



DEPARTMENT OF
HUMAN SERVICES

RESEARCH PAPER

Unplanned Teenage Pregnancy and the Support Needs of Young Mothers

Part B: Review of literature

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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.

- 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 socio-economic 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 longer-term 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).

- 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

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.

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.

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 Informat 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 Milne-Home 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.

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

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 al., 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.

□ 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.

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 behaviour 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

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).

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.

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 et 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.

□ 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).

□ 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 contraceptive 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

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).

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 behaviour:

- **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 the age gap was five years or more (Moore & Driscoll, 1997)

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

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).

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

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, non-representative 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).

Raphael (1972) pointed to a range of psychological issues underlying teenage pregnancy, e.g. depression, replacement of a loss, deprivation and hostility in childhood/family background, uncertain femininity and self-punishment. A history of loss in the six months prior to conception was reported to be very high (as much as two thirds of participants in the study by Neville, 2000). Records (1993), by comparing lives of pregnant and non-pregnant adolescents, identified change of school, interpreted as a loss event, to be a significant risk of adolescent pregnancy.

□ Education and other cognitive factors

Poor academic performance has been linked to teenage pregnancy (DuBois et al., 1992, Holden et al., 1993). Rauch-Elnekave (1994) identified a significant level of learning problems in the sample of American young mothers and suggested that motherhood may offer these women a sense of success in contrast to their academic failure. In this context, he proposed that pregnancies for these women might not be “unintended”. The available information in Australia seems to confirm the links between poor school performance and teenage pregnancy, however it is not clear if this is more a reflection of the socioeconomic areas from which the information was drawn rather than the characteristics of pregnant adolescents (Kenny, 1995). According to Holden & Dwyer (1992), the majority of young women who become pregnant in Australia leave school before becoming pregnant and truancy, particularly amongst very young teenagers, can provide an early warning sign.

Other cognitive factors identified in the literature include less ability to conceptualize the future consequences of actions and acting in a more impulsive manner (e.g. Trad, 1994). Lack of problem-solving skills as well as unrealistic expectations about parenting are also mentioned in this context. The study of Littlejohn (1992) found that 20% of pregnant teenagers thought they could not get pregnant. This indicates lack of understanding of the reproductive process or lack of acceptance of their sexuality. For some this reflects the sense of “invulnerability” and belief that this could not happen to them. Holden et al., (1993) found that pregnant adolescents, in comparison to non-pregnant adolescents, expected it to be much easier to parent. However, this may imply an attempt by pregnant teenagers to come to terms with the pregnancy (Kenny, 1995).

3.2 Decisions about pregnancy

Young women experiencing an unplanned pregnancy are faced with a decision whether to continue or terminate their pregnancy, and whether to raise the child or offer it for adoption. Some researchers have investigated factors that influence these decisions and differences.

Research in the UK (Tabberer et al., 2000) concluded that decisions about continuation of pregnancy were influenced by beliefs that were held before the pregnancy. The prevalence and visibility of teenage motherhood in the local area and community views on abortion shaped these views. Decisions were usually formulated in the first 7 to 14 weeks after the discovery of pregnancy, with young women

receiving little impartial advice at that time. The range and nature of advice as well as the young woman's expectations of family support post birth were identified as crucial to her decision. Young women often became dependent on their family of origin after giving birth, refuting an assertion that becoming a parent was a way to independence.

The UK research suggests that boyfriends were at times instrumental in the decision making process if they held strong views on the topic. Mostly however, they chose to leave that decision to their girlfriends. Some women saw their boyfriends as peripheral to their decision because they did not see the relationship as important or were assured of support from their own families (Tabberer et al., 2000).

□ Parenthood

Some young women are more likely than others to continue with the pregnancy and keep the child. Factors similar to those that emerged in relation to early sexual activity and pregnancy seem to be involved. **The prevalence of higher teenage birth rates reflects areas of social disadvantage, including socio-economic factors, education and career expectations, peer models, acceptance of and access to abortion** (Siedlecky, 1996).

Overseas research identifies other factors linked to poverty, such as employment opportunities, community norms, and family dysfunction, influencing early parenthood (Kirby et al., 2001). Lack of job opportunities or career prospects reduces the "cost" of early pregnancy. Poor areas are more likely to have a higher incidence of substance abuse, poorer schools, less attachment to school, higher drop out rates, lower levels of education among adults, fewer economic opportunities and higher crime rates, all of which are linked to sexual risk behaviour and early childbearing.

A South Australian study (Harris et al., 1987) on the impact of unemployment on pregnancy decision making indicated that two thirds of pregnancy outcome choices could be predicted on the basis of four variables. **Teenage mothers were more likely to keep the baby if they were poorly educated, had a low income, came from a large family, or if their mother had her first child as a teenager.** Harris et al., (1987) also found that those young women who kept their babies were more often married or living in a de-facto relationship and left school at a younger age, having achieved less well. Unemployment and a steady sexual relationship were identified as clear risk factors. However, the choice of having a child was not a way for young women to ensure an income, as at times has been suggested in the media, but rather because the mothering role seemed to be an obvious stage in their lives and more attractive in comparison to other options available to them.

The study by Clark (1984) in Sydney's western suburbs (lower socio-economic area) found that most pregnancies for the young women in the study occurred early in the relationship, were unplanned and no contraception was used at the time of conception. The young women did not see abortion or adoption as an alternative and accepted their fate (of being a parent). According to Montague (1991) many young women from disadvantaged backgrounds held conservative views with regard to pre-marital sex (inhibiting use of contraception) and were also less likely to be accepting of abortion.

Wilson (1989) stressed that adolescent experiences of pregnancies and parenthood are not uniform, with different groups reflecting different issues. She acknowledged that variables such as educational level, race, and area lived in are significant but she also stressed that for some young women mothering reflected a traditional role they expected to hold in the society. Wilson (1989) concluded that some teenage pregnant women see parenthood as their only logical career path, often repeating previous family history. However, she also suggested that decision making for these women was often subsumed by outside circumstances, expectations and views of the community they lived in, the influence of own mothers and expectations of the baby's father and his family. Wilson suggested that some pregnant teenagers in her study were inclined to delay acknowledging the signs of pregnancy to avoid being pressured to abort, having made their mind up to continue with the pregnancy. For others, avoiding facing the reality and the decision was the reason for the delay. For some young mothers the decision to carry on with the pregnancy was influenced by having a mother who was a teenage parent, or siblings or friends who had children (Genuardi, 1994; Nord et al., 1992; East & Felice, 1992; Holden et al., 1993).

Available literature on this subject supports the conclusion by Luker (1991):

“Young women often drift into pregnancy and parenthood, not necessarily because they affirmatively choose pregnancy as a first choice among many options but rather because they see few satisfying alternatives. As long as young women do not have a vision for the future that having a baby at an early age will jeopardize, they won't go to the lengths necessary to prevent pregnancy” (p.22)

□ Abortion

Each year about half of known teenage pregnancies in South Australia end in abortion (Chan et al., 1999). The decision to abort is influenced by a range of factors, most of which reflect social dynamics rather than the specific personality profiles of women making such choices (Wilson, 1989). Availability and accessibility of services, whether real or perceived, is undoubtedly influencing the decision making and outcomes of teenage pregnancy, with socio-economic factors impacting on this (Siedlecky, 1986). Young women who choose abortion are more likely to be doing well at school and have higher educational aspirations (Henshaw & Silverman, 1988). Women of all ages surveyed by Chan et al. (1994) and who chose abortion instead of parenting were more likely to be single, employed outside the home, have had a previous pregnancy, their current pregnancy was unplanned, have a tertiary education and be in a short term relationship.

