

# The Canadian Girl Child

Determinants of the Health and Well-being  
of Girls and Young Women



Prepared by Jennifer Tipper, MSW  
Canadian Institute of Child Health



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## EXECUTIVE SUMMARY

Since the rebirth of the women's movement in the late 1960's, the subject of women's health and well-being has received unprecedented attention. A strong body of feminist research and literature has emerged closely linking women's health and well-being to her gender, socio-economic, ethno-cultural and political status as "female".

Missing from this analysis of women's health and well-being, however, is a portrait of the specific developmental needs, concerns and outcomes of the girl-child. The Platform for Action of the Fourth World Conference on Women compels us to develop a better understanding of the determinants of health which influence the development of girls and young women. After all, "the girl-child of today is the woman of tomorrow" (United Nations, 1995).

Existing research shows that today's girls and young women are confronted by a range of obstacles and barriers along their path towards healthy development. Our challenge is to uncover the extent to which growing up female impacts the healthy development of girls and young women from birth to adulthood.

This report will outline how The Canadian Girl-Child project has taken us one step closer to building this knowledge and to advancing the status of the girl-child in Canada.

**Chapter I** will provide a brief overview of the original goals and objectives of the project and offer some initial conclusions as to the extent to which the project was able to fulfill these expectations.

**Chapter II** will describe the framework developed by the researcher for analysing the relationships between gender, child development and the determinants of health.

**Chapter III** will describe both the process and the outcomes of the review of the literature and research evidence related to the determinants of healthy development among girls and young women aged 0-18. Key gaps in the literature will be identified and future research priorities proposed. Specific reference will be made to ethno-cultural and visible minority girls and young women.

**Chapter IV** will outline the process and outcomes of the discussions held with a group of young women around issues related to their health and well-being.

**Chapter V** will also outline the process and outcomes related to the establishment and meeting of the Expert Advisory Group. Particular reference will be made to identify gaps in the research and future research priorities.

**Chapter VI** will conclude the report with suggestions for future project development.

# CHAPTER 1 - INTRODUCTION

## BACKGROUND

Many people have asked, “Why conduct a project that focuses exclusively on the health and well-being of the girl-child<sup>1</sup> in Canada?”. Part of the answer lies in the work feminist researchers have produced around gender as a critical determinant of health. This body of knowledge has expanded the definition of health beyond the mere absence of illness: health has been reconceptualized as the product of a complex interplay between a number of physiological, social, political, cultural, economic and environmental factors.

This work maintains that the way in which a woman experiences her health is directly related to her gendered identity as “female” in a world which, generally, privileges male over female, white over non-white, rich over poor, heterosexual over lesbian and able-bodied over disabled. In other words, inequities in health can be directly correlated with larger systemic and societal issues of gender-based oppression.

Unfortunately, this research has only provided us with a partial picture. As important as it has been to advancing our understanding of gender as a social construct and its links to adult women’s health, the majority of this analysis has failed to consider the extent to which growing up female impacts health and well-being from the moment of conception. With a nearly exclusive focus on adult women, the research has all but overlooked the critical determinants of healthy development among girls and young women.

From the limited data that we do have on the health and well-being of the girl-child, we know that girls face a number of unique challenges to their healthy development. We know that more young women than men report being depressed or lonely, that more young women report dissatisfaction with their bodies, are more likely to contract a sexually-transmitted disease or experience sexual abuse (Canadian Institute of Child Health, 1994).

The rest of the answer to the question “why girls?” lies in this knowledge gap. Without a clearer picture of how and why growing up female impacts the healthy development of girls and young women, our efforts to develop policies, programs and curriculums which are empowering and responsive to the developmental needs of girls and young women will continue to be limited.

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<sup>1</sup> The term “the girl-child” has been popularized to emphasize the effects of gender on child development. For the purposes of this research, the girl-child is defined within the context of the Convention on the Rights of the Child as a girl from birth to 18 years of age.

## PROJECT OBJECTIVES

This initiative was intended to advance our knowledge of the healthy development of girls and young women in Canada by meeting the following objectives:

- i. develop a framework for analysing the relationships between gender, child development and the determinants of health;
- ii. review the literature and research evidence regarding determinants of healthy development among girls and young women aged 0-18. Specific reference will be made to ethno-cultural and visible minority girls and young women;
- iii. identify key issues and gaps in our knowledge of the healthy development of girls and young women;
- iv. establish an Expert Advisory Body to develop an agenda for future research, and identify critical policy concerns;
- v. establish a girl's caucus, a young women's caucus, and an ethno-cultural and visible minority young women's caucus to inform the research agenda.

In general, this initiative has successfully met its objectives. This success, however, is only preliminary. The richness and depth of the broad range of factors which influence the healthy development of girls and young women has only been lightly sketched. Our knowledge of the critical determinants of health and well-being among this population continues to be severely restricted by the lack of thorough research evidence and policy support.

Adding colour and texture to this sketch will require all of our ongoing energy, resources and wisdom.

# CHAPTER II - THE FRAMEWORK

## DEFINITIONS

Before examining, in more detail, the strengths and limitations of conducting a gender analysis of the health and well-being of girls and young women in Canada, a clear understanding of the descriptive, prescriptive and proscriptive nature of the concepts 'sex' and 'gender' must be established.

*Sex* refers to the biological features which distinguish male from female.

*Gender*, although inextricably linked to sex, is a much more dynamic construct reflective of entrenched unequal relations between men and women.

*Gender identity* is "a person's intimate and profound conviction that they belong to one or the other sex, in a sense that goes beyond chromosomal and somatic characteristics" (Basso, 1993).

*Gender role* refers to "an individual's expression of masculinity and femininity, in keeping with the rules established by their society" (Basso, 1993).

## GENDER ANALYSIS

As a starting point for developing the research framework, the relationship between gender and child development was examined. There is little argument that gender identity determines, to a large extent, how boys and girls experience their environments and the life paths they choose. Because gender identity is developed at an early age (Serbin et al, 1993), these "identities" influence the type of activity and relationships in which most young people engage. In fact, by age of four or five, most boys and girls engage in activities and exhibit behaviours that are culturally defined as "appropriate" for their sex (Lipsitz Bem, 1995).

This project began from an assumption that one of the central components of self-conception is self-definition as either male or female. Beliefs and practices based on sexual identity guide the development of our self-identity (Richer, 1990). Behaviours, values and beliefs are informed, to a great extent, by a set of social expectations and norms around what it means to be male or female. As a result, biological sexual identity is converted into a gendered consciousness through a process of social construction.

In other words, we learn about the merits or perils of being a boy or girl from others and from the circumstances around us. By being exposed to gender-based beliefs and practices, boys and girls come to develop a gendered understanding of the appropriate roles expected of them.

Developing a gendered identity, however, is not an automatic or uniform process. The very notion of gender as a social construction implies variation among individuals by virtue of unique environmental, cultural, socio-economic and physiological factors.

Clearly, gender plays a key role in determining how children interact with their environment. Evidence suggests that developing a better understanding of the unique health risks and needs of girls requires a rigorous gender analysis of the determinants of healthy child development. Stella Cerruti Basso (1993) argues that “using gender roles as an analytical category to assess population health data allows for... a better understanding of the daily living situations that may constitute risks” (114). When using gender as the lens through which to assess girl-child development, the researcher is able to identify trends and patterns, and isolate critical developmental risks or successes among girls specifically.

In essence, gender analysis provides the researcher with an opportunity to assess the social, political, cultural and economic determinants of health status as they relate to the unequal relations between men and women, boys and girls. For example, questions around why girls are more likely than their male counterparts to be the victims of sexual violence, exploitation and harassment; to experience mental health difficulties; to have attempted suicide; to smoke; and, to contract sexually-transmitted diseases can be assessed more meaningfully.

Based on existing data, this research has used a gendered lens to begin to bring into the focus the extent to which growing up “gendered” - either male or female - influences health outcomes.

To date, relatively little research has been devoted to exploring the role that gender plays in determining or mediating the health and well-being of children throughout their development. In fact, it has only been in the past twenty years that researchers have begun to routinely disaggregate child health data according to sex. Consequently, our understanding of the unique health needs, issues and outcomes among boys and girls is limited.

## **LIFE TRANSITIONS**

Conducting a gender analysis of the health and well-being of girls and young women implies an assessment of a broad range of social, political, ethno-cultural and economic factors. To organize this analysis, a life-cycle approach to healthy development has been adopted which extends from birth to womanhood, and examines the girl-child’s experiences at each stage in so far as they inhibit or fulfill her developmental potential.

To capture the critical developmental experiences, the Ontario Premier’s Council on Health, Well-Being and Social Justice’s (1994) notion of life transitions is very instructive.

How a child experiences an environment is closely related to his or her developmental stage. We know children have the capacity to start learning very early; and we know that there are critical points during development when there is a greater possibility than at others of making a positive difference. These critical points are called transitions. They represent windows of opportunity to check, correct and influence healthy development.

In the original proposal (Appendix A), five age cohorts had been recommended for analysis. Based on available research evidence, it was decided to condense these into the following three categories: birth to early girlhood, girlhood, and adolescence.

### *Birth to Early Girlhood (Prenatal to 4 years of age)*

This period includes pregnancy, birth and infancy and all events surrounding the time before a baby is born until the infant is 4 years of age, including the pre-conceptual period, prenatal period, birth and the first years of life.

Pregnancy, birth and infancy provide significant opportunities for the beginning of healthy growth and development, both physically and in newly formed relationships. At the same time, it is a period of increased vulnerability for the woman, her baby and her family.

For girls, the time immediately after birth is a comparatively advantageous period in her development. Compared to her male counterparts, female infants in Canada are less likely to die during infancy, to contract respiratory infections, and they enjoy a higher life expectancy (Canadian Institute of Child Health, 1994).

This advantage, however, is not universal. For example, Aboriginal babies, in general, are almost twice as likely to die during infancy for all causes (Canadian Institute of Child Health, 1994). Similarly, international research points to the fact that in many families, the arrival of a baby girl is met with either hostility or ambivalence. For many girls, this means receiving inadequate nutrition and care - critical determinants of healthy development (Ramalingaswani et al., 1996).

Physically, young children develop from a stage where they are able to play independently to starting to speak to being ready to enter the school system and learning to use language in many ways. Emotionally, they are learning a sense of who they are and developing self-esteem.

By the very nature of their development, preschoolers have great potential for growth — physical, emotional and cognitive. What happens during these years can start them on the path to a secure sense of who they are or, conversely, leave them feeling insecure and hopeless.

This stage is also characterized by an emerging gender identity. Much of the research on gender identity formation points to the fact that by age four or five, most boys and girls engage in activities and exhibit behaviours that are culturally defined as appropriate for their sex. In other words, these emerging identities influence the type of activity and relationships in which most young people engage.

### *Girlhood (5-11 years of age)*

Unfortunately, comparatively little research has been conducted on issues beyond the physical and social development of children at this age, such as play behaviour and school achievement. We know relatively little about how being a girl influences the development of the girl-child throughout these middle years.

### *Adolescence (12-18 years of age)*

Adolescence marks the critical passage from childhood to adulthood. Youth are gaining a great deal of independence as well as striving to achieve increased independence during this stage of development. They become more responsible for their own actions and begin to make decisions that are complex and have consequences. Many youth experiment with risk-taking behaviour and with assuming greater personal autonomy. They have tremendous poten-

tial for growth, learning and developing life skills that will remain with them throughout their adult life.

