Commentary

Sexuality and sexual health of Canadian adolescents: Yesterday, today and tomorrow

Eleanor Maticka-Tyndale[1]

[1] Department of Sociology and Anthropology, University of Windsor, Windsor, ON

Abstract: A profile of the sexual health and behaviours of contemporary Canadian adolescents is developed based on current research and compared to adolescents in the latter half of the 20th century. While notable changes occurred in the sexual lives of youth between the late 1950s and the early 1990s, the patterns of behaviour established in the latter part of the 20th century, have continued into recent years. There is strong evidence that today's youth are experiencing better sexual health and taking more measures to protect their sexual health than prior generations of youth did. However, problems remain. Canadian teens and young adults continue to be challenged by STIs; many GLBTQ youth continue to face homonegativity and discrimination in their schools and communities; youth living in poverty, in rural areas and aboriginal youth carry the greatest burdens of poor sexual health and are the most poorly served by sexuality education and sexual health care. Recommendations are made to strengthen both sexuality education and sexual health services to meet the needs of all Canadian youth.

Introduction

Those who rely on media reports to keep them up to date about the sexual health of Canadian adolescents may well have come to the conclusion that we live in particularly troubling times. Over the past few years we have been told that pregnancies are sought after with little thought of the long-term needs of a child (Gulli, 2008; Lunau, 2008); there is a widening repertoire of sexual acts such as masturbatory displays for others via webcams and oral sex "games" that are believed to have become part of what teenagers regularly do in their sexual lives (Stepp, 1999; Wilson, 2004); teens are easy victims for adult predators who have ready access to them, especially via the Internet (CBC News, 2008b); and dramatic increases in sexually transmitted infections are a growing threat to the sexual and reproductive health of our youth (Pearce, 2008). There is also a persistent interest in age of first intercourse among teens and the sense that this is happening much earlier than in the recent past. In these and other such cases, we, the professionals and organizations who are the sources for the stories, are at times insufficiently careful in the way we present and explain our findings. When we turn to the actual research, we find that the impressions created by most of these claims arise from misunderstanding or misinformation reinforced by an underlying expectation that the news about adolescent sexuality and sexual health has to be bad. What the research evidence suggests is that although there remains room for improvement, the picture of the sexual health and well-being of today's Canadian teens is, in many ways, more positive than in previous generations. The picture is also far more complex and context laden than is often portrayed. This article reviews the evidence, considers the context, and suggests possible future directions for supporting the sexual health of youth in Canada.

Correspondence concerning this paper should be addressed to Eleanor Maticka-Tyndale, Department of Sociology and Anthropology, University of Windsor, Windsor, ON.

Adolescent sexuality and sexual health: Yesterday and today

Comparing adolescents in the most recent 10 years to earlier generations we find that the major changes in what adolescents 'do' sexually occurred between the 1950s and late 1960s. There have been few changes in the patterns of teenage sexuality since the time when many of today's adults were teens (1970s), and many aspects of adolescent sexual health have improved since then. Using data for recent adolescents from the *National Longitudinal Survey of Children and Youth* (NLSCY) and for adolescents in earlier generations from the *National Population Health Survey* (NPHS) (Statistics Canada, 1998) – two national surveys using comparable research methodologies – and comparing these data to findings from various other large-scale studies conducted nationally or regionally (Boyce, 2004; Boyce, Doherty, Fortin, & MacKinnon, 2003; McCreary Centre Society, 2004; Rotermann, 2008; Saewyc, Taylor, Homma, & Ogilvie, 2008; Tonkin, Murphy, Lee, Saewyc, and the McCreary Centre Society, 2005), we find that since the 1970s the age of first sexual intercourse has remained relatively stable. For the large majority, first sexual intercourse occurs at 16 to 18 years of age. Also relatively consistent throughout this period has been that around 15-22% have first intercourse before 16 years of age, with this percentage being lower for the most recent cohort than for earlier ones. Clearly, teens are not initiating sexual intercourse earlier, but rather slightly later than their parents' generation did.

What about claims of a more "casual" approach to sex, of oral sex becoming a common and early activity, and of teens engaging in virtual (or display) sex over the Internet? The best we can do in assessing the "casualness" of adolescent sexual encounters is to consider the number of partners they have. Comparing results from the *Canada Youth and AIDS Study* conducted in the late 1980s (King et al., 1988) to its sequel, the *Canadian Youth Sexual Health and HIV/AIDS Study* conducted after 2000 (Boyce et al., 2003) we find youth currently in-school reporting slightly fewer lifetime sexual intercourse partners in the more recent than in the earlier study. If we assume that more partners suggests more "casualness" about sex, these results suggest that we are seeing somewhat less "casualness" among current adolescents than we were 10-15 years ago.

With respect to oral sex, it is important to remember that over the last 30 to 40 years oral sex has become a normative aspect of the adult sexual script and this trend has been followed by youth. Studies conducted on adolescent populations in the United States and Canada during and since the 1970s consistently show that oral sex is about as common as sexual intercourse, is most typically initiated at about the same time as intercourse, but precedes first coital activity for 15-25% of adolescents (for U.S. see: DeLamater & MacCorquadale, 1979; Lindberg, Jones & Santelli, 2007; Newcomer & Udry, 1985; for Canada see: Boyce et al., 2003; Gillis, 2005; Herold & Way, 1985; Warren & King, 1994).