The study by Littlejohn (1996) looked at differences between women who chose abortion and those who continued their pregnancy. Women who chose abortion were more likely to be older, be at school before and after becoming pregnant, and have parents of higher socio-economic status and a larger number were living at home before and after becoming pregnant. In addition, those women who chose to terminate gave reasons for their decision based on the welfare of the child. According to Littlejohn, many young women who chose to continue their pregnancy justified their decision by saying they “did not believe in abortion” or would not consider adoption. In the study by Clark (1984) younger age and the extent to which the child was perceived to interrupt life plans were the major factors impacting on a decision to

terminate. The decision of very young teenagers was influenced to a large degree by their parents.

Research into decision-making of young women from the UK (Tabberer et al., 2000) based on in-depth interviews with 41 teenage women experiencing an unplanned pregnancy indicated few were considering an abortion. Anti-abortion views were quite prevalent in the group and abortion was not discussed as an option with families. Those who chose to have an abortion usually knew someone who had made this decision or who was willing to offer advice. Others felt that their circumstances were exceptional and therefore justified having an abortion.

Australian abortion laws differ in each State/Territory. While abortion is generally available to those that need/request it, there are still issues around its provision. In South Australia most abortions are performed in the public system, in contrast to New South Wales or Queensland where they are carried out in private clinics. However, transport problems, concerns about privacy, and understanding of the system, may be significant problems for young women in any state. No research exploring those issues was identified.

□ Adoptions

Another path opened to young women who continue with their pregnancy is adoption. This however, is not an option many young women choose (around 3% has been suggested by Sobol & Daly, 1992). Those mothers that choose adoption in a Canadian study by Sobol & Daly (1992) had higher socio-economic indices and were less influenced by negative views about adoption within their social networks. It seems that young women who are clear and confident about their future due to their success at school are more likely to seek termination or give their child for adoption (Boulden, 2000). The UK literature suggests that there is a considerable level of antipathy towards adoption amongst women in lower socio-economic groups (Blair Report, 1999). However, the longitudinal study of adoption in Queensland indicated that mothers who opted for adoption were usually young (under 19 years), poor and without a partner (Najman et al., 1991).

3.3 Hazards of adolescent pregnancy

Teenage pregnancy, particularly for young women under the age of 18, carries significant social and health risks. Pregnant adolescents, particularly younger women, have a higher rate of medical complications (Academy of Pediatrics, 1999; Adelson et al., 1992). The risk of repeated pregnancies and abortions is higher for those young women who fall pregnant at an early age. As most pregnancies are unplanned and many teenage women experiment with alcohol, cigarettes and drugs, they and their child are at risk. Lovell & Littlejohn (1997) found that half of their study participants smoked and one third consumed alcohol during pregnancy. 64% reported use of illicit drugs prior to pregnancy but this dropped significantly during pregnancy. The potential for birth defects as a result of alcohol consumption during pregnancy has been well documented. There is also sufficient evidence linking low birthweight and maternal smoking in pregnancy (Adelson et al., 1992, Chan et al., 2000). Low

birthweight can impact on health and development of children, even in later childhood (see section below). A review of research by Cunnington (2001) on health risks of teenage pregnancy confirmed the potential for poorer health outcomes for mother and child. The research suggested that increased risk of anaemia, prematurity, low birthweight, pregnancy-induced hypertension, intra-uterine growth retardation or neonatal mortality was mostly caused by the social, economic and behavioural factors that predispose some young women to pregnancy. However, the author stressed that a wide range of factors impact on pregnancy outcomes, some of them not known, making strong determination about cause and effect difficult.

The most consistent risk factor leading to adverse outcomes was the adequacy of antenatal care. Cunnington (2001) suggested this might not be so much the benefit of antenatal care but a reflection of the fact that those who report late in their pregnancy may represent the most disadvantaged groups. They may not realize they are pregnant or wish to hide the pregnancy and they may behave more dangerously during pregnancy (with regard to nutrition, drug use, and smoking). However, early and regular antenatal care and nutrition can be significant in improving the outcomes and reducing risks to babies.

Social costs, such as interruption to schooling and training, reduction in career prospects and interference in the process of transition into adulthood, potential grief and guilt associated with an abortion or adoption, poverty and reduced future opportunities for both mother and child, and the potential for social isolation – are some of the risks faced by teenage mothers. Some of these risks are discussed in more detail in the next section.

4. Teenage parenthood

Parenthood has a significant impact on parents regardless of age. It results in more constant demands on time, attention and energy, the loss of income and diminished independence, changed social standing and sense of self, including body image. Teenage parenthood presents particular risks and challenges.

□ Mothers

When parents are adolescents the transition to parenthood is often complicated by the developmental process of identity formation (Erikson, 1968). It has been suggested that the impact of having to assume adult roles before resolving personal identity issues may lead to low self-esteem (Lindsay et al., 1999). Self-esteem, in turn, has been closely linked to parental competence and mastery, impacting on the quality of interactions between mother and child and potentially leading to higher levels of stress (e.g. Lazarus & Folkman, 1984 in Lindsay et al., 1999). The importance of supportive networks in such circumstances is obvious.

Adolescent mothers vary in their parenting capacity and ability. Three sets of factors have emerged as influencing individual parenting competence in adults. These are the psychological health and well being of the parent, sources of stress and support and particular characteristics of the child (Shapiro & Mangelsdorf, 1994).

Research by Lindsay et al.(1999) examined parenting stress in adolescent mothers in Western Australia. Participants identified the relationship with the child's father as a main source of stress but other issues, such as a sense of competence and ability to cope with the baby, accommodation issues and lack of material resources, were also impacting. While most participants had a high level of family support few used community support networks. Those who were coping best had a level of support that allowed them to resume to some extent the lifestyle of their peers, for example by attending education. The research highlighted the vulnerability of adolescent mothers and the need for longer-term support post-delivery.

Young mothers in the study by Littlejohn (1996) identified accommodation and money as their most significant problems. Finding affordable and stable accommodation was difficult and women experienced prejudice when looking for housing. Most relied on social security payments and found it difficult to cope financially. Most had no contact with the father of the child and few received maintenance. The majority left school early. While some indicated an intention to return to study they found it difficult to do so, due to problems with childcare, transport, etc. Others did not wish to study further, however many wanted to improve their employment prospects. Social isolation was identified as an issue by the women, as was the need for support, information and contact with other young mothers.

The information gathered by Clark (1984) from a small group of teenage mothers indicated that all found motherhood challenging and hard but also rewarding. Having family support was of great importance. There was little involvement from the

fathers, who appeared to abrogate responsibility for the child. Young single parenthood was neither planned nor advocated by those who experienced it.

Burghes & Brown (1995) found that young women's experience of motherhood was often at odds with their expectations and hopes for a more "traditional" life. The information gathered from young parents in the UK suggests that while they loved their children they did not realize how hard being a parent would be (Blair Report, 1999). While for some the child provided a much needed trigger to change their lives (by giving up petty crime, drugs, or considering education) most found parenting much harder and felt ill prepared to cope with it. Many faced significant barriers to work and education.

Longer term prospects for teenage mothers are not much better. Kiernan (1995) examined longitudinal data to investigate social, educational and economic circumstances of teenage parents. Those who became parents at an early age were less likely to own their own home and more likely to have lower income than other families. They were more likely to receive income support and, in a small minority of cases, to have experienced homelessness. Mothers who started childbearing early tended to have larger families. Unemployment was twice as common amongst young fathers. By age of 33, from those who went on to live with the child's father, only one in three were still in that relationship. Teenage mothers who gave birth outside marriage were more likely to be living as single parents. The longitudinal Swedish study by Olausson et al., (2001) also supported a view that parenthood in adolescence posed a risk for socio-economic disadvantage in later life. In that study even adolescents from relatively comfortable backgrounds were affected.

The last ten years of research, particularly in the USA, attempted to challenge the negative view of teenage childbearing. Some suggested that early motherhood does not necessarily make the mother's situation worse and in some circumstance can in fact be beneficial to her socio-economic status (Hoffman, 1998). Most of such research focused on trying to compare outcomes for teenage mothers with a equivalent group, e.g. sisters who gave birth at different age, or teenagers giving birth to a single child in comparison to twins (assuming that the difference between having one and two children would be as valid as between those who had one and none), and young women who became pregnant and miscarried versus those who gave birth. Hoffman (1998) examined relevant literature and concluded that while **the new research** identified additional factors such as family and individual characteristics as significant contributors to poor outcomes it **did not provide compelling evidence that "the independent causal effects of teenage parenting are positive, zero or even just marginally negative"** (p.7).

