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Reworking the Structure of Sexual Education Sessions at Western Washington University

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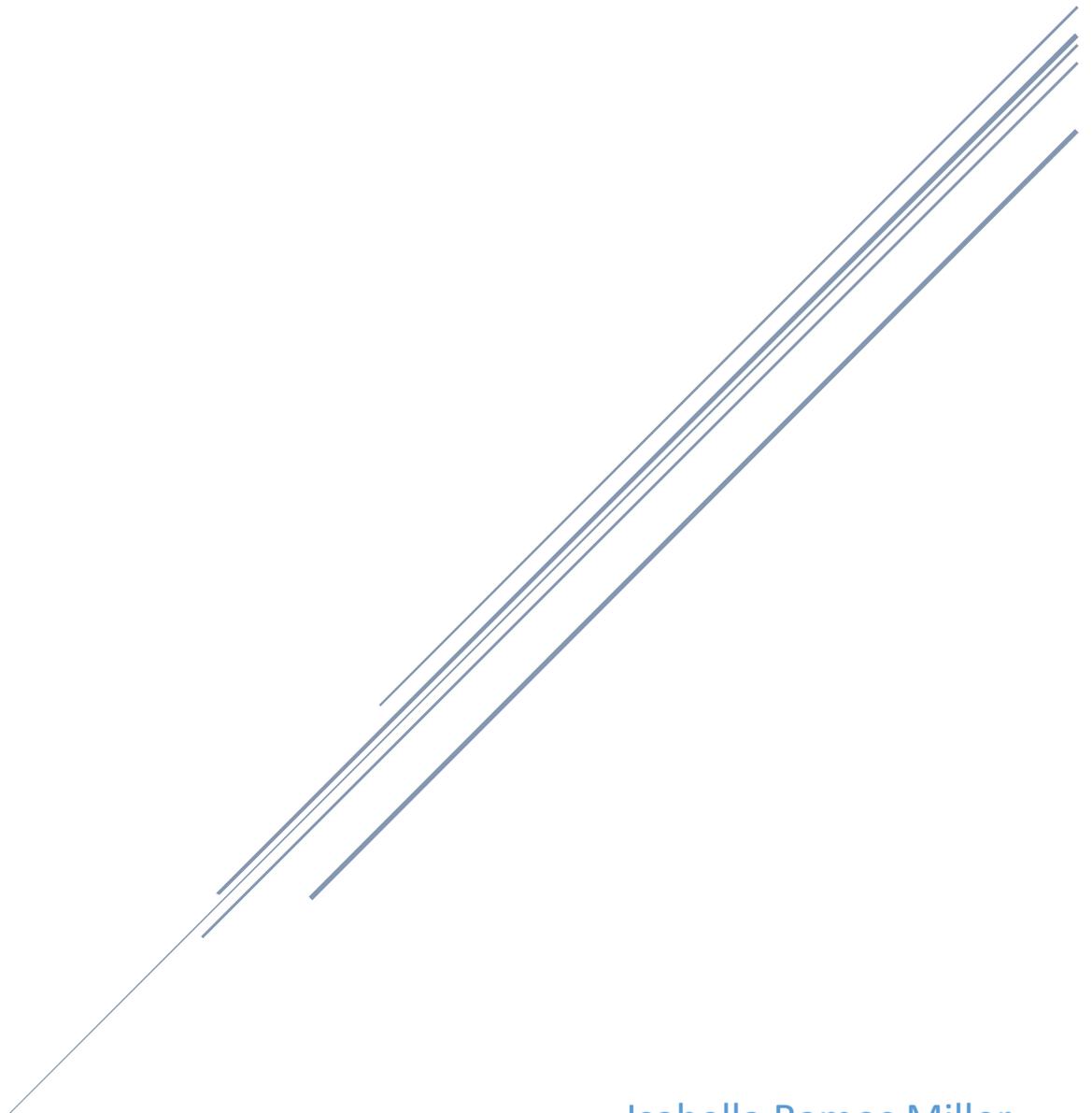
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SIMPLIFYING CARE: A PILOT STUDY

Reworking the Structure of Sexual Education Sessions at
Western Washington University



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Simplifying Care: A Pilot Study

Reworking the Structure of Sexual Education Sessions at Western Washington University

Introduction

The aim of this paper is to identify characteristics of the Western Washington Peer Sexual Health Educator program that bar students from receiving health care. We hope to accumulate available data on program use, assess barriers to care, suggest collection of additional data, and finally, make suggestions for program improvement.