Something that is new with the most recent generations of teens is the role played by communications technologies such as cell phones and the Internet. Here we have very little research other than basic counts that confirm what we already know, i.e., that adolescents and young adults are using cell phones and the Internet to an increasing extent and more than those who are older. An entirely new language and culture of communication has developed for text messaging and chat rooms. In her doctoral research, Smylie (2008) found that younger teens, who had more limited access to transportation or lived in peri-urban or rural areas, relied heavily on cell phones to connect with each other and maintain relationships while older, more urban adolescents relied more on face-to-face contact. Levine (2002), in interviewing adolescents in the United States about their sexual experiences quoted one 13-year-old girl as saying that she prefers experimenting sexually on-line because face-to-face is too "gropey" whereas on-line there is more talk. With every new technology—the printing press, movie theatres, telephones, automobiles, drive-in-theatres—youth have found ways to incorporate the technology into their rituals of "connecting" and adults have expressed dismay over what the implications are for morality and safety. What we can conclude about the sexual behaviours of contemporary Canadian teens is that they are maintaining patterns established in the late 1960s and early 1970s.

Sexual health trends

Pregnancy and parenting

The majority of Canadian adolescents are taking responsibility for their own sexual health by accessing contraception, using condoms, and seeking out abortion when necessary far more than any previous Canadian generation (compare, for example, trend data reported in Maticka-Tyndale, McKay and Barrett, 2000, to that in more recent reports on youth, e.g., Boyce, 2004; Boyce et al., 2003; McKay, 2006; Saewyc et al., 2008). In preventing pregnancies and postponing parenthood, teens today benefit from changes that were just beginning to be realized in the 1970s and '80s such as legal access to contraception and abortion as well as more recent changes such as the availability of emergency contraception (Pancham & Dunn, 2007). Legal access does not, however, guarantee access to all. Rural and very young teens remain poorly served by sexual and reproductive health services (e.g., Langille, Flowerdew & Andreou, 2004; Shoveller et al., 2007) and access to abortion remains limited or non-existent in some provinces and all territories. The continuing declines in pregnancy and birth rates (see McKay, 2006) speak not only to the greater availability of contraception and abortion today, but also to the ability of the vast majority of today's teens to take the necessary actions to prevent pregnancy and postpone parenthood.

Sexually transmitted infections

In comparison to pregnancy prevention, the picture for sexually transmitted infections (STI) is not as positive. Following a steady decline in reported rates for chlamydia among youth into the mid-1990s, rates rose steadily among 15- to 19- and 20- to 24-year-olds from 1997-2004. Paradoxically this increase in teen chlamydia rates occurred concurrently with a decline in teenage pregnancy rates and an increase in teen condom use over the same time period (compare teen condom use data from repeated surveys conducted among British Columbia youth in 1992, 1998, and 2003 as reported in Saewyc et al., 2008). These trends seem inconsistent with the increase in reported rates of chlamydia among teens and raise the question of whether increasing rates necessarily reflect an increase in prevalence of infection. Rising rates would also occur with introduction of more sensitive testing methods and more frequent testing, both of which would detect more cases but would not necessarily indicate a rise in the percentage infected (McKay & Barrett, 2008). However, regardless of whether the prevalence of chlamydia among youth has or has not increased, the present levels of infection are still grounds for concern. Many STI carry long-term consequences for health and reproductive potential (MacDonald & Brunham, 1997; PHAC, 2007) and efforts to raise the low levels of chlamydia screening of all sexually active 15- to 24-year-old youth by physicians (Hardwick, McKay & Ashem, 2007; Moses & Elliott, 2002) are thus an important health promotion priority. Indeed, a range of STI (in particular, human papilloma virus, HPV, and herpes simplex virus, HSV, as well as chamydia) are common in the teen population and require a sustained prevention effort from the education and health care systems.

Sexual abuse

While data on pregnancies and STIs, and policies and programmes designed to address them are within the domain of public health, sexual abuse, which is also a component of sexual health, is within the domain of the criminal justice system. Data on the actual prevalence of sexual abuse are not readily available, since only cases that are reported to the police are recorded and research suggests that this is a minority of cases. Several small-scale and regional studies conducted in Canada provide some insight into the extent of this threat to sexual health. Sexual harassment and unwanted sexual comments are experienced by the majority of female and gay adolescents of varying ages and this is the most prevalent form of sexual abuse (Berman, McKenna, Arnold, Taylor, & MacQuarrie, 2000; BC Ministry of Children and Family Development, 2002; Egale, 2008). As the severity of the sexual abuse increases, fewer adolescents are affected. However, various forms of unwanted sexual contact (being verbally, physically or forcefully coerced into sex play or sexual intercourse) are reported by up to 35% of adolescent women and approximately 15% of adolescent men (Bagley, Bolitho, & Bertrand, 1997; Bagley, Wood & Young, 1994; Murray & Henjem, 1993; Newton-Taylor, DeWit, & Giiksman, 1998; Rhynard & Krebs, 1997; Saewyc et al., 2008). Women are consistently more likely to be victims of

