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Introduction

"Adolescent Sexual Decision-Making in Newfoundland and Labrador" was a joint research project, funded by Status of Women Canada, between Planned Parenthood Newfoundland and Labrador (PPNL) and the Women's Health Network, Newfoundland and Labrador (WHNNL). PPNL is a non-profit sexual health centre that promotes positive sexual health through education, community partnerships, information and services within an environment that supports and respects individual choice. The WHNNL is a non-profit community-based research organization concerned with issues that affect women's health.

This study explored adolescent sexual decision-making and the factors that influence sexual decisions. Adolescents and professionals that work with adolescents participated in the study. The objectives of the study included: (a) identification of adolescent sexual concerns and behaviors, (b) identification of gaps in existing supports for adolescent sexual decision-making, (c) provision of recommendations to address adolescent sexual health needs, and (d) provision of a foundation for the development of a network of individuals, women's groups, community organizations and government departments concerned with the promotion of optimal adolescent sexual health. The findings will be widely disseminated to adolescents, professionals that work with youth, policy makers, school boards, community organizations and the general public.

The research has provided much needed evidence to further advocate for the development of an effective provincial strategy to promote informed/healthy adolescent sexual decision-making and behaviors in Newfoundland and Labrador. A long-term goal of this study is to create awareness and understanding of the sexual health needs of adolescents throughout Newfoundland and Labrador, and to create a network to advocate for the action needed to meet those needs by exploring the experiences of adolescents.

In this report, the findings from the focus groups with adolescents will be presented followed by a discussion of major themes. The findings from the surveys with professionals will also be presented and discussed. The final section will include a number of recommendations that are necessary to address the sexual health needs of adolescents in this province. PPNL and the WHNNL are dedicated to moving these recommendations forward in consultation with key stakeholders including adolescents, community organizations, educators, health care professionals, and government departments.

Literature Review

It is widely known that adolescents are particularly at risk for unplanned pregnancies, sexually transmitted infections and sexual violence (Health Canada, 1999). It is also known that adolescents are beginning to engage in sexual activity at a younger age (Boyce, Doherty, Fortin & MacKinnon, 2003), which further augments the risks of unwanted outcomes. At the same time, in general, there is more available access to sexual health education and resources than for previous generations. Despite this, however, it appears that education and resources are not meeting the needs of adolescents in terms of sexual health. It is necessary to explore this with regards to adolescent sexual decision-making.

In conducting the literature review for this report, the researchers found that limited inquiry has been completed regarding the knowledge, attitudes and behaviors of adolescents concerning sexual decision-making in Newfoundland and Labrador (NL). As well, research on the knowledge and attitudes of professionals that work with adolescents regarding sexual decision-making was also limited. Currently, there is no provincial sexual health framework or strategy to guide sexual health programming and service delivery in the province. Furthermore, through the work of Planned Parenthood Newfoundland and Labrador, it is recognized that services and programs throughout the province are not consistent or comprehensive. This means that adolescents, especially in the province's many isolated rural communities, may not have access to counselling, information or clinical services needed to promote informed and healthy sexual behaviors.

Although teenage pregnancy statistics have been declining in Canada (from 53.7 per 1000 pregnancies in 1974 to 48.8 per 1000 pregnancies in 1994), this country still has one of the highest teenage pregnancy rates among developed countries (Health Canada, 1999). In relation

to pregnancy prevention, Fisher, Boroditsky and Bridges (1999) reported that only 60% of 15-17 year olds in their study had always used some form of contraception. They also found that 58% of adolescents were sexually active prior to using any type of birth control. In Newfoundland and Labrador, the teenage pregnancy rate fell from 31.5 in 1998 to 28.5 in 2000 and was the lowest in Canada (Statistics Canada, 2004). However, the percentage of live births to teenage mothers continues to remain high in rural communities even though overall rates are declining. In 2001, the percentage of live births to teenage mothers in Labrador was 148 per 1000 births, compared to 49.2 per 1000 births in St. John's (Newfoundland and Labrador Centre for Health Information, 2003). The researchers cannot assume, however, that there are more teenage pregnancies in rural Newfoundland and Labrador than in the urban areas. It can only be stated that the rate of live births to teenage mothers is higher in rural areas of the province. Consideration also has to be given to factors such as culture, access to sexual health supports and information, and access to abortion. The rate of abortion among 15-19 year olds in Newfoundland and Labrador has been decreasing since 1998. At that time the rate was 9.7 and two years later in 2000 the rate was 8.4 per 1000 women (Statistics Canada, 2004). The Canadian average in 2000 was 20.2 per 1000 women. Does this mean that adolescents in NL are making more informed sexual decisions, have increased access to sexual health information and services, or are not as sexually active? At this point, these questions remain unanswered.

Incidences of sexually transmitted infections have been steadily increasing, and in 1997 Canada reported over 33,000 cases of chlamydia and 4000 cases of gonorrhea, with chlamydia infections for adolescent girls being nine times that of the national average (Health Canada, 1999). Studies have indicated that adolescents do not consistently use condoms to prevent STI's (Langille, Hughes, Tomblin Murphy & Rigby, 2002; Thomas, DiCenso & Griffith, 1998).

According to Fisher, Boroditsky and Bridges (1999), only 40% of 15-17 year olds had consistently used a condom in the previous six months.

Sexual violence is also an issue influencing the lives of adolescents. According to Campbell (1999), it can be estimated that 51% of women in Canada indicated that they had experienced at least one incident of sexual violence since they were 16 years old. Furthermore, in 1994, police reports indicated that sexual assaults accounted for 16% of violence against youth ages 12-19 years and 46% for youth under the age of 12 (Campbell, 1999).

There is evidence to suggest that adolescents are engaging in sexual activity at a younger age (Boyce, Doherty, Fortin & MacKinnon, 2003). In this study, it was found that the average age of first sexual intercourse was 14.1 years among boys and 14.5 among girls. Twenty-two percent of the sexually active grade nine boys reported having between 4 and 10 partners compared to 14% of the grade nine girls.

Westera and Bennett (1990) conducted a survey with youth between the ages of 15 and 19 years to obtain information about the values, attitudes, concerns and behaviors of Newfoundland youth regarding a multitude of factors related to issues such as school, smoking, alcohol/drug use, and sexuality. This was a province wide quantitative study that included 2300 high school students and 302 high school dropouts. Deciding what to do when they finished school was the top concern identified by high school students, followed by feeling time pressures and then boredom. Sexuality was rated as the lowest personal concern for high school youth. The majority of students reported that they felt that sex before marriage was acceptable in a loving relationship and nearly 100% agreed that teenagers should have access to birth control methods. The findings also indicated that 54% of participants did not appear to sanction casual sex. Adolescents also reported that they did not feel that adults respected either them or their

opinions. The media was reported as being very important to adolescents with 38% indicating that the media does influence their lives.

King, Beazley, Warren, Hankins, Robertson and Radford (1988) conducted a study to investigate knowledge, behaviors, and attitudes regarding AIDS and other sexually transmitted infections of grade 11 students in Canada. Cregheur (1992) replicated this study to determine if there were any changes in the knowledge, attitudes and behaviors among adolescents in Newfoundland and Labrador three years later. Adolescent responses were analyzed against responses given by Newfoundland and Labrador adolescents in the original study. There were some interesting results. Cregheur (1992) found that fewer NL students felt that their parents understood them or would ask their parents for advice, fewer students reported having lots of friends and more kept their problems to themselves. Slightly fewer NL students felt pressure from their friends to drink alcohol and be sexually active. Their knowledge about HIV/AIDS had increased along with information about other sexually transmitted infections. They also found that school played a more significant role in educating adolescents about HIV, sexually transmitted infections and sex than previously, but friends were still cited as the number one source of information about sex. The percentage of students who had intercourse had increased but the percentage of students who had sex frequently had decreased.

Part two of Cregheur's study evaluated the long-term effectiveness of the grade nine course entitled *Adolescence: Relationships and Sexuality.* They used case vignettes describing situations and scenarios, pertinent for adolescents, to inform students about sexual health issues, including HIV, and to evaluate their skills in sexual decision-making. Students who had taken the course were more likely to offer several options in the situation displayed in the vignettes and expressed less embarrassment when purchasing condoms.

A study of HIV seroprevalence in prenatal women was carried out in NL in 1993 (Ratnam, 1994). Results indicated that the HIV prevalence for the Eastern Region (including Conception Bay North) was 26.6/10,000 compared to a provincial prevalence of 8.7/10,000. This cluster of HIV caused a great deal of concern and generated education and research efforts. Donovan (1998) conducted a research study to explore the determinants of sexual behavior among youth at risk for the heterosexual transmission of HIV in the Eastern Region of the province. After reviewing the literature and the degree of effectiveness of prevention programming targeted to HIV transmission, Donovan found that "extensive prevention programming had not resulted in significant HIV testing which was considered to be an important tool in limiting the spread of HIV" (p. 1). Donovan's report indicated that education on HIV prevention alone was not sufficient to change adolescent sexual behaviors. Donovan felt that it was also important to analyze other individual and societal (community) factors that were impacting on the sexual behaviors of adolescents.

The study conducted with students in grades 4-6, 7-9 and 10-12, in the Eastern Region, yielded some interesting results relating to sexual activity, drugs and alcohol use, unwanted sexual activity, attitudes/community norms, self-perception, gender roles and knowledge acquisition. Donovan (1998) noted that 1% of elementary, 13% of junior high and 49% of senior high students reported having vaginal or anal intercourse. Males reported more sexual activity than the females. Twenty-two percent of elementary and 44% of senior high students reported using alcohol and 11% reported drug use. Fifty-eight percent of those youth reported that they had engaged in sex, on at least one occasion, while under the influence of alcohol. In terms of unwanted sexual activity, 33% of females and 15% of males in junior high school reported that they had experienced unwanted touching and 16% of females and 7% of males in senior high

school reported that they had experienced unwanted intercourse. The issues of experimentation and sexual stereotypes were addressed in the focus groups. Youth reported that sexual stereotypes were still persistent in their communities, and that experimentation with sex and alcohol/drugs often begins in junior high and becomes the "norm" in senior high. Junior and senior high school students voiced concerns related to pregnancy and sexually transmitted infections. Junior high females voiced more confidence than senior high female students in avoiding unwanted sexual activities with their peers. The senior high females indicated that substance use, peer pressure and spontaneous behaviors could impact a female's resoluteness in avoiding unwanted sexual activity. Both sexes cited a lack of anonymity and embarrassment as barriers to accessing safer sex resources.

Perceptions of differentiated gender roles were still existent and students talked about how guys who were sexually promiscuous were regarded positively as "studs" whereas females acquired a "reputation". For the girls, teenage pregnancy and loss of reputation were perceived as more serious issues than HIV/AIDS. Female students reported that they often felt intimidated to engage in sexual behaviors due to verbal or emotional abuse from their partners. Students felt that they were well educated about HIV/AIDS, but not about many of the other sexually transmitted infections. They did not regard their parents as preferred sources of information about sex, pregnancy or sexually transmitted infections. They viewed confidentiality as important when accessing information, and they wanted better access to birth control and condoms, and more information on the risks of sexual activity and improved access to health care professionals.

Hoskins et al. (2000) conducted a study with students in the Eastern Region to encourage "participants to think about how they currently make decisions concerning risky behaviors"

(p. 4). Of the 4894 students in grades 7-12, 36% reported that they had engaged in sexual intercourse. The most common responses from students about why they had sexual intercourse included love (44%), did not know why (15%), under the influence of drugs or alcohol (13%), to please their partner (12%), curiosity/boredom (9%), everybody doing it (4%) and were forced (2%). Students reported that peer pressure was one of the reasons why youth engage in sexual intercourse. Only 47% of those who had engaged in sexual intercourse during the six months prior to the study had always used condoms and 21% never used condoms. Seventeen percent reported that they had engaged in unprotected sex within that six-month period. The percentage was higher for females (18%) than it was for males (15%). Fear of pregnancy was cited as the number one reason that students used condoms (64%), followed by the fear of contracting a sexually transmitted infection including HIV (31%). Reasons for not using condoms included embarrassment about having to buy them, condoms not being affordable, not knowing where to access and how to use them, and fear of talking with their partner about condom use.

Cregheur (1992), Donovan (1998) and Hoskins et al. (2000) provide important insight into the sexual behaviors, decision-making and educational needs of adolescents in HIV prevention and risk-taking behaviors. However, the majority of this research was limited to the Eastern Health Region. Therefore, an in-depth analysis of adolescent sexual decision-making is warranted to explore these issues in more detail and to expand upon the work of Donovan and Hoskins in exploring adolescent sexual decision-making province wide.

In exploring adolescent sexual decision-making, it is important to understand the processes by which adolescents make sexual decisions. This literature review explores decision-making in the context of adolescent development. Adolescence is a time when individuals are developing skills to help them make effective decisions concerning their lifestyles, relationships,

education and independence (Federal/Provincial/Territorial Advisory Committee on Population Health, 2000). Adolescents are challenged to make decisions that will have a lasting impact on their future including those related to their career, school, sexuality, and risk-taking behaviors. Consequently, they need to be provided with opportunities to develop the necessary decision-making skills to deal with these issues in an effective and personal way.

Furby and Beyth-Marom (1992) describe decision-making as a process whereby the individual has to examine an issue in detail, consider all the possible ways of addressing the issue, regard the potential impacts of each decision and determine the chances of these impacts occurring. It also involves considering the ability to deal with these impacts, and then making a decision based on all these elements. The authors also report that adults and adolescents may differ in the decision-making process in terms of evaluating options, considering the consequences and determining the value and risk of consequences. Trad (1993) expressed that adolescents may have different perceptions of risky behavior and its potential outcomes and reiterates that "adolescent decision making skills may differ from those of adults" (p. 550). This certainly has implications for sexual health education and programming.

Risky behavior is regarded as normal in adolescence and experimenting with attitudes and behaviors is thought to help in the development of identity and personality. Risk also affects the development of initiative and self-confidence. At the same time this behavior may induce stress for the adolescent and this can affect the ability to make decisions in an effective manner (Trad, 1993). After reviewing several studies about adolescent decision-making, Trad points out that adolescent risk-taking behavior may not be the result of decision-making ability alone and that other factors need to be taken into consideration. Trad identified both internal and external factors as having an influence on adolescent decision-making. The internal factors include locus

of control (*perceived control over one's fate*) and cognitive abilities. The external factors include relationships with peers and family. Furby and Beyth-Marom, (1992) also recognize that developmental factors are influential and that decision-making skills develop with maturity and experience.

Donnelly and Davis-Berman (1994) found that when adolescents are given opportunities to enhance their decision-making skills they are able to make decisions that have more positive outcomes. According to Langille (2000), adolescents can develop the skills and knowledge for sexual decision-making and the prevention of unplanned pregnancies and sexually transmitted infections, but many adolescents are faced with barriers to accessing information and services that can prevent them from utilizing their decision-making capabilities. Langille refers to international data which shows that a more directed approach to sexual and reproductive health education and programming may result in more positive outcomes in adolescent sexual health, such as the prevention of unplanned pregnancies. However, he points out that this has to be a collaborative approach involving adolescents, professionals, educators, community organizations and parents. Health Canada (1999) asserts that "the best possible choices occur when a strong foundation of personal capacities has been set from the earliest days of life, and when information, education, and supports to enable health are in place" (p. 5).

The literature clearly demonstrates that the prevention programming in Newfoundland and Labrador has succeeded in increasing knowledge and awareness among youth; however, this alone has not been sufficient to produce widespread behavioral change in adolescents regarding their sexual activity. A greater understanding of how adolescents make decisions regarding their sexual health is needed if health care providers, educators and governments are to develop

appropriate and effective programs, services and policies to meet the sexual health needs of adolescents as they grow and develop.

Methods

In this study an exploratory descriptive design was used to describe the perceptions of adolescents with sexual decision-making and to identify some of the influential factors regarding those decisions. Focus groups with male and female adolescents were conducted in each of the six health care regions of the province (i.e., St. John's, Eastern, Central, Western, Grenfell, and Labrador).

Participants

Male and female participants aged 15-16 years were recruited for the study. Adolescents are reported to be engaging in sexual activity at an earlier age, with over 50% having sexual intercourse before finishing high school (Olatunbosum, 2001). There are currently no Canadian statistics that indicate the age of onset of other forms of sexual activity such as oral and anal sex. However, clinical experience at Planned Parenthood Newfoundland and Labrador indicates that the onset of sexual activity, in general, is beginning at an earlier age. Considering these facts, adolescents that were 15-16 years of age and were in level 1 in the high school system were targeted. This ensured capturing the experiences of adolescents while they were considering becoming sexually active or was already sexually active. The researchers aimed to have at least twenty (ten male and ten female) participants from each health care region for a total of 120 youth. A total of 86 youth participated in the 10 focus groups (54 females and 32 males). In two of the health care regions only female adolescents participated.

Procedure

To capture the extent and diversity of experiences of adolescents living throughout NL, the goal was to include adolescents in each health care region of the province. To recruit participants in the study, adolescents were accessed through the structured educational system. An information package explaining the study was sent to 10 of the 11 school boards in the province along with a letter requesting permission to contact schools in each district. The French school district was not included due to the fact that the researchers could not speak French and there were no resources available for French transcription. School board permission was granted from eight of the ten school boards. Schools within each school board district were then randomly selected to be contacted regarding potential recruitment of participants for the study. School personnel that agreed to participate were mailed information about the study and parent information packages for adolescents to take home. Parental/guardian consent was necessary for students to participate in the study and all students were asked to mail the signed consent forms in a sealed envelope to PPNL in the return stamped envelop that was included in the package. Parental consent was difficult to obtain at some schools and therefore the students were unable to participate. Additional schools were then randomly selected until there were sufficient parental consent forms mailed back to PPNL from one school in each health care region. Schools that participated in the study were provided with Honoraria of $200.00 to support their school programming. Following each of the focus groups, adolescents were provided with sexual health pamphlets from PPNL, as education was not the intention in conducting the focus groups. However, given the content of the focus group discussions, the researchers regarded the distribution of educational material as being essential. The researchers also provided participants

with contact information for PPNL so that they could access information on any sexual health related issues.

Same sex focus groups were performed so that the adolescents could speak freely among their own same sex peer groups. Focus group discussions followed a semi-structured format that included questions about adolescent sexual decision-making but also facilitated exploration of other issues that arose during the discussion. Open-ended questions were used to prompt or clarify statements. The questions were devised in collaboration with PPNL and WHNNL community partners and members of the study's advisory committee. Each focus group discussion was approximately 90 minutes in length and was audiotaped. Focus group participants were sent a copy of the findings to ensure that the report accurately reflected the focus group discussions. Focus group participants were given an honorarium of $30 to complete this review and provide feedback. A networking day was held with professionals that work with adolescents in the St. John's Region to identify questions that could capture the issues impacting adolescent sexual decision-making.

Ethical Considerations

Prior to commencing this study, permission was sought and granted by the Human Investigation Committee (HIC) at Memorial University of Newfoundland. Prior to conducting each focus group, consent was obtained from parents/guardians and participants. Participants were provided with a copy of the consent, including the researchers' names and phone numbers. Participants were informed that they could withdraw from the study at any time and refuse to respond to any questions posed by the researchers that they would prefer not to answer.

The researchers took all reasonable precautions to protect the anonymity of participants and confidentiality of information. There was no identification of participants on the tapes or in the transcribed data. Direct quotes were used to support emerging themes but the omission of identifying markers ensured confidentiality. Audiotapes were erased following a review of transcripts for accuracy. Focus group transcripts and consent forms were kept in a locked filing cabinet accessible only to the researchers.

Data Analysis

Following each focus group discussion the audiotape was transcribed verbatim. Each transcript was read and reread, while simultaneously listening to the corresponding audiotape. This not only ensured that the tapes had been transcribed accurately, but also allowed the researchers to grasp what was being "said" and acquire a deeper understanding of participant responses. The transcripts were analyzed using content analysis to identify common themes. The emerging themes from each focus group were compared and contrasted to allow commonalties and differences to become apparent. Finally, the researchers identified overall themes, which best described the participants' experiences with sexual decision-making. Once essential themes were identified, the researchers began the process of writing and rewriting facilitating a better understanding of the data.

Findings

The following section provides a detailed discussion of the findings identified from the 10 focus group transcripts of 86 adolescents. The findings are categorized into the following areas: meanings of sexual activity, healthy sexual decision-making, unhealthy sexual decision-making, perceptions of healthy/unhealthy relationships, factors influencing adolescent sexual decision-making, perceptions of gender roles, attitudes towards lesbian/bisexual/gay/ transgendered (LBGT) persons and access to information, services and support. The final section outlines participants' suggestions to improve adolescent sexual health in Newfoundland and Labrador.

