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# Rural Heterosexual Female Adolescents' Decision-Making about Sexual Intercourse and Pregnancy in Ontario

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A thesis submitted in partial fulfillment of the requirements for the degree in Master of Science

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RURAL HETEROSEXUAL FEMALE ADOLESCENTS' DECISION-MAKING  
ABOUT SEXUAL INTERCOURSE AND PREGNANCY IN ONTARIO

(Thesis format: Monograph)

by

Paulina Ezer

Graduate Program in Health and Rehabilitation Sciences

A thesis submitted in partial fulfillment  
of the requirements for the degree of  
Master of Science

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## **ABSTRACT**

Rural areas in Ontario tend to have higher rates of adolescent pregnancy. A constructivist grounded theory methodology was used to gain an in-depth understanding of rural female adolescents' decision-making process regarding sexual intercourse and their reproductive health, and how they view rural factors and circumstances influencing this process. The adolescent sexual decision-making process that emerged from the analysis involved prioritizing four influences that affect and are affected by the rural context: personal values and circumstances, family values and expectations, friends' influences, and community influences. Findings will improve our understanding of how rural female adolescents make choices regarding their reproductive health. This research has the potential to facilitate effective development of sexual health promotion initiatives in rural communities, and may help to inform rural health policy and practices and existing sexual education programs in rural communities.

**Keywords:** rural health, females, adolescents, reproductive health, sexual health, pregnancy, and constructivist grounded theory.

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## **CHAPTER 1: INTRODUCTION**

Rural Canadian female adolescents experience unique circumstances and barriers to sexual health care and information as compared to urban adolescents. These circumstances and barriers are largely due to their more isolated geographical location and rural socio-cultural factors (Leipert, 2005; Romanow, 2002; Sutherns, 2005). These circumstances may be contributing factors to a higher incidence of adolescent pregnancy in rural areas than in urban cities (Best Start, 2008; Ministry of Health and Long-Term Care [MOHLTC], 2009). Thus, this higher incidence of pregnancy may be due to the ways in which rural adolescents make decisions regarding engagement in sexual intercourse. However, rural female adolescent sexual decision-making process has rarely, if ever, been studied.

### **Definition of Key Terms**

Several key terms are specifically used in this study. These terms are reproductive health, sexual health, sexual intercourse, adolescent pregnancy, and rural. The following are definitions of these terms as they are used in this thesis.

#### **Reproductive Health**

The definition of reproductive health as used in this study is the one provided by the United Nations (1994), which states that:

Reproductive health [...] implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (p. 40).

The United Nations (1994) definition of reproductive health includes a definition of sexual health, which is defined as “the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases (p. 40).”

### **Sexual Health**

The definition of sexual health as was used in this study is the one provided by the World Health Organization (2006), which states that:

Sexual health is the experience of the ongoing process of physical, psychological, and sociocultural wellbeing related to sexuality. Sexual health is evidenced in the free and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching individual and social life. It is not merely the absence of dysfunction, disease and/or infirmity. For sexual health to be attained and maintained it is necessary that the sexual rights of all people be recognized and upheld.

### **Sexual Intercourse**

In this thesis, the term sexual intercourse is used to refer to penile-vaginal sexual intercourse.

### **Adolescent pregnancy**

Adolescent pregnancy refers to pregnancy among females aged 19 and under, including “the number of live births, fetal losses, stillbirths and abortions per 1,000 women/girls aged 19 and under” (Best Start, 2007, p. 2). In this study, we used this definition but narrowed the inclusion criteria to females ages 16 to 19 because the age of sexual consent in Canada is 16 (Bellemare, 2008).

Most pregnancy and birth statistics only include females between the ages of 15 and 19 (Best Start, 2007, p. 2). According to analyses of health units across Ontario, the MOHLTC (2009) found that, in 2007, the provincial average of adolescent pregnancies (including live births, still births, and abortions) was 25.7 pregnancies per 1,000 females



ages 15-19. These statistics are broken down by major health units in Ontario under the following categories: mainly rural, urban centres, urban-rural mix, and sparsely populated urban-rural mix. Adolescent pregnancies in mainly rural areas of Ontario tend to vary from 22.1 – 60.8 per 1,000 females ages 15-19 while those in urban centres of Ontario tend to vary from 9.5 – 30.8 per 1,000 females ages 15-19 (MOHLTC, 2009). Thus, the rate of most adolescent pregnancies in rural areas of Ontario tends to fall above the provincial average. Adolescent pregnancies in urban-rural mixes range from 32.4 – 41.8 per 1,000 females ages 15-19 and those in sparsely populated urban-rural mixes range from 31.4 – 44.6 per 1,000 females ages 15-19.

As a result of reporting statistics from health units that have a mix of urban and rural populations, the statistics are not completely broken down by rural and urban locations, and it is impossible to differentiate the rates between the two types of environments. For example, the District of Algoma Health Unit, which is classified under the category of sparsely populated urban-rural mix, has an adolescent pregnancy rate of 42.5 per 1,000 females ages 15-19. It is unclear whether this high rate is due primarily to rural rather than urban parts of the District of Algoma or whether they both contribute to this high rate of adolescent pregnancy. This is the case for other health units listed in this document, and is likely not due to a measurement error. Furthermore, adolescent pregnancy statistics that clearly compare urban versus rural rates are unavailable elsewhere. Thus, while some statistics on rural adolescent pregnancy are available, namely from the Ministry of Health and Long Term Care, they are neither plentiful nor clear.

## **Rural**

Although there is a lack of consensus regarding the definition of “rural” among policy-makers and researchers, some of the following common characteristics regarding Canada’s rural communities have been reported: (i) 95 per cent of Canada’s geography is rural (Canadian Institute for Health Information [CIHI], 2006); (ii) 30 per cent of Canadians are rural residents (Leipert, 2005); and (iii) 20 per cent of women live in a rural area (Leipert, 2005). In Ontario, rural communities are considered to be those that

have a population under 30,000 and are at a distance of at least 30 minutes in travel time from a community with a population that exceeds 30,000 (MOHLTC, 2010). This is the definition of rural that was used for this study. Rural communities are prone to low population density, isolation, limited access to resources, higher unemployment levels, lower educational levels, and less healthy behaviours (CIHI, 2006; Kirby & LeBreton, 2002; Romanow, 2002).

### **Understanding Rural Health Care**

The access to and delivery of health care in rural areas are influenced by a variety of circumstances, including: health care professional shortages (Leipert, Leach, & Thurston, 2012; Romanow, 2002; Sutherns, 2005); distance from health care services (CIHI, 2006; Romanow, 2002; Wong & Regan, 2009); isolation from more populated centres (Romanow, 2002); limited financial freedom or opportunities to have the financial means to pay for driving expenses to sexual health appointments or for birth control (Leipert, Matsui, & Rieder, 2006; Leipert, Landry, & Leach, 2012); familiarity with health care providers (Leipert et al., 2006); and a lack of anonymity, privacy, and confidentiality in both personal and professional contexts (Sutherns, 2005). All of these circumstances interact and affect each other to make delivery of and access to rural health care problematic for rural female adolescents in particular because they must be more dependent on local rather than distant services and resources due to economic and transportation challenges.

In addition to these circumstances, the limited data on rural women's health show that rural women face particular challenges to maintain their health (Leipert, 2012). Compared to women in urban settings, women in rural populations tend to have more children, and have their first child at a younger age (Ostry, 2012; Sutherns, 2005). Moreover, compared to rural men, rural women tend to have lower incomes, which may compromise their ability to access sexual and reproductive resources (Hemingway & McLennan, 2005). In addition, an unexpected pregnancy may further exacerbate a rural female adolescent's ability to continue her education or advance her career to best provide for herself and her child.

## **Significance of Adolescent Pregnancy**

One out of every five women in Canada lives in a rural area (Sutherns, McPhedran, & Haworth-Brockman, 2004). Compared to urban women, rural women, and specifically rural female adolescents, tend to have higher fertility rates (Leipert et al., 2006; Sutherns, 2005). Moreover, rural female adolescents have less access to health care services including sexual and reproductive health care (Leipert et al., 2006). It can be assumed that pregnancy during the adolescent years, especially among younger adolescents, is largely unintended (Sex Information and Education Council of Canada [SIECC], 2010). Adolescent pregnancy can therefore be used as “a reasonably direct indicator of young women’s opportunities and capacity to control this aspect of their sexual and reproductive health” (SIECC, 2010, p. 2).

Adolescent pregnancy can have long-term health and psychosocial consequences to both the young mother and her family, especially if the pregnancy is unintended and/or unwanted (Best Start, 2007). For example, pregnancy during adolescence can cause social, educational, and employment difficulties, such as school interruption or cessation, less employment opportunities, and lower income (Best Start, 2007; Kearney & Levine, 2007; Luong, 2008; Varpalotai, 2005). Pregnancy during adolescence poses greater health risks to both the mother and child given that, when compared to adult women, pregnant female adolescents have a higher risk of developing anaemia, hypertension, eclampsia and depressive disorders (Dryburgh, 2000; Paranjothy, Broughton, Adappa & Fone, 2009), and children of female adolescents have an increased likelihood of having low birth weights, being born preterm, and experiencing developmental, learning, hearing, visual, and chronic respiratory problems (Chen et al., 2007). In addition, children of teenage mothers have a greater chance of having a child during their own adolescent years, thereby continuing the cycle of adolescent pregnancy (East, Reyes, & Horn, 2007; Wellings, 2007). Thus, exploring rural female adolescent sexual decision-making process is an important area of research because of the far-reaching implications of adolescent pregnancy for individuals, families, and rural communities, including school interruption and girls’ dropping out from education, which may, in turn, lead to decreased employment and limited life choices (CIHI, 2006; Varpalotai, 2005).

## **Study Purpose and Research Questions**

The purpose of this constructivist grounded theory study (Charmaz, 2014) is to understand how rural female adolescents make decisions regarding sexual intercourse and pregnancy, and the impact the rural context has on this process. The research questions of this study are: (1) What is the process by which rural female adolescents make decisions regarding sexual intercourse and pregnancy?; and (2) How do they view rural factors and circumstances, such as geographical location, economic resources, and available health care, influencing this process?

## **Significance of the Study**

This study contributes to the existing literature on rural female adolescent health in several ways. First, while rural men's health access is also limited, there is a diversity of rural women's health issues that have not yet been addressed in the health literature, including the health of rural girls and youth (Leipert, Leach, & Thurston, 2012). Second, because to date, the limited research conducted on rural women's health has focused mostly on rural maternity care (Sutherns & Haworth-Brockman, 2012), more research is needed regarding understanding sexual decision-making and factors that contribute to higher rates of pregnancy among rural female adolescents. Further investigation of the decision-making process of rural female adolescents regarding their sexual and reproductive health and factors that affect their experience is necessary. Third, there is limited qualitative research on adolescent pregnancy. Qualitative research in this area provides an opportunity for the voices of rural female adolescents to be heard and to discover how they make decisions about sexual intercourse and pregnancy, and their perceptions of factors in the rural context that affect these decisions (Best Start, 2007). Finally, focusing on rural female adolescents between the ages of 16 and 19 is especially significant as this age range is used for reporting most pregnancy and birth statistics in Ontario (Best Start, 2007).

In addition to contributing to the research literature, the results of this study have the potential to facilitate development of effective sexual health promotion initiatives in rural communities and may help to inform rural health policy and practices and existing

sexual education programs in rural communities. This is an important area of research because of the adverse and long-term health and psychosocial implications of adolescent pregnancy for the young woman and her family, and for rural communities. This research will enrich our understanding of how rural female adolescents make choices concerning sexual intercourse and pregnancy.

### **Researcher's Assumptions**

As a researcher, I held certain assumptions prior to and during this research study. It is important to share the assumptions that I held during data collection and analysis, as they will have shaped my interpretation of the studying findings. One of my assumptions pertained to my expectation that all participants would have had some experience with sexual activity. I was surprised that some participants were not sexually active either out of circumstance or out of their own personal choice. My expectation was informed by my own experiences in a prevailing culture that expects adolescents to be sexually active.

Another assumption that I held is that adolescent pregnancy is, more often than not, a negative and unwanted outcome. It can be possible, however, for adolescent pregnancy to be a positive outcome for some rural female adolescents who may have chosen this option as a result of having chosen to remain in their rural town and to raise a family. Furthermore, leaving their rural hometown to attend post-secondary education may not be ideal for all rural female adolescents.

### **Summary**

Given the higher rates of adolescent pregnancy in rural environments, and that adolescent pregnancy has been shown to affect the long-term physical and psychosocial health of both the mother and her family, it is important to explore current barriers and facilitators that rural female adolescents in Canada experience when making sexual and reproductive decisions. Therefore, the purpose of this study is to understand how rural female adolescents make decisions regarding sexual intercourse and their reproductive health, and the impact that the rural context has on this process. In the following chapter, I will review the literature to outline the rural context and circumstances for sexual health

care, adolescent sexual decision-making, and sexual health promotion. In the third chapter, I will discuss the methodology and methods of this research study. In the fourth chapter, I will present the study findings. Finally, in the fifth chapter, I will conclude with a discussion of the findings in relation to the literature and will outline the implications of the findings.

## **CHAPTER 2: LITERATURE REVIEW**

One out of every five women in Canada lives in a rural area (Sutherns, McPhedran, & Haworth-Brockman, 2004). Although rural female adolescents have higher rates of fertility and incidences of sexually transmitted infections (STIs) (Ostry, 2012), they also have less access to health care services, including sexual and reproductive health care (Sutherns, 2005). Social determinants of health, which are factors beyond medical and lifestyle factors that affect health, such as social support or transportation, can affect rural female adolescents' health in unique ways (Raphael, 2003). In this literature review, I examine: (1) the social determinants of rural female adolescents' sexual health, (2) adolescent sexual activity, and (3) rural sexual health trends among adolescents. I will also identify limitations in the current literature regarding rural female adolescents' sexual decision-making and establish the significance of the current study.

### **Literature Search Strategy**

The literature was retrieved from the CINAHL database, ProQuest Nursing and Allied Health Source, Scopus, and PsycINFO. The following search terms were used in the search strategy: rural, rural health, female(s), girl(s), adolescent(s), teenager(s), teen(s), adolescence, reproductive health, sexual health, sexual intercourse, sexual decision-making, sexual behaviour(s), sexual behavior(s), attitude to sexuality, and sexual health promotion. All titles and abstracts found were screened for relevance to the focus of my research. Content was included with priority placed on Canadian and Western countries' research that are relevant to the Canadian rural health context, such as the United States, United Kingdom and Australia, that involved rural health and adolescent sexual decision-making. Articles were limited to peer-reviewed journals and books, which were located through academic databases, and government reports, which were located with the use of the search engine Google Scholar. The reference lists for each article found were also examined for additional relevant articles, and handsearching literature recommended by advisory members was also employed. The literature search on academic databases was limited to the years 2004-2014 in order to maximize the

relevance of the information and the most current literature. Literature from before 2004 was included if it was a seminal piece of literature, an article specifically discussing rural adolescent sexual health, which is a less published topic, or an article included in a reference list as an original source of information. In this thesis, 53 articles were included in the literature review with a remaining 45 cited in the other chapters.

## **Social Determinants of Rural Female Adolescents' Sexual Health**

### **Social Determinants of Health**

Social determinants of health are nonmedical and nonlifestyle factors that directly affect health (Raphael, 2003). Not only are social determinants of health the best predictors of an individual's or community's health, they influence a person's range of lifestyle choices and can interact with one another to produce better or worse health outcomes (Raphael, 2003). A World Health Organization working group recognized the following ten social determinants of health: the social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transport (Marmot, 2005). While these social determinants of health are applicable to any individual and population, including rural populations, existing research concurs that health in rural areas is influenced by additional factors, such as religiosity (Riddell, Ford-Gilboe & Leipert, 2009; Varpalotai, 2005), limited health care providers (Leipert & Reutter, 1998; MacKinnon, 2010; Romanow, 2002), distance to services and resources (CIHI, 2006; Wong & Regan, 2009), limited employment opportunities (Leipert et al., 2006), and lack of anonymity (CIHI, 2006; Varpalotai, 2005). Each of these factors influence each other to have an impact on rural health and rural female adolescents' sexual decision-making in unique ways.

### **The Rural Context**

Several features or characteristics of the rural context, such as geographical, sociocultural, economic, and health care contexts, are relevant to understanding the sexual decision-making of rural female adolescents (Leipert et al., 2012). Rural communities tend to be more religious and hold traditional values and beliefs, which can



preclude rural female adolescents from seeking or accessing health care services including birth control and abortion (Riddell et al., 2009; Varpalotai, 2005). Gender inequality may be especially pronounced in rural areas where traditional roles for women are often deeply ingrained (Riddell et al., 2009). Due to both the emphasis on procreation and traditional gender roles in such communities, options to address pregnancy prevention, such as birth control, or an unexpected pregnancy may be limited.

Rural communities struggle to attract and keep health care providers (Romanow, 2002). Health professionals may be discouraged from working in rural communities due to potential isolation, smaller networks of professionals, and heavier workloads (MacKinnon, 2010). As a result of these shortages, health services are often either unavailable, or irregular and insufficient, as compared to urban communities (Leipert & Reutter, 1998). When physicians are available in rural settings, they have typically been male (Kirby & LeBreton, 2002). Discussing sensitive topics, such as sexual health and reproduction with a male health care provider may be problematic for some rural female adolescents who would prefer such discussions with a female health care provider (Leipert et al., 2006). If a rural female adolescent is uncomfortable seeking sexual and reproductive health care from a male health care provider, she may forgo health care altogether. Thus, not only do rural female adolescents lack the privilege of choice of health care providers, their lack of options may further compromise their health (Leipert et al., 2006).

To receive health care, rural residents must often travel due to the distance from health care services and isolation from populated centres (CIHI, 2006; Wong & Regan, 2009). Such travel can be compromised by challenging weather conditions, dangerous roads, and expensive travel costs (CIHI, 2006; Leipert, 2005). Adolescents who do not have their driver's license, own a car, or have access to a vehicle may have to rely on their family's vehicle to travel for a sexual health related appointment, which may, in turn, force adolescents to disclose the purpose of their appointment to their family. These circumstances may prohibit or prevent rural adolescents from accessing health care. In addition, lowered accessibility to health care is linked to increased rates of sexually transmitted infections and adolescent pregnancy (DeLeeuw, 1998). This is especially

concerning because sexually transmitted infections can be transmitted quite easily in small communities due to increasing rates of intercourse (Varpalotai, 2005).

