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*Department of Social Work*

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*International Master of Science in Social Work*

# ***Teenage pregnancy: Risk-taking, contraceptive use and risk factors***

**International Master of Science in Social Work  
Degree report – 10 credits  
Spring 2007**

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**Acknowledgements**

***Thank you to all those that were willing to participate in interviews. Without your insights the study would not have been possible.***

***To my supervisor, Marie Törnbom, thank you for your patience and guidance throughout the research process, and for your willingness to share your expertise in the subject.***

***Thanks to Linneas Palmer for financial support.***

***Finally, special thanks to my parents, Rob and Betty Waddington, for all their love, support and encouragement.***

## **Teenage pregnancy: Risk-taking, contraceptive use, pregnancy and risk factors**

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Keywords:

Teenagers, sexuality, contraceptives

### **Abstract**

Five interviews with professionals working directly with the youth, specifically involved in intervention where sexuality is addressed, were conducted and formed part of a qualitative study. Interviews were conducted according to a semi-structured interview guide. The duration of the interviews was between 1 and 1.5 hours each, and professional experience of interviewees ranged between 2 and 35 years.

The aim of the study was to identify reasons for teenage pregnancy, as well as to examine existing services available to the youth with regards to sexuality. Participants were asked questions pertaining to the following themes related to teenage sexuality: The existence of resources, the accessibility of resources, the ability of teenagers to effectively utilize services within their current developmental phase, risk-taking behavior of teenagers and challenges faced in the system and in general.

Analysis took the form of meaning categorization, as responses were clustered into specific categories for analysis. Similarities as well as differences between responses were explored.

Sexual activity amongst teenagers is seen as a normal part of development. Results indicate that resources are relatively accessible to teenagers despite a lack of manpower, although it was noted that there is much room for improvement in the education system with regards to sexuality education. Youths with negative psychosocial circumstances were reported to be more vulnerable to risky sexual behavior, and negative risk-taking with or without contraceptives were found to be a common occurrence amongst teenagers. Some girls engage in risky sexual activity in an effort to prove their fertility, while others become pregnant as a result of continued risk-taking that previously cultivated no consequences.

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## **CHAPTER ONE - INTRODUCTION**

### **1.1 Introduction and motivation for the study**

Teenage pregnancy has long been viewed as a social problem affecting most societies (Benson, 2005).

In a study conducted by Dryfoos and Heisler in 1978, it was mentioned that in several years prior to 1978, over one million unintended pregnancies occurred in the United States in each respective year. In a later study conducted in 2000 by Hacker, Amare, Strunk and Horst, the statistics were no different, thus indicating little change in the occurrence of teenage pregnancy. Despite efforts to curb the high rates of teenage pregnancy all over the world, the phenomenon prevails and it is important to understand why teenage pregnancies continue to occur at such high rates, in order to formulate some form of effective intervention program to deal with the problem.

The basis for the concern of the researcher with teenage pregnancy rates in Sweden, despite rather extensive resources to prevent pregnancy, was initiated by the relatively high teenage abortion rates. Statistics suggest that teenagers in Sweden generally commence engagement in sexual activity at a young age, and thus the risk for teenage pregnancy is relatively high. In a study conducted by Edgardh in 2002, it was noted that 47 percent of boys and 31 percent of girls had had sexual experience by age 16. Whilst the researcher was acquainted with the fact that teenage pregnancies in Sweden occur at rather low rates in comparison to most other countries in the world, the question of interest arose from the thought that the possibility of a discrepancy between realistic service delivery and the daily functioning of adolescents may exist. The motivation for this study was therefore derived from an interest in the discrepancy between service delivery and the ability of teenagers to apply information provided to them by service providers with regard to healthy sexual functioning.

In gaining a better understanding of the reasons for high teenage pregnancy rates, it will allow for better informed development of intervention methods to address the problem. By studying reasons for high rates of teenage pregnancy, it will allow us to determine whether the basis of the problem lies on an organizational or personal level or both, and we can thus determine where changes need to be made in order to address the problem more directly. According to Kvale (1996, p11), "The sensitivity of the interview and its closeness to the subjects' lived world can lead to knowledge that can be used to enhance the human condition." The study may thus assist in the enhancement of prevention programs aimed at minimizing the problem of teenage pregnancies. According to Benson (2004), pregnancy affects the adolescent on physical, emotional and social levels and can have numerous implications not only for the individual, but also the family and society at large. The result of the study could therefore have its largest benefit to the individual, but may also assist in the facilitation of positive change on family and societal/organizational levels.

## **1.2 Research questions**

The topic of the study brings about the following research questions that need to be addressed within the study in order to satisfy the goals of the study as a whole:

1. How accessible are services to address sexuality as a whole to adolescents?
2. Why do teenagers engage in risky sexual behavior that could cause pregnancy?

## **1.3 Aims of the study**

The following objectives for the study have been identified:

1. To determine the availability of resources to adolescents with regard to sexuality.
2. To determine the accessibility of resources to adolescents with regard to sexuality.
3. To identify reasons for risky sexual behavior amongst teenagers.
4. To identify risk factors increasing the likelihood of engagement in risky sexual activity.
5. To explore possible areas of improvement with regard to service delivery with youth sexuality as a target.

In order to formally present the study, the report has been divided into several chapters:

The first chapter to follow (chapter 2) deals with previous research that is directly related to the current study. The nature of this chapter is factual and rather statistical, so as to provide the reader with comparisons of various phenomena in different countries and settings over the world. This chapter also includes a section on Legislation.

Chapter 3 entails a discussion on theories applicable to the study. The developmental phase of adolescence is discussed as a theoretical perspective, and is followed by an explanation of a risk-taking theory.

Chapter 4 focuses on the methodology of the study. There is a discussion on the choice of methodology, as well as the practical implementation thereof. Ethical considerations of the study also form part of this chapter.

Chapter 5 deals with the results and analysis of results of the study, in which findings of the present study are expressed and compared to previous research findings. This is followed by Chapter 6, which entails a general discussion and conclusion to the study, as well as suggestions for further research.

## CHAPTER 2 – LITERATURE REVIEW

### 2.1 Definition of core concepts

In order to satisfy the aims of this paper, it is necessary to clearly define the central concepts applicable to the study.

- 2.1.1 *Adolescence* can be defined as “the period of psychological and social transition between childhood and adulthood”. The boundaries of adolescence are broader than those of puberty, and alternatively include psychosocial and cultural characteristics rather than exclusively biological factors. The World Health Organization considers the period of adolescence to fall between the ages of 10 and 20 years (Wikipedia, 2007).
- 2.1.2 *Teenage pregnancy* – When pregnancy occurs in a woman under 18 years of age.
- 2.1.3 *Sexual Health* - The World Health Organization recently defined sexual health as "the experience of the ongoing process of physical, psychological and socio-cultural well being related to sexuality." "Sexual health is the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love".
- 2.1.4 *Contraception (Redirected as 'birth control')* – The intentional procedure by which, by a variety of methods, including actions, devices or medications, the possibility of a woman becoming pregnant or giving birth is reduced.
- 2.1.5 *Accessibility* - “Accessibility is a general term used to describe the degree to which a system is usable by as many people as possible. In other words, it is the degree of ease with which it is possible to reach a certain location from other locations” (Wikipedia, 2007).
- 2.1.6 *Availability* – Availability indicates the degree to which a system exists and operates or the level of functioning of a certain system.

### 2.2 Previous research

#### 2.2.1 Prevalence

The occurrence of teenage pregnancy appears to be an area of concern all over the world, yet rates vary from country to country and between various cultural and ethnic groups. In developed countries, teenage pregnancy is most often perceived to be a social problem and teenage mothers are often not married, while in developing countries, cultural traditions may allow communities to welcome teenage pregnancy and marriage is prominent amongst teenage parents. Teenage pregnancy, however, becomes a social problem in developing countries when coupled with poverty resulting in insufficient healthcare and malnutrition. “The general trend, worldwide, is that where fertility rates are lower, the share of births to young women is the highest” (Makiwane and Udjo, 2007). In other words, teenage pregnancy rates are often higher in societies with generally low fertility rates.

According to Westheimer & Lopater (2005), the United States is regarded as the country with the highest rate of teenage pregnancy among all developed countries with approximately 1 000 000 teenage pregnancies every year, although most recent



statistics indicate that the teenage pregnancy rate in the United States is currently at its lowest in sixty five years. Of the 1 000 000 teenage pregnancies in the United States annually, 428 000 end up in abortions (Westheimer & Lopater, 2005). Boys in countries such as the United States and the United Kingdom tend to have their sexual debut earlier than that of girls, while in Nordic countries girls tend to commence sexual intercourse at an earlier age than boys (Edgardh, 2000).

Teenage abortion rates are highest in Sweden compared to the other Nordic countries (Ekstrand, Larsson, Von Essen & Tyden, 2005). Abortion rates among Swedish teenagers, has increased by approximately 50% over the last decade. The main reasons attached to the increase in teenage abortions in Sweden since 1995 are “negligence in contraceptive use and intercourse under the influence of alcohol” (Ekstrand et.al, 2005, p980). Other possible reasons for high rates of teenage abortion in Sweden could be liberal approaches to adolescent sexuality and weakening of sexuality education in the school system (Ekstrand et.al, 2005).

Teenage pregnancy is also an area of great concern in the United Kingdom (Seamark and Gray, 1998). The significantly high teenage birth rate of 30.8 (per 1000 women between the ages of 15 and 19) in the United Kingdom confirms the fact that they have the highest rate of teenage pregnancy throughout Europe. Abortion rates in the United Kingdom are also of the highest in Europe. Teenage pregnancy rates in the United Kingdom, however, vary greatly between varying geographical areas. In 2002, the teenage pregnancy rate was 100.4 (per 1000) in Lambeth, London, while the rate was considerably lower at 20.2 (per 1000) in Rutland in the Midlands. Generally, teenage pregnancy rates have undergone a 4% increase over the last year, the highest annual increase in a decade (Womack, 2007).

Women in Africa generally tend to get married at younger ages than in other continents over the world, and thus the likelihood of teenage pregnancy increases. Teenage birth rates vary vastly between the various African countries, ranging from 7 in Libya and 92 in Zimbabwe, to 213 in Somalia and 233 in Niger (per 1000 women between the ages of 15 and 19). It is a well-known fact that there is a high teenage fertility rate in many developing countries, including South Africa. Statistics indicate that approximately 37% of girls in South Africa have been pregnant by the age of 19 and the majority, (80%) have their first sexual experience between the ages of 15 and 19. Despite an increase in the budget for the provision of education and preventative services, teenage pregnancy rates have nearly doubled in South Africa over the last year (Makiwane and Udjo, 2007).

### **2.2.2 Why do teenagers engage in sexual activity?**

The Guttmacher Institute indicated that it appears to be a global norm to have had sexual intercourse by the age of twenty. Sexual desire and the curiosity to experiment sexually are vital characteristics of the adolescent phase (Policy Program, 2006). “Adolescents make a personal decision to engage in sexual intercourse when they believe they are in love, are curious and seek excitement, and enjoy feelings of sexual arousal.” (Westheimer & Lopater, 2005, p 449). Westheimer & Lopater (2005) note that emotions play a large role for female adolescents, while males are more interested in physical pleasure.

One of the most obvious reasons for teenagers engaging in sexual activity can be assigned to normal biological development within puberty. Girls' breasts begin to develop and menstruation often commences soon after. In boys, the most obvious changes occur in penis size and the growth of facial and other bodily hair. Coupled with visible physical changes, sexual thoughts and feelings are considered a normal part of development for young adolescents. The adolescent most often becomes interested in members of the opposite sex. Boys become particularly interested with the shape and texture of girls' bodies, while girls often begin to take careful note of the boys' behavior. Hormones play a prominent role in the precipitation of sexual thoughts and feelings. Some form of sexual temptation amongst adolescents is unavoidable, and most often leads to masturbation, petting and/or sexual intercourse, usually in this order (Hilliard, 2006).

In a study conducted by Hacker et al (2000) among youths in Boston, United States, the three main causes of teenage pregnancy identified by young women were: becoming pregnant to keep a boyfriend, rebellion against parents and a need to have "someone of your own to love" (p280). Other risk-factors for teenage pregnancy were family circumstances, low self-esteem, problematic communication and pressure to be sexually active (Hacker et al, 2000). Hopkins (2007) confirms this by mentioning that according to research, characteristics that pregnant teenagers often have in common include negative self images and a lack of affordable, confidential contraceptive services.

In a study conducted in Norway with adolescents between the ages of 16 and 20, the majority of respondents indicated having engaged in sexual intercourse as a result of pressure from their partner. In a study conducted by the Kaiser Family Foundation, 29% of teenagers mentioned that they had felt pressured into engaging in sexual intercourse, while 33% indicated that they felt that their relationships were maturing too quickly sexually. In a survey administered to high school students in the United States in 2005, 7.5% of respondents indicated that they had been forced into engaging in sexual intercourse against their will (Eaton et. al, 2006). The trend is no different in some developing countries, as a 2006 survey in South Africa has shown that a third of South African girls mentioned that their first sexual experience was by force or threat thereof.

