SEXUAL HEALTH AND CANADIAN YOUTH: HOW DO WE MEASURE UP?

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ABSTRACT: *This paper assesses the current sexual health status of Canadian youth in relation to sexually transmitted infection, pregnancy rates and sexual practices. The paper begins with a discussion of the social and historical context of adolescence and adolescent sexuality in Canada. Of particular importance in understanding adolescent sexuality is that, at present, our society postpones the transition from adolescent to adult status well beyond the point of biological readiness for sexual activity. Insights are drawn from international comparisons of adolescent sexual health indicators, and priorities for adolescent sexual health research and promotion are discussed. Among these priorities are Canadian-based research on adolescent sexual health, greater collaboration among Canadians working to promote adolescent sexual health and, most importantly, a commitment to listen to our youth when developing programs and services.*

Key words: Canada Adolescence Sexual health International comparisons

ACKNOWLEDGEMENT: This paper was adapted from the author's keynote address to the 23rd Annual Guelph Conference and Training Institute on Sexuality, University of Guelph, Guelph, Ontario, Canada, June 2001.

INTRODUCTION

> A young woman leaves school to enter the labour force full-time at 14 years of age. By 16 she has met the 'love of her life' whom she marries just before her 17th birthday. Before she turns 18 she has given birth to her first child.

What are you thinking about this young woman and her child? If I told you the year she gave birth was 1914, would your thinking change?

We hear a lot about the problems of teen sex—particularly teen pregnancy and sexually transmitted infections. We most often think of teens as biologically, cognitively, and socially unprepared for parenting or even, some would say, for being sexually active. Let's take a look at this for a moment: biologically, a woman's fertility begins declining in her mid-twenties and in less than a century the mean age of menarche declined from 14.8 in the 1890s to 12.5 in 1988 (Forrest, 1993; Wyshak & Frisch, 1982). This seems to suggest that biologically, somewhere in their teens women are ready to bear children and consequently to be sexually active. Young men have seen the same decline in spermarche (when they first produce viable sperm) (Atwater, 1992).

What of cognitive and social development? Cognitive and social development are very much a consequence of two factors. First, our child rearing practices and treatment of our teenagers; second, how we structure our society in terms of education, access to information and resources, entry and acceptance into an adult status, and economic dependence or independence.

Child, adolescent, adult—when we look to our own history as well as cross-culturally we realize that these statuses are social constructions far more than they are dependent on biological markers. The young woman who was ready for the labour force, i.e., to take on an adult status, in her early teens just 3 or so generations ago, didn't even need a high school education to get a job. She had typically been sharing

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in the responsibility of family care since she was a young child. She fit into the social expectations of her family and community and was a responsible, adult member of society often before she reached 18 years of age.

Today things are very different. We postpone entry into adult status and prolong adolescence. Let's be clear about this—these are social developments that are not tied to biology. Though young men and women enter puberty before they enter their teens, the average age of marriage is approaching 30 (Milan, 2000). This means that by the time they marry young people have been biologically capable of reproduction for more than half their lives. It also means that by the time most women marry, their fertility has already begun to decline.

Whether it is industries looking for university graduates to work "on the line", cities preferring to hire university grads for police and fire-fighting work, or school boards that require teachers to have at least one university degree rather than the *normal school* completion required less than 50 years ago, a university degree is becoming the requirement for more and more jobs. So, by the time youth are ready to enter the labour force, college and/or university degree in hand, they are in their early to mid-twenties.

Biologically they are and have been adults for several years. Yet they have been kept in a state of social and economic dependency and immaturity. Judging by population data, many face several years yet before they are likely to marry. Add to all of this:

- a heightened focus on sex and sexuality in the marketplace;
- an increase in the time that youth are without adult supervision, a result of 2 career couples and rising divorce rates;
- an increase in mobility and urbanization and the accompanying increase in anonymity;
- a greater amount of money in the hands of youth despite the persistent presence of poverty and low income among 1/4-1/5 of Canadian families;
- an increase in commercialization of entertainment;
- globalization and the availability of and exposure to a huge amount and diversity of information and images as well as relatively anonymous communication with far-flung others;
- increasing uncertainty about the future.

Clearly, young people are ready to be sexually active and are faced with a diversity of messages and pressures that encourage them to be sexually active well before they are likely to establish a long-term permanent relationship.

How are young people responding to all of this in terms of their sexuality? How do our youth compare to those of other countries?

Before we turn to these questions, I want to return briefly to the young woman at the beginning of this introduction. I chose this example (by the way, it's a true story, that was my grandmother) to illustrate the fact that sexual activity in the teenage years is not something new. It has been relatively common throughout history and continues to be common if we look across cultures. Even childbearing during the teenage years is not uncommon when we look cross-culturally and cross-historically. What is new is the length of adolescence—that time between childhood and entry into roles that are markers of adulthood (such as husband, wife, or parallel status; employee in a permanent job; rentee or mortgagee). Adolescence is now a time when one is biologically mature but kept socially (and cognitively) immature, i.e., not yet ready to be an adult. I also wanted to illustrate that our impressions of what is desirable and undesirable in terms of sex and adolescents is very local, very specific to a moment in time, a group of people, and a place on the globe—it is not universal. It is also political. If you doubt this I suggest you spend time discussing approaches to adolescent sexuality with colleagues from other countries. It becomes apparent rather quickly that how we view adolescent sexuality and what we see in the consequences of teenage sexual activity has a pretty strong connection to our policies in areas that seem very distant from teenagers and their sexual activity; policies related to the labour force and employment, employee benefits, education, social and health services. It's also rooted in our understanding of the rights of citizens. I am in no way devaluing concerns about teenage sexuality. I am, however, trying to place our concerns within an historical, social and cultural context.

When we speak of concerns about teenage sexual

activity, what often comes to mind is teen pregnancies and sexually transmitted infections.

What I also hear is concern over the length of time teens are sexually active before they settle into a long-term relationship; the apparent casualness of some of their sexual encounters, and the number of them; and gay, lesbian and bisexual youth—how they are handling their growing sexual awareness, the homophobia they are likely to encounter in their communities and schools, how they are connecting to others and developing a sense of their own identity.

Let's take a look at these issues and place Canada into the international context wherever that is possible.

