Teenage Sexual and Reproductive Behavior in Developed Countries

Country Report For Canada

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Part I. Levels and Trends in Adolescent Sexual and Reproductive Behavior

Demographic Profile of Canadian Adolescents and Young Adults[1]

Canada's population is unevenly distributed over 10 provinces and 3 territories, with the bulk concentrated in Ontario (37%) and Quebec (25%), followed by British Columbia (12%). The Prairie region, comprised of the provinces of Manitoba, Saskatchewan and Alberta, and the Atlantic region, comprised of Nova Scotia, New Brunswick, Prince Edward Island and Newfoundland, have sparser populations and are treated as regions rather than separate provinces in the analyses in this paper. Canada's territories (Yukon, Northwest and Nunavut) are not included in these analyses, with only some mention of data relevant to the territories when considering birth, abortion and STD rates and social and economic disadvantage. Results of the 1996 National Population Health Survey (NPHS) and Cycle 10 of the 1995 General Social Survey (GSS)[2] are the major data sets used in this paper. These data sets are fully described in Appendix A and the operationalization of key concepts in Appendix B. The population of Canada is primarily urban with over 80% living in cities, the three largest of which, Montreal, Toronto and Vancouver are located in the three largest provinces (Quebec, Ontario, and British Columbia respectively).

The face of Canada has been shaped by immigration. Originally immigrants came primarily from the United Kingdom and France and, in fact, origins in these two nations still account for the largest proportions of the Canadian population (collectively over 50%). However, since 1981 newer immigrants to Canada have been more likely to come from Asia (48% between 1981 and 1991) than from Europe and the United Kingdom (25%), with the remainder coming from Central and South America (10%), the Caribbean and Africa (6%) or the United States (4%). Toronto receives the largest proportion of immigrants to Canada, followed by Vancouver and Montreal. After these, it is the more industrialized cities of Ontario that receive the bulk of new immigrants. Consequently, there is variation in the proportion of the population in any single region that is foreign-born.

Various measures of poverty (or poverty lines) are used in Canada.[3] In the data reported in the 1996 NPHS, individuals whose household income falls within the 1st and 2nd quintile provide a close approximation of households that fall below one of these "poverty lines," the low-income cut-off. Those in the 1st quintile are often referred to as the "very poor" and those in the 2nd quintile as the "poor." In the 1996 NPHS, 21.1% and 18.9% of youths aged 15–19 and 20–24 years respectively lived in households where the income was in the first or second quintile.

Using data from the 1996 NPHS, we see that few Canadian young adults marry before they reach the age of 20. Even in the 20–24 year cohort, the vast majority are single, with marriage more likely for women (23.4%) than men (12.8%). The typical age for completion of secondary education in Canada is 17–19. As seen in the 1996 NPHS, nearly 80% of 15–19-year-olds are in school (79.8%). However, nearly half of those in school are also employed (43.4%), with women more often than men combining employment with school (47.8% and 39.3% respectively). For young adults 20–24 years of age, most are not in school, with slightly more men than women out of school (63.6% compared to 59.8% respectively). Of those in school, a majority are also employed (28.7% in school and employed compared to 8.9% only in school).

Reproductive Behaviors of Adolescents and Young Adults

From Table 1[4] (page 10) we see that overall, the rate of births to teenage women has declined between the years 1980 and 1997.[5] This decline is related partly to

an increase in abortions, but, particularly for the years 1995 through 1997, birthrates have seen far greater changes (decreasing by 1.9 per 1000 women between 15 and 19 years of age from 1995 to 1996 and by 2.4 births per 1000 teen women for 1996 to 1997) than have abortion rates (increasing by 0.4/1000 women between 15 and 19 years of age from 1995 to 1996 and 0.1 per 1000 from 1996 to 1997). These differential changes have brought birth and abortion rates together such that the abortion rate (21.5) was higher in 1997 than the birthrate (20.2) for women between 15 and 19 years of age. What remains to be seen is whether the rates will continue in the same direction, resulting in abortions out-stripping births for those under the age of 20. When considering the effects of teenage pregnancy, what must also be taken into consideration is the proportion of teenage women who choose to raise their children as single mothers. This has seen a dramatic increase, from 25% in 1974 to 81% in 1994.[6] Considered together, the trend that appears to be emerging is for reductions in teen pregnancies coupled with more pregnancies ending in abortions than births and most teenage women who give birth choosing to embark on solo motherhood.

From 1980 to 1995, pregnancies to women in their mid-teens (15–17 years) were the most likely of those to any other age group to end in abortion, with the number of pregnancies ending in abortion slightly higher than the number ending in birth in 1995. Despite the high ratio of abortions relative to live births, the abortion rate for those under 18 years of age is lower than that for women 18–19 years (who have the highest abortion rates of all age groups) as well as that for women 20–24 years.

For all age groups, abortion rates increased most dramatically between 1985 and 1990. This coincides with the 1988 Canadian Supreme Court ruling that removed legal restrictions from access to abortion in Canada. Prior to this date abortions were only legally available in hospitals and were subject to a complicated approval procedure. Some free-standing clinics (i.e., not connected to hospitals) did operate prior to 1988. Though operating illegally, attempts to close them by bringing charges under the *Criminal Code* were generally unsuccessful, with juries consistently acquitting those charged. The 1988 Supreme Court ruling resulted in an increase in the number of abortion clinics in several regions of the country. The impact of the availability of abortions outside a hospital setting is seen in Wadhera and Millar's estimate that in 1994 1/3 of abortions occurred in free-standing clinics.[7] Though the Supreme Court removed the legal requirements that controlled hospital abortions, its ruling did not force hospitals to provide abortion services. Consequently, access to abortion continues to vary by province and region depending on the policies of local hospitals and the presence of clinics, with both of these subject to pressure from organizations that do not believe abortion should be available or that its availability should be severely restricted.

Birth and abortion rates vary across Canadian provinces and territories. Unfortunately, it is difficult to produce accurate rates of pregnancies and abortions by province since women may travel between provinces for clinic abortions, particularly when there are no clinics in their home provinces or near the region in which they live. Table 2 (page 10) shows the variation in live births by age and region for 1996.[8] The highest birthrates for each of three age groups (10–14 years, 15–19 years and 20–24 years) were found in the Canadian territories, with the next highest in the prairie provinces. The lowest rates, again for all three age groups, are in Ontario. Wadhera and Millar report the same patterns for abortion rates, using data from hospital abortions.[9] It is important to stress that these represent hospital abortions. Some provinces, such as Quebec, have an extensive clinic system, which is not represented in the figures reported by Wadhera and Millar; in others, like Prince Edward Island, there are no clinics and even hospital abortions are generally not available.

Sexually Transmitted Diseases (STDs)

While the incidence of STDs such as syphilis and gonorrhea has declined dramatically since the mid-1980s (see Table 3),[10] data on chlamydia, pelvic inflammatory disease, and viral STDs, and on the differentials between men and women, age groups, aboriginals and non-aboriginals, and regions in Canada suggest a cause for concern, particularly with respect to young women. Age and gender patterns are the same for chlamydia and gonorrhea. For each of these the incidence and prevalence are several times higher among women than men.[11] For women, rates are higher at younger ages (15–19 years) than for men (peak at 20–24 years). These gender differentials may be reflective of behavioral and biological factors: a tendency for women to partner with older men, or differences in efficiency of transmission, with transmission from infected men to women several times more efficient than from infected women to men. Data on viral STDs such as hepatitis B and herpes simplex 2,

when available, reflect similar patterns. Data on cases of pelvic inflammatory disease (PID) treated in hospitals and on ectopic pregnancy demonstrate the impact of undetected STDs. Here it is women 25–29 years of age with the highest incidence,[12] reflecting the time it takes for untreated STDs to produce such effects.

Regional distributions of chlamydia and gonorrhea follow similar patterns. Incidence is highest in the territories and prairie provinces and lowest in Newfoundland and Prince Edward Island (Table 4, page 11).[13] It is of interest that regions with the highest and lowest rates are the least urbanized of Canada's regions. The primary differences between these regions is in the proportion of aboriginal people concentrated in each, with proportions highest in the territories, followed by the prairie provinces and lowest in the maritime regions of Canada. The population of the prairie provinces also reflects the most conservative attitudes toward sexual matters when compared to other areas of Canada. Aboriginal peoples are among the most disadvantaged of Canada's population. They are concentrated in the lowest education and income categories and have experienced a history of systemic discrimination, cultural annihilation and institutional abuse.[14] They epitomize the association between disadvantage and the burden of negative health and social consequences which permeates Canadian society. The effect of this disadvantage is seen in rates of STDs which are four times higher among aboriginal peoples than in the Canadian population as a whole.[15] The association between economic disadvantage and sexual and reproductive health burden goes beyond Canada's aboriginal population, as demonstrated in research conducted in Toronto, Ontario, the largest Canadian city, with some of the most economically and socially advantaged of Canada's citizens. Hardwick and Patychuk compared the number of births to teenagers, the incidence of STDs, and the socioeconomic status of residents in city census tracts.[16] The correlation between these three factors was clearly evident with teen pregnancy and STDs concentrated in census tracts with the lowest mean socioeconomic indicators.

Age of First Sexual Intercourse

Most Canadian men and women initiate sexual intercourse activity before they leave their teens. For the youngest cohort for which we have full information about intercourse activity during the teenage years (i.e. those 20–24 years of age), over 70% in the NPHS (Table 5, page 12) engaged in their first intercourse before the age of 20. This proportion was only lower for women over 34 and men over 44 years of age in 1996. Considering successive cohorts, we see a linear shift downward in the age of first intercourse for both men and women, i.e. more Canadian youth are initiating intercourse at a younger age today than did so in the past.

This downward shift in age of first intercourse has been more accentuated for women than men. For older cohorts, men are more likely than women to report early initiation of intercourse (i.e. < 17 years); however, for the more recent, younger cohorts in the NPHS, there is greater equality between men and women in the proportions initiating activity at younger ages. This is seen, in particular, in the sub-cohort of youth 18–19 years of age, where virtually an equal proportion of men and women initiated intercourse prior to 18 years of age (51.5% of women and 51.0% of men) (see Appendix C, Table C1).

Earliest initiation of sexual intercourse is most likely among those who are in lower income groups, working in the labor force, Canadian-born rather than immigrants, and white rather than members of other racial groups.[17] When considering the income groups in the 1996 NPHS (Table 6, page 13), youth living in households in the lower income quintiles generally initiate sexual intercourse at younger ages than those in households in higher income quintiles. In the lowest income quintiles (1st and 2nd) there is also a greater disparity between the genders with more women initiating intercourse at younger ages than men, with one exception: initiation at younger than 15 years of age for youth between 15 and 19 years at the time of the survey.[18]

For both men and women and across both the 15–19 and 20–24 year cohorts, being in school was associated with later initiation of sexual intercourse (Table 7, page 14) and C3 in Appendix C). Those who were not in school had the highest proportion who initiated intercourse at the youngest ages, followed by those who were both in school and working. When the sample of respondents who were not in school was divided between those who had been employed in the past 12 months and those who had not been employed in the same period, a somewhat different pattern of sexual initiation is evident for men than for women. For men, those who had been employed initiated intercourse at an earlier age than those who had not been employed; for women this was the pattern for those 15–19 years of age, but it was reversed for those 20–24 years of age, i.e. those not employed initiated intercourse at a

younger age than those employed. The relationship between age of intercourse initiation and status with respect to school and working generally held for both age cohorts. The consistency across cohorts is particularly interesting since this suggests that both remaining in high school and continuing to post-secondary studies result in postponing initiation of sexual intercourse.

Data on initiation of intercourse by race and immigration status show that early initiation is more common among those who are Canadian-born (Table 8, page 15) and white (Table 9, page 15) than among immigrants to Canada and those who report their race as other than white. Because of the small number of immigrants and nonwhites who responded to the survey, age of first intercourse could only be compared for those who initiated prior to the age of 20 years and those who initiated at 20 years or older. The differences between groups based on race and immigration status were the most pronounced of all those considered in this paper. Seventy-three percent of Canadian-born young adults between 20 and 24 years of age reported initiating intercourse prior to their 20th birthday. There was no gender difference apparent in this group (73.6% women, 73.0% men). For those who were not born in Canada, fewer than half of the 20–24-year-olds reported initiating intercourse prior to their 20th birthday, and there was a sizable gender difference, with only 34.6% of women compared to 49.6% of men initiating in their teens. The same pattern is seen when comparing racial groups. For Canadians who refer to themselves as "white," nearly 3/4 of male and female respondents alike in the 20-24 year cohort initiated intercourse during their teens compared to 51.6% of men and 32.5% of women who refer to themselves as other than white. This raises the question of whether Canada's changing ethnic and racial composition will influence the profile of adolescent and young adult sexuality.

Age of initiation of intercourse varies across provinces (Table 10, page 16), with consistently larger numbers of young adults living in Quebec initiating intercourse at younger ages than those in other provinces and regions. The phenomenon of earlier intercourse in Quebec is most often explained by referring to the "Quiet Revolution" that occurred in this province during the 1970's and 1980's, when men and women moved away from adherence to the teaching of the Roman Catholic Church, particularly in the area of sexuality. The effect of the Quiet Revolution on sexuality in Quebec is evident in several examples: (1) Over the past 20-30 years Quebec has become the province with the highest proportion of young adults cohabiting; (2) Quebec now has one of the lowest birthrates compared to developed countries; (3) prior to the 1988 Supreme Court ruling on abortion, Quebec was the province with the first free-standing abortion clinics and the largest number of clinics and also the province in which Dr. Henry Morgentaler, a champion of a woman's right to an abortion and owner/operator of several of the clinics in Quebec, was repeatedly acquitted by juries when he was brought to trial on charges of performing abortions; (4) the University of Quebec at Montreal is the only university in Canada with a department of sexology and awards the largest number of undergraduate and graduate degrees in studies related to sexuality of any Canadian university. Researchers in this department consistently study the changing trends and patterns in sexual attitudes and behaviors of Quebecois, conducting research that is not seen elsewhere in the country. Research conducted in Quebec[19] repeatedly shows that the sexual behavior of young adult Quebecois varies with ethnic heritage. Francophone young adults initiate intercourse the earliest, followed by Anglophones, with Allophones initiating intercourse later than the two dominant language groups. Francophones are also the most likely of the three groups to use oral contraceptives prior to first sexual intercourse.[20] The numerical minority status of Anglophones and Allophones in this province results in the Francophone sexual and reproductive profile dominating in provincial statistics.

Number of Intercourse Partners in the Past Year

Engaging in intercourse with more than one partner in the previous year generally decreases with age (Table 11, page 17). When only those young adults who have initiated sexual intercourse are considered, it is those between the ages of 20 and 24 who are most likely to report having had more than one partner in the previous year. For women, 15–19-year-olds are next, while for men, 25–29-year-olds have the second highest proportion reporting more than one partner.

For men and women in both the 15–19 and the 20–24 year cohorts, higher proportions of those who are not in school than those who are in school (Table 12, page 18) reported multiple partners in the past year. While it is difficult to draw clear comparisons because of the small sample sizes in some groups, it appears that for women, the greatest difference is between those who are working, whether or not they are also attending school, and those who are only attending school. This

difference holds in both age cohorts. For men, however, the relationship between school, work and number of partners is progressive, with those not in school having the highest proportion with multiple partners, followed by those who are both in school and working, and those who are only in school reporting the fewest partners over the past year for both age cohorts.

