APPENDIX A

Literature Review

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INTRODUCTION

The issue of teen pregnancy as a health concern is an important one. Teen pregnancy reaches all people in Canadian society, whether directly or indirectly; it affects teenage girls, teenage boys, their families and their communities. Statistics Canada reports that the rate of teen pregnancy in Canada for youth between ages 15 to 19 is 49 per 1,000 (Wadhera, 1997). Studies have found that young women aged 18 and 19 years are at the most at risk. In comparison, rates of teen pregnancy in Sweden, Netherlands, Italy, Spain, France and Finland are all under 10 per 1,000 (Social Exclusion Unit, 1999).

This literature review will examine the issue of teen pregnancy in Canada, particularly *teen pregnancy prevention programs*, with the intention of determining the practices and programs that are the most (and least) effective, using a framework that incorporates determinants of health. It will highlight some of the gaps that exist within the literature and it will indicate missing elements in existing programs. Through a synthesis of the literature, this review will examine the role of education, community-based programs, organizational interventions and the role of youth themselves as agents of change, in the larger framework of the prevention of teen pregnancy.

This study was inspired by a number of concerns: Why are teenagers becoming pregnant? What characteristics do they have in common? Are some teens more likely to become pregnant than others? Why are some teens choosing to have a second, or third child? What can we learn from their experiences, skills and decisions? This literature review will look at the answers to some of these questions, and in doing so, it acknowledges the complexity of the issue while placing the health and well-being of young women and men (parenting or non-parenting) as central to the discussion.

This literature review contains four sections. It will:

- Contextualize the issue of teen pregnancy issues in Canada. It will highlight some vital statistics about the issue, and will demonstrate why embracing teen pregnancy as a priority is important. A 'determinants of health' approach and other related terms will be defined.

- Provide a background on teen pregnancy prevention, highlighting the findings of "The Canadian Girl Child" and "Forming a Canadian Coalition on the Prevention of Teenage Pregnancy," both of which were catalysts for this study.

- Synthesize existing information on teen pregnancy using a health determinants model from The Canadian Federal, Provincial and Territorial Advisory Committee on Population Health. This will include the following sub-sections: Social and Economic Environment, Physical Environment, Personal Health Practices, Individual Capacity and Coping Skills and Community Institutions.

- Discuss teen pregnancy reduction initiatives and programs, including Canadian and International ones, in terms of effective (and inconclusive) evaluation.

Rationale

This literature review is guided by a health determinants and health outcomes approach to ensure a holistic and comprehensive review of the complex interplay of factors. It relies on information gleaned from existing research and findings on teen pregnancy and teen pregnancy prevention. It begins with the belief that young women and men are autonomous individuals affected by layers of social structures and codes that have an effect on their decisions and ultimately, their health outcomes. The recognition that young women who are pregnant or parenting require adequate support and services underlies the entire process.

It is important to acknowledge the complexity of the issue of teen pregnancy. The inclusion of both male and female experience is vital to the analysis. This literature review recognizes that teen pregnancy is directly tied to the different social expectations, ideals and behaviours that girls *and* boys are expected to follow. In addition, it is also vital to state that there is little information available about the experience of both on and off-reserve First Nations peoples. Similarly, there is little written about Inuit peoples and teen pregnancy. Thus, this paper reflects opinions and writings of predominantly non-Native perspectives. It is hoped that future evaluation and research will contain statistics and solutions, both by and for First Nations peoples.

TEENAGE PREGNANCY

The Issue

Research and literature on teen pregnancy demonstrate that when young women become pregnant, they must make difficult decisions that will affect their health and their future, and these decisions can play a role in determining their future health and well-being. Some young women who become pregnant decide to have an abortion; a decision that may emotionally affect them for very long time. Similarly, a significant number of teenagers choose to raise their babies. Others decide to put their children up for adoption, and others still, have decisions about their babies made for them. For all of these young women and their offspring, there are particular health risks, both short and long term. These health risks are heightened when there are inadequate services, insufficient support or systemic barriers that inhibit them from living a life that has the same educational and health opportunities as non-parenting teens.

Research has shown that the chance that a teen mother will live in poverty is alarmingly high, particularly for a young mother who is Aboriginal or Inuit, who lives in a rural area, has a disability, or who does not speak either of Canada's official languages. These young women, their babies, their partners, and their families deserve a meaningful discussion about health concerns, institutional barriers, and future prevention. We feel that Canadian society needs to make a firm commitment to prevent unintended pregnancies for those young girls and boys who soon will be teenagers. After all, teenage pregnancy can, in many cases, be prevented. Prevention measures open up opportunities for youth to make their choices about future plans.

An important part of this examination includes the experiences, perspectives, and actions of youth themselves. Along with looking at the health determinants of young mothers, we believe it is important to acknowledge that growing up male in Canadian society also contains pressures, expectations and demands that will have an effect on the lives of girls and their children.

The body of literature examined in this study suggests that young people have been burdened by conflicting messages in Canadian society. On the one hand, young women and men are surrounded by images and messages that use sex and sexuality to promote products and ideas, and on the other hand, they are encouraged to abstain from being sexual, whether that be because of religion, culture, age, ability, fear of social stigmatism, or the fear of contracting infection or disease. Negotiating these societal expectations is a difficult, and in some cases confusing, challenge during adolescent development years. Regardless of the reasons why young people might or might not be engaging in sexual behaviour, one thing is certain: many young people are sexually active (Planned Parenthood Nova Scotia, 1996a; MacKay et al, 1993; Childbirth by Choice Trust, 2000a). This translates into a heightened risk of teen pregnancy.

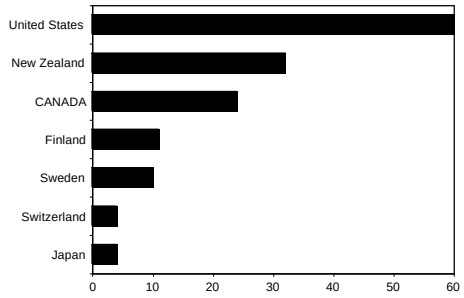
International Comparisons

While rates of teenage pregnancy in Canada are lower than in industrialized countries, such as New Zealand and the United States (Social Exclusion Unit, 1999), Canada's pregnancy rate is higher than most and has provoked genuine concern by researchers, policy makers, community

members and youth alike.

Norway, Denmark, Finland, Netherlands and Japan have been shown to have kept their rates consistently low (Singh and Darroch, 2000; Wadhera, 1991; Social Exclusion Unit, 1999). In the Netherlands, low rates have been attributed to "sex education, open discussions of human sexuality in the mass media, easier access to contraceptives, education programs and active participation of parents and teenagers in such programs" (Wadhera, 1997). Similarly, Sweden's success in reducing the rates of teen pregnancy can be credited to better sexuality education as well as the improved provision of contraceptives to adolescents (Singh and Darroch, 2000). Regardless of which country Canada's rates are compared to, it is reported that the rates are still high enough to warrant effective prevention strategies.

Live Births to Teenage Mothers, Ages 15-19 years
Selected Countries, 1995*

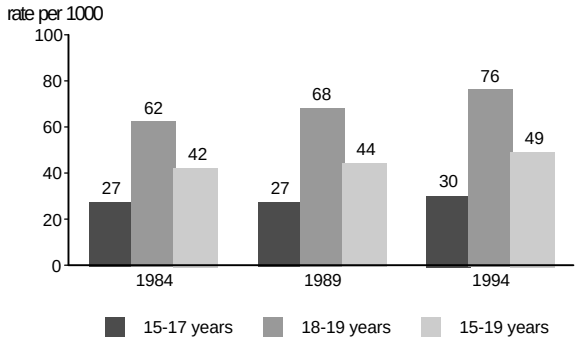


*Based on Progress of Nations Report, 1998 as cited by Laboratory Centre for Disease Control, Health Canada.