Furthermore, limited employment and lack of finances can affect rural female adolescents' ability to travel for health care services and procure pharmaceutical medication, including birth control (Leipert et al., 2006). Rural residents generally tend to have lower incomes and education; pregnancy during adolescence may further exacerbate these circumstances because it may lead to school interruption and dropping out, or peer exclusion upon return may discourage education completion (CIHI, 2006; Varpalotai, 2005). A lack of and difficulty accessing health care services for rural female adolescents is especially concerning because, compared to urban women, rural women have a higher probability of having more children, and conceiving their first child during adolescence (Ostry, 2012; Sutherns, 2005). With inaccessibility to sexual health care services, birth control, and abortion clinics, rural female adolescents may become and stay pregnant out of lack of alternatives (Eggertson, 2001). Moreover, during their pregnancy, rural female adolescents may find it challenging to receive prenatal care. Adolescent pregnancy, which is considered a risky pregnancy due to the increased risk of adverse birth outcomes, is further complicated in a rural area (Chen et al., 2007).

Rural residents tend to report a stronger sense of community closeness, belonging, and conservativeness than urban residents (CIHI, 2006; Varpalotai, 2005). However, conservative communities may not favour discussions of a sexual nature, particularly by young unmarried women (McNeely & Shreffler, 1998). The homogeneity and interconnectedness of rural areas can be more conducive to a supportive atmosphere, but can also reduce a person's sense of anonymity. A rural female adolescent's privacy and anonymity may be especially important for her to maintain when more sensitive issues are of concern, such as those relating to sexual health, because she may not feel comfortable with the risk that her concern may be exposed. For instance, when local pharmacies are available in a rural community, rural female adolescents may choose not to obtain or fill a prescription because they are known to the pharmacist or staff (Leipert et al., 2006). This can significantly compromise a rural female adolescent's access to contraception and reproductive resources if she or her partner feels uncomfortable being

seen procuring birth control medication or condoms. Another anonymity concern for rural female adolescents may be with regards to their health care providers. Due to limited number of physicians in a rural community, rural adolescents may be compelled to visit their family physician for reproductive counseling and care. Fears regarding anonymity and compromised confidentiality by clinic personnel, including physicians, may discourage adolescents from seeking such services.

### **Adolescent Sexual Activity**

Certain trends regarding Canadian adolescents' sexual activity have been identified. Most Canadians tend to have their first sexual intercourse experience during their teenage years (Maticka-Tyndale, 2008; Rotermann, 2008). More specifically, in 2005, 43% of Canadian adolescents and 37% of Ontario adolescents between the ages of 15 and 19 reported having engaged in sexual intercourse at least once (Rotermann, 2008). In the same year, the percentage of Canadian female adolescents who engaged in sexual intercourse between the ages of 15 and 16 was 21%, and 8% before the age of 15 (Rotermann, 2008); the total number of pregnancies among women under the age of 20 was 30,948 (Statistics Canada, 2008); and approximately one third of 15-19 year old Canadian adolescents who had had intercourse had done so with more than one partner while three-quarters of the same sample reported using a condom the last time they had intercourse (Rotterman, 2008).

Condom use decreases with age and is more common among those in short-term relationships (Rotterman, 2008). For example, the Canadian Community Health Survey found that 81% of sexually active 15-17 year-olds reported using a condom during their last intercourse as opposed to 70% of 18-19 year-olds (Roterman, 2008). This pattern of waning condom use among sexually active Canadian youth has also been noted in other surveys (Boyce, Doherty, Fortin, & MacKinnon, 2003; Saewyc et al., 2008). This discrepancy may be due to older adolescents' more ready access to transportation and other reproductive options such as the birth control pill.

Pregnancy rates in Canada have decreased significantly over the last few decades (McKay, 2006). For example, in 1995, the pregnancy rate among 15-19 year-old females

was 47.6 per 1,000, and 29.2 per 1,000 in 2005 (Statistics Canada, 2009). However, these are general rates for all of Canada and are not disaggregated for rural settings in particular. In a search of recent Statistics Canada data, pregnancy rates were limited to provinces and territories and were not broken down any further. It is unclear, therefore, whether pregnancy rates have also decreased in rural settings since 1995.

In general, adolescence is a period of development in which risk behaviours are common (Curtis, Waters, & Brindis, 2011). Risk behaviours can be amplified by barriers to health services and resources, such as distance and travel costs due to the rural sociocultural context, resulting in negative sexual health outcomes (Curtis et al., 2011). Adolescents tend to ignore sexual risks, such as pregnancy and STIs (Sieving et al., 2011). For instance, Canadian adolescents are engaging in increased high-risk sexual behaviours including engaging in unprotected sexual intercourse and sex with multiple partners (Kennedy & MacPhee, 2006), and sexual activity before the age of 16 is much more common than it was 40 years ago (Craig & Stanley, 2006).

Haley, Puskar, Terhorst, Terry, & Charron-Prochownik (2012) put forth a theory regarding a “reciprocal interaction of the personal, environmental, and behavioural factors influencing condom use” (p. 214). This theory is based on Bandura’s Social Cognitive Theory (Bandura, 1986), which states that behaviour is influenced by a reciprocal interaction of all three of these factors. In their research, Haley et al. (2012) found that rural adolescents are engaging in behaviours that are sexually risky, such as intercourse at age 14 and younger, multiple sexual partners, and lack of condom use. According to their theory, it is important to note the personal and environmental factors that influence sexual decision-making instead of only focusing on behavioural factors. For example, not understanding the importance of contraception (personal factor) and/or difficulty accessing appropriate services or resources (environmental factor) often leads to unplanned adolescent pregnancy (Craig & Stanley, 2006).

Blank, Baxter, Payne, Guillaume & Pilgrim (2010) found that adolescent health care use is lower than all other age groups in the UK. This is especially concerning given that high-risk sexual behaviours and STIs are on the rise among adolescents (Blank et al.,

2010). In general, adolescents cite several reasons for avoiding sexual health care. Adolescents may not seek sexual health care for a variety of reasons, including lack of confidentiality among, and trust in, health care providers; embarrassment; and lack of resources in terms of knowledge, awareness, and access to services (Jarrett, Dadich, Robards, & Bennett, 2011; Reeves et al., 2006).

Generally, both male and female adolescents tend to report that they are afraid of physicians compromising confidentiality and reporting medical and sexual information to their parents (Kennedy & MacPhee, 2006). This fear can prevent adolescents from both seeking sexual health care and being honest with their health care provider (Kennedy & MacPhee, 2006). Furthermore, female adolescents in particular may want to discuss sensitive health issues with their health care providers but may not bring them up unless they are prompted because of feelings of embarrassment (Shoveller, Johnson, Langille, & Mitchell, 2004). As such, adolescents specifically tend to look to their friends for sexual health information rather than health professionals, even though they know that their friends' advice may be inaccurate and unreliable (Kennedy & MacPhee, 2006; Marcell & Halpern-Felsher, 2007). All of these reasons for avoiding sexual health care can greatly affect adolescents' decision-making regarding access to sexual services and resources, and they may be compounded in a rural setting in which adolescents may be more familiar with their health care provider or staff at their pharmacy or grocery/convenience store, and in which conservative communities may not favour discussions of a sexual nature.

### **Rural Sexual Health Trends among Adolescents**

In rural Canada, age of first intercourse is decreasing faster among female adolescents than males (Yarber, Milhausen, Crosby & DiClemente, 2002). A study on rural youth in the United States found that becoming sexually active before the age of 15 is highly correlated with having many sexual partners and not using condoms, especially among females, thereby increasing the risks of sexually transmitted infections and adolescent pregnancy (Yarber et al., 2002). As Varpalotai (2005) mentions, adolescent

pregnancy is an area of concern in all populations, but is especially concerning in rural communities due to the high pregnancy rate.

Two key factors that mediate adolescent pregnancy have been identified. The first factor is motive, which refers to the reasons behind an adolescents' decision to engage in unprotected sexual intercourse. The second factor is means, which refers to the education and knowledge that would allow an adolescent to make an informed decision regarding sexual intercourse and use of contraception (Adamson, Brown, Micklewright, & Wright, 2001). Socio-economic inequity tends to have an impact on adolescents' motives (reasons to engage unprotected intercourse) more than their means (sexual health education and knowledge). In other words, circumstantial reasons affecting rural female adolescents' decisions regarding sexual intercourse (motives) may have more of an impact on the way they make such decisions (Best Start, 2007). For instance, while sexual education and knowledge (means) is useful, inability to access contraception due to distance of such resources (motive) will affect a sexually active adolescent who may thus decide to engage in unprotected sexual intercourse.

Clearly, rural female adolescents require adequate sexual health information and access to health care. However, even when sexual health services are available in a rural community, adolescents may continue to shy away from accessing them. Concerns regarding anonymity and confidentiality are common among adolescents seeking sexual health services (Reeves et al., 2006); however, they are more concerning in rural environments (Docherty, 2010). For instance, Docherty (2010) found that, in addition to concerns regarding asking embarrassing questions, receiving test results, and staff informing their parents of their appointment, rural adolescents were concerned that someone who worked at a sexual health service might know them. Similarly, Bell (2009) found that rural adolescents were reluctant to purchase condoms due to embarrassment related to high visibility in their rural towns in England. In a study conducted in rural areas in the UK, rural adolescents reported embarrassment regarding birth control and STIs because "everyone knows one another" and the person at the clinic's reception desk or in medical records could be either neighbours or relatives (Elliott & Larson, 2004). Another barrier experienced by these rural adolescents was transportation because access

to sexual services was limited in town and public transportation to services outside of town was lacking. In her study, Docherty (2010) found that rural females, in particular, were anxious about transport and travel time to sexual health services.

Similar sexual behaviour patterns were found among rural youth in British Columbia who cited the following rural factors as influencing them: religiosity, transportation difficulties, boredom due to limited leisure activities, limited youth access to sexual health care, social exclusion due to sexual behaviour and/or reputation, and future prospects and goals (Shoveller, Johnson, Prkachin, & Patrick, 2007). Furthermore, rural adolescents in the US listed the following barriers to accessing sexual health services: high visibility, familiarity, and “the sense of living in a ‘goldfish bowl’” in a small town; female adolescents losing their reputation due to the stigma of sexual activity; scarcity of accessible and discreet services; transportation difficulties; and traditional values (Craig and Stanley, 2006). Thus, even when sexual health services are available to rural youth, they may not access them due to geographic barriers (Elliott & Larson, 2004) and issues regarding maintaining confidentiality in small towns (Garside, Ayres, Owen, Pearson, & Rozen, 2002).

### **Limitations of the Current Literature**

This literature review reveals that, to date, the limited research conducted on Canadian rural women’s health has tended to focus mostly on the theme of rural maternity care (Sutherns & Haworth-Brockman, 2012). This may be due, in part, to the fact that rural women have a higher pregnancy rate and often have little access to maternity health care. Research on adolescent pregnancy often fails to include the voices of both those who are affected most by pregnancy (i.e., the young women themselves, and the young women who have successfully avoided pregnancy in their adolescent years) (Best Start, 2007). Information from both female adolescents who have and have not been pregnant, and a focus on their socio-economic and cultural circumstances, is important to understanding how rural female adolescents make decisions about sexual intercourse, and would better identify the needs of those who may benefit from sexual health promotion initiatives regarding adolescent sexuality (Best Start, 2007; Best Start,

2008). Furthermore, most of the Canadian literature on adolescents' sexual activity is not disaggregated for gender or for geographical location (i.e., rural versus urban). While some statistics on rural adolescents' sexual activity are available, they are neither plentiful nor clear. For instance, the statistics on adolescent pregnancies in Ontario that are provided by the Ministry of Health and Long-Term Care are only categorized by public health units, and statistics specific to various regions, including rural areas, are not provided (MOHLTC, 2010).

### **Summary**

Many adolescents are sexually active and an increased number of adolescents are engaging in risky sexual behaviours. Adolescent sexual decision-making relies on personal, environmental, and behavioural factors. Certain environmental factors and social determinants of health in rural areas can make sexual decision-making more challenging for rural adolescents compared to their urban counterparts. Sexual health promotion through sexual health education in schools is important to increase adolescents' sexual health literacy and decrease unwanted pregnancy and STIs; however, sexual health education in rural schools can be a challenge to implement successfully due to sociocultural and religious influences. Although research on rural populations in Canada is growing, rural women, specifically rural female adolescents, tend to be overlooked. The ways in which rural female adolescents make decisions regarding engaging in sexual intercourse remain unclear as this research is lacking. This gap in the literature fueled my motivation to study rural female adolescents' sexual decision-making process in Ontario. In the next chapter, I provide a detailed description the constructivist paradigm and grounded theory methodology that guided my methods for conducting my research.



## **CHAPTER 3: METHODOLOGY AND METHODS**

The purpose of this constructivist grounded theory was to explore the processes of rural female adolescents' sexual decision-making about sexual intercourse and pregnancy. In this chapter, I will discuss the constructivist paradigm and describe the methodology of grounded theory. In addition, I will explain the methods I used to collect and analyze this study's data, and discuss the measures taken to ensure a rigorous study.

### **Positioning of the Study**

#### **The Constructivist Paradigm**

Constructivism is a paradigm or worldview with the inherent ontology that assumes there are many realities (i.e., participants' realities are varied and layered), and the epistemological stance that the participant and researcher co-construct knowledge (Denzin & Lincoln, 2005). At the core of constructivist research is the belief that individuals construct meaning about their lives by interacting with their environment (Charmaz, 2014). Constructivism implies that participants' understandings and explanations of their experiences, and the researcher's interpretations drawn from data, are "constructions of reality" (Charmaz, 2014, p. 17).

#### **Methodology: Constructivist Grounded Theory**

This research was conducted using a grounded theory methodology informed by a constructivist framework. References will be made to Charmaz's guidelines (Charmaz, 2014) for constructivist grounded theory research because she established formal guidelines for the combination of this paradigm and methodology. Grounded theory is a qualitative methodology that is used to develop a theory to explain a process based on collected data, rather than using data to fit hypotheses developed *a priori* (Charmaz, 2014). Schreiber and Stern (2001) espouse this methodology as ideal for researching "how people manage their lives in the context of existing or potential health challenges" (p. xvii), and that it is especially useful for under-researched phenomena, which is appropriate for this study. In this study, rural female adolescents' decision-making

regarding sexual intercourse and pregnancy was regarded as a process influenced by their rural context.

Glaser and Strauss (1967) first developed grounded theory as a means to understand how individuals make sense of certain phenomena, including health experiences, and how these are understood in relation to the ways in which they overcome certain challenges (Schreiber & Stern, 2001). Grounded theory encourages researching the perspectives of individuals experiencing a certain phenomenon (Schreiber & Stern, 2001). However, understandings of these perspectives differ based on the paradigm of the researcher. Glaserian grounded theory takes the stance that the theory emerges from the data and exists separately from the researcher, thereby denying the subjectivity in the data (Charmaz, 2014). Traditional grounded theory of Glaser and Strauss (1967), and later Strauss and Corbin (1990), did not fit the purpose of this research because of their assertion of an objective reality, which is contrary to the constructivist paradigm. Charmaz (2014), however, espoused the importance of a subjective co-construction of data and knowledge between researcher and participant. In this study, co-construction of data between participants and me was based on participants' knowledge and experiences of living rurally and my knowledge of the literature related to rural health and adolescent sexual decision-making, my perspective on the phenomenon, and the experiences that I bring to the research, which are not value-free.

Charmaz encourages the constant comparative method of data analysis developed by earlier grounded theorists Glaser and Strauss (1967) and later refined by Strauss and Corbin (1990). Using constant comparative analysis, data are compared from the one individual at different points in time, different individuals at different points in time, and both existing and incoming data are compared with emerging categories and themes (Charmaz, 2014). This method allows for similarities and differences among all participant accounts to be revealed, which contributes to the developing theory (Charmaz, 2014). Therefore, when combined with a constructivist paradigm, grounded theory allows the researcher to formulate an interpretation of that which has been studied by

acknowledging the constructivist notion that each participant has their own unique reality and that each of these realities is legitimate (Charmaz, 2014).

Although this thesis is presented as a linear timeline beginning with data collection and ending with analysis, the methodology of grounded theory is circular and iterative because sampling, data gathering, and analysis are back-and-forth processes (Charmaz, 2014). Data collection and analysis constantly inform and direct each other because data that have been collected are analyzed and this analysis reveals further questions to be addressed in further data collection.

Grounded theory studies obtain research participants according to processes termed initial sampling and theoretical sampling (Charmaz, 2014). Initial sampling means including participants who fit sampling criteria developed prior to conducting the research study. Initial sampling is purposive because it allows the researcher to collect relevant data (Charmaz, 2014). Charmaz (2014) explains that, while “initial sampling in grounded theory gets you started, theoretical sampling guides where you go (p. 197).” Theoretical sampling means collecting data that better inform and contribute to categories emerging from the data. This can be done by interviewing participants who may offer a perspective, that has not yet been described by other participants, to gain further insight into the emerging theory. Theoretical sampling is not to be confused with sampling for population representation, but rather for explicating theoretical categories (Charmaz, 2012). Theoretical sampling directs the researcher as to where to proceed based on the analysis thus far, and continues until saturation occurs, that is, when information gathered becomes redundant and no new data are collected, i.e., until the researcher starts to hear the same things from participants (Schreiber, 2001). The notion of saturation is an elastic one because, as Mason (2010) explains, “new data (especially if theoretically sampled) will always add something new, but there are diminishing returns, and the cut off between adding to emerging findings and not adding, might be considered inevitably arbitrary (para. 60).” In this study, data collection ended, therefore, when new data were found less often than recurring data and when I judged that data was sufficient and in enough depth.

## **Study Methods**

### **Study Purpose and Research Questions**

The purpose of this study was to understand how rural female adolescents make decisions regarding sexual intercourse and pregnancy, and how they view rural factors affecting this decision-making process. The research questions this study seeks to address are: (1) What is the process by which rural female adolescents make decisions regarding sexual intercourse and pregnancy?; and (2) How do they view rural factors and circumstances, such as geographical location, economic resources, and available health care, influencing this process?

### **Sampling**

A purposeful and voluntary sample of eight participants was recruited for this study, and a total of 12 interviews were conducted. Charmaz (2014) purports that 12 interviews is sufficient for research that involves a homogeneous population with relatively common views and experiences. Female adolescents aged 16-19 years whose hometown was a rural area in Ontario with a population under 30,000 were invited to participate in this study. The reason for this age range is that the age of sexual consent in Canada is 16 years (Bellemare, 2008). Inclusion criteria for participants included: self-identification as female between the ages of 16-19 years, having lived in rural areas of Ontario with a population under 30,000 for the majority of their adolescence with a minimum of one year, heterosexual, unmarried, and not in a common law relationship. The reason participants were required to identify as heterosexual was because of the research focus on pregnancy. Informants who had been pregnant and/or had given birth were also invited to participate in the study. Adolescent females currently living in a city were also included in the study as long as they considered themselves rural adolescents; that is, that they had lived rurally for a significant period of their adolescences with a minimum of one year.