Some of the difficulties with firm conclusions about the impact of teenage parenthood relate to the fact that young mothers are not a uniform group. There are likely to be considerable differences in terms of risks and outcomes for a younger woman who is single, has very few resources and receives little support from her family and an "older" adolescent in a stable relationship, with clear life goals and supportive family.

□ Children

The development of children and their subsequent life chances are the product of a wide range of factors at individual, family and community level. It is clear that children living in impoverished and disadvantaged circumstances are at risk. Poverty is likely to have an impact on the child's life chances including education, employment, housing and health outcomes.

Lifestyle factors during pregnancy, such as nutrition, smoking, and the use of drugs may have an impact on fetal growth and development, with potential longer-term consequences for the child. While the relationship between risk factors and low birthweight is complex and influenced by psychosocial, economic and biological factors (Chomitz et al., 1995) the long term impact can be significant. For example, low birth weight babies have a higher rate of subnormal growth, illness, and neuro-developmental problems (Hack et al., 1995). However, the authors emphasize that adverse socio-demographic factors have a far greater impact on the cognitive development of low birth weight children. Living in poverty has been linked to a greater risk of developing conduct and emotional disorders (Steinhouser, 1998 in Jack, 2000) while having an adolescent mother has been linked to lower IQ, more physical health problems in later childhood, lower motor and mental development scores (Phipps-Yonas, 1980) and a higher likelihood of being a victim of child abuse (Bolton et al., 1980).

The issue of child abuse and teenage motherhood has been controversial. While some studies identify age as a clear risk factor for child abuse (Schellenbach et al., 1992; Connelly & Strauss, 1992) others point to more general social and economic factors rather than age (e.g. Bolton, 1990). Some suggest that the risks are a result of less attention, less interaction and less patience from young mothers (Christ et al., 1990; Culp et al., 1991). Others see socio-economic factors and education as significant in such outcomes (Buchholz & Korn-Bursztyn, 1993; Harris et al., 1987). In addition, Buchholz & Korn-Bursztyn (1993) identified factors such as level of support, insecurity about their parenting role, depression and stress as impacting on parenting skills of young mothers. They also suggested that financial, social and emotional stresses faced by the mothers, rather than age, are critical in determining levels of risk.

The research evidence is far from clear. Failure to uncover a direct link between maternal age and child abuse has led some researchers to conclude that there is no increased risk of teenage mothers abusing their children (e.g. Dubowitz, 1987). This view may be too simplistic. Buchholz & Korn-Bursztyn (1993) acknowledge that while maternal age alone may not be predictive of abuse, the risk of maltreatment for children of teenage mothers may lie within the stresses, both financial and emotional, faced by these women and lack of support from their families and partners. Some variables, such as lack of parenting skills, are important factors in child abuse and adolescents may be at greater risk of lacking such skills. Younger adolescents have also been identified as potentially experiencing higher risk of parenting difficulties (Hamburg, 1986) and their children have a worse prognosis than children of older adolescents (Buchholz & Gol, 1986; Hamburg, 1986).

Dukewich et al., (1996) examined maternal and child factors that place adolescent mothers at risk of abusing their children. They identified preparation for parenting as

the strongest predictor of child abuse potential, i.e. less prepared mothers had a higher potential for abuse. The research points to a lack of accurate understanding amongst mothers of children's capabilities and the responsibilities of parenthood as critical determinants of maltreatment. It has been suggested by Schorr (1989) that educating teenagers about the responsibilities and requirements of parenthood has the additional effect of reducing the likelihood of teenage pregnancy as young people realize they are not ready for parenthood.

■ Fathers

The literature relating to adolescent fatherhood is very scant, with Australian research on the topic practically non-existent. However, there is a growing interest and research in this area, particularly in the United States.

American studies indicate that boyfriends who are considerably older are responsible for the majority of teenage pregnancies (Elders & Albert, 1998). For example, over half of all infants born to women under 18 were fathered by adult men, with 40% of 15-year-old women having infants with partners aged 20 years or older (Landry & Forrest, 1995 in Elders & Albert, 1998). This research suggests that on average the age gap was 4.2 years for "older" adolescents and 6.7 years for "younger" teenagers. The prevalence of teenage fatherhood in the USA has been estimated at between 2% and 7% with higher rates amongst inner city and minority youth (Stouthamer-Loeber & Wei, 1998). A history of being involved in adolescent pregnancy was found to be clustered with other health risks and problem (Spingarn & DuRant, 1996). Stouthamer-Loeber & Wei (1998) found that fathers were twice as likely to be delinquent than non-fathers and the delinquency did not decrease after young person became a father. The young fathers were more likely to be less educated and more were frequent drinkers and drug dealers in comparison to a control group. A study of young men in Pittsburgh pointed to an association between those who did poorly in school and lived in adverse neighbourhoods and likelihood of becoming fathers (Breslin, 1998).

However, after reviewing relevant literature Parke & Neville (1987, in Moore and Rosenthal, 1993) concluded that partners of adolescent mothers are not a homogenous group with regard to age and background. As a result, their characteristics and ways of dealing with parenthood differ.

According to Moore and Rosenthal (1993), a "substantial minority" of teenage fathers never acknowledge their paternity. This may be a result of ignorance, disbelief, reluctance or fear of accepting responsibility. Osofsky, Hann & Peebles (1993) point to conflicting data regarding fathers' involvement and desire to maintain contact with their children and mothers. According to Parke & Neville (in Moore & Rosenthal, 1993), despite general perception to the contrary, young fathers maintain some contact with their children over time, although these efforts are far from trying to assume full responsibility for the child. In some circumstances this contact is affected by restrictions placed by the mother, acting as a gate keeper and determining the nature and extent of the relationship. Simms & Smith (1986) followed young fathers 6 months after birth of their child. Those fathers who remained in contact with the child were very positive about parenthood, although the extent or nature of their involvement was not clear. Many young fathers felt that decisions regarding

pregnancy were taken out of their hands with their wishes or needs often ignored. Lack of support services for teenage fathers meant that they were not provided with required information and assistance in adapting to their new role. The result was that young fathers often escaped their responsibility by leaving. The general view is that while young women carry the stigma of early pregnancy, the same is not the case for young men, who are seen as “getting away” from their responsibility or experiencing very few consequences of their own. The literature suggests that young fathers, as much as mothers, struggle with the transition to parenthood and associated stress caused by financial responsibilities, education, paternity decisions, and feelings of guilt and blame for the pregnancy. Some experience stress as a result of rejection from the child’s mother or from peers.

Miller (1997) highlighted some of the issues faced by adolescent fathers. These include in many cases a strong sense of obligation to the mother and child as well as a desire to be actively involved in child-rearing and decision making. Those that were excluded felt isolated and confused and were more likely to abrogate their responsibility. The role of maternal grandparents was often significant in determining the involvement of the child’s father.

Regardless of the initial involvement, fathers’ contribution tends to decline after a few years as the relationship with the mother changes. Factors that promote paternal involvement have been identified in research with African-American adolescent fathers. These included the presence of adequate support (from family, peers or service providers) and positive self-image. Adequate support of adolescent fathers was seen as essential in ensuring on-going and positive involvement in their children’s lives and current services were seen as insufficient. Those fathers who attempted to take some responsibility felt punished for doing so by having few supports, services and understanding about the difficulties they experience (Boulden, 2000).