all forms of sexual abuse (from unwanted comments and harassment to forced sex) than are men, and reports of sexual abuse increase as teens get older. Multivariate analyses conducted on data collected from youth across British Columbia show that experiencing sexual abuse is a precursor for other threats to sexual health such as very early sexual intercourse (before age 14), experiencing or causing a pregnancy, and lower likelihood of using condoms (Saewyc, Magee & Pettingell, 2004; Saewyc et al., 2008). A persistent finding across all studies is that sexual harassment, coercion, and violence are perpetrated most often by someone known to the victim. This extends from classmates, co-workers and neighbours, to friends and family members. Despite the "truism" that the danger most often originates within our circle of acquaintances, media attention and public fear focus on the danger posed by strangers, often identifying them as sexual predators.

Internet concerns

As Internet chat rooms and social networking sites have become more popular among teens, fears have mounted about sexual predators who make contact with teens via the Internet and lure them into sexual liaisons. Parents are advised to monitor Internet use and teens are cautioned against providing personal information or arranging face-to-face meetings with those met on-line. Police and service providers tell us that, as with all forms of sexual violence or abuse, the majority of cases are not reported, but that the dangers abound. Researchers from the Crimes Against Children Research Center and Family Research Laboratory at the University of New Hampshire recently published the first study of on-line predators and victims (Wolak, Finkelhor, Mitchell, & Ybarra, 2008). Based on their research, they conclude that social networking, posting personal information, and engaging in conversations with 'strangers' over the Internet are not associated with any elevated danger for teenagers. While there are adults who solicit sex from adolescents via the Internet, this is rarely done surreptitiously such as by feigning friendship or pretending to be a teenager. Rather, adults and adolescents searching for partners (of any age) for sexual conversation or sex in virtual or real time tend to be open about their interest and age. Most adolescents do not report distress over these encounters and "click off" when they encounter such communications, especially from adults. Wolak and her colleagues found that teenagers who engaged in Internet communication with adults about sex or met these adults did not display naïveté about the Internet or about these encounters. They were fully aware and willingly engaged in sexual liaisons in the virtual and/or the real world. Wolak et al.'s study suggests that with encounters initiated via the Internet, there is considerably less danger than we have assumed and adolescents are generally able to, and do, effectively protect themselves. These findings are less inflammatory than some police and media reports but are unlikely to dispel fears about safety surrounding Internet use by adolescents.

Concern over the safety of younger adolescents from older sexual predators, especially those encountered over the Internet, was voiced as a primary motivator for recent changes in age-of-consent laws in Canada (CBC News, 2008a). Bill C-22 ,which received Royal assent on May 1, 2008, raised the age of consent from 14 to 16 years with a "close in age" (five or less years) exemption. Critics of the change have questioned its necessity and raised concerns about its consequences including the concern that it may discourage youth under 16 from seeking preventive or therapeutic health care (for discussion see Wong, 2007). What is criminalized in age-of-consent laws is consensual sex based on age categories. Under the law's premise of providing new protection for 14- and 15-year-olds, the age of their chosen partner is regulated. While 12- to 15-year-olds are considered capable of consenting to sexual intercourse, they are not considered capable of consenting to sexual intercourse with partners who are more than five years older than they are. Under the new law, adolescents and youth of 18 (or even 17), 19, 20 and 21 years (as well as older youth and adults) are charged as felons if they engage in consensual sex with partners who are 12, 13, 14 or 15 years respectively. Such a charge carries a lifelong designation as a sex offender, exclusion from various occupations, prohibition on travel to some countries (e.g., the United States), and community ostracization. The way the new law will be implemented and its implications for Canadian youth remain to be determined.

Sexual health inequities

The picture of adolescent sexual health, as indicated by pregnancies, STIs, and sexual aggression or violence is not the same for all Canadian adolescents. The burden of poor sexual health is unevenly distributed across the adolescent population. Within Canada, teens who experience the poorest sexual health live in regions where families with particularly low incomes and tenuous connections to the labour force are concentrated (Hardwick & Patychuk, 1999; Langille et al., 2004), in more isolated and rural areas (Shoveller et al., 2007), and in provinces and territories with greater concentrations of rural and aboriginal populations (Canadian Federation for Sexual Health, 2007). In these regions, geographical, social, and economic forces interact to create environments that increase the likelihood that youth will become sexually active early in their teens, will experience early pregnancies, will be victims of sexual abuse, and will be more susceptible to STI. Social and health policies, programs and services are critical to improving the sexual health and well-being of youth living in these circumstances.

