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RAYMOND J. NOONAN, PH.D., CCIES WEBSITE EDITOR

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Preamble

This chapter, updated to January 2003, retains much of the content of the 1996-97 version, which we use, where possible, as a basis for comparison with current data and as a reference point, where necessary, for new or revised interpretations. Given Canada's ethnocultural, linguistic, religious, and urban/rural diversity (see Section A, Demographics, below), and its sociological and gender diversity (Sections 1, Basic Sexological Premises, and 2, Religious, Ethnic, and Gender Factors Affecting Sexuality), we continue to wonder whether it is possible to present an overview of the sexuality of Canadians. The risk in attempting to do so is that one will "homogenize" the rich diversity by taking the "average" opinion or the median frequency of specific behaviors as a reflection of what Canadians are like sexually. On the other hand, a focus on different subgroups within the population may beg the question of whether Canada has a national identity pertaining to sexual customs, beliefs, and practices. At the national ("macro") level, there are quantitative data about some aspects of behavior—although there have been no large-scale studies of adult sexual behavior in Canada—but it is often difficult to interpret such information in ways that would further our understanding about the particularities of "Canadian" sexuality. On the other hand, studies on selected populations in specific settings, the "micro" approach, are often designed to describe or explain the behavior of that group, but they are seldom done in ways that would permit comparisons across Canada or over time. While sexological research in Canada has grown significantly over the last 20 years, it is still a new field and these limitations on our national database are neither surprising nor insurmountable. Our compromise, therefore, has been to incorporate elements of both the macro and micro approaches, to provide quantitative information where possible, and to make cautious inferences where empirical evidence is lacking.

Demographics and a Brief Historical Perspective

A. Demographics

Canada occupies the northern half of the North American continent with the United States on its southern border, the North Atlantic Ocean on the east, and the North Pacific Ocean and Alaska on its western coast. Although geographically Canada is the largest country in the Western Hemisphere with 3.852 million square miles (9.976 million km^2), including the Yukon, Nunavut, and Northwest Territories, only about 10% of its landmass is suitable for permanent large-scale settlement, and only slightly more than that for permanent agriculture. The population of about 31.4 million (2002 Census data) is distributed unevenly among the ten provinces and two territories, with Ontario, Quebec, British Columbia, and Alberta accounting for 85% of the total (see Table 1). About 80% of Canadians live in cities, primarily in

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the southern regions of the country. In 2001, 51% of Canada's population were concentrated in four broad regions: the extended Golden Horseshoe in Southwestern Ontario; Montréal and nearby areas; the Lower Mainland of British Columbia and Southern Vancouver Island; and the Calgary-Edmonton corridor. A 3,300-mile (5,300-km) shared border with the United States, a free-trade agreement, and extensive consumption of U.S. media, expose Canadians to strong economic and cultural influences from a country with ten times its population. However, the history, composition (e.g., religious and ethnoracial mix, socioeconomic diversity), and structure (e.g., legal, medical) of the two neighbors differ in ways that have an important influence on sexuality in the two countries.

Canada's ten provinces, plus the Yukon, Nunavut, and Northwest Territories, are linked through a central federal government, but the various levels of federal, provincial, regional, and municipal government have differing levels of responsibility for health, education, social welfare, legislation, and other areas that have an impact upon sexuality and sexual health.

In July 2002, Canada had an estimated population of 31.4 million. (All data are from Statistics Canada or from *The World Factbook 2002* (CIA 2002) unless otherwise stated.)

Age Distribution and Sex Ratios: *0-14 years*: 18.7% with 1.05 male(s) per female (sex ratio); *15-64 years*: 68.4% with 1.01 male(s) per female; *65 years and over*: 12.9% with 0.74 male(s) per female; *Total population sex ratio*: 0.98 male(s) to 1 female

The proportion of Canadians over age 65 increased from 12% to 12.6% from 1995 to 2001, while the proportion under 15 dropped from 21% to 18.8% over the same period. In 1991, Beaujot predicted by 2010 a rise in the proportion over 65 to 16% and a drop in the proportion under 15 to 16%. This projection was based on continuation of what was then an unprecedentedly low fertility rate in Canada (1.67 in the early 1990s). In fact, the fertility rate continued to decline to 1.52 by 2001, suggesting that the shift toward more older and fewer younger Canadians may proceed more quickly than previously projected. The large segment of the population now in the middle years, i.e., the "baby boom" generation born between the late 1940s and the early 1960s, has exerted considerable influence on social and cultural patterns in Canada, from the "sexual revolution" of the late 1960s to the economic expansion of the 1980s. This generation currently holds many of the positions in government, business, healthcare, and the media, and might therefore be expected to influence public policy in relation to sexuality (i.e., in areas such as education, law, healthcare, etc.).

Life Expectancy at Birth: *Total Population*: 76.8 years; *male*: 76.3 years; *female*: 83.3 years

Urban/Rural Distribution: 80% to 20%

Ethnic Distribution: British Isles origin: 28%; French origin: 23%; other Europeans: 15%; Amerindian: 2%; other (mostly Asian, African, and Arab 6%; mixed backgrounds: 26%

Religious Distribution: (1991 census) Roman Catholic: 46%; Protestant: 36%; Muslim and Other: 18%. The changing age structure of the population, coupled with high life expectancy and a declining rate of natural population increase (0.6% in 1995), are all characteristic of the demographic transition seen in other industrialized northern countries (see basic demographic data for Canada in Table 2).

Birth Rate: 11.1 births per 1,000 population

Death Rate: 7.5 per 1,000 population

Infant Mortality Rate: 4.95 deaths per 1,000 live births

Net Migration Rate: 6.07 migrant(s) per 1,000 population

Total Fertility Rate: 1.52 children born per woman

Population Growth Rate: 0.96%

HIV/AIDS (1999 est.): *Adult prevalence*: 0.3%; *Persons living with HIV/AIDS*: 49,000; *Deaths*: 400. (For additional details from www.UNAIDS.org, see end of Section 10B.)

Literacy Rate (*defined as those age 15 and over who can read and write*): 97%

Per Capita Gross Domestic Product (*purchasing power parity*): $27,700 (2001 est.); *Inflation*: 2.8%; *Unemployment*: 7.2%; *Living below the poverty line*: 19.7% (1995; using Low Income Cut-Off)

Although the total fertility rate has been below replacement level for about 30 years (about 1.52 children per woman in 2001), a natural population increase of 0.33% per

Table 1

Population Distribution in Canada (Estimated 2002)

Province/Territory	Population (in Thousands)	Percentage of Total
CANADA (January 2002, est.)	31,414	
Newfoundland	531.6	1.7
Prince Edward Island	139.9	0.4
Nova Scotia	944.8	3.0
New Brunswick	756.7	2.4
Quebec	7,455.2	23.7
Ontario	12,068.3	38.4
Manitoba	1,150.8	3.7
Saskatchewan	1,011.8	3.3
Alberta	3,113.6	9.9
British Columbia	4,141.3	13.3
Yukon	29.9	0.1
Northwest Territories	41.4	0.1
Nunavut	28.7	0.1

Source: *Quarterly Demographic Statistics*, Statistics Canada, Catalogue No. 91-002, 2002.

Table 2

Basic Demographic Data for Canada (2001)

Total population:	31,081,900 (July 1, 2001)
Total population:	30,769,900 (July 1, 2000)
Births:	329,791
Deaths:	227,076
Natural increase:	102,715
Birth rate:	10.7/1,000 population
Death rate:	7.4/1,000 population
Rate of natural increase:	3.3/1,000 population (0.33%)
Immigration:	250,346
Net immigration:	199,605
Net immigration rate:	6.5/1,000 population (0.65%)
Total population increase:	302,320
Annual population growth rate:	0.98%
% population growth from natural increase:	34.0%
% population growth from net immigration:	66.0%
Population doubling time:	71.4 years
Total fertility rate (est.):	1.52 births/woman aged 15-49
Life expectancy at birth:	male 76 years; female 82 years

Data from: *Annual Demographic Statistics*, 2001. Statistics Canada, Catalogue No. 91-213-XPB, 2001. See also *Report on the Demographic Situation in Canada* 2002. Statistics Canada, Catalogue No.91-209-XPE.

year, coupled with a net immigration rate of 0.65%, gave Canada a growth rate of 0.98% in 2001 (see Table 2), one of the highest among the world's industrialized countries. Net immigration contributed about 66% of Canada's population increase in 2001, and projections for the future suggest that immigration will continue to have a significant impact on Canada's demography.

By law the federal government is required to state in advance of any year the intended total number of immigrants, refugees, etc., that will be admitted to Canada in that year. As a result of new legislation passed in 2002 (the Immigration and Refugee Protection Act), the most recent of these ongoing Annual Reports to Parliament on Immigration was the first to be submitted under the new Act. The plan for 2003 calls for 220,000-245,000 new permanent residents, of whom 60% are categorized as economic class, 26% as family class, and 13% as refugees. Family class refers to a foreign national who is the spouse, common-law partner, conjugal partner, child, or parent of a Canadian citizen or permanent resident. This category reflects a governmental commitment to family reunification. Economic class refers to those immigrants who are skilled workers. Unlike the earlier emphasis on occupation-based criteria, the 2003 plan looks to flexible/transferable skills in the trades, and in the technical and professional domains, as well as proficiency in English and/or French. While the government has maintained a commitment to those individuals entering Canada as Refugee class, economic and social factors (e.g., the presence of relatives in Canada) will also be taken into account. By 2011, immigration is expected to account for all of Canada's net labor force growth, and by 2031, for all net population growth.

Immigration patterns in the recent past and in the future will thus continue to alter the already varied ethnocultural composition of the Canadian population, particularly in the larger urban centers to which a high proportion of immigrants have been drawn. For example, in 2000, 90% of immigrants went to three provinces (Ontario, British Columbia, and Quebec) and 75% of these went to the largest urban centers in these provinces (Toronto, Vancouver, Montreal), with Toronto receiving well over half of this group. Canada's changing ethnocultural composition is worth considering here because the continuing trend to ethnocultural diversity means that a wide range of attitudes, traditions, and practices surrounding marriage, sexuality, sex-role expectations, and sexual taboos are now present as a source of both variety and potential challenge in Canadian society. For example, in contrast to the current national ethnic distribution data from the 1991 census, the top five sources of immigrants to Canada in 2000 were the People's Republic of China (16.2%), India (11.5%), Pakistan (6.2%), Philippines (4.4%), and Korea (3.4%). The United States and United Kingdom were seventh and tenth respectively, together representing 4.6% of immigrants in 2002.

B. A Brief Historical Perspective

ROBERT T. FRANCOEUR

The French explorer, Jacques Cartier, who reached the Gulf of St. Lawrence in 1534, is generally regarded as the founder of Canada, although John Cabot, an English seaman had sighted Newfoundland 37 years earlier, and Vikings are believed to have reached the same area centuries before either Cartier or Cabot. The French pioneered settlement by establishing Quebec City in 1606, Montreal in 1642, and declaring Canada a colony in 1663. The British acquired Acadia (Nova Scotia) in 1717 and captured Quebec in 1759. By 1763, Britain had gained control of the rest of New France. The Quebec Act of 1774 gave the French in Upper Canada the right to their own language, religion, and civil law. The English presence in Canada increased during the American Revolution, when many American colonists loyal to the crown moved north to Canada. Fur traders and explorers pioneered paths to the west, with Sir Alexander Mackenzie reaching the Pacific in 1793.

Upper and Lower Canada, later known as Quebec and Ontario, and the Maritime Provinces developed their own local legislative assemblies in the 1700s, and reformers called for a more responsible government. The War of 1812 between Britain and the United States delayed the move toward a more democratic government, but by 1837 political agitation had led to rebellions in both Upper and Lower Canada. Lord Durham's report recommended union of the two parts into one colony, to be called Canada. This union continued until 1867 when the Dominion of Canada was established with Ontario, Quebec, Nova Scotia, and New Brunswick. A federal system of government was developed, modeled on the British parliament and cabinet structure under the Crown. In 1982, Canada ended its last formal legislative link with Britain by assuming control over its constitution. In 1987, the so-called Meech Lake Agreement would have assured constitutional protection for Quebec's efforts to protect its French language and culture. Its failure in 1990 sparked a separatist revival which remains a major issue for the country. In 1992, the Northwest Territories approved creation of a self-governing homeland for the 17,500 Inuit living in the Territories, to be known as Nunavut, "Our Land." In June of 1993 the Canadian Parliament passed the "Nunavut Land Claims Agreement Act" and the "Nunavut Act." Finally, on April 1, 1999, the territory of Nunavut officially joined the federation of Canada.

C. Ethnocultural Composition: Ethnic Origins and Recent Immigration

The face of Canada, as is true for the United States and Australia, has been shaped by immigrants. European settlers from the United Kingdom (U.K.) and France are considered the two founding nations of Canada (and the current ethnic composition of the population still reflects that background). However, many First Nations groups were already inhabiting the region when these settlers arrived, including Cree, Dakota, Dene, Gitksan, Gwich'in, Huron, Innu, Inuit, Mohawk, Micmac, Naskapi, Ojibway, Saulteaux, and Salish. In the 1996 census, 1.1 million people (3.9% of the population) identified either single or mixed aboriginal ancestry. Overall, 28 percent of Canada's population in 1996 reported ethnic origins other than British, French, or Canadian. Data cited above on source countries for immigration in 2000 suggest that this percentage has probably shifted upward in the last 10 years.

Canada's 1996 census (the most recent data available at writing) provides the most accurate and current profile of the the ethnic origins of people living in Canada. A review of 1991 census data by Renaud and Badets (1993) and selected observations from a major study on families in Canada (Vanier Institute of the Family 1994) are also used below to summarize the increasingly diverse ethnocultural composition of Canadian society.

Ethnic origin is taken to mean the cultural or ethnic group to which one's distant relatives belonged. In the 1996 census, respondents were asked to indicate whether their ancestry was a single ethnic group (e.g., French) or multiple (two or more groups, e.g., British and French). Unlike the previous census, respondents were also given the option "Canadian" as a potential ethnic origin. It should be noted that the addition of the "Canadian" category changed the

relative distribution of ethnic origins significantly, particularly for the British and French categories, as well as rendering a direct comparison of 1991 and 1996 census data more difficult. Rounded percentages for the largest groupings for the 1996 census were:

Canadian (19%), British Isles only (17%), combination British, French, or Canadian and other (16%), combination British and French or Canadian (10%), European single origin (13%), French only, i.e., French and Acadian (9%), single East and South East Asian origin (5%), aboriginal (4%), and South Asian (2%).

A report by Badets and Chui (1994) documents the changing pattern of immigration to Canada that has produced such ethnocultural diversity. While early immigrants to Canada came predominantly from the United Kingdom and Europe, that trend has shifted, particularly during the 1980s, 1990s, and into the 21st century. Between 1981 and 1991, 48% of immigrants to Canada were born in Asian countries, 25% in Europe and the United Kingdom, 10% in Central and South America, 6% each in the Caribbean and Africa, and 4% in the United States. In 1991, about 16% of Canada's population was born outside the country, which is not much different from the 15% figure reported 30 years earlier. Of these, 54% were from Europe and the United Kingdom and 25% from Asian countries. Most of the 4.3 million people in Canada in 1991 who were born outside the country either had become or were expected to become Canadian citizens.

About 94% of them live in four provinces (Ontario, British Columbia, Quebec, and Alberta), predominantly in one of the three largest metropolitan areas (Toronto, Montreal, and Vancouver). For example, 38% of Toronto's population in 1991 was not born in Canada. This rich ethnocultural diversity in some areas of the country provides a variety of sociosexual customs and gender-role expectations that must be considered in education, healthcare, and public policy related to sexuality. These issues include: developing effective ways to prevent HIV infection among communities of First Nations people and other ethnocultural groups; differing attitudes and beliefs toward sexuality between first-generation immigrant parents and their children or between recent immigrants and the "predominant" culture; cross-cultural differences in gender-role expectations, deference to authority, emphasis on reproduction and childrearing as the rationale for marriage; arranged marriages; attitudes and policies toward women who experienced genital mutilation(female circumcision) and wish it for their children; willingness of some groups to use sex selection to provide a child of the preferred sex, usually male; and varied traditions concerning public discussion about sexuality, sex education, and discussion between the sexes about sexual problems and dysfunctions.

D. Linguistic Diversity

As expected from the ethnic origins of the population, 59% of Canadians reported English as their only first language (i.e., the one they learned at home in childhood and still understand), 23% French, and 18% one of the "nonofficial" languages (2001 census). In examining the ten-year trend from 1991 to 2001, the percentage of individuals claiming English as their first language changed only slightly from 61% to 59%. Similarly, the percentage claiming French as their first language dropped only slightly from 24 to 23%. The largest change, however, was noted in the percentage of individuals claiming a non-official language. This percentage rose from 13% to 17% from 1991 to 1996, and then from 17% to 18% from 1996 to 2001. The rise from 1991 to 1996 represents a 15% increase in people who claim a mother tongue other than French or English. Furthermore, this growth is 2.5 times faster than the overall growth rate of the Canadian population. Most French-speaking Canadians live in Quebec (in 1996, 86% of Canada's French-speaking population lived in Quebec), but there are groups of Acadians in New Brunswick and French-speaking communities in other parts of Canada. Immigrants (those not born in Canada) accounted for about two thirds of those whose first language was neither English nor French and for about three quarters of those who spoke a language other than English or French at home.

1. Basic Sexological Premises

A. Character of Gender Roles

At present, over half of Canadian women who are raising children also work outside the home. As of 1998, for individuals between 25 and 54 years of age, 81% of never-married women and 85% of never-married men were working. Among married individuals age 25 to 54, 77% of women and 94% of men were working. Compared to the fewer than 50% of married women working in 1976, this represents a sizeable increase in the number of married women employed outside the home (Vanier Institute 2000). Although single (never married) women and men are equally likely to be employed (59 to 60% for both sexes in 1981 and 1991), the proportion of married women employed increased from 47% in 1981 to 56% in 1991. This represents a major change in the employment experience of women and is a reflection of changed economic circumstances, more single-parent families, and the altered gender-role expectations and opportunities for women over the last 30 years. However, the majority of women continue to work in occupations where women are traditionally concentrated. In 2001, 70% of all employed women were found in the areas of teaching, nursing and related health occupations, clerical or other administrative positions, or sales and service occupations. This is compared with 30% of employed men. Thus, although the population of women in traditional female occupations has slowly declined from 1987 to 2001 (from 74% to 70%), and men and women are approaching equality in labor force participation, the labor force remains sex segregated with men and women concentrated in different areas.

In her book, *Gender Relations in Canada*, Marlene Mackie (1991) identified the evolution of feminism and of the feminist movement in Canada as a major influence on gender-role expectations, on women's social and economic status, on their perceptions of themselves as agents for change, and, hence, on the social and interpersonal aspects of relationships within and between the sexes. The most recent wave of that movement, beginning in the late 1960s, has gradually altered the legislative landscape regarding equal employment, pay equity, access to legal abortion and contraception, sexual harassment, maternity leave, daycare, and a range of other issues that affect women's social and economic well-being. Mackie (1991) suggests that the "official" beginning of the feminist movement in Canada occurred in the period that preceded the federal government's decision, in 1967, to establish the Royal Commission on the Status of Women. The commission's mandate was to assess the prevailing situation regarding the position of women in Canada, and then to "recommend what steps might be taken by the Federal Government to ensure for women equal opportunities in all aspects of Canadian society" (Mackie 1991, 255). Three years later, after hearings across Canada, the commission issued its report which contained 167 recommendations (Mackie 1991).

Mackie suggests that three dimensions of feminism—liberal, socialist, and radical—have each had an impact on different spheres of life in Canada. Liberal feminism mobilized

action to establish the Royal Commission and guided the emergence and agenda of large national organizations, such as the National Action Committee on the Status of Women, the Canadian Advisory Council on the Status of Women, and the provincial liaison groups. These groups have acted to achieve equity in the workplace, fair property rights when marriages end in divorce, and a host of other changes that reformed the existing social system. Socialist feminists challenged the oppression of women within the economic system and within the family and approached some of the same agenda items as liberal feminism but from a different perspective. Their focus on both class and gender issues aligned this branch of feminism with the concerns of lesbians, immigrant women, and women of color (Adamson et al. 1988, as cited in Mackie 1991). Radical feminists and socialist feminists, says Mackie, share the premise "that the dominant male culture promulgates a picture of reality that buttresses patriarchy and denigrates women." (Mackie 1991, 260). Citing Adamson et al. (1988), Mackie views radical feminism as instrumental in the establishment of rape crisis centers, in campaigns against pornography, and in founding shelters for battered women. The lesbian/gay liberation movement has taken place almost concurrently with the women's movement and embodies and is informed by many of the same concepts of gender equality, personal freedom, and human rights.

From an institutional and legislative perspective, it would appear that liberal feminism has influenced contemporary government policy and corporate practice. These changes have been the source of some conflict. For example, the Toronto-based group R.E.A.L. Women of Canada (Realistic, Equal, Active, for Life), founded in 1983, now has chapters in all provinces and is the most prominent of the organizations opposing at least some of the legislative and social trends encouraged by the feminist movement. This group opposes policies that it believes either undermine the family or promote homosexuality as an acceptable alternative to heterosexual marriage. It advocates programs that would allow women to choose to stay at home with their children (e.g., through tax credits that would permit this option in lieu of universal daycare). The organization is on the right politically and in terms of social policy and gender relations, and it espouses a more traditional and restrictive sexual philosophy than that of most Canadians. The growth of the political and religious right in Canada, although it has occurred to a lesser extent than in the U.S., suggests strong dissatisfaction, in this group, with some aspects of the trend to more egalitarian gender relations. Men's rights groups in Canada, e.g., In Search of Justice, also believe that some of the legislative changes influenced by the feminist movement have unfairly disadvantaged men. Most of their efforts have centered on issues of child custody and support following divorce.

The nascent men's movement in Canada—not to be confused with men's rights groups—has at least two "branches." One emphasizes the consequences for men of traditional, socially imposed male roles and seeks new ways to be male. The other, represented by groups such as Men Against Sexism, considers patriarchy and men's violence to be the major threats to women and seeks to change the structures and forms of social organization that perpetuate domination of one group by another at the interpersonal, social, or international level (see Kaufman 1987). The latter group has an annual white ribbon campaign to highlight men's opposition to violence against women.

B. Sociolegal Status of Males and Females

In the formation and enforcement of laws and policies, Canada is a federation of provinces and territories. Some areas of jurisdiction—e.g., the criminal code that governs sexual assault, sex work, divorce, and censorship—are federal and require the passage and modification of laws by the Canadian Parliament. The enforcement of most laws, through policing and the courts, however, as well as jurisdiction over matters of education, civil conduct (e.g., allowable conduct in various locations, property offenses, alcohol, and tobacco laws), family law (e.g., division of property in divorce, parental rights, and responsibilities), and delivery of healthcare, are within provincial or local jurisdiction. Consequently, it is difficult to draw conclusions that apply across the country. In some locations, most notably Quebec and British Columbia, federal and local laws have been applied in a manner that supports greater equality between men and women and protection of various segments of society from discrimination. In others, e.g., Alberta and Saskatchewan, there has been a more limited interpretation and application of related federal legislation and passage of fewer provincial laws providing protection of groups and guarantees of equal treatment.

Equality before the law, regardless of gender and sexual orientation, is a relatively modern development in Canada. Legislation and court rulings that established such equality, though generally considered to have begun in the late 1800s with the "Person's" case, in which women were included in all legal documents under the status of "person" (prior to this, only men were included), are primarily a phenomenon of the past 35 years. Several landmark changes, which will be referred to throughout this chapter, include:

- 1969—Sweeping legislative changes, referred to as "getting the government out of the bedrooms of the nation," were initiated by Parliament. These struck down a variety of laws restricting sexual activities, including the dissemination of information on birth control, and enshrined in law the principle that any activities between two consenting adults, conducted in private, were beyond the jurisdiction of law.
- 1970s—Universal provision of medical care without direct payment was instituted in each province. With this change, medical diagnostic and treatment procedures associated with sexuality, such as treatment for gender dysphoria, difficulties in sexual functioning, birth control, abortion, and infertility, became available to all Canadians without direct cost.
- 1968-1985—A series of changes in the laws governing divorce. Prior to this period, divorce required a parliamentary decree and could be granted only for reasons of adultery. The criteria for granting divorce were broadened and their application transferred to the courts. This change saw an immediate and sharp increase in the number of divorces granted across the country. It is noteworthy that property settlements and child custody matters are within provincial jurisdiction, and so vary across the country.
- 1980s—A series of changes in Quebec family law took Quebec from the position of having the most conservative to having the most progressive set of provincial statutes. Under the new laws, women were guaranteed an economic and legal status independent of that of their husbands. This was symbolized in women's retaining their name in marriage, and included equal sharing of family property, decision making, and of roles and rights as parents. Prior to this, for example, wives were under their husbands' control in determination of residence, property was owned wholly by men unless special contracts were arranged prior to marriage, decisions about children (e.g., with respect to medical care, education, and residence) were exclusively under the control of fa-

thers (at least in law), and the line of inheritance was primarily from father to son, with considerably less to wives and daughters.
- 1982—The Canadian Charter of Rights and Freedoms was declared law. This has been the basis for court challenges of other legislation, policies, and actions that have restricted or dictated rights and access, primarily of women, people with various disabilities, and homosexuals to areas and services in Canadian society (e.g., jobs, housing, insurance, particular medical services, spousal benefits, and parental rights).
- 1985—"Rape" was removed from the Criminal Code and replaced by several categories of assault that involve sexual contact, and laws addressing sexual contact with children were revised. Of note is the fact that the new law removed the onus of proof of lack of consent from women, and allowed women to file charges of sexual assault against their husbands. More recent changes and court rulings have further modified legal proceedings in this area. These are discussed in Section 8A, Significant Unconventional Sexual Behaviors, Coercive Sex.
- 1988—A Supreme Court of Canada decision overturned the laws restricting women's access to abortion. This continues to be a contentious issue among Canadians; but 15 years after this ruling, abortion still remains outside the jurisdiction of the Criminal Code.
- 1996—Sexual orientation was formally added to the Canadian Human Rights Act on June 20, 1996. Section 3(1) of the Canadian Human Rights Act was amended to prohibit discrimination based on sexual orientation.

While many other legislative changes and court rulings have influenced the sociolegal status of various groups of Canadians, these are generally considered among the landmarks that have established the contemporary position of men and women, adults and children, and people of different sexual orientations.

Today, men and women are equal before the law in Canada, and the Canadian Charter of Rights and Freedoms enshrines this principle. Both the public and private sector have adopted policies to increase the proportion of women in those work settings in which they have been traditionally underrepresented, and employment equity legislation has been implemented in the public sector in some provinces to rationalize pay scales according to job requirements. Men continue, however, to predominate in positions of power and leadership (e.g., government and major corporations).

Equal treatment of lesbian and gay individuals in law and in areas of employment, housing, and so on, is increasing, to a sizable degree because of court challenges and threatened challenges (which have used the Charter of Rights and Freedoms) to eliminate discriminatory practices. Equal treatment does not exist, however, with respect to parental rights, spousal relationships, employee benefits, and other such issues, although court decisions continue to set precedents in the absence of legislated change (see Section 6, Homoerotic, Homosexual, and Bisexual Behaviors). It is increasingly common for large corporations to extend such benefits even though they are not yet required in law to do so.

Current legislation regarding nonconsensual sexual behavior does not discriminate on the basis of sex (e.g., sexual assault law applies to both sexes). Children under the age of 14 cannot consent to sexual activity with an adult (i.e., anyone 18 or over), and an adult engaging in such activity with a child could be charged with "sexual interference," or "sexual assault" (because consent, even if given, is not legally recognized) (MacDonald 1994). An "invitation to sexual touching" would also be illegal if the invitee was under 14. In the foregoing offense categories, a person of 12 or 13 would be deemed able to give consent if the other person was not more than two years older and was not in a position of authority over the complainant.

The acts associated with sexual interference and invitation to sexual touching are also proscribed when done toward a person 14 to 17 by someone in a position of trust, authority, or dependency. The legislated age of consent for anal intercourse is 18, in contrast to 14 for other sexual activities. Specifically, individuals under the age of 18 cannot consent to anal intercourse unless legally married. However, this has been debated in the courts. In 1995, the Ontario Court of Appeal struck down the relevant section of the criminal code, with two judges finding it discriminatory with respect to age and one with respect to sexual orientation. A similar outcome was noted in a Quebec Court of Appeal in 1998.

There is also a statute on "corrupting children" (i.e., anyone under 18) by exposing them to adultery, sexual immorality, habitual drunkenness, and the like, but this provision is rarely prosecuted (MacDonald 1994). In general, the contentious nature of consent laws is also reflected in the frequent demands by various professional groups (e.g., Canadian Association of Chiefs of Police) and family and children's rights activists to raise the age of consent to 16. However, such amendments have yet to be considered.

Although Canadian law defines adults as those 18 or over, there are provincial variations affecting such things as tobacco, alcohol use, and age of consent to medical treatment. For example, it is illegal to sell tobacco products to someone under 18 in Canada, but that age was raised to 19 in Ontario. The ages at which it is legal to sell alcohol to someone vary across the provinces, ranging between 18 and 21 years. Consent to treatment provisions also vary by province. For example, for several years Quebec has set 14 as the general age of consent, including for birth control, abortion, and STD treatment. Ontario's Consent to Treatment Act, which became law in 1995, was designed primarily to regulate treatment, particularly of those incapacitated or vulnerable in some way, when existing law is unclear. It also applies to treatment of children. For example, physicians, nurses, and clinic staff working outside hospital settings may treat children of 12 or even 11 without parental notification based on the practitioner's judgment of the child's capacity to give informed consent. Contentious areas in this regard might include prescribing birth control pills, pregnancy counseling, or diagnosis, counseling, and treatment for STDs. Notification of parents when the child does not wish them to be informed is left to the prudent judgment of the practitioner, and confidentiality of records would be handled in a similar manner. However, if the treatment is given in a hospital setting, parental consent to treatment would be needed for children under 16. Some other provinces set age of consent to treatment closer to the age of 16. These issues reflect the current attempts to balance children's rights and parents' rights when the two appear to be in conflict. A similar balancing in relation to acceptance of children's testimony in court is also taking place in Canada (see Section 8A, Significant Unconventional Sexual Behaviors, Coercive Sex, on sexual abuse).

Canada is in a stage of change with respect to matters of law and policy regarding the status of men, women, children, the variously abled and disabled, and individuals of differing sexual orientations. If the trends of recent years continue, the change will be in the direction of provision of greater guarantees of equal treatment, increased access to a variety of sexual health services, protection of individual rights, and protection against discrimination. However, there are segments of Canadian society that challenge these changes and have

mounted various campaigns to limit their scope. The future picture with respect to legal matters cannot be predicted.

C. General Concepts and Constructs of Sexuality

There have been no systematic, large-scale national studies on the sexual attitudes or conduct of Canadian adults. In November 1993, a major Canadian polling agency (Decima Research) conducted a national telephone survey of 1,610 Canadian residents randomly selected from the ten provinces (*Maclean's*/CTV Poll 1994), in which a variety of questions involving sexual attitudes were included. [*Note*: Neither the Northwest Territories nor the Yukon were included because of their sparse population; sample sizes in the less-populated provinces were increased to reduce province-by-province errors.] The following sampling of the survey findings provides some background for subsequent speculation on Canadians' perspectives on sexuality and public policy. Given the small sample size and the methodological limitations of such a study, the results are at best indicative.

Most survey respondents felt that in the last 10 to 20 years, Canadian attitudes on sexual matters had become far more permissive (43%) or more permissive (30%), with a higher percentage of those over 55 years old viewing the change as far more permissive (e.g., 59% of 55- to 64-year-olds vs. 32% of 25- to 34-year-olds). One reflection of the change in permissiveness is Canadian attitudes toward premarital sex (i.e., premarital intercourse). In a 1990 national survey of adults, Bibby and Posterski (1992) found that 80% agreed or strongly agreed that premarital sex was acceptable. This compares to 68% in agreement in 1975. Approval ranged from 92% among 18- to 34-year-olds (vs. 90% in 1975) to 59% of those 55 and over (vs. 42% in 1975). Slightly more people disagreed than agreed that a person should have more than one sexual partner before marriage (50% disagreed, 39% agreed, and 11% had no opinion). In a 1995 study with a similarly representative sample of Canadian adults, Bibby (1995) found continued high levels of acceptance of sex outside of marriage (this includes "premarital" and "intermarital" activity) among the young (89% of 18- to 34-year-olds approved) and an ongoing increase in acceptance among older Canadians (62% of those over 55 approved vs. 42% in 1975). Bibby (1995) attributed the latter shift to aging of the baby boom generation that came of age in the 1960s, and suggested that by 2010, about 85% of Canadians would approve, with 15% remaining opposed.

With respect to having an extramarital affair, 80% of respondents to the *Maclean's*/CTV poll said it was never OK, 10% not usually OK, and 6% sometimes or always OK. This response did not differ according to gender, but respondents from Quebec, and French-speaking respondents in general, were less likely to say "never OK" (about 65 to 67% vs. 79 to 91% in the other provinces). Respondents were somewhat less likely to condemn extramarital affairs under all circumstances (e.g., "it is totally unacceptable for a married person to have an affair"). In this case, 70% agreed or strongly agreed, whereas 22% disagreed and 7% strongly disagreed. Men were slightly more likely to be accepting than women. There was no difference based on age, but respondents from Quebec were much less likely to agree strongly that it was always unacceptable (19%) and more likely to disagree or strongly disagree (45%). Bibby (1995) also found low levels of approval, in that 85% in 1995 said that extramarital sex was always or almost always wrong (compared to 78% in 1975). Although, responses differed by age (78% for 35- to 54-year-olds vs. 90% for those 18 to 34 and 55 and over), Bibby noted that overall, Canadians' attitudes toward extramarital sex have become less approving over the last 20 years. This does not seem to be a simple reflection of aging of the population, because young people are among the most disapproving.

When asked if they considered masturbation to be a healthy part of one's sex life, 8% strongly agreed, 57% agreed, 30% disagreed, and 5% strongly disagreed. There were no sex differences in agreement, older respondents were less likely to agree (although 52% of those 65 and older agreed), and Quebec again had the highest agreement, with 78% overall considering masturbation to be a healthy part of one's sex life.

When asked if they would feel uncomfortable talking with their children about sex, few indicated that they would be uncomfortable (about 17%). This indirect declaration of comfort was evident for both sexes and for the age groups most likely to be involved in rearing young children or teens. It is unlikely that this perceived comfort always translates into actual discussion, particularly in the area of sexual decision-making. For example, Bibby and Posterski (1992) found that while a sizable percentage of teens identified parents as the first source they would consult when making decisions about what is "right and wrong" (45%), or about school (45%) or a major problem (31%), fewer chose parents first for decisions about "sex" (8%) or relationships (7%); friends were most likely to be chosen in both of the latter categories (55% and 75%, respectively).

