. “*Health professional didn't always seem open to young people making their own decisions. I guess there were just more*

conservative attitudes around young people having sex” (Morgan’s Story). Participants expressed the importance of ensuring that women have access to birth control options where they can make informed choices and decisions about their reproductive rights.

Challenges Associated with Limited Access to Sexual Health Education and Services in the Schools and Community

In this category participants emphasize how the barriers they experienced in school and in the community affect their lives and the lives of their peers such as their ability to navigate healthy relationships, develop trusting relationships with teachers and health professionals, speak out against gender stereotypes and address high levels of violence against women.

What is a Healthy Relationship?

Sexual relationships are some of the most important relationships in our lives and they really didn't do a great job of going into any detail around what the relationship part of it would involve, we focused on the biology side of things. (Morgan’s Story)

A common theme amongst participants was the concept of healthy relationship training as part of the sexual health curriculum. Morgan expresses the importance of moving beyond the biological mechanics of sexuality to discuss the relationship piece as well. Vivian gives an example of an unhealthy relationship highlighting her example of the importance of offering healthy relationship training to prevent the following,

My friend got pregnant by this gross guy, he was like this older guy too, really sleazy kind of guy. He didn't want her to have an abortion and he was really pressuring her not to. I think stuff like that might have been a barrier too, with partners who were forceful or abusive in any way. We didn't really know how to deal with him. Imagine, these two teenagers girls going alone to this older guy's house to confront him about our rights? I remember that being a frightening memory of my childhood, having that happen. (Vivian’s Story)

It sometimes appears that society expects that people know what healthy relationships are, however participants suggest that this is a dangerous assumption to make. Many people did

not have positive examples of healthy relationships in their teens and in some cases did not know how to recognize unhealthy relationship in their lives.

Gender Stereotypes

People assumed that if you slept around you couldn't get raped. People thought she was doing it for attention because in her past she had used really negative ways to get attention, but you could tell, she went through this stuff for years and never retracted and you don't think it would be worth it after all those years. (Vivian's Story)

Participants reflected on the dangers of gender stereotypes amongst their peers, at school and in the judicial system. Vivian tells a formative story from her past where her “wild” friend was raped and was ostracized, and emotionally and physically abused from her peers. When she reported the crime little was done. Vivian shares that her friend had a reputation of sleeping around and therefore when she was raped she was blamed and her rape was dismissed because “someone so promiscuous could not be raped.” Even her close friends had to back away because their safety was threatened.

You can just see how these things get perpetuated—suggesting that women ask for it by the way they're dressed. There's often a lot of victim-blaming especially when it comes to a women and what she wears, whether she was walking late at night and how much she had to drink. Stuff like that. Or the mixed messages we get from the media where the onus is place on the person who was sexually assaulted. It just makes no sense. (Morgan's Story)

Morgan dedicates some of her time delivering consent workshops for youth in high schools. The workshops teach youth about the legal definition of consent by using the example of a real case that went to the Supreme Court of Canada. The workshop breaks down stereotypes that we all hold about women and attempts to address victim blaming. The workshop encourages attendees to reflect on personal examples of victim blaming and gender stereotypes that we all hold. Morgan would like to see consent be part of the sexual health

curriculum. Currently, these workshops are delivered in schools upon requested and during sexual assault prevention week.

Where do I fit? Hetero-normative Sex Ed

I don't think there was anyone that was openly gay in my high school. People went away and then came out. There were two girls that were accused of being gay at a camp in grade 6 or 7 because they slept in the same tent and people suspected they were fooling around. They were totally targeted and harassed. It didn't feel like a safe place for anyone to come out. I was a really strong independent woman in high school and as a result I was accused of being a lesbian and was really targeted. I couldn't imagine what it would be like for me if I was a lesbian here in high school. It would have been really, really challenging. I think that's why people wait to come out once they have moved away. They probably felt safer coming out away from here. (Vivian's Story)

Many participants expressed the importance and the need for inclusive sexual health education. Several stated that sexual health curriculum should not be designed solely to cater to those that are white heterosexuals as this would further the discrimination towards those that do not fit this mold. Participants stress the importance of creating a safe, non-judgmental, non-discriminatory space so all students feel included. *It is important that there is an open safe space...Education should not further marginalize people. (Clare's Story)*

Some participants mentioned the importance of creating a culturally safe space, especially for the First Nations youth who come in from the communities to attend high school.

Is there Anyone I Can Turn to for Support?

I couldn't go to the doctor without my mom also being in the room so I didn't feel comfortable asking questions about my sexual health while my mom was in the room. For a while I didn't even have a doctor, which is something that is normal in the Yukon for a lot of people. I kind of just went without. (Emma's Story)

Participants suggested that they had few people they could turn to for support in the area of sexual health. Often participants had questions such as Emma, but did not have

appropriate opportunities, trust in the healthcare provider, or confidence to ask their questions. *“We could pick up pamphlets and look at them as they were made very available, but there wasn’t any person that we could talk to about anything. At least I didn’t know if there was someone to talk to about them”* (Emma’s Story) Even as an adult Sam expresses her frustration with her doctor’s discomfort in response to her sexual health questions.

I have reproductive health issues, so I was seeing a gynecologist and I asked if there any sexual positions that are better for my husband and I to use for conception. He couldn’t say sex. He couldn’t look me in the eye. He was like, “well, you can look on the internet and there are some different things that it says on there about different ways to do it.”... I often leave there feeling like he just poked me and prodded me. I don’t go away with any of my questions answered. We really need a safe place in Yukon where women can go to get their reproductive health questions answered. (Sam’s Story)

Sam is not alone in her desire to see a safe space for women to feel heard, to ask questions about their reproductive health, and receive answers. Most, participants shared examples of this.

Can I Trust You?

It was crazy, I remember being at this party where we were arguing with these guys about it and I remember this guy grabbing me by my neck and slamming me up against this fountain and screaming at me saying my friend was a liar and that I was liar, and telling me and my friends to watch out. It was horrible. And the RCMP, they didn’t tell my friend where to go. They didn’t tell her what services were available to her. We didn’t know that the threats these guys were making were illegal. We didn’t know we could have gone for more protection. (Vivian’s Story)

Vivian returns to the story of her friend who was raped and reflects on the danger that she and her friends experienced just for being an ally to the girl that was raped. They were verbally and physically threatened and they felt like they had no one to turn to. When they reported the rape they were not referred to anyone for support and did not realize that the

threats that were being made towards them were illegal. They did not know where to access any form of support within the community.

My friends and I ended up self-counselling so that ended up being a major resource but of course it was only whatever information we knew when we were 16-17 years old. My friends and I were sexually active quite young, and we talked about that stuff and we were all really super confident young girls at that age. (Vivian's Story)

Participants such as Vivian often relied on peer counselling for their main source of support; however, she does admit that many of the issues they were dealing with required professional opinions. Due to limited trust in the system because of their negative experiences with various professionals they only trusted their small groups of friends.