Another group of adolescents whose sexual health is particularly threatened is teens who are gay, lesbian, bisexual, transgender or questioning (GLBTQ). Because of the heterosexist bias and homonegativity that permeate our social institutions and even the personal thinking of many Canadians, GLBTQ teens often struggle in isolation to make sense of their feelings and experiences and to develop a sexual identity in relation to their other identities (e.g., ethnic, familial, religious). Research in the United States has consistently shown that when youth are identified as GLBTQ they run the risk of psychological and physical assault and rejection by fellow students, co-workers, and even teachers, "friends" and family (Savin-Williams, 1999). Although Canadians are considered more accepting of diversity in sexual orientation and more supportive of equal rights than are Americans (Alderson, 2002), research has consistently demonstrated that GLBTQ students face psychological and physical harassment and violence in their schools precisely because they are GLBTQ (Bortolin, Adam, Brooke, & McCauley, unpublished; Bortolin, 2008; Egale, 2008; Saewyc et al., 2006; Sims, 2000; Youthquest, 2002). Preliminary findings from 1,200 respondents drawn from all provinces, territories and sexual orientations to an on-line survey about school climate launched in December 2007 by Egale together with University of Winnipeg faculty (www.climatesurvey.ca) show that sexual minority youth are far less likely to feel safe in their schools and are far more likely to have been verbally and physically harassed, or to have skipped school for safety reasons than majority youth (http://www.egale.ca/extra/1393-Homophobia-Backgrounder.pdf). The consequences of the sexual violence perpetrated on GLBTQ youth include higher school drop-out rates (Saewyc et al., 2006) as well as higher rates of depression and other forms of psychological distress, substance use, and suicide than experienced by "straight" youth (Savin-Williams, 1999). Homonegativity and heterosexism also pose barriers to access to social and health services. In both American and Canadian studies, GLBTQ youth report high levels of distrust of health and social service providers and feel they need to hide their identities to ensure better quality care (Barbara, Quandt, & Anderson, 2001; Travers & Schneider, 1996). Clearly, despite legal advances for gay and lesbian adults, GLBTQ adolescents continue to face serious impediments to their sexual health primarily as a result of the homonegativity and homophobia that continue to permeate many Canadian institutions.

Changing contexts

The changed biological and social contexts within which today's adolescents experience their sexuality present new challenges for their sexual and reproductive health. Teens today are looking towards more years as sexually mature singles than did previous generations. The age of sexual maturation has continued to dip below the teenage years while the median age of first marriage and childbearing remains at 29-34 years (Statistics Canada, 2006), leaving the majority of Canadian youth with many years from sexual maturation to first marriage. If the trend toward delayed childbearing continues, many of today's adolescents will be trying to become pregnant during years when the fertility of women is naturally declining. Given the negative impact of STI on sexual and reproductive health of both men and women, couples are more likely to face difficulties in becoming pregnant or maintaining a pregnancy (MacDonald & Brunham, 1997; PHAC, 2007). Increasing numbers are likely to seek fertility assistance or adoption, while others will not have children.

Relationship and family forms are also undergoing profound changes. With each succeeding census (Statistics Canada, 2006), there are increasing numbers of Canadians living in relationships and family forms other than the traditional form of two parents with biological children. Increasing numbers of today's adolescents are likely to find themselves living in such situations as: common-law couples, gay and lesbian marriages and families, singles, childless couples, divorced parents, blended families, and long-distance or geographically separated families. What do we know about the implications of these diverse forms of family and relationship for sexual health and well-being? Research, public health programs, sexual health education, and popular discourse have focused considerable attention on sexuality and sexual health during the adolescent years, most often with a focus on the burden of STI and their sequelae and the issues of unintended pregnancy and early parenthood faced by some teens. Less attention has been paid to the pervasive discrimination and threats faced by adolescents who are gay, lesbian, questioning or transgender (Egale, 2008), to the effects of legislation on the sexual well-being of adolescents, or to the challenges accompanying the changing social fabric of Canada. Yet, it is long-term changes in the social fabric that are likely to have the most profound effects on adolescent sexual health and well-being in the future.

Facing the challenges

A central challenge for policymakers and programmers is deciding how to promote and develop educational and health services and environments that enhance sexual health and well-being for all Canadian adolescents not only today, but throughout their lives. We are strongly influenced when setting policy and programs by the discourse of risky, irresponsible youth and sexual danger that permeates both media and public policy, much of it imported from our close neighbour, the United States (U.S.). Our media report events, evidence, and the ideological discourse from the U.S. as if they were our own. This being so despite the distinct differences between Canada and the U.S. in terms of demography, attitudes toward adolescent sexuality, adolescent sexual health outcomes (e.g., teen pregnancy and STI rates), and provision of sexuality education and health care. Perhaps more importantly, if we wish to set a course to improve adolescent sexual health and well-being we should look to countries with strong records of sexual health among their adolescents. For such examples, we are best to turn to western Europe (Singh & Darroch, 2001).