Legislation prohibiting discrimination on the basis of sexual orientation is now common in most provinces, and this trend, although actively opposed by some individuals and groups, reflects a shift in Canadian attitudes (Section 6 discusses gay/lesbian issues in more detail). Two of the *Maclean's*/CTV survey questions assessed attitudes toward homosexuality. When asked if "it would be fine if one of my kids turned out to be gay," 11% of respondents strongly agreed, 45% agreed, 29% disagreed, and 14% strongly disagreed. Women were more accepting than men in this regard (64% of men agreed vs. 49% of women), younger were more accepting than older respondents, and those in Quebec were more likely to agree (85%) than in the rest of Canada (46%). On the statement "It would bother me if openly gay and lesbian people were teaching in the schools," the responses generally paralleled those above (56% would not be bothered, 44% agreed that they would be bothered; women were slightly more accepting than men). Bibby (1995) also found evidence of increasingly accepting attitudes toward homosexuality (32% said it was not at all wrong and 16 % sometimes wrong in 1995), up from 38% acceptance in 1990 and 28% in 1975. This still leaves half the population considering homosexuality always or almost always wrong. Interestingly, Bibby (1995) also found that between 1990 and 1995, during a period of active debate about inclusion of gay rights in the Human Rights Code (which occurred in 1996), approval of the idea that gays and lesbian should have the same rights as other Canadians dropped from 80% in 1990 to 67% in 1995. Bibby saw it as somewhat paradoxical that "just when Canadians are exhibiting both an increasing acceptance of homosexuality and greater social comfort with lesbians and gays, they now are also exhibiting increasing discomfort with the idea of extending them equal rights" (Bibby 1995, 74). One might argue that this is a temporary shift based on a tendency of some Canadians to be displeased with both sides in periods of acrimonious and politicized debate.

Television, the print media, and film provide Canadians with regular reminders of social policy issues related to sexuality (pornography, prostitution, sexual abuse, etc.). While these themes will be examined in later sections, survey respondents' attitudes on selected examples give an indication

of the prevailing dynamic on such matters. For example, 52% agreed that prostitution should be legalized, with a slightly higher proportion of males than females and of Québécois versus non-Québécois agreeing. Interestingly, agreement was lowest among 18- to 24-year-olds (33% agreed but 57% disagreed, including 26% who strongly disagreed). In contrast, 60 to 64% of 35- to 54-year-olds agreed. Concerning the acceptability of people watching sexually explicit movies, 60% of males versus 34% of females said it was sometimes or always OK and 25% of males versus 48% of females said it was never OK. The statement "pornography is always degrading to women" yielded agreement from 69% of respondents (58% of men and 80% of women). Since respondents gave higher levels of agreement to the idea that "erotic magazines and movies can help make your sex life more interesting" (50% of males and 38% of females agreed) it would appear that Canadians make some distinction between the term "erotica" (which they associate with pleasure) and pornography (which they associate with harm). As we show in Section 8C, Significant Unconventional Sexual Behaviors, Pornography and Erotica, it is the latter distinction that forms the basis for current obscenity law in Canada.

Taken collectively, the foregoing observations support the conclusion that more Canadians in the 1990s than in prior years accept, or are at least tolerant of, a wider diversity of forms of sexual conduct, expression, and communication. This is particularly the case in areas outside the domain of marriage, as seen in the continued lack of acceptance of extramarital sex by the vast majority of Canadians, and by increased acceptance of an unmarried couple living together (in 1995, 78% of Canadians approved, Bibby 1995). However, as Bibby and Posterski (1992) observed, these changes are more a result of population change than of individual change.

> The sexual revolution changed the way Canadians viewed sex outside of marriage. But, having succeeded in transforming attitudes and behavior about sex, the revolution has long been over. What we have witnessed in the past decade or so is the transmission of the new sexual values from first-generation revolutionists to their offspring. The reason the national figures of acceptance have risen over the past 20 years is not because young people are becoming more permissive than their parents. Rather, the protests of grandparents troubled by the changes have—with their passing—been relegated to history. (Bibby & Posterski 1992, 40)

Of note is the consistently greater acceptance and tolerance of diverse forms of sexual expression on the part of French-speaking (primarily resident in the province of Quebec) as compared to other Canadians. This theme, repeated in other sections of our review, is considered by sociologists to be related to a general decline in the influence of the Roman Catholic Church in Quebec, coupled with the rapid move of women into the labor force in this province; again, this is reflective not so much of a change in individual attitude, but of population and demographic changes over the years.

2. Religious, Ethnic, and Gender Factors Affecting Sexuality

A. Religion and Religious Observance

In a report based on the 1996 *General Social Survey*, Clark (1998) examined the reported religious affiliations of Canadians 15 and over and found 45% to be Romans Catholic, 20% mainline Protestant (United, Anglican, Presbyterian, Lutheran), 6% conservative Protestant, and 3% claimed affiliation with one of the Eastern non-Christian religions (Islam, Hinduism, Buddhism, or others). In general, this reflects a drop in the number of individuals claiming mainline Protestant affiliation and an increase in those with Eastern non-Christian traditions. These figures reflect the British and French origins of the country and the historical predominance of British and European immigration. Other non-Christian religious affiliations, beginning with the First Nations peoples and extending to subsequent immigration by different groups, include: Judaism, Buddhism, Islam, Hindu, and Sikh. The Christian "fundamentalist" religious presence that has challenged sex education and secular sexual laws and attitudes in some parts of the U.S. is less prevalent in Canada, although "conservative" religious groups are among the only ones that have increased in numbers in recent years. The number of individuals 15 and over claiming no religious affiliation has also risen from 1% in 1961, to 13% in 1991, and finally, to 14% by 1996.

Attendance at religious services has generally been declining since the mid-1940s. In 1990, 24% attended at least once a week, 12% once a month, and 27% once a year. By 1996, only 20% of the adult Canadian population reported attending religious services every week, and 10% said they attended only once or twice a year. A further 32% who claimed religious affiliation did not attend religious services at all. This decline has also been noted across all age groups. Those 65 and over were more likely to be weekly attenders in 1990 (42%) than those of younger ages (15 to 24 years: 15%; 25 to 44 years: 18%; 45 to 64 years: 32%). By 1996, these rates has dropped to 34% for those age 65 and over and to 12% for 15- to 24-year-olds. Nevertheless, a telephone survey of 4,510 adults conducted in 1993 by the Angus Reid Group (a major polling agency) for *Maclean's* (a national news magazine with wide distribution) (April 12, 1993) reported that 78% affiliate themselves with a Christian denomination, 74% disagree with the statement "I am not a Christian," and about 65% stated belief in traditional Christian theological doctrines. Similarly, Bibby's Project Canada survey revealed in 1995 that the vast majority of Canadians (81%) still believe in God.

The trend to secular beliefs that conflict with Church doctrine is seen in the fact that, among self-described Roman Catholics polled, 91% approve of artificial birth control, 82% condone premarital sex, 84% would allow priests to marry, 55% view homosexual behavior as morally acceptable, and only 20% support the Church's stance that abortion should be opposed in all circumstances except when the life of the woman is at risk. At the other end of the spectrum, when a church moves away from traditional patterns, as the United Church of Canada did by accepting the ordination of non-celibate, homosexual clergy, a sizable minority felt the church was becoming too liberal in its teachings. Those on the conservative end of the belief spectrum within their denominations are the most active opponents of abortion and proponents of "abstinence-only" sex education in the schools.

Among the almost 4,000 15- to 19-year-old high school students surveyed by Bibby and Posterski (1992), though 79% identified themselves with a particular organized religious denomination, only 19% of 15-year-olds and 13% of 19-year-olds attended weekly religious services, 15% said they received a high level of enjoyment from their involvement in an organized religion, and 24% viewed themselves as committed. Despite the apparently low and declining interest in organized religion (10% considered religious involvement "very important"), 24% rated "spirituality" and 46% "the quest for truth" as very important. Bibby and Posterski (1992) found that teens are highly receptive to

spiritual and values-related issues. Supernatural beliefs also appeared to be more common than one might expect based on religious involvement. For example, the percentages agreeing with various supernatural beliefs were: God exists (81%), Divinity of Jesus (80%), some people have psychic powers (69%), life after death (64%), astrology (52%), extrasensory perception (52%), contact with the spirit world (44%), and 'I will be reincarnated' (32%). These percentages are similar in most respects to those for adults asked the same questions in a 1990 survey (see Bibby & Posterski 1992).

These data suggest that while most Canadians are moving away from active involvement in religious institutions, they retain a core of religious beliefs and an interest in spiritual ideas and philosophies. Given this trend, it would be expected that the specific teachings of and stands taken by religious institutions on issues of sexuality might have less influence on Canadians today than they did in the past. This is illustrated most explicitly in the attitudes of French Canadians compared to the teachings of the Roman Catholic Church. For some newer Canadians, however, results of some research suggest that affiliation with religious institutions and involvement in their activities may remain important, with churches, temples, and mosques providing a center for activities of ethnic communities (Maticka-Tyndale et al. 1996). Though to date there are no large-scale studies of the influence of religion and religious involvement in different immigrant groups, results from research by sociologists across North America suggest that the teachings of religious institutions will have more influence on individuals and communities where involvement in those institutions is higher.

B. Ethnocultural Diversity and Sexuality

The varied ethnocultural backgrounds of Canadians described above have significant implications for sexuality and sexual health. Behavior is strongly influenced by social and cultural factors, and recent immigrants to Canada, in particular, may face complex challenges in understanding and adapting to a new culture. However, it is difficult in a brief review to encompass the ways that cultural traditions in other spheres of social life both reflect and create expectations regarding sexual behavior for Canada's varied ethnocultural groups. In most cases, national statistical data on specific aspects of sexual behavior do not exist, and it is rare to find qualitative studies focused on the broad aspects of sexual activities and beliefs within different ethnocultural communities. Concerns about AIDS and sexual abuse have generated research within selected communities. Examples include a network of studies in several ethnocultural communities. The largest of these, the federally funded *Ethnocultural Communities Facing AIDS* study, was conducted in collaboration with representatives from six communities—Chinese, South Asian, Horn of Africa, English-speaking Caribbean, North African Muslim, and Latin American—in the three cities that receive the largest proportion of immigrants to Canada (Montreal, Toronto, and Vancouver). This project used a combination of ethnographic and survey techniques and had two goals: (1) the development of a knowledge base about cultural and psychosocial factors influencing sexual behaviors that place people at risk for HIV infection; and (2) formation of recommendations for prevention programming in these communities. Overviews of results and recommendations from the qualitative phase of research were published in the six-booklet report, *Many Voices:HIV/AIDS in the Context of Culture*. Final reports based on community surveys were also prepared (see Health Canada 1994a-f, for community reports; also Adrien et al. 1995; "HIV" 1996; Maticka-Tyndale et al. 1995).

3. Knowledge and Education about Sexuality

A. Government Policies and Programs

Because Canadian political structures and social life are based on a relatively nonintrusive conception of democratic society, formal sources of sex education have, for the most part, refrained from overtly imposing specific "doctrinal" sexual values on Canadians. For example, institutions such as the public schools have generally not sought to inculcate particular views on the acceptability of premarital sex. Instead, the school is more likely to offer information and guidance intended to help students make informed decisions about their sexual behavior; counseling and health facilities generally operate from the premise of providing information and care (e.g., to decrease sexually transmitted disease and unwanted pregnancy) regardless of position or status. This is not to say that sex education in the schools is free of ideology or that some Canadians would not wish stronger influence for their particular ideological position. Nevertheless, it appears that school-based sexuality education generally aspires to a non-doctrinal stance based on democratic principles (see McKay 1997).

Because education in Canada falls under provincial rather than federal jurisdiction, the Ministry of Education (or Department of Education) for each of the ten provinces and three territories usually has its own guidelines and/or curricula for sexuality education and its own procedures for implementing them. However, there are various programs through which the national government collaborates with the provinces and/or operates independently in this area, particularly within the context of the Division of Sexual Health Promotion and STD Prevention and Control. The federal government provides funding for a variety of provincial organizations and researchers concerned with education and treatment pertaining to sexual health (AIDS, STDs, sexual-abuse prevention, women's reproductive health, etc.). For example, both the AIDS Information and Education Services Unit of Health Canada, which operates within the Programs Division of the Health Promotion Directorate of the Health Programs and Services Branch, and the AIDS Care, Treatment, and Support Unit of Health Canada, which operates within the Preventive Health Services Division of the Health Services Directorate of the same Branch, provide this kind of federal-provincial linkage.

A joint venture between Health Services and Health Promotion led to production in 1994 of the *Canadian Guidelines for Sexual Health Education*. The *Guidelines*, produced by a national working group coordinated by the Sex Information and Education Council of Canada (SIECCAN) under a contract agreement with Health Canada, provide a unifying framework, a philosophy, and a set of principles to unite and guide those providing, planning, or updating sexual health education programs and/or services for people of all ages across Canada. The *Guidelines* can be used as a frame of reference for assessing both the overall network and the individual components of existing sexual health education programs and related services at the national, provincial, or local level. However, the document cautions against a single "authoritative" definition of sexual health as a static phenomenon that can be readily identified, and hence prescribed, by experts. Sexual health education is seen as "a broadly based, community-supported enterprise in which the individual's personal, family, religious, and social values are engaged in understanding and making decisions about sexual behavior and implementing those decisions" (Minister of Supply and Services 1994, 4). A revised set of guidelines is slated to be released in mid-2003.

Another joint venture that involved the federal government and the provincial ministries of health and education supported development and evaluation of "Skills for Healthy Relationships," a program about sexuality, AIDS, and other STDs for early high school students. Developed by the Social Program Evaluation Group at Queen's University, Kingston, Ontario, the program is now available to any school/school board or Ministry of Education that wishes to assume the cost of duplicating the materials (available from the National AIDS Clearinghouse of the Canadian Public Health Association). An in-service training session for teachers is an important component of the program, as was the large-scale program evaluation done independently by researchers not involved with development or implementation of the program (Warren & King 1994). Other federal and provincial/territorial government programs related to HIV/AIDS prevention and treatment (see Section 10, Sexually Transmitted Diseases and HIV/AIDS) and to other aspects of sexual health will be discussed as the relevant topics arise throughout the chapter.

Sexuality Education in Elementary and Secondary Schools

All provinces and territories have school programs that include sexuality education, although the content and extent of implementation varies considerably between provinces and within different parts of the same province. While school-based sexuality education programs are a provincial responsibility, the federal government has a variety of programs through which it can assist sexuality education in schools or sexual health education for all ages in the community. As noted above, the Division of Sexual Health Promotion and STD Prevention and Control, the National Health Research and Development Program, the Division of HIV/AIDS Epidemiology and Surveillance (Bureau of HIV/AID, STD, and TB in the Centre for Infectious Disease Prevention and Control Canada), and other government departments may support researchers and community organizations in diverse sexuality education programs and services. Local public health units within specific municipalities of each province are also actively involved in public education about contraception, AIDS and other STDs, sexual abuse, and other aspects of sexual health, and they may do so in school settings as well.

There have been only a few national surveys of the availability of sexuality education in Canadian schools (for reviews, see Barrett 1990, 1994), and no detailed national studies of the classroom content of sexuality education that would indicate the extent to which provincial guidelines and curricula are translated into classroom programming. There is, however, enough information from individual provinces to indicate significant advances in sexuality education over the past 15 years fueled to a large extent by emerging concerns about HIV/AIDS, other STDs, and sexual abuse, and also by ongoing concerns about teen pregnancy.

Survey findings throughout the 1980s, 1990s, and into 2002, have consistently shown broad public support for some form of sexuality education in the schools (Langille et al. 1996; Lawlor & Purcell 1989; McKay & Holowaty 1997; McKay, Petrusiak, & Holowaty 1998; Ornstein 1989; Weaver et al. 2001, 2002). As in earlier studies (Verby & Herold 1992), the more recent reports also show support for HIV/AIDS education, which now appears in many curricula in grades 5 and/or 6 (ages 9 to 11). Although it is often difficult for such studies to include detailed assessment of respondents' opinions about specific content, or their views on the more subtle aspects of philosophy and attitudes that they might wish to see inculcated, Canadians appear to be strongly supportive of the the involvement of schools in sexuality education. Nevertheless, a minority perceives contemporary sex education to be skewed toward liberal, secular attitudes, particularly in the areas of abortion, homosexuality, teen sexuality, and access to contraceptive information and services, and actively promulgates a more restrictive agenda in all of these areas. Although historically this view has been expressed as an opposition to sexuality education in the schools, at present it is more likely to focus on either the specific value positions that schools should adopt, the appropriateness of particular topics (e.g., homosexuality, contraception, and abortion), or the ways in which student behavior should be influenced (e.g., abstinence-only programs).

There are few settings other than schools through which almost all young people can be reached with a planned educational program that addresses the broad range of topics subsumed under the heading of sexuality education. Sexuality education in schools is almost invariably integrated into a broader program of Health Education, Personal and Social Relationships, Family Life Education, Religious and Moral Education, and similar subjects, but this varies between provinces (or even within provinces) and there is, therefore, no standard national curriculum for sexuality education. However, most school curricula are based on a statement of principles and a guiding philosophy that emphasizes self-knowledge, acceptance of individual development, social obligations, personal values, the avoidance of problems (e.g., sexual coercion, teen pregnancy, STDs, etc.), and to a lesser and varied extent, the development of satisfying sexual relationships. Material is presented in a hierarchy based on age appropriateness, with a number of previously excluded or delayed topics now appearing at earlier ages (e.g., AIDS and avoidance of sexual exploitation).

Sex education in schools is evolving in Canada, from first-generation programs that focused primarily on knowledge about reproduction and birth control (on the assumption that students would translate this information into self-protecting behavior), to second-generation programs that included factual information plus skills in communication and relationships (on the assumption that these generic skills would translate as above) (Kirby 1992; Kirby et al. 1994; McKay 1993), to the newly emerging programs that are rooted in conceptual models of behavior change that include knowledge acquisition, development of attitudes and behavioral intentions in support of sexual health, motivational supports, and development of situation-specific skills (see, for example, McKay 2000, 2001; McKay et al. 2001). The Skills for Healthy Relationships program for grade 9 students (aged 13-14) described above is an example of this approach (Warren & King 1994). This gradual transition in Canadian sexuality education (most programs are second-generation type) reflects an increasing desire of educators and public health professionals to design interventions that affect sexual health behavior and outcomes. There is also an emerging interest in applying these concepts to elementary school education (Wackett & Evans 2000), although deciding which behaviors to assess and the willingness of schools to survey younger students on such topics remain largely unmet challenges.

One of the complaints about traditional sex education has been that it does not work, i.e., teen pregnancies and STDs remain high. The problem is that early sex education programs simply anticipated such outcomes, although they were neither designed for nor taught in ways that would achieve these specific behavioral objectives. Students did become more knowledgeable and more insightful about their own and other people's feelings and behavior—both desirable

outcomes—but this type of knowledge-based sex education is not generally expected to have a major impact on behavior (for a review, see Fisher & Fisher 1992, 1998). With the continued concern about AIDS and other STDs, schools are being asked to influence behavior (postponing sexual involvement, encouraging abstinence, increasing condom use and safer sex practices, etc.) and not just to increase knowledge.

While Canada has experienced localized opposition to sex education in the schools, that opposition today, as noted above, is seldom to the school's involvement in sexuality education, per se, but to the presumed "liberal" values of such programs. Public discourse on this issue has affected curriculum development to varying degrees across Canada and it is against the competing pressures of heightened expectation, anticipated "traditional" opposition, and limited resources, that school-based sexuality education continues to develop. A detailed overview of recommended or required sexuality education content in Canadian elementary and secondary schools is beyond the scope of this chapter (for a review, see Barrett 1994).

Outcomes of School-Based Sexuality Education

The final report on the Skills for Healthy Relationships program (Warren & King 1994) is the largest study ever undertaken in Canada on the long-range outcome of a school-based sexuality education program. As noted above, the program was developed by the Social Program Evaluation Group at Queen's University, Kingston, Ontario, with collaboration and support from provincial and territorial ministries of education and health, the Council of Ministers of Education, Canada, the National Health Research and Development Program, and the Division of HIV/AIDS Epidemiology and Surveillance (Bureau of HIV/AIDS, STD, and TB in the Centre for Infectious Disease Prevention and Control Canada). The Skills for Healthy Relationships program provides grade 9 students (ages 13-14) with a carefully structured and theoretically based educational intervention on AIDS, other STDs, and sexuality. It features cooperative learning (small groups), parent/guardian involvement (six interactive activities), active learning (role playing, behavioral rehearsal), peer leaders (in small groups, modeling skills), video instruction, and journaling and development of a personal action plan (assertiveness goal). The skills component is a major feature of the program, and outcome measures, assessed by questionnaires just after students had taken the program and one and two years later, included indicators of change related to these skills (assertiveness, communication with parents, regular condom use if sexually active, etc.). The comparison groups in each of the four provinces in which the program was tested were students who took their school's regular grade 9 AIDS/STD program.

Two years later, students who took the program said they had been changed by the program in a number of ways: more comfort talking about personal rights with a partner (72%), talking about condoms (67%), ability to refuse or negotiate something I don't want to do (58% in both cases), more assertive (53%), and always use condoms with my partner (61%) (Warren & King 1994). Compared to the nonparticipant group, participants at the two-year follow-up:

- were more likely to have gained compassion toward people with AIDS;
- had more-positive attitudes toward homosexuality;
- showed greater knowledge of HIV/AIDS;
- were more likely to express the intent to communicate with partners about condom use;
- were no more likely to have the intent to use condoms (this was initially high in both groups);
- were no more likely to report "always" using a condom (about 41% of both groups said they always did so; about half reported using a condom the last time they had intercourse); and
- females were more likely to declare that they would respond assertively if they were pressured unwillingly to have sex.

As would be expected, in the period from grade 9 to 11, the proportion of students who had experienced intercourse increased for both sexes in both groups. However, the percentage of both sexes who said they had ever had intercourse was slightly lower in the participant group two years after the program (51% comparison vs. 42% participant for males; 49% comparison vs. 46% participant for females). The students from both groups who were most likely to have unprotected intercourse were those who took risks in areas such as alcohol consumption, use of cannabis, and skipping classes. They were also more likely to be doing poorly in school (Warren & King 1994). These latter observations highlight the important behavioral influence of social and relationship factors that may well be difficult to change through school-based interventions alone.

In Canada, Orton and Rosenblatt's (1986, 1991, 1993) pioneering research on a multisectoral approach to pregnancy prevention in Ontario showed that rates of adolescent pregnancy declined more rapidly in the late 1970s and early 1980s in those localities that provided young people with both school-based sexuality education and access to clinical services. Orton (1994) points out that the usual practice of reporting only province-wide data for teen pregnancy has tended to obscure the "inequality gap" between individual localities with respect to the decline in teen pregnancies. We have, therefore, been less likely to note the successes in localities that combined prevention programs in both the educational and public health sectors, and also less able, and willing, to recognize and target resources toward those settings that needed special assistance because they were less advantaged for providing such programs (e.g., rural and northern localities). Orton (1994) argues that: "Policies and programs of sexual health have the potential to reduce social inequalities by reducing rates of adolescent pregnancy and STDs, and also by reducing the wide variation in rates between jurisdictions and groups within Canada" (p. 223).

Based on an analysis of policies and programs in education, public health, and social services in Ontario, Orton (1994) argues that "intersectoral collaboration can contribute to greater and more equitable access to sexual health education and services," but that such collaboration requires "strong policy directives at all three ministries" (p. 222). Her findings in Ontario argue for "the effectiveness of centralized policy direction (public health), and the ineffectiveness of a decentralized approach (education and social services) to achieve equitable access to effective programs" (Orton 1994, 223).

There are numerous examples of the successful implementation of programs meeting Orton's criteria. The province of Saskatchewan is attempting to strengthen sexual health education. Its planning document, *Toward Sexual and Reproductive Health in Saskatchewan*, from a province attempting to strengthen sexual health education, shows how a centralized initiative from the Ministry of Health invited multisectoral collaboration in program and policy development (Saskatchewan Health 1993) along the lines that Orton (1994) recommends. Nova Scotia also provides another example of a multiple-component intervention (Langille 2000). Carried out between 1996 and 1999, the Amherst Initiative for Healthy Adolescent Sexuality brought together

community groups (including schools), parents, teenagers, healthcare professionals, and interested citizens to promote adolescent sexual health. Comparisons between 1996 and 1999 show important changes in knowledge, attitudes, and behavior among grade 9 to 12 students at Amherst Regional High School. Of particular note was a decrease of 31% in the age-adjusted pregnancy rate for Amherst women in 1998, compared to 1995 to 1997. Such a finding is encouraging, and certainly in support of a multisectoral approach.

[*Update 1999*: With a comprehensive compulsory sexuality education program in place in all of the Alberta province's schools since 1990, a recent survey found that teenagers in Alberta are postponing intercourse for longer than their counterparts in other Canadian provinces, leading some to argue that mandatory sexuality education programs play a role in encouraging teens to delay sexual activity. According to a survey of 82,000 Canadians published in the *Calgary Herald*, only 8% of females in Alberta ages 15 to 19 said they had sex before age 15, compared to the national average of 13%. Among Calgary's 15-to-19-year-olds, 7% reported having sex before age 15. Supporters of comprehensive sexuality education attribute these lower rates to a decade of comprehensive compulsory sexuality education in the schools and to easy access to family planning clinics. Calgary's teen pregnancy rate is among the lowest in Canada and the world. Critics of the program argue that an abstinence-based sexuality education program would drive the figures down even further. Critics also claim that sex education that does not specifically counsel abstinence has always increased teen pregnancy and STD rates (*Kaiser Daily Reproductive Health Report* 1999). (*End of update by R. T. Francoeur*)]

There are a number of issues facing the continued growth and improvement of sexuality education in Canadian schools. For example, the duration, content, and quality of such education varies considerably between schools and within and between provinces, but it is uncertain whether governments will continue to give sexuality education the required priority and resources. Canadian schools face increasing financial and staffing constraints and there is a growing demand to focus more on basic areas like language skills, science, computer technology, and so on, which may lead, by default or design, to either a lower priority for sexuality education or to a more limited, problem-centered focus on selected topics. Given the various sexual ideologies, religious traditions, and ethnocultural backgrounds within the Canadian population, it has been difficult to find a broad public consensus on how to deal with controversial issues in schools (teen sexuality, homosexuality, etc.). The past climate of cautiousness and conflict on such issues still continues to impede implementation of high-quality sexuality education programs in many areas. The goal identified in the *Canadian Guidelines for Sexual Health Education*, i.e., universal access to a broadly based, comprehensive, and integrated approach to sexual health education, suggests high national expectations and intentions, but uncertain resources and competing priorities are part of the reality facing attempts to fully implement such a program.

Sexuality Education and Related Services Through Public Health Units and Other Such Agencies

Provincial and Territorial Public Health Units play a major role in sexual health education and related services in Canada, and they are often in the forefront of community sexual health education campaigns. For example, the Program Requirements and Standards section of Ontario's *Mandatory Health Programs and Services Guidelines* (Ontario Ministry of Health 1989) lists four pages of expectations and program standards for sexual health and STDs. Boards of health and public health nurses are the front-line staff involved in addressing these issues with clients of all ages and socioeconomic status. The demands on this growing bureaucracy have increased in recent years in response to changing patterns of sexual behavior among youth, increasing ethnocultural diversity and immigrant populations in cities, population aging, AIDS, concerns about sexual abuse prevention for all ages, and other such issues. In the face of growing demand and limited resources, provision of service is varied across Ontario (this is probably true for all provinces) and, for the same reasons, the additional mandate to do community needs assessments and outcome evaluations of sexual health programs is also difficult to sustain.

A variety of nongovernmental agencies are also involved in sexuality education and related services. The Sex Information and Education Council of Canada (SIECCAN), founded in 1964, maintains a resource library and information service, publishes the *Canadian Journal of Human Sexuality* and the *SIECCAN Newsletter*, provides consultation services and professional education workshops, and facilitates development of new resources, such as the *Being Sexual* series (Ludwig & Hingsburger 1993), *After You Tell* (Ludwig 1995), and the previously described *National Guidelines for Sexual Health Education*. The Planned Parenthood Federation of Canada (PPFC) has a long history of advocacy, education, and resource distribution on contraception and sexuality. PPFC administers the Sex Education and Research Clearinghouse (SEARCH), a national center for distribution and development of sexuality education resource materials. Local Planned Parenthood offices now provide sexual health education and services and some, such as The House, in Toronto, administer adolescent health centers that are equipped to address a broader range of health issues than contraception and pregnancy counseling. The Canadian AIDS Society and local AIDS committees and organizations do educational outreach that includes some aspects of sexuality education, as do other groups with particular concerns about sexuality, such as the Disabled Women's Network and the British Columbia Coalition on AIDS and Disability. The Canadian Public Health Association, the Canadian Association of School Health, the Canadian Infectious Diseases Society, the Society of Obstetricians and Gynecologists of Canada, and a number of other nongovernmental organizations contribute at the national level to public sexuality education.

B. Informal Sources of Sexual Knowledge

Despite the growing role of schools and public health authorities in public education about such topics as contraception, STDs, and HIV/AIDS prevention, informal sources (peers, family, and the media) are probably the primary influence on sexual attitudes and knowledge. Adolescents have been the focus of most research in this area.

For example, when asked to list their main sources of AIDS information, grade 11 students ($N = 9{,}617$) surveyed in the *Canada Youth and AIDS Study* ranked television first, followed, respectively, by print materials, school, family, friends, and doctors/nurses (King et al. 1988). The first three rankings were the same for grade 7 ($N = 9{,}925$) and grade 9 ($N = 9{,}860$) students. Although these informal sources were identified as the main source of AIDS information for Canadian youth, a majority of the young people surveyed said they would have preferred a more formal source of information, such as doctors or nurses. A more recent study in Ontario found that school was the main and preferred source of health information (McKay & Holowaty 1997).

Ornstein's (1989) study of AIDS-related knowledge, behavior, and attitudes of Canadian adults ($N = 1{,}259$)

found that, similar to the students in King et al.'s study, television (39%) and newspapers (23%) led the list of respondents' self-identified "main sources of information about AIDS." Magazines were identified by 9% and health authorities (e.g., physicians, nurses, hospitals, and clinics) by only 2.5%. Although not asked to self-identify their sources of information, one study of British Columbia youth (McCreary Centre Society 1993) indicates that 84% of participants were taught about AIDS in school and 72% knew how or where to get information. This trend was seen to increase with grade level. As well, 50% had talked with their parents about AIDS.

In the survey phase of the *Ethnocultural Communities Facing AIDS* study, conducted in English-speaking Caribbean, Latin American, and South Asian communities (only men from the South Asian communities participated in the survey), the rank ordering of where respondents preferred to get information about HIV/AIDS was identical in all three communities and to both of the two earlier studies (Maticka-Tyndale et al. 1995). Ornstein's (1989) conclusion that "in the main, Canadians rely on the mass media rather than more specialized publications to learn about AIDS" (p. 52), clearly applies regardless of age and probably also regardless of ethnocultural background. Although no more recent studies have been done, this is likely still the case.

While various forms of media, particularly television, have been Canadians' main source of information about AIDS, the picture changes somewhat when sources of information on sexuality in general are examined. Again, informal sources of information predominate. However, with sexuality in general, as opposed to AIDS, peers and family become the most commonly cited sources of information. The World Wide Web and other computer-assisted information systems are having a growing impact on students' access to sexuality-related content, but the potential of this medium as a formal resource for sexuality education (see Humphreys et al. 1996) has yet to be exploited.

When King et al. (1988) asked a national sample of students about their main sources of information about sex, grade 7 (aged 11-12) and grade 9 (aged 13-14) students ranked family first out of six possible sources of sex information. Though friends were ranked fifth by grade 7 students, they rose to third for grade 9 students, and first for grade 11 students. The latter group ranked family a close second. Friends remained first for college/university students, with family dropping to third place, replaced by print materials in second. Interestingly, school dropouts ranked previous schooling first, friends second, and family third as their main sources of sex information. In a comparable study of Newfoundland students done in 1991, Cregheur et al. (1992) found that grade 11 students (aged 16-17) ranked friends first as their main source of information about sex, followed by school, television, family, and print materials. Interestingly, compared to the King et al. (1988) national sample, grade 11 students in the Cregheur et al. study (1992) were less likely to cite friends, family, television, and print materials as their main sources of information about sex, and more likely to cite school.

The role of peers and parents as important informal sources of information and support is evident from the results of three studies. King et al.'s (1988) study of Canadian teens found that, overall, teens agreed that they talked with their close friends about sex (increasing from 56% in grade 7 to 75% in grade 11), that people of the opposite sex like them (51% in grade 7, 73% in grade 11), and that they discuss their problems with their friends (62 to 71%). Among grade 9 students questioned in a 1992 evaluation of the "Skills for Healthy Relationships" program (see Warren & King 1994), 59% of females and 38% of males agreed that "I can talk to my mother about sexual matters" (26% of females and 41% of males agreed that they could talk to their fathers about sexual matters). Finally, Herold's (1984) study of young women visiting a birth control clinic found that two thirds of the women had received birth control information from girlfriends, about half from schools or reading materials, 25% from their mothers, and 2% from their fathers. The importance of peers is highlighted in Herold's (1984) conclusion that

> peers provide teenage girls with information, legitimization and support. Girlfriends are the most important source of information about birth control, and teenage girls who are socially isolated in the sense of having few friends often delay getting birth control because they lack peer support. (p. 105)

The impact of informal sources of learning on sexual values is a much-discussed issue in Canada. In a study of values and sex education in Montreal-area English-language high schools, Lawlor and Purcell (1988) surveyed 667 grade 9 and grade 11 students about a variety of topics related to sex education. Asked where they learned their moral values related to sexuality, the students again ranked peers at the top. Friends away from school were ranked first, followed, respectively, by classmates, home, television and movies, books and magazines, in school from teachers, in school from religious teaching, and rock/pop music and lyrics. It is noteworthy that these students ranked rock/pop music and lyrics last out of a possible eight sources of sexual values, since there has been increasing speculation in the Canadian media that popular music and rock videos may have a negative impact on the sexual attitudes of young people. For the eight sources for learning sexual values, the most pronounced gender difference was for the item "in the home," which was ranked third by grade 9 girls and second for grade 11 girls, but fifth by both grade 9 and grade 11 boys.

While public policy and sex education literature generally acknowledge the important role that parents play in the sexual development of children, there has been surprisingly little research on the direct communication of sexual knowledge from parents to their children. In a study of 200 Canadian university women (Herold & Way 1983), subjects reported which sexual topics they had discussed with their parents. Eighty percent had talked about attitudes towards premarital sex with their mothers, 55% with their fathers; 70% had discussed contraception with their mothers, 29% with their fathers; 15% had discussed oral sex or masturbation with their mothers, 2% with their fathers; and 9% had talked about sexual techniques with their mothers, less than 1% with their fathers.

Several general observations can be made based on these studies. First, family, peers, and media form a triad of influence and education with respect to issues related to the sexuality of young Canadians. In general, there is a developmental shift that occurs in the relative place of family, peers, and media sources during adolescence. Between about grade 9 (13 to 15 years of age) and grade 11 (16 to 17 years of age), peer influence rises to top rank, and that of family decreases in importance, in some cases even outranked by the more impersonal media (e.g., print materials). In addition, at least for university women, mothers in particular have been a potential source of information and influence in matters of sexuality. The foregoing results support Bibby and Posterski's (1992) observation that the apparent changes in attitudes and conduct are not individual changes, but a "coming of age" of a new generation of Canadians—the children of the "sexual

revolution" generation—who are forming their own reference groups of information and influence.

