Adolescent Pregnancy in Canada: Multicultural Considerations, Regional Differences, and the Legacy of Liberalization

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Keywords

Adolescent pregnancy in Canada · Abortion barriers · Canada's health care system · Developed countries · Ethno-cultural diversity · Gender inequalities · Human rights · In-hospital births · Sexual health education

Introduction

This chapter explores adolescent pregnancy among Canadians. Canada enjoys a relatively low teenage pregnancy rate compared with other Western nations, but aggregate statistics mask regional variations. As a vast nation with two European colonial settler populations and diverse Aboriginal peoples, Canada has historically been a diverse country. Canada's multicultural policy has further diversified the population, making large urban centers like Toronto, Montreal, and Vancouver among the most diverse cities in the world. Federally funded health care is managed at the provincial level making each province's priorities and delivery different. While a human sexual rights perspective broadly frames reproductive health and national guidelines for sexual health education, local programs are not bound to them. Women generally enjoy high levels of access to health care, abortion, and reproductive health information, but there is variation in access, attitudes, and behaviors. The ethno-cultural diversity of Canada's population, its regional differences, languages, and religions challenge aggregate analyses and social service implementation. These concerns are reflected in the body of research about adolescent pregnancy in Canada.

In this chapter we describe variation in, and attitudes toward, adolescent pregnancy and sexual behavior, with emphasis on adolescents and young women. These issues remain strongly influenced by Canada's extensive geographical realities as well as political, social, and economic values that reflect dedication to upholding multicultural differences, social justice, and freedom. Widely sanctioned reproductive choice and sexual education programs exemplify how Canadian values translate into rational and health promoting policies rather than punitive and restrictive agendas which lead to less effective health and mental health care for women and their newborns (Grimes et al. 2006;

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Singh et al. 2009). We discuss these issues in this chapter but first we begin by providing a brief description of Canada's history and its population.

Canadian History and Population

Canada is largely a nation of immigrants with two founding colonial nations: England and France. Remnants of Canada's first peoples, referred to as Aboriginal peoples (usually includes First Nations, Metis, and Inuit) remain today, but sadly colonization by the founding nations decimated most Aboriginal peoples. Canada's dedication to respecting the legacy of both founding European countries has resulted in an officially bilingual country and a predominantly Francophone Quebec population. Canada became the Dominion of Canada in 1867 retaining strong symbolic, familial, and political links to England. Canada is a constitutional monarchy with a democratic parliament and multiple political parties. Since confederation, Canadian governments have attempted to integrate elements of socialism and liberalism into a parliamentary model.

Canada is a vast country with a landmass of 9.9 million km, the second largest country by area in the world next to Russia. It is divided into ten provinces and three territories and stretches across six time zones. The geography is diverse ranging from temperate in the south to arctic in the north. Its only neighbor is the United States (USA) with which it shares the longest, largely undefended border in the world at over 8,000 km. It is bordered by three oceans: the Atlantic, the Pacific, and the Arctic and boasts the longest coastline in the world at just over 200,000 km.

Despite its large area, Canada's population density is 3.3 people per square kilometer with over 90 % of population living within 100 km of the Canada-US border. Population estimates in 2010 were just over 34 million (http://data.worldbank.org), or approximately 1/11th that of the United States, with 81 % of residents living in urban areas (http://www.who.int). Canada is a wealthy country, categorized as a high-income nation by the Organization for Economic Co-Operation and Development (OECD) standards with a Gross Domestic Product (GDP) of $1.5 trillion, 10.9 % of which is spent on health care (http://www.who.int). Infant mortality rates in 2007 were 5.1 per 1,000 live births (http://www.oecd-ilibrary.org). The percentage of Canadians who use antenatal care services (4+ visits) was 99 % in 2005. Similarly, births attended by a skilled health professional were also 99 % (http://www.who.int).

Canada is good place to live by health and wealth indicators and seems particularly so for women whose life expectancy at birth is 83 years (http://www.who.int), one of the highest in the world.

Pregnancy Rates, the Decriminalization of Abortion, and Emergency Contraception

In 2006–2007, the average maternal age in Canada (excluding Quebec) was 29.3 years. Some 13,000 births were to adolescents. This accounted for almost 5 % of in-hospital births (CIHI 2009). Teenage pregnancy statistics began to be collected in 1974. Since then, trend data show that adolescent pregnancy rates have declined overall, with minor fluctuations over that time span (Dryburgh 2000; McKay 2004; Wadhera and Millar 1997). In fact, adolescent pregnancy rates among Canadian females age 15–19 years have declined steadily since the 1990s from 49.2 per 1,000 females in 1994 (McKay and Barrett 2006) to 29.2 per 1,000 females in 2005 (Statistics Canada 2008a). While comparable declines are reported from other developed countries, Canadian rates are roughly half those of the United States and England and Wales (CIHI 2009). More recently, in 2009, total live births registered in Canada were 380,863 (Statistics Canada 2012). Of these, 104 births (or 0.03 %) were registered to mothers under 15 years of age and 15,534 (or 4.08 %) births were registered to mothers aged 15–19 years. Reasons for the decline are

speculative and include decreased social stigma associated with out-of-wedlock pregnancy, increased availability of contraceptives, and increased awareness of risks of unprotected sex associated with the AIDS epidemic (Dryburgh 2000).

Qualitative research among western Canadian women suggests that motherhood at a young age is less socially acceptable (Benzies et al. 2006). The American media, which most Canadians have full access to, have been accused of glamorizing teenage pregnancy, but the long-term impact of this glamorizing on the shame associated with teenage pregnancy has yet to be determined. At the same time, there appears to have been a concurrent increase in the number of abortions among teenagers between 1974 and 1994 (Wadhera and Millar 1997). Indeed, recent work by Al-Sahab et al. (2012) indicates that 50 % of teenage conceptions result in abortion. This is discussed in the next section.