Apart from pressure from partners to engage in sexual activity, peer pressure plays a large role, particularly during the adolescent phase, particularly amongst males. Peers constitute a group of more or less the same age-group and interests. The term peer pressure implies a person's changes, or enticement to change, in attitude, behavior and morals as directly influenced by those in the peer group. In a poll conducted by the Kaiser Family Foundation in 2003 with boys between 15 and 17 years of age, one in three boys indicated having been pressured by their friends to have sexual intercourse.

Another large influential factor for teenagers engaging in sexual activity, which also holds a strong link with peer pressure, is that of inhibition-reducing drugs including alcohol, although this feature may also vary between different cultural groups (Abrahamson, 2004). Abrahamson (2004) notes that in certain cultures it may be regarded as morally incorrect for youths to engage in drinking within social settings. Peer pressure is, however, evident in the majority of social settings with a high

likelihood of "...extensive drinking in youth with social pressure from an environment in which everyone drank" (Abrahamson, 2004, p72). Leonard Sax noted that "girls often become intoxicated before engaging in sexual activities because it numbs the experience for them, making it less embarrassing and less emotionally painful". Boys, on the other hand, have been reported to make use of drugs to postpone ejaculation. Research in the United States has indicated that teenagers who are sexually active by the age of 15 are much more likely to use alcohol at least once or more a week (Wagoner, 1998).

Mass media has also been known to have an influence on teenage sexual activity. Films, internet websites and television programs containing sexual content, as well as music presenting sexual messages have been known to influence teenagers to participate in sexual activity prior to the necessary levels of physical, emotional and psychological maturation. Coupled with media, is the lack of adult supervision for adolescents. In a study conducted by Cohen et. al (2002), it was found that a large majority of teenagers had reported engaging in sexual activity in their own homes, and usually after school when there was no adult supervision. The less adult supervision, the more likely teenagers were to engage in sexual intercourse (Cohen et. al, 2002).

### **2.2.3 Contraceptive use and risk factors**

The most common methods of contraception for youths over most of the world include condoms and the contraceptive pill (Holmberg, 2001). "Depending on life-style, self-esteem and the particular sexual relation, adolescents face several problems in relation to the choice and use of contraceptives" (Holmberg, 2001, p34). Abstinence from sex before marriage is not of primary concern in many countries including Sweden, and it is considered completely normal for teenagers to engage in sexual activity as part of the maturation process (Holmberg, 2001).

According to Holmberg (2001), in a study conducted in 1999, almost 13% of high school students had reported not having used any form of contraception at their latest intercourse, while almost 10% had used 'unsafe' methods such as withdrawal. The majority of youths at first intercourse made use of either condoms or withdrawal, and in 60% of young women, the commencement of oral contraceptives became important only at a later stage (Holmberg, 2001). According to Morrison, Gillmore, Hoppe, Gaylord, Leigh and Rainey (2003), condom use is most prominent in casual sexual relationships, and rates of condom use are higher when sexual intercourse is anticipated. Condom use becomes less important in stable sexual relationships and where other contraceptive methods are used (Morrison et. al, 2003).

Ekstrand et. al. (2005) mention, however, that many Swedish girls are weary to make use of hormonal contraceptives due to fear of side-effects. This notion was confirmed by Törnbohm (1999) in a qualitative study conducted on repeat abortion among Swedish women, where respondents indicated that they had ceased the use of certain contraceptives for fear of side-effects. In studying experiences of the side-effects of contraceptives of women, it was noted by Ingelhammar, Möller, Svanberg, Törnbohm, Lilja and Hamberger (1994), that approximately half of the respondents reported having had experienced side-effects from contraceptives at some time or another during their life-time. This confirms an earlier study by Luker (1975), where she found that some women were reluctant to make use of contraceptive methods such as

the contraceptive pill due to fear of side-effects. They might have heard of other women who had experienced negative side-effects or through the media and had chosen alternative, less safe methods such as the rhythm method (Luker, 1975). The most common side-effects reported by respondents in various studies (Törnbohm, 1999; Edgardh, 2002; Luker, 1978) were mood changes and weight gain and were mostly experienced amongst women using the contraceptive pill. Due to the fact that oral contraceptives are so freely available to young girls in Sweden, the likelihood of side-effects due to oral contraceptives is great.

In a survey conducted with high school students in the United States in 2005, it was found that 37.2% of sexually active students had not used a condom during their last sexual encounter. Teenagers may not prove to possess adequate information and access to contraceptive methods and they may experience humiliation and fear of approaching the subject, and thus tend to avoid it instead (Eaton et. al., 2006). Sex education can be defined as the process by which individuals and groups acquire information and are given the opportunity to shape opinions about sex, sexual identity and intimate relationships (Forest, 2007). Forrest (2007), notes that one of the main aims of education regarding sexuality, is to prevent negative consequences of sexual behavior, such as unwanted pregnancy.

A lack of appropriate information has been identified as a core underlying reason for teenage pregnancy throughout most countries over the world. "Knowledge and information about sexuality and contraception has been shown to contribute to increased contraceptive use, particularly among teenagers" (Fischler and Pine, as cited in Coble, 2007, p17). Research has shown that young females not attending school are also more vulnerable to teenage pregnancy (Edgardh, 2000). This was confirmed by a study conducted by Holmberg in Sweden in 2001, where it was shown that school dropouts reported contraceptive use at a lower rate than students attending school.

The provision of sexuality education and information in Sweden is seen as the most important means of creating healthy, responsible and positive attitudes towards sexuality, particularly among teenagers. In Sweden, education on sexuality in schools was deemed compulsory as from 1956, although a minority of schools currently have formally written guidelines for sexuality education. The result of this lack of formally written guidelines is fragmentation of services and uncertainty of what exactly should be included in sexuality education in schools.

Youth clinics arrange visits for all 15 and 16 year old students, in which services offered by these centers are discussed with the youth, and information about contraception is discussed within a group context. All youth in Sweden have equal and relatively easy access to quality, comprehensive services with regard to contraceptives. The youth clinics operate during weekdays throughout the year (Holmberg, 2001). The problem with operating hours such as these is that access to contraceptives becomes limited over weekends, the time when most teenagers find themselves in social settings and more vulnerable to engage in sexual activity (Holmberg, 2001). It was concluded in a study by Bishai, Mercer and Tapales in 2004, that the availability of birth control can have a positive influence on teenage sexual behavior and can deter risky sexual behavior. The challenge is to make contraceptives available to youths when they are needed most.

The Government of the United Kingdom, in an attempt to curb the high rates of teenage pregnancy, aims at providing better information about sexuality and different types of contraceptives to the youth, as well as making contraceptives more easily available. The provision of adequate and comprehensive sexuality education in schools is viewed as an aspect of vital importance in achieving this goal, although it is not compulsory. Information is also often limited to the reproductive system, while contraceptive use and access thereto is given at the discretion of the educator (Curtis, 2005). Young British people often say the sex education is too little, is given too late and is too biological in nature. One possible pitfall within the education system in the United Kingdom is that parents have the right to withdraw their children from sexuality education programs at their own discretion (Brook, 2005).

In countries such as Germany, however, comprehensive and all-inclusive sexuality education has been compulsory since 1970 and parents have no rights to withdraw their children from such programs (Berne and Huberman, 1999). It can be noted that teenage pregnancy rates in the United Kingdom, compared to those of countries such as Germany who provide more holistic sexuality education, are considerably higher, and this difference could possibly be assigned to varying levels and approaches to sexuality education.

In the United States, two out of every three public schools have some form of policy relating to the provision of sexuality education, while the remaining schools have no formal education system with regards to sexuality and the initiative to provide such education lies with teachers and is by no means compulsory. The majority of schools in the United States with a policy for sexuality education teach abstinence-only programs, and a high proportion of teachers believe that the focus of sexuality education should not fall on factors such as contraceptive methods, the correct use of contraceptives such as condoms, and where to obtain contraception. Even in cases where teachers may wish to provide comprehensive sexuality education to their students, they may be prohibited to do so according to State laws and individual school policy. (Dailard, 2002)

In Africa, the main aim of sexuality education programs is to limit the spread of HIV, although protection against sexually transmitted infections goes hand in hand with protection against unwanted pregnancies. The 'ABC' program focuses primarily on abstinence, fidelity to one partner and condom use. The implementation of this program appears to be gradually successful. In Uganda, for, example, the use of condoms has improved, and youths are beginning to delay the age at which they first engage in sexual activity (Lane, 2007).

In many cases, contraception methods are implemented but often incorrectly. Girls may forget to take oral contraceptives regularly, and condoms may not be used correctly due to inadequate experience and knowledge. In a study conducted by Hacker et al in 2000, 6.7% of teenagers indicated that they did not know how to use contraceptives, and therefore avoided contraceptive use altogether. 'Contraceptive neglect' can also be considered an important risk factor for teenage pregnancy. Törnbohm (1999) notes that 'contraceptive neglect' constitutes, amongst others, failure to take the contraceptive pill regularly, or forgetting to take even one single pill, or

neglecting to make contact with the appropriate health-care professionals in order to renew a prescription in time.

Luker (1975) discusses the implications of contraceptive use for women. The first implication she mentions is that when contraception is used, it causes women to acknowledge the fact that they are sexually active. For girls with cultural backgrounds where sexual intercourse prior to marriage is forbidden, this may bring about intense feelings of guilt and embarrassment, thus discouraging them to make use of contraceptives. In some, often very few cases on the other hand, girls may become pregnant in an attempt to confirm their fertility. According to Pengpid (2004), in certain cultural settings in South Africa, for example, social pressures, whereby a girl may only be accepted once their fertility has been proven, may result in these girls avoiding the use of contraceptives.

Should women decide to make use of contraceptives, they may also harbor a fear of judgment by healthcare professionals or others in general when obtaining the contraceptives. According to Hacker et. al (2000), many teenagers do not attempt to obtain contraceptives due to embarrassment. In a South African study conducted in 2006, it was discovered that teenagers were often reluctant to seek contraceptives due to the negative attitudes of some of the nurses providing these services. These nurses were of the view that teenagers should not be engaging in sexual activity. “They responded to requests for contraception in a manner that was highly judgmental and unhelpful. The girls described it as ‘harassment’.” (Cunningham and Boulton, 1996, p2) In a poll issued in the United States in 1997, 70% of girls reported having avoided purchasing contraceptives as it was “embarrassing to buy birth control or request information from a doctor”.

A particularly applicable point to teenagers is that the use of contraceptives may hinder a sense of spontaneity and they may be embarrassed to address the topic while engaging in the passionate act. Luker (1978), mentions that the unpleasantness of having to interrupt the romantic process for contraceptives, may cause women to ignore the use of contraceptives altogether, whether it be on a single or on several occasions, and it may take one single such an occasion to cause an unwanted pregnancy. According to the Kaiser Family Institute (1996), approximately a quarter of girls admitted to having unprotected sex when their partner refused to use a condom, and almost half of adolescents believed that pregnancy occurred as a result of failure to have contraception readily at hand.

On the other hand, however, Luker (1978) notes that for the majority of women, the ‘costs’ of an unwanted pregnancy by far outweigh the ‘costs’ of using contraception and this is often the greatest motivation for using contraceptives effectively. The implications of an unwanted pregnancy are most often viewed as much greater than having to use contraceptives. “The ability to think about the future and plan for sexual activity appears to be an important factor in consistent contraceptive behavior” (Hacker et al 2000, p287). Besides preventing unwanted pregnancy, certain contraceptives also provide protection against sexually transmitted infections and the combined use of both non-barrier as well as barrier methods of contraception is the most effective way to prevent pregnancy and disease (Manlove, Terr-Humen, Papillo, Franzetta, Williams and Ryan, 2002).

The majority of clientele making use of youth clinics in Sweden are girls. Youth clinics experience constant problematic in involving boys in service consumption (Edgardh, 2002). According to Luker (1978), men are often unaware of the types of contraceptive methods employed by their partners and some men were not at all attentive to whether or not their partner was using contraceptives at all. Ultimately, the use of condoms is the only contraceptive method that requires full responsibility of the man, while all other methods of contraception require female responsibility. This may place high levels of pressure on women, particularly due to the fact that the consequences of unwanted pregnancy are much greater to women (Luker, 1978) in comparison to that of men.

Age also appears to be a possible predictive factor for vulnerability to teenage pregnancy. According to the Justice and Democracy forum on the Leading Social Indicators in Nevada in 2004, the likelihood of contraceptive use is lower amongst younger teenagers, than that of older teenagers. Early menarche, according to Hopkins (2007), is also a risk factor for engagement in sexual intercourse at younger ages, and thus increasing the risk for teenage pregnancy.