4. Autoerotic Behaviors and Patterns

> In the insufficiently heated bedroom on the northwest corner of the house in Park Place, I was taken by surprise by the first intimations of a pleasure that I did not at first know how to elicit from or return to the body that gave rise to it, which was my own. It had no images connected with it, and no object but pure physical sensation. It was as if I had found a way of singing that did not come from my throat.
>
> —A man's recollection from his boyhood in *So Long, See You Tomorrow*, William Maxwell (1980)

In the early 1900s, the first sex education classes in Ontario schools taught young boys about the dangers of masturbation. Students were told that seminal fluid contained a vital force that nourished the brain and muscles, and that wasting it through any sexual excess, but particularly through masturbation, was physically and mentally depleting to the individual. Furthermore, students were also told that a man could pass this depleted condition on to his offspring. These dual beliefs in vitalist physiology and in the inheritance of acquired characteristics provided the "secular" rationale for prohibitions that were already part of the religious teachings of the time. Canada's long-abandoned eugenic sterilization law of 1902 had its origins in the period when such teaching became popular (for review, see Bliss 1970). Sex education at that time was generally silent on female masturbation—often ignoring its very possibility—but when it was mentioned, the dire consequences for reproductive health and mental stability were strongly emphasized. Mothers were told to be watchful lest their children fall into the habit that, they were warned, was notoriously difficult to break.

Over 90 years later, masturbation has gone from being a sin to a normal part of sexual development in children and a healthy aspect of sexual expression in adults. This general impression would have to be documented from qualitative sources, since we have been unable to locate any published national data on masturbation frequency in any age group. Survey results cited in Section 1C, Basic Sexological Premises, General Concepts and Constructs of Sexuality, indicate that a majority of Canadians adults view it as a healthy expression, although a sizable minority either disagreed (30%) or strongly disagreed (5%) with this view. Sex education literature almost invariably refers to masturbation as normal, and recommendations for parents usually pertain to the importance of privacy and of not instilling guilt. Sexuality education for children and young adults with developmental disabilities places particular emphasis on teaching in this area because public masturbation, even when it arises through lack of social skills, can lead to embarrassment, restriction of social opportunities by caregivers, or exploitation by others. The Sex Information and Education Council of Canada (SIECCAN) publishes and distributes a 17-booklet sexuality education series for people with developmental disabilities—*Being Sexual: An Illustrated Series on Sexuality and Relationships*—that includes clearly illustrated, detailed, sex-positive information about female masturbation (Ludwig & Hingsburger 1993) and male masturbation (Hingsburger & Ludwig 1993). The series is designed for people who have problems with language, learning, or communication, and all books are translated into Blissymbols, making the series the only resource of its kind in the world. Blissymbolics, a symbolic language developed by C. K. Bliss and described in *Semantography*, published in 1949, was intended to be a means of communication across all language groups. It is now used by people with disabilities, and others, to facilitate expressive speech. The Canadian organization responsible for this work is Blissymbolics Communication International.

One paper on childhood masturbation written by Canadian authors relies on U.S. statistics for occurrence and incidence data to suggest that 90 to 94% of males and 50 to 60% of females have masturbated during their lifetime, that the highest incidence is among 16- to 20-year-olds (86% masturbate; the frequency is higher in males than females), and that masturbation declines with age in men but increases toward middle age in women (Leung & Robson 1993). While some religious groups consider masturbation to be sinful or an unacceptable indulgence, the common reaction in Canada appears to range from benign acceptance (and little discussion) to enthusiastic approval, reflective of the general shift toward a larger proportion of the population's acceptance and endorsement of various forms of sexual expression.

5. Interpersonal Heterosexual Behaviors

A. Children

There have been no national studies on the sexual behavior or sex-role rehearsal play of Canadian children. While it seems likely that sexual curiosity and exploratory play would follow patterns similar to those described by U.S. researchers (see Martinson 1994), we do not know of any studies that would provide empirical support for this conjecture in Canada.

B. Adolescents

It is important to place the sexual behavior of Canadian adolescents as a group within the context of prevailing social, political, and economic conditions and of other individual variables, such as their personal characteristics and relationships, their attitudes toward sexuality, and their increasing exposure to sexual images and information through television, films, and magazines. Although it is misleading to generalize about such a diverse group, the findings of two national studies with large samples described earlier offer important background insights against which to assess more-recent reports on adolescent sexual health in Canada. The *Canada Youth and AIDS Study* (Social Program Evaluation Group, Queen's University, King et al. 1988) is the only large-scale national study of both the attitudes and sexual behavior of Canadian adolescents and young adults. The sample included approximately 19,500 grade 9 and 11 students, 14 to 17 years of age. "Project Teen Canada" 1992, which replicated a national survey of 15- to 19-year-olds conducted in 1984, had a sample of 3,600 15- to 19-year-olds and investigated attitudes and beliefs (not behavior) about a range of topics, including sexuality (Bibby & Posterski 1992). More recently, national data assembled by the Canadian team for the Alan Guttmacher Institute's international comparative study of adolescent sexual health in developed countries (France, England, Sweden, Canada, United States) (Darroch, Frost, Singh, et al. 2001) have provided a 1990s overview of selected aspects of the sexual health of Canadian adolescents (Maticka-Tyndale, Barrett, & McKay 2000; Maticka-Tyndale, McKay, & Barrett 2001; Singh, Darroch, Frost, et al. 2001; Darroch, Singh, Frost, et al. 2001; Maticka-Tyndale 2001). These varied sources, and others, are used below as a starting point to examine the sexual attitudes and behavior of Canadian adolescents.

Sexuality and Self-Esteem

Self-concept refers to the way individuals describe their abilities, personalities, and relationships, whereas self-esteem refers to the value placed on these personal characteristics (King et al. 1988). Research has repeatedly demonstrated strong associations between self-concept, self-es-

teem, and sexual conduct, particularly for adolescents. These are, therefore, important concepts to consider in this section on adolescent sexual conduct. In King et al.'s national study, while Canadian teens generally agreed that they had confidence in themselves (88 to 90% of grade 7, 9, and 11 males, 81 to 87% females) (King et al. 1988), ambivalence is reflected in a variety of areas, particularly for young women. Between 51% and 53% of grade 7, 9, and 11 females reported that they would "change how I look if I could" (vs. 37 to 38% for males); 37% of grade 7 females and 51% and 54% of grade 9 and 11 females agreed with the statement, "I need to lose weight" (vs. 21 to 24% for males); and 32 to 41% of females agreed that "I often feel depressed" (vs. 27 to 30% for males). At the same time, 84 to 89% said, "I have a lot of friends," 81 to 84% said "I am a happy person," and 71 to 74% said, "The future looks good to me."

Similar findings on self-esteem of Canadian 11- to 15-year-olds are reported in *The Health of Canada's Youth* (King & Coles 1992), part of an international collaborative study designed to collect comparative health-related information on young people in Austria, Belgium, Canada, Finland, Hungary, Norway, Poland, Scotland, Spain, Sweden, and Wales. In the section on social adjustment, King and Coles (1992) observe that, "compared with young people from European countries, young Canadians are experiencing more strain in their relationships with their parents and even with each other" (p. 96). Yet Canadian students were more likely than those in most other participating countries to find it easy to talk to friends of either sex about things that really bother them. This concurrence of positive self-regard on the one hand, and anxiety or dissatisfaction with specific areas of their lives on the other, has also been noted in other studies of slightly older Canadian youth as well.

For example, Bibby and Posterski (1992) also noted the generally high self-esteem of teens (e.g., 82% of females and 90% of males agreed that the statement, "I can do most things well," described them either very well or fairly well). However, these adolescents had concerns about a number of areas, including achievement in school (this was an issue for both sexes) and personal safety (a major concern for females). About three times as many females as males (56% vs. 20%) agreed that there was an area "within a mile (or kilometer) of your home where you would be afraid to walk at night." About 95% of both young women and men plan to have careers, but there appears to be a continuing gender gap in areas that may have an impact on sexual and gender relationships. For example, females were more likely than males to rate certain values as "very important" (concern for others, 75% vs. 48%; forgiveness, 71% vs. 45%, and honesty, 82% vs. 56%) (Bibby & Posterski 1992).

Though these studies support the general contention that Canadian adolescents have a relatively positive self-concept and high self-esteem, they also demonstrate clear and important gender differences. Young women express specific concerns about appearance and safety, and focus greater attention on values that relate to relationships than those of individual achievement or success. Considerably fewer young men, on the other hand, show concern for appearance or focus attention on relationship values and, by and large, they seem unconcerned about personal safety. These characteristics are of particular importance when considering their potential influence on relationships between young men and women and the ability of each to realize the expectations they have set for their futures.

Attitudes Toward Sexuality and Relationships

Attitudes toward sexual intercourse before marriage (i.e., "premarital sex") have been widely used as an indicator of sexual permissiveness. In King et al.'s study (1988), among grade 11 students (ages 15 to 17), 13% said unmarried people should not have sex and 76% said it is all right for people to have sex before marriage if they are in love (74% female, 78% male) (agreement combines the "strongly agree" and "agree" categories on a five-point Likert scale) (King et al. 1988). More recently, *Maclean's* (2001) reported findings based on R. Bibby's book, *Canada's Teens: Today, Yesterday and Tomorrow*, that 82% of Canadian teens believe that love is an acceptable reason for sex before marriage, while 58% feel that liking someone is sufficient.

In their slightly older sample in 1992, Bibby and Posterski found that: 86% of females and 88% of males agreed with sex before marriage for people in love (the value was 93% for both sexes in Quebec); 51% of females and 77% of males agreed with sex before marriage when the people involved liked each other (81% and 91%, respectively, in Quebec); 40% of females and 73% of males agreed that sexual relations were OK within a few dates (60% and 82%, respectively, in Quebec); and 5% of females and 20% of males agreed with sexual relations on a first date if people like each other (9% and 23%, respectively, in Quebec). A study of attitudes toward use of power in sexual relations among college students in Quebec (Samson et al. 1996) found that the majority of students refused to see the expression of sexuality as a locus of power, but viewed it more in the context of shared affection and pleasure.

The tendency toward increasing permissiveness with greater levels of affection is a longstanding North American tradition among young people and adults. In fact, Widmer, Treas, and Newcomb (1998), in an international comparison of attitudes toward nonmarital sex, found that a full 69% of Canadians felt premarital sex was "not at all wrong," with an additional 15% feeling it is "only sometimes" wrong. Similar findings were reported by Bibby (1995), with respondents endorsing "not at all wrong" 57% of the time and "sometimes wrong" 23% of the time. The greater levels of approval among Quebec students may be characteristic of the more sex-accepting attitude of Quebec society in general, and particularly of the francophone segment of the population. In contrast to their attitudes toward premarital sex, only 9% of young people in Bibby and Posterski's (1992) total teen sample approved of extramarital sex (12% vs. 9% for francophone and anglophone Quebec teens), with this figure falling to less than 5% for Catholic teens who attended church two to three times per month.

Bibby and Posterski (1992) found that 87% of teens outside of Quebec approved of unmarried people living together (95% among francophone Québécois and over 80% among Catholic students in Quebec). Among teens outside of Quebec, 65% approved of people having children without being married (88% among francophone Québécois).

In the areas of homosexuality and gay rights, teens were more likely to support social justice and rights for the gay population (68% approval overall outside of Quebec, 83% in Quebec) than to approve of homosexual relations (33% approval outside of Quebec, 55% among francophone Québécois). King et al. (1988) found a sizable percentage of grade 7, 9, and 11 students agreeing that "homosexuality is wrong" (45%, 42%, 38%, respectively) and a surprisingly small percentage agreeing that they would feel comfortable talking with a homosexual person (18%, 22%, and 29%, respectively). With increasing discussion of gay rights and homosexuality in the media, we might expect these numbers to change, although there remains a dichotomy between many young people's acceptance of gay rights and their acceptance of homosexuality. Since students with the lowest tolerance for people with AIDS also had the most negative

attitudes toward homosexuality, and vice versa (King et al. 1988), the widespread mandating of HIV/AIDS education in Canadian schools in recent years may well have led to greater compassion for people with AIDS and less stigmatizing of gay people because of their presumed association with AIDS. Indeed, a 1992 study (Warren & King 1994) of over 2,000 grade 9 students from four provinces who received an educational program about sexuality and AIDS ("Skills for Healthy Relationships") found that 23% considered homosexuality to be wrong (vs. 42% in the 1988 national sample) and 60% felt that "homosexuals should be allowed to be teachers" (vs. 39% in the 1988 study).

In fact, in a report on more recent work by R. Bibby, *Maclean's* (2001) revealed that while in the 1980s, only 26% of teens approved of same-sex relationships, a full 54% of young people now support same-sex relationships, with 75% believing that homosexuals should be entitled to the same rights as anyone else. In a slightly older sample, a study by Canadian Press/Leger Marketing (2001) shows that among 18- to 24-year-olds, 89% believe in equal rights for gays and lesbians, 81% support same-sex marriage, and 73% endorse adoption by same-sex parents. Taken together, these results suggest a growing tolerance among teens and young adults.

This background information on sexual attitudes and self-esteem provides a context for discussing the specific sexual behaviors of Canadian adolescents.

Sexual Behavior of Adolescents

The 1970s and 1980s saw gradual changes in sexual behavior of Canadian young people consistent with the "sexual revolution" in attitudes that began in the 1960s. University students were the common research sample for many of the past studies on sexual behavior of youth, because parents and school boards were generally disinclined to give approval for questions on the specifics of sexual behavior in surveys of younger teens. Although similarly restricted on some topics (e.g., questions about oral sex and anal sex were asked only of college/university students, school dropouts, and "street youth"), the *Canada Youth and AIDS Study* provided evidence that "young people are more sexually active than adults may realize." For example, 31% of grade 9 males (14 to 15 years old) and 21% of females reported at least one instance of sexual intercourse. For grade 11 students (16 to 17 years old), the figures were 49% and 46% respectively. For comparison, the values for first-year college/university students (19 to 20 years old) were 77% of males and 73% of females. Hence, a sizable majority of Canadian teens have had at least one experience of vaginal intercourse by the time they are 19. In data culled from the *National Population Health Survey* in 1996-1997, Maticka-Tyndale, McKay, and Barrett (2001) state that over 70% of youth then age 20-24 had experienced first intercourse before the age of 20. These and other findings are part of a linear shift downward for both men and women in terms of age of first intercourse, a shift that has been more drastic for women who are now catching up to men.

Over half of younger teens have engaged in some form of sex play. For example, about 74% of grade 11 students (75% of the males; 73% of the females) and over half of grade 9 students (61% of the males; 53% of the females) have experienced "petting below the waist" (King et al. 1988). Among the reasons offered for their first experience of sexual intercourse, 19-year-olds in the 1988 sample reported love (48% of the females; 24% of the males), physical attraction (8% of the females; 25% of the males), curiosity (16% of the females; 12% of the males), passion (8% of the females; 11% of the males), and drug and/or alcohol use (6% for both sexes). King, Coles, and King (1990) found that about 2% of both male and female 19-year-olds identified themselves as either homosexual or bisexual, but the details of their self-identification and behavior were not obtained.

In a late 1980s study of Quebec grade 11 high school students (N = 1,231, average age, 17 years), Otis et al. (1990) found that French- and English-speaking boys did not differ in the proportion who had experienced intercourse (62.4% vs. 54.1%), in number of partners among those with such experience (3.4 vs. 4.1), or in likelihood of condom use (46.9% vs. 48.8%). English-speaking male high school students were less likely than their francophone counterparts to report that a partner was using the birth control pill to prevent conception (33.7% vs. 48.8%). Among francophone versus anglophone high school girls, however, differences were apparent in terms of intercourse experience (61.5% vs. 30.1%), number of lifetime partners (2.8 vs. 1.8), use of the birth control pill (56% vs. 22%), and use of condoms (30.9% vs. 83.7%). These differences may reflect more longstanding relationships or sexual experience among francophone girls (age at first intercourse was 14.9 vs. 15.7) or a greater emphasis among francophone students on contraception and less so on STD prevention (see also Otis et al. 1994). In a recent review of research on the sexual behavior of different populations of high school students in Quebec, Otis (1996) noted that 12 to 23% of first-year and 47 to 69% of fifth-year high school students had ever had intercourse. Among those who had ever had intercourse, 1 to 8% reported same-sex sexual activity, 7 to 37% anal sex, and 1% involvement in prostitution. A sizeable minority of this group had six or more partners (12 to 22% for 15-year-olds; 27 to 47% for 18-year-olds, depending on the study).

Although peer pressure in its broadest definition undoubtedly affects teens in many ways, only a minority state that they feel pressure from their friends to be sexually active. Among grade 9 students, 16% of males and 8% of females agreed that they felt such pressure (21% and 6%, respectively for grade 11 students) (King et al. 1988). However, a sizable proportion of younger teens may have some uncertainty on this matter, since 55% of grade 9 students surveyed by Bibby and Posterski (1992) responded "don't know" to the statement, "I am not influenced by my peers" (41% agreed that they were not so influenced, 14% agreed, implying that they were). Even if peer group pressure does not usually influence the decision to be sexually active, peer group norms probably influence this and other important aspects of sexual behavior (e.g., decision to use condoms, safer sex practices, attitudes toward gender equity, etc.). Sexual health educators encourage the development of such peer norms as a positive reinforcement for "healthy" sexual behavior.

An evaluation study of the "Skills for Healthy Relationships" sexuality curriculum (Warren & King 1994), provides the most up-to-date national information available on the prevalence of vaginal, oral, and anal sex among grade 9 and 11 students in Canada (3,750 grade 9 and 3,000 grade 11 students from eight school boards in four provinces) (see Table 3). Overall, these findings indicate a large increase in experience of both vaginal and oral sex between grades 9 and 11, and considerable similarity between the sexes in both grades (particularly in grade 11) in terms of their reported experience of both behaviors. As we will note later in relation to sexual behavior of university students, similarity of acts between the sexes does not necessarily mean similarity of motivation, interpretation, or expectation with respect to these activities.

C. Adults

Premarital Relations, Courtship, and Dating

This material is addressed in Section 5B, Adolescents, above, and in the section below.

Sexual Behavior and Relationships of Single Adults

Most of the research on premarital or nonmarital sexual activity of single Canadian adults has been done on university students. The *Canada Youth and AIDS Study* reported that about 77% of men and 73% of women in college/university had experienced intercourse, 68% of males and 64% of females had engaged in oral sex, and 14% of males and 16% of females had at least one experience of anal sex. Among those who had had intercourse, 23% of the females and 15% of the males said they had only ever had one partner (two partners, 9% for males, 15% for females; three to five partners, 28% for males, 35% for females; six to ten partners, 22% for males, 17% for females; and 11 or more partners, 27% for males, 11% for females) (King et al. 1988). About 7 to 8% of both sexes reported having had a sexually transmitted disease (King et al. 1988). These findings are for first-year university students and probably underestimate the average experience of students in all years.

In the most recent review of sexual behavior of college students in Quebec (1 to 2 years younger on average than university students), Samson et al. (1996) reported that 76% had ever had intercourse. Within this group, 9 to 14% reported experience of anal sex, 8% same-sex contacts, and 27 to 42% had 4 or more partners. For university students (Otis 1996), 86 to 90% had sexual intercourse, 18% had anal sexual contact, and 35% had 5 or more partners. In a study of anglophone and francophone university students (*N* = 1,450 men and women from four universities in Montreal), Lévy et al. (1993) found that 88% of French-speaking versus 81.5% of English-speaking men had had intercourse at least once; the values for females were 88% versus 74.5%. While the sexes did not differ within language groups, French-speaking women were significantly more likely to have had intercourse than English-speaking women. This was also true for oral sex experience (86% vs. 79.2% in French-speaking vs. English-speaking men; 85.4% vs. 73.1% in French-speaking vs. English-speaking women).

This trend toward convergence of the overt sexual behavior of male and female university students in Canada (and elsewhere) has been noted since the early to mid-1970s (Barrett 1980). In terms of the occurrence of different sexual activities in a sample of 585 francophone university students in Quebec, one might suggest that this behavioral convergence is complete (Frigault et al. 1994; see Table 4). However, it would be incorrect to assume that similarity between the sexes in terms of sexual acts implies that similar "causal paths" influenced those activities (Maticka-Tyndale 1991). For example, Table 4 shows male/female differences in the perception of which sex has the greatest influence on the decision to engage in sexual activity. While neither sex assigned that role "mostly" to their partner (about 3% for both males and females), males were much more likely to perceive themselves as the influencer, whereas females perceived the decision to be equally shared or only slightly more influenced by the male. Females were also more likely to report that they had experienced sexual harassment or mistreatment and more likely to think often or very often about AIDS in the context of their sexual relationship. Despite the

Table 3

Occurrence of Vaginal, Oral, and Anal Sexual Activity in a Large Sample of Canadian Teens (1992)[1]

	Percentage Responding in Each Category			
	Grade 9 (*N* ~ 3,750)		Grade 11 (*N* ~ 3,000)	
	Female	Male	Female	Male
Vaginal sex				
Never	80	73	53	51
1 or 2 times	7	11	8	13
3 or more	13	16	39	36
Oral sex				
Never	79	73	53	52
1 or 2 times	8	11	11	13
3 or more	13	16	36	35
Anal sex				
Never	96	94	92	90
1 or 2 times	3	3	5	3
3 or more	1	3	3	7

[1]Respondents were students in the experimental and comparison groups of the Skills for Healthy Relationships program evaluation (8 school boards in 4 provinces) (Warren & King 1994). Grade 9 students are generally 13-15 years old; grade 11, 16-17 years old.

Table 4

Sex Roles and Aspects of Sexual Experience Among Francophone University Students (1994)

	Percentage Giving the Response	
Activity or Experience (in the past year unless otherwise indicated)	**Female (*N* = 316)**	**Male (*N* = 269)**
Ever had sexual intercourse	90.8	81.4
Ever had oral-genital sex	88.8	80.3
Ever had anal sex	18.7	18.7
Have you had a steady partner in the last year?	76.4	66.8
Who has the greatest influence on the decision to engage in sexual relations?		
Mostly you	8.4	28.1
You a little more so than partner	9.9	22.7
Equal	53.8	39.4
Partner a little more than you	24.8	6.4
Mostly partner	3.1	3.4
Have you had sexual relations with someone when you definitely didn't want to?		
Never or rarely	93.9	92.7
Have you ever given in to a partner's pressure for sexual relations?		
Never or rarely	78.3	72.4
Experiences of sexual harassment		
Unwanted physical advances (touching, kissing)	31.7	21.7
Physical violence of a sexual nature	6.7	1.1
Do you think about AIDS in the context of your sexual relationships?		
Never	41.4	42.3
Rarely, seldom	33.0	43.8
Often, very often	25.6	13.9

Data from Frigault et al. (1994). Respondents average age 21 years, 95% never married, 90% raised Catholic, all university-level students in Montreal, 1.5% said they were homosexual, 0.9% bisexual.

convergence of behavior, we suspect that sex differences in the social and interpersonal contexts for sexual activity are important considerations, and that these differences may be even more common among university students in other parts of Canada.

Maticka-Tyndale's (1991) study of factors that predicted Quebec college (i.e., CEGEP) students' (*N* = 866) perception of their susceptibility to HIV/AIDS also showed clear evidence of sex differences, despite considerable similarity between the sexes in overt behavior. (*Note*: Quebec is the only province with a two-year intermediate "college" program [CEGEP] between the end of grade 11 [age 16] and the beginning of university. CEGEP students are generally 17 to 21 years old and, therefore, younger than university students.) Maticka-Tyndale's conclusion about this group of students was as follows:

> Though the actions may be converging, the causal factors associated with male and female sexuality are decidedly different. If there is concern for understanding male and female sexuality, or with devising programs which will encourage changes in sexuality to reduce risk, it is these causal factors which must be addressed, not merely the final acts. (Maticka-Tyndale 1991, 60-61)

Since there have been few Canadian studies on ethnocultural differences in sexual behavior, Maticka-Tyndale and Lévy's (1992) comparison of sexual experiences among Quebec CEGEP students is of interest. Their results demonstrate differences between students from different ethnic backgrounds, but since the sample size is small (total *N* = 317, group sizes 10 to 196), the results should be viewed with caution. In their comparison of francophone Canadian, English Canadian, Greek, Haitian, Italian, and Jewish (both English- and French-speaking) students, French Canadians (*N* = 196) indicated the broadest range of heterosexual experiences (88 to 98% reported kissing, body kissing, body caressing, and genital caressing), 80% had oral sex, and 75% had experienced intercourse. At the same age, Greek (22%), Italian (33%), and anglophone Jewish students (38%) were the least likely of all groups to have engaged in intercourse, and Greek students were less likely to have participated in oral sex (27%) than were the other nonfrancophone Canadian groups (48 to 65%), and less likely to report body kissing (44%), genital caressing (29%), and the other noncoital behaviors.

Respondents who had experienced sexual intercourse were also compared on their use of various contraceptive methods. The question asked about methods they had ever used and, therefore, more than one response was possible. Among all students, the most common methods were the pill (43 to 81% across all groups), condom (45% to 88%), and withdrawal (45 to 67%). Some students may have sequentially tried several methods. For example, withdrawal, which is often employed in early experiences, was used at some time by about one half or more of all six groups (Greek students were not included in this analysis because of the small number with intercourse experience). Haitian and French Canadian students were significantly less likely to report this method (45% and 49%) than were English Canadians. Haitians were more likely to report "none" (37%), compared to 6% for French and English Canadian and francophone Jewish students and 11 and 12% for Italian and anglophone Jewish students. Haitian students were also less likely to report condom use (45% vs. 72 to 88% for the other groups). Interestingly, the differences noted above in some aspects of behavior were not generally observed in relation to personal assessment of AIDS risk among these Quebec students. The Haitian population in Montreal warrants special mention with respect to AIDS risk because their higher incidence of AIDS at the beginning of the AIDS "epidemic" in Canada led to the early, and incorrect, assumption that Haitians had a special susceptibility within the group.

Overall, these results suggest that most Canadian young adults will experience some tension between their own attitudes, expectations, desires, and behaviors, as well as between these and the expectations set by their family and cultural milieu. The reported behaviors of young men and women suggest a move away from what was typically referred to as a "double standard" (i.e., the application of differential norms, expectations, and penalties to the sexual actions of men and women). However, if one considers both the observed differences in some aspects of self-concept, self-esteem, and relationship values and the findings from research on the situational, personal, and interpersonal factors influencing male/female sexual conduct, it is clear that certain gender differences still prevail. With respect to comparisons between ethnocultural groups, research demonstrates both differences and similarities within and between Canada's ethnic groups. These observations reinforce our introductory contention that generalizing one pattern to all Canadians is not just difficult, but probably impossible.

The ethnocultural differences in actual behavior reported in the Quebec study (Maticka-Tyndale & Lévy 1992) reflect a common phenomenon in Canada's larger cities. First- and second-generation students from different cultural backgrounds do not all adopt the behavioral pattern of the dominant culture. Agencies providing sexuality education, counseling, and related services have had to become more conscious of the impact that Canada's linguistic and ethnocultural diversity can have on gender-role behavior, attitudes toward different types of sexual activity, dating customs, and a range of other issues that can directly or indirectly affect sexual health.

The current sexual behavior of French Canadian young adults in Quebec reflects, and in many respects exceeds, the pattern of liberalization seen elsewhere in North America and in other parts of Canada. For example, a review of studies of young adults and adults in Quebec found that among 20- to 24-year-olds, 89 to 93% had intercourse, with a high proportion (over 50%) reporting four or more partners. Among adolescents and young adults who were involved with youth centers that address problems of social adaptation, 70 to 93% had intercourse, of whom 48 to 60% had more than six partners and 5 to 15% had been involved in prostitution (Otis 1996). English Canadian youth and young people from other ethnocultural backgrounds are more similar than different in many aspects of their behavior, although young adults, overall, are not as homogeneous a group as their portrayal in the media might suggest.

Marriage and Family: Structure and Patterns

Profiling Canadian Families, a 1994 report by the Vanier Institute of the Family, used data from the 1991 Canadian census to provide a current profile of Canadian marriage patterns and family structure. A later update, *Profiling Canadian Families II* completed in 2000 provides more recent information. The Institute's broad and unconventional definition of family contrasts with the structural definition applied in statistical analyses. They state:

> Family is defined as any combination of two or more persons who are bound together over time by ties of mutual consent, birth and/or adoption and who, together, assume responsibilities for variant combinations of some of the following: physical maintenance and care of group members; addition of new members through procreation and adoption; socialization of children; social control of members;

production, consumption and distribution of goods and services; and affective nurturance-love. (The Vanier Institute 1994, 10)

While this definition acknowledges the continuing trend toward varied family constellations within Canadian society, it does not easily conform to that used for the purpose of statistical data gathering. Statistics Canada defines family in structural terms as

> a now-married couple (with or without never-married sons and/or daughters of either or both spouses), a couple living common-law (again 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. (Dumas & Peron 1992)

The latter definition applies to the marriage, family, and divorce information that follows.

The proportion of the population living in families, while declining since 1971 when it was 89%, stabilized between 1991 and 1996 at 84%. Because Canadian law does not recognize the "spousal" relationship of gay and lesbian couples, this number probably underestimates the percentage who perceive themselves as part of a family. However, as of 2001, Statistics Canada found 34,200 individuals identifying as same-sex common-law couples. This represents 0.5% of all couples. Among Canadians in families, 45% are married with children, 29% are married without children, 15% are lone-parent families (about one fifth of these are male lone-parent families), 6% are common-law without children, and 6% are common-law with children.

Several trends have been documented in the structure and form of Canadian marriages and families that have a direct impact on sexuality. These include age of first marriage, divorce rates and subsequent remarriage, number and timing of children, and spousal and parental roles. Since 1970, there has been a steady increase in the age of first marriage for both men and women. The average age of first marriage in 1970 for men was 25.1 years and 22.7 years for women. By 1990, this age had risen to 27.9 for men and 26 for women. By 1999, the age of first marriage for men was 29.8 and 27.8 for women (Vanier Institute 2000). For both men and women, this represents an increase of four years in the average age of first marriage since the mid-1970s. This trend toward later first marriage is relatively recent and reverses the earlier trend toward younger age at first marriage observed throughout the first half of the 20th century. It has accompanied the changes in attitudes and practices with respect to premarital sexual activity, the increase in formation of common-law unions, lengthening of time of education, and entry of women into the labor force in increasing numbers.

As already discussed, initiation of sexual activity occurs well before marriage for the majority of Canadians (ten years or more on average). Though there are no reliable studies of sexual activity in the early part of the 20th century, it is generally accepted that premarital sex, to the degree it is practiced today, is a phenomenon of the latter part of that century in Canada. In addition, marriage is no longer the first step for establishing a couple union. Younger Canadian women are more likely to start their conjugal life in the context of a common-law relationship, although many of these will eventually marry. According to Statistics Canada, 42% of women ranging in age from 30 to 39 in 2001 are likely to first enter a common-law relationship, yet close to 80% are estimated to get married later in their conjugal lives. However, this finding is not representative of all of Canada's provinces. Often the exception, in Quebec, first common-law unions are less likely to end in marriage. Among women ranging in age from 30 to 39 who began their conjugal lives in a common-law relationship, only one third of these married their common-law partner, compared with 59% for women in other Canadian provinces. In general, the total number of common-law relationships in Canada has grown significantly in the past 20 years. The proportion of all couples living in common-law relationships doubled in Canada from 6% to 10% between 1981 and 1991. In 1991, 1 in 9 Canadians lived common-law, compared to 1996 when 1 in 7 lived common-law. The shift from 1991 to 1996 represents a further growth of 28%.

In the *Ethnocultural Communities Facing AIDS* study, differences in proportion of respondents currently living common-law were documented for three participating groups. Nine percent of women and 17% of men in the English-speaking Caribbean communities, 8% of women and 5% of men in the Latin American communities, and 2% of men in the South Asian communities were in common-law relationships (Maticka-Tyndale et al. 1995). Of all the provinces, Quebec has the highest percentage of common-law families (24% of all couples were living in a common-law relationship in 1996). This represents a tripling from 8% in 1981 and indicates a general trend among the young in Canada, and particularly in Quebec, to begin their cohabiting relationships prior to marriage, and for some to continue to do so in lieu of marriage. Common-law couples are also prevalent in the Yukon (23%) and Northwest Territories (27%).

A second factor influencing marriage and family structure has been the large-scale entry of women into the labor force. In 1990, for example, 70% of couples with children under 19 had both partners employed compared to 30% in 1970 (Vanier Institute 1994). To examine the broader trend, for children under 15 years of age in two-parent families, the incidence of both parents working rose from 43% to 58% to 60% from 1981 to 1991 to 1996, according to Statistics Canada. This has provided women with greater independence and is considered an important influence on the delay in age at first marriage, age of first childbirth, single-parent (mother only) families, and divorce rate. It has also produced tensions within families, as many individuals and couples find it difficult to meet their own and others' expectations with respect to spousal, parental, broader familial, and occupational responsibilities.

Canadians are having fewer children and delaying the birth of the first child to a later age. Average age at first birth was 23.3 years in 1971, 24.8 years in 1981, and 26.4 years in 1991 (Vanier Institute 1994). As of 1995, the age of first births has remained constant at 26.4 (Vanier Institute 2000). In addition, there is an increase in the number of single-parent families, both as a result of divorce and of single women (and a small number of single men) raising children without partners. About 15% of families in Canada are "lone parent" families, with approximately 80% of these involving female parents (Statistics Canada 1996). Some of the foregoing factors are addressed more comprehensively in Section 9D, Contraception, Abortion, and Population Planning, Population Planning. Here we note only that these factors have an important influence on family structure, sexuality, and couple relationships.

Before 1968, divorce was permitted only if one of the partners had committed adultery. The divorce rate throughout the 1950s and early 1960s was around 200 divorces per 100,000 married women per year. The 1968 Divorce Act expanded the grounds for divorce to include: acts such as adultery or physical or mental cruelty; permanent marriage breakdown (e.g., desertion, imprisonment, or living apart for at least three years). The divorce rate rose steadily through the 1970s to around 1,100 per 100,000 married

women in 1981. A revised Divorce Act in 1985 made marriage breakdown the sole grounds for divorce; conditions included separation for one year or more (accounting for 93% of all divorces in 1986), adultery, physical cruelty, and mental cruelty (see Dumas & Peron 1992). By the time of the 1996 census, over 1.6 million reported being divorced, a 28% increase from 1991.

The number of years of marriage prior to divorce is decreasing and the incidence of divorce per marriage is increasing. Possibly 40% of couples married in the early 1990s will experience divorce. The rising divorce rate has increased the pool of people available for remarriage and, as a consequence, in 1996, one third of all marriages involved at least one previously married spouse. Nevertheless, the remarriage rate seems to be falling. In the 1990s, the rate of remarriage for men dropped from 63.2 per 1,000 population to 45.4, and for women from 22.8 to 19.4 The reason for this drop is likely because of the fact that many divorced people are choosing common-law unions over remarriage (Vanier Institute 2000). Despite the changing patterns described above, the average Canadian married in the 1960s will probably spend about 35 to 40 years of their life married to someone.

Of course, these data and trends can only be examined for those counted as "families" in various government and research documents. What must be remembered is that some Canadians also form what the Vanier Institute's definition would clearly identify as a "family," but their experiences are not represented in these data. These include gay and lesbian couples who form long-term commitments, share responsibilities and care for each other, and who may also raise children. They include the sometimes more communally shared commitments to fulfilling the responsibilities of family life found in some native communities. In the absence of research and documentation, we can only recognize that these alternative relationship and family forms exist, but cannot draw any conclusions about their prevalence or life course.