This is also a time in the life cycle where physical changes are as rapid as they are during infancy.

For young women, adolescence presents a number of challenges to her healthy development. It is at this stage that she begins to experiment with her identity and to concretize her self-image as a woman. The majority of the research on the healthy development of girls and young women has focussed on adolescence.

## **DETERMINANTS OF HEALTH**

In order to develop a better understanding of what impacts the health and well-being of girls and young women in Canada across these transition points, a population health approach has been adopted. Population health refers to the entire range of factors that influence health among an entire population: in this case, girls and young women.

We know that if there are certain factors present, the infant, child or adolescent will have a better chance of experiencing healthy development. These factors or influences are referred to as the **determinants of health**.

Research tells us that there are multiple pathways or determinants that effect the physical, social, psychological and cognitive well-being of children. Every child lives, learns and plays in various environments: school, home, playground, community, etc. Each of these environments has a unique impact on child development. Any attempts to address the healthy development of girls and young women must consider the impact of these multiple influences. Addressing only one environment will not produce the desired outcomes.

Determinants do not necessarily cause good or ill health, rather the presence of determinants can influence an infant's, child's, or adolescent's chance of achieving healthy development (Ontario Premier's Council on Health, Well-being and Social Justice, 1994). In other words, determinants of health establish the context within which we experience our health both individually and collectively.

The only viable way to influence population health status is by addressing the broad range of health determinants in a comprehensive and meaningful way. The challenge is to develop a framework for understanding and measuring the impact of these determinants.

To this end, the work of the Canadian Federal, Provincial and Territorial Advisory Committee on Population Health (1994) is instructive. The Committee has established a framework for grouping the determinants of health into five categories. These categories form the basis of the framework for developing strategies to measure and improve girl-child healthy development:

- 1. Social and Economic Environment:** Income, employment, social status, social support networks, education and social factors in the workplace;

2. **Physical Environment:** Aspects of the natural and human-built physical environment;
3. **Personal Health Practices:** Behaviours that enhance or create risks to health;
4. **Individual Capacity and Coping Skills:** Psychological, genetic and biological characteristics;
5. **Community Institutions:** Schools, religious organizations, service organizations and services to promote, maintain and restore health.

## **SYNTHESIS: GENDER, LIFE TRANSITIONS AND DETERMINANTS OF HEALTH**

Understanding the broad spectrum of factors which influence the healthy development of girls and young women is no simple task. Limited by a somewhat disparate and often sparse literature base upon which to paint a more comprehensive portrait of the health and well-being of the girl-child in Canada, one of the challenges of this project was to develop a framework for making sense of what we do know and for identifying gaps in our knowledge.

This framework began from the assumption that “gender” is comprised of a varied range of societally constructed roles, attitudes, behaviours and values ascribed differentially to both males and females. Gender, in this sense, is more than a simple determinant of health: it might be considered a “super-determinant”. Unlike some of the more conventional determinants such as socio-economic status or educational attainment, one does not typically move in and out of one’s status as male or female, nor does one typically become more or less male or female over time. Gender is an ever-present determinant which has a constant influence over how girls and young women experience their development.

This is not to say, however, that gender is a static construct. On the contrary, gender mediates every determinant of health, taking on different meaning and importance during different life transitions. Consequently, how a girl or young woman experiences her gender status is unique. Because gender construction is the product of multiple social, political, ethno-cultural and economic factors, it is ever changing. As a result, the researcher’s ability to make generalized statements based on how girls, and young women in general, experience their healthy development is influenced by this very diversity.

This constraint, however, need not be perceived as a limitation. Attention paid to diversity will lend the texture and depth to the portrait of girl-child development that is being sought. This framework, therefore, allows the researcher to use: a population health approach to grouping key health determinants; a life transitions approach as a way of assessing healthy development from birth to early adulthood, and a gender analysis which accepts the girl-child as the unit of analysis and which examines the impact that factors such as ethno-cultural diversity and socio-economic status have on healthy development.

Of equal importance is the fact that the framework offers the researcher a means of presenting the research findings in a manner which does not focus on risk or deviance outcomes. Rather, an emphasis can be placed on examining those factors which encourage or impede forms of positive, self-affirming resistance among girls and young women. This allows us to begin to

conceive of girl- and young womanhood as being a period of opportunity for healthy development, rather than a rite of passage into womanhood that is plagued by shame, insecurity, depression and risk.

## CHAPTER III - LITERATURE REVIEW

Discussing the current state of knowledge about gender and the determinants of healthy development among girls and young women is best characterised as an exercise in what we don't know as opposed to what we do know. It is the unfortunate reality that relatively little "gender" research has been conducted to date around child development. Of the research that has been conducted, the majority has failed to apply a rigorous gender analysis. This is particularly true of the work that has been done on young children.

Moreover, there are many examples of where research has been plagued by gender bias'. For example, much of the research around "aggressive" behaviour among girls and young women has had a tendency to categorize this population as delinquent or anti-social. The same is not necessarily true of research conducted with boys and young men for whom externalizing behaviour is considered normal, or at least acceptable.

Similarly, 'what' gets studied, and 'how', may be influenced by the researcher's own gender bias. The tools that a researcher uses and the conclusions that s/he draws are likely to reflect her or his own perceptions and interpretations of gender differences. Perhaps the most obvious example of gender bias in research can be found in Erik Erikson's seminal work on gender identity and child development done in the 1950s.

Erikson's research centred on the development of a model of "normal" child development which culminated at adolescence in a quest for independence and ultimate individual autonomy. Not unlike other researchers of the day, Erikson took the individual male's experience as his object of study and inferred universality from what he found. In addition to work already being popularized by Sigmund Freud, Erikson's conclusions cemented the "male as norm" model of developmental psychology. As a result, a single profile of healthy child and human development which fully excluded the experiences of girls and women became entrenched in Western thought. Reflecting upon this legacy, Emily Hancock (1989) notes that the "insidious implication that the female is to be understood via the male can only function to take women further away from a deeper knowledge of who and what they really are" (p.231).

Perhaps the greatest confounding factor in gender research is the fact that "gender" is not a static concept. Gender-sensitive factors or determinants often shift over time as life circumstance and environmental influences change. Moreover, the impact of gender on healthy development is further influenced by issues of ethno-cultural diversity, socioeconomic status, physical ability, etc. To date, very little attention has been paid to understanding the unique healthy development needs of girls from an ethno-culturally diverse background.

All of these factors present challenges to any researcher conducting a gender analysis of the healthy development of any particular child and youth population. Bearing in mind these limitations, this chapter will present briefly the literature review methodology and findings. As described in the framework, these findings will be organized by age cohort and by major determinant category.

## METHODOLOGY

In order to generate a clearer picture of the determinants of healthy development among girls and young women in Canada, a review of existing literature was conducted, and key informants and experts in the field were consulted. This was a somewhat iterative process, whereby various sources were consulted and re-consulted in response to identified gaps or helpful suggestions.

Various methods were used to locate literature and research evidence on girls and young women in Canada:

### *Electronic Searches*

A research assistant was hired to conduct searches on a number of databases to identify current Canadian and international research. The emphasis was placed on locating Canadian specific resources published over the last 10 years. The following databases were consulted: Eric, HealthSTAR, Medline, SocioFile, SPORTDiscus, Philosopher's Index and government documents.

Searches were organized by key concepts related to gender, girls and a broad spectrum of determinants of health. Efforts were also made to search specifically for references related to ethno-cultural diversity.

### *Manual Searches*

In addition to the database searches, library and Internet searches were conducted to identify relevant books and/or other resources. As well, the in-house resources of the Canadian Institute of Child Health were reviewed.

Not surprisingly, this search produced a substantial number of books that have been written around the topic of child development. The majority of these references, however, speak more specifically to issues related to gender identity formation among infants and toddlers. Relatively little has been written specifically about how gender influences healthy development; in particular, in so far as it relates to girls and young women.

### *Network of Experts*

By way of expanding this knowledge base and ensuring that the search methodology was producing the desired outcomes, a small group of Expert Advisors (see Chapter V) were also asked to recommend relevant articles or books for consultation. This process helped to round out the findings.

### *Results*

Overall, this exercise produced well over 1000 current references. Abstracts for the majority of these references were reviewed and the articles or books most relevant to the topic of girls, gender and healthy development were selected.

Given the large quantity of literature that has been developed in the area of childhood development, it was a challenge to sift through the material to locate those sources that referred

specifically to the development of girls and young women. In many cases, these references were only found imbedded in pieces which addressed broader issues of health and development.

In the end, this review process revealed a great paucity of literature which addresses issues related to gender and the healthy development of girls and young women, and, in particular to ethno-cultural diversity. Clearly, an enormous challenge is before us to begin to fill in some of these gaps.

## **ANALYSIS**

### **Birth to Early Girlhood**

Infancy and early childhood are characterized by rapid change and development. Many researchers argue that the first few years of life lay the foundation for future healthy development. Development during these early years is influenced by a complex and interconnected network of biological, social, economic, familial and environmental determinants.

Of the research conducted to date, relatively little has contributed to our understanding of how these various determinants impact differentially on the healthy development of boys and girls at this age. McKinnon and Ahola-Sidaway (1997) caution us, however, not to seek absolute gender differentiation when examining development among this age group. They argue that differences in the determinants of health behaviour and outcomes among infants and young children may be more a question of degree than of absence or presence.

Given the lack of gender-specific data available, this segment will look more generally at critical health determinants for all children, making specific reference to girls where the literature allows. Clearly, this discussion represents only a very small first step towards building a more comprehensive gender analysis of the healthy development of girls from the point of conception to early childhood. It does, however, give us greater insight into which areas of research require more attention.

### ***Social and Economic Environment***

A majority of the gender-based research on the determinants of early childhood development has focussed on two distinct areas: physical health and well-being, and social development. The former encompasses issues such as infant mortality, low birth weight, disability and chronic illnesses. The latter considers “problem” or “challenging” behaviours such as conduct disorder, Attention Deficit Hyperactivity Disorder, aggression and temperament. The debate which links these two domains of research centres around the role that each plays in determining the other.

In a review of the literature on the developmental and social influences on young girls’ early problem behaviour, Keenan and Shaw (1997) clearly expose the parameters of this debate. Their findings support the argument that social environments play a large role in influencing emotional and behavioural development among girls below the age of five.

Looking for reasons to explain differing rates of externalizing and internalizing behaviour among boys and girls, Keenan and Shaw note that, although only a few longitudinal studies have been conducted, the research indicates that there is increasing divergence in the prevalence of problem behaviour between girls and boys beginning around age four. Before this age, most of the research has found a lack of significant sex differences in behavioural problems during the infancy and toddler period. However, by school entry, boys are 10 times more likely than girls to exhibit conduct disorders; and by adolescence, girls experience an increase in the prevalence of internalizing disorders that exceeds their male counterparts (Offord et al., 1987).

### *Socialization*

To explain this divergence in behavioural patterns, Keenan & Shaw (1997) point to a number of key social determinants. Among the most commonly researched is the impact of socialization of sex differences. Many studies have found that various socializing agents (e.g. parents, peers, care givers, early childhood educators) selectively encourage traditional sex-typed behaviour, which, for girls, includes fearfulness, withdrawal, anxiety and emotionality.