Violence Against Women

Then a few days later we found out she had been raped by this guy at the party. She was this super crazy girl and she was kind of slutty and she did drugs and as a result had this bad reputation, but she was our friend and so she told us what had happened. Again, I don't know where we got this information, but we were like, "you gotta report this, this is ridiculous, you should go to the police." And so we went to the police and reported it. It took a really long time for everything to be processed. I think in the long run they dropped the case because our interviews were done too late after the fact for them to be counted as evidence or something. They said our memories weren't clear enough so that is the reason it didn't go to court, at least that's what I remember. (Vivian's Story)

Vivian tells the story of her friend who was raped and her struggle to support her during this difficult time. She states that she knew to report the crime, but did not necessarily know how she knew that it needed to be reported. She expressed her concern for those that might have seen the event as something that her friend may have asked for because of the way she was dressed, how much she drank or her "promiscuous reputation." Vivian knew it was wrong despite what her peers and other professionals said. Vivian learned at a young age that violence against women is alive in well in Yukon.

I started processing the trauma and began to realize how much bitterness and resentment I had towards being in a town where it was permissible to treat someone like that. Even now talking about it I can feel myself getting really heated, feeling that lack of justice of what happened to her. That was 12-13 years ago now. (Vivian's Story)

Due to the limited support she received from service providers in the community and the negative reactions from her peers it took Vivian a really long time to process the experience. She stated that years after the rape some of her peers still ask her if her friend was really raped. All participants voiced their concern about victim-blaming and the high levels of violence against women in Yukon. Sam suggests that one way to address the high levels of sexual assault in Yukon is to address issues such as consent, assault and rape in sexual health classes.

I think the high incidents of sexual assault that we have in the Yukon should be a huge component of sexual health education addressing things like sexual assault and rape. It should also address healthy relationships and what they should look like, which also allow people to identify what an unhealthy relationship looks like. That way people are taught that there should be a mutual agreement and consent before having sex. (Sam's Story)

Participants stress the importance of teaching students what a healthy relationship is. Stating that it is dangerous to assume that everyone has examples of healthy relationships and healthy sexual behaviour in their lives (peers, family, community). *We need to think critically about...healthy relationships because many people have only known unhealthy relationships, but we need to introduce alternatives to what is seen at home and in the community. (Clare's Story)* Participants suggest that because we cannot assume that examples of healthy relationships are available in someone's everyday life they have to be available in schools.

I Wish I had That When I was in High School

And the two girls who grew up in Vancouver were so savvy. They were so cool and urban and they knew where to get all this stuff, even things like sex toys...where to get free birth control; where to go and get an abortion; where

to go get support after your abortion; where to go if you were dealing with abusive relationships; where to get free pregnancy tests. (Vivian's Story)

A common theme amongst participants was their experiences after high school in university. Many participants such as Vivian were so impressed by the amount of knowledge some of their classmates from larger cities had about sexual health. Many participants began to see what their high schools were lacking when it came to access to sexual health curriculum. The same sentiments were expressed with the limited availability of sexual health services *“If someone had been readily available to provide me with non-discriminatory, non-judgmental information on birth control, I would have been on it far before I actually was”* (Sam's Story). Most participants have returned to Yukon with willingness and an active desire to make change. For most participants going away to school allowed them to see that change was possible because accessible sexual health curriculum and sexual health services exist in other jurisdictions outside of Yukon.

Utopia: Dreams For the Next Generation

In this category participants identify their hopes and aspirations for the next generation of women. They depict an inclusive, culturally safe, non-discriminatory, sex positive, sexual health curriculum that starts in kindergarten and follows students through to the end of high school. They speak to the importance of healthy relationship training and a sexual health clinic.

Start Young: Towards a K-12 Sexual Health Curriculum

I think sexual health education could start really young so that people become more comfortable with their sexuality and that way more educated detailed discussions can occur. If you only have a few hours dedicated to sexual health throughout school it becomes really difficult to have a comfortable conversation about sexual health. (Morgan's Story)

Participants articulated a desire to see sexual health classes start at a very young age to familiarize children with the topic of sexual health and to allow for meaningful conversations to take place as the years go on. That way sex will not be an uncomfortable, foreign topic. Morgan states how difficult it can be to have a meaningful, comfortable discussion about sexual health when a student has only had a handful of presentations on the subject throughout their school career.

It could be as simple as being able to label a penis and a vagina and knowing what a penis and vagina are. Knowing that it is not a hoo-ha and wiener, it is a penis and a vagina... I have a member of my extended family who was sexually assaulted by a grandparent and they didn't know how to talk about it or ask for help. This grandparent would cut the child's hair and then would blow it off the child's penis, but the child didn't know how to say that. The child just said, "Grandpa would blow the hair off me" which didn't sound bad because the word penis wasn't in there. If they had known the word penis the meaning of the story would have changed and something might have been done. (Sam's Story)

Sam speaks to the importance of knowing how to label sexual organs correctly and gives an example about sexual abuse stating that, children cannot accurately report sexualized assault when they cannot use the proper language to depict an event. Often the incident will not seem as serious without the proper language to shed light on the details. Sam's family did not speak about sexual health at home, which emphasizes the importance of having it offered at school.

I think I probably would have been a more confident person overall. I wouldn't feel like I have something to hide, I wouldn't feel ashamed for not knowing. That is something that I do grapple with. I would be healthier. Having access to these services would have affected my life in other ways, relationships-wise, maybe career-wise, I don't know, it would have affected a whole bunch of different things. (Emma's Story)

Emma reflects on the limited access to sexual health education that she had throughout her school career and feels like she would be a different person if she had regular sexual

health classes throughout school. Throughout her story she highlights her feelings of shame and embarrassment around sexual health. She had many questions, but did not have the needed resources or confidence to field questions.

Sex Positive Education

We have high rates of pregnancy and STIs. Terrifying students with videos of pregnancy and pictures of STIs isn't empowering them to take care of their bodies. I don't want to see people have to get wasted so they feel comfortable having sex. There are certainly ways to structure sexual health education in the classroom that isn't fear based. (Clare's Story)

Participants emphasized the importance of a sex positive approach to sexual health education. Although it is important to talk about pregnancy and STI prevention, it should not be the primary focus. Youth should not be made afraid of sex, but rather should have an opportunity to talk and learn about the positive fun aspects of safe sex. There is a fear amongst the participants that by solely providing negative information about sex, youth will have an unhealthy and uncomfortable relationship with sex. When youth feel uncomfortable with sex, there is little discussion and healthy negotiation between couples. Some participants feel that discomfort can lead to an increased use of alcohol and drugs to feel more comfortable with sex. This can lead to higher levels of violence as alcohol and drugs limit people's ability to accurately judge situations and are often used as an excuse to be violent.

