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Teen Sexuality in Edmonton

The Committee on Teenage Sexuality
February 1991

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Introduction

In the spring of 1989 the Community and Family Services Advisory Committee, which advises the City on making funding allocations to a wide variety of community-based social service agencies or programs in Edmonton, raised a concern about the funding required by agencies to provide counselling support to teenagers in crisis due to unwanted pregnancies. Could more be done in the community to prevent unwanted pregnancies among Edmonton's youth and to better address needs of young women confronted with an unwanted pregnancy?

The Committee on Teenage Sexuality was established to explore the above question and other related issues such as sexually transmitted diseases. Representatives from the United Way of Edmonton and Area, the Edmonton Board of Health, the City of Edmonton's Community and Family Services Department, Alberta Health and Edmonton Social Planning Council met to discuss possible initiatives that might be undertaken. It was evident to those involved that an important first step was to provide some research and statistical information that would help frame discussions on possible responses to the issues of teen sexuality. It was also appreciated that, before discussing "what might be done", it was important to outline some of the existing services that were already available in Edmonton in response to the concerns that surround teen sexuality.

Section A of the following document, pulls together the major statistical information and a listing of some government and non-government services that are available in Edmonton. As well, it highlights a number of initiatives that have been successfully introduced here and in other communities.

Section B describes the rationale and process utilized in obtaining information and ideas from the community on the issues of teen sexuality. Contributions from teens, parents, professionals and agency staff were made through a series of focus groups held in Edmonton in October 1990. An ad hoc Community Advisory Group was established by the Edmonton Social Planning Council to assist it in this process.

Section C presents recommendations for action by the Committee on Teenage Sexuality. It also identifies the agencies committed to convening meetings in the community in order to pursue action strategies. The five issues identified as major areas of concern are sexuality education of teens, sexuality education of parents, service delivery, sexuality education/training of professionals and management of teen pregnancy and parenting.

A. Statistics, Issues and Initiatives

Housing and Social Planning Branch
Community and Family Services
May 1990

I. Trends in Teenage Sexual Behaviour and Attitudes

A. Changing Social Norms

Information from a variety of sources indicates that social norms for teenagers around sexuality have become increasingly more liberal. A survey conducted in the fall of 1988 found that 70% of Canadians in the 18 to 24 age bracket first had sexual intercourse when they were less than 18 years old. By way of comparison, this was true for only 40% of those who were between 25 and 44 at the time of the survey (King et al, 1989). Students surveyed in the Canada Youth & Aids Study made the following comments.

> *"Parents don't know how sexually active we are and think we don't need information about AIDS."*
>
> *"Sexual attitudes and behaviours have changed so much parents can't understand our feelings and activities."*
>
> (King et al, 1989)

A 1981 Calgary study which investigated the sexual attitudes, knowledge and behaviour of students aged 13 - 18 found that "premartial sexual relations between affectionate partners is acceptable to almost three-quarters of the teenagers...". (Miekle et al, 1981). A 1987 Edmonton study investigating attitudes towards AIDS and AIDS prevention found that teenagers believed sexual intercourse was both acceptable and normal with others their own age. "It's natural for teenagers to be sexually active. You've just got to be ready to handle the responsibility if you get her pregnant, that kind of thing". (Male, 16-17 years). The study also found that girls more often than boys cited peer pressure and the right person as determinants in becoming sexually active.

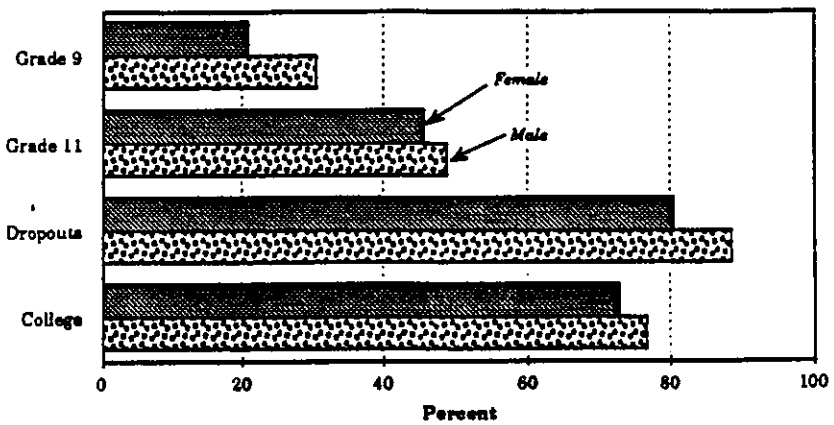
> *"I haven't had sex personally, but if the right guy comes along - sure. There's nothing wrong with being sexually active as long as you're taking precautions and you can deal with it." (Female, 16-17 years).*
>
> *"I bet if you ask anyone here, they'll say they've been in situations where it was incredibly hard to say no." (Female, 16-17 years).*
>
> (Results Group, 1987)

B. Sexual Behaviour

Recent studies conducted locally and nationally are consistent in their findings that nearly 50 percent of teenagers have had sexual intercourse at least once. A questionnaire administered to first year University of Alberta students found that 10 percent of the students reported first sexual intercourse at 13-15 years of age and 42 percent reported first sexual intercourse at 16-18 years of age. (Svenson and Varnhagen, 1990). The Canada Youth and AIDS Study found that 49 percent of grade 11 males and 46 percent of grade 11 females have had sexual intercourse at least once (Figure 1).

Figure 1

Sexual Intercourse



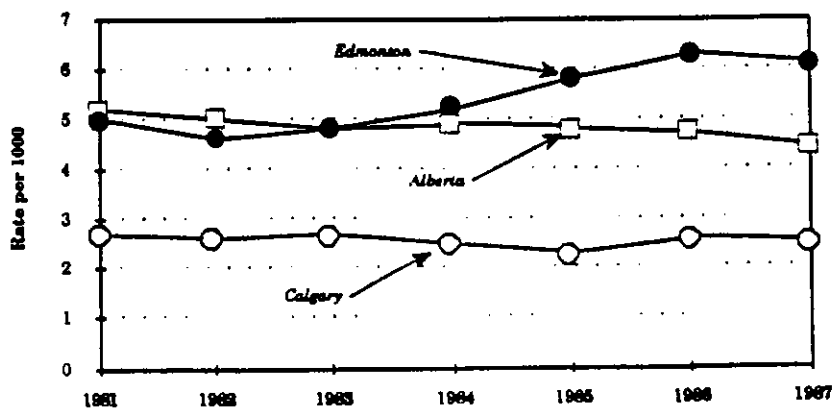
Source: King et al, Canada Youth and AIDS Study

C. Pregnancy Rates

Pregnancy rates are estimated by adding live births, still births and abortions performed in Alberta hospitals. The figures do not include ectopic pregnancies, abortions outside Alberta and spontaneous abortions. Data compiled by Alberta Health shows that the pregnancy rate in Edmonton has been rising since 1983 for 15 and 16 year olds and since 1985 for adolescents aged 17-19. Figures 2 and 3 illustrate pregnancy rates between 1981 to 1987 in two categories: all females aged 15 and under. and all females 16 to 19 years. The figures demonstrate Edmonton's trend upward above the provincial pregnancy rates as well as the large gap in rates between Edmonton and Calgary.

Figure 2

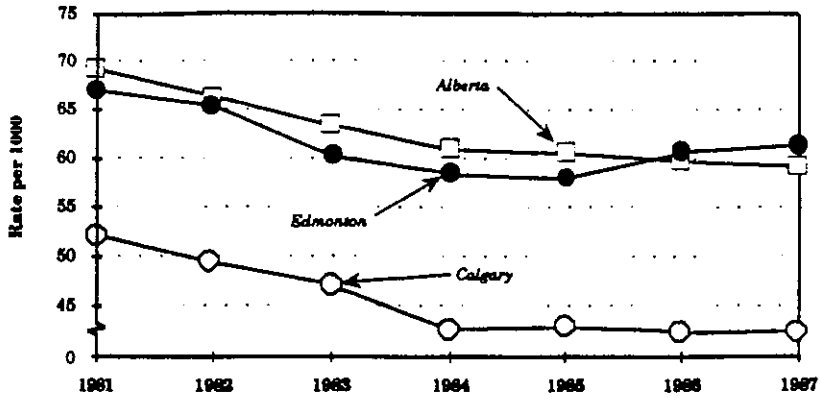
Pregnancy Rates (per 1000)
All Females, 15 Years and Under
Alberta, Edmonton, and Calgary (1981 - 1987*)



** Moving Average*
Source: Alberta Health

Figure 3

Pregnancy Rates (per 1000)
All Females, 16 to 19 Years
Alberta, Edmonton, and Calgary (1981 - 1987*)



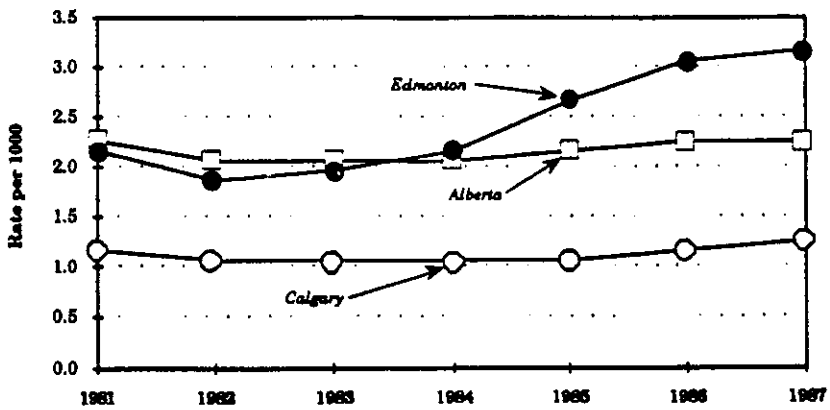
** Moving Average*
Source: Alberta Health

D. Live Birth Rates

Trends in the live birth rates among adolescents in Edmonton are similar to those exhibited by the trends in pregnancy rates, although the estimated pregnancy rates are 45 percent greater than the live birth rates. The Edmonton birth rate for females 15 years and under has shown a sharp increase since 1984, especially in comparison with the gradual increase by Calgary and in the provincial average (Figure 4). Between 1981 to 1987 the live birth rate for females aged 16 to 19 years corresponded closely with the provincial rate (Figure 5). A decline in birth rate is evident until 1985 at which time Edmonton's live birth rate for this age group began to slowly increase and rose above the provincial rate.