Meanings of Sexual Activity

The participants defined sex primarily by the physical aspects. Most participants described sex as sexual intercourse (vaginal and anal sex), oral sex, anything physical between two people, touching, and masturbation. In one of the female groups, the girls expressed that oral sex was not perceived as significant an activity as sexual intercourse. The girls expressed that sometimes, people do not even acknowledge oral sex as sex. One female commented: "Well, when you talk about oral sex. You don't mean it as sex. No one really takes it as that." Other participants defined sex to include intimacy, expressing love, pleasing each other, the next step in a relationship and fun. One participant perceived sex as a step to "getting serious."

Healthy Sexual Decision-Making

Female participants identified the following as examples of healthy sexual decision-making: being informed about sex, deciding to be monogamous in a relationship, practicing

abstinence until marriage, using protection and contraception, and having open communication with a partner. They also highlighted having respect for oneself, making sure that their partner did not have a disease, avoiding drugs and alcohol, and not being pressured to have sex by peers or the media. They felt that two people needed trust and communication with each other to make a healthy sexual decision. Many girls believed that commitment, communication and support in a relationship had a great impact on sexual decision-making. This was reflected in the following statement:

> . . . . make sure the two people engaging into the sexual act understands each other, each person's wants, needs, desires and things like that and being comfortable with the person so you can say "no".

Males identified examples of healthy sexual decisions as using birth control, practicing abstinence, being informed about sexually transmitted infections (STI), being emotionally ready to have sex, and having open communication with their partners. One participant stated: "You sit down and talk to each other about how you feel about each other. That's healthy. You need to communicate." Though all males were able to articulate what informed sexual decisions involved, many felt that they had to struggle with their hormones to act upon that knowledge. According to one male: "Making an informed decision really depends upon your personality and who you are." Another male felt that the way you were raised affected the way you made sexual decisions.

Male participants believed that an informed decision was based on one's knowledge of the risks and consequences of sex, such as teenage pregnancy and the spread of sexually transmitted infections. Males also felt it was important to find out whether their partner had a sexually transmitted infection, although they admitted that they did not feel comfortable approaching their partner on this subject and felt that this was something that their partners

should inform them of before engaging in sexual activity. Some of the male participants indicated that they did not feel comfortable asking their partners about sexually transmitted infections because they did not want to offend their partners, make them uncomfortable or indicate in any way that they thought that their partners were "sluts". According to one male participant: "If you ask a girl 'did she have anything', she'd definitely slap ya. . . .cause then she'd think that you thinks she got something." On the other hand, some male participants did not feel that STI's and HIV were issues in their community.

Unhealthy Sexual Decision-Making

When asked what constituted an unhealthy sexual decision, the males reported factors such as having sex without a condom, getting a girl pregnant, having sex with multiple partners, constantly fighting with their partner, cheating on their partner and pressuring girls to have sex. One participant stated: "You can put a bit of pressure on her *(partner)* and say you are going to break up with her." Other factors identified included a lack of communication with their partner about the risks and consequences of unsafe sex and contracting a STI.

Males agreed that conforming to peer or media pressure to have sex reflected unhealthy sexual decision-making. Many males were also concerned that sexual decisions, without effective communication between two people, could lead to the loss of friendship. These males discussed instances of having casual sex with female friends and how this situation could ruin a friendship if they did not have similar expectations of the relationship. Male participants commented:

> An unhealthy sexual decision could ruin your friendship with a girl if you're really close friends with her – and does something stupid. You don't talk to each other no more and you can ruin your friendship with them.

> . . . .like to have friendly sex, like casual sex, friend sex. The thing about having sex is that if you communicate right and understand that someone might say, just be satisfying the other, they might think it's a real relationship. When that happens, it runs into trouble and stuff like that.

The girls reported that cheating, teasing, slapping their partner, not using protection, lack of communication with partner, having sex in grade 6 or 7, and conforming to pressure to have sex reflected unhealthy sexual decision-making. The female participants identified several consequences of unhealthy sexual decision-making. These included "losing your friends, "screwing up your life", "screwing up your relationship", "getting a bad rep", and "getting cancer from your STDs." One group of females indicated that some girls are at risk for depression or suicide when they feel they have made the wrong sexual decision. One participant stated:

> If you knows you have an STD or if you knows that you're pregnant or something and can't deal with the pressure and you can't tell your parents or something and you don't want to get an abortion. . . .then it could lead you like into really heavy depression or suicide.

They felt that most adolescents were aware of the consequences of unhealthy sexual decisions. However, according to one participant, some "don't wanna accept the fact that it can happen to them."

Feelings of security by living in a rural area resulted in one group of female participants believing that they were not at risk for getting sexually transmitted infections. When asked if they were concerned about sexually transmitted infections, one girl stated: "Not around here. Usually you would know before, if you are going out with someone, they should tell you." These girls felt that you could not get a STI or AIDS in a small, rural community because as one female participant stated: "You know where they *(males)* grew up, and their family." Girls in

most of the other focus groups, however, felt that a sexual transmitted infection could be a consequence of unprotected sex no matter where a person lived.

The most significant consequence of unhealthy sexual decision-making identified by the majority of male and female participants was pregnancy. This was followed by sexually transmitted infections. According to one of the female participants: "The first thing that you think of is oh, I'm not pregnant, then I wonder if I have any diseases." Some of the males talked about the guilt that many of their friends have experienced and how an unplanned pregnancy "ruined their lives." One male participant reflected on how one of his friends felt in this situation: "The guy that got her pregnant is regretting it. He didn't mean to do it. He's sorry now though. But it's too late." However, another male expressed that "it take two to make the decision" and that they would "stick by their partners" if a pregnancy occurred. On the other hand, some of the males identified HIV as the "worst thing that could happen to a person" and felt that the impact of HIV on their health was more serious than the financial and social consequences of becoming a teenage father. One participant stated: "Disease is worse."

Perceptions of Healthy/Unhealthy Relationships

Males identified aspects of healthy relationships as being in love, displaying affection, respecting each other, and having trust. In relation to respect, one male participant stated: "Respect! It should be a relationship that is not just based on sex." However, they acknowledged that sex does not necessarily always take place in a monogamous relationship. Some participants stated that sex happens between two people who are not in love and therefore as one male commented: "Sex doesn't have to mean anything." However, most boys indicated

that relationships should be meaningful before sexual decisions are made. One male participant stated:

> You want it to mean something – some people will do it for pleasure and I suppose that's alright. But I mean, most sensible people want it to mean something, you know. You want to do it because you love the girl and not just for the sake of doing it.

Most males also felt that mutual respect and communication were keys to building healthy relationships. According to one participant:

> If you wanted to, you're going to decide to have sex, you got to really love the girl and spend time with her, and be with her all the time, and have good times, and be happy, and not fight, and agree on the same thing. . . .it can't just be one person. There has to be two people involved.

The girls perceived a healthy relationship as one, in which they are able to have fun, laugh, and get along well. They also believed that girls needed to feel comfortable with themselves and to feel that there was trust in the relationship. Many felt that displays of affection, holding hands, hugging or kissing strengthened a relationship and were indicators of the level of comfort between two people.

Many of the females identified jealousy as a significant sign of an unhealthy relationship and felt that feelings of insecurity led to fighting, verbal and physical abuse, as well as the painful consequence of breaking up. According to one female participant: "If there's another girl around their boyfriend in the same place – or with him by some chance – you'll see 'em beatin' the other one up. Jealousy is one big thing in this school." Another female participant stated: "Some people thinks that if they don't do it *(sex)* now, their boyfriend or girlfriend might go with someone else." Some girls felt jealousy arose in situations where their partners were older and had more sexual experiences or relationships.

Males described aspects of unhealthy relationships as arguing a lot, being dishonest, breaking up all the time, and physically fighting. Like girls, they worried about whether their

partners would be faithful to them and agreed that these fears influenced a relationship. The males in one group discussed the issue of power and control in relationships and felt that a relationship was unhealthy if one partner dominated it. Although they felt that girls are most often the victims of physical abuse, some males believed that girls had the potential to be dominating or verbally abusive, particularly by dictating who they could and could not "hang out with". One participant commented on a relationship in which one of his friends was being controlled:

> He's *(friend)* no fun. Don't do anything anymore. No, he don't do anything because of what she says. He never be's around. When he's home. . . .he don't go out. If he's home, she's home. They are always together.

The boys expressed that this was having a negative impact on their friend in terms of his self-esteem, as his girlfriend was always mad at him and telling him what to do. The boys felt that this was very unhealthy and could lead to becoming more abusive. When asked if they felt there were any supports to help this friend, they did suggest the guidance counsellor in the school. However, many males reported that they would probably not go to the guidance counsellor because they would feel embarrassed about the situation. They also wondered whether the guidance counsellor would consider this to be a significant issue. The males also reported that the topic of power and control in relationships was not being addressed in their current school curriculum.

Factors Influencing Adolescent Sexual Decision-Making

The data indicated that there are many factors that influence adolescent sexual decision-making. These factors included the media, peer pressure, alcohol and drugs, self-esteem, developmental influences, and parents/family.

Influence of the media.

The majority of the adolescents in this study expressed that the media influenced their sexual decision-making. One male participant stated: "The media makes it sound like it is easy to make the decision." Another participant reported that the media made youth question whether they should be having sex: "You sees people your age doing it *(having sex)* on TV. You ask, 'Should I do this'"? The participants indicated that they receive information about sex and sexual decision-making from television, magazines, music, videos, movies and the Internet. Even though females discussed the issue more, many of the males did express that television does give mixed messages about sex and often suggests permission to have sex if they want to "fit in" with the social environment. The female adolescents reported that the media provides them with many sexual messages that are confusing, inconsistent, and based on gender and media stereotyping. Many of the adolescents also felt that the media portrays negative images of gay men and is often demeaning to women, while still promoting sex as something that is, as one girl reported: "Cool to do." One male indicated that some of his male peers viewed sex as a competitive game learning this behavior from a television show:

> A group of guys will say, ok, you have sex with her, you get eight points in your name. They have points on a certain one. Like Level Threes *(grade 12 students),* if you have sex with a level three you're a five, but if you have sex with a grade nine you are a twenty points.

The females reported that over the past few years the media has promoted a more casual view of sex. One female participant referred to late night CBC programming as "CBC porn." Another participant described her feelings as follows:

> Over the years sex has been portrayed as less of a big deal. . . .there is more sex on T.V. and in the movies every time you watch something. Every time you turn on the T.V. there is someone who is doing it, not necessarily in bed, but some form of sexual activity, or someone talking about it or making jokes about it.

Some of the adolescents made reference to some of today's most popular teenage shows such as "Dawson's Creek" and reality shows such as "Temptation Island" where casual sex and sexual relationships are consistently being portrayed and normalized. One female participant reflected on the issue:

> Yeah, cause in all the teen shows, like Dawson's Creek, people are sleeping around all over the place. It gets portrayed as the normal thing to happen and that's what it is going to be like.

Adolescents expressed that the messages they receive from the media are explicit and that there is an expectation that sexual relationships will be like this for them as well. Some of the female participants felt that this often sets adolescents up for failure because once they do actually have sex it is not the same as what they saw on T.V. One female participant stated:

> You sometimes see sex to be romantic, candles lit and everything and when you and your boyfriend go to do it you say, 'Oh my God! Why did I do this? It's weird! It's not like I expected it to be.'

Adolescents also reported that television, magazines, and music videos are often filled with advertisements that attempt to appeal to and reach adolescents. The adolescents in this study indicated that the mixed messages portrayed by the media were confusing to them. For example, one magazine advertisement might promote sex as something bad while another one suggests that it is normal and acceptable to be in a sexual relationship. Several of the female adolescents suggested that this could also have an impact on self-esteem in that if you do not conform to what the media is suggesting, then you are not "in with the times" and may feel socially isolated. The following comments illustrates this point:

> They (*the media*) make you feel like you are all alone. Like you're not good enough for anyone. . . .like it seems like you have to do it *(sex)* just to be in with the times. . . .'Cause everybody's doing it, you have to do it to fit in.

> And like, what show is it, the guys said he can't go to college a virgin? It is like a big bad thing for guys. Like it is embarrassing at a certain age.

Some of the adolescents made an interesting point about the "perceptions" parents have of adolescents due to media influences. They felt that the media gave youth a bad reputation and that their parents were also hearing and believing messages that all adolescents were sexually active, even if this was not the case. One female participant stated: "They *(media)* ruins it for all of us. They make us have a bad rep *(reputation*). They think like we're all having sex and we're all doing drugs." Although many of the adolescents challenged the messages about sex and the portrayal of adolescents in the media, they felt they lacked the power to do anything about it.

Influence of peer pressure.

Peer pressure emerged as a significant factor in influencing adolescent sexual decision-making. In a heterosexual relationship, females were more likely to feel pressure from their partners to have sex and to concede to the pressure in order to maintain the relationship. Males, on the other hand, were more likely to feel pressure to be sexually active from their male peers and the sexual stereotypes that inform male behavior. There was no indication that females pressured males to have sex. Males indicated that the pressure to have sex can be so great among their peers, they will lie to their friends and tell them that they have had sex. According to one male participant: "If ya cares about what other people thinks you are going to give into peer pressure every time." Another male expressed that "like somebody will come up to you and say 'I had sex this weekend'. . . .yeah me too."

One female participant expressed that "males talk about sex more often with other males and it's always on their mind." Another female participant suggested that "boys are more ready than girls are" and are always ready for sex. Some girls did express that it is a concern for many young female adolescents that their boyfriends will break up with them, if they decide not to have sex. Most of the female participants agreed that this was not ideal, but indicated that this

fear concerned them and influenced their sexual decision-making.

Some girls also stated that they felt a certain amount of pressure to have sex when they found out that their other female friends were sexually active. One girl expressed this concern by stating: "But if you're insecure and like, your friends are having sex - you're like, oh God, I have to do that to fit in." In these situations girls feared being different or left out of new experiences.

Girls also indicated that there is a distinct rite of passage when entering senior high school that puts pressure on them to make sexual decisions. They talked about sexual decision-making in relation to popularity and according to one female participant: "A lot of people think that way. Having sex will make you popular. You get to hang out with the popular guys." However, other females challenged this idea and talked about the effects that this would have on the reputation of young girls. These girls perceived that adolescents are becoming sexually active at an earlier age and are experimenting because they want to be cool and fit in with their peer group. According to one female participant:

> From the grade 9 girls that came up here last year, I'd say, maybe, 85-90 % lost their virginity to a level three guy. You would never, ever expect. Like the biggest goody-goodies ever, who would never. They just did it to fit in. Just to come to high school.

Another female reflected on the young age at which adolescents are experimenting. According to this group, younger adolescents are maturing too early, becoming sexually active at a much younger age, and wanting to experience things for themselves. She stated:

> When you're in grade 6 and going to grade 7, sure the grade 7's up there, they drink, they smoke and they're sexually active or whatever. And the little grade 6's are going to be intimidated by it and say, 'Well, I got to do this to fit in.' They're going to be pressured into doing that stuff.

Influences of alcohol and drugs.

When asked if alcohol and/or drug use influenced adolescent sexual decision-making, the majority of adolescents expressed that this was an issue and that many adolescents make unhealthy sexual decisions, while under the influence of alcohol and/or drugs. However, there were varying opinions of the degree to which alcohol and/or drug use influenced their sexual decision-making.

Unhealthy decisions, while under the influence of alcohol and/or drugs, included not using protection and engaging in sexual activity when they would not have done so otherwise. The negative outcomes of using alcohol and/or drugs included getting pregnant, contracting a sexually transmitted infection, having no memory of what happened the night before, being sexually assaulted or raped, and ruining a friendship. Some participants expressed concern regarding alcohol and drug use by youth much younger than themselves.

Several of the participants felt that adolescents would not engage in sexual activity if alcohol and/or drug use among adolescents was not an issue in their community. One of the female participants stated: "I think if we didn't have drugs and alcohol here, I'd say everybody would be like - 95% virgins. Honestly, I really do think that."

Both the male and female participants suggested that alcohol and drug use gave adolescents the self-confidence to engage in sexual activity and risky behaviors. The participants felt that alcohol and drug use lowered inhibitions resulting in sexual activity that may not have occurred otherwise. According to one male participant: "Alcohol is liquid self-confidence." Another female participant reported that alcohol use could also affect an individual's perceptions of a situation so that a person doesn't really know what they are doing and often can't remember

anything at all. She stated: "I think that if you are drunk, you're not sensible enough to know what you're doing."

Several of the male participants talked about the use of alcohol by adolescents in relation to social awkwardness and as a means to feel more comfortable. Some of the males reported alcohol as being used in this way by many of their female friends. This was illustrated by the following comment:

> I know many girls who are not comfortable with themselves and do whatever so they get drunk and feel more comfortable and brave.

In one of the focus groups, several of the female participants perceived the use of alcohol and/or drugs as a barrier in accessing support from their parents in incidences of sexual assault. They felt that their parents would be so upset about the fact that they were drinking, that they would be blamed for the sexual assault and that the drinking would be the behavior on which the parents focused. This concern is captured in the following statement:

> If you got drunk and somebody raped ya when you were drinking, right? Like, it's not that big of a deal. But if someone got raped. . . .that's the sex part. . . .but when the alcohol is brought into it, that's what prevents 'em from talking to their parents. 'God, I got raped but I can't tell Mom right? Because then she'll know I was drinking'. Like, a lot of parents around here, they'd be upset over the fact you got raped right? But they'd be. . . .cause you were drinking. So a lot of parents - they'd overlook the rape part if it was due to the fact that you were drinking.

However, in another focus group, female participants reported that their parents would be supportive if they had been drinking and were sexually assaulted.

Although the majority of adolescents stated that alcohol and/or drug use could impair judgement when making sexual decisions, several of the participants felt that this was not an issue for them and that they were still able to make healthy sexual decisions in this situation. These decisions included the use of condoms if they were engaging in sexual activity, while under the influence of alcohol and/or drugs. According to one of the female participants: " I'd

say when people are under the influence of drugs and alcohol they still use condoms and stuff like that."

The adolescents in the study indicated that their relationships with peers had a great impact on their sexual decisions when under the influence of alcohol and/or drugs. They indicated that even though they did use alcohol and/or drugs, they felt that because they were living in a small community and were drinking with close friends, they did not have to worry about making unhealthy sexual decisions or being forced into a sexual relationship without their consent. The perception was that their friends would be there to take care of them and to prevent them from engaging in risky behaviors. One female participant stated: "Wise girls always go with their friends to ensure that no one harms them or rapes them." They felt that this was more of an issue for older youth and those in university experiencing the "downtown scene." One of the female participants stated:

> At our age, we go out drinking with a group of friends and nothing probably will happen because you are with people you know and are close with. But once you get older, you are going to parties with a lot of people you don't know.

Some of the male participants, however, did talk about the risk of ruining a good friendship with a girl if he was to engage in sexual activity when he and the girl were both under the influence of alcohol. One male participant stated: "Yeah, if you're drunk, having sex with a person. Yeah, oh man, I did that. A girl you slept with could be your cousin or a good friend. That could affect friendship."

Although most males in this study stated they would never consciously use alcohol and/or drugs to pressure a girl to have sex, they acknowledged that it was something that they felt did happen in their community. One male participant stated: "Some people try to get a girl drunk and slip something into her drink." However, several of the other males in the group

disagreed with him denying that it happens in their community.

In one group, several of the females talked about a similar issue and indicated that sometimes boys put particular pressure on them to have sex when alcohol is involved. In reference to "pit" or "shack" parties in their community, some girls felt that adolescents were unaware of the dangers of drinking. At these parties, for example, this is often the situation. Two female participants made the following comments:

> At shack parties, you got a lot of guys around here that are real jerks and they don't care if you have a boyfriend and they don't care about your boyfriend or about your relationship.

> They *(males),* it's like they sit around and they just wait. And it's like they wait until they're gone to the point where they can take ya. They will give the girls drinks too. They'll keep giving it to you. They'll just be like, 'Oh, have some of this.' It could be a date rape drug or anything you know.

The majority of participants expressed that alcohol was being used within their peer group and that some were using marijuana as well. They did not talk about other drugs such as ecstasy, cocaine, or heroin. The adolescents in the study also reported that alcohol use was prominent among their peer groups because there was "nothing else to do" in their communities and boredom was cited as a reason for teenage drinking. Both the male and female participants perceived that if there was more to do in their communities a lot of adolescents would not drink or engage in sexual activity. One male stated: "If we want to go around somewhere what we have to do is walk the road. If we stay at one place too long we get in trouble for standing in the ditch. There are not a lot of places to go."

Many girls identified boredom as having a major influence on their sexual decisions. Without recreational facilities, girls felt that adolescents were more likely to drink, take drugs, and be sexually active. One female participant indicated: "You'll notice around here that people

smoke out of boredom. In some places, they have sex out of boredom. Some girls indicated that there was "nothing else to do on the weekends."

One male participant indicated that there is a significant amount of teenage drinking in his community because teens lack recreational facilities, such as a youth center or sports complex. He felt that students would drink less and make better sexual decisions if they had a youth center where they could engage in recreational activities and access sexual health information.

Influence of self-esteem.