International cross-country comparative studies of developed countries conducted under the direction of the Alan Guttmacher Institute (Darroch, Frost, Singh & The Study Team, 2001) and by Advocates for Youth (2000) identified some of the environmental contributors to better sexual health among adolescents. Sex education and sexual health services for adolescents in North America are influenced by a pervasive concern about when, and in what type of relationship, it is desirable for youth to become sexually active. In the United States this is evidenced in a focus on promoting abstinence-until-marriage in sex education programs, as well as on the reduction of sexual health services available to adolescents, and increased requirements of parental notification and approval to receive services or participate in education programs. Even the more "comprehensive" sexuality education programs have been increasingly labelled as "abstinence-plus" programs. This contrasts with sex education programs in western European countries which are more often based on the assumption, and acceptance, that adolescents and young adults will engage in sexual activity prior to marriage or without it. Programs are founded on and teach values of responsibility, integrity, respect for self and others, together with techniques that contribute to safety and pleasure (Advocates for Youth, 2000; Darroch et al., 2001; Levine, 2002; Schalet, 2004). Freely available health care, accessible to adolescents without requiring parental approval, accompanies quality sex education in most western European countries. Contrary to concerns voiced by some in Canada (and more generally in the United States) that such permissiveness and openness to adolescent sexual activity will lead to earlier sexual activity and elevate the dangers to sexual health, the timing and forms of sexual activity among western European adolescents and young adults closely parallel those in Canada and indicators of sexual health point to better sexual health for western European youth (Darroch et al., 2001; Singh & Darroch, 2001). The example of western Europe, together with evaluations of sex education programs delivered in diverse countries,

is clear. The focus on abstinence that permeates sex education and the shift toward greater external regulation and control of the sexual lives and activities of adolescents evidenced in the United States do not contribute to an environment conducive to sexual health (Bruckner & Bearman, 2005; Darroch et al., 2001). Instead, the approach that Canada has already begun to take in the development of the *Canadian Guidelines for Sexual Health Education* (Health Canada, 1994, 2003) and in setting a framework for improving sexual and reproductive health (Health Canada, 2002) offers a far more promising direction.

There are, however, gaps to be filled and improvements to be made. With respect to professional education, a national study of sexual health-related residency training of physicians (Barrett & McKay, 1998) found considerable variability between programs with a sizeable degree of under-coverage of key field-specific topics. McKay and Barrett (1999) found decided limitations in the extent and content of sexual health pre-service training of teachers which they described as a missed opportunity to prepare educators to deliver sexuality education early in their training (thus placing greater pressure on in-service training thereafter). Canadian physicians do the sexual health assessments and routine chlamydia screening of all sexually active 15- to 24-year-old female patients (Hardwick et al., 2007; Moses & Elliott, 2002) at a frequency considerably below that recommended by the *Canadian Guidelines on Sexually Transmitted Infections* (Public Health Agency of Canada, 2006). Although the reasons for the low screening rates are complex, Hardwick et al. (2007) suggest a number of interventions to increase testing frequency given the time pressures of busy practices. A first essential step to filling the gaps in these and other areas of sexual health training and service is to prioritize the kind of training that will best prepare teachers to deliver broadly-based sexual health education and physicians to counsel and provide sexual health preventive, diagnostic, and treatment services to all Canadians. Broadly-based sexual health education as conceptualized in the *Canadian Guidelines for Sexual Health Education* (2003) that is accessible to all students in all schools is a must.

While we may well look to western Europe for examples of approaches that produce an environment conducive to sexual health and well-being among adolescents, Canadians must also consider several unique circumstances in Canada which are unlike those found in western European countries. Distinct subgroups of Canadian adolescents carry the very highest burden of poor sexual health. These include, first and foremost, aboriginal youth (Canadian Federation for Sexual Health, 2007; Devries,Free, Morison, & Saewyc, 2007) and also poor and rural youth (Hardwick & Patychuk, 1999; Langille et al., 2004; Shoveller et al., 2007). Broadly-based sexual health education and provision of better sexual health services suited to the environments in which these youth live are essential. But they are only a first step in relieving this burden. Policy and program initiatives that address the poverty, isolation, and lack of future opportunity are also necessary to improve sexual health and prepare these adolescents for the challenges of the future.

Canada also has a unique multicultural profile. We are second only to Australia in receiving immigrants, with increasing numbers of new Canadians coming from regions of the globe where sexuality is grounded in different social and cultural roots than those that dominate in Canada. These new immigrants and their children face unique challenges in adapting to the "sexual scene" they experience in Canada (e.g., Shirpak, Maticka-Tyndale & Chinichian, 2007) and to accessing sexual health care (e.g., Maticka-Tyndale, Shirpak, & Chinichian, 2007). Our official policy of multiculturalism provides an ideological guide for development of policies and programs that respect the integrity and address the needs of diverse cultural groups. Unfortunately, our ability and commitment to working out ideological disagreements about the delivery of sexuality education and sexual health services has considerable room for improvement. All too often we respond to disagreements by allowing parents to restrict their children's access to education and services. This reinforces divisions between groups and detracts from the weaving of a cohesive social fabric by creating two classes of adolescents (and future adults): those who have had education and access to care and those who did not. Canada needs to lead the way in developing models of sexuality education and

health care that respect and weave together diversities and differences whether they are differences in ethnicity, attitudes toward sexual orientation, or religion.