Sexual intercourse in short-term relationships is another factor that may increase the risk for teenage pregnancy. Intercourse is often not anticipated in temporary relationships (Luker, 1978). According to Törnbohm (1999), women in such relationships often forget to make use of contraceptives or did not have them at hand, or they were faced with feelings of embarrassment in having to broach the use of contraceptives during the build-up to intercourse. Luker (1978) found that women tend to fall into 'contraceptive patterns' when in a more stable relationship with one partner and many conclude the use of contraceptives when the relationship ends.

Psycho-social factors such as family circumstances have also been known to contribute to risky sexual behavior amongst some women, including teenagers. Törnbohm (1999, p65) found that several women seeking abortion of an unwanted pregnancy "were affected by a childhood of psycho-social problems of different kinds". Sexual temptations are often experienced more sharply by youths lacking affection and attention at home than those who come from loving and secure homes. Low self-esteem has also been noted to be a predictor of reduced condom use (Colon, 2007).

#### **2.2.4 Resources in Sweden**

The development of youth polyclinics throughout Sweden by the Swedish Society for Youth Centers since 1988, have made contraceptives easily available to the youth (Edgardh, 2000). The initiative to build the first such centre was taken by the child and adolescent physician, Gustav Högberg, in 1970 when he realized that young people need assistance in dealing with issues related to their existence. His initial intention was to consider the body, mind and soul in intervention, as well as matters pertaining to interpersonal relationships and try to relate these to education on sexuality. Nowadays, these centers focus largely on counseling in terms of sexuality and interpersonal relations, testing for STD's, the provision of contraceptives, counseling in terms of psychological and psycho-social issues, culture-related problematic, lifestyle issues and general medical problems (Policy Program, 2006). Contraceptives including condoms are provided free of charge and parental consent is not needed for teenagers to access these services (Edgardh, 2000). "Making

contraceptives available to youth also reduces adolescents' sexual risk-behavior. Confidential and low-cost contraceptive services ensure that sexually active teens have what they need to protect themselves and their partners from the risk of...unintended pregnancy" (Feijoo, 2007, p1).

### **2.2.5 Approaches to teenage sexuality**

There are many different approaches to sexuality around the world. Some are quite conservative in nature, while others are rather liberal.

As briefly mentioned previously, the United States has a somewhat inconsistent approach to teenage sexuality due to varying legislations in different States, as well as mixed messages between mass media, society and the Government. Sweden, on the other hand, is known to have a rather liberal and consistent approach towards teenage sexuality (Edgardh, 2000). Sexuality education has existed in schools for approximately 40 years (Holmberg, 2007). In Europe in general, there is positive cooperation between the media and service providers that promote a single, clear-cut message to teenagers about healthy sexual behavior. It has been noted that the Dutch act as a role-model for many countries in dealing with teenage sexuality as they focus on a variety of factors including morals, values, attitudes towards sexuality, communication and negotiation skills in general and in relationships, as well as biological aspects of reproduction (Barker, 1998).

In the majority of developing countries, however, education regarding sexuality is rather limited and inconsistent, although in Sri Lanka and Indonesia, for example, comprehensive sexuality education is provided according to a well structured policy framework for educators in schools (Villaneuva and Espada-Carlos, 2002).

The United Kingdom currently works according to a strategic program coordinated by the Department for Education and Skills of Children, Young people and Families, in which the focus falls particularly on the integration and cooperation of public services, as well as improved sex education, both for young people and their parents with a large focus on high risk groups.

"Research indicates that balanced realistic sexuality education – which includes both abstinence and contraception – can delay teens' onset of sexual activity, increase the use of contraception by sexually active teens, and reduce the number of their sexual partners" (Feijoo, 2007, p1). This finding was confirmed by a study conducted by the World Health Organization in which 35 schools around the world were involved. Results of this study showed that young people who have got education on sex commence their sexual life later, are more likely to make use of contraceptives and are less likely to expose themselves to sexual risk-taking (World Health Organization, 2007).

### **2.2.6 Legislation / Policy**

The legal age of consent for sex is 15 in Sweden. The statement of the Swedish National Committee for Public Health introduced three main objectives with regard to the sexuality of young people (STI/HIV Prevention Plan p.40):

1. To give young people equal opportunities to develop a healthy sexuality
2. To reduce the incidence of new cases of sexually transmitted infections (STI)



### 3. To reduce the number of unwanted pregnancies

Föreningen för Sveriges Ungdomsmottagningen or FSUM (Swedish Society for Youth Centres) was established in 1988 and the first policy program was written in 1992/1993. The policy program contains guidelines with regards to the content of activities to be conducted, the approaches of the staff to intervention, a description of duties as well as views on youth and sexuality. All activities in Sweden pertaining to children and young people are based on the "United Nations Convention on the Rights of the Child". Abortion became legal in Sweden in 1938 under the Abortion Act, although the Act maintained certain limitations to abortion. A woman could only abort if she had become pregnant as a result of rape, if her life were in danger, or if the child were likely to inherit a serious condition. The Abortion Act of 1974 stipulates that it is the choice of the woman to have an abortion for whatever reason she may decide to do so, up till the twelfth week of pregnancy, or otherwise under investigated circumstances.

Most recent legislation was implemented in 1996. The Governmental Proposition 1994/1995: 142 on abortion stipulates that abortion should be free and voluntary up until the eighteenth week of pregnancy, after which it can only be performed under special circumstances and under the final decision of the National Board of Health and Welfare up until the twenty-second week of pregnancy. Such circumstances include psycho-social problems, addiction to alcohol and other drugs, and psychiatric disorders amongst others. Induced abortions in Sweden may under no circumstances be performed after the twenty-second week. Illegal abortions are viewed as a serious crime and can be punished by the issuing of a fine to the offender, or in extreme cases, a prison sentence can be imposed. The law also stipulates that health-care professionals are obliged to offer both pre and post-abortion counseling.

The SOSFS 2004: 4(M) law indicates that information, both oral and written, should be given to the women before induced abortion is commenced with, preferably during the decision-making process. The medical doctor in supervising each case is specifically responsible for that case, and has the responsibility to monitor the patient after abortion in order to prevent additional unwanted pregnancies. Young girls under the age of eighteen years may choose to have an abortion and it is the responsibility of the professional in charge to inform the parents, according to chapter 6, section 11 of The Parental Code, unless there is substantial reason to believe that informing the parents is not in the best interest of the girl. Should the parents not be informed, another adult should be assigned to provide support to the young girl.

In Section 6.1 of The Abortion Act within The Health and Medical Services Act, it is stipulated that it is the responsibility of municipal councils to work towards the prevention of abortion. (Policy Program, 2006)

Legislation in the United States is somewhat different and more complicated due to the fact that each State applies the law in a unique way. Although the Supreme Court of the United States ruled abortion to be legal in 1973, abortion may be restricted in certain States depending on the jurisdiction of each State individually. Abortion in general and teenage sexuality are subjects of great debate in the United States. "It is ironic that the U.S. is the only industrialized nation to have an official government policy of no sex until marriage, yet our teenagers initiate sexual activity at an earlier

age than their European counterparts” (Wagoner, 1998, press release). The Congress of the United States contemplated parental consent for teenagers to access contraceptives, although this law never passed officially, however, the Congress passed a law in 1996 to provide financial support for abstinence-only educational programs for unmarried people (Barker, 1998). Messages passed on to the youth in the United States are very contradictory in that the media, in particular, and Congress provide mixed messages.

The 'Responsible Education about Life Act' as officially introduced at the 110th Congress of the United States for 2007 and 2008, advocates for a reduction in teenage pregnancy, and prevention strategies are slightly more comprehensive and holistic than previously. Information should be non-discriminatory and more objective. Abstinence is still of primary focus, although the Bill states that sexually active teenagers ought not to be discriminated against or ignored. The development of this Bill is a step in the right direction although successful implementation thereof remains the biggest challenge.

In the United Kingdom, abortion was first legalised in 1967 under the Abortion Act, and was considered to be one of the most lenient laws of its type in Europe at the time. This law only allowed for termination of pregnancy under certain circumstances and unless with good reason, abortion was to be performed before the 28th week of pregnancy. In 1990, the Abortion Act of 1967 was adjusted in Parliament under the influence of the Human Fertilisation and Embryology Act to limit abortion to before the 24th week instead, and legal abortion after the 24th week is only allowed to be performed under permission of the National Health Service according to specific criteria. Late abortions that are necessary due to negative physical, social and psychological aspects have been legalised and are less constrained than previously.

South African abortion legislation holds no limits for termination of pregnancy before the 12th week of pregnancy. Any women, regardless of age or any other factor, may request an abortion before the 12th week, while there are certain limitations for abortion after the 12th week. Abortion in South Africa is directed by the Choice on Termination of Pregnancy Act (Act 92 of 1996). Abortion in South Africa was only legalised in 1996 in a governmental attempt to curb sexism, in that women do not require the consent of men in their choice to have an abortion, and discrimination in terms of race as abortion is regarded as a means of preventing deterioration of living standards amongst poor communities, particularly predominantly black communities. The legalisation of abortion in South Africa has led to a decrease in deaths as a result of unsafe and self-induced abortions, although abortion has proven to be the third highest cause of death for infants under the age of one year.

## CHAPTER 3 – THEORETICAL FRAMEWORK

### 3.1 Developmental phase perspective

Developmental theories attempt to describe a particular phase of development, complete with all its characteristics and distinctions from other developmental phases (Miller, 2002). Wenar (1994) notes that problem behaviors are a typical characteristic in human development. Adolescence is viewed as a ‘critical period’ according to Passer and Smith (2004), in which it is important for the teenager to experience certain phenomenon in order to develop normally. The sexual behavior of teenagers is a topic of particular interest due to the fact that the onset of puberty brings about the capability for sexual reproduction, a period in which rapid development on all levels including sexuality takes place and hormonal changes can largely affect behavior during this phase of development (Passer et. al., 2004). Westheimer & Lopater (2005) note that adolescence marks the onset of an important link between physical appearance and self esteem.

According to Blos (1966), the phase of adolescence as such can be divided into several sub-phases:

1. The adolescent object choice phase  
This phase marks the first phase of actual adolescence in which identity becomes an important issue for the adolescent. Emotional maturation becomes better defined with specific goals and the essence of this sub-phase rests on the attempt of the adolescent to secure an identity for him/herself.
2. Early adolescence  
The development of masculinity amongst boys and femininity amongst girls is prominent during this sub-phase. Independence from the parental and family structures becomes important, and friends become the most dominant and influential system for the adolescent. Self-control is strongly compromised during this sub-phase, and such behavior often represents an attempt of the adolescent to avoid loneliness, depression and anxiety typical of this period of change. Early adolescence is also generally characterized as a period where the adolescent strives to identify an object of love and adolescents in this phase typically attempt to gain attention and affection of their peers, either through friendship or romantic relationships, but most often both, although romantic relationships are usually based on ‘crushes’.
3. Proper adolescence/middle adolescence  
Sexual relationships become a main focus in this sub-phase of adolescence and the construction of a sexual identity is of primary importance. The adolescent, as in all other sub-phases but particularly in middle adolescence, perceives the external world in a very unique manner, and is of the belief that others do not share this perception. Emotional self-absorption is a key characteristic of this sub-phase. The search for more serious romantic relationships becomes more prominent during middle adolescence.
4. Late adolescence  
During this sub-phase, the adolescent becomes more stable in their way of thinking. The identity of the adolescent is finalized and behaviors become

more purposeful. The adolescent experiences a higher degree of ownership over their life during late adolescence. The formation of sexual identity is completed and tends to be quite permanent throughout life.

Erik Erikson, a German psychoanalytical theorist, describes the various psychosocial stages of development over the average human life-span. In his view, physical development is coupled with personal and social consequences and he mentions that although all children go through the same stages of development in the same sequence, cultural norms may lead a child to develop in a certain way that may be somewhat different from that of other cultures (Miller, 2002).

Erikson discusses eight main stages of development, of which the adolescent developmental phase comprises that of the fifth stage. He names this stage 'Identity and Repudiation versus Identity Diffusion' and notes that "the concern for trust, autonomy and initiative reaches a climax during adolescence" (Miller, 2002, p155). Due to the fact that several biological changes take place during puberty, the adolescent is faced with the 'new' phenomenon of sexual urges. The development of an identity is of utmost importance in this phase, and this includes sexual identity or sexual orientation amongst others.

If adolescents are unable to successfully integrate their changing roles, identification or themselves, as a whole, they will enter into "identity diffusion" (Miller, 2002, p155). Due to the fact that youth make use of social networks as one means of developing an identity, association with a group with negative influence on an adolescent, in particular one suffering from "identity diffusion", may have devastating effects. They might be lured by feelings of acceptance and belonging, into believing that they have found their 'true' selves within a certain peer group that may in fact be influencing them negatively. Erikson believes that the ultimate challenge faced during this phase is "to be oneself or not to be oneself" (Miller, 2002, p155).