Studies on the influence of parents, in particular, have demonstrated that girls, relative to boys, are socialized by parents to “yield to their peers, think of the personal consequences of their actions, and err on the side of over-controlled rather than under-controlled behavior” (Keenan & Shaw, 1997: 102). Teachers and early childhood educators are also found to encourage sex-stereotyped behaviour among girls, which, in some cases, may lead to the development of stereotypical problem behaviour. Research evidence regarding the impact of peers on the development of sex-specific behaviour in early childhood is scant and requires more study.

### *Brain Stimulation*

Much of the new research being produced around the receptivity and vulnerability of the brain to external stimulus during the first three years of life corroborates these conclusions. Keating and Mustard (1996) speak to the importance of child/parent or child/adult bonding and early and repeated, positive stimulation as a critical determinant of emotional and physical development.

### *Parental Socio-Economic Status*

Among the most important determinant of early childhood development is parental socio-economic status. In Canada, poverty directly affects 1 in 5 children. For children living in a single-parent family headed by a woman, the risk of living in poverty is five times greater than for a two-parent family (Hanvey, 1993).

Poverty places children at risk for a wide range of health problems, physical and mental. In terms of emotional health, Lipman et al. (1994) maintain that a significant association has been found between family economic disadvantage and child psychiatric morbidity. Infants living in Canada’s poorest neighbourhoods experience an infant death rate almost twice as high as those living in the richest neighbourhoods; poor children are more likely to die from injuries, to have chronic health problems, to visit a hospital emergency room or be admitted to hospital than children living in middle to upper income families. Poor families are also 1.4 times more likely to have a low birth weight baby than their wealthier counterparts (Canadian Institute of Child Health, 1994).

Among those children in Canada at greatest risk of the negative effects of poverty are Aboriginal children. Although an accurate poverty rate for Aboriginal children is unknown, we do know that many live in conditions similar to developing countries where inadequate housing, poor heat, limited running water, and inadequate food supplies are the norm (Canadian Institute of Child Health, 1994).

Conversely, children in families with greater financial resources, generally, have more secure living conditions and greater access to social, health, educational, and recreational opportunities - all important factors in shaping healthy child development (Canadian Council on Social Development, 1996).

### *Violence*

Equally important to a child's social and emotional development during its early years is exposure to violence. Children can be effected as direct victims of abuse or indirectly as victims of family or community violence. The most prominent factors which place children at increased risk of experiencing abuse by parents are: a step parent in the household, young parents, poor parenting skills, marital violence, alcohol or drug abuse in the home, large family size, poverty, unemployment, and disability, poor health or prematurity in the child (Johnson, 1995).

Precise estimates of the prevalence of child abuse and maltreatment in Canada are unavailable. However, according to the National Clearinghouse of Family Violence (1997), infants and young children are involved in the most serious cases of maltreatment and are at greatest risk of injury and death.

According to a recent Ontario study published in the Journal of the American Medical Association, 21.1% of girls experience child physical abuse, fully 10% less than their male counterparts. Girls, however, are more likely than boys to be the victims of childhood sexual abuse: 12.8% vs 4.3%, respectively. It is not entirely clear at what age the incidence of abuse is highest (Macmillan et al., 1997).

In a review of child maltreatment research, Trickett and McBride-Chang (1995) draw some tentative conclusions about the impacts of abuse on early childhood development. They refer to evidence of cognitive and developmental delays in neglected and/or physically abused infants, as well as somatic complaints among sexually abused preschoolers (especially boys). They also note that physically abused boys tend to show more externalizing behaviour and girls more internalizing behaviour. Similar outcomes have been found among young children who witness wife abuse (Suderman et al., 1996).

Infants and newborns are at significantly higher risk of homicide than any other age group. Many cases of child homicide seem to be an extension of child abuse (Johnson, 1995).

Although the research is not conclusive on how abuse impacts early development, we do know that children who survive child abuse and neglect are at very high risk of developing numerous social, emotional and developmental difficulties which may have a lifelong impact such as: fear, anger, aggression, poor self-esteem, alcohol and drug abuse, self-mutilation, running away, poor school performance, sexually inappropriate behaviour, and an increased risk of future sexual victimization (Johnson, 1995).

### *Maternal Age and Education*

The research evidence is clear: pregnancy in adolescence is associated with an excess risk of poor outcomes for babies, including low birth weight and prematurity. In a study of white mothers 13 to 24 years old in the United States who had age appropriate educational levels and who received adequate prenatal care, Fraser et al (1995) found that “younger teenage mothers (13 to 17 years of age) had a significantly higher risk than mothers who were 20 to 24 years of age of delivering an infant who had low birth weight..., who was delivered prematurely..., or who was small for gestational age” (p.1111). The study also concluded that teenage mothers are more likely than older mothers to be “nonwhite, poor, less well educated, and unmarried, and they are less likely to have received prenatal care” (p.1111): all critical determinants of healthy birth outcomes. Unfortunately, the findings do not differentiate between risk factors for female vs male babies.

### *Mental Health*

Maternal physical and emotional health before conception, during pregnancy and in the first few years of an infant’s life are critical determinants of healthy child development. Research on the postpartum mental health of mothers suggests that infants who are cared for by a mother experiencing depression are more likely to experience negative health outcomes than infants whose mother is emotionally healthy. Rima Shore (1997) argues that “maternal depression can impede healthy brain development, particularly in the part of the brain associated with the expression and regulation of emotions. This effect appears to be exacerbated among infants who are from six to eighteen months old when their mothers suffer from depression.

In a recent Canadian study examining the impact that varying parenting practices have on developmental outcomes among children, Landy and Tam (1996) also found an important link between healthy child development and maternal mental health. Maternal depression, in particular, was found to have an adverse effect on most child outcome variables.

### *Social Support*

A parent’s, and, in particular, a mother’s access to social support during and after pregnancy is another important determinant of healthy early child development. Thompson (1990) defines social support as the comfort, assistance and information one receives from individuals or groups, formally and informally. There is growing concern among researchers that the impact of life stress and lack of social support are key elements in birth outcomes such as low birth weight (Canadian Institute of Child Health, 1992). One study of social support and teenage pregnancy in Canada found a statistically significant relationship between family support and birth weight outcome (National Council of Welfare, 1997b). Stressors such as poverty, unemployment, family violence and inadequate housing are all potential sources of negative stress among pregnant woman.

Although the research is not conclusive on the impact of positive social support on birth outcome, mothers involved in studies testing the effects of support typically showed improved emotional well-being. However, researchers caution that social support is unlikely to override the many effects and problems of being socially or economically disadvantaged (Oakley et al., 1990).

### *Ethno-Cultural Identity*

Canada's children are ethnically and racially diverse. While the majority of Canadian children can trace British or French ancestry, Canada is home to many more peoples from around the world. Canada's Aboriginal children represent 3% of the child population aged 0-14. Despite this diversity, very little research has been done on the impacts of ethno-cultural identity on healthy birth outcomes and early child development. In particular, missing from this picture is how gender and ethnicity combine to determine the healthy development of young girls.

Of particular interest would be research on how ethnicity influences access to prenatal health and support services, and how cultural and ethnic differences impact on the development of gender identity among young girls.

### ***Physical Environment***

#### *Housing*

Access to affordable, adequate housing has been proven to be a critical determinant of healthy child development, and an outcome of financial security. In a review of the literature related to physical environment as a determinant of health, Johnson et al. (1993) found housing type, noise, density, play equipment access, and homelessness to be closely related to healthy developmental outcomes among young children.

The children whose health is most severely compromised by poor housing are those living in poverty and on Aboriginal reserves where homes are often overcrowded, poorly heated and maintained, and without a clean water supply. It comes as little surprise that rates of infant mortality and the transmission of infectious disease among Aboriginal children are high compared to national averages (Canadian Institute of Child Health, 1994).

Young children are also particularly vulnerable to pollutants which compromise household air quality such as asbestos, lead, and environmental tobacco smoke. Other chemicals often used in the home such as pesticides, herbicides and fungicides also pose a potential threat.

#### *Environmental Contaminants*

Examining the impact of environmental exposures on early childhood development is a relatively new phenomenon. Birth defects, cancer, respiratory diseases and developmental difficulties are among the many health problems associated with contaminants in the air children breath, the water they drink, the food they eat and the areas where they play.

The rapid growth and development of fetuses, infants, and toddlers makes them particularly susceptible to environmental insults. Studies from The National Institute of Environmental Health Sciences (NIEHS) (1997) in the United States indicate that nursing mothers can transfer toxins such as PCBs to their infants through breast milk or, earlier, to the developing fetus.

Unfortunately, like most other areas of research on healthy child development, very little energy has been devoted to exploring how exposure to environmental contaminants determines the healthy development of girls, specifically. The NIEHS appears to be one of the few organizations considering gender-based differences. Preliminary data from two studies on the impact of exposure to lead indicate that girls exposed to lead store the metal in their bones. This

lead can be released when they become pregnant years later, exposing their fetuses to this toxic substance.

### ***Personal Health Practices***

Good infant health is closely related to the mother's health during pregnancy, to her life circumstances and to her health practices. Children of mothers who do not receive adequate prenatal nutrition, who smoke and consume alcohol or other illicit drugs during pregnancy are at higher risk of experiencing negative health outcomes than children of healthy mothers.

#### *Tobacco Consumption*

Among the most sensitive outcomes related to fetal exposure to tobacco (via maternal consumption or environmental tobacco smoke) is low birth weight. It is an unfortunate reality that approximately one in four pregnant women in Canada smokes (Canadian Council on Social Development, 1996). When a pregnant woman smokes, tobacco toxins and other harmful chemicals pass directly through the placenta to the fetus, reducing the fetus's oxygen supply (National Council of Welfare, 1997b). These dangerous toxins can also be passed on to an infant through breast milk or exposure to environmental tobacco smoke. Babies born to smoking mothers are also at risk of experiencing nicotine withdrawal and being more irritable and cranky.

#### *Alcohol Consumption*

Of similar concern is the development of fetal alcohol syndrome (FAS) among children born to mothers who consume alcohol during pregnancy. FAS involves serious neurological damage and is estimated to be the leading cause of developmental handicaps in Canada (Canadian Council on Social Development, 1996). Some research suggests that boys may be more susceptible to the negative effects of FAS than girls.

Children born with fetal alcohol effects (FAE) have normal intelligence, but suffer from behavioural problems and learning disabilities. The prevalence of FAS and FAE appears to be particularly acute in some remote and some Aboriginal communities.

#### *Breastfeeding*

Breastfeeding enhances the healthy development of newborns by contributing to healthy brain and nervous system development, helping to protect babies against respiratory disease, gastroenteritis and Sudden infant Death Syndrome, and supporting important mother-child bonding. According to the Breastfeeding Committee for Canada, "breastfeeding is the unequalled way to provide optimal nutritional, immunological and emotional nurturing for the growth and development of infants" (May, 1998).

Because breastfeeding prevalence rates in Canada are variable, it is difficult to conclude whether or not breastfeeding impacts differentially on the healthy development of girls and boys. Moreover, it is not known whether or not mothers persist longer in breastfeeding girls or boys, nor if there are differences in prevalence rates among different ethno-cultural populations.