Abortion Access

Until 1988, abortions were only legal in Canada for cases deemed dangerous to the life or health of a woman by a hospital-based "therapeutic abortion committee" (Kaposy and Downie 2008). In a landmark 1988 ruling, *R. v. Morgentaler*, the Supreme Court of Canada struck down the criminal law on abortion on the grounds that it violated a section of the Canadian Charter of Rights and Freedoms (Kaposy and Downie 2008). Most of the justices used a harmed-based rather than a choice-based analysis for their vote, citing the delays caused by abortion committees and the increased risk associated with delay in performing abortions. Canada is one of a handful of nations in the world, and the only Western nation without any punishment for performing abortions (United Nations 2007). Despite this extremely liberal position, abortion rates in Canada are comparable or lower than most Northern European countries, as well as the United States, which have slightly more restrictive abortion policies (United Nations 2007). The abortions that are performed are either done in private clinics or hospitals, but there are relatively few physicians whose livelihood is based solely on abortion. There are illegal abortions performed in Canada but estimates vary and assessing prevalence is clearly problematic (Wadhera and Millar 1997). Therefore, despite an absence of punishment in this area, other ethically based codes of conduct would apply to those who perform abortions. For instance, the Canadian Medical Association's Code of Ethics prohibits discrimination on several levels including medical condition and physicians who prevent access to abortion services are in breach of this code, risking lawsuits, and disciplinary action (Canadian Medical Association 2004; Rodgers and Downie 2006). Lower abortion rates in Canada compared with the United States may indicate a more tolerable climate for teenage pregnancy and parenthood (discussed below). Teenage pregnancy does not necessarily mean an end to an adolescent girl's dreams or quality of life and there seems to be increasing access to specialized education and social services for those who do not abort.

The decriminalization of abortion, however, has not resulted in uniform acceptance of abortion nor services and practices associated with the procedure. The *Morgentaler* ruling left open the possibility to challenge the legalization of abortion based on protecting the fetus (although few attempts to do so have occurred). Funding for abortions has been a contested issue since *R. v. Morgentaler*, which impacts access to services for pregnant adolescents and others. Some provinces have refused to fund the entire cost of the procedure; other provinces refuse to cover the cost of abortions performed in private clinics (Kaposy and Downie 2008). Two cases pertaining to the provinces of Manitoba [*Jane Doe 1 v. Manitoba*, 2004 MBQB 285, 248 D.L.R. (4th) 547 (Q.B.) and *Jane Doe 1 v. Manitoba*, 2005 MBCA 109, 260 D.L.R. (4th) 149 (C.A.)] and Prince Edward Island [Morgentaler v. Prince Edward Island (Minister of Health and Social Services) (1996), 144 Nfld. & P.E.I.R. 263, 139 D.L.R. (4th) 603 ((S.C. (A.D.)) Morgentaler (1996)] have upheld the province's decision to refuse public funding for abortions

performed in private clinics. In a 2006 class action suit [*Association pour l'access a l'avortement c. Quebec* (*Procureur general*), 2006 QCCS 4694, (2006) R.J.Q. 1938], the province of Quebec was ordered to reimburse 45,000 women who had paid additional fees for abortion services because the public system could not provide the necessary services (Carroll and Dougherty 2006; Kaposy and Downie 2008).

More recently, the majority conservative government of Prime Minister Stephen Harper presented a motion (M-312) before parliament to grant personhood to the fetus. This motion was debated in April 2012, with a second round of debate scheduled for September 2012. The vote is scheduled for September 19, 2012 and, if passed may lay the legal groundwork to challenge *R. v. Morgentaler* (Abortion Rights Coalition of Canada 2012).

Abortion Barriers and Geographical Variation

Despite the large number of adolescent pregnancies that end in abortion, numerous barriers remain for Canadian women, some of which may differentially affect teenagers. Access to abortion varies regionally. For instance, most abortion clinics and hospitals which offer abortion are located within 150 km of the Canada-US border, effectively isolating roughly 20 % of the population (Royal Canadian Mounted Police 2010).

There are provincial differences in age and consent processes as well. But, legal precedent upholds a mother's autonomy even when she is young. For instance, in a 1990s case, the parents of a pregnant 14-years old contested her decision to have an abortion. The region's Children's Aid Society sought and was granted custody of the girl in order to enable her to have an abortion [*Children's Aid Society of the Region of Peel v. S.* (1991), 34 R.F.L. (3d) 157, [1991] O.J. No. 1388 (Ct. J. (Prov. Div.))]. The adolescent was found to have made a competent and informed choice and the Children's Aid Society was found to be acting in her best interests (Kaposy and Downie 2008).

Decriminalizing abortion in Canada, however, has not necessarily led to universal access to services. Downie and Nassar (2007) call access to a safe and legal abortion as "illusory" as it was in the 1970s. By contextualizing this choice through a discussion of potential barriers, geographical and age-related differences emerge. For example, hospital–based abortion services are declining. The percentage of general hospitals offering abortion services declined from 35 % in 1986 (Tatalovich 1997) to 15.9 % in 2006 (Shaw 2006). The recent 2005 deregulation of the emergency contraceptive pill, Plan B®, from prescription-only status to availability from pharmacists without a physician's prescription may mitigate some of these barriers and will be discussed further below.

Despite the declining percentage of hospitals that offer abortion services, most abortions in Canada are still performed in hospital (http://abortionincanada.ca/). Many such services are predicated on family physician referrals but with a physician shortage estimated at 3,244 (Buske 2009), a shortage more acutely felt in remote areas, referrals could cause serious delays to service. Furthermore, some antichoice physicians have resisted their patients' attempts to seek a legal abortion in several ways: by allegedly refusing to give referrals for their patients; actively blocking patient attempts to secure referrals from other sources; threatening to withdraw services if abortion is pursued (Downie and Nassar 2007).

Private clinics are not spread evenly across the country and require financial resources for services, travel to the clinic, and accommodation, decreasing their accessibility for many women. For instance, clinics are absent in Prince Edward Island, Nova Scotia, Saskatchewan, the Territories, and Nunavut (http://abortionincanada.ca). Many clinics do not offer information about their practices over the telephone for fear of harassment (Downie and Nassar 2007). Violence against abortion service providers is prevalent with over 15,000 reported incidents over 30 years and three shootings in the 1990s (Downie and Nassar 2007). Service providers are often personally targeted and because of a lack of

training many are reluctant to perform abortions beyond certain points in the pregnancy. Less than one hour of training on performing an abortion in four years of medical school is all that is required (Koyama and Williams 2005). Lack of newly trained abortion practitioners is exacerbated by retiring physicians and hospital downsizing which increases the demand for operating rooms and surgical personnel often wait-listing pregnant women until they are forced to seek services elsewhere due to delays (Downie and Nassar 2007).