### **3.2 Risk-taking and decision-making**

The theory to be discussed in this section is commonly known as the decision-making theory and entails a process in order to reach and implement the decision. The theory is based on the assumption that individuals identify a variety of options available to them, they attach a significance to each of the options, they choose the option most applicable to their situation, after which they take action in attempting to practically apply the chosen option (Luker, 1978).

Luker (1978) discusses risk-taking as a choice, calculated differently according to varying life circumstances. A largely debatable subject amongst health-care professionals is whether information on contraceptives encourages contraceptive use or on the other hand, creates conflicting thoughts that may reduce effective use of contraceptives. Contraceptives can be experienced negatively in terms of side-effects and disadvantages on all levels of functioning. On the contrary, pregnancy can create positive effects for a woman in that pregnancy can confirm fertility and femininity is augmented. The consideration of all these factors contributes to the thoughts that either encourage or limit the decision to take risks, depending on the weight of each outcome and the advantages and disadvantages each option holds. In order to become pregnant as a result of risk-taking, Luker mentions that both the woman and her

partner must be biologically capable of producing children and risky behavior must exist over an adequate time-frame.

Fischhoff, Crowell and Kipke (1999) as cited in Brockman and Russell (2007) agree with Luker, and mention that the decision-making process consists of several stages in which options and consequences are weighed up against each other. Edgardh (2000) identifies a discrepancy among teenagers between the decision and the actual implementation thereof. She notes that while teenagers are able to make informed decisions due to widespread information and knowledge about safe sex, calculated decisions are not always put into practice.

Luker (1978) discusses decision-making in its general form, but for the purposes of the study, it is necessary to focus more particularly on adolescent decision-making. Ultimately, decision-making plays an important role in contraceptive use amongst teenagers. The ability to make good decisions becomes of particular importance during the adolescent phase, as this is the period when becoming independent is of priority (Brockman and Russell, 2007). Adolescents, however, face several difficulties in making decisions due to a variety of factors including the following:

- They may not possess adequate knowledge or control to identify a variety of choices, they often see 'either-or' choices (Fischhoff et. al, 1999 as cited in Brockman et. al, 2007).
- They may underestimate the actual risks of certain situations and behaviors and may overestimate their ability to deal with threatening situations (Fischhoff et. al, 1999; Ganzel, 1999 as cited in Brockman et. al, 2007).
- The likelihood that they will react purely according to emotions rather than engaging in rational decision-making is rather high (Fischhoff, 1992 as cited in Brockman et. al, 2007).
- They may succumb to peer-influence and make decisions according to perceived judgments of the peer group (Beyth-Marom, Austin, Fischhoff, Palmgren and Jacobs-Quadrel, 1993 as cited in Brockman et. al, 2007).
- They may not have a realistic perception of the consequences of negative behavior (Fischhoff, 1999; Ganzel, 1999 as cited in Brockman et. al, 2007).

Piaget discusses the 'Formal Operational Period' of cognitive developmental stages, and applies it to the ages of approximately eleven to fifteen years, which includes early adolescence. He notes that adolescents are able to identify all possible consequences, but test their self-made hypothesis of each option. This compliments the work of Luker, and indicates that Luker's decision-making theory is to some degree applicable to adolescents. In testing these hypotheses, adolescents apply what Piaget calls 'hypothetico-deductive thought'. Each possibility towards the suspected outcome is explored. In the social world of the adolescent, "the ability to consider abstract ideas, the future, and various possibilities" exists. Idealizations are made with regards to the future and roles they may wish to fulfill, and these roles and ideals are often tested. The fact that a degree of ego-centrism exists among adolescents, however, sometimes affects their ability to make realistic decisions (Miller, 2002).

Adolescence is seen by many as a period of experimentation. It is, however, important to note that the existence of a certain degree of risk-taking is regarded as an integral part of healthy adolescent development and is viewed as a positive strategy

for adolescents to be able to develop themselves, satisfy their curiosity and secure their identity. “Risk-taking is seen as a way of coping with normal developmental tasks such as exploration and achieving autonomy” (Millstein & Igra, 1995 as cited in Rolison & Scherman, 2002).

A risk can be defined as any action that has an uncertain outcome (Michael & Ben-Zur, 2007). Ponton (1997) suggests that there are various levels on which adolescents can engage in risk-taking, which enables us to distinguish between positive and negative risk-taking. According to Ponton (1997), risk-taking amongst adolescents becomes a negative factor when the risks pose a danger to either the adolescent, to others or both. There is a very fine line between positive and negative risk-taking, and the role of adults becomes an important factor in guiding the adolescent (Ponton, 1997). Along with adult responsibility comes the need of adolescents for positive role-models. Ponton (1997) mentions that teenagers have a tendency either consciously or unconsciously to observe and imitate adult behavior.

Due to the curious nature of teenagers, they are more likely to engage in risk-taking behavior that may lead to unwanted pregnancy. Despite the knowledge and awareness of consequences of certain behaviors, teenagers continue take risks, and this could be due to the fact that there is a mindset of consequences being distant to the individual choosing to engage in risky sexual behavior (Seamark & Gray, 1998). “Adolescents who think more egocentrically are somewhat more likely to engage in risky behaviors, due perhaps to a sense of invulnerability” (Greene et al., 2000, p403 as cited in Passer et al., 2004). According to a study conducted in the United States in 2001, sexual intercourse is considered to be one of the most prominent risk-associated behaviors among adolescents (Michael & Ben-Zur, 2007).

Despite any conscious efforts to become pregnant for any number of reasons, Törnbohm and Möller (1999) note that women may also gain, an often false, sense of safety after not becoming pregnant over a period of engagement in sexual intercourse without contraceptives. This may encourage further sexual risk-taking and continued non-use of contraceptives. Törnbohm and Möller (1999) note that it has also been revealed in several studies that some women believe that they can't become pregnant and thus often misjudge their own fertility.

Alcohol has also been known to hold a strong relation to sexual risk-taking and being under the influence of alcohol can also deter effective condom use (Jonsson, Karlsson, Rylander, Gustavsson and Wadell as cited in Törnbohm, 1999). “Several studies have shown positive relationships between drinking and risky sexual behavior among adolescents” (Morrison, Gillmore, Hoppe, Gaylor, Leigh and Rainey, 2003, p162). In study conducted by Dermen, Cooper and Agocha in 1998, it was found that many adolescents expected alcohol to influence risky behavior. Such adolescents are perceived to demonstrate higher levels of risk-taking when under the influence of alcohol and generally need higher levels of motivation and self-discipline to resist sexual risk-taking (Dermen et. al, 1998).

Leigh (2007) notes, however, that although some relationship may exist between alcohol use and sexual risk-taking of adolescents, other variables should also be taken into consideration. Alcohol cannot singly be assigned as a causative factor for lower levels of contraceptive use. This notion is supported by Morrison et. al (2003) in that

the findings of their research indicate that condom use did not differ between groups intoxicated before intercourse and those that were not. Some persons are even less likely to engage in risky sexual behavior when intoxicated with alcohol (Merritt, Janssen, Cohen and Finn, 1996). According to Merritt et. al (1996), the intensity of sexual arousal, rather, may be one of the factors to have the biggest influence on the willingness to take sexual risks.

## **CHAPTER 4 - METHODOLOGY**

### **4.1 Motivation for choice of method**

The researcher initially planned to combine both qualitative and quantitative research methods, but chose to implement only that of qualitative as the most effective method of data collection for this particular study due to the very complex nature of the research questions posed. Quantitative data was, however, included as part of the chapter on previous research, in order to indicate the prevalence of the problem and statistically portray the occurrence of the phenomenon and some related information over a variety of countries.

According to Silverman (2005), qualitative methods are best used to explore the everyday behavior of a certain target group. Silverman (2005) mentions that it is important for the researcher to consider the actual aims of the study when choosing a research method. Due to the fact that the study required more in-depth information from respondents, it was most advantageous to apply the interview method of data collection in attempting to answer the research questions. "Interviews yield rich insights into people's biographies, experiences, opinions, values, aspirations, attitudes and feelings" (May, 2001, p121) and "Through conversations we get to know other people, get to learn about their experiences..." (Kvale, 1996, p5). The aim of the study and ultimately the research questions, was to gain more insight into the thoughts, feelings, situations, circumstances and personal experiences that precipitate risky sexual behavior of teenagers and thus, increasing the likelihood of teenage pregnancy, through exploring the opinions of professionals specifically providing services in the field of teenage sexuality.

The research questions could not be effectively explored in a questionnaire for example, as they required elaboration of responses. Questions could not be particularly standardized to satisfy the requirements of the research questions, as personal experience and opinion varies from person to person and a semi-structured personal interview allowed the interviewer to probe for more in-depth data and allowed the respondents more freedom to express the information in the necessary detail, which could not easily be done in a questionnaire for example, and the semi-structured interview still allowed for a degree of comparability (May, 2001).

### **4.2 Sampling / Selection of data**

The first step taken was to define the population for the study. According to Gilbert (2001, p69), a population can be defined as "any well-defined set of elements". The researcher identified the population as professional persons working directly with issues pertaining to youth sexuality, within the geographical area in which the study was to be conducted. The challenge was to select a sample from the population that would be representative of the population as a whole as time limited the researcher to researching only a small group of respondents. In order to find appropriate interviewees for the study, the researcher made use of snow-ball sampling. This method of sampling entails contacting a member from the population and requesting referrals to alternative potential respondents that meet the criteria for data collection (Gilbert, 2001; May, 2001). The researcher made contact with a youth center providing direct services to the youth with regards to sexuality. After securing an interview with two professionals employed at this center, the researcher requested possible suggestions for appropriate alternative sources where data could be collected.



The researcher then made contact with the suggested potential interviewee and the process was repeated until the desired sample of five interviewees was recruited.

The researcher had the advantage that each of the initial interview candidates formed a network with the recommended candidates. Gilbert (2001) mentions that snowball sampling is only possible when target sampling group members are in some form of communication and cooperation with potential candidates who too meet the criteria for the study. Interviews were, however, not conducted exclusively with professionals from youth centers. This is important as Gilbert (2001) notes that one possible disadvantage of this method of sampling could be that the study is limited only to one specific network, thus jeopardizing fair representation of the population and increasing the likelihood of bias within the study.

### **4.3 Data collection**

The study was organized according to Kvale's (1996) 'seven stages of interview research:

Firstly, the researcher decided upon the actual purpose of the study (*thematization*), and from this decision had a choice of two target groups for data collection. In *designing* the study, it was the initial intent of the researcher to engage youths in data collection, but this may have posed some serious moral implications for the participants due to the sensitivity of the subject to be studied. The researcher therefore decided to interview professionals providing direct services to the youth regarding sexuality. *Interviews* were conducted according to a pre-determined semi-structured interview guide. In order to organize data for analysis, data was *transcribed* from recording equipment into written text. Results were clustered and this contributed to the *analysis* of the data. Finally, the researcher was able to *verify* the reliability and validity of the data and present the study as a whole in this report. (Kvale, 1996) Some of the above stages will be discussed in further detail throughout this chapter.

A total of five interviews were conducted as part of data collection. The researcher chose to conduct five interviews due to the limitation of time, although five interviews were sufficient to present the information needed to address the research questions. Two of the interviews were arranged personally, during a field visit to the involved organization as part of the field placement of the student/researcher. Consequent interviews with respondents willing to participate in the study were arranged both telephonically and via e-mail. Participants were informed of the nature and estimated duration of interviews, and then gave the researcher a date and time that was fitting for their schedules. In order to accommodate the busy schedules of participants, the interviews were conducted at the place of work of each participant. All interviews were held in an office separate from other office activities and were uninterrupted. The aim was to allow interviewees to feel comfortable within their own, familiar environment, while still allowing for data to be collected effectively. In this way, the interviewees were also able to save time in terms of traveling, and the researcher was able to obtain a realistic perspective on the geographical representativity of the participants for the study.

The duration of interviews varied, although all were between one and one and half hours long. The shortest interview was one hour and the longest was one and a half

hours long. The interviews could have been longer, and might then have provided more insight into the topics of discussion, but had to be limited in terms of time due to the busy schedules of the professionals being interviewed. The majority of respondents mentioned that they could only participate in the study if the interview was to be no longer than one hour, as this was all their schedule would allow for. The researcher did, however, manage to obtain the necessary data during the allocated duration of interviews.

Recording equipment was used a tool in data collection. The researcher made use of an audio recorder and chose this tool so that while recording speech, the researcher was still able to “concentrate on the topic and dynamics of the interview” (Kvale, 1996, p160). Should the researcher have made use of a video-tape recorder instead, interviewees may have been more reluctant to answer questions openly, and may have felt intimidated by the presence of such equipment. The nature of the study did not call for the use of video equipment and the use of an audio recorder proved to be adequate for the purpose of the study. It was, however, necessary that the interviewer make use of some form of recording equipment as Kvale (1996) mentions that the human memory is not necessarily a reliable method of recording data due to forgetfulness and the reliance on personal interpretation. All of the tape-recorded interviews were clearly audible, thus contributing to the accuracy of transcription.