Background

Western Washington University (WWU) is dedicated to the well-being of its college students. Basic mental and physical health care are included in student tuition; appointments are available at both an on-campus counseling center and health center at no additional charge. WWU's Prevention and Wellness Services (PWS) is an additional program dedicated exclusively to promoting the health and reducing health risks of students and community members. PWS educates and provides resources on numerous topics that are ignored by other institutions, including mental health, alcohol safety, violence reduction, and sexual health.

Of the many programs offered, PWS' sexual health education resources might be the most unique. PWS provides free, one-on-one, sex education information sessions taught by trained students and available to anyone in the Western community. These sessions cover a range of topics, including sexually transmitted infections (STIs) and birth control, as well as healthy partner communication and stigma reduction. The information provided is invaluable and almost unanimously recommended by students who attend. However, the program has structural flaws that may bar students from receiving health care.

Barriers to Care

Program Analysis and Literature Review

The Peer Sexual Health Education Program is innately well-intentioned. It aims to provide college students with a sex education program that many never received. Currently, only twenty-two states and the District of Columbia require that schools teach sexual education (Barr et al., 2014). Of the states that do tackle the issue, few provide information broader than abstinence and STI information (Barr et al., 2014). The education provided by PWS is comprehensive, taking a broader view of healthy sexuality that includes not only biological information and risk reduction, but also a larger range of issues that include stigma reduction, healthy communication, and inclusivity. These information sessions are conducted by WWU students who have taken a quarter-long class titled “Health of a College Student” and an additional week-long, in-depth program training.

Compared to other sex education programs around the country, PWS addresses a broad subject matter that leaves little room for critique. However, the structural organization of the program may unintentionally create barriers that prevent students from accessing care. The majority of students accessing Peer Sexual Health Educator (PSHE) services are referred by the Student Health Center (SHC) when they initially attempt to schedule a STI screening, birth control appointment, or female health exam. Instead of scheduling the appointment immediately, the SHC advises an appointment for a PSHE information session. The student then calls a separate office to set up an hour-long session with a PSHE. After this session, students are now “able” to schedule an appointment with the SHC, and must call back to do so. None of the calls or scheduling is automatic and all are completed by the student independently. This process presents many potential flaws. (1) There is a time delay that students experience between

deciding to make an appointment at the SHC and receiving one. They must schedule and attend an additional PSHE session, which often occurs on a separate day from the the initial desire for an appointment. (2) All of the scheduling must be initiated by the student, and at a minimum, three separate attempts at scheduling occur; the attempted initial appointment at the SHC, the PSHE appointment, and the second attempt at the SHC. (3) There is a spatial difference in SHE appointments and PSHE appointments; the SHC appointments occur in the health center north of campus and the PSHE appointments on south campus in Old Main. The physical separation of locations makes attending both more difficult than simply attending one. Each characteristic of the program can potentially bar students from accessing sexual health services. The subtleties associated with sexual health may also contribute other less obvious barriers to accessing care. These barriers should be assessed and appropriate changes made to streamline access to care on WWU's campus.

Current literature indicates that the above characteristics bar access to medical care. One study identified three main barriers that are prohibitive of accessing specifically STI testing (Tilson et al., n.d., 2004). Lack of knowledge about STIs, lack of privacy for seeking services, and long waiting periods for testing were all listed as dissuasive factors (Tilson et al., 2004; Adam et al., 2011). Other barriers to getting STI tests include feelings of anxiety around testing, fear of records of the test occurring at all (presumably worries of confidentiality) and provider sensitivity (Tilson et al., 2004; Mimiaga, Goldhammer, Belanoff, Tetu, & Mayer, 2007). Students also feel more embarrassed about testing when they have multiple interactions with multiple personnel (*Academy for Educational Development*, 2007). There are many characteristics of the PSHE program that contain these barriers to care: students are expected to wait a longer period of time before receiving a sexual health appointment and are asked to speak

with additional people (the PSHE program coordinator and a PSHE) about their sexual health. Because PSHEs are students, there may be additional worries about confidentiality among peers (*Academy for Educational Development, 2007*).