The sexual health and well-being of Canadian adolescents has fared relatively well compared to earlier generations. Challenges remain, including: unwanted pregnancies; the sequelae of STI; psychological and physical violence perpetrated against primarily women and GLBTQ teens; changing social, sexual and relationship structures; inequities in health and well-being based on geographical region, economic status, and sexual orientation; and ideological differences that restrict the access of some adolescents to the education and services they deserve. These are the realities that should stir news commentators and motivate public policy, educational programming, and improvements in health care services. Much can be learned by looking to the examples set by countries in Western Europe where the sexual health of adolescents is better than in Canada (see Maticka-Tyndale, 2001). However, there are also situations unique to Canada where we need to find our own solutions.

References

Advocates for Youth. (2000). *Adolescent Sexual Health in Europe and the US – Why the difference?* 2nd ed. Washington, DC: Advocates for Youth.

Alderson, K. (2002). Reflecting on shattered glass: Some thoughts about gay youth in schools. *The Alberta Counsellor, 27,* 3-11.

Bagley, C., Bolitho, F., & Bertrand, I. (1997). Sexual assault in school, mental health and suicidal behaviors in adolescent women in Canada. *Adolescence, 32,* 341-366.

Bagley, C., Wood, M., & Young, I. (1994). Victim to abuser: Mental health and behavioral sequels of child sexual abuse in a community survey of young adult males. *Child Abuse and Neglect, 18,* 683-97.

Barbara, A.M., Quandt, S.A., & Anderson, R.T. (2001). Experiences of lesbians in the health care environment. *Women and Health, 14,* 45-61.

Barrett, M., & McKay, A. (1998). Training in sexual health and STD prevention in Canadian medical schools. *The Canadian Journal of Human Sexuality, 7,* 305-320.

Berman, H., McKenna, K., Arnold, C., Taylor, G., & MacQuarrie, B. (2000) Sexual harassment: Everyday violence in the lives of girls and women. *Advances in Nursing Science, 22,* 32-46.

British Columbia Ministry of Children and Family Development. (2002). *The health and well-being of Aboriginal children and youth in British Columbia.* Vancouver, BC: BC Ministry of Children and Family Development.

Bortolin, S., Adam, B.D., Brooke, C., & McCauley, J. (unpublished ms) Gay, lesbian and bisexual youth's experiences of school climate. University of Windsor.

Bortolin, S. (2008). Exploring the interplay of masculinities and homphophobia in the high school climate. MA thesis. University of Windsor.

Boyce, W. (2004). *Young People in Canada, Their Health and Well-Being.* Ottawa, ON: Health Canada.

Boyce, W., Doherty, M., Fortin, C., & MacKinnon, D. (2003). *Canadian Youth, Sexual Health and HIV/AIDS Study: Factors influencing knowledge, attitudes and behaviours.* Toronto, ON: Council of Ministers of Education, Canada.

Bruckner, H., & Bearman, P. (2005). After the promise: The STD consequences of adolescent virginity pledges. *Journal of Adolescent Health, 36*, 271-278.

Canadian Federation for Sexual Health. (2007). *Sexual Health in Canada: Baseline 2007.* Ottawa, ON: Canadian Federation for Sexual Health.

CBC News. (April 29, 2008b). Internet predator stalking Surrey teens: RCMP. Retrieved June 20, 2008, from http://www.cbc.ca/canada/british-columbia/story/2008/04/29/bc-surrey-predator.html.

CBC News. (May 1, 2008a). Canada's age of consent raised by 2 years. Retrieved May 15, 2008, from http://www.cbc.ca/canada/story/2008/05/01/crime-bill.html.

Darroch, J.R., Frost, J.J., Singh, S., & The Study Team. (2001). *Teenage Sexual and Reproductive Behavior in Developed Countries: Can more progress be made.* Occasional Report No. 3. New York, NY: Alan Guttmacher Institute.

DeLamater, J., & MacCorquodale, P. (1979). *Premarital Sexuality.* Madison, WI.: University of Wisconsin Press.

Devries, K.M., Free, C.J., Morison, L. & Saewyc, E. (2007) Factors associated with the sexual behavior of Canadian aboriginal young people and their implications for health promotion. *AJPH,*

Dryburgh, H. (2000). Teenage pregnancy. *Health Reports, 12*(1), Statistics Canada, Catalogue 82-003.

Equality for Gays and Lesbians Everywhere Canada (EGALE). (2007). *The First National School Climate Survey on Homophobia in Canadian Schools* in conjunction with the University of Winnipeg. Retrieved January 12, 2008, from www.climatesurvey.ca.

Equality for Gays and Lesbians Everywhere Canada (EGALE). (2008). *Preliminary Results of the First National School Climate Survey*. Retrieved June 15, 2008, from http://www.egale.ca/extra/1393-Homophobia-Backgrounder.pdf.

Gay, Lesbian and Straight Education Network (GLSEN). (2005). *The 2005 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's school* (2005). New York, NY: GLSEN National.

Gillis, R. (2005) Examining the *National Longitudinal Survey of Children and Youth*: A profile of Canadian adolescent sexuality. MA thesis. Windsor, ON: University of Windsor.