The researcher made use of semi-structured interviews in order to collect data and made use of an interview guide to assist in structuring themes and some general content to be approached in the interviews (see appendix A). Kvale (1996, p29) mentions that “The qualitative research interview is theme orientated” and defines an interview guide as a document that specifies the general themes of the interview and indicates a framework for the practical progression of these themes, depending on the type of interview to be used. An interview that is conducted well can prove to be an insightful experience for the interviewee (Kvale, 1996).

The semi-structured interview was identified as the most appropriate method of data collection for the purposes of the study. This allowed the researcher to ask more or less the same questions to each interviewee, but to probe for further information where necessary and to change the sequence of questions and themes according to the responses of interviewees (Gilbert, 1996). The interview was divided into five main themes namely:

- The existence of resources for teenagers with regards to sexuality.
- The accessibility of resources for teenagers with regards to sexuality.
- The ability of teenagers to effectively utilize services within their current developmental phase.
- Risk-taking behaviors of teenagers increasing the likelihood of teenage pregnancy.
- Challenges faced in the system and in general.

A variety of questions were formulated in order to gain information from participants. The most common forms of questions utilized by the researcher were those of ‘introducing questions’, ‘follow-up questions’, ‘structuring questions’ and ‘interpreting questions’ (Kvale, 1996, p133-135).

#### 4.4. Method of analysis

In order to prepare the data for analysis, the researcher transcribed audio recordings of interviews into typed text, after which un-applicable and unimportant material was eliminated by condensing the text into meaningful data only (Kvale, 1996). Main themes were drawn from interview data and responses were then clustered into each of the applicable categories. According to Kvale (1996), it can be noted that the method of analysis is primarily that of 'meaning categorization'. Kvale (1996, p192) mentions that categorization entails the shortening of a text into meaningful categories by coding responses and clustering them together according to the "occurrence or non-occurrence of a phenomenon". It can be said that transcription was initially verbatim and was then condensed to selective transcription (Gilbert, 1996). By initially employing verbatim, and thereafter, selective transcription, the likelihood of biased and inappropriate selectivity was minimized. The fact that the researcher was the only one to transcribe the interviews eliminated the possibility of varying methods of transcription. Kvale (1996) notes that the style of transcription is important and styles may vary from a variety of persons transcribing, thus affecting the accuracy of transcription.

The researcher made use of color-coding as a tool for analysis. Each meaningful category was assigned a specific color and data was appropriately clustered together according to colors. Contraceptive use, for example, was assigned the color pink, and each response falling under the category of contraceptive use was colored pink and so on. Through the use of the color-coding technique as a tool for analysis, the researcher was able to interpret similarities and differences between responses and was able to organize valuable material logically.

'Meaning categorization' is a regularly used method for analysis, and is a familiar means of analyzing data within qualitative research (Kvale, 1996). The use of this method of analysis for this study in particular, has proven to be successful for several reasons. By employing this method of data analysis, the researcher was able gain a general overview of the occurrence of several phenomena such as contraceptive use, education and typical teenage behavior as expressed by the participants.

Secondly, this method of data analysis allowed the researcher to explore both similarities and differences in opinion and practical experience of certain phenomenon of participants. As the number of participants was uneven, it made it possible within several categories, for the researcher to identify whether the majority of responses were positive or negative for that specific category, allowing the researcher to draw conclusions based on majority responses.

Thirdly, the researcher was able to maintain focus of the study by eliminating data not applicable to the study. Categories most valuable to the study and pertaining to the research questions at hand could be identified and utilized and others eliminated. This contributes to the reliability of the study through cross-checking the aims of the study with the categories analyzed (Kvale, 1996). Through noting whether all categories were approached in each of the individual interviews, interviewer-reliability and consistency could be tested to a degree.

#### **4.5 Validity, reliability and generalizability of the study**

Reliability of interviews refers to the regularity of the research findings (Kvale, 1996). One of the major indicators of reliability in interview research is a lack of leading questions. Gilbert (1996) notes that it is of impeccable importance that researchers avoid the use of leading questions, and maintain the highest possible levels of objectivity throughout the research process. In order to minimize leading questions, the researcher preferred to ask open-ended questions as far as possible. Gilbert (1996) notes that the interviewer should attempt to pose questions as open-ended as possible. This was a great challenge for the researcher to employ successfully, due to the language barrier between the interviewer and interviewees, and the rephrasing of questions at times lead to a degree of leading questioning, although this never formed part of intentional influence during any of the interviews.

A common critique of qualitative research is that it may lack objectivity due to the degree of human interaction required in an interview (Kvale, 1996). Interviewer effects have a large influence on bias in qualitative research (Gilbert, 1996). In other words, the researcher may directly influence the responses of participants. This is another reason for why it was important for the researcher to use semi-structured interviews, in order to allow interviewees to elaborate on responses rather than being forced to answer the question in a completely structured manner. A completely structured interview may result in responses viewed as convenient for the interviewer rather than a true reflection of the thoughts of the interviewee (Gilbert, 1996). With all interviews and purposely prior to the use of recording equipment, the researcher engaged in general conversation with the interviewees, in order to create a relaxed atmosphere. "Being...overanxious to impress can distort response. A common problem here is where respondents give those answers they anticipate the interviewer wants to hear" (Gilbert, 1996, p138-139). It may have been useful that the researcher and all the interviewees were all female, although this may also be a limitation of the study, a lack of male insight into the problem area.

Validity refers to the degree to which the study accurately measures the concept being studied, the effective connection of theory to the study, and a lack of systematic error (Kvale, 1996; Gilbert, 1996). Validity can be measured on various levels and these will be discussed in application to the study.

Firstly, it is of utmost importance to consider the internal validity of the study (Gilbert, 1996). The initial idea was to combine quantitative and qualitative methods, but after close inspection, it was realized that this would not be the most effective way to approach the study. In the design phase of the research, the researcher took into consideration the possibility of negative consequences of participants (Kvale, 1996), and thus chose to eliminate the idea of inviting youths to participate in the study, and chose to focus rather on experience of professionals in the field of youth sexuality.

Secondly, in involving professionals with experience varying between two and thirty five years in the study, the researcher was assured relatively high levels of accuracy in the responses of participants. Questions were very much based on professional rather than personal experience. "A common critique of research interviews is that their findings are not valid because the subjects' reports may be false" (Kvale, 1996 p243). Due to the fact that there were no significant differences in positions held by interviewees with regards to professional power (Kvale, 1996), knowledge of

participants appears to be constructed on relatively similar levels, thus minimizing fragmentation of opinion due to power or professional position. This is important as Kvale (1996) notes that qualitative research is criticized for depending too much on subjective impressions of participants, and subjectivity may become augmented with power.

Thirdly, by cross-checking data clusters with the research questions and ultimately, the aims of the study, the validity of logical interpretations (Kvale, 1996) from responses of interviewees is increased. Kvale (1996) mentions that we need to investigate what we initially set out to investigate in order to maintain the validity of a study. Through the design of an interview guide, some structure was provided to the process and this assisted in maintaining the focus of the study during interviewing.

Validation during interviews was addressed through regular clarification of interviewees' responses. The researcher made use of rephrasing and repetition of responses in order to validate if the responses were heard and understood correctly. The questions 'what' and 'why' were used to further validate responses and gain confirmation through elaboration.

Pragmatic validity (Gilbert, 1996) has been of great importance in the study, in that the study was an attempt to seek the 'truth'. Validation in this sense took place through the researcher attempting to explore accuracy of participants' verbal statements by probing for practical examples to support these statements. The researcher made use of 'random probes' in order to seek more in-depth information of the responses of interviewees (Gilbert, 1996).

In terms of generalizability, it is uncertain whether the researcher was able to achieve satiation in the study, due to the fact that only five interviews were conducted. Satiation refers to the degree to which full gratification of a topic is achieved, a state of being unable to take on more (Word Web online, 2007). There may have been better opportunity for satiation if the researcher interviewed a wider variety of respondents from different professions. Responses were generally quite similar, and it can therefore be concluded that a high degree of generalizability was achieved amongst the target group for interviews, although it is difficult to measure to what degree generalizability was achieved for the topic of study as a whole.

## **4.6 Ethical considerations**

### **4.6.1 Informed consent**

The purpose of informed consent is to explain as fully as possible and in terms meaningful and comprehensible to participants, what the research is about, who is undertaking it and funding it, why it is being conducted and how it is to be distributed (Gilbert 1996; Kvale, 1996; May, 2001). In doing so, it is important that the researcher explains all possible risks as well as benefits from participation in the research.

In order to obtain full informed consent of respondents, the researcher made use of a standardized consent form (see appendix B). The document was discussed in detail with each interviewee, and interviewees were given the opportunity to ask questions at any point to clarify any concerns they may have had. The researcher included contact details of both herself, as well as her supervisor, should the

interviewees wish to make contact at any time for any reason related to the study. The researcher requested that each participant signed a consent form prior to the commencement of the interview. Interviewees received two forms, one in English, and one in Swedish, so as to avoid any miscommunication due to language barriers. Participants could choose to sign their name, or mark the form in any way that they could identify themselves with, that others might not be able to identify them with. The reason of the researcher for requesting some form of signature from participants was to “serve as a protection for both the interviewees and the researcher” if, for any reason, the interview may create conflict within the work place of the interviewee (Kvale, 1996, p154).

The informed consent (discussion and document) included the giving of information with regards to the study, its purpose and procedure, the role of participants in the study, confidentiality, the right to decline answering any questions at own discretion, the right of the interviewee to conclude the interview without having to provide reason for doing so, and finally, the right of the participant to withdraw from the study at any given time. The researcher indicated to participants that only she would have full access to interview material, while limited material would be available to authorized professionals at the educational institution supervising the study. All participants indicated that they fully understood this content and the researcher was given permission to pursue the study as necessary.

#### **4.6.2 Confidentiality**

Confidentiality in research implies that information identifying subjects will not be reported. Research participants have the full right to complete confidentiality. (Kvale, 1996; Gilbert, 1996; May, 2001)

On arrival at the work places of interviewees, the researcher mentioned only the person she had an appointment with and did not disclose any information regarding the nature of the appointment. Apart from one interview, the researcher had the advantage that she fell within the age-group for service delivery within these organizations and thus no suspicion was created. Interviews were conducted behind closed doors as a contribution towards confidentiality.

In ensuring that the confidentiality of all interviewees is preserved, the researcher marked audio tapes with dates of interviews rather than the names of the persons interviewed. During verbatim transcription, the names of interviewees were replaced with numbers and the names of the organization at which they worked were replaced with an X. Names of interviewees and organizations were completely omitted during selective transcription. The researcher took care not to change any of the major content of interview material in changing identifying information (Kvale, 1996). The interviews were transcribed solely by the researcher and earphones were plugged into the recording equipment to prevent others from possibly over-hearing material during the transcription process.

#### **4.6.3 Possible limitations of the study**

Due to the fact that the study was so small and only five interviews were conducted, the study may not be optimally representative of the population.

As mentioned previously, male insight into the study may have been useful, particularly with regards to contraceptive use of male teenagers. On the other hand, it is important to note that there are very few men working in organizations dealing directly with teenage sexuality and recruiting male participants would have proven a difficult task. Another point to note here is that the majority of teenagers seeking such services related to sexuality are female, and ultimately it was of more importance to the study to gain insight into female contraceptive use and risk-taking, topics more likely to be discussed with female professionals. The researcher attempted to arrange an interview with one male, with no success, however, as he was not available at the time of the study.

Information disclosed by participants may not have been as in-depth as initially aimed for by the researcher. This can be assigned to two primary reasons. Firstly, although all participants spoke English rather fluently, they were not all confident in the use of the language, and this may have deterred them from answering questions on a more in-depth level for fear of embarrassment. As one participant mentioned, "These are very big questions and if you want a good answer, I think from my point of view...we have to have someone to translate." Secondly, due to the compact schedules of participants, time for interviews was more limited than initially planned by the researcher. If more time was available for interviews, at least one and a half hour each, it is suspected that more insight into the topics at hand could have been gained.

## **CHAPTER 5 – RESULTS AND ANALYSIS**

### **5.1 Approach to teenage sexuality in Sweden**

Teenage sexuality in Sweden was described by interviewees as rather free and open, and there is little/no shame attached to sexuality. There is much freedom for teenagers to decide for themselves when they will engage in sexual activity, and with whom they wish to do so and sex before marriage is not forbidden. Sexuality is viewed as a normal, healthy part of growing up and the intention is not to prevent teenagers from having sex, but rather to encourage positive sexual behavior. Most girls have their sexual debut between the ages of 16 and 19 and the provision of information to the youth is an aspect of priority. Due to the rather liberal attitude towards sexuality in general, but also teenage sexuality in Sweden, the media has a large influence in placing pressure on teenagers to perform sexually, as sexuality is openly portrayed. The liberality of issues pertaining to sexuality in Sweden, were viewed rather positively by all respondents, while Ekstrand et. al (2005) noted that this liberal approach to teenage sexuality may be a possible reason for high rates of teenage abortion in Sweden.

