Chapter 14

Sexual Behaviour and Contraception

Sexual behaviour has two masks in Canadian society. Alternately, it is private or public, sacred or profane, and wholesome or obscene. Reflecting a gradual change in values, some aspects of sexual behaviour which a short while ago were censored or considered to be criminal are now more widely accepted. There has been much fantasy and ignorance and little fact about the changes in sexual behaviour and contraceptive use which have taken place and what they mean to our way of life. Dual standards are widespread. What an individual might do and accept personally, he might not say in public or accept in individuals who hold high public office. This conflict between private practice and the public morality and the inconsistency of values held about usual sexual behaviour is very much a part of how abortion is seen and dealt with in Canadian society.

There has been a proliferation in the use of sexual images in almost every aspect of daily life. In newspapers, television, and billboards, sexual glamour is used either subtly or directly to sell merchandise, to stimulate ideas about feminine and masculine roles, or on occasion, to promote public programs. These changes have occurred so gradually, but have become so pervasive, that they have minted new customs which are distinctive from those of the previous generation. Despite these trends many Canadians from different walks of life are uneasy when they discuss usual sexual behaviour and the use of contraception. Many persons either withdraw from a discussion of these issues, deal with them in a bantering fashion or adopt in public values which are a masquerade for what is actually done. So prevalent and one-sided is the emphasis on what it takes to be seen to be fully feminine or masculine, that it is often forgotten there is a negative social residue stemming from sexual activity.

While the image of the sexually active person is aroused by various means as a desirable pursuit, the consequences of illegitimate birth or induced abortion invoke a harsh stigma, and in general, are considered to be abhorrent by society. While there may be greater tolerance about illegitimacy now than in the past, few Canadians today enjoy being called by derogatory sexual epithets. A great deal of public attention has dealt with the social cosmetics of making men and women more stimulating and attractive to each other. But little is known, and because there is much stigma involved, little has wanted to

be known, about the socially rejected outcomes of sexual intercourse. Because information about what is the usual experience in these respects is scarce, how to deal with the unusual aspects of sexual behaviour is made more difficult for the law and the healing professions. We know little about the extent of sexual offences and the treatment, or the appropriate services for sexual offenders. There is no accurate documentation of the prevalence of sex-related diseases such as syphilis or gonorrhea, or their social implications for the Canadian population. Many teenagers who are under the age of legal majority have sexual intercourse. The mainstream of public morality in what is a collective ethical fantasy ignores these events. Minors and their partners who have had sexual intercourse are seldom charged under existing legal provisions. While deploring illegitimacy and abortion, Canadian society has had a blind eye when it comes to seeking an understanding of these issues and how they may be resolved.

Tens of thousands of women and their partners in Canada have had to face up to the dilemma of an unwanted or an unexpected pregnancy. Many women in this situation get married, or if they are married, give birth to unwanted children. When this is not done, most single women who have an unwanted pregnancy are faced with two socially condemned choices—the birth of an illegitimate child or an induced abortion. Between 1970 and 1973 there were 1,432,244 deliveries of which 130,543 were illegitimate births. During these years there were 124,129 officially reported therapeutic abortions. Together, illegitimate births and therapeutic abortions constituted 1 out of 6 (17.8 percent) of all deliveries in this four year period.

Because there is still much social ignominy associated with either outcome, these women seek counsel from only a handful of relatives and friends. Particularly for young women who are frightened by their dilemma, there is often a delay in seeking professional advice. Seldom discussed except under unusual circumstances, the fact of an illegitimate birth or an induced abortion is recalled with deep emotion as an intense personal experience. It is often kept as a life-long secret, one which is seldom shared because of an anxiety and a fear that what has been done may become known and jeopardize a marriage or a career at work.

The demographic contours of the Canadian population are well known in terms of the array of measures which are commonly used to gauge its composition. The birth rate has been declining, infant and maternal deaths are substantially lower, the average size of families has been getting smaller, and Canadians as a people now live longer than in the past. The number of births and the size of families vary by the social circumstances of individuals. The general characteristics of women who obtain induced abortions in Canadian hospitals are also known. In comparison with Canadian women giving birth in the reproductive years, these women are younger and more of them are single. But what is unknown in these vital statistics is precisely what it is that is vital to effecting these differences.

The unstated assumptions upon which the analysis of population growth and abortion are based are the facts of what is the usual sexual behaviour of

people and what measures they take to limit their fertility. The indices used in the study of population and abortion trends mean little unless it is known whether they represent fundamental differences in what is the usual sexual behaviour of individuals or in the nature of the birth control measures which they use. It has long been known that fertility and sexual activity vary greatly among individuals. In this context what is the experience of women who obtain abortions? Are they more or less sexually active than the average Canadian woman, or does the fact that they seek abortions mean they have had less experience or knowledge of the means of contraception? The Terms of Reference set for the Committee asked the question: "To what extent are abortions which are being performed in conformity with the present law seen to be the result of a failure of, or ignorance of proper family planning?" Information dealing with this question was taken from the national population survey and the national patient survey.

