Department of human services

Family, Teenage Pregnancy

DEPARTMENT OF HUMAN SERVICES Save $$$s onottled water!!!- Unplanned Teenage Pregnancy and the Support Needs of Young Mothers Part B: Review of literature Prepared by Krystyna Slowinski Research, Analysis and Information Team November 2001 Contents Executive Summary ..... 1 1.. Introduction ..... 5 1. 1 Background ..... 5 1. 2 Methodology ..... 6 1. 3 Language and Terminology ..... 6 2. Adolescent Sexuality and Behaviour ..... 7 2. 1 Determinants of sexual behaviour ..... 2. 2 Trends in sexual behaviour of teenagers .... 2. 3 Sexual knowledge ..... 2. 4 Contraception knowledge and use ..... 7 11 12 13 3. Teenage Pregnancy ..... 19 3. 1 Teenage pregnancy risk factors ..... 19 3. 2 Decisions about pregnancy ..... 21 3. 3 Hazards of adolescent pregnancy ..... 24 4. Teenage Parenthood ..... 26 5. Service Provision ..... 31 5. 1 Prevention ..... 31 5. 2 Support to pregnant and parenting adolescents ..... 35 6. Special Needs Groups ..... 38 7. Summary ..... 46 References ..... 49 Executive summary The literature review was conducted to identify risk factors associated with

teenage pregnancy and parenthood, including patterns of teenage sexual behaviour, as well as current knowledge about effective strategies in teenage pregnancy prevention. The impact of teenage parenthood on parents and children and ways of supporting pregnant and parenting young women was also explored. The review relied predominantly on Australian literature in order to reflect local issues and perspectives. However, the need to consider more recent or extensive research in some areas required the use of overseas literature, mainly from the US and the UK. The main themes that emerged from the review are as follows: Adolescent sexuality and behaviour There are indications that the proportion of young people engaging in sexual activity at an early age is increasing. Recent surveys of young people in Australia suggest that about 20% of 15 year olds and nearly 50% of 17 year olds are sexually active (Lindsay et al., 1997). The timing of sexual initiation and subsequent sexual behaviour is influenced by many factors, including family characteristics and relationships, peer pressure and cultural norms, as well as socio-economic factors and personal characteristics. Most teenagers report " curiosity" and peer pressure as reasons for initiating sexual activity. There are also indications that some teenagers are pressured to have sex. Overseas research suggests that a significant proportion of first sex experiences are unwanted and the younger the person the more likely this is to be the case. There is substantial evidence to link inadequate adolescent knowledge and understanding of sexuality to higher teenage pregnancy rates. While the Australian research is not always clear, some of it points to gaps in adolescent knowledge about safe sex, human reproductive biology, and contraception suggesting the

need for more information and education. The main sources of sexual knowledge for teenagers are school, family and friends. Studies report varied levels of contraception use amongst teenagers. Survey data has indicated 53. 4% of teenage females and 71. 5% of teenage males using condoms. However, teenagers are more likely to use contraceptives sporadically. Methods of contraception vary with age, relationship status and education with condoms being the most likely form of contraception for teenagers. Teenagers have a high failure rate with regard to contraceptives suggesting lack of adequate knowledge and information. Unplanned Teenage Pregnancy Research Project — Review of Literature 1 Adequate information/knowledge, easy access to contraception, personal skills in communication/negotiation, assertiveness, and sexual experience assist in contraception use. Substance abuse/risk taking behaviour, sense of fatalism, decreased vigilance and lack of control/power, as well as poor appreciation of risks all contribute to non use of contraceptives. Teenage pregnancy A number of risk factors have been linked to teenage pregnancy. These include early sexual activity and poor use of contraception, poverty/low socioeconomic status (linked to contraception access, peer models/norms, career and education prospects), poor school performance/dropping out of school, and low self-esteem or depression. In addition, young women with a history of sexual abuse, those with no stable housing, or with a family history of teenage pregnancy, as well as Aboriginal young women are at a particularly high risk of teenage pregnancy. Teenage women are more likely to continue with the pregnancy and parenting if they are poorly educated, have low income, come from a large family, or if their mother had her first child as a teenager. Education

and career expectations, peer models, acceptance of and access to abortion are significant factors in decision making around pregnancy. Teenage pregnancy, particularly for women under 18, carries significant social risks (interruption to schooling, reduction in career prospects, interruption to the process of transition to adulthood, potential poverty and social isolation) and health risks (low birthweight babies and higher rate of medical complications). Teenage parenthood Young mothers are not a uniform group but many experience long-term disadvantage with regard to housing, income, and employment. Research suggests that, in the long term, they are also more likely to be single parents and have larger families. Most find parenting much harder than anticipated and the experience of motherhood at odds with their expectations and hopes. The impact on children of having a teenage mother is a topic of a debate. The lifestyle factors during pregnancy (such as poor nutrition, smoking, substance abuse) increase risk of low birthweight and may also have an impact on longerterm health and development of children. However, it seems that living in poverty and social isolation places children at a much greater risk of cognitive delay and mental health problems. American studies indicate that boyfriends who are considerably older are responsible for the majority of teenage pregnancies. Being a teenage father has been found to be clustered with other risk factors (including poor education, substance abuse, delinquent behaviour). Unplanned Teenage Pregnancy Research Project — Review of Literature 2 The relationship between teenage fathers and their children is often problematic, with many fathers abrogating their responsibility or having limited involvement. Lack of adequate support to fathers (from family, peers

and service providers) is identified as contributing to this situation. Prevention strategies Effective strategies for prevention of teenage pregnancy and parenthood need to include sexual education, contraceptive access programs and alternatives to pregnancy and parenthood, with a focus on education, vocational training, academic tutoring and support, career counselling, employment and involvement in community. American research suggests that balanced, realistic sexual education, focused on both abstinence and contraception can delay the onset of sexual activity and increase use of contraception by sexually active young people. Sex education programs are most effective if they provide accurate information, and include decision-making, assertiveness and negotiation skills, as well as life skills. Effective contraceptive access programs provide a range of comprehensive and confidential services, including counselling, supply of contraceptives and follow up care to ensure proper and consistent use. They target teenagers before they become sexually active. Hard to reach and under-serviced youth need to be identified and targeted for specific attention. Access to Emergency Contraceptive Pill (ECP) can reduce unplanned teenage pregnancies and reduce abortions. However, better access and information is required. Educating teenagers about the responsibilities and requirements of parenthood can improve their future parenting skills but also assist them to realize their unpreparedness for parenthood and a better awareness of the short and long-term consequences of pregnancy and parenthood. Support services to pregnant and parenting teenagers Access to impartial information and support is critical to young women in decision making about their pregnancy. The