Gulli, C. (2008). Suddenly teen pregnancy is cool? For the first time in years, more kids are having kids—and not just in the movies. *Maclean's,* 17 January 2008.

Hardwick, D., McKay, A., & Ashem, M. (2007) Chlamydia screening of adolescent and young adult women by general practice physicians in Toronto, Canada: Baseline survey data from a physician education campaign. *The Canadian Journal of Human Sexuality, 16,* 63-76.

Hardwick, D., & Patychuk, D. (1999). Geographic mapping demonstrates the association between social inequality, teen births and STDs among youth. *The Canadian Journal of Human Sexuality, 8,* 77-90.

Health Canada. (1994). *Canadian Guidelines for Sexual Health Education*. First edition. Ottawa, ON: Minister of National Health and Welfare. Division of STD Control, Health Protection Branch and Health Services Systems Division, Health Programs and Services Branch, Health Canada.

Health Canada. (2003). *Canadian Guidelines for Sexual Health Education*. (Second edition). Ottawa, ON: Minister of Health. Community Acquired Infections Division, Population and Public Health Branch, Health Canada.

Health Canada. (1999). *A Report from Consultations on a Framework for Sexual and Reproductive Health*. Ottawa, Government of Canada.

Health Canada. (2002). Reported *genital chlamydia/ gonnorhea cases and rates in Canada by age group and sex*. Division of Sexual Health Promotion and STD Prevention and Control, Bureau of HIV/AIDS, STD and TB. Ottawa, Government of Canada. http// :www.hc-sc.gc.ca/pphb-dgspsp.

Herold, E., & Way, L. (1985). Oral-genital sexual behavior in a sample of university females. *The Journal of Sex Research, 19*, 327-338.

King, A.J.C., Beazley, R.P., Warren, W.K., Hankins, C.A., Robertson, A.S., & Radford, J.L. (1988). *Canada Youth and AIDS Study*. Ottawa, ON: Health and Welfare Canada.

Langille, D., Flowerdew, G., & Andreou, P. (2004). Teenage pregnancy in Nova Scotia communities: Association with contextual factors. *The Canadian Journal of Human Sexuality, 13,* 83-94.

Lindberg, L.D., Jones, R., & Santelli, J.S. (2007). Non-coital sexual activities among adolescents. *Journal of Adolescent Health*, *42*, S44-S45.

Levine, J. (2002). *Harmful to Minors.* Madison, WI: University of Wisconsin Press.

Lunau, K. (2008). Babies are the new handbag. *Maclean's.* January 17, 2008.

MacDonald, N.E., & Brunham, R. (1997). The effects of undetected and untreated sexually transmitted diseases: Pelvic inflammatory disease and ectopic pregnancy in Canada. *The Canadian Journal of Human Sexuality*, *6*, 161-170.

Maticka-Tyndale, E. (2001). Sexual health and Canadian youth: How do we measure up? *The Canadian Journal of Human Sexuality, 10*, 1-17.

Maticka-Tyndale, E., Barrett, M., & McKay, A. (2000). Adolescent sexual and reproductive health in Canada: A review of national data sources and their limitations. *The Canadian Journal of Human Sexuality, 9,* 41-65.

Maticka-Tyndale, E., McKay, A., & Barrett, M. (2001). *Teenage Sexual and Reproductive Behavior in Developed Countries: Country Report for Canada,* Occasional Report No. 4. New York, NY: Alan Guttmacher Institute.

Maticka-Tyndale, E., Shirpak, K.R., & Chinichian, M. (2007). Providing for the sexual health needs of Canadian immigrants: The experience of immigrants from Iran. *Canadian Journal of Public Health, 98*, 183-186.

McCreary Centre Society. (2004). *Healthy Youth Development: Highlights from the 2003 Adolescent Health Survey III.* Vancouver, BC: McCreary Centre Society.

McKay, A. (2006). Trends in teen pregnancy in Canada with comparisons to U.S.A. and England/Wales. *The Canadian Journal of Human Sexuality*, 15, 157-161.

McKay, A., & Barrett, M. (2008). Rising reported rates of chlamydia among young women in Canada: What do they tell us about trends in the actual prevalence of the infection? *The Canadian Journal of Human Sexuality, 17,* 61-69.

McKay, A., & Barrett, M. (1999). Pre-service sexual health education training of elementary, secondary, and physical education teachers in Canadian faculties of education. *The Canadian Journal of Human Sexuality, 8,* 91-101.

Moses, S., & Elliott, L. (2002). Sexually transmitted diseases in Manitoba: Evaluation of physician treatment practices, STD drug utilization, and compliance with screening and treatment guidelines. *Sexually Transmitted Diseases, 29,* 840-846.

Murray, J., & Henjum, R. (1993). Analysis of sexual abuse in dating. *Guidance & Counseling, 8,* 181-202.

National Longitudinal Survey of Children and Youth (NLSCY); Human Resources Development Canada and Statistics Canada. www.statcan.ca/english/sdds/4450.htm.

Newcomer, S.G., & Udry, R.J. (1985). Oral sex in an adolescent population. *Archives of Sexual Behavior, 14*, 41-46.