Definitions of terms used

A number of terms with specific definitions were used in the analysis of the sexual behaviour and the use of contraceptive means of women who have had induced abortions. Sexual behaviour refers in this Report to sexual intercourse, any means used to limit or prevent conception, and subsequent steps which may be taken to alter the outcome such as interrupting a pregnancy. The means of contraception which are commonly used include: oral contraceptives (pills); condoms (safes, rubbers); intra-uterine device (I.U.D., loop, coil); coitus interruptus (withdrawal, pulling out); rhythm (safe period); vaginal spermicides (foam, cream, jelly or suppository); diaphragm (cap); or sterilization (tubal ligation, vasectomy). The effectiveness of contraception refers to the extent to which its use limits conception from occurring, and this result can also be defined in terms of theoretical effectiveness versus their effectiveness in actual use.

Fecundity and fertility are two related aspects of reproduction which refer respectively to a woman's biological capacity to conceive and to having had a conception. An unknown number of women in Canada, sometimes estimated to be between 5 to 10 percent, cannot conceive. General studies of the population usually consider the experience of women in the reproductive years between the ages of 15 and 44 years. The fertility of these women is measured in terms of the range of outcomes of conception. These outcomes of pregnancy calculated in terms of frequency per 1,000 women involved include: (1) live births (premature childbirth and full-term childbirth); (2) the death of the infant (neonatal, perinatal, and infant deaths); (3) the death of mothers; (4) spontaneous abortions which are defined as the termination of a pregnancy from natural causes; and (5) induced abortions. The difference between the potential and the actual fertility rate is the total number of women who have conceived minus the number of conceptions which do not result in the live birth of a child (infant deaths and abortions).

A woman's fertility, or the fact of conception, can be limited by a number of optional means. The moral imperatives of our way of life, while not vigorously adhered to, sanction sexual intercourse between women and men who are married to each other. For those individuals who abide by these values, being single or the loss of a partner through death, separation or divorce, are means of limiting their fertility. Their decision of abstinence effectively limits their fertility. A major change in the reproductive behaviour of Canadians whose repercussions have not been precisely documented in terms of fertility or population policy has been the marked upsurge since the start of the 1960s in the use of various means of contraception. In its work the Committee has sought to document the distribution of contraceptive means, the extent to which they are used, and by whom, and the implications of their use for women who have had induced abortions. There is little accurate information on this issue which is important to an understanding of changes in the nation's birth rate and in terms of population growth in the future. Sterilization, the tying of the tubes, which prevents conception, has become an operation which is now extensively done. So rapid has the change been in this respect that its permanent impact on the size of the average Canadian family and on the total size of the population are just now being recognized. The use of this permanent means of contraception varies substantially from one region to another in the country, the extent to which it is used being inversely correlated with the values which individuals hold about the propriety, the effectiveness, the safety or the convenience of the use of other forms of contraception.

All categories of abortion are the final means by which the potential fertility of women is limited. While spontaneous abortions are defined as resulting from natural biological causes, that this is so is not readily apparent from their uneven provincial distribution throughout Canada, their changing prevalence by the type of ownership of hospitals, or their variable frequency among hospitals which have established or have not established therapeutic abortion committees. In addition to spontaneous abortions and the sizeable number of abortions not specified as induced or spontaneous which are reported each year, the rising number of induced abortions serves to limit directly the potential fertility of women in the reproductive years between 15 and 44 years.

Sexual behaviour of males

The sexual behaviour of males and their use of contraceptive means are the unknown sides of the issue of induced abortion. The point is often tacitly forgotten that sexual intercourse involving males and females frequently includes the decision of both partners to use or not to use contraception. There is no baseline study which establishes whether the sexual behaviour of men and women in Canada has changed over the years. The rough indicators on this point are contradictory in their implications: a falling birth rate which may suggest less sexual activity contrasted to the recent higher sales of contracep-

tives which would indicate a relatively frequent occurrence of coitus. What can be said is that the sexual activity of many Canadians starts during their early to mid-teens and continues over a period of several decades. Coupled with a rising level of sexual activity, which increases with age and marriage, there is a selective increase in the use of contraception which varies by the different social circumstances of men and women.

For all of the males in the national population survey, 16.0 percent said they never had coitus, 21.1 percent had coitus once monthly or less often, 26.6 percent had coitus once weekly, and 36.3 percent had coitus several times each week. Overall, males in the national population survey had coitus on an average of 1.19 times each week. For males who were 15 years, 30.0 percent had had coitus of whom 25.0 percent had this experience once a month or less often and 5.0 percent once a week. These proportions rose amoung males between 16 and 17 years, with 41.6 percent having had sexual intercourse. The frequency of coitus increased among this age group, with 27.3 percent of males between 16 and 17 years having coitus once a month or less often, 8.4 percent once a week, and 5.9 percent several times each week. Most of the young males between 15 and 17 years were single and still attending high school. Because the sample used in the national population survey was drawn to be representative of the Canadian population, these findings on the level of sexual activity of young males are taken to be representative of the experience of other young males in the population across Canada. Overall, the findings indicated that 2 out of 5 young males between 15 and 17 years in 1976 regularly had coitus.