specific needs of pregnant adolescents need to be considered in providing antenatal care, with programs going beyond health and including a focus on housing, income, access to services, self-esteem and relationships. The particular vulnerability of teenage mothers and their children calls for support that continues post-natally. Access to education and childcare, building of support Unplanned Teenage Pregnancy Research Project — Review of Literature 3 networks including peer support and practical assistance should be facilitated by such programs. Successful parenting programs are characterized by flexibility and the ability to respond to group and individual needs as well as provide continuity of relationships. The importance of addressing needs of adolescent fathers is identified in the literature. Services to males should be similar in content to services for females, covering child development, and parenting as well as information on contraception and should include educational/vocational support. Special needs groups A higher proportion of rural, as compared to urban, youth are sexually active according to a recent survey (39. 3% compared to 31. 8%). Access to suitable services in rural areas is a problem for adolescents in the country, with lack of choice, lack of female doctors and distances, all creating barriers. Problems with confidentiality and privacy around sexual matters are significant issues, particularly for adolescent females. Rural recession, and lack of educational and employment opportunities for youth, is also a factor, reducing the alternatives to young parenthood. Homeless young women are a particularly vulnerable group, with transient life style, poverty, drug use, risky sexual practices, poor health status and little concern for personal safety often a norm. The focus on basic survival means

sexual health needs are not a priority. Trusting relationships built over time provide the best basis for providing support. Most of the women who have been homeless or transient require intensive support in addition to stable housing. There are many social factors increasing the vulnerability of Aboriginal adolescents to early pregnancy and birth, including poverty, substance abuse and community norms. Despite the fact that Aboriginal young women are at a high risk of giving birth at a young age, there is little research in this area. According to one South Australian study, Aboriginal women were less likely to use contraception, had lower awareness of services, and were more likely to rely on their mother for information about contraception. In planning services for Aboriginal young people, their different patterns of service use, particular barriers to accessing services and the advantages and limitations of Aboriginal specific and mainstream services need to be considered. Unplanned Teenage Pregnancy Research Project — Review of Literature 4 1. Introduction 1. 1 Background The Australian teenage fertility rates have been declining over the years, reaching its lowest point of 18. 1 births per 1000 women aged 15 to 19 in 1999 (ABS, 2000). While Australia’s rates are significantly lower than those in the USA, UK, or New Zealand, a number of countries, particularly in Western Europe and Asia, have much lower rates. South Australia’s teenage fertility rate has followed the national trend and recorded a figure of 15. 5 births per 1000 women aged 15 to 19 in 1999 (ABS, 2000). While the decline in teenage births is encouraging there is still around 1000 women aged under 20 that give birth in South Australia each year. A similar number undergoes an induced abortion as a result of unplanned pregnancy (for

example, in 1999, 1019 teenage women gave birth and 1169 had an abortion (Chan et al., 1999)). These numbers are concerning in view of the significant health and social risks associated with teenage pregnancy, termination and birth. Developing strategies to reduce the prevalence of unplanned pregnancies in South Australia, and supporting teenage women who choose to continue with their pregnancy and parenting role, are the key objectives under the Metropolitan Division Business Plan and Healthy Start. To advance these objectives and assist in service planning and development, a research project was commissioned to provide evidence base for this process. The project includes examining statistical information, reviewing literature and research, mapping existing services and interviewing young women who have experienced pregnancy or birth. This paper presents information from literature and research reflecting current state of knowledge about teenage pregnancy and parenthood and examines it along the continuum of a reproductive pathway: Sexual activity (including teenage sexuality/sexual behaviour, sexual health knowledge, use of contraception). Teenage pregnancy (known risk factors, decision making regarding the continuation or termination of pregnancy). Teenage parenthood (known risks to mother and child, long term impact of teenage parenthood, issues relating to adolescent fathers). In addition, issues relating to particular “ at risk" groups, such as Aboriginal, homeless, and country youth, are examined. Service provision, particularly components and characteristics of effective services in areas of pregnancy prevention, support for pregnant adolescents and young parents, are explored. Unplanned Teenage Pregnancy Research Project — Review of Literature 5 The review focuses predominantly on

Australian literature. However, the need to consider more recent or extensive research on some topics required the use of overseas texts, mainly from the USA and the UK. Teenage pregnancy is associated with and influenced by a number of complex factors. This complexity is reflected in the volume and range of literature on the topic. This review does not attempt to cover all relevant issues and is by no means exhaustive. It attempts to provide a broad overview of current thinking on the subject of adolescent sexual behaviour, pregnancy and parenthood, and examines social factors and influences rather than medical aspects of teenage pregnancy. 1. 2 Methodology The literature search was carried out using Informit databases (including AMI; APAIS-Health; CINCH-Health; DRUG; Health & Society; RURAL; ATSIHealth; APAIS; FAMILY). Topics explored covered teenage/adolescent pregnancy, abortion/termination, birth, and contraception. The literature search excluded items written pre 1980 and preference was given to material produced from 1985 onwards, with only pertinent older references included. The majority (approximately two thirds) of the titles covered by this search originated in the decade between 1985 and 1995, with only a third written in the last five years. It is not clear whether this fact reflects a lack of research funding in the area or declining interest in this topic. The information gathered through the above process was supplemented by materials obtained through an Internet search and overseas references of particular significance/interest identified in recent Australian literature. SHine library collection and resources were also used in the preparation of the review. 1. 3 Language and terminology Some literature relating to teenage pregnancies/parenthood uses terminology/language of pathology (e. g. “

