



PLANNED PARENTHOOD OF TORONTO

Young Parents' Sexual Health Consultation Report

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PPT IS A UNITED WAY MEMBER AGENCY

TABLE OF CONTENTS

Executive Summary	3
1.0 PPT Philosophy of Service	5
2.0 The Consultation Process	7
2.1 Young Parents Working Group	7
2.2 Focus Groups	8
2.3 Key Informant Interviews	8
2.4 Participant Profiles	9
2.5 Limitations	10
3.0 Life as a Young Parent	11
3.1 Stigma	11
3.2 Economic Status	13
3.3 Relationship with Parents	14
3.4 Relationship with Partners	15
3.5 Violence	15
3.6 Relationship with In-Care Environments	16
3.7 Support Networks	17
3.8 Self-Esteem and Mental Health	18
4.0 Immigration and Newcomer Youth	19
4.1 Mental Health	19
4.2 Language	19
4.3 Racism and Culture	19
4.4 Documentation	20
5.0 Health Information and Young Parents	22
5.1 Anatomy and Fertility Awareness	22
5.2 Birth Control	22
5.3 Planned Pregnancy	23
5.4 Sexually Transmitted Infections	24
5.5 Lack of Parenting Education	24
6.0 Where Young Parents get their Information	
6.1 Families and Peers	26
6.2 School System	26
6.3 Lack of Education of Health Care Providers	27
Conclusion	28
Acknowledgements	30
References	31
Appendices	33
Terms of Reference	33
Key Informant Interviews	34
Focus Group Questions	36
Participant Profiles	38
Consent Forms	40

EXECUTIVE SUMMARY

During the consultation process for this report, a young parent who participated in a focus group said that she often heard disparaging and judgmental comments during her pregnancy and after her child was born. One of the most hurtful comments she said she heard was “babies having babies”.

The significance of this quote is reflected throughout this report. During the consultation process, we heard from a diverse group of youth who told us not only about the challenges they face as new parents, but also of the unexpected challenges they were forced to deal with because of the stigma associated with being a young parent. Youth said they felt that this stigma affected their interaction with service providers, contributing to, on some occasions, difficulties in accessing services, over involvement from in-care providers and exclusion from decisions that impact their health and well-being.

The objective of our consultation was to present, in their words, the opinions, experiences and recommendations of young parents and service providers across Toronto for the purposes of understanding what the sexual and reproductive health needs of young parents are and what issues they face in accessing health and support services.

The need for this consultation was identified through Planned Parenthood of Toronto’s (PPT) Strategic Plan and Community Programming Strategy and our work with young parents in shelters, group homes and maternity homes. Over the course of a year, PPT established a Young Parents Working Group that held five focus groups with a diverse group of young parents between the ages of 16 and 25 and individually interviewed service providers from 18 agencies and health centres across Toronto. The information shared in these encounters shapes this report and highlights a number of themes that emerged during the consultation process.

As the process began, two broad themes quickly emerged. The first encompassed a number of issues that affect the daily lives of young parents. These issues include stigma, economic status, personal relationships and support networks, violence and mental health. These are the issues that affect young parents’ lives on a broader perspective, but that have also been identified by them as major barriers to accessing primary and sexual health services. These issues have been presented as the first part of this report under the section titled *Living as a Young Parent*.

The second theme was sexual and reproductive health information. Within this theme, we sought answers to the following questions: What do young parents know or not know about sex and sexual health? Where do they get their information?

Over 60% of youth consulted self-identified as belonging to immigrant or newcomer communities. It became apparent that this group of young parents also experienced barriers in relation to their cultural and racial identities and immigration status. A separate section has been included in this report that addresses the specific primary and sexual health needs that were identified by newcomer and immigrant youth including settlement issues, language barriers and social isolation.

Throughout the report, recommendations by focus group participants and key informants have been included and wherever possible, a direct quotes from key informants or participants have also been used to ensure accuracy and proper representation.

Generally, the information revealed in this report suggests that both young parents and service providers share common perceptions of the issues facing young parents. They identified stigma as one of the most pervasive issues that affects the health of young parents. They all felt lack of accurate and appropriate information and education was a problem. Finally, they discussed the need for more services and programs that not only address sexual and reproductive health issues but that also integrate the underlying social determinants that affect young parents' overall health.

Young parents also discussed how their interactions with some service providers left them feeling isolated, unprepared and unwelcome. For example, young parents who planned their pregnancy felt that they encountered negative and hostile attitudes from service providers who had difficulty understanding why a young woman or couple would choose to get pregnant.

This consultation was a dynamic and valuable experience for PPT. The stories and opinions shared by young parents and key informants affirms and supports PPT's philosophy of service delivery and commitment to community health values. It is our genuine hope that the findings presented here encourage those working with young parents to continue to explore and develop new programming initiatives, challenge stigma and help to reduce barriers for young parents seeking sexual health services.

1.0 PPT PHILOSOPHY OF SERVICE

Planned Parenthood of Toronto (PPT) is a community based, pro-choice agency committed to providing accessible and inclusive services that promote healthy sexuality and informed decision making to the people of the City of Toronto. For over 40 years, PPT has developed and delivered comprehensive programs and services that address the sexual and reproductive health needs of the communities that we serve. All services at PPT are designed and delivered in a way that is relevant to the lives and is based on the experiences of the clients we serve.

PPT's volunteer-based programs, Woman2Woman and the volunteer services at the House Community Health Centre provide face-to-face peer education and information to women and youth throughout their reproductive years on sexual and reproductive health issues. The House also provides multi-disciplinary primary health care and promotion services. The Teen Sex Information Program provides anonymous and confidential sexual health information services to Toronto-area teens ages 13 to 16 through the operation of the Teen Sex InfoLine, a peer-based phone line, Spiderbytes.ca, a sexual health web site, E-mail and MSN Messaging. PPT has also taken an active role in training teachers, health professionals and other service providers.

PPT's approach to sexual and reproductive health goes beyond common perceptions of sexual health being viewed as the prevention of unplanned pregnancies and sexually transmitted infections. While prevention is a core component of all of our services, PPT approaches our work through a community health model that "views health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1948).