As the age of young males rose, their level of sexual activity increased. For many males this change coincided with their marriage. Among young adult males between 18 and 23 years, 27.0 percent had not had coitus, 26.6 percent had sexual intercourse monthly or less often, 20.5 percent weekly, and 25.9 percent several times each week. Between the ages of 24 and 49 years, males of these ages had the highest levels of sexual activity among all the males who were surveyed. Few males between 24 and 49 years had never had coitus (4.8 percent between 24 and 29 years, and 1.3 percent between 30 and 49 years) and over 80.0 percent had coitus weekly or several times each week. This trend declined for males 50 years and older, of whom 16.0 percent never had coitus, 34.3 percent had coitus once a month or less often, 32.5 percent once a week, and 17.2 percent several times each week.

Combined with age, a male's marital status was the second major factor accounting for differences in the levels of usual sexual activity. A third of single men (36.2 percent), a majority of whom were teenagers or young adults, never had coitus. A fifth of single males (20.1 percent) had coitus several times each week. In contrast, 4.0 percent of married men never had coitus, while 33.5 percent of married men had coitus once a week, and almost half, or 45.2 percent, had coitus several times each week. The sexual activity experience of the once married men, those males who were widowed, divorced, or separated, closely parallelled the level of frequency of coitus of single men.

Two characteristics of males—their age and marital status—accounted for the major differences in the frequency of sexual intercourse among the

Canadian men in the national population survey. None of the several other social characteristics of males accounted for more than 1.0 percent of these differences, and in some cases had even a more negligible effect. The attributes of males which might be related to the usual frequency of sexual intercourse were a male's level of education, his type of work, the language he spoke or his religious affiliation.[1] If each of these attributes are considered separately, it would appear that substantial differences might occur as for instance by a male's level of education or his religious affiliation. For the most part these trends are spurious. They tend to disappear when they are analyzed by means of the statistical procedure of multiple regression. Overriding most of these apparent differences were a male's age, his marital status and the extent to which a means of contraception was used. Younger and single males less often had sexual intercourse than older married males, and among all males, the frequency of sexual intercourse increased with the use of contraception. These results tend to set aside certain popular myths about the particular virility of one or another group in the population. They indicate that the sexual behaviour of Canadian males is largely a function of maturation and marriage, regardless of what other special attributes males may have.

Sexual behaviour of females

The overall frequency of coitus reported by women and men in the national population survey was almost identical. Small-scale studies relying on information from a selected group of individuals and some work done in other countries have found on occasion not readily accountable differences in the overall frequency of sexual intercourse between the sexes. The weekly frequency of coitus was 1.18 among females compared to 1.19 among males, or it was essentially identical for both sexes representing an average frequency of coitus five times each month.

Most of the females who were 15 years (91.7 percent) had not had coitus. This proportion declined to 81.4 percent for females between 16 and 17 years. The weekly frequency of coitus was 0.12 for females in this age group (15 to 17 years). This pattern changed sharply for young women between 18 and 23 years, 60.1 percent of whom had coitus and all women of these ages had coitus on an average of once a week (0.98 times each week). Women between 24 and 29 years had the highest coital frequency among all age groups of both sexes of 1.87 times each week. One out of twenty women (5.1 percent) in this age group never had coitus. This level of sexual activity was maintained by females between the ages of 30 and 49 years, but declined sharply among women 50 years and older who had coitus on an average of once every two weeks. A third of these older women (35.2 percent) never had coitus.

The bell-shaped distribution by age of coital experience among females, a distribution which was initially low, then high, and followed by declining rates as age increased, was comparable when the proportions of women who had

[1] Appendix 1, *Statistical Notes and Tables*, Note 4.

coitus once a week and several times each week were considered. The proportion of women in each age group who had coitus once a week or more often was: 2.8 percent for females 15 years; 9.0 percent between 16 and 17 years; 42.9 percent between 18 and 23 years; 87.5 percent between 24 and 29 years; 82.0 percent between 30 and 49 years; and 31.2 percent for females who were 50 years and older.

The age of the sexual partners of young females between 15 and 17 years was unknown. Among these females, 8.3 percent who were 15 years, and 18.6 percent between 16 and 17 years had had sexual intercourse. In these categories for brides and grooms in Canada in 1974, 0.05 percent of the females who were married were under the age of 15 years, 0.31 percent were 15 years old, and 1.78 percent were 16 years old. None of the males married in 1974 were under 15 years, 0.001 percent were 15 years old, and 0.07 percent were 16 years old. On the basis of these rates by age of marriage and the usual discrepancy in the ages of females and males at the time of marriage, it is likely that most of the sexual partners of these young females were their age or older.

The frequency of coitus varied directly with the marital status of females. Almost two-thirds (63.9 percent) of single women never had coitus and the average weekly frequency for these women was 0.44. The coital experience of women who had once been married (widowed, divorced, separated) was similar to single women, with both groups having coitus on an average of once every two weeks (0.44 for single women; 0.49 for widowed, divorced, and separated women). In contrast, almost all married women (97.3 percent) had coitus with an average frequency of 1.57 times each week. The proportion of women who had coitus weekly or more often was: 21.6 percent for single women; 81.2 percent for married women; and 25.4 percent for women who were widowed, divorced, or separated.