When poverty status is considered, the proportion with multiple partners generally decreases as income increases (Table 13, page 19). This pattern is strongest for women. Men between 20 and 24 years of age are the exception to this pattern, with a higher percentage of those in the highest two income quintiles reporting more than one partner than in any lower quintiles.

Additional comparisons based on geographical regions, race and immigration status are difficult to make because of the small sample sizes in various sub-categories. Overall, however, there is little difference between groups based on race and immigrant status. The only difference is for women, where women in nonwhite racial groups appear less likely to have had more than one partner in the past year than women who report their racial group to be white.

Contraceptive Use

There are two studies available that used national samples to examine contraceptive use, the 1995 General Social Survey[21] (GSS) and the Canadian Contraception Study (CCS), conducted in 1993,[22] 1995,[23] and 1998.[24] Results of these national studies coincide with each other and with results of smaller scale studies. All studies show a consistent pattern of contraceptive awareness and use among Canadian adolescents. For example, in the 1995 CCS, 99% of 15 to 17-year-olds report awareness of the birth control pill and condom,[25] with these two contraceptives being the most frequently used by adolescent women and men[26] by a wide margin. From data in Table 14 (page 20),[27] it is clear that for women, oral contraceptives are the most commonly used method among those under the age of 30 years, whereas for men, this is condoms. Of interest is the shift to sterilization beginning around the age of 30 for men and 25 for women. By 35 years of age, this is the most common form of contraception reported by both men and women.

When the percentages reporting no sexual intercourse on the NPHS (see Table 5 and C1 pages 12 and 47 respectively) are removed from the cohorts between 15 and 24 years of age, we see that it is the youngest men and women (15 to 17 years of age) who are *most* likely to report use of contraceptives (estimated at 81% of women and 91% of men based on removal of proportions from the sample of those who reported no sexual intercourse on the NPHS).

In the largest recent study of adolescent sexual health related behavior, a survey of over 15,000 grade 7 to 12 students from the province of British Columbia, 49% of students with sexual intercourse experience reported that they used condoms, 25% used birth control pills, 8% used withdrawal, 2% used other methods, 13% did not use any method, and 3% were not sure what method was used. Overall, 33% of the males and 28% of the females reported having sexual intercourse at least once and of these students, 76% of females and 77% of males reported using some form of birth control the last time they had sexual intercourse. In all samples of Canadians, the pattern of contraceptive use changes with age. In the British Columbia study, 4% of grade 7 females used the pill at last intercourse, 55% used condoms, and 25% used no method; by grade 12, however, 45% used the pill, 36% used a condom, and 8% used no method.[28]

Commentary

It is important to recognize that the methodology used to collect the data presented in this paper excludes youth who are at greatest risk of sexually transmitted disease and teenage pregnancy. These include aboriginal youth and youth on the streets. While these youth represent a minority of Canadians of their age, the risks to their health and well-being surpass those represented in this report. Risks for aboriginal youth are seen in teen pregnancy and STD rates that are four times higher in aboriginal than non-aboriginal populations.[29] The risks experienced by street youth are evident in the data in Tables 15 and 16 (page 21), which are based on research with street youth conducted in 1988.[30] The median age of first intercourse in this sample is 13 years and the rates of STDs are many times higher than in adolescents in the general population.

Table 1. Birth and abortion rates per 1000 women aged 15-19, 15-17, 18-19, and 20-24 for selected years between 1980 and 1997

		All Women			
Year	Age	Birth rate	Abortion rate	Number of births	Number of abortions
1980	15-19	27.6	17.5	32,596	20,765
	15-17	15.0	13.8	10,546	9,650
	18-19	45.2	22.8	22,050	11,115
	20-24	100.1	19.0	112,542	22,947
1985	15-19	23.7	15.4	23,263	15,183
	15-17	13.1	11.7	7,493	6,658
	18-19	37.9	20.5	15,770	8,525
	20-24	85.3	18.8	98,272	23,177
1990	15-19	25.4	19.3	24,093	18,274
	15-17	14.1	13.8	7,817	7,635
	18-19	41.3	27.0	16,276	11,639
	20-24	85.5	26.5	83,816	28,056
1995	15-19	24.5	21.2	23,416	20,498
	15-17	13.6	13.8	7,846	7,978
	18-19	40.0	32.2	15,570	12,520
	20-24	70.6	31.5	71,142	31,812
1996	15-19	22.6	21.6	21,597	21,138
1997	15-19	20.2	21.5	19,702	21,204

For sources, see reference 4 in text.

Table 2. Live births by age group and region, 1996

Region	Age Group	# Live Births	Live Births per 1000 women
Canada	<15	227	0.23
	15-19	21,597	22.60
	20-24	61,515	71.35
Maritimes	<15	20	0.25
	15-19	2,247	26.78
	20-24	6,119	73.50
Quebec	<15	46	0.21
	15-19	3,962	16.42
	20-24	16,733	74.23
Ontario	<15	51	0.14
	15-19	6,967	20.50
	20-24	21,327	60.64
Prairies	<15	83	0.46
	15-19	5,770	34.23
	20-24	14,467	89.60
B.C.	<15	23	0.19
	15-19	2,348	19.85
	20-24	8,391	68.99
Territories	<15	4	0.97
	15-19	303	86.60
	20-24	728	207.41

For sources, see reference 8 in text.

Table 3. Reported cases and rates/100,000 population of selected sexually transmitted diseases by age and sex, Canada, 1996 and 1997

Year	Sex	Age	chlamydia	gonorrhea	syphilis	Year	PID[1]
1996	F	10-14	44.0	6.5	0.0	**1994-5**	**--**
		15-19	998.6	86.4	0.9		98.2
		20-24	941.2	65.0	0.9		120.7
		25-29	322.0	29.0	1.3		125.5
		30-39	81.5	8.0	0.4		96.6
	M	10-14	2.2	0.5	0.0		
		15-19	148.5	33.6	0.3		
		20-24	302.7	66.6	0.7		
		25-29	155.6	54.8	1.2		
		30-39	51.2	30.6	1.0		
1997	F	10-14	36.7	5.0	0.0		
		15-19	938.7	69.7	0.2		
		20-24	931.7	56.9	0.9		
		25-29	312.6	21.0	0.9		
		30-39	80.8	7.1	1.5		
	M	10-14	4.9	0.3	0.0		
		15-19	156.2	31.5	0.1		
		20-24	314.2	57.4	0.5		
		25-29	161.5	51.4	0.7		
		30-39	57.5	29.2	2.1		

[1]Pelvic inflammatory disease
For sources, see references 10-12 in text.

Table 4. Reported rates/100,000 population of genital chlamydia, gonorrhea and infectious syphilis in Canada by province/territory, 1996 and 1997

	1996			1997		
Region	**chlamydia**	**gonorrhea**	**syphilis**	**chlamydia**	**gonorrhea**	**syphilis**
Canada	114.8	16.8	0.4	111.2	14.7	0.4
Newfoundland	48.8	0.4	0.0	60.1	0.5	0.0
Prince Edward Island	95.8	0.7	0.0	101.3	0.7	0.0
Nova Scotia	113.9	10.3	0.3	119.6	10.8	0.1
New Brunswick	109.3	5.4	0.0	99.1	4.9	0.0
Quebec	90.1	6.5	0.2	77.5	7.3	0.1
Ontario	94.2	20.5	0.7	92.6	16.8	0.1
Manitoba	224.4	48.4	0.1	218.9	37.4	0.0
Saskatchewan	219.3	39.5	1.0	220.7	29.3	0.2
Alberta	174.3	16.9	0.0	171.9	17.2	0.4
British Columbia	106.7	13.7	0.5	104.4	12.1	1.2
Yukon	458.6	31.8	0.0	543.8	0.0	0.0
Northwest Territories	1344.9	187.8	0.0	1549.0	219.2	0.0

For sources, see reference 13 in text.

Source for data for tables 5-13 and appendix tables: Statistics Canada, 1998, *National Population Health Survey, 1996-97*, Ottawa: Statistics Canada.
Statistics Canada has specific guidelines for release of data.
U Estimates marked with a U do not meet Statistics Canada's quality standards for this statistical program and will not be released.
* Estimates marked with a * are subject to high sampling variability.
n.a. Information for this cell is not available.

Table 5. Cumulative percentage distribution according to age of first intercourse by age at survey and gender, NPHS, 1996

Females							
Age when first had intercourse	**Respondent's age at survey**						
	15-19	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**
<14	4.3	3.4*	3.5	2.1	1.9	U	U
14	12.8	8.3	8.4	5.8	4.6	2.9	0.9*
15	24.0	20.0	17.5	13.0	10.5	7.3	4.2
16	35.7	35.4	31.9	25.7	23.2	16.6	8.6
17	41.9	49.0	46.1	39.8	34.4	27.6	18.2
18	44.9	61.1	61.8	56.5	50.5	42.5	33.1
19	46.8	68.5	68.9	65.7	58.5	54.5	45.9
20	n.a.	72.7	73.6	71.8	67.2	64.5	55.8
21 or older	n.a.	76.5	85.7	84.4	81.5	79.8	80.3
Never had intercourse	45.1	15.2	3.5	1.5*	1.5	2.1	1.2*
Age not reported	8.1	8.3	10.8	14.1	17.2	18.1	18.5
Weighted N	1,024,800	924,300	1,005,300	1,257,300	1,340,600	1,252,200	995,900
Unweighted N	2,202	2,759	3,422	4,150	4,068	3,367	2,866
Males							
Age when first had intercourse	**Respondent's age at survey**						
	15-19	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**
<14	3.6*	3.2*	6.1	3.5	3.1	3.4	3.2
14	9.6	8.4	11.3	9.1	7.1	7.2	5.3
15	17.8	18.9	20.8	17.3	18.2	14.3	13.2
16	27.5	34.5	36.8	33.0	31.2	25.3	21.8
17	33.5	50.0	50.1	48.0	46.4	37.4	32.7
18	37.7	65.2	62.5	61.8	60.1	55.3	49.0
19	38.1	70.5	69.7	66.7	64.7	63.9	55.2
20	n.a.	72.6	74.2	71.6	70.6	70.1	64.4
21 or older	n.a.	76.3	82.2	80.7	80.2	80.7	77.4
Never had intercourse	52.7	10.6	4.7	2.5*	2.2*	U	U
Age not reported	9.2	13.1	13.2	16.8	17.6	18.6	21.9
Weighted N	1,086,000	948,300	1,003,100	1,205,800	1,398,700	1,246,200	1,048,600
Unweighted N	2,247	2,394	2,940	3,704	3,953	3,296	2,776

Table 6. Cumulative percentage distribution according to age of first intercourse by age at survey, gender and household income quintile, NPHS, 1996

Females	**Income Quintiles**					
Age of first intercourse	1st & 2nd		3rd		4th & 5th	
	Age at survey		***Age at survey***		***Age at survey***	
	15-19	20-24	15-19	20-24	15-19	20-24
<15	13.4*	13.8	18.6	9.6*	10.3*	5.2
15-17	50.6	48.3	40.4	39.2	35.2	29.5
18-19	63.5	74.4	49.3	74.2	38.7	65.6
20 or	n.a.	77.4	n.a.	81.0	n.a.	79.1
Never had intercourse	34.2	13.8	44.0	14.6	46.5	15.4*
Age not reported	U	U	U	4.5*	3.8	5.5
Weighted N	100,000	185,600	287,100	252,000	382,400	316,400
Unweighted N	299	662	489	691	781	820
Males	**Income Quintiles**					
Age of first intercourse	1st & 2nd		3rd		4th & 5th	
	Age at survey		***Age at survey***		***Age at survey***	
	15-19	20-24	15-19	20-24	15-19	20-24
<15	24.3*	U	7.8*	9.1*	6.7*	7.6*
15-17	37.8	35.9	26.4	38.9	27.5	34.1
18-19	45.0	75.3	36.1	72.8	41.3	72.4
20 or	n.a.	78.4	n.a.	80.3	n.a.	77.7
Never had intercourse	43.6	U	58.0	10.4*	53.1	10.4*
Age not reported	U	U	U	U	U	U
Weighted N	155,500	168,600	251,400	218,800	437,300	396,800
Unweighted N	276	383	466	564	897	1,053

Table 7. Cumulative percentage distribution according to age of first intercourse by age at survey, gender, and school status, NPHS, 1996

Females	**School and Work Status**							
	Not in School				In School and		In School only	
Age at first intercourse	Not Working[a]		Working[b]		Working[b]			
	Age at survey		***Age at survey***		***Age at survey***		***Age at survey***	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<15	U	18.2*	18.4*	9.1	13.2	5.2*	8.4*	U
15-17	52.2	65.7	56.6	54.8	43.7	39.6	31.7	30.8
18-19	54.6	79.2	69.7	74.4	49.8	62.5	32.9	46.1
20 and over	n.a.	84.3	n.a	81.3	n.a.	72.9	n.a.	55.5
Never had intercourse	U	U	23.1	11.5	44.1	21.3	56.9	28.0
Age not reported	U	11.6*	U	7.2	6.1*	5.9*	10.2	U
Weighted N	50,926	101,026	118,016	454,708	489,179	277,306	363,819	88,378
Unweighted N	106	351	351	1424	917	708	819	265
Males	**School and Work Status**							
	Not in School				In School and		In School only	
Age at First intercourse	Not Working[a]		Working[b]		Working[b]			
	Age at survey		***Age at survey***		***Age at survey***		***Age at survey***	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<15	U	U	15.8*	9.3	6.6*	6.1*	7.9*	U
15-17	41.5	43.7	45.1	52.4	33.5	50.9	24.3	34.4
18-19	44.2	62.0	58.1	73.8	38.2	67.9	25.5	61.5
20 and over	n.a.	62.9	n.a.	78.6	n.a.	75.8	n.a.	69.7
Never had intercourse	38.0*	U	29.6	6.8	56.9	16.7	61.6	U
Age not reported	U	U	U	14.6	4.9*	7.4*	12.9	U
Weighted N	66,574	42,398	179,273	563,059	426,894	259,391	405,394	79,012
Unweighted N	107	105	375	1,465	866	630	891	177

[a] Have not worked in the past 12 months.
[b] Have worked in the past 12 months.