Sam highlights this in a story about her younger sister,

My sister was passed out in a bathroom and there was puke all over her and she had wet herself it was really horrible. We took her to the emergency room at the hospital and we told the nurse that we thought she needed to have a check done to see if she has been raped. Anyway that incident set the stage for her exploration into sex, which was crisis focused. I think if she had more exposure to positive sexual health education this might not have happened. (Sam's Story)

Sam explains that her sister's experience with sex is crisis focused. She worries about youth who have few healthy experiences with sex. Her sister had no positive examples of what sex was or could be like. Sam worries that this will become a pattern for her sister.

Sex is this incredible thing. I think it is really important to talk to them about their first sexual experience. I think a lot of young women have very disappointing sexual experiences, and they are expecting to have this sex that they see in movies and it doesn't happen. I would love for people to have less frightening more realistic knowledge. (Vivian's Story)

Vivian addresses the issue of popular culture and the role it plays in many people's initial encounters with sex. In some cases this can paint an unrealistic picture for some. Vivian wants to see a more realistic less frightening approach to sexual health education.

Moving Away from Hetero-normative, Whitewashed Sexual Health

Education should not further marginalize queer people, like that's completely pointless. We have to ensure that sexual health education is not just hetero-normative. It must be inclusive. (Clare's Story)

Participants were vocal in their desire to see inclusive, non-judgmental, non-discriminatory, culturally safe sexual health education, meaning that sexual identity and cultural diversity would be incorporated into the curriculum. Clare states that sexual health education cannot further marginalize people. People who are considered to be "minorities" have a right to a sexual health curriculum that is meaningful and safe and they should not be overlooked.

Healthy Relationship Training

Public Health and public education should play a role in interacting in cycles of violence. We need to think critically about gender roles and healthy relationships because many people have only known unhealthy relationships, but we need to introduce alternatives to what is seen at home or in the community. (Clare's Story)

Participants identified a common desire to have a holistic approach to sexual health where the physical, mental, and emotional well-being of the student is taken into consideration. Participants such as Clare identified not only a shortage of sexual health classes throughout school, but more often than not the classes focused primarily on the physical, biological side of sex. There was little time designated to the mental or emotional aspects such as healthy relationship training. Participants expressed the importance of teaching youth what a healthy relationship is. Too often, youth do not have examples of healthy relationships in their everyday lives and need to be given concrete examples of healthy relationships.

Safe Space: Sexual Health Centre

I have yet to encounter a space where an actual conversation could happen between a healthcare professional and a client where there is a sex positive, woman positive, space. Where they honour and believe what you're saying about your body. (Clare's Story)

The theme of a sex positive, woman positive space where people could go to access sexual health services came up in every participant's story. The participants were adamant about the centre being an accessible safe space for those seeking reproductive healthcare. Currently, Yukon does not have an abortion clinic or an all-encompassing space where women could go to get counselling, information about STIs, birth control and abortions.

I think it would be better if there were another kind of drop-in centre where you could get sexual health education and services. A place where you could get information on pregnancy, birth control, STIs abortions and all of those services... If there were a lot of different services available at the clinic people wouldn't necessarily know why you went there. For example if you went to the clinic to get an abortion you could say that you went there to look into birth control options or something. (Sam's Story)

Sam expresses the importance of having all of the centre's services in one place. If a woman went to access an abortion at a health centre that offered many services such as counselling,

birth control, STI testing etc. she would not only have an opportunity to access many services at once, but if she was there for an abortion she could just say she was there for counselling or to get information about birth control. This makes the space more accessible for women.

Participants also expressed the importance of having a health centre that had flexible hours of operation, which would allow youth who are in school and/ or working women access to services in the evening. Many participants referenced centers that are in operation in the south. Although the initial startup cost of a sexual health clinic would be costly it would most likely become cost effective in the long run by contributing to the sexual health and well-being of the community at large. There are many sexual health clinic models that currently exist in southern jurisdictions that could be adapted to meet the unique needs of those in Yukon.

Metathemes

In the third phase, a meta-analysis was used to identify common themes, patterns and connections across all of the participants' stories. The following themes were not identified in the early phases of analysis, but are the binding, overarching metathemes of the study:

Trust, Accessible Sexual Health Education and Services, Desire for Positive Change.

Trust

All participants who were interviewed struggled with finding professionals such as counsellors, teachers, nurses and doctors they could trust within the formal education system or within the public healthcare system. Some participants had parents that they could turn to for support, but most relied on their peers for advice and education. All participants expressed concern for women who might not have the confidence to question healthcare providers, teachers and counsellors about sexual health advice or to seek out a second

opinion. All participants shared stories of having no one to turn to in times of need and expressed a desire to see additional services in place to bridge gaps and allow for a positive knowledge exchange between teachers and students and patients and healthcare providers.

Accessible Sexual Health Education and Services

All participants' stories highlighted the gap between accessible sexual health services and the student or client in need. Participants expressed a desire to see service improvement within the greater community by opening a sexual health clinic that provided accessible, non-judgmental, non-discriminating services in a safe environment. The clinic would have flexible hours and many different services under one roof so those accessing the services could go after work or school and have more anonymity. All participants want to see a sexual health curriculum in all grades throughout all Yukon schools. The curriculum would be inclusive, it would include a healthy relationship component, it would address violence against women, it would examine gender stereotypes, and it would be delivered with a sex positive lens.

Desire for Positive Change

All participants experienced limited accessibility and barriers to sexual health services within their community and as a result all demonstrated a desire to see change within their community so the next generation of women will have improved access. All participants have been working towards positive change in their community in the area of sexual health by delivering violence prevention workshops, working at women's centers and youth organizations, or delivering sexual health workshops. All participants expressed a concern for the voiceless, those that are not in a position to speak-out or question services and service

providers. All participants noted that their lives would be different if they had accessible sexual health services in their community.

Summary

Phase two and three of the research process revealed the thematic results. Although the participants had unique voices, many of their experiences with sexual health education and services were similar. All participants felt that more comprehensive and inclusive sexual health education was needed along with better access to sexual health services in the greater community.

In phase three, the metathemes revealed the common overarching themes of all the participants. Participants expressed a lack of trust in professionals such as teachers, counsellors and health professionals. This lack of trust discouraged participants and as a result many did not feel like they were able to ask valuable questions or seek professional advice on sexual health concerns. Participants also feared for others who may not have access to personal supports. Participants had an overwhelming desire to see positive change for the next generation of women. Participants were constantly reflecting on the negative outcome limited services had on their lives and did not hesitate to provide recommendations for change.

Chapter Six: Discussion and Reflections

The final chapter provides a reflection on the research process along with a discussion of the existing literature and the themes the participants shared as they related to the principle and secondary research questions. Cultural safety, the social determinants of health, women's empowerment and gender equality, the right to health and sexual health, Canadian guidelines for sexual health, sexual health education in Yukon, access to contraception, abortion services in Yukon, violence against women in Yukon, sex positive education, healthy relationship training, and violence prevention are some of the themes discussed. In this chapter I also include the limitations of the study, and implications for future research and practice.

Reflections on the Research Process

I was interested in hearing women's stories of access to sexual health education and services in the North, which was best suited to a qualitative research design with a narrative approach. There are high levels of sexual assault and violence against women in the North, and the statistical numbers reflect this, but we do not hear the stories behind the numbers. Using narrative inquiry ensured that I entered each interview with an open mind, and allowed the participants to decide which direction their story should go.