No Australian research specifically focused on fathers could be identified. A study by Lovell and Littlejohn (1996) looked at the relationship of adolescent mothers with the child’s father. They noted that most of the fathers were “missing” or absent. A high number of these relationships were characterized by violence. Many teenage mothers formed new relationships during pregnancy or after birth but these usually were brief. The relationship with the child’s father was often conflictual and contact quite negative, focusing on child support payments and access arrangements. Many mothers in the study were reluctant to put the father’s name on the birth certificate because of the tensions in the relationship. However, the majority (71%) wanted the father to be involved. Women in the study emphasized lack of support for fathers around issues of becoming a parent.

5. Service provision

With early pregnancy and childbearing linked to a range of social, cultural, economic and psychological factors, it is not surprising that there is no simple solutions to the problem and single interventions are unlikely to succeed. However, research provides some indication of effective strategies for teenage pregnancy prevention and positive ways of supporting young women during pregnancy and post birth. These will be examined in this section of the review.

5.1 Prevention

Overseas research and European experience point to the need for a range of strategies. Review of the US research suggests a three pronged strategy of prevention consisting of sexual education, contraceptive services and motivational opportunities and related services (Advocates for Youth, 2001/e). Effective aspects of each intervention are outlined below.

□ Sexual education

Available information suggests that narrowly focused sex education programs are not likely to succeed. For example, a review of programs from around the world indicates that programs that only teach abstinence are less effective, or in some instances ineffective, in comparison to those promoting delay of sexual activity as well as improving contraception knowledge amongst those that are sexually active (Baldo, et al., 1993 in Advocates for Youth, 2001/f). Research suggests that balanced, realistic sexual education, focused on both abstinence as well as contraception can delay the onset of sexual activity, increase the use of contraception by sexually active young people and reduce the number of their sexual partners (Advocates for youth, 2001/e).

Educational programs are most effective if they provide accurate information, are developmentally appropriate and encourage skills development, including decision-making, assertiveness and negotiation skills as well as life skills, training and goal setting (Frost & Forrest, 1995; Howard & McCabe, 1990; Kirby et al., 1991 in Advocates for Youth, 2001/e). They need to actively involve adolescents and be culturally specific and sensitive (Advocates for Youth, 2001/g). Use of peer counselling and support is often indicated. There is compelling evidence to suggest that well prepared programs promoting safer sex can delay sexual activity and increase contraceptive use (Grunseit et al., 1997; Gourlay, 1996) and comprehensive sexual education does not increase the level of sexual activity (SIECUS, 1999). Overseas experience provides clear evidence that sexual education aimed at normalizing sexuality, providing accurate medical information, promoting values of respect and responsibility and encouraging communication in a relationship have been an important part of the strategy to reduce teenage pregnancies in some European countries (Kelly & McGee, 1999; Moore , 2000). Mass media campaigns used to promote open discussions about sexuality and emphasizing the need for responsible/ethical sexual behaviour and informed choices were also a part of this approach. Sexual education within the school system was often widely integrated into

a range of subjects as well as being taught as a special unit (e.g. Germany and France). The low pregnancy and birth rates in those countries point to the success of these approaches.

The Blair Report (1999) offers some examples of effective programs from the UK, the Netherlands, and the US. These programs include an anonymous telephone helpline, training of parents to assist them with providing positive sexual education to their teenage children, multi-dimensional developmental programs for young people, school-based programs promoting abstinence as well as sex education, peer education programs, and programs aimed specifically at sisters and daughters of teenage mothers.

Girls Inc. provides an example of a multifaceted program that focuses on:

- educational and career pursuits and skills to avoid pregnancy;
- a positive relationship with parent/s with a particular focus on communication about sexuality and values;
- strategies to resist pressure to become sexually active;
- establishing links to community health services including access to contraception.

The evaluation of the program indicated that while no single component was effective, the program as a whole was successful in reducing the pregnancy rates (Advocates for Youth, 2001/g).

Goldman (2000) sees sexual education as moving into new domains and being delivered in more an instantaneous, accessible and individualized way through use of new technologies. Already a range of sexual information is available on the internet. Undoubtedly many young people will benefit from this information provision, but its effectiveness is yet to be evaluated. Issues of access need also be considered, particularly for those from disadvantaged backgrounds (e.g. young people dropping out of school, living in poverty).

Littlejohn (1992) has advocated for more adequate sex education programs in schools, comprising life skills, nutrition, self-esteem, assertiveness training and parent support/education. Peer education was one of the strategies suggested. More information about the nature of motherhood as well as about abortion would need to be provided as part of a sexual education program.

□ Contraceptive Access Programs

Effective contraceptive access programs provide contraceptive counselling, supply of contraceptives and follow up care to ensure proper and consistent use. Such comprehensive approach helps to overcome the barrier identified in contraception use by teenagers and including cost, lack of knowledge where to access contraception and fear about possible side effects. Brindis & Davis (1998) provide the following list of service tasks and characteristics required of a teenage family planning service:

1. Targeting teenagers before they become sexually active;
2. Assuring accessibility of services;

3. Providing intensive, community wide outreach services;
4. Providing a range of comprehensive and confidential services;
5. Identifying teenagers at risk and targeting hard to reach and under served youth.

Cromer & McCarthy (1999) interviewed a range of professionals on issues relating to adolescent pregnancy in four countries (Great Britain, Netherlands, Sweden and USA). The information was used to develop an ideal family planning service for young people. Such a service comprised **multidisciplinary staff** who were friendly and non-judgmental, provided **continuity of care**, **counselling** was included in family planning visits, **outreach** was provided to inform teenagers regarding the service, **location** was convenient (near school or in residential areas), hours were **flexible** and **cost** of service low .

The Blair Report (1999) describes some successful programs involved in improving access to contraception. These were characterized by having extended opening hours, offering a range of services around pregnancy testing, contraception advice and counselling, and support around sexual health choices. In one of the programs, an outreach worker linked with young people who did not attend school. The advice was free, confidential and a free taxi service was available to access services, which also provide emergency contraception.

Reducing barriers to contraceptive availability and accessibility is reflected in European practices. Oral contraceptives are provided free of charge and following minimal examination and information gathering (Moore, 2000). The sexual health services are either free or low-cost and have generous hours of operation (Kelly & McGee, 1999). In France, condom distribution machines are provided in schools and use of contraceptives is supported by wide-spread public education campaigns (Boonstra, 2000)

The effectiveness of a well run and comprehensive contraception program is illustrated by an example of a South Carolina school/community program (Advocates for Youth, 2001/g) in which a school nurse provided condoms, assisted teenage women with access to the local family planning clinic, and provided counselling. In addition, teachers and administrators were offered extra training in areas of sexual education, adolescent decision-making, self-esteem and communication. Information was also available to local church leaders, clergy and parents. The strategy was supported by a media campaign. The rate of teenage pregnancy in the community was halved (from 77 per 1000 in 1981/82 to 37 per 1000 in 1984/86). Subsequently, the rate rose to 66 pregnancies per 1000 in 1987/88, when the state prohibited dispensing contraceptives in school grounds.

The “Girls at risk” report prepared by Women’s Coordination Unit in NSW (1986) emphasizes the special health needs of young women. The report identifies some of the factors that hinder access to health information and services for this client group. These include ignorance about available services, misinformation about health needs, the threatening/intimidating nature of professional medical services, difficulty in obtaining sympathetic and confidential advice, and cost. Lack of knowledge of where to go, fear and embarrassment in seeking assistance and having no one to accompany them were also high on the list. The cost of services and not identifying outside help

as an option were also mentioned. Outreach services were favoured by many. The report also suggests that workshops on a range of topics vital to this client group should be conducted in venues frequented by young women.

Emergency Contraceptive Pill (ECP)

The Emergency contraceptive pill (ECP) has the potential to reduce unplanned teenage pregnancies, with US research indicating a potential of averting as many as 50% of teenage pregnancies (Trussell et al. (1992). However, there are problems with access (Walling, 1997). The lack of knowledge/information about ECP amongst women and medical staff was identified as a problem in the US (Advocates for Youth, 2001/d). Various strategies have been proposed to improve awareness as well as access. It has been suggested that young women should be provided with an “in advance” pill to avoid access problems and delays in the post-intercourse period (with the pill being only effective if administered within 72 hours of intercourse). Other options offered as solutions included allowing pharmacists to provide ECP without prescription (Advocates for Youth, 2001/d).