Table 8. Cumulative percentage distribution according to age of first intercourse by age at survey, gender, and immigration status, NPHS, 1996

Females	**Immigration Status**			
Age of first intercourse	Foreign-born		Born in Canada	
	Age at survey		***Age at survey***	
	15-19	20-24	15-19	20-24
<20	18.7*	34.6	49.4	73.6
20 and older	n.a.	42.3	n.a.	81.7
Never had intercourse	65.9	39.6	42.7	11.5
Age not reported	15.4*	18.2*	7.9	U
Weighted N	103,900	122,000	920,200	801,800
Unweighted N	161	245	2,040	2,502
Males	**Immigration Status**			
Age of first intercourse	Foreign-born		Born in Canada	
	Age at survey		***Age at survey***	
	15-19	20-24	15-19	20-24
<20	21.4*	49.6	39.8	73.0
20 and older	n.a.	67.8	n.a.	77.3
Never had intercourse	69.8	17.9*	50.9	U
Age not reported	U	14.3*	U	12.9*
Weighted N	100,300	98,100	985,500	849,000
Unweighted N	142	221	2,104	2,169

Table 9. Cumulative percentage distribution according to age of first intercourse by age at survey, gender, and race, NPHS, 1996

Females	**Racial Group**			
Age at first intercourse	White		Other	
	Age at survey		***Age at survey***	
	15-19	20-24	15-19	20-24
<20	48.6	74.2	22.2*	32.5
20 and older	n.a.	81.1	n.a.	45.0
Never had intercourse	41.6	11.5	65.0	39.7
Age not reported	U	U	12.8*	U
Weighted N	870,200	797,900	150,900	112,800
Unweighted N	1,974	2,468	218	277
Males	**Racial Group**			
Age at first intercourse	White		Other	
	Age at survey		***Age at survey***	
	15-19	20-24	15-19	20-24
<20	40.1	73.5	27.7*	51.6
20 and older	n.a.	77.7	n.a.	67.7
Never had intercourse	51.1	9.0	61.9	21.2*
Age not reported	U	13.3*	10.4*	11.3*
Weighted N	918,900	819,300	163,800	126,100
Unweighted N	2,005	2,121	232	263

Table 10. Cumulative percentage distribution according to age at first intercourse by age at survey, gender, and Region, NPHS, 1996

Females	**Region**									
Age at first intercourse	Atlantic		Quebec		Ontario		Prairies		B.C.	
	Age at survey		***Age at survey***		***Age at survey***		***Age at survey***		***Age at survey***	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<15	U	U	U	U	6.5*	5.2*	5.4*	8.1*	U	U
15-17	36.3*	61.7	57.2	60.8	30.7	39.7	39.0	51.1	46.1	45.4
18-19	40.3*	80.7	61.7	77.1	34.2	62.2	43.7	72.2	56.6	59.8
20 and older	n.a.	85.1	n.a.	84.0	n.a.	70.3	n.a.	78.4	n.a.	74.4
Never had intercourse	55.7	U	33.9*	U	51.5	15.1	47.5	12.5	39.1*	U
Age not reported	U	U	U	U	14.3	14.6	8.7	9.2	U	U
Weighted N	90,300	81,600	256,100	208,100	369,500	360,200	166,600	153,400	142,300	121,100
Unweighted N	126	154	93	92	1,101	1,471	840	997	42	45
Males	**Region**									
Age at first intercourse	Atlantic		Quebec		Ontario		Prairies		B.C.	
	Age at survey		***Age at survey***		***Age at survey***		***Age at survey***		***Age at survey***	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<15	U	U	U	U	7.3*	6.9	7.3*	6.6*	U	U
15-17	28.3*	58.7	42.7*	59.6*	30.8	41.5	32.1	47.3	U	U
18-19	32.8*	74.2	48.4*	77.6	35.0	62.8	35.1	68.3	U	79.6
20 and older	n.a.	81.4	n.a.	77.6	n.a.	70.6	n.a.	75.4	n.a.	88.2
Never had intercourse	58.6*	U	45.6*	U	52.5	14.1	51.6	13.6	63.3*	U
Age not reported	U	U	U	U	12.4	15.2	13.3*	11.0	U	U
Weighted N	96,000	80,500	26,130	246,500	382,000	352,800	198,000	155,400	148,700	113,100
Unweighted N	124	118	89	83	1,104	1,273	878	867	52	53

Table 11. Percentage distribution according to number of sexual partners in the past year by age at survey and gender, NPHS, 1996

Females							
Number of sexual	**Respondent's age at survey**						
partners in past year	15-19	20-24	25-29	30-34	35-39	40-44	45-49
Never had sex	45.1	15.2	3.5	1.5*	1.5*	2.1*	1.2*
No partners past year	4.7	6.9	5.6	6.2	7.0	9.2	12.9
1 partner	32.0	57.6	75.8	79.4	77.5	75.7	73.0
2 partners	7.3	9.1	5.9	2.8	2.1	1.8*	U
3 or more partners	3.2*	4.7	2.4*	1.8*	1.0*	U	U
Don't know	7.4	5.7	6.8	8.3	10.8	10.5	11.3
Weighted N	1,024,800	924,300	1,005,300	1,257,300	1,390,600	1,252,200	995,900
Unweighted N	2,202	2,759	3,422	4,150	4,068	3,367	2,866
Males							
Number of sexual	**Respondent's age at survey**						
partners in past year	15-19	20-24	25-29	30-34	35-39	40-44	45-49
Never had sex	52.7	10.6	4.7	2.5*	2.2*	U	U
No partners past year	6.1	7.2	6.2	4.5	4.3	5.5	6.5
1 partner	21.5	50.8	65.6	73.8	77.9	78.9	75.7
2 partners	5.7	12.0	7.9	4.4	3.3	2.4*	2.8*
3 or more partners	5.9	8.9	6.9	4.4	3.0*	2.2*	U
Don't know	7.2	10.4	8.7	10.6	9.3	10.3	12.5
Weighted N	1,086,000	948,300	1,003,100	1,205,800	1,398,700	1,246,200	1,048,600
Unweighted N	2,247	2,394	2,940	3,704	3,953	3,296	2,776

Table 12. Percentage distribution according to number of sexual partners in the past year by age at survey, gender, and school status, NPHS, 1996

Females	**School status**							
	Not in school							
	Not Working[a]		Working[b]		School and Work		School only	
Number of sexual	**Age at survey**		**Age at survey**		**Age at survey**		**Age at survey**	
partners in past year	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
0	U	U	U	5.1*	5.4*	10.5*	U	U
1	40.3*	62.6	40.5	56.5	32.3	47.1	22.1	41.1
>1	U	15.2*	19.3*	13.4	9.8*	11.6*	5.2*	U
Never had intercourse	U	U	23.1	11.5	44.1	21.3	56.9	28.0
Number not reported	26.3*	16.1	18.4*	13.5	8.3*	9.5*	12.1	17.6*
Weighted N	50,926	101,026	118,016	454,708	489,179	277,306	363,819	88,378
Unweighted N	106	351	351	1,424	917	708	819	265
Males	**School status**							
	Not in school							
	Not Working[a]		Working[b]		School and Work		School only	
Number of sexual	**Age at survey**		***Age at survey***		***Age at survey***		***Age at survey***	
partners in past year	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
0	U	U	U	4.9*	4.9*	10.4*	U	U
1	U	29.7*	30.9	49.2	21.2	45.9	13.6	50.5
>1	U	U	22.2*	11.7	10.1	15.5	5.5*	U
Never had intercourse	38.0*	U	29.6	6.8	56.9	16.7	61.6	U
Number not reported	U	U	13.2*	16.4	7.0*	9.5*	13.0	U
Weighted N	66,574	42,398	179,273	563,059	426,894	259,391	405,394	79,012
Unweighted N	107	105	375	1465	866	630	891	177

a. Have not worked in the past 12 months.
b. Have worked in the past 12 months.

Table 13. Percentage distribution according to number of sexual partners in the past year by age at survey, gender, and household income quintile, NPHS, 1996

Females	**Income quintiles**					
	1st & 2nd quintile		3rd quintile		4th & 5th quintile	
Number of sexual	***Age at survey***		***Age at survey***		***Age at survey***	
partners in past year	15-19	20-24	15-19	20-24	15-19	20-24
0	U	U	U	U	U	9.0*
1	29.1*	51.2	33.8	62.9	33.2	62.6
>1	23.2*	24.9*	10.2*	13.4*	9.5*	9.2*
Never had intercourse	34.2*	13.8*	44.0	14.6*	46.5	15.4*
Number not reported	U	U	U	U	U	U
Weighted N	160,000	185,600	287,100	252,000	382,400	316,400
Unweighted N	299	662	489	691	781	820
Males	**Income Quintiles**					
	1st & 2nd quintile		3rd quintile		4th & 5th quintile	
Number of sexual	***Age at survey***		***Age at survey***		***Age at survey***	
partners in past year	15-19	20-24	15-19	20-24	15-19	20-24
0	U	U	U	11.5*	6.7*	6.2*
1	21.3*	60.7	21.5*	55.4	23.5	49.5
>1	20.1*	16.9*	U	17.3*	11.2*	24.6
Never had intercourse	43.6	U	58.0	10.4	53.1	10.4*
Number not reported	14.9*	U	U	U	U	9.5*
Weighted N	155,500	168,600	251,400	218,800	437,300	396,800
Unweighted N	276	383	466	564	897	1,053

Table 14. Percentage distribution according to contraceptive method currently being used*, by age at survey and gender, GSS, 1995

Females	**Respondent's age at survey**							
Percent currently using each method	15-19	*15-17*	*18-19*	20-24	25-29	30-34	35-39	40-44
Sterilization	0.0	0.0	0.0	U	11.1*	28.7	50.3	65.7
Oral contraceptives	28.1	21.7*	40.1*	42.3	29.7	20.4	6.0*	U
Condoms	U	U	U	9.3*	10.0*	11.3*	11.1*	6.6*
Other	U	U	U	U	6.3*	4.9*	5.1*	U
Method not reported	U	U	U	U	11.0*	9.7*	5.8*	U
No method used or never had intercourse	60.0	66.0	49.0	36.4	28.6	22.0	18.6	15.4*
Not at risk for unintended pregnancy**	U	0.0	0.0	U	U	U	U	U
Weighted N	959,900	62,460	335,300	1,005,800	11,132,300	1,314,700	1,287,400	1,157,300
Unweighted N	350	210	140	434	578	720	682	546
Percent using both condoms and selected medical method***	U	U	U	U	U	U	U	U
Males	**Respondent's age at survey**							
Percent currently using each method	15-19	*15-17*	*18-19*	20-24	25-29	30-34	35-39	40-44
Sterilization	0.0	0.0	0.0	U	U	16.8*	34.8	47.0
Oral contraceptives	U	U	U	18.3*	17.4*	14.9*	10.1*	U
Condoms	28.6	21.7*	37.4*	33.8	30.2	19.8*	15.9*	11.4*
Other	U	0.0	U	U	U	U	U	U
Method not reported	U	U	U	U	13.9*	15.2*	10.6*	8.2*
No method used or never had intercourse	61.2	69.5	50.8	38.1	32.3	28.5	23.8	22.7*
Not at risk for unintended pregnancy **	U	U	U	U	U	U	U	U
Weighted N	1,012,700	564,300	448,400	1,024,200	1,122,100	1,340,900	1,300,900	1,148,400
Unweighted N	354	209	145	351	472	619	627	539
Percent using both condoms and selected medical method***	U	U	U	U	U	U	U	U

* If multiple methods were reported, classified by the most effective method used.
** Not at risk because currently pregnant, seeking pregnancy, infecund or sterile.
*** Medical methods include sterilization, oral contraceptives, IUD.
For sources, see reference 27 in text.

Table 15. Age of first intercourse for street youth, *Canada Youth and AIDS Study*, 1988

Age of first intercourse[a]	Percent Reporting
< 10 years	12%
10 years	3%
11 years	7%
12 years	11%
13 years	17%
14 years	21%
15 years	14%
16 years	9%
>16 years	6%
(N)	(617)[b]

[a] Age range of sample was 15-20 years.
[b] Sample N=656. 94% of sample had engaged in sexual intercourse; 33% before puberty.
For sources, see reference 30 in text.

Table 16. Percent of street youth reporting various STDs, *Canada Youth and AIDS Study*, 1988

STD[a]	Percent Reporting
Chlamydia	6%
Herpes	2%
Gonorrhea	11%
Syphilis	1%
Other	8%
(N)	617

[a] Age range of sample was 15-20 years.
[b] Sample N=656. 94% (617) of sample had engaged in intercourse
For sources, see reference 30 in text.

Part II. Societal Attitudes about Sexuality

Canadian Attitudes and Norms about Sexuality and Sexual Behavior

With respect to the general level of "openness" towards sexuality, relative to the other countries examined in this study, Canada can be considered to be slightly more conservative than Sweden and France, similar to England, and more liberal than the United States. Over the last two decades, Canadian society has gradually, but steadily, become more comfortable with the open discussion of sexuality and sexual behavior, particularly in the media. Parallel to this, Canadians have become increasingly tolerant, if not accepting, of a wider diversity of sexual norms and behaviors. In general, the increasing tolerance of sexual diversity in Canadian society can be seen in the evolution of societal attitudes and government legislation related to sexual orientation, both of which have become more accepting of same-sex sexual behavior and of the legal rights of gays and lesbians. With respect to adolescent sexuality and reproductive health, societal attitudes have also evolved, particularly with respect to the recognition that adolescents require access to reproductive/sexual health education and services as well as a growing belief that premarital sex involving older teenagers can be morally acceptable.

From both a public and governmental perspective, adolescent sexual/reproductive behavior is generally not considered to be problematic as long as no laws are being broken and the behaviors do not occur in such a way that they have negative health consequences for the individual or, at a collective level, place an economic burden on society. In other words, in Canada, the discussion of adolescent sexual and reproductive behavior tends to be focused not on the moral or religious implications of teenage sexual activity, but rather on the potential negative health consequences (i.e. STD infection, unintended pregnancy) and, increasingly, on the costs of social assistance and medical services to teenage mothers and their children.

Although the overall government responsibility for health and funding for the health care system fall under the jurisdiction of the federal government, health care delivery is the responsibility of the provincial governments. In addition, education, including the delivery of school-based health curricula, is a provincial responsibility. Thus, at the governmental level, there have been few programs to change adolescent sexual and reproductive behavior that have been national in scope. *The Canadian Guidelines for Sexual Health Education* issued in 1994 by Health Canada,[31] the federal government's department of health, does represent a national effort to improve adolescent sexual and reproductive health. The guidelines were developed to "guide and unify" those developing and delivering programs to promote "healthy sexuality" and "sexual health" in schools, public health units, and other community settings. The federal government also provided support for the development of *Skills for Healthy Relationships*,[32] a program about sexuality, AIDS, and other STDs for early high school students. Several nongovernmental organizations work at the national level to improve adolescent sexual and reproductive health. These include the Sex Information and Education Council of Canada (SIECCAN) and the Planned Parenthood Federation of Canada (PPFC). Both organizations provide advocacy, professional education, and resource distribution related to adolescent sexual and reproductive health.

National Efforts to Change Adolescent Behavior

The national efforts at both the governmental and nongovernmental levels reflect an awareness, which

has evolved over the last two decades, that programs to improve adolescent sexual and reproductive health are important. This, in and of itself, is an indicator of an increasing openness toward sexuality in Canada. However, these efforts occur in an environment where a wide array of public health priorities compete for attention, increasingly limited funding, and resources. As a result of these realities, awareness of need and good intentions are not always matched by adequate resources and funding.