Pregnancy

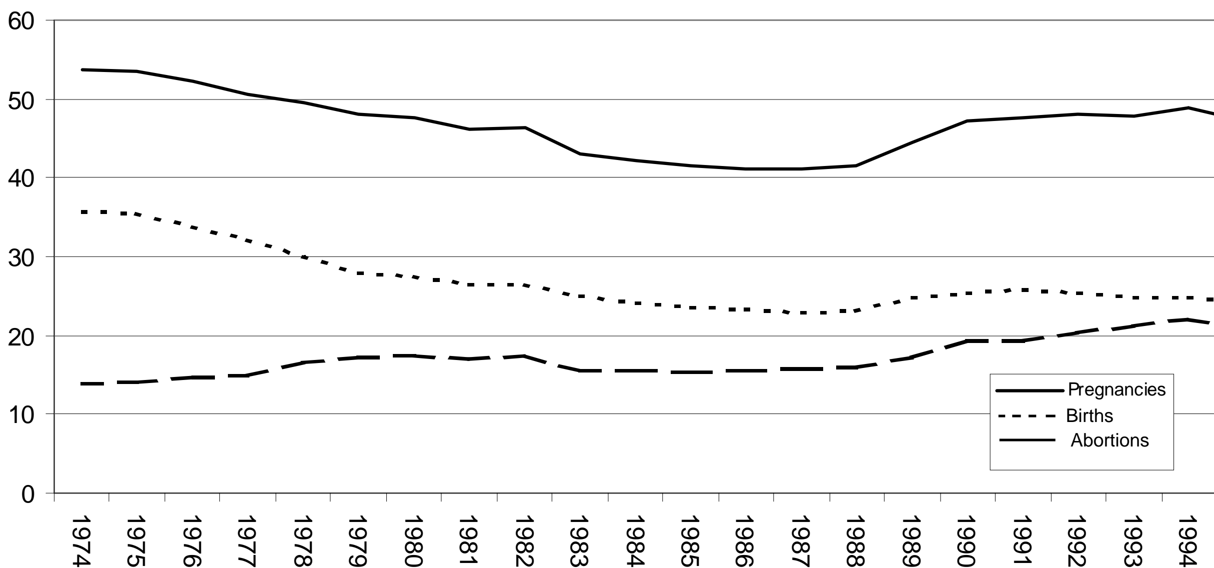
What we see in Fig. 1 is generally good news for Canada. For the most part, pregnancy rates are coming down. There are a few 'blips' in the trend but that is almost always the case with long-term population data. It's interesting that the rise in pregnancies in the late 1980s and early 1990s that we saw in Canada coincided with a similar rise in many other countries. This suggests that something was going on at these times that caused pregnancy rates to temporarily rise a little and this something was probably pretty uniform across western societies. This could be an interesting area for research if graduate students are looking for a thesis topic.

Another piece of good news is the decline in births to teenage mothers. Most teens who get pregnant recognize that the social and economic structure of Canada in the latter 20th and early 21st century requires a prolonged period of adolescence in order to complete enough education to fit easily into the labour force. Thus, teenage is not the best time to become a parent and teens are using that long fought for right to abortion.

How do birth and abortion rates in Canada compare to other countries?

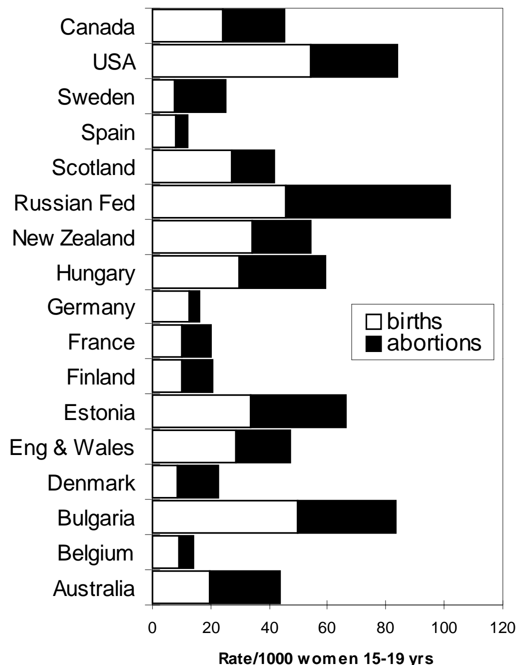
Our rates of teen pregnancy (the full size of each bar in Fig. 2) and birth are far better than our closest neighbour, the United States, about the same as Australia, England and Wales, and Scotland, but compared to France, Germany, Belgium and the northern European countries, we would have to say that if postponing childbearing until young women are out of their teens is desirable, we have room for improvement (Singh & Darroch, 2000).

Figure 1 Rates of Pregnancy, Birth and Abortion per 1000 Canadian Women Aged 15-19 Years, 1974-1994.



Drawn from numerical data in Dryburgh, 2000. Rates per 1000 young women 15-19 years.

Figure 2 Rates of Births & Abortions/1000 Women Aged 15-19 Years for Selected Countries, 1995 and 1996.



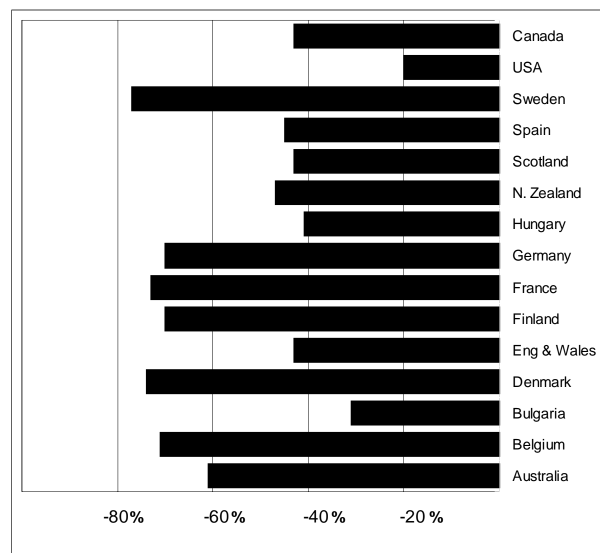
Drawn from numerical data in Singh & Darroch, 2000. Rates per 1000 women 15-19 years.

Not so good news is how much we've improved relative to other countries. Fig. 3 shows changes in rates of pregnancy between 1970 and 1995—the same countries with low pregnancy rates have had greater decreases than Canada. Those with the same rates as Canada have changed about the same. And the United States, with the highest current rates has seen the least change. There are other countries where pregnancy rates have increased, most notably Russia and countries of the former Soviet Union. However, for countries we usually take as a point of comparison, teen pregnancy rates are coming down, in some faster than in Canada (Singh & Darroch, 2000). On the plus side again, pregnancy rates in Canada dropped from 47.1/1000 in 1995 to 42.7/1000 in 1997 (Dryburgh, 2000).

In the past, teen pregnancies most typically resulted in marriage or in placement of the child for adoption. Today, the most common choices are abortion and single parenthood (Daly & Sobol, 1993). Single parenthood is generally not seen as good news because of higher rates of poverty, shortened education of mothers, and a greater risk of poor health, functioning and well-being outcomes for both mothers and children. There is extensive research documenting the poor outcomes for teen parents, most of it from the United States where this is a larger problem than in Canada. It should be noted that such outcomes may be correlated with pre-existing social disadvantage and are not always or necessarily caused by early parenthood (Bissell, 2000).