The most meaningful piece for me as a researcher was the interview process, restorying and analysis. I felt honoured to hear the stories of the participants. They let me into their lives and allowed me to hear very personal stories about their lived experiences. I felt privileged that the participants allowed me to restory their words and create something new. The process took much longer than I anticipated. I found myself listening to the digital audio recordings over and over again, and reviewing my journals for tone to ensure that I was

capturing the correct meaning of what was being said. Once the interviews were transcribed, I spent hours re-reading the transcriptions ensuring that nothing was lost in the restorying process.

At times I struggled with trusting my ability to capture the participants' true voice, experiences and meaning. At first I was concerned that I might lose something valuable in the process, however the knowledge that is shared in the co-construction process negated my previous concerns and my confidence was restored. I am reminded through the participants' voices that there is so much more work that needs to be done in the area of access to sexual health education and services in the North. Too often, the voices of women, especially young, marginalized women are silenced and as a result their struggles go unnoticed by the general public and decision makers. It is my hope that we can continue to allow these voices to be heard, and in turn, demand change.

Analysis Discussion

The following provides a discussion of the research findings and relevance to some of the existing literature as it relates to the principle research question: What are women's stories of sexual health education and services and how have these stories affected their sexual health and overall well-being? Personal answers to the secondary research questions were also provided: How do women describe culturally safe, non-judgmental and non-discriminatory health education and services? What would women want to see implemented in current sexual health education and services to improve overall well-being and quality of life?

Cultural Safety. The focus of cultural safety is on transforming attitudes within mainstream institutions, specifically as it relates to health. This can be done in part by recognizing and honouring the histories of Aboriginal people, specifically the legacy of

colonization and residential school (Brown & Fiske, 2001). All participants voiced the importance of having a space that was inclusive to all, meaning that people should not be deterred from accessing sexual health education and services because of their race, sexual orientation, gender, age, status, etc. Some participants felt more marginalized than others; however there was great concern amongst all participants for anyone who might feel excluded from education and health care.

All participants expressed views on inaccessibility when it comes to both the education and health services available to them in the community. Many felt that services were inaccessible in part due to their gender and age. All participants agreed that women who were from more rural, remote areas, women who were poor, and women of sexual minority and race would face greater challenges. Many participants worked directly with women who face incredible barriers due to gender, age, race, sexual orientation and status. “These inequalities in health...cannot be glossed as lifestyle, behaviour or cultural issues; rather they are manifestations of the complex interplay of social, political, and economic determinants that influence health status and access to health services” (Brown & Fiske, 2001, p. 128). Participants who self-identified as First Nations or other minority members did not explicitly express facing additional barriers to education and care based on race, but did speak to the barriers women in their family and or community face.

Social Determinates of Health. The social determinates of health suggest that gender, race, disability, social network, social exclusion, the health and social services and education received, food security, housing, etc. effect an individual’s overall health and well-being (Mikkonen & Raphael, 2010). There is a general assumption amongst Canadians that we have control over the conditions in which we live, however these conditions are generally

imposed on us “by the communities, housing situations, work settings, health and social service agencies, and educational institutions with which we interact” (Mikkonen & Raphael, 2010, p. 2). When there are imbedded inequalities within the social services and education systems provided to a region the overall quality of health of the people who are accessing those services are negatively affected. Often people are using services within public institutions to improve health, not to contribute to negative health outcomes.

We suggest that accumulated disadvantage from past colonization and contemporary processes of ongoing colonization have a direct effect on Aboriginal women’s access to social determinants of health and impede their ability to develop a healthy sense of identity that can contribute to personal well-being. (Bourassa, McKay-McNabb & Hampton, 2005 p. 24)

Participants went to health professionals to encourage positive sexual health outcomes, but all participants encountered many barriers to care. Likewise, participants attended school with the expectation that sexual health education would contribute to their knowledge and improve overall well-being and sexual health, but in most cases participants did not feel like they learned enough to contribute positively to their sexual health. Most information learned was done through their own research, peers and family. All participants expressed concern for those that did not have access to a circle of supports as they had in their personal lives.

Women’s Empowerment and Gender Equality. All participants felt disempowered as young women in their community and many linked this disempowerment to their inability to access sexual health education and services, especially in their youth. Many participants identified their feelings of disempowerment when they left Yukon to attend University. Vivian remembers feeling very empowered by her new friends at University who knew so

much about their sexual health rights and where to access services. It was there that she began to realize the limited sexual health education and services available in her hometown. When she had completed school she had a newfound desire to see change in Yukon.

The literature suggests that empowerment can be accomplished in part by improving sexual and reproductive health. Women's sexual and reproductive health can be improved by increasing access to sexual health education and services, improving access to health information and care, limiting discriminatory practices as it pertains to women and sexual health, promoting culturally safe environments for minority populations, implementing legal and policy changes to promote sexual health education and access and encouraging zero tolerance of violence against women (Black, et al., 2011). These suggestions are aligned with the education and service improvement suggestions made by participants.

Participants expressed their desire to see changes made within the sexual health services offered within their community, recommending that services should decrease barriers faced by women, especially for those who face increased barriers such as young women, Aboriginal women, women of other minorities, and women who are facing economic challenges. Their hopes, desires and suggestions for change complement the literature, which proposes that women's empowerment and reproductive rights can be effectively implemented into the work of health professionals to improve sexual health services. This can be accomplished by insisting health professionals become familiar with underlying social, economic and cultural factors that have caused poor sexual health outcomes; ensure all women have equal access to services, which treat everyone with respect, despite their cultural background, religion, age, disability, and socioeconomic status. Health professionals contribute positively to culturally sensitive and safe environments by providing community

based sexual health education for those who are no longer in the formal school system and by providing appropriate referrals for situations of violence against women. (Black, et al., 2011).

The Right to Health and Sexual Health. Based on the definitions that were previously given to define health, sexual health and sexual rights, Yukon women struggle to have these rights upheld. As previously mentioned, the right to health states, individuals should have access to basic health, preventative care, treatment, and access to medication (Black, et al., 2011). Likewise, sexual health can only be maintained when the sexual rights of the person are respected and upheld, meaning they have equal access to sexual health education and services and do not face discrimination or dangerous practices. Finally, sexual rights suggest that all people have the right to a high standard of sexual health, which includes access to sexual health care services; access to sexual health education; consensual sexual relations; ability to pursue a safe and pleasurable sexual life; and an ability to decide to be sexually active or not (Public Health Agency of Canada, 2008).

Sadly, participants implied that some women are not in a position to exercise their right to health and sexual health, specifically those who face poverty and discrimination. As a result, their sexual rights are not upheld. Literature insinuates that, living in small communities, racism, and cultural insensitivity create barriers for women and as a result women do not receive the sexual health care needed. Women who are marginalized and poor often have little say in their sexual health and well-being (Kinnon, et al., 2002).