The majority of participants discussed the significance of self-esteem and how it can influence sexual decision-making. Males reported that good self-esteem was necessary for making healthy sexual decisions and for feeling good about their sexual relationships, particularly as it relates to sexual performance. In relation to self-esteem and decision-making, participants stated:

> Your level of self-esteem can affect the decisions you make. Like if you have high self-esteem, you probably say yeah I can make a decision about this. But if you have low self-esteem you think I'm not going to bother because I would probably screw up.
>
> It *(self-esteem*) affects everything. It affects the way they *(partner)* think about ya and it affects how much they want to be with ya and stuff like that. It affects everything.

The males reported that having high self-esteem was important in terms of making the right decision and being able to commit to that decision regardless of any pressure that one might feel from a partner to make a different decision. The male participants expressed that adolescents with low self-esteem would probably second guess their decisions and might suspect that they were making a wrong decision but did not have the capacity to verbalize their feelings and concerns. One participant stated:

> If you have lower self-esteem you probably do what your partner says. You regret making your decision. But with high self-esteem, you say 'no'. You probably feel you never made a mistake.

Male participants also expressed that self-esteem can affect other areas of a relationship such as communication with their partner and power and control within the relationship. In one group, the males discussed the relationship between communication and self-esteem. One male participant stated:

> You got to know, well, if I'm going to do this *(have sex)*, I'd think about it. If you go out, you got to have enough self-esteem to talk to someone about it.

One participant related an example of how his friend was always being put down by his girlfriend and how this was affecting his self-esteem. Other male participants talked about how they often joke about these issues amongst their peers and how it is not taken seriously.

The majority of girls perceived self-esteem as the key to having a healthy relationship and making informed sexual decisions. According to one female participant: "I think that people who do it *(have sex)* a lot have low self-esteem and they want to feel loved." The girls also attributed low self-esteem to adolescents who have sex with multiple partners. Female participants stated:

> Maybe they *(those with low self-esteem)* don't get very much attention in the first place. They don't have very much self-confidence.

> If you don't have self-esteem. . . .you're more vulnerable to, like, to consent to sexual activity even when you don't want to. You don't think a lot of yourself so you think this is my only chance or something. No one will like me if I don't or try to fit in.

Many felt that girls with low self-esteem might feel more pressured to have sex because they wanted to be attractive to boys. One group of female participants believed that males valued female sexual performance and many girls with low-self esteem felt pressured by this. One female participant stated:

> Because where guys like to talk a lot about girls they have been with and if you're no good. They say if this girl is no good, don't go with her or this girl is great, you should get with her, yeah! She may be the meanest girl ever, but if she's good in bed it doesn't matter.

The females also perceived that self-esteem issues affected males differently. For example, the girls reported that males might avoid sexual activity because they are concerned with their sexual performance. They felt that males with low self-esteem would most likely be afraid to approach girls for dates or sex because they fear disappointment or ridicule.

The female participants also discussed the issue of self-consciousness and body image as influencing self-esteem and sexual decision-making. The fear of gossip and rumors is a concern for females and can affect self-esteem as it relates to body image. One participant stated: "It's because we are self conscious about ourselves. . . .some girls wouldn't have enough confidence in themselves, like they may feel ugly or something, or too fat. If something like that happens, that something goes around *(rumors)* that they are. . . .that puts them down even more."

Developmental influences.

The content of the focus group discussions reflected the influence of various developmental factors on adolescent sexual decision-making. These included feelings of invincibility and curiosity and the need to experiment. The males reported that having the information on healthy sexuality and acting on the information are two separate issues. Many of their comments reflected feelings of invincibility and reported that the "it can't happen to me" attitude influences their sexual decision-making. Many did not see the issue of HIV as something that they needed to be concerned about in their communities. According to one of the female participants: "I think they *(adolescents)* think it can't happen to them and I think a lot of

people around here think that way, like, 'oh, I can't get AIDS. I'm not a loser. There is no AIDS here, but there is AIDS in XXXXX."

Some of the male participants' comments also indicated feelings of invincibility. They also felt that curiosity and being "hormone crazy" contributed to their decision to engage in sexual activity and that sometimes adolescents are in "too much of a rush. . . .they wants to get it over with." Another stated: "Because you wants to know what it *(sex)* feels like, see what it tastes like, so badly that it is either I do it now or never." The following quote illustrates feelings of invincibility and impetuous decision-making that is often associated with sex:

> They *(youth)* really don't take the time to find out the consequences. But mainly because they think they are young now and it won't happen to them. Yeah, they don't think much because it doesn't even come to their minds to start thinking of that. As soon as the button comes undone you don't have very much time to think.

The participants' descriptions of some of their sexual activity reflected risk-taking behaviors. Many of the participants reported that adolescents were more inclined to make unhealthy and uninformed sexual health decisions in the "the heat of the moment" because they weren't thinking about the risks and consequences and because they "don't think anything could happen to them." The girls talked about experimentation as way of learning about sex. According to one of the female participants: "Everything I learned I experimented with myself. I tried it myself and learned from my mistakes."

Parent/family influences.

Adolescent participants reported that parents had an influence on adolescent sexual decision-making, sometimes positive and sometimes negative. A few of the male participants indicated that they would feel comfortable talking to their parents about sex and sexual decision-making or someone else in their family such as an uncle or sibling. One of the male adolescents

felt that his mother was an excellent source of information and felt very comfortable talking with her given that this was something his mother did in her profession as a community health nurse. However, males stressed that it was important for parents to have accurate information and to "not get mad" at them for asking questions relating to sexual health and sexuality. On the other hand, others expressed that they felt uncomfortable talking to their parents and that their parents did not provide them with sexual health information. Some attributed this to the fact that they felt that their parents were uncomfortable talking with them about this issue. Participants stated:

> It's not that I don't feel comfortable. It's just that they *(parents)* don't feel comfortable. If I had to go up and talk to them, they'd bawl and ground me.
>
> Like some parents don't even like the thought about their children having sex. They are hoping they are too young to know about it and don't inform them.

Some participants felt that their parents do not understand what it is like living as an adolescent today. Many of the female participants identified that the issues which adolescents face today differ from those their parents faced when they were adolescents. One of the female participants suggested that "what was abnormal back then is pretty much normal now." Two other female participants stated:

> They have some idea but they think everything is the same as it was back then. I think now there's a lot more peer pressure and stuff to use drugs and alcohol and have sex. Like back then, there didn't seem like there was a lot, but now it seems like there's more.
>
> All humans are pretty much the same. We experience the same emotions but society is different now than what my parents grew up in. I mean there's a lot of different things that they don't know we know.

Perceptions of Gender Roles

In this research study, adolescents were asked if they felt that there were different gender roles for males and females in terms of sexual decision-making. The majority of adolescents reported that there were different gender roles. One group of males stated that they were aware

of distinct gender roles because they learned about women's rights in school. The girls indicated that they thought differently about sex than the boys. One female stated: "I think that guys have a huge influence on sex. . . .cause they think so different from girls." The girls reported that they consider sexual decisions in terms of commitment and intimacy in the relationship and that guys are ready for sex at any time. In relation to sex, the female participants felt that "girls are more emotionally attached." Females expressed that they think more about the decision to become sexually active than the males do and reflect on the emotional aspects of the relationship and feelings of closeness with their partner. These thoughts were illustrated by the following comments:

> Guys just want to have sex. Girls will think about a lot more stuff. They think of the consequences. If I'm going to get pregnant, should I do this? I'd say well, I can get pregnant. Girls want it more special than guys. Guys don't care if it is in the back seat of a truck. Sex is more special to girls.
>
> Maybe it's just me but when girls have sex they ask if they are going to be with him (*guy*) for a long time.

Female participants also felt that they had greater responsibilities in sexual decision-making. These included ensuring they don't get pregnant, protecting their reputation, and maintaining the relationship. Two participants commented:

> It is more risky for us, like for pregnancy and stuff. It is not like a decision for us. The guys like to do it with whomever and whenever, but for us it is to do it when we are ready. What happens when something happens? They get diseases too but pregnancy is the first thing that you think of.
>
> The girl has to worry about pregnancy, STD's, rumors, everything.

When considering sexual decisions, the girls placed emphasis on their reputation and how others viewed them. They felt that boys did not have to protect their reputation nearly as much as girls when faced with a sexual decision. When asked to explain their thoughts on teenage pregnancy,

girls indicated a fear of losing respect from their parents, teachers, and peers, particularly if they dropped out of school. Female participants stated:

> Around here things can get blown up really quickly. It *(stories about a girl's sexual activity)* goes around a lot.

> Once you gets that reputation, it stays with you and I got friends that have made some mistakes and they're still paying up for their mistakes. People think they're scum basically.

Male students also agreed that boys and girls view sexual relationships differently. This is captured in the following statements:

> They say for guys it *(sex)* is always something cool to do. Girls see it as a commitment. It is different for guys. Guys think that sex is cool and you gotta do it.

> The guys may consider commitment if he's around his partner but if he's around his peers, he just won't.

In relation to protection and birth control, some males stated that they felt responsible for obtaining condoms, whereas girls were responsible for obtaining birth control pills. Other males indicated that they were both responsible. The males also reported that they attempt to initiate sex more often than girls do and engage in more sex because some treat it like a competition with other guys. One participant stated: "And they talk about it like it's a competition. 'Oh, I had her. She's good in bed'."

Male participants also discussed the social stereotypes that are placed on male and female adolescents who are "sexually active" in relation to sexual decision-making. For example, they reported that guys who are sexually active with multiple partners are considered "studs" whereas girls are considered "sluts." Girls concurred with this perception and felt that this influenced their sexual decision-making. Even among their own peer groups, the females view other girls who have multiple sexual partners as "players" and "skanks."

Some of the female participants also brought up the fact that these social stereotypes can affect access to information and support. There is a perceived fear that a professional would judge them negatively. One female remarked: "If I felt I did something wrong, it is not that I wouldn't care of what people thought, but I think she (*guidance counsellor*) may think I'm a slut. I would be worried of what she thinks."

Some of the male participants perceived that the decision to become sexually active was more of a personal decision for females and that the girls talk about it as being a more difficult decision. The males identified that when making a sexual decision, females had a more difficult decision to make because of the risk of an unplanned pregnancy, as they would be the ones to "carry the baby" and live with this "burden". They perceived that girls wanted sex to be perfect "with romance and candles". Although the majority of males in this study expressed that love, honesty, trust and being with the person for a long period of time were important in terms of sexual decision-making, they felt that girls had the final say in the decision to have sexual intercourse**.** According to one male participant: "They (*the girls*) decide, guys give the pressure."

Attitudes Towards LBGT Issues

Overall, participants indicated that negative attitudes towards LBGT individuals prevailed in their communities. Some of the participants in the focus groups made comments that reflected negativity and feelings of discomfort, but others were very accepting of LBGT persons and indicated that they "had no problem with it" and had friends that were gay, lesbian or bisexual. The majority of participants reported that there was minimal education about LBGT issues in school. Many of the girls reported that much of the negativity in the communities was

due to the fact that people were not exposed to LBGT persons and so viewed them as different. One of the female participants compared this to seeing people in their communities who were non-caucasian: "It's different. It's like being black or something. You got different color skin."

Many of the adolescents reported that parental attitudes were also very negative and that people were ignorant about this subject because they lacked exposure to LBGT persons. One participant stated:

> I don't think they *(parents)* would be supportive because when they were little they were not exposed to that. They would probably be more hostile towards it *(LBGT)*.

The majority of participants had difficulty defining sexual orientation, however they understood the meanings of the words gay, lesbian and bisexual. The participants did not mention the term transgendered.

Some of the adolescents reported that the negative attitudes towards LBGT individuals stemmed from family values and experiences. One participant explained:

> When I was a little girl, I seen my mom and dad together. I see my sister and a boyfriend. I never had the experience of somebody of the same sex having a relationship. . . .I grew up all my life thinking that a man should marry a woman.

The girls reported that this has been a long-standing issue and that the negative attitudes are rooted in history. According to one female participant: "It's only 'cause of past perceptions about it. Everything has always been negative."

The female participants also made reference to the fact that because they were from a small, rural community, people were less accepting. They felt that this would inhibit people from disclosing their sexual orientation to people in the community. One female participant stated: "They're (*community citizens)* not very accepting at all. Not in a small town like we're in. Everybody talks about everybody."

The girls also discussed the influence of the media in shaping people's attitudes towards LBGT issues. Two participants commented:

> They *(media*) choose what to show and choose what we see and when they show us a TV show with gay people they are portrayed in a good light. Like it is more accepting in society because the media shows it. But it (*media)* can also show homophobic shows.

> They (*media*) all make fun of all the gay people and all the bisexual people.

Overall, the females appeared to have a better understanding of LBGT issues than the males. Some of the females reported that the attitudes of guys were very negative. Many of the female participants talked about love and how you couldn't help whom you fell in love with. However, several female participants did not agree with LBGT relationships and expressed a fear of lesbian women "coming on" to them. This fear was also expressed by many of the male participants. Many of the males reported that gay relationships disturbed them and that they wouldn't want to be alone with a gay man. However, sometimes it is more of a case of comfort level than actual fear. One participant explained:

> If you know someone is gay and you are getting changed, you would feel uncomfortable with them. Yeah, you would because you know they are gay. You're in there with the gays getting changed and they are staring at you. It would be very uncomfortable.

However, many males reported that they felt that bisexual/lesbian females were "cool" whereas gay relationships gave them discomfort.

Both the male and female participants discussed the issue of violence in relation to LBGT relationships. Some participants felt that this violence towards LBGT individuals was deserved given the fact that they were openly "out" in the community. This is reflected in the following statement:

> Well, they *(LBGT individuals)* go around and ask for it *(violence)* sometimes. They go around and stand up and hold hands saying "We are gay."

Some of the male adolescents did address how many of the homophobic behaviors of people led to violence in their schools and communities. Two participants reported:

> Some people play homophobic tricks. In my gym class, I am after hearing people say there is a gay guy in our school and they will beat the crap out of him. I'm serious.
>
> If someone around here was gay and they went walking around, they'd get so many beatings around here, it's not even funny.

The girls also expressed that they feel that names such as "fag" or "lesbian" are often used in very hurtful ways and that this affects whether a person will disclose his/her sexual orientation. The girls expressed that if there was more exposure and education, people would have a better understanding of LBGT issues and there would be more general acceptance. One participant commented:

> If it happened more in the hallway. . . . that girls were more open and they could kiss their girlfriends and the guys could kiss their boyfriends. If it happened more often, I could get used to it.

Accessing Information, Services and Support

The participants indicated that sex and sexual health are uncomfortable topics of conversation for many people. The majority of adolescents in the focus groups reported that they obtained most of their sexual health and decision-making information from friends, school, Internet and parents. Other sources of information included books, magazines and other family members such as an aunt, uncle or sibling. However, the number one source of information identified was friends/peers. Adolescents expressed that their friends were trusted sources of information and that they felt more comfortable talking to friends about sex and sexual decision-making. One participant stated: "But when you're with your friends, it's like more comfortable and you're willing to listen."

Many of the male participants expressed that the issue of sex often arose in general conversations with their male friends. According to them, these conversations were lighthearted and talked about in a joking manner. In one of the male focus groups, the issue of peer counsellors was discussed. The males reported that peer counsellors were in their school and young people could talk about issues of concern to them. However, there was some discussion on whether or not young people would access peer counsellors and some actually reported that they would not feel comfortable talking to a peer counsellor because they didn't know them on a personal level.

The majority of female participants also reported that friends were a trusted source of information on sexual health. According to one female participant, girls felt comfortable talking to their same sex peers because "your friends is gonna understand cause they know exactly what it is like." Some of the subjects that females talk to each other about include whether or not they are ready for sexual activity, whether their friends are sexually active, safer sex methods, and various relationship issues. One group of female participants acknowledged that their friends might not have all of the correct information but that they frequently learn from their experiences. They like to use the combined information to get a better perspective of what is involved, and from that make their decision. One participant stated:

> It's like you have a whole group of like, really close friends that you can talk to. Like three or four people – and then all your knowledge combined makes like, practically everything.

Many of the participants reported that they received sexual health education at school. Some of the male participants felt that they received enough education but questioned whether this information was current and comprehensive. One male stated:

> We think it's enough so we don't complain for a change. We don't know if there's anything else to know. There's only a certain amount you can read. If you have any questions, they might not be answered.

It was expressed by many of the adolescents that they don't receive any of this information after grade nine, a time when it is needed most. Others expressed that they learned more outside school. The majority of female participants reported that sexual health education is not consistent throughout junior and senior high school and that some classes are not receiving it at all.

The male participants expressed that they find it most useful when the information they get in the schools is accurate, non-judgmental and not a lecture on "what not to do". One of the male participants described what he liked about the education in his school:

> They are not telling you not to have sex, they are just telling you to have safe sex. They can't stop you from having sex. But they teach safe sex. If they teach you to have no sex, then you might do the wrong thing.

Many of the girls reported that their teachers and guidance counsellors were sources of support and information, but that many would feel uncomfortable talking to them due to the fact they were living in small, rural communities and that their families all knew each other. Concerns regarding a lack of trust and perceived breaches of confidentiality were frequently expressed as reasons for not accessing support from professionals such as guidance counsellors, doctors, nurses and pharmacists. One participant elaborated on these concerns in relation to a guidance counsellor:

> No, we really don't know the guidance counsellor so we would feel uncomfortable walking in to say, I would like to know more about sex. Personally, I would feel uncomfortable doing it. Especially around here where the guidance counsellor knows your boyfriend, and knows you, and to say that the guidance counsellor is a good friend of boyfriend's mother. And you're afraid that, oh my God, if I think about sex she will go and tell his mother because where it is a small community, everyone talks to everybody.

Many of the adolescents expressed concerns about confidentiality and their parents finding out if they were sexually active. Some of the girls expressed fear that if they were to use their parents insurance or access birth control from a pharmacy, then their parents could easily find out that they were sexually active. For many of the young girls, this influenced the decision about using birth control. As one female participant stated: "It makes you think twice 'cause you're just afraid that your parents are gonna find out."

When accessing health care providers, many had concerns about confidentiality and trust. When the males were asked if they would feel comfortable talking to a counsellor at the hospital, one of the boys responded by saying: "No! We wouldn't know if we could trust them." A female participant stated: "I don't trust my doctor." Some of the adolescents expressed that because their family doctors were also their parent's doctors, many felt they could not trust their doctors to keep their information private from their parents. The following passage captures how one participant felt about the issue of confidentiality:

> When I had had my last doctor's appointment, the woman was asking me questions that. . . .I could see my mom. . . . I could picture my mom saying the exact same thing. I said, "Well is this totally confidential?' and she said "yes". But I know if my mom went in there and asked "Is my daughter having sex?" I'd say nine chances out of ten she *(doctor)* would tell my mom.

Also reflecting the participants' perceived lack of trust and confidentiality were issues related to accessing contraception, information and services. Many adolescents reported that access to condoms was limited in their communities. The majority of adolescents expressed that having to buy condoms at the local store or pharmacy was problematic given the fact that they were living in small communities and felt embarrassed to go into the store to purchase them. One male participant stated:

> That's another thing. We're a small community. You don't want to go in to the store. You go in and buy a condom in the drugstore, guaranteed that someone in there is going to know your parents right?

According to some of the adolescents, condoms were used when youth had access to them and when sex was planned. Condoms were not used as often when sexual activities were more spontaneous. While some schools did have condom machines, the adolescents expressed that they were not being used because of price and/or conditions of the condoms (i.e., not a good brand, easily breakable, too small, etc.). Many reported that this lack of access is often why youth decide to engage in unprotected sexual activity. One male participant stated: "That's why a lot of people decide to do it *(sex)* unprotected because they're way too ashamed or they're way too nervous."

Participants' Suggestions to Improve Adolescent Sexual Health in Newfoundland and Labrador

Adolescents were asked to provide input on what sexual health services and information they felt should be available to youth in Newfoundland and Labrador. The majority of participants expressed that sexual health education and programming should begin at an earlier age to help youth understand sexual decision-making. They recommended beginning this education in grades 5, 6 or 7 and continue through to grade 12 with a gradual building of the information as grade level increases. According to one female participant: "The longer that you are informed, the better decisions you make." Participants expressed that there needs to be a course designated to sexual health in the school curriculum and that this course should be a mandatory credit course such as math. Some felt that if a nurse or teacher only addressed the subject of sex education in school once or twice a year, then it is not deemed important.

Participants reported that the person providing sexual health information in the schools should be someone trained in the area of sexual health so that students could be provided with the most current and up to date information. They also expressed that this person should feel comfortable providing this information. The adolescents also felt that having guest speakers from community organizations come into the school to discuss sexual health issues would be helpful. For many of the adolescents, they felt that having someone approximately their own age, who has experienced a teenage pregnancy or sexually transmitted infection would appeal to youth. As one female stated: "Someone who has been there and done it and is prepared to actually talk to you." Participants felt that this education should be delivered to males and females together so that they can be educated together about each other's physical and sexual development. According to one of the female participants:

> I think it should always be together because guys need to know just as much about girls. The guy needs to know about birth control methods and what to be aware of and pregnancy too. They need to be informed just as much as we do and it should be together.