Some preliminary research using Canada's Longitudinal Survey of Children and Youth suggests that the picture is not nearly so negative for children born to teen moms in Canada. They have a rough start, but when multivariate analyses are used to identify the specific influences on outcomes, it appears that before they begin school there are no noticeable differences in social, emotional and cognitive development between the children of teen moms and of older moms. And, family environment, which is the major area of improvement for teen moms during those first few years, far more than the age of the mother, is the major source of influence on outcomes for children (Dryburgh, 2001).

Figure 3 Percentage Change in Birth Rates, 15- to 19-Year-Old Women in Selected Countries, 1970-1995.



Drawn from numerical data in Singh & Darroch, 2000.

Sexually Transmitted Infections

What about sexually transmitted infections (STI)? Well, the picture has also changed here historically. In Canada, we are on the verge of eliminating the old dreads like syphilis (see Wong & Jordan, 2000). However, there are new concerns, primarily chlamydia, human papilloma virus (HPV), gonorrhea, herpes, and HIV. Chlamydia is a particular concern. It often remains asymptomatic. For women this means that infection may be present for a considerable number of years prior to detection, resulting in serious damage to the reproductive tract. Serologic studies conducted in Canada lead to the conclusion that 64% of tubal infertility and 42% of ectopic pregnancies are attributable to chlamydia (Davies & Wong, 1996).

Chlamydia isn't the only concern. Strains of the HPV are related to an increased risk for cervical cancer. Herpes transmitted from an infected mother during the birth process can have serious consequences for the child. And there's HIV which continues to have potentially debilitating effects.

What do we see among Canadian youth? The picture is not an easy one to get into focus since not all STIs are reportable, not all those who are infected know it, and even the known reportable infections are not always reported. What we do know, however, is worrisome.

Gonorrhea and Chlamydia

Rates for gonorrhea were decreasing pretty steadily over a 10-year period well into the late 1990s, but recently have begun to increase (Fig. 4). Notice, however, that we are dealing with fewer than 100 cases/100,000 for 15 to 19 and 20 to 24-year-olds.

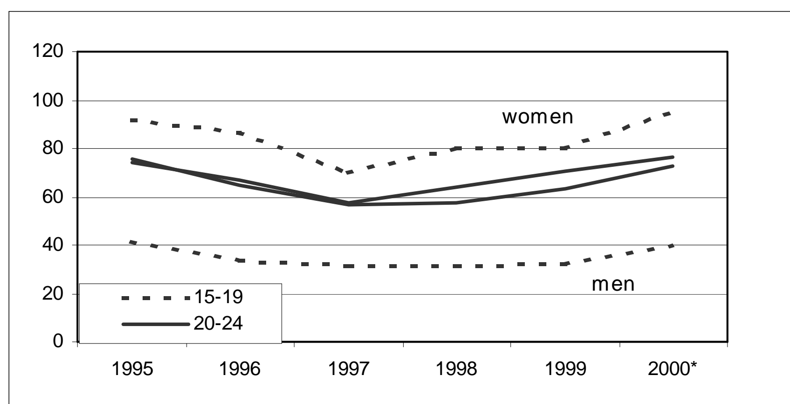
Chlamydia is a major problem for youth in Canada, especially young women. Not only have rates consistently increased in recent years, but the scale places these rates at several hundred/100,000 for men and 1000 or more for women (Fig. 5).

How do we compare to other developed countries?

Figs. 6 and 7 show new reported cases of gonorrhea and chlamydia in 1995/1996. For gonorrhea we are far better off than the United States, about the same as England and Wales, but well behind other western European countries that have virtually eliminated gonorrhea (Fig. 6).

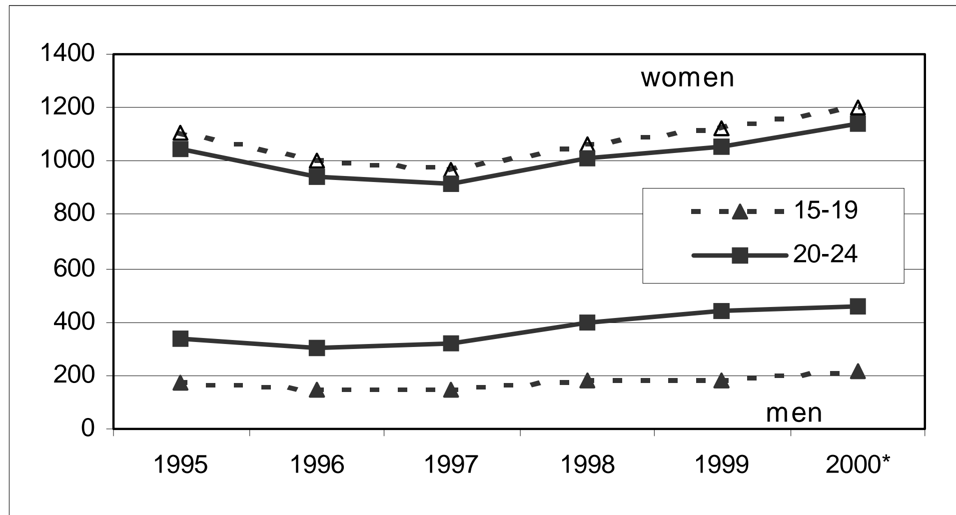
For chlamydia the picture is more complex (Fig. 7). With the exception of Belgium and France, none of the other countries represented here is doing well; look particularly at Denmark, a country which has low rates of teen pregnancy, and almost no gonorrhea; rates of chlamydia among young women, however, are exceptionally high. It's difficult to find a country that is doing well here.

Figure 4 Rates of Gonorrhea in Young Adults in Canada, 1995-2000.