Figure 4

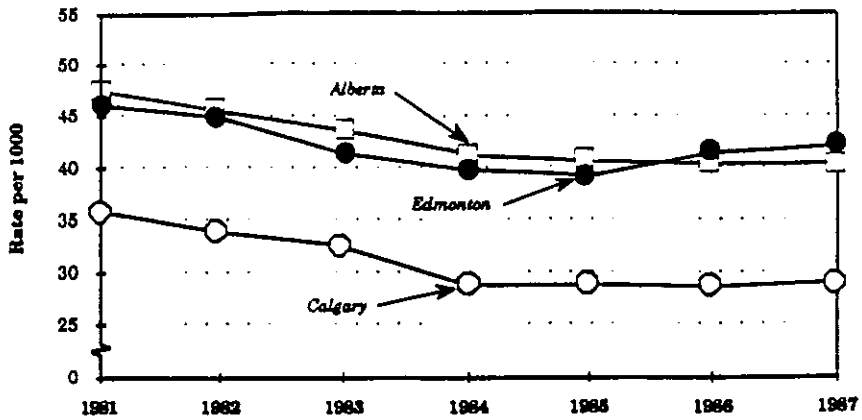
Live Birth Rates (per 1000)
All Females, 15 Years and Under
Alberta, Edmonton, and Calgary (1981 - 1987*)



** Moving Average*
Source: Alberta Health

Figure 5

Live Birth Rates (per 1000)
All Females, 16 to 19 Years
Alberta, Edmonton, and Calgary (1981 - 1987*)



* *Moving Average*
Source: Alberta Health

Provincial figures of births for 1988 and 1989 were not available, but 1989 preliminary data for Edmonton were made available by the Edmonton Board of Health. The birth rate of 5.7 per 1000 for females aged 15 years shows the rising trend in births among younger adolescents is continuing. The trend for females aged 16-19 years (40.2 per 1000) appears equivalent to 1987.

Teen Birth Rates
All Females, 15 to 19 Years - Edmonton (1989)

Age Group	Births	Population	Birth Rate (per 1,000)
15	18	3,159	5.7
16	66	3,295	20.0
17	149	3,288	45.3
18	208	4,491	46.3
19	257	5,228	49.2
15-19	698	19,461	35.9

Source: Edmonton Board of Health

E. Sexually Transmitted Diseases

The reporting of sexually transmitted diseases, or S.T.D.'s, is governed by the Alberta Public Health Act and accompanying regulations. Variations in provincial reporting occur accross Canada. However, information obtained through the analysis of laboratory reports from across Canada in 1987 show that Alberta males and females aged 15-24 years had the second highest rate of all provinces reporting for chlamydia (Todd et al, 1989). As well the incidence of pelvic inflammatory disease among 15-19 year olds in Alberta is 60% above the national rate (Adebayo, 1989). The more serious consequences of sexually transmitted diseases are infertility or death: at present there are 2 teens between 15 and 19 years with AIDS in Edmonton and 57 adults aged 20-29 years with AIDS, suggesting they may have contracted the HIV virus in their teens.

Between 1981 and 1987 syphilis and gonorrhea rates among female adolescents in Edmonton remained considerably above Calgary and the provincial average. Figure 6 provides the S.T.D. rates for females aged 15 and under and Figure 7 the S.T.D. rates for females 16-19 years. Edmonton shows a downward trend beginning in 1985 for females 15 and under, and in 1986 for females 16-19 years.

Figure 6

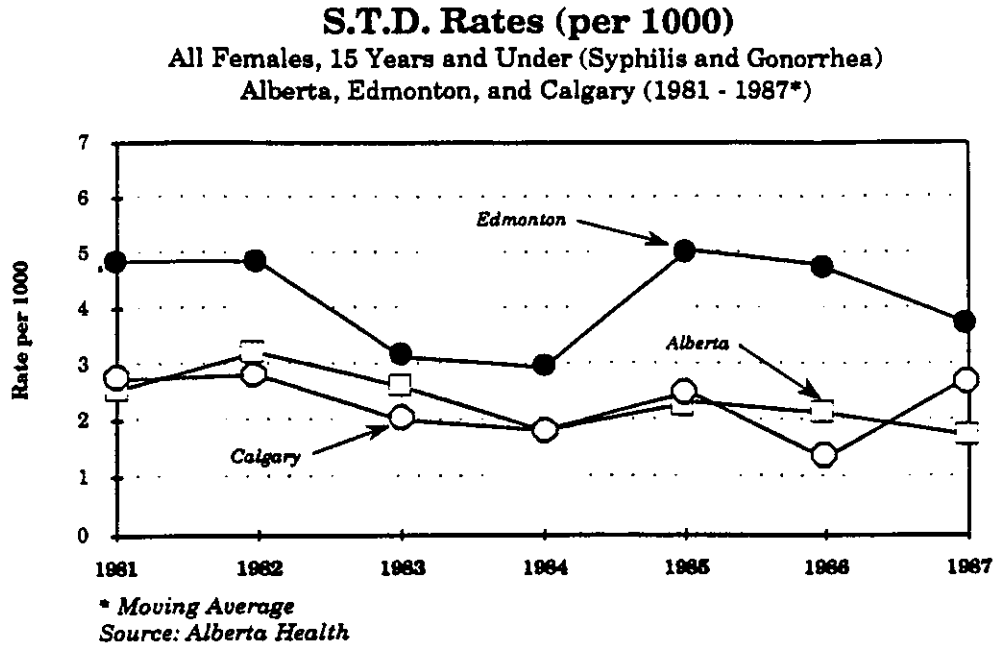
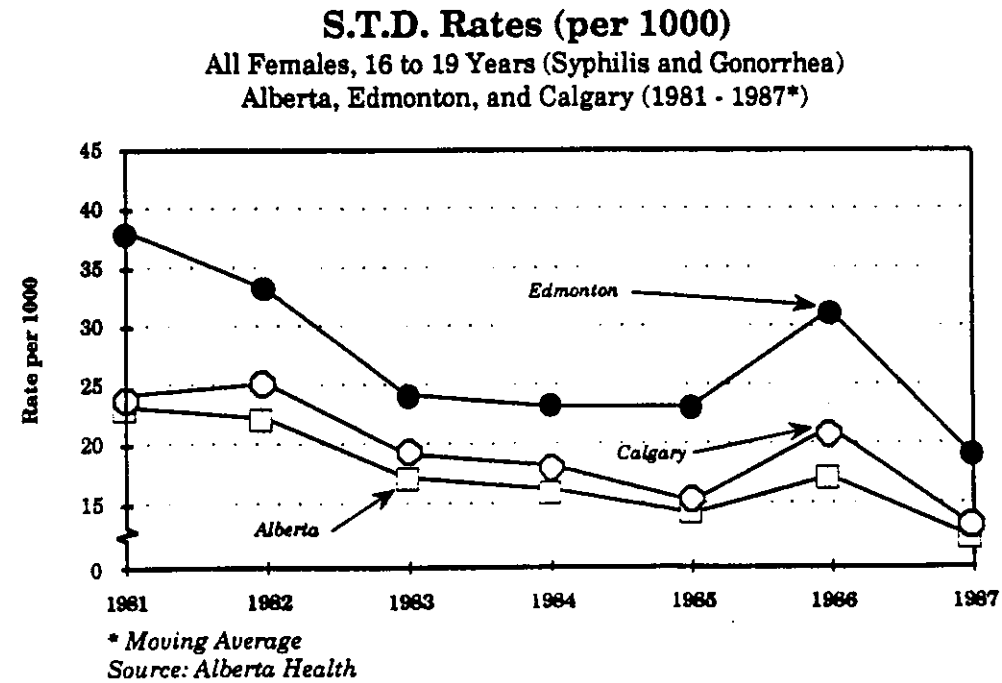


Figure 7



F. Conclusion

Alberta's two largest cities, Calgary and Edmonton, have considerable differences in their rates of adolescent pregnancy, births and sexually transmitted diseases. Calgary has a larger population of youth than Edmonton and measurements of the rates of sexual activity of students are similar (Meikle, Svenson). While several factors associated with increased risk of teen pregnancy can be ascribed to Edmonton, there is no conclusive explanation for higher rates in Edmonton.

Data from the 1986 Federal census shows that Edmonton has:

- a higher proportion of single-parent families than Calgary
- a greater proportion of the population with less schooling
- a 1985 average income level approximately $5,000 below Calgary
- a higher incidence (16.5% vs. 13.2%) of low income

A low socio-economic status (SES) has been associated with higher risk of teen pregnancy. However, as information on the socio-economic status of pregnant teenagers in Edmonton is not recorded, it is not known the extent to which the differing SES indicators of the two cities is a factor. Also unknown is the extent or type of programs and services in Calgary which address teenage sexuality other than with the Calgary Board of Health, which has a Health Services Sexuality Division consisting of seven sexuality educators and five administrative/support staff. Also, it can be assumed that sexuality education is offered in schools beginning in grade 4, since Alberta Education made it a mandatory part of school curriculum in 1989.

The next section provides an indication of sexuality programs and services for teens in Edmonton, the general foci of those services, and some issues with the existing teen sexuality service system.

II. TEEN SEXUALITY RESOURCES IN EDMONTON

A number of organizations and agencies were identified as providing direct or indirect sexuality services to teens in Edmonton (see list A. below). Direct services to teens include agencies/ organizations such as the Birth Control Clinic, TERRA, Planned Parenthood and the School Boards. Indirect services include Alberta Health and Alberta Education where sexuality resources and programs are developed largely to support professionals providing direct services to teens. Some of the direct service providers such as the Birth Control Clinic, Planned Parenthood and AIDS Network also provide inservice training to professionals or educators serving the teenage population. The table below categorizes services into four areas in order to reflect the major focus of each agency's sexuality service(s) to teens. Information services include pamphlets, consultation over the telephone, prerecorded tapes, information on (and possibly referral to) other resources/agencies. Clinic services involve a nurse practitioner or doctor providing services such as health and lifestyle assessment, examination, testing, and provision of contraceptives or other medication. Education services refer to information that is organized, preplanned and targeted to a specific audience such as teachers, parents or students. Counselling services usually include providing information on personal responsibility in decision-making, analysis of consequences of various sexual behaviours, contraceptive, S.T.D. and pregnancy counselling and referral where necessary. Most of the agencies identified offer information and education services. The majority of sexuality education services provided go beyond the physical aspects of sexuality to include consideration of relationships, values and decision-making.