Attitudes Toward Premarital and Extramarital Sex

There are several national surveys that, together, provide indicators of Canadian attitudes towards sexuality among the adult population. At a general level, several national studies of sexual attitudes suggest that since the 1970s, Canadian attitudes toward sexuality have become more permissive. For example, Bibby[33] found that the percentage of adults who agreed or strongly agreed that premarital sex was acceptable increased from 68% in 1975 to 80% in 1990. Results of a more recent international comparative study by Widmer, Treas and Newcomb found that a majority of Canadians believed that sex before marriage was either "not wrong at all" (69%) or "only sometimes" wrong (15%).[34] This suggests that increases in acceptance of premarital sex that occurred during the 1970s and 1980s have been maintained. However, Canadians are less approving of young people under the age of 16 having sex, with 75% believing it to be always or almost always wrong.[35] Although Canadians increasingly believe that sex outside of marriage (i.e., premarital and intermarital) is acceptable, and this trend is expected to continue, there appears to be a growing disapproval of extramarital affairs. Similar to the findings of Widmer, Treas, and Newcomb, Bibby's national survey found that 85% of Canadians felt that extramarital sex was always or almost always wrong (compared to 78% in 1978).

Attitudes Toward Homosexuality

While Canadians remain divided in their attitudes toward homosexuality, in general Canada is among the most tolerant of Western industrialized countries with respect to homosexual sex and the rights of gays and lesbians. Widmer, Treas, and Newcomb found that 56% of Canadians believe that homosexual sex is wrong only sometimes or not wrong at all. A recent national poll found that 53% of Canadians want gay marriages legalized.[36] It should be noted that on these measures, residents of the province of Quebec tend to be more liberal in attitudes towards sexuality. It should also be noted that although Canada is located next door to the United States and shares many of its social values, with respect to the attitudes towards sexuality considered here, Canadians have considerably more liberal attitudes than their American neighbors to the south.[37]

Communication About Sexual Matters

No national studies have assessed the percentage of adolescents who report talking to their sexual partners about safer sex/contraception or the percentage that have spoken to their parents about these issues. However, there is some information available concerning attitudes towards talking with partners and degree of comfort in talking with parents. The *Canada Youth and AIDS Study*[38] surveyed 38,000 young people, aged 11 to 21, from across Canada on their AIDS-related knowledge, attitudes, and behavior. With respect to communication, 68% of street youth and 81% of school youth reported that "I would talk to a person I am having sex with about using a condom." Canadian youth look to their families as a main source of information about sex and contraception. However, little is known about the nature and frequency of such communication. In a large-scale, but not nationally representative, study,[39] 59% of adolescent females and 38% of males agreed that "I can talk to my mother about sexual matters" and 26% of females and 41% of males agreed that they could talk to their fathers about sexual matters.

Legal Regulations

In Canada, legal regulations which have bearing on adolescent sexual and reproductive behavior are primarily motivated more by a concern for the basic legal rights and protections of young people than they are a reflection of an attempt to regulate adolescent sexuality. For example, references to the legal age of sexual consent in the *Criminal Code of Canada* pertain to potentially abusive situations in which a young person is sexually exploited by an older person. For these purposes, a young person under the age of 14 is assumed to be unable to give consent to sexual activity. However, as MacDonald notes, this prohibition does not apply if "the child is at least twelve years old, is consenting, and the other person involved is less than two years older than the child and is not in a position of trust, authority or support toward the child."[40] Technically, statutory rape does not exist in the *Criminal Code of Canada* since "rape" itself is not used

in the code. Rather, coercive sexual activity is covered under provisions related to "sexual assault." Sexual activity between an adult and a person under the age of 14 is included in the criminal code under the category of "sexual interference" and carries a penalty of up to 10 years' imprisonment.[41]

Depending on the province, the legal age of marriage without parental consent ranges from 18 to 19 years of age. With parental consent, the minimum age for marriage in most provinces is 16. A court order is needed for a person under age 16 to get married.[42] Generally speaking, these laws have little impact on adolescent behavior. Age of sexual consent only becomes relevant when an adult is involved or there is a large discrepancy in the ages of two young people (e.g. an 18-year-old and a 13-year-old) and it is likely that in the latter case the matter would be resolved before it reached a court of law. The laws pertaining to the age of marriage also have little impact on adolescent sexual and reproductive behavior since very few Canadians choose to marry before they are twenty and most wait until they are in their mid- to late-twenties.

In 1988, the Supreme Court of Canada effectively decriminalized abortion in Canada by declaring the existing law unconstitutional. As a result, there is currently no abortion law in Canada, and, as such, the practice of abortion is regulated by the medical profession. Neither the Society of Obstetricians and Gynecologists of Canada (SOGC) nor the Canadian Medical Association (CMA) have parental consent policies that pertain specifically to abortion. In general, young adolescents who are deemed competent by clinic staff to make such decisions are able to obtain abortions at free-standing abortion clinics without parental consent. Abortions, treatment for STDs and birth control clinic services are available to all Canadians without charge, although prescriptions for birth control must be paid for by the individual. Most provinces do not have legislation that establishes an age of consent for medical treatment. "A minor can consent if he or she is capable of understanding the information about a treatment and of appreciating the risks and likely consequences of the treatment."[43]

Media Representations of Sexuality and Contraception

Any analysis of the representation of sexuality and contraception in the media in Canada must take account of the fact that a large percentage of media consumed by Canadians is imported directly from the United States via television, magazines and movies. However, there are some important differences between the two countries with respect to formal and informal broadcast and magazine/newspaper standards related to the presentation of sexuality and contraception. In Canada, the advertising of prescription medications, including contraceptives requiring prescription, is not permitted in mainstream media (i.e., magazines, television), but is allowed in medical journals. However, the advertising of condoms on television and in magazines has become increasingly common. For example, Canada's music video station, which broadcasts across the country and is popular among teens, regularly carries advertisements for condoms. Interestingly, although it is not a formal standard, these ads only refer to condoms in terms of STD prevention, but not as a means of contraception.

There have been no systematic large-scale studies examining the frequency or content of sexual representations in Canadian mainstream media such as television, general interest and teen magazines, or daily newspapers. In recent years, the public, media, and policy makers have been more concerned about the level of violence on television and movies than they have about sexual content. In general, full frontal nudity or explicit sex is not shown on prime-time television or in non-sexually oriented magazines. Using a classification system developed by the Canadian Radio-Television and Telecommunications Commission (CRTC), television programs with "mature themes," frequent violence, or nudity include a parental warning before the program begins, and a symbol indicating that the program is not suitable for persons under the age of 14 or 18 appears on the upper left corner of the screen. Subscribers to cable television services are able to obtain access to X-rated videos during the evening. To date, proposals to directly regulate information, including sexually explicit material, available through the Internet have been rejected by the CRTC.

Socialization of Young People about Sexuality

No national studies have directly elicited young people's opinions about the quality of the sex information that they receive. One national study and several small regional studies have surveyed adolescents about their current and preferred sources of sex information. The *Canada Youth and AIDS Study*[44] asked Grade 7 (age 11–12), Grade 9 (age 13–14), and Grade 11 (age 16–17) students to list, out of a choice of six sources, their 1st and 2nd main sources of information about sex and birth control (Table 17).[45]

Table 17. Canadian adolescents' main sources (1st & 2nd) of information about sex and birth control (BC)

Source of Info.	Age 11-12(%)		Age 13-14(%)		Age 16-17(%)	
	Sex	BC	Sex	BC	Sex	BC
Family	49	38	40	33	34	28
School	34	24	36	41	29	39
Print	23	35	24	34	25	35
Television	30	40	24	27	23	21
Friends	22	16	31	24	38	30
Dr/Nurse	5	12	5	13	5	19

For sources, see reference 30 in text.

Overall, the adolescents in this study ranked their family (37%), and the school (34%) as their main sources of information about sex and birth control, followed by print materials (29%), television (28%), friends (27%) and Dr/Nurse (10%). Friends increasingly become a main source of information for both sex and birth control as adolescents get older, while television becomes less of a main source. Several smaller, more recent, studies from the province of Ontario indicate that the school is increasingly cited by adolescents as a main source of sexual health information, with family continuing to be a primary source of such information.[46] In both of these smaller studies, about 60% of adolescents agreed that "My school has done a good job of providing the sexual health information that I need" and "My parents have done a good job of providing the sexual health information that I need."

Sexuality Education

Because formal education is a provincial responsibility, there are no national guidelines which mandate the teaching of sexuality in the schools (use of the *Canadian Guidelines for Sexual Health Education*[47] is voluntary). All the provinces and territories of Canada have school programs, usually taught within health classes, that include sexuality education, but the content and extent of implementation varies considerably between provinces and within different parts of the same province. There have been no detailed national studies of classroom content of sexuality education that would indicate the extent to which provincial guidelines and curricula are translated into classroom programming. An overview of sexuality education programs available in Canadian schools suggests that "The vast majority of, if not all, Canadian young people have access to some form of sexuality education through school-based programs. This level of accessibility, however minimal it may be, represents significant progress for sexuality education in Canada."[48] Although most Canadian children receive some form of health education, with some information related to reproduction, during the elementary years (grades 1–6), most provincial/territorial ministries of education place a greater emphasis on sexual health instruction during grades 7 to 9. In the vast majority of school boards across Canada some minimal form of sexuality education is compulsory through mandatory participation in a health or human development course. Such teaching typically focuses on reproduction and STD prevention. It is clear that advances in Canadian school-based sexuality education over the last two decades have been fueled, to a large extent, by concern over the spread of HIV/AIDS in Canada. Still, at present, it is unknown whether a majority of Canadian adolescents receive, through school-based programming, sexuality education sufficient, in terms of both time and quality, to have a significant impact on their sexual and reproductive behavior.

• *Abstinence.* The topic of "abstinence" is included in nearly all school-based sexuality education for adolescents. However, with the exception of a few communities in different parts of the country, so-called "abstinence-only" sex education programs have not been implemented in Canadian schools. Although abstinence is typically presented as "the only 100% sure way to avoid STDs and unwanted pregnancy," it is generally not presented in the public schools as the only acceptable pattern of adolescent behavior. Rather, abstinence is presented as a good choice, but not as a moral necessity. An exception is Roman Catholic denominational schools, where premarital chastity is taught as a moral standard.

• *Contraceptive use.* The topic of contraceptive use is included in the vast majority, if not all, public school sexuality education programs for adolescents (basic descriptive information about contraceptives is given in the Roman Catholic schools). Canadian adolescents attending public schools will receive fairly thorough descriptive information about contraceptive methods, including instructions on how to use them and where

they can be obtained. The Canadian Contraception Study,[49] a national study of Canadian women's contraceptive knowledge and practices, which was conducted in 1993, 1995 and 1998, consistently indicated a near-universal awareness of the pill and the condom as contraceptive methods among Canadian women of all age groups, including those aged 15 to 17.

• *Ideological controversies*. Although ideologically based controversies over the content of school-based sexuality education do occur in Canada, they are relatively infrequent, and perhaps less volatile and more easily resolved, compared to the United States. Such controversies or debates have not occurred at the national level in either government or media. Rather, controversies over sexuality education typically occur within a particular community or school board and are characterized by the organization of a group of parents, often backed by literature provided by a conservative religious group, who lobby for the provision of abstinence-only sex education in the schools. In most cases, such groups do not receive the support of the community or the school board, and a broadly based approach to sexuality education is adopted or maintained. A number of local surveys of Canadian parents indicate strong support for a broadly based approach in which both abstinence and contraception/safer sex is taught.[50]

• *Improving parent-child communication.* Helping parents to communicate effectively with their children about sexuality has received increased attention among the public health community in recent years. Although there have been no major efforts to help parents in this regard that have been national or provincial in scope, some local public health units, as part of their mandates to promote healthy sexuality, conduct information sessions for parents to assist them in talking to their children about sexuality. Peer educators are increasingly being utilized in school-based sexuality education programs in Canada. The only published study on the effectiveness of peer educators using a Canadian sample suggests that adolescents react favorably to peer sexuality educators and that they are effective in positively influencing adolescents' attitudes towards and intentions to use condoms.[51]

Large-scale Interventions Related to Adolescent Sexuality and Reproductive Health

The Canadian Guidelines for Sexual Health Education[52]

The *Canadian Guidelines for Sexual Health Education* represent the national government's most significant direct effort to improve the sexual/reproductive health of Canadian adolescents. The guidelines were developed on the recommendations of the Expert Interdisciplinary Advisory Committee on Sexually Transmitted Diseases in Children and Youth and the Federal/Provincial/Territorial Working Group on Adolescent Reproductive Health. Among the recommendations made by the groups was that a statement of principles for sexual health education be developed to guide the area. Funded by Health Canada, the guidelines were developed by a national working group coordinated by the Sex Information and Education Council of Canada (SIECCAN). In 1994, 20,000 English-language copies and 10,000 French-language copies of the 33-page booklet were produced, and since 1997, both versions have been available online through the Health Canada web site.

The stated goals of the guidelines are to provide a unifying framework and philosophy and a set of principles to guide those providing, planning, or updating sexual health education programs and/or services. The guidelines are also intended to be used as a tool to evaluate existing sexual health education programs and services. Although the guidelines address programs and services for people of all ages, they were designed to have specific applicability to adolescent and school-based sexual health education programming. For example, the guidelines state that,

> As the single formal educational institution to have meaningful contact with nearly every young person, schools are a vital resource for providing children, adolescents, and young adults with the knowledge and skills they will need to make and act upon decisions that promote sexual health.[53]

Among the introductory sections of the guidelines is a philosophical framework for sexual health education based on the basic principles of a democratic society and a minimalist concept of sexual health which emphasizes the achievement of positive outcomes (e.g., rewarding human relationships, respect for self and others, sexual satisfaction) and the avoidance of negative outcomes (e.g., unwanted pregnancy, STD infection, sexual coercion). The guidelines are organized around five principles: access to sexual health education for all; comprehensiveness; effectiveness and sensitivity of educational approaches and methods; training and administrative support; and program planning, evaluation, updating and social development. A six-page evaluation checklist based on the five principles is included. In addition, the

guidelines suggest and describe the necessary elements of effective sexual health education: acquisition of knowledge; development of motivation/personal insight; development of skills that support sexual health; and creation of an environment conducive to sexual health.

There have been no formal evaluations of the impact of the development and distribution of the guidelines on sexual health education in Canada. There is evidence that the guidelines have provided the foundation for a number of initiatives to develop and improve sexual health education programs for adolescents,[54] and a recent study of sexual health education training in Canadian faculties of education indicated that of the 21 university programs in elementary, secondary, or physical health education that offer a course related to human sexuality, 13 (62%) use the guidelines in their training.[55] In addition, a special theme issue of *The Canadian Journal of Human Sexuality* was devoted to implementing the guidelines in different settings, including schools.[56]

Skills for Healthy Relationships[57]

Skills for Healthy Relationships, a curriculum on sexuality, AIDS, and other STDs for grade 9 students (age 13–14), is a joint venture involving the federal government and the provincial ministries of health and education. Developed by the Social Program Evaluation Group at Queens University, Kingston, Ontario, the program is available to any school, school board, or ministry of education that assumes the cost of duplicating the materials for its own use. An in-service training program for teachers delivering the curriculum is also available.

The program was designed to support three basic behaviors: abstinence; use of protective measures by sexually active youth; and compassion/tolerance. The curriculum provides students with an educational intervention based on well-substantiated social psychological and educational theories and divided into four units: Transmission of HIV, Responsible Behavior: Abstinence, Safer Sex, and Health Enhancing Supports. The units include cooperative learning (small groups), parent/guardian involvement (six interactive activities), active learning (role playing, behavioral rehearsal), peer leaders (modeling skills), video instruction, and development of a personal action plan (assertiveness goal). The program components include 28 student activities, teacher manuals, peer leader training guide, parent/guardian guide, overheads, wall charts, and a video.