The limited availability of ECP as an option is reflected in South Australian research on the use of contraception (Taylor et al., 2000), which identified only 2 women (out of 4278 respondents) as users of the morning after pill. The mean age for these women was 49 years. A Victorian survey of women attending a health clinic for pregnancy counselling indicated that most women (80%) had heard about the ECP. However, only a quarter (26%) knew that it had to be taken within 72 hours of intercourse and only 9% had used it (McDonald & Amir, 1999). The authors argued for the increased availability of the ECP by making it available without a prescription. Such an approach seems justified in view of the research conducted in NSW by Weisberg & Fraser (1995). The researchers surveyed knowledge, attitudes and practices of general practitioners in NSW with regard to the ECP. They found that women and rural GPs were more knowledgeable, while women and urban GPs were more likely to prescribe it. There was also no consistent practice of providing women patients with information about the ECP. The authors concluded that gender, attitude and knowledge of GPs influenced the likelihood of women being made aware or being given ECP in NSW.

□ Multifaceted Programs

“Education, employment and self-esteem are the most powerful contraceptives of all” according to Gleick et al. (1994). Comprehensive programs, focused on alternatives to pregnancy through vocational training, academic tutoring and support, career counselling, part-time employment or involvement in community service are therefore an essential element of successful interventions with vulnerable populations. Sexuality/reproductive health education and life skills training form part of such programs. While costly, these approaches have been identified as critical for disadvantaged youth and those at high risk of early childbearing (Advocates for Youth, 2001/g). The US Teen Outreach Program provides an example of such an approach. It is aimed at high school students and offers information on reproductive health, assists in the development of life skills and provides opportunities for community service. The program is offered in small groups and the facilitator acts

also as a mentor. The evaluation of the program points to fewer pregnancies, fewer course failures and fewer school suspensions for the participants.

5.2 Support to pregnant and parenting adolescents

The earlier sections of the review indicate the need for support services to pregnant young women in relation to decision making, antenatal care and post-birth support. This section will look at what constitutes an effective service for this client group. However, it has to be noted that the available literature is more of a descriptive nature, with few programs supported by sound evaluations and clear evidence of effectiveness.

Access to impartial information and support at the time of pregnancy is critical, particularly for young women who do not want to conform to the norms and expectations of their community, family or partner. Nash (1998) describes a pregnancy service for young women in Geelong, where **confidentiality, availability of accurate, up to date and unbiased information and support** to assist them with a decision making process, are seen as essential service elements. **Quality of staff**, not only having relevant clinical skills and knowledge but also able to demonstrate their genuine liking of and interest in young people, was also seen as critical. **Co-operation with other agencies** and services was identified as important in ensuring consistent and responsive delivery of services.

The Victorian Department of Health (1990) surveyed the health needs of young pregnant women in Victoria. The resulting report pointed to the fact that while the young pregnant women form a relatively small group, they have particular needs. Their irregular attendance at antenatal clinics, tendency not to participate in hospital based childbirth education classes, and higher level of dissatisfaction with their antenatal care were identified through the survey. The study also noted that young women continued to face difficulties in the post natal period, with limited family or social support, unrealistic expectations of having a baby, and limited financial resources contributing to the problem. The higher risk of postnatal depression for younger women was also identified.

Tilbury et al. (1990) attributes poor antenatal attendance to young women feeling intimidated by main stream services and judgmental staff attitudes, feeling powerlessness and not having the confidence to face the pregnancy as well as lack of knowledge about the importance of care during pregnancy. Services therefore should be geared to the specific needs of this client group. Better access to existing services as well as provision of alternative programs is emphasized. **Such programs need to go beyond obvious health issues and include focus on housing, income, access to services, self-esteem and relationships.**

Lack of preparedness for the stress and responsibility of parenting and lack of peer contacts were identified by Zubrzycki et al. (1991) as requiring post-birth attention and support. Facilitating peer contact and on-going participation in services through

"buddy system" was a strategy used by the authors. The "buddy system" and provision of transport were effective in maintaining motivation and participation in the program. Formal recognition of young mother's parenting role, an aspect often neglected in mainstream services, was also seen as critical. Other significant aspects of service delivery for this client group identified in the literature included location ("place already seen as acceptable to young people"), a holistic approach, and non-judgmental staff (Pollard et al., 1992). Morris (1993) emphasized continuity of care, outreach and informal network formation and peer support. Advocacy and lobby for extra resources was also seen as important. Littlejohn (1992) stressed the need for better access to education, improved childcare, peer support, assistance with housing and financial support.

Healy (1996) examined the support needs of young mothers from a child protection perspective. The research identified the extreme vulnerability of young mothers to a wide range of pressures, including poverty and social isolation, further affected by transience. The study discussed appropriate responses to the needs of young families. The absence of formal or informal childcare opportunities was identified as a significant issue contributing to parenting stress. The need for respite from daily responsibilities and opportunities for socializing and relaxation, as well as social isolation and stress, could be assisted with appropriate childcare support. The research also examined women's views about the contribution of their partners to the well being of the family and concluded that more caution should be exercised in evaluating the partner's role. Some women pointed to the fact that having a partner created an impression of support, which could keep other services/friends away while in fact the presence of a partner was a significant stress factor.

The Blair Report (1999) provides examples of effective teenage pregnancy support from the UK. These are characterized by a range of services beginning in pregnancy and continuing post natally. Services are provided on an individual or group basis, with continuity of staff considered very important. Involvement of families and the father is encouraged in order to develop support networks for the mother. Continuity of education is also strongly encouraged. Specific programs, such as Newpin Teenage Mum's project, offer a broad range of service delivery models including support groups, personal development programs, a telephone support line as well as practical support.

Local programs provide examples of effective service provision for teenage mothers. Barkaway & Ranford (1993) established a group for teenagers with babies in the western suburbs of Adelaide. The majority of young women who attended the group were physically and emotionally isolated, with strained family relationships and little support from their friends/peers. Most were single parents or in an unstable, often violent relationship. Many were victims of abuse with a history of contacts with helping agencies that made them fearful and distrustful. The mothers in the group lived from crisis to crisis, experiencing problems with housing, finances, relationships and health. Many used drugs and felt powerless to change their lives. Attempts at including these women in existing programs were not successful. The aspect of the group identified as particularly important was an **ability to respond to young women's needs** (which ranged from transport to provision of food), and the **ability to assist them in times of crisis, and adjust the program to suit their particular interests and needs. The process of involving young women in the group was**

gradual, beginning with visits from the CAFHS (currently C&YH) nurse. **Making a connection with someone in the group** was also important for young woman's on-going participation. The most significant aspect of the service was **flexibility** and **adequate resourcing** which allowed the provision of practical assistance.

The recently evaluated Parenting Network provides services to families “at risk of poor social and health outcomes” in the western metropolitan region of Adelaide. About a third of the clients of this service are young parents (under 18 years of age) and many have complex needs. The service has a capacity to **work intensively and over an extended period of time**. It provides linkages to other services as well as direct support to parents. The evaluation report (Tesoriero & Chung, 2000) points to the **flexibility** of the service as an important factor. Having no specific type of intervention or time limit, the service can respond to the diverse needs of clients in an individual way. The evaluation points to participants' increased confidence and ability to cope with their parenting role in the longer term. Participants valued the information provided by the program, the advocacy role of the Parenting Network and the “respectful and encouraging warmth of the workers”.

Another recently evaluated program in Adelaide – “Talking realities...young parenting project” (Jolley, 2001) – used a peer education model to provide training and support to young mothers to develop a parenting and health program for school students and other groups of young people. The program aimed at “increasing the capacity of young people to make informed choice regarding parenting and health” through better knowledge and information. At the same time, the program aimed at improving social health outcomes for young parents in their role as peer educators. The evaluation points to the benefits of the program for both peer educators and recipients of the presentations. Young mothers demonstrated increased life, parenting, communication and conflict resolution skills as well as greater confidence and assertiveness, organizational ability, leadership and knowledge about services and resources available. Recipients of the training increased their understanding of social, emotional and economic issues facing young parents, knowledge of services for young parents and awareness of where to go for information on sexual health.