A. Sexuality Programs and Services Which Target Teens

	Information	Clinic	Education	Counselling
AIDS Network	✖		✖	✖
Alberta Education			✖	
Alberta Health			✖	
Boyle McCauley Health Centre	✖	✖		
Edmonton Board of Health	✖	✖	✖	
Life Choices (Big Sisters)	✖		✖	✖
Planned Parenthood	✖		✖	✖
Public School Board			✖	
Reproductive Health Clinic (Royal Alexandra Hospital)	✖	✖		✖
Safe House (Catholic Social Services)	✖			✖
Separate School Board			✖	
Sexual Assault Centre	✖			✖
S.T.D. Control	✖	✖	✖	
Teen Aid			✖	
TERRA (Association for Assistance to Unwed Mothers)	✖		✖	✖
U of A Health Services	✖	✖	✖	
Youth Emergency Shelter Society	✖			✖

B. Issues and Needs

A number of agency representatives were interviewed and provided their perspectives on issues and needs relating to teenage sexuality in Edmonton. These perspectives have been organized to reflect the major themes emerging from issues and needs identified. The categories under which comments fall are as follows:

1. Professional Training Opportunities and Resources

- professionals who are involved, or have the potential to be involved, such as public health nurses, doctors, teachers and social workers, need to have specialized training in order to increase their competence and comfort level in this area. Such training should be included in their professional post-secondary education
- opportunities are needed for specialized training and access to resources, consultation and support for those professionals currently providing sexuality education and information
- availability of specialized training through current community resources, such as the Edmonton Board of Health, S.T.D. Control, Planned Parenthood and A.I.D.S. Network, are limited
- training, besides focusing on the positive and preventative aspects of sexuality, needs to include developing competency in addressing the needs of teens confronted with the negative impacts of their sexuality decisions

2. Easy Access to Family Planning Services for Teens

- need birth control clinics and services dispersed throughout the City and accessible outside school hours, i.e. evenings, weekends
- absences from school while accessing birth control information often hard to explain or keep confidential
- strong need for long-term follow-up counselling

3. Comprehensive Sexuality Education for Teens

- need for an intersectoral approach to sexuality education including health, social services, education, and advanced education
- need for accurate and specific information to dispel myths around sexuality, e.g. condoms break easily, "it won't happen to me", it only happens to identifiable groups such as gay men or IV drug users

- concern with the lack of comprehensive knowledge that teens have re: sexuality, e.g. not aware that some medications or illnesses may reduce effectiveness of the pill
- focus should be holistic health ; time issue - present school health curriculum is limited to 40-75 hours
- sexuality education is fragmented and connections made by teens are often erroneous
- sexuality education needs to be early in school system to catch kids before they drop out
- need to update elementary sexuality education program
- need to legitimize various methods of birth control as some teens perceive the risks of some methods of birth control as higher than the risks of pregnancy/ S.T.D.'s
- methods of imparting information needs to be on their level and appeal, e.g. AADAC - needs to be delivered in a variety of formats
- needs to come from a variety of sources as everyone has their own bias

4. Funding Programs and Services

- lack of money to run program more frequently or to allow expansion of programs into community
- need adequate and ongoing funding of services

5. Accessible Support and Education for Parents

- some existing resources for educating parents require too much of a commitment - e.g. 6-10 weeks
- need to assist parents to recognize new social norm amongst a growing number of teens for sexual experience not chastity
- need to know how to better support/empower families

6. Media

- need to recognize and deal with role played by media in changing social norms
- societal pressures towards living for the moment, enjoying "here and now" - persuasive in all areas of life, not just sexual
- need to use media effectively to educate public on sexuality issues
- important to combine messages from S.T.D. Control, A.I.D.S. program and AADAC into a sexual health theme rather than separate promotional health techniques

7. Motivating and Skill Building with Teens

- concern with teens utilizing knowledge to change behaviour
- new sexual norms cause pressure on teens to have sex
- getting/delivering services to youth - how do you access youth?
- many teens have no emotional connection with educational information
- kids are concrete - need things to be concrete to understand yet students need more than facts/information - need to learn skills about relationships

8. Program Coordination and Collaboration

- need better linkages between services - to ease access as well as to gain information that can be used to support clients until they can become engaged in service, e.g. how to support clients who disclose sexual abuse until they can access specialized services at the Sexual Assault Centre
- need to improve relationship with federal counterparts in regard to collaboration on resources developed, e.g. Health and Welfare Canada recently designated one of their staff to be Reproductive Health Consultant
- need to look at all issue areas relating to teens and jointly address them, not just focus narrowly on sexuality area
- need redistribution of resources, e.g. placement of Public Health Nurses - put in schools/ areas where needs are greatest
- need centres that teens can access for a variety of information including sexuality (should be open evenings)

C. Key Factors in Successful Service Delivery

Before embarking on new initiatives to address teen sexuality or making changes to existing teen sexuality services, it appears useful to have some knowledge of the key ingredients in successful service delivery. Research studies have identified the following as key factors in successful programs:

- early intervention
- physically accessible - e.g. on major buslines, close to targeted neighbourhood, near or on a school campus
- affordable - inexpensive, free, or sliding scale fee
- culturally sensitive - with multilingual and multiethnic male or female staff, as appropriate

- caring atmosphere - seeing whoever comes in, responding promptly, adapting professional schedules and habits to teenage needs
- continuity - long-term follow-up, sustained financial and social support
- targeting - age, gender, socio-economic, cultural background
- institutionalization - commitment from school boards, medical professionals, parents, community groups, government and business

These factors can be used as a basis for assessing the existing teen sexuality services in Edmonton and for identifying complementary programs from the initiatives described in the next section.

III. INFLUENCES AND INITIATIVES

A. Influences on Adolescent Sexual Activity

Indications are that adolescents are increasingly at risk for becoming sexually active, for contracting sexually transmitted diseases and for experiencing early pregnancy. Factors such as the earlier onset of biological ability to bear children, along with the lengthened process of educational and social maturation required in today's modern industrial society to prepare young people for independence and adulthood, contribute to the risk of early sexual activity. Other factors influencing adolescent sexual activity include the following:

1. Family

Parental involvement through communication of values and support have been identified as important in delaying the initiation of sexual activity. In the Canada Youth and AIDS study most respondents cited family members as the preferred source of information on sex and contraception.

2. Socio-Economic Status

It has been said that the best contraceptive is a hopeful future. Adolescents living in poverty or experiencing failure in school often develop the view that nothing worthwhile will be lost by dropping out of school, committing crimes, or getting pregnant.

3. Media

Messages from television, radio, film, videotapes, song lyrics and advertising have been criticized for promoting sexual activity without portraying the possible negative outcomes of such activity or the responsible use of contraception. Studies show that teenagers witness approximately 20,000 scenes of suggested sexual intercourse and behaviour, sexual comment and sexual innuendo in a single year of prime time television viewing (Brindis & Jeremy, 1988).

4. Peers

Adolescents look to peers for acceptance and emotional support and are therefore susceptible to their influence in the area of sexual activity.

5. Religion

Studies show that teenagers who attend church regularly are less likely to be sexually active. Traditional values and greater social support for delaying sexual activity are likely factors.

6. Risk Taking Behaviours

Sexual activity is but one of a number of risk-taking behaviours in which adolescents become involved. Other risk-taking behaviours which some teenagers participate in include smoking, use of alcohol and drugs, school drop-out and delinquency. As these behaviours are related to normal adolescent development and youth's perception of their own invulnerability, it is felt that these patterns will continue to occur unless specific, developmentally appropriate strategies are implemented to reach adolescents while still at school.

It has been demonstrated that early sexual activity is not dependent on the presence of any one circumstance or risk factor. However, each risk factor vanquished reduces the odds of early sexual activity and pregnancy or sexually transmitted diseases.

B. Initiatives Addressing Teenage Sexuality

Current interventions which address teenage sexuality fall into three major categories:

1. Programs that support deferring sexual activity.

2. Programs that maximize adolescents' abilities to make responsible decisions about sexual activity in the context of their lives.

3. Programs that facilitate sexually active adolescents' access to contraceptive services.

The models presented below are examples of initiatives undertaken locally, provincially and in other parts of Canada or the United States. Information on outcomes of some of the initiatives presented below was not always available.

1. Programs That Defer Initiation of Sexuality Activity

Target population: Young adolescents (ages 12-15)
Goals: To reach adolescents early i.e. while still in school and before they become sexually active.
Objectives:

- to provide information on how and why to defer sexual activity
- to increase teenagers' awareness of pressures to become sexually active
- to reinforce their ability to say no
- to build positive assertiveness skills

Approach: Class or group teaching method utilizing curriculum

Key Actors: Parents (who are provided special information sessions so that they can reinforce the teens' learning experiences at home). Peers (who receive special training).

Initiatives:

a) *Postponing Sexual Involvement* - Developed by Grady Memorial Hospital and Emory University in Atlanta, this "How to Say No" Program helps adolescents become aware of the social pressures and messages that make it difficult to say no. They are provided an opportunity to develop assertiveness skills through role-playing and are encouraged to consider realistic alternatives to becoming sexually active. Evaluation data show that 63% of students attending found it easier to defend their own points of view with friends regarding sexual involvement.

b) *It's Cool to Know your Way in a Relationship* - Alberta West Central Health Unit. The program trains peer leaders to provide fellow students with information on relationships and sexuality.

c) *Alberta Education - Junior High Health and Personal Life Skills Program.* The grade eight curriculum of this program includes a section on decision-making which covers such topics as:

- external influences on sexual attitudes,
- respect and sexuality,
- exploitation,
- decision-making process, and
- assertiveness

d) *Family Life Education* - Research has found that children delay the initiation of sexual activity when sexuality is talked about in the home. Programs have therefore been developed that focus on parent-children communication around values and sexuality. Planned Parenthood Association Edmonton and Family Life Education Council offer such programs locally on a regular basis. Topics include "How to Talk to Your Kids About Sex", "Raising your Child Conservatively in a Sexually Permissive World", "The Stork Didn't Bring You" and "Mothers and Teenage Daughters". Programs vary from one-time presentations to weekend workshops or weekly sessions over a designated period of time. Costs range from $20.00 to $65.00, depending on program length and ability to pay.

2. Programs that Assist Informed Decision-Making

Target Population: Adolescents aged 16-19
Goals: To reduce adolescent pregnancies
Objectives:

- to develop decision-making and communication skills
- to enhance self-esteem
- to understand human reproduction and contraception
- to foster responsible decisions about sex

Approach: Family life education messages targeted simultaneously at parents, teachers, church representatives, community leaders and students; seminar series; theatre; support and counselling services.

Initiatives:

a) *Public Health Information and Education Intervention Project - South Carolina* - Messages on developing decision-making and communication skills, enhancing self-esteem, understanding human reproduction and contraception were targeted simultaneously to a variety of audiences in the community. Over a period of two years the pregnancy rate and the number of live births dropped 50 percent in the county in which the program operated.

b) *Project Alpha: A Man to Man Talk About Teenage Pregnancy* - This program focuses on helping young men learn about their role in responsible child-bearing. The national program was initiated in 1979 in Chicago and is sponsored by Alpha Phi Alpha Fraternity, Inc. and the March of Dimes/Birth Defects Foundation.

c) *New Teenage Theatre* - Interact Theatre, Medicine Hat and the "On Thin Ice Program by Quest Theatre in Calgary are Alberta examples of sexuality education theatre. Theatre is used to show, through a series of vignettes, adolescents making responsible choices about sexuality, drug abuse, peer pressure and suicide. The performances cause adolescents to think about the issues through involving them in discussion about the topics presented in the plays, and to see positive role models deal with situations they encounter in their own lives.

d) *The Summer Training and Education Program* - Recognizing that school drop out and pregnancy go hand in hand for many teenagers, the program targets teens who are at high risk of school drop-out. The program model involves remediation in basic skills, a life skills component that includes making decisions about sexuality, and paid work experience during two consecutive summers. Students are followed throughout the academic year and provided support and counselling services in order to maintain their progress and remain in school. The program has shown some early successes, including reducing summer learning loss which is a contributing factor in school drop out and which poor youth experience more than their better-off peers. The Public/ Private Ventures group in Philadelphia started the program in 1985 and it is now being tested in a five-site national demonstration project.

e) *Peer Education Program* - The University of Alberta Health Services piloted this program in October 1988. The objective was to hire and train peer educators to provide information to first and second year students on AIDS. Now, because of student requests, information is also offered on sexually transmitted diseases, birth control, breast cancer, stress and mental health. Educators work in pairs and make presentations to groups or classes. Presentation format depends on the size of the audience and ranges from lecture to theatre and games.