### *Play Activity*

As already discussed, research on children's play behaviour has shown that by age 3, children select and play with same-sex stereotyped toys more than with toys sex-typed for the opposite sex. There is general agreement among researchers that boys' choices and play tends to be more rigidly sex-typed than that of girls (Trautner, 1993). Boys also tend to be more influenced by their peers than girls. Trautner concludes that, in general, young girls tend to be less motivated by gender stereotypes in early play.

This differentiation may have to do with the fact that male-identified objects or modes of play have a higher social value, thereby placing more pressure on young boys to adhere more rigidly to a process of development which enables them to acquire the related "masculine" skills or traits.

### ***Individual Capacity and Coping Skills***

#### *Genetic Endowment*

Exploration of the biologically sex-based differences in child development is a relatively new phenomenon. As already mentioned, female infants appear to have a biological advantage over their male counterparts. Boys experience a higher rate of birth-related complications than do girls: boys suffer a higher incidence of birth defects, and more negative effects from fetal alcohol syndrome than do girls (Eme and Kavanagh, 1995). Boys under the age of 1 are also more likely than girls to be born low birth weight, to be admitted to hospital and to suffer respiratory system problems (Canadian Institute of Child Health, 1994).

Keenan and Shaw (1997) note that at birth girls are already considered to be 3 weeks ahead of boys in terms of physical maturation, and by school entry they are on average 1 year ahead. Girls also develop pro-social behaviour, empathic response capabilities and language facility earlier than boys. This early linguistic advantage appears to persist regardless of parental interventions, preschool programs, and family and personal risk factors.

Many researchers point to biological differences and chromosomal weaknesses for the answers as to why boys are more vulnerable to various congenital and environmental factors during early childhood development than girls. Unlike their colleagues in the "social determinants" camp, these researchers examine issues related to early neurological impairment, male organismic immaturity, chromosomal inactivation, and fetal testosterone levels (Eme & Kavanagh, 1995).

Some of the most compelling research done around biological determinants of healthy development has been in relation to psychological stress and the onset of conduct disorders among young children. In a review of the literature, Eme & Kavanagh point to a seminal study conducted by Rutter (1970) which affirmed a biological link between gender and susceptibility to psychological stress. Boys were found to be more seriously affected by stress than girls. Subsequently, researchers have concluded that girls seem to have a physiological buffer which enables them to weather psycho-social stress relatively unscathed.

## *Brain Development*

Equally compelling is the case that many researchers are putting forward about the importance of the brain in relation to the development of a child's individual capacity and coping skills. At birth, a child's brain is a somewhat primitive structure. It may be compared to a computer: wired to perform, but requiring a lot of programming. Circuits in different regions of the brain mature at different times. The brain is most receptive to the greatest, and perhaps most important, degree of "programming" during the first three years of life.

The brain develops through neural connections. Connections that are reinforced through a baby's exposure to language, images, sound, facial expressions and rudimentary lessons in cause and effect become permanently imbedded in the brain. Connections that are not reinforced through repeated early exposure are lost forever. Consequently, children who do not receive positive early stimulation do not develop a brain equipped with the same degree of advanced wiring as a child who does (Newsweek, 1997).

According to researchers like Keating and Mustard (1996), it is the brain that mediates, to a large extent, a child's present and future ability to negotiate the challenges presented by their environment. Consequently, children who are not given the opportunity to fully develop their brain's capacity through adequate and sustained stimulation face social, emotional and developmental disadvantages.

Keating and Mustard (1996) reference a study conducted on a group of high-risk Jamaican children randomly allocated into four groups at birth - no intervention, nourishment, stimulation, stimulation plus nourishment - and followed until age two. The group of children given both stimulation and nourishment reached the same level of development as the normal group of children. Children in the other groups achieved only 50% of the development of the control group by the age of 2. Although no follow-up studies have been conducted to assess long-term impact, there is no question that inadequate early support and stimulation deprives a child of the essential building blocks necessary to fully develop. Little has been done to assess the neurological differences between male and female children.

## *Disability*

Research on the impacts of physical and development disabilities on the health and well-being of children in Canada is relatively sparse. Results from the 1991 Health and Activity Limitation Survey show that 7.2% of all children in Canada have a disability. At every age, more boys than girls have a disability, except in the 15-19 year old category where the percentage of young women with a disability is 8.3% vs 7.4% among the young men.

The most common long-term condition suffered by children 0-14 years of age is a learning disability. 46% of children in this age group are limited or prevented from participating in school, play or other normal activities because of their disability. Similarly, many of these children are unable to access community physical recreation programs or competitive sporting opportunities. Most young people and youth with disabilities would like to be more physically active and participate more in the community.

Accessing appropriate support services is also a challenge for infants and preschoolers with a disability. 43% of all children aged 0 to 4 with disabilities have needed child care at some

time. Twelve percent of these children have been refused the service. Similarly, children aged 5 to 14 report that their disability has interfered with their education in some way. 1.5% of all children and youth with disabilities need specialized accommodation features but do not have them (Canadian Institute of Child Health, 1994).

Young women with disabilities are particularly vulnerable to violence and abuse. Research has shown that these young women are more likely than their able-bodied peers to experience violence (Canadian Panel on Violence Against Women, 1993).

Despite the lack of research specific to the needs and concerns of girls and young women with disabilities, it is clear that as a society we are not meeting the needs of our young people with special needs.

## ***Community Institutions***

### *Early Childhood Programs*

The extent to which early childhood programs produce long-term benefits in children's cognitive development, socialization and school success is a matter of some controversy. In a review of 36 model, early childhood demonstration projects and large-scale public programs in the United States, Barnett (1995) concludes that, in the short-term, these programs can produce benefits for children on intelligence quotient (IQ), and sizable long-term effects on school achievement, grade retention, placement in special education, and social adjustment. This research does not make a distinction between benefits to boys and girls individually.

### *Parent Support Programs*

In Canada, there is a wide variety of community-based programs to help parents and care givers support healthy child development. Numbering over 2,000, family support/resource programs are as diverse as the families they serve. Family resource programs typically provide a range of services which can include: drop-in centres, parent education, crisis intervention, family counselling, referral services, child care, toy lending services, and resources for child care providers. These services provide families with the essential support and resources they need to respond appropriately to their child's developmental needs.

## ***Conclusion***

Drawing conclusions about the determinants of healthy girl-child development during the first few years of life is a challenge. As demonstrated above, the majority of the findings do not point to differentiating determinants of healthy development for girls and boys. This is, in part, due to the fact that until recently gender-based research was not a common practice in the field of child development.

Of the research that has been conducted, the findings are limited by methodological problems such as small sample sizes, homogeneity of study participants, reporting bias, and gender bias imbedded in research tools and questions. Much of the work completed to date has focussed on characterizing "normal" vs "abnormal" behaviour. This either/or approach may result in the researcher overlooking the more subtle differences which distinguish various developmental outcomes as they relate to boys and girls specifically.

Moreover, greater efforts need to be made to develop a more complete bio-psychological profile of the determinants of healthy development. A more holistic approach is needed to properly address questions such as: the influence of peers on sex-stereotyped behaviour; the manifestation of anxiety and stress in boy and girl-children; the impact of ethnicity and cultural diversity on healthy girl-child development; and, the early symptoms of depression among young girls.

## **Girlhood**

Very few researchers have explored the specific determinants of healthy development among pre-adolescent girls. This developmental period has all but been lost between the highly dynamic periods of early childhood and adolescence. The most compelling research conducted on this age group relates to gender identity and play and leisure activity.

### ***Play and Leisure Activity***

As discussed earlier, the process by which biological sex is translated into a gender role, and, ultimately, into a gendered identity or self-consciousness is a process of social construction. Children learn about what it means to be a boy or a girl by being exposed to accepted beliefs or norms about gender, by observing and engaging in gender-based activities, and by receiving support or censure for engaging in such activities.

Perhaps one of the most critical sites of this process of social construction is in the field of play. In a comparative analysis of children's play in Canada and Poland, Richer (1990) maintains that it is within the playworld of children that the earliest beliefs about gender are presented and reinforced.

Children learn to express gender in play by taking on sex-specific roles, by reproducing their gendered reality and by defending their gendered identity. Most of the research done on play suggests that boys are more likely than girls to engage in competitive (win/lose) activities. This can partially be explained by the fact that competitiveness and aggression are highly valued as male attributes. Carole Gilligan, in her celebrated book, *In a Different Voice* (1992), also notes that by participating in competitive games, boys learn essential societal skills related to the development of masculinity. Conversely, girls play, which tends to be done in similar groups, is often of a more cooperative nature which fosters the development of valued "feminine" attributes such as empathy, sensitivity and communication.

In his study of drawings done by grade six students in Canada and Poland depicting favourite play activities, Richer (1990) found that children typically construct their reality along male and female lines. Richer (1990) concludes that the greater the gender differentiation in a society, and the greater the perceived pay-off for replicating gender differentiation, the more likely children are to reproduce gendered stereotypes in their play, thereby, further entrenching gender roles in society.

## ***Conclusion***

Clearly, a great deal more energy needs to be devoted to exploring the various determinants of healthy development among girls during this period of growth. Given that the majority of the research conducted on adolescent girls points to adolescence as a time when many girls lose their sense of self, become insecure and preoccupied with fulfilling traditional gender stereo-

types, it would be instructive to investigate what is going on before girls experience this loss of self. We need to examine the protective factors that enable some young women to emerge from adolescence relatively unscathed, while others plunge into bouts of depression and self-doubt. Are there early signs of vulnerability that can be identified to help predict which girls will be at greatest risks? Are there critical differences in how young women of colour or young women from other marginalized populations navigate this transition from girlhood to womanhood? These are questions that must be explored.

## **Adolescence**

Growth and development during adolescence manifests itself in rapid physical, psychological and social changes for girls. For the majority of young people, adolescence is a time of self-discovery, exploration and excitement. Most adolescents enjoy physical and psychological well-being as they begin and proceed through this critical transition to adulthood.

For many adolescent females, however, the teenage years are less than happy and healthy. It is a time marked by a loss of confidence in herself and her abilities, by a scathing critical attitude toward her body and an emerging sense of personal inadequacy. Characterized by a metamorphic identity, adolescence represents a time when young women are perhaps at greatest risk of engaging in health-threatening behaviours. Young women of this age consistently report experiencing greater unhappiness, depression and anxiety than do their male counterparts (Canadian Institute of Child Health, 1994). They also report greater dissatisfaction with their bodies and their appearance than do young men (King et al., 1996).

As discussed earlier, most girls have the skills to meet the demands of the preschool and school-age periods. These same girls, however, do not seem equipped with the appropriate tools to navigate adolescence with comparable ease. Adolescent girls appear to be more vulnerable to emotional and behavioural problems during this period than at any other period throughout their development.

Is there something unique about this developmental phase that places otherwise “well-adjusted” girls at high risk for a number of negative health outcomes? Or, is it that these girls were showing signs or symptoms of vulnerability all along, and simply being ignored or overlooked?

A great deal more research needs to be done before these questions can be answered. As already mentioned, we know very little about the protective factors which enable some girls to navigate this turbulent period with their health and identity intact, while others meet with the fates of ravaging eating disorders, depression, teen pregnancy, and violence.