Additionally, young adults tend to underestimate their own risk in the context of sexual health (*Academy for Educational Development, 2007*). When interviewed, many young adults perceive STIs to be a less serious concern and these people are less likely to be tested than those that perceive a high risk (*Academy for Educational Development, 2007*). Because most STIs are asymptomatic, this affects the likelihood of college students pursuing testing if they are not experiencing symptoms (*Academy for Educational Development, 2007; Adam et al., 2011*). This indicates that WWU students may be less likely to pursue STI appointments and general sexual health appointments if they are asymptomatic or do not have pressing concerns. In these cases, especially, there is greater risk of students avoiding or getting discouraged by the long process to acquire a sexual health appointment, if they are inclined to believe it is unnecessary.

Project Methods

As a pilot study, this project has many parts. Initially, we performed a comprehensive literature review to accumulate information about barriers to sexual healthcare that exist in other settings. If PSHE program practices are similar to these other settings, the same barriers may be present within the program. Secondly, we conducted interviews with individuals associated with the PSHE program and the SHC. Three were conducted with professionals associated with the PSHE or SHC, assessing their perceptions of the PSHE program in relation to access to SHC appointments. These interviews provide information about the subtleties that may exist as barriers to accessing health services, and the perspectives held by professional members of both programs. Four additional interviews with students who have scheduled or attempted to schedule

a sexual health appointments contribute individual perceptions of the program and its effects on student behavior. Student interviews were requested by a public Facebook post. Six students initially came forward with the desire to be interviewed for the project, but only four interviews were conducted due to study time constraints. Unfortunately, it was impossible to remove bias from these interviews as the students were self-selected and might have been more likely to choose to interview if they had a strong reaction to the PSHE program or scheduling process.

I collected numerical data with respect to PSHE appointments scheduled and the number of STI and sexual health appointments scheduled at the student health center. This data allows preliminary numerical analysis of both the prevalence of PSHE appointments and sexual health appointments. However, more important is the potential numerical difference between students who initially call the SHC to make a sexual health appointment and those that actually receive care. As students are initially “turned away” from the SHC during the referral to speak with a PSHE, there is a chance that students do not take another step in the process towards receiving health care. If there is a large discrepancy between the number of students who initially call to receive appointments and the number of students who receive these appointments, then there is a chance that the PSHE program is barring students from accessing health care services. Therefore, as part of this proxy study, we recommend the implementation of a continued study meant to assess the difference in SHC scheduling attempts and actual SHC appointments that occur. Ideally, there will be little discrepancy in these numbers, but assessment of the literature indicates that the existing process of accessing services may deter students. The continued study could be implemented after the 2016-2017 school year begins in September 2016, so that data can be collected by the SHC while school is in session (and PSHE appointments are occurring).

Finally, I accumulated a number of suggestions that might be used in altering the implementation of the PSHE program in order to eliminate and avoid the barriers that might be found to exist. These changes will address the spatial and temporal barriers that are currently characteristics of the program. Some changes might include ensuring that students know the PSHE appointments are not necessary and scheduling a PSHE appointment and SHC appointment for one, longer session in which both happen on the same day, in the same location, sequentially. Although these changes might require more schedule manipulation, they may be essential if current practices are barring students from accessing care.

Interviews

Professional Interviews

Our data collection process allowed the interview of professionals involved in different capacities with PSHE and SHC appointments. Interviewees included a PWS program coordinator who oversees PWS scheduling and two SHC nurse practitioners. For the purposes of confidentiality, the names have been changed, but job descriptions may allow for the identification of interviewed individuals. All opinions expressed during interviews were personal and are not necessarily opinions shared by PWS, the SHC, or WWU.

Sarah* - PWS Program Coordinator

Sarah is white, female, holds her Masters in Education, and has been working with PWS for a year. She is often the first point of contact students have with PWS and facilitates the scheduling of PSHE appointments. In the 2015-2016 academic year she scheduled 249 appointments out of 912 sessions provided. During our interview, she described the process that students take in accessing PSHE and SHC appointments, her interactions with these students,

*names have been changed.

and some barriers to care that might be built into the current system. The following is a summation of the ideas expressed by Sarah during our thirty-minute interview.

Sarah interacts with students early on in the process of seeking a SHC appointment. She explained that typically, students call the SHC to schedule a sexual health appointment. The SHC then informs them about PSHE appointments and generally “patches the call” through to Sarah, who then helps students schedule an appointment with a PSHE. Generally, students can receive an appointment with a PSHE within a day or two, but that time can be longer if their needs are more specific or are calling before a weekend. Sarah will often offer to forward the student back to the SHC after an appointment with a PSHE is made; if this does not happen, students are also given the option to make an appointment with the SHC during their PSHE appointment. While describing the scheduling process, Sarah described PWS and SHC as viewing the PSHE appointments as “mandatory,” and that students feel that they “have” to see a PSHE in order to schedule a sexual health appointment at the SHC.