In recent times there has been greater recognition of the needs of adolescents fathers. Most US programs for young men focus on contraception, with some also looking at the responsibilities of parenthood and men's role in child rearing (ReCAPP, 2001). There are indications that such programs are working, with a higher proportion of participants using contraception and expressing more positive attitudes about the need to discuss contraception before sexual intercourse and taking responsibility for children they father. Miller (1997) argued for services for adolescent males to be similar in content to services for adolescent females, covering child development and parenting classes. Adequate employment and vocational training were also important for this group.

6. Special needs groups

Certain groups of teenagers, such as country, Aboriginal and homeless youth face particular problems with regards to unplanned pregnancy. This section of the report examines available literature relevant to those groups.

▪ Country youth

The Rural Mural research project (Hillier et al., 1996) examined issues relating to sexual behaviour of young people living in rural Australia. The study involved nearly 1200 secondary school students from 8 country towns (with a population less than 10,000) from three States of Australia (Tasmania, Queensland and Victoria). The age of participants ranged from 12 to 17, with 5% of individuals in the study identified as Aboriginal or Torres Strait Islanders. The study suggests that rural young people are not any less sexually active than other Australian youth, with young women and men in the sample commencing sexual experimentation and intercourse at an age similar to urban adolescents (27% of the study participants were sexually active). Similarly, the reported rate of condom use was comparable to that found by Donald et al. (1994) amongst Australian secondary school students. In contrast, the 1997 research by Lindsay et al. (1997) noted differences 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 a similar survey was conducted in 1992, where urban youth was more likely to be sexually active.

The adequacy of sex education was explored in the Rural Mural study and described as “varied”, with some students receiving only minimal information on the subject. It seems that in provision of sexual education the emphasis was placed more on “biomedical topic” (such as STDs, contraception, and menstruation) and less on socio-cultural. Surveyed students indicated a desire to find out more about “resisting pressure to have sex” as well as “the values about sex” in addition to having more information on contraception and abortion.

The Rural Mural research emphasized particular problems for country youth in ensuring privacy and confidentiality with regard to sexual matters. Young women in particular experienced a sense of being watched and judged by the community with regard to their sexual conduct. This created considerable problems in accessing contraception or sexual health services. One of the significant issues that emerged for country youth was the strong presence of double standards for young men and women with regard to sexual behaviour. This created pressure for both sexes. Boys felt pressured to conform to what was expected of them as males (which included sexual relationships). Girls had to deal with a pressure from the boys to have sex while at the same time being expected to appear sexually naïve and inexperienced. This left them with little room to negotiate for their own sexual safety. While this is not a problem unique to country youth the “visibility” and lack of privacy make this problem worse in a small community.

Not surprisingly, access to services was identified as problematic. In some States, the availability of helplines (such as Kids Helpline in Tasmania) afforded young people access to information and privacy. A number of young women in the study identified lack of access to a female doctor as a problem. Distance to services, lack of services due to geographical barriers, isolation, lack of access to educational and retraining opportunities, as well as “small town issues” of confidentiality were identified by Littlejohn (1992).

Bull et al. (1996) examined the support needs of pregnant adolescents in rural communities in Australia. Disadvantages faced by this group included lack of choice, information and privacy, limited access to services and problems with transport. Teenage women in the country, similar to their counterparts in metro areas, were reluctant to use mainstream services. The study examined six different services for pregnant and parenting adolescents operating in rural areas in order to identify most effective service delivery models. The features of the best practice model included:

- **Flexibility** (ability to respond to specific needs/demands of the target group identified through actively seeking out and listening to consumer feedback).
- **Accessibility** (access to transport, hours of operations, allowing walk-ins, presentation).
- **Continuity** (same staff member continuing with same client as much as possible).
- **Acceptance** (attitudes and philosophy expressed in staff behaviour and in the procedures of the service and atmosphere of the premises).
- **Confidentiality** (consideration given to how much information is needed, issues relating to mandatory notification).

In addition strong community ties, good networking and support from staff were seen as important.

▪ Homeless youth

The high level of vulnerability and complexity of needs faced by homeless youth is reflected in the available research examining the sexual health of this client group. Howard (1995) looked at sexual risk behaviour of Sydney street youth and concluded that while knowledge of safe sex was generally good, less than half of the study participants (46% of females and 47% of males) indicated adhering to these practices on a regular basis. A high proportion of those surveyed (40% of females and 19% of males) stated that they did not practice safe sex. Females in the study presented as a much more disadvantaged group affected by physical and sexual abuse, drug abuse, emotional problems, and family conflict at a level much higher than males in that group.

The sexual health of young homeless people was the subject of research conducted by National Centre in HIV Social Research. The first part of the research (Hillier et al., 1997) focused on describing the sexual health profile of the homeless youth in Australia constructed on the basis of nearly 850 questionnaires completed by participants aged between 12 and 25 from urban and rural areas of Victoria and

Queensland. 10% of participants were born outside Australia and 12% were of Aboriginal &/or Torres Strait Islander descent, indicating a considerable overrepresentation of Aboriginal/TSI youth in the homeless population. The survey was supplemented by in-depth interviews with 75 young people. While the study did not look specifically at issues of pregnancy and parenthood, sexual practices and problems were discussed.

The research indicated that most of the young people surveyed were sexually active (with 86% having experienced sexual intercourse). The average age of first sexual intercourse for this group was 2 years earlier than for the “mainstream” adolescent. The level of knowledge of safe sexual practices was lower in comparison to the general adolescent population, and the level of unprotected sex was higher. Girls were less likely to “always” use a condom and more likely to “never” use it. Reasons for not using condoms included dislike/discomfort, expense, and difficulty in negotiating their use, being in a regular relationship, and higher payment for sex without a condom. Not surprisingly, the group had a higher level of STDs as well as more general health problems. High level of drug use was also prevalent in the group and linked to less stable housing and more risky sexual practices. Engaging in sex work was common and placed them at particular danger. In some cases the risky practices young people were engaging in were a reflection of their poor quality of life and lack of concern about what happened to them. The research highlighted the difficulties involved in balancing personal safety with the everyday pressures and problems associated with homelessness.

In a number of ways the needs of young homeless people, for adequate information and skills to deal with sexuality issues, was similar to those of “mainstream” adolescents. However, the fact that a priority for this group was basic survival made it more difficult to address sexual safety. The research suggests that establishing close relationships between a young person and a worker was important. The service qualities valued by participants included “non-judgmental” and trusting relationship built over time and “workers who tended to ‘look out’ for the young person”. Such workers were sought out when young people needed support around health, sex and drugs issues.

The research identified differences with regard to service usage between those aged 18 and over and those 17 and under. The “older” group was more likely to report feeling comfortable about contacting services such as family health planning clinics, hospital and sexual health clinics, doctors or student welfare coordinators. The “younger” group found it more difficult to access sexual health support services highlighting their particular vulnerability. This group was less likely to have an income and had fewer housing options. At the same time, they were as sexually active as the older group, with the similar number of sexual partners in the last six months.