Together the changes described above portray Canadian marital and family relationships as units with flexible boundaries. Later marriages, common-law unions, divorce, and remarriage speak of the flexibility of boundaries, with an increasing number of individuals moving in and out of marriage or marriage-like relationships. Canadians remain committed to marriage, however, with most spending more than half of their adult lives in marriage or marriage-like relationships.

Children are more likely to experience the influence of several parent-like individuals in their lives and to be aware of and familiar with a variety of relationship types as an increasing number of parents move through several partnerships. Courts, however, remain relatively conservative in their custody and visitation rulings in cases of divorce, at times restricting custody and access to children on the part of a parent who is openly involved with a sexual partner who is not her spouse. This appears to reflect a dominant view of the preferred family form for childrearing as consisting of a heterosexual, married couple. This is evident, in particular, with respect to a parent who is gay or lesbian, with courts most commonly granting custody, whenever possible, to a nongay or lesbian parent and often restricting or placing limits on visitation on the part of the gay or lesbian parent.

Sexual Behavior of Adults

In the absence of a Kinsey-type national survey of sexual behavior, Canadians have historically relied on U.S. statistics to draw inferences about the situation in Canada. Such inferences are less common today as social scientists increasingly document ways in which Canadians differ from their American neighbors in family patterns, laws, attitudes, and health. However, the only available Canadian data typically pertain to selected groups (teens, university students, gay men, etc.) rather than to the adult population as a whole, and come from studies done for a specific purpose (e.g., to assess risk behaviors related to HIV infection, to determine the occurrence and incidence of coercion in sexual relationships, etc.). This makes it difficult to obtain a global sense of the sexual behavior of adult Canadians.

The 1990 *Health Promotion Survey* from Statistics Canada asked a few questions about adult sexual behavior (e.g., number of partners, opinions about various methods of preventing STDs, age at first intercourse, etc.). Among the approximately 6,000 respondents to the question on the age at first intercourse (excluding those who refused to answer or had not had intercourse, approximately 3.3% in each case), the results were: under 15, 4.7%; 15 to 16, 16.3%; 17 to 19, 38.2%; 20 to 24, 32.9%; 25 to 29, 6.0%; over 29, 2.0%. These results were for the entire sample of adults of all ages. As previously mentioned, the National Population Health Survey in 1996-1997 revealed over 70% of youth then age 20 to 24 having experienced first intercourse before the age of 20 (Maticka-Tyndale, McKay, & Barrett 2001). On a much smaller scale, a 2002 poll conducted for *Maclean's*, Global TV, and *Southam News* consulted 1,400 Canadian adults by phone. Fifty-seven percent of these respondents reported first intercourse at under 19 years of age, while 15% were under 15 years of age.

Three recent surveys conducted by Health Canada provide some information on selected aspects of adult sexual behavior in Canada. These are the National Population Health Survey (NPHS), conducted in December 1994 and January 1995, and the Canada Health Monitors (CHM) surveys (1994 and 1995). Given the range of issues addressed in such surveys, the focus of sexuality-related questions that are included is often on selected behaviors associated with health risks, rather than on the broader psychosocial aspects of sexuality and relationships. For example, the CHM (1994) survey found that among 15- to 19-year-olds who had experienced intercourse in that year, 44% of males and 33% of females had more than one sexual partners. Comparable figures for 20- to 24-year-olds were 41% for males and 19% for females; for 25- to 29-year-olds, 20% for males and 8% for females; and for those 30 and over, 14% for males and 4% for females. These findings approximate those from the NPHS 1995 study which had a total sample size of approximately 7,200 (in comparison to CHM 1994 which had about 2,200). CHM 1994 also found that among 15- to 19-year-old males, 41% said they used a condom always or most of the time with a regular partner, whereas 85% did so with a non-regular partner. This type of survey information is of some interest for STD or HIV/AIDS prevention, but it does not provide the kind of insight into the social context and intra/interpersonal dynamics of behavior that would be afforded by a national study focused broadly on sexuality and sexual health (e.g., comparable to the study in the United States by Laumann et al. 1994).

The previously cited Decima Research poll (*Maclean's*/CTV Poll 1994) and a comparable national telephone survey in 1995 (*Maclean's*/CTV Poll 1995) provide information on selected aspects of adult sexual activity in Canada (see Table 5). While the decline in frequency of sexual activity with age (i.e., from the mid-50s onward) is expected, it is difficult to analyze this finding in more depth because the results are uncorrected for marital status and access to partners, and also because it is unclear how respondents interpreted the term "have sex." Similarly, the fact that about one in ten said they had had an affair while married is of interest, but we do not know how men and women of different

ages understood the term “affair” or how they might have responded to the question, “Have you ever had sex with someone other than your partner while married?” The fact that we have such limited national data on adult sexual behavior is an impediment to informed public discourse, policy development, and provision of sexual health education and related services.

Studies of adult sexual behavior and attitudes in Quebec reveal a significant shift away from the traditional sexual script that linked sex, marriage, and reproduction, to one that places greater emphasis on communication and pleasure. There are few Canadian studies that address the frequency of different sexual behaviors of married and cohabiting adults, let alone the more complex variables of pleasure, desire, and sexual satisfaction. The work of Samson et al. (1991, 1993) is therefore of particular interest in this respect. Their research addressed these questions in a study of married and cohabiting, heterosexual, French-speaking Montreal adult residents ($N = 212$, mean age 36.9) surveyed in the late 1980s. Based on the respondents' estimates of their annual number of intercourse experiences, they found weekly intercourse frequency rates varied with age as follows: 3.1 times per week (18- to 24-year-olds), 2 times/week (25 to 34), 1.8 times/week (35 to 44), 1.6 times/week (45 to 54), 0.8 times/week (55 to 64), and 0.9 times/week (65 or older). Overall, male and female subjects (respondents were not each others' partners) did not differ significantly in reported average frequency. Duration of relationship influenced intercourse frequency, with those in “new dyads” (less than two years) averaging four times per week, in “young dyads” (two to ten years) averaging 2.3 times per week, and those in “older dyads” (over ten years) averaging 1.4 times per week. This difference held even when age was factored out (Samson et al. 1991).

Composite sexual satisfaction scores were calculated from questions on frequency, desire, pleasure, and overall assessment of the respondent's sexual life. These scores did not correlate with either age or duration of relationship, but those with the higher satisfaction scores reported significantly more frequent intercourse. Respondents also rated their general satisfaction with their regular partner. Overall, 50% of the respondents said they were “fully satisfied” with their regular sexual partner. This was the upper response on a scale that proceeded from “fully satisfied” to “not at all satisfied” and suggests a high level of satisfaction in this sample. The fact that general satisfaction did not correlate with age or duration of relationship, but did correlate with intercourse frequency, suggests some link between intercourse frequency and relationship satisfaction, although response bias may confound the findings (e.g., satisfied subjects may overestimate intercourse frequency).

Respondents were also asked about occurrences of active oral-genital sex in the preceding year, where “active” is defined as “stimulated with the mouth the genitals of their regular sexual partner” (Samson et al. 1993). Overall, 80% had engaged in active oral-genital sex (no difference between the sexes), but the percentages were higher for younger groups (e.g., 90% for those 18 to 34, 81% for those 35 to 54, and 38% for those over 55). Those with higher than average education (13 years or more) were more likely to engage in the behavior than those with less (88% vs. 74%). The average weekly frequency rates according to age grouping were: 1.6 times per week (18 to 34), 0.8 times per week (35 to 54) and 0.4 times per week (55 plus). There was no sex difference in average reported frequency, but, as with intercourse, oral-genital sex was more frequent in new and young dyads versus older dyads. Frequency was also greater in couples with no children and in those who had one child compared to those with two or more children. These differences remained when age and length of relationship were factored out. As with intercourse frequency, oral-genital sex frequency also correlated with both sexual satisfaction and general partner satisfaction, perhaps because these behaviors are correlated with each other and are an increasingly common part of the sexual script of many adults (Samson et al. 1993). The authors also noted that for those who engaged in oral-genital sex, neither “religiosity” nor church attendance affected annual frequency (although “religious” people were less likely to include oral sex in their sexual repertoire).

During the 1960s, a number of factors began to influence sexual values in Canada, including the introduction of the contraceptive pill, the increasing media coverage of sexuality, and the opening up of public discourse about sexuality that began in the 1960s and continued into the 1970s and 1980s. The concurrent impacts of the feminist movement, the gay rights movement, changes in legislation, and the increased freedom in the media to portray and “commercialize” sexuality, produced conflict with, and gradual change of, many traditional attitudes and behaviors. These changes have occurred across Canada, but francophone Quebec appears to have changed more, and more rapidly in some respects (see Lévy & Sansfaçon 1994). The development of sexology as an academic discipline in Quebec in the early 1970s may have had a modest or—as Gemme (1990) suggests—a major influence on these changes. What can be said with certainty is that since Canada's only university department of sexology was founded at the University of Quebec at Montreal in 1969, sexologists in Quebec have had an opportunity to document these changes in a segment of the population, francophone Québécois, in a way that has not occurred to the same extent for Canada as a whole. As is true elsewhere in Canada, the research emphasis in the 1980s and 1990s has been on youth, primarily university students, preuniversity CEGEP students, and, more recently, younger high school students.

The most recent data on sexual behavior of Canadian adults comes from a 1995 mailed survey of 1,713 respondents (return rate about 60%) who were proportionally representative of the overall population in terms of community size, gender, marital status, edu-

Table 5

Selected Data on Sexual Activity of Canadian Adults

	Percentage Responding in Each Category						
	Two or More Partners in Past Year[1]		Ever Had an Affair While Married[2]	Frequency of “Having Sex” per Month			
	Male	Female		None	1-5	6-10	11+
Male (total)	—	—	13.9	—	—	—	—
Female (total)	—	—	7.3	—	—	—	—
18-24	32	18	7.3	15	38	17	30
25-34	30	5	7.5	6	25	34	35
35-44	4	4	10.1	9	30	33	28
45-54	18	1	17.4	16	41	31	13
55-64	5	0	13.2	23	52	17	8
65+	5	2	6.5	54	42	2	2

[1] *Maclean's*/CTV Poll (1994). $N = 1{,}610$ respondents across Canada contacted by telephone.

[2] *Maclean's*/CTV Poll (1995). $N = 1{,}200$ respondents across Canada. Those never married (10% women, 19% men) and not responding to this question (8% women, 3% men) are not included in the average.

cation, ethnic origins, and age. The latter included 35% aged 18 to 34, 38% aged 35 to 54, and 27% aged 55 or over (Bibby 1995). Responses to the question, "How often do you engage in sex?" yielded the following national percentages: daily (3%); several times a week (25%); once a week (25%); two-to-three times a month (14%); once a month (9%); hardly ever (13%); never (11%). Bibby noted some provincial variations (e.g., 35% of Quebec respondents said several times a week or more vs. 24% in Ontario), but gave no explanation for the differences.

Not surprisingly, people under 40 reported higher frequencies. Once a week or more was reported by 58 to 78% of men and women aged 18 to 49 (never was 2 to 7%). Although this rate was lower for 60- to 69-year-olds (men 30% with 5% never; women 25% with 41% never) and for those over 70 (22% for men with 25% never; 7% for women with 58% never), Bibby points out that about 1 in 5 men and 1 in 15 women over 70 reported this upper end of his scale of frequency of sexual activity. Bibby also found little difference in the weekly frequency of sexual activity of various religious groups, although married Roman Catholics (64%) were slightly more likely to report weekly or greater sexual activity than the conservative or mainline Protestant denominations (50 to 55%). Those with no religious affiliation reported 77%, a finding that Bibby explains as related to the younger age of this group rather than to religious affiliation. Other data on adult sexual behavior are discussed below in the context of condom use and safer sex practices (Section 10, Sexually Transmitted Diseases and HIV/AIDS).

Ethnocultural Variations in Sexual Behaviors of Single Heterosexually Experienced Adults

Because the focus of the survey phase of the *Ethnocultural Communities Facing AIDS* study was on heterosexual transmission of HIV/AIDS, only certain questions were asked about sexual activity. In this study, 377 men and women from the English-speaking Caribbean communities in Toronto, 364 men from the South Asian communities in Vancouver (the survey team was advised that it was inappropriate to survey South Asian women about sexual matters), and 352 men and women from the Latin American communities in Montreal were surveyed. Participants were located through community organizations and in locations where members of each community were known to congregate. To insure a broad representation from each community, the samples were stratified by age (respondents ranged from 16 to 50 years), time since immigration to Canada, and also by gender in the Latin American and English-speaking Caribbean communities. Great care was taken in developing appropriate wording of the survey items and in translation of those items to the dominant ethnic language in the Latin American (Spanish) and South Asian (Punjabi) surveys. Table 6 summarizes responses of single adults to questions on current sexual partnerships and sexual activity during the past year. (*Note*: Given the limitations of such a study, including wide age range and small sample size in particular subgroups, the results should be interpreted with caution. However, these are the only data of their kind available for specific ethnic communities, and given Canada's changing pattern of immigration and increasing ethnocultural diversity [see Section C in the introductory demographics and historical perspective section], they merit attention in this chapter.)

Different patterns of relationship formation are evident in each of the communities as well as for men and women (Table 6). Overall, men reported a larger number of sexual partners and a higher proportion entered sexual relationships with new partners in the previous year. However, the variations between men and women across the different groups were as great as those between men and women in any one group. These results, and others from this study, support the observation that has already been made that diverse patterns of sexuality are represented in Canada's population.

Sexuality and Disability

While Canadians are aware of the social rights of people with disabilities, the issues surrounding sexuality and disability do not appear to have had a great impact on public consciousness. The concern about sexual abuse of people with disabilities may be an exception to this generalization. However, healthcare professionals and people with disabilities have raised the profile of sexual health issues (privacy, autonomy, rights to information, services, etc.) in the last 20 years, and there is a growing literature on the sexual implications of various disabling conditions and chronic illnesses.

The first major conference on sexuality and physical disability in Canada took place in Toronto in 1974. Cosponsored by the Canadian Rehabilitation Council for the Disabled and the Sex Information and Education Council of Canada (SIECCAN) and intended as a local event, it drew 150 participants from across Canada, an indication of the limited attention the topic had received prior to that time. Subsequent changes in attitudes and awareness have led to increased education on sexuality and disability among re-

Table 6

Sexual Behavior of Single[1] Heterosexually Experienced Respondents in the *Ethnocultural Communities Facing AIDS* Study: English-Speaking Caribbean, South Asian, and Latin American Communities

	Percentage Responding in Each Category				
	English-Speaking Caribbean		South Asian	Latin American	
	Women (*N* = 190)	Men (*N* = 187)	Men (*N* = 364)	Women (*N* = 176)	Men (*N* = 176)
Total number single respondents (*N*)	119	106	123	91	95
Number sexual partners in past year					
None	6	9	5	8	17
1	46	34	17	74	38
2-5	39	46	49	11	35
6 or more	9	10	29	8	11
Number with any sexual partners in past year	*N* = 103	*N* = 91	*N* = 117	*N* = 84	*N* = 82
New sexual partner in past year	54	70	75	28	51
In a long-term relationship	69	65	41	65	59
Number in long-term relationship	*N* = 71	*N* = 62	*N* = 47	*N* = 50	*N* = 45
Monogamous	79	60	65	94	84
Partner monogamous	36	54	52	68	93

N values in brackets = total respondents in survey sample.
Data adapted from Adrien et al. (1996).
[1]Includes never married and previously married (separated, divorced, widowed).

habilitation and healthcare professionals, either in their original training or through in-service workshops and seminars. For example, SIECCAN representatives have conducted over a hundred of the latter events in the last 20 years, and other organizations, such as the former Alberta Institute for Human Sexuality in the 1970s and 1980s, have also raised professional consciousness in this field.

In British Columbia, the Sexual Medicine Unit at the University Hospital, Shaughnessy Site, pioneered the development of assessment and treatment strategies for sex-related consequences of physical disabilities and chronic illness, including training of sexual healthcare clinicians in this specialty area (Miller et al. 1989), and research on sexuality and spinal cord injury (Szasz 1989), sperm retrieval for fertility enhancement (Rines 1992), sexual implications of multiple sclerosis in both sexes, and a variety of other such areas. Across Canada, a number of associations for people with disabilities or chronic illnesses now provide resource materials on the sex-related aspects of specific conditions, and some, such as the Multiple Sclerosis Society of Canada, have been particularly active in public education and professional training about sexuality and multiple sclerosis (Barrett 1991). Recent issues of the *Canadian Journal of Human Sexuality on Sexuality and Disability* (1992) and *Sexuality and Cancer Treatment* (1994) also reached a national audience of professionals.

The Disabled Women's Network has produced a number of publications addressing sexuality and disability issues, including a guide for healthcare professionals (DAWN 1993a) and a resource book on healthcare for women with disabilities (DAWN 1993b). Although there are no national professional or consumer groups that focus specifically on sexuality and physical disability, a variety of advocacy groups address this issue—e.g., the British Columbia Coalition for the Disabled has an AIDS and Disability program and the Coalition of Provincial Organizations of the Handicapped has also written on sexual rights of disabled persons (COPOH 1988). In 1992, Linda Crabtree began publishing *It's Okay*, which grew into a 32-page, consumer-written quarterly on sexuality, sex, self-esteem, and disability distributed across Canada and internationally (Crabtree 1994). Currently edited and published by Susan Wheeler (1996), *It's Okay* is the first and only publication of its kind in Canada that provides a forum for personalized discussion of sexual health and relationship issues for people with a variety of disabling conditions.

Sexual issues that affect people with developmental disabilities (sex education, privacy, contraception, marriage, sterilization, etc.) have been an ongoing focus of attention and policy development since the early 1970s. At the provincial level, most schools, Associations for Community Living, and residences for developmentally disabled children and adults have acknowledged the right to sexuality education and counseling, and have developed curricula and other services to meet those needs. In Ontario, a network of groups concerned with sexuality education, counseling, and related services has formed an umbrella organization, the Ontario Sexuality and Developmental Disability Network (OSDDN), to facilitate communication, professional development, resource sharing, and advocacy within the field. There is still too little training in sexuality for professionals who work with developmentally disabled clients, although in-service workshops in this area are increasingly common. These have resulted, to a great degree, in response to recognition of the frequency of occurrences of sexual abuse of people with disabilities (Roeher Institute 1992; Sobsey 1994; Sobsey et al. 1994). The Federal government's Family Violence Prevention Division has funded national and local programs to prevent abuse of people with disabilities, and the National Clearinghouse on Family Violence assembles and distributes resource materials on this topic, including those on sexual abuse. The National Health Research and Development Program (NHRDP) of Health Canada has also funded national research on sexual abuse of people with disabilities (e.g., Mansell & Wells 1991).

Sexuality education for disabled teens and adults increasingly recognizes the positive as well as the problem-prevention aspects of sexuality, and Canadian resources reflect this trend (Ludwig 1991; Maksym 1990). The previously mentioned 17-booklet series, *Being Sexual: An Illustrated Series on Sexuality and Relationships*, published by SIECCAN in 1993, is the only resource of its kind in the world to include Blissymbol translation of key messages along with the English text. It is designed specifically for use with people who have problems with language learning and communication and includes a user's guide and explanation of all Blissymbols used in the text of each book (SIECCAN 1993).

It is generally accepted that people with developmental disabilities have the right to contraception and to other services available to any individual in society, although this theoretical right implies that support will be available to access such services, and this is not always the case. The Canadian Supreme Court in the "Eve" decision effectively prohibits sterilization of people with developmental disabilities unless they are able to give informed consent. Although it is now more common for people with developmental disabilities to marry, the right to marry is confounded by at least three different types of legislation (Endicott 1992). In some settings, e.g., Ontario and the Northwest Territories, it is against the law for any person to issue a marriage license to or to perform a service of marriage for someone who the person might reasonably know is mentally handicapped. This statute has been changed in Ontario to omit reference to mental handicap and to place the restriction on people who "lack the capacity to marry," but as Endicott (1992) points out, this provision may discourage marriage even if it does not violate the Canadian Charter of Rights and Freedoms. In other provinces, e.g., Alberta, Manitoba, and Quebec, a person who has been declared incapable in other areas, such as handling finances, is considered incapable of marrying, unless he or she provides certification from a doctor or other "official" source that he or she understands the responsibilities involved in marriage. British Columbia and Prince Edward Island prohibit marriage for people with developmental disabilities, whereas Saskatchewan, New Brunswick, Nova Scotia, Newfoundland, and Yukon have no law blocking marriage (i.e., people should have the "capacity" to marry, but there are no statutes to enforce the rule about capacity) (Endicott 1992).

Incidence of Anal and Oral Sex

Since the 1969 change to the Criminal Code, sexual activity in private between consenting adults has generally not been a criminal concern in Canada. Previously taboo behaviors such as oral and anal sex have become increasingly common in the heterosexual population, but even with the recent research interest generated by concerns about HIV/AIDS, there have been few population studies on the incidence of these behaviors. A late-1980s study in Montreal, Quebec, reported that 75% had engaged in oral sex and 15% in anal sex in a sample of heterosexual university students (mean age 22 years); 64% of both sexes reported engaging in unprotected (without condom use) oral sex and about 6 to 7% in unprotected anal sex (Samson et al. 1990). Previous parts of this section provide other limited data on these behaviors in adults.

In the *Ethnocultural Communities Facing AIDS* study (see Table 6 and prior references), participants who had initi-

ated new sexual partnerships in the past year were asked about anal intercourse in these relationships. In the English-speaking Caribbean communities, 20% of women and 21% of men reported anal intercourse, as did 17% of women and 41% of men in the Latin American communities, and 41% of men in the South Asian communities (Maticka-Tyndale et al. 1996). Qualitative, in-depth interview methodologies have demonstrated different meanings attached to anal intercourse. For some, for example, this is an alternative to vaginal intercourse when it is necessary to maintain virginity. Both incidence and meaning would have to be taken into consideration in creating a profile of sexuality; however, there is no research available that fully explores these issues.

Although sexual activity in private between consenting adults is not generally a concern of the Criminal Code, anal intercourse is listed as an offense punishable on summary conviction. It is not "illegal" when engaged in, "in private, by a husband and wife, or by any two persons, each of whom is 18 years of age or more, both of whom consent to the act." In law, a person under 18 cannot consent to anal intercourse; age of consent for most other sexual activities is generally 14, although a number of restrictions apply to 14- to 17-year-olds, some of which will be discussed elsewhere (for review, see MacDonald 1994). An act is considered not to have been done in private if a third person participates or is present (e.g., group sex or if someone is watching or able to observe because of the setting). This provision of the Criminal Code has been used to prosecute gay men, but it sends an indirect signal to heterosexuals about the taboo nature of anal sex, at least in the "official" sense that any law implies disapproval. This taboo may well be an impediment to safer sex practices or to disclosure of STD infections acquired in this way.

6. Homoerotic, Homosexual, and Bisexual Behaviors

A. General Observations

There has been little historical analysis of same-gender sexual activity in Canada, and the record that exists in court documents, press reports, and other archival material is sometimes confounded by the various coded ways in which same-sex activity and relationships were described. In his history of the regulation of gay and lesbian sexuality in Canada, Kinsman (1987) notes that native societies had a variety of names and meanings for same-sex relations, that English and French colonists in the 19th century used labels such as "crime against nature," "secret sin," "sex perversion," "sexual immorality," "social evil," "sodomy," and "buggery" (the latter was proscribed in Canadian law until 1969), and that "homosexuality" and "lesbianism" appeared only with the emergence of the medical and social sciences in the early 1900s and "gay" only recently. He offers evidence of cross-dressing by white women in 19th-century Canada (this activity provided access to economic and social privilege and perhaps to erotic relationships with women) and of the emergence of male homosexual networks in the 1880s, which created a public consciousness and identity for this disapproved, and now publicly labeled, category of men called homosexuals. He recounts the recent emergence of gay and lesbian networks in the 1950s and 1960s and the legislative and political changes that led, in 1969, to the decriminalizing of homosexual acts between consenting adults over the age of 21. The subsequent legislative changes of the 1980s and 1990s reflect the emerging legal protection of the rights of gays and lesbians concurrent with a gradual shift in public acceptance of gay relationships.

As of June 20, 1996, section 3(1) of the Canadian Human Rights Act was amended to prohibit discrimination based on sexual orientation. While the human rights codes in a number of provincial and territorial governments also reflect a commitment to protect the rights of gays and lesbians, this has not come without a certain degree of controversy. The case of Vriend v. Alberta (1996) is particularly noteworthy, wherein the Supreme Court of Canada reversed a 1994 ruling protecting the omission of sexual orientation from Alberta's Individual Rights Protection Act. With the reversal, the Supreme Court proclaimed that the Legislature's omission was tantamount to approving ongoing discrimination of homosexuals and was in violation of section 15 of the Canadian Charter of Rights and Freedoms. This set a precedent for all other provinces and territories whose human rights codes do not explicitly protect the rights of gays and lesbians.

Federal practice has already been altered in the military after a 1992 decision in which a woman, released from the Canadian military because of her lesbian relationship, successfully challenged the ruling. The decision noted "that the military's policy prohibiting homosexuals is not valid, because it violates the constitutional guarantee of equality and freedom of association" (Bell 1991). In October 1999, the government officially ended its policy of barring homosexuals from joining the Canadian armed forces. This followed a decision to admit women to all branches of the armed forces, except submarines and combat roles.

However, a wide range of rights now extended to married and common-law heterosexual couples are not available to gay couples, and legislative change in these areas has, therefore, been one of the focuses of gay rights activity in Canada. The presence of publicly gay members in the federal Parliament, and of an increasing number of provincial and municipal gay politicians, is a reflection of changing public attitudes in this area. Nevertheless, Kinsman's (1987) identification of homosexuality as one of the "battlefields of sex" in Canada is probably still correct—the others are prostitution, abortion, women's reproductive rights, sexuality of youth, pornography, and sexual violence against women and children. Nevertheless, a number of recent court rulings have shown movement in this area.

In May 1999, the Supreme Court of Canada handed down one of the most far-reaching homosexual rights rulings anywhere, when it declared in an 8-to-1 decision that Ontario's Family Law Act was unconstitutional in denying homosexuals the right to apply for alimony from each other. In ruling that the legal benefits available to "spouses" cannot be limited to heterosexual couples to the exclusion of same-sex partners, this decision opened a challenge to a wide range of federal and provincial laws, including those governing adoption, marriage, pensions and taxes, that include reference to "spouse."

In February 2000, the Canadian government announced an overhaul of 68 federal statutes to erase most legal differences between heterosexual and homosexual couples. When the overhaul is completed, homosexual couples will enjoy the same benefits and responsibilities as heterosexual couples, whether married or cohabiting. The only remaining differences appear to be that marriage takes effect immediately and brings the ability to get divorced and change family names, while a cohabiting or same-sex couple have to wait one year for legal recognition. Government estimates suggest there are about 140,000 homosexual households in Canada, although it is not known how many of these are actually homosexual relationships and how many are simply two persons of the same sex living together for family or convenience reasons.

In addition to securing benefits for same-sex couples, other legal work has concerned itself with the definition of marriage. Appearing as a rider to the Same-Sex Recogni-

tion Bill in 2000, marriage has been defined as a union between "one man and one woman." Given such an understanding, debate continues in Canada over marriage and legal recognition of same-sex unions, revealing a country divided, with contradictory opinions and rulings among provinces, and between the courts and Parliament. In a 2002 Discussion Paper presented by the Department of Justice, the Government of Canada has suggested that Parliament is the appropriate venue for sorting out such questions. However, the courts have made rulings that have presented a direct Parliamentary challenge. Amidst this turmoil, what can be said with great certainty is that the amount of movement in this area in recent years has been without precedent.

In the fall of 2001, the British Columbia Supreme Court upheld the opposite-sex requirement of marriage, arguing that while it results in inequality for gay and lesbian couples, it was not based on a discriminatory set of beliefs. Furthermore, they argued that the inequality was justified, as the Charter does not require that marriage be made into something that it is not by definition. Nor did they feel that the federal Parliament has the constitutional authority to alter the opposite-sex meaning of marriage.

In Ontario, the Divisional Court in 1993 also upheld the opposite-sex requirement of marriage. However, in July 2002 a different panel of the Ontario Divisional Court found this requirement to be in breach of the guarantee of constitutional equality for gays and lesbians, ruling 3 to 0 that Canada's Charter of Rights and Freedoms requires the provincial government to recognize the right of gays and lesbians to marry people of their own gender. Activists hailed the ruling as a major legal victory with national consequences. The suit was brought by a lesbian couple and a gay male couple after the Ontario government refused to register their January 2001 joint wedding ceremonies performed at a Toronto church. Parliament was given two years to address this issue and, if they fail to do so, the common law in Ontario will be automatically changed to allow unions of "two persons." In September of 2002, the Quebec Superior Court made a similar finding as that of the Ontario Divisional Court. Currently the case in Ontario and the aforementioned case in British Columbia have been merged into one and are awaiting a Supreme Court decision that will have far-reaching consequences.

In examining the position of Parliament in this domain, one finds contradiction. In 1999, Parliament voted to take all reasonable steps to maintain the opposite-sex meaning of marriage. Further, in 2000, section 1.1 was added to the Modernization of Benefits and Obligations Act, which clarified the continued understanding of marriage as the "lawful union of one man and one woman." Finally, in 2001, the opposite-sex meaning of marriage was also confirmed in Quebec in section 5 of the Federal Law-Civil Law Harmonization Act, No.1. The decisions of the Ontario Divisional Court and the Quebec Superior Court are inconsistent with the Parliamentary stance, and some have expressed concern that the courts may be "over-stepping" their constitutional role and engaging in "judicial activism."

On a provincial level, four provinces have enacted or are considering laws relating to same-sex unions. In June 2002, the Quebec legislature unanimously granted same-sex couples the right to form "civil unions," which entitle gay couples to virtually the same rights and obligations as heterosexual married couples have. Nova Scotia and Manitoba have enacted similar legislation allowing gay and lesbian couples to record their relationships in a civil registry. Alberta, in its Marriage Act set out that marriage requires partners to be of the opposite sex for the purposes of solemnization, yet, in a bill before the legislature, raised the possibility of legal recognition of same-sex couples. With the exception of Alberta's Marriage Act, many lesbian and gay activists consider these provincial decisions to be highly positive.

Because the ten Canadian provinces have the power to register marriage ceremonies while the federal government regulates marriage qualifications, experts expect considerable legal wrangling before the issue is finally resolved by the Supreme Court (Krauss 2002). As for the role of Parliament, they are currently gathering national opinion about the issue in preparation for future action. [*Editor's Note*: See "Canada" in Last-Minute Updates chapter at end of volume.]

Metropolitan Community Church and other churches in Canada covenant gay relationships in a public ceremony, but this is not legally recognized as a marriage. While no law expressly prohibits marriage, a 1974 court decision on this matter ruled that the definition of marriage meant an opposite-sex couple. Since common-law couples in Canada now receive most of the employee benefits that accrue to married couples, many municipalities and some corporations are extending these benefits to gay couples (i.e., domestic partnerships based on the same conditions of relationship that apply for common-law couples). Since the gay and lesbian population in Canada includes people with a variety of relationship and lifestyle choices, there is no universal agreement in the gay community about whether couples in general should have privileges that others do not, or whether gay couples want to be governed by statutes designed primarily for heterosexual couples with children. Nevertheless, altering existing legislation and policies that discriminate against gay couples has been used as one way of achieving social equity. As with other areas of contention about sexuality and public policy, these issues are often decided in the courts rather than the legislature.

B. Gay and Lesbian Adolescents

While men have generally self-identified as gay at an earlier age than women, it appears that young people of both sexes are now self-identifying as gay, lesbian, or bisexual at an earlier age. This may be explained by the increasing acceptance of gay people, the visible presence of a supportive gay community, and greater awareness of sexuality. However, many gay youth have strongly negative experiences in high school, either because of overt discrimination if they are open about their orientation or because fears of mistreatment keep them from disclosing. Gay bashing still occurs, and this fear, coupled with uncertainty and self-recrimination about their sexual feelings and the difficulty of finding people to confide in, can make this an intensely negative period in the lives of gay youth. Because they are often stigmatized and isolated, it is likely that gay youths have a higher risk of suicide than do teens on average. Counseling and support services for gay youths are now available in some cities, and a number of programs, such as the Sexual Orientation and Youth Project of Central Toronto Youth Services, have helped to sensitize and train teachers and health professionals about these issues. Overall, gay youths in Canada still face major challenges in their personal development, particularly if they live in smaller cities and rural areas. From its inception, an Ontario telephone hotline for gay, lesbian, and bisexual youths in Ontario (1994) was overwhelmed with calls for advice and information, and the provincial government, therefore, offered additional funding to meet the demand.

The process of self-identification and coming out has been discussed extensively in Canada, but there is little quantitative research done to document these experiences for gay and lesbian youth. In interviews with 60 gay and lesbian youth (average age 19), Schneider (1991) identified

the factors frequently named as contributing to their labeling themselves gay or lesbian—most chose more than one factor. Emergence of same-sex attraction and feelings was mentioned most often by both sexes, but males were more likely to identify this as "general same sex attraction" (7% of females vs. 73% of males), whereas females associated their sexual feeling with falling in love with someone of the same sex (83% of females vs. 10% of males). Same-sex sexual experience was identified by 33% of females and 37% of males as a validation of their ability to experience pleasure with the same sex and of the sense that "it seemed right for them." Males were more likely than females to identify "casual and anonymous sex over an extended period of time" as a factor in their self-identification as gay (0% of females vs. 40% of males). Although a number of young men who listed this option said they often felt guilty about such encounters and vowed to stop them, they also noted that the experiences contributed to their recognition that their attraction was toward men.

Lack of interest in the opposite sex (10% of females vs. 33% of males) was a relevant factor in that most had dated heterosexually and were aware of their disinterest, but it was less influential as a salient clue in self-identification because many assumed early on that they would eventually be attracted to opposite-sex partners. More than half identified "contact with lesbians/gays" (67% of females vs. 50% of males) as an important influence, suggesting that positive role models reinforce self-acceptance. This seems likely since such contact was also the most common contributor to their feeling positive about their lesbian/gay identity (93% of females vs. 80% of males). First long-term relationships contributed to self-identification for 73% of females and 37% of males (Schneider 1991).

These findings are consistent with the self-identification and coming-out processes encountered in other countries with restrictive religious and social traditions surrounding homosexuality. The effect of these negative social attitudes and experiences is reflected in the high levels of thoughts of suicide or suicide attempts, periods of extreme anxiety and depression, social withdrawal, and loneliness—all of which occur in teens, but were often associated by this group with their struggles surrounding sexual orientation and acceptance by others (Schneider 1991).

Canadian schools have been slow to introduce adequate discussion of gay and lesbian sexuality into school curricula, and those that attempt to do so often encounter strong opposition from organized groups from the religious right—the larger mainstream denominations may be less restrictive and some even supportive. The only high school curriculum resource guide in Canada on homosexuality and homophobia was developed by the Toronto Board of Education in the late 1980s amidst extensive public debate. The Board approved the curriculum guide in 1992. The Toronto Board of Education's Student Support Services program also administers a Human Sexuality program in which an educator/counselor visits local high schools to talk directly about homophobia and to let gay/lesbian/bisexual students know, without singling them out, that the board has a counseling and support group designed to address their needs. At the time of writing, this was the only program of its kind in Canada and one of two such programs in North America.

C. Service Agencies

There is an extensive network of lesbian/gay/bisexual organizations, service agencies, and interest groups in most large Canadian cities, and national organizations such as EGALE (Equality for Gays and Lesbians Everywhere), and provincial ones, such as the Coalition for Lesbian and Gay Rights in Ontario, provide a centralized focus on particular issues.