National Comparisons

Canadian research shows that over 45 000 young women aged 15-19 years become pregnant each year in Canada (Evans, 1998). This is echoed in the findings of P. Stewart, who presents a statistic that states that 47 000 young women became pregnant in 1994 (Stewart, 1998). According to Health Canada, the rates of teen pregnancy have risen over the last ten years, particularly within the 15 to 19 year old age group (Wadhera, 1997). The following chart, based on a chart from "The Health of Canada's Children: A CICH Profile" (Kidder, 2000) demonstrates the rate in 1994:

Rate of Pregnancies, by Age Group
Canada, 1984, 1989, 1994



Source: Wadhera, S. et al. (Statistics Canada). 1997. Teenage Pregnancies. *Health Reports*. Vol. 9 No. 3.

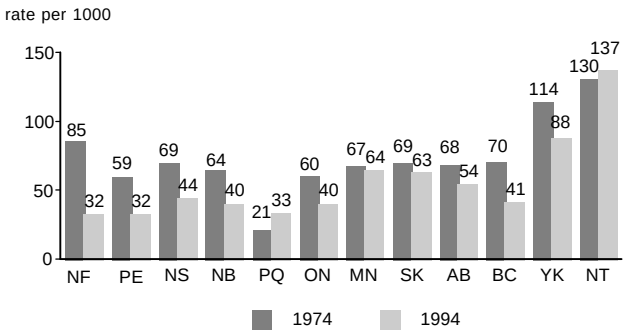
The rates of pregnancy in Aboriginal and Inuit communities are significantly higher. This is an area that desperately needs attention. Despite the fact that most Aboriginal and Inuit communities have substantially higher rates of teen pregnancy, documentation of these statistics is difficult to acquire. Health Canada states the following:

- "The rate in younger First Nations adolescent girls (under the age of 15) was especially high, particularly on reserve, where it was about 38 times higher than the general Canadian population (11.0 per 1000 live births versus 0.6, respectively)."

- "Data from the Atlantic provinces, the Prairies and British Columbia show 1997 teenage pregnancy rates in First Nations that were up to four times higher than the 1995 national rate" (Health Canada, A Diagnostic on the Health of First Nations and Inuit People in Canada, November 1999).

When the rates are divided by region instead of ethno-cultural background, it is possible to see differences across the country, as shown in the following chart from "The Health of Canada's Children: A CICH Profile" (Canadian Institute of Child Health, 2000):

Teenage Pregnancy Rate* Women Aged 15-19,
Provinces and Territories 1974 and 1994

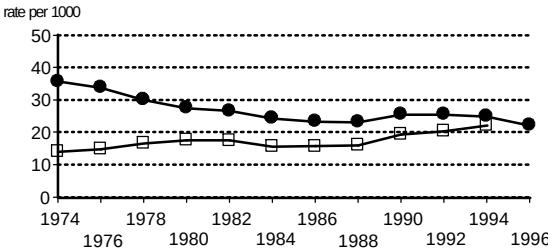


*total of live birth, abortion and miscarriage/stillbirth rate
Source: Wadhera, S. et al (Statistics Canada). 1997 Teenage Pregnancies. *Health Reports*. Vol.9 No.3.

- There were 16, 698 pregnant teenagers in Ontario in 1995, mostly between the ages of 15 and 19 years. These numbers have been increasing since the mid-1980s.
- In Québec, between 1980 and 1995, the pregnancy rate among adolescents under 18 years of age rose from 12.6 to 18.5 per 1000 (Gouvernment du Québec, 1998).
- In 1998, the rate of teen pregnancy in Nova Scotia was 39.9 per 1000 for youth aged 15 to 19 years (Planned Parenthood Nova Scotia, 12).
- Manitoba has one of the highest teen pregnancy rates in Canada: 64.4 pregnancies per 1000 girls aged 15 to 19 years (Paulsen, 1999).

As indicated above, the rate of teenage pregnancy has risen. The rate of teen pregnancy is said to be between 45 and 50 per 1000 (Health Canada, 1999a; Wadhera, 1997; Singh and Darroch, 2000, Hanvey as quoted in BC Alliance Newsletter, 1999b). One study found that younger teens who became pregnant had a significantly higher rate of abortion, most likely because it is common for older teens to be cohabitating or sexually active (Singh and Darroch, 2000). Rates of abortion are also said to be higher for middle and upper-class youth. However, while abortion rates have gone down, the birth rate has steadily increased. According to one study, the percentages of abortion declined by almost 55% (Singh and Darroch, 2000). The latest rates are shown in the following chart from "The Health of Canada's Children: A CICH Profile" (Kidder, 2000):

Teen Pregnancy Outcomes, Aged 15-19 Years
Canada 1974-1996



	1974	1976	1978	1980	1982	1984	1986	1988	1990	1992	1994	1996
Live births	36	34	30	27	27	24	23	23	25	25	25	22
Abortions	14	15	17	18	17	16	16	16	19	20	22	N/A

Source: Laboratory Centre for Disease Control. 1999.
Measuring Up: A Health Surveillance Update on Canadian Children and Youth.

Hidden in the statistics is a new phenomenon; while many young women have become pregnant unexpectedly, others have made the active *choice* to become pregnant, and some choose to become pregnant more than once (Best Start, 2000). Regardless of the reasons why teens are becoming pregnant, there is widespread concern that the rates of teen pregnancy are causing alarm both nationally, and internationally. There is considerable concern that unintended teen pregnancy needs to be tackled as an important health issue. For example, Health Canada states that the need to diminish rates of teen pregnancy is critical, especially considering that "teen parents often have lower lifetime earnings, and more social problems throughout life" (A Report from the Consultations, 1999).

Teenagers who experience pregnancy are not always destined to live life confounded by poverty or unhappiness. Using an approach that focuses on determinants of health, it is possible in this review to examine the similarities of teen parents who are achieving high rates of success, and those who are physically, emotionally, and economically healthy. This health determinants framework can also be applied to an understanding of those teens who are have not become pregnant, or who have postponed pregnancy.

How Will We Analyse the Issue?

As indicated, this literature review will examine and discuss research findings, articles, theories, and social policy related to the prevention of teen pregnancy. It will highlight some statistics, key findings, and recommendations to determine effective prevention strategies. It will be guided by a health determinants and health outcomes approach to ensure a holistic and comprehensive review of a complex interplay of factors.

Determinants of Health

This phrase refers to the large number of multi-layered and interplaying factors that participate in determining the health of an individual. A health determinants approach "specifies that determinants do not necessarily cause good or ill health, however, the absence of determinants can influence a person's chance of achieving healthy development" (Tipper, 1997). Using this approach, determinants refer to personal health practices, personal capacity and coping skills, the social, political, and economic and physical environment, the community institutions, as well as cultural and biological aspects of young women.

The economic, social, and political climate is constantly changing, and health determinants change with the evolving social and developmental context in the lives of youth.

The Canadian Federal, Provincial and Territorial Advisory Committee on Population Health divides determinants of health into five categories. These categories are useful to the understanding of determinants of health in relation to teen pregnancy. The categories used here are as follows:

> **1. Social and Economic Environment**: income, employment, social status, social support networks, education and social factors in the workplace.
> **2. Physical Environment**: aspects of the natural and human-built physical environment
> **3. Personal Health Practices**: behaviours that enhance or create risks to health
> **4. Individual Capacity and Coping Skills**: psychological, genetic and biological characteristics
> **5. Community Institutions**: schools, religious organizations, service organizations and services to promote, maintain and restore health.

These determinants can be used to specify the similarities of teens who have characteristics or life situations in common, or conversely, they can outline differences in those do not. This understanding of teen pregnancy through a health determinant lens will become an effective tool for evaluation. Since each individual's experience of physical and emotional development is unique, these categories provide links between health *determinants* and health *outcomes*.

Healthy Sexuality

Health sexuality will be referred to here as "a positive and life affirming part of being human. This includes knowledge of self; opportunities for healthy sexual development and sexual experience

[and] the capacity for intimacy" (Health Canada, 1999a). The concept of healthy sexuality acknowledges that emotional, physical, and spiritual health are cornerstones of successful sexual health. This not only includes the knowledge of birth control and risk behaviours, but ways to negotiate difficult decisions about intercourse, abstinence, sexuality and sexual activity. Healthy sexuality depends on both informed individual self-direction and mutually protective collaboration between individuals (Orton, 1994).