Canadian Guidelines for Sexual Health Education. All of the participants independently identified and shared very similar thoughts regarding service delivery. Participants want to see sexual health education that is inclusive, culturally safe, non-judgmental and non-discriminatory. The Canadian Guidelines for Sexual Health Education

(2008) recommends that sexual health education should provide effective, diverse, accessible, non-judgmental, and non-discriminatory, far reaching sexual health education to everyone to ensure that individuals have the skills and resources to be successful health advocates (Public Health Agency of Canada, 2008). It goes on to recommend that sexual health education be delivered in a safe environment, and should be non-judgmental and non-discriminatory. Since formal education systems such as public schools are the only institution that has mandatory contact with youth they should be providing accessible sexual health education to their students (Public Health Agency of Canada, 2008).

Finally, the guidelines recommend that sexual health education be made available to all citizens, as sexual health is a key component to healthy living. The goals of sexual health education are to help people achieve self-esteem, non-exploitive relationships, self-respect and make informed choices. In turn, the participants identified similar solutions for improvement.

Sexual Health Education in Yukon. The Canadian Guidelines for Sexual Health Education (Public Health Agency of Canada, 2008) emphasizes the importance of ensuring accessible education and services are available to persons with disabilities, youth, seniors, sexual minorities, First Nations and individuals who live in geographically isolated areas, however participants' stories reveal that curriculum in the formal school system does not reflect the above outlined guidelines. More specifically, the document highlights five principles that characterize effective sexual health education programming. These principles are: accessibility, comprehensiveness, effectiveness of educational approaches and methods, training and administrative support, and finally planning, evaluation, updating and social development (Public Health Agency of Canada, 2008).

Many participants such as Clare, stated that sexual health education should be taught in school and we cannot assume that students are getting this knowledge elsewhere. The guidelines agree with this stating that since formal education systems such as public schools are the only institution that has mandatory contact with youth they should be providing accessible sexual health education to their students (Public Health Agency of Canada, 2008).

Access to Contraception. Participants were challenged with accessing contraception in their youth and into adulthood. Sam states that if high schools do not allow condoms there are few places where youth can access free condoms, as many of the free condoms are located in bars. Sam reveals that her main form of birth control was the emergency contraceptive pill. She recalls her doctor telling her that it would be beneficial for her to not use emergency contraceptives as often as she did, however he did not recommend anything else to her. She now wishes that her doctor had initiated the conversation. Clare continues to struggle with access to birth control options, suggesting that she is well informed and knows what kind of birth control she would like, but is often advised against her preferred option by health professional.

Women's struggles to obtain contraceptives are not unique to Yukon. Women worldwide struggle to access contraceptives however, Yukon is unique in that it has some of the highest abortion rates in the country, which suggests that women could benefit from more accessible birth control options. This could mean partially funded options and/or health professionals who are willing to discuss options with clients instead of presenting one option only.

Abortion Services in Yukon. Yukon has some of the highest abortions rates in the country (Johnston, 2008), however it does not have an abortion clinic and it only has one abortion doctor. Yukon has a small population, however the population is spread over a large

land mass. Yukon has a total of 14 communities and women living in communities far from the central hub experience many barriers to access.

As previously mentioned, the abortion process is time consuming compared to other jurisdictions. The process takes approximately four days, including pre and post-op care (Yukon Government, 2009). Abortions are performed in the O.R. at the hospital and the room can only be booked on certain days. Women who struggle to make it to appointments, particularly those from communities may have few opportunities to rebook. Sam works with women from many of the Yukon communities and she recalls women who wanted abortions, but just could not access them.

Participants advocated for a sexual health clinic where women could access abortions and reproductive health related services. Considering that Yukon has some of the highest abortions rates in the country, a clinic seems necessary in order to meet the basic needs of clients. Effective preventative measures such as non-judgmental, non-discriminatory sexual health education delivered in a culturally safe environment may also be an effective way of reducing high abortion rates in Yukon.

Violence Against Women in Yukon. Women on the Yankton Sioux Reservation in South Dakota created a reproductive rights platform. Under the platform they consider domestic abuse and sexual assault as a reproductive rights issue (Smith, 2005). Similarly, participants voiced a real concern for the high levels of violence in their community, requesting that violence prevention be a part of sexual health education. All participants share similar views to Morgan who suggested that healthy relationships training and consent workshops might help to reduce negative gender stereotypes and decrease violence against women. Participants concerns about violence in their community are aligned with the Yukon

Health Status Report (Yukon Government, 2009), which states that sexualized assault and male-violence against women is 2-3 times higher in Yukon than any of the provinces (p. 23).

Anonymity. A common concern amongst participants was their right to privacy when accessing sexual health services in a small town. My preliminary research findings suggested that privacy and anonymity would be a concern for women in Yukon, however I did not realize all participants would voice similar concerns and fears of having their privacy violated as it relates to sexual health services. No one should feel deterred from seeking health related information and services (Public Health Agency of Canada, 2008). Some participants delayed seeking medical advice about a sexual health concern for fear of privacy violations. This is aligned with research, which advises that clients will delay seeking medical attention if they are worried about violations of privacy (Black, et al., 2011). Would their doctor tell a coworker, or family member? In Vivian's case a school counsellor violated her privacy by telling a coworker private information. Unfortunately, this information was then leaked to most of the student body. In all cases, participants did not return to health professionals, counsellors or teachers after their privacy was violated and many did not go for fear of privacy violations.

It is impossible to control some aspects of privacy in small northern communities, as there is a chance that someone will see clients heading to the health care clinic, or sitting in the waiting room at the communicable disease clinic. However, improvements can be made within the institutions and with health professionals to ensure that the utmost importance is placed on privacy. Location of clinics and hours of operation play a role in ensuring privacy. Clinic hours should have flexible hours of operation and diversity of services to allow clients to have more anonymity (Public Health Agency of Canada, 2008). Most participants voiced

their concerns about privacy at a sexual health clinic. Participants' suggestions complimented the Canadian Guidelines for Sexual Health suggesting that clinic hours be flexible with a diversity of services offered within each clinic. With this approach, someone accessing an abortion could say they were going to get information about birth control.

In addition, the Yukon Government is working on Personal Health Information Legislation. This legislation will set rules for how personal health information is collected, used and disclosed by health care providers in Yukon. Most jurisdictions have this legislation in place already. This proposed legislation will benefit clients in many ways for example, the legislation will require health care provider to have a safe, secure storage place for all personal health data, and clients will be informed about any privacy breaches, theft, loss, or unauthorized access of health information (Yukon Government, 2012).

Sex Positive Education. A sex-positive approach to sexual health education moves beyond the highly gendered depiction of sexuality, where women are seen as 'promiscuous' if they enjoy talking about and having sex. This approach moves past the mechanics of how to put on a condom. It does focus on preventative methods of care such as using barriers (condoms and dental dams, etc.) and birth control, but it also speaks to pleasure. Pleasure is often something that is left out of sexual health education and students are left with questions about how to have pleasurable sex, how to masturbate, how to arouse partners, etc. (Singh, 2009). Many participants wanted sexual health education to be fun, where sexual pleasure was discussed.