In discussing student attitudes toward PSHE appointments, Sarah categorized students into three categories: students who are referred and never make an appointment, students who are “iffy,” or who express no real positive or negative opinion about the process, and students who are “frustrated” that a PSHE appointment is mandatory. She also described a small percentage of students who feel positively about the program because they are likely “sexually competent academics.” She described the current process of scheduling appointments as “prohibitive,” partly because of the demographic of students accessing care. We discussed groups within the WWU student body that might be considered more at risk for being deterred by the PSHE scheduling process. These groups include those of traditionally repressed gender identities, those who are undocumented, those from low socioeconomic status, and those that

*names have been changed.

have experienced sexual assault. Additionally, Sarah identified that sexual health stigmas, convenience issues, and time required to make two appointments provide additional barriers to health. Ideally, Sarah identified the possibility for scheduling both the information session and the sexual health appointment during the same block of time. Throughout our interview, Sarah acknowledged that the PSHE program provides invaluable information, but may have some structural flaws.

Jennifer and Bonnie* - SHC Nurse Practitioners

Jennifer and Bonnie are white, female, nurse practitioners who conduct sexual health appointments at the SHC. In the 2015-2016 academic year, there were 404 STI testing appointments, but no data about other sexual health appointments or STI testing done on other types of visits. The interviews were conducted at the same time, however the majority of the interview was conducted with Jennifer, a nurse practitioner who has been working at the SHC since 2001. Bonnie joined the interview later on to contribute insight. Unless otherwise indicated, the following summarizes Jennifer's interview.

Jennifer has “a particular interest and passion in women's healthcare and sexual health.” She has worked with individuals of all ages but now specializes in college health. She conducts sexual health appointments 60-70% of the time. During our interview, Jennifer identified college students as unique because they are beginning “to make decisions without parental supervision” and “are in a time of exploration about what they want their sexual life to mean.”

As of now, there is no record of the proportion of students who have a sexual health appointment and have seen a PSHE before hand, but according to Jennifer, it is usually possible to identify if they have. Bonnie estimated that 60% of asymptomatic sexual health appointments

*names have been changed.

have seen a PSHE beforehand. Students who receive a sexual health appointment and have not seen a PSHE do so because they choose not to have a PSHE appointment or are not able to make one. Jennifer expressed that “it is enormously helpful if they have seen a PSHE” beforehand because they are “much more focused and educated” and “open” to the nurse practitioner’s information. Generally, “they seem more confident [...] less nervous” and information communication is more streamlined.

When asked, Jennifer expressed that seeing a PSHE is not mandatory to receive a SHC appointment. According to Bonnie, students who call that are currently experiencing symptoms are given an appointment immediately and are not obligated to see a PSHE beforehand. Asymptomatic students, or students seeking birth control or a female health exam, are referred to a PSHE appointment before a SHC appointment is made. *Both Jennifer and Bonnie said that they do not see students who are dissatisfied with having a PSHE appointment; Jennifer said that she had only seen one student who did not want to have a PSHE appointment.* Bonnie did acknowledge that there may be students that “occasionally misinterpret” the recommendation for a PSHE appointment as a necessity and “feel like they need to push” to have an appointment. Bonnie estimated that about 50% likely do not feel that they need appointments because they feel that they are already educated. However, the majority of the time they “always say that they learn something” from the PSHE appointment.

When asked, Jennifer and Bonnie acknowledged that some groups might be more likely to find obstructions in the current system. Groups included are transgender, gay and lesbian students, who have a “historical feeling of disenfranchisement” from medical professionals. Additionally, college-age students may be less capable of assessing their own risk when it comes to sexual health because many are not aware that the majority of STIs are also asymptomatic.

*names have been changed.

Despite the potential barriers discussed, Jennifer expressed that she did not see any need into alter the structure of the program.