Methodology

A number of sources were used to inform this literature review. First, a search of the holdings at local university libraries in Ottawa was conducted to find resources relating specifically to teen pregnancy *prevention*. The search branched out into related topics such as rates of teen pregnancy, historical perspectives on teen pregnancy, pre- and post-natal programs aimed at teens, as well as current risk behaviours of Canada's youth. A similar search was conducted at the National Library of Canada in Ottawa. Through this search, a number of academic papers were found, as well as a select few examples of teenage pregnancy prevention programs.

Databases on CD ROM were also used to conduct a preliminary search, including Medline, Women's Resource International, Canadian Periodical Index, Sociological Abstracts 1985-1996, and Canadian News Disk. Specific keywords were used, most frequently in a Boolean search format, including: teen, pregnancy, sex, education, sexuality, contraception, and self-esteem. Although teenagers generally prefer to be called 'youth', when doing searches for topics on teen pregnancy, the term 'teen' or 'teenager' was used.

A vast amount of information was found through an Internet search. Sites such as *Planned Parenthood of Canada*, *Best Start*, *Canadian Health Network*, the *Program Archive on Sexuality Health and Adolescence* (PASHA) and the *Sex Information and Education Council of Canada* (SIECCAN/SIECUS) include website links with vital information about organizations and prevention programs. Similarly, the Alan Guttmacher website proved to be particularly helpful, because it has current and relevant journal articles (unavailable at local public libraries) that can be downloaded from the Internet. They include *The Guttmacher Report on Public Policy*, *Family Planning Perspectives* and *International Family Planning Perspectives*. The Internet made it possible to access smaller sites and programs from the United States, as well as larger databases including ReCapp (Resource Centre for Adolescent Pregnancy Prevention).

Initially, in order to be considered for this examination, the literature was to be published between the years 1990 to 2000. However, it became clear that literature from the 1980s (and in some cases the 1970s) holds relevance. Particularly, Singh/Darroch, Fisher, and Wadhera provide an historical perspective as well as a theoretical base at which to begin. Finally, a number of key informants were contacted. Many individuals sent copies of material they were working on, journals they had come across, or documents that they thought would be helpful. Each document ultimately steered the research towards another lead.

An effort was made to include a diverse representation of topics and perspectives relating to teen pregnancy. Research on Aboriginal youth, youth with entho-cultural diversity, youth with disabilities, and non-urban youth were part of the search process, although little Canadian research has been done in these areas in terms of teen pregnancy prevention programs. Occasionally, perspectives from these reference points were found, but they were mostly from American sources. Notably, initial searches turned up many documents and data that focused on teens who were already pregnant, but these documents did not address the *prevention* of teen pregnancy. Overall, nearly 100 documents have been reviewed in this analysis. They range from theoretical academic papers to examples of posters used in programs to spread the word about the prevention of teen pregnancy, to youth-led initiatives in the education system. They provide this literature review with a more comprehensive understanding of teen pregnancy prevention in Canada today.

BACKGROUND

Historically, for the majority of Canadian society, prevention of teen pregnancy has been an ethical issue, one that has been framed in terms of morality. Teen pregnancy was considered a taboo topic, not always appropriate for open, public discussion; it was generally considered the fault of a young woman, a result of promiscuity, and she was to suffer the consequences. This often included shame and embarrassment directed towards herself, her family, and her community (Petrie, 1998). As Anne Petrie describes in her historical account of young (and unmarried) women who became pregnant in the 1950s and 60s, unwed mothers in Canada were sent away to special 'homes' run by Catholic nuns. The shame was so great that they were hidden from society, and often from their community, while they prepared to give birth (Petrie, 1998).

At an international conference in 1968, the United Nations established access to sexual and reproductive information and services as a human right (Planned Parenthood Nova Scotia, 1996b). The next year, women in Canada saw a shift in social policy which would directly affect their reproductive rights. An amendment to the Canadian Criminal Code made the use of contraceptives legal and allowed abortion under specific conditions. For the first time, it was legally possible to control pregnancy using legally sanctioned 'medication'. As Maureen Orton asserts, this amendment reflected the beginning of a conceptual shift in the definition of pregnancy as a deviant behaviour[1] (having sexual intercourse and becoming pregnant in general) to a problematic consequence of sexual behaviour related to inadequate conditions[2] (having sexual intercourse without choosing birth control).

Presently, birth control (in many forms)is used by adults and youth alike. While not all members of society condone the use of contraceptives, they are nonetheless used extensively in Canadian society. In the last twenty years, there has been a rise in the rate of contraceptive use, as well as awareness, as a direct result of the HIV/AIDS epidemic (Evans, 1998). Girls particularly, are becoming sexually active more frequently, and at a younger age. (McKay, Best Start, 2000; Hanvey in BC Alliance Newsletter, 1999b).

Sex, Birth Control and the Young Girl

The ways in which girls experience sexual activity and their sexuality may be related to other socially constructed gendered behaviour, such as the expectation to be 'nice', 'sweet', or non-aggressive (Tipper, 1997; Dubinsky, 1993). Through a number of outlets (such as media, peer pressure and social expectations), many girls look for love, affection, and attention and feel that they can find them through intimacy with members of the opposite sex. Some girls may be struggling with their sexuality and in trying to 'fit in' may participate in heteronormative

[1] As Orton states, this would include 'immoral sexuality outside of marriage and immoral birth control even within marriage'

[2] For example, a "lack of universal access to effective preventive resources."

behaviour. In some cases, they may date boys, or appear to like boys to seem 'normal'. Girls often achieve status through having a boyfriend; having an older boyfriend often translates into higher status. However, when girls are going out with older partners, there is even more pressure to become sexually active (Youth Consultations, 2000).

Boys, too, must make difficult decisions about sexual risk behaviour. In mainstream society there is pressure for many boys to adhere to social expectations. Boys are expected to want to date girls; value is placed on aggressive behaviour and those who do not conform to these expectations may feel ostracized. It is often assumed that all young men are sexually active (or want to be), especially considering the negative value often placed on virginity by peers. However, there is little research done specifically on growing up male in Canada, particularly in relation to healthy sexuality.

As indicated by Jennifer Tipper in *The Canadian Girl Child*, there are many unwritten dating rules that girls must follow. While it is deemed important to have a boyfriend, having too much sexual activity, or having sex with more than the appropriate number of boys (even if they were at one time a boyfriend) can affect a girls life negatively (Tipper, 1997). They may be ridiculed, stigmatized or ostracized. Girls must negotiate the fine line between being sexually active enough that they will fit it, but not so much that they will be labeled 'easy' or promiscuous.

That is not to say that all girls are following these unwritten rules, nor is it intended to suggest that these 'rules' apply to all sectors of society. Certainly cultural upbringing and geographical locations will affect societal expectations in relation to sexual activity and gendered expectations. We posit that many girls and young women are challenging social norms. Others have a strong religious or cultural upbringing that does not accept dating before marriage as an option, let alone sexual behaviour (Bashir, 1997). Other girls choose to be intimate with other girls. Furthermore, that is not to suggest that all girls are interested in dating, or are sexually active. Many choose to abstain from dating and sex altogether.

That most young girls experience more pressure to have sex, coupled with the recent statistics which say that girls are more sexually active at younger ages than they were even fifteen years ago, demonstrates a need to embrace teen pregnancy as an important issue to examine.

A Place to Begin

The Canadian Girl Child: *Determinants of the Health and Well-being of Girls and Young Women* and three preliminary studies in *Forming a Canadian Coalition on the Prevention of Teen Pregnancy: Three Background Papers* provide a point of departure for this literature review.

The Canadian Girl Child

Through a detailed and comprehensive examination of the existing literature, Jennifer Tipper acknowledges the lack of research done on health determinants of growing up female in Canada. Tipper highlights some of the unique challenges girls face, and develops a framework for analysing gender and health determinants with healthy development. She asserts that there has been a significant amount of literature and research conducted on child development, but notes that gender is rarely taken into account. When research does exist, Tipper found that it generally

focuses on 'deviant' or 'problem' behaviours (1997). Sexual activity, and by extension teenage pregnancy, is considered one of these deviant behaviours. We believe her research strengthens the call for more frequent and more effective action to be taken towards healthy sexuality in the lives of young women.