The frequency of coitus varied by the ages of women and men, a fact largely accounted for by the social mores relating to the patterns of courtship and marriage in Canada. It is a broadly held practice in courtship and marriage that men are usually slightly older than women. The age at marriage of brides and grooms in Canada is an example of this trend. Of the women who were married in 1974, 27.2 percent were between 15 and 19 years, 45.8 percent between 20 and 24 years, 13.2 percent between 25 and 29 years, 8.6 percent between 30 and 44 years, and the remainder, 5.2 percent, were 45 years and older. In contrast, fewer young males were married but proportionately more men who were older were married. Among the males who were married in 1974, 7.9 percent were between 15 and 19 years, 48.9 percent between 20 and 24 years, 23.0 percent between 25 and 29 years, 13.3 percent between 30 and 44 years, and 6.9 percent were 45 years and older. Overall, almost 3 out of 4 women (73.0 percent) who were married in 1974 were under the age of 25 years, while only slightly over half of the men (56.8 percent) were in this younger age group. Conversely, fewer women (13.8 percent) than men (20.2 percent) were married who were 30 years or older.

With the exception of young females and males between 15 and 17 years, a majority of whom were single and still attending high school, the frequency

of coitus of females and males parallelled the usual age differences at marriage of members of both sexes. Women who were between the ages of 18 and 29 years had an overall 4.6 percent higher frequency of coitus than males of the same age. For both sexes the highest frequency of coitus, averaging between seven and seven and a half times a month, occurred for individuals between 24 and 29 years. The frequency of coitus decreased among older females and males, with the trend among the younger individuals being reversed. Among individuals who were 30 years or older, men had a 17.3 percent higher frequency of coitus than women, a difference which is partly accounted for by the usual difference in the ages of the couples.

As with males, the age and marital status of women were the major factors which accounted for their frequency of sexual intercourse. None of the other general attributes of a woman's circumstances was related to differences in the frequency of sexual intercourse. In a multiple regression a total of 25 variables were considered of which 21, such as education, religion, or language usually spoken, each accounted for less than one percent of the variance.[2] What these results of the regression analysis mean is that for the women from whom information was obtained in a nationally representative sample of the population, and within the context of the types of information which were available, their frequency of sexual intercourse was highly correlated (49.8 percent) with three attributes. These were: (1) maturation (age and marital status); (2) availability of a sex partner; and (3) the reliability of the contraceptive method. More young and single women never had coitus and among those who did their frequency of sexual intercourse was substantially lower than among older and married women. Predictably, the occurrence of coitus and its frequency were the highest among married women in the child-bearing ages. These levels declined with age and the loss of male partners. A third factor which accounted for the occurrence and the frequency of coitus was the use of contraception. These levels were significantly lower among those women who either felt contraceptive means were not needed or who used none. Their lack of use served as a restraint to coitus. Again, as in the case of males, some popularly held myths about the alleged characteristics of sexually active women are not supported on the basis of these findings. It was a woman's age, her marital status, and her use of contraception (or by her partner), which accounted for the occurrence and the frequency of sexual intercourse.

When these findings are considered in the context of the demographic composition of the nation, certain predictable trends emerge. Broadly, these trends are influenced by the ratio of women to men in each region, the relative youthfulness of a region's people, the proportion who are married and the relative use or the non-use of contraception. Across the country in 1971 there was a marked east-to-west difference of 19.1 percent in the ratio of women to men who were between the ages of 15 and 49 years. In the Maritimes for instance, where there were more women than men in these age groups, the ratio was 1:0.85, while the trend was reversed in British Columbia with men outnumbering women by a ratio of 1:1.05. To the extent that these broader

[2] See Appendix 1, *Statistical Notes and Tables*, Note 4.

demographic differences occurred, there was almost a marketplace trend, but only that, involving the proportion of females and males between the ages of 15 and 49 years and their general level of coital frequency. Where men in these ages outnumbered women, there tended to be a higher weekly frequency of coitus. Conversely, where women substantially outnumbered men, as in the case of the Maritimes, the general frequency of coitus was lower. In the terms of the ratio of women to men between 15 and 49 years in each area, or for each woman how many men there were, the regional distribution with the average weekly frequency of coitus among women and men was:

Region	Ratio of Women to Men 15 to 49 Years	Weekly Frequency of Coitus of Women 15 to 49 Years	Weekly Frequency of Coitus of Men 15 to 49 Years
Maritimes	1:0.85	1.15	1.01
Quebec	1:1.01	1.03	1.21
Ontario	1:1.03	1.16	1.10
Prairies	1:1.03	1.18	1.50
British Columbia	1:1.05	1.30	1.29

The Committee found no evidence to suggest that there were biological differences affecting the prevalence of sterility among women and men in different areas of the country. In the absence of such information, it is concluded that three social factors accounted for the differences between the fertility rates of women and their frequency of coitus. Based on their self-reports, while females and males were more sexually active in the West than in the East, a trend accounted for by different ratios of women to men, there was no direct relation with these trends and the number of children who were born in each region. Combined with different female-male regional distributions which accounted for different levels of sexual activity, two intervening factors masked the general fertility rates of women living in the five regions. These factors were the prevalence of induced abortions which were obtained in each area, a rate which was substantially lower in the East than in the West, and the regional differences in the relative use of contraceptive means including surgical sterilization.