In accordance with theoretical sampling, sampling for this study began broadly and became more specific as concurrent data analysis proceeded, and codes and

categories were revealed (Charmaz, 2014). For example, after I had interviewed two female adolescents who were sexually active and secular, I sought to interview female adolescents who were not yet sexually active and/or religious because they may have had a different perspective on their sexual decision-making. In other words, theoretical sampling directed me to examine initially collected data and seek to answer research questions from this data through further diverse and focused empirical data collection (Charmaz, 2014). Questions and knowledge gaps that appeared from initial sampling and analysis were explored by interviewing new participants and asking them more focused questions that sought to address questions that had not yet been addressed. For example, after having discussed the types of health professionals available to students participants' high schools, I asked participants which health professionals would be best suited to address sexual health concerns of rural female adolescents at school.

Furthermore, snowball sampling, which refers to initial participants spreading the word about the study to their peers, was employed without success. For example, after each interview I asked participants to inform their friends who fit the inclusion criteria of this research study but none contacted me.

## **Recruitment**

Study advertisements, such as tear-off flyers and brochures (See Appendices A and B), were placed in various locations: namely, health units in Ontario that cater to rural populations and that expressed interest in and support of the study, hospital lobbies, community centres, shopping malls, movie theatres, grocery stores, and other stores that were relevant and available to rural adolescent females. Flyers were also posted at Western University to recruit female adolescents who had left their rural hometown to pursue their education and thus had experiences living rurally as an adolescent. When participants contacted me with interest in the study, I explained the nature of the study in more detail, answered any of their questions, and asked them a set of questions to determine their eligibility (See Appendix C). If they were eligible, we set up a time, date and location for the interview based on their availability. I kept a password-protected and encrypted file with the names of participants who contacted me with information about

their age, rural background, and sexual and reproductive history, and referred to this file for initial sampling.

### **Data Collection Strategies**

Constructivist grounded theory researchers begin with an openness to learn about their subject matter (Charmaz, 2014). A state of openness refers to attempting to engage in an attitude that is free of prejudice and receptive to another person's point of view. Data were collected using two methods: intensive one-to-one interviews with each rural female adolescent participant, as well as reflexive field notes. Interviewing is a data-gathering method that was useful in this research because of the highly sensitive nature of the study. Participants' comfort in expressing their personal and private experiences in a private one-to-one setting was likely greater than in a focus group setting. Charmaz (2014) defines intensive interviewing as "a gently guided, one-sided conversation that explores a person's substantial experience with the research topic" (Charmaz, 2014, p. 56).

For this study, I conducted one interview with each of the eight participants and re-interviewed four of these participants for a total of 12 interviews. I re-interviewed participants to better saturate my categories. I selected participants for additional interviews based on the following two reasons. First, I sought to re-interview participants who had demonstrated clarity in expressing their experiences to allow me to gain further insight and clarification about their perspectives and also about the analysis and emerging findings. Second, I chose participants who had been interviewed first, third, fifth, and eighth in the first data collection period. I re-interviewed participants from different points of data collection because, in between the first and eighth participant, I had obtained a lot of new data and my interviewing skills had developed and improved. It was important, therefore, to gain feedback about the data obtained during the first round of interviews with the first participants and then to compare this data with data from the re-interviews with later participants. A table that describes participants' interview dates and lengths of each interview can be found in Appendix D.

Participants were given the opportunity to select the interview location whether in their hometown in an area they felt most comfortable, on campus, over the telephone, or over Skype. Six out of eight of the original interviews were in person and took place in Western University meeting rooms and library rooms, and in meeting rooms of a public library and medical center in small towns. The other two participants were interviewed over the telephone, as were the four participants who were re-interviewed. Original interviews lasted approximately one to two hours and re-interviews lasted approximately 30 to 45 minutes. All interviews were audio-recorded to allow for a permanent recording for analysis and further data collection through theoretical sampling. Audio-recordings also allowed me to stay focused on and attentive to the conversation during the interview in order to ask relevant and focused questions to both clarify answers and to address research questions.

Prior to the interview, participants completed a socio-demographic form with questions related to their age, rural background, and relationship status (See Appendix E). Once the form was complete, we began the interview, which involved an in-depth exploration of participants' experiences with decision-making regarding sexual intercourse and pregnancy. I asked participants open-ended questions to explore their: i) experience living in a rural or small town as a female adolescent; ii) access to sexual health education, information, and care; iii) decision-making regarding engaging in sexual intercourse; iv) decision-making experiences regarding pregnancy; and v) factors that affect personal, family, and community expectations about sexual intercourse and pregnancy (See Appendix F). Particular emphasis was placed on exploring how the rural context affects rural female adolescents' experiences regarding such sexual decision-making.

My role as interviewer was to listen, observe, ask questions, and encourage responses. Through the interview process, my aim was to understand the participants' lives as much as possible from their perspective (Charmaz, 2014). Gathering data that are rich is an important foundation for data collection and analysis; the more descriptive the data, the more grounded the theories because they are more specific to the data (Charmaz, 2014). Rich data, according to Charmaz (2006) entail information that "get beneath the

surface of social and subjective life” (p. 13). They are “detailed, focused, and full. They reveal participants’ views, feelings, intentions, and actions as well as the contexts and structures of their lives” (Charmaz, 2014, p. 23).

The usefulness of open-ended questions is their non-suggestible nature, as they try not to be leading questions (Charmaz, 2014). Open-ended questions allow for unanticipated data to emerge while more focused questions allow for clarifying the details of the data (Charmaz, 2014). Once a participant provided her answer to a question, I asked more focused questions regarding the experiences she shared with me to elicit more details or clarification. For example, when a participant revealed that she had never been in a relationship, I asked her further questions about the circumstances that affected this decision. In line with constructivist grounded theory interviews, I gradually narrowed the range of interview questions as more interviews were conducted to limit repetitive information and gain more in-depth understanding of the emerging process, its concepts and relationships (Charmaz, 2014). For example, after several participants had explained to me their general views on living in a rural town as adolescents as well as their views on sexual decision-making rural towns, I spent less time asking later participants about the former and more about the latter.

I created an open environment to learn about participants’ experiences by engaging in active listening and exercising a non-judgmental attitude during interviews. By doing so, I attempted to refrain from imposing my own views and assumptions onto participants’ shared experiences with me, and instead remained receptive, accepting, and understanding. Knowledge construction came about through conversations with participants, analysis of data, and consultation with my thesis supervisor and committee, which resulted in an interpretation of reality rather than an objective account of reality.

The other method through which findings were constructed was field notes. Field notes refer to notes that a researcher writes to record observations and perceptions in the field (Charmaz, 2014). For the purposes of this study, I recorded field notes based on any observations I made before, during, or after an interview with a participant. For example, after having interviewed my first participant who identified strongly with her faith and



was not sexually active, I noted that, during the interview, I felt I had to change many of the interview questions to target her experiences and beliefs, as my interview questions had been written and geared towards adolescents who were sexually active, which was an assumption on my part. Not only did I then revise my list of questions for future participants, I also made a note to interview another participant who identified as religious and who was not sexually active as well as participants whose decision to remain sexually inactive was not due to their faith in order to gather their perspectives. Thus, these field notes provided me with a sounding board for my own reflections on the interviews and helped guide me throughout the process of sampling participants through theoretical sampling.

### **Data Analysis Process and Methods**

I began the process of analysis during data collection, and continued analysis after the first interview, during transcription, while reading transcriptions, and during subsequent interviews. This meant that I was able to compare what was said in the first few interviews while the next few interviews were being conducted. Analysis of grounded theory requires the researcher's immersion in the data (Charmaz, 2014). I began immersion by listening to the audio recordings of the interviews and transcribing the data myself, which allowed me to attend closely to participants' feelings, perspectives, and points of view. Once transcribed, I listened to each audio-recording and transcript together to ensure congruence and accuracy, and to further familiarize myself with the data. During this process, I would have read each transcript many times, and I not only familiarized myself with the data, but also began to jot down emerging ideas.

The next stage of analysis involved using QSR International NVivo 10 qualitative data analysis software for managing the coding, or labeling segments of data, which helps to sort and categorize data to make analytical comparisons (Charmaz, 2014; Richards, 1999). I chose to use NVivo because the software allows researchers to better manage and organize the data and to assist with data retrieval as compared to coding by hand, especially when transcripts are extensive and rich in data (Richards, 1999). Coding becomes the framework for subsequent analysis, and, when combined, codes become the

beginnings of theoretical categories (Charmaz, 2014). Coding begins with openness to theoretical interpretations, and becomes more focused as coding proceeds (Charmaz, 2014). At each stage of data analysis, hunches are tested against codes developed from the data to generate a core category and eventually a theory of behaviour, or, in this case, a theory for the decision-making process (Schreiber & Stern, 2001).

My data analysis followed the three coding guidelines for constructivist grounded theory as set out by Charmaz (2014). First, I began by reading transcribed interviews line by line, while paying special attention to the language used by participants, to select phrases or words that have intrinsically identifiable meanings, i.e. *in vivo codes*, which are small portions of data that still contain participants' wordings (Charmaz, 2014; Schreiber, 2001). For example, when a participant mentioned that she was not interested in having sexual intercourse until she was married, this transcript excerpt was labeled as "no sex before marriage."

The second stage of coding, known as focused coding, involves examining and sorting recurring codes to organize the data into smaller portions, and to develop more abstract categories based on initial codes (Charmaz, 2014; Schreiber, 2001). I began focused coding when I began to notice similarities in the concepts found in initial coding. During this stage, I engaged in constant comparison analysis of interview transcripts, which allowed me to continue to compare initial codes to both incoming data and to already existing data (Schreiber, 2001). For instance, I compared the already existing code labeled "no sex before marriage" to any incoming data to verify whether this was a commonality among many rural female adolescents.

At this point in the process, I started to develop tree codes, which are codes that are structured hierarchically. For example, when participants explained that they wanted to postpone sexual intercourse for marriage because this was important to their family, I moved the code "no sex before marriage" under another code for "avoid disappointing family," which was placed under the larger category of family influences. Similarly, when participants explained that they tended to "spend the majority of their time with their family," all data with this code were also filed under family influences. Thus, the

category of family influences had several branches of codes, each of which had another set of branches leading to sources of transcript data.

The iterative process of constant comparison and theoretical sampling allowed me to first develop abstract concepts from specific data, and then to verify and develop these abstractions against more specific incoming data by asking later participants questions based on initial findings (Schreiber, 2001). In this way, I assessed similarities and differences of the concepts, and identified gaps in the data for further data collection or clarification. Eventually, in keeping with the constructivist approach of constructivist grounded theory, five categories were constructed between participants and me: rural context, personal values and circumstances, family's values and expectations, friends' influences, and community influences.

The third stage of coding is the theoretical level, in which my evolving hypotheses about the concepts, their relationships, and the emerging theory continued to be developed and tested during ongoing data collection and analysis in order to confirm or disconfirm my preliminary theories (Schreiber, 2001). I developed a working theory based on relationships among the codes and categories constructed (Schreiber, 2001). I used the process of diagramming the theory to better understand the ways in which the categories fit with each other. Cues for evidence of a theory included a category that occurred repeatedly throughout multiple sources of data and also one that linked other categories together (Schreiber, 2001).

The identified theory encompassed a central phenomenon for rural female adolescents' sexual decision-making process, which entailed an interaction among the five categories. Of the four re-interviewed participants, two of them were asked general comments about the theory while it was still being developed while the later two were asked specific questions to verify the nearly-developed theory and diagram and to receive their input. These last two participants confirmed that the categories and process of prioritizing influences reflected their perspectives and experiences to make a sexual decision in a rural environment.

I engaged in memo writing throughout the data collection and analytic process. Memos are notes of ideas and questions that surface during data collection and analysis (Schreiber, 2001). Charmaz (2012) explains that memo writing is also “the intermediate step between coding and writing the first draft of your manuscript” (p. 9). Researchers use memos in grounded theory to reveal their pre-existing assumptions, document their methodological choices during the study, and record speculations during data analysis (Schreiber, 2001). Memo writing also helped me keep track of ideas regarding developing codes and their comparisons. For example, memo writing helped me keep track of my ideas regarding the prevalence of sexual activity at rural parties because, at first glance, it was no more different than the prevalence of sexual activity at urban parties. However, with further memo writing, I developed ideas as to how the two party locations might affect the sexual decision-making process differently and verified these thoughts with new and re-interviewed participants. In addition, engaging in memo writing allowed me to consider different codes and categories to explore similarities and differences between them. For example, memo writing enabled me to examine the ways in which four of the categories are embedded in the fifth category, namely, the rural context.

## **Ethics**

Ethics approval was obtained from the Health Sciences Research Ethics Board (HSREB) at Western University (See Appendix G), and the research study abided by the ethical principles of respect for persons, concern for welfare, and justice. Respect for participants involves respecting their autonomy by giving them the time and space to express themselves without interruption or judgment. To respect participants’ privacy, I requested an ethics waiver of need for parental consent based on the premise that the research topic is sensitive in nature and participants might not want their parents to know that they are involved in such a study. Participation hinged on free, informed, and ongoing consent. Before the interview, I discussed the study’s letter of information (See Appendix H) with each participant, and answered any questions they had pertaining to it. The letter of information emphasized that participants have the right to withdraw from the study at any point or to refrain from answering any question they are uncomfortable with,

without fully opting out of the study. All participants were required to sign a consent form, and before they did so, I also explained to them the notion of process consent, the process whereby participants and I revisit consent throughout the interviews (Usher & Arthur, 1998). I revisited consent during interviews if I gauged that a participant felt uncomfortable answering a question or if she needed a break. I also revisited consent prior to second interviews with participants.

Concern for participants' welfare was enhanced by minimizing harm and any risks. In-depth interviews can affect participants emotionally, especially if the topics are personal and bring up difficult past experiences (Nunokoosing, 2005). Relating these experiences to a researcher can be intimidating if the researcher is viewed as having power or control over the participant (Nunokoosing, 2005). I minimized this view of one-sided power by reminding participants that they have the right to refuse to answer or elaborate upon a question they feel uncomfortable discussing. Interviews were also conducted in places of participants' choosing where they felt comfortable and safe. At the end of each interview, I provided each participant with a list of resources for them to contact should they wish to, such as distress phone lines, local resources such as public health nurses, nurse practitioners, and counselors, based on availability in the community, and informational websites on sexual health.

Interviews were kept private and confidential, and were conducted at locations that were accessible and acceptable to each participant. To protect participant identities, I asked participants to select their own pseudonyms, which were used both when transcribing the interviews and when writing this thesis. Each transcription and audio-recorded file was stored digitally, saved as the participant's pseudonym, and was securely password protected in an encrypted folder.

The ethical concern of justice refers to the obligation to treat all participants fairly and equitably (Canadian Institutes of Health Research [CIHR], Natural Sciences and Engineering Research Council of Canada [NSERC], & Social Sciences and Humanities Research Council of Canada [SSHRC], 2010). This involves ensuring that inclusion criteria are necessitated by the research questions, and that they do not exclude

individuals arbitrarily (CIHR, NSERC, & SSHRC, 2010). Participants who did not meet the inclusion criteria were given a full explanation as to why they were not able to participate in this study.

## **Reflexivity**

Charmaz (2014) explains that it is natural to hold assumptions about the topics that participants discuss. In fact, even the research questions and the methods used for data construction and analysis are shaped by these assumptions (Charmaz, 2014). What the researcher brings to the data inevitably influences analysis of the data (Charmaz, 2014). In order to address this, I engaged in reflexive self-awareness throughout the research process. Self-awareness regarding the reasons for and methods of gathering and analyzing data allowed me to better assess and develop my effectiveness as a researcher.

I engaged in reflexive writing throughout the research process from the development of my research until completion. I recorded my reflexive thoughts about interview questions, emerging codes, categories, and theories before, during, and after interviews with participants as well as during transcription and data analysis. For example, Charmaz (2014) suggests that researchers ask themselves the following questions in each stage of data collection, analysis, and writing to reveal their own preconceptions: “How does my coding reflect the incident or described experience? Have I created clear, evident connections between the data and my codes? Have I guarded against rewriting [participants’ words]” (p. 160). I revisited these notes throughout the research process to keep myself aware of my own assumptions. Engaging in reflexivity ultimately keeps any preconceptions in check and limits theories that are not grounded in the data from emerging during the analytic process (Charmaz, 2014), including assumptions regarding participants’ rural experiences.

Reviewing my reflexive notes and engaging in reflexivity while reading and analyzing data allowed me to assess whether I was gathering rich and useful data pertaining to my research topic, and helped me find more effective interview questions that better addressed my research questions. For instance, when a participant mentioned that it was common to have strict parents in rural towns, I explored this factor in

subsequent interviews, and, to do so, I reflected on the most effective ways to bring up this issue with upcoming participants so as not to influence or bias data collection and analysis.

Although it is important to gather rich data, doing so can be emotional for participants if the topic or question is a trigger for a difficult event or circumstance. Therefore, I also endeavored to engage in reflexivity about the interviews to recognize whether I was pushing participants beyond their comfort level. For example, when a participant revealed that she had been through a difficult relationship, which affected her current decision not to have sexual intercourse, I was careful to assess whether asking her more questions about this relationship would add to the richness of the data. In this case, this participant had already discussed her relationship at length and moving on to a different question to gather more information on other topics, I reflected, would more effectively and sensitively advance the richness of the data.

### **Quality Considerations**

To facilitate the quality and trustworthiness of my study, I incorporated Charmaz's (2014) four quality criteria into this study: credibility, originality, resonance, and usefulness. Credibility of research is the acceptance of the research through independent assessment by a reader based on the provision of sufficient evidence for the claims made (Charmaz, 2014). The criterion of credibility is achieved when the researcher has familiarized herself with the research topic and has gathered sufficient data (Charmaz, 2014). Charmaz (2014) defines sufficient data as data that provide a full picture of the topic at hand and a strong foundation for analysis. Gathering sufficient data entails going beyond surface understandings, and searching for multiple views that allow for comparisons to be made. I attempted to achieve this criterion by conducting an extensive literature review of my research topic, practicing my interview skills with colleagues, and developing research questions that delved deeply into the subject matter. Conducting theoretical sampling also allowed me to gather data from varied perspectives and to gather rich data from prolonged conversations with participants to elaborate understanding of the categories constructed. The criterion of credibility was further

achieved through regular meetings with my supervisor and committee members to review the nature and comprehensiveness of the data, my interview techniques and questions, and analysis procedures and findings.