Tipper's findings also reveal that a number of young women are missing from the discussion of healthy development, "including lesbian women, young women with disabilities, young women of colour, young women who are happy and high achieving, young women who are homeless and living in poverty and young women who are meeting the everyday challenges of growing up a girl in predominantly patriarchal society" (Tipper, 1998). This is consistent with literature surrounding teen pregnancy; very few articles mentioned any from the list above.

Forming a Canadian Coalition on the Prevention of Teen Pregnancy: Three Background Papers

In the report, *Forming a Canadian Coalition on the Prevention of Teen Pregnancy: Three Background Papers*, three preliminary studies show the importance of a) looking at teen pregnancy as a timely and important issue b) the effectiveness of prevention programs and c) the significance of coalition building to come together effectively making a difference in lowering the rates of teen pregnancy.

The first article, "Population Health Approach to the Prevention of Teenage Pregnancy: Research Evidence for Action" (Stewart and Associates), asserts that the rate of teen pregnancy is rising, particularly with youth between the ages 15 and 19 years (1998). Stewart stresses that many factors influence the rates of teen pregnancy, and that researchers need to take an approach that incorporates healthy sexual development with a range of strategies.

The article highlights some of the social and economic factors that are associated with teen pregnancy including power, power distribution in society, boys and girls as constructed beings, and the dominant culture as materialistic, self-centred, hedonistic, competitive and violent (1998).

Stewart argues that a focus needs to be put on the 'resiliency' of teens who have coped with, (and often overcome), challenging social expectations and issues.

The second article, "Evidence About What Works to Prevent Teenage Pregnancy," by Wright and Associates highlights some prevention programs that have been proven to be effective. Her findings are discussed in more detail further on in this review.

The third article, "Strategies for Building an Effective Coalition for the Prevention of Teenage Pregnancy," by Davis and Flett highlights identify some of the 'best practices' that are vital to the development of successful coalitions. Through personal interviews and a library/internet search, they show the effectiveness of coalitions in involving community involvement, and examining health issues. They define a number of different types of coalitions, and specify some important collaborations in relation to healthy sexuality/teen pregnancy. The purpose of their paper is to

demonstrate stages in coalitions, acknowledge some challenges and highlight successes that can be followed to build successful coalitions to effect change. Their findings can be used towards creating a coalition to prevent teen pregnancy.

These three background papers lay a foundation to better discuss the prevention of teen pregnancy. Together, with Tipper's findings in *The Canadian Girl Child*, these articles complement each other and provide a solid base at which to begin an analysis of teenage pregnancy prevention programs in Canada.

HEALTH DETERMINANTS OF PREGNANT TEENAGERS

With the high rates and substantial numbers of teenage pregnancies in Canada, particularly in First Nations and Inuit communities, we feel that it is important to create an understanding of who these youth are, identify who is most at risk, and to strategize about effective prevention and reduction of rates. This understanding will be accomplished by using the determinants of health model by the Canadian Federal, Provincial and Territorial Advisory Committee on Population Health as previously indicated.

Categorically defining the characteristics of young women who become pregnant is a difficult, if not impossible, task. Research demonstrates that young women who become pregnant come from many diverse backgrounds. It cannot be assumed that there is one specific formula that will predict or determine who will become pregnant. However, when looking at health determinants of young women who have become pregnant (an intended or unintended pregnancy), there are some notable similarities in their experiences. For example, young women who live in poverty, and those who live on the street are at a higher risk of becoming teen mothers (BC Alliance Newsletter, 1999). Aboriginal youth are disproportionately at risk (Health Canada, 2000). Outcomes may be influenced by factors such as marital status, age, education, employment status, religious beliefs, sexual behaviour and practices, knowledge and use of contraception, the availability and accessibility of family planning and related health care facilities (Wadhera, 1991). There are a large range of factors that might influence increased sexual behaviour, or rates of wanted or unintended pregnancies.

Social and Economic Environment as a Health Determinant

The reason(s) why teenagers are getting pregnant or giving birth more frequently are difficult to categorize. Together, the body of literature examined here reports that the rise in rates are attributed to the fact that more teenagers are sexually active, that teens are using less contraception, or that there is an individual desire to become pregnant. Poverty, school achievement, and self esteem are all factors that have been said to play a role (Stewart, 1998). Although there are no easy answers, there have been studies that have attempted to pinpoint exact reasons why more teens are becoming pregnant.

The factors that researchers cite as the reasons why teens are becoming pregnant have changed. In a study conducted in 1976, three factors were attributed to early pregnancy. The first was finding out that the mother was an inadequate role model. The second was that there was a seductive father-daughter relationship that excluded the mother. The third was that there was a distancing in the parents marriage, ‘as opposed to either an affectional or overtly poor relationship.’ (Thomas, 1990). The same study also decided that the root of the problem was low self-esteem of the young girl, or ineffectual or unemployed fathers. Serious mental health problems were also cited as being part of the problem. This 1976 study proved that delinquent behaviour increased the possibility of getting pregnant by 20 times when compared with what they call ‘normal females’.

Newer research has illuminated a number of different reasons, and generally cites socio-economic status as a concern. Research illustrates that the lack of opportunity and socioeconomic disadvantage significantly contribute to teenage childbearing (Singh and Darroch, 2000).

Poverty

One of the most widely cited associations of teen pregnancy is living in poverty. Teens living in poverty are more likely to become pregnant than those who do not, and furthermore, teen parents often have lower lifetime earnings, as well as more social problems throughout life. (Health Canada, 1999a; Planned Parenthood Nova Scotia, 1996b; Singh and Darroch, 2000; Gouvernement du Québec, 1998; Evans, 1998; Picard, 1998; Stewart, 1998; BC Talk Force, 1999).

Highlights from the research:

- Teen pregnancy is almost five times more common in the lowest compared to the highest income neighbourhoods (Health Canada, 1999a; Stewart, 1998).

- It's estimated that 50% of all pregnancies are unintended. The poorer the woman, the more likely the pregnancy was unintended (Childbirth by Choice Trust, 2000b).

- In a study conducted in Sudbury, Ontario, almost one quarter of the teens who participated in a teen prenatal study lived on a total income less than $10,000 (Picard, 1998).

This indicates the association between poverty , the likelihood of teen pregnancy and the economic status of many parenting teens. There are also findings to suggest that whether or not a young women comes from a life of poverty, a disproportionate number of young single mothers will live in poverty when her child is born. Despite the fact that the numbers may vary, depending on the source, research cites similar findings:

- In Canada, 60% of single mothers and their children live in poverty (Evans, 1998).

- In Canada, 81% of single mothers aged 18 to 24 have incomes below the poverty line (Planned Parenthood Nova Scotia, 21).

- 62% of single mothers 18 years old and under, in Canada, live below the poverty line (BC Task Force, 11)

Research suggests that young women who come from higher income families are more likely to consistently use contraception and if they do get pregnant, they are less likely to carry the baby to term; one source states that these young women are more likely to have an abortion, particularly because motherhood is incompatible with their plans for a future of a job and a planned family life (Gouvernement du Québec, 1998).

Physical Environment as a Health Determinant

There is little written about the relationship between youth's environment (both natural and

human built) and teen pregnancy. One study suggests that in many cases, the number of teen pregnancies is the highest in the northern (rural) regions and disadvantaged urban communities. (Gouvernement du Québec, 1998). Teen mothers often feel social isolation, discrimination, a lack of support systems and many have a high tendency to experience crisis (Planned Parenthood Nova Scotia, 1996b).

There are some conspicuous gaps in the scope of the research. For instance, as Evans emphasizes, "there have been no studies that have included the Canadian North. There should be some serious consideration into providing funds and conducting research in this unique region of Canada. The Yukon and the NWT have the highest teen pregnancy rates and greatest rates of chlamydia in Canada" (Evans, 1998). Similar gaps exist in information for young people with disabilities, young women of colour and people from non-North American cultural backgrounds. This area needs special attention since those who live on a reserve face greater rates of poverty, and have access to fewer services.

Personal Health Practices as a Health Determinant

Although it is difficult to prove that certain behaviours make teens more likely to become pregnant, literature below has suggested that there is a relationship between risk behaviours (such as drinking, smoking, and an early age of one's first sexual experience) and the likelihood of becoming pregnant.