Participants stressed the need to consider the emotional maturity of adolescents and to use proper terminology when providing the education so that youth are not confused by what educators are trying to tell them. One of the female participants explained:

> Instead of saying penis, they will say 'you know when a guy and a girl gets together right'. And to a grade five, they don't know. They think they're talking about a boy who is their friend and they get confused.

The males in several of the focus groups expressed that there was a need for more information on power and control in relationships in the school curriculum. Although they felt that it was important to talk about violence against women, the males felt that they too could be involved in abusive or unhealthy relationships and that this should be addressed along with the emotional aspects of sexual decision-making. The female participants also discussed the need to

have information regarding the emotional aspects of sexuality and sexual activity rather than just presenting the facts and talking about the negative aspects and consequences of sex and sexual decision-making. As one female commented: "But when they tell us about it (*sex*) at school, they make it seem so horrible." Both the male and female participants reported that they would like more positive information on sex and decision-making.

The majority of male participants identified that education regarding sexual performance was missing from the current education and that they would like to receive more information on this issue. According to one male: "I don't think we learns enough about the G-spot and stuff." Many male participants reported this was a major issue for them and that it was important they know how to please their partners and as one male put it to "perform and satisfy." The boys felt that this should be addressed in sexual health education as it was influencing their decision-making. When asked what topic males had most difficulty obtaining information about, performance was the number one response.

Adolescents want current information on birth control methods such as the needle and the patch, information about the prevalence and incidence of STI's in NL, where to get tested for a STI, developing communication skills and the emotional aspects of decision-making. They expressed that this information needs to be connected to "real life". For example, one of the female participants expressed that they know about the birth control pill, but they wanted information on where they can access the pill. They also want information on how to talk to their partners about sexual decision-making, relationship issues and what to do if they experience signs of a sexually transmitted infection or believe that they might be pregnant. One female stated:

> What would you do if you got into a situation that you thought you were pregnant? What would you do after that? What about the morning after pill? Go to what doctor? What do

I ask? What do I do?

Both male and female participants expressed that it's just not enough to receive the facts; they want practical information that they can use such as how to negotiate condom use with a partner or how to say no if they are not ready for sex. One of the female participants explained:

> Protection, they talk about protection and different ways about how you go and get it and how you can go about using it. You hear people saying no, no, I'm not ready, but what do you do if they *(partners)* won't take no?

Adolescents expressed that they would like to be more involved in education programming in the schools and to have some input into what subjects get covered and what services are available. As one of the girls explains: "It's for our benefit. That's why we should have something to say about it." Some of the girls even complained about not having tampon machines available in the school, which they would like to have implemented.

Participants expressed that it was important for them to have someone in the school that they could talk to about sexual health and decision-making such as the guidance counsellor. However, this service needs to be promoted by the professional so that all youth are aware of this person and what the person can offer in terms of counselling or resources. As one female explains: "I know most of us know she (*guidance counsellor*) can be trusted, but some people don't even have a clue of even her name. If she was more out there it would help."

Participants reported that having a doctor that they could access in their communities to discuss sexual health in a confidential setting was important for young people. Many of the participants suggested that schools have full-time doctors on staff so that they could access sexual health services in the school without having to miss class or to try and arrange outside transportation. One female stated: "Teenagers are in school. It would be easier to go at recess and go in and talk about it." Others suggested a more feasible alternative such as having a public

health nurse in the schools that could also do STI and pregnancy testing and give prescriptions for birth control. The adolescents felt that this would alleviate some of their concerns about confidentiality and barriers to access.

The majority of adolescents felt that free condoms should be made available to youth or that the schools should implement condom machines in the schools that were affordable and of better quality. The adolescents disagreed with a common belief that supplying youth with condoms and sexual health information promotes sexual activity. The adolescents stated that it "doesn't promote, it educates". One of the female participants explained:

> There's a lot of people around that thinks like that. Like ah, they won't have these programs in school for children because it promotes sex and stuff, but it educates. If you don't teach 'em, then they are going to find out on their own. They're gonna suffer the consequences, 'cause they're going to find out the hard way, that's right. "Cause they're going to find out one way or another, so it's just as well that somebody tell 'em.

Both the male and female participants reported that they would like to have on-site resources in their community, with workers that they could trust to keep their issues confidential and who would have the most accurate and up to date information. Others reported that they would feel more comfortable accessing the information by calling a toll free information line.

Participants also reported that they would like to have more recreational activities in their communities such as sporting events and a youth centre, which they felt might prevent some of the adolescent drinking and sexual activity. As one male explains:

> Probably less sexual activity would take place if we had youth centres across the province. We would have something to do. We wouldn't be drinking and be more vulnerable to sex.

The adolescents reported that they would like to see more parental involvement in sexual health education and have parents that are comfortable addressing these issues. As one girl expressed: "Try to convince parents to make it easier to talk to them more." Adolescents

expressed that there should be a course for teenagers and parents to help them communicate better about sexual health and teenage issues. As one female stated:

> Well if they had like people who could come and explain to them in like health groups and sessions – with like parents and teenagers and it might give our parents a clearer idea of what like teenagers are going through.

Participants also expressed that education around LBGT issues should start at an earlier age so that people would be more understanding and it might decrease many stereotypical attitudes from being formed. However, a few of the participants voiced concerns over the amount of education that people should receive on these issues. One female participant stated that it should only be discussed with adolescents who were gay or lesbian. Some of the male respondents also expressed that there should be more positive messages in the media.

Discussion

"Adolescence involves a complex interplay of biologic, cognitive, psychologic and social changes, perhaps more so than at any other time of life" (Hockenberry, Wilson, Winkelstein, & Kline, 2003, p. 803). It is a time when individuals are faced with a multitude of cognitive conflicts in making the transition from childhood to adulthood. Pressures from many sources compete to influence behavior and, therefore, it is a difficult time for many, fraught with struggles that are imposed both internally and externally. Adolescents struggle with issues such as identity, independence, autonomy, body image, peer relations and self-exploration. Conformity with peer group norms, relationship development, sexual exploration, risk-taking behaviors and the quest for control are integral components of adolescent growth and development.

Adolescence is a critical time in the development of sexuality in which adolescents are

faced with making decisions about sexual issues. Therefore, adolescent sexual decision-making needs to be analyzed and understood in the context of changes that normally occur during the adolescent period. The findings from this study reflect many of the complex issues and factors that influence adolescent sexual decision-making. In analyzing these findings, several themes emerged: searching for trust and confidentiality, fear of being judged, discrepant gender attitudes towards sex, seeking power and control, taking risks but seeking security, and empowerment through communication.

Searching for Trust and Confidentiality

Adolescents in this research study expressed the need for trust and confidentiality when accessing sexual health information and services. There was a perception that they could not trust teachers, guidance counsellors, nurses, pharmacists or doctors in their communities to keep their personal information confidential. Many of the participants indicated that they would not seek supportive services due to fear that their parents would find out that they were contemplating sexual activity or were already sexually active. The adolescents indicated that living in rural communities augmented this fear and heightened concerns about issues of trust and confidentiality.

Adolescents provided examples during the focus group discussions of how this fear influenced their sexual decision-making. The majority of participants acknowledged that many adolescents do not use condoms for fear of being seen buying them at the local pharmacy and having this information reported to others. There was a perceived fear that this information would be relayed to their parents. Adolescents also reported that they would not feel comfortable seeking sexual health care for fear of meeting someone who knew their parents.

Many of the female participants reported that they did not feel comfortable talking with their family doctors about sexuality and sexual decision-making as they felt that the doctor might inform their parents of their conversation. This need for confidentiality was also reported in a research study with students in Ontario (DiCenso et al., 2001). In their study, confidentiality was reported to be the major concern for all the students. The students in this study wanted to discreetly access a health care professional or counsellor in a low traffic area of their school. Students who were living in rural areas expressed concern about confidentiality when accessing sexual health services given the high risk of being seen. This is not only a Canadian concern. Hadley (1999) also identified the need for adolescents to seek out confidentiality when accessing sexual health services. She reported, "Even in Holland where attitudes towards teenage sex are very open, teenagers want contraceptive services to be completely confidential" (p.10). According to research conducted by the Brook Advisory Centres in the U.K. (as cited in Hadley, 1999), adolescents wanted reassurance of confidentiality when accessing sexual health information and services before they would consider a sexual health service "safe to use" (p. 11).

The lack of trust in professional confidentiality prevented many adolescents in the current study from seeking and accessing sexual health care services in their communities. In a study aimed at understanding barriers that prevent young women from accessing sexual health services and education in a Nova Scotia community, participants identified concerns about trust and confidentiality in the client-physician relationship, when accessing physician services (Langille, Graham & Marshall, Blake, Chitty, & Doncaster-Scott, 2000). The consequent lack of access has implications for adolescents not receiving quality sexual health care. In the Henry J. Kaiser Family Foundation study (as cited in Porter, 2002), only 37% of adolescents from the age of 12 to 17 had ever received sexual health information from a health care professional. Also, only

one in four adolescents, whether they were sexually active or not, had ever talked to a health care professional about their sexual history.

The adolescent quest for trust and confidentiality in sexual decision-making is often a struggle as it can be embarrassing to talk about sexual issues. Consequently, many adolescents are reluctant to talk about these issues with an adult or professional. Participants in this study reported that they would like to see improved access to sexual health information and services and to have a site where they could access confidential sexual health services with someone they could trust. Professionals can play a key role in this process by informing adolescents about available services, how to access them, and provide assurance that confidentiality would be maintained.

In this study adolescents reported that friends were the only people they trusted completely in discussing sexual issues. All the adolescents cited friends as the number one source of information for sexual health education. There was an inherent trust established within peer relations because as the adolescents expressed, they were all facing similar issues and concerns as they related to sexual health. DiCenso et al. (2001) reported a similar finding in that students indicated that their friends and other sources of informal information filled in the gaps and "important stuff" that they felt was lacking from formal sources.

The fact that friends are a trusted source of information and support has important implications for program development and service delivery. Existing research indicates that adolescents are more likely to internalize messages and change their behaviors about sexual decision-making when their peers provide this information (Milburn, 1995). Given the importance of friends, as reported in the findings of the current research study, educators and health care professionals need to place more emphasis on peer-based sexual education. The

value of friendships can also be utilized in planning and delivering sexual health education and services.

Fear of Being Judged

Much of the data indicated that adolescents in this study were afraid of being judged negatively by their peers, parents, teachers, health care professionals and residents of their community. This is a time when they are struggling with their identity development and self-image and are influenced by what others think of them. They indicated that living in a small community made them more open to judgment. Everyone knows everyone else's business. Adolescents were afraid of being judged if, for example, they were seen buying condoms, accessing the nurse in their community, or going to the guidance counsellor's office at school. Once seen, the individual then assumes that the observer is making a negative judgment about them. They were also concerned that if they got pregnant or contracted a STI, they would be judged negatively or labeled as "bad" or "skanky" by those in their school and community, including their parents. The female participants were also concerned about being judged negatively if they were engaging in sexual activity with multiple partners.

There is also a fear of negative judgment from their peers about their identity. They want to fit in with and be accepted by their peers and they don't want to be different. This need to identify with the norm is also reflected in their perceptions of others. They fear being rejected by their peer group and don't want to be considered " losers". According to Short and Rosenthal (2003), peer relations and the social milieu have an impact on adolescent decision-making and choices. They found that there is a direct relationship between an adolescent's sexual behavior and the behavior of his/her peers. They found that if adolescents perceived that their friends

were engaging in sexual activity, were having unprotected sexual activity, and/or having multiple sexual partners, then they too were more likely to engage in these behaviors.

Fear of being judged was also reflected in the adolescents' comments about gays and lesbians. The adolescents in this study don't want to be regarded as gay or lesbian if they are not. In addressing LBGT issues, the data reflected that some participants had negative attitudes and homophobic reactions to persons who are lesbian or gay. Some of the participants fear being around people who are lesbian or gay because they do not want to be "hit on." In this study, this was more of an issue for males than for females.

Fear of judgment about their sexual performance also emerged from the data. In fact the participants indicated that performance was an issue they would like addressed in education classes. Sexual performance was more of an issue for males and they had a fear that if they didn't perform well, their friends would find out. This could have negative implications for their reputation and self-esteem. One group of boys talked about scoring points for sexual encounters. Certain girls were worth more points than others. These boys felt that their sexual prowess was judged according to the number of points they scored and the boy who scored the most points was considered to be a sexual "stud."

Discrepant Gender Attitudes Towards Sex

Adolescents indicated that there are discrepant gender attitudes regarding to sexual activity that influence their sexual decision-making. In this study, the female participants emphasized the importance of emotional aspects of a sexual relationship and reported that "sex is more special to girls." On the other hand, male comments reflected greater emphasis on the physical act of sex and more worry about performance. The data also indicated a double

standard for males and females in relation to sexual activity. Both males and females identified that it is more accepted by their peers and society for males to engage in sexual activity and with multiple partners. Males were considered "studs" if they had active sexual relationships whereas females were perceived as "sluts." Because these attitudes are so prevalent in society, they need to be considered when planning sexual health education. Such attitudes need to be further explored and challenged as they may have significant implications for self-image and self-esteem.

DiCenso et al. (2001) reported that there were different expectations and codes of behavior for males and females. Unlike males, females acquired a bad reputation if they had sex with multiple partners. The findings in their study are also supported by The Kaiser Family Foundation (2002) in that more than a third of teenagers said that there is a double standard for boys and girls and four in five agreed that parents have different expectations for boys and girls. Nine out of ten also indicated that girls get bad reputations when they become sexually active or would lose their partner if they didn't have sex. This is not the same for most males.

Seeking Power and Control

In striving for independence, adolescents are seeking power and control in their lives in general, and in this study they indicated that they need power and control in their decision-making. The adolescents expressed that they, and their peers, are making sexual decisions (which can include deciding not to become sexually active) and that they would like to have access to information and services so that they can make informed decisions. Power and control are related to several other factors in this study such as education, access to information and services, self-esteem, confidence and body image.

Education and access to information on sexual health matters can provide adolescents with more power and control in their decision-making about sexual activity. They have indicated clearly that they want more information, they want current information and they want it presented in more appropriate ways. Although, school was listed as a source of sexual health education, there were differing opinions on how available this education was to them. They reported that they would like to have education that is ongoing within the school curriculum and would like some input regarding content, programs and services. McKay and Holowaty (1997) found that eliciting input from adolescents is an important first step in the design of effective education programs on adolescent sexual health to ensure the relevance of these programs and to captivate adolescents. A sexual health education program that results in adolescents "tuning out" will not be an effective intervention.

Adolescents in this study reported that they would like to receive more education on testing and treatment for STI's, birth control methods, how to communicate with partners, relational issues, and alcohol/drug use in relation to sexual health and decision-making. They want this information to be practical, meaningful and relevant to their own lives. McKay and Holowaty (1997) surveyed 406 grade 7-12 students in southern Ontario and reported similar education priorities for youth. Students in their study placed high importance on topics such as preventing, testing for and treating STI's, sexual assault and rape, birth control methods, pregnancy and birth. Also rated as important were topics that included building good/equal relationships, making decisions about sexuality and relationships, parenting skills, talking with girlfriends/boyfriends about sexual issues, peer pressure, puberty and saying "no" to sex. Similar findings were reported by others (DiCenso et al., 2001; Kaiser Family Foundation, 2003).

Although the current study did not explore parents' attitudes towards sex education in schools, other research indicates that most parents are in favor of sexual health education within the school curriculum (Langille, Langille, Beazley & Doncaster, 1996; Weaver, Byers, Sears, Cohen & Randall, 2002). McKay, Pietrusiak, and Holowaty (1998) found that 95% of parents in their study strongly agreed or agreed that sexual health education belongs in the schools. The topic that received most support from parents was that of building equal healthy relationships among adolescents. The fact that parents feel that education about sexual health belongs in the schools (McKay et al., 1998) may not mean, however, that parents do not want to take responsibility in this area. In fact, Weaver et al. (2002) in a New Brunswick study reported that 95% of parents felt that sexual health education should be a shared responsibility between the parents and the school. The adolescents in the current study indicated that parents could be influential in their sexual decision-making but generally there were limitations caused by embarrassment, discomfort, etc. on the part of the adolescents as well as their parents. Additional research is needed to explore the attitudes of parents with regards to school-based sexual health education and to determine the topics they feel should be addressed in schools in NL.

In this study, participants reported that they are aware that adolescents are engaging in sexual activity at a much younger age. They indicated that they regard this as an issue particularly at times when they are moving from the younger grade levels, into the junior and senior high school levels. Adolescents also reported that they would like education on sexual health to begin at earlier grade levels as they feel younger adolescents are not adequately educated about sexual health and are often getting misinformation from their peers (i.e. you cannot get pregnant the first time you have sex). This is also consistent with other findings

(DiCenso et al., 2001; Langille & Curtis, 2002). Langille and Curtis (2002) reported that 11.8 % of their study sample had engaged in sexual intercourse before the age of 15. They found that intercourse before age 15 was associated with an increased risk of pregnancy and STI's, less contraceptive use and increased likelihood of having more than one sexual partner.

Based on the current research findings and findings from other studies, education about adolescent sexual health and decision-making needs to focus on incorporating a collaborative approach amongst adolescents, parents, schools and health professionals. In planning education and sexual health services for adolescents, the aforementioned facts should be taken into account. This collaborative approach could result in adolescents deriving more power and control over their sexual decision-making. A comprehensive sexual health course needs to be developed for students in the school system within NL. Many of the education priorities identified by the adolescents in this study are reflected in the Canadian Guidelines for Sexual Health Education (Health Canada, 2003) which should be used in the schools as a starting point for program evaluation and the delivery of effective and comprehensive sexual health programming. It is also important that the Departments of Education and Health and Community Services be involved to explore adolescent access to sexual health information and services and work from an evidence-based approach. The authors of this study are aware of the current education outcomes as defined by the Department of Education around sexual health education, but it is unclear what is being taught in each of the schools across the province. It was beyond the scope of this research study to interview teachers about this, therefore additional research is required to analyze the content and delivery of sexual health education in NL.

In this study, adolescents reported that there was limited access to sexual health information and services in their communities and they expressed the need for enhanced sexual

health services. They felt it was important to have ready access to condoms, affordable birth control options, and confidential sexual health services. Contrary to the opinion of some, research shows that providing youth with information about sexual health and access to birth control does not increase adolescent sexual behaviors (Franklin, Grant, Corcoran, O'Dell Miller, Bultman, 1997; Hadley, 1999; Wellings, Wadsworth, Johnson, Field, Whitaker, & Field, 1995).

Included in the adolescents' need for more power and control are issues related to self-esteem and confidence. These issues, of course, are affected by a multitude of factors. The findings indicate that self-esteem is regarded as a major influencing factor on adolescent sexual decision-making. It can lead to one individual having more power and control in the decision-making process over another. One participant pointed out if you have low self-esteem, you do what the person with higher self-esteem says. It is important then to emphasize and encourage the development of healthy self-esteem in sexual health education and services.

Regarding confidence issues**,** the adolescents appear to be struggling with this internally. On the one hand, they may feel confident in deciding they want to be sexually active. They know they need condoms, but they may not have the confidence to buy them because of fear of being seen, etc. Those with confidence will be more empowered in their sexual decision-making.

At times it appears that attaining power and control is well out of reach for adolescents. They face an ongoing struggle between opposing forces. As an example, the data revealed that on the one hand girls want sex within a meaningful relationship, but on the other hand they often become sexually active just to "fit in" with their peer group. Adolescents want control of their bodies and in decision-making. However, while they are striving for power and control, other forces such as partners, peers and the media are exerting significant control over them.

Power and control may also be difficult to attain when the media influences adolescents' sexual decision-making. In this study the media was reported to have an influence on participants' self-perception, self-esteem and body image. It is unclear to what extent the media directly affects sexual decision-making and adolescent behaviors, however the media does appear to influence how adolescents view sexual decision-making and media stereotyping of sex is still an issue that youth face. The media portrays sex in a very casual light and as something normal and good to be doing. If an adolescent does not conform to the expectations reflected in the media, this might affect their self-esteem and lead to feelings of inadequacy. Many of the participants in the current study indicated opposition to the media's casual portrayal of sex. However, the media is out of their control, and instead, it has power and control over them. They appear to find this disconcerting.

Overall, as adolescents strive for independence they have an increasing need for power and control. This need is also inherent in sexual decision-making. Adolescents require education, access to sexual health services, healthy self-esteem and confidence to help them develop power and control in making healthy sexual decisions.

Taking Risks but Seeking Security

Risk-taking is a normal part of adolescence in terms of emotional and sexual development. The data in this study indicated that while youth take risks, they also need a sense of security in relation to sexual decision-making. On the one hand, adolescents often engage in risky behaviors and have feelings of invincibility, but on the other hand, they need some reassurance of safety and security. Even though many of the youth in this study were aware of the risks and consequences associated with risk-taking and sexual decision-making, there is still

a feeling among adolescents that "nothing bad will happen" to them. Emotional security is potentially derived from many sources such as friends, families, and trusted educators/health care professionals. Many adolescents also feel a sense of security, in relation to risk-taking, by having knowledge about sexual decision-making, being able to access condoms and birth control, having valued friendships, and having an adult with whom they can talk. Adolescents feel that they need to have accurate information in order to make informed sexual decisions and have the knowledge and resources to deal with consequences such as a pregnancy or infection. As one girl commented: "experiment when you have the information." In essence, adolescents still want to take risks but with reduced odds of unwanted consequences.