Within this broad and holistic context, sexual health not only involves prevention, but also stresses the importance of integrating the social determinants of health that impact individual and community into the delivery of programs and services. These determinants are:

- Income and social status
- Social support networks
- Education, employment and working conditions
- Housing situations
- Social and physical environments
- Personal health practices and coping skills
- Gender and culture
- Perception that one can make a meaningful contribution and participate fully in one's community
- Immigration status

Our approach, then, to sexual health work supports the health promotion values of optimal health, participation, capacity building and, ultimately, social change by fostering healthier relationships, promoting safety and freedom from harm, reducing access barriers to accurate primary and sexual health information and services and working from a perspective that values choice over control.

2.0 THE CONSULTATION PROCESS

2.1 Young Parents' Working Group

The Young Parents' Working Group was established to conduct this consultation and prepare this report. Members of the working group included staff across different disciplines within PPT. The members of the working group include:

Lorena Murialdo	Community Health Promoter
Jay MacGillivray	Community Health Promoter
Nadjla Agahbanaei	Clinical Receptionist
Priya Rajani	Physician
Rose Gutierrez	Director of Community Programming

This consultation process used a qualitative approach for the data collection. The process was a descriptive inquiry that examined the experiences and views of young parents related to their sexual and reproductive health and their experiences as parents. The consultation process also provided an opportunity for service providers and young parents to provide programming recommendations. The two methods for consultation were key informant interviews and focus group interviews. The goals of the consultation process were:

1. To gather documents on issues related to parenting and family planning.
2. To determine the primary, sexual and reproductive health needs of young parents.
3. To identify existing services and programs.
4. To identify gaps and barriers in health services.
5. To develop recommendations for PPT's work with young parents and pregnant youth.

2.2 Focus Groups

The priority of the focus groups was to include the voices of marginalized youth communities between the ages of 16 and 25. In order to be as inclusive as possible, focus groups were conducted in a range of youth-serving organizations, group homes, shelters and maternity homes. The focus groups were conducted at the following locations:

1. Jessie's Centre for Teenage Parents (Mothers)
2. Jessie's Centre for Teenage Parents (Fathers)
3. Shout Community Health Center
4. Robertson House Residence
5. Humewood House Association

The majority of focus group participants were young mothers. A smaller sampling of young fathers was also included. Each focus group consisted of 8-15 participants, facilitated by different members of the working group. Five focus groups were

conducted in total. The purpose of the focus group interviews was to gather information from the participants about their personal feelings, ideas, desires, opinions, expectations and challenges they faced before, during and after pregnancy, including parenting and related sexual and reproductive health issues

2.3 Key Informant Interviews

The key informant interviews were conducted with representatives from a wide range of agencies, organizations and shelters that work with youth communities and young parents in the field of sexual and reproductive health. The key informants were asked to discuss their views about the needs of young parents as they pertain to sexual and reproductive health, the barriers in accessing information and services, suggestions about possible solutions to improve programming and services for young parents. There were a total of 18 key informant interviews. Members of the working group relied on existing partnerships with youth-involved agencies for the selection of key informants. The working group worked closely with agencies that belonged to a city-wide network, 'Young Parents No Fixed Address,' whose primary mandate is to work with young parents who are marginalized by homelessness and unstable housing situations.

The key informant interviews were conducted with a representative from the following agencies:

1. Supporting Our Youth, a Program of Sherbourne Health Center
2. The 519 Church Street Community Center
3. David Kelly, LGBT Parenting Network
4. Humewood House Association
5. Native Child and Family Services of Toronto
6. Beatrice House
7. Regent Park Community Health Center
8. Jessie's Center for Teenage Parents
9. The Stop Community Food Bank, Davenport Perth Community Health Center
10. Robertson House, Toronto Community and Neighborhood Services, Hostel Services
11. St. Michael's Hospital, Community Outreach Program
12. Parenting with Disability Network
13. Canadian Hearing Society, Connect Counseling Program
14. Catholic Children's Aid Society
15. Toronto Public Health, Sexual Health
16. Toronto Public Health, Young Parent's no Fixed Address
17. Shout Community Health Center
18. Birkdale Community Center

2.4 Participant Profiles (self-identified)

Total male participants - 12

Young Fathers		
Characteristics	Profile Results	%
Age	16-19	33%
	20-25	67%
Race	Black	47%
	White	33%
	Latin	20%
Immigration Status	Canadian Citizen	66%
	Landed	9%
	No Answer	25%
Disability	Yes	0%
	No	100%
In Relationship	Yes	0%
	No	100%
School	Yes-Full Time	8%
	No	66%
	No Answer	26%
Employment Status	Part Time	8%
	Full Time	50%
	Not Working	42%

Total Female Participants: 44

Young Mothers		
	Profile Results	%
Age	16-19	43%
	20-25	50%
	Other	7%
Race	Black	57%
	White	32%
	Latin	0%
	Aboriginal	7%
	Afghan	2%
	South Asian	2%
Immigration Status	Canadian Citizen	52%
	Landed	18%
	Aboriginal	2%
	Refugee	2%
	No Answer	26%

Disability	Yes	9%
	No	68%
	No Answer	23%
In Relationship	Yes	39%
	No	45%
	No Answer	16%
School	Yes-Full Time	41%
	No	55%
	No Answer	4%
Employment Status	Part Time	0%
	Full Time	7%
	Not Working	77%
	No Answer	16%

2.5 Limitations

PPT decided to focus this inquiry on a specific youth community. The priority for this process was to include marginalized youth who may already be experiencing unstable emotional, economic, and social conditions. This process did not include youth with disabilities or queer parents. PPT’s previous work with SexAbility, a program partnership between PPT and the Anne Johnston Health Station, highlighted the complex nature of the sexual and reproductive health needs of youth with disabilities and the importance of ongoing research and programming in this area. Similarly this report did not examine the issues that affect queer young parents. Key informants working with this community reported that although queer parents experience some of the same barriers as heterosexual parents, there are several other concerns that are specific to this group that need to be addressed. Due to limited resources we were unable to fully explore the issues related to these two communities.