In the BC Alliance Newsletter, one writer presented the opinion that it is "those who are least well-prepared to nurture and raise a child who are most likely to become parents"[3]. The examples given for those most likely to be teen parents are those who have substance abuse problems, those who do not do well in school, those who have low aspirations, and those who live in disadvantaged families (BC Alliance, Fall 1999).

The literature suggests that there is a correlation between young people who are substance users (or abusers) and **smokers**, with those who become pregnant. King et al. state that 23 percent of Grade 10 girls are daily smokers, a concern which they state is a serious health problem (King et al, 1999). For instance, Health Canada reports that in one program surrounding teen pregnancy, 64% of participants were smokers (King et al, 1999). In the LEAP (Lifestyle, Education for Adolescent Parents) Program in New Brunswick, it was found that a significant number of participants were smokers (Simpson, 1999). Furthermore, before they knew they were pregnant, 90% of the pregnant teens had regularly smoked in a prenatal study in Sudbury, Ontario (Picard, 1998).

The **age** at which young people have sexual intercourse has also been linked to the likelihood of becoming pregnant. The age at which youth are having sex for the first time is said to be getting younger. For example, in 1976, 8% of 15 year old young women had had 'coitus' (Wadhera, 1997). By 1996, Canada's Population Health Survey found that half of young people aged 15-19

[3] BC Alliance Newsletter, Fall 1999, p. 23.

had had sexual intercourse (Hanvey in BC Alliance Newsletter, 1999b). In Nova Scotia, in 1997, 60% of youth surveyed had experienced sexual intercourse by the age of 16 (Planned Parenthood Nova Scotia, 1996a).

A number of factors have been cited as increasing the likelihood of having early intercourse, and thus, these sections of the population are at higher risk of becoming teen parents. In one Ontario study, it was determined that 70% of street youth in Kingston had intercourse before the age of 15 (Planned Parenthood Nova Scotia, 1996b). In the same report, these youth were also described to be at higher risk of sexually transmitted infections, because a high percentage of them reported having more than one partner (Planned Parenthood Nova Scotia, 1996b). Other variables associated with a higher incidence of sexual intercourse, as cited by the Nova Scotia Planned Parenthood Technical Report, are: "living independently, less agreeable relationships with parents, behaviour less regulated by parents, geographic family mobility, more social activity, friends with both genders, and a higher incidence of other high risk behaviours (eg. drinking, smoking, drugs)" (1996b).

Conversely, it has been suggested that there are some factors that seem to 'protect' against adolescent pregnancy. These factors have been described as religious practice and educational ambition (Miller, 1995).

The body of literature did not state that participating in any of the risk behaviours would certainly mean that a teenage pregnancy would definitely occur. However, coupled with other risk behaviours, or with the lack of many healthy determinants, these behaviours increase the likelihood of becoming pregnant at a young age.

Individual Capacity and Coping Skills as a Health Determinant

Some teen pregnancies are a result of a lack of proper (or effective) sex education. There is a concern that teen pregnancy has not been examined within the context of a society that does not provide adequate social services, in relation to information and/or contraception. Other young people are *choosing* to have children, sometimes because of a lack of future orientation, the need for attention/affection, a negative outlook towards the future or because they simply have carefully considered it and decide to do so. Teen pregnancy, then, becomes an example of one of many social inequities that need to benefit from effective prevention strategies (Orton, 2000).

Many Teen Pregnancies End in Abortion

A significant portion of the literature reports that in many cases, a teenage pregnancy is an unintended one. As one author states, "45% of the women [in one study] chose to have an abortion" (Stewart, 1998). In the Region of Ottawa/Carleton, Ontario, 62.5% of pregnancies ended in abortion in 1995 (Stewart, 1999). Statistics Canada observes that the total number of reported abortions performed in 1995 was 108,248, as compared to a total of 114,848 abortions performed in 1997(Statistics Canada, 2000). Of these reported numbers, 20,275 abortions were performed in 1995 for young women between the ages of 15 and 19 years, and 21, 204 abortions were performed in 1997 for the same group (Canadian Institute for Health Information, 2000).

Some Girls are Parents by Choice

It has been discovered that many young parents are consciously deciding to become pregnant, to carry their baby to term and to raise their child. It has become apparent that over time, nonmarital childbearing has become more acceptable, for both adolescents and young women older than twenty (Singh and Darroch, 2000). There are a number of theories as to why some young people are *choosing* to have babies:

- Those who have less formal education may feel that having a baby is more gratifying choice than looking for employment; an area where they may not feel like they have the same opportunities (Stewart, 1998; Thomas, 1990).

- Teens with a strong sense of future orientation, who have concrete goals are statistically less likely to become pregnant. Similarly, young people who do well in school, are active in the community and have a strong sense of self are also less likely to become pregnant (Stewart, 1998).

- The Brighter Futures for Healthy Children in Ottawa have compiled a list of 24 reasons why many young women are becoming pregnant (Brighter Futures, 2000). Some include: pressures to be an adult, they equate fathering to "being a man" or equate mothering to "being a woman", giving birth is equated to an achievement, having a lot of idle time and cultural pressures.

Often, young women who become parents are presented as young people whose futures are jeopardized. However, for many young parents, a new child has changed their life in a positive way. In many cases, having a child gives young parents a reason to prepare for the future. In a focus group conducted in Ottawa, 2000, we found that young parents felt that the responsibility of having a child could be scary but also noted that the challenge of raising a child can be a catalyst for change (in their words: "to better oneself").

The idea of a baby as a catalyst for change has been exemplified by a number of young parents who attend schools designed specifically for parenting teens. In many urban centres across the country, programs are in place that support young women who are pregnant and/or parenting. For these youth, these services have provided them with a sense of hope for the future, and have

given them important skills necessary to achieve success. As one young parent states: "for my child, I have stopped taking drugs. I went back to school. It has given me the desire to live again" (Youth Consultations 2000). As we found in youth consultations for this report, parenting teens say they know how to be good parents, be responsible and recognize that having a baby is a focus and motivation for positive change (Youth Consultations, 2000).

Sometimes, young mothers become pregnant more than once. There is a definite gap in the research about the reasons for, and consequences of, having a second or third child as a teenager. Some researchers see additional babies (after one has already been born) as the result of a lack in future planning (Gillmore, 1997). However, it has been suggested that young women who decide to have multiple children do not have concrete plans for the future, in terms of their personal career, or education. The government of Québec addresses this concern head-on: "Indeed, it is known that if adolescent women do not become committed to a life plan, such as continuing their schooling, or getting a job, the risk of finding themselves pregnant once again is higher. Perhaps they believe that by doing so they are escaping from their emotional isolation and financial problems" (Gouvernement du Québec, 1998).

Another factor for having more than one child at a young age might be due to the lack of understanding about the possibility of becoming pregnant again. In a study of young teenage mothers who gave birth at the Ottawa General Hospital, one third of the young mothers did not receive information about the need for contraception during the postpartum period (Lena et al, 1993). If these young mothers had not received information, they may not have known that it is possible to become pregnant even while breast feeding.

Furthermore, in some cultures, having many children at a young age is acceptable and in some cases encouraged. This is an area of research that needs to be explored.

No matter why youth are deciding to become parents, they need effective services and understanding to support their choices.

Community Institutions as a Health Determinant

Unintended pregnancies are often said to be a result of a lack of accurate contraceptive knowledge and lack of accessible contraception (Thomas, 1990; Manitoba Association of School Trustees, 2000). Sex education is believed to be the most important medium for youth to learn about decision-making and contraceptive choices and one of the largest community institutions for learning about healthy sexuality (MacKay, 1993; SIECCAN, 2000). What, then, is the role of sex education? How effective is it?

Historical Context

Sex education in mainstream Canada has gone through a number of stages. It began as a result of a number social, political and economic factors. For instance, in Ontario, prompted by the belief that 'sex delinquency' was rising, there was a shift towards school-based sex education during the late 1940s. Many members of society felt that sexual delinquency– which included

homosexuality, sex crimes, promiscuity, venereal disease and marriage breakdowns (Sethna, 1995)– was destroying the moral fabric of society. Specifically, venereal disease was seen as the greatest threat[4] to a Canadian society that aspired to keep its white, patriarchal, 'nuclear' families intact. Thus, sex education provided a space where children would be given 'accurate' and persuasive information about the 'dangers' of sexual activity, promiscuity and homosexuality (Dilworth, 1999). Health education started out as a means to concentrate on the development of personality and personal appearance (Sethna, 300).