Projects such as the Sexual Health, Education & Pleasure Project (SHEPP) are committed to equitable sex education where their goals are to provide "accessible, inclusive and empowering sex education to youth, with a focus on youth of colour" (Singh, 2009, p.91).

SHEPP involves youth from the onset, asking them what they want to learn about at the beginning of each workshop. This way youth are engaged and willing to learn because they know that they will learn about something they are questioning in their own lives. Yukon could benefit from a sex positive outreach program similar to SHEPP as it meets youth where they are at along with addressing gender inequalities that currently exist for women in more traditional sexual health classes.

Healthy Relationship Training. Participants mentioned countless times the importance of having healthy relationship training as a component of sexual health education, stating that we cannot assume that everyone has healthy relationship examples in their everyday life. If students do not have examples of healthy relationships in their lives how can they be expected to know what is healthy and what is not. Healthy relationship training is a form of violence prevention and teaching students self-care, self-love, how to identify healthy and unhealthy relationships, how to have healthy relationships, along with offering resources and supports for those that are not in healthy relationships (Perry, 2008).

Moving away from Hetero-normative Sexual Health Education. All participants expressed a desire to see sexual health education that is inclusive of people with different sexual orientations, suggesting that through sexual health education students could expand their understanding of sexual orientation and relationships. Some participants suggested sexual health education could begin to tackle negative gender and sexual orientation stereotypes faced by sexual minorities. The queer community is often exploited, bullied and misinterpreted because of false information that is portrayed about them. Sexual health education could play a role in positively effecting and tackling negative stereotypes.

“My own discomfort with my changing body, inability to connect socially with other boys my age and my increasing awareness of my own queer sexuality was only reinforced by sex ed class” (Saravanamuthu, 2009, p. 31). All too often people who do not fit into the hetero-normative sexual health formula provided do not have a safe space to voice their sexual health concerns or ask questions, especially if the primary focus of this education is pregnancy and STI prevention. “I could hear the others whispering about me when the teacher started talking about ‘intercourse’ ... Vijay never has to worry about getting girls pregnant” (Saravanamuthu, 2009, p. 31). Sexual minorities such as gay men are at greater risk of contracting HIV/AIDS and therefore it is essential that they have education and services available to them that are non-exploitive and safe (Public Health Agency of Canada, 2008).

Saravanamuthu (2009) goes on to identify issues he had with sex ed class in high school, which are aligned with many of the participants concerns. First, he states that the education was based on “colonially-derived values” that only spoke to male-female sexual relationships. Second, hetero-normative values only reinforced the exclusion and homophobic climate that prohibited him from seeking advice and advocating for his own sexual health rights. If a safe space is created for people who do not fit into the mainstream hetero-normative mold, they may not feel isolated and realize that others may also be seeking similar kinds of support, motivating them to pursue additional information and services that may address their needs (Public Health Agency of Canada, 2008). Today, Saravanamuthu (2009) is a sexual health educator who educates students about cultural and sexual diversity along with HIV and STI prevention.

We deconstruct colonially prescribed identities of ‘man’ and ‘women’ and look at how words such as ‘fag’ and ‘dyke’ can have an impact on LGBT peoples...I feel a sense of accomplishment when I see young minds take a step back to think about how both actions and words can have a profound impact on someone’s health. (Saravanamuthu, 2009, p. 32)

When we think of promoting inclusion in large institutions such as public schools, sexual health education is easily overlooked. Saravanamuthu (2009) gives us strong reason to rethink this outdated practice.

Violence Prevention. Sexual health education plays a role in violence prevention and can help to reduce negative gender stereotypes. All participants articulated a desire to incorporate violence prevention into sexual health education, specifically as it relates to consent and negative gender stereotypes by suggesting that women ask to get raped if they are out past a certain time, wearing revealing clothing, flirting, etc. otherwise known as “implied consent.” Kent (2009) is a former sexual health educator. She expresses the dangers of not addressing sexual assault in sexual health class, which is similar to the examples participants gave.

When teachers treat sexual assault as if it’s a taboo, dirty topic, it makes student view it that way...the delay and secretiveness around such topics allows students to be exposed to and believe sexist and oppressive ideals about relationships and sexual assault. (Kent, 2009, p. 39)

The Women’s Legal Education and Action Fund (LEAF) delivers consent workshops to high schools across Canada. Their most popular workshop entitled “No means No” addresses the legal definition of consent through a hands-on review of the *Ewanchuk* decision, which explains consensual relationships, gender discrimination and the impact of sexual assault on

Canadian women. The workshop pushes the principle that no one can sexually touch another person without clear consent and that implied consent is not enough (Women's Legal Action Fund, 2013).

Violence prevention must include boys and men. Workshops such as the LEAF workshop target both males and females, recognizing the importance of also educating boys and men, as men are generally the perpetrators of violence against women (Duffy & Cohen, 2001). The hope is that by casting a large net and educating everyone, negative gender stereotypes and the true definition of consent will be widely known.

Limitations of the Study

The participants in the study were women between the ages of twenty and thirty living in the same geographical area. The participants were recruited from four women's organizations that provide services to women and children in Yukon. Although the stories shine a detailed light on issues women face when accessing sexual health education and services in Yukon, they do not reflect the experiences of all women in Yukon. I have worked as a sexual health promotion worker, a women's health researcher and a policy analyst and I am very aware of some of the "hidden" issues women face daily. This study attracted women who are involved in the women's community and are very aware of the troubles the greater community faces. Many of these women have been involved in changed based initiatives in their personal and professional lives. Their stories reflected the voices of the young women's advocate community. The stories of younger youth who are currently in the school system may have been quite different. The stories of women in communities and women from different generations would also bring to light different issues. Although this study focuses on Yukon, variations of the issues presented in this research also happen throughout Canada, especially

in rural, remote communities. Unfortunately, despite all of the advocacy and work surrounding sexual health, the services available to the younger generation of women within the public school system and in the community has not noticeably improved.

The quality of the research was dependent on my ability to recruit, and maintain a good, transparent relationship with the participants. My ability to collect, analyze, interpret and present data directly affected the final research findings. I conducted each interview knowing that participants were free to guide their narrative in a way they thought was appropriate and could divulge as much or as little information as they felt comfortable with. The research was a collaborative process between myself and the participants. After the initial one-hour interview each participant reviewed the research. The participants provided feedback on my interpretation of their stories, at that point new meanings were negotiated through the co-construction of knowledge between myself and participants.