Increasingly, abortion services are located in urban areas, adding financial burdens to rural women seeking services (Downie and Nassar 2007). Clinic abortions in Canada range in cost from $400 to $1425, with added costs of transportation, lost wages, accommodation, and possibly childcare. Not only are these costs more difficult to meet for poor women, and more costly for women living remotely, they are more problematic for adolescents and may necessitate the involvement of adults to facilitate abortion. Adolescents living remotely would need to secure more resources and then be separated from family and friends and a familiar environment in order to secure abortion services. This excess burden may account, at least in part, for the high live-birth rate among teenage mothers living in Nunavut. It certainly seems logical that the provinces with the highest rates of live births to adolescent mothers also have large rural populations and few or no abortion services. Nunavut has no private clinics and the only practitioner willing to perform abortions worked in a hospital that has lost its accreditation (Downie and Nassar 2007).

Age of consent legislation is a barrier specific to pregnant teens seeking abortion services. Some provinces (Ontario, British Columbia, Saskatchewan, Prince Edward Island, Quebec, and Manitoba) have specified an age at which minors can consent to treatment. Others use the age of majority that is either 18 or 19 years depending on the province. Complicating the issue are variations in hospital policy, which often requires parental consent, driving many adolescents to private clinics that believe that consent from those aged 14 years and older is necessary and sufficient. Those least capable of managing the financial costs of abortion services are those most likely to seek uninsured options.

Emergency Contraception

The earlier adolescents become sexually active, the longer they are at risk for unwanted pregnancies and exposure to sexually transmitted diseases. Large-scale Canadian surveys are performed periodically and offer data for comparison over time concerning teenage sexual behavior. Not all these instruments are identical but often have enough overlap in fields for comparative purposes. For instance, Rotermann (2008) found that fewer adolescents aged 15–19 years reported being sexually active in 2005 compared with 1996/1997. As with most national data in Canada, there are provincial variations. The proportion of teens in Nova Scotia reporting they had had sexual intercourse rose from 31 % in 1996/1997 to 49 % in 2005 whereas the figure fell from 41 to 37 % among Ontario adolescents (Rotermann 2008). Unfortunately, Rotermann does not offer any potential explanations for these data. Provincial differences in immigration settlement or sexual health education may explain some of this variation, but this remains speculative.

Approximately 75 % of teenagers reported using condoms the last time they had intercourse (Rotermann 2008). The odds, however, of not using a condom were higher for females who started having intercourse at the beginning of their teens (Rotermann 2005). The prevalence of oral contraceptive use among 15–19-year olds was 27 % in 1996/97 (Wilkins et al. 2000) and rose to almost 67 % by 2006 (Black et al. 2009).

On December 1, 2000, British Columbia became the first province of Canada to grant independent prescriptive authority to pharmacists allowing them to issue emergency contraception (known as "Plan B®") without a physician's prescription (Shoveller et al. 2007). By 2005, it was scheduled to be available to women across the country in this manner, and by 2008, the

National Association of Pharmacy Regulatory Authorities (NAPRA) recommended it be made available as an over-the-counter drug to increase accessibility (http://www.cmaj.ca). As with so many issues in Canada, the recommendations of NAPRA needed to be approved by the pharmacy regulatory authorities of each province and territory before implementation. Quebec, however, is not a member of NAPRA, so the recommendations are moot within that province. Currently, Plan B® is available in every province and territory. It is still kept behind the counter in Saskatchewan and available in Quebec with a pharmacist's prescription (http://www.planb.ca). However, in Ontario where pharmacies were surveyed before and after deregulation, Plan B® became more widely available post-regulation, although rural access remained constrained by more limited pharmacy hours than in urban centers (Dunn et al. 2008).

Research based in British Columbia compared the use of emergency contraceptive pills before and after pharmacists were authorized to dispense without a prescription and found that availability expanded and there was an increase in provincial use post-policy compared with pre-policy (Soon et al. 2005). Likewise, despite deregulation removing one barrier to access, another has been created, namely a fee for "counseling" or administration that is charged by some pharmacists. This fee is typically about $20 in addition to the drug, which is roughly $26 (Eggertson 2008), but the extent it may vary in price and application across the country is unknown. Although some provinces cover such fees, most women will be faced with this additional cost (Pancham and Dunn 2007).

Sexual Health Education: A Human Rights Perspective

Sexual health education began in the 1970s in Canada and has evolved considerably since that time. Initial aims focused on reducing teen pregnancies but by the 1980s had evolved to incorporate growing concerns about HIV/AIDS (Martinez and Phillips 2008) and more recently to pilot programs among elementary school children (Wackett and Evans 2000). From an information only approach in the early days, the focus changed in the 1990s to incorporate strategies for behavior and decision-making skills. The Public Health Agency of Canada has periodically published national guidelines for sexual health education since 1994 (http://www.phac-aspc.gc.ca). Its 2003 version recognized the environmental and social determinants of sexual health that included discussions of sexual pleasure and was built around international recognition of sexual health as a rights issue (Martinez and Phillips 2008). These values are reflected in the text below taken from the recommended sexuality education program to help parents talk to their children about sexuality called "Talk to Me"—Sexuality Education for Parents made available in Canada's Public Health Agency Web site (www.phac-aspc.gc.ca/publicat/ttm-pm/index-eng.php):

Parents will become more knowledgeable of the different methods of contraception and the benefits of dual protection. They will have a chance to discuss each method and explore the advantages and disadvantages, as well as what may make one method more appropriate for their teen than another. The participants will also become more familiar with the main difficulties teenagers face related to birth control methods and will have the opportunity to assess the impact of their own roles and values in matters of contraception.

The above recommendations encourage parents not only to become informed of the various contraceptive options but also to discuss these with their children so that young people can make informed decisions. These recommendations build upon Canada's 2008 Guidelines for Sexual Education (Public Health Agency of Canada 2008), which happen to be the revised guidelines from 2003, have the following two goals (p. 8):

1. To help people achieve positive outcomes (e.g., self-esteem, respect for self and others, non-exploitive sexual relations, rewarding human relationships, and informed reproductive choices); and

2. To avoid negative outcomes (e.g., STI/HIV, sexual coercion, and unintended pregnancy).

It is not difficult to appreciate the perspective that human sexuality should be viewed as a human right when the philosophy and educational elements of the Canadian guidelines are considered (Public Health Agency of Canada 2008, pp. 11–12). We list these below. As stated in the report, effective sexual education:

- does not discriminate on the basis of age, race, ethnicity, gender identity, sexual orientation, socioeconomic background, physical/cognitive abilities, and religious background in terms of access to relevant, appropriate, accurate, and comprehensive information.
- focuses on the self-worth, respect and dignity of the individual.
- helps individuals to become more sensitive and aware of the impact their behaviors and actions may have on others and society.
- stresses that sexual health is a diverse and interactive process that requires respect for self and others.
- integrates the positive, life-enhancing, and rewarding aspects of human sexuality while also seeking to prevent and reduce negative sexual health outcomes.
- incorporates a lifespan approach that provides information, motivational support and skill-building opportunities that are relevant to individuals at different ages, abilities and stages in their lives.
- is structured so that changes in behavior and confidence are developed as a result of non-judgmental and informed decision-making.
- encourages critical thinking and reflection about gender identities and gender-role stereotyping. It recognizes the dynamic nature of gender roles, power and privilege, and the impact of gender-related issues in society. It also recognizes the increasing variety of choices available to individuals and the need for better understanding and communication to bring about positive individual health and social change.
- challenges the broader and often invisible dynamics of society that privilege certain groups (e.g., heterosexuals) and identifies those dynamics, which marginalize or disadvantage others (e.g., sexual minorities, people with disabilities, and street-involved youth).
- addresses reasons why antioppressive (sexual) health education is often difficult to practice.
- recognizes and responds to the specific sexual health education needs of particular groups, such as seniors, new immigrants, First Nations, Inuit and Métis communities, youth, including "hard to reach" youth (e.g., street-involved and incarcerated), sexual minorities (e.g., lesbian, gay, bisexual, trans-identified, two-spirited, intersex, and queer) and individuals with physical or developmental disabilities, or who have experienced sexual coercion or abuse.
- provides evidence-based sexual health education within the context of the individual's age, race, ethnicity, gender identity, sexual orientation, socioeconomic background, physical/cognitive abilities, religious background and other such characteristics.

It is indeed striking the comprehensiveness of the health promotion aspects and extent to which the guidelines focus on the wellbeing of the individual while taking into considerations macro issues. These guidelines, firmly framed within a social welfare perspective, rely on evidence-based research to promote sexual wellbeing.

There is some evidence and concern, however, that despite the well-articulated human rights perspective evident in the guidelines, the implementation, and consequent impact may be less than adequate. For instance, Martinez and Phillips' (2008) study of Ottawa area teachers and young adults document some of the tensions between the risk-focused biomedical approach and the inability to address inequities based on race/ethnicity, gender, or sexual identity. Although professionals serving teenagers such as educators, counselors, and others may use but are not bound to these guidelines these provincial curricula are the basis for the implementation of sexual education in Canadian classrooms. A more detailed discussion of geographical variation is presented later in the chapter in the section entitled *Regional Variation*.

Adolescent Pregnancy as "Risky Business"

Risk discourse is a common vehicle used among claims-makers to influence public opinion. In the public and professional literature related to adolescent pregnancy, a *risk discourse* is commonly used by researchers, educators, and service providers. Researchers often link risk with increased health care costs for services to adolescent mothers. The economic burden of teenage pregnancy to the health care system (see Al-Sahab et al. 2012, for instance) is another way of framing discussions about teenage pregnancy as a problem not limited to the individual and the families in which the pregnancy occurs, but for all taxpayers. By framing the discourse to include the population at large the business of risk verses cost moves from the individual (private) to the collective (public).

Currently, Canadian hospitals spend 1 dollar in 10 on health care for all mothers and babies (CIHI 2006). In 2002–2003, hospitals outside Quebec and Manitoba spent $1.1 billion on pregnancy and childbirth services for typical maternal inpatients and typical newborns (CIHI 2006). Furthermore, adolescent pregnancy can be placed as many Canadian health care initiatives are, as a risky, costly problem that is to be prevented.

Prevention is a key trope within Canada's health consciousness and it fits without conflict within two strong social imperatives: *individually focused health concerns and collective health care agendas like keeping costs low*. Researchers cite risk of low birth weights and associated health problems among babies born to teenage mothers (Al-Sahab et al. 2012; Dryburgh 2000; Health Canada 1999; Shrim et al. 2011; Wadhera and Millar 1997). Similarly, pregnant adolescents are at greater risk of anemia, hypertension, renal disease, eclampsia, and depressive disorders (Combes-Orme 1993; Dryburgh 2000; Turner et al. 1990). Risky sexual behavior has been associated with substance use and unplanned sexual intercourse among Canadian adolescents (Poulin and Graham 2001). Some researchers cite more "upstream" sources of this disparity such as poverty (Al-Sahab et al. 2012, for instance). Al-Sahab et al. (2012) compared teenage mothers with average aged mothers. Their robust sample size of 6,188 respondents to their Canada-wide survey revealed that teen mothers were more likely to have low socioeconomic status, be non-immigrant, have no partner, reside in the prairies, have experienced physical or sexual abuse, and would have preferred to have had their pregnancies later in life. Some researchers cite low pregnancy rates as indicators of young Canadian women's ability to control their reproductive health (McKay 2004). The argument is that if Canadian youth had less control, the pregnancy rates would be higher, closer to rates in the United States and United Kingdom. Shoveller and Johnson (2006) have argued that the assumption of teen agency and control may be overestimated in these models.

Given this climate of risk and prevention, government reports about the health of Canadians indicate that mothers younger than 20 years are associated with the highest rate of "small for gestational age" (SGA). SGA babies are born with a birth weight below the 10th percentile for gestational age and sex at 10 % (CIHI 2009). The authors of that report maintain that understanding the factors related to SGA births can help reduce costs. Teenagers are more likely to give birth to a SGA baby due to their physical immaturity and the inability of their bodies to adapt to the physiological demands of pregnancy (CIHI 2009). So there is physical risk for both the teenage mother and the SGA baby, but government reports also link these medical concerns with the approximately 1.6 times higher hospital costs for SGA babies (CIHI 2009). It is important to note that data in this report exclude the province of Quebec because of data unavailability. From a population health perspective, this may be a significant oversight because roughly ¼ of the country's population reside in Quebec. However, English language publications rely heavily on Statistics Canada datasets and failure to report (or record) in Quebec makes national claims difficult.

Socioeconomic status is associated with many adverse health outcomes including teenage pregnancy (CIHI 2009) and other possibly linked issues including substance and tobacco abuse (Jacono et al. 1992). Langille et al. (2003) reported that lower SES was significantly associated with drinking excessively among both adolescent males and females surveyed in rural Nova Scotia. As well, SES was significantly associated with driving after drinking among males and marijuana use among females (Langille et al. 2003). An earlier unpublished manuscript by Curtis demonstrated that adolescents living in low-income families were more likely to drink and smoke regularly (Langille et al. 2003). Studies indicate that despite universal access to health care, women living in poor neighborhoods may not use health care resources "effectively" (Dunlop et al. 2000). Unfortunately, this language blames individuals for not accessing services and may indicate a possible need for increased effects toward health literacy among Canada's poor. Small for gestational age babies (SGA) rates are highest among poor neighborhoods (CIHI 2009). Though the majority of teenage births do occur in low-income neighborhoods, 22 % occur in high-income neighborhoods suggesting the need to address these issues widely (CIHI 2009).