Over the years, health education (and subsequently, sex education) has changed dramatically. In 1969 when the amendment to the Canadian Criminal Code made it legal to sell, disseminate and distribute contraceptives, and information about them, health education (where it has existed) has often focused on abstaining from sexual behaviour.

In the last ten years, there has been an increased importance placed on school-based sex education. This includes greater public support for including sex education in the school system (Langille, 1999). One influencing factor in the greater public support for sex education is likely a result of an attempt to counter the HIV/AIDS epidemic (Singh and Darroch, 2000; Wadhera, 15). The information and advice surrounding sexual risk behaviour given out to battle HIV/AIDS has ultimately provided young people with more information about the importance of sexual health and the prevention of teen pregnancy, sexually transmitted infections and HIV/AIDS.

Why the school system?

It has been suggested in the literature that the public school system is a logical venue to provide young people with information. Schools provide a large audience who have the responsibility of attending every day. Often people who teach in the school system work closely with youth, and can often see first-hand some of the realities that they face (Frost et al, 1995). Public and private schools have resources and capabilities to document the need to change curricula to reflect the changing realities of the students. In the classroom, if teachers observe that a large percentage of youth know how to prevent pregnancy, but see that they don't know how to actually *use* the contraceptive they are learning about, the teachers can adjust the curriculum accordingly. Whether or not this happens in all classrooms is impossible to determine. However, the possibility is there.

Research suggests that students are a captive audience for specific interventions and can usually be re-interviewed, or retested to be able to determine the effectiveness of the initiative (Frost et al, 1995). Students themselves have expressed that they prefer to get sexual health information from schools. In a study done in 1997 by McKay and Holowary, adolescents rated their school as their preferred source of sexual health information, from six possible sources in total (Evans, 1998). However, one of the concerns apparent throughout the literature is that the school system does not always reach some of the individuals who are at the highest risk: those who might be skipping

[4] See Joan Jacobs Brumberg, "Learning to Menstruate the American way 1850-1950," Jay Cassel, "Making Canada Safe for Sex: Government and the Problem of Sexually Transmitted Diseases in the Twentieth Century," and Christabelle Sethna's The Facts of Life: The Sex Instruction of Ontario Public School Children, 1900- 1950.

school, youth living on the street who have finished school, or those who are not presently attending school. Youth who live on reserves also may not be able to access this information.

Opponents of School-based Sex Education

Although there has been a move towards more frequent and better sex education in schools, there is still some opposition. Opponents of school-based sex education in mainstream society argue that talking about sex and sexuality either encourages youth to participate in sexual activity, or that it promotes or encourages young people to participate in sexual intercourse, or worse, that it gives them permission. These arguments are not uncommon. However, there is evidence to suggest that talking about sex does not promote, or encourage sexual activity, nor does is increase the rates of sexual activity.

- Research conducted by Planned Parenthood Federation shows that balanced programs that discuss abstinence and contraception do not increase sexual activity among teens (Hanvey in BC Alliance 1999b; Miller, 1995).
- Planned Parenthood Nova Scotia cites similar findings: "there is widespread, global belief that talking about sexuality with adolescents will 'unleash' sexual behaviour. There are neither studies nor evidence to back this fear" (Planned Parenthood Nova Scotia, 1996b).
- The same Planned Parenthood report cites a World Health Organization study which reviewed thirty-five relevant studies and found no evidence that sex education leads to earlier or increased sexual activity.
- According to the Timiskaming Health Unit in the Durham Region Health Department, it is a myth that "Education about sex arouses curiosity and leads to experimentation... In fact, research studes show that sexual health education does not lead to earlier or more frequent sexual activity" (Timiskaming Health Unit, 2000).

Other opponents state that parents do not want sex education in schools. However, studies have shown that Canadian parents do want sexual health education in schools. For example, an initiative in a non-urban community in Nova Scotia found that 100% of parents who were polled stated that adolescent pregnancy and STIs among adolescents are important problems that need to be addressed (Langille, 1999). In 1996, 85% of parents who responded, agreed with the statement, "Sexual health education should be provided in the schools: (Evans, 1998; SIECCAN, website, 2000). Similar studies in Aboriginal and Inuit communities have not been conducted. This is an area that needs much more attention. Parents and students alike have been found to favour school-based education on sexual health topics.

How do we determine if school-based sex education is effective?
One of difficulties in assessing the effectiveness of Canada's sex education system is that Canada does not have a mandatory sexual health education curriculum in all provinces and territories. A book of guidelines was published in 1997 called *Canadian Guidelines for Sexual Health Education*. It was developed on the recommendations of the Expert Interdisciplinary Advisory Committee on Sexually Transmitted Diseases in Children and Youth (EIAC-STD) and the Federal/Provincial/Territorial Working Group on Adolescent Reproductive Health. However, as stated in the preface of the guidelines, "statements do not recommend specific curricula, nor do they outline specific teaching strategies, both of which can be found in other sources" (Health Canada, 1997).

This makes it necessary for each and every individual board, school and teacher to decide what to teach and how. Consequently, some teachers may not teach sex education, or specific aspects of it because of their own issues, or lack of comfort with the material. (Evans, 1998). Thus, it is difficult to evaluate in terms of the *success* in preventing teenage pregnancy. We can only speculate, as the government of Québec does, that "if these courses did not exist, the pregnancy rate...would likely be more widespread than [it is] at present" (Gouvernement du Québec, 1998).

There are institutional barriers in the provision of effective sexual resources, such as a lack of parental involvement as sexuality educators, language barriers, poverty issues, religious doctrine conflicts, cultural differences and distances from services (Orton, 1994). Undoubtedly, all of these factors have played a role in the arguments surrounding the inclusion, or exclusion, of sexual education in the school system.

Some researchers have taken up the task of measuring the success of sexual education programs. In 1981, Orton and Rosenblatt found three components to gage school-based sex education's effectiveness. Positive impact on the population increases with the help of the following 1) if all schools in the geographic area provided sex education 2) if within these classes both family planning and contraceptive use are taught; 3) if the lessons are given to youth before the age of sixteen (as cited in Planned Parenthood Nova Scotia, 1996b). Other research support these recommendations: the most significant way for sex education to work, or to be effective is to couple the education with adequate access to services and information (Orton and Rosenblatt, 1981; Health Canada, 1998; Planned Parenthood Nova Scotia, 1996b; International Planned Parenthood Federation, 1995; Frost et al, 1995; Langille, 1999).

Based on findings from Fisher and Fisher (1998), Health Canada (1994) and Kirby et al (1994), the Sex Information and Education Council in Canada (SIECCAN) asserts that sex education can be an important means of prevention. It states that the most effective programs give students the opportunity to gain skills necessary to use information they are given, as well as the skills to delay first intercourse. On its website (2000), SIECCAN states that "research consistently shows that well designed programs employing this dual approach are effective in both delaying first intercourse and increasing the use of contraceptives/condoms for those who are sexually active".

Another significant factor in linking education with services is geographical location. This links

with the environment as a determinant of health. Urban areas generally have more services than non-rural areas, and these services can be advertised as being completely anonymous. Conversely, when youth enter a facility in a small town, it is likely that they will know one of the employees. There might be a fear of being recognized by a local member of the community who might disclose to his or her parent that someone they know was accessing a sexual health clinic. Evidence of this has been documented in Nova Scotia, where non-urban youth are seriously disadvantaged when it come to access and service, simply because of their place of residence. (Planned Parenthood Nova Scotia, 1996b; Amherst Initiative for Health Adolescent Sexuality, 1999; and for rural regions in general, Wadhera, 1991).

Accessing Resources and Services

Knowing every single thing about how contraception works is still not going to change the fact that buying contraceptives, or accessing clinics can be filled with shame, fear or embarrassment. In Nova Scotia in 1996, forty-three percent of youth who responded to a questionnaire cited shame, fear, and embarrassment as the single biggest reason for staying away from sexual health centres (Planned Parenthood Nova Scotia, 1996a). Furthermore, being female, from a cultural minority, being lesbian or gay makes accessing resources that much more difficult (Planned Parenthood Nova Scotia, 1996a). "Youth are engaging in unprotected sex because they don't want to get caught buying condoms. Youth are not asking questions of adults because they don't know who they can trust...they know sex is a taboo subject, so are afraid to seek help. (Langille, 1999).