Implications for Future Research

I was most interested in the lived experiences of the participants and as a result demographic information was not collected. However in the telling of their stories some women self-identified as First Nations or other minority members. All participants attended elementary school and high school in Yukon. This was important to the research as I wanted the study to reflect the stories of women who had experience with the education system and the health services available to them in Yukon. Although participants from more rural and remote communities face even greater challenges, none of the participants in this study had lived for long periods of time in smaller communities in Yukon. However many of the participants had worked for women who live in smaller Yukon communities and relayed some of their stories of access. Additional research needs to be carried out to hear the stories

of these women as I know they experience greater barriers than women in more populated areas. I believe it would be more appropriate for First Nations' women to carry out this research due to the cultural sensitivity and knowledge that would be needed to successfully and respectfully carry out this research.

It is necessary to conduct more research on sexual health education and service improvement. What does accessible sexual health education look like in practice? Are there other jurisdictions in Canada who have a K-12 sexual health curriculum? What changes need to be made in the community to allow for a more trusting, reliable, and accessible delivery of sexual health services? These are key questions that would give services providers and policy makers more information to improve services and better meet the needs of women in the community.

Implications for Practice

A significant theme throughout the study was a desire to see service improvement within the greater community by opening a sexual health clinic, which would provide accessible, non-judgmental, non-discriminatory services in a safe environment. The Canadian Guidelines for Sexual Health recommend that sexual health services be accessible and diverse for the same reasons participants noted (Public Health Agency of Canada, 2008).

All participants want to see a sexual health curriculum in all grades throughout all Yukon schools. The curriculum would be inclusive, it would include a healthy relationship component, it would address violence against women, it would examine gender stereotypes and it would be delivered with a sex positive lens. Service improvement might lead to lower levels of sexual assault and violence against women in the North.

This desire to see change is not new, especially within the women's community. The local women's community is very aware of the limitations faced by many regarding access to sexual health services and they have been advocating for a women's health centre for some time now. In the spring of 2012, a local women's organization successfully hosted a women's pregnancy options symposium where they brought in reproductive rights specialists who spoke with local women and health professionals about pregnancy options such as birth control, abortions, etc. They also discussed the stereotypes and restrictive practices that take place, which can negatively affect women's sexual health, and provided viable options.

The women's community also provides violence prevention workshops to local schools during violence prevention week, advocates for healthy relationship training, and improved access to sexual health in schools, along with hosting a girls club, which encourages knowledge sharing and empowerment. Unfortunately, their request for adequate funding, a women's health centre and overall improvement to sexual health services goes largely unheard and very few changes have been made within government institutions such as schools and health care centers. In order to encourage large changes within health and education we need to have funding allocated to large public institutions such as schools, health centers and hospitals and a commitment to make positive changes to programming and service improvement through effective collaboration at the community, territorial, and federal levels (Public Agency of Canada, 2008).

I do want to acknowledge the commitment, strength and desire to see change within grassroots, and NGO based organizations. The accomplishments they have made should not be overlooked or undervalued. In addition, I would also like to acknowledge teachers and health professionals who are doing their part to effect change despite the systemic flaws

present within the institutions in which they work. I believe this research reflects some of their views. I can only hope that these issues will continue to be raised, and in time changes will be seen.

Summary

Throughout the research process I was struck by the strength and resilience of the participants. All the participants have experienced incredible barriers to access, yet have continued to advocate for change within their lives and their communities. The participants were the first to recognize all the work that has yet to be done, showing no signs of backing down from the struggle to see and witness change. I was encouraged by their strength and perseverance.

My goal as a researcher was to uncover womens' experiences of sexual health education in Yukon through a narrative research study with the hope of providing awareness to sexual health educators and health professionals in Yukon concerning accessibility of sexual health for women. The research questions were illuminated through the interview, retorying and analysis process. Participants were concerned about accessibility of sexual health services within the greater community, suggesting that a sexual health clinic that provides abortions services along with sexual health education, contraceptive care, STI testing and counselling would help fill current gaps.

Participants spoke to the importance of creating a non-discriminatory, non-judgmental, culturally safe space in the classroom and within the greater community for persons accessing sexual health education and services. The finding from this study on the lack of safety in sexual health services was surprising and very informative. Many participants did not feel safe within the classroom or when accessing sexual health services in the community

as they feared their privacy was at stake. Participants had little trust in health professionals, counsellors or teachers and had few places to seek sexual health related guidance and care. For some it was the fear of running into to a peer, relative or acquaintance in the waiting room of the communicable disease clinic; seeing your family doctor at a family gathering, or having a counsellor breach confidentiality. Participants were concerned for those that did not have personal supports in their lives and want to see improved accessibility to services for future generations. Participants stressed the importance of ensuring that everyone has equal access to sexual health education and care. The current system operates with the assumption that people have personal supports, knowledge and advocates in place to navigate available sexual health services, but the participants suggested that this is a dangerous assumption.

It is clear from the stories of the participants that there is much work to be done. I will continue to discuss alterations to the current sexual health curriculum with the help of the information I have learned from the participants. These open discussions may facilitate the changes that need to be made to allow for accessible sexual health education for all women in Yukon.

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Appendix A: Sample Interview Questions

Women's Accessibility to Sexual Health Education and Services in Yukon

- Please tell me your story of access to sexual health education in Yukon.
- Did you, or do you experience barriers in accessing meaningful sexual health education/services in this community?
- If yes, what are the barriers to care? Have these barriers affected your quality of life?
- If yes, how?
- If no, how did you overcome the barriers to care?
- Do you think that sexual health education/ services can be improved?
- If yes, what would those changes look like?
- If no, why not?
- If you had the power to effect positive change in the way sexual health education and services are delivered for the next generation of women, what would these positive changes be?

Appendix B: Research Participant Information Letter

You are invited to participate in a study entitled *Women's Accessibility to Sexual Health Education and Services in Yukon*. The research is being carried out by Linnea Rudachyk under the direction of Dr. Linda O'Neill through the University of Northern British Columbia (UNBC).

Why is this research being done?

The reason for this research project is to better understand northern women's experience of accessing meaningful sexual health education in Yukon. I am interested in learning about the barriers to sexual healthcare women may have experienced throughout their lives. How have these barriers affected their lives? What improvements could be made to improve women's experience and therefore improve access to sexual health education?

Why was I chosen?

You are being asked to participate in this study because:

- You are 19 year of age or older
- You attended school in Yukon
- You have experienced barriers to sexual health education and services
- You have a desire to see positive change to the current sexual health curriculum and services available in your community
- You are willing to participate in the research process

What is involved?

If you agree to voluntarily take part in the study, you will be asked to:

- Take part in a private one-on-one interview that will last about an hour. You will be asked to share your experiences with barriers to sexual health education and services throughout your lifetime, and how these barriers have affected your life. Finally, you will be asked to provide ideas on changes that could be made to effect positive change for women in terms of sexual health education. The interviews will be audio digitally recorded so the researcher can later analyze the material. You may turn off the digital recorder at any time. The interview can be terminated at your request and all data will be destroyed at your request.
- After the interviews have been analyzed, you will be asked to help check the results. This will involve a short interview lasting about 30 minutes. You will

be able to add any information and let the researcher know if the results are accurate.

What are the benefits and risks involved in taking part in the study?