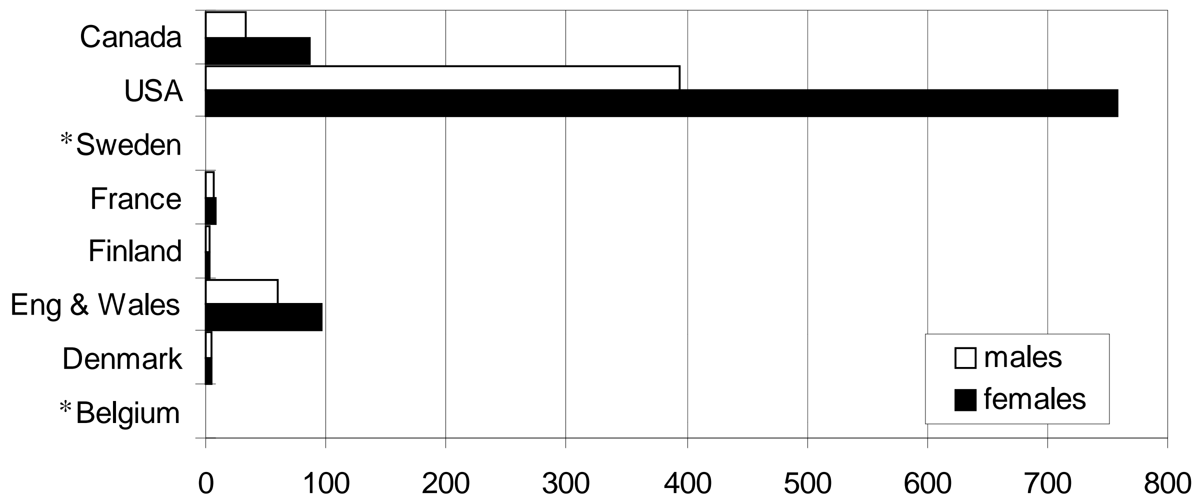
***Cases incomplete, changes anticipated. Division of Sexual Health Promotion and STD Prevention and Control, Health Canada. Rates per 100,000 in each age group by sex.**

Figure 5 Rates of Genital Chlamydia in Young Adults in Canada, 1995-2000.



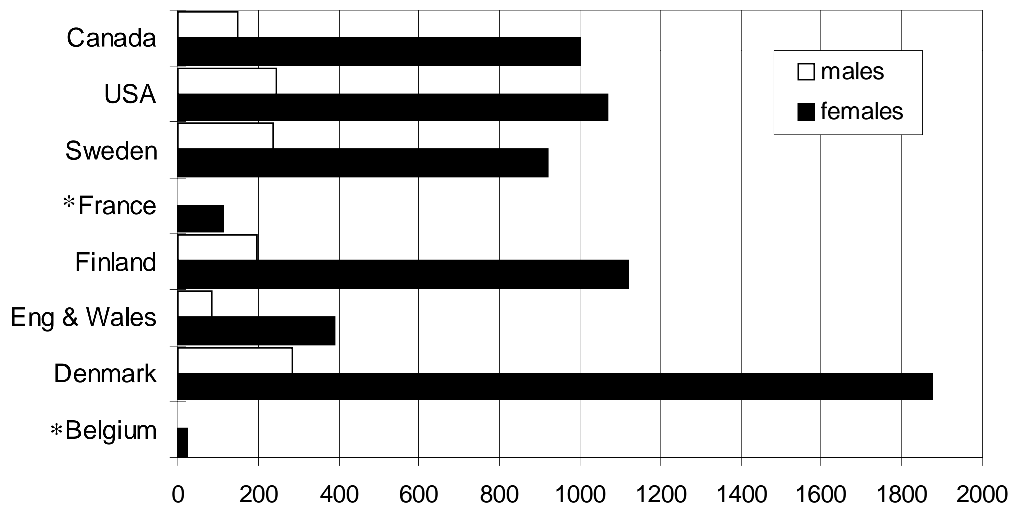
***Cases incomplete, changes anticipated. Division of Sexual Health Promotion and STD Prevention and Control, Health Canada. Rates per 100,000 in each age group by sex.**

Figure 6 Annual Reported Rates for Gonorrhea for Selected Countries, Males and Females, 15-19 Years of Age, 1995/1996.



Drawn from numerical data in Panchaud et al., 2000. Rates per 100,000 in each age group by sex.
***Rates from Sweden and Belgium were too low to be visible on this scale.**

Figure 7 Annual Reported Rates for Chlamydia for Selected Countries, Males and Females, 15-19 Years of Age, 1995/1996.



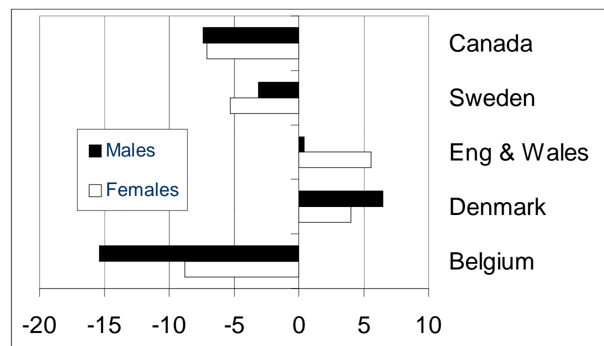
Drawn from numerical data in Panchaud et al., 2000. Rates per 100,000 15- to 19-year-olds by sex.
***Rates for 15-19 year old males from France and Belgium were too low to be visible on this scale.**

How do countries vary in their average annual rates of change in newly reported cases of gonorrhea and chlamydia from 1990 to 1996?

For gonorrhea Canada's rate of reduction is in the mid-range of the scale, ahead of the United States and England and Wales, but behind Belgium, Denmark, France and Sweden (Fig. 8).

For chlamydia the picture is more difficult to draw since chlamydia is not reportable in all countries, and has only just become reportable in others so the data are more meagre. From what is available (Panchaud et al., 2000), we would say that Canada is doing well. Our rate of decline is considerably ahead of England, Wales and Denmark where rates are increasing on average, and also ahead of Sweden but behind Belgium (see Fig. 9).

Figure 8 Average Annual Rate (%) of Change in Gonorrhea Incidence Among Females & Males Aged 15-19 Years in Selected Countries, 1990-1996.



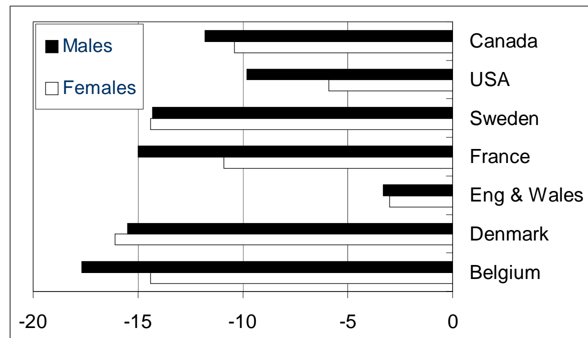
Drawn from numerical data in Panchaud et al., 2000.

HIV

It is particularly difficult to estimate the effect of HIV on teens since it is very likely to remain undetected for many years resulting in low rates of known infection compared to the rates of silent infection among youth.

What we see in Fig. 10 is that HIV that is thought to have been transmitted through sexual contact between men is rising after a prolonged downward trend and that HIV that is thought to have been transmitted through sexual contact between men and women continues to rise very slowly. What is important

Figure 9 Average Annual Rate (%) of Change in Chlamydia Incidence Among Females & Males Aged 15-19 Years in Selected Countries, 1990-1996.