Studies have shown that even if teens do know about contraception, as a result of sex education, they still may not use adequate precautions for a variety of reasons. Research suggests that most teen mothers are aware of contraceptive measures (Englander, 1997; Paulson, 1999). In Manitoba, 99% of adolescents between the ages of 15 and 19 who became pregnant said that they were aware of birth control methods" (Paulson, 1999). Similarly, one study states that while 85% of adolescents describe themselves knowledgeable about birth control, only 42% actually used it (Posterski & Bibby, 1988). In yet another study, it was found that an adolescent will wait on average 17 months after the inception of sexual activity before seeking contraception from their doctor (Miller, 1995). This demonstrates the difficulty in choosing programs that will be the most effective. However, people who are actively working in the area of sex and sexuality education recommend that the curriculum be theory-driven, broadly-based, spiritually driven programs, which includes a shared responsibility for the community (Evans, 1998).

As shown, sex education is most often described as the most important and effective preventative technique that exists. While many young people are exposed to sex education, there are still other ways to present prevention strategies.Often these prevention programs go hand in hand with the education youth receive. Together, school-based prevention programs are important parts of the overall effort to prevent teenage pregnancy.

ASSESSING PREVENTION PROGRAMS

Literature reviewed in this study attempts to stress the importance of prevention by citing economic advantages of preventing teen pregnancy.

- Planned Parenthood says that for every dollar spent on prevention of teen pregnancy, ten dollars could be saved on the costs of abortion services and the short and longer term costs of income maintenance to adolescent sole support mothers (Planned Parenthood Donor Update, 1999).

- An Ontario cost-benefit analysis showed that preventive programs between 1975 and 1983 helped to avoid over 21,000 adolescent pregnancies, a net savings of $25 million (Childbirth by ChoiceTrust, 2000b).

- In 1986, Orton and Rosenblatt estimated that for every $1 spent on family planning services, more than $10 is saved in welfare and family benefits alone (CBC Trust, 2000).

Evaluations of some programs have determined that early intervention of sexual health education is successful in postponing the initiation of sexual activity (Frost et al, 1995). Health Canada concurs:

- "...decisions about sexual activity and reproduction become crucially important. 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" (Health Canada, 1999a).

Early intervention is important when looking at many concepts surrounding prevention. In a prevention–related study surrounding sexual health and HIV/AIDS, it was concluded that the desired strategies of prevention were most effective "by intervening early and comprehensively to increase knowledge and awareness of HIV/AIDS and to promote safe sexual behaviours" (Meda, 2000). These findings can relate to the prevention of teen pregnancy. They demonstrate that early intervention is vital.

Some particular strategies have been proven effective. The following describes key elements of proven approaches, and is taken directly from the final report of the teen pregnancy prevention program project done for CAPC/CNPP projects:

ProActive Strategies

The National Crime Prevention Council mentions several protective factors that reduce the effects of risk and thus lower the chances that a youth will develop serious anti-social tendencies or other behavioural problems. Some examples of protective factors are (National Crime Prevention Council, 1997) problem-solving, life and communication skills, sociability, resilient personality or temperament; a sense of belonging; secure attachments to positive parent(s) or family; positive relations with "pro-social" peers; access to other caring and supportive adults; appropriate

discipline, limit-setting and structure from parents; and opportunities to experience success and build self-esteem.

Dryfoos (1990, 1992, 1993) has done extensive reviews of the literature on adolescent risk-taking. For best results in risk reduction, she recommends approaches which combine individual-based interventions with school-based and community-based ones. Those which have been shown to be promising include:

Individual:

- provision of individual attention in dealing with peer influences and job readiness (mentors, counselors, case managers)
- experiential skill development
- home visiting with family in early childhood and pre-adolescence.

School-Based Interventions:

- school organizational approaches which increase probability of success for disadvantaged children such as alternative schools, special education, teacher training, creating effective roles for parents within the school
- special services offered within the school such as counselling and mentoring, health services, opportunity advancement community mental health programs

Community-Based Multi-Component Interventions

- community education and media campaigns
- school/community collaboration on advocacy regarding conditions which affect access to contraception, abortion, cigarettes and alcohol and access to opportunities (jobs, recreation, further education

- advocacy for broad social changes to narrow inequities (education, homelessness, poverty, racism, employment, welfare)

- A culturally appropriate approach which is owned by the community should be used within Aboriginal communities. The approach should take into account the following (Stout and Kipling, 1995):

    - serious reservations remain regarding the adoption or fostering of Aboriginal children by non-Aboriginal families. The practice coerces Aboriginal people into inter-racial relationships, posing a serious risk to the future vitality of Aboriginal culture and language

    - the breakdown of the extended family has resulted in increased risk for teenage parents and their children. Because children have become increasingly disconnected from grand-parents, aunts and uncles, lack of positive role models places them at heightened risk of falling into a pattern of self-destructive behaviour

    - recognizing that youth bring new reserves of creativity, older generations must make strong and sincere efforts to work with young people's energy and interests,

especially when they make decisions that affect them

- inter-generational conflict has become increasingly pronounced in many Aboriginal communities, and has led to such problems as alienation, substance abuse and early onset of sexual activity. Grandparents and elders are being excluded from the child-rearing process, resulting in a loss of language and traditional knowledge on the part of the younger generation

Postponement Strategies

Sex Education and Access to Contraception

Studies have shown that sex education is most effective if:

- access to free contraceptives in a confidential way is also provided (some Canadian jurisdictions have adolescent health clinics staffed by primary care workers offered within or near schools)
- healthy sexuality is part of the programs from kindergarten on
- healthy sexuality education includes interactive experiential skill-building which involves different self-discover, awareness and practice techniques such as role-playing (Franklin et al, 1997) – curricula provided in didactic format without skill development has been shown to be ineffective (Cockey, 1997)
- The following topics are included: negotiating agreements, relationship development, communication, decision-making, goal-setting, body image, dealing with sensations and feelings, use of contraceptives, masturbation, sexual preference, alternatives to coitus, etc.
- Aim to help students postpone first intercourse, and use contraceptives/condoms when they do become sexually active. Approaches that advocate abstinence only have been shown to be ineffective in preventing pregnancy (Cockey, 1997)
- Skill development related to sexuality is provided by an outside resource person who is an experienced sex educator and credible to students. Orton and Rosenblatt's study, which was based in Ontario, found that public health nurses are best prepared to provide school-based sex education, but unable to provide full coverage. Key informants told us that cutbacks to public health across the country have significantly undermined the capacity of public health departments to provide sex education.
- Parents are oriented to what student are learning and how they can reinforce the messages and help parents increase comfort in talking with their children about issues from a young age.
- For Aboriginal youth: (as recommended by the Aboriginal Roundtable on Sexual and Reproductive Health)
    - sex education programs must be culturally appropriate, and must encompass a holistic human sexuality. Parents need to be included in education initiatives so that can communicate openly and honestly about their children's sexual development.
    - Ready availability of family planning resources in Aboriginal communities is crucial, and resources must be culturally appropriate and of high quality. Moreover, they must inform community members about the benefits and risks of various family planning methods.

Canadian Models

A combination of quality sex education coupled with access to contraception services for young people has been proven effective in Canada (Hanvey in BC Alliance, 1999b; Langille, 1999). The most important factor in the prevention of pregnancy is said to be establishing and maintaining support from the community (Langille, 1999). Along with receiving community and parental support, The Manitoba Association of School Trustees believes that the best strategy to reach out to youth, and gain their approval and support, is to create messages that are realistic, instead of judgemental (Manitoba Association of School Trustees, 2000).