One potential benefit of participating in this research is you may feel rewarded by discussing your experiences of sexual health education. You may feel satisfied in knowing that you are contributing to research and providing knowledge to the community. A potential risk is that it may be uncomfortable talking about your experiences of access to sexual health education and services. You will be provided with a list of community resources which you can access to get additional support if you would like it.

You can refuse to answer any questions and you may stop the interviews at any time. Your participation is completely voluntary. If you choose to withdraw from the study during the interview, the tape recordings and any information you provide will be destroyed.

How will my identity be protected? (Anonymity)

Your interview will be transcribed (typed word by word) by the researcher. Transcripts will be identified by a code number and pseudonym not your name. Any information that might identify you will be removed from the final research document.

How will my information be kept private? (Confidentiality)

Everything you discuss during the interviews as well as the forms you fill out will be kept confidential. This means that your information will not be shared with others. Only my supervisor and myself will have access to the information. Your information and tapes will be stored in a locked filing cabinet for two years and then will be destroyed.

How will I be compensated?

As a way to show my appreciation for your time and effort, you will be given a \$40 gift certificate. You will not be penalized if you decide to withdraw from the study and will still receive the gift certificate. If you agree to meet for a second interview to check the results you will receive an additional \$20 gift certificate to thank you for your time.

What will be done with the results?

The completed research will be presented at my thesis defense at UNBC. It is anticipated that the results will be presented at conferences, to community organizations, and published in professional journals or reports.

You can obtain a copy of the research results by contacting the researcher, Linnea Rudachyk at (867) 335-4364 (cell) or Rudachyk@unbc.ca, or Dr. Linda O'Neill at loneill@unbc.ca.

How will the information be destroyed?

Data from the study will be destroyed two years after publication. Hardcopies will be shredded and electronic data will be erased from the hard drive.

Who should I contact if I have more questions?

Please feel free to contact the researcher, Linnea Rudachyk at (867) 335-4364 (cell) or Rudachyk@unbc.ca if you have any questions. Any concerns about the project should be directed to the Office of Research at the University of Northern British Columbia (250) 960-6735 or by email: reb@unbc.ca.

Appendix C: Research Participant Consent Form

	Yes	No
Do you understand that you have been asked to be in a research study?		
Have you read and received a copy of the participant information letter?		
Do you understand that you are free to refuse to participate or withdraw from the research study at any time?		
Do you understand the benefits and risks of participating in this research study?		
Do you understand that the interview will be audio recorded?		
Do you understand that some of the actual words may be published in written form?		
Has the issue of confidentiality been explained to you?		
Do you know what community resources are available for additional support?		
Do you understand who will have access to the information you provide?		
Have you had an opportunity to ask questions about the study?		

This study was explained to me by: _____

Printed name of Research Participant: _____

I agree to participate in this research study:

Signature of Research Participant

Date

Appendix D: Information Letter

To Whom It May Concern,

My name is Linnea Rudachyk and I am currently attending the University of Northern British Columbia (UNBC) in the Masters of Education in Multidisciplinary Leadership program. I am planning to carry out thesis research under the direct supervision of Dr. Linda O'Neill. I am interested in exploring northern women's accessibility to sexual health education in Yukon. In particular, I hope to learn about some of the barriers women have experienced and how these barriers have affected their lives. I would also like to hear about changes that could be made to effect positive change for women in Yukon.

I originally became interested in conducting research in this area based on my personal experiences of working as a sexual health promotion worker in Yukon. It was when I began working in this field that I began to realize the barriers that exist for women, specifically surrounding accessibility to culturally appropriate delivery of services. It became apparent that many northern women were at a disadvantage. We see this reflected in our quantitative analysis found on Statistics Canada, but we rarely hear the individual stories of those who have been affected.

I plan to interview women who are 19 years of age or older, who have experienced barriers to sexual health education in Yukon. The interviews will last about an hour and will be audio digitally recorded so the material can later be analyzed by me. To protect the anonymity of the participant's names and identifying characteristics will be removed from the data. Additionally, all their information will be stored in a locked filing cabinet in my office. Only myself and my supervisor will have access to their information. Participants can terminate the interview at any time and any data collected will be destroyed.

I hope to work closely with community agencies that provide services to women in Yukon. I am asking for your help in suggesting appropriate ways to recruit women. I am wondering if I might be able to post recruitment posters in your agency and interview the women at a space within your agency?

I look forward to the opportunity to speak with you regarding my research. Thank you for your consideration of this matter. I can be reached via email or telephone for further discussion or the possible arrangement of a meeting.

Sincerely,

Linnea Rudachyk
BA, Med (Candidate)
(867) 335-4364 (cell)
Rudachyk@unbc.ca

Appendix E: Agency Consent Form

Women's Accessibility to Sexual Health Education and Services in Yukon

Form to be filled out by a representative of the agency.

	Yes	No
Have you read and received a copy of the community agency letter outlining the research study?		
Have you agreed to allow the researcher to display information posters at your agency?		
Have you agreed to help the researcher determine appropriate ways to recruit participants?		
Have you agreed to allow the researcher to conduct interviews at a space within your agency?		

This study was explained to me by: _____

Printed Name of Agency/Organization: _____

Printed Name of Professional (agency representative): _____

Signature of Professional

Date

Appendix F: Request for Research Participants

*Women's Stories:
Accessibility to Sexual Health Education and Services in
Yukon*

- Are you 19 year of age or older?
- Are you a woman?
- Have you attended school in Yukon?
- Have you experienced barriers to sexual health education and services in Yukon?
- Do you have a desire to see positive change to the current sexual health curriculum and services available in your community?

If you would like to volunteer to share your experiences of barriers to sexual health education in Yukon, I would like to hear from you.

Your participation would include:

- A private audio-taped interview
- One check-in
- Compensation for your time and effort

**For Further information please contact:
Linnea Rudachyk at (867) 335-4364 (cell) or
Rudachyk@unbc.ca**

Appendix G: Community Resources List

Counselling and Support Services:

Many Rivers Counselling and Support:

Whitehorse- (867) 667-2970

Haines Junction- (867) 634-2111

Dawson City- (867) 993-6455

Watson Lake- (867) 536-2330

Women's Centres and Women's Organizations:

Victoria Faulkner Women's Centre- (867) 667-2693

Les EssentiElles- (867) 668-2636

Whitehorse Aboriginal Women's Circle- (867) 668-7532

Elizabeth Frye Society of Yukon- (867) 334-2419

Yukon Status of Women Council- (867) 667-4637

Yukon Aboriginal Women's Council- (867) 667-6162

Liard Aboriginal Women's Society- (867) 536-2097

PSAC Whitehorse and Dawson City Regional Women's Committees (RWC)- (867) 667-2331

Shelters and Crisis line:

Kaushee's Place / Yukon Women's Transition Home- (867) 633-7720

Crisis Line- (867) 668-5733 (collect calls accepted from outside Whitehorse)

Dawson City Women's Shelter- (867) 993-5086

Help and Hope For Families: Watson Lake Transition Home/Women's Shelter- (867) 536-7233 24 hours