teenage psychosocial morbidity" in Cubis et al., 1985), deficiencies or deviance (e. g. Holden et al., 1993). This is an unfortunate approach and every effort has been made to avoid such terms and descriptions in this paper. Concerns have also been raised about such terms such as “ teenage" or “ adolescent" pregnancy or motherhood, which are viewed as carrying negative connotations (Milne-Home et al., 1996). Such language is often a reflection, according to MilneHome et al. (1996), of a “ judgmental stance towards young women who become pregnant especially if they complete their term of pregnancy and become teenage mothers" (p. 6). While this problem is acknowledged, the terms offer the most accurate description of the target group and therefore have been used. Unplanned Teenage Pregnancy Research Project — Review of Literature 6 2. Adolescent sexuality and behaviour 2. 1 Determinants of sexual behaviour Being sexually active is the first step to potential pregnancy and parenthood. Overseas research indicates that as the average age of puberty decreased in recent years, the average age at first intercourse has also declined (Sonenstein et al., 1996; US Dept. of Health & Human Services, 1997 in Advocates for Youth, 2001/a). A weak association has been found between sexual maturity and earlier dating and intercourse (Cubis, et al., 1985), suggesting the influence of biological factors. However, the determinants of sexual behaviour are complex and include biological, as well as social and psychological influences. The impact of puberty, personal characteristics as well as family, peers and cultural norms all influence the timing of sexual initiation and subsequent sexual behaviour. Moore & Rosenthal (1993) provide a comprehensive list of factors shaping young people’s sexual views and

practices. Some of these are outlined in this section of the review. Family influence Overseas research identifies various ways in which parents influence adolescent sexual behaviour. For example: Marital and child-bearing behaviours of parents acting as role models, including experiences of divorce, remarriage, living arrangements and behaviour towards the opposite sex have been identified as having an impact (Ostrov et al., 1985). There is a strong relationship, for example, between a mother's sexual experience and that of her daughter. Girls from single parent families tend to become sexually active earlier. However, it is not clear if lack of supervision or behaviour modeling is at the core. Parental supervision seems to have an impact on adolescent women but not so much young men (Fingerman, 1989). Non-authoritarian parenting has been found to be associated with non-virginity in youth as is permissiveness and lack of parental support. Parental attitudes and views may influence adolescents, but the available research evidence suggests that this is very limited. For example, Moore et al., (1991) found that parents who held strong traditional views about premarital sex and communicated these to their daughters were the only group able to influence their children's sexual behaviour (Moore & Rosenthal, 1993). Relationships within the family are also significant. It has been suggested that there is a link between the young people's satisfaction with their child-mother relationship and the likelihood of them being sexually experienced (Jaccard et al., 1996). The lack of attentive and nurturing parents was linked to early sexual Unplanned Teenage Pregnancy Research Project — Review of Literature 7 activity while a stable family environment was associated with later initiation of sexual intercourse (Whitebeck et al.,

1992). Parents also may be important in influencing young people’s use of contraception. Direct discussions about sexual behaviour between teenagers and their mothers were found to be most effective in year 9 and 10 (Baker et at., 1988). In later high school years and beyond, peer approval was more influential (Treboux et al., 1995). The available information suggests that parental influence may be particularly significant through indirect means and, to a lesser extent, through direct communication. The relevance of these findings to Australia is not clear where studies have found little association between teenage sexual experience and parental relationships (Cubis et al., 1985; Finlayson et al., 1987). Peer influence Peer association has been indicated as one of the strongest predictors of adolescent sexual behaviour (DiBlasio & Benda, 1994). Youth that do not engage in sex tend to have friends who also abstain. Those that are sexually active tend to believe that their friends are sexually active as well. Males, particularly those over 16, report more pressure from peers to be sexually active while females report more pressure from partners (Guggino & Ponzetti, 1997). Moore & Rosenthal (1993) point to the following ways peer influence can operate: Through sharing of information, which can serve as a guide in decision-making about sex (this may include inaccurate information). Through prevailing attitudes about sexuality (implicitly reflected in their behaviour and serving as a role model or explicitly stated in discussions etc.). For example, there is some research evidence that the age of first intercourse is related to the perceived peer approval of premarital intercourse (Daugherty & Burger, 1984). The influence of peers appears to differ between genders, for example the use of contraception by young women, but not men, was

found to be influenced by peer attitudes (Thompson and Spanier, 1978). Similarly, Udry (1985) reported that the sexual activity of girls was influenced to a greater extent by their friends, in contrast to boys whose sexual activity was more related to biological factors. McCabe (1995) suggests that while the peer group has traditionally encouraged adolescents to be sexually experienced, the current norms no longer support random or exploitative sex but rather “ sex with affection". How reflective this standard is of all adolescents is not clear, particularly in view of the fact that many of the surveys on teenage sexual attitudes and behaviour in Australia are drawn from first year university students, rather than more representative samples of youth. Unplanned Teenage Pregnancy Research Project — Review of Literature 8 Youth culture and the media Moore & Rosenthal (1993) point out that in western societies the prolonged transition to adulthood has given rise to a distinct youth culture. This culture has a considerable impact on teenagers’ opinions and behaviours, with many young people conforming to particular fashion, music or leisure activities as well as sexual attitudes and behaviour. The major influences on this culture are mass media. Television, films and other forms of media have removed a lot of the mystery surrounding sex by increasingly explicit portrayal of sexual acts, which can provide a model of sexual behaviour. The stereotypic portrayals often do not provide positive role models with hedonistic values rather than responsibility being promoted (e. g. planning for sex being rarely included). According to McCabe (1995) the media’s message is that adolescents should be sexually experienced. More positive use of media in counteracting these messages and promoting information about sexual health has been demonstrated by