3. Programs that Increase Access to Family Planning Services

Target Population: Sexually active teens
Goals: To overcome young people's psychological barriers to seeking care using education and outreach.
Objectives:

- to increase accessibility by providing clinic and education services in community settings
- to encourage healthy life-styles among teens
- to discourage risk-taking behaviours in teens

Initiatives:

a) *School-based Clinics* - Located in or on the grounds of junior high schools, the health services provided range from treatment of minor injuries and illnesses to health education and counselling in areas such as mental health, drugs and alcohol use and sexual decision-making. School -based clinics are in operation in Toronto and the Ottawa-Carleton School District. Studies in Kansas City and Baltimore showed no increase in sexual activity among students after clinic openings. Students already sexually active were more like to use contraceptives than nonpatients or students in control schools.

b) *Inwood House Teen Choice Program* - An outreach program in New York which utilizes social workers placed in seven junior and senior high schools to provide indepth counselling and life options support to students. Features include continuity of care, coordination and comprehensiveness of services, targeting of at risk adolescents, collaboration between students, parents, schools and service agencies, flexibility in care delivery and integration of health education, preventive health services and counselling within the student's educational world.

c) *Condom Vending Machines* - St. Albert, located northeast of Edmonton, recently became the fourth school district in Canada to install condom vending machines in high school washrooms. The process involved the collection of local data on rates of pregnancy and S.T.D.'s, an assessment of student knowledge, attitudes and behaviours, and input from school staff, students, the general public and health professionals. Ongoing evaluation will determine how this initiative, intended to be preventive, protective and integrated with the school health and sexuality curriculum, will affect student sexual behaviour.

In considering initiatives or programs that address teenage sexuality, it is important to include a variety of strategies that reflect diverse systems, cultural differences, and economic and educational disparity (Brindis and Jeremy, 1988). Viewing sexual behaviour and attitudes as strictly a moral issue ignores the associated health and social issues. In a democractic society it is necessary to provide adolescents and their parents with choices in confronting the issues of sexuality. Only with meaningful and realistic alternatives for youth will society make gains in preventing unwanted adolescent pregnancies and sexually transmitted diseases.

IV. CONCLUSION

The curent trends in Edmonton of increasing adolescent sexual activity, pregnancy rates and rates of live births clearly indicate a need for concerted action by community members in addressing teenage sexuality. Both individuals and society pay a high price for the unintended outcome of adolescent sexual behaviour. Personal costs related to teen pregnancy include the loss of childhood, education, friends and economic well-being. Public costs include provision of social and economic support programs and lost productivity. The 1987 Alberta report, In Trouble.....A Way Out, estimated the annual cost of providing social assistance to a parenting teen to be $8,776.00.

We know that last year in Edmonton 698 babies were born to adolescents aged 15-19 years. Since at least 85% of adolescents giving birth keep their babies, the cost of providing social assistance to them for one year if required, could approximate $5,204,168.00 per year. When the medical and hospital costs for treatment of sexually transmitted diseases are also considered, the community stake in avoiding the negative outcomes of adolescent sexual behaviour is enhanced.

Edmonton has several programs and services which address the sexual needs of adolescents. The major issues identified with the existing service system include:

- the need to assist adults recognize the more liberal sexual attitudes and behaviours of youth
- the lack of sexuality training for professionals such as teachers, social workers, public health nurses and doctors
- the lack of comprehensive sexuality information provided to adolescents
- the fragmented manner in which sexuality information is offered to adolescents
- the need for long-term follow-up support and counselling
- the need for better access to and cooperation among existing services
- the need for flexibility and creativity in delivering sexuality information and education services to youth of various ages and backgrounds
- the need for more funding as well as the reallocation of existing resources to high risk neighbourhoods
- the need for early intervention in the school system

The literature suggests that bringing together an array of agencies and programs that share their efforts and resources will allow development of more targeted approaches to meet the specific needs of adolescents at multiple points in their lives (Brindis and Jeremy, 1988). As such, teenage sexuality should not be considered the exclusive domain of health, education or social services. Rather, teen sexuality issues require the resources and specialities of each domain working collaboratively.

"We can do what needs to be done at a price we can afford; prevention is a bargain compared to the current cost of our failures."

(Schorr, 1989)

V. REFERENCES

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B. Community Consultations

Edmonton Social Planning Council
November 1990

I. Project Approach to Community Consultations

The assumption underlying the project's approach is simple: the people who are closest to the issues and the experience of teen sexuality know best what those issues are and what solutions are appropriate.

The recommendations and feedback collected from the eight constituent groups consulted has uncovered abundant ideas and suggestions, as well as a richness of experience pertaining to teen sexuality which is specific to Edmonton.

The project's method was directed by a community advisory group. In early June, project staff met with the group to decide what approach would be most appropriate, what constituent groups should be included, and who — from the human services, health, and education sectors — should specifically be invited to the focus groups held on October 3rd and 5th.

A concerted effort was made to include, first and foremost, teens themselves. In the end, approximately 120 youth were involved in the consultation process. Parents were also identified as a critical group to contact. Approximately 40 parents participated in two evening meetings held. People who work in fields which serve teenagers were also considered integral to the process. At this professional level, 40 teachers, counsellors, public health nurses, doctors, outreach workers and staff from community agencies were involved.

A concern voiced by community advisors was that homosexual teens not be left out of the process. Several attempts to contact a youth group for gay and lesbian teens were made, but unfortunately, efforts to connect with the group were unsuccessful.

Advisors also highlighted the need to look at the issues and concerns of youth who are outside of the mainstream education system. The voices of Native youth, street youth, illiterate teens, and those from various cultural backgrounds were seen to be particularly important, if the project's approach was to be comprehensive and inclusive.

In keeping with these recommendations, the next page provides a list of the community groups consulted during the project.

II. Community Group Profile

- AUGUST — Ten **Community Advisors** to the project were asked to comment upon and add to the issues identified in the research paper which was prepared by the City as the first part of the project.

- OCT. 1 — **TERRA Association for Unwed Mothers**
  Focus groups were held with 53 young mothers and pregnant teens.

- OCT. 2 — **M.E. Lazerte Composite High School**
  Collective theatre vignettes by 33 grade 12 drama students were recorded on video.

- OCT. 3 & 5 — **Focus groups** for health care professionals, educators, and human services staff were held; 40 people participated in this process.

- OCT. 22 — **Foster Parents Association of Edmonton and Area**
  The Teenage Sexuality project was introduced after which TERRA presented a panel of teen mothers. Recommendations for action were then solicited from the 17 people in attendance.

- OCT. 24 — **Ross Sheppard Composite High School**
  A focus group consultation was held; 27 students participated, all but three of these being part of the school's peer support group.

- OCT. 24 — **Public High Schools' Parent Group** - Organized and hosted by Ross Sheppard's parent group, a TERRA panel of young mothers and fathers led into a general discussion. Twenty parents were asked to write down and submit their recommendations.

- OCT. 24 — **Inner City Drama** - As part of a popular theatre project focusing on AIDS, a closed session to explore issues pertaining to teen sexuality was held (and tape recorded) by the facilitators and inner-city youth who are part of this group.

III. Proceedings From Community Consultations

Summary of Teen Sex Questionnaire Responses

Community Advisors:

Mary Masson	• Edmonton Board of Health
Liz Massiah	• GALA
Penny Cuddy	• Birth Control Clinic (EBH)
Cheryl MacKay	• Reproductive Health Clinic
Diane Goodall	• Parent
Irene Kerr	• Boyle St. Co-op
Sandra Maygard	• TERRA Assoc. for Unwed Mothers
Gail Williams	• Youth Emergency Shelter
Marg Johnson	• Ross Sheppard H. S. Counsellor
Korrie Bokalo	• Teen Mother

The following excerpts reflect the varied response we received from a questionnaire sent to the project's community advisors. The purpose of the questionnaire was to ascertain whether or not the issues identified in the background research paper were accurate, and whether the ideas presented were sufficiently specific and inclusive of teens' experience.

The issues from the background paper are in bold type; queries from the questionnaire are prefaced with dots; the comments of community advisors are in italics.

1. **Adults need to recognize that youth have more liberal sexual attitudes and behavior.**

• Are sexual attitudes and behavior among teens more liberal?

"Yes, these are more liberal than their parents... but the attitudes held remain quite "traditional"."

"No. I see teens becoming more conservative about many aspects of life (including sexuality), often out of fear. They may be having sex at a younger age, but many of the old sexual stereotypes still exist and are constantly reinforced."

"Yes, teens are experimenting with sex at a younger age, however I do believe that they are a lot more careful."

"Yes, teens are having sex at earler ages due to both experimentation and peer pressure. However, with the scare of AIDS and other STDs, it appears that teens are more conscious of using condoms."

"Because of the influence of media... youth today do have more liberal attitudes and behavior."

"I think that since our culture is so obsessed with sex, it seems only reasonable that teens share this obsession.""

"Many teens hold very traditional, conservative, and negative attitudes which often prevent them from dealing with their sexual decisions in responsible ways. Lack of information, belief in some traditional myths, and denial are all contributing factors to what is often perceived as immature, irresponsible, and careless sexual expression on the part of the teens.""

• If so, do you agree that adults need to recognize these facts?

"Absolutely, as adults, we do an amazing amount of denial ... we need to be honest."

"Adults do need to be more aware of the facts involved with adolescent sexuality, and need to become comfortable speaking about not only adolescents' sexuality, but their own.."

"We have to recognize 'what is' and then develop our strategies."

"To deny that adolescents are sexual beings who will make choices as to their sexual expression will not stop the process. ... Adults need to be taking a more active and visible role in teaching children and teens the skills they need to make responsible decisions."

• Is the term 'adults' specific enough, or should parents, professionals, other be mentioned in particular?

" Yes, professionals and parents need to be targeted differently."

2. **Generally, there is a lack of sexuality training for professionals, including teachers, social workers, public health nurses, and doctors.**

• How well informed do you feel that people working in these fields are?

"They may be well-informed; they are not passing it on."