Drawn from numerical data in Panchaud et al., 2000.

to recognize here is that despite some media reports that rates of HIV have stabilized, we are far from having beaten it or even brought it under control.

So the picture is definitely mixed in terms of STIs. The classic old ones are at low levels, but we have a particularly worrisome situation with respect to chlamydia and HIV, and we don't have data that help us assess the situation with respect to herpes or HPV.

Sexual Practices

That brings us to the sexual practices of youth. One logical question is whether the cross-national differences in pregnancy rates and STIs are reflected in differences in sexual practices.

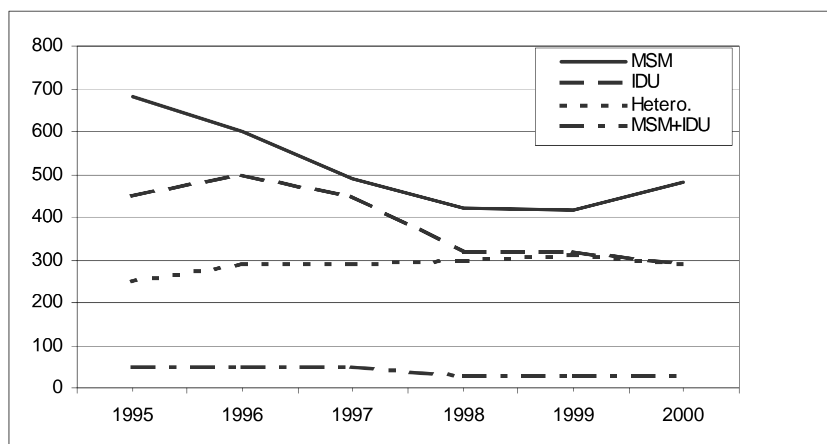
The 1996 *Canadian National Population Health Survey* (*NPHS*) provides the most recent data we have and includes a large nationally representative sample. We do have some excellent provincial surveys, but we can't get a national picture from these since questions were asked differently, samples were drawn differently, and not all provinces have collected their own data, and from analyzing the *NPHS* it is clear that things are different across provinces.

Compared to the United States, England, France, Sweden, The Czech Republic (and others), Canada is far behind in conducting research that would help inform and evaluate our programmes and policies. We tend to use data from other countries (usually the United States) and assume it applies to Canadians. That is not a good practice since it leads to invalid conclusions.

Age at First Intercourse

For organizations and agencies working with teens, a common program goal has been to find ways to get them to postpone first intercourse. The "Virginity

Figure 10 Positive HIV Test Reports Among Adults in Canada by Exposure Category, 1995.



Health Canada. Surveillance Report to December 31, 2000. Values are number of positive test reports by year.

Pledge" campaigns that are advocated in some areas are perhaps one of the most extreme examples of this goal. The goal is supported with three sorts of claims:

(1) that teens are not emotionally or cognitively ready for sex and that many or most initiate sex because of pressure or coercion not because of personal choice,
(2) that the longer the time young people are sexually active before they form a permanent relationship, the more likely they are to be exposed to risks of pregnancy and STIs,
(3) that sex outside marriage is immoral (this is often the message associated with the Virginity pledge or "just say no" campaigns).

All of these claims can be disputed. In any case, it is clear that making postponement of first intercourse the sole objective of sexual health education is both ineffective and disrespectful of the core democratic right of informed decision-making.

One thing that tends to be forgotten in the discussions of age of first sexual intercourse is that there are other forms of sexual activity that teens engage in, some of which carry less risk of pregnancy and STIs, but others that carry as much or potentially greater risk. Yet, these are, by and large, ignored. And, we have almost no data at all on forms of sexual interaction other than vaginal intercourse. The one exception is anal intercourse for which we have some information, primarily about the sexual practices between young men, thanks to research funded under the AIDS initiative.

This says a great deal about what we think is really important with respect to the sexuality of our youth. Despite lots of talk about "outercourse" or forms of sexual pleasuring other than vaginal or anal intercourse, and despite claims that our concerns are with sexual health, we certainly don't think these are important enough to address in research.

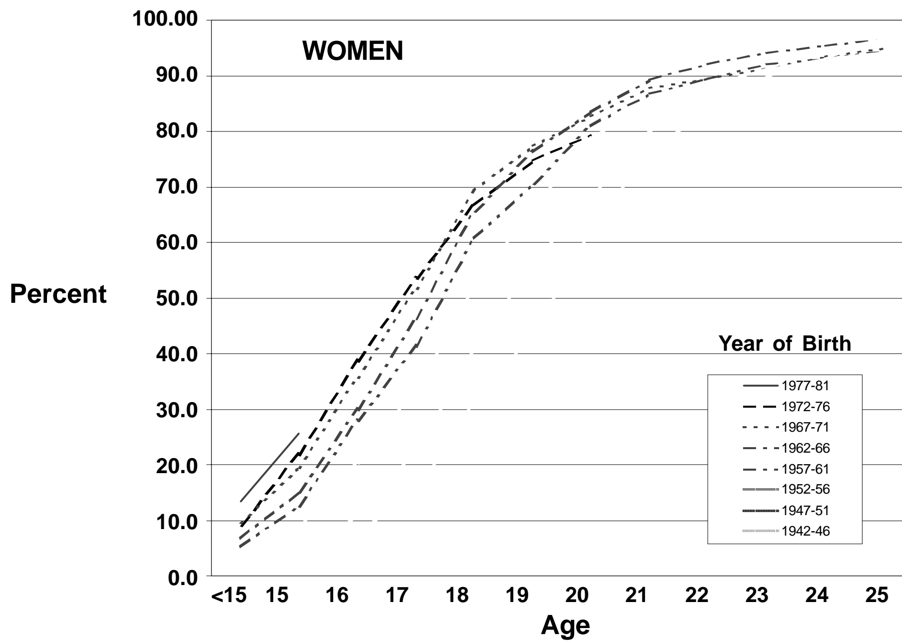
Abbreviated versions of Figs. 11 and 12 have appeared previously in *The Canadian Journal of Human Sexuality* (Maticka-Tyndale et al., 2000). They merely illustrate what you probably already know—that more young people are initiating vaginal intercourse at younger ages with each new birth cohort and that this trend toward decreasing age is greater among women than men. But what we have to keep in mind is that the median age of first intercourse for both men and women is 17 and this has been the case for women since the cohort born between 1967 and 1971 (today they are 33 or younger) and for men the cohort born between 1952 and 1956 (today they are 49 or younger). For the most recent data we have, what does the median age of first intercourse tell us? If we look at a group of teens who are 17 years of age, we are probably looking at a group where half have experienced vaginal intercourse. If the group is 16 years of age about 40% have experienced intercourse, at 15 years about 25% for women and 20% for men. Below 15 years we have between 10% and 13% initiating intercourse. In fact, based on the latest data in the National Longitudinal Survey of Children and Youth it looks like less than 2% initiated intercourse before 14 years of age.