some European countries (Moore, 2000). Schools With the varied and often biased nature of messages provided to adolescents about sex, schools have an important role in offering appropriate information to young people about sex, relationships and contraception. While the research suggests that many teenagers obtain most of the information about sex and contraception from school, that information is not always relied on by young people, who do not perceive it as credible (Moore & Rosenthal, 1993) preferring to rely on parents or peers (see section on contraception below). Lack of trust in teachers' knowledge or discretion was identified as a major reason for teenager's doubt about this information (Goldman & Goldman (1982). Race/ethnicity and culture Race/ethnicity and culture have been identified as powerful influences on adolescents' sexual experience. The research in the USA indicates considerable differences in the acceptability of early sexual experience and motherhood between African-American and white youth. The reasons for this appear to be quite complex with some writers suggesting that socio-economic differences play the major part and others suggesting cultural norms (Barone, et al., 1996). The literature search did not locate any research examining differences in sexual experience and attitudes between Aboriginal and non-Aboriginal adolescents in Australia. However, it is possible that very high birth rates amongst teenage Aboriginal women reflect to some extent cultural norms (as well as a wide range of other factors including poverty, education, lack of alternatives, etc.). Cultural norms and expectations were identified by Siedlecky (1996) as playing a significant role amongst Lebanese-born women in Sydney where more than half the study participants were married before the age of 20, with many

becoming mothers in their teens. Unplanned Teenage Pregnancy Research Project — Review of Literature 9 International surveys of sexual attitudes and experiences point to considerable differences. For example, Japanese adolescents have been identified as having less sexual experience in comparison to their American counterparts (Asayama, 1975 in McCabe, 1995). Differences were also observed between English, German and Norwegian adolescents and their Canadian and American counterparts (with the first group being less restrictive in their attitudes and behaviours — in McCabe, 1995). Australian studies examining the impact of culture on sexual behaviours provided mixed results with some finding no differences (McCabe & Collins, 1990) while others indicating some dissimilarity in behaviour. Rosenthal et al. (1990) and Khoo (1985) point to diversity of views about and practice of pre-marital sex between young women of Chinese and Greek, or more generally, Southern European background compared to those of Anglo-Celtic background. Rosenthal & Moore (1991) found considerable differences in sexual behaviour in relation to ethnicity, with Greek males least likely to be virgins (23%) compared to Chinese men (60%). The proportions of women with no sexual experience were 62% for Italian women surveyed, 78% for Chinese and 32% for Anglo-Saxon women. Socio-economic factors McCabe & Collins (1990) suggested that social class had no impact on sexual activity. However, there is evidence in Australian research of a correlation between employment status and sexual experience (Cubis et al., 1989). From the surveyed group of sexually experienced adolescents in the Newcastle area, 53% were unemployed, compared to 12% at school, 17% at a tertiary institution and 28% working (Cubis, et al., 1985). Overseas research has also

identified poverty as a predictor of early sexual intercourse, while increased family income was a factor associated with delay in sexual activity (American Academy of Pediatrics, 1999). Brewster (1994) found that teenage females living in a socio-economically disadvantaged urban environment were more likely to be sexually experienced. Substance abuse and high risk behaviour An association between sexual activity and alcohol consumption and antisocial and impulsive bahaviour has been highlighted by Cubis et al., (1989). In fact, Finleyson et al. (1987) found alcohol to be the best predictor of sexual experience of older adolescents. However, the relationship is believed to be complex, with alcohol acting as a disinhibiting factor or stimulant on one hand, and on the other, impairing ability to make decisions and making young women more vulnerable to sexual aggression. American studies have examined links between sexual activity and alcohol and drug abuse. In one study 78% of females reported that it was “ easier to have sex" when using alcohol or other drugs (Millstein, et al, 1993). Another study found 33% of males and nearly 17% of females reporting use of alcohol or drugs at their last intercourse (Centre for Diseases Control and Prevention, 1996 in Advocates for Youth, 2001/b). Substance use was linked to a number of “ risk" behaviours, including high risk sexual behaviour. Association has also been found between higher Unplanned Teenage Pregnancy Research Project — Review of Literature 10 risk sexual activity and unexcused school absence, staying out late without permission, stealing, and running away from home (Schuster et al., 1996). Education/academic performance A link has been established between sexual activity and lower academic performance. Research by Ohannessian & Crockett (1993) suggests that

academic achievement by girls predicted postponed sexual activity. It has been suggested that young women who fail at school may seek sexual relationships as a confirmation of their individual worth. For young men academic failure can often be cushioned by, for example, sports success. Education, or more specifically, educational achievement and clear educational goals, have been identified as impacting on sexual activity with high achievers having lower rate of pre-marital sex amongst both males and females (Moore & Rosenthal, 1993). However, educational factors are often mediated by other influences, such as coming from a well-to-do family and having clear plans for the future. Personal characteristics and other factors Personal characteristics and behaviour have also been identified as having an impact on sexual conduct of individuals. Learnt restraint or the ability to delay gratification, exercise impulse control and consideration for others, have been identified as factors useful in predicting sexual activity of adolescent boys (Moore & Rosenthal, 1993). 2. 2 Trends in sexual behaviour of teenagers There are suggestions that the proportion of young people engaging in sex at an early age is increasing (Lindsay et al, 1997; Sonenstein et al., 1996). However, the Australian literature on the topic is not very clear. Sexual experience A number of studies have been conducted to determine the level of sexual activity among Australian teenagers. Cubis et al., (1985) surveyed what he describes as a representative sample of high school youth aged 14 to 16 in Newcastle. About a quarter of those participating indicated that they had experienced sexual intercourse. For those aged 14, 23% of males and 18% of females reported having experienced intercourse. The proportion was higher for 16 year olds, with 42% males and 28% females

indicating sexual experience. Overall, these figures are high when compared to more recent surveys. Raphael et al. (1990) conducted a study using students from high schools in lower Hunter region in NSW (with around 2000 participants, mean age 15. 4 with less than 1% of the sample being younger or older than 14 and 16). They reported that 30% of males and 21% of females were sexually active. A higher proportion of participants from “ disruptive" families reported being sexually active (40% boys and 31% girls). Unplanned Teenage Pregnancy Research Project — Review of Literature 11 A more recent study by Lindsay et al. (1997) examined sexual practices of year 10 and 12 students, replicating a similar survey conducted in 1992. The sample included mainly urban adolescents (76%) and less than 3% of Aboriginal students. The proportion of sexually active adolescents in the study was 20% for year 10 and 48% for year 12, with no change being observed since the previous survey. The mean age of intercourse in that sample was 16. 5 for males and 15. 9 for females (average of 16. 2). By comparison, an average age at first intercourse varied from 16. 3 in the USA to 17. 7 in the Netherlands (Advocates for youth, 2001/a). Wellings (1994 - in Blair Report, 1999) indicated 17 years as an average age for young people starting having sex in the UK. The survey by Lindsay et al. (1997) did not identify gender differences with regard to sexual activity. However, young women from an ethnic background were less likely to be sexually active. Differences were also noted with regard to geographic location, with rural youth having a higher proportion of sexually active individuals (39. 3%) compared to urban youth (31. 8%). This was particularly relevant to young rural women, with 40% being sexually active compared to 30. 5% in urban