Social meanings of sex

On the basis of previous work, much of which comes from the United States and the United Kingdom and seldom from basic inquiries done in Canada, it has been found that the accuracy of reporting of the sexual behaviour of females and males varies by their social circumstances and their satisfaction with the sexual partnership. In the case of some studies which have been done in the United States, these trends have been based on "samples"

which usually over-represent the experience of middle-income, married, and college-educated whites. The explanation sometimes given to account for the differences in the reported sexual behaviour of females and males is that there is a broadly held myth that men may have stronger and more constant sexual needs than women. According to this perspective women are expected to defer to the wishes of their male partners, in short, to be more submissive and, if married, to consider having coitus as part of their marital duties. Other studies involving a handful of individuals have suggested that the preferred frequency of coitus may not be constant, but vary for both sexes by their sense of mutual satisfaction and their degree of personal accommodation to each other. The preference for the frequency of coitus may be similar between the sexes, higher for women, or alternately, higher for men. The general conclusion, albeit a tentative one, from much of this work suggests that women report more accurately than men about the nature of their sexual behaviour, and usually more men than women say they prefer to have coitus more often. These time-dated findings do not reflect the broad move toward social parity which is occurring between the sexes in all respects, a trend which has been gaining momentum and can be expected to reshape fundamentally how women and men see sexual behaviour, what they expect from their partners, and the extent to which they honestly discuss these socially sensitive issues.

While the average frequency of coitus of females and males was the same for individuals in the national population survey, there were some marked and consistent differences. The average weekly frequency of coitus was substantially higher for males than females who were: young (0.12 females versus 0.18 males, or by 50.0 percent in the 15 to 17 year age group); single (0.44 females versus 0.71 males, or by 61.3 percent); or widowed, divorced or separated (0.49 females versus 1.88 males, or by 283.6 percent). Overall, these men said they had coitus more frequently than women who had similar social circumstances. Conversely, substantially fewer men than women in each of these categories said they had never had coitus. This difference was particularly marked for young and single males, and males who were widowed, divorced or separated.

With the exception of once-married males, married women and men had the highest levels of coital frequency. Married women reported having coitus slightly more often than married males, but the difference was negligible. Few in each group never had coitus. Both single males and those men who had been widowed, divorced, or separated had substantially higher rates of sexual intercourse than women in these marital categories. Without considerable additional analysis which goes beyond the scope of this inquiry, it is not apparent why this is so, or indeed, if it is actually the case. For both of these types of men, the young single males and the older once-married men, there may be over-reporting of their actual coital experience, a fact which results from their perspective of what it takes to be seen to be masculine.

Two ideas involving an individual's memory—the length of recall and the saliency of the event—may be relevant in accounting for some of the differences in the reported frequency of coitus of young males and older men which was higher than the rates cited by women of comparable ages. The sexual

values of Canadian society put considerable emphasis on the fact that having coitus is integral to being masculine. Men more than women are prone to boast about their sexual "conquests". In the folkways of young males who socially and physiologically are in transition between childhood and manhood, there is much braggadocio about their sexual potency and their alleged sexual liaisons. It is often thought that to be a man is to be sexually intrepid, and to be seen to be so. From the information obtained in the national population survey it is not readily apparent from the higher rate of coitus of once-married men and young males between 15 and 17 years than females, with whom sexual intercourse occurred unless this happened extensively with older women by younger men and between older men and younger women.

TABLE 14.1

COITAL EXPERIENCE OF FEMALES AND MALES

NATIONAL POPULATION SURVEY

Characteristics of Individuals	Coital Experience			
	Females		Males	
	No Coitus	Coitus	No Coitus	Coitus
	percent		percent	
AGE				
15 years	91.7	8.3	70.0	30.0
15-17 years	81.4	18.6	58.4	41.6
18-23 years	39.9	60.1	27.0	73.0
24-29 years	5.1	94.9	4.8	95.2
30-49 years	5.2	94.8	1.3	98.7
50 years & over	35.2	64.8	16.0	84.0
EDUCATION				
elementary	28.9	71.1	20.8	79.2
high school	25.6	74.4	19.9	80.1
technical	20.0	80.0	5.0	95.0
college/university	21.7	78.3	10.8	89.2
MARITAL STATUS				
single	63.9	36.1	36.2	63.8
married	2.7	97.3	4.0	96.0
widowed, divorced, separated	56.1	43.9	31.5	68.5
RELIGIOUS AFFILIATION				
Catholic	27.5	72.5	18.5	81.5
Jewish	25.0	75.0	4.5	95.5
Protestant	23.9	76.1	15.8	84.2
Other	23.9	76.1	11.0	89.0
AVERAGE	24.6	75.4	16.0	84.0