Most of the large Protestant church denominations in Canada accept ordination of gay and lesbian clergy. Unitarian-Universalist churches were the first to ordain gay and lesbian clergy who are in sexual relationships and to have an official policy of welcoming gay and lesbian members and affirming their relationships. Of the large Protestant denominations in Canada, only the United Church of Canada, after prolonged and divisive debate, has extended acceptance into the clergy to those who are in sexual relationships. All others require, at least in terms of "official" policy, that gay and lesbian clergy be celibate. This applies also in the Roman Catholic Church, in which celibacy is required of priests (only men are permitted to be priests) regardless of sexual orientation. Most large denominations also have identified groups for gay and lesbian members (Dignity—Roman Catholic and Integrity—United Church) and some, such as the United Church of Canada, are seeking ways to find congregations prepared to accept qualified openly lesbian/gay ministers.

Canada has many gay and lesbian organizations at the provincial and local levels. Some address social justice and legislative and policy issues, others emphasize community service and education. The various AIDS Committees across Canada have drawn heavily on the gay community for expertise in all areas of their mandate and also for volunteer work and peer support. In addition, local groups, such as PFLAG (Parents and Friends of Lesbians and Gays) in Ontario, also provide information and mutual support for families of gay and lesbian youth or adults.

D. Behavioral Patterns

There have been few large-scale studies of gay male sexual behavior in Canada and none of lesbian sexual behavior. *Men's Survey 90* surveyed the sexual practices of 1,295 men (mean age 34, 73.7% with partial or complete college education) recruited from 12 bars and three bathhouses in Toronto in 1990 (Myers et al. 1991). This is the largest number of gay and bisexual men ever surveyed in Canada, but the results may not apply to smaller cities or rural areas elsewhere in the country. The study was designed to investigate AIDS knowledge, attitudes, and behavior. The AIDS-related findings will be reported in Section 10B, Sexually Transmitted Diseases and HIV/AIDS, HIV/AIDS.

About 48% said they had had sex only with men in their lifetime, 35.3% had previously had sex with women but had only done so with men in the past year, and 13% were bisexual. The reported number of partners in the past year ranged from none (6%), one (16.8%), two to nine (37.8%), 10 to 14 (12.4%), 15 to 24 (9%), to 25-plus (18.1%). Among those who reported a current relationship with a man (35.8%), 33.9% said it was monogamous, 55.7% that it was not or presumed not to be monogamous, and 10% were uncertain; 5.4% had a regular female sex partner.

When asked about sexual activity in the past three months, 11% said none, 28.4% said no anal sexual activity, 39.9% said protected (i.e., with condom) anal sex, and 20.7% unprotected (no condom used) anal sex. In the latter group, the measure was based on even one act of unprotected anal sex and the percentage was higher for a monogamous partnership (31.4%) versus 14.1% for unpartnered men. Other sexual practices reported in the previous three months included mutual masturbation (81.7%), insertive oral-genital sex (76.2%), deep tongue kissing (75.9%), receptive oral-genital sex without seminal contact (74.1%), receptive and insertive oral-anal sex (33.9% and 27.9%), and receptive oral-genital sex with ejaculation (27%). Unprotected anal

sex in the last three months was more common in men under 35, in those with high school or less versus college education (26.7% to 30.7% vs. 17.5% to 18.6%), and in men who were previously heterosexual or previously bisexual in their behavior.

Lévy et al. (1994a) have also studied sexual behavior and safer sex practices in a sample of gay men in Montreal, Quebec; see Section 10B, Sexually Transmitted Diseases and HIV/AIDS, HIV/AIDS, Table 17.

7. Gender Diversity and Transgender Issues

Although Canadians have become less rigid in their gender-role expectations for both sexes in recent decades, their reaction to cross-dressing and cross-gender behavior is often a mixture of discomfort and fascination. The popular media have given considerable coverage to issues of transsexualism, transvestism, gender-reassignment surgery, and cross-dressing, although to date, no studies have formally measured Canadian's awareness of these matters, nor does knowledge always equate with tolerance. In addition to prejudice, individuals seeking gender reassignment may face additional problems financing such surgery as well. For example, as of October 1, 1998 the Government of Ontario delisted coverage for sex-reassignment surgery as a benefit of the Ontario Health Insurance Plan. Other Canadian provinces that cover the costs of surgery include Manitoba, Saskatchewan, Alberta, and Newfoundland. Furthermore, accessing such surgery in Canada has become much more difficult than in previous decades.

At the time when Blanchard and Steiner (1990) published their work on the clinical treatment of gender identity disorder, Canada had four centers that did gender-reassignment surgery as part of the treatment for gender identity disorders: the Gender Identity Clinic at the Clarke Institute of Psychiatry in Toronto, Ontario (Blanchard & Steiner 1990); the Gender Dysphoria Clinic at the Vancouver General Hospital in British Columbia (Watson 1991); the Human Sexuality Unit at the Montreal General Hospital in Quebec (Wilchesky & Assalian 1991); and the joint program of the Department of Sexology, University of Quebec at Montreal and Le Comité sur le Transsexualité of Centre Hospitalier de l'Hôtel Dieu, also in Montreal.

Since that time, however, a number of recent changes have altered this state of affairs, and while these programs continue to provide consultation, there is far less surgery done in Canada. The Gender Identity Clinic at the Clarke Institute (currently and henceforth referred to as the Centre for Addiction and Mental Health, CAMH) has largely faltered because of a lack of public (i.e., government) funding for the CAMH program. As a result, few individuals seeking assistance for transgender issues use the CAMH services. In fact, there is currently no gender-reassignment surgery conducted at all in Ontario. In the last decade, all surgeries done under the auspices of Clarke/CAMH were performed in England. Similarly, the majority of surgeries previously performed in Vancouver now take place in Colorado. In Quebec, the majority of surgery is conducted by private surgeons, Drs. Brassard and Menard, who also run a private clinic for aftercare on Yale Island.

All programs employ more or less similar formats and criteria for treatment, generally adopting the "Standard of Care" advocated by the Harry Benjamin Society. This is an internationally respected protocol observed the world over with few variations. The Vancouver program is reportedly somewhat less restrictive in the circumstances under which it approves hormone treatment and surgery. The Vancouver program uses a variety of factors to develop a "management plan." These include "intensity of cross-gender identification, degree of obsession with cross-dressing, extent of investment in versus abhorrence of sex and reproductive organs, desire for cross-gender hormone administration, need versus fantasy of sex reassignment, and nature of eroticism." "Sexual orientation is considered an independent factor not directly relevant in the evaluation of gender disorders" (Watson 1991, 4). The plan may include a combination of hormonal treatment, psychotherapy (individual, family, and group), speech therapy, and vocational rehabilitation. The decision about referral for surgery is based on "the extent of cross-gender identification and proven ability to adapt in the chosen gender role" (Watson 1991, 8), the latter evidenced by a minimum of one year living in the new role.

The program at CAMH requires a one-year "real-life test" prior to hormonal treatment and a minimum of two years living in the cross-gender role before approval is given for surgery. Specific requirements that must be met before recommendation for surgery is approved include: employment or student status in the new role (this requirement is a potential source of conflict with current or future employers); change of all documents (bank account, driver's license, health insurance, etc.) providing proof of cross-living (employer letter, statement of earnings, etc.); proof of divorce in the case of those who are legally married (a protection for the surgeon); and other such requirements (Clemmensen 1990). The rationale for these restrictions, which can generate anxiety and animosity among patients, is that postoperative regret and poor outcome are more likely if these criteria are not followed, although there is debate in the research literature as to the actual degree of postoperative regret experienced by transsexuals choosing surgery.

The Montreal General Hospital group has similar criteria and a varied program that includes a strong emphasis on group support (Wilchesky & Assalian 1991). The Department of Sexology/Hôtel Dieu program was established in the early 1970s and follows assessment criteria similar to those described above for the Clarke Institute. It is different from the others in that the Department of Sexology does the assessments, therapy, and recommendation for surgery for the hospital clinic and is also an active center for research on gender identity. Group counseling is provided, but when the department itself offers such groups, it is because the activity includes a research component, not because it is a standing service.

The legal status of postsurgical male-to-female and female-to-male transsexuals is precarious in Canada, and they have little or no protection in 8 out of 10 provinces. However, their civil rights status is becoming clearer in Ontario and British Columbia. British Columbia has enshrined "gender identity" in their Human Rights Code and position papers have been forwarded in Ontario. Although the health plans in about one half of provinces will cover surgery and it is legal to change one's birth certificate postoperatively, the law appears to define one's sex based on chromosomal composition. A more recent case in Quebec, however, presents a better indication of the complicated picture for transsexual individuals. As it currently stands, a name can be changed only in the face of complete surgical alteration. For female-to-male, this includes a double mastectomy, hysterectomy, phalloplasty, and removal of the ovaries. For male-to-female, this entails complete neovaginal surgery. Furthermore, even with such surgical interventions, sex cannot be changed on any document.

In a 1992 legal decision in Ontario, the judge annulled the marriage of a woman and a female-to-male transsexual on the grounds that the law does not permit marriage between

two people of the same sex. This means that a postoperative male-to-female transsexual can legally marry another female (and this has occurred in Canada), and that postoperative transsexuals who marry (the issuing of a marriage license is based on appearance and not genetics) and later seek divorce, may have their marriage declared invalid.

At the social level, transsexuals face significant problems with education, employment, and social acceptance. Support groups are present in some large cities, and organizations such as the Metamorphosis Research Foundation have shown the importance of support and education services for people with gender conflicts. Other programs, like the 519 program in Toronto, one of the first outreach programs for transsexual and transgender youth and sex workers, also provides free counseling and food to a group of individuals who are multiply marginalized within the larger social matrix.

The problems and issues faced by intersex individuals—personal, legal and medical—are different, yet again, from those of transgendered individuals.

8. Significant Unconventional Sexual Behaviors

A. Coercive Sex

Sexual Abuse of Children

In Canada, child abuse refers to physical, sexual, and emotional abuse or neglect. All provinces and territories, except the Yukon, require any person who knows of or suspects such abuse to report it to child welfare authorities. The Yukon identifies teachers and childcare workers as the groups with a legal duty to report. It is difficult to estimate the prevalence of child abuse because of the secrecy and privacy involved, and because jurisdictions vary in what and how they report (e.g., some record both allegations and investigations while others report only the latter [Johnson 1996a]).

Sexual contact between children and adults is strongly proscribed in Canada, and the phenomenon of child sexual abuse is now increasingly recognized as a longstanding problem that has been insufficiently addressed at all levels of society. Major reports of such abuse in the past ten years have focused public and professional attention on child abuse in general, and sexual abuse in particular. For example, the criminal conviction of Catholic brothers for physical and sexual abuse of male residents at a Roman Catholic orphanage in Newfoundland, the growing reports of sexual abuse of children in some aboriginal and First Nations communities in which poverty, alcoholism, and drug use are widespread, and the response to disclosure of similar abuses of large numbers of children in a small Ontario community have been among the most publicized of many such accounts. These incidents reinforced the concerns expressed in the *1984 Badgley Commission Report, Sexual Offenses Against Children and Youth*, which indicated that by age 16, approximately 5 to 9% of males and 15 to 20% of females had experienced some form of unwanted sexual touching, and that 1 to 3% of females under 16 had experienced forced intercourse (Lindsay & Embree 1992).

Changes in the Canadian Criminal Code in 1988 expanded the old provision that prohibited sexual intercourse with a person under 14. For example, the relevant section of the code speaks of a "young person," defined as a person 14 years of age or more but under the age of 18. Changes were also made with the inclusion of the offenses of "sexual interference" (s.151), "invitation to sexual touching" (s.152), and "sexual exploitation" (s.153). Sexual interference is explained as follows:

> Every person who, for a sexual purpose, touches, directly or indirectly, with a part of the body or with an object, any part of the body of a person under the age of fourteen is guilty of an indictable offense and liable to imprisonment for a term not exceeding ten years or is guilty of an offense punishable on summary conviction. (MacDonald 1994, 16)

The addition of "invitation to sexual touching" makes it an offense

> to invite, counsel, or incite a person under fourteen to touch him/herself or any other person, directly or indirectly, if the invitation is made for a sexual purpose. For example, it is a criminal offense to suggest that a young boy masturbate for the voyeuristic pleasure of the person making the suggestion. (MacDonald 1994, 16)

Finally, although including the types of acts covered under sections 151 and 152, the offense of "sexual exploitation" under the Criminal Code refers specifically to sexual acts carried out by a person

> who is in a position of trust or authority towards a young person or is a person with whom the young person is in a relationship of dependency.

Section 150(2) of the Canadian Criminal Code provides further clarification of the role of consent in regard to sexual offenses with young persons. This section provides that where an accused is charged with sexual interference, invitation to sexual touching, exposure, or sexual assault with respect to a complainant at least 12 years of age but under the age of 14, it is not a defense that the complainant consented to the activity unless the accused is at least 12 years of age but under 16, is less than two years older than the complainant, and is not in a position of trust or authority towards the complainant, nor in a relationship of dependency with the claimant. In short, MacDonald (1994, 16) notes that since children under 14 are not assumed to be able to give consent, "it is not a defense that the complainant consented to the activity that forms the subject matter of the charge" (MacDonald 1994, 16). Further, MacDonald notes that the prohibition on sexual activity with a person under 14 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" (MacDonald 1994, 17). Sexual contact between an adult and a child would also fall under the sexual assault section of the Code (a child cannot give legal consent to the contact), thus adding to the variety of provisions in Canadian law that address sexual contact between adults and children.

The Canadian Incidence Study of Reported Child Abuse and Neglect (CIS) was the first nationwide study to examine child maltreatment in Canada. Conducted between October and December 1998, this study provides data on physical abuse, sexual abuse, neglect, and emotional maltreatment of children age 0 to 15 based on 7,672 investigations from 51 separate cites in all of Canada's provinces and territories. In Ontario, it is mandatory for children's aid societies to investigate all reports of abuse. These are then deemed "substantiated" (there is sufficient evidence for the investigator to conclude that abuse occurred), "suspected" (can neither substantiate nor rule out abuse), or "unsubstantiated" (there is sufficient evidence that maltreatment did not occur). Child sexual abuse occurs when an adult or youth uses a child for sexual purposes. Sexual abuse includes fondling, intercourse, incest, sodomy, exhibitionism, and commercial exploitation through prostitution or the production of pornographic materials.

In the case of sexual abuse investigations reported in the 1998 CIS study, the most common forms of substantiated sexual abuse were touching/fondling genitals (68% substantiated), attempted and completed sexual activity (35% substantiated), and exposure (12% substantiated). Sexual exploitation (6% substantiated) and sexual harassment (4% substantiated) were less common forms of child sexual abuse (Trocmé et al. 2001). An analysis of victim characteristics reveals that 69% of victims are girls and 31% are boys, with girls age 4-7 and 12-15 victimized about twice as often as those in the 0-3 and 8-11 age categories.

Among all cases of substantiated sexual abuse in the 1998 CIS, the majority of alleged perpetrators were either relatives (44%) or non-relatives (29%). Of those alleged perpetrators who were related to the victim, they were equally likely to be a biological father or stepfather and less likely to be the biological mother, foster, or adoptive parent. Those who fall under the category "other relatives" were by far the single most significant category comprising 44% of those who commit sexual abuse.

In the past decade, there has been an increasing involvement of police in situations that could lead to criminal charges, particularly where sexual and physical abuse are concerned. According to the 1998 CIS, sexual abuse was by far the most likely type of maltreatment to result in charges laid by police (70%).

On a provincial level, the 1998 *Ontario Incidence Study of Reported Child Abuse and Neglect* (OIS 1998) (Trocmé et al. 2002), conducted as part of the 1998 CIS study, was based on a sample of 3,053 child-maltreatment investigations. Figures do no include maltreated children who were not reported to a children's aid society. Findings from this study show that between 1993 and 1998, the estimated number of child-maltreatment investigations increased 44% in Ontario. The total number of substantiated cases doubled from 12,300 in 1993 to 24,400 in 1998. Over this time period, there was a 44% decrease (3,400 in 1993 to 1,900 in 1998) in substantiated investigations of sexual abuse. This is consistent with a similar decrease noted in the United States (Jones et al. 2001). Trocmé et al. (2002) suggest that while such a decrease could indicate more-effective prevention programs and criminal-charging policies, it is also possible that these same policies have caused victims and their parents to be less willing to disclose and report sexual abuse.

The *Étude sur l'Incidence et les Caractéristiques des Situations d'Abus, de Négligence, d'Abandon et de Troubles de Comportement Sérieux Signalés à la Direction de la Protection de la Jeunesse au Québec* (EIQ) [*Quebec Incidence Study of Reported Child Abuse, Neglect, Abandonment and Serious Behaviour Problems*] is also the first study of its kind ever to be carried out in Quebec. The EIQ was based on referrals reported to the Director of Youth Protection between October 1 and December 31, 1998. Sixteen of Quebec's 19 child-protection agencies took part in the study by documenting the child-maltreatment or serious behavior problem referrals reported during that period. The study found 3.0 per 1,000 cases of sexual abuse, with girls being reported for sexual abuse more commonly than boys. Situations of sexual abuse referred to touching/fondling in most cases (64%), with relatives (27%) often identified as perpetrators, as well as "another" person (28%). About 26% of child victims of sexual abuse lived with at least one parent who was him- or herself a victim of maltreatment during his or her childhood, suggesting a potential intergenerational reproduction of maltreatment. These findings are based on a 2002 summary posted by the Centre of Excellence for Child Welfare, with the permission of the Institut Universitaire dans le Domaine de la Violence chez les Jeunes, Les Centres Jeunesse de Montréal.

Although the overall incidence of substantiated child maltreatment in the Ontario study is about one half that in the U.S.A. in 1990 (21/1,000 vs 43/1,000), this difference is almost entirely because of the higher rate of child neglect in the U.S.A. (4.64/1,000 vs. 2.0/1,000). The substantiated sexual abuse rates were very similar in both countries (1.57/1,000 vs. 1.65/1,000 in the U.S.).

Such findings and the growing public concern about sexual abuse of children have led some to wonder about the possibility of fabrication of such allegations in divorce or child-custody proceedings.

In Canada, the Divorce Act governs both custody and access and requires that the courts consider the best interests of the child as the standard in such cases. Zarb's (1994) detailed analysis of the legal situation in Canada indicates that legal decisions in this area are rare because such matters are usually settled without a trial. When a trial does occur, transcripts are often kept confidential. She notes that when allegations are unfounded, the court generally awards unsupervised access, and sometimes full custody, and that unproven accusations lead to supervised or unsupervised access depending on the judge's perception of the best interests of the child. In weighing the rights of an accused parent (almost invariably the father) against the possible risk to the child, Zarb indicates that Canadian courts should and do err on the side of caution.

Zarb (1994) points out that there is a greater occurrence of allegations of sexual abuse on interim applications for custody, but she argues that this does not necessarily mean that false allegations are generally and cynically used as a "bargaining chip" in such cases. Among the possible reasons for unfounded allegations, she cites (1) the excessive influence of media reports that lead to overinterpretation of innocuous behavior as abuse, (2) the emotional fragility of newly separated parents, (3) the belief among some adults that children do not know enough about sex to be able to make up events and, therefore, that there is no reason to doubt their reports, (4) the lack of trust in separated couples, and (5) the fear that failure to report suspicions may lead to an accusation of negligence. When accusations are founded, Zarb notes that case law offers "no clear consensus in Canada with respect to how much contact a child victim of incest should have with his or her abusive parent after disclosure" (Zarb 1994, 108). She sees a consensus for continued access in such cases (in Canadian law access means, at a minimum, the right to make inquiries and to get information about the child's schooling, health, etc.) only when the child wants it, when the abusive parent has affirmed that the child's accusation was correct, and when the other parent can protect the child from the offending parent, if necessary.

This area is a source of debate in Canada, as is the growth of an "assessment industry" that some perceive as predisposed to finding sexual abuse when other explanations for alleged incidents are possible (Zarb 1994). In the absence of judicial consensus on many of these contentious issues, Zarb (1994) sees the need for much more research on the prevalence of sexual contact between adult relatives and children, and on the related issue of "the child's best interests," when such allegations are made and/or substantiated.

When child sexual abuse cases go to court, there have been a number of recent changes in Canadian law and procedure that make the experience less onerous for the child witness while respecting the right of an accused to a fair trial. Young's (1992) review of evidentiary issues in cases of child sexual abuse in Canada cites measures that include: use of screens so that the child witness need not see the accused while testifying, use of closed circuit television, use of videotaped statements, and increasing acceptance of children as

reliable witnesses under appropriate circumstances. All have been challenged as contrary to the rights of the accused, but Young (1992) sees the legislative trend leaning toward a balance that recognizes the past disenfranchisement of children in the courts for reasons that some now consider invalid.

In 1997, a Parliamentary committee, the Special Joint Committee on Child Custody and Access, was asked to assess the need for a more child-centered approach to family law policies and practices, and in December 1998 released its report, *For the Sake of the Children*. The Government of Canada has taken an approach to family justice reform that is consistent with the spirit of this report, in that it removes the terms custody and access from the Divorce Act and bases parenting decisions solely on the best interests of the child. While the "best interests of the child" has been the core principle of family law in Canada for some time, this core principle was reaffirmed and strengthened by adding a list of best-interest criteria to the Divorce Act. In instances where allegations of sexual abuse are present, weighing the "best interests of the child" against the threat of false allegations of abuse are identified as serious complications associated with high-conflict cases. The lack of data pertaining to the actual incidence of false allegations in Canada was identified as an additional worry in the Government of Canada's Response to the Report of the Special Joint Committee on Child Custody and Access tabled on May 10, 1999. A serious problem, though, is that the actual incidence of false allegations of child abuse in Canada is not known, and it is an inherently difficult issue to research.

This issue, moreover, is one that crosses jurisdictions and will require the cooperation of numerous agencies and organizations if it is to be addressed properly. We therefore agree with the Committee's recommendation that the Government of Canada work with the provinces and territories to encourage child welfare agencies to track investigations of allegations of abuse in the context of parenting disputes in order to provide a statistical basis for a better understanding of this problem.

Sexual Harassment

Sexual harassment is illegal in Canada under the Canadian Human Rights Act and also under all provincial and territorial acts respecting human rights. Aggarwal's (1992) detailed review notes that the first such documented case in Canada occurred in Ontario in 1980, when the Ontario Board of Inquiry determined that "sexual harassment amounts to sex discrimination prohibited under the Ontario Human Rights Code." This decision has become the basis for judgments by human rights tribunals in other provinces and at the national level.

In 1983, the Canadian Human Rights Commission adopted a definition of sexual harassment as including:

> (1) verbal abuse or threats; (2) unwelcome jokes, remarks, innuendoes, or taunting; (3) displaying of pornographic or other offensive or derogatory pictures; (4) practical jokes which cause awkwardness or embarrassment; (5) unwelcome invitations or requests, whether indirect or explicit, or intimidation; (6) leering or other gestures; (7) unnecessary physical contact such as touching, patting, pinching or punching; (8) physical assault. (Aggarwal 1992)

There are now many different definitions of sexual harassment being applied in labor relations codes, university policies, and guidelines covering a range of agencies and work settings. Most definitions, such as that adopted at one Canadian university, indicate that sexually harassing behavior "is sexual in nature and is unwanted by the person to whom it is directed." In order for a behavior to constitute sexual harassment, it "must affect the recipient's employment, instruction, or participation in university activity or interfere with the recipient's environment, performance, or evaluation" (cited in Aggarwal 1992).

Although the application of these codes has been a source of debate in some settings, there appears to be general agreement that sexual harassment is a problem, and that some form of control and/or redress is needed. A 1991 poll cited by Aggarwal (1992) indicated that 37% of women and 10% of men had experienced such harassment; other studies of selected groups have indicated larger percentages, mostly of women, frequently involving incidents in the workplace, and often unreported.

Most provincial human rights codes specifically identify sexual harassment in the workplace as a violation. Ontario's 1990 Code, for example, specifies that every person should be free from:

1. a sexual solicitation or advance made by a person in a position to confer, grant, or deny a benefit or advancement to the person where the person making the solicitation or advance knows or ought reasonably to know that it is unwelcome.
2. a reprisal or threat of reprisal for the rejection of a sexual solicitation or advance where the reprisal is made or threatened by a person in a position to confer, grant, or deny a benefit or advancement to the person. (Aggarwal 1992)

This definition implicitly notes that sexual harassment is a misuse of power and constitutes a "poisoning of the work environment" and is not simply misunderstood courtship behavior. Nevertheless, misunderstandings in this area abound and most procedures appear to incorporate the intentions of fairness to each party, confidentiality (although not anonymity of the complainant with respect to the respondent), adjudication, and the potential for remedy without formal disciplinary proceedings. It would be unwise to assume universal agreement and comfort with harassment codes, particularly on university campuses, where such policies have been cited as a threat to academic freedom and to open discourse on discomforting topics. Defenders claim that such policies, and the administrative machinery needed to adjudicate them, are not simply a way of reinforcing "political correctness," but a means of addressing a problem that disadvantages not only women but other groups such as gay/lesbian/bisexual students or employees.

Many policy and procedural guides on sexual harassment now include harassment on the basis of sexual orientation. This is consistent with the inclusion of sexual orientation as a protected category in most provincial human rights codes. The Criminal Code also has sections on "stalking," the persistent following or watching of someone. It is also illegal to watch or beset a person's residence or place of work. The popular media have reported on entertainment celebrities being "stalked," usually women stalked by men, and have thereby raised awareness of this phenomenon in the general population.

Sexual Abuse and Sexual Assault (Rape)

Readers interested in an overview of legal and legislative aspects of sexual assault can find an excellent review of Canadian trends in the 1980s and early 1990s in *Confronting Sexual Assault: A Decade of Legal and Social Change* (Roberts & Mohr 1994). In addition, the Canadian Panel on Violence Against Women received 800 submissions and heard thousands of personal stories from individuals in 139 communities across Canada. The Panel's final report, *Changing the Landscape: Ending Violence, Achieving Equality* (Min-

ister of Supply and Services 1993), while providing a broad sampling of personal stories and recommendations concerning women's experience of violence in Canada, is less reliable as a source of statistical data on the incidence or occurrence of such experiences. The large volume of publication and government activity in the area of sexual abuse and assault during the 1980s and into the 1990s is a reflection of the consciousness raising that has occurred in the past ten to 15 years. The report of the 1984 Committee on Sexual Offenses Against Children and Youth and the more recent revelations of sexual abuse of children in care (see Gripton & Valentich 1990) are but two examples of this burgeoning awareness.

Although forced sexual intercourse is a serious offense, the word "rape" is no longer used in the Criminal Code of Canada. The offenses of rape and indecent assault were replaced in the code in 1983 by the categories of sexual assault (level I), sexual assault with a weapon (level II—victim threatened with a weapon or caused bodily harm), and aggravated sexual assault (level III—victim is maimed, disfigured, or has her or his life endangered during the assault).

The new laws have produced several important changes in how sexual assault is viewed and treated in the courts. First, it is now possible to charge one's spouse with sexual assault, something that could not be done under the former "rape" laws. Second, the law is nongender or sexual-orientation specific. Thus, assault of men by women, and assault by someone of the same gender are all offenses under this law (though, to date, charges have rarely been brought in the latter). Finally, it is less common for interrogations of victims about past sexual behaviors or the specific sexual acts that occurred to be permitted in court proceedings. The specific circumstances under which such interrogations may occur are now prescribed in a bill that outlines how questions of consent and mistaken belief of consent should be handled in court proceedings.

Possible maximum prison sentences for levels I to III sexual assaults are ten years, 14 years, and life respectively, although sentences are usually less, and many occurrences that would probably meet the legal definition of sexual assault, particularly level I, go unreported or do not go to trial.

The first level of these offenses, sexual assault, is not defined in the code. Sexual assault incorporates the legal definition of assault (use of force or threat of force on a person against her or his will) coupled with the idea that the assault was of a sexual nature or violated the sexual integrity of the victim. The prevalence of sexual assault, or of offenses that would have legally constituted sexual assault had they been reported, is difficult to assess, but some authors suggest that only one in ten of such occurrences is reported. Recorded sexual-assault statistics for Canada in 1995 list 28,216 incidents (10% of all violent incident reports) with 97% level I and 3% level II or level III. The national report rate of 124/100,000 population in 1992 was 10% higher than in 1991, consistent with a trend of about a 12%-per-year increase since the new assault law was introduced in 1983. This probably reflects an increase in reporting, although the incidence may also have increased. Rates varied from 64/100,000 in Quebec to about twice that in Ontario, and 895/100,000 in the Northwest Territories (Statistics Canada 1992; Roberts 1994). Non-sexual-assault rates show similar variability. The rate of level I sexual assault in Canada in 1995 (approximately 100 per 100,000) was 11.9% lower than in 1994, the second year in a row of decline after the prolonged period of increase from 1983. This rate was still 35.5% higher than in 1985 (Johnson 1996a; Hendrick 1996). At present, it is difficult to assess the relative contribution of the varied factors (law reform, better reporting, and increased incidence of offenses) that led to the 1983-1993 increase and the recent 1994-95 decline in level I sexual assault incidents (Johnson 1996b). In contrast to level I sexual assaults, the less common level II and level III assaults have declined since 1985; both dropped about 35% between 1991 and 1995 (Hendrick 1996).

In 14% of level I incident reports in 1992, the police did not pursue the case beyond preliminary investigation. The "unfounded" rate (i.e., police have determined that a crime was not committed) for level I to III cases has been fairly consistent at 10 to 15% since 1983. To say that a report was "unfounded" does not necessarily imply that an intentionally false allegation was made. When there is sufficient evidence to lay a charge, the case is "cleared by charge." This happened 49% of the time for level I reports in 1992, 57% for level II, and 64% for level III, indicating that charges occur more often in cases in which the definition of the offense is clear, and therefore, more likely to lead to conviction. Clearance rates for all charges have increased since 1983 (43% in 1983-85 vs. 50% in 1990-92). In 1991-92, incarcerations occurred for 60% of level I convictions and 90% for levels II and III. An analysis of reports to selected police departments in Canada in 1992 found that 84% of assault victims were female, 98% of those charged were male, most of those charged were over 25 years of age (67%), and most assaulted were under age 18 (63%). About 20% of assailants were reported as strangers, 32% as casual acquaintances, and 28% as parents or other family members. The reported assaults usually took place in a private dwelling (63%), 61% involved threat of physical force, 1% involved firearms, and 18% other weapons.

To what extent do official reports reflect actual experience? Statistics Canada's *Violence Against Women Survey* (1993) surveyed 13,300 Canadian women 18 and over to assess their experience of physical and sexual violence. The study was reported to be the first national survey of its kind anywhere in the world (*The Daily*, Statistics Canada 1993). The specific findings on "sexual assault" are based on recent and lifetime experience of "unwanted sexual touching" ("Has a stranger or man other than a spouse or boyfriend ever touched you against your will in any sexual way, such as unwanted touching, grabbing, kissing, or fondling?") and of "sexual attacks" ("Has a stranger, date or boyfriend, spouse or other man ever forced you or attempted to force you into any sexual activity by threatening you, holding you down, or hurting you in some way?"). Using these definitions, 39% reported experiencing one of these since age 16 (24% sexual attack, 25% unwanted sexual touching, and 10% both). Overall, 58% had more than one lifetime experience of sexual touching and 42% of sexual attack; 5% reported at least one experience of either in the previous 12 months (Roberts 1994). While the experience had negative emotional impact in 85% of cases, only 6% said they had reported these incidents to police (11% in the case of sexual attacks, 4% for sexual touching), and of those reported to police, 63% of the complainants were under the age of 18. Reasons for not reporting included: the incident was too minor (44% overall; 28% for sexual attack vs. 53% for unwanted sexual touching), the expectation that police would not be able to do anything (12%), protection of privacy (12%), or it was dealt with in other ways (12%) (Roberts 1994).

When participants in the *Ethnocultural Communities Facing AIDS* study were asked whether they had ever been coerced or forced to have sex with someone against their will, 37% of women and 19% of men from the English-speaking Caribbean communities, 5% of men from the South Asian communities, and 8% of women and 1% of men in the Latin American communities reported they had.

Of particular interest is the fact that in the English-speaking Caribbean communities, percentages reporting coercion or force were higher for those who had been in Canada longer (34% of those in Canada longer than 15 years, men and women combined, vs. 20% of those in Canada less than 15 years). This was so even when age and marital status were held constant, suggesting that coercion is a more common experience here than in the Caribbean (Maticka-Tyndale et al. 1995).

In the *Violence Against Women Survey*, the lifetime reports of unwanted sexual touching and sexual attacks (collectively referred to as "sexual assault" according to the expanded legal definition) were usually linked to dates or boyfriends or someone known to them, and less often to strangers (19%). Based on reports of one or more such experiences in the previous 12 months (5% of the sample), Roberts (1994) estimates that 18% of women aged 18 to 24 years had experienced some form of sexual assault. Figures for the other age groups were: 8% (25 to 34), 5% (35 to 45) and 2% (45 to 54) (results exclude data involving marital partners). In addition, report rates among women with post-secondary education were double those for respondents with high school education or less (Roberts 1994).

Treatment for Victims and Offenders

Treatment for children and adults who have been sexually abused is in great demand and, despite the growth in such services in recent years, the need outstrips both financial resources and the availability of adequately trained professionals. Canada has over 70 community-based, sexual-assault services staffed primarily by volunteers. These kinds of services (telephone crisis lines, accompaniment of victims in hospital, police interviews, court, counseling and support groups, etc.) are responding not only to current reports of assault, but to past abuse that is only now being dealt with as a result of publicity surrounding this issue.

Marshall (1992) recommends three areas of societal response to sexual offenses: preventing or at least reducing the incidence; assistance to victims; dealing with offenders through incarceration and specialized cognitive-behavioral treatment programs. He notes that treatment programs for sex offenders have been employed with some success in Canadian penitentiaries, hospitals, and community-based outpatient clinics. Since most offenders will eventually be released, such treatment is considered a vital part of social policy. Marshall (1992) cites recidivism rates of 10% in a five-year follow-up study of treated offenders who had a comprehensive program that addressed five target areas: cognitive factors, sexual issues, social functioning, life management, and relapse prevention; for untreated offenders, the recidivism rate was 35%. Antiandrogen treatment is used with some offenders during treatment and subsequent to release.

"Gating" (i.e., immediate rearrest upon release) of offenders who have completed their sentences, but are still considered dangerous, has been used in Canada, as has the placing of conditions on released offenders (e.g., restricting men who have committed offenses against children from going near schools, etc.). The former has been declared in violation of charter rights, and a current test case in Ontario will determine whether the latter does so as well. Both issues reflect the extensive concern that prevails in Canada around the risk of sexual assault and abuse. Growing public awareness of the long-term consequences for many victims of sexual abuse has undoubtedly contributed to the perception of dangerousness that colors public discourse about sexuality.

Sexual Coercion and Assault—College and University Students

A large-scale study of unwanted sexual experiences conducted at the University of Alberta in 2000 (LoVerso, 2001) paints a picture of sexual assault on one university campus. This study revealed examples of sexual assault, particularly among first- and second-year students. Of the 1,297 students participating, 37% of participants' most serious unwanted sexual experiences happened while registered at the University of Alberta. Over 90% of the most serious unwanted sexual experiences were perpetrated by men, 41.8% of which were non-romantic acquaintances compared with 27.9% who were romantic acquaintances. Physical force was reported in 23.5% of the most serious cases, while the majority involved some form of coercion or pressure.