Student Interviews

Due to scheduling needs, the majority of student interviews were conducted after the professional interviews. This made compiling the qualitative data even more compelling, as it was collected against the backdrop of professional interviews. At the beginning of the project, six students contacted myself as a result of a Facebook posting requesting individuals who had experience scheduling a sexual health appointment at the health center and/or a PSHE appointment through PWS. However, only four were available for interview in the time span of this study. It's necessary to acknowledge that because the students self-selected to be interviewed, they may be more likely to hold strong opinions about the program and may not accurately reflect the average opinion. However, many of experiences shared by interviewees seem to contain similar themes and perceived barriers to care follow much of the data collected from literature accumulated prior to conducting this study.

Case Study 1: Charlie*

Charlie* is a white, 22-year-old, heterosexual, female at WWU. She was referred and met with a PSHE and then received a sexual health appointment, a long two months after her initial appointment request.

Charlie's experience with the SHC and PSHE occurred when she was a Freshman at WWU in 2012. During our interview she explained that she first attempted to make an appointment with the SHC in order to refill a pre-existing birth control prescription. She went into the SHC to make an appointment and was told that she "had" to make an appointment with a PSHE before she could get an appointment at the SHC. The receptionist had told Charlie that the

*names have been changed.

appointment was necessary to receive an appointment at the health center, and *until our interview she was still under the impression that a PSHE appointment was mandatory to receiving a sexual health appointment*. Charlie expressed that “maybe they address it [as mandatory] to encourage people to [see a PSHE] because I feel like people wouldn’t [see a PSHE] if it was advertised as optional.” After getting referred to a PSHE, Charlie said that it took a month or two months to make an appointment with a PSHE because “it was just another step to go through.” She said it takes “confidence and readiness” to make a sexual health appointment at the health center and “having another step is another barrier to getting all that information.” Charlie said that she only eventually made an appointment with a PSHE “because she was about to run out of birth control” and if there hadn’t been a pressing need for the appointment she “probably would have waited even longer”. Charlie said that after she finally decided to see a PSHE, she again called the SHC and had an appointment within a week.

Case Study 2: Erik*

Erik* is a white, 21-year-old, heterosexual, male at WWU. Erik was deterred by his conversation with the SHC receptionist and the PSHE referral, and eventually lied to the SHC about experiencing STI symptoms in order to avoid a PSHE appointment.

Erik had two separate experiences scheduling sexual health appointments at the Student Health Center, once in Spring 2015 and again in Spring 2016. He said that his first experience scheduling an appointment did not involve a referral to a PSHE. According to Erik, this was likely because he was experiencing STI symptoms; “I said probably something along the lines of “I think I got an STI, can I get this checked out.” They proceeded to schedule a STI appointment without recommending a PSHE appointment. According to the SHC nurse practitioners, this

*names have been changed.

follows the practice of immediately scheduling STI appointments when symptoms are present, but according to procedure, Erik should have still been referred to a PSHE after the appointment.

Erik's description of his second appointment is slightly more concerning. According to Erik, he called the SHC in 2016 to schedule another STI appointment, but this time, he was asymptomatic. When he called, they asked why he wanted to be tested. Erik said "[he] had unprotected sex and [...] want to not have any uncertainty as to [his STI] status." In our interview, Erik said he was upset by the SHC response: "*they told me [...] if I really wanted no uncertainty then I should've used a condom in the first place.*" I clarified this statement with Erik, and he reiterated that he felt judgment when scheduling the appointment at the SHC: "I said 'well I didn't [use a condom] so I want to be safe and get tested.'" According to Erik, the SHC receptionist responded "if you actually wanted to be safe, then you should've used a condom." According to Erik, they did not schedule a sexual health appointment and gave him the phone number to make a PSHE appointment. "They ended up giving me the number for the place and told me to call back after I saw the [PSHE]. So I hung up then didn't get tested. Then like two weeks later and called and [untruthfully] said [...] 'I'm pretty sure I have a STD [...] can I get this checked out' then I got in that day. *I was upset by the fact that I couldn't get tested without having to jump through hoops.*"

Erik was very satisfied by the SHC appointment once he was scheduled. He said, "the doctor I saw was super helpful and got me tested without asking too many questions and without offering their perspective on the sexual decisions I had made, which I appreciated." His frustration existed instead with the relationship between the SHC and PSHE program; "I think the PSHE [program] probably offers good information, but shouldn't be forced upon people [...]"

*names have been changed.

It shouldn't be made to feel like a prerequisite for getting a STI screening appointment.