The final report on the *Skills for Healthy Relationships* program[58] documents the largest evaluation study ever undertaken in Canada on the outcomes of a school-based sexuality education program. The outcome evaluation involved 6,750 students from four provinces who had either taken the *Skills for Healthy Relationships* program or had taken their school's regular AIDS/STD program. A follow-up evaluation conducted two years after students had taken the program found that, compared to students in the comparison group, students who had taken *Skills for Healthy Relationships* were less likely to have experienced first intercourse and were more likely to express the intent to communicate with partners about condom use but were no more likely to have the intent to use condoms (high in both groups) or to report always using a condom (about 41% of both groups reported that they did so).

Part III. Reproductive Health Services for Adolescents

Accessibility of Reproductive Health Care to Adolescents

In general, most Canadian adolescents do have access to reproductive health care services (i.e., contraceptive information and services, STD and HIV testing and treatment, prenatal and maternity services and abortions). These services are considered to be within the rubric of "medically necessary services" as stipulated by the Canada Health Act. Such services are, therefore, available to all Canadians through Canada's health insurance system (popularly known as medicare).

Theoretically, then, when Canadians need medical care, including reproductive health services, they can go to the physician or clinic of their choice, present their provincial medical insurance card, and receive the necessary medical services without any direct cost. In addition, there is a fairly broad but tacit agreement in Canadian society that adolescents should have access to reproductive health services. The need for such services has also been recognized by the national government. In 1990, the federal government's department of health issued a Report on Adolescent Reproductive Health in which it recommended:

- That provincial and territorial governments be encouraged to use a community-based model in the development of comprehensive sexual health services (including STDs) that cater to the unique needs of adolescents in each community;
- That these services be accessible and readily available to adolescents in both rural and urban areas.[59]

However, as discussed in more detail below, while it may be accurate to say that most Canadian adolescents are able to obtain reproductive health care services, levels of access to comprehensive sexual health services vary significantly from community to community and from region to region.

Canadian Health Care System

Canada's health care system is a predominantly publicly financed, privately delivered, system that consists of an interlocking set of ten provincial and two territorial health insurance plans which provide access to universal, comprehensive coverage for medically necessary hospital, in-patient and out-patient physician services. Aside from visits to hospital emergency rooms, primary care physicians (e.g., family physicians and general practitioners) usually provide Canadians' initial contact with the formal health care system and they control access to most specialists, allied providers, hospital admissions, diagnostic testing and prescription drug therapy. Most primary care physicians are private practitioners who work in independent or group practices. Others work in community health centers, hospital-based group practices or work in affiliation with hospital outpatient departments.[60] In general, the structure of health care services is the same for youth and adults, although there are some notable exceptions pertaining to sexual and reproductive health education and services. As discussed below, in some areas of Canada, adolescents have access to specialized adolescent-focused services such as teen clinics in some hospitals and Planned Parenthood or affiliate clinics.

Services for Adolescents

With respect to the source of health care services in general and reproductive/sexual health care services in particular that are provided to Canadian adolescents, very little documentation or research exists. In order to better understand adolescent access to and use of these services, the authors conducted a brief survey of adolescent reproductive/sexual health specialists and practitioners from across Canada (see Appendix D). Respondents were asked to assess adolescent access to general health care and sexual/reproductive health care

in their specific communities. On a four-point scale ranging from "poor" to "excellent," most respondents indicated that adolescent access to health care in their community was "good" (48%) or "fair" (39%). The general ratings of adolescent access to health care did not vary considerably between different regions of the country, although several respondents noted that adolescents living in rural areas may have reduced access to health care. This concern is consistent with research indicating that access to health care in Canada is uneven by virtue of the varying distances people must travel to see a physician. For example, almost all (99%) residents of large urban centers (1 million or more people) are within 5 km of the nearest doctor. However, outside of these centers, far fewer residents (56%) are living that close to a doctor. Distance to physicians is considerably greater for people living in the northern regions of the country, with 64% of the population living 100 km or more from the nearest doctor.[61] The aforementioned *Report on Adolescent Reproductive Health*[62] noted that adolescents living in rural areas lacked adequate access to reproductive and sexual health services.

According to Canada's *National Population Health Survey, 1996–97,*[63] 41% of males and 53% of females aged 12 to 14 visited a doctor two or more times during 1996–97. Among those aged 15 to 17, 50% of males and 59% of females visited a doctor two or more times. With respect to physician care, some Canadian adolescents will rely on a specific family physician for all of their health care needs, including reproductive health services, while others utilize walk-in clinics where they may see a different physician each time they visit. There has been no research to ascertain what percentage of adolescents use family physicians and what percentage use walk-in clinics. In our survey of adolescent reproductive health specialists, it was estimated that about 64% of adolescents use family physicians for general health care, while 25% use clinics, and the remaining 11% do not access formal health care facilities. However, for reproductive health care needs, our respondents estimated that 58% of adolescents use family physicians and 42% use clinics.

In order to assess Canadian adolescents' access to reproductive health services, we asked our survey respondents to characterize adolescents' access to reproductive and sexual health related health care in their communities. None of our respondents characterized access to such services in their community as "excellent," while 41% rated it as "good," 46% rated it as "fair," and 14% rated it as "poor." In Canada, clinics that specialize in providing reproductive health services to adolescents are an important and increasing source of sexual/reproductive health education, counseling, and services for Canadian young people. There is a general perception, most notably among the public health community, that youth-focused clinics are particularly well suited to the provision of sexual/reproductive health services to adolescents, since such clinics are often designed to create a comfortable environment in which confidentiality is assured. Although some adolescent women in Canada are comfortable speaking with their family physicians about reproductive health matters, others are not.[64] Most (83%) of the adolescent reproductive health specialists who participated in our survey reported that their communities had clinics that specialize in providing reproductive health services to adolescents. Such clinics take a variety of forms, including those established by or affiliated with public health departments or hospitals. The Planned Parenthood Federation of Canada (PPFC) and their affiliates operate a network of reproductive health clinics across Canada.[65] Although PPFC clinics serve women of all ages, nearly 40% of PPFC clients are under the age of 19.[66] PPFC runs clinics in all the provinces except Prince Edward Island and the territories. According to a recent survey of PPFC affiliates, 83% of those surveyed reported that they provided contraceptive counseling, 75% provided unplanned pregnancy counseling, and 71% dispensed contraceptives.[67] PPFC clinics are independently operated, relying mainly on community support rather than direct government funding. All PPFC clinics provide referrals to medical services when necessary.

Canadian adolescents wishing to use contraception can access it from a variety of sources. Condoms are the most easily accessible. All pharmacies have condoms available on the store shelves (i.e., condoms are not kept behind the counter). Many convenience stores also sell condoms, usually in packages of 3 to 6. There are no age restrictions on the sale of condoms. For condoms sold in stores, the price typically ranges from C$9.00 to C$11.00 including taxes for a box of ten. Adolescents who visit teen-focused health clinics, Planned Parenthood clinics, STD clinics, and other such facilities can often obtain condoms for free. Birth control pills are more difficult to obtain, since the individual must first obtain a prescription from a physician. In addition to physicians' offices, prescriptions for birth control pills can often be obtained through various types of clinics. In all cases,

the visit or consultation for birth control services is free of charge, and at some specialized birth control or teen-centered clinics, adolescents can obtain their first cycle of pills for free. Thereafter, however, the majority of young women using the pill will have to pay for their prescriptions. We asked our survey sample of adolescent reproductive health professionals how much adolescents in their community had to pay for a one month cycle of pills. The estimated price for a one month cycle of pills ranged from C$5.00 to C$17.00 with an average price of C$9.40.

Services for Young Men

Although school-based sexual health education programs focus equally on the educational needs of males and females, the creation and delivery of reproductive health services in Canada has been disproportionately targeted at young women. While there are some obvious reasons why this might be the case (e.g., it is the female who becomes pregnant), in terms of teen pregnancy prevention, the male sexual partners may be more difficult to directly contact for outreach education services because of their tendency to be somewhat older than their adolescent female partners. For example, for 15–17-year-old women who gave birth in the city of Toronto in 1993, over 50% of the fathers were 20 years of age or older.[68] School-based sexual health education programs are unlikely to reach many males past their teenage years. When we asked our survey group to assess the availability of services and/or programs to provide young men with contraceptive information and supplies in their communities, 0% rated it as "excellent" and only 29% rated it as "good" while 29% rated it as "fair" and 42% rated it as "poor."

Delivery of Messages that Encourage Responsible Contraception and Disease Prevention

At the national level, there have been few large-scale or concerted efforts to deliver messages that encourage responsible contraceptive and disease-preventive behavior that reach large numbers of Canadian adolescents on a consistent basis. This is not to say that the federal government, through its ministry of health (Health Canada), has not been active in supporting initiatives to promote adolescent sexual health. The *Canadian Guidelines for Sexual Health Education*, the *Skills for Healthy Relationships* curriculum,[69] and a nationally distributed STD prevention booklet are examples of national initiatives to support adolescent sexual/reproductive health. However, public messages directed at youth, although sometimes funded by Health Canada, are far more likely to be conceived and delivered at the local level. For example, the public health department in the city of Toronto, Canada's largest city, has put posters promoting condom use and emergency contraception in city bus shelters. At the provincial/territorial level, "Style: Doing the Right Thing," a social marketing campaign aimed at 15 to 29 year-olds in the Yukon Territory, was designed to reduce rates of chlamydia through radio spots, bus signs, and the distribution of prevention brochures and condoms in a case designed to look like a rock CD.[70]

In 1995 a program targeting physicians was piloted in Alberta.[71] Physicians were provided with information, posters, and pamphlets and a risk assessment card, the latter for distribution to patients, promoting the use of condoms together with oral contraception. The title of the campaign was, "It Takes Two: Condom and Pill." The purpose of the pilot study was to assess whether a campaign targeting physicians could increase awareness, intention, and use of condoms together with oral contraception on the part of patients. It was based on research on contraceptive scripting that identified a progression in stages of use of contraception, with condoms used early in new relationships. As relationships progress, the female partner is most likely to initiate the use of oral contraceptives. Once oral contraceptives are used, condom use stops. Several studies have demonstrated that one of the strongest predictors of lack of condom use is the use of oral contraception.[72] The success of the campaign was evaluated based on responses to questionnaires administered to physicians and patients. The program was well received. While the majority of physicians reported that they had already been counseling patients that oral contraception did not provide protection against STDs, and the majority of patients said they were already aware of the risk and importance of using condoms, both groups of respondents reported that the campaign increased the effectiveness of the counseling and the intention of patients to talk about and insist on condom use. While this campaign did not specifically target teenage or young adult women, since a large proportion in these age ranges are likely to be starting oral contraceptive use, these are the women who were most likely to be affected by the campaign.

These are a few examples among many locally designed and delivered messages to youth. However, because such initiatives tend to be localized, their delivery is limited geographically and may be one-time

or intermittent in nature. In our survey of adolescent reproductive health professionals from across Canada, we asked, "To what extent are reproductive health services for adolescents advertised in the community?" Only 4% said there was "considerable advertising," while 38% said there was "some advertising," 50% reported there was "minimal advertising," and 8% said there was "no advertising."

With respect to the public promotion of condom use directed at youth, radio and television advertisements by condom companies are the most prominent. There is very little discussion of contraceptive use by popular media personalities or on popular television programs in Canada, many of which are imported from the United States. Call-in radio programs that provide advice on sexuality matters to youth and young adults are increasingly common in Canada and are available in many parts of the country. These programs tend to be non-judgmental in nature and frequently emphasize consistent contraceptive and condom use in a sex-positive manner. Although there have been no studies to evaluate the impact of the programs on their listeners' behavior, they may be an important source of messages that affirm contraceptive and safer sex behaviors among those sexually active adolescents who listen to them.

As noted earlier, the provision of sexual health education in Canadian schools, while improving, remains inconsistent and varies from community to community. Similarly, reproductive/sexual health clinic services directly linked to schools or indirectly linked through referrals are inconsistent in Canada. In some communities, high quality reproductive health clinic services are available to youth through both on-site school-based clinics and teen clinics set up in the vicinity of schools. Such clinics often provide free or low cost condoms and other contraceptives.[73] However, in other communities, such clinics may be few or non-existent. When we asked our sample of adolescent sexual/reproductive health professionals if schools in their communities provided reproductive health services, only 13% said all or most schools in their communities provided such services, while 42% said less than half of schools did, and 46% said no schools in their community did. We also asked our sample if schools in their communities provided referrals or direct linkages to reproductive health services and 48% said all or most schools did, while 52% reported that less than half or no schools did. These results suggest that while adolescent access to reproductive health services through the schools, either directly or through referrals, may be quite strong in some schools and communities, the provision of these services can vary from school to school and from community to community.

As noted earlier, although there are some exceptions, Canadians are generally tolerant and accepting of the diversity of norms and values related to sexuality that exist in Canadian society. While many Canadians, including public health authorities, are concerned about the potential health consequences of adolescent sexual activity, this concern has typically not translated into the public moral condemnation of, for example, premarital sex. Thus, messages directed toward adolescents concerning sexuality, contraception and STD prevention emanating from the federal and provincial governmental levels have been relatively nonjudgmental in nature, reflecting what may be called a democratic approach to sexual health education. Canadian school-based and public health programs increasingly reflect this democratic approach in that they balance the encouragement of postponing first sexual intercourse, abstinence, and consistent contraceptive and safer sex behaviors. Ideologically, these democratically oriented programs promote critically appropriate sexual/reproductive health decision-making within the context of the individual's moral, ethno-cultural, and religious values.[74] The *Canadian Guidelines for Sexual Health Education* and, increasingly, curricular guidelines and curricula reflect this philosophical approach.

However, in some cases, Canadian adolescents are confronted with competing, and at times inconsistent, messages regarding what constitutes responsible sexual behavior. Canada is a culturally diverse country with a large and varied immigrant population. As of 1996, 17% of the Canadian population, about 5 million people, were immigrants (i.e. people born outside of Canada whose parents are not Canadian). Young people with parents who emigrated from countries with more conservative sexual norms and values than contemporary mainstream Canadian society can find that their parents' perspectives towards adolescent sexuality and birth control conflict with the norms and values of the larger culture. In other words, parents from more traditional cultures may seek to instill in their children the sexual norms and values of the country of origin. In this respect, adolescents in such families must grapple with what are sometimes opposing messages related to sexuality.

In addition, in some parts of Canada, so-called "abstinence-only" curricula have been used in a number of schools, particularly in the prairie provinces.[75] In

some instances "chastity" groups visit schools to deliver the message that abstinence is the only responsible lifestyle for unmarried teenagers.[76] These abstinence-only curricula and presentations can conflict with more balanced programs in that they often actively dismiss contraception and safer-sex practices as unacceptably risky. Although abstinence-only programs and presentations have made inroads in some places, most communities, when faced with pressure to replace balanced sexual health education with abstinence-only programs, have opted to maintain broadly-based programs that encourage responsible behavior through the provision of accurate information on contraception and safer sex as well as encouraging abstinence and postponing first sexual intercourse, particularly among younger adolescents. In sum, messages that describe adolescent sexual behaviors as aberrant, unhealthy and socially unacceptable, or that discourage contraceptive use by only pointing out or exaggerating its risks, are less prevalent in Canada than in the United States.