As one can imagine given Canada's vast geography, aggregate national statistics mask the variation that exists across the country. Within Canada's vast and varied geographical landscape, the ethno-cultural, social, political, and health "scapes" are equally varied and in flux. The total picture is, perhaps, difficult for educators and health professionals to apply locally. This is reflected in focused research projects that attempt to grasp local complexities. Aggregate statistics do tell us that the composition of new Canadians (recent immigrants) is changing and may mean constant shifting of resources and supports for emergent communities such as in some pockets of Toronto. The next section explores this variation.

Regional Variation

Although health care in Canada is "universal," payments from the federal government are transferred to provincial governments for management and distribution. This results in a patchwork quilt of health care services, policies, and priorities among and within provinces. Registration of some vital statistics may also vary by province/territory and over time (CIHI 2009). Similarly, adoption of new services such as emergency contraception, available without a physician prescription from pharmacists, or over the counter has been adopted at different times across the country (Shoveller et al. 2007). This geo-economic variation overlay the complexities of rural–urban variation and ethno-cultural differences over vast geographical spaces. People who live in small remote towns may rely on health services located in different towns, sometimes hundreds of kilometers away. In the far north, there may not be roads or railways that link a place of residence to the nearest health care services. This becomes a problem of access predicated on geographical isolation and the severity of climatic conditions associated with it and the economic burdens of remote air transportation for people among the poorest in the country.

These challenges are reflected in Canada's vital statistics. For instance, Nunavut and the Northwest Territories had the highest proportion of babies born to teenage mothers at 22.7 and 11.2 %, respectively (CIHI 2009). Of the provinces, Saskatchewan and Manitoba had the highest babies born to adolescents at 10.3 and 9.1 %, respectively. While very few (0.0–1.7 %) fetal deaths (stillbirths) occur out of hospital in most provinces, non-hospital fetal deaths in Manitoba were 14.7 % in 2009 (Statistics Canada 2012). Canadian adolescents are also very diverse with behaviors ranging from very sexually active to abstinent, with a multiplicity of cultural, social, and religious circumstances that may contribute to those behaviors (McKay 2004).

The higher prevalence of teenage pregnancies among those living in the Prairie Provinces and Territories is sometimes linked with an elevated proportion of Aboriginal peoples in these regions. Aboriginal peoples comprise 85 % of the populations of Nunavut, 50 % of the Northwest Territories, 25 % of Yukon, 16 % of Manitoba, and 15 % of Saskatchewan (Statistics Canada 2008b). Aboriginal youth are four times more likely to have teenage pregnancy (Murdoch 2009). There are hints of cultural differences with Al-Sahab et al. (2012) citing research that Aboriginal communities do not consider teenage pregnancy a tragedy (Best Start 2007). This ethno-cultural variation, specifically related to Aboriginal communities, has been cited by others (Bissell 2000; McKay 2004).

Live births registered in Nunavut account for 20 % of the live births registered to mothers age 15–19 years old. Manitoba, Saskatchewan, and the Northwest Territories also have higher proportions of live births among this age cohort with 8.9, 8.9, and 8.6 %, respectively (Statistics Canada 2012). Interestingly, 14.3 % of these births are recorded by Statistics Canada with "unknown" geography. While no explanation is offered concerning this ambiguity, it may reflect regional variation in health care access that forces many people to travel across provincial borders for services.

Research tends to focus on local experiences and implementations of national guidelines and policies. For example, Ninomiya's recent study (2010) of the experiences of junior high school sexual educators in Newfoundland and Labrador explored the topics, comfort levels, and opinions about curricula and professional practice. Langille et al. (2003) focused on high school students in rural Nova Scotia and numerous articles are based solely on the Toronto Teen Survey. It is difficult to extrapolate local results to the wider population due to regional variations of economics, environment, access to services, laws, funding, knowledge and attitudes, and ethno-cultural landscapes.

Multicultural Policy and Ethno-Cultural Variation

The Pearson government of the 1960s appointed a Royal Commission on Bilingualism and Biculturalism (the B&B Commission) in response to a perceived national crisis originating in Quebec. The report emphasized Canadians' desire to feel united as one, rejected the perceived duality of the Canadian identity legitimized and disseminated through popular phrases like "two founding nations" (Mansur 2011). The commissioners thought that the overwhelming presence of the United States obscured Canadian identity. The term "multiculturalism" was used by non-Francophone Canadians who expressed a desire to have all ethnic groups recognized as equals rather than just the "equal partnership" of "two nations" that privileges people of British and French descent. On the heels of the B&B Commission, Liberal Prime Minister Pierre Trudeau introduced the Official Languages Bill, which was passed into law in 1969 making Canada an officially bilingual country (Mansur 2011). The next step came in 1971 with the Multicultural Policy that was formally presented as a policy of multiculturalism within a bilingual framework (Mansur 2011). The Multicultural Policy had the support of all political parties with the only notable voice of opposition coming from Quebec Premier Robert Bourassa who was concerned with the defense of the French language and culture if the federal government was assuming responsibility for the cultural freedom of all Canadians. The Canadian Multiculturalism Act was passed in 1988 under Conservative Prime Minister Mulroney, making Canada the first Western liberal democracy to use multiculturalism as a defining characteristic of the nation and a directive principle for the government to abide by and promote.

With these policy changes came what has been dubbed a "polite revolution" (Ibbitson 2005), a dramatic refashioning of the Canadian

society. Changes came in many areas including immigration, education, and employment equity policies. Discourses of identity emphasized Canada as a "cultural mosaic" (often juxtaposed with America's "melting pot") and dubbed immigrants "new Canadians." Certainly, the demographic profile of Canada has changed dramatically over the last 40 years, and large cities like Toronto, Montreal, and Vancouver have very large proportions of their populations who are born outside of Canada. Fifty percentage of Torontonians for instance were born outside Canada, making it one of the most diverse cities in the world. Only 26 % of Torontonians were born in Canada to two Canadian-born parents (Schellenberg 2004). There are over 140 languages and dialects spoken there. It is not uncommon to find schools in Toronto with dozens of mother tongues that are not English or French. Of course, there are rural–urban differences, north–south differences, variation within the Canadian-born population, and differences in the spectrum of cultures between Canadian cities. Further, the countries of origin for immigrants are dynamic, making culturally appropriate policy, services, and education an ongoing challenge, with concerns about adolescent pregnancy and sexual health education illustrative of these challenges.