Case Study 3: Marcia*

Marcia* is a white, 22-year-old, heterosexual female who is currently a student at WWU. Marcia received an appointment at the SHC without being referred to a PSHE. Marcia was a unique interview because she is both a student and a PSHE, however her expertise as a PSHE fell under the Student Health Outreach Team (SHOT). The SHOT program is responsible for group sexual health information sessions, known as Cookies and Condoms, in the dorms on campus. She therefore has extensive sexual health information and an insight into the PSHE program as a professional. However, Marcia chose to share her experience as a student utilizing the program.

Marcia's first experience with the SHC and PSHE program as a student didn't occur until 2015, during her fourth year at Western. She expressed during the interview that despite her extensive knowledge about sexual health, she had personally "put off" a sexual health appointment. She explained "I was involved in the SHOT team so I was educated about the process [of seeing a PSHE] and that *it was usually supposed to be a requirement*. I knew it was pretty tedious and wasn't looked upon very fondly." She said she "called the health center knowing [she] would do whatever it took not to see a PSHE because [she] didn't feel like [she] would learn anything." However, Marcia said that the *PSHE program was never mentioned to her and she easily scheduled an appointment*. She did not know the reason for not being referred to a PSHE appointment, but felt positively about avoiding the extra appointment. When I asked Marcia to clarify why she did not want to make a PSHE appointment she said that she was "*one hundred percent influenced by the time and hassle of seeing a PSHE.*"

Like many of the other students interviewed, Marcia agreed with the concept of the program - enough that she participated as an educator. "I think it's really beneficial to be talking

*names have been changed.

to a peer and [that] peer education is really beneficial but [the PSHE program] is structured badly.” She said she has also “talked to people who [...] expressed frustration with the process but all [who completed it] experienced gratitude for the process overall and in the end really liked having the [PSHE] experience and education.”

Case Study 4: Chloe*

Chloe* is a white, 22-year-old, heterosexual female currently a student at WWU. Chloe initially attempted to make a sexual health appointment at the SHC but eventually went to Planned Parenthood to avoid the extra PSHE step and save money.

Chloe first attempted to make a sexual health appointment at the SHC when she was already in the office for a non-sexual health appointment. She asked to get an STI test but did not “because they wanted [her] to contact another office to interview and figure out what to get tested for. It seemed like too much work and I’m more comfortable at Planned Parenthood [...] so I went there.” She said that “a preemptive appointment to [her] actually testing [...] seemed like a lot.” She said that she wanted to get tested before [...] summer and wasn’t sure if [she] could get both appointments in a two-week period.” Like Marcia, Chloe expressed that she expected she would not need the information from the PSHE appointment: “I feel like they probably would have told me stuff I already know and it would have been a rather useless step” she said. During our interview, she also expressed that she had heard STI testing at the SHC was more expensive than elsewhere, so choosing Planned Parenthood was a combination of “time, money and convenience.”

*names have been changed.

Interview Analysis

Name*	Age	Gender	Role
Sarah	*unknown	Female	PWS Program Coordinator. Schedules PSHE apts.
Jennifer	*unknown	Female	Nurse Practitioner. Conducts sexual health apts. at the SHC.
Bonnie	*unknown	Female	Nurse Practitioner. Conducts sexual health apts. at the SHC.
Charlie	22	Female	Student. Sought birth control apt. Attended PSHE apt.
Erik	21	Male	Student. Sought STI testing apt. Did not attend PSHE apt.
Marcia	22	Female	Student and PSHE. Sought STI testing apt. Did not attend PSHE apt.
Chloe	22'	Female	Student. Sought STI testing apt. Did not attend PSHE apt. Had an apt. at Planned Parenthood.

Figure 1: Table shows the professional and student interviews conducted during the study. Shows the name, age, gender, and role of the interviewee.

There are substantial differences in the opinions of professionals and students interviewed. The professional interview differences likely exist because of the roles each individual plays in the PSHE/SHC scheduling process. Sarah meets students who are referred to her from the SHC after attempting to schedule a sexual health appointment. Jennifer and Bonnie saw students who often progress through all three steps and are finally receiving sexual health appointments. Interestingly, there are major differences in opinions about the process and barriers to care that exist within it. Jennifer and Bonnie, the nurse practitioners conducting sexual health appointments, articulated that *they did not see any substantial barriers in the structure of the programs*, and that they saw almost no students who expressed that the PSHE appointment was a deterrence. However, Sarah expressed that *she saw the current structure being prohibitive*

*names have been changed.

in accessing care. This difference suggests that the latter is the case. The nurse practitioners see students who have completed a PSHE appointment or decided to seek a SHC appointment without a PSHE appointment. These students have succeeded in accessing SHC services, which had been their initial goal. Sarah is involved at an earlier step and may see a larger proportion of students, some of whom may be deterred by the multiple steps required in receiving a SHC appointment.