Originality of research is the refinement of current research (Charmaz, 2014). The criterion of originality addresses whether the research offers innovative insights and an elaboration of current ideas found in the literature (Charmaz, 2014). Current rural women's health research exists but no Canadian research thus far has focused on rural female adolescents and their sexual decision-making. As my research questions have rarely been examined in other studies, concepts and the working theory constructed in my study will significantly add to the current body of knowledge by shedding light on the ways that rural life affects female adolescents' decision-making regarding sexual intercourse and their reproductive health.

Resonance is the "fullness of the studied experience" (Charmaz, 2014, p. 337). The criterion of resonance is met when analytic categories represent the complete gathered data (Charmaz, 2014). I attempted to achieve resonance by adhering to constructivist grounded theory guidelines, such as theoretical sampling, which ensured that categories were fully elaborated and refined including many participant viewpoints. Categories were constructed between participants and myself based on all of the information collected during the interviews, and from field notes and memos.

Lastly, usefulness of research is defined as whether it contributes to current knowledge and to creating a better world. The criterion of usefulness is ensured when research seeks to address an existing knowledge gap (Charmaz, 2014). Since much of rural women's health research has focused on maternity health care services and has overlooked pregnancy among rural female adolescents and their perspectives on sexual decision-making, my research serves to fill a gap regarding this topic. Through publications and presentations, findings from this research will contribute to the current literature and help to create a better world through informing health care practices and sexual health promotion initiatives.



## **Summary**

In this study, the constructivist grounded theory methodology was used to explore rural female adolescents' decision-making regarding sexual intercourse and their reproductive health. Using theoretical sampling, eight participants, ages 16-19, were selected to each take part in an interview with me, and four of these participants also were interviewed a second time to verify and elaborate on constructed concepts and relationships. Data collection and analysis included both field notes and individual interviews in person and over the telephone. I analyzed the data for emerging themes to construct a theory to understand the participants' experiences making sexual decisions in a rural environment. In the following chapter, the findings from this study are described, and the process of sexual decision-making that participants engaged in is examined.

## CHAPTER 4: FINDINGS

In this chapter, I describe the findings that were constructed throughout the stages of data collection and analysis. I begin by describing the study's participants. Next, I present findings related to the rural context within which the study's constructivist grounded theory is embedded. Finally, I illustrate the sexual decision-making process at play among rural female adolescents in this study, describe the four major influences that emerged from the data and that form this process, and explore how each influence relates to rural female adolescents' sexual decision-making process. These four influences are: personal values and circumstances, family's values and expectations, friends' influences, and community influences. Within each influence, sub-categories are described, and the study's participants' sexual decision-making process is revealed.

### Participant Demographics

For the purpose of this study, I interviewed eight female participants who had lived in rural towns for the majority of their adolescence. Demographic information, relationship status, and brief sexual history of study participants are shown on Table 1. To protect the identity of the study's participants, each participant chose her own pseudonym. These pseudonyms are used in the table below and in all cited comments. Pseudonyms with an asterisk next to their name represent participants who were interviewed twice.

Table 1

#### *Participant demographics*

Pseudonym	Age	Hometown Population	Relationship Status	Interpersonal Sexual Experience
Melissa *	18	830	Casual sex with one partner	Vaginal intercourse, oral stimulation, manual stimulation

Molly	18	2,000	Dating one partner	Vaginal intercourse, oral stimulation, manual stimulation
Cindy *	19	1,100	Single	None
Lizzie	16	1,000	Single	Oral and manual stimulation without intercourse
Robin *	18	5,200	Dating one partner	Oral and manual stimulation without intercourse
Allison	18	985	Single	None
Sally	18	985	Single	Manual stimulation without intercourse
Jenny *	17	9,146	Single	None

## **Rural Female Adolescents' Sexual Decision-Making Theory**

### **The Rural Context**

The process that rural female adolescents experience in sexual decision-making is situated in, influenced by, and influences the rural context. There are four subthemes within the rural context: (1) living in a secluded or isolated area; (2) everyone knowing everyone and everything; (3) growing up in a religious, traditional, and conservative environment; and (4) dating constraints (See Appendix I).

**Living in a secluded or isolated area.** Living in a rural area presents several challenges in the form of seclusion or isolation, which creates distance between rural

female adolescents and the options that may or may not be available to them. In a rural town, houses are spread further apart and there are fewer options for entertainment than in a city. As such, many participants discussed the inherent boredom of living rurally as an adolescent. As Allison joked: *“The number one thing that you would do on a Friday night is go to the grocery store.”* Most participants explained that their high schools contained students from several feeder schools located in smaller towns in their region. Therefore, their closest friends from school could live several towns away and, unless they were able to visit their friends, participants had little opportunity to socialize outside of school. Because of this, participants mentioned spending the majority of their time outside of school at home with their family, which they described as *“tight-knit”* and their *“best friends.”* The demographics of their hometowns contributed to their seclusion and isolation in that there may be few friends to choose from, especially if the town’s adult population is greater than its adolescent population. Similarly, participants explained that there were few male adolescents to date in their hometown.

Participants explained that driving was a requirement for living in a rural setting because most people, services, and activities were located further away. All participants from northern rural towns mentioned that dangerous winter driving conditions may affect whether a rural female adolescent drives either at all or on her own. The same winter conditions may preclude rural female adolescents from walking or biking to their destination. In any rural region, walking and biking long distances is not ideal and may be dangerous options when walking along the side of a highway with no sidewalks and no street lights, and biking, unless directly in town, may involve either busy roads or little traveled back roads. As Cindy explained, *“If you get hurt or something [on a quiet back road], no one’s gonna see you for...perhaps...days.”* Public transit is also lacking in rural towns. Lizzie stated that her town’s buses were on a three-hour cycle, and when she took the bus to health-related appointments, she said that it was an intimidating process because bus routes can be confusing and she did not have an alternate route if she were to get lost. Lack of public transportation can interfere with making or keeping a health-related appointment, as rural female adolescents may not prioritize their health if they are unable to travel safely and independently. Furthermore, there are limited local sexual health services and resources in rural towns, which reduces rural female adolescents’

options to access the services that they may require without relying on some form of transportation.

Living in an area in which driving is a necessity does not allow for last-minute decisions. Due to the high dependency on cars and limited alternative transportation options, participants explained that, before they had their driver's license, they needed to tell their parents where they were going and plan their trip based on a coordination of family members' schedules to ensure that one of them could drive them. Once participants had their driving licenses, they had a bit more freedom but still had to plan to borrow the family's car(s), take time out of their day for a long drive, and have the money to pay for gas. As Melissa explained, "*It's expensive to go everywhere so you kind of think twice about going out before you do.*" Thus, transportation issues can make access to sexual health care or resources difficult in a timely fashion or at all.

**Everyone knows everyone and everything.** Depending on the size of a rural town, it is very possible that community members may recognize each other and/or know each other well. Sally explained that familiarity with community members may also depend on the female adolescent and/or her family's involvement in the community, such as with town events or attending church-related activities. When community members know each other well, it may be difficult for rural female adolescents to keep their sexual or reproductive decision-making private: "*People would be scared to [...] get [...] condoms because they would run into people that they know (Robin).*" Furthermore, Lizzie explained that, in smaller towns, community members may not only know if a rural female adolescent is pregnant, they may also know who they are dating or sleeping with, and who might have a sexually transmitted infection (STI). STIs are also easily passed around in rural towns because, as Melissa stated, "*Everybody's kinda sleeping with the same people.*"

When a rural female adolescent's private life is common knowledge to community members who know each other well, her privacy and anonymity are reduced and efforts to safeguard privacy can disrupt her sexual decision-making if she is trying to safeguard her privacy. Jenny explained that many rural female adolescents have the same

doctor or nurse practitioner and that the likelihood of running into someone they know in the waiting room is very high. She also explained that she and others would feel very comfortable innocently asking why the other person was at the clinic. Participants also mentioned that when the risk of running into someone they knew was high, they were less likely to want to risk being seen purchasing contraceptives, the morning after pill, or a pregnancy test out of fear that the information would circulate. Instead, Melissa explained that: *“People will get that kinda stuff for [...] friends [...] or, um, they’ll go to, like, the next town over instead where you’re less likely to see somebody.”* However, this would only apply in situations in which the rural female adolescent or her friends had available transportation and/or services and resources, such as a pharmacy, sexual health clinic, or health professional, were locally available to her. In this situation, she would have to prioritize which risk was most important to her when making her decision: being seen buying sexual resources, not buying the appropriate resources, or asking a friend to help her out and hoping that the friend keeps it a secret.

Gossip is quite prevalent in rural communities. In fact, both Allison and Sally mentioned that there is a specific restaurant in their town where *“if you want to hear anything about somebody else, that’s where you go [laughs] (Sally).”* Adolescence is a time in which females are still developing, maturing, and learning who they are, and during this time, a judgmental attitude from community members may make them question or feel guilty about their sexual or reproductive choices. Participants also explained that some rural female adolescents who are pregnant may drop out of school because of this type of gossip.

**Religious, traditional, and conservative environment.** All participants explained that their hometowns had a religious Christian presence and that traditional and conservative values were also very common. As Jenny explained: *“There are A LOT of churches around here. And almost everybody goes to a church and they have some [...] kind of, um, religious upbringing [...] to stay abstinent ‘til you’re married.”* Allison similarly identified a connection between high religiosity and conservatism regarding premarital sexual activity: *“My town has eight churches and there are only 1,000 people so [...] it’s a very high religious area up here. Um, and I think that that is a big defining*

*factor to how sexually activity is viewed.*” Furthermore, Sally explained that her town is made of religious families who were raised in an “*old fashioned*” manner and who tend to be stricter with their children in terms of forbidding pre-marital sex.

With religious values at play, rural female adolescents are likely to be more influenced to delay sexual intercourse until marriage or to be judged negatively by community members if they choose to engage in premarital sex. They may also avoid accessing contraception for fear of being found out and identified. Jenny explained that if she decided to become sexually active before marriage, and if her Church community were to find out, she would risk being excluded by her community: “*A lot of times it would be the parents [who] would tell their kids to not talk to me and not go anywhere near me because I’m a bad influence.*”

Adolescent pregnancy, in particular, may elicit judgmental conversations in a rural town and may deeply affect a rural female adolescent’s decisions because of the high religiosity and traditional values related to women’s roles. As Jenny explained, her community would blame the female adolescent for her pregnancy because “*she was the one who engaged in it and didn’t make him wear protection.*” Jenny also said that if an adolescent was pregnant, “*everybody would talk [about it]. There would be people who would stop talking to her, friends that would ditch her, [...] and just a lot of people who would criticize her for her actions.*”

**Dating constraints.** One factor that can affect a rural female adolescent’s rural dating experience is the lack of privacy in a rural setting. Lizzie stated that being alert is part of the rural dating experience because “*you just have to constantly think about who would see what and who would hear what.*” For instance, “*We’d be, like, watching movies [at home] and this little old lady banging on the window, she’s like, ‘What movie are you watching?’ (Lizzie).*” Allison also expressed a similar sentiment regarding dating in a rural town: “*When you’re dating someone, EVERYONE knows that you’re dating that person [...] within the first day.*”

Another factor associated with rural female adolescents’ lack of privacy when dating was the opinions of community members. For instance, Lizzie explained that, “*It*

*made it a lot harder because you had to constantly THINK [...] what is the whole community gonna think of [my boyfriend]?"* This visibility, community interest, and judgment can affect who a rural female adolescent decides to date or engage in sexual activity because she may not feel comfortable being the talk of the town. It was more common, therefore, for participants to struggle to find privacy both in general and for sexual activity. Participants mentioned that the few contexts for sexual activity included the car, their parents' home if they believed they might not get caught, or at parties.

Another factor that participants stated affected dating and sexual decision-making in a rural town was the geographical distance between rural couples. Long distances may impact relationships because there are fewer opportunities to see each other outside of school, more commuting expenses, and issues with available transportation. However, distance can also decrease the opportunities and temptations to engage in sexual activity. For instance, Molly explained that if she had lived in closer proximity to her partner, she would have seen him more often and likely would have engaged in more sexual activity with him. For this reason, participants explained that travel time and distance between dating partners could facilitate a rural female adolescent's decision to not have sexual intercourse.

Participants explained that in towns with smaller populations, there is often a larger age gap between adolescent friends and romantic partners. Furthermore, issues of compatibility may arise when there are fewer options for relationships. Allison explained that her decision not to date *"mostly has to do with the quality of male people around here."* Robin similarly explained that her friends *"would stick with the same person even if they didn't like them because there weren't any more cute boys around."* With fewer partners to choose from, Cindy said that adolescents tended to broaden their age range and that, often, an older male adolescent would date a younger female adolescent but that *"the girls who were dating older guys almost always got pregnant."*

### **Rural Female Adolescents' Sexual Decision-Making Process**

Four factors were identified as influencing the participants' sexual decision-making process, namely personal values and circumstances, family's values and



expectations, friends' influences, and community influences (See Appendix I). However, making sexual decisions in a rural town was not a linear process for participants. Rather, sexual decision-making involved a constant evaluation of their rural upbringing, their particular circumstances related to their community, peer groups, and their personal concerns. More specifically, the core sexual decision-making process that participants engaged in consisted of prioritizing the four influences.

The process of prioritizing involved assessing the influences present in their own lives, evaluating the advantages and drawbacks of each decision, and, finally, prioritizing which influence affected them the most. Each of these influences is embedded in the rural context, which has its own unique characteristics described above. Therefore, while each of these influences can be general influences in and of themselves, they become specifically rural when placed in a rural context, and they influence rural female adolescents' sexual decision-making process in a uniquely rural way. For instance, friends are an influence for all adolescents whether they live in a rural or urban setting. However, in a rural town, admitting to sexual activity to even one friend means risking the rest of the community finding out because news travels quickly and privacy is hard to maintain in rural settings where everyone knows each other.

When a rural female adolescent is making a decision regarding sexual intercourse, she is actively deciding which of the influences is most important to her and prioritizing the influences based on her personal milieu. When competing influences are at play, rural female adolescents prioritize these influences based on which influence is more important to them. For example, a rural female adolescent may feel that her family's secular values regarding premarital sexual activity are more important than her community's religious values because she is closer to her family than to her community, and she may then decide to prioritize her family's influence over her community's influence and engage in sexual activity. Other times, influences coincide with each other and may thus more smoothly facilitate participants' sexual decisions.

The sexual decision-making process is highly personal and also highly specific to the adolescents' circumstances; that is, the size of her community, availability of sexual

resources in her community and at school, her family members, and her peers. As such, the decision-making process is very subjective. Furthermore, while some of the influences are not intrinsically rural and could apply to any adolescent, the general characteristics of living in a rural environment that are described above (living in a secluded or isolated area; everyone knows everyone and everything; religious, traditional, and conservative environment; and limited dating options) influence their subjective decisions. In the following section, participants' specific sexual decision-making processes, as well as their strategies to overcome rural barriers, are revealed.

**Personal values and circumstances.** The subcategories of personal values and circumstances are: (1) assessing personal readiness; (2) maintaining reputation; (3) managing transportation and financial resources; and (4) assessing future goals.

*Assessing personal readiness.* Factors such as participants' values they created and inherited from their upbringing were central to their sexual decision-making process. Participants evaluated personal readiness as especially important for their first experience with sexual intercourse. Assessing personal readiness was a personal and subjective experience for participants, based on their age, availability of a partner, presence of a sexual partner, and personal beliefs regarding premarital sex. Assessing their personal readiness in relation to their boyfriend or sexual partner was also of importance to participants: trusting the person with whom participants were considering sexual activity, and feeling comfortable with that person, influenced their sexual decision-making process.

Parties were mentioned as a common place for adolescents to engage in sexual activity because geographic distance limited adolescents from getting together on a more regular basis and a lack of privacy affected their ability to engage in sexual activity when they did get together. At parties, which were not supervised by adults and often in remote locations further from home, the adolescents expressed having more privacy and autonomy and, if they decided to, were able to engage in more sexual activity than they would otherwise be able to do. This, in combination with impairment of alcohol and/or drugs, increased sexual activity at rural parties. Furthermore, pressure from a boyfriend or

sexual partner affected sexual decision-making significantly. Melissa explained that alcohol and drug use could affect the aggressiveness of male adolescents and their persistence to engage in sexual activity when she stated that: “*I know A LOT of people that have slept with hockey players [because] they’re so [...] persistent. [...] Especially if there’s [...] drugs or alcohol involved, then people just do things that they regret.*”

For some participants, religious beliefs played a significant role in their sexual decision-making, while for others, it did not. For instance, Cindy stated that, “*being Christian, I believe that sex is for marriage.*” Participants who identified as religious explained that their religion played an important part in their sexual decision-making process. They also explained that their family’s religiosity was a major influence for their own religious values and decisions to remain abstinent. If a rural female adolescent is involved in her Church community, this may have even more of an impact on her sexual decision-making. Jenny mentioned her church youth group, for example, emphasizes abstinence and encourages adolescents to delay sex until marriage. Additionally, Melissa explained that if a rural female adolescent grows up in a religious household, she may not have merely learned to delay sex until marriage, but that engaging in sex is a meaningful act between two people in love and that, “*if [sex] becomes about being meaningful, you’re less likely to go to a party and just, like, hook up with somebody.*” Other participants were more concerned with waiting for the right person, and not necessarily for marriage. Participants who identified as non-religious and felt comfortable with premarital sex were raised in a secular household. Thus, family had an important part in forming participants’ beliefs regarding their religion and sexual decision-making, and if these two are in line with one another, they will likely be prioritized over other influences when making sexual decisions.

***Maintaining reputation.*** Maintaining their reputation in a rural town was an important factor for participants to take into account when making sexual decisions. The risk of being judged by their small community for either having premarital sex or being overly sexually active influenced their decisions. Criticisms from community members were especially of concern if participants’ hometowns had a greater population of adults who may be more conservative regarding premarital sexual activity. Melissa expressed

this when she said: “*Where I’m from, like, the people that sleep around have a very BAD reputation [...] and it gets around and, because it’s such a small town, EVERYBODY knows about it.*”

In a rural town, a community member’s reputation can be very difficult to change, and making certain decisions, such as engaging in sexual activity outside of a relationship or out of wedlock, can ruin a rural female adolescent’s reputation. If a rural female adolescent has a reputation for sleeping around, it may be difficult for her to find employment because, as Melissa explained, employers in town would not want to hire a female adolescent who is promiscuous and deemed irresponsible. Participants also explained that there is decreased availability of rural employment and that finding a job in their rural town was highly dependent on their connections, and that when job searching, an adolescent’s reputation is taken seriously. As Jenny stated in discussing job opportunities, “*It’s more who you know than what you know.*” Participants also indicated that they run the risk of not being hired or of being fired from their job due to gossip regarding their reputation.