So age has been decreasing but there is a clustering of first vaginal intercourse between 16 and 18 years of age. Very few Canadian youth begin before 15 and it is rare to find a 14-year-old who has had intercourse. It's important to spend time on this because depending on how statistics are presented it can look like many very young teens are sexually active and that simply isn't the case. Also, when statistics are presented for teenagers in general, or all high school students, or teens between 15 and 19 years of age, what is being lumped together into that single category is youth with very different experiences. Most of those at the bottom end of the age range are not sexually active while most of those at the top end are. Those who work specifically with groups of youth at the upper end may have a different set of concerns than those who work with late starters.

How do we compare internationally with respect to change in age at first intercourse?

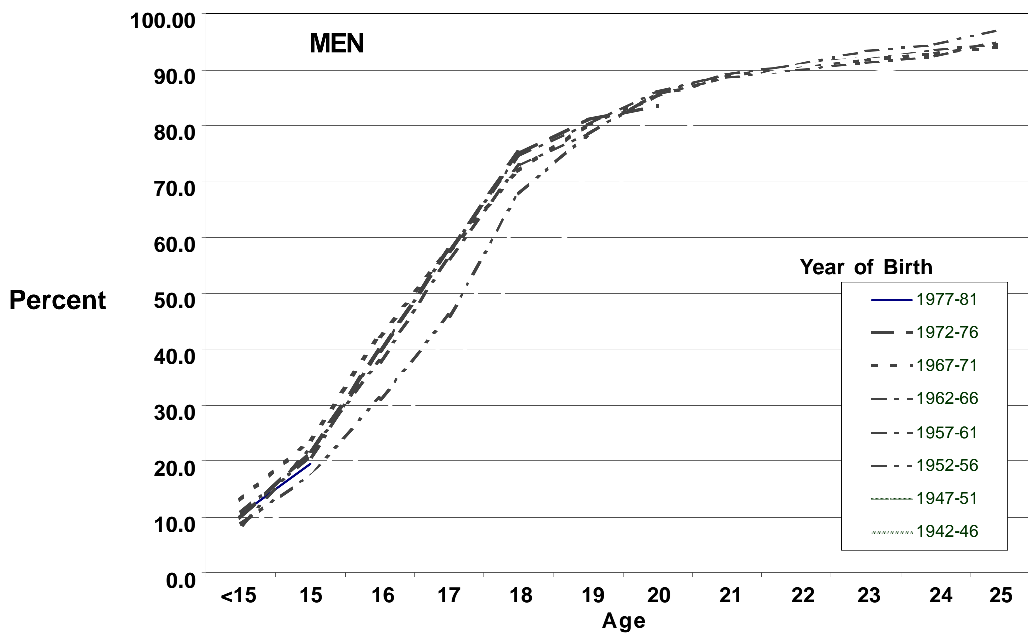
Countries like the United States, France and Great Britain have seen an increase in the proportion of youth who initiate sexual activity sometime during their teens (Fig. 13). Sweden has seen a decrease. However, more Swedish youth begin sexual activity in their teens than youth in the other countries represented here. Canada is similar to the first set of countries but continues to have slightly lower

Figure 11 Cumulative Percentage of Canadian Women who had Participated in Sexual Intercourse at Each Age.



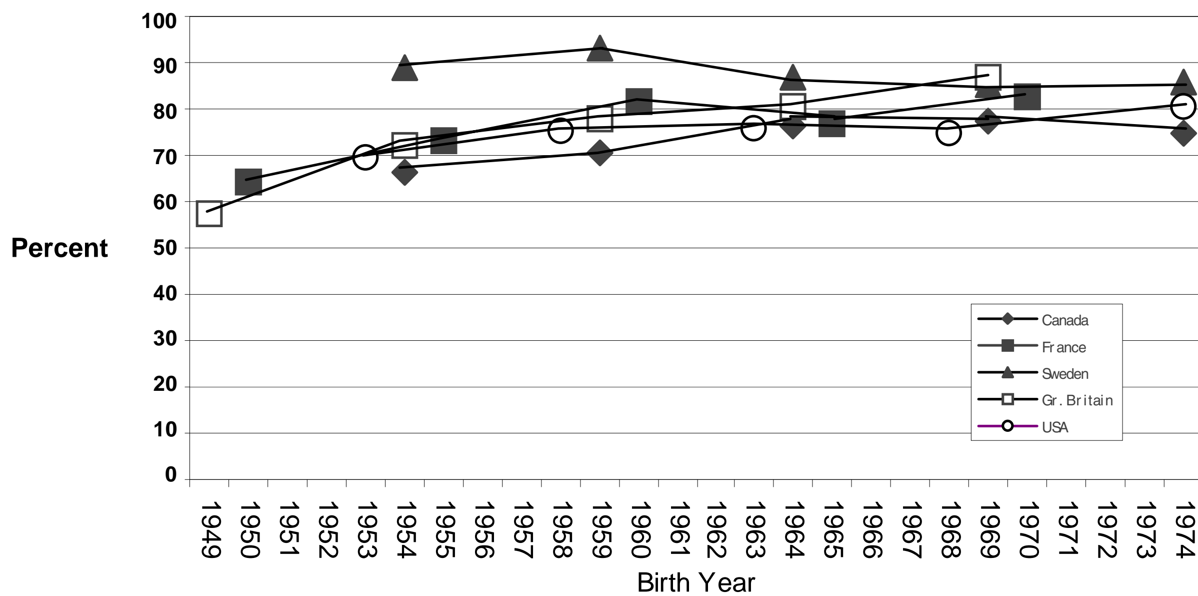
Maticka-Tyndale et al., 2000.

Figure 12 Cumulative Percentage of Canadian Men who had Participated in Sexual Intercourse at Each Age.



Maticka-Tyndale et al., 2000.

Figure 13 Percentage of Women in Selected Countries who Initiated Intercourse Before Age 20 by Birth Year.



Drawn from sources including Bajos et al., 1997 (France), Wellings et al., 1994 (Great Britain) and 1996 *NPHS* (Canada).

proportions of youth initiating sexual activity in their teens.

Looking at data for a larger number of countries and considering the percentage who had intercourse before the age of 16 years (Fig. 14), we see that Canadian men are at the low end and women are about in the middle.