The student case studies paint a drastically different picture than that of the nurse practitioners. It is relevant to acknowledge that the low number and self-selected nature of the case studies mean that the nature of the interviews may not reflect the sentiment of the majority. Unfortunately, without a mass survey assessing how many students initially attempt to make appointments at the SHC, we are unable to determine to what extent students are being affected by the scheduling process. However, each case study provides insight into the barriers that exist within the PSHE/SHC program. Charlie, the female student seeking birth control, ended up waiting an additional two months before scheduling a PSHE and finally receiving a SHC appointment. Erik was deterred by the PSHE appointment and lied to the SHC about his health status to receive an appointment. Marcia was never recommended a PSHE and instead was scheduled without further questions. Chloe was so deterred by the PSHE requirement that she sought out a STI test elsewhere, at Planned Parenthood. Fortunately, all case studies resulted in successfully scheduling a sexual health appointment. However, each one highlights areas within the PSHE/SHC system that are problematic for students. All four case studies identified that the PSHE appointments were a deterrence, largely because of the extra time required to attend another appointment. The “extra” PSHE appointment was often a convenience issue and many students cited preexisting sexual knowledge as an explanation for not needing the appointment.

This finding corresponds to research about sexual health and medical appointments in general: time and space can be a large barrier to receiving health appointments, and students tend to underestimate their sexual health risks and overestimate knowledge.

For all case studies, *there was a lack of clarity about whether PSHE appointments are mandatory*. Excluding Marcia, who was never referred to a PSHE, all students interviewed believed PSHE appointments were on some level mandatory in order to obtain a sexual health appointment. Erik felt that he needed to lie about his sexual health status in order to avoid a PSHE appointment, Charlie grudgingly attended one, and Chloe avoided the health center completely. According to the Nurse Practitioners at the SHC, the PSHE appointments are not mandatory. If this message was successfully conveyed, all three students would have accessed a SHC appointment immediately. Presumably, the conversation between students and SHC receptionists seem not to convey this message; all three students did not want to visit a PSHE and yet felt that they were required to. This lack of consistency in the conversation between SHC receptionists and students can be seen in Marcia's experience as well: she was never recommended a PSHE appointment. It is clear that there is some discrepancy between patient, doctor, coordinator communication, and further research can identify where this discrepancy is especially prevalent.

Study Limitations and Suggestions for Further Research

There are limitations to this pilot study, which largely revolve around time and access to information. The students interviewed were all white and heterosexual, therefore unable to represent other groups of Western students who may have different experiences with the program. There was also very little numerical data available that can be utilized to assess barriers; the number of PSHE appointments scheduled may not accurately reflect the number of

PSHE appointments completed, as some students do not show up to interviews and this goes unrecorded. The number of PSHE appointments scheduled does not reflect the number of students who initially request a SHC appointment, as some may never seek an appointment with a PSHE. Additionally, the number of appointments documented by the SHC only includes scheduled STI appointments, and does not include appointments scheduled for female health exams or birth control, neither the STI testing that can occur at appointments originally scheduled for other health reasons. We were not able to conduct interviews with SHC receptionists, as they are not in the SHC during summer quarter. We also do not have what would be the most useful data: the number of calls initially made to the SHC to schedule sexual health appointments.

Further research necessitates collecting this aforementioned data. In order to determine the extent to which the program may be prohibitive, research should include collecting numerical data quantifying the number of students who initially contact the SHC for a sexual health appointment, the number of students who access PSHE appointments, and finally, the number of students who attend sexual health appointments. This data can be collected by a simple tally system recording the number of contacts made. If the number of students who initially call the SHC for sexual health appointments is much lower than those that receive appointments, there may be substantial barriers in the way that the system is organized. Additionally, it would be helpful to collect more qualitative data from both affected students and SHC receptionists in order to determine perspectives on appointments and scheduling.