These cultural variations that result from multicultural policies are reflected in the research variation about fertility and pregnancy that emerges from Canada. For instance, some research focuses on specific cultural groups such as Chinese reproductive behavior in Canada and their decreased fertility rates associated with relative economic insecurity that accompanies minority membership and the immigration process (Tang 2004). Other work highlights cultural comparison. For example, Mitchell's (2001) work compared attitudes toward heterosexual cohabitation among ethno-culturally diverse young adults living in the Greater Vancouver Regional District. Studies vary in approach, theoretical lens, and disciplinary focus. "Culture" is widely used but rarely defined. Sometimes, the word "culture" is used interchangeably with ethnicity; sometimes, this includes or overlaps with religious affiliation; and, sometimes, the culture in question is youth itself. In Netting's study (1992) of the "youth-culture" among university-aged students, three sexual "subcultures" were identified: celibacy, monogamy, and free experimentation. Qualitative work by Shoveller et al. (2003) situates adolescent sexual development within sociocultural contexts and emphasizes the embeddedness of teenagers and their experiences within family, peer, community, and broader social contexts. This work is increasingly plentiful as local practice demands more information, but interestingly, the authors of this chapter note that this growing literature appears to represent a mosaic of stories that so far loosely hang together. It may be that another decade of research is needed for findings to tie these various studies together and allow for more universal generalizations.

Multicultural policies are aimed at assuring equality among numerous cultures, and they may have, at least theoretically, created a space in which Aboriginal cultures can also be discussed as components of the Canadian mosaic. Many might argue that special consideration ought to be given to Canada's First Nations given a history of genocide, relocation, and structural violence. Certainly no discussion of adolescent pregnancy in Canada is complete without research that touches on this topic despite problems of poor and incomplete data, and a lack of population-based linked data of Aboriginal births, stillbirths, and infant deaths (Luo et al. 2004). Rotermann (2007) points out that provinces and territories with high rates of second of subsequent births to teens tend to have relatively large numbers of Aboriginal residents. Unlike other Canadians, Aboriginal peoples have not seen a trend toward delayed first births (Rotermann 2007). For instance, in 1999, more than 20 % of First Nations babies were born to mothers aged 15–19 years (Health Canada 2005) compared with 5 % of non-Aboriginal babies (Rotermann 2007).

The Toronto Teen Survey is a community-based participatory research project that engaged 1,216 ethno-culturally and sexually diverse youth aged 13–18+ years in Toronto (Flicker

et al. 2010). Youth older than 18 years were not excluded from the survey if they wanted to participate. The partnership between the Toronto Teen Survey team, a Youth Advisory Committee, and Planned Parenthood Toronto administered surveys in 90 community workshops (Flicker et al. 2010). Care was taken to include populations who experience increased vulnerability to poor sexual health outcomes such as queer youth, young parents, and newcomers. Ninety percentage indicated their sexual orientation was heterosexual, 65 % were born in Canada, and 22 % were born outside Canada but had lived in Canada for four years or more. The sample was racially diverse with 14 % identifying as White, 14 % as Black, 38 % as East/Southeast Asian, and 13 % as multiracial. Several analyses have been derived from these data and offer an interesting glimpse into the challenges of implementing culturally appropriate services to adolescents.

Pole et al. (2010) explored the associations between sociodemographic factors and sexual behavior. Aggregate statistics are consistent with national statistics: 3 % of Torontonian teenagers experience their first sexual intercourse by age 13 and 28 % of teens aged 15–17 years report having had sexual intercourse at least once (Pole et al. 2010). East/Southeast Asian youth, Muslim youth, and newcomers were less likely to report high levels of sexual behavior. The authors suggest that professionals targeting these three groups ought to pay particular attention to issues of acculturation and intergenerational ideas about sex and sexual behavior (Pole et al. 2010). These data challenge some racially based stereotypes of sexual behavior with 32 % of Black adolescents reporting having had intercourse compared with 49 % of White adolescents. Risk for intercourse sexual activity was doubled among respondents who identified as LGBTQ. Young men who have sex with men are at increased risk for HIV/AIDS and young women who have sex with women were more likely to report intercourse activities compared with their heterosexual peers (Pole et al. 2010). Other studies indicate higher rates of pregnancy among sexually diverse young women (Saewyc et al. 1999).

Causarano et al. (2010) used data from the Toronto Teen Survey to assess exposure to sexual health education topics and teens' desire for more information about specific topics and associations with religious affiliation. They found that youth most frequently reported having learned about HIV/AIDS, STIs, and pregnancy and birth control but would like to learn more about healthy relationships, HIV/AIDS, and sexual pleasure (in that order) (Causarano et al. 2010). Lower age of respondent was associated with less desire for more information and higher age was associated with increased desire to learn more. Muslim youth were significantly less likely to desire more information on any topic than those youth who reported no religious affiliation. Protestant youth were more likely to have learned about STIs than those who reported no religion (Causarano et al. 2010).

Gender Inequalities

Unfortunately, as successful as Canada has been in preventing and reducing inequalities, gender inequities are still present. Varcoe et al. (2007) point out that women die prematurely from largely preventable conditions; they die in the prime of their life in greater numbers than men (largely due to cancers); and they experience higher levels of disability compared with men. In fact, violence against women in Canada persists as a major social problem despite declining reported rates of spousal homicide and violence (Statistics Canada 2006). Statistical trends are difficult to estimate accurately due to the private nature of the problem and the stigma that is associated with it. As well, the complexity of interpersonal violence is appreciated by researchers who are quick to point out that a significant number of people accused of spousal homicide do so in self-defense (Statistics Canada 2006). Nevertheless, several things remain clear from the available data, both men and women experience intimate partner violence. However, the severity of violence experienced by women is far greater than that for men. Surveys conducted in 1993, 1999, and 2004 indicate

a statistically significant decline in the rate of violence against women; in 1993, 12 % of respondents indicated they had suffered violence in the preceding five years compared with 7 % in 2004 (Statistics Canada 2006). The economic cost of violence against women has been estimated by several studies. For instance, a study by Greaves et al. (1995) estimated the economic burden of criminal justice, compensation, medical, shelter, and other services and lost productivity at $4.2 billion annually. Women under 25 years are at greater risk of sexual assault (6 %) and criminal harassment (9 %) than women in older age groups over a one-year time period (Statistics Canada 2006). Similarly, women between 15 and 25 years experience spousal homicide at higher rates than older age groups (Statistics Canada 2006). Psychological, physical, and social costs are readily acknowledged but more difficult to assess (Statistics Canada 2006). Also, Canadian men experience intimate partner violence at significantly lower rates than their female counterparts (Statistics Canada 2006). Rates vary within the country with rates of spousal violence (referring to both marital and common-law unions) against women in the territories higher than the provincial average (12 and 7 %, respectively) (Statistics Canada 2006). Increasing awareness of the problem, and programs and policies to combat it are expanding. The number of shelters available to women survivors of intimate partner violence is increasing, specialized domestic violence courts have been established, and discussions of what constitutes healthy intimate relationships have been worked into sexual and reproductive health curricula.