3.0 LIFE AS A YOUNG PARENT

This section of the report focuses on the experiences of young, marginalized parents. Focus group participants were asked to share their prenatal, birth and postnatal experiences within health care systems. The following issues were repeatedly discussed by the participants:

3.1 Stigma

For the most part, society largely functions under the 'unwritten rule' that sex and sexual health are personal matters that should not be discussed. This 'rule' places restrictions on an individual's ability to seek information and ask questions. It also serves as a social barrier for those who, consciously or not, challenge it by bringing issues of sex and sexuality into the public sphere. Young parents pose such a challenge. Broad assumptions are made about young parents: they must be single parents, they have short term or sporadic relationships, they probably have had many sexual partners, they will make inadequate parents and they are uneducated and irresponsible. One young woman in a focus group said she hated the expression "babies having babies" because it made her feel bad. These assumptions lead to stigma and this stigma is clearly felt by young parents.

This stigma has placed the focus of sexual and reproductive health education on whether or not young people are having sex. There is very little emphasis on the quality of young people's relationships, sexual pleasure, communication and negotiation skills, and achieving a more equitable balance of responsibility within those relationships. Often, because of this stigma, intimate relationships between young people are seen as a concern because they may lead to intercourse. Furthermore, there is still a widely held belief that discussing birth control with youth may actually promote sexual activity (Darroche, E. J., Frost, J. J., Singh, S., & Study Team, 2001).

Within health care settings, this stigma has created barriers for young, marginalized parents who expressed that they felt constantly scrutinized by adults in positions of authority.

One young father related his and his partner's story in which their nurse was changed at the last minute without the parents being informed. Reflecting on their interactions with their physicians, most focus group participants felt discouraged at not being able to develop a trustworthy, comfortable and confidential relationship with their physician. Some participants sensed a reluctance to discuss sexual health issues and their appointment times were usually too short, which left little or no time to engage in discussions around sexual health concerns.

One focus group participant shared her experience with one doctor:

“My baby’s heart beat kept skipping beat. My doctor says he can’t do anything for him. Was totally rude. I asked if he could send me to ultra sound to see what is wrong. He said, ‘Don’t ask. I’ll think about it and call you.’ ”

“Needed people to respect our space, not breathe down our back. Sometimes it’s too much.”

Quote: Focus Group Participant

One woman expressed frustration with the home visits:

“They kept calling and coming and showing up, getting on my nerves.”

Quote: Focus Group Participant

Another participant noted that the increased level of involvement from some service providers made them feel:

“Like we can’t be trusted to do a good job.”

Quote: Focus Group Participant

Young parents’ stories reveal that their experiences can be characterized by both extremes of care provision. In most circumstances, focus group participants felt their issues were ignored or not taken seriously by health care providers.

The result of this kind of treatment is that young parents try to avoid any interaction with service providers. It is common for them to miss and to rarely schedule regular check ups.

The stigma that young parents feel was also a concern of many key informants who noted that the fear of being judged and criticized by health care professionals was a significant barrier that young parents consistently encountered. One key informant spoke about several instances in which a health care provider was blatantly disrespectful. For example: asking a series of intrusive, personal questions to a young couple in a packed waiting room; homeless and under-housed clients kept waiting longer to be seen; not recognizing a young parent’s chosen family; and a lack of understanding that food security and shelter take precedence over health.

Key informants stated that some doctors often do not make a point of explicitly informing youth that services are completely confidential and that their parents would

not be contacted. However, not all clinical experiences were negative. One participant recounted receiving excellent service from a midwife and others spoke highly of nurse practitioners and nurses who provided breastfeeding information and support.

The belief that young people are unable to make informed decisions about their sexual and reproductive health and well-being is an unfounded notion. Acceptance that part of a young persons' development includes the development of their sexual identity, can be a way of supporting youth in facing complex circumstances effectively. Long-term studies on resilience have shown that despite difficult life situations and vulnerabilities experienced by youth, they possess the resources and abilities to face these life challenges with success, if provided with a supportive and flexible environment (Federal/Provincial/Territorial Advisory Committee on Population Health, 2000).

3.2 Economic Status

According to Statistics Canada, the poverty rate of young families with children increased by 56% between 1981 and 2001. In 2001, 38.1% of all young families with children in Toronto lived in poverty, up from 33.5% in 1991 (Family Service Association of Toronto & Community Social Planning Council, 2004)

It was common to hear young parents say that lack of money was one of the biggest problems. In one focus group only 1 of the 15 young mothers had enough money to purchase a stroller. When focus group members were asked if they didn't have to pay for TTC what they would do with the extra money, several participants called out:

“Groceries”, “Clothes”, “RRSP’s”, “College savings”, “Would buy better stuff”, “Upgrade stroller”, “better housing”

Quote: Focus Group Participants

None of the participants in one focus group could afford a car seat. Another young woman commented that she couldn't afford birth control pills. They also emphasized that not having money was “hardest” when they became parents and financial demands increased. One woman said,

“I often go without my needs to be able to provide needs of my baby.”

Quote: Focus Group Participant

She also added that she misses appointments if she cannot afford to go.

One woman recalls:

“[Having no money] made me cry a lot. Worried about money, clothes, pampers. I was living at a maternity home.”

Quote: Focus Group Participant

Young fathers expressed that being the sole income earner added additional anxiety as they tried to cope with the pressures of balancing work and family responsibilities. Some fathers identified that they needed more resources in order to find jobs.

Most key informants named poverty as an issue that is intertwined with all other social determinants of health. As one key informant stressed:

“Poverty affects young parents and poverty means they have to move a lot. This means they are often unable to maintain the same caregiver; this leads to fragmented care, and unmet needs, with no time for trust to be established.”

Quote: Key Informant

High mobility can create additional personal upheaval and can contribute to increased financial constraints. Most of the young parents interviewed grew up in low-income families. After discussions with five focus groups it became apparent that the cycle of risk factors often repeats itself in the next generation.

3.3 Relationship with Parents

Several young women described the nature of their relationship with their parents as a source of stress and one based on fear with little or no support. According to one focus group participant, there was always something to worry about and that their family environment did not lend itself to any kind of open discussion, least of all around sexuality. Some said there was no relationship. In fact, several young mothers were completely cut off from the family structure when they disclosed their pregnancy. One young mother mentioned that she would never seek advice from her mother because she herself had had a baby at 16 years of age. Fearing the consequences, several women hid their pregnancies from their mother until it became obvious. One young woman recalled the disclosure of her pregnancy to her mother:

“I called my mother after I was already showing. My mom wanted nothing to do with it. She said that she did not send me to Canada to get pregnant. I didn’t care. I was already on my own in Canada.”