The second part of the report (Harrison & Dempsey, 1997) reflected information gathered from service providers working with homeless youth. This information highlights the increased risks faced by this client group with regard to sexual health, further compounded by the impact of poverty on their general health and nutrition. Service providers identified a number of **barriers to safe sexual practices** including **low self worth, lack of knowledge, the expense and accessibility of contraception,**

pressure to have sex, and a transient lifestyle. The high incidence of sexual abuse experienced by young homeless people reflected their vulnerability, further reinforced by the prevailing gender norms and role definitions. Sex was often used as means of survival (for example, exchanging sex for a place to sleep) leading to a considerable power imbalance and little scope for ensuring safe sex practices. Sexual health was given a low priority by both clients and service providers, with the main focus being on meeting basic needs for accommodation and food. Many workers felt ill equipped to provide the necessary information and support, with lack of knowledge in some areas, discomfort in talking about sexual matters, particularly when talking to members of the opposite sex, concern about overstepping role boundaries or cultural and religious taboos, all acting as barriers. Many agencies providing housing to young homeless had policies discouraging sexual relationships between clients, an approach that forced those relationships underground and made dialogue about sexual issues difficult. Some of the workers involved in service provision commented on the low level of knowledge about sexual health and safety amongst homeless youth. Many young people in the group gave an impression of being able to keep themselves safe and some service providers make incorrect assumptions about the level of knowledge and experience the young people had.

Service providers participating in the research were asked to identify what they considered as successful or unsuccessful sexual health interventions with homeless young people. The following characteristics of **successful interventions** were identified: **informal, interactive and experiential, participant driven, user friendly in employing an appropriate language, involving peer education and a variety of media for teaching and learning.** Unsuccessful interventions, on the other hand, were in lecture format, involved large groups, used complex language, provided irrelevant information and reflected a judgmental approach. Single gender groups were seen as more successful than mixed.

The rising numbers of young homeless and pregnant women were identified by the Adelaide's St. John's Service for homeless youth. Their report suggests that twice as many young pregnant women were using their service in 1998/99 compared to 1994, with 15% of all young females accommodated at St. John's in 1998/99 being pregnant (Malycha, 1999). The information collected by the service suggests that these women received less assistance in comparison to other teenagers when pregnant, when in hospital, and after discharge. For example, out of 164 young mothers accommodated at St. John's in a two year period, only 10% accessed pre-natal classes, 23% accessed post-natal care or support, and only 15% had breastfed their baby. Concerns about the level of care provided by these mothers and their ability to cope resulted in 97 notifications of child abuse/neglect to statutory authorities. These figures reflect the level and complexity of needs of this group.

The needs of homeless pregnant or mothering young women were a subject of a Victorian research by McDonald (1992) who was able to interview 27 women. Her findings highlight the vulnerability of this group, with very limited financial resources and lack of adequate, stable housing. While for some women pregnancy/motherhood precipitated the housing crisis, more than half were homeless before becoming pregnant. Most left home as a result of conflict, alcoholism or violence. These factors underline the particular risks for these women, living with the aftermath of conflict, neglect or abuse and chronic homelessness. The need for on-going and wide-

ranging support was stressed by the author. While this is a particular problem for single young women, McDonald suggests that young couples affected by poverty and lack of support are similarly at risk.

The health needs of homeless young people have been frequently identified in the literature and include poor nutrition and dental care, multiplicity of health issues, reluctance to seek help except in crisis, and a history of physical and sexual abuse, alcohol and drug abuse. McDonald's study collated information from health professionals regarding issues of pregnant adolescent women. Participants commented on a significant level of denial of pregnancy amongst teenage mothers, particularly in the early stages of pregnancy. This impacted on the preparation, both physical as well as emotional, for birth, and also resulted in young women delaying any required changes in their lifestyle with a possible impact on pregnancy outcome and decision making, narrowing the range of available choices. In the post-natal period, failure to maintain contact with health practitioners, low level of breastfeeding, post-natal depression, drug and alcohol abuse, ignorance about nutrition and hygiene, and chronic health problems (such as asthma for both mother and child, and respiratory and middle ear infections for children) were prevalent. Existing problems were further compounded by poor education, substandard housing, domestic violence, and poverty.

McDonald (1992) stressed access to appropriate affordable and stable housing as most significant intervention for homeless young women with children. However, for many, additional support was required. According to young women and workers interviewed by McDonald (1992) important aspects of support would include financial assistance and management training, community integration, personal support, practical assistance, assertiveness training and advocacy. There was less clarity about the most successful methods for delivering such services. Support groups were generally unsuccessful. Outreach by a family aide or trained volunteer was effective, as were less formal interventions that equalized power and provided practical assistance. The main strategies for improving health provision included outreach in the antenatal and post-natal period, increasing sensitivity of mainstream services to the needs of this client group and better coordination of existing services and responses.

The Australian literature provides descriptions of a range of programs for this client group that appear to be effective. Sageman & Cook (1995) outlines an outreach midwifery program for homeless pregnant young women in North Melbourne. The focus of the program was on reducing high-risk pregnancies and poor post-natal outcomes amongst young homeless women. Again, the characteristics of the program included flexibility, continuity of care and a holistic approach with financial, housing and health needs support. The program was tailored to individual needs.

A Young Parent Program was one of a range of innovative health service for homeless youth in Queensland (Fatur et al., 1992). It was provided on a one to one outreach basis, with a focus on education, assistance with attendance at medical appointments and support throughout the pregnancy and post birth. The important advantage of services for this client group was being a part of an established youth service.

■ Aboriginal youth

Aboriginal young women are at particular risk of giving birth at a young age. The Aboriginal teenage fertility rate for 1999 was more than four times that for all teenage births in Australia (77.1 births per 1000 compared to 18.1 - ABS, 2000). In addition, Aboriginal mothers, and Aboriginal teenage mothers in particular, carry additional health risks including higher perinatal mortality rate and low birth weight babies (Day et al., 1999). Higher risks of poor outcomes for Aboriginal teenage births were also pointed to by Chan et al. (2000) and linked to smoking as well as age, malnutrition and lower intake of micronutrients. Despite this situation, research in the area of Aboriginal teenage pregnancy is practically non-existent. Selected studies relating to Aboriginal women provide some insight into issues. However, the relevance of this information has to be considered not only with regard to age but also differences between urban, rural and remote Aboriginal communities.

Some surveys discussed earlier in this paper, included a proportion (sometimes as high as 12%) of Aboriginal young people. However, none provided a separate analysis of Aboriginal data. As a result, little is known about the sexual behaviour of Aboriginal adolescents and reasons behind high rate of births. Burbank (1995) provided an anthropological analysis of teenage pregnancy within a small rural Aboriginal community. The author suggested that premarital pregnancy was a reflection of adolescent resistance to an arranged marriage and a wish to choose own partner. It also provided a means of “being a mother without being a wife”. While the role of mother was expected, accepted and valued within the community, the relevance or contribution of husbands to the household was at times questioned by females.

There are many social and cultural factors affecting Aboriginal adolescents, which contribute to their vulnerability to early pregnancy and birth as well as other health problems. Brady (1993) links the increase in births to changing sexual practices, drug and alcohol use and relaxation of ritual seclusion between the sexes. However, Brady (1993) also pointed to the “protective” role of early motherhood, with teenage women invariably ceasing petrol sniffing once pregnant.

Little is known about attitudes and use of contraception by Aboriginal teenagers. Samisoni & Samisoni (1980) examined contraceptive use amongst Aboriginal women in Brisbane. While most relied on the contraceptive pill (57%) the failure rate was very high (69% for all forms of contraception with the pill accounting for most failures). Harris (1988 in Brady, 1992) interviewed young Aboriginal mothers in Burke (rural NSW) and concluded that their pregnancies were not necessarily an outcome of poor contraceptive knowledge but rather premature school leaving and poor life opportunities and expectations. Khalidi (1989 in Brady, 1992) came to a similar conclusion in his study of fertility amongst Aborigines in Central Australia. Age at leaving school was a clear determinant of fertility, with motherhood providing focus and social position in the community. However, the Aboriginal concept of “women’s business” and associated belief that such matters were private and personal created a barrier to effective management of fertility for some women (Chan et al, 1994).