DeKeseredy and Kelly (1993) conducted a national study of sexual mistreatment and assault on university campuses using a sample of 1,307 men and 1,835 women from classes in over 40 universities and community colleges across Canada. Respondents were young (median age 20 for females, 21 for males), unmarried (about 80% for both sexes; those married were asked to respond based on their dating relationships), and primarily in their first or second year of study (66%). The results presented here are for women's reports of their experiences of abusive behavior in dating relationships and men's reports of their own abusive behavior. (For commentary on the study and the circumstances of its public release, see Gartner 1993, Fox 1993, and Kelly 1994.)

The study determined incidence rates (past year) and prevalence rates (since starting university or college) for a variety of experiences that were described in detail in the research questionnaires and that corresponded, in some cases, to legal definitions of sexual harassment or level I or II sexual assault. For example, "Have you ever given in to sex play (fondling, kissing or petting but not intercourse) when you didn't want to because you were overwhelmed by a man's continual arguments and pressure?" yielded an 18.2% incidence response (7.8% of men said they had been the source of such an outcome for a female partner in the past year) and 31.8% prevalence (14.9% of men said they had exerted such pressure on a partner since beginning university/college; see Table 7.

DeKeseredy and Kelly (1993) suggest that their reported incidence and prevalence figures for sexual abuse in dating relationships may be underestimated, that the problem is as serious in Canada as has been reported for the U.S.A., that the attempt of some males to "mirror the dynamics of patriarchal marriages" in their dating situations may contribute to mistreatment of their partners, and that men and women bring different interpretations of consent to such relationships. Kathleen Cairns (1993) at the University Calgary has identified the different self-perceptions and scripts that many men and women in university bring to these interactions (sexual entitlement on the part of males and sexual accommodation on the part of females) and suggested that attention to such scripts could provide a basis for understanding and eventually reducing the incidence of coercive behavior. She proposes that sex education for young women should focus on assertiveness and refusal skills, on "development of a sense of self as sexual subject, and on the related understanding of the nature of female sexual desire" (Cairns 1993, 211). Young men should learn how to develop a broader awareness of sensuality, feeling, and of girls and women as persons; both sexes need to recognize that it is social-derived sexual scripts and power differences, not immutable biology, that leads to sexual coercion.

Research by Sandra Byers and her students at the University of New Brunswick also adopts a sexological rather than purely legalistic and legislative approach to understanding and changing sexually coercive behavior (see Byers 1991; O'Sullivan et al. 1994; O'Sullivan & Byers 1993). For example, Byers and Lewis (1988) found that desired level of sexual activity was the same for men and women in 90% of dating for college-age couples, that women were no more likely than men to refuse a partner's sexual initiation (although men initiated more often), that when disagreements occurred in desired level of sexual activity, men did not, in the vast majority of cases, try to persuade, coerce, or force their partners, and that most stopped the unwanted activity when asked. While these and other findings suggest that Canadian college students are at various stages in the transition to more egalitarian gender and sexual relationships, the level of mistreatment experienced and perceived by college and university women remains a significant issue on many campuses.

Sexual Assault and Coercion of People with Disabilities

There is a high prevalence of sexual assault and abuse in the lives of people with physical or developmental disabilities, and this area has generated a variety of educational, research, and prevention programs (The Roeher Institute 1992; Sobsey 1994; Sobsey et al. 1994). The Disabled Women's Network has been particularly active in raising awareness of this issue at both the local and national level through pamphlets for consumers and an educational guide for healthcare professionals. The federal government's Family Violence Prevention Division funds a variety of programs that deal with violence in general, and sexual abuse in particular, against people with disabilities.

Physician-Patient Sexual Contact

Patient-physician sexual involvement is an important area of professional misconduct that has received increased attention in Canada in recent years. Subsequent to the report in Ontario of the Task Force on Sexual Abuse of Patients (TFSAP 1991), an act was passed (Regulated Health Professions Amendment Act, 1993, SO1993, c37) which identified "strict guidelines for reporting such activity and disciplining physicians" (Lamont & Woodward 1994). A task force of the College of Physicians and Surgeons of Ontario (CPSO) mandated to respond to the report that the CPSO had commissioned, identified three categories of impropriety that would receive different penalties. They were:

1. Sexual impropriety: any behavior such as gestures and expressions that are sexually demeaning to a patient or that demonstrate a lack of respect for the patient's privacy.
2. Sexual transgression: any inappropriate touching of a patient, short of sexual violation, that is of a sexual nature.
3. Sexual violation: sex between a physician and a patient, regardless of who initiated it, including but not limited to sexual intercourse, genital-genital contact, oral-genital contact, oral-anal contact, and genital-anal contact. (CPSO 1992, as cited in Lamont & Woodward 1994, 1434).

The Committee on Physician Sexual Misconduct established by the College of Physicians and Surgeons of British Columbia (1992) proposed 97 different recommendations for responding to the issues surrounding patient-physician sexual contact. The College also funded a mailed survey of all practicing physicians in British Columbia (4,513 responses, 72.3% response rate, 78.9% males), which found that 20.7% of the responding physicians, and 62.3% of psychiatrists, had seen a patient who reported having had sexual contact with another physician (Maurice et al. 1994a). Female physicians were more likely than male physicians (31.2% vs. 17.8%) to indicate that they had heard such a revelation from a patient. Among the physicians who were asked questions about their personal behavior, 3.5% of the 1,414 who responded (69.5% response rate) said they had had at least one sexual experience with someone who was a current patient at the time of the sexual contact (3.8% of male vs. 2.3% of female respondents). This figure was 7.4% for

Table 7

Incidence and Prevalence Rates for Different Aspects of Sexual Abuse Reported by a National Sample of Canadian University/College Students

	Incidence[1] (%)		Prevalence[1] (%)	
Situation	**Women (*N* = 1,835)**	**Men[2] (*N* = 1,307)**	**Women (*N* = 1,835)**	**Men[2] (*N* = 1,307)**
Have you given in to sex play (fondling, kissing, or petting, but not intercourse) when you didn't want to because you were overwhelmed by a man's continual arguments and pressure?	18.2	7.8	31.8	14.9
Have you had sex play (fondling, kissing, or petting, but not intercourse) when you didn't want to because a man threatened or used some degree of physical force (twisting your arm, holding you down, etc.) to make you?	3.3	1.1	9.4	2.2
Has a man attempted sexual intercourse (getting on top of you, attempting to insert his penis) when you didn't want to because a man used some degree of physical force (twisting your arm, holding you down, etc.) but intercourse did not occur?	3.9	0.6	8.5	1.6
Have you given in to sexual intercourse when you didn't want to because you were overwhelmed by a man's continual arguments and pressure?	11.9	4.8	20.2	8.3
Have you ever had intercourse when you didn't want to because a man threatened or used some degree of physical force (twisting your arm, holding you down, etc.) to make you?	2.0	1.7	6.6	1.5
Have you had intercourse when you didn't want to because you were drunk or high?	7.6	2.2	14.6	4.7

[1]Incidence (in the past year), prevalence (since beginning university/college).
[2]Male responses indicate percentage who said they had been the source of such experiences for a woman.
Data from DeKeseredy and Kelly (1993). Median age for females 20 years, for males 21 years.

those who said they had had sexual contact with a former patient (8.1% of male vs. 4.3% of female respondents).

Maurice et al. (1994b) have also surveyed members of the public in British Columbia to assess their opinions and experience concerning patient-physician sexual contact. Questionnaires mailed to 6,000 women and 2,000 men yielded 2,456 responses (2,079 women, 376 men). When asked whether a physician had ever touched their private body parts for what seemed to be sexual reasons, 4.7% of the women and 1.3% of the men said yes. In addition, 6% of women and 2.5% of men said a doctor had made sexual remarks that upset them and 0.3% reported sexual activity with a former physician (0.7% with a doctor who was their current physician at the time of the contact).

Ontario and British Columbia have now passed legislation that requires physicians to report to their provincial medical college (i.e., registration body) any suspicions or knowledge they may have of physicians engaging in sexual contact with patients.

A large sample of Canadian obstetricians and gynecologists (i.e., 782 members of the Society of Obstetricians and Gynecologists of Canada, response rate 78%) has also been surveyed on this issue via mailed questionnaire (Lamont & Woodward 1994). Based on the CPSO definitions of impropriety, transgression, and violation: 37% of female respondents and 19% of males said they were aware of actions by a colleague that fitted one of the categories; fewer (10% overall) knew another obstetrician-gynecologist who had done so; 3% of males and 1% of females reported such involvement themselves; and 4% and 2%, respectively, said they had been accused of such involvement; 97% said such contact was never therapeutic and 58% saw it as an abuse of power. Respondents varied in the type of penalty they felt should be applied for different levels of offense, with a hierarchy based on level and with females generally favoring stronger penalties (e.g., 39% of females vs. 21% of males favored permanent loss of license for a sexual violation, 11% vs. 3% for a transgression). Respondents differed on the amount of time they felt should elapse before it was permissible to begin a relationship with a former patient that might lead to sexual activity (never acceptable, 14%; 6 months to over one year, 53%; OK after public termination of the professional relationship, 11%). The Canadian Medical Association published a *Policy Summary* on these matters, both to guide physicians and the public and to generate discussion and ongoing review of the policies (CMA Policy Summary 1994).

Sexual Homicide

Although sexual homicide is rare, the horror of such events and the publicity surrounding them is a source of considerable anxiety and concern in Canada. As a consequence, amendments have been proposed to the Criminal Code, the Prison Reformatories Act, and the Corrections and Conditional Release Act that would permit continued incarceration of dangerous offenders even after their court-imposed sentences for previous crimes have been completed. Using homicide statistics from 1974-86 in Canada, Roberts and Grossman (1993) found that about 4% of recorded homicides were sexual homicides (i.e., murders that occur as part of the commission of a sexual offense). Over this period, the number of such homicides did not increase nor did the proportion of homicides classified as sexual homicides. The victims were primarily female (85%) and the perpetrators were almost exclusively male (99%). Compared to the period 1961-70 when 20% of the victims were under age 21, the more recent period had 49% under the age of 21. About 30% of such crimes involved a stranger and 33% an acquaintance. Close family members were infrequently victims, in contrast to other homicides (about 12% of all murders were of spouses), and alcohol and drugs were involved in 25% of sexual homicides, slightly less than for homicides in general. The wide publicity given to sexual homicides has focused attention on all aspects of sexual assault and violence. Research and public policy initiatives address the complex problems of preventing sexual assault of all kinds, of treating victims and their families, of treating offenders, most of whom will eventually be released from prison, and of predicting dangerousness of adults after the fact and of youth before they offend.

B. Prostitution

While prostitution among consenting adults has never been illegal in Canada per se, the practice has long been considered immoral, and the Criminal Code has been used to prosecute prostitutes and, more recently, their customers. In 1983, the Special Committee for the Study of Pornography and Prostitution (the Fraser Committee), established by the Justice Minister in 1983, was mandated to examine all aspects of prostitution in Canada and to make recommendations for changes in what was perceived, at the time, to be an unenforceable law on solicitation. In their 1985 report, the Fraser Committee made more than 100 recommendations, including one that prostitution-related activities by both prostitutes and customers be removed from the Criminal Code and another that small-scale, nonresidential commercial prostitution establishments should be allowed to operate. The federal government, however, did not act upon these two recommendations. The Committee's 15 recommendations dealing with adult prostitution included the proposal that, because it was the nuisance aspect of public solicitation by adult prostitutes that most concerned the public—teen prostitution will be addressed below—an addition to the nuisance provisions of the Criminal Code pertaining to solicitation would help to alleviate this problem (Gemme 1993).

In a review of legal, criminological, and sexological perspectives on prostitution in Canada, Gemme (1993) examined the implications of legal changes made subsequent to the Commission's report. He notes that although prostitution is not strictly illegal,

> almost all activities which permit one to practice prostitution are illegal (solicitation; to deliver service to many in the same place; to operate or to find oneself in a bawdy house; to transport toward this place; to initiate someone into prostitution or to live from the prostitution of others. (Gemme 1993, 227)

The increased visibility of street prostitution in Canadian cities throughout the 1980s may account for both the public perception that it is a "serious problem" (about 25% of Gallup poll respondents said so in 1984, 1988, and 1992) (Wolff & Geissel 1992) and for the 1985 change in the law which prohibited not only solicitation, as in the past, but also communication for the purpose of prostitution. In attempting to eliminate the nuisance effect of prostitution on nonparticipating members of the public, the law also defined automobiles as a "public place" in which such communication might occur. These changes were intended to decrease street prostitution, to make it easier to get prosecutions, and to prosecute both clients and prostitutes (Gemme 1993).

One effect of the 1985 change in the law was an increase in the recorded number of prostitution offenses from 1,225 in 1985 to 10,134 in 1992. Of the latter, about 90% were for communicating (reflecting a significant increase in client prosecutions), with the remainder split between procuring and bawdy-house convictions (Wolff & Geissel 1992). Juris-

dictions may vary in the extent to which they prosecute and, although they cannot legislate in areas already covered by the Criminal Code, some have applied municipal regulations in order to facilitate prosecution (e.g., Montreal prostitutes convicted in one area were prohibited from being found in that area for one year). In assessing the law's application in Montreal, a city that accounted for 16% of Canada's reported prostitution offenses in 1992, Gemme (1993) and Gemme and Payment (1992) made the following observations:

1. Police efforts to implement the law in areas where prostitution was prevalent reduced the number of prostitutes in those areas, but shifted them to other areas, including residential ones, without reducing total numbers.
2. Arrests were easier and more frequent, since the courts had agreed that charges could be laid even though an undercover officer was "posing" either as a prostitute or client. The vast majority of communication arrests of potential clients involved a police officer posing as a prostitute.
3. Although 20 to 25% of prostitutes were male, only 11% of prostitution arrests were of males and no clients of male prostitutes were arrested (because police officers were less inclined to "pose" in that situation).
4. Although the pursuit of equity in application of the law has led to more clients being charged, the overall approach to prostitution in Canada continues to marginalize sex trade workers and often exposes them to mistreatment and abuse, experiences that preceded the entry of many into prostitution (e.g., 44% of Gemme's (1993) interviewees reported sexual abuse and 33% rape prior to entry into prostitution).

Adolescent prostitution is a significant concern in the large cities where adult prostitution is also more common (e.g., Toronto, Montreal, Vancouver, Calgary, and Edmonton accounted for about 80% of all recorded communicating offenses in 1992) (Wolff & Geissel 1994). Given the sizable number of runaway and subsequently homeless youths who gravitate to the urban core, service agencies are called upon to address the reasons for their running away from home (which may include physical or sexual abuse) and the subsequent consequences should they become involved in prostitution. While it is a criminal offense in Canada "to obtain or attempt to obtain the sexual services of a person under age 18, for consideration (i.e., any kind of payment or reward)" (MacDonald 1994, 19), Wolff and Geissel (1994) suggest that adolescent prostitution is a survival strategy arising from prior stressors and that supportive environments may be more important than legislative measures in addressing this problem.

C. Pornography and Erotica

Canadians have a long history of debate over what legal sanctions the government could or should impose on sexually explicit books, magazines, films, and the like. As these materials became more readily available in the 1970s, it became popular to attempt to distinguish between obscenity and pornography on the one hand and erotica on the other. The growth of video sales, cable television, satellite technology, computer networks, and other communication technologies has made access to a wide range of sexual materials, particularly film and video, both more common and more likely to be used and approved at some level by women and men. For example, a 1992 Gallup Poll reported that 55% of Canadians 18 and over felt that adults should be able to buy or rent videos with explicit depictions of sexual intercourse; 37% said no and 7% had no opinion. Approval was highest in Quebec (69%), in accord with the more permissive and accepting attitudes of Québécois in the area of sexuality, and lowest in Atlantic Canada (49%). Approval was higher among men (64%) than women (46%) and among young versus older respondents (66% of those over 65 disapproved vs. 30% for those 18 to 29).

The current Obscenity Law—pornography is only mentioned in a new section on "child pornography"—applies to the making of a book, film, magazine, object, sex aid, recording, painting, and so on, that "corrupts public morals." "For the purposes of this Act," the law states, "any publication a dominant characteristic of which is the undue exploitation of sex, or of sex and any one of the following subjects, namely crime, horror, cruelty, and violence, shall be deemed obscene" (p. 22). MacDonald (1994) points out that obscenity is that which exceeds contemporary standards of community tolerance. The court's perception of this standard has shifted over time so that "nowadays hard-core pornography involving consensual adult sex is not considered legally obscene. However, scenes of sexual violence, degradation, and humiliation are still generally prohibited. Depictions of ejaculation upon another person, for example, are sometimes held to be degrading and therefore obscene" (MacDonald 1994, 22).

Despite a 1985 government committee report (Fraser Commission 1985) that could find no evidence for a causal link between pornography and crimes against women, Canadian public opinion and legislative sentiment has leaned toward legal control, particularly when sexuality and violence are involved. A 1992 Supreme Court decision in the Butler case adopted the notion that it was social harm, not necessarily the explicitness of the sexual content, that should be proscribed. Justice Sopinka's judgment argued that "we cannot afford to ignore the threat to equality resulting from exposure to audiences of certain types of violent and degrading material. Materials portraying women as a class as objects for sexual exploitation and abuse have a negative impact on the individual's sense of self-worth and acceptance." The decision, which now guides the way obscenity cases are charged, interpreted, and prosecuted in Canada, is based on the judge's definition of harm, i.e., that the material "predisposes persons to act in an antisocial manner as, for example, the physical or mental mistreatment of women by men, or what is debatable, the reverse." Avoidance of the presumed harm associated with pornography is, according to the judgment, "sufficiently pressing and substantial to warrant some restriction of the full exercise of the right of freedom of expression."

The guidance offered by the Butler decision does not alter the Criminal Code, which still includes the defense of serving the public good, i.e., "No person shall be convicted of an offense under this section if the public good was served by the acts that are alleged to constitute the offense and if the acts alleged did not extend beyond what served the public good." The notion of doing good while doing harm is difficult, but apparently not impossible, to reconcile.

In practice, it is the local police who lay charges and customs officials who detain books and magazines destined for entry into Canada. Rather than have the matter decided after the fact, some provinces such as Ontario have boards that view, in advance, all videos and films approved for distribution or showing. Nevertheless, it is still possible for local police to charge distributors of material approved by the board, and for subsequent prosecution under federal law. Despite official statements to the contrary, it appears that Canada Customs has been particularly restrictive on publications destined for the gay/lesbian/bisexual audience. Both Glad Day Books in Toronto, a pioneer in marketing gay and lesbian literature, and Little Sister's Book and Art Emporium in Vancouver, initiated lawsuits over books blocked by Customs. The latter is being supported by the British Columbia

Civil Liberties Association in a 1994-95 challenge to the provisions of the Customs Act that have allowed Customs to ban and detain books. The detentions usually apply to visual or verbal descriptions of sex with violent overtones (sadism and masochism, bondage, etc.), but other materials are also stopped if the title implies restricted content. Ironically, even a book by American feminist Andrea Dworkin, an opponent of pornography but not a proponent of Canada's new "harm-based" law as a way of dealing with it (Toobin 1994), has been stopped at Customs. Shortly before the Little Sister's case began, Canada Customs removed depictions of anal penetration from its guidelines for detaining or banning books, a restriction that probably contradicts provincial human rights code provisions that prohibit discrimination based on sexual orientation. In 1996, the court subsequently granted the plaintiff bookstore an interim injunction to enjoin the continued policy of systematic inspection by customs.

Human rights legislation in Canada may also be invoked in attempts to limit access to sexually explicit materials. For example, in early 1993 the Ontario Human Rights Commission established a board of inquiry to address complaints that local stores selling *Penthouse* and *Playboy* created a "poisoned environment" for women. Although the board of inquiry was halted in late 1993, the issues surrounding legislative regulation of sexual depictions is likely to continue.

Canada's "child pornography law," introduced in 1993, makes it an offense punishable by a maximum of ten years imprisonment to make, print, publish, or possess for the purpose of publication, any material classified as "child pornography." Possession is also prohibited and punishable by up to five years. In both cases, someone charged could be found not guilty "if the written material alleged to constitute child pornography has artistic merit or an educational, scientific, or medical purpose." Child pornography is defined as "a photographic, film, video, or other visual representation, whether or not it was made by electronic or mechanical means" that has one or more of the following features: (1) it "shows a person who is or is depicted as being under the age of 18 years and is engaged in or is depicted as engaging in explicit sexual activity"; (2) "the dominant characteristic of which is the depiction, for a sexual purpose, of a sexual organ or the anal region of a person under the age of 18 years"; or (3) "any written material or visual representation that advocates or counsels sexual activity with a person under the age of 18 years that would be an offense under this Act" (MacDonald 1994, 23).

However, the initial introduction of the child pornography law was considered hasty by some and in need of fine-tuning. A series of subsequent legal cases pertaining to this law are instructive in this regard. In October of 1993, Toronto artist Eli Langer was charged under this law for paintings of people engaged in sexual activity. Some of these individuals appeared to be males under the age of 18. A judge ruled the work to have "artistic merit" and the charges were dropped. Nevertheless, the Ontario government used a forfeiture application to seize the work as child porn. Langer's work was subsequently returned to him. In February of 2000, an Ottawa father of two children was arrested after a photo-lab technician flagged pictures of this man's four-year-old son playing without pajama bottoms. The charges were dropped, but the husband and wife involved were required to take a parenting course and spent the majority of their savings in legal expenses. Most recently, the Supreme Court of Canada ruled on the case of John Robin Sharpe, a 67-year Vancouver man charged with possession of child porn. Sharpe had pictures of boys as young as seven engaged in sex and a collection of his own writings titled "Kiddie Kink Classics." The Supreme Court and two lower courts in British Columbia acquitted Sharpe on the basis that the charge violated his rights under the Charter of Rights and Freedoms.

Contention surrounding the child pornography law has centred around the need to balance the protection of children from sexual exploitation with the need for freedom of thought, belief, and expression this is protected in the Charter of Rights and Freedoms. One British Columbia judge who had been involved in the Sharpe case expressed concern that the law, as currently understood, was perilously close to criminalizing merely "objectionable thoughts." That said, there was agitation to remove the offense of possession from the child pornography law. However, critics pointed out that the removal of the offense of possession as unconstitutional would make it exceedingly more difficult to investigate and prosecute more serious offenses, such as the sale and distribution of pornographic materials. This debate was played out in the Supreme Court of Canada with a decision coming forth in January of 2002. The child pornography law that was ultimately upheld prohibits not only the possession of pornographic material involving children, but also written material depicting unlawful sexual activity with a child. The exceptions to this include material that is "for the public good" or otherwise defensible for it's artistic, educational, medical, or scientific merit. Two further exceptions were also added at that time, the first of which speaks to written materials or visual representations created and held by the accused alone, exclusively for personal use. The latter includes visual recordings created by or depicting the accused that do not depict unlawful sexual activity and are for private use only (Baer, 2002).

Court proceedings on obscenity cases have been a common occurrence in Canada, and the courts, rather than legislators, appear to be the ultimate arbiters who weigh research evidence and public opinion in such matters. The development of phone sex lines, computer sex services, and other such means for accessing sexually explicit content are also testing the Canadian penchant for legislation in such areas. Although it is subject to some legal restriction, sexually explicit material is widely available in Canada.

9. Contraception, Abortion, and Population Planning

A. Contraception: Attitudes, Availability, and Usage

Although contraceptive pills, condoms, and other forms of contraception were available in Canada prior to 1969, it was only in that year that the law was changed to legalize the advertising, dissemination, and distribution of such methods for the purpose of contraception. The establishment of the Family Planning Division within the federal ministry of health in 1972 was consistent with the government's policy that adult Canadians should be able to determine voluntarily the number and spacing of their children. An important aspect of the division's work was to support development of community public health programs to reduce teen pregnancy. When the division was discontinued in 1976, due in part to opposition from quarters opposed to its mandate, the loss impaired development of services in smaller communities that needed both the resources and initiative provided by this kind of federal program (Orton & Rosenblatt 1993) Other divisions within Health Canada took up this mandate, as did the provinces, and contraceptive information and services are now generally available through public health units, Planned Parenthood centers, private physicians, pharmacies, and a variety of clinics and health centers. While knowledge about contraceptive meth-

ods is generally good, application of that knowledge, in terms of both motivation and finding a method suitable for each individual, is still a significant issue, not only for teens, but also for young adults who are increasingly postponing childbearing until their 30s and beyond.

While availability of contraceptive education and services for adults and teens has increased following legalization in 1969, a 1990 *Report on Adolescent Reproductive Health* (Health and Welfare Canada 1990) noted that teens, particularly in rural areas, still lacked adequate access to contraception and related sexual health services. To the extent that this deficiency reflected teen discomfort with the settings in which such services were provided, some high schools have established Sexuality Health centers (Campbell 1991) and some jurisdictions have introduced condom machines in the high schools (A. Barrett 1992). Neither of the above was then, or is now, a common occurrence in Canadian schools. Such programs generally arise only after an assessment of community needs and consultation with parents. When they do occur, they probably reflect an already high level of community acceptance. Indeed, the school-based sexuality education programs described in Section 3A, Knowledge and Education about Sexuality, Government Policies and Programs, and community agencies, such as public health units, Planned Parenthoods, and so on, are among the most common "official" sources through which students can get accurate information about contraception. Physicians also provide contraceptive information, as do websites sponsored by such organizations and by prominent medical groups such as the Society of Obstetricians and Gynaecologists of Canada. As a result, the 1998 Canadian contraception study found widespread familiarity with, and generally favorable opinions about, the contraceptive pill, condoms, and male and female sterilization among women aged 15-44 (Fisher, Boroditscky, & Bridges 1999). Familiarity and favorable ratings were lower for the female condom, injectable contraception, spermicides, cervical cap, and other such methods that might expand the range of options available to women as they make changes in contraception suitable for them at different times in their reproductive lives.

Table 8

Reasons Identified by Heterosexual University Students for Not Using a Condom the Last Time They Had Unprotected Sexual Intercourse[1]

Reason for Not Using a Condom During Last Act of Unprotected Sexual Intercourse[2]	Percentage Citing the Reason: Female	Male
Was with regular sex partner	55.7	49.1
Thought we were safe	44.3	47.4
Did not have a condom[3]	24.6	45.6
Did not want to use one	27.0	35.3
No sex with anyone else	25.8	24.3
Sex was so exciting[4]	17.4	30.6
Partner didn't want to use one[5]	13.8	27.8
Using drugs or alcohol[3]	4.2	13.3
Had just met partner[5]	4.2	12.1
Was embarrassed to buy	3.6	5.2

[1]Results from Myers and Clement (1994, 52). Sample includes 249 male and 237 female heterosexually active university students (average age ~22 years); 83.6% of respondents had used condoms at some point in their lives, 69.4% in the last year.
[2]Percentages add up to more than 100 because some respondents picked more than one of the 15 possible reasons on a list of options.
[3]sig. diff., $p < 0.001$
[4]sig. diff., $p < 0.005$
[5]sig. diff., $p < 0.05$

Contraceptive Practices

The 1993, 1995, and 1999 Canadian Contraception Studies (CCS) (Fisher, Boroditsky, & Bridges 2000; Fisher & Boroditsky 2000; Boroditsky, Fisher, & Sand 1995, 1996) are among the few national sources of information on trends and current practices in contraceptive use in Canada in the 1990s. The 1995 General Social Survey also asked a national sample about current contraceptive use, but because it did not ask about current sexual activity, authors who use these findings have done so with caution (see Maticka-Tyndale, Barrett, & McKay 2000). This section relies on these national sources and a sampling of provincial studies to document current contraceptive practices in Canada and trends through the 1990s and into 2003.

For a variety of reasons, including religious conviction, some Canadians choose to use natural family planning methods (symptothermal method, etc.), and a number of organizations (e.g., SERENA) and agencies (clinics in Catholic hospitals) offer education and support for users of this method. Overall, however, Canadians are most likely to use the pill, condoms, and IUD early in their sexual lives, with sterilization (tubal ligation and vasectomy) being a popular method in later years.

Based on reports of current use among all married women aged 18-44 who were having intercourse, the 1998 CCS found that 28% used oral contraception, 31% condoms, 26% male sterilization, 14% female sterilization, 8% withdrawal, and 2-4% rhythm, IUD, or barrier methods. A small percentage used multiple methods. Among unmarried women aged 15-44, the comparable values were 66% pill, 64% condom, 1-3 sterilization, 12% withdrawal, 4% barrier methods, and 2% rhythm. Because most studies throughout the 1990s in Canada have focused on contraception and condom use among teens and young adults, these latter observations provide a reference point for the findings that follow.

Although young adults who are regularly involved with a sexual partner are most likely to use birth control pills for contraception, public health officials have encouraged the additional use of condoms as added protection against STDs. Free condom distribution by public health units has been used as a means to promote "dual protection" among pill users (Ullman & Lathrop 1996). In a survey of 249 male and 237 female urban, heterosexually active (in the past year) university students, Myers and Clement (1994) found that 52.2% of males and 39.7% of females reported condom use during vaginal intercourse. All respondents indicated at least one instance during the past year in which they had not used a condom during intercourse. Table 8 gives some of their choices from a list of 15 possible reasons for not using a condom the last time they had unprotected intercourse.

In their replies to attitudinal questions about sex and condom use (strongly agree 1 to strongly disagree 5), females more strongly disagreed than males with the statements "safer sex is boring" (mean scores of 4.1 for females vs. 3.7 for males), "condoms are a turnoff" (3.4 for females vs. 3.1 for males), "it's safe for long-term lovers to have whatever sex they want with each other" (2.6 for females vs. 2.4 for males), "it's hard to have safer sex with alcohol or drugs" (3.2 for females vs. 2.6 for males), and "it's hard to have safer sex with an attractive person" (4.0 for females vs. 3.4 for males). Although both sexes agreed that "sexual enjoyment is an important part of life," females gave slightly more agreement (1.9 for females vs. 1.7 for males) (Myers & Clement 1994). Overall, female university students showed more positive attitudes toward condom use and a stronger be-

lief in their ability to use condoms than did male university students. This, in turn, translated into more conscientious practices reported by women than men. Two important subtexts in negotiations about condom use are a behavioral norm of serial monogamy among Canadian university students (i.e., there is never more than one partner, but partnerships do not last for more than a few months) and the traditional cultural norm that leads women to trust and defer to their partners, and men to expect this.

In a 1991 study of young adults (aged 15 to 29) in Quebec, 14.7% of sexually active respondents said they had never used a condom (9% for ages 15 to 19, 15.2% for ages 20 to 24, 16.8% for ages 25 to 29 years old). Another 41.3% said they had stopped using them (28.5% for ages 15 to 19, 40.2% for ages 20 to 24, 48% for ages 25 to 29), and 44% said they still used them (62.5% for ages 15 to 19, 44.6% for ages 20 to 24, 35.2% for ages 25 to 29). Among those in the total sample who were respectively either currently using or had previously used condoms, the reasons for ever having used condoms (multiple choices possible) were: contraception (77%, 83%), danger of STD (65%, 45%), new partner (29%, 27%), many partners (11%, 8%), and had or have an STD (2%, 4%) (Santé Quebec 1991). The findings suggest that many young people in Quebec may use condoms for contraception early in their sexual interactions and then shift to other methods of contraception and away from condoms as they get older and perhaps more established in a relationship.

Among college students (CEGEP) in Quebec, 18% said they had not used a contraceptive method the first time they had intercourse, 14% used a condom and the pill, 11% the pill only, and 55.3% a condom only. When asked about the contraceptive method used the last time they had sexual intercourse, 4.2% said none, 18% said the condom and pill, 49.2% the pill only, 26% the condom only, and 1.7% used other methods (Samson et al. 1996). In a study of contraceptive use by 745 sexually active anglophone and francophone university students in Montreal and Ontario, Lévy et al. (1994b) found that in the previous six months (1992-93) 72.4% overall reported using the pill, either alone (35.4%) or in combination with a condom (19.1%) or with other methods (17.9%), whereas condom use with the pill or other methods was less common (41.7%). The sizable percentage using some method of contraception (97.7%) and the lower percentage incorporating condom use (41.7%) is consistent with the suggestion that pregnancy prevention still predominates over STD/HIV prevention in the decision-making of a sizable percentage of university students. Although most students had only one partner in the previous six months (85.2%), having had more than one partner was the variable that correlated most strongly with condom use. Condom use was less common among those with higher coital frequency.

Tonkin's (1992) study of 15,549 students in grades seven to 12 in public and independent schools in British Columbia provided data on a variety of social and health-related issues affecting young people. With specific reference to sexual activity and contraceptive use, he found that 33% of males and 28% of females in the sample had ever had intercourse. For those in grade 12 (ages 17 to 18), the figures were 55% for males and 52% for females. Among the British Columbia high school students who were currently "sexually active," 64% of males and 53% of females said they used a condom in their last experience of sexual intercourse. Overall, 49% of sexually active students said they used condoms, 25% birth control pills, 8% withdrawal, 2% other methods, and 13% no method; 3% said "not sure."

A convenience sample of 660 15- to 18-year-old females in Toronto (Insight Canada Research 1992) found that among the 41.8% who said they were sexually active, the contraceptive methods used were condoms (29%), condoms and the pill (24%), the pill (22%), condoms and foam (4%), other (3%), or no birth control (26%).

The 1995 Canadian Contraception Study (Boroditsky et al. 1996) used a self-administered questionnaire to assess the contraceptive attitudes and practices of a random sample of 1,428 women aged 15 to 44 (57.5% married, 42.5% unmarried) drawn from 20,000 households that had previously agreed to be subjects in market research studies. Based on all respondents in the sample, the percentages currently using various methods of birth control were as follows: the pill (30%); condom (25%); male sterilization (14%); female sterilization (12%); IUD (11%); no method (15%); none because pregnant or trying to get pregnant (7%); withdrawal (5%); hysterectomy/menopause (3%); cream/jelly/foam (3%); rhythm (3%); IUD (1%); and diaphragm (1%). Not surprisingly, sterilization (male or female) was used by 38% of all married women versus 7% of not currently married women of all ages. Since the study did not determine the proportion of young unmarried women who were sexually active, or lesbian, it is not known what proportion of the 15% of nonusers had no need of contraception. However, among teens who have ever used the pill, 35% said they started using it before their first intercourse, 22% as soon as they became sexually active, and 33% within one year.

Based on his research with university students, William Fisher (1989), from the University of Western Ontario, has described a "Contraceptive Script" that Canadians typically follow. This script outlines a common progression of contraceptive methods that are used as individuals first become sexually active and form committed relationships. When young Canadians first become sexually active they typically use either no contraception or one or a combination of condoms and withdrawal. The use of oral contraception is usually begun after a woman has been sexually active for a period of time, or when she considers her sexual partnership to have become "long-term" or "committed." When relationships are terminated, it is not uncommon for contraceptive practices to return to an earlier form (e.g., to cease using oral contraception and rely on withdrawal or condoms in new partnerships), though as women move through a larger number of partnerships, they more typically continue using oral contraceptives. Though there has been no single large- scale national study to test Fisher's script, the studies cited here, and others, consistently provide support for the conclusion that the Contraceptive Script is commonly followed.