Quote: Focus Group Participant

Key informants indicated that for the majority, the relationship with their parents was often dysfunctional. There was general consensus among key informants that many young parents themselves grew up in situations fraught with tension and uncertainty because their parents struggled with trying to make ends meet. One key informant reported that many of the women she worked with came from single parent families.

3.4 Relationship with Partners

Most of the young parents described their relationships with their partners as extremely strained.

Young fathers felt they did not know how to manage all the new responsibilities related to parenting. One father commented that no one had taught him how to multi-task. Other participants commented that they did not realize the change in lifestyle would be so huge and so fast. Finally, many young fathers commented that the only thing that now mattered to their partner was the baby.

Conversely, young women stated that their priority was the health of the baby and everything else was secondary. Young women spoke of not only feeling unprepared to deal with the multitude of changes in their lives but also feeling too stressed out and exhausted to do anything about it, especially the young women whose partners left them. At the same time, young women in the focus groups also said that having their partners around did not necessarily alleviate their stress and fatigue. Shifting priorities in order to adjust to new expectations, additional responsibilities and changing their behaviours in order to be parents were all challenges that young women spoke about.

What constitutes a healthy relationship for some women was staying with their partner even in situations of abuse. One key informant stated that the majority of women they serve have experienced repeated sexual abuse and that it is common to see that same pattern emerging in young parents' relationships.

3.5 Violence

Within the focus groups, young women were reluctant to discuss issues of partner abuse and violence, but acknowledged that it was a concern. Some young women disclosed being called names but did not identify any of their experiences as abuse or violence. A few remember their mothers being abused by partners or boyfriends. One woman felt that it was more important that the baby have a connection with the father even if there was a threat of violence to her.

However, when the discussion focussed on broader experiences with violence, young parents had a lot to say. Most young parents have had first hand experiences with different forms of violence. In one focus group, 90% of young women had histories of violence, some of which are unresolved. One key informant spoke of the tremendous social and emotional impact that being a childhood sexual abuse survivor can have on adult relationships. The triggers often surface when one becomes a parent. Women with histories of abuse have significantly higher levels of anxiety and depression. These women are also more likely to use substances like alcohol, tobacco and other recreational drugs and are less likely to eat well (Best Start, 2002). There is also a connection between violence and rapid repeat pregnancy. The majority of key informants all agreed that young women possess little awareness and ability to recognize power dynamics, consent issues and exploitation in a relationship as well as abuse, specifically emotional and psychological. There is also little or no knowledge of sexual

rights and how to exercise those rights in an effective way. This can be seen in a young woman's inability to negotiate condom use for fear of being left by her partner or being accused of infidelity. As one key informant said:

“The power dynamic of the street culture is that the man decides if a condom is to be used.”

Quote: Key Informant

This was also demonstrated by women in two different focus groups who indicated that their priority is for the family to remain together for the sake of the child even if this means living in constant fear of abuse. Women identified that there is no alternative as leaving a partner can lead to increased social and economic instability, threats to personal safety and increased barriers to health care services. Another key informant expressed the importance of early intervention, as partner abuse tends to intensify during pregnancy.

One key informant felt that it was a challenge to integrate discussions around violence in the current programming because women are mostly interested in their immediate needs which are: wanting to know all about their baby, their pregnancy and how to take care of their baby.

3.6 Relationship with In-Care Environment

A significant issue raised by a number of young parents was their tenuous relationship with social workers at in-care environments. In one focus group, 8 out of the 14 participants were at one time involved with in-care services. Focus group participants recalled:

“A social worker came into my room and asked me if I wanted to give my baby up for adoption, I guess because I was young.”

“I was told I had to be in the shelter to keep my baby even though I had a place to live.”

Quotes: Focus Group Participants

A chief complaint among young parents was the fact that social workers often paid them visits without any warning.

Some young parents commented that social workers were helpful when it came to providing services around food, money, information and resources.

Both key informants and focus group participants consistently discussed the negative interaction that young parents had with in-care services. According to one key informant, for young parents these negative experiences translate into feeling intimidated by authority and create fear of the health care system. Another key informant spoke about the discrimination that young parents encounter from most child welfare organizations based on perceived class, appearance, gender identity and /or sexual orientation.

3.7 Support Networks

Both key informants and focus group participants agreed that many young parents had little or no support networks available to them. One focus group participant felt that for her, what was most important and least available was:

“People to talk to, who know what it is like.”

Quote: Focus Group Participant

One young woman added:

“If you have no support, you feel like you are not doing a good job.”

Quote: Focus Group Participant

One participant stated that if it had not been for the agency that helped her through her pregnancy and well into the baby’s first few months, she would have been completely alone. This young woman’s partner left her when he found out she was pregnant and she did not have any friends with children. One woman spoke to the group about her girlfriend who was having a party and wanted her to sleepover and commented:

“Friends who do not have kids don’t understand what it’s like, so are not helpful.”

Quote: Focus Group Participant

Many key informants discussed the lack of social support networks in the lives of these young parents. Negative experiences with parents, detachment from the school system, traumatic experiences with domestic abuse and peer pressure to conform to certain behaviours or adopt certain practices, leaves young parents feeling isolated and disconnected from daily interactions with the outside world.

One key informant described what she experienced in the community her agency works with:

“Many young women never leave their apartment; they mostly stay at home with boyfriends who come and go...most are abusive relationships.”

Quote: Key Informant

3.8 Self-Esteem and Mental Health

While focus group members did not specifically name self-esteem, some of the participants discussed how they felt self-conscious and lacked control over many aspects of their lives. Key informants stated that, in their experience, young women who feel they have little control tend to exhibit low self-esteem, lack confidence and have a negative body image. Key informants also emphasized that these issues can be greater if the pregnancy was unplanned or a result of sexual coercion. One key informant reiterated that a lot needed to be done around young women and body image. She remembers one young woman who said she:

“Was too fat,” and that “her breasts were only sexual and for her boyfriend” and felt that ‘it was disgusting to breastfeed in public.’ ”

Quote: Focus Group Participant

According to one key informant, mental health issues are often overlooked in this population because more immediate and pressing concerns such as housing and financial needs are the priority. Although the rate of some mental illnesses among youth is high (e.g. depression, anxiety, eating disorders), the number of youth accessing services is low (Federal/Provincial/Territorial Advisory Committee on Population Health, 2000). Many youth cite fear of ridicule and harassment from peers and stigmatization as reasons for not seeking mental health services. Language and cultural barriers and the lack of free services also pose obstacles to accessing service.