The majority of the adolescents in this study cited pregnancy as the number one negative consequence of unhealthy sexual decision-making with contracting a sexually transmitted infection being second. This finding was also reported by the Kaiser Family Foundation (2003). Many of the adolescents were not as concerned about contracting an STI because they felt a sense of security in a rural community as they felt they would know whether or not their partner had an infection because their partner or friends would inform them. Many also reported that they did not think they needed to be concerned about HIV in their communities. The fact that many adolescents in this study were not as concerned about HIV as they were about pregnancy is a significant finding, given the amount of education that was provided in NL schools as a result of high rates of HIV in a rural NL community in the 1990's. This lack of concern about HIV was reflected in another Canadian study. It was found that two thirds of children in grade seven and one third of adolescents in grade eleven thought that HIV was a curable disease and not something to worry about (Boyce et al., 2003). The study also indicated that knowledge of HIV, in general, has been declining.

Despite concerns regarding lack of anonymity in small communities, there were positive aspects to this. Adolescents reported feelings of safety and security because everyone tends to know everyone else. They also highly value close friendships that provide them with a sense of security in that their friends will look after them in high-risk situations. For example, the participants reported that when adolescents went out drinking with friends, they relied on them to prevent them from engaging in high-risk behaviors while under the influence of alcohol and/or drugs. The adolescents perceived that their friends would "look after them" therefore providing a sense of security and safety.

Adolescents in this study reported that oral sex was not regarded as significant as sexual intercourse. In fact, participants expressed that for many youth oral sex is not considered sex and is not considered as risky as sexual intercourse. The Kaiser Family Foundation (2003) found that youth are often unaware of the risks associated with oral sex, and many do not even believe that sexually transmitted infections can be spread through oral sex. Many even reported using oral sex as a means of avoiding sexual intercourse. Additional research is needed in Newfoundland and Labrador to explore adolescent sexual decision-making in relation to oral sex.

Empowerment Through Communication

The findings of the study indicated that adolescents regard open and effective communication as very important with regards to sexual decision-making. This includes communication with parents, health professionals, educators, peers and partners. Adolescents identified open communication as a component of a healthy relationship and indicated that effective communication is empowering. For example, adolescents were empowered in their decision-making by having good communication with their partner regarding sexual issues such

as using birth control, practicing safer sex and pleasing each other. Effective communication skills also enable adolescents to access information and services. As well, interactions with health professionals and educators may be enhanced and produce improved outcomes in terms of informed sexual decision-making. This too may facilitate trust and allay concerns about confidentiality. Effective communication may also facilitate the development of confidence and healthy self-esteem.

Even though the adolescents in this study indicated they would like to talk to their parents about sex, many reported that they did not feel comfortable with this, nor did their parents. Adolescents perceived that their parents would be angry with them if they found out that they were sexually active and give them a lecture and "bawl" at them. DiCenso et al. (2001) also found that students had limited conversations with their parents about sexual health issues and that they perceived that their parents would not be comfortable talking to their children about sex. This discomfort could result in parents remaining silent on the subject or reinforcing negative messages about sex and decision-making.

However, there were some adolescents in this study who had positive experiences talking to their parents about sex and reported that their parents were trusted sources of information. They felt comfortable talking to their parents about safer sex, birth control and decision-making. It is important that parents are aware of this and that programs are put in place to educate parents on how to talk to their children about sexual decision-making. Parents should have open dialogues with their children about sex and sexual health so that adolescents will feel comfortable talking to them and will seek appropriate services and information. Research suggests that family members can influence the sexual behavior of adolescents in many ways including a later onset of sexual activity, use of contraception, and sexual assertiveness (Short &

Rosenthal, 2003). Although the adolescents in this research study discussed the importance of family and relationships with parents, the researchers did not interview parents to identify their views on adolescent sexual decision-making. Additional research is needed to explore parental attitudes/knowledge and comfort levels in talking with their children about sexual health and decision-making.

Sexual Health Service Providers' Perceptions of Adolescent Sexual Decision-Making

Introduction

There are few "specialized" sexual health service providers in Newfoundland and Labrador. Individuals providing sexual health services often do so on a part time basis and come from a variety of professions within education, health care, social work, religious denominations, and youth services. In the absence of any provincial coordinated strategy to meet the unique sexual health needs of the adolescent population in this province, the principal investigators designed a qualitative questionnaire to find out what current sexual health services providers perceived to be important influences on adolescent sexual decision-making. The specific objective of this section was to provide professionals with an opportunity to voice their opinions about the influences on adolescent sexual decision-making.

Methods

The principal investigators from Planned Parenthood Newfoundland and Labrador (PPNL) and the Women's Health Network, Newfoundland and Labrador (WHNNL) held a meeting with provincial stakeholders to identify professionals providing sexual health services to youth. In consultation with the stakeholders and the project's advisory committee, several questions were designed and distributed to adults who work with youth. The purpose of the survey was to explore the perceptions of sexual health service providers with regards to adolescent sexual health experiences and to determine the type of sexual health services and information they feel youth need. The final format of the questions resulted in a questionnaire that contained 13 open-ended questions and eight quantitative questions.

Participants

Three hundred of these surveys were distributed to professionals working with youth in the province's six health regions (50 to each region). The researchers targeted teachers, social workers, community health nurses, physicians, guidance counsellors, and community workers. Forty-four of the three hundred surveys were returned to PPNL. Given this response, follow up letters were sent to the professionals to remind them of the study and request that they return the questionnaires if they had not already done so. In the end, the return rate was 14.7%.

It is important to note that the majority of respondents were between the ages of 40 and 49 and lived within the Avalon health region. Twenty-five percent of the respondents were guidance counsellors, followed by community health nurses (20.5%), clergy and youth leaders (15.9%), social workers (13.6%), high school teachers (11.4%), community workers (6.8%) and physicians (6.8%). The respondents' years of experience with adolescents ranged from .7 to 30 years, while the most frequent number of years of experience was 15.

Quantitative Data From Professionals' Survey

This section includes demographic characteristics of the respondents and results of responses to eight quantitative questions. The response rate of only 14.7% must be taken into account when interpreting the data.

Age Profile of Respondents

Figure 1.1.1

Percentage Distribution of Respondents by Age

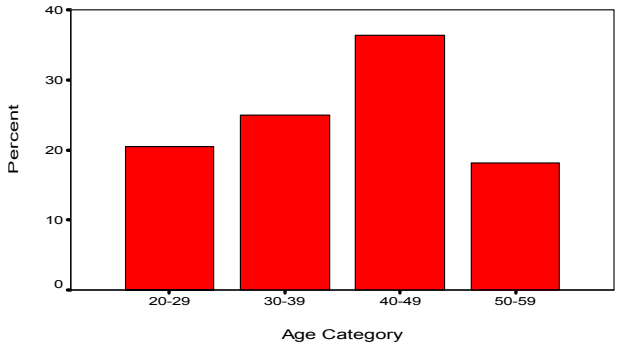
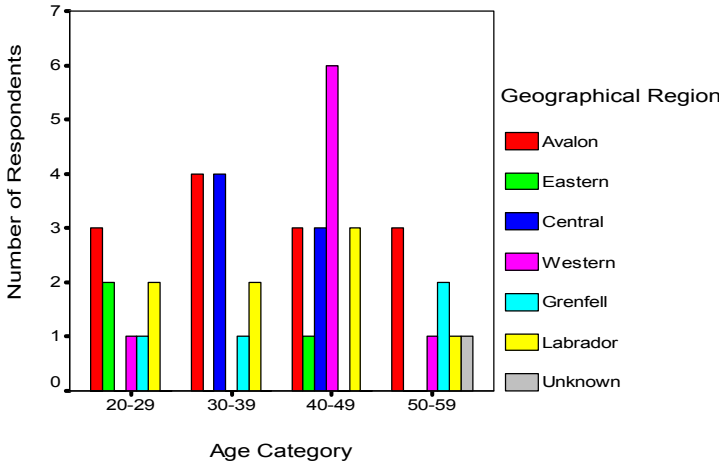


Figure 1.1.2

Age of Respondents According to Geographical Regions



Distribution of Respondents in the Various Health Regions

Figure 1.2.1

Percentage Distribution of Respondents by Geographical Region

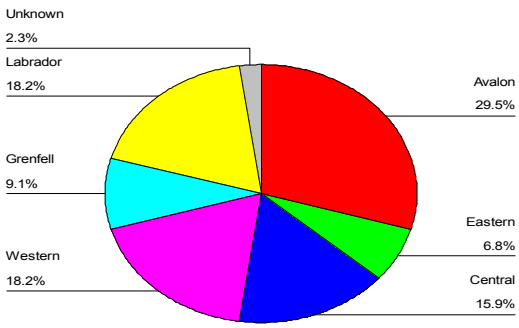


Figure 1.2.2

Percentage Distribution of Respondents by Affiliation

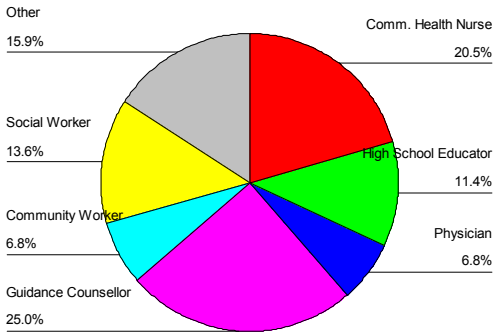
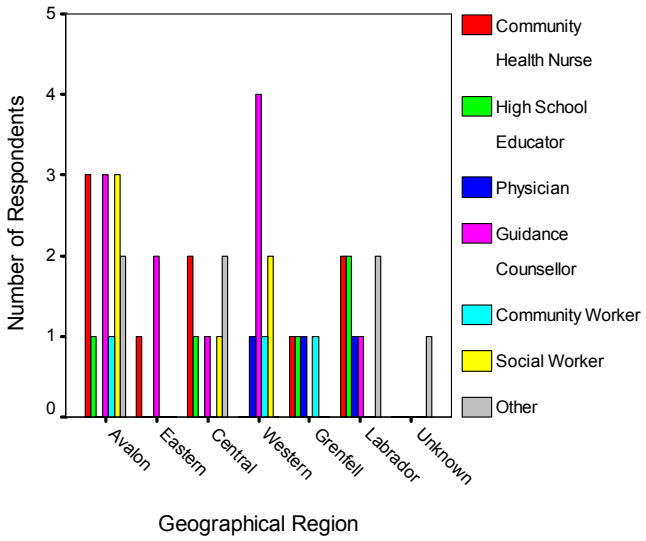


Figure 1.2.3

Affiliation by Geographical Region

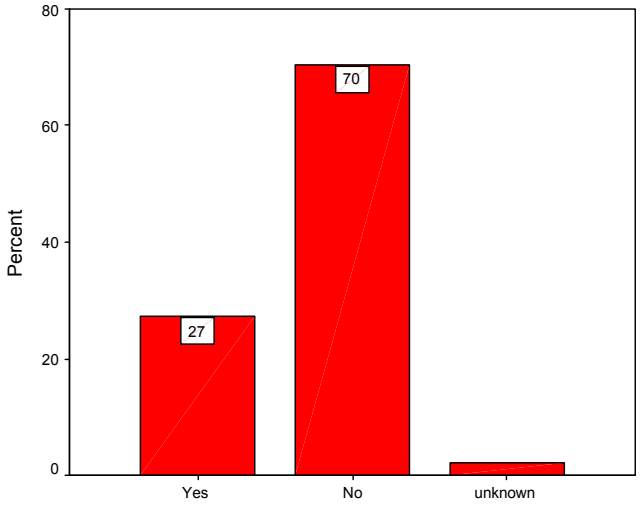


2.1. Do adolescents in the community have difficulty accessing information and services regarding sexual health issues?

According to survey results, 27% of the total population of respondents indicated that adolescents in their communities have difficulty accessing information and services regarding sexual health issues. Seventy percent of the total population of respondents indicated that adolescents in their communities do not have difficulty accessing information and services regarding sexual health issues. Three percent of the total responses from the population surveyed are unknown.

Figure 2.1.1

Percentage Distribution of Total Responses



3.1. Do some adolescents make unhealthy sexual decisions even though they are unaware of the risks and consequences?

One hundred percent of the respondents reported that adolescents make unhealthy sexual decisions even though they are aware of the risks and consequences. This finding indicates a need for further research in this area and needs to be considered when planning and implementing sexual health education and services.

4.1. Do you provide sexual health information and services to adolescents?

Figure 4.1.1

Percentage Distribution of Responses

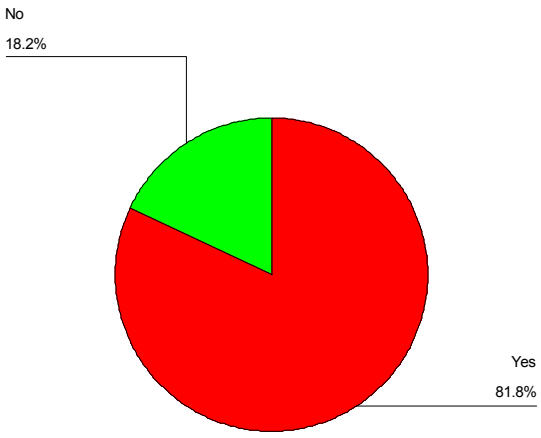


Figure 4.1.2

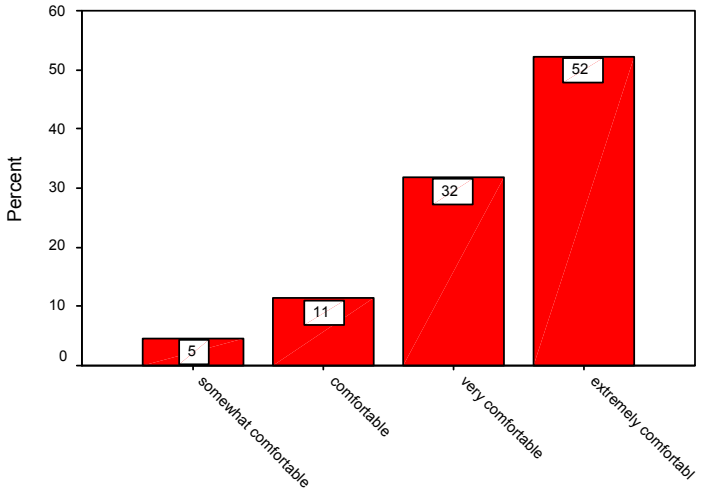
Percentage According to Affiliation

		Yes	No	Total
Affiliation	Community Health Nurse	77.8%	22.2%	100.0%
	High School Educator	80.0%	20.0%	100.0%
	Physician	100.0%		100.0%
	Guidance Counsellor	100.0%		100.0%
	Community Worker		100.0%	100.0%
	Social Worker	83.3%	16.7%	100.0%
	Other	85.7%	14.3%	100.0%
Total		81.8%	18.2%	100.0%

5.1. How would you rate your comfort level in providing sexual health information and services to adolescents?

Figure 5.1.1

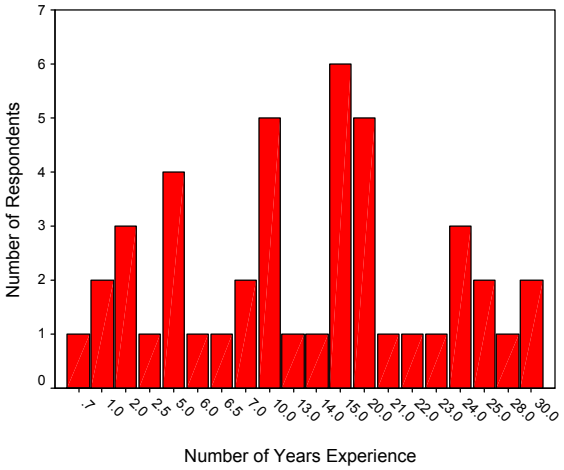
Percentage Distribution of Responses by Comfort



6.1. How many years of experience do you have working with adolescents?

Figure 6.1.1

Number of Years of Experience



Findings

The following section provides a summary of the professionals' responses to the open-ended survey questions. The findings are categorized into the following sections: service provider perceptions of healthy and unhealthy sexual decisions, factors that impact adolescent sexual decisions, community attitudes toward lesbian/bisexual/gay and transgendered persons, and perceptions of the kinds of sexual health information and services that are available to youth.

Service Providers Define Healthy and Unhealthy Sexual Decisions

Professionals in each of the six health regions of Newfoundland and Labrador were asked to give a definition of healthy and unhealthy sexual decision-making. Most respondents in the qualitative survey stated that healthy sexual decisions reflected choices made by individuals who were informed of the risks and consequences of sexual activity. Some felt, for example, that individuals could make responsible decisions about sex after researching and, as one respondent stated, "carefully considering all available information." One respondent reported that individuals needed access to "all the necessary information" available to make more healthy decisions.

Many indicated that knowing your own values, having communication with your partner, consenting to sexual activity with your partner, and being emotionally ready were important prerequisites to making healthy sexual decisions. One respondent summarized all of these points in the following statement:

> Healthy decision-making is based on looking at personal emotional readiness, looking at personal physical readiness, use of effective birth control, discussion with partner - ramifications of sexual activity, personal choice.

Others felt that healthy sexual decision-making should occur between two mature individuals who were equally informed, understood the risks and consequences of sexual activity, and could reach a consensus about a positive course of action.

Most of the professionals agreed that adolescents needed to be informed about the risks and consequences of sexual activity. Some of the respondents felt that it was the responsibility of the adolescent to seek sexual health information. Others felt that it was the responsibility of the service providers to provide that information. One service provider felt, for example, that sexual health information could be more accessible to adolescents, if professionals learned to foster more open communication with adolescents. Another respondent felt if adults provided adolescents with learning opportunities to develop self-esteem, adolescents could make better decisions. A community health nurse, for example, felt that it was not enough for adolescents to have sexual health information, they also needed "self-esteem building skills" to help them feel in control of their decisions.

The respondents gave a variety of definitions to explain what unhealthy sexual decisions were. Overall, unhealthy sexual decisions entailed putting yourself at risk without planning ahead, considering the consequences, or seeking sexual health information and counselling. When the professionals were asked whether adolescents made healthy sexual decisions, most respondents indicated that while some do, most do not. They felt that many factors contributed to adolescents' inability to make healthy sexual decisions. These included lacking maturity in controlling sexual impulses, feeling pressured by partners or peers to have sex, not being able to cope with conflicting messages from the media, abusing alcohol or drugs, and not receiving enough support from family members, teachers, and health care providers to ask questions. The

following section explains in depth the barriers professionals' identified as having a negative impact on adolescent sexual decision-making.

Factors that Contribute to Unhealthy Adolescent Sexual Decision-Making

Professionals identified several barriers that they felt influenced adolescent sexual decisions negatively. These influences relate to psychosocial functioning and include: pressure (cultural or otherwise) to use drugs and alcohol, level of maturity according to one's age and emotional development, the inability to cope with peer pressure, confusion over media messages, and community responsibility for sexual health. Many adolescents, according to the respondents, are informed about practicing safer sex. They continue, however, to make unhealthy sexual decisions when the following factors come into play.

Influence of alcohol and drugs on sexual decision-making.

Many of the respondents in the survey identified adolescent experimentation with alcohol and drugs, when asked what factors negatively influence adolescent sexual decisions. They acknowledged that all adolescents' experience pressures to fit in and gain acceptance, as a part of growing up, but felt that some adolescents experience these pressures more than others. Adolescents can be vulnerable to using alcohol and drugs if they have low self-esteem or negative experiences at home. The following comment illustrates this point:

> I feel that many adolescents make healthy decisions. However, some adolescents are vulnerable to making poor decisions based on a number of factors such as substance abuse, issues related to past abuse in the family, poor self-esteem, etc.

The professionals suggested that there is a strong link between substance abuse and high-risk behavior. They felt that unhealthy sexual decisions were related to individual and cultural values that accept health-compromising activities. Adolescents are particularly susceptible to risky activities because youth is characterized as a period of experimenting with new things.

According to one professional some youth do experiment with alcohol. This, in turn, "lends its way for young adolescents to be more exposed to situations where sex occurs without any discussions, planning, or protection." Another respondent felt that adolescents are unaware of the consequences of alcohol consumption and as a result can be "talked into it (*sex*)." Many of the respondents felt adolescents could make healthy sexual decisions if they were taught at an early age how to avoid becoming vulnerable to health-compromising situations. When asked if there were any supports in the community to help youth discuss sexual issues, no one identified a specific prevention program that taught them the risks associated with substance abuse. One individual felt that adolescents were drinking because they were "not taking advantage of - or seriously - the program/people/opportunities available to them." Most of the respondents indicated that they offered adolescents counselling on reproductive health issues, sexual abuse, dating violence, and safe sex practices. There seemed, however, to be a gap in counselling services offered to youth on substance abuse.