Despite these changes, there is a growing concern that nationally focused strategies may not be equally appropriate given the cultural diversity of the country (Shirwadkar 2004). For instance, consistently lower rates of partner violence in Quebec compared to the rest of Canada has led researchers to ask questions about Quebec's "culture" of male partner violence against women compared with the other provinces and territories (Brownridge 2002). Brownridge's analysis indicated that the rates of violence against women in Quebec were lower than rates from the rest of Canada and that men in Quebec who hold more rigid patriarchal attitudes were more likely to be violent than those who did not (Brownridge 2002). A telephone survey among the 2,120 female Francophone Quebecers indicated victimization rates of 6.1 % for physical violence and 6.8 % for sexual violence with significantly higher rates in the presence of controlling and humiliating behaviors by their partners (Rinfret-Raynor et al. 2004). A representative sample of 7,115 immigrant women in Canada demonstrated that women from developing countries had the highest rate of violence and that the sexually proprietary behavior of their partners was the key explanatory variable (Brownridge and Halli 2002). There is also concern about specific ethno-cultural groups of women and their considerations and concerns about accessing services or seeking help. For instance, a qualitative study among East Indian immigrant women in Ontario revealed that Canadian policies and services were inadequate to meet the complex needs of this community. Understanding the power dynamics of family, the caste system, and community pressures were central to the behaviors and potentially impactful interventions (Shirwadkar 2004). The author emphasizes the tremendous diversity *within* the Indian-Canadian community that was beyond the scope of her study. Many of these concerns are generalizable across many ethno-cultural groups in Toronto and other diverse cities in Canada.

When a Canadian Teenager Becomes a Parent

When a teenage girl becomes pregnant in Canada, she can access (at least theoretically) emergency contraception or abortion services assuming she has the resources and the inclination to do so, as discussed above. But what about those teenagers who choose to have their babies? Some will opt to place the baby for adoption, although research indicates that adoption is the

least discussed potential resolution for pregnant teens. Adoption as a resolution to an unplanned pregnancy in Canada had declined to 2 % in 1989 (Daly 1994). Daly (1994) administered questionnaires to 175 Ontario students between 15 and 19 years old to explore their values, attitudes, and knowledge about adoption. The author found that although adoption was viewed favorably, there was concern among respondents about how friends and family would feel (Daly 1994). For those who raise their babies, it may not be as limiting as it once was. A few high schools for teenage parents have been opened in Canada, giving adolescent parents a chance to complete their education in a less isolating and stigmatizing environment. The Louise Dean School in Calgary, Alberta, is one such school dedicated to educating pregnant and parenting teens. The school falls under the auspices of the Calgary Board of Education, is easily accessible by public transportation, and offers on-site daycare for 40 babies with nursing and social worker services. A glimpse into the experiences of an adolescent mother, her pregnancy, and how her pregnancy impacted her relationships and life is partially reproduced below. These excerpts are based on interviews conducted by Macleans magazine, a Canadian national news magazine and are available online at macleans.ca (Lunau 2008).

Kayla Clark, 18, got pregnant at age 16. Clark's baby, William, will be two years old in April. She is now a student at Louise Dean Centre. Here, Clark tells Macleans.ca *what it's really like being a teenage mom.*

***Macleans*.ca**: **Talk about when you found out you were pregnant.**

Kayla Clark: I took two home pregnancy tests, and they came back negative. Then I went to the hospital because I was having really bad pains. And they did a pregnancy test, and it was negative. So a week later, I went to my family doctor, and he did a pregnancy test and it was negative. He sent me for an ultrasound, to see what was causing my pains. [That's when] I found out I was pregnant.

The first thing that went through my head was, "This has to be a mistake." There was no way I could be pregnant, after multiple pregnancy tests all being negative. I thought, "I have no idea what I'm going to do." I'm alone—I broke up with the father. I had no one, and I didn't know what my parents would do. Finding out I was pregnant was one of the hardest things, because me and my dad were best friends. And when I told him I was pregnant, his heart broke. He didn't even talk to me for a week; every time I came into the room, he'd just leave. He couldn't stand to be around me.

***M*: Did you seriously consider abortion or adoption as options?**

KC: My mom looked into abortion at first for me. But because I found out in an ultrasound, the first thing they did was show me the baby's heartbeat. And right then, I knew I couldn't get rid of him. I knew it would be too hard. I made a pros and a cons list, and the cons side was huge—how to go to school, raising him by yourself, no housing, no support, everything. But the pros were I'm having a baby, I'm bringing somebody into the world. Somebody that I should be able to take care of.

***M*: Has having a baby been different than what you expected?**

KC: While I was pregnant, I lived with my parents. They weren't supportive at the beginning, but as it got closer and closer to the time I was going to have him, my mom came around. It took my dad until he was born to come around. My parents really helped me with buying the crib, buying clothes, the car seat, and all that. The school was helpful too. If I needed stuff, the social workers there were always looking, keeping an eye out. Teachers would bring in donations from their house.

When I was pregnant, my dad told me that if I kept the baby, I would have to move out. It really got my butt in gear to find a place. I have two little twin brothers, they were 15 when I was pregnant. So it was really hard, because they wanted all the attention. They couldn't have another baby in the house. Now I live in subsidized housing. It's a lot more work being on your own.