4.0 IMMIGRANT AND NEWCOMER YOUTH

Key informants agreed that young immigrant parents not only face the pressures of being young parents, but also experience additional settlement issues including mental health, language and racism.

4.1 Mental Health

According to one key informant, immigrants coming from war torn countries and those who are victims of torture or political persecution, often experience loss, displacement, trauma and other psychological issues. Struggling with mental health issues is therefore not uncommon for immigrants, refugees and newcomers according to key informants. The same key informant expressed that this kind of circumstance compromises coping capabilities and makes it difficult to focus on issues such as bonding with a child and creating a positive home environment for a child.

4.2 Language

Another common theme identified was language as a barrier. Key informants stated that newcomers whose first language is not English, find the health care system confusing and difficult. One key informant stated that finding information in different languages that is tailored to young parents is a constant challenge. This situation not only impedes helpful interactions with service providers but may also account for discriminatory treatment by providers, misunderstood care instructions and therefore refusal of service and uninformed consent. With all the demands of raising a family with few resources and a lack of familiar community supports in a new country, little time and energy is left to learn a new language.

4.3 Racism and Culture

According to one key informant, challenging a clinician or someone in a position of authority is unlikely as newcomers may fear deportation, may be unaware of their rights and abide by the belief that “doctor knows best”. Given this situation, many young immigrant families feel isolated from the broader community. Key informants also identified that while many newcomers arrive with high levels of education, few employers and professional bodies recognize internationally obtained credentials, skills or experience. Newcomers find themselves in poorly paid jobs with no health benefits. For young immigrant parents, these issues are amplified by discrimination and racism.

One dominant theme that emerged from all key informants was the lack of culturally competent health care providers. Key informants reported that on many occasions health care providers were unaware of different cultural practices around attachment and bonding, cultural views toward sexuality and birth control, food and nutrition and a wide range of parenting styles. Giving information to young immigrant parents based on the western notion of what good parenting entails can make young parents feel inadequate and question one’s parenting skills. Key informants raised the issue that when discussing sexual and reproductive health issues, many immigrant women do not

feel comfortable with some of the ways in which information is delivered, particularly group settings and workshop style situations. Key informants stated that for some immigrant women this kind of structure was not conducive to disclosure or in depth discussions about sexual health concerns. Another key informant expressed frustration when she spoke about family home visitors. While they speak a whole range of languages and dialects, few are trained in the field of sexual and reproductive health and due to cultural and religious beliefs; many do not feel comfortable discussing sexual health issues.

4.4 Documentation

One persistent theme that arose in both key informant and focus group interviews was documentation. Some participants did not have health coverage due to their status. Others spoke of facing many obstacles when trying to obtain a health card such as not being familiar with the health care system and a general fear of dealing with government services and health care providers. Focus group participants spoke at length about their experiences:

“I took a while to see a doctor. My health card was expired and I didn’t know how to renew it. I would have gone sooner if I had known how to renew card.”

Quote: Focus Group Participant

Sometimes service providers can interpret this as an example that indicates irresponsibility or lack of motivation to get things done. But most young women say that they do not have the necessary information to know what is available to them and what they are eligible for. Another woman remarked:

“Payments are ridiculous, too expensive. I live in a shelter. There is no way I can pay. No OHIP and no way to get money.”

“Fried. Sick. Had infection. Not landed. Can’t go to doctor. Was afraid that I would have to pay.”

“I had no OHIP. Went to midwife who helped me with forms.”

Quotes: Focus Group Participants

There were also situations in which some hospitals did not give babies a health card. In some instances, the impact of not having appropriate documentation can lead to compromised care and in some cases it can be quite devastating:

“My child was taken away because I did not have documents, and because I did not have documents, I could not get prenatal care. My mother would not let me have my documents.”

Quote: Focus Group Participant

This issue has many dimensions that constrain young parents' ability to access quality health care and services. Many key informants reported that non status-immigrants encounter even more barriers and difficulties. With linguistic barriers, little or no knowledge of the health care system and without health coverage, immigrant families must rely on community supports such as community health centres which have limited resources to serve non-insured clients. Along with CHC's, a whole host of community agencies and community workers are fundamental as they engage in extensive advocacy work on behalf of the families.

5.0 HEALTH INFORMATION AND YOUNG PARENTS

The second major theme identified by focus group participants and key informant interviews was the lack of accessible information and education that young parents have access to about a wide range of sexual and reproductive health issues.

5.1 Anatomy and Fertility Awareness

The discussions among focus group members indicated that there was a gap in the information they knew about their bodies and reproductive system. Key informants expressed an urgent need for education regarding basic anatomy, physiology, body function and fertility awareness.

5.2 Birth Control

The most common method of birth control used by young women in the focus groups was the birth control pill. When focus group members were asked about birth control, a number of issues emerged. The most dominant was the lack of accurate and consistent information. Many young women made their birth control choices based on common myths and erroneous information. Reflecting on why she did not use birth control, one young woman stated:

“[I] heard the pill could mess you up, get bad acne, short temper and you get fat.”

Quote: Focus Group Participant

When asked about condom use, the majority of responses from the participants indicated that they only used condoms sometimes. In addition, young women also expressed frustration about the perception by their partners/boyfriends that birth control was their sole responsibility but also acknowledged that discussing condom use with their male partner was difficult.

Key informants stressed the importance of young men’s roles in birth control decisions and broader sexual and reproductive health issues. Although recently there has been some programming and resources aimed at young fathers, including PPT’s *Young Men’s Consultation Report* (April 2005), most sexual and reproductive health education and programming has been designed to focus on women and their concerns. The exclusion of young men from sexual and reproductive programming reinforces this perception. Many key informants highlighted the need for more programs and services that address young men’s sexual health needs in a context that is relevant to their experiences.