There is one particularly notable program that has been evaluated in Canada called the Amherst Initiative for Healthy Sexuality. In Amherst, Nova Scotia, members of a non-urban community noticed that many youth were participating in what they felt were unsafe sexual practices. Acknowledging the need for adequate sexual health services, a non–profit organization was formed, called "Amherst Association for Healthy Adolescent Sexuality." The Association joined forces with existing community structures to improve the sexual health of youth in their neighbourhood. A variety of methods were used, including school-based sexual health education, a media campaign, the creation of a teen health clinic, and the formation of a coalition of parents, educators, teens and community workers who were dedicated to the betterment of the sexual health of young people. The Association formed partnerships with people in the community from a number of backgrounds: researchers, educators, policy-makers and youth themselves. A community-based philosophy was central to its success, including the inclusion of local individuals as team members, and paid workers. This participatory action research (PAR) has been identified by the Initiative as an appropriate way to achieve success in communities.

The stated overall objective of the research was to "determine whether coordinated and intersectoral community action on determinants of sexual health at the level of social, learning, and health services environments of a community could lead to risk-reduction in the sexual behaviours of adolescents."[5] The conclusions from the final report of this initiative are central to the success of prevention programs. It found that after two years of interventions, youth in Amherst were more likely to take control of their sexual health, and use contraception more frequently and consistently (Langille, 1999).

The final report cites the success of the program as being linked with three key attributes of Amherst, Nova Scotia (1999):

> 1) Various social organizations had teenage sexuality issues as part of their agendas, thereby preparing the community for readiness to act on these issues.
>
> 2) The community recognized links between its high rate of pregnancy in young women and the extent of sexual activity, especially high risk sexual activity among its young

[5] Langille, 3.

people as evidenced by survey research, and the need for intervention.

3) The local Project Co-ordinator was responsible for the promotion of Amherst Initiative for Health Adolescent Sexuality's (AIHAS) efforts was from the community.

The Amherst Initiative presents evidence that prevention programs can be effective, especially when youth themselves are involved, and at the same time are respected and supported, and are not threatened, or dismissed. It came up with a number of recommendations for policy and practice. The initiative's final report suggests the following:

- school-based health centres should be further explored, and should include an outreach programs for those who do not attend school.
- health services for adolescents should be confidential.
- the entire community should be involved.
- individuals who teach sexual health issues need access to adequate training.
- school-based sex instruction needs to be accompanied by administrative support.

The Amherst Initiative demonstrates the effectiveness of community commitment and involvement to adolescent health. It outlines advantages of community participation as "enabling organizations to be involved in issues without sole responsibility for them, ability to build public support, maximizing power, minimizing duplication of effort, and participation of diverse constituencies" (1).

Overall, the Amherst Initiative provides an evaluated program that, according to its final report, works. Its findings highlight the importance of community-based, cooperative programs that work effectively to prevent teenage pregnancy through the promotion of healthy sexuality. It highlights the importance of actively participating with youth themselves to create effective strategies that reach those who need it most. Furthermore, the initiative demonstrates the effectiveness of partnerships; if run successfully, these partnerships minimize the duplication of work and effort. It is one of the few prevention programs in Canada that has been evaluated, and its successes can be built upon.

International Models

The British Teenage Pregnancy Report was conducted by the Social Exclusion Unit in 1999. It describes teen pregnancy as a cause and consequence of social exclusion and has two specific goals: to reduce the rate of teenage conceptions and to get more teens into education, training, or employment to reduce their risk of long term social exclusion. The Report stresses that there is not one single explanation for the high rates of teen pregnancy in Britain; instead it cites a number of factors including low expectations of teens, ignorance and mixed feelings as determinants.

The Report cites 'neglect' (both societal and governmental) as the greatest barrier to the elimination of teen pregnancy. It cites the lack of an accountable body who will take

responsibility for the rates of teen pregnancy. Instead, the Report highlights the importance of highly collaborative strategies, which include educators, policy makers and youth themselves.

The Report focusses on the issue of teen pregnancy, and some of its potential causal factors, but it also begins a dialogue about some important changes that need to be made. The Report also takes a stance on supporting those teens who do have children.

Other Initiatives/Resources

There are some initiatives that focus on issues related to teen pregnancy, such as education, contraception distribution or issues relating to healthy sexuality. Often, a discussion of teenage pregnancy is included in the dialogue, but is not necessarily the focus. The following examples address the issue of teen pregnancy head on and can be used as resources.

Manitoba Regional Youth Consultations (1998). In 1998, the Manitoba Association of School Trustees facilitated Regional Youth Consultations. Three hundred and seventy-five youth were involved. With community support, they created a media campaign that included television spots and radio advertisements.

Big Break Comics (1988). This initiative uses a youth-friendly medium: a comic book. In a colour copy of a short comic book, it provides the reader with three scenarios about teen pregnancy, using representations of youth and by recounting situations that youth might actually have to face. Games, quizzes and questionnaires related to teen pregnancy, are included throughout the comic book, as well as other topics youth might find interesting. Between vignettes, there are advertisements for help lines, briefings on sexually transmitted diseases, assaults, safer sex and pregnancy as well as the repetition of the number of the Facts of Life line in Winnipeg (where the comic book is based).

Algoma Best Start: Human Mathematics Poster. This program is an example of successful youth participation. Seventy-nine youth were involved in the creation of a poster for a french-speaking high school. It was also translated into english. It says: *"Human Mathematics: Think About It." Under the caption is the equation " 1♀ + 1♂= 3. "*

ReCapp Scavenger Hunt (2000)**.** This American program consists of an on-line scavenger hunt where students had to look for information and services about teen pregnancy on the Internet.

Advocates for Youth (1999). Every year, this organization organizes a National Teen Pregnancy prevention Month in October. The program is run by youth and adults alike, all across the United States.

In the United States, there are a number of organizations whose mandates are to prevent teen pregnancies. Two are described below:

Alan Guttmacher Institute. This Institute has a substantial website with a large number of relevant links. According to their mission statement, they provide reliable, balanced, nonpartisan information on sexual activity, contraception, abortion and childbearing. This involves a commitment to identifying key questions, collecting and analyzing data to answer them and publishing the answers.

PASHA (Program Archive on Sexuality Health and Adolescence) pulls together research findings of the effectiveness of existing teenage pregnancy initiatives and STI/HIV awareness. It provides access to materials needed to reimplement and reevaluate them (Card, 1999). According to J. Card, its three impacts are the increased abstinence or a delay in initial intercourse, improved patterns of contraceptive behaviour and lower pregnancy rates. However, Card also notes that the programs have had little effect on the number of sexual partners or the frequency of intercourse among teenagers.

CONCLUSION

As shown by findings in the literature on teen pregnancy, prevention is an important task. However, it a complex issue that relies on cooperation between communities, policy makers, researcher and youth participants.

This literature review has discussed research which has suggested that statistically, young parents face the a life of poverty, have lower levels of education, and have less opportunity in the workplace than non-parenting teens. When there is research on teen pregnancy prevention, it usually focusses on negative aspects of being a teen parent. For example:

- There is a close correlation between dropping out of school, early pregnancy, and poverty. (Gouvernement du Québec, 1998)
- Children of teenage parents are more likely to have problems and to become teenage parents themselves, thus perpetuating the cycle of poverty begun by a teenage birth (Evans, 1998).
- Teen mothers often find themselves to be undereducated, underemployed and underpaid, promoting a generational cycle of disadvantaged families).
- Early childbearing holds a risk of delaying emotional development, of high stress and potentially abusive environments, and of the reduction of life opportunities for both mother and child (Planned Parenthood Nova Scotia, 21).
- The costs of adolescent parenthood for society are numerous. The mother's education is often interrupted or terminated, leading to a loss of or reduction in future earning power, and a life of poverty (Thomas, 1990).

Despite these findings, many young parents will say that their child has provided them with more joy than they have ever known. With resilience and determination, many balance a family with strong personal goals and become successful individuals and role models. There is a lot of hope for young teens who become pregnant. However, it is clear that a prevention approach must be embraced. This literature review can be a first step in defining the issues, and highlighting existing strategies.

Planned Parenthood Nova Scotia determined that for every $1.00 spent on prevention of unhealthy sexual outcomes, $10.00 is saved in health and social assistance (22). Although it is problematic to measure the effects of teen pregnancy economically, these findings indicate a strong need to embrace teen pregnancy prevention as a priority. No matter what decision teens make about their sexual health, their choices need to be supported.

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