"I feel people are informed... however, the comfort level of people discussing sexuality hinders communication with teens. Also, in dealing with teens who have multiple issues, it appears that other issues hold priority."

"The continued prevalence of sexual sterotypes among many professionals in "helping" fields show the above statement to ring true.... If their first 'seeking help' experience is a negative one, youth find it very difficult to easily give us adults another shot."

"There is a real range of knowledge and level of comfort across all the professional groups. Unfortunately, many professionals working with teens are judgemental, uncomfortable with their own sexuality, and/or uninformed as to the issues, resources, and/or gaps in their own knowledge base."

"Very poorly, and particularly about the many ways we can express our sexuality other than heterosexuality which is viewed by many as the only way to express sexuality that is acceptable."

"I think teachers, social workers, and nurses are making strong efforts to become well-informed. Some are highly skilled. Doctors, however, need more education."

3. **There is not enough comprehensive information about sexuality available for adolescents. The information that is available is presented in a fragmented manner.**

• Do you agree? Is the question of adequate information, or something else?

"There isn't adequate information available in an easily accessible manner."

"Because sexuality involves many aspects of a person's life (morality, knowledge, behavior, self-identity, etc.), it must be addressed in a holistic manner."

"Yes, the accurate, positive information available for lesbian and gay teens is minimal and what is available is frequently suppressed."

"It is not enough to only talk about birth control and/or abstinence. Issues of accurate information need to be combined with positive self-esteem decision-making, and a realistic assessment of the potential consequences of sexual decision-making."

"Relevant 'teachers' and methods of 'teaching' this information that makes sense to them (is necessary). Info. and method getting it across must be geared for different groups of youth (ie)' street kids' ; native component; literacy level; gay/lesbian population."

"There is comprehensive information available, but it is not always delivered at the teens' level or in a format which they understand, relate to, and accept."

• Is a more coordinated strategy necessary?

"Education needs to begin as early as elementary school in order to try to change the total societal attitude."

"...There is a real need to have someone or some body acting as the co-ordinator. Some of the obvious groups needing to be involved include health care, education, funders, and agencies and/or services designed to offer programming to adolescents."

"Information provided in the school must be backed up with discussions in the home and availablility of counselling in areas of sexuality as identified by needs."

"Yes." (several)

4. **Earlier intervention in the school system is required.**

• Would you dispute this claim? Does 'intervention' need to be defined more specifically?

"Not earlier, just better."

"Intervention should be defined and incorporated into curricula starting in kindergarten."

"Our sexuality starts being defined for us at birth by the way our parents deal with sexualtiy - we should be addressing the needs of parents of young children as primary sexuality educators and be supporting this role with school programs."

" I would say so — intervention suggests something is wrong — information, education and the opportunity to explore and learn positively is a more useful concept."

"We must be very clear about what we mean by intervention. Does it just mean education or what?"

"The schools need to be involved with teaching the necessary information which will be used by teens in their choices of sexual expression, from a very early age. The skills of assertiveness training, building of positive self-esteem, communication, decision-making, and goal-setting are all crucial... and should be a basic part of every school curriculum from day one."

"If intervention is not specifically defined, we run the risk of continuing to place the majortiy of the responsibility in the area of the schools."

"I don't see it as intervention but as protecting people with information."

5. More flexible and creative delivery of sexuality education and information services is needed.

- Is this true? Are there existing gaps in these services, are some groups of teens not being served?

"Absolutely, Kids who aren't in school, kids who don't have status in the child welfare system and kids with minimal literacy levels are often left out." (several)

"Yes, services must be lifestyle appropriate, culturally appropriate, language appropriate, and literacy appropriate (use pictures, cartoons, videos.)"

"The delivery of sexuality education and information services needs to be more creative and flexible. The teens themselves are rarely asked for their input, and need to be more involved with how services could be delivered more effectively."

"Yes. I don't think enough monitoring of the school health curriculum is carried out. So many teens also drop out of school so they need this education early."

"Lesbian and gay teens are silenced by our culture and by our services."

"Yes, we need to talk to teens at their level, with full respect for their decision-making abilities and sense of responsibility."

6. **A need exists for more long-term follow-up support and counselling for teens with respect to sexuality issues.**

• Is on-going support and individual consultation available to teens?

"I think that if there are such programs that the kids are unaware of them."

"Professionals must be willing to connect with non-traditional services (not 'school counsellors' or 'nurse') for youth that typically do not readily make connections to these. In other words make information available in a relevant way where those youth already feel comfortable going on a regular basis."

"It is there but I don't think teens seek it out. It also might not be advertised/communicated well enough."

"Not available for gay and lesbian teens...."

"No, I don't think post-secondary institutions follow through with sexuality courses.... Birth control clinics should be readily available in these institutions."

• Do most teens have the knowledge and confidence to access existing supports?

"They may have the knowledge but they lack confidence. They are scared to go to a doctor."

"No, they don't have either."

"Older teens are more capable of accessing existing supports but younger teens (< 15 yrs.) have much more difficulty...."

"No. Many services and/or programs are viewed to be intimidating, scary, and not welcoming.... The problems often include: some teens thinking they have enough information and not needing the service; teens not knowing these services exist; not knowing how to access them; having concerns about confidentiality; and not having the language and/or confidence to speak to strangers about very personal issues."

"Teens are still relying on their peers for info."

7. **More funding and the reallocation of existing resources are needed to address teens in** high **risk neighbourhoods.**

• What, if any, are high risk neighbourhoods in Edmonton?

"Inner city. Pockets of 'inner city type neighbourhoods in Eastwood, J.P., Woodcroft."

"Inner city, shopping malls."

"At TERRA, we see teens from three major areas: the Northeast, the far West end, and Millwoods, with a fair number from Sherwood Park. While we don't have many clients from the core areas, this would also be viewed as a high risk area. "

- What other groups, areas, or teens might be considered particularly at risk?

"Single parents, run-aways, immigrants, native groups and physically and mentally handicapped teens."

"Again, gay and lesbian kids everywhere are ignored, silenced, and ridiculed daily in our culture...."

"Any transient youth, youth on their own or with limited education, social support networks."

"The groups we would see as being at risk would be teens who: have low self-esteem, come from chaotic family backgrounds; have had difficulty in school; have few close friends; have not developed the skills necessary for independent decision-making; have been involved in the child welfare system; and/or have been sexually or physically abused."

"Teens that have a low literacy level are certainly at risk of not getting information about sexualtiy issues. Native youth and immigrant youth often relay to us that "those kind of things" are never discussed at home.... Language and generational issues separate immigrant parents and their teenagers."

8. There is a need for better access to and cooperation among existing services.

- Are the available sexuality services for teens easily accessible to them?

"Yes, but again teens' confidence in seeking such services is still an issue."

"No. Accessibility is limited due to hours of operation being limited to working hours, distance from home, and lack of accurate knowledge of how they will be received."

"...More important is the teen's recognition of need for these services."

"The Birth Control Clinic is quite accessible but there's only one and it is far removed from some of the needy areas."

- Is there communication, coordination, and cooperation among the existing service agencies?

"There is some but it should be developed into a more cohesive network. Hospitals should be more involved as they could also set up birth control clinics to serve their area."

"Not enough."

"Could be improved."

"While there is some co-operation and communication between some of the agencies, most of us work in varying degrees of isolation. There is a real need for much more co-ordination and communication, if we are to meet the needs of teens effectively."

"Yes! There has been a close connecting network of youth agencies operating through Youth Interagency Association (approx. 30 agencies)...."

"...It appears that agencies are beginning to realize that they cannot serve every issue for a teen."

"There are some.... However, a 'divide & conquer' approach to funding coupled with a focus on number-crunching for stats undermines greater cooperation."

Additional Comments

"It is appalling that the issue of sexuality has been viewed so narrowly - all the supporting information I was given assumes that all kids are heterosexual and that if we have traditional values, etc., then we'll be able to prevent pregnancy, which seems to be the major concern.

Why is this group of 'experts' who prepared this proposal so silent on the issue of homosexuality - it simply shows the struggle and lack of awareness and information about the subject."

TERRA Association for Unwed Mothers
October 1, 1990

Focus Group Consultation

The discussions held with young mothers and pregnant teens at TERRA began with a large group question-and-answer session, followed by work in small groups to explore what should be done, and a final presentation of recommendations from the small groups to the large group. Approximately, 55 people attended the session.

Questions

1. How many people here chose to become pregnant?

   Of the 55 women in the group, 13 planned to have a child. One young mother noted that she wanted to have a child quite young, but not as young as she did (i.e. 14 years).

2. What does 'sexuality' mean to you?

   A variety of responses were given:

   - *Sex is simply an action that isn't very meaningful.*
   - *Sexuality is more than just sex; it's part of your personality, your beliefs, . . . everything. "It's how you feel about yourself."*
   - Rape and its influence on sexuality were discussed. One woman who was raped now views anything to do with sex as negative while another confided that she too had been raped, but didn't feel negative about sexual activity in the future.

Small Group Discussions — Recommendations

Included here are the recommendations made by the young women present. Where similar suggestions were made, one is listed with the total number of times it was mentioned in brackets. Comments made by participants are in *italics*.

Education — Communication

- ***Teens need to feel comfortable with the topic of sex** before they can talk openly about it. More communication about sex is needed between parents and children. People need to be more honest and open about their feelings.*
- ***Teach parents to talk about sex:** have support groups and pamphlets. Teach them to be open; teach them to talk to their children. (4)*
- *Have groups for parents and children where you can communicate about sexuality and other issues.*

- *We need to understand **the importance of support, guidance and decision-making** (e.g. if you get pregnant being able to make the decision of keeping, placing, and aborting, and to know what all the consequences are.) We need more people to talk to.*

- ***Peer pressure:** let your kids tell other kids that it is all right to say "NO".*

- ***Don't condemn children** for what has already been done.*

Education — Information

- *People are getting pregnant too young. We need **more information** made available to young people. More is needed about giving up babies for adoption and about abortion.*

- *Explain **more about STDs:** symptoms, causes, consequences, prevention.*

- *Teach **sex education at a younger age** while they're still eager to learn things (i.e. not in grade 12 religion class). Bring interest to teaching. Also, present realistic alternatives (don't say 'be celibate').* There should be *more sex education on contraception at school.*

- *More information* should be available ***over the phone** for people who are alone.*

- There is a need for ***informative T.V. programs** on pregnancy and STDs.*

Specific Strategies

- *There should be **condom machines in the bathrooms** at school. This saves embarrassment, allows easy access, and prevents STDs.* (Contraception in school: 4 groups)

- *Offer **more free recreation activities** for teenagers e.g. teen dances, free swim, open gyms for sports activities in the community, adult-supervised.*

- *People should **be more cautious** about their sex partners (STDs).*

- There should be ***more financial support for young moms.** More schooling and housing for single mothers and pregnant women* is needed.