With respect to contraception and STD prevention at first intercourse, a study of grade 10 and 12 high school students in Regina, Saskatchewan, in 2000 suggests that the stereotype of unplanned and unprotected first intercourse may be changing. Among the 539 females and 470 males who reported on their contraceptive use at first intercourse, 42.3% overall used condom only, 27.8% used condom and pill, 6.6% used pill only, and 6.8% used other methods alone or in combination (Hampton, Smith, Jeffery, & McWatters 2001). Overall, about 80% used a reliable method of contraception and 72% used a condom. Males and females did not differ in this respect, nor in the percentage who used no method (15.9% of females and 16.3% of males). Among all students who had intercourse, about half felt that their parents would strongly or somewhat disapprove of their having sex, whereas over 70% of student surveyed who had not had intercourse expected such parental disapproval. Interestingly, a high percentage of all students who anticipated parental disapproval for their having sex felt that their parents would approve of their using condoms.

Among unmarried women aged 18-29, the 1998 CCS found that well over 80% used contraception at first inter-

course with their current partner, and slightly fewer used contraception at their most recent intercourse with this partner (Fisher & Boroditsky 1999). However, condom use was noticeably higher at first than most-recent intercourse, and pill use was higher at most-recent than first intercourse.

In the *Ethnocultural Communities Facing AIDS* study, respondents in long-term relationships were asked about their current contraceptive practices. Eighteen percent of women and 28% of men from the English-speaking Caribbean communities reported no contraceptive use, compared to 12% of South Asian men, and 20% of women and 24% of men from the Latin American communities. Condoms were the most common contraceptive reported in all communities (62% of English-speaking Caribbean women and 54% of men, 47% of South Asian men, and 37% of Latin American women and 44% of men), followed by oral contraceptives (49% of English-speaking Caribbean women and 33% of men, 26% of South Asian men, and 30% of Latin American women and 22% of men) (Maticka-Tyndale et al. 1995).

B. Teen Pregnancy

Canadian statistics on teen pregnancy do not distinguish between married and unmarried teens, nor is it possible to determine the extent to which marriage may have been precipitated by unintended pregnancy (although this tendency is much less likely than 20 years ago). Given that teen marriage rates are low and that most teen pregnancies are assumed to be unplanned and unwanted, Canadians generally approach teen pregnancy as a problem (although this may not be so in some northern aboriginal or First Nations communities where teen sexuality and pregnancy are less stigmatized).

A major review of teen pregnancies in Canada from 1974-1997 (Dryburgh 2000) plus Statistics Canada data for 1998 provide background to the current situation. The pregnancy rate is established by combining data on registered live births, therapeutic abortions in hospital (and only since the 1990s, in free-standing clinics), plus registered stillbirths, hospitalized cases of spontaneous abortion, and so on. From 1974 to 1997, the teen pregnancy rate (births per 1,000 women aged 15 to 19) dropped from 53.7 in 1974 to 41.1/1,000 in 1987, and then, in a reversal of this downward trend, increased steadily each year to 48.8/1,000 in 1994, whereafter, it has declined each year to 41.7/1,000 in 1998. This unexplained shift upward in teen pregnancy rates in the late 1980s and early 1990s was observed in a number of developed countries (Singh & Darroch 2000). The residual effect in Canada may be a continuing public perception that teen pregnancy rates are increasing. While this is not so, the percentage decline in teen pregnancy rates in Canada from 1970-1995 was less than in some of the countries that we often use for comparison (e.g. France, Germany, Sweden, Denmark, and Australia), although comparable to others (e.g. England, New Zealand, Scotland, and Spain) (see Singh & Darroch 2000; Darroch, Singh, & Frost 2001; and Maticka-Tyndale 2001).

Teen pregancy rates vary by province and territory, with the lowest levels in 1998 in Newfoundland and Labrador (31.5/1,000) and the highest in Yukon, Manitoba, and Northwest Territories (including Nunavut) (58.3/1,000 to 90.3/1,000) (see Table 9). Because teen abortion rates also vary by province, the birthrates to 15-19-year-olds range from 14.9/1,000 in Quebec to 90.3/1,000 in the Northwest Territories (including Nunavut), with an overall national rate of 19.8/1,000 (comparable to England, lower than the United States, and double or more the rates in Sweden and France) (see Darroch, Singh, & Frost 2001).

Table 9

Rates of Teen Pregnancy, Abortion, Miscarriage, and Birth for Canada, the Provinces and Territories in 1998[1]

Province/ Territory	Rate per 1,000 15-19 Year Old Females			
	Pregnancy	Abortion	Miscarriage	Birth
CANADA	41.7	20.9	1.0	19.8
Newfoundland/ Labrador	31.5	9.7	1.4	20.4
Prince Edward Island	36.4	5.6	1.0	29.7
Nova Scotia	39.7	15.3	0.4	24.0
New Brunswick	37.8	10.0	1.3	26.4
Quebec	40.0	24.4	0.7	14.9
Ontario	38.1	20.3	0.6	17.2
Manitoba	65.2	23.2	3.4	38.7
Saskatchewan	52.8	13.4	1.5	38.0
Alberta	50.9	23.3	2.2	25.4
British Columbia	38.8	21.7	0.9	16.1
Yukon	58.3	29.6	0.0	28.7
Northwest Territories[2]	117.0	24.9	1.9	90.3

[1]1998 was the fourth consecutive year of decline in Canada's teen pregnancy rate subsequent to a high of 48.8/1,000 in 1994.
[2]Includes Nunavut.
Source: Health Division, Statistics Canada (2002).

Given the tendency of teenaged females to have somewhat older male partners, a sizable percentage of the males involved in the pregnancies of 18- to 19-year-olds may not have been "teens" themselves. An analysis of U.S. teen pregnancies and births (which occur at a significantly higher rate than in Canada) reported that 70% of the male partners were over 20 (Males 1992). A comparable national analysis has not been done in Canada, but an update on adolescent birth statistics for the City of Toronto in 1993 (Phillips 1994) revealed a similar pattern to that in the U.S. Of the 364 births to 15- to 19-year-olds in Toronto in 1993, 54% ($N = 196$) had a record of the father's age. Of these fathers, 25% were 15 to 19, 45% were 20 to 24, and 30% were over 25. Among the 18- to 19-year-old females (65% of the births in the sample), the father's age was 15 to 19 for 18%, 20 to 24 for 51%, and over 25 for 31%. Among the 15- to 17-year-old females who gave birth, fathers' ages were 15 to 19 (44%), 20 to 24 (30%), and over 25 (26%). The available data covering STD cases for 1992 also support the conclusion that a sizable percentage of STD cases in female adolescents were acquired from males over the age of 19. Although these results cannot be generalized to the entire population, they are an indication that the majority of teen pregnancies may not involve male teen partners. It is not known what proportion of the pregnancies were either planned or desired.

In 1989, 58% of pregnant 18- to 19-year-olds gave birth (66% in 1975), 36% had induced abortions (25% in 1975 when abortion was less accessible), and 6% had other recorded pregnancy terminations (9% in 1975). In 1989, the absolute number of births to 15- to 17-year-olds was 46% less than in 1975, and to 18- to 19-year-olds, 40% less. Given the personal consequences of teen pregnancy for parent and child, prevention of unwanted pregnancy remains an important sexual and reproductive health issue in Canada (Wadhera & Strachan 1991).

C. Abortion

In 1988, the Supreme Court of Canada effectively decriminalized abortion in Canada by declaring the existing law (revised in 1969) unconstitutional. Prior to this, abortion

was illegal unless done by a doctor in an approved hospital, following certification by the hospital's therapeutic abortion committee that the woman's life or health would be endangered if the pregnancy continued. The Supreme Court decision was based on a woman's right to "life, liberty and the security of the person" under Canada's Charter of Rights and Freedoms. That decision has not eliminated the continuing struggle by some antiabortion groups to discourage abortion and block legal access to it. Campaign Life Coalition, Alliance for Life, Canadian Physicians for Life, and Human Life International are among the best known of the groups supporting this view. The groups most identified with retaining and improving women's right and access to abortion and educating about these issues are, respectively, the Canadian Abortion Rights Action League (CARAL) and Childbirth by Choice. A major impetus to change in the Canadian law has been the repeated charging, conviction, and subsequent acquittal of Dr. Henry Morgentaler for providing illegal abortions, i.e., illegal because, although medically safe and performed in a clinical setting, it was not done in an accredited hospital.

Dr. Morgentaler (and others) have now established clinics in a number of Canadian cities; all have been extensively picketed and some have been directly attacked—the original Toronto clinic was destroyed by arson in 1983. Many providers of abortion in clinics and hospitals continue to experience varying levels of picketing and/or harassment by protesters. In several provinces (e.g., Alberta and Ontario), the harassment of patients, staff, nurses, and/or the physicians who perform abortions has led to injunctions to prevent protesters from demonstrating directly in front of some clinics or physicians' residences.

The impact of public attitudes and disagreements about abortion, and the continuing acrimony surrounding this issue, extends widely into debates about sexuality education in schools, availability of clinical services, public health policies, and religious beliefs. A 1989 national survey found that 27% of Canadians thought abortion should be legal under any circumstance, 59% legal under certain circumstances, 12% illegal under all circumstances, and 3% had no opinion. This pattern of response has been consistent since 1975 (Muldoon 1991). In 1989, at the time that the federal government was considering a bill to recriminalize abortion (i.e., effectively a return to the 1969 version of the law), a national opinion poll commissioned by CARAL found that 62% disagreed with this plan, 28% agreed, and 9% had no opinion or did not reply. One year later, after the bill had been passed by the House of Commons and sent to the Senate for approval, a similar poll had responses of 66%, 25%, and 9%, respectively. The Senate defeated the "recriminalization" bill in January 1991. This meant that no federal law was in place and that abortion would be dealt with, as in other medical matters, by provincial and medical regulations. That is the current situation.

At present, all provinces except Prince Edward Island (PEI) provide varying degrees of access to abortion in hospitals, and all but PEI (which pays under special circumstances) will pay some or all of the cost under health plan coverage. There are now a total of 17 free-standing clinics (i.e., separate from hospitals) in Canada that provide abortion (none in Saskatchewan, PEI, or the territories) with the host province paying full costs in two provinces, partial costs in four, and no costs in the remaining four. Access to abortion still varies considerably across Canada, and there is significant financial hardship involved for women in many settings, particularly in remote Northern areas and in PEI, Newfoundland, and Saskatchewan (the three most rural provinces). Abortion continues to be a focus and flashpoint for differing beliefs and ideologies about sexuality and social policy.

When asked to identify the circumstances of pregnancy under which they would consider legal abortion acceptable, Canadians surveyed in 1990 gave higher approval under conditions such as harm to the woman's health (82%), pregnancy from rape or incest (73%), or the strong chance of serious defect in the baby (69%), than under specific social conditions, such as low family income (38%) (Muldoon 1991). These distinctions have prevailed in such surveys for over 20 years and suggest that Canadians, although generally approving of legal access to safe abortion, also have opinions about the criteria they would like to see used when such decisions are made.

In 1998, there were 110,520 therapeutic abortions in Canada, 61.7% in hospitals, 38% in free-standing clinics, and slightly less than 0.3% in the U.S. (see Tables 10, 11, and 12). This represents 32 abortions per 100 live births and 15.4 abortions per 1,000 women aged 15 to 44. The inci-

Table 10

Abortion Data for Canada (1998)

Year	Total Abortions[1]	Abortions per 100 Live Births	Percent Abortions Reported from:		
			Hospitals	Clinics	U.S.A.
1998	110,520	32.2	61.7	38.0	0.3
1997	111,819	32.0	64.3	35.5	0.3
1996	111,757	30.5	66.7	33.0	0.3

[1]Abortion rate (1998): 15.7 abortions/1,000 women aged 15-44.
Source: Canadian Institute for Health Information and Health Division, Statistics Canada (2002).

Table 11

Age-Specific Abortion Rates and Percentages for Canada (1998)

Age Group	Age Specific Abortion Rate/1,000 in Age Group[1]	Percent Distribution of Known Hospital and Clinic Abortions According to Age Group
15-19	20.9	18.9%
20-24	32.4	29.3
25-29	21.1	20.1
30-34	13.6	14.8
35-39	8.1	8.8

[1]Abortion rate (1998): 15.7/1,000 women aged 15-44.
Source: Canadian Institute for Health Research and Health Division, Statistics Canada (2002).

Table 12

Marital Status and Prior Abortion History of Women Receiving Abortions in Canada (1998)

Percent Abortions in 1998 According to Marital Status[1]		Percent Abortions in 1998 According to Prior Abortion History[1]	
Single	57.8%	No prior abortions	60.6%
Married	17.4%	One	25.6%
Separated	2.3%	Two or more	11.8%
Common Law	6.0%	Unknown	2.1%
Widowed	0.3%		
Unknown	14.4%		

[1]Based on known cases in hospitals, plus clinics in Ontario and Alberta, collectively representing about two thirds of abortions in Canada in 1998.
Source: *Therapeutic Abortion Survey*, Canadian Institute for Health Information and Health Division, Statistics Canada (2002).

dence of unreported abortions is unknown but probably quite low. It has been suggested that the increase in the absolute number of abortions in the late 1980s and early 1990s may have been because of a prolonged economic recession, but this pattern may also reflect younger women's desire for greater financial security prior to childbearing, which fits with the continued decline in fertility rates (Wadhera & Miller 1997). In 1998, women under 20 accounted for about 21% of abortions, and about half of the women who sought abortions had one or more children. The 1998 teen abortion rate of 20.9 abortions/1,000 women aged 15 to 19 is within the range observed throughout the 1990s (19.3-22.0/1,000 15-19-year-olds) and represents about one half of all pregnancies in this age group. This rate is consistent with the national and international evidence (reviewed by Bissell 2000) that an appreciable number of teens (excluding those who are married or do not have access to abortion services) may have chosen to become pregnant or to continue an unplanned pregnancy.

One problem for Canadian women seeking access to hospital abortions has been the waiting time involved. This is an issue not only because of increased risk and anxiety, but because of the restrictions placed on late abortions in some settings. Data collected on 59,694 therapeutic abortions conducted in hospital settings in 1992 showed that almost 90% were within the first 12 weeks of pregnancy. Time since conception for all cases was: less than 9 weeks (35.5%); 9 to 12 weeks (53.5%); 13 to 16 weeks (6.7%); 17 to 20 weeks (1.7%); over 20 weeks (0.3%); and unknown (2.2%). The so-called abortion pill, RU-486, which disrupts gestation early in pregnancy, has not yet been approved for testing or release in Canada.

D. Population Planning

To the extent that a population policy attempts to influence the size, rate of growth, distribution, age structure, or composition of a population, Canada does not have such a policy. Federal government policy ensures the right of people to regulate the number and spacing of their children, but does not directly advocate increasing population size through more births. The fertility rate has been below replacement since 1971 and a *de facto* policy favoring continued growth was in the setting of higher immigration levels at about 250,000 per year for the 1989-94 period, which was considerably higher than in previous years. The federal government's immigration plan for 2003 projects 220,000 to 245,000 immigrants and reflects a continuing blend of economic and humanitarian goals, rather than a population policy per se.

At the provincial level, Quebec, has offered a financial incentive to women who give birth in any year, presumably as a means of maintaining the francophone population (and perhaps total population as well, since Quebec's fertility rate is the lowest in Canada). Quebec also has some influence on immigration to that province (i.e., to maintain Quebec's share of total population, which was 23.7% in 2002), an agreement arising from Quebec's relationship with the rest of Canada, and an option that some other provinces also wish to exercise. In fact, the actual proportion of immigrants to Canada who settle first in Quebec has been dropping annually from 22.4% in 1991 to 12.5% in 1994 (Dumas & Belanger 1996). Overall, Canada has no stated national policy concerning distribution of the population. Immigrants settle predominantly in only a few provinces where jobs and other family members are located (e.g., over half of all immigrants come to Ontario, 25% of these to the Metropolitan Toronto area), but this is the result of circumstance and economics and not as a guided policy decision regarding population distribution.

10. Sexually Transmitted Diseases and HIV/AIDS

A. Sexually Transmitted Diseases

Incidence, Patterns, and Trends

The final report of the Royal Commission on New Reproductive Technologies, published in 1993, argued that a countrywide strategy was needed to prevent STDs and that this "must become a priority if we are to reduce the prevalence of infertility among Canadian couples in the future" (Royal Commission on New Reproductive Technologies 1993). Research done for the commission showed that many people lacked adequate access to quality reproductive health services that could either reduce their risk of acquiring STDs or provide rapid diagnosis and treatment. This was noted particularly for isolated and rural areas, and for many adolescents, single adult women, people with disabilities, and cultural and linguistic minorities.

Despite the decreasing incidence of some STDs in the early 1990s, Gully and Peeling (1994) reported that STDs remained the most common reportable infections in Canada. This was and is an ongoing concern because about one third to one half of women who acquire an STD (usually chlamydia or gonorrhea) will develop pelvic inflammatory disease (PID), representing about 80% of all cases of PID. While it is difficult to estimate accurately the rates of PID, Health Canada data cited in the Royal Commission report gave age-specific rates of between 243/100,000 and 306/100,000 for women in the four age groups 15 to 19, 20 to 24, 25 to 29, and 30 to 34. STDs appear to play only a small role in male infertility in Canada, but the most recently available incidence data presented in Table 13 suggest that STDs continue to be an important health concern for both sexes. In the 10 years that followed publication of the Royal Commission report, we have seen both gains and reversals in STD-prevention efforts.

Table 13

Number and Percentage of Selected Reportable Sexually Transmitted Disease Cases by Age and Sex in Canada (2000)*

	Number of Reported Cases (Percentage of All Cases)			
Categories (Age/Years)	Gonoccocal Infection	Infectious Syphilis	Chlamydia	Hepatitis B*
Rate	20.2/100,000	0.7/100,000	151.1/100,000	10.5/100,000
Total	6,222	171	46,452	2,815
Male	3,850 (61.9)	111 (64.6)	13,557 (29.2)	1,805 (64.1)
Female	2,368 (38.1)	60 (35.1)	32,869 (70.8)	984 (35.0)
Under 15	58 (0.9)	0 (0.0)	554 (11.9)	77 (2.8)
15-19	1,407 (22.6)	7 (4.1)	14,792 (31.8)	176 (6.3)
20-24	1,566 (25.2)	15 (8.8)	17,003 (36.6)	360 (12.8)
25-29	963 (15.5)	23 (13.5)	7,163 (15.4)	482 (17.1)
30-39	1,477 (23.7)	59 (34.5)	5,064 (10.9)	860 (30.6)
40-59	690 (11.1)	56 (32.7)	1,592 (3.4)	684 (24.3)
60+	51 (0.8)	11 (6.4)	74 (0.2)	135 (4.8)

Note: Numerical totals may not match since age and/or sex unspecified in a small proportion of cases.

*Hepatitis B data are for 1995.

Data source: Division of Sexual Health Promotion and STD Prevention and Control, Bureau of HIV/AIDS, STD & TB, Health Canada 2002.

In 1997, Health Canada published national goals for STD prevention that set cautiously optimistic targets (based on 1995 rates) for reductions by 2000 and 2010 in the rates of all major STDs and their sequelae (see Patrick 1997a in a special theme issue of the *Canadian Journal of Human Sexuality* on STDs and Sexual/Reproductive Health). For example, based on a steady 5-year decline in reported cases of chlamydia to a rate of 127/100,000 in 1995, a goal of 80/100,000 for 2000 and 50/100,000 by 2010 was reported (Patrick 1997b). Infectious syphilis was to be maintained at less than 0.5/100,000 by 2000, with endemically acquired syphilis to be eliminated by 2010 (Romanowski 1977). Similar expectations for declines in gonorrhea (Alary 1997) and PID and ectopic pregnancy (MacDonald & Brunham 1997) were reported, as were conceptual analyses of the behavioral and social changes needed to achieve these goals (Maticka-Tyndale 1997; Fisher 1997). Health Canada's routinely updated *Canadian STD Guidelines* also provide guidance for STD prevention and management.

The most recent data available show an unexpected resurgence of STDs in the late 1990s and early 2000s (Patrick, Wong, & Jordan 2000). For example, reporting rates for gonorrhea, which had declined from over 40/100,000 in 1990 to a low of 14.9/100,00 in 1997, increased in each of the three subsequent years to a rate of 20.2/100,000 in 2000 (Table 3). Similar changes have been noted for chlamydia, which had declined to 112/100,000 by 1997, but increased yearly thereafter to 151/100,000 in 2000, and for infectious syphilis, which remained below the national goal at 0.4/100,000 in 1997, but increased to 0.7/100,000 in 2000.

About 78% of reported cases of chlamydia in 2000 (58% in the case of gonorrhea) involved youth aged 15-24 (Table 13). The reported chlamydia rate among females aged 15-19 in 2000 was over 5 times that for males, and rates for both sexes were considerably higher in 2000 than in 1997 and over double the national goal set for 2000 (Patrick et al 2000). Although some slight increase in chlamydia rates had been expected in the mid-1990s as a result of more sensitive and less-invasive testing, the recent upward trend, which is also seen in gonorrhea, is unlikely to be explained solely by improved detection of existing cases. The trend is also not unique to Canada. International comparative studies of STD rates among youth in developed countries suggest that Canada has lower gonorrhea rates among teens of both sexes than the United States, comparable rates to England and Wales, and higher rates than Sweden, France, Finland, Belgium, and Denmark (Panchaud et al. 2000). In the case of chlamydia, rates in the mid-1990s were high in all but Belgium and France among these comparator countries, with Belgium and France showing the most sizeable rates of decline in chlamydia rates among teens from 1990-1996. Subsequent increases in Canada and other developed countries will require a revisiting of this analysis, along with an explanation for the recent upward trend.

STD rates vary considerably between provinces, reflecting differences in age structure, migration, and socioeconomic circumstances. For example, in 2000, the national gonorrhea rate of 20.2/100,000 included values of 0-6/100,000 in Newfoundland, PEI, and New Brunswick, 6.0-9.1/100,000 in Nova Scotia and Quebec, respectively, 16.9-24.2/100,000 in Yukon Territories, British Columbia, Alberta, and Ontario, 44.7-57.3/100,000 in Saskatchewan and Manitoba, respectively, and 318-346/100,000 in the Northwest Territories and Nunavut. Overall, the gonorrhea rate in Canada has declined by more than 50% in the last 10 years, even with the increases from 1997-2000. The national goal to eliminate endemically acquired gonorrhea by 2010 will require efforts to reverse that trend. In the case of infectious syphilis, the national goal set in 1996-97 was to maintain rates below 0.5/100,000, which was seen at the time as the most realistic option, given the low likelihood of a global eradication plan. More recently, in response to a localized outbreak of syphilis in Vancouver, British Columbia, and several neighboring regions, Wong and Jordan (2000) renewed the call for a national strategy to eradicate endemic syphilis in Canada.

Given that the Royal Commission on New Reproductive Technologies identified STDs as the primary preventable cause of infertility among Canadians, the continuing high incidence of chlamydial infection, particularly among young women, is a major concern that might also be well served by a national elimination strategy. Both diagnosis and treatment for chlamydia are widely available in Canada, but there are significant problems with control of this disease, because many people show no symptoms, the duration of infectiousness is long, and many people do not complete their course of medication if symptoms clear up quickly (Gully & Peeling 1994). These issues are particularly significant for teenage females who have the highest rates in Canada for chlamydia (Table 14).

Among the nonreportable STDs, herpes simplex 2, and human papilloma virus (HPV) infections are the most worrisome in Canada. Although it is difficult to obtain accurate national data, the evidence suggests that HPV is becoming more common, particularly in the younger age groups. Herpes simplex 2 seroprevalence has probably also increased in Canada in the last ten years as in the U.S. There were approximately 55,000 recorded patient visits for genital herpes in Canada in 1993, a number that includes multiple visits and probably underestimates the prevalence of infection.

There have been no studies specifically addressing perception of risk for STDs, and actions taken by individuals to prevent STDs, though studies on prevention of sexual transmission of HIV/AIDS, and some on contraceptive use also address STD prevention through condom use. In the Santé Quebec study (1991), about 50% of women and 60% of men in all age categories perceived themselves to be at risk

Table 14

Rates for Selected Sexually Transmitted Diseases Among Canadian Teens (15-19 Years of Age) (1997-2000)

		Males		Females	
		Cases	Rate/ 100,000[1]	Cases	Rate/ 100,000[1]
Chlamydia	1997	1,510	145.6	9,588	971.6
	1998	1,934	184.0	10,599	1,063.4
	1999	1,976	186.7	11,428	1,138.9
	2000	2,339	220.0	12,451	1,236.1
Gonococcal infections	1997	333	31.5	725	69.7
	1998	327	31.1	799	80.2
	1999	337	31.8	798	79.5
	2000	435	40.9	971	96.4
Infectious syphilis	1997	1	0.1	2	0.2
	1998	2	0.2	5	0.5
	1999	1	0.1	8	0.8
	2000	0	0.0	7	0.7

[1]Age specific rates.

Data source: Division of Sexual Health Promotion and STD Prevention and Control, Bureau of HIV/AIDS, STD & TB, Health Canada 2002.

of contracting an STD. When asked what factors they thought would increase the likelihood of their using condoms (responses were "agree," "more or less agree," "disagree"), the statement "partner requested it" was the only one that received more "agree" than "disagree" responses (66% agree, 23% disagree). Other suggested options that might have influenced condom use were: if condoms were less expensive (32% agree, 54% disagree), condoms were more accessible (38% vs. 53%), thinner condoms (26% vs. 58%), better knowledge about how to use them (24% vs. 69%), and more use of condoms by those around me (36% vs. 55%).

B. HIV/AIDS

The tragedy of HIV/AIDS has focused public attention on a wide range of sexual, ethical, and public policy issues touching all segments of society. Its devastating impact on gay men, on people with hemophilia, and increasingly on other segments in society, has forced Canadians to address not only the pragmatic aspects of prevention and treatment, but also the core questions of homophobia, discrimination (not only toward gay men and lesbians, but also toward people who are ill or disabled), our attitudes toward different sexual practices, our comfort with explicit discussions of sexual behavior, and a broad range of issues unresolved during the "sexual revolution" of the 1960s and the "gay rights revolution" of the 1970s.

Incidence, Patterns, and Trends

As of June 30, 2002, Health Canada's Centre for Infectious Disease Prevention and Control (CIPDC) had received reports of 18,336 cases of AIDS (90.9% in adult men, 7.8% in adult women, and 1.1% in children under 15 (see Table 15). However, estimates in the 1990s indicated that only about 85% of cases will eventually be reported (i.e., for a variety of reasons, underreporting is about 15%). Because there are also delays in reporting in any year and because the annual figures are corrected for such delays and for underreporting, Canada has probably had closer to 14,000 cases of AIDS in adults to the end of 1993. Based on these adjusted estimates, the growth in the number of cases of people with AIDS in Canada is as follows (value is total cases for the indicated time period): 1979-83 (107); 1984-88 (3,889); 1989 (1,668), 1990 (1,756); 1991 (1,906); 1992 (2,267); 1993 (2,379).

Table 15

Reported Cases of AIDS in Canada as of June 30, 2002[1]

Adults	Total Reported Cases	Percent of Total	Reported Deaths
Male	16,669	90.9	11,721
Female	1,437	7.8	814
Subtotal	18,124[4]	98.7	12,535
Children[2]			
Male	111	0.6	NR
Female	97	0.5	NR
Subtotal	208	1.1	117
Total	18,336[5]	100.0	12,652[3]

[1]*Source*: Health Canada, HIV/AIDS in Canada. *Surveillance Report to June 30, 2002*, Division of HIV/AIDS Epidemiology and Surveillance, Centre for Infectious Disease prevention and Control, Health Canada.

[2]Children under 15 years of age.

[3]Delays for both AIDS reporting and death reporting make it inadvisable to subtract the latter from the former to calculate the number of Canadians living with AIDS.

[4]Subtotal includes 18 cases where gender was unknown.

[5]Total includes 4 cases where age was unknown.

During the period between April 1991 and March 1992, Canada had an annual AIDS incidence rate of 5.7 cases per 100,000 person years. Compared to the 31 European countries, this incidence rate was higher than all but Spain, Switzerland, France, and Italy. However, for this time period, Canada's 5.7 per 100,000 incidence rate was substantially lower than the 17.7 per 100,000 rate in the United States (Remis & Sutherland 1993). Based on known cases of people with AIDS reported in Canada during 1992 ($n = 1,330$), 93.9% were male and 6.1% female, distributed according to age as follows: 0 to 14 years (1.2%); 15 to 19 (0.2%); 20 to 24 (2.3%); 25 to 29 (12.9%); 30 to 39 (46.2%); 40 to 59 (34.9%), 60 and over (2.3%).

It is estimated that over 80% of the deaths to date have been gay men. While men who have sex with men accounted for 79% of all new cases of AIDS in 1987, that percentage had dropped to 69% in 1994 (*CCDR* 1996). In contrast, injection drug use, which was the risk factor associated with 1% of new cases in 1987, accounted for 6% of cases reported in 1994. Based on the experience of AIDS in adults to 1994, the risk factors identified with transmission were: homosexual/bisexual activity (77%), injection drug use (3%), both of the above (4%), heterosexual activity (9%), receiving HIV-infected blood or clotting factor (4%), and no identified risk factor (4%) (LCDC 1994).

It is unknown how many people in Canada are currently infected with HIV. One estimate from the *Canadian Communicable Disease Report* (1992) put the number at 30,000 to 40,000. In the 1996 *CCDR*, the estimate was 45,000. Estimates cited by Remis and Sutherland (1993) state that the prevalence of HIV infection among homosexually active men is 10 to 15%. The same report cites seroprevalence estimates in intravenous drug users ranging from 1 to 2% in the city of Toronto to 15 to 20% in the city of Montreal. Seroprevalence estimates from seven separate studies on adult women indicate seroprevalence rates per 1,000 adult women of 0.1 in Alberta, Saskatchewan, Manitoba, Prince Edward Island, Yukon, and Northwest Territories, 0.2 to 0.3 in British Columbia, Ontario, New Brunswick, and Nova Scotia, 0.6 in Quebec, and 1.2 in Newfoundland. Four provinces, Ontario, British Columbia, Alberta, and Quebec, account for 95% of all cases in Canada.

Shifts in the epidemiology of the disease and the potential for further change make it difficult to predict the incidence and distribution of HIV infection among specific populations. For example, the proportion of cases of AIDS in adults resulting from male-to-male sexual transmission has been steadily decreasing from 81.5% in 1988 to 73.5% in 1992 and 1993. The proportion of adults with AIDS who are injection drug users has been increasing from 4.6% in 1988 to 10.2% in 1993 (LCDC 1994). The number of people who acquired AIDS from blood products (hemophiliacs and others) peaked in 1988 and blood testing initiated in 1985 has almost eliminated this risk factor. (A national commission is currently investigating the Canadian blood supply [Krever Commission] and may identify populations who received blood products during or prior to 1985, but have not been notified or tested.) Reported cases of AIDS in women increased in each of the three-year periods between 1982 and 1990, and the cumulative incidence of AIDS in women in Quebec is almost four times the national average (probably because of the higher number of immigrants from countries where AIDS is more common) (Remis & Sutherland 1993).

Prevention, Treatment, Government Programs, and Policies

The development of strategies and policies to prevent the spread of HIV infection has required basic research on Canadians' knowledge about AIDS, their attitudes toward people with AIDS, their perception of the government's role in prevention and treatment, and on aspects of their behavior that might place them at risk of infection. As of the mid-1980s, there had been no large-scale national surveys available as a basis for addressing such questions. In late 1988, the Institute for Social Research at York University conducted a national telephone interview survey of a representative sample of 1,259 Canadian adults to obtain data relevant to these issues (Ornstein 1989). By the time of the survey, there had been considerable public discussion about AIDS in the media and most respondents were knowledgeable about transmission, the distinction between AIDS and HIV infection, and the effectiveness of different methods of prevention. Nevertheless, 26% believed that blood donors were at risk of infection and another 5% did not know. In addition, a sizable minority (9 to 12%) believed that HIV could be spread by food preparation, that it could be cured if treated early, and that people who were infectious would show symptoms of the disease. Another 12 to 18% did not know the answers to these questions.

Among the groups or agencies that respondents perceived as having a major responsibility for AIDS education (as opposed to "some" or "should not be involved"), parents were identified most often (82%), followed by doctors and STD clinics (about 75%), and federal and provincial governments, public health agencies, and community AIDS organizations (58 to 70%). While 45.6% said churches should have some responsibility, 35.2% said they should not be involved. It is perhaps a reflection of Canadians' deference to medical and parental authority that doctors and parents were rated so highly, since neither group has been a major source of HIV/AIDS information for most people. Indeed, television and newspapers were the most frequent sources of AIDS information identified by respondents (39% and 23%, respectively).

Ornstein (1989) summarized his findings on Canadian attitudes toward some of the sociopolitical aspects of AIDS as follows:

1. Sixty-nine percent of Canadians would permit their child to continue to attend a school class taught by a teacher who was infected with HIV, and another 8% would do so with qualifications.
2. Eighty percent of Canadians believe that HIV-infected persons should be legally protected from discrimination by landlords and employers. [*Note*: Discrimination in employment based on HIV status is generally prohibited in Canada, and people with AIDS cannot be summarily dismissed because of that status.]
3. By more than a two-to-one majority, Canadians support anonymous testing for HIV. [*Note*: Although AIDS is a reportable disease, anonymous testing for HIV infection is available in some clinics. In addition, samples may be submitted anonymously by a physician who knows the identity of the donor.]
4. There is very strong support for allowing physicians to demand a test for HIV from patients they suspect to be infected, and for compelling HIV-infected individuals to disclose the names of their sexual contacts.
5. About 60% of Canadians oppose providing needles to injection drug users. [*Note*: Needle-exchange programs are now operating successfully in a number of Canadian cities.]
6. A nearly two-to-one majority indicates support for allowing high school students to obtain condoms in their schools (Ornstein 1989, 101).

HIV/AIDS Issues in Various Ethnocultural Communities

In late 1989 and early 1990, Health Canada (then called Health and Welfare Canada) initiated national consultations to identify the specific needs of ethnocultural communities with respect to HIV/AIDS prevention. The *Ethnocultural Communities Facing AIDS* project arose from those discussions. Epidemiological and demographic data gathered in the first phase were used to identify six participating communities (South Asian and Chinese in Vancouver, communities from the Horn of Africa and English-speaking Caribbean communities, and Latin American and Arabic-speaking communities in Montreal). Community-identified representatives for each group formed the six Regional Research Groups, which met regularly with the researchers. Each community group included community leaders, healthcare professionals, people working in the AIDS field, and others. Six in-depth reports were produced as a result of the qualitative research (focus groups in each community and interviews) (Health Canada 1994a-f; available from the National AIDS Clearinghouse). The reports illustrate "the ways in which individual life experiences in the country of origin, combined with the challenges of recent emigration, can affect sexual health." Selected observations from the reports give an indication of the type and complexity of issues involved for the different communities.

Many recent immigrants find Canada to be a country of relatively liberal sexual values compared to their country of origin. Because they often come to Canada with more conservative sexual norms and customs than found in "mainstream" Canadian culture, members of some ethnocultural groups require HIV/AIDS-prevention education programs that are designed to be culturally appropriate for their particular group. In some of these ethnocultural communities, an explicit discussion of sexuality between parents and children or between men and women is taboo. For example, in a focus group, Punjabi women discussed how "some girls do have sexual experiences before marriage, but will never talk about them because doing so would 'wreck their reputation'" (Health Canada 1994e, 11). Or as a woman from the Horn of Africa commented, "Since our childhood, sex was presented to us negatively, and there is no way we can appreciate talking about it" (Health Canada 1994b, 16).