Being known as a female adolescent who is overtly sexually active, or who has family members who are sexually active, can cause loss of friends if other parents decide that she might be a bad influence on their children. Lizzie mentioned that some of her friendships were ruined when her older sister became pregnant at age 16 because her friends’ parents assumed that Lizzie would end up in the same situation and would be a bad influence on other children. Lizzie explicitly stated that: “*When my sister first got pregnant, um, we were shunned by a lot of [...] the town.*” In this case, Lizzie prioritized maintaining her reputation by deciding to postpone sexual intercourse.

***Managing transportation and financial resources.*** Participants lived in isolated locales, and driving was a necessity. Thus, participants applied for their driver’s licenses as soon as they could. As Melissa explained, “*You can’t get ANYTHING. [...] Nothing’s accessible to you. [...] So everything has to be driven to.*” Before the age of 16, participants relied on family members driving them everywhere, including health related appointments. However, having a driver’s license did not ensure their access to a vehicle,

as they often had to share the family car(s). Therefore, if participants wanted to access a sexual health clinic or a health practitioner in order to go on birth control or have an STI or pregnancy test, they would likely have to tell their parents to either have the parent drive them or secure access to a car to drive themselves. This is problematic for rural female adolescents who do not feel comfortable telling their parents about their sexual health appointment, decisions, or activities, and their priority to access sexual health services might change.

In addition to managing access to a vehicle after having received their driver's licenses, participants stated needing the financial resources to pay for gas to get from place to place, whether it was the pharmacy, health clinic, or variety store to buy contraceptives. This was especially the case if they wanted to drive to a different town to avoid being recognized by their own community members while buying these items. Furthermore, if they wanted to pay for condoms, monthly birth control pills, the morning after pill, or a pregnancy test without their parents knowing about it, they would need to hold a part-time job and manage their finances to go towards these expenses.

If a rural female adolescent either comes from a family that cannot afford such expenses, does not feel comfortable going to her family for financial help regarding her sexual health, and does not have a part-time job to help finance these purchases, she may not have many other options to take control of her sexual health and she is at a higher risk of pregnancy if she is sexually active. Furthermore, a rural female adolescent's personal values may be undermined by her family if they do not want her on birth control, which further increases her risk of pregnancy due to influences out of her control.

***Assessing future goals.*** Participants' future goals had an important influence on their sexual decision-making. Participants had clear goals in mind: those who were still in high school wanted to graduate from high school and attend university and those who were in university wanted to graduate from university and find a job in their career path. Some wished to have a family but not until they were out of school and financially secure. Preventing pregnancy was a specific concern for participants because they wanted to wait until they had finished their education and were settled in future careers. As Molly

explained: “*It would be a lot longer [after pregnancy] to try to finish your degree if you EVEN went back to it.*” Robin observed that many rural female adolescents who get pregnant “*have not gone to post secondary education [and] some of them haven’t even [...] graduated secondary education.*” As such, they end up with fewer employment opportunities and life choices. While pregnancy can result in a rural female adolescent in high school or university postponing or ending her education early, it can also be challenging to have the resources to raise a child at that age. Allison explained that, while it is possible to be a great parent in your adolescent years, and she knows several rural mothers who were parents as adolescents, it makes the process more difficult.

**Family’s values and expectations.** Four subcategories were part of this theme: (1) spending the majority of time with family; (2) family members’ attitudes towards sex; (3) negotiating family’s rules; and (4) avoiding family disappointment.

*Spending the majority of time with family.* A rural female adolescent may be more influenced by her family in making sexual decisions because she may spend more time with, and be closer to, her family than an urban female adolescent might be. For instance, after having moved to a large city for university, Allison discovered that “*apparently, until now, everyone else [urban adolescents] has NOT been spending time with their family!*” Because of both the proximity and tight-knit nature of a rural family, a rural female adolescent’s family’s values and expectations might play a significant role in her sexual decision-making. For example, Melissa explained that: “*There’s a lot of people who are really close with their families and if [...] [their families] would think badly of a decision like [...] having sex randomly [...], you’re less likely to do it.*”

However, time spent with family does not necessarily mean that the family is close, consulted, or sought out regarding sexual decision-making. For example, Sally mentioned that she spent a lot of time with her family but never felt close enough to them to talk to them about sex. Jenny also explained that it is one thing to spend a lot of time at home and another to spend a lot of time with one’s family. Thus, the nature and quality rather than the quantity of time spent with their family affected participants’ decisions to

talk to their family about sex or to be affected by their family's values and expectations regarding their own sexual decisions.

*Family members' attitudes towards sex.* Family members' openness regarding sex affected whether participants would be likely to approach them for help with relationships or with sexual health related questions and concerns. Participants explained that parents who were approachable regarding sexual discussions assured participants that they were a resource because they preferred that their daughters be educated about sexual health and remain informed and cautious with their sexual decisions. Participants whose family remained approachable preferred talking to their mothers out of all family members. However, they were reluctant to broach discussions of a sexual nature unless, as Molly explained, they "*had problems or [...] a serious question,*" such as pregnancy or a medical concern that might warrant the need for birth control or treatment. This reduced their likelihood of obtaining sexual information from their most accessible resource in their rural town: their parents. Some participants came from families that did not discuss sex. The topic was unmentionable in Cindy's family so much so that even the word sex was not used. Similarly, Sally explained: "*My family [...] would NEVER give us information on [sex]. [...] That was such a taboo subject.*" Sally further explained that if she were having relationship issues, her parents would "*never even be an option*" even though she wished they could be.

The marital and sexual history of family members affected participants' sexual decisions. In some cases, participants wished to emulate their parents' marriage. For instance, Cindy's most important future goal was to get married and have a family because her family and her faith placed marriage and family as the most important goal for her to achieve. In other cases, participants wished for a different future for themselves than that of their family. For instance, Lizzie's older sister had twins at the age of 16 and her other older sister was pregnant at 19 years of age. Lizzie mentioned several times that, even though her family and community expected her to also be a mother in her adolescence, she wished to postpone pregnancy until she was settled in her career and future relationship.

Family marital and sexual history can also have an effect on the way that children are parented or raised. Sally's mother, who had been an adolescent mother herself, was strict with her daughters so as to prevent their own chances of an adolescent pregnancy. However, Sally felt that her mother was too over-protective and that she would likely not be as strict with her own future children. She also felt that her mother's parenting was hypocritical because the standards that her mother held to her daughters were not the same as those that she had once held to herself: "*When she found out that my sister had had sex for the first time before she was married, it was, like, a HUGE deal.*"

***Negotiating family's rules.*** A rural female adolescent's family's rules can impact her sexual decision-making process by influencing her ability to make her own decisions and by limiting her options. Her privacy when engaging in sexual activity may be reduced due to both the nature of her rural environment and her parents' rules. Lizzie recounted that, when her boyfriend was in her room while her mother was home, they had to leave the door open, and the lights on with no loud music playing. Melissa also remembered that her "*parents really wouldn't leave us home alone for the longest time.*" While Robin was allowed to see her boyfriend, her mother's rules almost ended their relationship for some time: "*It came to a point where he broke up with me because my mom was so controlling [...] of me and became controlling of him.*"

Although Melisa's parents let her attend parties, they never let her sleep over at other people's houses because they knew that those spending the night had a higher likelihood of engaging in sexual activity. Melissa said that: "*My mom would always insist [on] picking me up. [...] And I had friends who would like stay over at parties but those were the people that always ended up sleeping with people because they stayed over.*" In this situation, Melissa's parents both limited and gave her the freedom to make her own sexual decisions while she was at parties by placing rules around her attendance of parties. As difficult as it may have been for her while she lived at home, Robin appreciated her mother's strictness in the end: "*In a way, I am thankful that she was very strict. [...] I never really realized why she was strict until, like, I realized that there was that part of town where [adolescent pregnancy] happens.*"



***Avoiding family disappointment.*** Many participants mentioned that their decisions to either not engage in sexual activity or to avoid telling their parents about their sexual activity involved wanting to avoid disappointing their family. For instance, Cindy explained that, when her family referred to people living together before marriage as “*shacked up*,” it was a clear sign that it gave premarital sex a “negative connotation” and that “*You don’t wanna do something that’s negative.*” Similarly, Jenny, who was also raised not to engage in premarital sex, said that if she had decided to engage in sexual activity before marriage, “*it would be very devastating*” to her parents and that “*they would cry over it and pray for me a lot.*” Thus, in a rural environment in which family closeness is regarded highly and in which families spend the majority of their time together, participants explained that disappointing their family would be particularly difficult and meaningful, and priority would be placed on avoiding family disappointment.

### **Friends’ influences.**

There are four subcategories within the influence of friends: (1) friends’ views on adolescent sex; (2) preferring to talk to selected friends about sex; and (3) attending rural parties.

***Friends’ views on adolescent sex.*** Participants’ most immediate friend groups tended to have similar interests and values regarding adolescent sexual activity. For instance, most of Molly’s friends were sexually active but they engaged in safe sex because their primary concern was an uninterrupted education, and this was Molly’s primary concern as well. Jenny, on the other hand, was not sexually active and neither were her closest friends. Participants’ friend groups also shared similar activities, whether it was Sunday school or youth group get-togethers with Jenny’s friends, extra-curricular musical theatre practice for Robin, or friends who also attend rural parties, such as Melissa’s friends. Jenny stated that her church friends were more of an influence on her decisions regarding sexual activity as compared to her friends from school because of shared values and increased time spent with one another. Furthermore, Molly explained that having friends who were sexually active before her normalized adolescent sexual

activity for her, and that this affected her personal readiness to have sex at a younger age than she had originally planned because it “*changed some of [her] thoughts.*”

***Preferring to talk to selected friends about sex.*** Participants noted that female adolescents who live in rural areas may not have many people they can talk to about sex unless their family and friends are open to such discussions. Participants mentioned that they considered their friends as resources, especially if they came from families that did not discuss sex at all. As Sally explained: “[*Friends were*] *how I found out what sex WAS! I didn’t know ANYTHING from home.*” Similarly, Jenny explained that, “*I would talk to [my mom], um, about [relationship issues] but [...] I would sooner go to a friend about some kind of sexual issue.*” Jenny explained that, as much as her friends may criticize her for her decisions, her friends’ criticisms would be less judgmental than her parents’. This was a common decision among participants who prioritized talking to their friends about sex over their families.

While friends were both resources and soundboards for participants, they could not always be trusted with private information. This was an important decision-making concern for participants because of the speed and expanse at which news travels in a small community and its effect on reputations, employment, friendships, and other areas of life. Rural female adolescents in this study often found themselves striking a fine balance between being overly sexually active, thereby risking ruining their reputation, and making sure they were engaging in safe sex or no sex so as not to ruin their reputation. Avoiding criticisms from peers was also a priority mentioned by participants that affected both participants’ sexual decision-making and their ability to find a friend who would be supportive rather than critical of their decisions.

***Attending rural parties.*** Parties in rural towns in this study were often located in isolated areas and were not supervised by adults. In general, parties were considered a convenient place to engage in sexual activity especially when spending the night at the party and the likelihood of parents finding out is low. However, participants explained that rural female adolescents who decided to engage in sexual activity at a party might be

making a decision in the moment that they are unable to prepare for ahead of time. A sexual decision at a party is also potentiated by alcohol and/or drug use.

Participants' decisions to attend parties were based on their peer group, their parents' rules, and their own interests. To those attending, parties were one of the few social opportunities available to the rural participants due to otherwise limited social venues and opportunities in small rural towns, as Cindy explained: "*there's not as much entertainment [...] in the more rural areas.*" Jenny clarified that those who get invited to parties tend to be more popular and that popularity, in part, is due to parents allowing their adolescents to attend parties. If rural female adolescents do not have their parents' permission to attend a party, they cannot easily sneak out and walk over, as they might be able to in a city; they would need to secure a ride. Melissa perceived that parents who grew up in a rural area themselves are aware of the sexual activity at parties, and allowing their children to attend is, in a way, giving them the freedom to decide for themselves whether they want to engage in sexual activity or not.

As revealed above, social interactions with friends of different ages were common because there are fewer people in general in rural areas. Participants noted that it was not unusual, therefore, for there to be a significant age variance at a rural party and to have younger adolescents engaging in sexual activity with older adolescents who may be more sexually experienced. As Melissa noted: "*You get to know all the different age groups and then everybody becomes your friend. So, like, you party with your friends.*" Robin recounted that one of the biggest events in elementary school was a dance where most people started to drink alcohol because older students or students who had dropped out of high school would sneak in to the dance and bring alcohol. The dance was located in a town ten minutes from hers with a population of about 1,000, so "*in order for [the party] to be successful [...] they really had to widen the age group.*" This same dance was also "*very loosely chaperoned [by adults]*" and was known to be a party where adolescents engaged in sexual activity. Thus, participants posited that much of the sexual activity at parties was due to both the alcohol available to them and to the boredom and limited social opportunities of living in a rural town.

### **Community influences.**

The four subcategories within community influences are: (1) experiences with adolescent pregnancy; (2) assessing community supportiveness; (3) limited local access to sexual resources in town or at school; and (4) sexual education in rural schools.

*Experiences with adolescent pregnancy.* Every participant had known several females who had experienced an adolescent pregnancy, whether a sister, mother, friend, or acquaintance. Marrying and starting a family at a young age was also common to participants. For example, Lizzie mentioned that, while her town had few teenagers, it had many young adults starting families at around 19 and 20 years of age. Robin posited that many older adolescents and young adults get married and start families at a young age because there are limited dating options in a rural town and “*they think that they won’t be able to find anyone else.*” Furthermore, it was not unusual to have parents or parents’ friends who were adolescent parents themselves.

Participants explained that it was also not unusual for a rural female to become pregnant during her adolescent years, while still in school, as young as in grade seven, and sometimes by an older male adolescent, especially with the amalgamation of junior and high schools due to depopulation and school closures. Cindy stated that, “*I believe at one point there was 22 girls in my school who were pregnant. [...] It wasn’t unusual to be a [...] high school student with a [...] child.*” Seeing other rural female adolescents’ pregnancy experiences influenced participants’ decisions because they saw the difficulties that these young women endured, including dropping out or staying in school amidst gossip, struggling to raise their child with little resources, or having to give their child up for adoption. Having heard or witnessed these types of experiences was a strong motivator for participants to engage in safe sexual intercourse or to postpone sexual intercourse until marriage or a serious relationship. Cindy recounted her friend’s experience, which greatly influenced her decision not to have premarital sex: “*I had one friend who was [...] 14 I think when she first became pregnant. [...] Her daughter got taken away and I...see a lot of pain from that.*”

***Assessing community supportiveness.*** Participants had mixed feelings regarding the support they felt from their community with regards to their sexual decision-making. They explained that, in some ways, they felt that community members were not supportive of rural female adolescents' decisions to engage in sexual activity. For instance, Allison explained that, even though she did not go to a Catholic school, she still found that "*it was a struggle to get the high school to stop teaching abstinence as a sexual education program*" due to the high religiosity in her town. Allison went on to say that it would be easier to make safe sex decisions if the topic were openly talked about.

However, while some adults in rural communities remain "*old fashioned,*" Sally said that times are slowly changing. She explained that more and more parents do not have a problem with safe, premarital adolescent sexual activity: "*You still do hear of a lot of people [...] saying how [adolescent sexual activity is] wrong but, at the same time, I hear [of] a lot [...] of parents who will go and buy their kids birth control.*" According to participants, these parents also tend to be open to their daughters being on birth control, and they understand that adolescents will likely engage in sexual activity, so they prefer that they be safe.

***Limited local access to sexual resources in town or at school.*** Participants noted that rural towns are often lacking in health practitioners, pharmacies, and stores that sell contraceptive measures, such as condoms. Depending on the resources available in a particular rural town, sexual health resources at school can sometimes be the only sexual health resources available to rural female adolescents due to the distance of health services and health services geared towards an older population. Each participant had varying levels of sexual health resources in town or at school, for example a guidance counselor, community health nurse, sexual health nurse, or a combination of these three.

Having access to a sexual health nurse at school was not always helpful to rural female adolescents. Cindy's high school had a sexual health nurse available to students but students rarely accessed this service because the office was not easily accessible anonymously as it was "*down a hall [that] [...] was an off-branch of the main hall.*" Cindy also thought that most students did not access this service because their only

chance to do so was during their lunch break, and this was also their only time to socialize with friends. Students likely did not want to spend their only break from class with the nurse or they did not feel comfortable telling their friends the reason they were not spending lunch together.

In comparison, Jenny's school had a sexual health nurse who was available every Tuesday and her town also had a medical centre within walking distance from the school. While students who did not live directly in town may not have been able to visit the clinic on weekends, they could do so after school or on Tuesdays at school. Students making sexual health appointments at school were ensured anonymity. Even though the health unit, which included a guidance office, was located across the main hall, other students would not be able to know if the appointment was for guidance or sexual health. In addition, if the appointment was made during class time, students would not be penalized for missing class, as they might be if they were to make an appointment outside of school, and parents would not have to know that an appointment had been made or that class was missed. The opposite was true for Lizzie who had to miss school in to commute by bus to her health appointments because she did not have a nurse available to her at school.

Participants explained that students were also highly unlikely to make a sexual health appointment at school, or even collect condoms or pamphlets with information, if there was any risk of being seen and made fun of. Melissa explained that, if other students saw them, a rumor would immediately spread about the fact that she is pregnant or has an STI. Both Lizzie and Sally spoke of condoms and sexual health pamphlets made available to students but that no one risked taking them because condoms were handed out in the main hallway and pamphlets were located outside the guidance counselor's office, which were both highly visible locations. Thus, while some schools provided resources to their students, such as condom distribution and/or sexual health nurse availability, they did not ensure their students' privacy, which was a prime concern for participants and their friends.

*Sexual education in rural schools.* Participants discussed the benefits of sexual education for making informed sexual decisions. However, the way that sexual education was provided was often highly dependent on the school's values and articulation of the curriculum. Teaching sexual education was also largely up to the teacher. For instance, Allison's school had a big division between older teachers who tended to be more conservative and religious and younger teachers who tended to be more open-minded. In addition, the physical education teachers at Melissa's Catholic school were required to teach abstinence but often taught them more diverse sexual education instead “[be]cause they knew that people were sexually active [and they wanted to] make sure that people knew [...] how to be safe.”

Allison's school only devoted one week per year to sexual education. Students who may have been absent for one or all of these classes that week due to the weather, their health, or skipping class, may have missed their only opportunity to be educated on safe sexual activity. In addition, the classroom might have been their only opportunity to learn about safe sexual activity if their family would not discuss it. Melissa further explained that many students attended Catholic school in her rural community, not because they were religious, but because it was the closest school to them, and other schooling options were too far away.