However, the participants in the young men’s focus group took issue with this perception. The young men in this group, who were part of a young father’s support group that meets regularly, took an active interest in their partner’s pregnancy,

participated in the birth and are fully involved in parenting. Many fathers commented that having a baby encouraged them “to get their act together.” At the same time, the young fathers acknowledged that they knew very little about their own or their partner’s sexual health and found it difficult to communicate openly with partners about sexuality. Although the fathers in this focus group spoke highly of their support group, they all felt that most sexual health services they had encountered were geared towards women’s needs. They also felt labelled by service providers as irresponsible, immature and careless.

Key informants felt that accurate, unbiased information and education about birth control options was essential. Many stated that youth rely on their peers, commercials, and the media for their birth control information. Many women make decisions based on misconceptions about birth control.

In addition, key informants pointed out that while some women may know about birth control, not all are given birth control. In one focus group, in the early post-partum period, most women were given limited information about birth control and only 50% received it.

5.3 Planned Pregnancies

Some young parents spoke about consciously making the decision to get pregnant and raise children while other parents, although they were not actively trying to get pregnant, were also not actively trying to prevent it. Although the pregnancy may have been a surprise to many, it was not considered an accident. One young father commented:

“I didn’t think we planned it. I just said I’d be there if a baby came. It wasn’t a surprise.”

Quote: Focus Group Participants

One focus group participant revealed that the reason she and her boyfriend wanted to have a baby was because they felt it would be the only legitimate way that their parents and family would allow them to remain together. Regardless of the motive, when a young woman gets pregnant there is a tendency from service providers to assume that it is unplanned. The idea of planned pregnancy may come as a surprise to many. Whether young couples are consciously or unconsciously choosing to parent, the notion of preparing for pregnancy and planning for parenting does not seem to be a consideration. Discussion with key informants about the priorities of their work revealed that the majority of their work is focused on prevention and on addressing the multiple challenges young parents face once they become pregnant. Few proactive efforts are made to equip young women and men with the information, resources and support to make informed choices. Key informants did not discuss the occurrence of planned pregnancies.

5.4 Sexually Transmitted Infections (STIs)

Despite the increasing rates of sexually transmitted infections among young people in Toronto, there was little discussion and concern about STIs in the focus groups. One participant did state that although she had STI checks, she had no idea what she was being tested for.

Many key informants felt that health care providers tended to focus so much on preventing pregnancy that there was little or no mention of protection against STI's. Conversations around birth control rarely included discussion about STI prevention.

5.5 Lack of Parenting Education

Although many focus group participants indicated that they did receive some form of parenting education, the majority felt that the information they received was not useful to them once they arrived at home with the baby. One woman recalls not knowing whether she was supposed to hold him all the time, let him cry or feed him. Many young women spoke about not knowing what to do when the baby got sick. One woman relied on a telephone support service, but said that some of the parenting advice she was given was completely unrealistic given the elevated stress and insecurity she felt. One woman did indicate that she knew what to do when she got home because she had stayed at a maternity home for 10 months before the baby was born and learned from the other women.

In the young men's focus group, few of the participants had attended prenatal classes and felt that they were unprepared to go into the delivery room. The young fathers stated that they lacked the practical knowledge they needed for the arrival of the baby. One father added that he had not received any formal education about parenting through any community programs, only through educational programs on television.

Key informants identified that young parents will not access services that are unfamiliar, do not reflect their issues or interests or do not have the concrete supports they need including TTC tickets, food, money and childcare. Key informants also felt that prenatal education is not as inclusive of the range of cultural customs practiced throughout pregnancy and birth. They also noted that information about contraception is not effectively integrated into prenatal programs.

Most key informants agreed that attendance at prenatal classes is a strong predictor of a healthy pregnancy and positive birth outcomes. However, they noted that few women actually attended prenatal classes or started late into their pregnancy. They also noted that personal circumstances may pre-empt women from attending prenatal care, such as:

- Belief that they already know about pregnancy and birth
- Concealing pregnancy because fear of judgment

- Difficulty scheduling an appointment
- Domestic violence
- Exhaustion and fatigue
- Fear of health care providers
- Feeling sick
- Financial restrictions
- Isolation
- Lack of support
- Language and cultural barriers
- Literacy
- Living in substandard housing
- Location of health facility, unfamiliar with area
- No childcare provision
- No transportation
- Stress and Depression
- Uncomfortable in health facility settings
- Using drugs and alcohol

As one focus group participant remarked:

“I got pregnant the first time I had sex, I didn’t tell anyone for 5 months. I just kept doing track and exercises. Then I got care...”

Quote: Focus Group Participant

6.0 WHERE YOUNG PARENTS GET THEIR INFORMATION

6.1 Family and Peers

Although many focus group participants spoke about being afraid to ask questions for fear of being judged or fear that information will not be kept confidential, they all agreed that their friends were their primary source of information around sexual and reproductive health issues. In general, focus group participants did not discuss sexual health matters with family members. Many youth simply stated that they did not want to approach their parents or other family members for any sexual health information because then they would know that they were sexually active. The majority of young parents talked about a 'tight knit peer group' and that they would first go to their peers to discuss any sexual and reproductive health issue. Some focus group participants reported that they didn't trust anyone else and felt that only friends could be counted on for unconditional support.

Key informants agreed that the majority of youth rely on their immediate peer group for sexual health advice. However, they also expressed that youth are receiving inaccurate, unbalanced information from equally misinformed peers. Key informants noted that women often present with various misconceptions about various birth control methods, abortion information and general sexual health information. One key informant recalls an instance with a young woman who was told by her peer that she would not be able to become pregnant again if she had an abortion.

6.2 School System

Schools and educational institutions have the potential to reach a diverse and large group of youth. However, it was strongly felt by both key informants and focus group members that receiving sexual health information at school is not the preferred avenue. Although most young parents expressed a desire to continue their education, they felt that being a parent made it difficult to attend classes. In one focus group, one woman said: "The hardest thing is getting ready in the morning and being at school on time. Classes need to start later and we need schools with daycare."