Ross Sheppard Peer Support Group

Focus Group Discussions from October 24, 1990

The issues and recommendations listed below were identified by 27 high school students who are part of a peer support program. As part of their weekly training sessions, focus groups were held at the school. In four small groups, issues were identified and prioritized; solutions were then proposed.

ISSUES

Communication

- *In relationships with family and friends there is a lack of communication, an inability to talk about sex with parents.*
- *Most kids can't discuss their emotions with their parents.*

Decision-making

- Teens often feel *insecure*, have *low self-esteem*, and face *social pressures. Peer pressure* is a major influence. Teenagers *need to control their lives and they need affection.*
- *Decision-making* needs to involve *value systems, peer pressure, future consequences, and the immediate situation.*
- It's hard *not knowing where you stand. Teens need more self-confidence.*

Attitudes

- *Societal values* are ambiguous: *no sex; sex is OK; don't care.*
- Parents *deny* that their children have any sexuality issues; they think *'that is my little girl/ boy'*.
- People are taught to be *scared about AIDS; should people be told about it in a frightening way?*
- *Negative attitudes* towards *homosexuality* are *destructive.*
- *Sexual Stereotyping* is a problem which often creates *guilt.*

Problems with Birth Control and Other Services

- *Kids are embarrassed to go to the store to buy condoms.*
- Often teens are *scared that their parents will find out if they go to the doctor to get birth control.*

- *There is a myth about condoms: they're not supposed to be romantic. This makes kids feel they're bad.*

Information

- Teens need to know the options: *birth control, how to have safe sex, abortion/adoption, etc.*

- *More information is required about STDs: knowledge, access to services, where to go.*

General Concerns

- *AIDS, STDs*

- *teen pregnancy*

- *date rape and sexual abuse (incest, physical violence).*

SOLUTIONS

Communication

- *Learn to talk about sex with your parents, boyfriend/girlfriend, and friends. Strive for parent-child openness, both in groups and one-to-one.*

- *Talk to your kids **before** problems arise.* Parents need to be *open-minded.*

- *Mandatory parenting classes prior to birth of the child and during adolescence* are needed. *Parents should educate their kids early in childhood.*

- Education should happen *at school, home, clinics,* and over the *phone: as much awareness as possible.*

Decision-making

- *Students should be involved in decisions concerning them. They should have input into education in schools.*

- *Decide what you want to do and stick with it.*

Attitudes

- *Make contraceptives a **positive** issue.*

- *Don't use fear to teach teens about sex.*

- *Try to make using condoms more romantic (i.e. acceptable).*

Services — General

- There should be *no age limit for doctor's appointments concerning birth control methods.*
- (See also 'At School' suggestions)

Services — Adolescent Resource/Drop-In Centres

- These would *combine health clinics with information (i.e. pamphlets on adolescent concerns) and support groups organized within the centres. Concerned students could work as part of support groups. Experienced people, especially teens, would be best.*
- People could *purchase contraceptives, get medical help, and counselling — all in one place. The broad-range of services should include help with decision-making.*
- *Funding could come from government and municipal organizations for clinics and adolescent resource centres.*
- *These centres should be located near high schools.*

At School

- *Kids our age, with experience, can go into classes and talk about sex. High school students could go to their old junior high to speak.*
- *Put condom machines in school washrooms; make sure they are maintained.*
- *Have a full-time nurse at school.*
- *Education should start at a younger age.*
- *Increased availability of counselling in schools* is needed.

General Recommendations

- *Know* ***how*** *to use the birth control.*
- *Use more than one kind of birth control.*

Inner City Drama Group

Taped Talk Back Session of October 24, 1990

These issues and recommendations listed below were made by teenagers who are part of the Inner City Drama Group. As part of a 'non-interventionist' approach, no outside facilitators were involved. Rather, Edmonton Social Planning Council Staff met with the group's regular facilitators and agreed upon a method suitable to the group's own project development, as well as that of the Teenage Sexuality Project. The two facilitators then led the regularly planned session which was recorded on cassette. Questions posed by facilitators are in quotations; the young people's comments are in *italics*.

ISSUES

- "Before you have sex, is the possibility of getting AIDS or getting pregnant on your mind?" (majority response: *no*)

  - *It won't affect me.* (denial)

- "Do you read those pamphlets on AIDS?"

  - Some kids were very aware of various birth control methods based on information from pamphlets.

  - *Pamphlets are boring, especially the ones without pictures.*

  - *I've only read one all the way through. There are so many.*

- "Do young people decide to get pregnant?"

  - *Some of them do.*

  - Most don't.

  - *There isn't much choice involved; there should be.*

  - *Some young girls are paid to get pregnant and then they buy the baby from them.*

  - *I found out how desperate people can get when they want money, you know. They do so many stupid things, eh, childish things. Like, um, I know this one person who steals plastic bottles from one bottle depot at night and then sells them at another bottle depot the next day.*

  - *You know on the fridge how there is that magnet. Well, some people take the magnet off and put it on the parking meter, and you pull the coin out. You can make a lot of money that way.*

• "What do you do to avoid having to make money on the street?"

— *Sell stuff to pawn shops. That's a good way to make money.*

• General discussion

— *Homosexuality can be caused by being sexually molested when you're young.*

RECOMMENDATIONS

• *Be very open about sex with your friends. It helps to share your concerns and views, you know. I'm intimate with my friends. It's something we talk about all the time.*

• *To prevent STDs a condom is best, if it doesn't break. Have fun putting on the condom; it makes you and your partner feel more comfortable.*

• *I.U.D. is dangerous if a person has more than one partner, like if you get chlamydia.*

• *Don't do needles; don't share needles. If you do needles, make sure you get tested.*

• *Get well-informed, especially on the various methods of birth control.*

Teenage Sexuality in Edmonton:
Focus Group Summary

On October 3rd and 5th, 1990 focus groups for human services staff, educators, outreach workers and other professionals were held to discuss issues related to teen sexuality and some solutions to the problems identified.

The dialogue during these discussions uncovered the complexity of issues and the diversity of experience from various perspectives.

This summary is organized into two parts — following the original structure of the focus groups themselves. First, the issues will be presented. The range of concerns considered to be 'most important' spans from attitudes and systemic problems to more concrete details of service coordination and operating hours.

In the second part, solutions and strategies are summarized. Ranging from abstract guiding principles to concrete tasks, recommendations have been made.

In assembling all of these ideas, an attempt has been made to be inclusive and specific. The final project report will glean the main points made here, but this summary intends to be a complete and original record, as much as possible. Quotes from the flip chart paper are in *italics*.

DEFINITION

Groups from both days found it necessary to clarify the meaning of 'sexuality', agreeing that it is not a commonly understood concept.

One participant asked, *'do we need to address teen sexuality or do we need to address the undesirable consequences of sexual intercourse?"* This distinction helped to frame subsequent discussion.

Sexuality is a reality. What teens do with it is another matter.

Teenage sexuality includes relationships, maleness and femaleness. *It is an integral human dimension and part of natural, healthy development.* There is often confusion between intimacy and sexual activity.

We need to *normalize* sexuality. There is a *general lack of comfort discussing sexuality* and a *lack of vocabulary* to effectively communicate concerns, questions, and values pertaining to the subject.

THE MOST IMPORTANT ISSUES

Unhealthy attitudes

- *There is an unwillingness to acknowledge teens as sexual beings.*

- Homophobic attitudes are real and harmful to gay and lesbian youth.

- The attitudes of some health care professionals towards street kids leave something to be desired. Youth who seek treatment for infection or other services face the attitude: '*these teens deserve what they get; they ask for it.*'

•*Teenage immortality*, the belief held by some youth that they are immune to the problems of the everyday world, also contributes to problems of teen sexuality. Teens often feel *invincible*, that - for example - pregnancy is impossible in their own case. Such perspectives, several participants pointed out, are common among teens and reflective of their developmental stage.

Gaps In Services

- *Services tend to be crisis-oriented rather than preventive. What kind of message is this?*

- Gaps in service are *both real and perceived. Perceived inaccessibility* to services must be recognized.

- *Suitability and accessibility of services* should be improved. *Location is very important. Hours of operations are too limited.*

- There is a lack of *'normalized' preventive measures.*

- Health care and support services are too often *segmented.* Our approach to sexuality education and services is too fragmented. While teens may understand the logistics, there is no long term planning or discussion.

- There are no services to allay adolescents' fears about STDs and pregnancy.

Community Issues

- Problems related to sexuality are viewed in *isolation* to other social conditions. This approach is artificial and ineffective. Issues like family stability, poverty, sexual abuse, and substance abuse can all be part of a complex web of experience which must be addressed comprehensively.

- *The system is punitive. Messages about sexuality tend to be negative.* They are often *reactions* to problems or crises encountered which often stem from denial of teens as sexual beings. This creates a cloud of *fear* for teens and does not promote a healthy vision of sexuality. The stigma of accessing services for treatment of disease or unwanted pregnancy is sometimes a deterrent to teens who want to access preventive services at the same location.

- *Cycles of poverty* persist. That *Alberta has the highest divorce rate* in Canada means family poverty is more prevalent. More specifically, *teen parents lack adequate resources to raise their families.*

- *Sexual abuse contributes to confusion* about sexuality. *Abuse may prevent healthy attitudes from developing* and can profoundly *affect future relationships.* Without confronting such experiences in a supportive, professional environment, symptoms of this damage will persist.

- *Sexual stereotyping is a problem.* Myths about roles and needs are being perpetuated.

- *Males are under-represented* in education, treatment, and dialogue pertaining to sexuality. The relative absence of men in sexuality educator's roles and their lack of participation in what has been termed *women's work* contributes to the problems at hand.

In contrast (but on the same subject), there are a lack of roles for teen fathers' to participate in their children's lives. *Men are excluded from the process*, and this prevents very important bonding between children and their parents.

- There is confusion over the responsibility of families and schools as to who is supposed to provide what kind of sexuality education.

- *Teens feel hesitant* to ask for help. They experience concerns about their sexuality in relative *isolation.*

Family Issues

- Many parents are both unsupported by their communities and unsupportive to their teenagers. In the area of sexuality education poor parenting skills are widespread. Insufficient leadership is shown in addressing the information needs and personal concerns of teenagers. *Parents assume that values and education are coming from somewhere else, or they wait for their child to ask for help* when they need it.

- *There is not enough moral guidance* from parents in terms of values and judgement in decision-making. *Young people don't have enough training or life experience to make a wise decision. They are unable to understand the responsibility involved.*

- Parents often lack both the ability to talk to their children about sexuality and to provide the information they require. *Many parents feel ignorant* about sexuality-related services and practices, and are *non-commital* about providing moral guidance.

- Parents' authority, in terms of the knowledge and experience they have, can be respected by teens. Parents' authority as a means of controlling their children's behavior is not viewed as legitimate. *Children have a right to education* (in accordance with the UN Convention), of which sexuality is a part, and that *parents cannot abdicate their role as educators*, nor *deny their children access* to education.