In addition, in some of these culturally distinct Canadian communities, there is a denial of the existence of gay, lesbian, and bisexual behavior among community members. As one focus-group participant from the South Asian community suggested, "A man who has sex with men won't accept the fact that he is gay" (Health Canada 1994e, 12). Or, as told by a study participant from the Horn of Africa, "People do not want to acknowledge or believe that homosexual behavior, or gay men, lesbians, and bisexuals, exist in their community. This denial leads those men and women who want to have same sex relationships to hide their behavior 'in the closet'" (Health Canada 1994b, 14).

Negotiating condom use is particularly difficult in some of these communities. For example, in the Chinese communities, "Most people who participated in interviews and focus groups report that condoms are not being used to prevent AIDS and other STDs. Women feel they are powerless to instigate condom use with their husbands or male partners, because it raises issues of 'trust' and 'promiscuity'" (Health Canada 1994f, 13). In some ethnocultural communities, condoms are seen as preventing a male from fulfill-

ing his role in procreation or in maintaining his family line or the racial group. A woman from the English-speaking Caribbean islands suggests that within her communities, "There's a general conception that the condom equals genocide. You commonly hear men saying, 'my seed has to flow'" (Health Canada 1994c, 12).

The findings of the qualitative phase of the *Ethnocultural Communities Facing AIDS* project illustrate that the values, norms, and customs related to the discussion of sexuality, sexual orientation, gender roles, and condom use, among other issues, are sometimes unique to particular ethnocultural communities. In the third survey phase of this project, questions were asked about various sexual experiences, risk perception, condom use, and psychosocial determinants of condom use with new sexual partners. Table 16 summarizes a selection of results in each of these communities.

Perceptions of personal risk and of the degree to which AIDS poses a problem varied between communities. For example, respondents from the Latin American communities were most likely, and those from the South Asian communities were least likely, to consider AIDS a problem in their communities. South Asian men were least likely, by far, to consider themselves at risk for HIV infection and also the least likely to have been tested for HIV. No more than four individuals from any of the communities reported that they had tested positive for HIV infection. Reports of condom use with new partners support the conclusion that a minority in each of the communities is using condoms consistently. There was no statistical association between frequency of condom use and perception of risk in any of the communities.

The survey also examined the major psychosocial determinants of planning to use condoms in future sexual relationships. Both the strength of these determinants and their specific content varied across the communities. These results, together with those from the qualitative phase, underscore the need in Canada to develop HIV/AIDS intervention strategies suitable for the target audience's ethnocultural identity.

National, Provincial, and Local Resources for Prevention

The Canadian AIDS Society, a coalition of over 90 local AIDS Committees and other community-based organizations, is actively involved in advocacy, public education, treatment, care, and support for people with AIDS. Most community AIDS initiatives in Canada began in, and are sustained by the gay community, with support from all levels of government and the local community. The second revised edition of the Society's *Safer Sex Guidelines* (Canadian AIDS Society 1994) provides authoritative guidance for educators and counselors on assessing the risk of HIV transmission via different sexual behaviors and on reducing that risk.

Safer Sex Practices of Selected Populations

Gay and Bisexual Men. In 1991-92, the first national survey in Canada to assess possible effects of different variables on HIV-test-seeking and sexual behavior of men who have sex with men was conducted in 35 cities across Canada (Myers et al. 1993). The sample of 4,803 men (20.9% over the age of 22) was recruited from gay-identified settings in seven geographical regions, and questionnaires, administered in English or French, were used for data collection. The salient measure of sexual risk-taking reported in the study was at least one instance of unprotected anal intercourse in the previous three months. Overall, 22.9% reported at least one instance of unprotected anal intercourse (15% reported having had unprotected receptive anal intercourse), 64.7% said that they had had an HIV test, and 11.8% reported that they were HIV-positive.

Comparisons based on city size (cities under 500,000, 500,000 to 1 million, and over 1 million), indicated that those from smaller cities were considerably less likely to have been tested (55.2% vs. 63.2 and 69.2%) and somewhat more likely to have engaged in unprotected anal intercourse (26.3% vs. 23.5% and 20.9%).

Lévy et al. (1994a) reported higher levels of condom use during anal sex among francophone gay men who were in occasional versus stable partnerships, and lower levels of condom use in both groups during oral sex (Table 17). The findings are consistent with other reports of increased use of safer-sex practices among multipartnered gay men.

High School Students. The *Canada Youth and AIDS Study* reported on the knowledge, attitudes, and behavior with respect to AIDS of over 38,000 Canadian youth aged 11 to 21 (King et al. 1988). The study, which provided a fairly comprehensive picture of the sexual behavior of Canadian high school students, found that 31% of males and 21% of females had had intercourse by grade 9. By grade 11, these percentages increased to 49% for males and 46% for females. AIDS was second to pregnancy as the outcome of sexual intercourse that high school students worried most about. Although this study did not measure condom use among high school students, 48% held negative attitudes toward condoms.

In a late-1980s study of grade 11 students (N = 1,275, average age 17 years) in

Table 16

Selected Responses to Questions Related to HIV/AIDS Risk and Perception of Risk in Communities Participating in the Ethnocultural Communities Facing AIDS Project

	Percentage Responding in Each Category				
	English-Speaking Caribbean		South Asian	Latin American	
	Women (N = 190)	Men (N = 187)	Men (N = 364)	Women (N = 176)	Men (N = 176)
AIDS is a problem in our community:					
Agree	50	48	30	90	86
Neither agree nor disagree	11	8	39	7	11
Disagree	38	44	32	2	3
Believe at risk for HIV infection:					
Yes	32	30	11	29	40
Maybe	38	41	29	30	25
No	30	29	60	40	35
Have been tested for HIV	38	37	21	30	32
Frequency of condom use with new partners:					
Never	12	6	13	12	14
Sometimes	62	66	38	59	56
Always	26	29	47	28	30

Data adapted from Maticka-Tyndale et al. 1996.

Montreal, Quebec, Joanne Otis and her colleagues found that 53% of respondents who had had intercourse (about 60% of both sexes) said they used a condom the first time. Only 18.2% said they did so constantly thereafter; 67.2% reported using the pill for contraception (Otis et al. 1990). The best predictor of a student's stated intention to use a condom with a future new partner was whether or not the female was using oral contraception, i.e., the intention to use condoms was lowest if it was assumed that the female would be taking the pill, and greatest if she was not. Otis et al. (1990) proposed that Canadian educators should reinforce the acceptability and desirability of condom use with a new partner, even if the female partner is using oral contraception (see also Otis et al. 1994). In a recent review of studies on adolescent sexual behavior, Otis et al. (1996) made the following observations related to HIV prevention among high school students in Quebec in 1995: (1) 50 to 75% said they had used a condom at first intercourse, an increase between 1988 and 1995; (2) about 50 to 60% of all sexual contacts involved condom use and 13 to 48% used a condom in all their sexual relations; (3) 22% of 15-year-olds and 39% of 18-year-olds said they had taken an STD test and 14% of high school teens had taken an HIV test. In the population of adolescents surveyed at youth or leisure clubs and at youth centers (for young people with social or other problems), the numbers were higher in all categories. For example, at youth and leisure clubs, 65% reported condom use at first intercourse, 38% used condoms in all their sexual relations, and 41% had taken an HIV test.

Studies in the provinces of Alberta and Nova Scotia have also reported on the frequency of condom use among high school students. In the Alberta study, 41% of "sexually active" high school students indicated that they either did not or infrequently used condoms, and 59% reported that they frequently or always used condoms during sexual intercourse (Varnhagen et al. 1991). In one study of Nova Scotia high school students, 55% reported using condoms "more than just some of time"; 35% always used condoms (Langille et al. 1994). Another school-based survey in Nova Scotia (Poulin 1996) found approximately 61% of grade 12 students having had sexual intercourse during the past year, 40% indicating they had had two or more sexual partners. Of those who were sexually active, only 32% reported always using a condom.

Although the reported frequency of condom use among Canadian high school students is less than adequate for HIV/AIDS prevention, this group appears to use condoms more frequently than either college/university students (e.g., King et al. 1988; Ramsum et al. 1993) or adults (e.g., Ontario Ministry of Health 1992).

Table 17

Condom Use and Sexual Behavior in Francophone Gay Men: A Comparison of Men in Stable Partnerships and Men with Occasional Partners

Sexual Activity in Past Six Months	Percentage of the Group Reporting the Behavior: Stable Partnerships[1] (*N* = 276)	Occasional Partners[2] (*N* = 336)
Fellatio (active)	92.6	92.8
Used condom[3]	3.8	9.4
Fellatio (received)	94.1	96.7
Used condom	3.9	6.4
Anal sex (active)	54.6	43.0
Used condom	61.3	90.7
Anal sex (received)	51.5	34.8
Used condom	59.9	92.9

[1]66% said the relationship was exclusive.
[2]29% said they had one partner in the last 6 months (Average for group = 10).
[3]Condom used means in all such activities in the previous 6 months.
Data from Levy et al. (1994a).

College/University Students. Because they are mostly young, single, highly sexually active, and accessible to researchers, college/university students have been widely used in studies of knowledge, attitudes, and behaviors related to HIV/AIDS. The *Canada Youth and AIDS* study found that among college students, 77% of males and 73% of females had at least one experience of intercourse. Sixty-eight percent of the males and 64% of the females reported having oral sex; 14% of the males and 16% of the females reported having anal sex. Numbers of partners for males and females, respectively, was: one (23%, 36%); two (12%, 17%), three to five (29%, 26%), six to ten (17%, 14%), and 11 or more (19%, 7%). Forty-four percent of males and 30% of females identified AIDS as the outcome of sex that worried them most (pregnancy was much higher at about 60%, and other STDs much lower at 4%). When those who had intercourse were asked about condom use, the responses for males and females, respectively, were: always (19%, 11%), most of the time (16%, 9%), sometimes (43%, 52%), and never (22%, 28%) (King et al. 1988).

A comparison of British Columbia university students surveyed in 1988 (in the same year as the *Canada Youth and AIDS* study), and again in 1992, indicated no change in the number who reported being sexually active within the last six months (62%), a slight decline in the proportion with multiple partners (i.e., 2 to 7 partners in the last 6 months) from 30% to 24% of those who were sexually active, and some increase in the proportion using condoms "always" (17% to 25% in 1992) or "most times" (6% to 15%). However, the number reporting never used condoms (51% vs. 40% in 1992) or sometimes used (26% vs. 20% in 1992) remained high (Ramsum et al. 1993). This study is consistent with the findings of other studies of university students that have found that, although they are highly knowledgeable about HIV/AIDS, this group's perceived risk has not been sufficient to overcome some of the barriers to consistent condom use (e.g., immediate accessibility, inconvenience, peer-group perceptions, religious beliefs, influence of alcohol, etc.) (Ramsum et al. 1993).

Another study of college students in Montreal found that perceived risk of HIV infection was correlated with having a friend who had had an HIV test and having more than one coital partner. For women, the level of trust in a relationship was also correlated with perceived risk of HIV ("I trust this person, I must be at low risk"). For men, their confidence in their ability to assess whether or not it was necessary to use condoms with a particular partner was also correlated with perceived risk of HIV infection (Maticka-Tyndale & Lévy 1993). Recent reviews on condom use among college students in Quebec (Otis et al. 1996; Samson et al. 1996) found: 47 to 67% used condoms at first intercourse, an increase from 1983-1995; condom use was less common with a regular partner (38%) than with occasional partners (66%; 34% had taken an STD test and 14% an HIV test). The comparable findings among university students (Otis et al. 1996) were: 42.5% said they used condoms at first intercourse, fewer used condoms with a regular partner (34%)

than with an occasional partner (88%), and 14% had taken an HIV test. Current prevention efforts with this group are increasingly using theoretically based approaches to behavior change (Fisher & Fisher 1992) that stress information, motivation, and behavioral skills (IMB), and identification with people known to have AIDS (i.e., influencing personal perception of risk). Because empirical research increasingly indicates that educational interventions based on an IMB approach are successful in helping people perform sexual health problem-prevention behavior, the IMB approach is recommended by Health Canada's *Canadian Guidelines for Sexual Health Education* (Minister of Supply and Services Canada 1994).

Street Youth. Street youth represent a particularly high-risk group for HIV infection because of the greater likelihood of involvement in prostitution, IV-drug use, unprotected homosexual or bisexual activity, and backgrounds of family disruption, abuse, and attendant low self-esteem. As part of the *Canada Youth and AIDS* study, 712 street youth aged 15 to 20 were interviewed about their sexual practices and HIV-risk behavior (Radford et al. 1990). Ninety-four percent of the sample was sexually active, 32% never used condoms, 32% used condoms sometimes or most times, and 26% always used condoms; 75% used drugs and 12% occasionally injected drugs (half using shared needles). Needle-exchange programs in several major cities have helped reduce the spread of HIV in street youth, but this selected population remains at high risk and is therefore the focus of significant outreach programs by a variety of youth-serving agencies. The First National Conference on HIV/AIDS and Youth held in Toronto in 1989 led to publication of a *National Inventory of AIDS Organizations for Youth*, listing over a hundred such organizations and agencies across Canada.

More recent studies of street youth (Frappier & Roy 1995; McCreary Centre Society 1994) indicate that 85 to 98% have had sexual intercourse. For over 60%, age of first intercourse was before 13 years. Fifty-two to 78% reported having six or more sexual partners in their lifetime, with many reporting inconsistent condom use.

First Nations People. Few studies have investigated the incidence of HIV infection among First Nations People in Canada. One study of a high-risk population in the city of Vancouver found an infection rate of 6% among First Nations People (Rekart et al. 1991).

The *Ontario First Nations AIDS and Healthy Lifestyle Survey* (Myers et al. 1993) is the largest Canadian study to date on the HIV/AIDS-related knowledge, attitudes, and behavior of First Nations People. At the time the study was initiated in 1989-90, there was little AIDS education for this population, but there was significant concern about the risk of infection in such close communities with a tradition of early sexual activity and ongoing experience of "social, economic, psychological, spiritual, and political concerns" and of other factors contributing to "the inequities in health that First Nations People experience" (Myers et al. 1993). Consultation with four Provincial Territorial organizations (Association of Iroquois and Allied Indians, Grand Council Treaty Number Three, Nishnawbe-Aski Nation, and the Union of Ontario Indians) resulted in interviews with 658 individuals (about an equal number of males and females) from 11 First Nations communities across Ontario.

In this sample of First Nations People, overall knowledge of HIV/AIDS was relatively low. For example, although 97.6% knew that "A person can get AIDS from having sex without a condom with someone who has AIDS," 85.3% incorrectly believed that donating blood could result in HIV infection for the donor; 18.3% gave an incorrect answer and 49.1% were uncertain in response to the item "Using Vaseline with a condom makes it weak and easier to break." Of the respondents who had heard of AIDS, 6.8% reported having been tested for HIV (7.8% of this group had tested positive) and 71.9% felt they had no risk for HIV infection. An additional 18.9% felt they had only a small chance of getting AIDS. About 40% of the men and 18% of the women had two or more sexual partners in the past year. Approximately 16% of the respondents reported having participated in anal sex at least once in their lifetime. In the 12 months prior to the survey, 29.8% of the respondents reported no sexual activity, 44.8% inconsistently used HIV-infection prevention measures when having sex, 12.1% never used condoms for vaginal or anal intercourse, and 13.3% reported engaging in only mutual masturbation or always using condoms for vaginal and anal intercourse. A recent analysis of the data on condom use from the study identifies a range of sociodemographic and behavioral factors associated with use or non-use of condoms, and discusses the findings in the context of the limited research available on safer-sex practices in First Nations populations (Burchall 1997).

The authors of the Ontario First Nations AIDS and Healthy Lifestyle Survey concluded from their findings that in order to be successful, HIV/AIDS-prevention efforts aimed at First Nations People must be culturally appropriate. They write, "The approach must be holistic and rooted in the culture, traditions, and customs of aboriginal communities, and therefore must embrace the entire community including the youth, parents, elders, and community leaders" (Myers et al. 1993, 63). For a country of considerable multicultural diversity, this principle of cultural appropriateness is an important facet of HIV/AIDS-prevention efforts aimed at Canadian audiences.

The Direct and Indirect Costs of AIDS

Efforts to figure the costs of AIDS commonly focus on calculating the direct medical costs of treating persons with HIV and AIDS, the costs of healthcare professionals' salaries, research, hospital care, medication, and psychological support for affected families and close relatives. The direct medical costs of treating one Canadian with HIV/AIDS from the time of infection to death is estimated at between $150,000 and $215,000.

Seldom, if ever, considered are the indirect costs of the disease in lost future earnings caused by AIDS-related deaths. In a pioneering 1995 study sponsored by the British Columbia Center for Excellence in HIV/AIDS, economist Robin Hanvelt and colleagues (1994) estimated that AIDS has already cost Canada $3.3 billion in lost future earnings for all the men aged 25 to 64 years old who died from AIDS between 1987 and 1992. The average estimated loss of future earnings per death was $651,200 in 1990 figures. The total loss in future earnings attributable to HIV/AIDS in Canada was exceeded only by those for ischemic heart disease, suicide, motor-vehicle accidents, and lung cancer. Hanvelt believes his calculations, based on a six-year study of 5,038 Canadian men who died of HIV/AIDS, are conservative. While the annual future loss of income remained relatively stable or declined for other causes of death, earnings lost through HIV- and AIDS-related deaths more than doubled from $309 million in 1987 to $817 million in 1992. Hanvelt estimates that the indirect costs of AIDS-related deaths in Canada will exceed $1.5 billion in 1996.

Combining estimates of direct and indirect costs of HIV/AIDS provides a clearer and more realistic picture of the social costs in terms of lost creativity, skills, knowledge, and productivity resulting from the premature death of thousands of young people.

[*Update 2002*: UNAIDS Epidemiological Assessment: It is often instructive to examine the rates of HIV infection by subgroup. However, it should be noted that estimates of positive HIV-test results by exposure category are limited to the extent that such statistics reflect only those cases where exposure category is reported. As a result, these figures tend to underestimate total exposure rates by category and are much lower than overall totals.

[Information on HIV prevalence among pregnant women is available since 1989. HIV-prevalence studies among pregnant women indicate an overall rate for Canada of between 3 and 4 per 10,000. Large metropolitan areas generally have higher prevalence rates: for example, 5.1 per 10,000 for Vancouver versus 1.9 per 10,000 for the rest of British Columbia province (outside Vancouver) in 1989 to 1994; 13 to 20 per 10,000 for Montreal versus 0 to 3.5 per 10,000 for the rest of Quebec in 1994 to 1995. Although women in general continue to be a minority of those newly infected with HIV, it is noteworthy to examine the absolute number of new positive HIV-test results for females from 1995 to 2000. While a decline was noted from 1995 to 1996 to 1997 (528, 541, and 456 cases, respectively), this did not continue in 1998, 1999, and 2000 (493, 544, and 544 cases) (Health Canada 2001).

[For sex workers (both male and female), there are six HIV-prevalence studies that had such information. Overall, between 1985 and 1993 and in major urban centers, the prevalence rates ranged from 1.9% for sex workers only and 1 to 22% for sex workers who were also injection drug users.

[Recent prevalence data on men who have sex with men in Canada shows a decline until 1998, which leveled off in 1999 and appears to have increased in 2000. The 2000 increase is the first noted since the 1980s. Prior to this time, there had been a trend toward decline in positive HIV reports among men who have sex with men (Health Canada 2001). Studies of specific cohorts in Vancouver have also shown this trend, but not in Montreal (Martindale et al. 2001; Remis et al. 2001).

[In examining the rates of positive HIV-test reports among injection drug users in Canada, one sees a general decline from 1995 to 2000. For example, the highest rates of incidence and reporting in some of the larger cities in 1996 (about 500 new cases) appears to have dropped notably in 2000 (about 300 new cases) (Health Canada 2001; Patrick et al. 2001). Nevertheless, it is unclear whether this decline is a function of saturation of the highest risk populations as opposed to the success of public policy (Patrick, Wong, & Jordan 2000).

[Among clients at STD clinics, HIV prevalence rates in sites outside major urban areas were approximately constant at about 1% during 1985 to 1994. However, the rate in major urban areas appears to have decreased from 15.8% in early 1985 to 1988 to 1.5 to 6% in 1991 to 1995. Interpretation of the validity of this decrease is complicated by the paucity of truly comparable data.

[The gradual decline in the number of new cases of HIV infection in Canadian adults from 1995 to 1998 has not continued (Patrick, Wong & Jordan 2000). According to Health Canada (2000), the rate of decline has leveled off between 1998 and 2000.

[The estimated number of adults and children living with HIV/AIDS on January 1, 2002, were:

Adults ages 15-49:	55,000 (rate: 0.3%)
Women ages 15-49:	14,000
Children ages 0-15:	< 500

[An estimated less than 500 adults and children died of AIDS during 2001.

[No estimate is available for the number of Canadian children who had lost one or both parents to AIDS and were under age 15 at the end of 2001. (*End of update by the Editors*)]

11. Sexual Dysfunctions, Counseling, and Therapies

Dr. Stephen Neiger, the founder of the Sex Information and Education Council of Canada, was probably the first practitioner to introduce "modern" sex therapy to the Canadian scene in the early 1960s. Neiger's behavioral approach to the common sexual dysfunctions (primary or secondary anorgasmia, vaginismus, and painful intercourse in women, erectile dysfunction and premature ejaculation in men) was a contrast and challenge to the traditional belief that treatment of such problems required psychotherapy to determine their root causes. Neiger viewed many such problems as a product of inadequate education, cultural taboos, and the anxiety and negative reinforcement generated by unrealistic performance expectations. The growing North American interest in sex therapy in the early 1970s, spurred by the release of Masters and Johnson's *Human Sexual Inadequacy*, and by the prospect of rapid, symptom-oriented treatment, led to increasing demand for such help and the implicit expectation that medical professionals would be adequately trained to provide it.

While such training has indeed become more available in Canada and more accessible to Canadian therapists because of developments in the U.S., the situation at present is quite limited. Canadians do have wide access to counseling about sex-related topics, since professionals from a variety of backgrounds (physicians, social workers, psychologists, public health nurses, occupational therapists, school guidance counselors, and clergy) may be trained, to varying degrees, to assist with sexual concerns as part of their broader work requirements. They do this counseling in a variety of settings, including private practice, hospitals, community health centers, family service agencies, sexual assault centers, and so on, and are bound by the ethical standards of their professions and individual agencies. Such individuals have generally not been trained as sex therapists and would probably refer clients with problems that required such therapy. There are still few people trained as sex therapists and few opportunities for such training in Canada. The Department of Sexology at the University of Quebec at Montreal and the Department of Family Studies at the University of Guelph in Ontario are the only institutions in Canada to offer postgraduate training and degrees in sex therapy (see addresses in Section 12B, Sex Research and Advanced Professional Education, Canadian Sexological Organizations and Publications).

Since there are no official self-regulating colleges of sex therapy in the provinces or nationally as there are for other medical specialties, the question of who is a sex therapist and how they are trained is a continuing issue in Canada. Alexander's (1990) review of sexual therapy in English-speaking Canada identifies this concern about standards for training and practice as a primary reason for the formation of the Board of Examiners in Sex Therapy and Counseling in Ontario (BESTCO) in 1975. The ten founding therapists, all members of the Ontario Association for Marriage and Family Therapy (OAMFT), established criteria for training and certification of therapists that they then applied to themselves and to subsequent members. They assumed that provincial or national certification of sex therapists was imminent and that the group would be prepared for that event. That step toward regulation of sex therapists has not taken place. BESTCO remains the only group in Canada that has a formal, nonstatutory certification procedure for certifying already-accredited marriage and family therapists who wish

to have their specialization in sex therapy recognized by a body of their peers.

Some sex therapists in Canada are certified by the American Association of Sex Educators, Counselors, and Therapists (AASECT), by the U.S.-based Society for Sex Therapy and Research (SSTAR), by the American Board of Sexology, and/or by other comparable international organizations specifically identified with sex therapy; others are certified for work in their field, e.g., medicine, nursing, psychology, pastoral counseling, marriage and family therapy, and related fields, which may or may not require specific advanced training before unsupervised practice in sex therapy can be done. For example, physicians can do sex therapy but do not have a formal requirement for certification of that specialty, despite the scarcity of such training in most medical schools. On the other hand, there are many physicians in Canada who are specialists in sexual medicine, but whose specialty is still not recognized by the Royal College of Physicians and Surgeons of Canada.

Only physicians and psychiatrists are permitted to bill the provincial health plans for sex therapy services, but their numbers are insufficient to meet the demand. Private sex therapy can be expensive for the average person, although some insurance plans will cover part of the cost of therapy if done by psychologists, social workers, or other health professionals covered by specific plans. Because of Canada's size and the location of therapists in large urban centers, sex therapy is simply not available to most people in smaller communities.

Canada has also had a chronic shortage of trained therapists who can work with people with paraphilias, gender disorders, psychiatric disorders, or medical conditions with sexual implications. Professionals who treat children and adults who have been sexually abused or assaulted, and those working with sex offenders, also require more training in sexuality than is currently available.

Sex therapists are expected to have accredited training in marital, family, and relationship therapy and to then acquire advanced skills and experience in sex therapy. The options for the latter in Canada include:

1. attending the week-long, Intensive Sex Therapy Training Institute offered at the University of Guelph, Ontario, prior to the annual Guelph Sexuality Conference;
2. obtaining supervision time with a therapist credentialed as a supervisor by a recognized accrediting body (AASECT, BESTCO, etc.);
3. taking the clinical training program in the Department of Sexology in the University of Quebec at Montreal (in French); or
4. becoming a member of a sexual medicine unit that trains therapists (e.g., the Sexual Medicine Unit at the University of British Columbia has had a longstanding program to train nurses and social workers as sexual healthcare clinicians, an excellent grounding for subsequent certification in sex therapy).

Continuing issues influencing the development of sex therapy in Canada include:

1. Feminist redefinition of "dysfunction" and development of new models for thinking about sexual response in the context of women's experience, rather than as a biologically mandated sequence of physiological events;
2. recent technological and pharmacological developments in the treatment of erectile dysfunction (e.g., injections and vacuum constriction devices), sexual desire disorders, and paraphilias;
3. the relationship between sex therapists and self-help movements, such as the 12-step programs for sex and love addiction (e.g., Sex and Love Addicts Anonymous);
4. the debate about the role of therapists in facilitating recovered memories of childhood sexual abuse and the therapeutic, legal, and political implications of practice in this area; and
5. dealing equitably with ethnocultural differences pertaining to sexuality. For example, the Canadian Medical Association recently banned physicians from doing the procedure referred to as ritual circumcision (Brighouse 1992) or genital mutilation (Omer-Hashi & Entwistle 1995), which is common in some parts of Africa and requested by some immigrants to Canada.

12. Sex Research and Advanced Professional Education

A. Sexological Research and Postgraduate Programs

Most sexological research in Canada is done by individuals or groups linked either directly or indirectly with universities. This work almost invariably occurs within specific academic disciplines (e.g., history, sociology, psychology, women's studies, philosophy, medicine, epidemiology and public health, education, family studies, criminology, etc.) rather than in a university department of sexology. The Department of Sexology at the University of Quebec at Montreal is the only department of sexology in Canada. Founded in 1969, it offers Bachelor's and Master's programs in human sexuality taught in French by approximately 20 full-time academic staff representing many fields of specialization. The master's program, which began in 1980 and was officially recognized by the university in 1985, offers internships, projects, courses, and other practical training in counseling and sex education (Dupras 1987). Candidates for the master's program in counseling come primarily from related fields, such as medicine, psychology, criminology, and social work, while those in the education stream usually come from the Bachelor of Human Sexuality Program (Dupras 1987; Gemme 1990). The Department is the major center for research on human sexuality in Quebec and also publishes *Bibliosex, a biannual bibliography of sexuality literature in Canada and internationally.*

Some academic departments in other parts of Canada offer graduate programs in human sexuality (e.g., University of Guelph, Department of Family Studies), but it is more common for graduate research on sexuality topics to occur within master's and Ph.D. programs in specific academic disciplines. Since 1978, the Family Studies Department has sponsored an intensive week-long annual June conference and training institute on sexuality at the University of Guelph, Ontario. The Departments of Psychology at both the University of Western Ontario and the University of New Brunswick are two examples of strong graduate research training in sexuality within a particular field. The Department of Sociology and Anthropology at the University of Windsor has the largest complement of sociologists—four—in a single department who are actively conducting research in sexuality. The department offers three undergraduate courses and one graduate seminar in sexuality, and students are able to pursue an undergraduate honors or a master's degree specializing in Family and Sexuality.

A number of medical faculties also provide postgraduate training in sexology. For example, the Sexual Medicine Unit at the University of British Columbia offers a clinical and research setting through which residents in Obstetrics and Gy-

necology and in Psychiatry can obtain advanced training. A number of other hospitals have Sexual Medicine Units or similar specialized services (e.g., the Sexual Health Unit at Montreal General Hospital), but there have been no national reviews of postgraduate sexuality training for physicians or for any of the other health disciplines, either as it pertains to research training, the subject of this section, or sex therapy training, which was discussed in Section 11, Sexual Dysfunctions, Counseling, and Therapies.

In her report to a 1994 gathering of Chinese and North American sex educators and researchers in China, Byers (1995) noted that training in sexological research within specific disciplines is highly variable across Canada. Such training often occurs only because a faculty member hired for expertise in another academic area is also interested in sexuality. This situation makes the necessary multidisciplinary requirements of sexological training more difficult to find, and trainees, particularly in smaller centers, may not have easy access to a network of like-minded colleagues. She notes that this fragmentation has made it hard for sex research to flourish as a field in English Canada, even though individual researchers and research groups have achieved considerable recognition (Byers 1995). For example, the Gender Identity Unit at Toronto's Clarke Institute of Psychiatry is internationally known for research on transsexuality, the Social Program Evaluation Group at Queen's University in Kingston, Ontario, has published major studies on adolescent sexual behavior, the Department of Psychology program at the University of New Brunswick is well known for research on the psychology of male-female sexual interactions in dating and longer-term relationships, the Sexual Medicine Unit at the University of British Columbia is known particularly for work on sexuality, disability, and chronic illness, researchers in the Sociology and Anthropology Department at the University of Windsor have developed international reputations for their qualitative and multimethod research on homosexuality and on sexual transmission of HIV, and the research done in the Department of Psychology at the University of Western Ontario has influenced Canadian policy and practice in the prevention of teen pregnancy, STDs, and HIV infection. Despite these achievements, the discipline-based focus of much sex research has made it difficult to achieve a public profile for the sexological research community in Canada.

The Canadian Sex Research Forum, founded in 1969, is Canada's only national organization dedicated to a multidisciplinary focus on sexological research. The *Proceedings* of the CSRF meetings have been published annually by the Sex Information and Education Council of Canada, first in the *SIECCAN Newsletter* (1982-1985), then in the *SIECCAN Journal* (1986-1991), and now in the *Canadian Journal of Human Sexuality* (1992-present). In Quebec, l'Association des Sexologiques de Québec promotes various aspects of sexual science, and the biannual journal *Revue Sexologique/Sexological Review* publishes national and international papers, the majority in French, many by Quebec researchers.

There appear to be many more people doing sexuality research in Canada than the approximately 100 Canadians who are members of CSRF and/or the Society for the Scientific Study of Sexuality (SSSS) in the United States. A systematic record of this large group would both identify, and perhaps unify, those individuals who, despite their primary identification with another academic discipline, also share a common interest in sexology. Such a record might also enhance training and supervision of sex researchers by facilitating cross-disciplinary communication. This issue is one of many that a workshop at the 1993 Canadian Sex Research Forum meeting identified as a major deficiency in the training of many sex researchers in Canada and internationally (Aronoff, McCormick, & Byers 1994).

B. Canadian Sexological Organizations and Publications

Addresses of Organizations

L'Association des Sexologues de Québec, 695 St. Denis, Suite 300, Montreal, Quebec, Canada H2S 2S3.

Sex Information and Education Council of Canada (SIECCAN), 850 Coxwell Avenue, East York, Ontario, Canada M4C 5RI.

Canadian Sex Research Forum, c/o Pierre Assalian, M.D., Executive Director, 1650 Cedar Avenue, Room B6-233, Montreal, Quebec, Canada H3G 1A4.

The Department of Sexology, University of Quebec at Montreal, 455 Boulevard Rene Levesque East, Montreal, Quebec, Canada H3C 3P8.

Planned Parenthood Federation of Canada, 1 Nicolas St., Suite 430, Ottawa, Ontario, Canada K1N 7B7.

Sexological Publications

Three Canadian publications provide a professional focus on sexological issues and research:

Canadian Journal of Human Sexuality (4 issues per year), Sex Information and Education Council of Canada (SIECCAN), 850 Coxwell Avenue, East York, Ontario, Canada M4C 5RI.

Revue Sexologique/Sexological Review (2 issues per year), c/o Editions I.R.I.S., 4932 rue Adam, Montreal, Quebec, Canada H1V 1W3.

Bibliosex (2 issues per year), c/o Professor Robert Gemme, University of Quebec at Montreal, Department of Sexology, Case Postale 8888, Canada H3C 3P8.

Conclusions

Four themes run through this profile of sexuality in Canada. The first is of a country composed of a variety of ethnocultural groups including the oldest, aboriginal inhabitants, the dominant English and French residents, and the newer arrivals from a variety of countries. Though there has been little "group specific" research, the available evidence suggests that different groups can have quite distinctive cultural attitudes and practices in the area of sexuality. Canada's French-Canadians, about whom there has been considerable research, consistently demonstrate attitudes that are more accepting and permissive than those of other Canadians; they initiate sexual activity somewhat earlier than others and are more likely to form committed partnerships without the legal status of marriage. Quebec, the province where the majority of French-Canadians live and the location of Canada's only Department of Sexology, has demonstrated the greatest acceptance of individual choice in sexual matters and has the most egalitarian family laws of any province in the nation. Considering the historical domination of the Roman Catholic Church in Quebec, these results demonstrate the reduction of influence of religious institutions in the lives of French-Canadians, a change that is now occurring for some other groups of Canadians as well. While French-Canadians set one end of a continuum of attitudes and practices, each ethnocultural group in Canada has its own distinctive pattern of attitudes and practices, each embedded in unique communities and community institutions.

The second theme is of a country in which formal services, research, and education in sexuality are scattered and varied. In some regions, these are comprehensive and sophisticated, in others they are sparse and few. Research, graduate and postgraduate training, and therapeutic and clinical work in sexuality are not organized or provided in a

coherent manner and are highly dependent on the presence of interested individuals. Sexuality as an academic discipline, and sexual health services beyond those related to reproduction and sexually transmitted diseases, are not generally recognized or supported through national associations or university departments.

The third theme is of a country that is in the process of reconceptualizing gendered and sexual relationships in its laws, culture, and policies. This is seen in the recent changes in laws, and in court challenges in areas such as sexual assault, sexual harassment, pornography and obscenity, access to medical procedures as part of sexual and reproductive health, and guarantees of equal treatment and rights for all Canadians regardless of gender, ability, or sexual orientation. It is also seen in the changing portrayals of sexuality in culture.

Finally, Canada is a country in which liberal and conservative (or permissive and restrictive) perspectives on sexuality compete for influence in the marketplace of ideas and ideology. To date, changes in legislation and policy have been in the direction of supporting individual rights, freedom of choice and expression, and recognition of diversity. Not all Canadians support these changes, however. Whether this direction will continue as part of Canada's future will be influenced, in part, by developments in all four of these themes.

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