areas. This represented a change since the 1992 survey, where urban youth were more likely to be sexually active, and is in contrast to some overseas research findings where adolescents with early sexual experience were twice as likely to live in urban areas (AGI, 1994). Reasons for initiating sexual activity The most frequently reported reasons for initiating sexual activity were “ curiosity" and peer pressure. However, in the research by Cubis (1996) two-thirds of participants reported having sex because of a close relationship with a partner and 9% reported being pressured to have sex. American research indicates that about 8% of women aged 15 to 44 reported their first intercourse as involuntary, while for 24% the sex was voluntary but unwanted (Moore & Driscott, 1997 in Advocates for Youth/c). Cheesebrough (1999), reporting on findings from the US, suggests that a significant proportion of first sex was not wanted and the younger the person the more likely sex was unwanted. For example, the proportion of under 13s who reported their first intercourse as unwanted was 70%. For those aged under 16 at the time of the first intercourse, 16% reported it as involuntary, compared to just 3% of women who had first sexual intercourse at age 20 or older (US Dept of Health and Human Services, 1997 in Advocates for Youth, 2001/b). According to the American research the majority of high school students found sex a difficult issue to deal with. Most young people felt that there was pressure on adolescents to have sexual intercourse whether they wanted to or not, while fear of pregnancy was the major reason for abstinence (Juhasz, Kaufman and Meyer, 1986). Collins & Harper (1985) looked at the sexual behaviour and expectations of teenage women in Australia. Their findings highlight the considerable pressure on young women

to conform to what is perceived to be the “ norm", but not necessarily a reality, with regard to sexual experience. Unplanned Teenage Pregnancy Research Project — Review of Literature 12 2. 3 Sexual knowledge There is substantial evidence to suggest that adolescent knowledge and understanding of their sexuality is closely linked to the teenage pregnancy rate in Western societies (Gallois & Callan, 1990). A survey of 37 countries by Jones at al., (1985) found low rates of teenage birth rates in countries where there was openness about sex, greater availability of contraception, confidential advice about its use, and high quality sex education. British research pointed to ignorance about sex as a key risk factor for teenage pregnancy (Blair Report, 1999). There is no comprehensive Australian research that assesses the effectiveness of the current system of sexual education, particularly with regard to prevention of pregnancy. The majority of studies in this area focus on safe sex practices in relation to HIV/AIDS or other sexually transmitted diseases (STDs). Extent of knowledge Earlier Australian surveys conducted in the 70s and 80s indicated poor sexual knowledge amongst adolescents. Abraham (1985) surveyed 14 to 19 year old women of which over half reported having inadequate information about menstruation or no knowledge of the timing of ovulation. Many young women in a study by Lei et al. (1997) were not clear when pregnancy could occur during menstrual cycle. Johnson & Chopra (1980) tested the sexual knowledge of adolescents and identified significant gaps with regard to human biology, contraception and STDs. Waite & Sullivan (1995) also pointed to evidence of significant gaps in knowledge about safe sex amongst Australian teenagers. However, surveys of year 8 and 9 high school students

in Queensland (Botfield, 1995) indicate a fairly high knowledge of contraception. About 70% of year 8 and 96% of year 9 students recalled having sexual health education, but often it appeared to be HIV focused and did not always include pregnancy prevention. The need for more knowledge was reflected in a high proportion of participants (75%) wanting more information about sexual health as well as communication and decision making with regard to sexual interactions. A more recent survey of secondary students by Lindsay et al. (1997) concluded that knowledge of STDs other than HIV/AIDS was poor. No other knowledge was tested in the survey. Studies by Littlejohn (1996) and Lovell & Littlejohn (1997) involving teenage mothers concluded that the participants had a high degree of knowledge of contraception, despite the fact that the majority of pregnancies in both groups were described as unplanned. In a 1991 UK survey two thirds of participants thought they should have been better informed about sex when they became sexually active. A large number of respondents wanted more sex education at school (The Blair Report, 1999). Most research in this area relies on self-assessment, which may not accurately reflect the level of knowledge of the participants. Unplanned Teenage Pregnancy Research Project — Review of Literature 13 Sources of information/advice The majority of students in Botfield’s survey (1995) preferred information about sexual health to come from their mothers and peers, as well as steady partners, but less so from teachers, suggesting that closer relationship was important in conveying information about sex. This finding is not consistent with results of studies in the UK, where over 90% of parents and young people looked to schools as a preferred source of sex education. Furthermore, British studies

suggest that those who learnt about sex mainly from schools were less likely to become sexually active under age, compared to those relying on family or friends (Blair Report, 1999). Information from the USA also identified teachers/school as the best source of information, followed by parents and friends (Kaiser Family Foundation, 1996). However, the importance of parental input into the sexual education of their children is highlighted by the UK study of Wellings et al. (1990; in Blair Report, 1999). The findings indicate that young women who did not discuss sex easily with their parents had a far greater chance (more than double) of becoming pregnant. In an Australian study of young pregnant women in Victoria (Littlejohn, 1996) school was identified as the main source of knowledge of contraception and sexual knowledge (70% of respondents), with friends and family the next most common sources. A small proportion of study participants was asked about the usefulness of information they received about contraception and sexuality. Seven out of eleven respondents were satisfied. Most of the total group of 183 participants also felt that they had enough knowledge. A survey by Lindsay et al. (1997) revealed that half of male students (49. 6% from year 10 and 49. 9% from year 12) never sought advice about contraceptives. The most likely source of advice for males was parents, followed by teachers. Females were more likely to seek advice, with 38. 2% of females in year 10 and 27. 3% in year 12 never seeking advice. Of those who looked for information, parents were the most likely source. For the older group (year 12 students) General Practitioners were the second most important source of information, while for younger year 10 students, teachers and “ others" were the most likely sources. While parents may be the preferred source and