### **5.2 Available resources and the accessibility thereof**

As indicated by respondents, many resources that provide sexuality information to the youth exist in Sweden. Such resources include parents, friends, the media, such as television, books, magazines and internet, school nurses and youth reception centers and information leaflets are distributed by the public sector. The media as a resource for teenage sexuality was viewed as having both positive and negative influence. It was thought that parents and teachers ought to play a large role, although the quality of sexuality education and support from parents and teachers is variable.

As noted by Holmberg (2001), the provision of information regarding sexuality is considered the most important means of creating healthy, responsible and positive attitudes towards sexuality in Sweden. The ability to make positive decisions also relies largely on the information available to the individual. As Luker (1978) states, decision-making entails the consideration of a variety of options, but ultimately, if the individual is not aware of all the options, the ability to make informed decisions becomes limited. Brockman and Russell (2007) note that decision-making plays an important role in adolescent contraceptive use. Thus, the provision of information in order to enhance decision-making of adolescents is of utmost importance.

Respondents mentioned that youth centers have existed in Sweden for many years, as a government initiative. The main aim of these centers, as expressed by respondents, is prevention and they focus on the following areas of service-delivery: provision of contraceptives and prevention of unwanted pregnancies, providing information to the youth, counseling in terms of depression, anxiety, eating disorders, teenage pregnancy, abortion, self-destructive behavior, family and/or relationship problems, identity problems, and any other psychological or emotional malfunction, and the prevention of sexually transmitted infections. This is consistent with Sweden's Policy Program of 2006 in which it is stated that the focus of youth centers, nowadays, is on counseling in terms of sexuality and interpersonal relations and the provision of contraceptives amongst others.



Respondents mentioned that youth reception centers offer free services to male and female clientele, couples, and sometimes families. They serve youths from any age up until the age of 24 and parents who may have concerns about their teenager may call for advice. Condoms are provided free of charge and the contraceptive pill is very inexpensive. All students in the 8<sup>th</sup> grade are invited for an information session.

This is positive as “confidential and low-cost contraceptive services ensure that sexually active teens have what they need to protect themselves and their partners from the risk of...unintended pregnancy”. (Feijoo, 2007, p1) Bishai et. al (2004) also concluded that the availability of birth control can have a positive influence on teenage sexual behavior and can deter risky sexual behavior.

According to the professionals interviewed, these centers work according to a holistic perspective and the effective functioning as a multi-disciplinary team including doctors, midwives, social workers, counselors, nurses and gynecologists, is of utmost importance. They strive to approach the youth with a non-judgmental attitude and to create a friendly, safe environment where an adult support system can guide the youth to have safe sex instead of trying to prevent them from having sex. Services are provided according to several legislative guidelines such as the Law on Healthcare, Parental Responsibility Law, the Secrecy Act, and a law on sexual abuse and statutory rape.

The fact that Sweden’s Policy Program contains formally written guidelines with regards to working with the youth (Policy Program, 2006) limits the likelihood of fragmentation of services within youth centers, particularly where several professions are involved in service delivery within the same problem area. The Policy Program contains guidelines with regards to the content of activities to be conducted, the approaches of the staff to intervention, a description of duties, as well as views on youth and sexuality. The Swedish Law SOSFS: 2004 states that when parents are not informed of a teenage pregnancy, another adult is to be assigned to provide support to the pregnant youth. In addition, Ponton (1997) notes that the role of adults becomes an important factor in guiding adolescents.

All responses indicated that youth centers are popular amongst the youth, and it is considered an easily accessible resource. The youth are aware of these centers, and schools, parents, teachers and society as a whole are also well-aware of the existence of these centers as well as the services they provide. One of the organizations administers feedback questionnaires to schools in their area of service delivery on an annual basis, and it was mentioned that feedback from the youth is generally very positive. One respondent felt that resources were not equally accessible to youths throughout the geographical area of the study, as some centers have equal resources but higher caseloads in comparison to other centers. Participants employed in organizations working with the immigrant population were positive about the accessibility of services to girls prohibited from using such services due to culture and family values.

Girls with cultural backgrounds where sexual activity before marriage is prohibited, may be weary to make use of services due to feelings of guilt and embarrassment (Edgardh, 2002). Edgardh (2000) notes that accessibility is good as parental consent is not required for teenagers to access these services. All youth in Sweden have equal

and relatively easy access to quality, comprehensive services with regard to contraceptives (Holmberg, 2001).

Service delivery was regarded by all participants as effective, although the majority indicated that there is still a need for improvement of services. It was mentioned that the resources in Sweden are very good in comparison to other countries, especially countries where sexuality is not openly discussed. One respondent mentioned that services were regarded as effective due to the fact that the teenage pregnancy rate had not increased over the last 8 years, while another mentioned that services are not as effective as they ought to be as the teenage pregnancy rate had not decreased.

Despite having low rates of teenage pregnancy compared to most other countries, Sweden has the highest rate of teenage pregnancy of all the Nordic countries (Ekstrand et. al, 2005). Another point of concern is that teenagers in Sweden generally commence engagement in sexual activity at very young ages, and thus the risk for teenage pregnancy is relatively high (Edgardh, 2002).

All responses indicated that most teenagers take the services offered seriously and a high degree of motivation to utilize services exists. Some responses indicated, however, that there are groups, particularly boys of a younger age that do not really attach any seriousness to the services delivered, although this was also seen as a positive aspect, as there is often an underlying curiosity. Two respondents mentioned that the services are taken more seriously when the teenagers have serious questions or problems at hand.

It was noted by one respondent that some teenagers are weary to make use of the services for fear of being identified, although the majority demands the services available to them. This respondent mentioned that immigrant boys are often more confident in demanding services than that of their Swedish counterparts. A first visit to the center was viewed as a stressful event for some teenagers, particularly girls, although consequent visits appear to be easier. The majority of teenagers seeking services are girls.

This is consistent with the findings of Edgardh (2002) as she noted that the primary consumers of services at youth clinics are girls.

### **5.3 Existing sexuality education**

Sexuality education in Sweden was introduced approximately 50 years ago. The law states that sexuality education should be provided in schools. Responses indicated that the quality of sexuality education varies between schools and that sexuality education does not exist in all schools. The majority of schools have a relatively new subject called 'the knowledge of life' which includes sexuality education on a broader level than merely biological aspects of sexuality. Several respondents identified good sexuality education as the inclusion of not only biological aspects, but also emotional, psychological, relational and safety-related aspects. The choice of whether or not to provide sexuality education rests very much on the individual teacher, and almost all of the interviewees indicated that teachers are not as involved in sexuality education as they ought to be. Some responses also indicated that parents ought to take more responsibility in educating their teenagers on sexuality. All responses indicated that there was much room for improvement within the formal education system.

Swedish Legislation officially states that sexuality education is compulsory within the school system. Edgardh (2002) notes that very few schools in Sweden have formally written guidelines for sexuality education. This leads to fragmentation in the provision of sexuality education in schools, and also leads to uncertainty of what exactly should be included in sexuality education in schools. “Research indicates that balanced realistic sexuality education – which includes both abstinence and contraception – can delay teens’ onset of sexual activity, increase the use of contraception by sexually active teens, and reduce the number of their sexual partners” (Feijoo, 2007, p1). This finding was confirmed by a study conducted by the World Health Organization in which 35 schools around the world were involved. Results of this study showed that “young people who have got some sex education start their sexual life later, are more likely to use contraceptives and less prone to expose themselves to risky sexual behavior” (World Health Organization, 2007).

#### **5.4 Teenage behavior and thought patterns**

Adolescence is viewed by respondents as a period where teenagers are very curious. Interviews revealed that adolescence is seen as a risky period in life, where levels of experimentation are high and risky behavior is viewed as normal. Friends become an important network, and family becomes less important. The teenager becomes very aware of his/her body and that of others and finding love is important. Physical appearance was noted as an important factor during adolescence.

These findings run parallel to those of several authors. According to Westheimer and Lopater (2005), adolescence marks the onset of an important link between physical appearance and self-esteem. According to Blos (1966), the development of masculinity amongst boys and femininity amongst girls is prominent during this sub-phase. Independence from the parental and family structures becomes important, and friends become the most dominant and influential system for the adolescent.

Teenagers were described as ‘seeking’ beings who like to ask questions. Most interviewees mentioned that teenagers are very impulsive and ‘live for the moment’. They are often not afraid of the consequences of their behavior and despite knowing the rules they take chances. As one respondent stated, the ability to maintain self-control during this phase of development becomes severely compromised, and this is often due to confusion with regards to a changing/developing identity. Another respondent thought that teenagers have the ability to exercise self-control:

“I think you are touching the edges everywhere, every time, but most of them are inside the edges”. (1)

All respondents mentioned that most teenagers have an ‘it can’t happen to me’ attitude and the testing of limits is viewed as a common teenage characteristic.

Blos (1966) mentions that self-control is strongly compromised, particularly during early adolescence, and most often in an attempt of the teenager to avoid loneliness, depression and anxiety typical of this period of change. Identity development is important during early adolescence (Blos, 1966) and Erikson explains that an inability of teenagers to successfully integrate into their changing roles, identification or themselves as a whole may create ‘identity diffusion’ (Miller, 2002). On the other

hand, Piaget wrote that teenagers do possess the ability to “consider abstract ideas, the future and various possibilities” (Miller, 2002).

In a discussion on adolescent decision-making (Brockman and Russell, 2007), it was noted that teenagers may not have a realistic perception of the consequences of negative behavior (Fischhoff, 1999; Ganzel, 1999 as cited in Brockman et. al, 2007) and they may underestimate the actual risks of certain situations and behaviors and may overestimate their ability to deal with threatening situations (Fischhoff et. al, 1999; Ganzel, 1999 as cited in Brockman et. al, 2007)..

Responses were mixed concerning the ability of teenagers to practically apply the information given to them. The major response was that teenagers are aware of the rules and have the necessary information, but are generally not able to apply the information practically. As one interviewee noted:

“I think we will give information in many ways and many times, but I still think they have a behavior or they’re taking risks, but they have been given the information but it still doesn’t change their behavior”. (3)

### **5.5 Contraceptive use**

According to interviewees, the most popular form of contraceptive amongst teenagers is that of the contraceptive pill and condoms, although they tend to experiment with other types too, as there are many options nowadays. Respondents mentioned that contraceptive use of teenagers is generally very inconsistent, that it is used sometimes, but not always, and it is very common not to make use of any protection at all.

Holmberg (2007) confirms that the most common methods of contraception amongst youth all over the world include condoms and the contraceptive pill, while there are some teenagers that use no contraceptives at all.

Several responses indicated that girls are weary to take the contraceptive pill for fear of side effects. The most feared side-effects include weight gain, skin problems, blood clots, change in libido and mood changes. The media has a large influence on the choice of girls not to use contraceptives pills as the negative side-effects are advertised and are often a topic of public discussion. Some girls choose either to use condoms, or no contraceptive method at all, rather than taking the contraceptive pill. Some begin to use the contraceptive pill, but cease doing so after experiencing side-effects, and that is when the risk to become pregnant is also high. Another popular form of contraceptive is the emergency pill. It was mentioned by some interviewees that it is very common for girls to request the emergency pill on Mondays.

The notion of the fear of side-effects was also mentioned by Ekstrand et. al (2005) and in a study conducted by Törnbohm (1999), where side-effects most feared by women included mood changes and weight gain. In another study, Ingelhammar et. al (1994) found that almost half of respondents had experienced negative side-effects of contraceptive pills.

Several responses indicated that using the contraceptive pill to prevent pregnancy is often not effective in teenagers due to inefficient administration of pills. A miniscule amount of girls get pregnant despite the correct use of contraceptives. Most girls that

became pregnant while using contraceptives mentioned to interviewees that they had in fact forgotten to take a pill or that they had used a condom but too late. Condoms are also known to break if not used correctly. The above-mentioned results are demonstrated clearly in the following response:

“Well, often enough they say that ‘Well, I was trying to protect myself, I was using a condom, I was using the pill, but I got pregnant anyhow’. So, often enough, they say that they tried to protect themselves...It’s a lack of effective use I think. The condom slipped off or broke. I don’t understand how that really could happen. Maybe it’s something they say, but instead it was that they didn’t use it.” (5)

According to Hacker et. al (2000), in many cases, contraceptive methods are implemented but often incorrectly. Girls may forget to take oral pills regularly and condoms may not be used correctly due to inadequate experience and knowledge. Törnbohm (1999) discusses the term ‘contraceptive neglect’, which constitutes the failure to take the contraceptive pill regularly, or forgetting to take even one single pill, or neglecting to make contact with the appropriate health-care professionals to renew a prescription in time.