The South Australian study on contraception and abortion (Chan et al., 1994) is one of a few that considers issues of Aboriginal women in some detail. The study included 31 Aboriginal women of various ages. In comparison to non-Aboriginal participants, Aboriginal women had a higher proportion of younger participants, reflecting the younger age at which Aboriginal women tend to become pregnant. The greater disadvantage of the group was reflected in lower education and income levels. A large proportion of the Aboriginal women in the study relied on their mother for information about contraception, with less using doctors as a source of information. Their awareness of services was generally lower. Aboriginal women in the study were also more likely to state that “no one took responsibility for contraception” (with 23% giving this response in comparison to 4% for all women). This proportion was particularly high for women who continued with their pregnancy (45%). Aboriginal women had a higher mean number of previous pregnancies (96% having had a previous unplanned pregnancy and 81% describing their current pregnancy as unplanned). Use of contraception was low with the main reason for not using it being “did not consider”.

Effective service provision to Aboriginal young women is an important issue. Some research points to a different pattern of service usage by Aboriginal youth with less likelihood of voluntarily approach for assistance, more likelihood of “falling out” of the system in the process of referral and re-referral and greater expectation of immediate practical response (DHS, 1998). The importance of the “word of mouth” in promoting services, and lack of knowledge of service availability and what they provide was also identified as characteristic for this group (DHS, 1998). Access could also be affected by the fact that it may be considered “shameful” to be seen using particular services (Jordan, 1995). The tensions between offering generalist and Aboriginal services is often reflected in the literature, with the generalist services seen as not always equipped to deal with sensitive cultural aspects, while privacy issues may arise in Aboriginal services. Another barrier suggested by the research relates to negative expectations some young people have about service providers, suspecting them to be judgmental.

Problems and barriers faced by young Aboriginal mothers attending birthing services at a Rockhampton Hospital were examined by Dorman (1997). The Aboriginal women interviewed for the project indicated the need for wide ranging services, including a comprehensive child health service, and a vigorous promotion of antenatal care. A community midwifery program was developed in Rockhampton as a response. The following features were seen as critical to program success:

- location of the service in the area where ATSI people tended to reside;
- home visiting;
- intensive promotion of the service using various strategies;
- provision of transport;
- antenatal services and post birth support;
- involvement of the client group in setting directions for the program;
- provision of a wide range of services and support.

The particular difficulties faced by Aboriginal young people in situations such as admittance to hospital need to be recognized and support provided. This can significantly improve compliance and continuity of treatment (AAAH, 1992).

For those most at risk, such as homeless Aboriginal youth, highly mobile and flexible outreach services have been identified as most appropriate. Regular presence in the streets is essential in establishing rapport and trust. Provision of social activities, education programs and a drop-in service is also important.

7. Summary

The literature relating to teenage pregnancy and parenthood is extensive if not always consistent in its conclusions. There is, however, some clear directions emerging. For example, there are obvious linkages between teenage pregnancy and parenthood and the following risk factors:

- **Lack of knowledge, skills, resources and motivation to protect against pregnancy.**

Having adequate knowledge about reproductive facts, resources to be able to access effective contraception, skills to negotiate safe sex and above all motivation to avoid pregnancy are essential elements of pregnancy prevention. Leaving school early, poverty and lack of educational or employment prospects impact on these elements.

- **Poverty and disadvantage**

The statistical information gives a clear picture of higher rates of teenage births in areas of socio-economic disadvantage. The literature points to earlier initiation of sexual intercourse, less likelihood of contraceptive use, and higher likelihood of continuing with the pregnancy amongst teenagers from disadvantaged backgrounds. While many factors are at play, lack of resources to ensure sexual safety as well as lack of motivation to delay parenthood contribute to this situation.

- **Family background and relationships**

There is a clear intergenerational pattern with daughters of teenage mothers more likely to become adolescent parents. In addition, family structure and functioning is linked to the age of sexual initiation and contraception use.

- **School performance**

Many teenage parents perform poorly at school and often drop out at an early age. School performance can act as a warning sign of early parenthood.

- **High risk behaviour**

Drug and alcohol abuse, lack of stable accommodation, and multiple sexual partners are some of the situations that increase the risk of unplanned pregnancy. Young people in those circumstances may also have little regard for own safety.

Despite some voices to the contrary, the literature is also convincing about negative impact of teenage parenthood, with both mother and child at a serious risk of social and economic disadvantage. Strategies aimed at reducing teenage pregnancies are therefore critical in reducing disadvantage. As Hoffman (1998) points out:

"...reduction of early parenthood will not eliminate the powerful effects of growing up in poverty and disadvantage...but it represents a potential productive strategy for widening the pathways out of poverty or, at the very least, not compounding the handicaps imposed by social disadvantage." (p.8)

Overseas research and experience provides extensive information about strategies for pregnancy prevention programs. To be effective they need to be wide reaching and provide information, access to contraception and alternatives to early parenthood. Universal provision of balanced, realistic sex education, focused on both abstinence and contraception has been effective in delaying sexual activity and increasing use of contraception amongst sexually active teenagers. Normalizing sexuality, promoting values of respect and responsibility and encouraging communication in a relationship have been an important part of the strategy in European countries, where very low teenage birth rates are a standard. Similarly, reducing barriers to contraceptive availability and accessibility has been linked to reduced teenage pregnancy rates.

The research highlights the importance of skills required to ensure personal sexual safety (such as assertiveness, communication and negotiation skills) as well as the motivation to avoid early pregnancy and parenthood provided by alternative life plans/goals. Programs that assist in the development of personal skills and offer educational support, vocational training, employment or community involvement are an important element of prevention.

Ensuring that these strategies are wide reaching universal programs needs to be balanced with initiatives targeting at risk adolescents and hard to reach and under-serviced groups. In Australia, this may include Aboriginal youth, homeless young people, those from disadvantaged backgrounds and those living in areas of high teenage birth rates.

Special consideration needs to be given to the needs of pregnant and parenting adolescents, with access to unbiased information and support in the initial stages of pregnancy and specifically designed wide-ranging services and supports in the antenatal period. These should be extended post-birth to ensure best outcomes for mother and child. Adolescent fathers must also be supported.

The literature is quite consistent in describing the characteristics of successful services for adolescents. The main features of such services include:

- Confidentiality;
- A non-judgmental approach;
- Flexibility;
- Easy access (outreach, flexible hours);
- Based on relationships/trust/continuity.

Strategies aimed at reducing unplanned teenage pregnancies and supporting pregnant and parenting young women and their partners must be wide-ranging and be provided along the continuum (as outlines in the following table).

A CONTINUUM OF INTERVENTIONS IN ADLOLESCENT PREGNANCY PREVENTION AND SUPPORT

<p>Prior to Intercourse</p> <p>Aim: - to delay sexual activity and prevent pregnancy and STDs</p>	<p>Strategies:</p> <ul style="list-style-type: none"> ▪ age-appropriate, skill-based balanced realistic sexual education ▪ parent-child communication about sexuality ▪ life opportunities/youth development ▪ academic support ▪ self-esteem enhancement ▪ communication skills ▪ creation of realistic awareness of potential short and long-term consequences of parenthood ▪ information about contraception ▪ targeting of ‘at risk’ groups
<p>Sexually active adolescents</p> <p>Aim: - to encourage use of contraception and prevent pregnancy</p>	<p>Strategies: ...as above and...</p> <ul style="list-style-type: none"> ▪ readily accessible contraception and information about available options (including emergency contraception) ▪ counselling and follow up service to ensure proper and on-going use
<p>Pregnant adolescents</p> <p>Aim: - to provide necessary information and support with regard to making decision</p> <p>- encourage regular antenatal care</p>	<p>Strategies: ...as above and...</p> <ul style="list-style-type: none"> ▪ confidential, easily accessible pregnancy options, counselling providing unbiased information and support ▪ adolescent specific prenatal care providing health services and support with regard to housing, practical needs, income, access to services, self-esteem and relationshipsence
<p>Adolescent Parents</p> <p>Aim: - work towards best outcomes for young parents and children</p>	<p>Strategies: ...as above and...</p> <ul style="list-style-type: none"> ▪ child care ▪ parenting skills training ▪ education/training ▪ employment ▪ support networks ▪ flexible support

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