Maturity and emotional development.

Adolescents' ability to acquire skills to make healthy sexual decisions differ according to age, gender, cognitive development, and social/cultural environment just to name a few. The majority of respondents in this survey highlighted some of these differences to explain why some adolescents were not able to make healthy sexual decisions. These included internal factors (such as self-concept, control, and curiosity), external factors (such as peer pressure) motivational factors (such as personal values), and developmental factors (such as the onset of sexual activity or the cognitive ability to understand the risks and consequences of sexual activity). Most professionals gave precedence to one or two of these factors, when considering

why adolescents make unhealthy sexual decisions. Very few indicated gender as a determining factor in adolescents' interpretation of sexual health education.

A few professionals, for instance, believed that some adolescents make unhealthy sexual decisions because they lack self-control and maturity to consider the risks and consequences of sexual behavior. Some of these adolescents exhibit a "It Won't Happen To Me" attitude, as illustrated in the following comments:

> Some adolescents understand the risk of STD's and pregnancy however do not use condoms and/or birth control. 'The it won't happen to me' attitude is evident.
>
> I think most teens have heard the messages about STDs, teen pregnancy, date rape, etc. but yet the prevailing attitude seems to be 'it can't happen to me - those things happen only to other people.' This fatalistic attitude seems to be a real barrier to educating this population.
>
> At 16, 17, or 18 - you feel untouchable. The attitude is that 'I' will never get AIDS, die in a car accident, take too many drugs.

Some professionals felt that adolescents tended to act on their hormones, ignoring any risks and consequences they might have learned. One professional indicated, for example, "that emotions and feelings can get in the way of rational decision-making." Another respondent stated: "Some kids will simply not be able to handle the pressures of an intimate situation. Whether it be pressure or hormones, the body will outvote the brain!" These respondents felt that impulsive behavior, characterized by youth, encouraged health-compromising activities.

Many of the professionals felt that age was an important factor to consider when teaching adolescents the consequences of unhealthy sexual behaviors. Adolescents, who have sex at a really young age, were not mature enough to understand or handle the emotional and psychological consequences of high-risk behaviors. One respondent felt that it was difficult to give educational sessions to younger adolescents because at this age they "are not thinking through the consequences." Another respondent felt that "children are getting sexually active at

too early an age and often they do not realize the emotional aspect of their decision." The respondent felt that older youth have greater cognitive abilities to make healthy decisions, while the younger ones do not.

One respondent was concerned about age gaps and thus power imbalances in adolescent relationships, particularly in situations where one partner (usually male) was a lot older than the other (usually female). To empower girls to make healthy decisions, this respondent felt that schools could do more to help girls build self-esteem. One respondent indicated that he/she often separated males and females when discussing sexual issues, depending on the subject matter. This respondent recognized that boys and girls have different needs and values related to sexual health services and education. Though most respondents emphasized age and emotional maturity as factors impacting adolescent sexual decisions, there seems to be a need for social supports that recognize gender as a determinant of adolescent sexual health.

Peer pressure.

Many respondents felt strongly that peer pressure influenced the way adolescents respond to sexual situations. How adolescents cope with pressure to engage in sexual activity greatly depended upon their personal values, self-esteem, and relationship with friends and partners. It also depended upon their education (ability to identify risk) and maturity to say "no" to cultural pressures.

According to the professionals, adolescents often make unhealthy sexual decisions because they feel vulnerable to act in ways to fit in and the decision to have sex is not based on personal decisions or values. As adolescents age, they spend a greater amount of time with their peers and become greatly influenced by the behavior of their friends. One professional, for instance, stated that from his past experience with adolescents, they "don't know the back end

from the front end and that's really scary. They are too bashful to fully listen in school and take friends' word of mouth to heart as gospel."

Some professionals felt that adolescents do not only succumb to peer pressure because of the close bonds they make with each other, but because they lack the maturity and self-esteem to say "no." This is illustrated in the following comment:

> Not all adolescents (I feel) make healthy sexual decisions primarily because of peer pressure, and the unwillingness and/or lack of desire to think maturely about consequences. Of course their self-esteem and self-confidence also play a big role.

Some of the respondents identified low levels of self-esteem particularly among female youth. One respondent felt that "many of (*her*) female students rely on a sexual relationship to provide them with status within the school and to make them feel wanted and needed." Other professionals felt the same way. Some respondents indicated that many young women are "unassertive" or "give into partners so the relationship won't end." These respondents felt that sexual health education should allow adolescents to think critically about power imbalances in relationships and give them opportunities to examine their own morals, values, and needs. They recognized that adolescents are particularly vulnerable in relationships because they have a strong desire to please others and do not identify or understand their own needs and values.

Influence of the media.

The professionals identified popular culture in the media as a powerful source of influence on adolescents. They felt that music videos, movies, magazines, and television had a lot of sexual content that could be particularly harmful to youth and the sexual decisions they make. The respondents felt that the media often provided adolescents with mixed messages as to what is acceptable sexual behavior.

Several of these professionals indicated that adolescents tended to believe, at face value, what they see, hear, or read in the media. Another respondent felt that the media offered adolescents information "without any moral code around which to frame it." Feeling that much of the media information was incorrect, some expressed concern with the way youth discussed sexual content in the media with friends. One respondent's comment illustrated this point:

> I think adolescents make sexual decisions based on info/misinformation from friends and the media. While sometimes they may receive accurate information from these sources often they do not and thus are unable to make informed decisions.

This respondent feared that the media had the power to set "norms" in adolescent discussions. This, in turn, had the potential to lower adolescents' sense of risk in making sexual decisions.

Many of the professionals felt that adolescents were particularly vulnerable to the messages because they had not developed the cognitive ability to think critically about the information. One of the respondents indicated that she had worked a lot with youth to try and dispel some of the myths that the media portrayed as normal adolescent sexual behavior. When asked where adolescents got their information about sex, one respondent stated:

> In my opinion, mostly from popular media. We work to dispel the common myths and inaccuracies which they learn from television, radio, magazines, movies, peers and even parents.

Another professional felt the media inaccurately stereotyped or exaggerated adolescent sexual behavior, and was concerned that youth were more likely to learn from popular culture. This respondent stated: "I believe very little of what adults tell them sinks in." Most professionals expressed the view that it was difficult to inform adolescents about the risks and consequences of sex when popular culture seemed to "normalize" risky behavior.

Community responsibility for sexual health.

Many professionals felt that the adolescents with whom they work are not equipped with the necessary skills for effective decision-making. In their opinion, these adolescents are not mature enough to make sexual decisions and therefore need adequate direction from adults. The professionals had different ideas about who could best assist adolescents in their sexual decision-making. Some respondents felt that adolescents needed to be given adequate direction at home. Another respondent felt that the responsibility of educating youth should fall upon the schools: "There is no doubt that we could be doing more in our schools - This has to start at the lower grades."

Several respondents expressed the view that a variety of community members should work together to offer adolescents the sexual health support they need. This is illustrated in the following comments:

> If there is open communication between parents, teachers, health care workers, etc. adolescents can make informed sexual decisions.
>
> If adults are involved to discuss, provide info then they are more likely to make a better decision. Adults/peers also can provide vital emotional support which can be more important than info on sex.

One of respondents expressed concern that adolescents receive "a composite of tremendously mixed messages from society, peers, and sometimes family." This individual went on to explain: "If there is no consensus between community agencies and parents, then they (*adolescents*) are left to move in every direction and nobody knows what is right or wrong."

One respondent felt that small-town gossip was a major barrier to healthy sexual decision-making, deterring adolescents from seeking the information that they need. This respondent remarked: "They (*adolescents*) are fearful of purchasing condoms/birth control because their parents may discover they are sexually active." Many adults are uncomfortable

discussing sexual issues with youth. Some avoid the topic completely, hoping that the issue will just go away. Most of the respondents felt that a positive social and cultural environment around the topic of sexual health could change this trend. If communities did more to accept the challenge to foster openness and support, then youth would be more likely to seek sexual health information and support. Fostering open communication between parents, teachers, health care providers, and adolescents seemed to be the most popular professional strategy to help adolescents get the information they need.

Factors Contributing to Healthy Adolescent Sexual Decision-Making

Many of the professionals felt that they are several factors that contribute to healthy sexual decision-making in adolescence. In their opinion, these factors included a strong sense of self worth, a positive home environment, education, and access to information and services. One respondent felt, for instance, that "parents could play a bigger role here. Schools could help as well. It seems that students from close families rarely get into trouble in this area." Another respondent felt that adolescents from middle-class families had greater access to sexual health information and services than those from low income homes. Adolescents from middle-class families, for instance, had use of home computers, the internet, books, and transportation to and from health care facilities. Adolescents who experience healthy relationships and open communication with adults were deemed to respond more positively to pressures involved in sexual decision-making.

Several professionals felt that those who made healthy sexual decisions did so "because they take advantage of the information that is available for today's youth." The prevailing attitude in this statement reflects the idea that adolescents should be able to make informed decisions because there is a lot of information available to them. Other respondents had similar

opinions:

> I do feel that adolescents make informed sexual decisions because they do have sufficient resources available to them.
>
> There is loads of info available to the concerned adolescent if he/she wants this info.

These professionals identified school counsellors, parents, relatives, help lines, youth services, and the media as potential sexual health resources. However, one respondent articulated the difficulties adolescents have approaching these adults for sexual health information. In this respondent's opinion: "I feel many adolescents do not make informed sexual decisions because of the embarrassment of talking openly about sex and sex-related topics." While education is an important part of decision-making, this respondent believed that adolescents also needed someone to confide in or someone who allowed them to express their thoughts and feelings. The professional recommended that service providers and parents find ways to approach adolescents about sexual issues.

Some professionals emphasized the idea that there are social and economic disparities preventing some adolescents from seeking and finding sexual health information and services. Yet one professional felt that it was the service providers' responsibility to make youth aware of the services available to them. This respondent stated: "I believe that informing them is part of our responsibility, for then they at least know what's what about healthy sexual practices."

One individual indicated the importance of the way the information is delivered to adolescents. Distinct differences between youth enable some youth to respond to sexual health education better than others. This respondent remarked:

> Given the same information, a number of them (*adolescents*) will seem to be very well informed and decide to wait, others will use protection always, some of them will use protection sometimes and then there are those who don't use any protection.

Another respondent felt that there were educational factors preventing even the most well-informed adolescent from making a healthy decision. Youth, who receive sexual health information, will continue to make health-compromising decisions, if they are not also taught about the consequences of using drugs and alcohol or how to stand up to peer pressure.

Overall, respondents felt that adolescents who make healthy sexual decisions have open communication with parents and a variety of adults, are able to easily identify a sexual health provider that they can trust, have fair access to sexual health supports and educational opportunities to acquire self-esteem, and the skills to say "no" to peer pressure. A youth leader suggested that a peer support service might be an appealing source of sexual health information. When asked where adolescents received their sexual health information, many professionals identified peers in addition to parents, teachers, health care providers, and the media. Peer counselling and a public awareness campaign of sexual health services were considered important strategies to effectively disseminate sexual health information to adolescents.

Attitudes Towards LBGT Issues

Adolescent sexual decisions involve developing a sexual identity. Part of the sexual decision-making process of youth is to explore their sexual orientation. Therefore, the principal investigators asked the professionals to reflect on their community's attitudes toward LBGT issues. In this study, the principal investigators wanted to understand if there were community support for adolescents to discuss their questions and concerns around sexual orientation.

The majority of the respondents felt that their communities had little understanding of the support needs of LBGT youth. They also indicated that their communities were largely ignorant of the concept of sexual orientation, making it extremely difficult for adolescents to discuss and explore their sexual identity. It is evident in the following comments that there is a strong stigma

in Newfoundland and Labrador attached to homosexuality and that schools, parents, and health care professionals are not addressing sexual identity issues. One respondent stated that sexual orientation is "Not typically discussed openly. . . .the negative connotation lasts - often you listen to students calling each other names - i.e. gay, queer, fag etc." Another respondent indicated that it was "Not acceptable for youth to reveal their sexuality" due to fear of discrimination. One respondent stated that several homosexual couples in his/her community had to move because their families and community did not accept them. This respondent felt that the community's homophobic response to the couple was driven by "a heavy influence of religion" in the region.

Many respondents also noted that there was little education in their communities to address these issues and that often the issue is ignored unless someone in the community openly expresses their sexual orientation. They indicated that there was a clear reluctance of parents, educators and health care providers to talk about this issue, unless individuals come to them and identify themselves as lesbian/gay/bisexual/ and transgendered. This is illustrated in the following comments:

> I don't see a whole lot of acceptance but at the same time there has not been a massive focus on educating the uninformed.
>
> Unfortunately, I think we largely ignore these issues unless a relationship is established with the young person first.
>
> Children make fun and/or are embarrassed to talk about it. Professionals are often reluctant to talk about it. Parents give negative messages, even well-informed parents.
>
> There is a stigma attached. Not acceptable for youth to reveal their sexuality.

From these opinions it is clear that in communities where homosexuality is ignored, homosexual youth are not learning sexual health information specific to their own needs. Heterosexual youth, in turn, lack the necessary education to respect diversity and the democratic principle of non-discrimination.

Several of the respondents brought up the issue that people living in rural and remote areas of the province may exhibit less tolerance towards LBGT individuals than those living in more urban centres. This is illustrated in the following statements:

> I work in a rural setting where the negative attitudes towards lesbians/gays is slow to change. Verbal abuse is most prominent. Few individuals have ever openly declared their sexual preference to be gay/lesbian.

> Our community is small. The overall attitude is very negative towards these issues.

Another respondent indicated that community attitudes are more liberal in urban areas "than rural or isolated communities." Disclosing sexual identity in a small community can be very problematic if members of the community exhibit hostile or ignorant attitudes towards homosexual individuals.

Other respondents felt that there were gender differences in attitudes towards homosexuality with girls being more tolerant than boys. In the words of one professional, "Female clients seem more tolerant of the gay/lesbian/bisexuality than the male clients." Another professional had a similar opinion:

> From adolescents that I deal with, the thought of lesbians is great because most are adolescent boys, and it is in their peer programming that they are supposed to be like this. But gay is not tolerated and is hated. Most adolescent boys, when this is mentioned, react very defensively and violently. Girls? I don't deal with them so I don't know."

This respondent highlighted the attitudes and values of the male heterosexual culture and pointed out a distinct dichotomy between general acceptance of lesbians and outright rejection of gay males.

It is clear from the professionals' opinions of community attitudes toward LBGT issues that sexual orientation is a sensitive topic in Newfoundland and Labrador. Most of the professionals acknowledge the fact that their communities either ignore homosexuality or outright discriminate individuals based on their sexual orientation. According to the

professionals' comments it appears that educational programs around sexuality are not addressing the diverse needs of all students.

Access to Information and Services

In answer to many of the open-ended questions, the professionals acknowledged that there were a variety of supports available in their communities to help adolescents make healthy sexual decisions. Some of the main supports include services offered by community health professionals, Health and Community Services, schools, churches, and physicians. Others acknowledged the importance of print materials and information distributed by family members or peer counsellors.

Twenty-five percent of respondents believed that adolescents had all of the support and information that they need. One person felt that students knew how to access birth control and other kinds of sexual health resources because they lived in a small community. Another person felt that "there is plenty of information available from the schools counsellors, parents, relatives, help lines, youth services, and printed material." Other individuals stated that sexual health services are available, but adolescents will not go to service providers for help. They did not indicate whether adolescents were aware of these services.

Many of the respondents agreed that access to sexual health services is important in adolescent sexual decision-making, yet more than one half identified barriers that prevent adolescents from getting the sexual health programming they need. Many adolescents, for example, do not know what kinds of information and services are available and professionals do not have the time and resources to concentrate on reaching out to students. Some of the respondents pointed out the difficulties in accessing sexual health services in small communities. Some adolescents, for example, did not even have a regular family doctor. Approaching health

service providers in small communities was also identified as problematic. These respondents indicated that adolescents are not confident that their questions can be kept confidential.

Although some respondents identified key community resources available to adolescents, they also indicated that these services could be limited in their outreach. One person stated, for example, that adolescents were often unaware of the sexual health services provided in their community. Another respondent pointed out that "Health and Community Services is available but I am not sure that adolescents know they can turn to us for help should they need it." Several respondents indicated that there were services available through the school or the health clinic. Unfortunately, the students have to be assertive to ask for them.

Other respondents indicated that adolescents may not be assertive seeking these supports because they are either too embarrassed to talk to adults or lack confidence in the level of confidentiality provided. One professional stated that being assertive "may be a barrier as confidentiality is a concern for many young people." Another respondent indicated that the only supports in the community "are through health care and the XXX women's centre. There is no where in this community devoted to sex issues."

Some of the respondents also felt that adolescents have limited access to information because there is a lack of human resources, particularly specialists, working in this area with youth. Reflecting upon their own jobs, some respondents felt that "other" adolescent issues took priority. Some also highlighted the fact that many professionals, such as community health nurses, do not have occupations where they could devote their time to adolescents on a continuous basis. Concerns about the lack of personnel and time devoted to adolescent sexual health issues are reflected in the following statements:

> If students ask me questions about sexuality we discuss it. However, given the fact that I am only half time in the high school, usually the work demands are so great in other

> areas (crisis) that little time is spent helping youth with sexuality.
>
> Public health used to take on a larger role but health administration has decided not to staff an additional public health nurse.

Maintaining sexual health and preventing unwanted pregnancy and sexually transmitted infections also presented problems in terms of access to services. Some of the professionals indicated that adolescents have difficulty following safer sex advice when condoms are not accessible in schools. In the words of one respondent: "I understand for a period of time condoms were given out for free. This practice was stopped - the reason given it was too expensive." Another respondent indicated: "Many don't feel they have a family doctor or have one they feel comfortable with, especially with these issues. There are no other services available for many adolescents in the area."

Several of the respondents felt that adolescents living in rural areas of the province had less access to services than those in the larger towns or St. John's. This is illustrated in the following comments:

> The more rural areas would have less access. The youth in these areas have very little in terms of people to talk to.
>
> I think they (adolescents) get what they need in (XXXX...small community). But if they do need to go to a clinic or find a private spot to discuss they probably have to go to a (XXXX...larger community) if the guidance service is not enough.
>
> A common theft here is of condoms and pregnancy tests. Many youth have limited funds. Condoms should be free and easily accessible to those who need them and want them.
>
> Youth are fearful of purchasing condoms/birth control because their parents may discover they are sexually active. Gossip in small towns is a big issue.

One respondent felt that adolescents were not seeking sexual health information and services because young people worried whether professionals would keep their identity confidential.

He/she stated "while there is information accessible in a health course through the public health nurse, myself (guidance counsellor) etc. it is not as confidential as we would like."

Many of the respondents did offer recommendations on how to overcome barriers to adolescents' access to sexual health information and support. These suggestions included:

Improvements in the School Curriculum

Many of the respondents noted that adolescents were not receiving on-going sexual health education within the school system. For many adolescents the information that they did receive was limited to one course in high school or the odd visit they received from a sexual health educator. The professionals felt that the high school course was not presented in a way that was meaningful to adolescents. When asked whether adolescents had difficulty getting sexual health information, several professionals believed that they did. Problems delivering sexual health education through existing course work were identified in the following comments:

> Sometimes at school but this is often "bare bones" and does not always include reflections on decision-making. Covering the health curriculum seems to be 'optional' in many schools.
>
> Very few adolescents have access to information, only through one high school course that all kids don't take. This information is not a one course subject. It needs to be discussed and repeated throughout the adolescent years.
>
> The library is very small and limited and lots of times the internet just leads to porno sites when looking for educational sex material and the teens get distracted easily. The odd sex educator that comes in to inform the teens aren't taken seriously. All the teens remember is the fake penis and vagina. But there is always a small few that get help from this. But there needs to be more continuity.

Many of the school educators indicated that they did talk to adolescents about birth control, safer sex, and other sexual health issues both in the classroom and individually. The need for continued sexual health education, however, was well supported. Some of the respondents felt

that "in areas where education re: making healthy decisions was available it appeared the adolescents were making healthier decisions."

Educating Adolescents at an Earlier Age

Some of the respondents felt that adolescents are engaging in sexual activity at an earlier age and hoped that sexual health providers would tailor their services to meet the needs of this population. For example, one respondent stated that "children are getting sexually active at too early of an age and often do not realize the emotional aspect of their decision." Several respondents felt that adolescents were not making informed sexual decisions because they received sexual education too late. This is reflected in the following comments:

> It is very important that training or information be started early, and not to try and stop it (sex) after the fact.
>
> I feel that while adolescents appear to be very informed about sexual matters (issues) they are very ill-informed as to many of the emotional/psychological effects of having sex at a young age.
>
> School programs are often offered too late - need to reach very young adolescents and build on their knowledge as they mature. Parents are still often reluctant to discuss these issues with their children.