## ***Social and Economic Environment***

### ***Gender Identity***

Adolescence is widely acknowledged as a time when young women begin to seriously experiment with a proscribed “feminine” gender identity. It is a time when cultural norms and values related to what it means to be a woman are tested, learned and adopted. In her acclaimed book *Reviving Ophelia*, Mary Pipher (1994) refers to adolescence as the time when “the gender roles get set in cement, and that’s when girls need tremendous support in resisting the cultural definitions of femininity” (p.286).

Preoccupied with what her peers think of her, the adolescent girl is vulnerable to stereotypical gender images which outline what it means to be a popular, successful, happy and healthy young woman. Many of these images idealize being underweight, smoking, being promiscuous and being submissive to men. Anxious to conform, many young women place their healthy development in jeopardy in a bid to fit-in and fulfill a proscribed gender identity.

Interestingly, researchers Covey and Feltz (1991) have found that an androgenous gender role identity is associated with good adjustment for adolescent females and that it is the independent contribution of the characteristics of masculinity that appear essential for the positive adjustment of adolescent females.

### *Peer Relationships*

Adolescence is often characterized as a period of emerging independence and autonomy. At this age, many girls begin to pull away from their attachment to family and begin to identify more directly with their peer group. This is a time of searching for the self in relationships, a time when peer opinion and validation takes on unprecedented importance. The question perhaps foremost on young women's minds is "am I okay, do I fit in?". Group identity is often defined by style of clothing and favourite music (Artz and Riecken, 1996).

While peers can be supportive and positively mutually reinforcing, they can also be punishing and growth-destroying. Today's peer culture can be very demanding on young women. Desperate to be considered "one of the gang", most young women are vulnerable to pressure from peers to conform to a certain image or to engage in a certain behaviour. For some, this may mean engaging in risk behaviour such as smoking, drinking, violence and unprotected sexual activity.

Mary Pipher (1994) speaks to the potential damaging impact of peer pressure on the healthy development of girls and young women. She tells the story of one young woman who was so dependent on peer approval that she engaged in early sexual behaviour based not on her own needs or desires, but on her sense of what other people wanted from her.

Generally, socialized from birth to be "other identified" and to put the needs and wishes of others before their own, young women are particularly vulnerable to the pressures of a peer culture which emphasizes "belonging" and group identity at all costs.

### *Family Relationships*

As peers take on a greater importance in the lives of adolescent girls, family relationships often take on a different importance. Young women begin testing the boundaries of their own independence, often inciting parental conflict or disagreement over what is acceptable or safe behaviour. Young women try out new roles and identities in search of what Mary Pipher (1994) calls their "true self". Many researchers argue that a smooth transition into a through adolescence is facilitated by supportive parents and families. Socialized to protect and nurture familial relationships, young women may be more influenced by family functioning and processes than their male counterparts (Ratti et al, 1996).

Not all young women, however, have the benefit of supportive families. For many young women, the family home is characterized by violence, absentee parents, alcoholism, poverty

and neglect: all factors which place them at risk of experiencing negative emotional, physical and social health outcomes.

The research suggests that family may also play a unique role in the lives of many young women from ethno-culturally defined communities where the father holds all of the power within the family. In some situations, this may mean that the father maintains his power through physical and emotional coercion (Report on an Information Session with Ethno-cultural Communities on Family Violence, 1994).

### *Socio-Economic Status*

The link between poverty and poor health outcomes has been well established. In 1996, the poverty rates for children in Canada under 18 years of age rose to 20.5% (National Council of Welfare, 1997a). Different studies have shown that teenage mothers, low-school achievers, and homeless young women are at high risk of living in poverty.

One critical determinant of long-term poverty is early school leaving. According to Statistics Canada and Health and Welfare Canada (1991), 18.9% of females drop out of school. The four most common reasons cited are: boredom, preferring work to school, problems with school and other reasons not stated. Among 16-17 year old youth, poor youth drop out of school at least twice as frequently as their non-poor peers (Thomas and Brunton, 1997).

### *Violence*

An alarming number of young women experience violence at the hands of family members, boyfriends, acquaintances and strangers. A growing body of literature has emerged examining the impacts of violence on young women. Research on the long-term impacts of child sexual abuse suggests a broad range of symptomology that includes: depression, low self-esteem, fear, guilt, interpersonal problems, sexual difficulties, suicidality and self-destructive behaviour (i.e. slashing or self-mutilation) (National Clearinghouse on Family Violence, 1997).

A large number of young women also experience violence on a daily basis in the form of sexual harassment. June Larkin (1994) calls upon us to acknowledge the experiences of young women attending average Ontario high schools where, as they walk along the corridors, young women may find themselves graded by their male peers on a scale of 1 to 10 for the appearances of their legs, their breasts and their overall body shape. And, where particularly sexually active males are highly respected as “studs”, and sexually active girls degraded as “sluts”. Many young women have to withstand verbally abusive language of a sexual nature repeatedly each day. So inured to verbal sexual abuse, most of these young women no longer regard it as abuse, viewing only rape and other violent physical interference as abusive. They, nonetheless, are hurt by it.

Simply being a young woman is a risk factor associated with vulnerability to violence. Research on family violence and ethno-cultural communities suggests that young women from these communities may be particularly vulnerable to the affects of family and dating violence. According to a report detailing the outcomes of an information session held with ethno-cultural communities on the subject of family violence in Ottawa (1994), there is great fear among women who are victims of familial abuse to report the abuse and risk being ostracized from their family and community. Moreover, women who do report or who leave abusive situations

are often confronted by a social service delivery system which is not responsive to her particular needs or sensitive to her cultural frame of reference.

Similarly, because some cultures do not accept dating, young women who experience dating violence are often forced to remain silent to avoid the risk of being caught dating and perhaps further abused.

Violence directed at young women from an ethno-culturally defined community does not always take the form of physical abuse. These young women are often assaulted by racist language, attitudes and behaviour. For others, violence may come in the form of Female Genital Mutilation (FGM). According to a new report presented to the 47th World Health Assembly, between 85 and 114 million girls and women have been subjected to female genital mutilation - some of whom are living in Canada. FGM is an issue of concern as it relates to the health, well-being and human rights of women and children. It is a reflection of discrimination against women and has immediate dangers for the girl-child, affecting her physical, sexual and psychological development (National Organization of Immigrant and Visible Minority Women of Canada, 1995).

More research needs to be done to examine the risks of experiencing violence associated with being a young women of colour or a young women from an ethno-culturally defined community.

### ***Personal Health Practices***

#### *Alcohol Consumption*

The use and abuse of alcohol among young Canadians can be a precursor to varied health related problems. According to Statistics Canada (1992), most young Canadians drink to be sociable and to relax and feel good. In a cross-country study of student health behaviours, King et al. (1996) found that 12% of girls aged 13 and 38% of 15 year old young women in Canada reported having been really drunk two or more times in the past school year.

These same young women are at higher risk of smoking and low school achievement than their non-drinking peers. Moreover, young women who drink to the point of drunkenness leave themselves more vulnerable to physical and sexual assault.

Despite these risks, young men are more likely than young women to report alcohol related problems; and, teenage girls are less likely to engage in drinking and driving (Statistics Canada, 1992).

#### *Smoking*

In November of 1994, 29% of adolescent women aged 15-19 in Canada smoked, compared to 26% of young men. Approximately 2/3 of these young women smoked daily - an average of 11 cigarettes per day (Health Canada, 1994). Over one quarter of these young women started smoking before the age of 13. Smoking prevalence is much higher in Northern Canada where 26% of girls aged 10 to 14 and 62% of young women aged 15-19 are smokers (Edwards).

The reasons compelling young women to begin smoking are many and varied. Some begin smoking to gain social status, others are influenced by peer pressure, some are enticed by the media and advertising and others by a desire to be perceived as rebellious or independent. Young women with low levels of education or academic success are more likely to smoke than their high achieving peers (Edwards). Pregnant teens are also more likely to smoke than their non-pregnant peers.

Research indicates that female adolescent smokers are likely to cite stress and worry as reasons for smoking. Studies have also shown that smoking behaviour is highly influenced by family and peers. Teens who live in homes where adults smoke are twice as likely to smoke themselves. Similarly, young adolescent women who have a best friend who smokes are also highly likely to be smoking (Edwards).

Perhaps the most troubling determinant of female adolescent smoking behaviour is the desire to be or to remain thin. Concern about body image and weight control plays a large role in the decision to smoke among this population. According to the CAAWS, “adolescents who smoke to control their weight are more likely to be Caucasian, older girls who are restrained eaters” (p.14).

In a study of 30 Ontario female students - smokers and non-smokers, alike - one young woman commented, “I know a lot of girlfriends who [used smoking to lose weight]. In fact, the majority of girls that I know use it to lose weight” (Edwards). Among current smokers, the fear of weight gain is a clear deterrent to quitting. For these young women, choosing smoking over healthy eating allows them to maintain a coveted “control” over their bodies while achieving a closer approximation of the feminine ideal of thinness.

### *Physical Activity*

The physical and emotional health benefits of regular physical activity have long been proven at every stage in life. The Canadian Association for the Advancement of Women and Sport maintain that regular physical activity will help young women to:

- buffer the effects of stress, anxiety and depression;
- to partake in group activities, make friends and develop meaningful relationships with peers and caring adults;
- to engage in activities (i.e. hockey, rock climbing) as a way to rebel against societal pressure to assume a passive female role;
- to gain social status. This may be particularly helpful to improving the status of teenage girls from minority groups;
- to maintain a healthy weight;
- to build physical, social, and general self-esteem. Australian research has shown that girls who are physically active have higher self esteem (Frydenberg and Lews, 1993).

Research has also shown that physical activity practised at an early age is associated with a lower prevalence of breast cancer among women (Moisan et al, 1991). Moreover, studies of

the relationship between self-reported physical activity levels and self-image, gender role identity and self-perceived physical ability and attractiveness suggest that physical activity during adolescence is associated with better emotional health. Physical activity may, in fact, help build competency and resiliency among young women.

Despite these obvious health benefits, an alarming number of previously active girls stop participating in sporting and other physical activities upon entry into adolescence. Published in 1992, *The Health of Canada's Youth* (King et al., 1996) shows that Canadian girls become much less active than Canadian boys between the ages 11 to 15. The study found that at age 11, 70% of boys and 51% of girls exercise at least 4 times per week out of school. By age 15, these numbers drop to 61% and 36% respectively. Moreover, by age 15, 17% of boys and a startling 41% of girls exercise only once per week, or not at all. This, combined with the fact that 15 year old girls are more likely to smoke and drink than their male counterparts, places them at greater risk of experiencing negative physical and emotional health.

So, why the sudden decline in physical activity at the onset of puberty among young women?

The CAAWS points to systemic or institutionalized gender bias to more fully explain the decline in female physical activity. They maintain that traditional sports programming has been largely unsuccessful in attracting girls, in particular, those who are at highest risk of engaging in risk taking behaviour such as smoking. Overall, society does not encourage girls and young women to be active to the same extent as boys and young men. Girls are expected to be less interested in physical activity. Historically, women have been presented with two options: womanhood or athleticism. The image of the athletic woman runs smack in the face of a more traditional gender stereotype of woman as quiet, non-competitive, weak and submissive. In the past, women who have pursued sport as a career have often been the brunt of sexist and homophobic attacks, accused of neglecting their womanly duties, or of being a lesbian (McNinch, 1996).