TABLE 14.2

WEEKLY FREQUENCY OF COITUS OF FEMALES AND MALES

NATIONAL POPULATION SURVEY

Characteristics of Individuals	Weekly Frequency of Coitus	
	Females	Males
AGE		
15-17 years	0.12	0.18
18-23 years	0.98	0.95
24-29 years	1.87	1.77
30-49 years	1.52	1.60
50 years & over	0.50	0.77
EDUCATION		
elementary	0.88	0.99
high school	1.14	1.12
technical	1.53	1.42
college/university	1.27	1.30
MARITAL STATUS		
single	0.44	0.71
married	1.57	1.48
widowed, divorced, separated	0.49	1.88
RELIGIOUS AFFILIATION		
Catholic	1.08	1.12
Jewish	1.01	1.03
Protestant	1.19	1.15
Other	1.28	1.39
AVERAGE	1.18	1.19

While many of the traditional values about the family in Canadian society have disappeared or been reminted, there are still strong vestiges of the patriarchal family which subtly persist, not the least of which involve the usual age of marriage of women and men and their relative values about sexual behaviour. The move toward social parity has resulted for some, but far from all, individuals in profoundly changed ideas about sexual partnership and marital relations. Values now more widely accepted emphasize for women a sense of personal and social security between partners. While sexual compatibility is important to women, it may be less often an end in itself than a vital component of female-male companionship, one which is integral to the meanings of pregnancy and marriage.

As single women get older there is considerable social pressure, which is real or felt, that equates femininity with having a durable female-male companionship, or getting married. In contrast with men, women may tend to see the act of coitus more in terms of what their partners may expect and its long-term implications. Few women boast of their sexual "conquests". To be known as a sexually active single woman in Canadian society is still seen to be

a social liability, one which may restrict a woman's opportunities for marriage. In the speech of every day there is a bundle of sex-related words which are supposed not to be used in circles which consider themselves to be polite, but whose meaning is widely known. These words are less important for themselves than for what they subtly, sometimes insiduously, represent about the images of females and males. For women, these words are often demeaning, one-sided. They represent the male in Canadian society as the aggressor in sexual relations, one who initiates sexual behaviour.

The meaning of sexual promiscuity is seen differently by women and men. The values of our way of life make it more acceptable for males to talk openly about sexual intercourse than is the case for women. Few sanctions apply with any stringency to the sexually active male. This is not the case for women. If an unexpected or unwanted pregnancy occurs, single women are faced with the stigma of illegitimacy or of having an abortion. Even if this does not occur, women more often than men maintain a sense of greater anonymity about the nature of their sexual activity.

On the basis of these broad values about the meaning of coitus, males are more likely than females to recall having had coitus, or what they may feel has been sexual intercourse for a longer period of time. Particularly for young males by whom it is considered a necessary initiation into manhood, this act may have more importance for different reasons than for young females. Because the act of coitus itself may be less important to young and older females for whom it is not associated with marriage or childbirth, more women at these ages may forget or be less accurate in their recall of having had sexual intercourse. In contrast, not only did women and men between 18 and 29 years have more frequent coitus than younger and older individuals, thus contributing to a more accurate recall, but for each sex, this was seen to be an important experience involving parenthood and marriage. As the frequency of coitus rose, occurring once a week or several times each week, there were minimal differences in the frequency reported by females and males.

The general findings on the sexual behaviour of females and males, when combined with information on the relative use of contraceptive means and the volume of abortions, have fundamental implications for the size and the growth of particular regions and provinces. **For the nation as a whole, information about the usual sexual behaviour, the contraceptive use, and volume of induced abortions if coupled with changing external migration trends (immigration, emigration), constitutes a necessary basis for the establishing of basic social indicators for the health of Canadians, the supply and demand of public services, and the changing shape of the economy. This information is the necessary cornerstone to the consideration of national (or regional) population policies.**

Women who had abortions

In addition to the national population survey, information was obtained about women having abortions in the national patient survey. These two studies

obtained different types of information from different groups of individuals. By including individuals of all age groups, the national population survey provided a vignette of the sexual behaviour and the abortion experience of women over a period of time, and in the case of induced abortions, where and by whom these operations were done. For this reason the characteristics of the women who obtained abortions were different from the attributes of the women from whom information was obtained in the national patient survey. The women in this second study represented a cross-section of patients who obtained abortions in 1976 in Canadian hospitals. By definition, this group was considerably younger than the women in the national population survey who had had abortions. This survey did not include women either who had illegal abortions or who obtained abortions abroad.

Despite the differences in the two sources of information about women who had abortions, several trends emerge. In comparison with all of the women in the *national population survey*, women who have had abortions in general had a higher level of education. In the national population survey, 82.2 percent of all women had an elementary or high school education, while 17.8 percent had technical, college, or university training. In contrast, 68.5 percent of women in the national population survey who had abortions had an elementary and high school education, while 31.5 percent had had technical and college training. While the females in the *national patient survey* were considerably younger than either group of women in the national population survey, their level of education approximated that of women who had had abortions over a longer period of time. A quarter of this group (25.5 percent) had attended college or university. Considering the youthfulness of the women in the national patient survey, and the fact that 21.7 percent were afraid that if they had gone to term they would have had to stop going to school, it is probable that the general level of academic training of these women will increase even further in the future.

Consistently in both groups of women who had had abortions, there were fewer Catholic women and an over-representation of members of other religious affiliations. The smaller proportion of Catholic women who had abortions than their numbers in the population accords with Catholic ethics concerning abortion. The proportion of Jewish women who had had abortions was higher in both surveys than their representation in the national population survey. There were more Protestant women who had had abortions in the national population survey than their overall numbers, but their representation was comparable in the national patient survey to the numbers of women in the national population survey who had not had abortions. Women whose religious affiliation was with smaller denominations or who had no stated faith were substantially over-represented among both groups of females who had had abortions.