In summary,

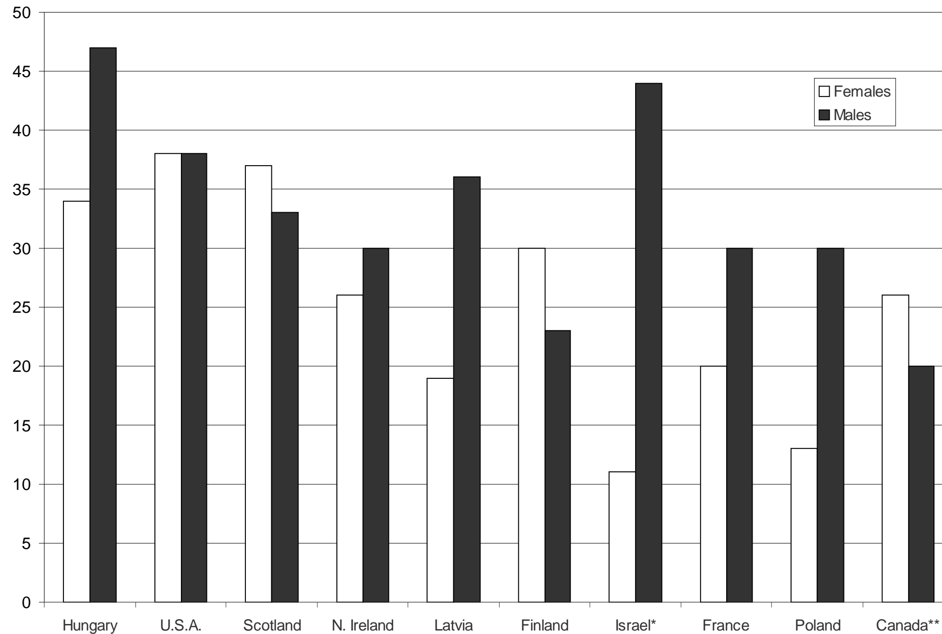
1) Adolescents in most developed nations initiate vaginal intercourse some time in their teens.
2) This is somewhat less likely for Canadian youth than youth in the other countries we've been looking at and especially less likely for Canadian men under 16 years of age compared to men under 16 in the other countries.

What does this signal in relation to the findings already discussed on pregnancy and STIs? We have fewer sexually active teens than Great Britain but approximately the same rate of teen pregnancies and about the same rate of gonorrhea and a higher rate for chlamydia. We have fewer sexually active teens than France or Sweden, but higher rates of teen pregnancies and gonorrhea than both countries. Our rate of chlamydia is higher than France though about the same as Sweden. It seems that it isn't "having sex" that necessarily leads to STIs or pregnancies, nor does it seem that teens are necessarily unable to handle disease or pregnancy prevention, otherwise the picture wouldn't be so different in other countries. It seems that our teens are not doing as well at self-protection as teens in these other countries.

What can we say about Canadian youth who are likely to initiate intercourse at a younger age? Who are they? They are youth who are not in school, are from lower income households and are born in Canada rather than immigrants to Canada (Maticka-Tyndale et al., 2000). Clearly, this is not a random sample of Canadian teens. This profile parallels that of young women who become single mothers.

Half of young people do not initiate sexual intercourse until after their 17th birthday—approximately 3/4 do not initiate until their 16th birthday or later. Surveys of attitudes of adult Canadians consistently show a difference in our acceptance or comfort with sexual

Figure 14 Percentage 15-Year-Olds who Reported having had Sexual Intercourse (1997/1998).



Redrawn from Ross and Wyatt (2000) except for Canada (1996 NPHS). *Jewish sector only.**

activity of our teens; over 16, acceptable, under 16, not acceptable (Bibby, 1995; Widmer, Treas & Newcomb, 1998). The vast majority of teens are thus following the expectations that adults hold for them. What of the very young sexually active teens? Research suggests that they are a distinct subset of adolescents who differ from the majority not only in their sexual practices, but in a variety of other ways as well. This is not to ignore them, but to suggest that we need to look carefully at who they are and what factors contribute to early sexual activity.

Casualness

Another area of concern is the number of sexual partners that young people have and the apparent casualness of these encounters. From earlier research we know that youth generally move through a pattern of serial monogamy—they are with one partner for a period of time and when that relationship ends they eventually move on to another partner. However, we also know that some youth occasionally engage in sex outside that primary relationship. This could be in conjunction with travel as on spring break or summer trips (e.g. Mewhinney et al., 1995; Maticka-Tyndale et al., 1998), or with time spent away from the primary partner such as when they have a summer job or a semester away, or it could be a casual encounter (Herold & Mewhinney, 1993). How youth view numbers of partners and the degree of casualness or commitedness in a sexual partnership, how different forms of sexual partnering fit into their sexual scripts or self perceptions, has not been examined in research. We don't know what youth think about this.

The best that we have is some data on number of partners in the past year, a pretty meagre piece of information, but here it is.

Most sexually active teens have had one partner in the past year. About 1/4 of women and between 31% and 38% of men who are in their teens seem to report two or more partners in a year. However, the cumulative number of partners a teen has can add up over the years and, unfortunately, we have little research on longer term patterns of adolescent sexual behaviour (Institute de la Statistique du Quebec, 2001; Langille, 2000; Maticka-Tyndale et al., 2000).

Table 1 Number of Intercourse Partners in Past Year.

	Males	Females
NPHS 1996[1]		
15-17 years - > 1 partner	31%	24%
18-19 years - > 1 partner	38%	24%
Nova Scotia 1996 - Gr 10-12[2]		
15-18 years > 2 partners	20%	17%
Quebec 1998[3]		
15-19 years > 1 partner	32%	33%

[1]Maticka-Tyndale, 2001; [2]Langille, 2000; [3]Institut, 2001.

How do we compare internationally?

The data in this area are so poor, that not much can be said other than it looks like Canadian youth are not much different from youth in other developed countries.

Who are the youth that are more likely to have more partners? What we see again, is that those not in school and with lower household incomes tend to report more partners. In addition there are considerable variations across ethnic groups and in some ethnic groups between men and women (e.g., Maticka-Tyndale et al., 1996).