Some participants said that their sexual education in school was informative and helpful. Sexual education lessons seemed to be most helpful when they were gender segregated because the class felt more comfortable asking questions. Jenny spoke of the usefulness of her teacher's anonymous question box from which she would answer students' questions the following day, after having removed any inappropriate questions. This method both allowed students to have their questions answered without embarrassment and decreased the likelihood that their online searches would be found in their search histories either at school or at home. Jenny said that her class found this method helpful and that it stimulated many conversations about sex after class among friends, thereby normalizing open discussions of a sexual nature. However, Jenny also explained that her school was an anomaly in terms of its sexual education because, according to her friends at other neighbouring schools, teachers often left the sexual

health unit until the end of the year with the hopes of running out of time in the school year and avoiding the lesson altogether. Participants further explained that it was important that teachers be comfortable with, and informed on, the topic because it was unhelpful to students when they were not.

### **Summary**

As described above, the sexual decision-making process of rural female adolescents is a complex and nonlinear process that involves prioritizing many influences. The influences that participants of this study described as being part of their sexual decision-making process were: personal values and circumstances; family values and expectations; friends' influences; and community influences. Although these influences may be common to all adolescents, they impact the sexual decision-making process by influencing and being influenced by factors that make up the rural context. When influences coincided, they strengthened participants' sexual decisions, whereas when influences opposed each other, participants felt conflicted and prioritized the influence that had the most effect on their personal lives and future goals. In the following chapter, I will discuss this study's findings in relation to the literature on adolescent sexual decision-making and rural health from a health promotion perspective, and I will discuss implications of these findings for education, practice, and future research to enhance rural adolescent females' sexual decision-making.



## CHAPTER 5: DISCUSSION

Findings from this study indicated that rural female adolescents' sexual decision-making involved prioritizing the following influences within a rural context: personal values and circumstances, family's values and expectations, friends' influences, and community influences. Supportive or unsupportive factors in each of the categories in the findings can help or hinder a rural female adolescent's sexual decision-making process. In this chapter, I will discuss implications for the meaning and significance of the barriers and facilitators encountered by participants and relate them back to the literature on this topic. I will also offer recommendations to help promote rural female adolescents' informed sexual decision-making based on their rural context. Study findings can help inform rural female adolescents and their families, communities, schools, and health care providers in addressing the sexual health issues of rural female adolescents. Suggestions offered in this chapter relate to: (1) rural schools, (2) rural communities, and (3) rural female adolescents. Strengths and limitations of this study will also be discussed, as will implications for future research.

### **Facilitators to Rural Female Adolescents' Sexual Decision-Making**

Adolescence can be a pivotal period of development in which positive sexual health practices are established (Curtis et al., 2011). According to the *Ottawa Charter for Health Promotion* (1986), health promotion is defined as “the process enabling people to increase control over, and to improve, their health” (World Health Organization [WHO], 1986). Health promotion seeks to enable people to develop their health through their particular facilitators (Eriksson & Lindstrom, 2008).

Participants in this study noted that facilitators, such as those noted by Vesely et al. (2004), can help a rural female adolescent make decisions that are appropriate for her regarding sexual intercourse and her reproductive health. In Vesely et al.'s (2004) research, sexual facilitators among youth included “non-parental adult role models; peer role models; family communication; use of time (groups/sports); use of time (religions); good health practices (exercise/nutrition); community involvement; future aspirations; and responsible choices” (Vesely et al., 2004, p. 357). More specifically, in the study

described in this thesis, participants identified novel supportive factors in each of the four categories described in the findings that help them deal with sexual decision-making barriers within the rural context. For instance, participants identified distance from a partner or friends as a facilitator for rural female adolescents who do not wish to be sexually active. Participants also claimed that friends can be a facilitator because social interactions with like-minded adolescents can inform and sustain a rural female adolescent's sexual decisions. Furthermore, some participants explained that health professionals in rural areas may be more flexible with appointments and may be more willing to take drop-in patients because they understand the difficulty of traveling to a clinic. Reassurance from parents and ability to consult parents, especially when other sexual health resources are limited or unavailable, can be helpful to a rural female adolescent who is developing sexually and may have questions or concerns that she wishes to discuss.

Participants also explained that health class was considered a facilitator for sexual health information if an informed and dedicated teacher taught it, especially if parents and other rural services and resources were inaccessible. This is in line with the literature that suggests that one of the best ways to help to ensure that adolescents are promoting their sexual and reproductive health is by increasing their knowledge through education (Banister, Begoray, & Daly, 2011). In fact, schools are uniquely able to reach all children, adolescents, and young adults with the opportunity to learn to “make and act upon decisions that promote sexual health throughout their lives” (Public Health Agency of Canada, 2008, p.19). Contrary to the belief of some (Varpalotai, 2005), providing youth with sexual health education does not lead to earlier or more frequent sexual activity; rather, some programs may even delay or decrease sexual activity or increase use of condoms or contraceptives, and reduce the risk of adolescent pregnancy and STIs (Sexual Information and Education Council of Canada [SIECC], 2010). A Canadian study conducted by Shoveller and colleagues (2004) highlight the importance of adolescent sexual education as a means of encouraging their open sexual discussions. In this study, adolescents identified two reasons they felt ashamed to claim or reveal that they are sexually active (Shoveller et al., 2004). The first reason was that they were used to hearing explanations of sex as pathological or associated with disease. The second

reason was due to a silencing of sexual discussions. When sexual discussions are silenced due to rural teachers', school administrators', or community members' discomfort with the topic, rural female adolescents are denied one of the most important facilitators for their sexual and reproductive health: their sexual education. While researchers agree that sexual health education is an important sexual decision-making facilitator, this study highlights that participants themselves also believe in the importance sexual health education and are open to it if it is taught effectively and informatively.

### **Barriers to Rural Female Adolescents' Sexual Decision-Making**

Participants in the study listed several barriers to sexual decision-making in a rural town, which echoed the existing literature on this topic, including limited options and decreased access to sexual health services, information, and health professionals; having to miss school; delayed, untimely, or inability to access sexual health care; distance to services; travel and sexual health resource expenses; accessibility to a vehicle; lack of privacy and anonymity; gossip and reputation; religious and traditional values; and gender expectations. Many of these barriers are in line with rural literature in Canada, the United States, and United Kingdom, discussed in the literature review. Specifically, Canadian research conducted by Shoveller and colleagues (2007) in British Columbia found that certain social and geographical forces can affect sexual health, such as religiosity, transportation difficulties, boredom due to limited leisure activities, limited youth access to sexual health care, social exclusion due to sexual behaviour and/or reputation, and future prospects and goals. While this study is very similar to the one described in this thesis, there are several distinct differences between the two. Shoveller and colleagues (2007) focused their research in one rural town in British Columbia and their findings pertain to the barriers of living in a rural town. They do not list any possible facilitators to for rural youth's sexual and reproductive health. The major difference between the two studies is that the study described in this thesis offers a sexual decision-making theory that includes categories not discussed by Shoveller et al. (2007), such as sexual education in rural schools, experiences with adolescent pregnancy, and family influences.

Canadian research conducted by Kennedy and MacPhee (2006) found that rural female adolescents need sexual health services that they feel comfortable accessing locally and anonymously. Craig and Stanley's (2006) research on rural American adolescents identified barriers to accessing sexual health services, such as high visibility, familiarity, and "the sense of living in a 'goldfish bowl'" in a small town; female adolescents losing their reputation due to the stigma of sexual activity; scarcity of accessible and discreet services; transportation difficulties; and traditional values. In addition, literature from the United Kingdom found that rural adolescents experience embarrassment due to visibility, familiarity, and issues with maintaining confidentiality in their hometowns (Bell, 2009; Docherty, 2010; Elliott & Larson, 2004; and Garside et al., 2002).

Participants also stated that boredom in rural towns can lead adolescents to have sex for recreation, and that rural parties are often the first places that adolescents will start to drink alcohol or try drugs, which can facilitate sexual activity or decrease inclination to use protection. Unanticipated sexual activity at a rural party is especially problematic due to the isolated locations of these parties, the limited stores at which to walk to and buy contraceptives in the area, and the inability to drive to any possible store while inebriated. Furthermore, there is an increased age gap both in general and at rural parties between adolescents due to depopulation in rural area. Thus, temptations to engage in sexual activity may be more prominent in an environment in which friends and dating partners may be older and more sexually experienced.

In addition to overlapping findings of this thesis study and other previous research, participants in this thesis study identified several other rural barriers to sexual decision-making. For instance, they explained that they preferred to see a female health professional for sexual health related appointments. However, with fewer health professionals to choose from in rural areas, participants have less options and may need to go to whichever health professional is available to them. Participants explained that if male doctors are the only option available to them, they may not book a sexual health related appointment or bring up a sexual health concern during a regular health appointment. Conversely, participants felt more comfortable seeking sexual health care

from a female health care provider. In addition, pharmacies, grocery stores, and convenience stores, if available in their hometown, may be smaller and carry less items, including condoms, pregnancy tests, or the morning-after pill.

Participants in this study explained that traditional gender and family roles in their rural environment put the onus on women to take care of children and may blame women for an unintended pregnancy. Similarly, participants explained that if rural female adolescents have a reputation for promiscuous sexual activity, this can affect their job prospects while males' job prospects would likely remain less affected based on their sexual activity or inactivity. This is especially important in rural towns where jobs are not plentiful. Furthermore, an adolescent mother may need a job more desperately to take care of her new family if she does not have the support of her parents or partner. Moreover, as participants in this study explained, although news can travel quickly in any environment, it tends to travel much faster in a small town in which community members know each other well. In addition, the reputation of being a female adolescent who is promiscuous or pregnant is very difficult to reverse in a rural town. As participants explained, this type of reputation is considered negatively and would be wanted to be reversed, but would be difficult to do so due to familiarity of community members. Thus, engaging in premarital sex could lead a rural female adolescent to be isolated in a small community, especially if it is a religious, traditional, or conservative community. It is important to be aware of these barriers to rural sexual decision-making when planning and implementing effective sexual health promotion initiatives for rural female adolescents.

### **Recommendations to Facilitate Rural Female Adolescents' Sexual Decision-Making**

In this section, recommendations will be made to facilitate sexual decision-making for rural female adolescents. Some recommendations come from participants directly and others are based on relevant research. These recommendations will be made for (1) rural schools, (2) rural communities, and (3) rural female adolescents.

## **Rural Schools**

**Adolescent sexual health education.** As stated by the Society of Obstetricians and Gynecologists of Canada (2004), the most important aspect of effective sexual health education programs in schools is that enough time is set aside in class for teachers who are well-trained on the topic and motivated to teach it. However, as participants in this study noted, rural adolescents' access to sexual resources and education may be mere luck, depending on the administration and values of each individual school. Rural communities, due to their traditional and conservative values, are not always willing to adopt comprehensive sexuality education (Haley et al., 2012; Ott, Rouse, Resseguie, Smith, & Woodcox, 2010). Increased religiosity in rural communities can promote opposition to sexual health curricula in rural schools (Blinn-Pike, 2008; Varpalotai, 2005).

Parental opposition to sexual health education in the classroom may cause a health teacher to struggle with balancing provincial guidelines for the health curriculum, students' needs and interests, and respect for community values, which may compromise their students' sexual health education (Varpalotai & Leipert, 2006). However, it is a teacher's responsibility to adapt the provincial curriculum to their classroom, based on the school and community's beliefs and cultural practices (Varpalotai & Leipert, 2006). This is important because, if a rural female adolescent is sexually active, does not have access to information about sexual decision-making, and is unable to discuss safe sexual activity with her family, as some participants in this study experienced, her lack of education will affect her ability to make informed sexual decisions, such as when and with whom to engage in sexual activity. Thus, one recommendation is that sexual education of community members may be equally important as sexual education in school.

Another important aspect of rural sexual health education is tailoring it to the particular rural community being taught. However, today, many schools include students from both rural and urban communities, and teachers sometimes no longer live in the rural communities in which they teach (Varpalotai & Leipert, 2006). Teachers who are

not familiar with the rural community in which they are teaching should become more informed about it so as to properly teach the sexual health concerns specific to that community (Varpalotai & Leipert, 2006). For instance, if there is a higher prevalence of adolescent pregnancy in that school, teachers could make pregnancy prevention the main focus of their sexual health education program.

Teachers who remain up-to-date regarding their youth's culture and needs and the nature of the information on the Internet, may find it easier to incorporate effective and valid websites and information into their curricula (Varpalotai & Leipert, 2006). Having the knowledge of which rural services are available to them, including reputable educational websites and help lines when in person services are inaccessible, would be particularly useful for rural female adolescents. Teachers who work in rural schools that do not allow sexual education, such as Catholic schools, can distribute general health websites that include sexual health information. Furthermore, online course options for adolescent mothers would allow them to stay in school, do school work from home, and still obtain their high school diploma.

If teachers are looking for support in teaching sexual health in class, they may be able to call on a local public health nurse or sexual health promoter to help facilitate the sexual education portion of the curriculum. In fact, adolescents may be more trusting of anonymous health professionals who are not teachers and who they will not see in class afterwards (Quilliam, 2007; Reeves et al., 2006). Rural adolescents may be even more inclined to want an anonymous health professional to be responsible for their sexual health education in class if their teacher is a part of their rural community and knows them well. For example, Blinn-Pike (2008) found that rural sexual health education in the United States was affected by the physical and emotional closeness between teachers and students in rural schools, which can minimize open discussions of embarrassing topics such as sexual health. This embarrassment could thus be mitigated with the help of public health nurses who could co-teach or help teach such classes. It is important to note, however, that while Ontario's public health mandate public health units to provide sexual health programs or services in schools, rural areas may be affected by less in-school support due to travel distance and fewer rural staff in rural health units, which can result

in decreased delivery of sexual health education programs in rural schools (Ministry of Health Promotion, 2010). If public health units are unable to provide in-person support to a rural teacher, they could still provide rural teachers with educational techniques and resources to help them lead informative and less embarrassing sexual health information.

One way to address rural adolescent sexual behaviour and sexual social skills is to increase their health literacy through sexual education. Health literacy is defined as “the degree to which people have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (Ratzan, Parker, & Lurie, 2003, p. 147). Health literacy is a form of empowerment that allows an individual to take control over her own health by seeking out information that is appropriate for her own particular contexts, such as a rural context (Kickbusch, 2001). Based on participants’ explanations, improved sexual health literacy for adolescents living in a rural environment could include knowing where to anonymously seek out accurate sexual and reproductive health information, effectively communicating sexual and reproductive needs with rural health professionals, and making knowledgeable decisions about their sexual and reproductive health.

**Adolescent sexual health care in rural schools.** Health literacy is, of course, limited by adolescents’ access to health care providers in rural areas. Health professionals who are near or at school, participants claimed, could be a facilitator if they offer sexual health services that ensure the patient’s anonymity. In Varpalotai’s (2005) study of a Wellness Centre, which offered comprehensive health services, including sexual health services, in a rural secondary school in Southwestern Ontario, these services were otherwise unavailable in this rural town and adolescent pregnancy was a major concern among this population. Varpalotai’s (2005) research suggests that, when provided with confidential access to health professionals, rural female adolescents are likely to take advantage of these services to gain more information on sexual health. They may also consider options that they may not have previously considered. For example, before the Wellness Centre was established in this school, most pregnant adolescent females tended to leave their school and community. After the Centre was established, some pregnant adolescents continued their education until they gave birth, and some even returned to



school afterwards. Confidential sexual health services at school are thus beneficial for rural female adolescents.

Availability of adolescent sexual health care in rural schools would be particularly useful in rural communities because they would allow for increased access to health care providers, information on sexual health, and resources such as condoms and birth control (Craig & Stanley, 2006; Varpalotai, 2005). This is especially important in towns where rural female adolescents' access to a health professional outside of school is challenging. However, participants in this study explained that, while having access to sexual health services in rural schools can be helpful, the type of resource provided is also important. For example, participants explained the benefits of a public health nurse over a sexual health nurse at school because with the former, other students would not be able to know what health service was being sought and rumours would less likely spread. Participants also explained that it is easier to bring up a sexual question or concern with the nurse as an aside to a different health concern rather than making an appointment specifically about a sexual concern. Thus, if a rural school's clinic were to have a public health nurse, they should still make it clear that they offer all type of services, including sexual health. This role for public health nurses could significantly enhance information access and decrease anxiety for rural female adolescents seeking anonymous and reliable sexual, reproductive, and other health concerns. Furthermore, public health nurses who address health generally, including sexual health material, may be more accepted and possible in schools that do not offer sexual education.

Rural schools are encouraged to work with the local public health unit to have a public health nurse visit the school on a regular basis in order to provide health services to students. When sexual health appointments are not kept anonymous or are unavailable to students at school, rural female adolescents might have to skip class to make an appointment elsewhere or they may not be able to access sexual health resources at all. Furthermore, if rural female adolescents do not tell their parents about their health appointment outside of school to receive their permission to skip a class, their school might notify the parents of the student's absence, thereby reducing the student's privacy. Thus, sexual health promotion strategies need to be more available to rural female

adolescents at school but also need to acknowledge the relevance of factors such as stigma and gossip in a small town.

## **Rural Towns**

**Adolescent sexual health care in rural communities.** Systematic variables regarding rural sexual health care access need to be addressed through local clinics. For example, due to distance, transportation, and anonymity issues, services outside of school need to be accessible after school and on weekends, not just during business hours when adolescents are in school. In addition, rural female adolescents would benefit from enhanced access to female health practitioners (community health nurses, nurse practitioners, and physicians) because, as participants in this study confirmed, they may be more comfortable talking to female health providers about reproductive issues (Leipert, 2005).

As participants in this study noted, sexual health services also need to ensure confidential access to rural female adolescents without family involvement. Craig and Stanley (2006) suggest that rural professionals and sexual health services need to make it clearer to adolescents that their services are confidential, for instance, with the posting of a sign to assure adolescents about the confidentiality of services. Similar to the study described in this thesis, rural female adolescent participants in Nova Scotia viewed traditional health care services as too risky for their use as confidentiality may be broken and parents may be informed of their sexual health concerns (Kennedy & MacPhee, 2006). An alternative resource recommended by Kennedy and MacPhee (2006) is the Youth Health Centre, which offers health services to young people without the need for parental consent. Currently, Youth Health Centres are available in rural and urban schools in the Maritimes but are not currently available in most rural communities in Canada (Kennedy & MacPhee, 2006). Of course, the cost of such services may be a dissuading factor; however, the cost of not providing sexual and reproductive health services may have an impact on future health and social costs (Kennedy & MacPhee, 2006). This discrepancy must be assessed by each individual community and by provincial governments, which are responsible for health care in Canada.