In the national patient survey the highest proportion of Catholic patients, 62.8 percent, lived in Quebec. Asian and non-western religions were more often reported in British Columbia, and the proportion of patients who said they had no religious affiliation was also higher in British Columbia than elsewhere. About one-third of the patients in Ontario and the Maritimes were Catholic

and one-half were Protestant. The patient survey was not a representative sample of all women having abortions in 1976 in Canadian hospitals. Despite this fact regional representation was achieved in the survey. It is estimated on the basis of the annual rate of increase of therapeutic abortions done in Canada that the women in this survey represented at least a third of the abortions done in the nation at the time of the survey. With this reservation, the findings of the two surveys may indicate trends in terms of the religious affiliation of women who obtain induced abortions. There may be a decline in the number of Protestant and Jewish women who obtain abortions and an increase in the proportion of women who were Catholics or who belonged to other denominations who had this operation.

TABLE 14.3

CHARACTERISTICS OF WOMEN WHO HAVE NOT HAD AN ABORTION AND WOMEN WHO HAVE HAD AN ABORTION

NATIONAL POPULATION SURVEY & NATIONAL PATIENT SURVEY*

Characteristics of Individuals	Experience with Abortion		
	Not Had an Abortion (Population)	Had an Abortion (Population)	Had an Abortion (Patient)
	percent		
AGE			
15-17 years	11.0	1.9	10.2
18-23 years	15.6	16.6	42.6
24-29 years	16.9	31.5	28.3
30-49 years	38.3	46.3	18.8
50 years & over	18.2	3.7	0.1
EDUCATION			
elementary	16.0	10.6	7.9
high school	66.2	57.9	66.6
technical	6.3	10.5	**
college/university	11.5	21.0	25.5
MARITAL STATUS			
single	27.9	28.1	64.5
married	61.6	54.4	25.0
widowed, divorced, separated	10.5	17.5	10.5
RELIGIOUS AFFILIATION			
Catholic	50.5	31.5	35.3
Jewish	0.5	3.7	2.3
Protestant	44.0	51.9	45.0
Other	5.0	12.9	17.4

* The age categories used by Statistics Canada and the percent of abortion patients in each category in 1974 were: 31 percent, under 20 years; 48 percent, 20-29 years; 17 percent, 30-39 years; 3 percent, 40-49 years; and less than 1 percent, 49 years and older. The 1974 national distribution by marital status was: 58 percent single; 31 percent married; and 10 percent other and unknown.

** The category of technical education was not used in the hospital patient survey.

Predictably, there was a substantial difference in the age distribution of the women who had abortions in the two surveys. The national population survey, as indicated, represented a cross-section of all ages in Canada while the national patient survey measured a cross-section at one point in time. What these findings indicate, when considered in conjunction with information about the increasing volume of abortions which have been obtained during recent years, is that more females at an earlier age are getting abortions now than in the past. For the population was a whole in the national population survey, 11.0 percent of females were between 15 and 17 years of age and 1.9 percent in this age group had had abortions. In contrast, almost an equal number of young women in the national patient survey (10.2 percent) had had abortions as the proportion of women in the national population survey (11.0 percent). If women between the ages of 15 and 23 years are considered, they represented 26.6 percent of the females who had not had an abortion in the national population survey and 52.8 percent of women in the national patient survey.

The national population survey took a sample of females in the reproductive years, and for this reason the proportion of women who had abortions who were married was considerably higher than would be the case if a total population survey had been taken. Over a quarter (27.9 percent) of females in this survey were single, 61.6 percent married, and 10.5 percent were widowed, divorced, or separated. The marital status of women in the national population survey who had had abortions was somewhat comparable, with slightly fewer being married and more who were once married. In contrast, in the national patient survey which provided a cross-section of females who had abortions in 1976, almost two-thirds of the patients were single (64.5 percent), 25.0 percent were married, and 10.5 percent were widowed, divorced, or separated. This distribution was of the same order as the marital status listed by Statistics Canada for women who had abortions in 1974. These findings are indicative, not conclusive. What they suggest is that many young single women who get abortions subsequently get married.

In the national patient survey, approximately a third of the patients were foreign-born. In the Maritimes and the Prairies, most of the women (an average of about 90.0 percent) had been born in Canada. Elsewhere, the number of Canadian-born patients was between 63.2 and 67.8 percent. The heavier concentration of foreign-born patients were: Asian and United Kingdom patients in British Columbia; women born in the West Indies and Southern Europe in Quebec and Ontario. In British Columbia, Ontario, and Quebec, the 13.3 percent of the patients whose primary language was neither French nor English may have introduced an additional difficulty in their seeking an abortion.