Over the last twenty years there has been a growing acknowledgement within Canadian society that contraception is a shared responsibility between men and women. A study of adults aged 18–44 in three countries (the United States, the Netherlands, and Canada) indicated that Canadians are more likely than people in the other two countries to believe that choosing a contraceptive method and ensuring its use is a shared responsibility (43% and 49%, respectively). For ensuring that a method is used, 12% of Canadians believe it is a male responsibility, while 33% believe it is a female responsibility.[77] Increasingly, school-based sexual health education programs in Canada stress the need for males to share responsibility for contraception. However, public perceptions continue to be influenced, to some extent, by traditional notions that women, and particularly young women, are the "gatekeepers" of sexual behavior and have the ultimate responsibility to control fertility. Although attitudes in Canadian society may be gradually changing in this regard, outside of sexual health education programs in the schools, public messages promoting greater male responsibility for contraception are lacking.

Interventions to Assist Disadvantaged Youth, Focusing on Sexual and Reproductive Behavior

Research in the area of adolescent reproductive health services is often regional or local in scope and, if national, is not totally representative of the Canadian situation. Truly comprehensive national research would need to reflect the multicultural and bilingual nature of Canada, as well as address regional and socio-economic differences inherent in Canadian society. Large-scale projects that address all these issues have yet to be implemented; however, smaller projects on national, provincial and regional scales have been undertaken, and provide valuable insights into the availability and accessibility of existing sexual and reproductive health services.

Make Noise! Empowering Youth to Confront HIV/AIDS and "Bright Red Hair…and Sliced Bread": Models of HIV/AIDS Youth Programs in Canada

Empowering Youth to Confront HIV/AIDS is a project of the Canadian AIDS Society funded by Prevention and Community Action Programs of Health Canada under the National AIDS Strategy Phase II. Two reports representing two phases of the project have been issued to date. A third phase of the project is currently in process. Each phase of the project has been designed and implemented by youth participants, with the dual purpose of identifying HIV/AIDS issues affecting youth across Canada, and suggesting more effective ways of delivering prevention and education programs to youth.

Phase I was the preliminary study to document the range of issues concerning youth and HIV/AIDS issues in the Canadian context. Eleven youth representatives from various regions of the country designed the survey, conducted the interviews and wrote the final report. Interviewers consulted over 600 youth (ages 13–25) across Canada and asked questions regarding where youth obtained HIV/AIDS information, the quality and accessibility of existing services, and recommendations for improving services to youth. The results of Phase I, published in the manual Make Noise, highlighted several inadequacies in existing programs and services and offered practical advice to youth on how to have their voices heard, with the ultimate goal being the implementation of relevant prevention programs for youth.

Phase II of the project was undertaken in 1998 as a follow-up to the initial report. The results of this study were published in the manual Bright Red Hair…And Sliced Bread. This manual documents several "youth driven programs in Canada to serve as models for anyone interested in starting their own HIV/AIDS prevention education program for youth."[78] The working group for this phase of the project consisted of ten youth from different regions in Canada. Programs were chosen for inclusion in the manual based on the following criteria: 1) emphasis on prevention

education, 2) targeted for out-of-mainstream youth aged 13–25, i.e., young gay men, HIV-positive youth, aboriginal youth, street-involved youth, youth in-care, youth with diverse ethnocultural backgrounds, 3) youth-driven, 4) community-based. A total of six programs were selected, each meeting the stated criteria and representing different regions of Canada.

The third phase of the project continues the process of consultation and work with youth and community agencies across the country. From December 1998 to August 1999, a series of workshops were held in various regions of Canada. Youth and those who work with youth attended the workshops to discuss how to use the two manuals from Phases I and II of the project, and to identify regional issues in the formulation and implementation of HIV/AIDS programs. An additional goal of Phase III is the compilation of evaluation tools used by the various agencies consulted in the research process. This is an ongoing project. While there has been no formal evaluation of the effectiveness of the Empowering Youth to Confront HIV/AIDS Project, response from individuals and community agencies has been very positive.[79]

Just Loosen Up and Start Talking!

Planned Parenthood of Nova Scotia produced the resource document Just Loosen Up and Start Talking in 1996. The provincial government, through the Department of Health, provided financial and advisory support for the project. The final document is described as being a "resource that holds a collective voice of Nova Scotian youth – their stories and their advice for improving their sexual health."[80] Just Loosen Up and Talk is intended to be used by agencies, community groups, schools and government as a tool to aid in the development of effective and relevant health promotion and prevention programs.

The experiences of the Planned Parenthood provincial office in Halifax and its five affiliates across the province identified the need for a provincial survey of the sexual health education needs of young people. Many youth in the province were either dissatisfied with existing programs and services or unable to access them. The study was undertaken to document barriers to education and services and to explore possible solutions to problems of delivery and access. The approach taken by Planned Parenthood was that of community action research. The involvement of youth as both interviewers and interviewees was of primary importance to the study. In 1995, 17 youth from across Nova Scotia were trained as interviewers. They conducted 220 face-to-face interviews with youth from across the province. In choosing the sample, there was an attempt to ensure diversity in the areas of gender, age, sexual orientation, culture, and situational and geographical factors. The age range of respondents was from 14 to 24, with 51% of those interviewed being female and 49% male. Two-thirds of those surveyed lived in rural areas, since the largely rural nature of the province was initially identified as being a factor in the lack of access for some youth to services and education. Thirty-seven health service providers were also surveyed.

The final report presents a narrative summary of comments and advice from those interviewed. Also included are guidelines for implementing new programs and services as well as criteria for evaluating existing services. An accompanying volume, the Technical Report, includes a literature review, a summary of the health services providers' survey, and the data report for the youth survey. No formal evaluation of the effectiveness of the report as a tool for change in the area of sexual health promotion has been undertaken.

Developing Understanding from Young Women's Experiences in Obtaining Sexual Health Services and Education in a Nova Scotia Community

In 1998, the small town of Amherst, Nova Scotia, was the focus of the report Developing Understanding From Young Women's Experiences in Obtaining Sexual Health Services and Education in a Nova Scotia Community: Lessons for Educators, Physicians and Pharmacies. The research project was coordinated by the Department of Community Health and Epidemiology at Dalhousie University in partnership with the Amherst Society for Healthy Adolescent Sexuality (ASHAS), a coalition of community members and representatives from the non-profit and governmental sectors. The Maritime Centre of Excellence for Women's Health, one of five national center for research in women's health issues supported by Health Canada's Women's Health Bureau, funded the project.

This qualitative, descriptive study investigated the barriers to accessing sexual health services and education as experienced and described by 28 young women (ages 15–18) from Amherst and surrounding areas. A Dalhousie University student conducted in-depth interviews between April and July of 1998. The study results were divided into the following three sections 1) barriers to school health education, 2)

barriers to obtaining physician services, and 3) barriers to use of pharmacies for sexual health needs. Barriers in each of these areas were clearly identified and illustrated with the women's own words and experiences, and suggestions for improving the delivery of services and education were listed.

Although the sample size of this project was small, the dissemination plan for the final results is intended to ensure that they reach a broad cross-section of community and professional groups as well as the government departments responsible for the development and implementation of sexual health curricula. Physicians and pharmacists in the area have responded to the results of the study by working together to produce accessible information for adolescents about contraception. A health center, offering sexual and reproductive health services as part of its mandate, has also opened in the local high school.[81]

Part IV. Public Policy and Programs for Disadvantaged Groups

Internationally, STDs and teenage pregnancy have been found to be concentrated in socially disadvantaged groups.[82] The situation is no different in Canada. Ross, Scott and Kelly, in their study of child poverty, report that 18% of teenage women in Canada who are living in households with incomes less than C$30,000 reported a pregnancy in the previous five years as compared to 4% of teenage women living in households with incomes above C$30,000.[83] Hardwick and Patychuk's Toronto study demonstrated similar associations between economic status and teenage pregnancy and STDs.[84] From this it is clear that it is important to consider the form and extent of inequality in Canada and the nature of programs designed to alleviate the burden of negative sexual and reproductive health consequences on teenagers and young adults who live in situations of disadvantage. At least three forms of inequality receive substantial attention in Canada: economic inequality, ethnic inequality, and gender inequality.

Extent of Inequality and Disadvantage

Economic Inequality and Disadvantage

When economic inequality is discussed, attention turns to poverty. A discussion of the extent of poverty in Canada must always be set within the context of the debate about what constitutes a "poverty"-level income. A wide variety of organizations and commissions have studied poverty in Canada, each producing different "poverty lines."[85] Two different approaches are used to establish these lines: poverty relative to average income and/or expenditures, and poverty based on the cost of providing for basic needs. The first approach establishes a line that shifts as income levels shift. It is based on the argument that poverty is relative to average income and that in a country with the wealth of Canada, poverty consists of a restriction on the ability of an individual to participate in the benefits available in society. This approach produces "high end" poverty lines. The highest is the poverty line established in the Canadian Council on Social Development's income guides which set the poverty line at half of average family income as reported by Statistics Canada.[86] The most commonly used, and somewhat lower, poverty line is Statistics Canada's Low Income Cut-Off (LICO). LICO is calculated to represent the level of income at which 56.2%[87] or more of pre-tax household income is required for food, clothing and shelter. While Statistics Canada warns that LICO should not be used as a poverty indicator, the National Council on Welfare, which advises the Canadian government on issues related to low income and poverty does, in fact, use this as the poverty line. Table 18 (page 36) provides provincial comparisons of income and the proportion of the population with incomes below LICO by province.[88]

The second approach to setting a poverty line is seen in the work of municipal, provincial, and federal governments to develop a Market Basket Measure (MBM) which would represent the income required to purchase nutritious meals, and to obtain adequate shelter and other necessities. To date, there is no consensus on what should be included in the market baskets, with income estimates based on these varying widely.[89] The low-end of poverty lines, the Basic Needs Level (BNL), is found in the Fraser Institute[90] sponsored publication, *Poverty in Canada.*[91] BNL represents "what it costs to maintain long term physical well-being: a nutritious diet, shelter, clothing, personal-hygiene needs, health care, transportation, and a telephone."[92] The BNL is described as a basic level of subsistence and is calculated based on family size and composition, individual and family life stage, and location of residence. It excludes from its calculations of necessities payment for items such as dental care and eyeglasses on the grounds that these are either available under special supplements in provincial assistance

programs, or are made available to the poor through charitable organizations (e.g. Lions Club). It also fails to make allowance for any discretionary spending.

The importance of establishing which poverty line is used prior to a discussion of economic inequality is seen in the estimates of the number of Canadians living in poverty based on these different poverty lines. For example:

- Based on the BNL, the Fraser Institute estimates that just over 8% of Canadians live in poverty.[93] However, based on LICO and using data from the 1996 census, 19.7% of Canadians were living in poverty in 1995.[94]
- The National Council of Welfare estimates that the income provided to a 1-parent family with 1 child under the age of 2 years through government financial assistance programs in most provinces is between 60% and 63% of LICO (with Alberta providing 50% and Newfoundland providing 68% representing the outliers); i.e., all such families are living in poverty. However, Emes and Kreptful, in their Fraser Institute sponsored report, calculate that in 1998, total benefits received through government financial assistance programs by a single-parent family with either 1 or 2 children exceeded BNL in all provinces. For a single-parent family with 2 children, the excess was over C$2,000 in most provinces, and ranged from a low of C$402/year in British Columbia to a high of C$2,776 in Saskatchewan,[95] i.e., no families receiving government financial assistance live in poverty.
- Using LICO, 83% of single mothers under the age of 25 years live in poverty.[96] However, using the BNL, no single mother receiving provincial income assistance[97] lives in poverty.[98]

A second question that is often debated in Canada is whether economic inequality is increasing. Those who argue that inequality is increasing use examples such as:

- In 1996, families in the upper income decile had 314 times as much income as those in the lowest decile. This is a considerable increase over the 21-fold difference between these two deciles in 1973.
- The income gap between the highest and lowest quintiles increased by C$3,000 between 1994 and 1996.[99]
- Over the past 10 years, income provided through government financial assistance programs has decreased relative to LICO in all provinces and territories. Between 1986 and 1996 decreases ranged from 2% to 5% in most provinces, with Alberta's 23.6% decrease an outlier.[100]

Table 18. Selected income statistics at year end 1995 for individuals and families, 1996 Census

Province/Territory	% population below LICO[1]	Mean individual income	Median individual income	Mean family[2] income	Median family income
Canada	**19.7**	**25,196**	**18,891**	**54,583**	**49,951**
Newfoundland	21.4	19,710	13,972	42,993	36,339
Prince Edward Island	15.2	20,537	15,931	47,125	41,342
Nova Scotia	18.8	21,552	16,000	46,110	40,420
New Brunswick	19.0	20,755	15,211	45,010	39,649
Quebec	23.4	23,198	17,234	49,261	42,891
Ontario	17.7	27,309	20,678	59,830	51,520
Manitoba	20.6	22,667	17,161	50,236	43,758
Saskatchewan	18.3	22,541	16,643	49,483	43,477
Alberta	18.4	26,138	19,444	59,916	49,057
British Columbia	19.6	26,295	19,982	56,527	49,207
Yukon		29,079	24,790	61,807	55,695
Northwest Territories		29,011	20,387	61,631	53,218

[1] LICO (Low Income Cut-Off) is the income at which 56.2% is required to pay for food, clothing, and shelter.

[2] Census family refers to a now-married couple (with or without never-married sons and/or daughters of either or both spouses), a couple living in a common-law marriage (with or without never-married sons and/or daughters of either or both partners) or a lone parent of any marital status, with at least one never-married son or daughter living in the same dwelling. The total income of a census family is the sum of the total incomes of all members of that family.

For sources, see reference 88 in text.

Those who argue that inequality is relatively constant in degree point out that data used to argue increases in inequality ignore the relative worth of a dollar in lower and upper income groups and consequently overestimate the degree of change in inequality. They point to a relatively constant proportion of total Canadian income in each income quintile over the past 30–40 years.[101]

From this discussion, it is clear that there is no simple answer regarding the degree of poverty, income inequality or economic disadvantage in Canada or whether government-provided financial assistance is or is not adequate to raise an individual or family above the poverty line.

Ethnic and Racial Inequality or Disadvantage

Canada shares with its neighbor, the United States of America, the unenviable history of mistreatment of visible minorities (in Canada this includes aboriginal people, blacks, Chinese and Japanese) and prejudicial and discriminatory treatment of Canadian residents of non-British ancestry[102] with respect to educational and occupational access and income. Recent research has shown that while the British advantage with respect to income has been eliminated for Canadians of European background, those who belong to visible minorities continue to have significantly lower incomes than other Canadians at all educational levels.[103] This shifts the fundamental basis of inequality and disadvantage in Canada from ethnicity to race. Such ethnic/racial inequality is seen most profoundly in comparisons between Canada's aboriginal peoples and the remainder of the Canadian population. The 2.8% of the Canadian population that are aboriginal peoples are, by far, the most disadvantaged ethnic or racial group in Canada. Income, housing, education, and social services available to or accessed by on-reserve populations are at the very bottom of the scale. The standard of living on many reserves has been equated to that found in a developing country rather than in one of the world's most developed countries. This is particularly relevant to this report when we realize that the aboriginal population is younger than the rest of the Canadian population, with over 50% of aboriginal peoples under the age of 25 years[104] and that twice as many aboriginal children under the age of 15 years (32%) as children in the remainder of the population live in one-parent families.[105] The social and health problems that accompany extreme poverty are evident among aboriginal populations: high infant mortality rates, high rates of alcoholism, suicide (particularly among youth), abuse, chronic and communicable disease, teenage pregnancy, and high rates of incarceration.