Focus group participants also discussed how the information they receive in school is not relevant to the kinds of sexual health concerns they have. Participants who received sexual and reproductive health education described it as "boring" and quite removed from the reality of their sexual experiences. They felt that what they were taught was left to the discretion of the teacher and depended on how he/she felt about a certain topic. They also felt that some teachers seemed uncomfortable and/or others were judgmental.

Key informants discussed different issues when asked to comment on sexual health in the school system. According to one key informant, some young parents may not attend school full time and therefore may not benefit from the sexual health information provided by the school. Furthermore, several key informants expressed concern about the declining resources allotted for sexual and reproductive education and the decrease

in health care providers within the school system. Key informants also mentioned that sex education is often ineffective because the goals, approaches and content is not appropriate to the age, experience, and cultural background of the students. According to one report, sexual health teachers are often not knowledgeable in various areas of sexual health and tend to teach using limited curriculum strategies (Department of Community Health and Epidemiology & Amherst Association for Healthy Adolescent Sexuality, 1999). The report also noted that professional development opportunities in this area were limited and may cause some teachers to back away from addressing more complex and challenging issues.

6.3 Lack of Education of Health Care Providers

Throughout their pregnancy and as young parents, youth may have numerous encounters with a wide range of health care providers. Many focus group participants felt that sexual and reproductive health issues were rarely addressed by health care providers. Providers tend to focus on health during pregnancy, nutrition, and post-natal health of mother and well baby checks. Often there is no time for discussion and sexual health issues are not seen as a priority for health care providers.

There was consensus among key informants that there is a pronounced lack of health care providers who have accurate and correct information about sexual and reproductive health issues. As one key informant commented:

“We worry about healthy sexuality education for youth but professionals lack consistent appropriate information. Service providers often don’t have a clue about human sexuality and give inappropriate information.”

Quote: Key Informant

Key informants also stressed that some health care providers do not have the knowledge and understanding of the economic and social reality that young parents face. There was also an indication that clinical and non-clinical staff are not properly trained to work with young parents and to respect and validate their needs. In fact, one key informant arranged to have professional development focusing on sexual and reproductive health issues at her own expense. Most organizations must rely on public health for training. Although the information is useful, this format does not allow for continuity in training. This may lead to gaps in knowledge of current practices and new and emergent trends in the field of sexual and reproductive health. Given this situation, the potential to utilize health care providers as an effective way to acquire sexual and reproductive health information remains untapped.

CONCLUSION

The objective of this consultation was to better understand what the specific sexual and reproductive health needs of young parents are and what barriers they face in accessing health and support services to meet their needs. Through speaking directly with young parents and service providers, we learned this and much, much more.

We learned that stigma is one of the most pervasive issues facing young parents. Preconceived notions and assumptions about their lives create difficulties for young parents to access appropriate services and negotiate health care systems. Even for youth who gain access, they may again face stigma in the form of the values, beliefs and services provided by the institutions and the workers they meet with. Systemically, this stigma also limits the choices that young parents are given about the type of services they receive and generally makes them feel like they have no say or control over what happens to them.

We learned that a major concern for young parents is money. For many young parents, meeting basic needs such as food, childcare, housing, transportation, medication and school-related costs is an ongoing struggle. Many young parents said that it was difficult, if not impossible, to focus on their own needs. For many, it meant that they couldn't afford the cost of going to a medical appointment (transportation, child care or taking time off from work) and couldn't afford the cost of medications.

We learned that young parents consider their personal relationships and support networks extremely important, but also find that they can be a source of conflict and hard to maintain. For young parents, communication with their partners, especially after the baby was born, was stressful and difficult. With regards to family members, some young parents felt that this relationship was a great source of support and understanding, while other youth spoke about fearing the reactions of or disappointing family members with news of their pregnancy. In terms of friends and other support networks, most youth felt that it was difficult for their friends without children to understand and relate to their issues. Other youth simply no longer had time to maintain friendships or seek out other forms of support including groups and programs.

We learned that dealing with issues of violence and abuse were common among young parents, however, there is also a fear and/or reluctance to discuss partner abuse. For many young women, maintaining a family for the child's sake became the priority even if this meant living with an abusive partner. Given this situation, the many young women who disclosed violence in their lives felt that they have little or no ability to exert control in their day-to-day lives and continue living in violent circumstances.

We learned that self-esteem and mental health issues, especially issues around body image for young mothers, are often overlooked or not addressed because of more immediate health and parenting concerns. As well, many youth discussed the stigma that exists around mental health issues as a main reason why they would not seek

mental health services. For immigrant and newcomer youth, mental health issues rated as a high concern, however, they also reported language, cultural barriers and access to health care as significant barriers.

We learned that young parents identified a lack of accurate and appropriate sexual health information as a major barrier. Ranging from anatomy and fertility awareness to STI prevention, most young parents felt that their knowledge of health issues was not adequate. While some young parents did receive some form of education at school or through pre-natal classes, they generally felt the information was either presented in a judgemental, boring way or did not meet them at the point they were at in regards to their sex lives. Many youth relied on their peers for information but acknowledged that the information they received was not always accurate. For immigrant and newcomer youth, a main barrier to finding information was the limited availability of resources in other languages.

We learned that young parents and service providers believe that programs designed to meet the sexual and reproductive health needs of young parents must also address and accommodate the social, economic and environmental realities that young parents experience. While both focus group participants and service providers acknowledged that young parents' sexual health needs were somewhat different from their childless peers, it was more strongly expressed that there was an urgent need to promote overall health and well-being among young people. Young parents are concerned about their sexual health, however, there are more pressing life issues that take priority. According to key informants, programs that focus on sexual health must view it not in isolation, but from a more holistic perspective of overall health and well being,

As a pro-choice, health promotion agency, PPT operates from a philosophy that views health from a broad and holistic perspective that encompasses the social determinants of health and embraces and promotes choice over control. We believe it is necessary to create and deliver sexual health programs that connect the social, economic and environmental conditions experienced by young parents. The information presented in this report will provide a framework for future programming initiatives at PPT.

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APPENDICES

Appendix A

Terms of Reference

PPT Mission Statement:

Planned Parenthood of Toronto is a community-based, pro-choice agency committed to the principles of equity and to providing accessible and inclusive services which promote healthy sexuality and informed decision making to the people of the City of Toronto.