Consequently, young women are provided with fewer positive female role models for sport participation and are given fewer opportunities to develop the specific skills and motor control necessary to enjoy a variety of physical activities. For some young women, the pressures to conform to a female gender identity stereotype impede their ability and desire to engage in physical activity. Researchers over the past 3 decades have been suggesting that the decline in physical activity is largely due to the conflicting demands of being physically active and maintaining a feminine gender role (Covey and Feltz, 1991).

Gender stereotyping, however, does not exclusively explain the lack of female participation in various physical activities. Some girls cite pressures due to school, work or family responsibilities as primary impediments. Others say that cost is a barrier. And yet others sight unfair treatment, bullying and sexist attitudes of teen men as reasons not to participate (Edwards).

Unfortunately, very little has been written about the relationship between ethno-cultural identity and physical activity as a determinant of health among girls and young women. It would stand to reason, however, that the already marginalized status of so many girls and young women of colour would only serve to further impede their participation in physical activity.

### *Sexuality and Reproductive Health*

Sexual health is an integral aspect of the overall health and well-being of every individual. A tragic expression of our failure as a society to support the development of healthy sexuality among young women is the high incidence of pregnancies, abortions and STIs (sexually transmitted infections). It is estimated that 12% of young women have engaged in sexual intercourse at least once before the age of 15. Among young women aged 15 to 19, 83% report having had one sexual partner in the past year (Canadian Institute of Child Health, 1994).

Somewhat alarming in and of themselves, these statistics takes on greater significance when considered in relation to the fact that:

- age of first intercourse is a strong predictor of one's future number of partners and the possibility of becoming infected with a sexually-transmitted disease (Planned Parenthood Nova Scotia, 1996);
- the majority of youth do not use condoms (Planned Parenthood Nova Scotia, 1996);
- 57% of 15-19 young women believe that they are at not risk of acquiring a sexually-transmitted disease (Canadian Institute of Child Health, 1994);
- 15-19 year old women have the highest reported rate of chlamydia and gonorrhea (Planned Parenthood Nova Scotia, 1996);
- untreated sexually-transmitted diseases can result in irreversible female infertility
- 26% of 15 to 18 year old young women who are sexually active use no form of birth control (Canadian Institute of Child Health, 1994)
- 64% of 15 to 19 year old pregnant teens carry their babies to term (Canadian Institute of Child Health, 1994)

It is the unfortunate reality that young women are often reluctant to seek birth control because of the negative stigma attached to young women who plan to have sex. Young women who openly engage in sexual activity risk being labelled a "slut" and ostracized by her peers. These same young women are exposed to stereotypical views reinforced by the media and by pornography that women are to be passive and men aggressive and powerful in the context of sexual decision-making.

These prevailing attitudes lead many young women to deny their sexuality and to deny their need to protect themselves. The barriers to accessing appropriate sexual health information and protection are perhaps greatest among visible minority, lesbian and disabled youth who are already marginalized from mainstream services (Planned Parenthood Nova Scotia, 1996). This, despite the fact that various studies have proven that inaccessibility to quality health services and education is a determinant of unsafe sexual behaviour. Similarly, research has shown that access does lead to postponement and reduced sexual activity (Planned Parenthood Nova Scotia, 1996).

### *Teenage Pregnancy*

The healthy development of a small number of young women in Canada is seriously compromised by teenage pregnancy. Teenage mothers and their infants are at higher risk of toxemia, anemia, premature labour, stillbirths, perinatal death, and low birth weight babies than non-teen mothers and their babies. These outcomes are often compounded by factors related to socio-economic status, lack of prenatal care, nutrition, lifestyle, ethnicity, and marital status (Isberner and Wright, 1987).

In addition to the immediate health risks posed to teenage mother and baby, the long term social and physical health impacts of early pregnancy are equally important. Canadian and American research has pointed to the fact that teenage mothers are at higher risk of dropping-out of school, of experiencing lower formal educational achievement, and poor occupational outcomes, of losing employment opportunities, experiencing the trauma of abortion, relying on welfare, being abused, and divorcing than their non-pregnant peers (Grindstaf, 1988, Holden et al, 1993).

These same mothers are also more likely than their non-pregnant peers to have an unstable family background and to have a peer group that models deviance, and/or a close relative or friend who was or is a teenage parent. Similarly, a link has been found between poor school functioning and risk for teenage pregnancy. Not surprisingly, pregnant adolescents have also been found to engage in sex more frequently and are more likely to do so without contraception than their non-pregnant peers (Holden et al, 1993).

### *Violence*

Violence impacts the lives of many adolescent women. The majority of research conducted on the effects of violence on the health and well-being of girls and young women has focussed on the girl as victim. Over the past ten years, the complexion of this research has changed to reflect an emerging interest in the girl as perpetrator. However, because violence among adolescent girls is a recent phenomenon that has not been studied systematically, the nature and extent of the problem remains largely unknown.

To date, the majority of research on the determinants and impacts of adolescent violence has been dominated by male subjects. Where adolescent females are concerned, little appears to have been written which addresses the cultural and contextual dynamics which influence female aggression and violence. In a study of violence among adolescent female students in a suburban school district in British Columbia, Artz and Riecken (1996) attempt to fill in some of this missing knowledge.

Based on the findings from a Survey of Student Life and from a series of interviews and focus groups with girls who had been both victims and perpetrators of violence and their families, teachers and school administrators, Artz and Riecken (1996) explore the socio-cultural factors contributing to violent behaviour among female adolescent students. Despite the small sample size ( $n=6$ ), this study reveals some compelling findings.

Not surprisingly, the survey found that males engage in deviant and violent behaviour to a much greater degree than do females (90% vs 10%). Of note, however, is the fact that

20.9% of the females who participated in the study said that they had beaten up another kid at least once or twice in the past year.

Compared with girls overall, the high deviance girls reported higher levels of smoking without permission, skipping classes and school, lying to parents, staying out all night without parental permission, stealing, carrying a weapon, damaging property. It is noteworthy that the level of participation in deviant behaviour drops off as the behaviour becomes more serious.

Membership in an identified peer group was of particular importance to deviant girls. These girls placed a higher value on freedom, humour, their looks, being popular, wearing the rights clothes and belonging to a group or gang than girls overall. Not surprisingly, the deviant girls endorsed violence as a form of acceptable behaviour.

Given the higher level of violence in their lives, deviant girls reported being more afraid of experiencing physical and sexual abuse than girls overall. In general, the highly deviant girls had been victimized more often than girls overall. They reported being the victim of physical abuse at a rate of 19% vs 7.2%; and the victim of sexual abuse at the rate of 26.9% vs 11.1% for girls overall.

For many girls, the family home is where they first experience violence either as a direct victim or a witness. Artz and Riecken (1996) also found that the majority of girls who engaged in deviant behaviour were from homes where aggression, intimidation and emotional violence are strategies used to deal with conflict.

In a study of 59 families with a delinquent daughter and 59 families with daughters of the same age who were not in conflict with the law, Offord et al (1979) found that young female offenders were much more likely to come from a “broken” home. A positive correlation was also found between maternal mental illness and delinquency. Fathers of delinquent daughters were more likely to have a history of law involvement; and, both mothers and fathers of delinquent young women were more likely to have a welfare history.

Historically, our understanding of the “delinquent girl” has been tainted by institutionalized gender bias. In a review of the literature around female delinquency and the role of women in society, Sherrie Barnhorst refers to the entrenched stereotype of a young woman in conflict with the law as being “emotionally troubled and promiscuous”. In essence, the delinquent young woman is perceived as someone who is unable to adjust to or accept her female role.

The question remains, however, as to why some girls respond to these expectations and life circumstances in a manner which places her in conflict with the law while others do not. We need to examine the impact that factors such as peer involvement in delinquent behaviour, social environment, socio-economic status and ethno-cultural diversity have on determining delinquency among girls and young women.

### ***Individual Capacity and Coping Skills***

Because adolescence is a time of tremendous change and adaptation, for many adolescents it is a time of stress. In a paper on adolescent coping, Frydenberg and Lewis (1993) report on an Australian study of secondary students which assessed problem-solving and emotional regulation in response to a particular concern. The study found that, not unlike adult women,

young women are more inclined than their male counterparts to rely on friends or to use their own personal resources to deal with a problem. These same women are also more inclined to use problem-solving, wishful thinking and withdrawal as coping strategies. The study concludes that when confronted with a concern, boys turn to sport and physical relaxation, and girls use existing relationships and wishful thinking in coping.

Perhaps of greatest interest and concern is the fact that young women use “tension reduction” strategies more frequently than their male counterparts. These strategies may include: crying, screaming, smoking, drinking, drug use, and, in more extreme circumstances, self-mutilation. Young women also report putting more energy into somewhat more dubious strategies such as worry and self-blame. Like wishful thinking, these last two approaches may be reflective of a young woman’s feelings of powerlessness to alter her situation in a world which continues to privilege male over female.

And whereas the majority of the research on young women’s coping has focussed on the weaknesses or damaging aspects of these common strategies, a new, more empowering body of literature has begun to recast these strategies in a new light. These works attempt to understand responses such as smoking and self-mutilation in so far as they represent a young woman’s understandable response to a world which continues to place undo pressure on her to conform to a rigid and often confusing gender identity stereotype. These responses become a form of resistance rather than weakness.

### *Menstruation*

Menarche is recognized as an important transition point in the emotional, social and physical development of girls. The age of onset of menarche has been found to be a critical predictor of various physical and emotional developmental outcomes. Strongly associated with body weight (Moisan et al., 1991), the onset of menstruation represents a pivotal point in the development of a young woman’s body image and sexual identity.

Not all young women, of course, experience the onset of menarche at the same age. There is debate as to the impact of early, late or standard onset on healthy mental and physical development. In a study of age of onset, Caspi and Moffit (1991) argue that “no other group experienced more adjustment difficulties throughout adolescence than early maturers with a history of behavioural problems earlier in childhood” (p.166). This subject necessitates a great deal more research attention.

### *Mental Health*

Research has long held that women express their mental health problems quite differently than men. The same goes for girls and young women. In general, females are expected to express distress through internalizing behaviour which, typically, manifests itself in outcomes such as depression, anxiety, low self-esteem, eating and personality disorders.

All too often, a form of biological determinism is used to explain these differences. Alternative explanations should look to women’s disadvantaged social status, her vulnerability to violence, poverty and social isolation for a more appropriate assessment of the factors contributing to her behaviour. Researchers need to examine the relationships between the social experience of being female and a woman’s way of expressing her distress or unhappiness. This

is perhaps of greatest importance when considering the health and well-being of women who experience multiple layers of oppression due to race, ethnicity or socio-economic status.

### *Depression*

One of the most commonly identified mental health problems among adolescent women is depression. Depression can occur in varying degrees of intensity, from general feelings of sadness to suicide ideation. Research has shown that young men and women respond differently to depression. King et al. (1996) have found that 25% of 15 year old boys and 39% of 15 year old girls report feeling low or depressed once a week or more. Depressed boys tend to be irritable, withdraw socially and suffer from insomnia, whereas girls become less positive about their body image, they lose their appetite, experience bouts of sadness, unhappiness, social isolation and loneliness.