Aboriginal people are concentrated in the provinces of Manitoba and Saskatchewan, where they account for over 11% of the provincial populations, and in the Yukon and Northwest Territories, where they account for 20.1% and 61.9%, respectively, of the populations.[106] In provinces and regions with high concentrations of aboriginal peoples, their social and economic deprivation and the resulting inequities in health and well-being are reflected in provincial and regional statistics. This is seen in STD rates, teen pregnancy rates, and the prevalence of a wide variety of health problems in the populations of the prairie provinces and Canada's territories.

Gender-based Inequality or Disadvantage

The final form of inequality, gender inequality, is reflected in some of the discussion that has already occurred in this section. Advances toward gender equity are seen in the increase in the number of women completing post-secondary education, in enrollments in schools of law and medicine, in employment equity and pay equity policies and in court rulings in a variety of jurisdictions. Despite these advances, women in Canada continue to earn C$0.70 to C$0.72 for every C$1.00 earned by men, and when all relevant factors are controlled (e.g. education, time in labour force, occupation), women still earn 10–20% less than men. In addition, the vast majority of single-parent homes are headed by women, and most (83%) of these households operate on funds that are below LICO. This is particularly salient to the topic of this paper when we recognize that reference to the higher burden of teenage pregnancy and STDs carried by those who are economically disadvantaged is referring disproportionately to women.

Canada's System of Social Welfare

Financial assistance is available through all three levels of government in Canada (federal, provincial/territorial, and municipal). It is provincial income assistance (IA) which is usually referred to as "welfare." In 1998, 2.6 million people, or 8% of Canada's population, were receiving IA.[107] In 1997, single women with children represented 27% of all those receiving IA and 28% of all women receiving IA.[108] These women would be considered "low-income" by any definition; however, whether the income and other benefits they received was adequate to meet their basic needs depends on how basic needs are determined. Whether they are

considered "poor" depends on which definition of poverty is subscribed to.

Federal Assistance

The Canada Child Tax Benefit, National Child Benefit, and Goods and Services Tax Credit are administered by the federal government. The first two are available to all Canadians with dependent children and family[109] incomes at or below C$66,721. Support is provided on a sliding scale based on the number of dependent children and family income. The highest support is allocated to families with a gross annual income at or below C$20,921.[110] Five provinces (Nova Scotia, New Brunswick, Quebec, Saskatchewan and British Columbia) also provide child benefits beyond those provided by the federal government.

The Goods and Services Tax (GST) Credit is designed to offset the impact on low income individuals (income at or below C$20,921) of paying the GST. It is available to all adult Canadians (with or without children) based on the number of individuals in the family unit.[111] Five provinces (Quebec, Ontario, Manitoba, Alberta and British Columbia) provide provincial tax credits similar to the federal GST credit. This ranges between C$500 and C$1000 depending on family size, income and province.

Besides these two programs, the federal government also works to equalize the economic differences between individuals through its graduated income tax scheme and between provinces by providing transfer payments to the poorest provinces. These transfers level the playing field somewhat between the provinces with respect to the services and programs they can provide to their citizens.

Provincial Assistance

Income Assistance (IA) is nontaxable, paid jointly by the federal and provincial governments, and administered by provinces/territories. In some provinces, responsibility for administration of IA has been assigned to municipalities, while in others it remains with the province. IA is provided for unemployed adults in all provinces. Employed adults who earn below minimum cut-points are also eligible for IA.

Levels of assistance vary between provinces and, in all cases, also by whether an adult is employable or unemployable (i.e., unable to work due to physical or mental conditions certified by a medical practitioner), and whether an adult or adults have dependent children. In all cases, employable adults without dependent children receive the least financial support, while unemployable adults and adults with dependent children receive the most support.

In every province and territory, IA is designed to cover food, clothing, utilities, personal care, household maintenance and shelter, all at a "basic" level (i.e., incurring the lowest possible expenditure). Often the cost of shelter and household maintenance are calculated separately as a housing allowance, with all other needs comprising a living allowance.

Eligibility for IA is usually restricted to those between the ages of 18 and 65 years. However, a person who is under 18 years of age and has a dependent child, or a person under 18 years of age who is unable to live with parents or adult guardians, may be considered for IA. Single parents must demonstrate that they have attempted to get court-ordered support from their child's non-custodial parent. A "needs test" is applied in all provinces. Budgetary needs (determined on a provincial basis) are compared to assets and household income. Any non-essential assets must be liquidated and used to pay budgetary needs prior to eligibility for IA. Essential assets which are exempt from liquidation include: principal residence, furniture, clothing, and, in some provinces, a car and property and equipment required for employment. IA recipients are permitted to keep between C$1200 and C$5000 (varying by province) of non-essential or liquid assets and are also permitted to earn a few hundred dollars/month without losing any portion of IA.[112] Each province also provides supplementary benefits and discretionary benefits when need is demonstrated. Those provided in all provinces which are most likely to be relevant to single mothers include: medical expenses not covered by medicare, drug costs, essential dental services, eyeglasses, legal aid, winter clothing supplements, travel supplements and daycare subsidies. Some provinces also provide additional assistance to cover baby food, or costs of additional food during pregnancy and breastfeeding.

Single mothers who, with their children, live in their parents' home are eligible for IA. If they are paying rent, this is covered with a housing allowance. If no rent is paid, they do not receive a housing allowance, but do receive a living allowance. However, their living allowance is often assessed at a lower level than if they were living on their own.

Students in post-secondary institutions are not eligible for IA in most provinces, and in those where they are, stringent conditions are applied. IA and low-income families are eligible for child care subsidies to

cover daycare or babysitting costs if all parents are in the labor force or in school.

Every resident of Canada, regardless of income, is covered by comprehensive medicare and hospitalization schemes. Under medicare, visits to doctors, hospitals and clinics are free of cost to individuals. Hospitalization and provision of a semi-private room is also without cost to individuals. In addition, all Canadians are provided with 12–14 years of tuition-free education, and government-subsidized student loans are available, based on need, to students pursuing post-secondary education.

Municipal Assistance

In some provinces, IA is administered at the municipal level. In addition, food banks, drop-in centers for women with young children, courses and support groups run by health units, programs offered by the municipal parks and recreation departments, and various programs (e.g., individual or group counseling, nutrition consultation, child care classes, employment training) offered through municipal agencies are available to low-income women at reduced or no cost.

Programs and Interventions Targeting Youth from Economically or Socially Disadvantaged Populations

There are three subpopulations of youth that are commonly referred to as economically or socially disadvantaged in Canada: youth from low-income homes, aboriginal and inu youth, and youth living on the streets. All three groups of youth demonstrate what have been referred to as poor sexual and reproductive health outcomes. These are seen in:

- Younger age of first intercourse (Table 6) and larger number of intercourse partners (Table 14) for youth from lower income backgrounds;
- Higher teen pregnancy rates and STD rates in regions of the country with a high proportion of aboriginal and inu populations (Table 2 and 4);
- Younger age of first intercourse, larger number of intercourse partners, presence of "survival sex," and high rates of STDs among street youth (Tables 16 and 17).

Government programs targeting disadvantaged youth are under the jurisdiction of provinces/territories and municipalities. Non-government organizations also provide programming in some jurisdictions. There is no consistent, coherent set of programs targeting disadvantaged youth. Programs vary from location to location. In cities with local health units (in Quebec these are CLSCs, Centres Locale Service Communautaire), branches of the YMCA, Boys and Girls Clubs, Community Centers, Planned Parenthood Federation chapters, and local community development/service organizations, there are usually programs targeting several different groups of youth, including those from low income homes, aboriginal populations, minority cultures and street youth. Programs may focus on providing social support, recreational facilities, information, and a variety of workshops and skills-building activities. They may focus directly on addressing issues such as self-esteem, decision-making, or sexuality, or these may be informally or indirectly incorporated into programming of a more diverse and non-specific nature.

There has been an increase in programs and research specifically addressing sexual health issues for street youth since the mid-1980s as a result of concerns related to vulnerability to HIV and other STDs.[113] These programs and research projects exist primarily in the largest cities, most notably Montreal, Toronto, Ottawa, Calgary, and Vancouver. Street youth exist in many smaller cities as well, and in some locations the sub-populations of street youth and aboriginal youth overlap to a large degree (e.g., Winnipeg, Saskatoon), producing a doubly disadvantaged and vulnerable population. However, smaller cities are less likely to have the programming found in larger centers. Programs targeting street youth usually include an outreach component, provision of counseling, sexual health resources (e.g. condoms), and testing for HIV and other STDs. These have been referred to as "backpack clinics." In addition, street youth are referred to a variety of existing services.

The survey of sexual and reproductive health educators and professionals referred to earlier in this report included questions on programs specifically targeting disadvantaged youth. All respondents indicated that some such programming existed in their area. In rural areas and smaller provinces, Planned Parenthood Federation may be the only organization which specifically has programs for low-income youth. In larger metropolitan areas there may be several organizations with a variety of programming for low income and/or street youth.

In the province of Quebec, most programming is delegated to the CLSCs. CLSCs are located in communities and mandated to provide services that specifically address the needs of their community. Consequently, CLSCs in areas with high immigrant populations design services to meet the needs of new

Canadians; CLSCs located in the downtown core specifically target youth and young adults who frequent the area; and CLSCs in low-income areas develop programs specific to the needs of low-income populations.

Responses from rural areas revealed the fewest programming options and the greatest difficulty in providing programming to rural youth who are often widely scattered and lack transportation.

None of the respondents to the survey felt programming for disadvantaged youth was adequate. All expressed concern that recent funding cuts to government organizations (e.g. health units, CLSCs) produced a cut in essential programming for the most vulnerable populations and shifted an increased responsibility to volunteer-based organizations funded largely through public donations.

There have been no published studies of the effectiveness of programs targeting disadvantaged youth.

Part V. Conclusions

The past half-century has seen changes in the attitudes of Canadians toward youthful sexual activity that parallel changes in the sexual activity of young Canadians. The attitude of most Canadians toward youthful sexual activity can be described as one of tolerance and passive acceptance. Opinion polls consistently demonstrate that the majority of Canadians accept the sexual behaviors of teenagers and young adults; their concerns focus on early pregnancy and STDs, but not on the sexual activity itself. This acceptance can be considered "passive" rather than "active" in that public opinion is not highly mobilized to pressure governments for stronger programs and policies on teen sexual health. While all provinces have governmental (e.g. public health) and non-governmental programs (e.g. NGOs, community organizations) and services geared to the sexual health concerns of youth, access is uneven across the country and, in many cases, insufficient to the need and demand. Similarly, Canada has nationally endorsed guidelines for sexual health education, along with tested and packaged educational programs in healthy sexuality and relationships, but these resources are used neither widely nor consistently. The same applies to the delivery of medical and health services related to sexuality. While most young adults have access to contraceptive counseling and prescriptions, STD testing, abortion services, and related sexual health services without direct charge, the settings may not be optimally "user-friendly" for young people. This is particularly so for youth in rural areas and those in marginalized groups (e.g., street youth, aboriginal and ethnic minority youth, lesbian/gay/bisexual/transgender youth) who may find it much harder to locate services geared to their specific needs.

There has been a gradual downward shift in the age of first sexual intercourse over the past fifty years. This shift is more pronounced among women than men. A comparison of the youngest to the next oldest cohort included in the NPHS suggests that age of first intercourse is continuing to decline for women, though it may be stable for men. Most sexually active teenagers report one partner over the past year, suggesting that monogamy is the normative pattern. However, research conducted on a smaller scale than the NPHS has led to the conclusion that adolescents follow a pattern of serial monogamy, resulting in an accumulation of several sexual partners over the years between initiation of intercourse and the eventual formation of a stable, long-term relationship such as marriage.[114]

When considering sexual and reproductive health outcomes that typically affect teenagers (e.g., births, contraception, abortion, teenage parenthood, STDs), the picture is mixed. Birthrates among teenagers have generally decreased in the past half century (for women between 15 and 19 years of age birthrates were 58.2/1000 in 1961, 40.1 in 1971, 27.6 in 1980, 25.4 in 1990 and 22.6 in 1997). The decline in the birthrate among 15–19-year-old women, despite an increase in the number and proportion who are sexually active, suggests that many women are using contraception (which became legal in Canada in 1969) and abortion services (particularly since the 1988 Supreme Court ruling which removed abortion from the *Criminal Code of Canada)*. In fact, when the data are examined more carefully, it is clear that contraceptive use accounts for more of the decrease in births to teenage women than abortions. Research in the 1990s consistently showed that women of all ages are aware of effective contraceptive methods such as the oral contraceptive pill. Data from the 1998 Canadian Contraception Study demonstrate that 67% of 15–17-year-olds who engaged in sexual intercourse in the six months prior to being surveyed and 68% of unmarried (63% of married) 18–24-year-olds used oral contraceptives.[115] Though fewer teenage women are giving birth, those who do are

choosing to become single mothers more often than they did in the past.[116] This is a disturbing trend when we consider the negative social and economic correlates of single motherhood for both women and their children.[117]

A second disturbing trend is in the area of STDs. While teenage women appear to be moving toward increasing effectiveness in the use of contraception, they are not effectively protecting against STDs. Although the overall rates of STDs such as syphilis and gonorrhea have declined drastically in the population, the concentration of STDs has shifted from men in their late twenties to women in their teens and twenties. This is especially evident for chlamydia and for two sequelae of untreated STDs, pelvic inflammatory disease and ectopic pregnancy, which are experienced exclusively by women. Clearly, young women are more effective at protecting themselves against pregnancy than against STDs. This is supported by data on condom use. Reported use of condoms is higher among men than women, and few use both condoms and other forms of contraception, resulting in poor protection from STDs.