Newton-Taylor, B., DeWit, D., & Giiksman, I. (1998). Prevalence and factors associated with physical and sexual assault of female university students in Ontario. *Health Care for Women International, 19,* 155-165.

Pancham, A., & Dunn, S. (2007). Emergency contraception in Canada: An overview and recent developments. *The Canadian Journal of Human Sexuality*, *16*, 129-133.

Pearce, T. (2008). Chlamydia in teens jumps 50%. *Globe and Mail.* February 13, 2008.

Public Health Agency of Canada. (2007). *Supplement: 2004 Canadian Sexually Transmitted Infections Surveillance Report.* CCDR 2007; 33S1, 1-69.

Public Health Agency of Canada (PHAC). (2006) *Canadian Guidelines on Sexually Transmitted Infections.* Ottawa, ON: Public Health Agency of Canada.

Rhynard, J., & Krebs, M. (1997). Sexual assault in dating relationships. *Journal of School Health, 67,* 89-93.

Rotermann, M. (2008) Trends in teen sexual behaviour and condom use. *Health Reports, 19(3).* Statistics Canada, Catalogue no. 82-003-XPE.

Saewyc, E.M., Magee, L.L., & Pettingell, S.E. (2004). Teenage pregnancy and associated risk behaviors among sexually abused adolescents. *Perspectives on Sexual and Reproductive Health, 36,* 98-105.

Saewyc, E.M., Skay, C.L., Pettingell, S.L., Reis, E.A., Bearinger, L., Resnick, M., Murphy, A., & Combs, L. (2006). Hazards of stigma: The sexual and physical abuse of gay, lesbian, and bisexual adolescents in the United States and Canada. *Child Welfare*, *85*, 195-213.

Saewyc, E., Taylor, D., Homma, Y., & Ogilvie, G. (2008). Trends in sexual health and risk behaviours among adolescent students in British Columbia. *The Canadian Journal of Human Sexuality*, *17*, 1-13.

Savin-Williams, R.C. (1999). Matthew Shepard's death: A professional awakening. *Applied Developmental Science, 3,* 150-154.

Schalet, A. (2004). Must we fear adolescent sexuality? *Medscape General Medicine, 6.* 22 pages. Retrieved March 3, 2006, from http://www.medscape.com/viewarticle/494933_print.

Shirpak, K.R., Maticka-Tyndale, E., & Chinichian, M. (2007). Iranian immigrants' perceptions of sexuality in Canada: A symbolic interactionist approach. *The Canadian Journal of Human Sexuality, 16*, 113-128.

Shoveller, J., Johnson, J., Prkachin, M., & Patrick, D. (2007). "Around here, they roll up the sidewalks at night": A qualitative study of youth living in a rural Canadian community. *Health and Place, 13,* 826-838.

Shoveller, J., Johnson, J., Langille, D.B., & Mitchell, T. (2004). Socio-cultural influences on young people's sexual development. *Social Science and Medicine, 59,* 473-487.

Sims, M.W. (2000). Gay/straight alliance clubs—understanding our differences. Retrieved from sss.bchrs.gov.bc.ca/PressRelease2000.asp.

Singh, S., & Darroch, J. (2001). Adolescent pregnancy and childbearing: Levels and trends in the developed countries. *Family Planning Perspectives, 32,* 14-23.

Smylie, L. (2008). The influence of social capital on the timing of first sexual intercourse among Canadian youth. Doctoral dissertation, University of Windsor.

Statistics Canada. (1998). *National Population Health Survey (NPHS)*, 1996-1997. Ottawa, Canada.

Statistics Canada. (2006). Family portrait: Continuity and change in Canadian families and households in 2006: Highlights. Retrieved June 20, 2008, from http://www12.statcan.ca/english/census06/analysis/famhouse/highlights.cfm.

Stepp, L.S. (July 8, 1999). Unsettling new fad alarms parents: Middle school oral sex. *Washington Post.* July 8, 1999.

Tonkin, R.S., Murphy, A., Lee, Z., Saewyc, E., and The McCreary Centre Society. (2005). *British Columbia Youth Health Trends: A Retrospective, 1992-2003.* Vancouver, BC; McCreary Centre Society.

Travers, R., & Schneider, M. (1996). Barriers to accessibility for lesbian and gay youth needing addictions services. *Youth & Society*, *27*, 356-378.

Warren, W.K., & King, A.S. (1994). Development and evaluation of an AIDS/STD/sexuality program for grade 9 students. Kingston, Ontario. Social Programs Evaluation Unit, Queen's University.

Wilson, S. (2004). Good girls do. *Globe and Mail.* 7 February 2004.

Wolak, J., Finkelhor, D., Mitchell, K.J., &Ybarra, M. (2008). Online "predators" and their victims. *American Psychologist, 63,* 111-128.

Youthquest. (2002). Youthquest! Low-cost, high impact: Programs for lesbian, gay, bisexual and transgender youth. *Youthquest! 2002 Strategic Services Plan.* Retrieved from www.youthquest.bc.ca/servplan2002/needassessment.htm#ftnref2.