**Church-based sexual health promotion.** Some participants in the study noted that the Church was a resource for youth activities. The Church can also be a resource for rural populations who have compromised health resources (Plunkett & Leipert, 2013), such as rural female adolescents. It can provide church-led activities, meeting rooms, or established groups to facilitate health promotion in their parish (Buijs & Olson, 2001; Campbell et al., 2007). Faith community nurses, who are registered nurses who work within a faith community, are another means for providing health care whose churches are a significant presence and where these nurses can be afforded if the church has sufficient funds to employ them (International Parish Nurse Resource Centre, 2009). Small rural parishes may not be able to afford faith community nurses or may need to share the cost of one nurse.

Although the Church may be inclined to support the health of rural women, their values may not be aligned with a health promotion strategy that includes sexual and reproductive health care for rural female adolescents (Campbell et al., 2007). Several participants in this study noted both the positive and negative influence of the Church and religious values on their sexual decision-making as well as the tangible religious atmosphere in their rural towns. While some rural female adolescents may feel comfortable with and capable of adhering to religious beliefs and teachings regarding sexual activity, others may not agree with these tenets. Furthermore, it may be more difficult to adhere to abstinence, which may be a Church-based value, due to factors such as peer pressure, especially in a town where there are few friends from which to choose. Health and religious communities must therefore work together to help rural female adolescents make effective decisions regarding their sexuality that reflect and support the values of rural female adolescents. This collaboration between health and religious staff could include the education of ministers on adolescent values and sexual and reproductive health choices and options to help rural female adolescents make informed sexual decisions that will not compromise their future or put themselves at risk.

**Family-based sexual health promotion.** Due to the lack of services and resources in rural towns, families can be an immediate resource for sexual health information if the family is accepting of discussing sexual health openly and

informatively and is knowledgeable themselves. Such open sexual discussions are highly dependent on the family, as participants in this study noted. However, the impact of family as a sexual health resource can be very useful to rural adolescents. For instance, Wang, Simoni, & Wu (2006) found that family connectedness and adolescents' having high aspirations and goals for the future can delay the onset of sexual activity among rural female adolescents. Similarly, Aspy, Vesely, Oman, Rodine, Marshall & McLeroy (2007) found that parental communication regarding sex influenced adolescents' sexual decisions. For example, if parents taught their children how to say no to sexual activity with their partner and to set clear rules about sexual activity, adolescents were more likely to delay sexual intercourse. Among adolescents who were sexually active, they were more likely to use birth control if their parents had taught them how to use it and how to have safe sex. This demonstrates that some parents may have the ability to have an effect on children's sexual behaviour decisions and that they can be encouraged to act as resources for their children growing up in a rural environment (Boyas, Stauss, & Murphy-Erby, 2012).

However, discussions about sex between rural adolescents and parents are characteristically infrequent (Boyas et al., 2012). When they occur, parents tend to talk to their children about sex as a general topic but do not talk about specifics, such as how to avoid getting pregnant (Boyas et al., 2012). One option to encourage open family discussion about sexual activity and relationships is a rural nurse's family session that could educate parents on sexual health, how to approach this topic with their children, and adolescent perceptions regarding confidentiality and sexuality (Kennedy & MacPhee, 2006). Such education could also focus on changing rural attitudes on gender roles regarding sexual activity and pregnancy. Much like the study described in this thesis, Reeves et al. (2006) found that adolescents are more likely to ask friends and family questions about sex rather than health professionals, so it is important that services provide information to family as well as friends. Adolescents should also be encouraged to discuss relationship and sexual health concerns with their parents if their family is open with this topic. If adolescents are embarrassed to ask their family questions about their sexual health, which was the case for some participants in this study, they may be missing out on one of their more valuable and accessible resources until their situation

becomes one that needs to be resolved rather than one that could have been prevented, such as an unplanned pregnancy. It is therefore important to educate both families and adolescents on the value of open sexual discussions, especially families who tend to hold traditional values and beliefs.

### **Rural Female Adolescents**

**Rural female adolescent sexual health promotion.** The above recommendations address delivery of sexual health information and care to rural female adolescents. Another important aspect of sexual health promotion involves empowering rural female adolescents. For instance, it is important to help rural female adolescents determine or identify their values regarding sexual activity. Some participants in the study explained that it was often more comfortable to have non-co-ed sexual education sessions at school. Although it is important for both males and females to have an understanding of each other's sexual and reproductive experiences, and to encourage such dialogue between the two sexes, additional female-specific sessions that involve empowerment regarding sexual decision-making would be very useful. Empowerment of rural female adolescents' sexual decision-making process would involve increasing their control over their decisions through education and knowledge of how and where to access the sexual health care, resources, and information that they need. These sessions could be led by any of the above individuals and institutions, such as teachers, peers, family, schools, health practitioners, health promoters, or churches.

**Telehealth services.** Telehealth has become an increasingly popular method of health care in rural areas due to its ability to increase health care access to isolated rural individuals and to lower travel costs for health care (Gagnon, Duplantie, Fortin & Landry, 2006). Thus, telehealth has the potential to be used with rural female adolescents as well. Research on telehealth in rural areas of Quebec has found that telehealth allows for better access to specialized services in rural and remote areas, better continuity of care, and more information available to them (Gagnon et al., 2006). More specifically, a research study on receiving medical abortion services as facilitated by telehealth in rural Iowa found that both patients and health care providers were pleased with the advantages of less travel for both patients and physicians and more options for locations and

appointment times as compared to in-person appointments (Grindlay, Lane, & Grossman, 2013). Moreover, participants explained that they felt that their appointment over telehealth was just as, if not more, secure than an in-person appointment (Grindlay et al., 2013). Another research study examining rural Australian youth's perspectives on a telehealth sexual health consultation found that most youth preferred the telehealth consultation over in-person physician consultation (Garrett et al., 2012). Thus, through telehealth, a rural female adolescent could obtain quick and confidential access to a health care professional for sexual health care or information. To make telehealth accessible to rural adolescents, public health units, hospitals, and health care providers will have to coordinate their services. Adolescents would also have to ensure their privacy for their telehealth appointment, which may be difficult for some if, as participants explained, their families spend much of their time together, but may not be as difficult as privately securing a ride to their nearest health practitioner.

**The Internet.** Participants in this study referenced the Internet as an accessible resource for their sexual decision-making. In their research, Tomnay, Bourke, & Fairley (2014) sought to examine the availability and use of health services among rural youth in Victoria, Australia, and to compare the usefulness of in-person versus online sexual health testing and treatment. Younger rural adolescents in this study explained that they preferred the online option because it was more comfortable and they would not have to lie to their parents to get a ride to the doctor's office, while older adolescents who could drive preferred to see a health care provider in person. The Internet helps with protecting privacy and anonymity as it can provide both information and confidential support to rural female adolescents looking to protect their privacy (Campbell, 2005). The Internet can also be used to look up sexual health information and can be used as a confidential source and to answer questions regarding sexual education that may be lacking at school (Campbell, 2005). For families or adolescents who can afford a personal laptop or smart phone, the adolescent would be able to look up this information more privately. For those who are not able to afford it, computers at public libraries or at school can be used as well; however, these are less private alternatives.

The Internet may not provide sufficient, adequate, or reliable information on sexuality, when used on its own (Campbell, 2005; Sutherns et al., 2004). For instance, it can be difficult to navigate and to discern the nature and value of the potentially overwhelming amount of information found on the web, and it can be difficult to make informed decisions with inaccurate information (Varpalotai & Leipert, 2006). Thus, Internet resources should be used in concert with reliable sexual health information from a health care provider or health educator particularly for the population of rural youth.

**Text messaging services.** Text messaging can also be used as a way for adolescents to access sexual health information as well as sexual and reproductive health services, and it has been used successfully among at-risk adolescents in San Francisco (Levine, McCright, Dobkin, Woodruff, & Klausner, 2008). The option of text messaging services with health professionals may be preferable to looking up information on the Internet in rural areas that do not have good internet access. Text messaging also has the potential to provide immediate contact with a health professional, quick answers to a sexual health question, and the benefit of not having to travel for this information.

### **Strengths and Limitations of this Study**

There are several strengths in this study. This study is a contribution to the literature in the field of rural female adolescent health and sexual health promotion by incorporating the views and experiences of rural female adolescents in Ontario, which are rarely included in research. Little rural research focuses on women and adolescents so this research contributes to these under researched populations. Another major strength of this study is that it is one of the first to explore sexual decision-making by rural female adolescents in Ontario. In addition, participants' willingness to share their experiences and insights adds strength to this research.

One of the limitations to this study was that I did not have the opportunity to interview a participant who had been pregnant and/or given birth during her adolescence for her perspectives regarding pre-pregnancy sexual decision-making, such as access to birth control, as well as her experiences with decision-making regarding abortion, adoption, or keeping her baby. One reason for this limitation is that snowball sampling

was considered not effective in this research possibly because interviewed participants wished to keep their participation private given the sensitive topic of the research or because other potential participants did not want to participate. A second limitation was that most interviews were not conducted in the participants' hometowns as some of them had recently moved away for university and other reasons, and other interviews were conducted over the telephone, which limited the researcher's understanding of participants' rural context. As such, some important observational and experiential rural data could have been missed. Given that this study used a qualitative methodology, generalizations cannot be made to all rural female adolescents beyond the context of this study. However, the value and utility of this richly-detailed research is that it may be transferable to other similar populations (Tracy, 2010).

### **Implications for Future Research**

Canada's geography is predominantly rural, yet while Canadian research on rural health is growing, such research remains limited in its scope (Kulig, 2005). To date, the limited research conducted on rural women's health has focused mostly on the theme of rural maternity care (Sutherns & Haworth-Brockman, 2012). As research on rural populations is growing in Canada, rural women, including rural female adolescents, tend to be overlooked, and the factors involved in rural female adolescents' sexuality and pregnancy remain unclear. Therefore, further investigation of barriers and facilitators to sexual decision-making in rural communities is needed. For example, investigating adolescents', teachers' and/or parents' views of sexual education, knowledge of sexual health, and the impacts of adolescent pregnancies in rural communities would help inform relevant sexual education in schools, communities, and families. Such investigations would also help to effectively direct public health policy and public awareness initiatives, such as through public health units.

More specifically, it may be beneficial for future studies to explore sexual health education in rural public schools and rural religious schools, such as Catholic and Mennonite schools. Implemented sexual health promotion initiatives in rural schools and/or communities should also be evaluated regarding their impact on adolescent sexual



decision-making and sexual health literacy. Perspectives from rural health care providers should also be sought for their unique insights regarding sexual and reproductive health of rural adolescents. Furthermore, telehealth and social media research on rural adolescent sexual decision-making and health care would also be useful. Younger adolescent age groups, such as ages 13-16 should also be included to better understand their perspectives and experiences and better tailor rural sexual health promotion initiatives to various age groups' needs. While many of the above recommendations could be assumed to apply to other rural areas in Canada, rural male adolescents, and other rural cultures, such as Aboriginal or immigrant adolescents, it is important that research be conducted with these populations to better understand their rural sexual decision-making experiences and their particular rural needs.

Most of the literature on adolescents' sexual behaviour is not disaggregated for gender or for geographical location (i.e., rural versus urban). While some Canadian statistics on rural adolescents' sexual behaviour is available, they are neither plentiful nor clear. For instance, the statistics on teenage pregnancies in Ontario that are provided by the Ministry of Health and Long-Term Care are only disaggregated by major health units, and statistics specific to various regions and populations, such as female adolescents, including rural adolescent females themselves, are not provided. Thus, it would be useful to have more statistical information about these gap areas.

### **Conclusion**

In conclusion, this study reveals significant, new, and preliminary information about rural female adolescents' sexual decision-making factors that affect them both positively and negatively. It has revealed a gap in both existing rural research and rural adolescent sexual health services. The outlined recommendations are provided to ameliorate rural female adolescents' sexual decision-making experiences and ensure that they are empowered and knowledgeable to make the sexual decisions that are appropriate for them.

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APPENDIX A

STUDY FLYER

 <p>Principal Investigator: Dr. Beverly Leiper, PhD, RN, Western University Co-Investigator: Paulina Ezer, MSc Candidate, Western University</p> <h1>Adolescent Attitudes Towards Sexual Interactions Study</h1>  <p>Are you a heterosexual <b>female</b> between the ages of <b>16-19</b>? Are you from a <b>rural/small town</b>? Single/in a non-committed relationship, we need your help!</p> <p>Researchers at Western University are looking for female teens to participate in 1-2 one-on-one interviews about romantic interactions in rural/small towns</p> <p><b>All information is strictly confidential</b> A Tim Horton's gift will be provided upon study completion</p>	Adolescent Attitudes Towards Sexual Interactions Study Paulina Ezer	Adolescent Attitudes Towards Sexual Interactions Study Paulina Ezer	Adolescent Attitudes Towards Sexual Interactions Study Paulina Ezer	Adolescent Attitudes Towards Sexual Interactions Study Paulina Ezer	Adolescent Attitudes Towards Sexual Interactions Study Paulina Ezer	Adolescent Attitudes Towards Sexual Interactions Study Paulina Ezer	Adolescent Attitudes Towards Sexual Interactions Study Paulina Ezer	Adolescent Attitudes Towards Sexual Interactions Study Paulina Ezer	Adolescent Attitudes Towards Sexual Interactions Study Paulina Ezer
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**APPENDIX B**  
**STUDY BROCHURE**



**Adolescent Attitudes  
Towards Sexual  
Interactions Study**

If you are:

- ✓ Female
- ✓ Heterosexual
- ✓ 16-19 years old
- ✓ From a rural/small town
- ✓ Single/in a non-committed relationship

**We need your help!**

Participation involves one interview.

**All information is strictly confidential.**

A small thank-you gift will be provided upon study completion.

If interested, contact  
**Paulina Ezer**

**Primary Investigators:**  
Dr. Beverly Leipert, PhD, RN  
Paulina Ezer, MSc Candidate



## APPENDIX C

### TELEPHONE SCRIPT

Hi, my name is Paulina Ezer and I am contacting you about the Adolescent Attitudes Towards Sexual Interactions Study that you emailed/phoned about. Do you have a few minutes to talk about this now?

→ **IF NO:** When would be a better time for me to call you back?

→ **IF YES:** I'd like to tell you a bit about this study so that you have all the necessary information before you decide whether to participate. The goal of this study is to understand how rural female teens make decisions about sexual activities and their reproductive health, and also how they see rural factors and circumstances impacting their decision-making process.

If you decide to participate, the study involves an interview with me in the location of your choice where you would feel most at ease. The interview will last approximately 1-2 hours. There may be a second interview later in time for clarification purposes.

When we meet, I will ask you to complete a short socio-demographic form. Then, we will start the interview, which will be audio-recorded for reference during data analysis.

All of your information will be kept strictly confidential. You won't be identified by your name in any records (you will be assigned a participant ID and a pseudonym of your choice that will be used when transcribing the interviews and in the final dissertation). Also, all of these files will be stored digitally and will be password protected.

Do you have any questions about this study or your participation?

Are you interested in taking part in this study?

→ **IF NO:** Thank you very much for your time. Have a nice day/evening.

→ **IF YES:** Before I schedule your interview, I will have to make sure that you are eligible to participate. Do you consent to me asking you some questions to determine your eligibility for this study?

→ **IF NO:** Thank you very much for your time. Have a nice day/evening.

→ **IF YES:** Proceed to questions.

1. What is your age?
2. Do you identify as female?

3. What is your sexual orientation?
4. What is your hometown?
5. What is the population of the town you live in or near/grew up in? How near to the town do you live (if they live on a farm or acreage)?
6. How long have you lived/did you live in a rural area?
7. Are you married/in a common-law relationship?
8. Are you sexually active?
9. Have you ever been pregnant?

**If not eligible:** “Sorry, but it looks like you are not eligible to participate because [reason they are ineligible]. Thank you for your time. Have a nice day/evening.”

**If eligible:** Schedule date, time and location of interview.

## APPENDIX D

### PARTICIPANT INTERVIEWS

Participant Number	Pseudonym	Interview Date	Interview Length (minutes)	Number of Transcript Pages
1	Melissa	October 21, 2013	36	26
2	Molly	October 28, 2013	44	24
3	Cindy	November 5, 2013	44	25
4	Lizzie	November 15, 2013	101	82
5	Robin	December 4, 2013	88	51
6	Allison	December 14, 2013	54	24
7	Sally	December 29, 2013	64	36
8	Jenny	March 19, 2014	77	56
3	Cindy	April 10, 2014	26	12
1	Melissa	April 28, 2014	46	23
5	Robin	June 11, 2014	28	15
8	Jenny	June 25, 2014	36	19

## APPENDIX E

### SOCIO-DEMOGRAPHIC FORM

1. What is your date of birth? (Month/Day/Year) \_\_\_\_\_
2. Where do you live? (please circle all that apply)
  - On a farm or acreage  
What is the distance from your farm or acreage to the nearest centre that you would call “your town”? \_\_\_\_\_ km.
  - In a town  
What is the size of your town? \_\_\_\_\_ (Number of people)  
  
In a city: \_\_\_\_\_
  - Other: (please describe) \_\_\_\_\_
3. How long have you lived there? \_\_\_\_\_
4. How many brothers do you have? \_\_\_\_\_ What are their ages? \_\_\_\_\_
5. How many sisters do you have? \_\_\_\_\_ What are their ages? \_\_\_\_\_
6. Were you brought up in a religion?  
Yes, Which one? \_\_\_\_\_  
No
7. Do you currently identify with a religious community?  
Yes, Which one? \_\_\_\_\_  
No
8. What is the highest level of education you have completed? (please circle one)
  - Grade 8
  - Grade 9
  - Grade 10
  - Grade 11
  - Grade 12
  - 1<sup>st</sup> year University/College
  - 2<sup>nd</sup> year University/College
9. How would you describe your financial circumstances during the past year? (please circle one)
  - I have barely enough to make ends meet
  - I have enough to get by
  - I have a little left over after all my obligations have been met
  - I am quite comfortable
  - I have all I need and more

11. What is your current relationship status?

- Single, not dating
- Casual sex\* (excluding vaginal intercourse) with one partner
- Casual sex (excluding vaginal intercourse) with multiple partners
- Casual sex (including vaginal intercourse) with one partner
- Casual sex (including vaginal intercourse) with multiple partners
- Dating one partner (no sexual activity)
- Dating one partner (with sexual activity, excluding vaginal intercourse)
- Dating one partner (with sexual activity, including vaginal intercourse)

\* *Casual sex refers to sexual activity outside the context of a committed relationship.*

12. Which sexual activities have you engaged in? (please circle all that apply)

- Vaginal intercourse
- Non-vaginal intercourse
- Oral stimulation without intercourse
- Manual stimulation without intercourse
- None

13. Which of the following have you or a sexual partner used to prevent pregnancy or sexually transmitted infections? (please circle all that apply)

- |                                    |                  |
|------------------------------------|------------------|
| Birth control pill                 | Nuva Ring        |
| Depo Provera                       | Patch            |
| Foam, cream, jelly, or suppository | Homonal IUD      |
| Diaphragm                          | Copper IUD       |
| Sponge                             | Condom           |
| Withdrawal/pulling out             | Nothing          |
| Something else: _____              | N/A (abstinence) |

14. Have you ever been pregnant?

- Yes, Age when you became pregnant: \_\_\_\_\_
- No

15. What are your goals for your future? (please circle all that apply)

- |                                      |                               |
|--------------------------------------|-------------------------------|
| Finish high school                   | Go to college/university      |
| Finish college/university            | Get married after high school |
| Get married after college/university | Not marry                     |
| Have children                        | Not have children             |
| Other: _____                         |                               |

16. Other comments:

***Thank you for taking the time to complete this form.***

## APPENDIX F

### SEMI-STRUCTURED INTERVIEW GUIDE

1. Tell me a bit about yourself/hometown/family.
  - a. Tell me about your family and friends and your relationship with them.
2. Tell me about what it is like to be a teenager living in a rural setting.
  - a. What do you think influences your sexual health decisions (probe birth control, intimate relationships, sexual activity)?
  - b. How does where you live affect your decisions regarding sexual health (probe birth control, intimate relationships, sexual activity)?
  - c. How do[es] your family/friends/community view teenage sexual activity for teen males? For teen females?
  - d. How have your relationships with your family/siblings/friends changed since you started engaging in sexual activity? (If applicable)
3. What are your experiences with sexual health education?
  - a. Have you ever seen (or heard) any advertisements related to sexual health?
4. What is it like for you in this rural setting/community to seek information about sexual health?
  - a. Have you ever tried to seek sexual health information?
  - b. How would you go about getting information if you wanted to?
  - c. What information do you look for?
  - d. Where do you go for information? Who do you talk to?
  - e. How comfortable are you talking about sexual topics with your parents/siblings/friends?