schools the most likely to provide information about sexual health, friends and media are also powerful sources of influence and information (Goldman, 2000). 2. 4 Contraception knowledge and use The decline in teenage birthrate over the years has been linked to greater availability of and better access to contraception and abortion. Siedlecky (1986) suggested that, while contraceptive use has been readily accepted by Australian women, “ young women were the most at risk group, with few using contraception at first intercourse and relying on ineffective methods, such as withdrawal or rhythm" (p. 7). Unplanned Teenage Pregnancy Research Project — Review of Literature 14 Use of contraception by teenagers A number of Australian studies conducted in the 70s and 80s pointed to the low usage of contraceptives, with between 23% and 18% of adolescent women indicating their use (Connon, 1971; Ward & Biggs, 1981; Mannison and Clark , 1988 in Chan et al., 1994). Similarly, low contraceptives use was reported by Moore and Rosenthal (1991), who found that only 28% of young people used condoms with casual partners and 18% with regular partners. Out of 15 young women in the study by Clark (1984) who had experienced an unplanned pregnancy, only 4 were using contraception. The remaining women, while admitting to having some knowledge of contraception, did not use it because they “ never got around to it", were “ too scared to ask parents about it", “ did not think they would fall pregnant", or “ did not plan sex". A study of family planning clinic attendees in Victoria (Kovac et al., 1986) indicated higher contraceptive usage with 52% of 460 participant teenage women reporting using contraception at their first intercourse. The research shows that younger, less sexually active adolescents are less likely

to use contraceptives and that contraception use improved with age (Collins and Robinson, 1986). Cubis, et al .,(1985) found that only 45% of sexually active females aged 14 used contraceptives (while 75% believed that they could obtain them) in contrast to 70% of 16 years old females reporting their use (with 85% indicating that they could obtain them). The same study reported only 19% of males using condoms. More recent research suggests that condom use amongst adolescents has increased. A large survey of over 4000 Australian secondary students had 71. 5% of males and 53. 4% of females reporting using condoms at their last intercourse (Dunne et al., 1993). A survey of young pregnant or parenting women in Victoria (Lovell & Littlejohn, 1997) indicated that 95% of participants used some form of contraception. Similarly, a high level of contraception use was reported by participants in the study by Littlejohn (1996). However, most pregnancies in that group were unplanned suggesting inappropriate or inconsistent use. In its report on teen sex and pregnancy, the Alan Guttmacher Institute (1999) stated that while contraceptive use among teenagers in the USA has improved considerably (reaching 78% at first intercourse), teenagers were more likely to practice contraception sporadically. Methods of contraception used Methods of contraception vary with age (Santow, 1991 in Chan, et al., 1994) and are influenced by relationship status and education (Collins & Robinson, 1986). Australia’s Health 2000 report (AIHW, 2000) describes contraception use amongst women aged between 18 and 49. About half (49. 7%) of the women indicated using contraception, with most of this group relying on the contraceptive pill (66. 3%) and 32. 2% relying on a condom. In contrast, a survey of contraceptive practices of year 10 young women in

Sydney (Kang & Zador, 1993) suggested that condoms were the Unplanned Teenage Pregnancy Research Project — Review of Literature 15 most likely form of contraception, with less than 15% of those sexually active relying on the pill. Of concern is the fact that only 43% of sexually active adolescent women in the sample used what was deemed effective contraception. Wider availability of condoms, their utility in prevention of HIV and reluctance of young women to approach a family doctor or medical practitioner were suggested as reasons for use of condoms rather than a contraceptive pill. Overseas studies report various trends. For example, condoms were the most popular form of contraceptive amongst teenagers (54% reported condom use, while 17% reported use of birth control pills) according to Kann et al., (1996; in Advocates for Youth, 2001/b). However, only 11% of females and 50 % of adolescent males reported current condom use. 46% of teenage males who reported condom use indicated inconsistent use (Sonenstein et al., 1996). The Alan Guttmacher Institute (1999) reports that USA teenage women were relying mostly on the pill (44%), followed by a condom (38%), with 10% using the injectable contraceptive and 3% the implant. More recent American research suggests a move away from the pill to injectable contraceptives, particularly for those young women who had already experienced an unplanned pregnancy (American Academy of Pediatrics 1999; Blair Report 1999). Teenagers have a high failure rate with regard to contraceptives use. Failed contraception was reported by 42% of pregnant or parenting adolescents in Littlejohn’s study (1996). While 39% of the women did not know the reason, others indicated missing taking the pill (11%), not being protected by the pill (first week taking) (17%), taking

antibiotics/medication effecting the pill (8%), vomiting when on the pill (3%). According to Brook & Smith (1991) factors that decrease the effectiveness of the pill were not well understood by teenagers. Access to emergency contraception could provide a possible solution against unwanted pregnancy. The emergency contraceptive pill has been identified as an important option for adolescents. However, lack of ECP knowledge amongst adolescents and medical professionals as well as limited availability prevents its more extensive use (Advocates for Youth, 2001/d). British research indicated that 70% of women requesting an abortion would have used ECP instead but they did not know how to get it (Duncan, 1990 in Blair Report, 1999). Only 13% of 16 to 24 year olds in the UK have used ECP on one or more occasions (The Durex 1999 Report in Blair Report, 1999). The US research also points to issues of cost and access (transport, hours of operation of clinics, issues of confidentiality, side effects, requirements for medical examination and blood test) as potential barriers to its use. Factors influencing teenage use of contraception Research indicates a considerable discrepancy between knowledge of contraception and its use, with many teenagers having sufficient knowledge and believing in safe sex practices yet not necessarily practicing it (Cubis, 1992; Littlejohn, 1996). It is clear that a range of factors influences the use of contraception (Chan et al., 1994). However, the importance of contraceptive knowledge is supported by research evidence pointing to an improved use of contraception amongst those teenagers who received relevant education in comparison to those who did not (Kahn et al., 1996 in Advocates for Youth, 2001/b). Unplanned Teenage Pregnancy Research Project — Review of Literature 16 Considerable research has been