For both early pregnancies and STDs, rates vary by geographic region and economic status. The highest rates of both STDs and early pregnancies are found in Canada's territories, followed by the prairie provinces. The lowest rates are in the maritime region and in Ontario, with Quebec and British Columbia holding the middle ground. Age of intercourse initiation also varies by economic and social status and region of residence. Those at the lowest end of the income scale, those who are in the labor force rather than attending school, the Canadian-born and Canadians who identify themselves as "white" generally tend to initiate intercourse at an earlier age and are more likely to have multiple partners in a particular year. When social and economic status, region of residence, sexual behavior and sexual and reproductive health outcomes are considered together, the complexity of their relationship is apparent. For example, while more youth in Quebec initiate intercourse at early ages than those elsewhere in Canada, rates of early pregnancy and STDs are not especially high in this province. There is an extensive body of literature on cultural changes which support a shift to more liberal attitudes and behaviors in the province of Quebec than elsewhere in Canada. These changes appear to be accompanied by more consistent self-protection against pregnancy. It is noteworthy that Quebec was the first, and for many years, the only province where abortions were available outside a hospital setting, in defiance of federal law. On the other side of the spectrum is the province of Ontario, whose population tends to consistently have more conservative sexual behaviors. This is also the province which receives the largest proportion of new immigrants to Canada and has the most ethnically diverse population. Since age of first intercourse varies depending on immigrant status and race, it is reasonable to expect that these variations may explain the status of the population of Ontario with respect to sexual behavior patterns. However, this explanation is clearly too simplistic when we consider the city of Toronto, located in Ontario and the largest city in Canada. Toronto receives more immigrants than any other Canadian city, but has higher rates of teenage births than the rest of the province, despite comparatively easier access to health care than in most other cities and regions in Ontario. The Prairie and Maritime provinces are between these extremes with respect to the sexual behavior of their young residents, and might be said to represent the established Canadian pattern, their data influenced the least by immigration and recent changes in cultural patterns. However, these regions are not in the middle range when considering STD and pregnancy rates. Finally, it is important to recognize that Canada's territories, where a high proportion of the population is aboriginal, are not included in either the NPHS or the GSS, and consequently they do not appear in the comparisons of sexual behavior. However, the rates of early pregnancy and STDs are many times higher in these regions, suggesting that their young adult populations carry a disproportionate burden of negative sexual and reproductive health outcomes. Clearly, more research is needed to improve our understanding of the interplay between social, cultural and economic factors, sexual and self-protective behaviors, and sexual and reproductive health outcomes. The data presented in this paper raise as many questions as they have answered.

In sum, Canada, as a country, has the knowledge, resources and infrastructure to respond to many of the pressing sexual health concerns facing youth and has made considerable advances in some areas of teen sexual health. While it is encouraging that national goals have been formulated on some of these issues (e.g., five and ten year national goals for reduction in STDs, a framework for sexual and reproductive health[118]), mobilization of the resources needed to have an impact on the determinants of sexual health will require an action plan and the political will to implement it. A comparative analysis of teen sexual

health in Canada in relation to other industrialized countries may well focus attention on what Canada can and should aspire to in this important area of health policy.

Appendix A

Methodological Issues and Description of Studies Used to Produce this Report

There have been two federally funded national studies that collected information on reproductive and sexual behaviors in the form required for this project: Cycle 10 of the General Social Survey (GSS) conducted in 1995 and the National Population Health Survey (NPHS) conducted in 1996. In addition, there have been three national studies of women's contraceptive behaviors (1993, 1995 and 1998) funded by the Janssen-Ortho pharmaceutical company. However, the sample, while national, is small, and published reports based on these surveys do not use the same age categories as those used in this project. Finally, British Columbia and Quebec have conducted provincial surveys that included information on the sexual practices of adolescents and youth. Other surveys of sexual behavior have either been local, with small, non-representative samples, or have categorized behaviors differently than required for this project.

Therefore, the data in the Canadian report relied primarily on the two federally funded surveys, the 1995 GSS and the 1996 NPHS. Both of these are governed by standards set by Statistics Canada for release of data. These standards require that any results whose weighted numerators are below a certain level (ranging from 21,000 for percentages below 5%, to 10,000 when the percentage is 50%) may only be reported with a warning that they are unreliable estimates. An additional range of results must be reported as tentative because of high sampling variability. These include, for example, results of 5% or lower when numerators are between 21,000 and 85,000 and results of 50% when numerators are between 7,000 and 25,000. Because of these requirements, tables reporting data by poverty class, region, immigrant status, racial group and school status have a considerable number of empty cells. To facilitate comparison with data from other countries, categories on the dependent variables (age of first intercourse and number of partners in the past year), and in some cases on the independent variables (e.g. poverty status measured by income quintiles) were collapsed.

General Social Survey, Cycle 10, 1995

The General Social Survey is designed to collect information related to a variety of issues relevant to the planning and evaluation of government-funded programs. Cycle 10 is the only cycle that included questions relevant to fertility issues. Data for the GSS were collected using computer-assisted telephone interviewing and random digit dialing. A total of 10,749 Canadian households were surveyed with an overall response rate of 80.7%. The sample excluded the 2% of households without a telephone, Canadians living in the Yukon and Northwest Territories, and full-time residents of institutions. Questions related to contraceptive use were asked of respondents who were not in a same-sex relationship and who were between the ages of 15 and 50 years of age. In addition, men whose female sexual partners were under 50 years of age were also included. Results are weighted to take account of the population without a telephone, differences in the size of provincial populations, non-respondents, and households with multiple telephones.[119]

There are several problems with using data from the GSS for this study. First, sample sizes for males and females between 15 and 24 years of age are small, with estimates of contraceptive use prone to unreliability. Second, respondents were not asked whether they had ever participated in sexual intercourse. This is particularly problematic for the youngest respondents. Based on NPHS results in 1996, we might expect 45.1% of females and 52.7% of males between 15 and 19 years of age and 15.2% of females and 10.6% of males between 20 and 24 years of age never to have engaged in intercourse. These respondents would have no need for contraception. Third, the GSS asked about contraceptive methods that are currently being used rather than the method used at last intercourse. This makes GSS results difficult to compare to those produced based on last intercourse. Fourth, the GSS did not ask whether respondents were attempting to get pregnant. This most particularly affects interpretation of results for 20–24-year-olds, a high proportion of whom are married and in their prime childbearing years. Finally, though the GSS included information on personal income, there is none on household income. Consequently, socioeconomic status cannot be calculated.

National Population Health Survey, 1996

The National Population Health Survey program is designed to collect information related to the health of the Canadian population. It consists of both cross-sectional and longitudinal sample components. The first cycle of data collection began in 1994, the second took place in 1996, and data collection will continue every

second year. In the 1996 cycle of this program, questions from the 1990 Health Promotion Survey and the Longitudinal Study of Children and Youth were integrated into the NPHS survey process. Data were collected from a representative sample of household residents in all 10 provinces, with the exclusion of those on Indian Reserves, Canadian Forces Bases and some remote areas in Quebec and Ontario. A multi-stage stratified sampling procedure was used, with results of the study weighted to represent the regional and age composition of the Canadian population.[a] Data were collected using computer assisted interviewing with 95% of interviews conducted over the telephone. The remaining 5% of interviews were conducted face-to-face. Each household resident over the age of 12 years in selected households replied to a portion of the questions in the survey (including those on sexual behaviors), while other questions were answered by a representative of the household. Response rates ranged from 80% to 98.7% depending on whether the respondent was part of the longitudinal or the cross-sectional sample, the age of the respondent, and on the way in which the respondent was reached. While the NPHS provides excellent demographic and socio-economic information about a representative sample of Canadians, it includes few questions related to sexual and reproductive health and behaviors.

Canadian Contraception Studies 1993, 1995, 1998[120]

The Canadian Contraception Studies were funded by the Janssen-Ortho pharmaceutical company and administered by a market research firm, the Medical Studies Division of International Surveys Ltd. Each survey was mailed and self-administered. The samples were drawn from a databank of 20,000 households that had previously agreed to participate in market research studies. Samples were chosen to correspond to the Canadian population in age, marital status and region of residence for women 15–44 years of age. The data were weighted during analysis to correspond to women in this age range for region, age and marital status using the 1991 Canadian Census. In 1995, only 438 of the women in this sample were between 15 and 24 years of age, making conclusions drawn based on this sample highly tentative. In addition, results are most often reported for women 15–17 and/or women 18–34 years of age, making age comparisons with the NPHS difficult. The survey focused on knowledge and attitudes about various forms of contraception, which methods had "ever" been used, and which were currently being used. There was no information on use at first or last intercourse.

[a] See the 1996-97 NPHS Public Use Microdata Documentation for additional details.

Appendix B

Definition of Terms

Definitions are those used by Statistics Canada. These apply to tables calculated using both the 1995 General Social Survey and the 1996 National Population Health Survey.

Poverty Status

This is measured using income quintile. The 1st and 2nd quintiles are below what have been variously referred to as "poverty" and "low income" cut-points by Statistics Canada. Income quintiles were calculated for the National Population Health Survey by Statistics Canada.

Since the sample sizes in each quintile were small, producing potentially unreliable estimates, results were presented grouping the quintiles into 1st and 2nd (representing those living in households that fall below Statistics Canada's low income cut-point), 3rd (representing those living in middle income households), and 4th and 5th (representing those living in upper income households).

School Status

School status was calculated based on responses to two questions: Whether attended school in the past 12 months; whether employed for pay during the past 12 months. Categories:

Not attending school in past 12 months (these may or may not have been employed in past 12 months)

Attending school and working for pay in the past 12 months

Only attending school in the past 12 month (not working for pay during this period)

Immigrant Status

Immigrant status was based on self-report in response to the question:

In what country were you born?

If Canada, coded as native-born; if outside Canada, coded as foreign-born.

Race

Race was based on self-report in response to the question:

How would you best describe your race or color?

All choices other than "white" were coded as "other."

Region

The usual breakdown for Canada was used:

Atlantic Provinces (Newfoundland, Nova Scotia, New Brunswick, Prince Edward Island)

Quebec

Ontario

Prairie Provinces (Manitoba, Saskatchewan, Alberta)

British Columbia

Appendix C

Detailed Tables (Note: For Part I most detailed tables are integrated into the text)

Table C1. Cumulative percentage distribution according to the age of first intercourse by age at survey and gender, NPHS, 1996

Females		
Age when first had intercourse	**Respondent's age at survey**	
	15-17	18-19
<18	34.1	51.5
18-19	n.a.	63.5
Never had intercourse	57.9	26.9
Age not reported	7.9	9.6
Weighted N	600,968	423,831
Unweighted N	1,236	966
Males		
Age when first had intercourse	**Respondent's age at survey**	
	15-17	18-19
<18	23.2	51.0
18-19	n.a.	63.5
Never had intercourse	66.3	29.6
Age not reported	10.6	6.9
Weighted N	683,334	402,664
Unweighted N	1366	881

Table C2. Cumulative percentage distribution according to age of first intercourse by age at survey, gender and household income quintile, NPHS, 1996

Females	**Income Quintiles**					
	1st & 2nd		3rd		4th & 5th	
Age when first had intercourse	**Age at survey**		**Age at survey**		**Age at survey**	
	15-17	18-19	15-17	18-19	15-17	18-19
<18	34.8	57.3	42.4	49.3	30.8	60.0
18-19	n.a.	69.3	n.a.	62.4	n.a.	75.0
Never had intercourse	52.2	19.1*	50.7	31.2*	65.8	20.7
Age not reported	U	U	U	U	U	U
Weighted N	45,706	54,340	188,588	98,476	227,384	155,023
Unweighted N	118	181	303	186	474	307
Males	**Income Quintiles**					
	1st & 2nd		3rd		4th & 5th	
Age when first had intercourse	**Age at survey**		**Age at survey**		**Age at survey**	
	15-17	18-19	15-17	18-19	15-17	18-19
<18	28.3*	60.9	23.6	43.7	22.7	56.2
18-19	n.a.	66.2	n.a.	66.2	n.a.	68.4
Never had intercourse	54.7	29.5*	70.6	28.0*	71.0	26.9
Age not reported	U	U	U	U	6.2*	U
Weighted N	87,116	68,334	177,404	73,972	259,853	177,435
Unweighted N	142	134	314	152	545	352

Table C3. Cumulative percentage distribution according to age of first intercourse by age at survey, gender, and school status, NPHS, 1996

Females	**School and Work Status**					
	Not in School		In School and Working		In School only	
Age at first Intercourse	**Age at survey**		**Age at survey**		**Age at survey**	
	15-17	18-19	15-17	18-19	15-17	18-19
<18	49.2	57.8	38.6	49.9	27.7	46.7
18-19	n.a.	71.7	n.a.	63.1	n.a.	52.3
Never had intercourse	32.4*	17.6*	57.2	28.8	62.8	35.6
Age not reported	U	10.7*	4.2*	8.0*	9.6*	U
Weighted N	49,118	119,826	264,355	224,825	285,493	78,326
Unweighted N	106	351	497	420	627	192
Males	**School and Work Status**					
	Not in School		In School and Working		In School only	
Age at first intercourse	***Age at survey***		***Age at survey***		***Age at survey***	
	15-17	18-19	15-17	18-19	15-17	18-19
<18	34.9	56.6	23.9	50.5	20.4	40.2
18-19	n.a.	71.5	n.a.	63.5	n.a.	46.5
Never had intercourse	52.5	22.5	71.8	30.4	66.2	43
Age not reported	U	U	4.4*	6.0*	13.5	U
Weighted N	76,889	168,958	273,607	153,288	40,862	79,819
Unweighted N	136	346	511	355	714	177

Appendix D

Survey of Sexual and Reproductive Health Professionals

In order to complement existing documentation on adolescent access to reproductive health services in Canada and to gather information on those questions for which no data exist, the authors conducted a brief survey of professionals knowledgeable in the field of adolescent sexual/reproductive health from across Canada. The sample consisted of public health department personnel working in the area of adolescent sexual/reproductive health, Planned Parenthood affiliate personnel, academics specializing in adolescent sexuality, and physicians focusing on adolescent reproductive health. Participants were faxed the questionnaire and it was requested that they return it within seven days. This took place in the 2nd and 3rd week of September 1999. In addition, individuals attending the Canadian Sex Research Forum, September 30 – October 2, 1999, who were deemed to be knowledgeable in the field of adolescent sexual/reproductive health were asked to complete the survey.

The two-page questionnaire contained 19 items. Respondents were asked to provide information on where they worked and the size of the community in which they worked. As described in the text, most of the items focused on adolescent access to sexual/reproductive health services in the respondent's community. Most items employed a four-point scale, a Yes or No response, or asked for estimated percentages.

Thirty questionnaires were distributed, and 24 were returned in the one-week time frame (response rate = 80%). None of the respondents worked in a community with a population under 5,000. Two (8.3%) worked in a community with a population of 5,000 to 20,000. Four respondents (16.7%) were from communities with a population of 20,000 to 50,000, and an additional 4 (16.7%) were from communities of 50,000 to 100,000 people. Six respondents (25%) were from a community of 100,000 to 500,000 and 8 respondents (33.3%) worked in a community of 500,000 or more persons. The regional distribution of the respondents is given below. It should be noted that although the sample includes respondents from all of the regions of Canada, the regional distribution of respondents does not correspond precisely to the regional distribution of the Canadian population.

Regional Distribution of Respondents

Atlantic	5 (20.8%)
Quebec	3 (12.5%)
Ontario	7 (29.2%)
Prairie	6 (25%)
B.C.	2 (8.3%)
Territories	1 (4.2%)

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108. Single fathers represented 2.6% of IA and 1.9% of all men receiving IA. National Council on Welfare, 1998, op. cit. (see reference 100).

109. Family is defined here as at least 1 adult with at least one dependent child under the age of 18 years.

110. In 1999, the two benefits combined equaled C$1,625/year for the first child and C$1,425 for each additional child for families with C$20,921 income/year.

111. In 1999, C$199/year was paid to the head of the household, C$199 to the spouse or a second household member under 19 years of age, C$105 to each additional person under 19 years of age.

112. In Ontario, for example, an IA recipient may earn up to C$275/month without affecting benefits received.

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