***M*: Some people say teen pregnancy is more accepted today than it was years ago. Do you think there's still a stigma out there against pregnant teens?**

KC: I don't think [teen pregnancy] is as taboo. Parents, and society, are more accepting of the fact that young people are having children. Some older people will ask me, "Why now? Why wouldn't you let someone adopt your baby?" It's hard, because you want to explain to them why you couldn't. But at the same time, the way they were brought up, [they were taught] it was wrong to have sex before you were married. So I can understand where they're coming from. You get your licks from them, and you get your licks from teenagers—they say, "Wow. She must be easy. She had sex, and didn't use protection." But it's not like that. I was on two forms of birth control, and I still got pregnant.

***M*: With all the images of pregnant celebrities in the media, do you think that impacts teens and the way they see having a baby?**

KC: I think it's huge. Angelina Jolie, or JLo—they all seem to get pregnant now, and it's turning into a fad. The younger generation thinks everyone's having babies, and they don't realize it's not *just* the nine months that you're pregnant. It's forever.

***M*: What's next for you?**

KC: I start at [the University of] Lethbridge in September. My major is exercise science—it's kinesiology. I want to do sports medicine.

These excerpts reflect several predominant ideals in Canada regarding health and welfare. The young woman had access to reproductive health care during and after her pregnancy. Her experience was a family matter. She is attending a school specifically designed for teenage parents that assists with childcare and life coaching, and she is looking forward to a career. Arming a teenage mother with an education and the necessary support in the short term in order to assist her self-sufficiency in the future reflects the values that guide Canada's health care system. Unfortunately, the statistics about teenage pregnancy reflect other realities not reflected in these stories such as a history of childhood abuse, increased use of alcohol and drugs among teenage mothers, and lower socioeconomic status that may impact access to reproductive health services. Also, this story is a southern Canadian story. For adolescent teenagers living in Canada's arctic, culture, geography, and economic considerations that shape teenage pregnancy experiences are very different. Consider the following quotes taken from a qualitative study of teenage pregnancy in Inuit communities (Archibald 2004). Interviews and focus groups were conducted with 53 teenagers and adults. When asked about the ideal age to start having children, respondents said between 13 and 20 years, either when menstruation began or when they were socially mature enough to care for a family (Archibald 2004).

Question: When is it ideal to start a family?

Elder Response: "I had my first child at 14… My grandchildren live in another world entirely… Thirteen- or 14-year olds today are still babies."

Response: "The methods that parents used were, when a young woman or man could sustain or look after themselves, and learn to sew for a woman and learn to make snow houses for a man. These were used as indicators that they could look after themselves or others."

Q: Is pregnancy a problem?

R: "Young ladies are getting pregnant too early, not living with their boyfriends, not living together. Grandparents cannot always help out with the necessities like milk and diapers and the whole family suffers, especially the baby." "I see kids in school who are hungry, poor, not dressed properly. I also see children in school having difficulties because the mother took drugs during her pregnancy."

Q: Why do teenage girls become pregnant?

R: "They look for love, for someone to love them." Some girls "come from homes where there are alcohol and other problems so they have been denied the nurturing care themselves and they may be looking for something that's their very own…" [Many pregnant teenage Inuit girls leave the community to have their babies, which would effectively distance them from abusers. Being pregnant enables them to have a modicum of financial independence with access to the child tax credit (Archibald 2004)]. "Some

Inuit teenagers get pregnant by older men. Young girls sometimes get used by older men…" "…just to sleep with a white man…"

R: "Now, there are many people in the community whereas before there were only a few families living together. The families had more control." [This refers to a shift in community organization in the 1950s and 1960s when Inuit peoples were settled into communities from smaller-scale camps composed of a few families (Archibald 2004)]. "In bigger communities and with schools, they tend to take away the role of the parents, then they should start teaching things the parents used to teach…. Put more elders in the schools."

Q: Regarding contraception…

R: "I approve of contraception such as birth control pills, but if the young woman is healthy and strong and able to bear a child, then I prefer to use the body well."

Q: regarding talking about sexuality…

ER: "Not only mothers and daughters, but the whole world."

Q: What are the challenges of teenage pregnancy?

R: "Their education ends up suffering if they planned to finish high school or they might give up plans to go to university." "…a lot of young women will keep their babies in the beginning but when they start struggling and have more problems, they give them up to social services. They know that social services will put the baby in a good home, and that the baby will be provided for." "…the mother is usually the one who ends up with the responsibility. Girls are faced with this more to the point where they're not afraid to die or kill themselves." "If family is not well off financially, everybody will suffer. We are not a society that can just say "okay, go get an abortion." ….the mother and baby will both suffer."

Concluding Remarks

The provincial funding formula, a long-standing national focus on policies of "multiculturalism," the emergence of cities classified as "super-diverse" such as Toronto, and the vast social geographical variation beg questions about teenage pregnancy national aggregate statistics and their utility at a local level. Canada's enormous diversity and public health care system is an interesting research crucible to explore social determinants of reproductive health. But it also raises questions about "cultural competence" of both educators and health care professionals involved with pregnant teenagers or attempting to reduce the "risk" of adolescent pregnancy. How can professionals possibly be "competent" in a city such as Toronto? Perhaps the notion of "cultural humility" is a better "best practice" aim than cultural competence (Ortega and Faller 2011). Large cosmopolitan cities such as Toronto are not static, but rather constantly evolving and altering; therefore, it calls for flexibility to meet the changing needs of the community, rather than to gain mastery over discrete populations. Furthermore, research focused on points of delivery (classroom, religious institutions, community centers) might be a more applicable stream than research that focuses on one or several distinct groups of adolescents. This is especially poignant if we are to consider long-term sustainable care and service delivery.

If Canada is to stand behind the antidiscrimination guidelines mentioned earlier, then the true challenges will be measured in how to implement and sustain their commitment to human rights. We have noted that Canada has decriminalized abortion throughout its provinces; however, there remain widespread issues including lack of access to safe affordable clinics especially for young women who live in non-urban settings. Continued gender inequalities taint the private and public domain when it comes to female sexual health, which translates into ineffective sexual education and interventions. Sadly, these discriminatory practices infect the social structures, which provide preventive and treatment health care services for women and more vigilance needs to be made in this area.

Finally, although Canada has shown attention to these issues, we caution that funding streams, education, and access to services should not be hampered by ideological debate and grandstanding. Adolescent female health is vital to the

future of families and communities throughout Canada. The outcomes not only affect the young women themselves, but their children, families, and communities. Researchers, intervention strategists, and policy makers therefore would benefit from the cultural humility of constantly re-evaluating self-knowledge rather than relying on political rhetoric in dealing with female adolescent sexual health. In this way, Canada could be an even greater leader and innovator for better access to services and overall health outcomes for their young population.

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