carried out to determine the reasons for teenagers not following safe sex practices, with the main focus being on attitudes towards condoms. Waite and Sullivan (1995) collated relevant information and identified the following barriers: Negative attitudes towards condoms, with some individuals believing they reduced sexual pleasure, were difficult to use, were embarrassing and implied promiscuity (research by Turtle et al., 1989). Non-appreciation of danger with the majority of young people believing they were participating in safe sex despite not using appropriate precautions. Sense of fatalism, powerlessness and lack of control while for some non-use of condoms was part of a “ life is full of risks anyway" approach, for others it was a reflection of lack of confidence to take control over the situation. The spontaneous nature of sex presented practical problems, effective contraception requires planning and preparation. Decreased vigilance, as a result of alcohol/drug use, was also an issue. Collins and Robinson (1986) list the following variables as influencing contraceptive bahaviour: Acceptance of own sexuality — a fact made difficult by confusing and contradictory messages given to young people, and particularly women, about their sexuality (“ sex is dirty, or fun, degrading or mature, sophisticated or cheap"). Planning and preparation for intercourse implies premeditation and in the above context is difficult. Relationship status with consistent use being associated with greater stability in a relationship, and most likely a better environment to communicate about and negotiate safe sex. Collier & Robinson (1986) found that discussion of contraception with a sexual partner was linked to a greater likelihood of using some method of protection. Sexual experience - many studies suggest that most teenagers do not use

contraception at their first intercourse. While contraception use improves with sexual experience, for some adolescents it takes up to a year to obtain contraceptive (Moore, et al., 2000). Age, with younger adolescents less likely to use contraception. Young people who started sexual relationships later in life were also more likely to use contraception. The age gap between adolescent females and males also seems to influence condom use. Partners with an age difference of two years or less were more likely to use contraception in comparison to those where age the gap was five years or more (Moore & Driscoll, 1997 Unplanned Teenage Pregnancy Research Project — Review of Literature 17 in Advocates for Youth, 2001/c) confirming the need for a power balance in relationships to ensure safe sex practices. Educational aspirations and goals as well as performance are associated with more consistent use of contraception. Women with higher level of education were also more likely to take contraceptive precautions in comparison to those with lower educational level. More consistent use of contraceptives was also strongly associated with good relationships with parents and friends (for males only), anticipation of a satisfying future, less involvement and fewer friends involved in delinquent behaviour and more frequent attendance at religious services (males only) (Costa et al., 1996). Not surprisingly, positive attitudes towards condoms were the strongest predictor of its use (Reitman et al., 1996 in Advocates for Youth, 2001/c). The influence of structural and environmental factors has generally been acknowledged, with those most socially and economically disadvantaged having limited access to education and health services being less likely to use contraception (Elford, 1997 in Campbell & Aggleton, 1999). The issue of

availability of contraceptives was raised in the Newcastle study (Cubis et al., 1986) with many adolescents indicating access problems. While access to contraception does not ensure its use (Collins & Robinson, 1986), making condoms available in selected American schools increased their use among young people who were sexually active without increasing the sexual behaviour of others (Guttmacher et al., 1997; Furstenberg et al., 1997). In the survey carried out by Lindsay et al. (1997) neither geographical location nor cultural background seemed to have an impact on condom usage (those in rural areas and those from non-English speaking backgrounds were just as likely to use condoms). However, a different perspective is provided by Hillier et al. (1997), with the lack of privacy in small communities creating problems, particularly for girls, in accessing condoms and other health resources. There are indications of gender differences in contraceptive use with males less likely to use condoms (Cubis et al, 1985; Finlayson et al., 1987) and having more negative attitudes to their use (Chapman & Hodgson, 1988). The authors of the later study suggest that in this context greater emphasis should be placed on female-initiated condom use (“ if it is not on it is not on" approach). This assumes a power balance in the relationship and assertiveness on behalf of the female. Greig & Raphael (1989) argued that many young women would not have the power to negotiate safe sex with their partners. A study by Abbott (1988) found that 23% of women participants were having sex when they really did not want to. In the survey of secondary students by Lindsay et al. (1997) the majority of students were confident about their ability to communicate about sex, with most feeling able to say no (with females being more confident than males) and to

persuade a new partner to use a condom. However, students’ feelings about their last sexual encounter indicate that nearly 13% of year 10 females felt “ used" and nearly 18% felt “ worried". Only 46% of year 10 females and 41% of year 12 females discussed avoiding pregnancy at their most recent sexual encounter. A Unplanned Teenage Pregnancy Research Project — Review of Literature 18 higher proportion, 73% and 62% respectively, discussed using condoms. 82% of year 10 and 67% of year 12 female students reported condoms being available at the last intercourse and 75% of year 10 and 58% of year 12 students used them (it is not clear if other form of contraception was available/used). Most males reported that both partners suggest condom use while most females indicated that they raised the issue. Recent international research suggests that despite being informed about sexual risks, many high school students were unprepared to negotiate safe sex with their partners (Troth & Paterson, 2001). The individual’s communication style, family history of communication, personality and current circumstances, all impact on individual willingness to discuss sex with their partner. Skills in assertion, negotiation and conflict resolution (through role plays etc.) need to be provided to the young people in addition to information about safe sex practices. In the survey conducted by Lindsay et al. (1997) about 28% of year 10 and about 25% of year 12 students reported being drunk the last time they had sex (Lindsay et al., 1997). Alcohol and drug taking partly explains the lower use of condoms in relation to their availability, with a number of year 10 females not using condoms because they were too drunk or high. There was an association between binge drinking and having sex amongst both males and females. Among those