These respondents felt that young people were having sex at an earlier age and it was not being recognized or acknowledged by parents or the schools. They felt that parents and schools should teach sexual health education to younger adolescents because youth were making decisions to have sex before they were emotionally ready for that choice.

Peer Education

There were several respondents in this study that indicated that most adolescents discuss sexual issues and information with their friends and peers. Many expressed that this information is often inaccurate. A few respondents recognized the influence of peer-based education and

suggested that this would be a positive direction to take with adolescents in addressing adolescent sexual health issues. When asked the question, "Do adolescents in your community have difficulty accessing information and services regarding sexual health issues?" one of the respondents replied:

> There are services/professionals available but teens tend to take the advice of their peers. There needs to be more peer information networks that encourage sharing of accurate information.

One of the respondents stated that sexual health education can be embarrassing for adolescents and that having the education delivered by someone around the same age may make a difference. In the respondents words:

> As a teen I wish someone had provided my friends and I with info from the perspective of a teen and delivered by a teen. I think Sex Ed from an adult may seem embarrassing and irrelevant. Had we been told about a teens experience with pregnancy or STDs, the message that we were not safe from the same risks may have been received.

Professional Education

The majority of respondents indicated that they felt comfortable providing information and services to youth to help them make healthy sexual decisions. However, many of them expressed a desire for more education and opportunities to upgrade their skills. Some suggested that they needed sufficient time to provide sexual health education, indicating that their workloads were heavy. One respondent stated, for example, that as a guidance counsellor, he/she was shared between three schools, including two high schools. "I find it very difficult to schedule time for this subject despite the relevance and significance of the topic." The following statements indicate that many of the service providers in the community desire more training in sexual health education to assist youth:

> I feel more comfortable the more that I am involved in this function. However, from a teaching aspect I would prefer to have received more training.

> This is an area that can be very difficult for most people. People have to gear up to and learn the techniques that best work, especially when talking to 12, 13 years old.

Some of the respondents felt that sexual health was a topic that they felt uncomfortable discussing with youth. Many of them listed specific reasons for this:

> I strongly believe that the state has no place in the bedroom of the nation. As an educational agent of the state, I have no place in the bedroom. I do however encourage them to be safe.

> As an older person I'm quite comfortable with myself. One difficulty is I'm personally rather conservative compared to the youth that I work with. I am conscious not to let personal bias creep into my counselling but sometimes it might.

Professional education would be extremely important in terms of addressing some of these issues and ensuring that adolescents have access to professionals who are trained and can provide them with the information that they need.

Sexual Health Site or Coordinated Sexual Health Services

Many of the respondents identified sexual health supports in the community for adolescents, but indicated that adolescents were either not aware of them or had concerns about confidentiality issues prior to accessing these services. Several of the respondents also indicated that there was no structured service in the community where adolescents could turn. In the words of one respondent, " I'm sure there is one teacher, health care professional, organizational leaders who are supports for some kids. But there is no organized supports for all kids." In the words of a guidance counsellor, "I don't advertise as such but on an individual basis students have invested their hopes and dreams in me to help them arrive at healthy decisions regarding: sexual activity, homosexual lifestyle, transvestite lifestyle, pregnancy, masturbation, etc." One community worker indicated that the adolescents do not take seriously the infrequent sex

educator who comes to the school to inform them about safer sex. “There needs to be more continuity.”

Many professionals felt that if sexual health services were coordinated better, then service providers could reach out to a greater number and variety of teens. The professionals offered a few suggestions to improve service delivery, which are reflected in the following statements:

> It would be great if Planned Parenthood had offices across the province.
> There are a couple of adults who are available to talk to them but there is no specific place assigned for these adults to afford privacy except at the Public Health office which is attached to the clinic. A place in the community assigned as a guidance counselling space would probably be quite helpful.
>
> I also feel that if the PHN had more access at school it would probably help to increase their knowledge base.

Clearly, many professionals feel that all youth should have equal access to sexual health information and services. In their opinion, youth should be able to identify the kinds of services available in their community, but this is not the case in Newfoundland and Labrador. Even the professionals had trouble identifying the supports and services in their community. In several of the responses, the professionals indicated that the province should explore a method for developing a provincial sexual health site or the option of establishing coordinated services throughout the province.

Parental Involvement

Many of the respondents felt that parents were a support for adolescents in terms of sexual decision-making and that parental communication with their children was important. However, some expressed concern that parents and adolescents were not discussing sexual health issues with each other at home. According to one respondent “parents are still often reluctant to discuss these issues with their children.” Another respondent felt that some parents are reluctant

to discuss safer sex practices with children because they have strong religious convictions. One of the professionals surveyed indicated that he/she would not offer sexual health information to an adolescent without the parents' consent. His/her mandate was to respect parents' wishes because he/she worked with youth involved in criminal offences.

Some of the professionals indicated that the best way to help adolescents make healthy sexual decisions is for the community to come together to develop open communication between parents, teachers, adolescents and health care workers. Some adolescents have negative experiences at home which makes it much more important for the service providers to foster communication and respect between children and their parents. One regional health nurse indicated that partners and/or parents are welcome in the clinic, if the client desires their attendance during an appointment.

Discussion

This discussion explores several significant topics that emerge from the findings of the survey conducted with professionals who work with adolescents. These include perceptions professionals have about adolescents' use of sexual health services, comfort levels of professionals who provide sexual health information and services to adolescents, recognition of social, gender, and developmental differences among adolescents and recognition of different values and sexual health needs of adolescents.

There is a dearth of research both in this province and across Canada that discusses service providers' perceptions of adolescent sexual decision-making and the availability of sexual health services. This discussion draws on research of sexual health programs and services offered to adolescents in Canada, the United States, and Britain, as well as the evidence backing

some of the policy recommendations put forth by government officials, educators, professional associations, and researchers. When appropriate, this discussion also provides a balanced perspective to professionals' perceptions of adolescent sexual health services and sexual decision-making by offering a comparative analysis of adolescents' views. It also highlights, where possible, some existing program and policy solutions that address the needs of both adolescents and professionals to enhance adolescent sexual decision-making and the delivery of sexual health information and services.

Adolescent Sexual Health Services

The findings of this study suggest that effective coordination of sexual health services would benefit adolescents in making healthy sexual decisions. Many professionals provide adolescents with sexual health information and services, but often work in isolation. Although the professionals identified an array of sexual health service supports in their communities, it is clear that there is little public awareness as to where adolescents can turn for help. Many professionals, for instance, indicate that they only provide sexual health information or services upon the request of adolescents. Focus groups with males and females in this study suggest that this practice may pose a barrier to adolescents in need of sexual health services.

Males in the focus groups indicated that they were uncomfortable seeking support from guidance counsellors around the issue of partner abuse, particularly verbal abuse. A research study investigating gendered values in sexual relationships and decision-making in Britain indicates that sexual health services can actually discourage men from seeking support because of the way it is advertised in the community. Thomson and Holland (1998) point out that sex education tends to focus on girls, on reproductive health facts and the dangers of unsafe sex

practices. Prescriptions of traditional male and female sex roles and conventional ideas of masculinity and femininity do little to change evidence-based research that shows that males continue to receive less sexual health education and services.

The professionals' confidence in adolescents' ability to find and seek sexual health services and information indicates a lack of knowledge about how adolescents utilize supports. Adolescents in this study indicated that they looked to peer-supports and occasionally older siblings and relatives for sexual health information. Recent research supports the need for professionals to initiate communication about sex with youth, and to work with other information providers, such as peer groups and parents of adolescents.

Mackie and Oickle (1997) reviewed research in Canada that clearly identifies a role for physicians in promoting Comprehensive School Health (CSH) in Canadian communities. Several national organizations, including the Canadian Medical Association, have defined the term CSH as "a broad spectrum of programs, policies, services, and activities that take place in schools and their surrounding communities" (p. 4). These services including adolescent sexual health programs are delivered within an integrated community approach and have become the responsibility of parents, youth, health and social services professionals, educators, and governments. Mackie and Oickle indicated that a "task force of the College of Family Physicians of Canada published a report on adolescent health that included recommendations on CSH" (p. 4). The report recommended strategies that physicians can apply in their office and community to assist adolescents with their health needs. These included accommodating adolescents through youth-friendly "drop-in" services; launching "bring a friend" campaigns to encourage reluctant adolescents to bring a trusted friend along to appointments; advocating for school health programs and services for youth; advising schools on educational programs and

materials, and participating on school boards and in community organizations. Mackie and Oickle also indicated that the concept of CSH (or school-based health promotion) is now recognized in nine provinces, with the exception of Quebec, for its "value in changing the health behaviors of young people as well as coordinating the many different services and programs responding to the health needs of children and youth" (p.1301). Although the researchers in the current study did not ask sexual health service providers whether they were aware of CSH initiatives in their communities, many of these professionals felt that the community (parents, service providers, and youth) should learn how to come together to openly discuss adolescent sexual health needs.

In the current study's findings with youth and professionals, it was clear that adolescents are receiving different degrees of sexual health information from school, parents, the media, and peers. Some professionals and many adolescents were unclear about the availability of sexual health services for youth. According to some adolescents, a community health nurse would come to the school about once a year to offer a sexual health education seminar. Sometimes a representative from PPNL would go to the schools to give a presentation. While adolescents indicated that guest speakers were helpful, they did not want curriculum developers to rely on community service providers to offer the only form of sexual health education they received in a given year. They also expressed concern that sexual health education was not offered in their schools consistently from year to year. Many of the professionals identified this problem by indicating that they did not have the time or the resources to concentrate on reaching out to adolescents to provide sexual health information. In some Newfoundland and Labrador communities, schools do not always have full-time counsellors or resource rooms where students can obtain private counselling and information as they need it.

Health Canada (2003) recommends that sexual health educators be given the time and resources for in-service training and continuing education to optimize their services. The guidelines also recommend that parents and primary caregivers have access to a variety of opportunities to learn about sexuality and sexual health, "which will in turn give them the knowledge and skills that will help them to speak to children about sexual health education" (p. 27). Effective health education should encourage training opportunities in all areas related to sexual health for a variety of individuals involved in peer education, counselling, or advocacy.

Many of the females in the focus groups indicated that they were exposed to information about sexual decision-making and relationship issues from a variety of sources including schools, peers and the media. They recognized that some of this exposure negatively influenced their sexual decision-making. Similarly, many of the professionals were also concerned about the influence of peers and the media on adolescent sexual decision-making. They felt that the media overemphasized and normalized adolescent sexual activity. Recognizing the power of the media, some of the professionals felt that adolescents learned more about sexuality and sexual health from popular culture or word of mouth than they did from the professionals' teachings.

Offering adolescents courses in media studies might be an important step to empower adolescents to make healthy sexual decisions. The American Academy of Pediatricians has published a series of policy statements on "media effects, including sexuality and contraception" and embraced "media literacy" as an important strategy to reduce health-compromising behavior in youth. Media literacy is defined as "the ability to access, analyze, evaluate and communicate messages in a variety of forms" (Brown, Steele, & Walsh-Childers, 2002, p. 21). Local groups in Canada are working with community centers, schools, and parents to teach them how to be critical media consumers. Media literacy advocates are challenging consumers to uncover

hidden messages, assumptions, and values and to consider the political, economic, and social contexts in which media messages are created. Brown, Steele, and Walsh-Childers (2002) indicate that media literacy is also being offered in some Canadian schools. Teachers have embraced this strategy by encouraging adolescents to think critically of sexual messages in the entertainment media.

Studies have shown that the media can also be a powerful resource to create awareness of sexual health education and services. Studying prevention strategies of unplanned pregnancy, Allen (1998) argued that publicity campaigns aimed at both youth and professionals can be helpful in the planning stage for developing sexual health services. Sexual health services should be advertised extensively in places that adolescents frequent. Allen (1998) indicated that word of mouth publicity was just as important as media advertising and she felt efforts should be made to "tap into" the youth's interests and "grapevine" (p.133). Though Allen did not suggest how program developers could get the word out to professionals, awareness campaigns advertised through professional associations and journals would be a positive step.

Getting the message out to parents is also important yet difficult. Coleman and Roker (2001) argue that "parents of teenagers are more isolated than other parents" (p. 11). These parents do not gather in common social environments, such as at the school gate, and therefore have no obvious place to network. Coleman and Roker highlight social differences between parents of adolescents and other parents because they feel policy makers and practitioners should recognize that these parents have distinct support needs (p. 12). In Britain a wide variety of strategies are being developed to offer formal advice and support to the parents of adolescents. In one pilot project, a local school recruited a parent advisor to offer a drop-in and telephone service; it also offered a parenting course called 'Living with Teenagers' (Roker & Richardson,

2001, p. 169). According to Short and Rosenthal (2003) clinicians can also assist parents in developing skills to discuss sexual matters with their adolescents. Parents can be provided with guidelines regarding appropriate limit-setting and the level of supervision that adolescents might require. These skills can be fostered while still maintaining confidentiality for the adolescent. In Newfoundland and Labrador more research is needed to explore parent-adolescent relationships, their information and support needs in discussing sex with their children, and how parents would like to receive this service.

Findings from this survey with professionals suggest that there must be clear identification of the types of services they can provide adolescents, parents, and other service providers. What is clear from this research with sexual health service providers is that they would like more resources and education as well as a coordinated community strategy to deliver sexual health services to adolescents. It is recognized that service providers need more support from government, schools, community agencies, and parents to understand how to more effectively meet adolescent sexual health needs. Service providers also recognized the need to have adolescent input and were anxious to learn what adolescents had to say about sexual decision-making.

Comfort Level between Service Providers and Adolescents

In this study, the principal investigators wanted to know how comfortable service providers were delivering sexual health information or counselling to adolescents. The majority rated their comfort level in providing sexual health information and services to adolescents as very good or excellent. The reason for the high number of confident responses is not surprising. It likely reflects the population group that returned the questionnaire to Planned Parenthood

Newfoundland and Labrador. Descriptive demographic statistics on these participants indicate that the majority were between 40 and 49 years old while the most frequent number of years of experience was 15. It is unclear whether comfort level in providing adolescents' information and services is directly related to length of time in the field.

A few of the professionals indicated that they were uncomfortable providing adolescents with sexual health information or counselling because they felt they did not have enough training and experience in this field. A study on adolescent sexual health in New Brunswick asked teachers to rate their knowledge and comfort level in teaching a variety of sexual health topics. The findings indicated that the teachers felt "only somewhat knowledgeable about, and somewhat comfortable with, these topics" (Byers, Sears, Thurlow & Voyer, 2003, p. 4).

The adolescents in this study indicated that they were not very comfortable approaching professional service providers (guidance counsellors, teachers, and health care professionals) for sexual health information. Lacking confidence in service providers' ability to maintain confidentiality, adolescents indicated that they preferred to seek advice, information, or counselling from their peers. One of the factors that discouraged adolescents from going to a sexual health provider is the fear of having their identity, questions, or concerns exposed to parents, partners, and/or other members of the community. Many of the adolescents spoke about gossip within their school and community, and how they feared being the subject of rumor and ridicule. They expressed a desire for local services that were inconspicuous and discreet, but also well publicized and easy to locate. Given these facts, it is likely that adolescents would feel more comfortable seeking sexual health information and services, if professionals could publicize the level of confidentiality that they can provide.

Recognizing Different Values and Sexual Health Needs Among Adolescents

Professionals in this study recognized differences between adolescents' needs and values, and expressed a desire for more education on issues related to with self-esteem, sexual orientation, and gender specific sexual health needs. The professionals felt that youth had some education on safer sex practices, contraception, and personal relationships, but expressed concern that adolescents may have individual needs in these areas. They pointed out that adolescents receiving the same sexual health education were not equally motivated by the lessons to make healthy sexual decisions.

A few of the respondents felt that some adolescents' inability to put sexual health education into useful practice had a lot to do with self-esteem issues experienced by males and females. One professional felt that low self-esteem in heterosexual girls increased the likelihood that male partners would become idealized and related to in a passive, dependent manner. Many of the females in the focus group also felt that low self-esteem increased their vulnerability to stay in unhealthy relationships. Both males and females in the focus group indicated that some adolescents might use alcohol and drugs to boost their self-confidence. Substance abuse, in turn, lowered inhibitions to engage in risk-taking behaviors, particularly the ability to weigh the consequences of unsafe sex. A research study on risk-taking activities among youth in Eastern Newfoundland found that "males are more likely to drink regularly, to take drugs…and to report more than one sexual partner in the last six months, compared with their female counterparts" (Hoskins et al., 2000, p. 26). These researchers recommended that programs be adapted for males and females to reflect the needs and concerns of each sex.

Professionals and adolescents in this study recognized that low-self esteem among adolescents increases risk-taking behavior associated with sexual activities. This has direct implications for practitioners working with adolescents. Social workers, health care

professionals, educators and parents should learn how to provide youth with self-esteem building tools to help them make healthy sexual decisions. Some studies have documented how specific service providers can make significant contributions toward the goal of reducing the risks associated with unhealthy sexual decision-making. Coleman and Roker (1998) suggests that sexual health education should be more than the provision of information. Adolescents need the skills and confidence to discuss sex and other relationship issues with their partners fairly and openly. According to Thomson and Holland's (1998) study on adolescent sexual decision-making, "sex education rarely addresses the importance of good communication between men and women, nor does it give young people an opportunity to explore the conventional notions of masculinity and femininity" (p. 69). Although gender values around sexual decisions may seem obvious, they are often overlooked in sexual health programs.

Establishing single sex classes when planning sexual health education in Newfoundland and Labrador may seem like a plausible solution, but is not advisable from the viewpoint of the adolescents in this study. Females in this study indicated that they preferred to have co-educational discussions around safer sex practices, reproductive health, sexual decision-making, and relationships. Allen (1998) found that adolescents in her study valued "fairly structured discussion with members of the opposite sex in the context of a discussion group and they valued the input of experts" (p. 131). Because males and females have different needs and values around sexual health, it might be best if service providers prepare to offer gender-specific information and counselling on an individual basis.

Professionals and adolescents in this study indicated that there were very few supports and services to meet the needs of LBGT individuals. They also felt that there was a great deal of homophobia in their communities that mitigated against education and open discussions about

sexual orientation. Research has shown the anxiety and stress that adolescents face when they do not have safe and comfortable environments in which to discuss sexuality issues. Some individuals shroud themselves in secrecy or present themselves to others as heterosexual to avoid encountering verbal insults and physical abuse (Moore & Rosenthal, 1998). When sexual health education is tailored to a heterosexual population, gay and lesbian youth also do not receive the information they need about safer sex practices and healthy relationships.

Issues about sexual orientation have implications for sexual health programs. Coleman and Roker (1998) state that sex educators, "hopefully with support from colleagues and researchers, must be willing to stand up for established opinion, whether it originates from politicians, from school governors, or from parents, and argue for the inclusion of certain topics in the curriculum, even if these are controversial" (p. 197). The authors caution that the needs of gay and lesbian youth "cannot be addressed unless such young people feel safe from prejudice and the possibility of harassment" (p. 198). It is the adults' responsibility to create a safe environment. Coleman and Roker note that adults "represent powerful role models," and that "their own behavior relating to sexism will be very influential in determining the climate of the classroom or group" (p. 198).

Professionals who answered the questionnaire acknowledged the importance of being prepared, as service providers, to meet the needs of different adolescent groups. Many of the sexual health providers indicated their awareness of the influence of gender, sexual orientation, and self-esteem on adolescent sexual decision-making. Some of the respondents to the questionnaire indicated however that they would like more training and direction in these areas. Cole's (1998) study on lesbian and gay identity in adolescence outlines some practical guidelines that service providers can follow to assist youth with questions concerning their sexual

development and identity. For instance, every adult should know that they can assist lesbian and gay youth with sexual health information and decision-making, by checking "service provider's attitudes to, training in and experience of lesbian and gay issues" (Cole, 1998, p. 184). Cole indicates that core qualities in any affirmative practice provides adolescents with advice on what to look for in appropriate counselling or health services. To counteract social situations that devalue lesbian and gay sexualities, service providers must give adolescents education "in which being gay or lesbian is presented as a life choice of equal value to heterosexuality" (1998, p. 185). To locate resources, service providers can also connect with the closest lesbian or gay social and political groups. If there are no such groups within the geographic region, Cole states that it may be useful to connect with educational institutions or youth workers. As advocates of social inclusion, they may be willing to act as a channel to involve gay and lesbian young people in the development of their services or sexual and reproductive health projects (1998, p. 181).

Conclusion

A comparison was conducted between the professionals' survey findings and those that arose from the focus group discussions with adolescents on sexual decision-making. The results were interesting and rather surprising. It was expected that there would be many divergent viewpoints with perhaps some similarities. However, the results yielded many more similarities than differences with regards to professionals' and adolescents' opinions and concerns about adolescent sexual health education and services. Adolescents and professionals also identified similar factors as influencing adolescent sexual decision-making. Furthermore, the adolescents and the professionals suggested very similar recommendations regarding adolescent sexual health education and service planning and delivery.