Goals of the Working Group:

- 1) To gather documents on issues related to parenting and family planning
- 2) To determine the primary, sexual and reproductive health needs of young parents
- 3) To identify existing services and programs
- 4) To identify gaps and barriers in health services
- 5) To develop recommendations for PPT's work with young parents and pregnant youth

Target Population:

Young parents ages 13-25 from diverse backgrounds including race, culture, orientation, ability, class etc.

Structure:

The Young Parent's working group includes staff from multiple disciplines at the House. It consists of the following individuals.

Jay MacGillivray	Community Health Promoter
Lorena Murialdo	Community Health Promoter
Nadjla Agahbanaei	Clinical Receptionist
Rose Gutierrez	Director of Community Programming
Priya Rajani	Physician

Functions:

Meetings will take place during designated program meeting times. The Working Group will summarize documents on issues for this target population. The working group will define the focus of the consultation. The Key Informant Interviews will be conducted with various agencies and individuals from across the City. Focus groups will be conducted with the target population. The results from the interviews and focus groups will be analyzed in the report.



Appendix B

**Young Parent's Sexual Health Consultation
Key Informant Interview**

Name of Organization:	
Contact Information:	
Interview done with:	
Title:	
Date of Interview:	Interview done by:

Goals of the Young Parent's Sexual health Consultation

1. To gather documents on issues related to parenting and family planning.
2. To determine the primary, sexual and reproductive health needs of young parents.
3. To identify existing services and programs.
4. To identify gaps and barriers in health services.
5. To develop recommendations for PPT's work with young parents and pregnant youth.

1. What is your agency's mandate relative to young parents?
2. Describe the community of young parents and pregnant youth that you serve? (Age range, community)
3. What would you identify as the sexual and reproductive health needs of young parents and pregnant youth?
4. Does your agency provide specific and current sexual and reproductive health care training or awareness for staff or clients?

5. Can you identify any issues accessing sexual and reproductive health services unique to young parents of colour, immigrant and newcomer young parents, homeless and under-housed parents, queer, transgendered and transsexual young parents or young parents with disabilities?
6. Do you know of any gaps in, or barriers to, accessing sexual and reproductive health that your clients have encountered?
7. What type of sexual health programming is needed for this community?
8. Do you currently refer clients to any sexual health programs (clinical and health promotion)? What made it successful? OR, Why didn't it work?
9. If PPT were to offer sexual and reproductive health programming for young parents and pregnant youth, what would you suggest as program priorities?
10. Any last thoughts....



Appendix C

Focus Group Questions-Young Parents

Pregnancy

- 1) How was your pregnancy?
- 2) What challenges/issues did you experience during your pregnancy?
- 3) What kind of prenatal care did you receive?
- 4) How do you feel about the prenatal care that you received?
- 5) What would you change about your prenatal care next time?

Sexual Health

What were your sexual health issues during your pregnancy? Where do you get your information and how do you get your sexual health needs met? Did your caregiver discuss BC/STI'S with you?

Birth

- 6) How was your birth?

Parenting

- 7) What were the circumstances after your birth?
- 8) What was involved in caring for the baby?
- 9) What about your health? How did you get you needs met?
- 10) What was your experience with caregivers?
- 11) How do you feel about parenting now?

12) What do you need as a parent now?

Sexual Health

What are your sexual health issues after you gave birth? Where do you get your information and how do you get your sexual health needs met?

BC, STI'S



Appendix D

Participant Profile

Thank you for agreeing to be a part of our focus group for young parents. This form is completely anonymous and voluntary

Gender: _____ Age: _____ Number of pregnancies: _____

Race: (For example Asian, Black etc) _____

In what country were you born? : _____

When did you come to Canada if you were not born here? _____

What is your Immigration status: (For example Canadian Citizen, Landed etc)

What language are you most comfortable using: _____

Do you have any disabilities? (For example mobility disability, visual problems etc)

Yes _____ No _____

Are you Deaf? _____ Are you hard of hearing? _____

Are you in a relationship? _____ No _____ If Yes, how long? _____

Are you in school right now? _____ No _____ Yes (full-time, Part time, Upgrade, High school etc) _____

Employment status: (For example Working full time, Not working etc.)

Children: _____ Ages _____

Does your child(ren) live with you? _____ No _____ Sometimes _____ Yes

If Yes, do you parent equally with someone? _____ If YES, are you the primary parent? _____ No _____ Yes

How old were you when a health care provider told you that you were pregnant?_____

How many weeks, months were you when you started prenatal care?_____



Appendix E

Informed Consent Form

Planned Parenthood of Toronto is a community based, pro-choice agency committed to the principles of equity and to providing accessible and inclusive services which promote healthy sexuality and informed decision making. In our efforts to provide programs that are sensitive to the needs of our client group, we have embarked on a community consultation process to identify the key sexual health needs of pregnant youth and young parents living in Toronto.

As part of this process, we are currently holding focus groups with small groups of young parents to find out what they think are the sorts of services and supports that are missing and what would be useful. Thank you for agreeing to be part of one of these groups. As a participant there are several things you should be aware of:

1. The groups will be run by a facilitator, who will ask questions, facilitate discussion and write your responses on a flip chart;
2. Participation is voluntary and you are free to withdraw from the process at any time;
3. You will receive \$20 at the end of the session for participating in the group discussion;
4. You are free to decide to not answer any question;
5. Discussions in the sessions are confidential.
6. You will receive a copy of the Informed Consent Form to sign;
7. Group discussions will be documented in several ways to accurately represent participants' comments and the issues participants identify as important. There will be a recorder present taking notes of the discussion as well as an audio tape recorder to document the session. The written notes and audio tapes will be kept in the agency. Documentation generated in the focus groups may be used as the basis for written reports, research papers and publications, media articles,

conference presentations, and program evaluations. In all cases the names and identifying information of participants will be kept confidential, unless specific permission is requested and granted. All identifying information will be kept in the agency for a maximum period of 7 years. All information will then be shredded.

Questions about the project may be directed at any time to the Group Facilitator

Name and Title

Or Rose Gutierrez, Director of Community Programming (416-961-0113 ext 227).

I am fully aware of the nature of this project and have agreed to participate. I have read, understood and been given a copy of this consent form.

Signature of participant

Date

Printed name of participant

Signature of focus group facilitator