- f. In what ways do you find it helpful/difficult to talk to someone for advice in regards to your sexual health?
5. What is it like for you in this rural setting/community to seek sexual health care (probe birth control, pregnancy test)?
  - a. Where do you seek sexual health care? From who?
  - b. When you think of the services you have received, what has helped the most? Least?
  - c. What are some of the barriers to sexual health care for female adolescents in your community?
6. What are your thoughts on teenage sex?
  - a. What influences your thoughts about sex and teenagers (probe religion, family values, upbringing, past experiences)?
7. What does safe sex mean to you?
  - a. How important is practicing safe sex to you?
  - b. What are some things you think about before engaging in sexual intercourse with a partner?
  - c. How much support do you receive from your community in making safe sex choices?
8. **If participant has been pregnant:** Tell me about your pregnancy.
  - a. Was the pregnancy planned?
  - b. **If not:** What led to the pregnancy? What could have prevented it?
  - c. What were your thoughts when you first found out you were pregnant?
  - d. What was the response of friends and family?

- e. What did you do about the pregnancy (if no miscarriage)?
    - i. Abortion? (Where/how were you able to access this care?)
    - ii. Keep the baby?
  - f. What/who influenced these decisions?
  - g. How did this pregnancy affect your sexual activity/information needs and access after the pregnancy?
9. What suggestions do you have to improve sexual health education for teenagers living in a rural setting?
10. What suggestions do you have for improving access to services and resources (e.g., health care practitioners, clinics and centers, pharmacies, birth control pills and devices, etc...) for female adolescents in rural settings?
11. Is there anything else you would like to tell me that I didn't ask you?



# APPENDIX G

## ETHICS APPROVAL



Research Ethics

### Use of Human Participants - Ethics Approval Notice

Principal Investigator Dr. Beverly Simpson  
 File Number: 102184  
 Review Level: Full Board  
 Approved Local Participants: 20  
 Protocol Title: Rural Female Adolescents' Decision Making Regarding Sexual Intercourse and their Reproductive Health  
 Department & Institution: Health Sciences Faculty, UH Health Sciences, Western University  
 Sponsor:  
 Ethics Approval Date: July 28, 2015  
 Ethics Expiry Date: July 31, 2016

**Documents Reviewed & Approved & Documents Received for Information:**

Document Name	Comments	Version Date
Other	Approval of Semi-structured interview (Clean Copy)	20150722
Other	Recruitment Letter (Clean Copy)	20150722
Other	Approval of Semi-structured Forms (Clean Copy)	20150722
Letter of Information & Consent		20150722
Recruitment Items	Brochure	20150722
Recruitment Items	Participant Telephone Script	20150722
Recruitment Items	Flier	20150722
Other	HSPRC Response Letter July 23, 2015	20150722
Western University Protocol		

This is to certify you that the University of Western Ontario Health Sciences Research Ethics Board (HSREB) which is organized and operates according to the Tri-Council Policy Document: Ethical Conduct of Research Involving Humans and the Health Canada/CCO Board of Health Practice Protocols: Consolidated Guidelines; and the appropriate laws and regulations of Ontario has approved your proposed research to the above referenced study on the approval date noted above. The membership of the HSREB also complies with the membership requirements for REEFs as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study does not remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time, you must request it using the University of Western Ontario Updated Approval Request form.

Members of the HSREB that are members of any organization in research studies, or declare a conflict of interest, do not participate in discussions related to, or provide input, such studies when they are presented to the HSREB.

The Chair of the HSREB is Dr. Josephine Johnston. The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number 015-00000340.

\_\_\_\_\_  
 Signature

Signature

**Ethics Officer to Contact for Further Information**

Date Issued 20150722	Location HSREB	Signature 
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This document is not valid unless signed by the original signer(s).

## APPENDIX H

### LETTER OF INFORMATION

#### **Study Title: Rural Female Adolescents' Decision-Making Regarding Sexual Intercourse and their Reproductive Health**

##### **Principal Investigator**

*Dr. Beverly Leipert, PhD, RN*

Associate Professor, School of Nursing, Western University, London, Ontario

##### **Co-investigator**

*Paulina Ezer, MSc Candidate*

Health & Rehabilitation Sciences, Western University, London, Ontario

##### **Purpose of the study**

You are being invited to take part in a study being conducted by researchers who are studying how rural female adolescents make decisions about engaging in sexual activity and their reproductive health, and how living in a rural community impacts their decision-making process. This research is important to help rural adolescents make more informed decisions regarding sexual intercourse, decrease adolescent pregnancies in rural communities, and decrease school withdrawal rates. Female adolescents who are 16-19 years of age, heterosexual, and who live in a rural area are invited to participate in this study.

##### **What will I have to do if I choose to take part?**

If you agree to participate, you will meet with one of the study investigators in a location of your choice in which you feel comfortable. At the beginning of the meeting, you will be asked to complete a short form to provide information about your age, relationship status, sexual experiences and social situation. Throughout the rest of the meeting, the researcher will ask you questions about sexual health, sexual activity and sexual information. This meeting will last about one to two hours and will be audio-recorded. You may be asked to complete a follow-up interview for further clarification later in time. A follow-up interview will be conducted if clarification or elaboration of information is needed.

##### **Are there any risks or discomforts?**

There are no known risks to participating in this research. However, some of the questions asked in the questionnaire and interview cover sensitive topics, such as sexual experiences, and you may experience some discomfort answering some of these questions. You are not required to answer any questions that you feel uncomfortable answering. In the case that you do experience distress from answering some of the questions, we will provide you with a list of resources for various health, counseling, and educational agencies within your community.

## **Compensation**

You will receive a \$10 gift card to Tim Horton's to thank you for participating in the research.

## **What happens to the information that I tell you?**

You have the option to choose whether or not the interview(s) will be audio-recorded. If you request that the interview(s) are not audio-recorded, notes will be taken by hand, which will later be typed out and stored digitally. If you agree to have the interview(s) audio-recorded, these files will be stored digitally. What you say on the recording will be typed out. The only people who will listen to the recordings will be the researchers, and the recordings will be destroyed once they are transcribed and analysed. To protect your identity, only pseudonyms will be used to identify recordings, transcripts of the recordings, and notes from the interview(s). These digital files will be password protected through encryption. Hard copies of the consent form and questionnaire will be stored in a locked cabinet in a secure office at Western University.

## **What are the benefits of taking part?**

Your first hand experience of the influences of rural life as a female adolescent on rural women's sexual health is very important information that only you have. Your views may help to influence the sexual health programs and policies that are put in place for rural female adolescents. You may benefit personally from your participation by gaining more information about sexual health and rural female adolescents' health, and a sense of empowerment by being part of the research.

## **Confidential nature of this study:**

Your participation in this study is strictly confidential and will not be disclosed to anyone **except** when law requires reporting, that is if:

1. There is suspicion that a child presently under the age of 16 has been or is being abused
2. You are likely to harm yourself
3. You present a serious danger of violence to others
4. You reveal that you have been sexually abused by a healthcare provider covered by the Regulated Health Professionals Act

With your permission, the information you share may be presented to others through journals, publications, and at conferences and meetings in order to both increase awareness of this topic and to help institute sexual health promotion initiatives in rural communities. If the results of the study are published, your names will not be used and no information that discloses your identity will be released or published without your permission.

Representatives of the Western University Health Sciences Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of the research.

**Other Information about this Study:**

Participation in this study is entirely voluntary. This means that you may refuse to participate, refuse to answer any questions, or withdraw from the study at any time. If you do drop out of the study, any information that you have provided may still be used in the research findings. You do not have to answer any questions on the form or in the interview. You do not have to talk about anything in the interview if you do not want to. Being in this study or dropping out will not affect your care in a hospital or in the community.

If you have any questions or require additional information, please telephone collect Paulina Ezer. If you have any questions about the conduct of this study or your rights as a research participant you may contact the Office of Research Ethics, University of Western Ontario at (519) 661-3036, or by email at: [ethics@uwo.ca](mailto:ethics@uwo.ca).

This letter is for you to keep.

**Consent Form for Participation in the Study**

**Rural Female Adolescents' Decision-Making Regarding Sexual Intercourse  
and their Reproductive Health**

**STUDY INVESTIGATORS:** Dr. Beverly Leipert and Paulina Ezer

I have read the Letter of Information, have had the nature of the study explained to me  
and I agree to participate. All questions have been answered to my satisfaction.

I agree to my participation in this study being audio recorded. YES NO

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Participant

\_\_\_\_\_  
Signature of Person Obtaining Consent

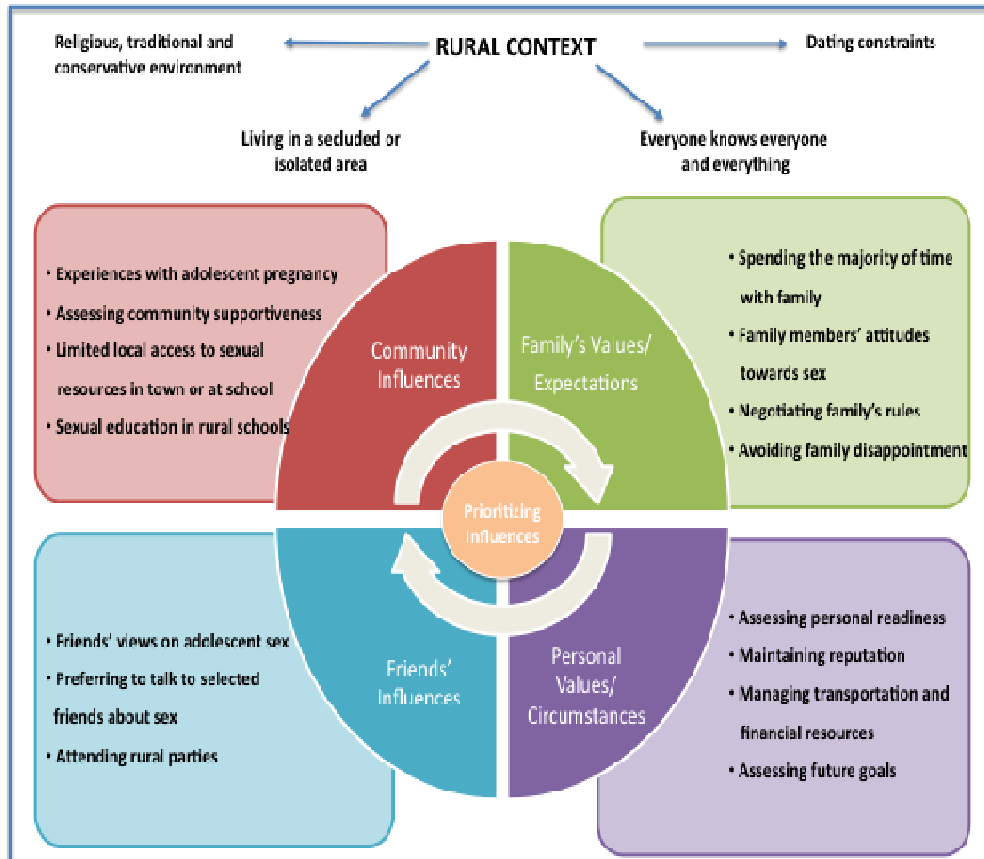
\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Person Obtaining Consent

## APPENDIX I

### DIAGRAM OF RURAL FEMALE ADOLESCENTS' SEXUAL DECISION-MAKING

#### Rural Female Adolescents' Sexual Decision-Making Process



## CURRICULUM VITAE

### Education

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**M.Sc. Candidate, Health Promotion**, Western University, London, Ontario, 2012 – 2014

- Supervisor: Dr. Beverly Leipert, Ph.D.
- Thesis: Rural female adolescents' decision-making regarding sexual intercourse and their reproductive health

**B.A. (Honours), Psychology, Religious Studies**, Queen's University, Kingston, Ontario, 2006 – 2010

### Honours, Academic Awards & Scholarships

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- Honours Bachelor of Arts with distinction, Queen's University (2010)
- Dean's Honour List, Queen's University (2007 – 2010)
- Queen Elizabeth II Aiming for the Top Scholarship, Ontario Student Assistance Program, \$3,260 per year (2006 – 2009)
- Excellence Scholarship, Queen's University, \$2,500 (2006)
- Entrance Award, Queen's University, \$1,640 (2006)
- The Robert Bater Award in Jewish Studies, Queen's University (2006)
- Sceptre Investment Counsel Limited Award, Queen's University (2006)

### Publications & Presentations

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#### Peer Reviewed Journal Articles:

1. Sutton, K. S., Goldfinger, C., Boyer, S., **Ezer, P.**, & Pukall, C. F. (2012). To lube or not to lube: Experiences and perceptions of lubricant use in women with and without dyspareunia. *Journal of Sexual Medicine*, 9(1), 240-250.

#### Poster Presentations:

1. **Ezer, P.** & Leipert, B. (June, 2014). Promoting sexual health for female adolescents in rural Ontario. Poster presented at the 36<sup>th</sup> Annual Guelph Sexuality Conference, Guelph, Ontario, Canada.
2. **Ezer, P.** & Leipert, B. (March, 2014). Rural female adolescents' perspectives on sexual decision-making. Poster presented at the 2014 Faculty of Health Sciences Research Day, Western University, London, Ontario, Canada.

3. **Ezer, P.** & Leipert, B. (May, 2014). Rural female adolescents' perspectives on sexual decision-making. Poster presented at the 27<sup>th</sup> Annual Nursing Research Conference, London, Ontario, Canada.
4. **Ezer, P.** & Leipert, B. (March, 2013). Female adolescents' decision-making regarding pregnancy in rural Ontario. Poster presented at the 2013 Faculty of Health Sciences Research Day, Western University, London, Ontario, Canada.
5. Goldfinger, C., Bergeron, S., Pukall, C. F., & **Ezer, P.** (June, 2011). The application of cognitive-behavioural therapy to dyspareunia. Poster presented at the 2011 Annual Convention of the Canadian Psychological Association (CPA), Toronto, Ontario, Canada.
6. Almas, A., Grusec, J., & **Ezer, P.** (April, 2009). Mothers' negative parenting characteristics predict adolescent internet usage and online interactions with friends. Poster presented at the Biennial Meeting of the Society for Research in Child Development, Denver, Colorado, USA.

**Peer-Reviewed Conferences:**

1. **Ezer, P.** & Leipert, B. (February, 2013). Female adolescents' decision-making regarding pregnancy in rural Ontario. 2013 Health & Rehabilitation Sciences Graduate Research Forum, Western University, London, Ontario, Canada.

**Guest Lectures:**

1. **Ezer, P.** (December, 2012). Rural Female Adolescents: Sexual Health Care and Information Access. Presented to Nursing 3380 at Western University, London, Ontario, Canada.

**Invited Presentations:**

1. **Ezer, P.** & Pukall, C.F. (June, 2011). Sexual Health Research Laboratory. Presented at the Queen's University Group for Research in Reproductive and Developmental Origins of Health, Disability and Disease, Kingston, Ontario, Canada.

**Research-related Presentations:**

1. **Ezer, P.** & Zendo, S. (December, 2012). Let's Talk about Sex: Sexual Health Promotion Among Adolescents. Presented to Health Sciences 9721 at Western University, London, Ontario, Canada.
2. **Ezer, P.**, Mehta, S., & Zendo, S. (October, 2012). Article Review of a Sexual Health Promotion Initiative among Adolescents. Presented at Health Promotion Seminar, Western University, London, Ontario, Canada.



## **Teaching Experience**

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**Teaching Assistant:** Health Policy (HS3400A), School of Health Studies, Western University, London, Ontario, September 2013 – December 2013

**Teaching Assistant:** Health Policy (HS3400A), School of Health Studies, Western University, London, Ontario, September 2012 – December 2012

## **Research Experience**

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**Research Assistant,** Big Brothers Big Sisters – Go Girls Program Evaluation, London Ontario, December 2012 – May 2013

**Research Coordinator,** Sexual Health Research Laboratory, Queen’s University, Kingston, Ontario, May 2010 – August 2012

**Research Assistant,** Social Psychology Laboratory, Queen’s University, Kingston, Ontario, May 2010 – August 2010

**Study Manager,** Social Development Laboratory, University of Toronto Child Study Centre, Toronto, Ontario, May 2009 – August 2009

**Directed Research Course,** Social Psychology Laboratory, Queen’s University, Kingston, Ontario, September 2008 – December 2008

- Supervisor: Dr. Tara MacDonald
- Research Project: The influence of social rejection and anxiety levels on condom use in adolescent females

**Research Assistant,** Social Development Laboratory, University of Toronto Child Study Centre, Toronto, Ontario, May 2008 – August 2008

**Research Assistant,** Social Psychology Laboratory, Queen’s University, Kingston, Ontario, September 2007 – April 2008