- More specifically, *there is a general lack of support of teenage mothers. TERRA is not enough.* There are services for single mothers but not teenage mothers who have specific needs. Generally speaking, *policies exist which perpetuate the marginalization of young mothers.*

Education Issues

- *Education isn't enough to change attitudes.*

- *Education needs to start earlier.* Everyone needs it. For teens, it must be *appropriate to their development stage.*

- *Methods of teaching need to be improved.* Present formats are usually lecture-style; approaches have to be more multi-media and comprehensive. *Teacher discomfort and lack of training* must be addressed. Exposure at school is compulsory but limited.

- Education, however it's delivered, *needs to include emotional aspects and consequences of teenage sexuality*. Many *teens have the 'facts'*, but they lack guidance on decision-making skills and dialogue on *what becoming sexual activity will mean to them* personally.

Problems with the Media

- Teenagers receive *mixed messages* through the media. These have a *negative impact on teens*. Youth from strong families are more immune to this negative impact.

- *Advertising exploits sexuality*, particulary its association of youth and sex.

- Society is not taking a stand on what is acceptable. If it did, we would not tolerate some of the present media we consume (TV, advertising, movies).

Other Concerns.

- Cultural differences are important, but are not recognized.

- Peer pressure influences teens' behavior. It can be countered by *confidence, self-esteem*, and a supportive family milieu.

- *We need to recognize the complexity of decision-making for teenagers. They have many other issues and people to deal with*; sexuality is only one.

- *There are few safe places and opportunities to talk* about sexuality.

THE MOST IMPORTANT SOLUTIONS AND STRATEGIES

Most of the strategies recommended by five individual groups fall under two headings: improvements in education and in service provision. A few guiding principles were also articulated. These general principles are listed first, followed by more specific solutions made by focus group participants.

- **A comprehensive *'package'* approach** is needed. *Education, clinical services, and advocacy* must be *coordinated.*

- We *need to* ***ask teens*** what they need. *They need to know they have rights* ***and responsibilities****; they need to know it's okay to ask for help.*

- We need to provide ***adolescent-friendly services in an integrated, coordinated, multi-disciplinary, developmentally appropriate fashion****. There are too many bits and pieces.*

- There is a need *to look for commonalities across differences in values and definitions*, a common purpose. Individual views, personal beliefs and experience should still be communicated, as this will put a *human face* on the issues.

- The goal: *to promote positive, healthy sexuality: positive,* ***educated, responsible.*** *Self-esteem, respect, and social responsibility —especially for males—* should be encouraged.

- A *community organization model for community involvememt* should be part of the approach taken.

SERVICE PROVISION

- Services must be provided as part of a *two-pronged approach.* Every existing service should be ***integrated*** *with sexuality education.*

- *We need a* ***SUPERSTORE approach*** *to sexuality-related services for teens: health promotion, family planning, and STD clinics under one roof.*

- *Services should be health-oriented and not punitive, preventive* ***and*** *crisis-oriented.*

- ***Increase male involvement*** *in the provision of services.*

- *Encourage* ***greater interagency sharing of resources*** *— staff transfers— among governments and agencies. Breakdown territorialism among agencies. There should be more information-sharing between school counsellors and social service workers.*

- *Create an* ***adolescent health network*** *to coordinate existing but discrete services to teens.*

- A ***parent hotline*** and a ***STD hotline*** should be set up. *The phone is a critical link: low-cost and very accessible.* These services could be integrated with the existing Health Line.

- ***Cultural barriers*** *need to be recognized; we need translators in all major language groups. Cultural stereotypes need to be broken down.*

- ***Native involvement*** *in determining solutions and strategies is critical. Cultural differences are very important.*

- ***Services must be very approachable to teens.***

    - *Store-front options* in locations such as *West Edmonton Mall, Southgate, and Boyle McCauley Health Ctr. are required. Follow the Toronto 10 model, 'The House' drop-in centre.*

    - *More flexible hours are required, including weekends.*

    - *A combination of appointments and drop-in services is required; an element of choice* in accessing services is needed.

    - *Services should be free* (they are part of basic health care).

    - The social costs of *waiting lists* are too dear; *more resources are needed.*

    - There should be *teen health clinics and information in every high school.*

- *Services could be school-based but also must be available via outreach 'street workers' to youth outside the school system. Build on what works; more outreach and education to street kids is needed.*

- *TERRA is good, though it can only offer limited support to pregnant teens or young mothers who want to remain at school in their own communities where they have existing support networks.*

- *More support for pregnant teens, like TERRA,* is needed. Services should be *broadly-based, respectful and inclusive of different values and choices.*

- ***More resources and counselling are needed for people who have been sexually abused and/or who are substance abusers.*** This is *especially important for teen parents and other parents* because *cycles of abuse, and the poverty they perpetuate, will only stop once these experiences have been dealt with.*

- *The Edmonton Board of Health should establish* ***a sexuality division*** *(like the one in Calgary).* It would be able to *do in-services for staff in schools and community agencies and provide support to educators who lack the skills and comfort level to address sexuality issues.*

- There should be *more alternatives to pregnancy.* More places like the Youth Emergency Shelter, where teens can find a safe and supportive environment to look at options other than pregnancy, are needed.

EDUCATION

- **Education for everyone** (children of all ages, all parents, and all professions who serve people) in **all places** (family, school, community) **at all times** (from birth, on-going) is required.

- *Health education which allows for the acknowledgement and understanding of healthy sexuality development* is critical. ***Not until our society is comfortable with its own sexuality can it effect change.***

- *Sexuality must be understood within* ***a context of choices.*** *To say yes or to say no, this decision should be informed and supported by families, schools, and the media.*

- Sexuality education must be viewed in the broadest sense; it is not limited to the institutionalized form. Learning about healthy sexuality is part of basic education and *should not be separated or segregated from the mainstream curriculum.*

- ***We need to ask teens*** *what they need and learn to talk to them about sexuality. Teens need awareness of sexuality and the consequences of sexual activity.*

Education - messages

- *Messages need to be positive, not based on fear.*

- *Establish common ground and consistency in the messages teens receive (see also MEDIA section).*

- *Use a multi-media approach; many sources of information are needed (newsletters, videos, social marketing techniques).*

Education - delivery

- *Approach needs to be age-appropriate, in sync with adolescent development.*

- A need exists to *spell out curriculum, so that there is no latitude for teachers to sidestep.*

- Education in the schools is *too structured.* Lecture formats are not conducive to debate and discussion around 'the facts'.

- *Sexuality edcuation could be delivered to parents with their children in class at elementary school.*

- In one sexuality education class kids were sent home with a survey of questions to ask their parents. This approach helps to *'open doors' and establish lines of communication.* It also helps to illustrate *a variety of experience and 'normality'* with respect to sexuality in subsequent group discussions.

- Evaluation of health education/CALM curricula by students in class is required, as is *research, development, and evaluation using outside agencies.*

Education - peers

- *Kids need help dealing with peer pressure.*

- *Peer support programs should be expanded.* They encourage teens to take responsibility for the issues affecting them.

Education - training

- Sexuality education should be *incorporated into all post-secondary education, especially the Faculty of Education.*

- *All professionals who work with people* require sexuality education.

- *All physicians, especially G.P.s, should be required to take compulsory adolescent training.*

Education - community

- There is a *need to clarify the difference between natural affection and sexual abuse. Not all physical contact is sexual contact.*

FAMILY

- *Parents should be reminded they have responsibilites. They may not have adequate information to answer all their children's questions, but they shouldn't rely only on outside 'experts'.*

- *Parents can pass on positive values. At present, they are encouraged to be non-commital.*

- *Competing demands on parental roles require empowering parents to be parents and promoting family values. Parents need access to informations that is clear and concise* (see phone line above).

- ***Both** parents should be encouraged to share the responsibility of teaching their children about sexuality.*
- *Community and health agencies should offer parenting courses which include sexuality education, on an on-going basis. Such training is needed **before** parents become parents.*

- *Some families need support in multiple areas.* Teen pregnancy is often a symptom of an unstable family situation. *Earlier intervention and detection of problems is needed.*

- *Parents do not have the right to deny their children access to sexuality education. Sexuality education is/should be compulsory; it is part of basic education and is therefore a child's right.*

ADVOCACY

- *Children have a right to education* (including sexuality education).

- As a community, we must advocate *for children's health.*

- *Communicate with the media.*

- ***Coordinate a strategy.** Write to the Minister of Education, the education caucus, the Minister of Family and Social Services, and the Minister of Health. Contact Perrin Beatty, Minister now responsible for children.*

ADDITIONAL COMMENTS

After the focus groups were conducted and the summary prepared, all participants were sent a copy of the proceedings. A response sheet was enclosed with the summary to elicit any corrections, additions, and criticisms. The additions listed below have been taken from these follow-up responses.

- The present medical service is not user friendly to unwed pregnant teens.

- There is a lack of medical facilities for mothers and children where both are taken care of the same physicians. The Toronto Hospital for Sick Children has a clinic which provides this kind of service delivery.

The purpose of such clinics is not only to provide health care to mothers and children, but also to monitor effectively bonding between parents and infants. Physicians are more able to detect high-risk situations which may lead to emotional deprivation and/or child abuse.

- Non-compulsory sexual education in some schools coupled with very poor services for teens, particularly in rural areas, account for a high pregnancy rate in our province.

Foster Parents' Association of Edmonton and Area
Recommendations from October 22, 1990

The following comments and recommendations were made by foster parents who participated in a panel discussion presented by TERRA, the Association for Unwed Mothers. The young people on the panel included four teenage single mothers who were 'interviewed' by TERRA director, Sandra Maygard. Sixteen parents attended; their suggestions are in *italics*.

Family

- *Communication of the subject* (sexuality) *between parents and children is essential.*
- *Time for young people and parents to talk* is required.
- *Use clear information and language that teens understand.*
- *Be approachable to your teenagers; let them know that you are willing to discuss sex or anything else with them. Be honest and above board with your children.'*

Education

- *It would be better if the information could be given at home, but it can often be given better in a neutral location such as a school.*
- *Schools should be there as a last resort, in case the kids can't talk to parents.*
- *Parenting courses* are needed.
- *Ensure schools and communities receive new findings on sex education.*
- *Train teachers in schools to effectively and non-judgementally teach sex education.*

Ross Sheppard Composite High School
Parents Recommendations from October 24, 1990

The following comments and recommendations were made by parents who participated in a panel discussion presented by TERRA, the Association for Unwed Mothers. The young people on the panel included two teenage single mothers, and a young married couple who were 'interviewed' by TERRA outreach worker, Jan Marlow. Twenty parents attended; their suggestions are in *italics*.