sexually active, 13% of males and 14% of females were binge drinking at least weekly, were having sex with casual partners and using condoms inconsistently or not at all. Howard (1995) emphasizes the importance of the context in which young women have to negotiate safe sex. Adolescent relationships are often uncertain and awkward, and not conducive to discussing safe sex. In this context campaigns that promote safe sex, for example by encouraging use of condoms, are unlikely to be effective. The need to consider context and interpersonal aspects of sexual encounters and negotiations has been also stressed by Rosenthal & Moore (1991), Barnard & McKeganey (1990 in Howard) and Davies & Weatherburn (1991 in Howard). Health-related behaviours are not always a result of a conscious and rational choice, but are tied to particular circumstances and reflecting the power and ambiguity of the situation. Gupta et al., (1996) suggests that the dominant ideology of femininity in some instances encourages ignorance on sexual matters, and prevents young women from seeking information or services. While young women are expected to appear ignorant about sex, young men are under pressure to appear knowledgeable making, it equally difficult to seek information, support and services (Campbell & Aggleton, 1999). Unplanned Teenage Pregnancy Research Project — Review of Literature 19 3. Teenage pregnancy 3. 1 Teenage pregnancy risk factors Research has been directed at trying to determine why some adolescents get pregnant and others do not. Factors identified in early sexual activity and contraceptive use are obvious precursors to becoming pregnant. Similarly, the frequency of sexual intercourse has an impact on the likelihood of pregnancy. Holden et al., (1993) found that pregnant adolescents had

unprotected sex more often compared to non-pregnant adolescents (pregnant adolescents reported having protected sex 20% to 40% of the time compared to 60% for non-pregnant adolescents). Cubis et al., (1985) conducted a longitudinal study of teenagers in the Hunter region of NSW examining characteristics of young women who had been pregnant and those who had not. The findings indicated there were no difference between girls that were sexually active and became pregnant and those who had not. The authors concluded that “ chance" was a likely explanation for many teenage pregnancies. However, it is possible that other factors not examined in the research influenced the outcome. The most common reason given by young women for unplanned pregnancy in the study of Littlejohn (1996) was “ it just happened" (59%) or “ wanted to have sex" (58%). While 89% of pregnancies in the study were unplanned, the author suggests, they were not necessarily unwanted. A small proportion of teenage women indicate wanting to have a child (about 10% of respondents). The reasons included such statements as “ I like babies/want a baby", they or their boyfriends wanted a family, wanting “ something of mine/someone to love", “ showing own mother how to care for a child". For some young women who reported an intended pregnancy, this was a choice based on a view of their role and their relationship with their partner. However, the retrospective nature of the studies may have resulted in “ adjustment" of intentions. Those who did not want to become pregnant generally did not feel ready to parent. Most study participants were sexually active, with only 7% reporting becoming pregnant as result of first intercourse. On the basis of information from 183 participants, Littlejohn, (1996) constructed a profile of women at risk of early

pregnancy and parenthood. She identified the following factors: history of sexual abuse, low socioeconomic status, unstable housing and dropping out of school. The Alan Guttmacher Institute report (1999) examined teenagers' pregnancy intentions and decisions. Most women involved in the study became pregnant unintentionally. According to the authors, becoming pregnant reflected their disadvantaged background, sexual activity with poor use of contraception, poor communication about contraception and low motivation to avoid pregnancy. The research conducted among young pregnant/parenting women in Wagga Wagga identified two distinct groups (Smith & Grenyer, 1999). One group consisted of young women who had high self-esteem, were employed or engaged in education, had good support and a stable relationship, had a partner of a similar age, and lived with a partner or family. This group was more likely to have planned the pregnancy. They Unplanned Teenage Pregnancy Research Project — Review of Literature 20 were also more likely to have a mother who was pregnant in adolescence, had a supportive father and more education. The other group was more likely to smoke and have poor self-esteem, have little social support, be single, live alone or with friends. There was a greater disparity in age between the young woman and her partner, the pregnancy was unplanned, the young women were more likely to have other children and less education, and also a less supportive partner. The research suggests that the variables influencing teenage pregnancy could be clustered into situational (poverty, socio-economic and social factors), psychological (low self-esteem, alienation, sense of loss/depression) or biological (puberty/sexual activity) (Chilman 1979 in Holden et al., 1993). Holden et al. (1993) also includes

cognitive influences. Socio-economic and social factors There is extensive evidence to suggest that economic factors play a significant role in teenage pregnancy and birth rates. In the USA Kirby et al., (2001) identified close links between teenage birthrates and low income. Poverty was still a significant factor after ethnicity and race factors were controlled. While 38% of American adolescents live in low-income families, 83% of those who give birth and 61% of those who have an abortion are from low-income families (Academy of Pediatrics, 1999). In Australia, the data on teenage births also shows considerable variation within each State, with disadvantaged areas having much higher rates. For example, Siedlecky (1996) examined available statistical information for NSW on fertility and abortion rates for various health regions. Her analysis identified Sydney's most affluent areas, such as North Sydney, as having the lowest teenage pregnancy rates (5. 4 per 1000) compared to West Sydney (23. 2 per 1000) or Orana/Far West (48 per 1000). Siedlecky (1996) concluded that these rates were associated with socio-economic differences of the regions and reflected differences in employment, education, peer models, levels of information on sex and contraception/access to contraception, acceptance and access to abortion and cultural differences. She suggested that teenagers in more affluent suburbs with better education and career prospects were better informed and motivated to use contraception and abortion. Montague (1991) suggested that women in lower socio-economic groups were less likely to have the required knowledge and resources to access contraception or abortion services. Psychological factors Low self-esteem is often indicated as being linked to teenage pregnancy (e. g. Holden et al., 1993). Holden found

pregnant adolescents having lower perception of self worth compared to non-pregnant peers. However, other studies (Robinson & Frank, 1994) do not confirm this association. Kenny (1995) suggested that small, nonrepresentative samples of pregnant adolescents, control groups with potentially different characteristics, and difficulties in measuring self-esteem might have contributed to such mixed results. While low self-esteem is assumed to be an antecedent of teenage pregnancy, some suggest that becoming pregnant may in fact result in loss of self-esteem (Kenny, 1995). Unplanned Teenage Pregnancy Research Project — Review of Literature 21 Raphael (1972) pointed to a range of psychological issues underlying teenage pregnancy, e. g. depression, replacement of a loss, de