The only main area of divergence of opinion between the adolescents and the professionals was with regards to access to sex education and services. The quantitative data revealed that 70% of professionals felt that adolescents did have ready access to sex education and services, whereas the majority of adolescents reported that such access was very limited. The response rate by professionals was low. It is possible that those who did respond were those who took an interest in the area of adolescent sexual health and tried to ensure that adolescents had ready access to sexual health education and services. The qualitative data, however, indicated that there were many barriers in accessing education and services.

It is encouraging that the service providers and educators are "on the same wavelength" as the intended recipients. This suggests that improving education and services, to more effectively address adolescent sexual decision-making, might be readily accomplished. The research indicates that professionals must find ways to take a comprehensive and coordinated approach to adolescent sexual health care. Parents, educators, health care professionals, community workers, and government must work together in collaboration with adolescents to ensure that education and service provision meets the sexual health needs of adolescents in NL.

Recommendations for Policy/Program Development

In this research study, adolescents were given the opportunity to make recommendations to the investigators in terms of sexual health programming for youth. Overall, there is a general perception among adolescents and professionals who work with adolescents, that access to sexual health information and services is limited and adolescents want increased accessibility to education and services province wide. The recommendations that follow emerged from the focus group findings, the literature review, current research, and feedback from professionals who work with adolescents.

Education

1. **Conduct a comprehensive review and evaluation of sexual health education in Newfoundland and Labrador schools.**

Sexual health education is available throughout schools in Newfoundland and Labrador, however, based on the information obtained through this research, this education is limited and inconsistent. A comprehensive review and evaluation of sexual health education province wide is needed to assess sexual health content in the current curriculum. The Canadian Guidelines for Sexual Health Education (Health Canada, 2003) should be used as a checklist for program evaluation and all education programs should incorporate these guidelines in the development of comprehensive sexual health program and curriculum outcomes. Teachers and educators should be directed to these guidelines as a tool for program development to ensure that sexual health education is consistent and comprehensive throughout the province.

2. **Establish an accountability framework to ensure that sexual health education is being delivered effectively and efficiently in the school system based on the guiding principles and components of sexual health education as outlined in the Canadian Guidelines for Sexual Health Education (Health Canada, 2003).**

These guidelines include the components of acquisition of knowledge, development of motivation and personal insight, development of skills that support sexual health, and creation of an environment conducive to sexual health as key factors in the development of an effective education program. The researchers recommend that all education programs delivered in the schools should be reviewed on an annual basis to ensure that each of these components is being addressed. This will require a coordinated effort between the Department of Education and the regional school boards. It is also recommended that each school board have a program consultant on staff that would oversee the sexual health program, ensure sexual health training for teachers, and evaluate the education program.

3. **Implement mandatory sexual health education in Newfoundland and Labrador schools that begins in primary school and continues throughout the curriculum until the completion of senior high school.**

Sexual health education in the schools should be based on a comprehensive and non-judgmental model of teaching that incorporates knowledge acquisition, skill development in communication and decision-making, gender inclusion, values and attitudes, and community resources. Building communication skills is extremely important as effective communication

can positively influence and pervade all aspects that relate to adolescent sexual health and decision-making. This education should begin in primary school and continue until the completion of senior high school. This education needs to be consistent throughout each school district and in each school. Each year, the sexual health program should reinforce previous content and integrate further learning that is age appropriate and current.

4. Develop more interactive and innovative sexual health programming in the schools that goes beyond the presentation of facts and information.

Adolescents want information that is relevant to them and that they can use in everyday life. For example, teaching adolescents about condom use may not be effective unless the reasons for not using condoms as outlined in this report are discussed. Adolescents are requesting sexual health information that is current and non-judgmental. It is not sufficient simply to present the facts. This alone does not result in significant behavior changes among adolescents in terms of their risk-taking behaviors. Teaching methods must also consider adolescent sexual decision-making, the influences of peer pressure, media, alcohol/drugs, self-esteem, and gender values and must also reflect the recognition that adolescents will indulge in risk-taking behavior. These factors must be taken into consideration when developing the content and implementation of education programs and in promoting healthy and informed sexual decision-making.

Heightened emphasis should be placed on self-esteem, confidence and decision-making skills and adolescents must be presented with opportunities to use this information and practice

these skills. HIV/AIDS education must be emphasized and incorporated into sexual health education as the findings suggest that adolescents are rather complacent about HIV. It is also important that educators provide adolescents with opportunities to challenge their thinking and attitudes about various issues that influence them. One example of this would be to engage adolescents in critical analysis of the media's portrayal of sexuality, sexual activity, gender issues and relationships.

In considering some of the themes that emerged from this study i.e. fear of being judged, taking risks but seeking security, empowerment through communication, discrepant gender attitudes towards sex, and searching for power and control, it is important to address these findings in a comprehensive sexual health program. Educators must attempt to dispel some of the double standards around sexual decision-making that adolescents identified in this study and engage adolescents in critical thinking about gender and power imbalances from an empowerment perspective.

5. Elicit input from adolescents, educators, health professionals and parents in developing and revising sexual health education programs.

Health Canada (2003) describes elicitation as the first step in a model to gain important insight into the educational needs of the target population. This is extremely important in terms of the development of a sexual health education program that is relevant to the lives of today's adolescents. For example, from this research, sexual performance was identified as an important issue for young males. To address this issue, education on sexual performance

is warranted. It is also important that parents are involved in this process so that they can be supportive of their adolescents at home with regards to sexual decision-making and can encourage open dialogue. Sexual health education will not be effective unless adolescents, parents, health professionals and educators work together. Sexual health experts and organizations involved in sexual health such as Planned Parenthood Newfoundland and Labrador should also be involved as partners in this process.

6. Enhance and/or develop peer-based education programming within the schools throughout the province, and take into account the value of friendships among adolescents.

Adolescents rated their friends as the number one source of information regarding sexual health issues. Adolescents between 15 and 17 years of age place significant emphasis on the importance and influence of peer relations reflecting the fact that adolescence is a time when conformity to peer values is at its highest. The adolescents in this study indicated when youth have questions or are in trouble, the first person they turn to is a friend. It is important that educators encourage peer-based education programs in the schools and that these programs must be inclusive of the entire school population so that youth are not intimidated by those adolescents delivering the program. For example, if only those youth, who are actively involved in school leadership and have excellent academic standing are selected for peer education programs, then other students might be excluded from these educational opportunities. This can create a dichotomy within the student population. It is also critical that educators recognize and explore the value that youth attribute to their friends regarding

information sharing on sexual health issues. Educators can be innovative in the classroom and have adolescents engage in role-plays and activities that are pertinent to adolescents and their peers.

7. Implement more inclusive and accessible education in the school system.

It was quite evident from this research, that LBGT issues were not being adequately addressed in the school system. This contributes to the lack of awareness of these issues and to some of the negative attitudes that exist throughout the province among adolescents and professionals that work with adolescents. This is an area that needs to be addressed in more depth in the school system and there needs to be sensitivity training for educators, health care professionals and others that work with youth. It is also important that education is pertinent to youth with disabilities and reflects cultural diversity.

8. Provide professional development opportunities in sexual health education for educators and guidance counsellors.

Education must be initiated in post-secondary school and continue throughout the professional's career so that they can stay current with the latest sexual health information. In addition, educators and guidance counsellors should receive sensitivity training if they work with adolescents who are at risk, have disabilities, or are LBGT. The provision of sexual health information and materials to educators and guidance counsellors is also necessary and should be reviewed on an annual basis by the Department of Education in

consultation with the regional school boards and sexual health experts such as Planned Parenthood Newfoundland and Labrador.

9. Provide sexual health education for all professionals, community workers, and volunteers that work with adolescents.

These professionals and volunteers are often the first point of contact for adolescents. It is essential that these people are equipped with the skills and knowledge to educate adolescents about sexual health and engage in purposeful conversations with them.

10. Provide sexual health education for parents and information on how to talk with adolescents about sexual health issues.

Adolescents in this study felt that their parents were a potential resource for sexual health information, but that often their parents were not educated about sexual health and therefore did not understand what they were experiencing as adolescents. The youth did express that they would feel more comfortable talking to their parents if they were more educated.

Health

11. Coordinate sexual health services for adolescents through the development of a sexual health framework or strategy for the province.

The adolescents and professionals in this study reported that access to sexual health services was lacking to different extents and that there were disparities between the regions, particularly in rural areas. It is important that there is effective coordination of sexual health services for adolescents throughout the province so that regardless of where an adolescent lives or goes to school, access is equal. Because of a lack of physicians in rural areas, it may be effective to consider expanding the role of health care professionals such as nurses to provide sexual health services.

12. Provide accessible sexual health services for adolescents that are flexible in terms of hours of operation, location, and cost of contraception.

Adolescents reported that they were not aware of many resources in their community that they could access for sexual health services. For example, many of the females did not know where they could go if they were sexually assaulted, and many did not know to whom they could talk about sexual health in their communities. Yet, professionals reported that there were services available to youth. It appears that either youth are not being informed of these services or they are not deemed accessible to adolescents in terms of hours of operation, location, and costs. It is imperative that services are accessible and youth friendly. Adolescents need to be informed about these services and the onus has to be on the

professionals to provide pro-active outreach sexual health services for adolescents. For example, physicians should inform adolescents that they are open to talking about sexual health issues.

13. Educate adolescents, parents and professionals about age of consent, consent to treatment and confidentiality.

Many youth are unaware of their rights regarding age of consent, consent to treatment and confidentiality. Adolescents, parents and professionals that work with youth need to be educated on these issues so that the information provided to adolescents is consistent throughout the province. Policies regarding confidentiality for health care professionals need to be clearly defined and adolescents need to be aware of these policies. In recognizing the adolescent's need for trust and confidentiality, adolescents must be informed about confidentiality rights, before any information or treatment is initiated. The health care professional must also inform adolescents of any limits to confidentiality such as child abuse.

14. Establish sexual health centres throughout the province.

Adolescents felt that with an increased presence throughout the province, youth would have more access to sexual health services. This is also important in terms of reducing the stigma around sexual health.

15. Implement school based STI screening, pregnancy testing and birth control counselling in partnership with a physician or nurse to alleviate adolescent concerns about transportation, confidentiality and access.

Adolescents expressed that school was a logical place to provide adolescents with access to STI testing, pregnancy testing and birth control counselling given their concerns about transportation, confidentiality and access.

16. Provide adolescents with access to affordable birth control options including condom machines in the schools or in other places frequented by youth.

More affordable and accessible birth control methods are necessary for youth to promote safer sexual practices. This includes access to free condoms and affordable contraceptives.

Other

17. Establish a provincial youth sexual health advocate. This individual would oversee sexual health programming in the province, develop recommendations for policy, and deal with the sexual health issues/concerns brought forward by youth. This would allow for a more coordinated provincial approach to addressing sexual health.

18. Implement a coordinated approach by all key stakeholders to ensure that adolescent sexual health is a priority in Newfoundland and Labrador.

19. Increase funding for sexual health education and services.

Implications for Future Research

1. Additional research is needed to explore the knowledge and comfort levels of educators, parents and professionals in providing sexual health education to adolescents.

2. Additional research is needed to explore parents' knowledge of and attitudes towards school-based sexual health education in NL.

3. Oral sex among adolescents is an area in which little research has been conducted. More research is needed to explore adolescent sexual decision-making and oral sex from a gender based analysis approach.

4. Boredom was cited in this research as a reason why adolescents engage in sexual activity and alcohol and/or drug use. It is important to explore this in more detail to determine if there is a direct correlation between boredom and adolescent engagement in risk-taking behaviors.

5. Research is required to explore the lack of trust adolescents have in health care professionals

maintaining confidentiality.

6. Research is required to explore the relationship between alcohol and/or drug use and sexual behavior among adolescents in NL.

7. Additional research is required to explore why some adolescents make unhealthy sexual decisions, despite knowledge of possible negative consequences. While risk-taking behavior may be related to feelings of invincibility and normal growth and development, it would be interesting to explore this phenomenon in greater depth.

References

Allen, I. (1998). Strategies for preventing unplanned pregnancies. In J. Coleman & D. Roker (Eds.), *Teenage sexuality: Health, risk and education* (pp. 121-136). Canada: Overseas Publishers Association.

Boyce, W., Doherty, M., Fortin, C., & MacKinnon, D. (2003). *Canadian youth, sexual health and HIV/AIDS study*. Toronto: Council of Ministers of Education.

Brown, J., Steele, J., & Walsh-Childers, K. (Eds.). (2002). *Sexual teens, sexual media: Investigating media's influence on adolescent sexuality*. New Jersey: Lawrence Erlbaum Associates, Inc.

Byers, S., Sears, H., Thurlow, J., & Voyer, S. (2003). An adolescent perspective on sexual health education at school and at home: 1. High school students. *Canadian Journal of Human Sexuality*, *12*(1), 1-17.

Campbell, J. (1999). *Environmental scan of sexual and reproductive health in the Atlantic provinces.* Halifax: Health Promotion and Programs Branch, Atlantic Regional Office.

Cole, A. (1998). Developing lesbian and gay identity in adolescence. In J. Coleman & D. Roker (Eds.), *Teenage sexuality: Health, risk and education* (pp. 165-187). Canada: Overseas Publishers Association.

Coleman, J., & Roker, D. (1998). Adolescent sexuality and adult professional behaviour: Future directions for policy and practice. In J. Coleman & D. Roker (Eds.), *Teenage sexuality: Health, risk and education* (pp. 189-201). Canada: Overseas Publishers Association.

Coleman, J., & Roker, D. (2001). Setting the scene: Parenting and public policy. In J. Coleman & D. Roker (Eds.), *Supporting parents of teenagers: A handbook for professionals* (pp. 7-21). London: Jessica Kingsley Publishers.

Cregheur, L. A. (1992). *Sexuality, AIDS and decision-making: A study of Newfoundland youth*. St. John's: Author.

Crowley, M. (2001). Professional development in the parenting context. In J. Coleman & D. Roker (Eds.), *Supporting parents of teenagers: A handbook for professionals* (pp. 181-195). London: Jessica Kingsley Publishers.

DiCenso, A., Borthwick, V., Busca, C., Creatura, C., Holmes, J., Kalagian, W., & Partington, B. (2001). Completing the picture: Adolescents talk about what's missing in sexual health services. *Canadian Journal of Public Health*, *92*(1), 35-38.

Donnelly, B., & Davis-Berman, J. (1994). A review of the chance to grow project: A care project for pregnant and parenting adolescents. *Child and Adolescent Social Work Journal*, *11*(6), 493-506.

Donovan, C. (1998). *Community HIV prevention project – An exploration of the determinants of sexual behavior among youth at risk for heterosexual transmission of HIV*. Funded by the HIV/AIDS Prevention & Community Action Program under the National AIDS Strategy, Health Canada.

Federal/Provincial/Territorial Advisory Committee on Population Health. (2000). *The opportunity of adolescence: The health sector contribution.* Ottawa: Author.

Fisher, W., Boroditsky, R., & Bridges, M. (1999). The 1998 Canadian contraception study. *Canadian Journal of Human Sexuality, 8*(3), 161-227.

Franklin, C., Grant, D., Corcoran, J., O'Dell Miller, P., & Bultman, L. (1997). Effectiveness of prevention programs for adolescent pregnancy: A meta-analysis. *Journal of Marriage and the Family*, *59*, 551-567.

Furby, L. & Beyth-Marom, R. (1992). Risk-taking in adolescence: A decision-making perspective. *Developmental Review*, *12*, 1-44.

Hadley, A. (1999). Improving teenage sexual health. *Primary Health Care*, *9*(6), 6-11.

Health Canada. (1999). *Report from consultations on a framework for sexual and reproductive health.* Ottawa: Author.

Health Canada. (2003). *Canadian guidelines for sexual health education*. Community Acquired Infections Division, Centre for Infectious Disease Prevention and Control. Ottawa: Author.

Hockenberry, M., Wilson, D., Winkelstein, M., & Kline, N. (2003). Wong's nursing care of infants and children (7th ed.). Toronto: Mosby.

Hoskins, R., Donovan, C., Merhi, S., Pascual-Salcedo, M., Cockcroft., & Andersson, N. (2000). Dialogue with youth about risk and resilience. St. John's: Author.

King, A., Beazley, R., Warren, W., Hankins, C., Robertson, A., & Radford, J. (1989). *Canada youth & AIDS study*. Kingston: Queen's University.

Langille, D. (2000). *Adolescent sexual health services and education: Options for Nova Scotia*. Policy Discussion Series Paper No. 8. Halifax: Maritime Centre of Excellence for Women's Health.

Langille, D., & Curtis, L. (2002). Factors associated with sexual intercourse before age 15 among female adolescents in Nova Scotia. *Canadian Journal of Human Sexuality*, *11*(2), 91-99.

Langille, D., Graham, K., Marshall, E., Blake, M., Chitty, C., & Doncaster-Scott, H. (2000). Developing an understanding from young women's experiences in obtaining sexual health services and education in a Nova Scotia community. *Centres of Excellence For Women's Health Research Bulletin*, *1*(1), 20-21.

Langille, D., Hughes, J., Tomblin-Murphy, G., & Rigby, J. (2002). Contraception among young women attending high school in rural Nova Scotia. *Canadian Journal of Public Health*, *93*(6), 461-464.

Langille, D. B., Langille, D. J., Beazley, R., & Doncaster, H. (1996). *Amherst parents' attitudes towards school-based sexual health education*. Halifax, Nova Scotia: Dalhousie University.

Mackie, J. & Oickle, P. (1997). School-based health promotion: The physician as advocate. *Canadian Medical Association Journal*, *156*, 1301-1308.

McKay, A., & Pietrusiak, M. (1998). Parents' opinions and attitudes towards sexuality education in the schools. *Canadian Journal of Human Sexuality*, *7*(2), 139-145.

McKay, A., Pietrusiak, M., & Holowaty, P. (1997). Sexual health education: A study of adolescents' opinions, self-perceived needs, and current and preferred sources of information. *Canadian Journal of Human Sexuality*, *6*(1), 29-38.

Milburn, K. (1995). A critical review of peer education with young people with special reference to sexual health. *Health Education Research*, *10*, 407-420.

Moore, S., & Rosenthal, D. (1998). Adolescent sexual behaviour. In J. Coleman & D. Roker (Eds.), *Teenage sexuality: Health, risk and education* (pp. 35-57). Canada: Overseas Publishers Association.

Newfoundland and Labrador Centre for Health Information. (2003). *Live birth trends*. St. John's: Author.

Olatunhosum, O. (2001). Teenage pregnancy. *Journal of Society of Obstetrics and Gynaecology*, *23*(3), 205-206.

Porter, C. (2002). Female "tweens" and sexual development. *Journal of Pediatric Nursing, 17*(6), 402-406.

Ratnam, S. (1994). *The Newfoundland and Labrador prenatal study of HIV seroprevalence*. Final Report to National Health and Research Development Program. St. John's: Author.

Roker, D., & Richardson, H. (2001). Schools as a context for working with parents. In J. Coleman & D. Roker (Eds.), *Supporting parents of teenagers: A handbook for professionals* (pp. 163-179). London: Jessica Kingsley Publishers.

Short, M., & Rosenthal, S. (2003). Helping teenaged girls make wise sexual decisions. *Contemporary OB/GYN*, *48*(5), 84-95.

Statistics Canada. (2003). Health Indicators, 2003(2). Retrieved February 15, 2004 from http://www.statcan.ca/english/freepub/82-221-X1E/01103/tables/html/411.htm

The Kaiser Family Foundation. (2002). *Gender roles: A series of national surveys of teens about sex.* Sex Smarts, publication #3309. Menlo Park, California: Author.

The Kaiser Family Foundation. (2003). *National survey of adolescents and young adults: Sexual health knowledge, attitudes and experiences*. Menlo Park, California: Author.

Thomas, B., DiCenso, A., & Griffith, L. (1998). Adolescent sexual behavior: Results from an Ontario sample. Part 11: Adolescent use of protection. *Canadian Journal of Public Health*, *89*, 94-97.

Thomson, R., & Holland, J. (1998). Sexual relationships, negotiation and decision-making. In J. Coleman & D. Roker (Eds.), *Teenage sexuality: Health, risk and educat*ion (pp. 59-79). Canada: Overseas Publishers Association.

Trad, P. (1993). The ability of adolescents to predict future outcomes. Part 1: Assessing predictive abilities. *Adolescence*, *28*, 533-555.

Weaver, A., Byers, E., Sears, H., Cohen, J., & Randall, H. (2002). Sexual health education at school and at home: Attitudes and experiences of New Brunswick parents. *Canadian Journal of Human Sexuality*, *11*(1), 19-31.

Wellings, K., Wadsworth, J., Johnson, A. M., Field, J., Whitaker, L., & Field, B. (1995). Provision of sex education and early sexual experience: The relation examined. *British Medical Journal*, *311*, 417-420.

Westera, D., & Bennett, L. (1990). *Project teen Newfoundland: A comprehensive survey of 15-19 year olds*. St. John's: Author.