Society

- *We need to recognize that the fundamental values of our society (not only sexual values) have a profound influence on teenage sexuality.*

- *Is it too easy to 'have a baby' and keep it(i.e. financial support to single moms)?*

Teens

- *Empower young people. Emphasis must be put on a teen's ability to make choices. We must help them obtain skills in decision-making.*

- *Recreate the student movement with enthusiasm to make it* (teenage sexuality) *part of the students' agenda.*

- *Choices should be made available for pregnant teenagers (i) abortion, (ii) keep/further counselling, (iii) seek more information on open or private adoption.*

- *Should teens be encouraged more often to 'just say no'?*

Families

- *Parents: Listen to your children. Make time for them.*

- We need to *help our family units with support — social, emotional, and financial.*

- There is a *need for constant openness in the home to discuss all issues. Parents should talk about sexuality as one part of a relationship.*

- *As parents, we are at a learning stage all of our lives.*

- *Kids must be taught about their sexuality at an early age.*

- *Parents should communicate that sex within a good relationship can be fun, exciting, rewarding, etc. but that sex for sex's sake can be ugly and lead to pregnancy or disease.*

- Parents need *information* on *how to communicate with their kids and on how to prevent teenage pregnancies or drug use, etc.* Also, *how can parents best help their kids if they get into trouble?*

Education

- *The school* should *not be forced to have total responsibility for sexual education.*

- *Perhaps schools should provide more opportunity for parent (i.e. adult with child) discussion, rather than strictly information sessions as their sexuality education. Not only sex education, but also parenting classes* could be provided through the schools.

- *Parents' education about sexual issues is probably more important than children's or teens. More courses for parents on how to talk about sexuality* are needed.

- Parents *are or should be their child's number one source of information.*

- *It may be helpful for junior and senior high students to be involved in this sort of panel discussion; they take information from peers in a different way than from adults* (mentioned 4 times).

- *Make sexual education mandatory in the schools.*

- *Outreach activities on the part of the school to parents and the community* are needed. Schools need *to show leadership.*

C. Recommendations

Housing and Social Planning Branch
Community and Family Services
January 1991

Sexuality Education of Teenagers

A greater variety of approaches in providing sexuality information to teenagers, sexuality information targeted to various subgroups of teens, and closer partnerships between schools, parents and community organizations were all identified by community participants as necessary in making the sexuality education of teenagers more comprehensive, integrated and inclusive. The need to include skill-building, for e.g. in communication and decision-making, was also stressed.

> *Information provided in the school must be backed up with discussions in the home and availability of counselling . . . (member, Community Advisory Group)*
>
> *"The schools need to be involved with teaching the necessary information which will be used by teens in their choices of sexual expression, from a very early age. The skills of assertiveness training, building of positive self-esteem, communication, decision-making, and goal-setting are all crucial... and should be a basic part of every school curriculum from day one." (member, Community Advisory Group)*
>
> *. . . accurate, positive information available for lesbian and gay teens is minimal and what is available is frequently suppressed. (member, Community Advisory Group)*
>
> *Kids our age with experience, can go into classes and talk about sex. High school students could go to their old junior high to speak. (student, Ross Sheppard High School.*

Recommendation

That Alberta Health and Alberta Education convene a meeting with Edmonton Public and Separate School Boards, Planned Parenthood Association of Edmonton, Edmonton Board of Health, University of Alberta (Peer Education Program) and any other interested parties including teens, to discuss/evaluate existing methods of sexuality education in schools and agencies in the community, and to propose strategies for incorporating changes identified through the above process and through the teenage sexuality community consultation process. Concerns and suggestions identified in the recent community consultation process include:

(i) Question as to whether enough monitoring of the school health curriculum is carried out. (member, Community Advisory Group)

(ii) There is a need for for informative T.V. programs on pregnancy and S.T.D.'s . (participant, TERRA)

(iii) There should be more sex education on contraception at school. (participants, TERRA)

(iv) More (information) is ended about giving up babies for adoption and about abortion. (participant, TERRA)

(v) Education should happen at school, home clinics, and over the phone ... (Student, Ross Sheppard High School)

(vi) Students ... should have input into education at schools. (student, Ross Sheppard High School)

Sexuality Education of Parents

Both teens and parents who contributed through the consultation process in the community indicated a desire and responsibility to discuss sexuality in the home. Parents indicated a need for information on sexuality, communication skills to use with teens and on related community resources.

Parents' education about sexual issues is probably more important than children's or teens. More courses for parents on how to talk about sexuality (are needed). (parent, Ross Sheppard High School)

> *. . .we should be addressing the needs of parents of young children as primary sexuality educators and be supporting this role with school programs. (member, Community Advisory Group)*
>
> *Teach parents to talk about sex: have support groups and pamphlets. Teach them to be open; teach them to talk to their children. (group participants, TERRA)*
>
> *. . . how can parents best help their kids if they get into trouble? (parent, Ross Sheppard High School)*

Recommendation

That the Edmonton Board of Health establish a vehicle to involve Edmonton Public and Separate School Boards, Family Life Education Council, Planned Parenthood Association of Edmonton, and Alberta Health in planning and coordinating sexuality education initiatives offered to parents in Edmonton, as well as to act upon the following suggestions made by participants in the community consultation process.

(i) *A parent hotline . . . should be set up . The phone is a critical link: low-cost and very accessible . (participant, ESPC)*

(ii) *Sexuality education could be delivered to parents with their children in class at elementary school. (participant, ESPC)*

(iii) *In one sexuality class kids were sent home with a survey of questions to ask their parents. This approach helps to 'open doors' and establish lines of communication. (participant, ESPC)*

(iv) *Competing demands on parental roles require empowering parents to be parents and promoting family values. (participant, ESPC)*

(iv) *Community and health agencies should offer parenting courses, which include sexuality education, on an ongoing basis. (Participant, ESPC)*

(vi) *Perhaps schools should provide more opportunity for parent (i.e., adult with child) discussion . . .(parent, Ross Sheppard High School)*

(vii) *Outreach activities on the part of the school to parents and the community are needs. (parent, Ross Sheppard High School)*

Service Delivery

Coordination, access and greater emphasis on prevention were identified by focus group participants as primary considerations in improving sexuality service delivery to teenagers.

> *Services tend to be crisis-oriented rather than preventive. What kind of message is this? (participant, ESPC)*
>
> *Many services and/or programs are viewed to be intimidating, scary and not welcoming... (member, Community Advisory Group)*
>
> *Accessibility is limited due to hours of operation being limited to working hours, distance from home, and lack of accurate knowledge of how they will be received. (member, Community Advisory Group*
>
> *There is a real need for much more coordination and communication, if we are to meet the needs of teens effectively. (member, Community Advisory Group)*

Recommendation

That Community and Family Services convene a meeting with service providers identified in the community consultation process, and invite other interested community members, to collaborate on strategies for improving teenager's access to sexuality services. Suggestions put forward through the community consultation process for improved access and coordination include the following:

> *Hospitals should be more involved . . . set up birth control clinics to serve their area. (member, Community Advisory Group)*
>
> *More information should be available over the phone . . . (participant, TERRA)*
>
> *There should be condom machines in the bathrooms at school. This saves embarrassment, allows easy access, and prevents S.T.D.'s. (several participants, TERRA)*
>
> *Offer more free recreation activities for teenagers . . . (participant, TERRA)*
>
> *Set up adolescent resource/drop-in centres near high schools. Available services to include support groups, contraceptives, medical help, counselling help with decision-making. (comments from students, Ross Sheppard High School)*
>
> *. . . services must be lifestyle appropriate, culturally appropriate, language appropriate, and literacy appropriate (use pictures, cartoons, videos). (member, Community Advisory Group)*
>
> *More resources and counselling are needed for people who have been sexually abused... (participant, ESPC)*

Sexuality Education/Training of Professionals

The training of professionals to comfortably and competently deal with teenagers on matters related to sexuality was raised through the community consultation process and through interviews conducted in preparing the community briefing paper.

> *Train teachers in schools to effectively and non-judgementally teach sex education. (foster parent)*
>
> *The present medical service is not user friendly to unwed pregnant teens. (participant, ESPC)*
>
> *Sexuality education should be incorporated into all post-secondary education, especially the Faculty of Education. (participant, ESPC)*
>
> *Teacher discomfort and lack of training must be addressed. (participant, ESPC)*
>
> *The attitudes of some health care professionals towards street kids leave something to be desired. (participant, ESPC)*
>
> *The Edmonton Board of Health should establish a sexuality division (like the one in Calgary). It would be able to do i-services for staff in schools and community agencies and provide support to educators who lack the skills and comfort level to address sexuality issues. (participant, ESPC)*

Recommendation

That Alberta Health and the Edmonton Board of Health approach the University of Alberta and Department of Advanced Education to explore possibilities for increasing access to sexuality training opportunities and expertise in Edmonton.

Management of Teen Pregnancy and Parenting

The community consultation process raised concern around the needs of teens already pregnant or parenting. Support issues such as access to counselling for clarity and support in decision-making, education and information on contraceptions, S.T.D.'s , adoption, and abortion, and financial and other resources to meet basic needs were identified by young mothers, pregnant teens and professionals. Creating avenues in related services, which would encourage greater involvement of young men, was identified as important, as well as creating policy changes to better support teen mothers.

> *We need to understand the importance of support, guidance and decision-making (e.g. if you get pregnant being able to make the decision of keeping, placing, and aborting, and to know what all the consequences are). We need more people to talk to. (participant, TERRA)*

> *People are getting pregnant too young. We need more information.... about giving babies up for adoption and about abortion. (participant, TERRA)*

> *There should be more financial support for young moms. More schooling and housing for single mothers and pregnant women is needed. (participant, TERRA)*

> *Males are under-represented in education, treatment and dialogue pertaining to sexuality... there are a lack of roles for teen fathers' to participate in their children's lives. (participant, ESPC)*

> *More specifically, there is a general lack of support for teenage mothers. TERRA is not enough. There are services for single mothers but not teenage mothers who have specific needs. Generally speaking policies exist which perpetuate the marginalization of young mothers. (participant, ESPC)*

Recommendation

That the United Way convene a meeting with TERRA, Planned Parenthood Association of Edmonton, Boyle Street Co-op (Youth Unit), Birthright, Edmonton Public and Separate School Boards, Alberta Family and Social Services and any other interested parties to plan and implement, where possible, strategies addressing the issues raised by participants in the teenage sexuality community consultation process. Strategies should incorporate the following concerns/suggestions:

> *TERRA is good, though it can only offer limited support to pregnant teens or young mothers who want to remain at school in their own communities where they have existing support networks. (participant, ESPC)*

> *More support for pregnant teens, like TERRA, is needed. Services should be broadly-based, respectful and inclusive of different values and choices. (participant, ESPC)*

> *Choices should be made available for pregnant teenagers (i) abortion, (ii) keep/ further counselling, (iii) seek more information on open or private adoption. (parent, Ross Sheppard High School)*

> *We need to help our family units with support — social, emotional, and financial. (parent, Ross Sheppard High School).*