Finally, there is some research on specific contexts that contribute to casual sexual encounters (and the consequent increase in number of partners). What kind of contexts? The examples that follow are small-scale studies so the results are only suggestive. The contexts they describe include:

- Certain peer subcultures which value casual sexual partnerships;
- Raves and bars, both because they involve meeting new people and the presence of alcohol or drugs that may reduce inhibitions (Adlaf & Smart, 1997; Herold & Mewhinney, 1993);
- Travel and vacation, both of which bring new people in contact, and take the traveller or vacationer away from usual normative frameworks (e.g., Maticka-Tyndale & Herold, 1997; Maticka-Tyndale et al., 1998; Mewhinney et al., 1995; Smeaton & Josiam, 1996);
- Alcohol and drugs because they affect inhibitions, and in the case of drugs may be associated with the sex-for-drugs trade (e.g., Desiderato & Crawford, 1995; Graves, 1995; Leigh, Temple, & Trocki, 1994; McEwan, McCallum, Bhopal, & Madhok, 1992);
- Living on the streets because for youth on the streets, sex often becomes a necessary survival tactic (e.g., Roy et al., 2000a; Roy, Nonn, & Haley, 2000b);
- Marginalization, because youth who are marginalized and kept out of dominant peer and community networks may search for belonging and intimacy in sexual encounters. They are also, together with youth living on the streets, often subject to sexual exploitation.

Gay, Lesbian and Bisexual Youth

Most research on gay, lesbian and bisexual (GLB) youth has been conducted in the context of HIV/AIDS. What we know is primarily from studies in Vancouver, on Vancouver island, Montreal and certain areas of Ontario (e.g., Heath et al., 1999; Otis et al., 2001; Samis & Whyte, 1999; Trussler, Perchal, Barker, & Showleret, 1999):

- Most GLB youth remain closeted in school and with friends;
- Often they are also closeted at home. Many are rejected by families if they come out with rejection as extreme as being kicked out of the house and left to live on the streets;
- Adolescence is a time when all youth struggle with issues of identity, sexual scripts and self-esteem. This is heightened for GLB youth who have few role models, media images or other points of reference for who they are and what that means. The images portrayed in the media are ones with which many prefer not to identify;
- After years of decreases in new HIV infections among men who have sex with men we have recently seen an increase, and particularly among young gay men;
- Vancouver research has documented the same trends of higher suicide rates found in American research among gay youth. These together with higher rates of substance abuse are attempts to escape from a present and future that appear untenable;
- The good news is that GLB youth who have friends who accept them for who they are report an immense sense of empowerment as a result;
- Programs and drop-ins now found in most cities

also have a strong positive influence. Again, such programs have come about primarily in response to and with assistance from AIDS money.

I find it quite telling that virtually the only research we have on GLB youth is as a result of funding for HIV/AIDS prevention. There is a huge amount we need to learn if we are to provide good quality education and services for our youth. In qualitative needs assessments conducted with all youth (regardless of sexual orientation) there is repeated reference on the part of youth to their desire and need for more information about gay, lesbian and bisexual issues. Coming out, relationships, identity, are mentioned by adolescents as information and discussions they want to have regardless of their own sexual orientation (e.g., Caputo, 2000).

Good or Bad News?

I've presented a considerable amount of data on teens and sexual health and sexual practices. What's the bottom line? Are we in the midst of a disaster in teen sexual activity? I would suggest that in many ways we aren't. Most teenagers are following the normative patterns that are evident in the attitudes of Canadian adults with respect to teen sex and sexual health and this applies to when, for example, they first initiate sexual intercourse.

It is important to note that the use of condoms for disease protection and contraception to prevent unwanted pregnancy has seen major increases. In the *NPHS*, 70% of teenage women and 81% of teenage men report they used a condom at last intercourse (which is the best measure we have in survey research of condom use). Condom use is higher for younger than older teens, and it is highest in casual encounters or sex with new partners. All of that is precisely what we should hope to see. Is condom use 100% ? No, and it isn't likely it will ever be. We tend to think and talk as if risk is 100% preventable but that isn't the case for any risks. Is there room for improvement? Of course there is and improvement is what those of us working to promote adolescent health must continually strive for.

So, do we have cause for celebration?

Yes, in some instances, but not if we consider that poor sexual health outcomes are not randomly distributed in the teen population. Certain groups of teens are decidedly disadvantaged, and these tend to be teens who are already marginalized, disenfranchised in terms of accessing the full range of resources and potential we consider available in our society. They are marginalized because of their sexual orientation, their social class, their race or ethnicity, or the place they live. These are issues far broader than sexual health per se and yet they are issues that are persistently found to affect the sexual health of our youth as well as that of adults.

If we are to compare ourselves to other countries, those most appropriate for such comparison are probably Great Britain, Australia and possibly France because of statistical similarities for some measures of adolescent sexual health. Those who are decidedly better are the northern European countries. We have known for some time that these countries are by far the world leaders in adolescent sexual health. France may also be included as a leader in some of these categories.

The United States presents such a different profile that we should be especially cautious of using research data from our closest neighbour to reflect on the Canadian situation. We are very different!

Where do We go From Here?

First, we need to do our own Canadian-based research on adolescent sexual health rather than borrowing conclusions from research in other countries that may not apply to Canadian youth. Second, we need greater collaboration and networking among Canadian health professionals and educators working to promote adolescent sexual health as opposed to working in isolation as we so often do now. Third, and most important, we need to listen to our youth. In qualitative research that has consulted youth in British Columbia, Alberta, Ontario, Quebec, Nova Scotia (there are probably other studies as well) youth consistently tell us they need sexual health education that talks more about feelings, arousal, foreplay, weighing alternatives and making choices, gay and lesbian lifestyles and identity, confidential access to information, contraception and condoms. They also want sexual health education that is respectful of their choices (Caputo, 2000; Langille, 2000).

Youth consistently tell us they feel competent to make healthy choices about their sexuality. They are making those choices, whether we like it or not. What they want from us is to be treated as adults. Though we may continue to restrict their access to adult status in terms of jobs, homes, and economic independence, in this domain it is essential that we recognize their adulthood.

We can learn from those countries that are doing better than we are. In recent work that I have been involved in with researchers from France, Sweden, Great Britain and the United States, one of the lessons I learned was that how well a country was doing with respect to the sexual health of their youth was not only related to things like sex education and availability of sexual health services but to how youth were integrated into their communities and into society as a whole, how the concerns and needs of youth in areas that they themselves felt were most important (i.e., education, preparation for the labour force, family relationships, community involvement) were addressed. And related also to how sexuality, sexual needs, sexual health, and relationship and family needs, for people of all ages, were viewed and provided for in the society. A number of recent publications provide documentation for these and earlier observations concerning the sexual health of youth in developed countries (Darroch, Frost, Singh, & the Study Team, 2001; Darroch, Singh, Frost & the Study Team, 2001; Maticka-Tyndale, McKay, & Barrett, 2001; Singh, Darroch, Frost, & the Study Team, 2001; The Alan Guttmacher Institute, 2001).

Sex isn't something that can be isolated from the rest of our lives. What happens in our families, communities, schools, and jobs, the policies formulated in the areas of child care, health care, labour force, immigration, social regulation and control, all have an impact here. And, if we look carefully, we see that impact reflected in the sexual health of our youth.

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