In a study of adolescent depression among girls, Petersen et al. (1991) identify a number of key determinants of depression onset among young and older female adolescents. They note that the differences in depressed affect between boys and girls appears to be related to changes experienced in early adolescence. Their research found that depression was more likely to be identified among early maturing girls (early onset of menarche) who had experienced negative family and school events than in later maturing girls, thereby providing further evidence that young women appear to be more susceptible to negative affective consequences when confronted with coinciding stressful events.

Findings from the Health and Activity Limitation Survey also point to the fact that almost 9% of young women aged 15-19 with a disability reported often feeling depressed or very unhappy (Canadian Institute of Child Health, 1994).

Peterson et al. (1991) suggest that closeness with parents helps to moderate the negative effects of early adolescent changes on later adolescent mental health. Similar closeness with friends does not seem to produce the same buffer effect.

### *Body Image*

Body image can be understood as one's perception of current body size. A body image ideal reflects one's desired body size. Research has demonstrated a link between body image ideals and eating behaviours. Although eating disorders such as bulimia and anorexia nervosa typically have their onset during late adolescence (Tiggerman and Pickering, 1996), weight concerns begin before adolescence.

It has long been maintained that young women with body image concerns are at higher risk of engaging in disordered eating than young women without concerns. Once considered rare, bulimia, anorexia and obesity have become mainstream determinants of the health and well-being of a growing number of girls and young women in Canada. In Canada, it is unclear exactly what percentage of young women suffer from these disorders. We do know, however, that in a recent study, 38% of 13 year old girls and 48% of fifteen year old girls in Canada felt that they needed to lose weight (King et al., 1996).

In a study of non-obese second, fourth and sixth graders and their eating and body image concerns, (Thelen et al., 1992) found that among the fourth and sixth graders, girls indicated

more concern than boys about being or becoming overweight, about the effects of eating food, and a desire to be thinner. Similarly, in the United States, the majority of girls report dieting before the age of 12.

A number of hypotheses have been put forward to explain this early preoccupation with body image and thinness. Many feminists point to the fact that in most Western countries thinness has become the cultural epitome of feminine success. Beauty has become the cultural currency in a society which values thinness and youth above almost all else. Constantly bombarding young women with thinness messages and images, the media has all but made it a woman's personal responsibility to strive for thinness, at all costs. To do otherwise is nothing less than a rejection of her prescribed role as a female - it is indicative of personal failure.

Some of the research points to a correlation between membership in a dysfunctional family and vulnerability to eating disorders among adolescent girls (Button et al., 1997). Other works maintain that early pubertal development and its accompanying increase in body fat are a risk factor for the development of eating disorders (Swarr and Richards, 1996).

A frequent theme in the literature on disordered eating is that low self-esteem precedes or coincides with disordered eating. A study of school girls aged 11-12 in the United Kingdom found an association between low self-esteem and greater fatness concern. These same girls were followed up at age 15-16. The follow-up study revealed that girls with low self-esteem at the age of 11-12 were at significantly higher risk of developing symptoms of eating disorders and other psychological problems by middle adolescence.

Girls who suffer from severe eating disorders such as bulimia and anorexia nervosa also place their physical health at great risk. By starving themselves and/or bingeing and purging, they are denying their body of the essential nutrients and building blocks that their bodies need to develop healthily.

Unfortunately, missing from most of this analysis in Canada is the impact that ethnicity and socioeconomic status has on the development of body image ideals. Moreover, the research has all but failed to examine the extent to which young women use their bodies as a site of resistance against prevailing gender role expectations. In this context, the determinants of eating disorders such as bulimia and anorexia nervosa could be explored in so far as they represent an effort to define one's self out of a collectively proscribed gender identity.

## ***Community Institutions***

### *School*

Over the past two decades, feminist researchers have devoted a great deal of energy to studying the influences that the traditional educational environment has on the healthy development of young women. The majority of the work has focussed on the impact that gender bias in the curriculum and among teachers has on the ability of female students to learn and to develop scholastic competence and confidence.

In a seminal study of middle school girls in the United States, Peggy Orenstein (1994) explores the "hidden curriculum" that shapes how girls and young women experience their educational environment. This curriculum refers to the ways in which schools reinforce gender

roles; to persistent stereotypes about girls's inability to achieve, particularly in math, science and technology; to the tendency on behalf of most teachers to encourage more assertive behaviour in boys at the expense of female participation, and; to the tacit acceptance of sexual harassing and discriminatory behaviour in the classroom.

For many girls, the hidden curriculum results in a loss of interest in academic excellence. For others it means retreating from all forms of active classroom participation for fear of looking or sounding "stupid". And yet for others it means suffering the detrimental affects of sexual and/or racial harassment in silence. In essence, the hidden curriculum serves to reinforce existing gender inequities which limit a young woman's ability to develop a healthy sense of self and to achieve academically.

In a piece on risk, resiliency and resistance among adolescent girls in the United States, Debra Schultz (1991) references research conducted by Nancie Zane which revealed that sexist and racist stereotypes, coupled with low income girls' perception of school as irrelevant to their needs, heighten pressure on those most at risk of dropping out. Similar research needs to be conducted in Canada.

### *Community Health Services*

Research on the relationship between accessible, community-based health services and the health and well-being of adults has produced unequivocal results: the availability and use of health care is central to the health of both individuals and populations (Evans and Stoddart, 1990). Similar research conducted in the context of multicultural populations has also found that access to responsive, culturally-sensitive health care services are a critical component of adult health (Ontario Ministry of Citizenship, 1987).

Unfortunately, relatively little research has been conducted in Canada linking access to health services and the healthy development of girls and young women. As already mentioned, one of the few areas where access to resources has been directly linked to positive health outcomes among adolescents is in the field of sexual health. Despite the lack of research, it stands to reason that increased access to a broad range of age appropriate and culturally sensitive health services would serve to augment the health status of girls and young women in Canada.

### *Conclusion*

Clearly, young women face a number of gender-based barriers to successfully navigating adolescence. Unfortunately, the research base has focussed almost exclusively on examining "deviant" or "problem" behaviour among this population. Missing from this picture are the faces of young lesbian women, young women with disabilities, young women of colour, young women who are happy and high achieving, young women who are homeless and living in poverty, and young women who are meeting the everyday challenges of growing up a girl in predominantly patriarchal society.

## CHAPTER IV - FOCUS GROUPS WITH GIRLS AND YOUNG WOMEN

The original intent of this segment of the project was to engage three separate groups of young women in a discussion of their own healthy development. The reason for doing so was threefold:

- i. To ensure the participation of girls and young women in the project, in particular, young women from varied ethno-cultural communities;
- ii. To provide space for young women to express their views, opinions, concerns, and desires in relation to their own health and well-being;
- iii. To contrast the issues raised by these groups with the research findings.

Unfortunately, these goals were not wholly achieved. In the end, a discussion was conducted with only one group of 13-15 year old young women, thanks, in large part, to the generous participation of the coordinators of the POWER Camp<sup>2</sup>. Despite multiple efforts, illness and programming conflicts made it impossible to coordinate a similar discussion with the 11 and 12 year old POWER Campers.

Perhaps most disappointing was the researcher's inability to locate a group of ethno-culturally diverse young women with which to engage in conversation. After many unsuccessful attempts to locate a leader in the community to facilitate this process, the researcher was forced to abandon this piece of the project completely. As a white woman without a great deal of personal experience working in an ethno-culturally defined community in Ottawa, the researcher felt unable to proceed on this matter alone.

### **Process**

The discussion was guided by a series of questions previously developed by Kathryn Grand of the Calgary Coalition: Centres of Excellence for Women's Health (1995) for a similar series of focus groups with young women in Alberta. The questions included:

1. What does "healthy" mean to you? (describe a healthy teenage girl)
2. What does a teenage girl need to do to stay healthy
3. What are some of the things that can put your health at risk or make you sick?
4. What do you do when you are sick?
5. Where do you get your health information from? Where would you like to get it from?

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<sup>2</sup> The POWER Camp is an Ottawa-based non-residential, all-girls camp that focuses on the developmental needs of pre-adolescent and adolescent girls. The POWER Camp helps young women to explore their creativity, the outdoors, community issues, group activities, social justice issues and self-empowerment. The POWER Camp is specifically designed as a counter-measure, as well as a preventative measure to aid the community in enhancing the physical and mental health of young women.

Working as a facilitator, the researcher recorded key words and phrases on a flip chart during the 2 hour session to reflect major discussion areas and issues. Participants were ensured confidentiality, consequently, their ideas and words are not attached verbatim. Some general conclusions, however, will be drawn from the discussion.

### ***The Group***

The group was comprised almost exclusively of white, English speaking 13-15 year old young women from varied socio-economic backgrounds. Further details about their living circumstances were not obtained. Their names were also kept completely confidential.

Perhaps the most important feature of this group is that each girl was a voluntary participant in a two week, all female “empowerment” camp. By virtue of their “camper” status, the group was already well acquainted with the concepts of women’s oppression, sexism and gender discrimination. It would be fair to say to this was a unique group of young women whose consciousness about issues related to their health and well-being had already been raised above the norm.

### ***The Discussion***

Anxious to share their ideas and opinions, the group spared no time in identifying a number of critical determinants of their health: friends, family, physical activity, nutrition, school, happiness, violence, poverty and the media.

Not surprisingly, when asked to describe a healthy teenage girl, a portrait of the “perfect” teenager emerged. Some young women commented that they would become sick if they tried to be this healthy. For some, being healthy seemed unattainable.

The discussion took a natural turn into a sharing of ideas around what young women fear most about their health. The list was long and eye-opening, including issues such as: breast cancer, pregnancy and abortion, depression, sexual assault, community/school violence, racism, addiction, isolation, peer pressure, discrimination. Clearly, today’s young women are negotiating a number of frightening and threatening realities.

In terms of where young women get most of their information about health, the primary sources identified were: school, parents, friends, and magazines. Few girls felt comfortable getting information from either parents or doctors and preferred to talk to friends or read books and magazines.

By exploring some of the barriers to accessing good health and good health information, the question of Female Genital Mutilation (FGM) was raised. An open discussion ensued about FGM and about the challenges that many young women from non-mainstream communities often face when trying to access culturally appropriate health services and information.

### ***Conclusions***

It is difficult to draw many conclusions from one discussion group. However, the researcher feels confident saying that these are the voices and concerns that need to be more effectively incorporated into future research. These young women continue to struggle every day with

issues of identity and gender role expectations as they navigate their own route to healthy development. They are our reality check.

As a society, we must continue to find ways to afford girls and young women greater opportunities to explore their fears and their assumptions, to be empowered to take more control over their health and well-being, and to engage in activities that will enable them to learn about themselves, their health and their environment.

# CHAPTER V -THE EXPERT ADVISORY GROUP

A central component of this project was the creation of an Expert Advisory Group composed of women committed to advancing the health and well-being of girls and young women in Canada. The Group was comprised of leading academics in the field, representatives from national non-governmental organizations, young women, a politician, and a government official.

Members participated in a two day meeting in Ottawa to:

- i. Engage in discussions around the current state of Canadian research on the determinants of healthy development among girls and young women;
- ii. Identify a future research and action agenda (see attached Principles, Goals and Objectives).