It was noted from interviews that condom use is generally very low in Sweden. Some responses indicated that many girls and boys prefer not to use condoms, but that girls are also often influenced by boys to have sexual intercourse without a condom. Many interviewees mentioned that teenagers indicate not having had a condom at the time of intercourse, yet chose to have sex anyway. Even if a condom was available, it was noted that many girls, especially those that are younger, avoid demanding its use as this may ruin the chances of having a sexual encounter at all.

“I think it’s hard for them both to get the condom, to open the condom, to get it on. It’s hard for the boy to make the interruption and it’s hard for the girl to demand it”. (1)

Luker (1975), mentions that the unpleasantness of having to interrupt the romantic process for contraceptives, may cause women to ignore the use of contraceptives altogether, whether it be on a single or on several occasions, and it may take one single such an occasion to cause an unwanted pregnancy. According to Kaiser Family Institute (1996), many girls had admitted to having unprotected sex when their partner refused to use a condom.

It was also mentioned that girls most often prefer to take the responsibility for contraceptive use as the consequences of pregnancy weigh more heavily on them than on boys. The only contraceptive where boys are majorly responsible is that of condoms, while girls are majorly responsible for all other types.

## **5.6 Risk-taking**

Risk-taking was viewed by some respondents as necessary for healthy development as long as they are within limits. Teenage pregnancy was, however, seen as a consequence of risky behavior rather than the inability to use contraceptives effectively. For most respondents, teenagers taking risks were associated with the thought that

“Some of them are...living in a pretend world, well, ‘It won’t happen’.” (5)

Despite the knowledge and awareness of consequences of certain behaviors, teenagers continue to take risks, and this could be due to the fact that there is a mindset of consequences being distant to the individual choosing to engage in risky sexual behavior (Seamark & Gray, 1998). Previous research indicates that a certain degree of risk-taking is regarded as an integral part of healthy adolescent development and is viewed as a positive strategy for adolescents to be able to develop themselves, satisfy their curiosity and secure their identity. "Risk-taking is seen as a way of coping with normal developmental tasks such as exploration and achieving autonomy". (Lavery et. al, 1993; Millstein & Igra, 1995 as cited in Rolison & Scherman, 2002). According to Ponton (1997), risk-taking amongst adolescents only becomes a negative factor when the risks pose a danger to either the adolescent, to others or both.

All responses indicated a strong relationship between risk-taking while under the influence of alcohol. Drinking alcohol is seen as a factor increasing the likelihood of teenagers having dangerous sex. These were the responses of two interviewees when asked about alcohol use amongst the youth:

"Taking risks when you have been drinking alcohol, it's very common. There are teenagers who...always have sex when they are drunk but not when they have not been drinking. So, I think its alcohol...it makes them take more risks." (3)

"Well, we have this saying that when alcohol goes in, the good thinking goes out. Well, it's like that. You get more easy-going when you drink. The same for adults but even more for teenagers, they are not used to drinking." (4)

The use of contraceptives let alone effective use is compromised when teenagers are under the influence of alcohol and other drugs. Alcohol also increases the risk of forgetting what happened.

Alcohol has also been known to hold a strong relation to sexual risk-taking and being under the influence of alcohol can also deter effective condom use (Jonsson et. al as cited in Törnbohm, 1999). "Several studies have shown positive relationships between drinking and risky sexual behavior among adolescents" (Morrison et. al, 2003, p162). Leigh (2007) notes, however, that alcohol cannot singly be assigned as a causative factor for lower levels of contraceptive use.

Some respondents mentioned that the realization of teenagers that their behavior was negative often comes after the risky sexual act.

"It is the moment. That moment I didn't care. I just wanted to have sex with him'." (4)

Some teenagers constantly engage in risky behavior and therefore place themselves at even higher risk for sexual abuse. It was mentioned by one respondent, that some teenagers are unable to distinguish between right and wrong. They engage in risky behavior and there is no afterthought.

Several of the respondents reported that some girls take sexual risks due to the fact that they have done so in the past and never experienced any negative consequences. Many of them consequently believe that they cannot fall pregnant and thus continue

to have unprotected sex. Some girls may even want to confirm their fertility, even though they do not really want to be pregnant.

This is consistent to findings of Törnbohm and Möller (1999), where they note that despite any conscious efforts to become pregnant for any number of reasons, women may also gain, an often false, sense of safety after not becoming pregnant over a period of engagement in sexual intercourse without contraceptives. This may encourage further sexual risk-taking and continued non-use of contraceptives.

Most of the respondents also believed that there is a strong relationship between sexual risk-taking and unstable family circumstances. One respondent mentioned that teenagers from unstable families often do not take care of themselves and are therefore more vulnerable to risky behavior. Another respondent mentioned that teenagers with little optimism for the future tend to be more likely to engage in risky behavior. Peers have been reported to have an influence on risky behavior, and teenagers involved in groups where the norm is risky behavior, are themselves more prone to risky behavior.

Erikson, in his theory on the adolescent developmental phase, states that due to the fact that youth make use of social networks as one means of developing an identity, association with a group with negative influence on an adolescent, in particular one suffering from “identity diffusion” may have devastating effects. They might be lured by feelings of acceptance and belonging, into believing that they have found their ‘true’ selves within a certain peer group that may in fact be influencing them negatively. (Miller, 2002)

As indicated by one respondent, another reason for teenagers making the decision to engage in risky behavior was expressed as follows:

“The knowledge you have in your head isn’t always there when you end up in bed with someone. The feelings rush away and things like that.” (4)

The likelihood that teenagers will react purely according to emotions rather than engaging in rational decision-making is rather high (Fischhoff, 1992 as cited in Brockman et. al, 2007).

### **5.7 Psycho-social factors**

Most respondents indicated that family problems play a large role in negative sexual behavior amongst teenagers, although it is not seen as a direct cause of teenage pregnancy. It was noted that there is a high divorce rate in Sweden and often this results in teenagers feeling lonely and deserted. Parents are sometimes viewed as too involved with their careers and do not pay enough attention to their teenagers. The result may be that these teenagers turn to romantic and often sexual relationships in order to fulfill their need for love, attention, affection and acceptance. This was seen as particularly prominent where fathers were absent and appears to affect both boys and girls. One respondent stated that it is often difficult for teenagers to accept when their fathers remarry and start a new family. These teenagers often feel forgotten.

Sexual temptations are often experienced more sharply by youths lacking affection and attention at home than those who come from loving and secure homes (Colon, 2007).

Professionals felt that there may be a lack of positive role-models for teenagers, especially where they need guidance in terms of right and wrong and some parents set a bad example for their teenagers in terms of sexual behavior. One interviewee mentioned specifically that it is common for girls to engage in risky behavior when they have parents that do not take enough responsibility. Chaos and instability in the family and at school can limit the teenager's ability to distinguish between right and wrong.

Ponton (1997) mentions that teenagers have a tendency either consciously or unconsciously to observe and imitate adult behavior.

Other family problems such as financial difficulty were also mentioned by respondents. One such example is as follows:

“If you're not sure where you're going and life looks a bit bleak at the moment. Mother and father are unemployed as in this area a lot of them are...then it's the moment that becomes more important than thinking forward. 'I might as well do that, it doesn't look too good anyway'.” (2)

Parents who use alcohol, who are under great amounts of stress and who have many children to care for may pay less than necessary amounts of positive attention to their teenagers. Uneducated girls with negative family circumstances were identified by one respondent as being particularly vulnerable to getting pregnant as they do so in order to experience feelings of closeness. One respondent mentioned a study that was recently conducted by a psychologist, in which it was found that girls living a sexually promiscuous life often had not attached positively to their parent or caregiver during early childhood.

Self-esteem and self-confidence are important for teenagers, and a lack of these limits the ability of the teenager to exert him/her self positively and to enforce decisions strongly. One response was as follows:

“If you've got a low self-esteem it becomes even more important to prove that you're worth something. It's [sex] a way around feeling better.” (2)

According to Colon (2007), low self-esteem has also been noted to be a predictor of reduced condom use.

Society as a whole was also mentioned to have an influence on the way in which teenagers think and behave. One interviewee discussed societal pressure into becoming famous and mentioned that there is a lot of pressure that often involves sexuality.

“The last couple of years it's been a lot more on tele, the 'Big Brother' thing. Where you have to have sex in front of the camera and then you get famous.” (2)

Piaget discusses decision-making of adolescents and notes that idealizations are made with regards to the future and roles they may wish to fulfill, and these roles and ideals are often tested (Miller, 2002).



To the other extreme, one respondent mentioned that some girls may not engage in risky behavior, but may be overly-controlling of themselves due to societal pressures in terms of physical appearance. Such behavior is displayed in eating disorders, for example.

Peer pressure and pressure to have sex within a relationship are another two risk factors identified by all interviewees. Girls are often pressured into having sex by their boyfriends, while both boys and girls are often concerned with the reactions of their peer group if they do not engage in sexual activity. It was, however, mentioned that peers may also have a positive influence on certain members of the peer group in guiding them as to what is right and wrong and providing positive support for the risky teenager.

Teenagers may succumb to peer-influence and make decisions according to perceived judgments of the peer group (Beyth-Marom et. al, 1993 as cited in Brockman et. al, 2007). According to Erikson, independence from the parental and family structures becomes important, and friends become the most dominant and influential system for the adolescent (Miller, 2002).

### **5.8 Differences between younger teenagers and older teenagers**

According to all responses, younger girls are more prone to risky behavior than that of older teenagers, although it was also mentioned in one interview that younger girls have less sexual partners than that of older girls.

When looking at the difference between younger and older teenage girls in their utilization of services, it was noted that older teenagers are more likely to attend appointments and can maintain self-control better than younger teenagers. Reasons mentioned during interviews were that younger teenagers have not yet developed to the full in terms of identity and may be physically mature to engage in sexual activity prior to appropriate mental maturity. As one interviewee mentioned:

“Well, when you’re 13, 14, 15, you’re much more...you don’t know yourself that well. When you’re 18, you’re a bit more acquainted with yourself and you have passed the turbulence of adolescence. I mean, all the tricky feeling about, not just the hormones, but the emotional development.” (5)

It is important to note that older teenagers can also be risky at times but it was felt by professionals that it is easier to intervene with them. Older teenagers are also generally more disciplined with contraceptive use.

According to Erikson, the most important developmental task of younger adolescents is to attempt to secure an identity. In late adolescence, the teenager is more stable in their way of thinking and the identity, including sexual identity, is finalized. Erikson also notes that during middle-adolescence, teenagers are often emotionally self-absorbed. Piaget agreed with Erikson when he mentioned that a degree of ego-centrism exists among adolescents between 11 and 15 years of age, and this sometimes affects their ability to make realistic decisions. (Miller, 2002)

One respondent noted that when younger teenagers become pregnant, they are often more concerned with the reactions of their parents, while older teenagers are more concerned with how they will be able to cope with pregnancy. Younger girls need to

be challenged more with questions regarding their sexuality and professionals place much emphasis on trying to involve them in service delivery.

### **5.9 Problems/needs**

All interviewees revealed that the biggest challenge currently faced in service delivery is a lack of resources. When asked to specify, most respondents mentioned long waiting lists for teenagers at youth reception centers, although some waiting lists were considerably longer than others. The shortest waiting period reported was one week, while another report mentioned that teenagers sometimes have to wait up to three months for an appointment, depending on the nature of the appointment. This problem was assigned to a lack of financial resources from the government to employ additional staff, including additional male staff. Another problem mentioned by an interviewee was that other departments often refer inappropriate cases to youth centers, while such cases are not within their description of service delivery.

Another common problem identified by interviewees was that other role-players do not always take the necessary responsibility. Parents are not involved enough in informing their teenagers about sexuality and some do not have the skills to do so. All respondents felt that the formal education system needs to take more responsibility for sexuality education. Some teachers avoid the subject altogether, while others give only selective information. Some schools do, however, have good sexuality education programs.

The main problem identified with sexuality education in schools, was that sexuality education was not compulsory during teachers' training and this results in teachers not having the appropriate skills to effectively teach sexuality education, particularly when teenagers are between 16 and 19 years old. Some interviewees felt that a qualification in sexuality education should be a requirement to become a teacher and some felt that there was not enough control over sexuality education in schools and that the quality and mere existence of sexuality education is largely at the discretion of each individual teacher. Two professionals mentioned that they had heard from teenagers that they are not satisfied with the sexuality education they had received at school. According to one response, immigrant girls are particularly disadvantaged in this sense due to the fact that many of them had not been given any form of sexuality education before coming to Sweden. It was also important for some respondents that each school has a trained nurse and counselor, as at present not all schools do.