Conclusions and Suggestions for Program Improvement

As a pilot study, we can make preliminary conclusions about the PSHE program and barriers to care. The student case studies indicate that there are students who have found the

PSHE program to be prohibitive of accessing care - many more than estimated the nurse practitioners. If the PSHE program is indeed optional, students are frequently being misled when they call to initially make a sexual health appointment. Even Sarah, who conducts scheduling, felt that the PSHE appointments are marketed as mandatory, for this reason and the others described above, Sarah accurately estimated that the current structure could be prohibitive. Students expressed that the main reasons for avoiding a PSHE appointment is the additional time and convenience issues associated with a second appointment. The many steps required to schedule a sexual health appointment provide many opportunities for students to “drop out” of the process (see Figure 2). Further research and interviews can provide insight into the program and its effectiveness.

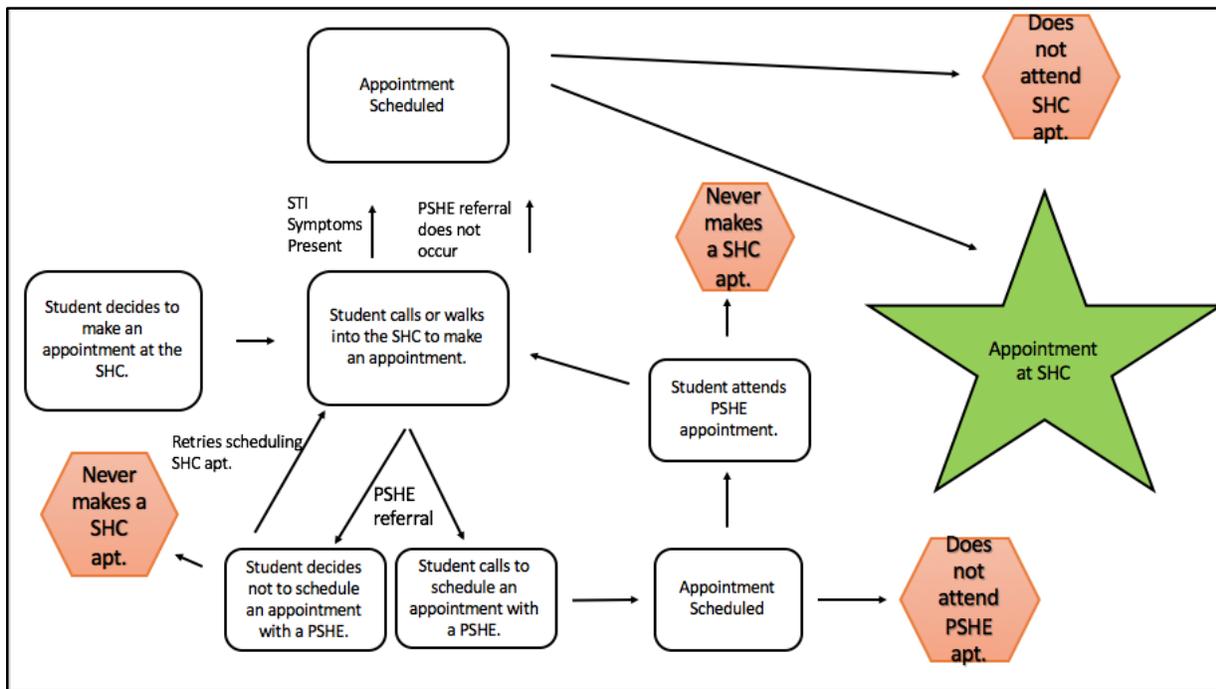


Figure 2: Chart showing the steps a student takes to schedule a PSHE appointment and potential areas where they “drop out” of the process.

We suggest strategies for system improvement if further research continues to indicate that program structure is prohibitive. All students that call the SHC should be scheduled for a

sexual health appointment immediately, in order to reduce the chance of students “giving up” after the initial SHC contact. This would also remove the necessity of students making more than one call to the student health center and remove perceived mandate for students to attend a PSHE appointment to receive a sexual health appointment. This may reduce the number of students who choose to meet with a PSHE, but would increase sexual health appointments, which should be the stated goal of both programs. Because the PSHE information sessions provide invaluable peer education and information, an ideal system would eliminate the two appointments and combine both the PSHE and sexual health appointment, similar to Sarah’s recommendation. Both appointments could be scheduled as one, longer appointment conducted at the SHC to eliminate the space barrier in the two meeting sites. Continuation of this study and improvement to both programs is essential. Sexual health, especially on a college campus, is integral to promoting overall health, ensuring a safe educational environment, and encouraging life-long self-health practices. Improving the existing structures can help an already excellent PSHE program and SHC best serve the WWU population.

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