Held on July 14 and 15, 1997 at the Albert at Bay Suites Hotel, the meeting was a resounding success. The enthusiasm and commitment shared around advancing the health and well-being of girls and young women was inspiring. The mix of participants provided for very stimulating and varied conversation. Each member generously shared her ideas and expertise and expressed her desire to continue working as a group to ensure that the importance of gender-based research, programming and policy development does not slip off the public and political agenda.

## DAY 1

The agenda for the meeting was built around three key components: Research, Program and Policy (see attached Agenda). The first day was devoted exclusively to reviewing the research base, identifying gaps and listing future research priorities.

### ***Identifying Gaps in the Research: What Would We Like to Know?***

Participants were asked to identify gaps in the current knowledge base on the healthy development of girls and young women in Canada. In the end, the exercise turned into more of a brainstorming session on issues and topic areas that participant's wanted to see explored. The results of the discussion have been broken down into three age cohorts: infancy, girlhood, and adolescence.

#### *Infancy*

- impact of father involvement in childbirth and child rearing
- impact of multiple births on physical and emotional development

#### *Girlhood*

##### *Health Risks*

- pets

### *Technology*

- girls and technology: available resources and support systems
- equal access to technology
- role of media on self-image - how do children relate to a visual culture?

### *Smoking*

- prevalence of smoking and age of start-up - physiological vulnerability to nicotine addiction in brain receptors
- alternative outlets to smoking

### *Anger*

- what do girls do when they get angry?
- anger and the internalization of feelings

### *Health seeking behaviour*

- how do girls take care of their health? (i.e. singing in the shower rather than crying)
- child-to-child methodology
- intergenerational interaction
- how do children form relationships?

### *School Health*

- the “disadvantaged” boy phenomenon
- impacts of school reform
- home schooling as an alternative to traditional educational model

### *Adolescence*

- how do young women teach each other?
- does mentoring of young women by young women work better than mentoring of young women by older women?
- knowledge of, accessibility to health information
- healthy sexuality
- resistance
- how do young girls access, understand and act on “choice”
- ‘relational violence’ - how and why young women compete
- impacts and support for early menstruation
- the health and well-being of lesbian and bi-sexual youth
- resiliency
- poverty - sources of income and health

The group also identified two overarching determinants of healthy development which cut across each age cohort and requires immediate research attention: **ethno-cultural diversity and socio-economic status.**

### ***Methodological Limitations***

Perhaps the most informative portion of this exercise involved the identification of a variety of methodological weaknesses inherent in the current research base. Consensus quickly developed around the fact that painting a clearer picture of the relationship between gender and healthy girl-child development requires much more than disaggregating data by sex.

Research on girls and young women must begin by asking the “right” questions and using gender and age appropriate tools to both develop and analyse the answers. A critical component of asking the right question is the active involvement of girls and young women in the development, implementation and analysis of all research projects that relate to their health. To date, the majority of this research has failed to actively incorporate the voices and perspectives of girls and young women. And, whereas it was acknowledged that child and youth participation in research can be challenging, it is a challenge that must be overcome if research findings are to more accurately reflect the realities of this population.

The Group also felt strongly that researchers must begin to employ more creative ways of engaging young people in describing their life circumstances and relating their feelings. For example, engaging children in role playing or drawing was suggested as a more appropriate way to elicit authentic self-expression than the more traditional methods of data collection.

A great deal of time was spent discussing the failure of most researchers to examine the gender bias inherent in their own research methods. Researchers must be careful never to pre-judge their findings. Similarly, it was strongly felt that most research findings needed to be decoded and examined in so far as they reflect entrenched gender stereotypes rather than the authentic reality of the subjects being examined.

### ***Identifying Research Questions***

The latter part of the first day was spent in small groups discussing critical future research priorities, and identifying methods for measuring healthy girl-child development. The small groups reconvened and shared the following ideas with the larger group for discussion:

#### *Priority Research Topics*

1. Resistance - what are the strategies and circumstances that foster it?
2. Anger - how does anger impact mental health?
3. Power dynamics - where do girls feel their power?
4. Adolescence as a watershed in girl development - why do they lose ground, why do they go underground?
5. What is healthy development?
6. Where are the girls in our research?
7. Abuse - what are the cyclical consequences?
8. What does being healthy mean to young women?
9. The body - the ultimate site of resistance and vulnerability
10. Gender identity - how does it influence behaviour?

## Alternative Methodologies

| <i>Infancy</i>                                                                                                                                                                                                                                                            | <i>Girlhood</i>                                                                                                                                                                                                                                                                                                                       | <i>Adolescence</i>                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><i>Information sources:</i><br/>           parents<br/>           prenatal maternal health<br/>           grandparents<br/>           health records<br/>           community</p> <p><i>Research methods:</i><br/>           interviews<br/>           observation</p> | <p><i>Information sources:</i><br/>           girls<br/>           health records<br/>           teachers<br/>           parents<br/>           community<br/>           school records</p> <p><i>Research methods:</i><br/>           observation<br/>           focus groups<br/>           drawing<br/>           role playing</p> | <p><i>Information sources:</i><br/>           young women<br/>           peers<br/>           teachers<br/>           parents<br/>           community<br/>           school records<br/>           health records</p> <p><i>Research methods:</i><br/>           focus groups<br/>           existing research<br/>           surveys<br/>           journal writing<br/>           interviews<br/>           role playing</p> |

## DAY 2

The second day began by refocusing the discussion on the question of how to involve girls and young women in research, programming and policy initiatives. Participants were divided once again into 3 small groups: Group 1 was asked to explore barriers to girls involvement in developing programs to meet their needs; Group 2 explored barriers to engaging young women in research projects; Group 3 discussed involving young women in the policy development process.

### **Programming**

| <i>What kinds of groups/ programs could be delivered?</i>                                                                                                                                                                                                                                                                                                                | <i>Ways to get girls involved in programs</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• retreats</li> <li>• one-day conferences</li> <li>• regional focus groups</li> <li>• equity groups i.e. schools</li> <li>• computer conferencing</li> <li>• camps</li> <li>• community workshops</li> <li>• school workshops</li> <li>• videos</li> <li>• mentoring and leadership programs</li> <li>• peer mentoring</li> </ul> | <ul style="list-style-type: none"> <li>• invite them (some concern was expressed around how to get the message out)</li> <li>• make girls a part of the planning or implementation committee with age-appropriate involvement</li> <li>• engage their input from the beginning</li> <li>• allow them to prioritize the issues that are important to them - reality check</li> <li>• encourage contributions to the development of resources, manuals</li> <li>• publicize program, ie radio, presentations at conference, videos</li> </ul> |

This group also identified the critical need to develop a database or network of programs across the country that have been developed for, by and with girls and young women. This information would enable other groups or individuals interested in working with girls to explore existing programs and build upon developed resources.

**Research**

| <i>Barriers</i>                                                                                                                                                                                                                                                                                                                                                                                                                          | <i>Solutions</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• building research questions from a girl’s/young woman’s perspective</li> <li>• “short term involvement” - it is difficult for most girls and young women to make a long term commitment to a project</li> <li>• language: academic language can discourage involvement</li> <li>• lack of sensitivity to their material needs (e.g. money to travel)</li> <li>• not valuing children</li> </ul> | <ul style="list-style-type: none"> <li>• ask girls / youth for their opinions / their questions</li> <li>• unpack/decode existing research literature and methodologies</li> <li>• provide research effectiveness training for researchers</li> <li>• promote child-to-child research</li> <li>• adopt new research tools, ie. telling stories</li> <li>• involve students e.g. course work to brainstorm research questions and methodologies</li> <li>• involve youth serving organizations to brainstorm how they would circulate findings</li> </ul> |

**Policy**

This group was challenged by their task of discussing the role of girls and young women in the policy development process. A great deal of time was spent discussing “what is a policy” and “where do policies get developed.” The group noted that policy efforts which encourage the involvement of young women must be clearly beneficial. Time and energy must be devoted to critically assessing whether or not a specific policy initiative is aimed at dismantling the good things instead of improving the bad.

The group also felt that one of the best ways to engage the voices of girls and young women in the policy process is through advocacy organizations that are currently engaged in policy development. One of the primary barriers to engaging young women in the policy process is the fact that the majority of our national/provincial and local policies fail to consider this population entirely.

One of the first critical steps that must be taken towards building a more girl-friendly policy environment is encouraging existing children’s organizations and governmental departments to incorporate gender analysis directly into their own research and advocacy efforts.

## ***Next Steps***

The final minutes of the meeting were spent discussing critical next steps in furthering the achievements of this project. Each participant expressed a desire to remain connected to the group and to be involved in future girl-child initiatives. Suggested future activities included:

1. Building an inventory or database of existing girl-child programming.
2. Developing fact sheets or brochures on the healthy development of girls and young women
3. Adapting the “POWER Camp” model to meet the needs of a younger group of girls (7-8 years old).
4. Building gender-focussed parent education programs.
5. Establishing on-line chat networks around topics related to the healthy development of girls and young women.

## CHAPTER VI - NEXT STEPS

Building advanced knowledge around issues related to gender and healthy girl-child development is not simply a question of routinely disaggregating research data. Any future efforts must begin with a rigorous analysis of how research has been conducted to date, what are the strengths, what are the weaknesses and which methodological approaches can be used to produce the type of clarity and depth of knowledge that is needed.

As discussed in the literature review, the majority of the research to date on the healthy development of girls and young women has focussed on “problem” behaviour. The tools and models used to assess girl development have often been gender biased, thereby obscuring the findings. The problem-centred approach has created an imbalance in the research whereby research on negative health outcomes such as teenage pregnancy and eating disorders has come to dominate the literature. “Problem” behaviour should be recast in terms of female resiliency and resistance in a male dominated culture.

Moreover, the current research base has failed to adequately examine populations which lie outside of the mainstream. Research on young women of colour or young women from marginalized ethno-cultural communities must not be seen as simply filling in a gap, rather as contributing new perspectives that can enhance our understanding of healthy child and youth development.

Clearly, a significant amount of resources and energies need to be engaged in the pursuit of generating a more detailed portrait of the determinants of the health and well-being of girls and young women in Canada.

### **Next Steps**

As outlined in Appendix A, this project represents a first step towards the development of a more comprehensive initiative aimed at supporting the healthy development of girls and young women in Canada. The Canadian Institute of Child Health is committed to continuing to partner with governments, the private sector, academics, community activists, and girls and young women to advance this agenda.

In response to recommendations from the Expert Advisory Group, the Canadian Institute of Child Health will endeavour to fulfill the following steps:

### **A**

- i. Inventory:** Collect information on current programs and policy initiatives pertaining to the girl-child from the local, provincial/territorial and national level. Create a case study book of some of the exemplary programs.
- ii. Dissemination:** Develop a plan to disseminate the findings among key stakeholder groups for discussion and action.

## **B**

### **i. Statistical Profile:**

- a) Analyse the NLSCY data
- b) Reconvene the Expert Advisory Group to review the findings and collaborate in the development of a statistical profile of the health development of the girl-child in Canada. Presented in magazine format, this piece would blend qualitative and quantitative research.

### **ii. Dissemination/Action:** Develop a plan to distribute the profile among key stakeholders: young women, advocates, service providers, decision and policy makers, educators, etc with a view to supporting individuals and groups to begin to take action around issues of key concern and importance.

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