One interviewee mentioned that there is a need for services over weekends. "They often come Friday afternoon and things like that, and Monday they come for this pill that you take after intercourse, and of course if we had some kind of open hours on Saturday or Sunday that would be good for them." The same problem was identified by Holmberg (2001), when it was mentioned that clinics operate only on weekdays and that the problem with operating hours such as these is that access to contraceptives becomes limited over weekends, the time when most teenagers find themselves in social settings and more vulnerable to engage in sexual activity.

Several respondents indicated that services need to be more inclusive of parents and there needs to be more in depth discussion with the youth regarding sexuality. Boys need to be more involved in service consumption and most felt that it was their responsibility as professionals to encourage boys to utilize services more. Current

services should be maintained, but complimented with additional services such as discussion groups and more elaborate information sessions. Some respondents were not sure if they are approaching teenagers correctly but did not have any suggestions for change in this sense.

## CHAPTER 6 – DISCUSSION AND CONCLUSION

Respondents indicated a need for parental involvement in sexuality education. The fact that adult supervision is lacking (Cohen et. al, 2002) is a problem of great concern. The majority of parents in Sweden are nowadays very involved in the employment sector, and this results in less time for family activities and support. Even with fixed working hours, parents may be too tired to spend quality time with their children, and in addition to this often have other responsibilities outside of the family to fulfill. Parents are therefore less able to strictly enforce values and are less aware of possible risks their teenagers might be taking. It was noted by Törnbohm (1999), that negative family circumstances increase the likelihood of sexual risk-taking. The more parental supervision there is the less possibility for youths to engage in negative behavior (Cohen et. al, 2002). In addition to this, parents would be able to identify negative behaviors and educate their children on what is right and wrong.

Parents need to take more direct responsibility for the well-being of their teenagers and need to be more involved in the lives of their teenagers. Involvement of parents creates a sense of security and belonging for teenagers. Although peers become the most influential factor in the lives of most teenagers (Brockman and Russell, 2007), parents should teach their children from young ages, and this can positively affect the choice of a teenager to belong to a certain peer group. It is also important that parents are positive role-models for their children. This was also a need identified by respondents. As mentioned by Ponton (1997), teenagers have a tendency to consciously or unconsciously observe and imitate adult behavior.

It may be advantageous for service providers to focus more on parents. Parents need to be taught skills in terms of communication and relationship-building with their teenagers and it is important to equip them with skills to address sexuality with their children. As one respondent indicated, parents do not always know how to talk to their children about sex. Responses also indicated that resources are accessible to the youth, and although there is currently a lack of manpower in the service delivery sector, teaching parents to educate their children on sexuality could result in an eventual decrease in demand for services, as this may prevent certain problems.

The biggest problem with service delivery as expressed by all respondents is a lack of resources. Due to the high teenage abortion rate in Sweden (Ekstrand, 2005), the costs for the public health sector are relatively high on various levels. According to legislation, the patient must receive medical as well as psychological care and service delivery in terms of abortion takes place over a period of time, with several appointments. If municipalities were to invest more financial resources, and thus ultimately manpower, into prevention services, it may limit not only the financial costs of abortion, but also the physical and emotional trauma of the patient, thus decreasing the need for counseling services related to abortion. Even in cases not related to abortion, with attempted suicide for example, an increase in resources of psychiatric wards, would allow youth centers to focus more on sexuality issues rather than having to accommodate clients referred by overloaded psychiatric units.

According to responses, girls form the largest group of consumers. As noted by Edgardh (2002), girls are the major consumers of services related to sexuality and

contraceptives. The media could have a positive effect in encouraging boys to take more responsibility for contraceptive use. More emphasis could be placed on condom use where men are generally required to take more responsibility and this could have positive effects not only on decreasing rates of unwanted pregnancies, but could also limit the spread of sexually transmitted infections. The more condom use is advertised, the more likely teenagers would be to consider the use of condoms. Decision-making is related to choice (Luker, 1978) and if condom use were better advertised, it can increase the awareness of condom use as a choice, and a significance can then be attached (Luker, 1978) to condom use as part of the internal negotiation of teenagers of whether or not to take risks. Additionally, it may be advantageous to employ more male staff as this may encourage boys to make better use of services.

As some respondents indicated, services are not as accessible as they ought to be in terms of contraceptive availability. Contraceptives should also be available over weekends and at night. Holmberg (2001) states that the challenge is to make contraceptives available to youths when they are needed most. Fully stocked condom vending machines could be placed strategically, for example. This means that condoms are available at all times. One positive aspect in Sweden is that the morning after pill is easily available at pharmacies, but continuous use of this pill may have negative biological effects for women on the long-term and teenagers do not always take the responsibility to purchase this product after unsafe sex.

All of the interviewees mentioned the need for improvement of sexuality education in schools. All schools ought to have the same policy on sexuality education as this promotes equality and prevents discrimination on grounds of educational opportunities pertaining to sexuality. Efforts should be made to equalize sexuality education in schools, so as to create equal advantage for all youths. Each school ought to have a set of formally written guidelines that clearly indicate what should be included in sexuality programs and that provide teachers with the necessary information on how to teach youths about sexuality. Particular emphasis should be placed on targeting younger teenagers, as previous research (Hopkins, 2007), Piaget's theory (Miller, 2002) and interviewee responses all indicate that younger teenagers are more prone to risky behavior and negative decision-making.

Responses indicated that there is need for professionals to be more involved on community level. Professionals only reach youths requesting services, although there are a great amount of teenagers in need of services that aren't reached. These are often the teenagers that are most vulnerable to teenage pregnancy (specifically girls).

Ultimately, cooperation between all role-players in society is of utmost importance and the individual responsibility of each role-player within its own body of expertise and within the context of teenage sexuality, be it parenthood, teaching, a medical or mental health-related profession or the media, should be made clear and practically implemented to the optimal benefit of teenagers.

In relation to the research questions of this study, it was found that the primary services involved in teenage sexuality in Sweden are youth reception centers and the education system. Youth reception centers appear to be easily accessible to the youth, although a lack of manpower for the appropriate service delivery causes long waiting

lists, thus decreasing the degree of accessibility. In terms of age, ethnicity, and gender, the youth centers are fully accessible to the youth.

Although sexuality education in schools is compulsory, the accessibility thereof relies largely on each individual school and its educators. This results in an inconsistency of sexuality education throughout Sweden. It can therefore be concluded that sexuality education in schools is a subjective matter, and this limits equal accessibility of students to sexuality education. Even in cases where sexuality education is accessible, programs may not be adequate, and may not include aspects that deem sexuality education successful and effective. The media has been known to provide both positive and negative education and influence with regards to teenage sexuality, and it appears that parental responsibility in terms of sexuality education needs to improve.

Not all teenagers engage in negative risky behavior although there are several reasons why some teenagers engage in negative risk-taking that may lead to unwanted pregnancy. Reasons for vulnerability to negative sexual risk-taking include alcohol and drug use, psychosocial factors such as peer and partner pressure, negative family circumstances such as divorce of parents, lack of parental involvement, lack of adult supervision. Other possibilities include continuous risky behavior after long periods of risky behavior that previously yielded no consequences, thus an underestimation of fertility and the tendency for teenagers to continue to engage in sexual risk-taking. Although some girls may become pregnant in an unconscious (or conscious) attempt to confirm their fertility, this is not a common occurrence. Teenagers might not have the ability to assess the possible consequences of their behavior realistically and have been known to believe that consequences are distant from themselves.

Many studies with regards to teenage sexuality have been conducted, although there still remains a need for further research in terms of certain aspects. Firstly, it could be advantageous to further research the effectiveness of sexuality programs in schools. In gaining more in-depth insight into this topic, it would allow for the improvement of sexuality programs in schools and an indication could be given of to what degree sexuality education in schools need to be improved. Secondly, there is a need for research in terms of the Swedish family concept in relation to teenage sexuality. The topic of has been touched upon in several studies all over the world, but there has been little research in this area within the Swedish context as such. A final suggestion for further research is that of sexuality issues amongst teenage girls with an immigrant background. Due to the fact that the majority of immigrants coming to Sweden originate from cultures quite different to that of the Swedish culture and where sexuality is approached somewhat differently, it is necessary to gain insight into the sexual adaptation into a liberal society. Another aspect that could be included within this topic is the utilization of services for sexual health amongst immigrant youths, particularly girls.

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## APPENDIX A

### Semi-structured Interview Guide

Estimated duration of interview: 1-1½ hours

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General points to be dealt with prior to commencement of the interview:

- Welcome and introduction of those involved
- Purpose of the interview and roles of those involved
- Recording equipment
- Ethical issues such as confidentiality

Main themes of the interview:

- \* **The existence of resources for teenagers with regards to sexuality**
- \* **The accessibility of resources for teenagers with regards to sexuality**
- \* **The ability of teenagers to effectively utilize services within their current developmental phase**
- \* **Risk-taking behavior of teenagers increasing the likelihood of teenage pregnancy**
- \* **Challenges faced in the system and in general**

#### **Theme One: The existence of resources for teenagers with regards to sexuality**

- What resources exist with regards to teenage sexuality?
- What is the main focus of these resources?
- To what degree are these resources effective in dealing with teenage sexuality?
- Open floor for discussion on points mentioned by interviewee

#### **Theme Two: The accessibility of resources for teenagers with regards to sexuality**

- Are resources equally accessible to all teenagers?
- Are resources socially accessible to teenagers?

#### **Theme Three: The ability of teenagers to effectively utilize services within their current developmental phase**

- Do teenagers make maximal use of the facilities available to them?  
Please elaborate.
- How seriously do you think teenagers take the services available to them?
- Do you think teenagers have the ability to apply information given at service centers within social settings?

**Theme Four: Risk-taking behavior of teenagers increasing the likelihood of teenage pregnancy**

- What do you consider to be the main reasons for teenage pregnancy?
- To what degree do you believe teenagers are able to exercise self control given the very nature of teenage behavior in general?
- Why do teenagers engage in risky sexual behavior even when they are aware of the consequences of their behavior?
- Are there any strategies in place to attempt to curb risky sexual behavior amongst teenagers? If yes, please elaborate

**Theme Five: Challenges faced in the system and in general**

- What are the biggest challenges that the youth are faced with, with regards to sexuality nowadays?
- What challenges are faced with the implementation of services with regards to teenage sexuality?
- Could you please give an explanation of how you would like to see services improve?

Conclusion of interview:

- \* Allow the interviewee to add any information valuable to the study
- \* Thank interviewee for their insights

## APPENDIX B (1)

### Informed Consent

The following is a presentation of how we will use the data collected in the interview.

The research project is a part of our education in the International Masters program in Social Work at the University of Gothenburg, Sweden. In order to insure that our project meets the ethical requirements for good research we promise to adhere to the following principles:

- Interviewees in the project will be given information about the purpose of the project.
- Interviewees have the right to decide whether he or she will participate in the project, even after the interview has been concluded.
- The collected data will be handled confidentially and will be kept in such a way that no unauthorized person can view or access it.

The interview will be recorded as this makes it easier for us to document what is said during the interview and also helps us in the continuing work with the project. In our analyze some data may be changed so that no interviewee will be recognized. After finishing the project the data will be destroyed. The data we collect will only be used in this project.

You have the right to decline answering any questions, or terminate the interview without giving an explanation.

You are welcome to contact us or our supervisor in case you have any questions (e-mail addresses below).

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## APPENDIX B (2)

### **Informerat samtycke Information**

Vi vill på detta sätt ge dig en kortfattad information om vårt uppsatsprojekt samt hur insamlade uppgifter handhålls och utnyttjas.

Uppsatsprojektet ingår som en del i utbildningen till socionom vid Göteborgs universitet. Inom vårt uppsatsprojekt följer vi de forskningsetiska principer för humaniora samt samhällsvetenskap, vilka utarbetas av Vetenskapsrådet.

Dessa principer innebär i korthet att:

De som medverkar i uppsatsprojektet ska få information om uppsatsens syfte

Deltagaren har rätt att bestämma över sin medverkan

De insamlade uppgifterna ska behandlas konfidentiellt och förvaras på ett sådant sätt att ingen obehörig kan ta del av dem.

Du är när som helst välkommen att kontakta oss eller vår handledare om du har några frågor.

Du har rätt att avstå från att svara på frågor eller avbryta intervjun, utan att lämna någon anledning till detta.

Vi vill använda bandspelare vid intervjutillfället. Detta gör det lättare för oss att dokumentera det som sägs under intervjun samt underlättar vårt fortsatta arbete med uppsatsprojekt. Vid utskriften kommer vissa uppgifter (t ex namn och arbetsplats) att ändras så att du inte kan identifieras av någon utomstående. Efter utskrift av intervjun raderas bandet. Allt insamlat material förvaras på ett sådant sätt att utomstående inte kan komma åt uppgifterna.

De insamlade uppgifter kommer endast att användas för uppsatsprojektet.

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