Most of the abortion patients (about three-quarters) assessed their health as being "good". The regional variations in this respect were slight, with 32.8 percent of the patients in the Maritimes saying they were in "average" or "poor" health. In British Columbia, 81.2 percent of the patients had a family doctor with this less often being the case for women living in the Prairies, (71.3 percent) and Ontario (72.0 percent). Among women living in Quebec and the Maritimes, 55.2 percent and 61.9 percent respectively had family doctors. For

these reasons the extent of continuity of care and medical follow-up after an abortion operation was done, might be lower in those areas where a family doctor was not routinely responsible for the health care of these patients. In the patient sample, nearly all of the women saw a doctor at least once a year, 25.1 percent saw a doctor twice a year, and 36.3 percent saw a doctor three or more times annually. The medical consultation rates were lowest among the women living in the Prairies and Quebec.

Previous contraceptive experience

Each respondent in the *national patient survey* was asked if she had "Ever used any of these contraceptive methods?" This question was followed by a list of the major techniques of conception control. More than 4 out of 5 of these women had at one time used one or more techniques (84.8 percent).[3] The most frequently reported methods which had ever previously been used were the oral contraceptive (63.1 percent) and the condom (44.3 percent). The IUD was less popular, having been used by 13.6 percent of the women. The use in the past of other methods was 31.3 percent, withdrawal; 19.0 percent, foam and other spermicides; 26.5 percent, rhythm; 6.1 percent, diaphragm; and a small proportion of the patients had used other techniques. **A large proportion of the women (84.8 percent) who were seeking an induced abortion were contraceptively experienced. It was factors other than their lack of knowledge or exposure to contraceptives that were involved in accounting for their unwanted pregnancies.**

There was a positive association between the level of education and the proportion of women who at one time had used each of the seven methods. Over half (50.9 percent) of the women with an elementary schooling had used the pill, but the proportion of university trained women who had once used an oral contraceptive was higher (73.5 percent). There was the same range involving the previous use of most of the other methods. The prior use of condoms was 64.0 percent among university graduates, a level which was more than double the rate (28.5 percent) of women who had had a high school education. The overall level, and differences by education, were lower for withdrawal and the previous use of the diaphragm. While overall the diaphragm had not been much used, this method was more often used in the past by women with a university training. The use of withdrawal had been used at a moderately high level by women of all levels of education. In spite of these variations, the differences by education were relatively consistent for all methods.

Whether a woman was working, living at home or was attending school had a more modest effect on her previous contraceptive experience. It was only with the previous use of the pill that clear differences occurred. Seven out of

[3] The previous use of a variety of contraceptive methods was common among these patients with: 27.2 percent, one method; 22.7 percent, two methods; 18.0 percent, three methods; 10.1 percent, four methods; 4.7 percent, five methods; and the remainder, six or more methods.

ten of the women who were working or who lived at home had once used the pill compared to 2 out of 5 (38.3 percent) of those women who were still in school. The use of condoms, withdrawal, rhythm and diaphragm showed no major differences between the primary roles of being at school, work, or housework. The previous use of the IUD and foam was modestly higher among women who were at home or who were working.

The effects of age on the previous use of contraceptives was less marked than that of education. For females who were under 18 years, the use of condoms was the commonest method of birth control; it remained the second most popular method for each of the older age groups. After age 18, the pill was the most popular method, with 49.7 percent of women between 18 and 19 years having previously used oral contraceptives. Among women between 25 and 29 years, the use of oral contraceptives increased to 79.9 percent, but declined in each of the two older age groups so that 58.2 percent of the women who were 35 years and older said they had ever used the pill. Overall, the previous use of contraceptive methods was generally the highest among the women who were between 25 and 29 years. However, the pattern for the prior use of most of the methods was an increasing proportion of use up to that age group and a not unexpected decline among women over age 30. For two methods, rhythm and diaphragm, the increasing proportion of prior use continued throughout the oldest age groups. The effects of age were moderate in the prior use of condoms, withdrawal and rhythm, where the pattern was a relatively high initial use at the earliest age which increased only slightly with succeeding age groups.

The earlier use of the pill, diaphragm, foam and the IUD was the lowest among single women, significantly higher for married women and higher yet for women who were widowed, separated or divorced. Over one-half of the single women had used the pill, but their previous use of other methods was considerably lower. About one-half of the women in each marital category had ever used condoms, one-third had used withdrawal and slightly less had used the rhythm method.

The regional variations in the previous use of contraceptive methods among the women in the national patient survey were:

Region	Previous Use of Contraceptive Methods
	Percent
Maritimes	77.1
Quebec	85.6
Ontario	85.1
Prairies	81.2
British Columbia	88.5

The women in British Columbia in this survey had not only more often used a contraceptive method before but a higher proportion had previously used each method more often than women who lived in nearly all other regions. In Quebec, the previous use of withdrawal and rhythm was higher than in any

other area as was the use of withdrawal in the Maritimes. The prior use of oral contraceptives was low in the Maritimes, where 52.2 percent of the patients had used this method compared to 69.1 percent of the patients in British Columbia. The range was between 61.7 and 63.6 percent among women in the other regions. About half of the patients in British Columbia (51.6 percent) had used condoms as compared to the prior use of this method of between 40.1 to 44.2 percent in other regions.

A similar pattern was found for the previous use of the diaphragm and the IUD , with patients in British Columbia reporting an 18.6 percent previous use of the IUD compared to other areas which ranged between 10.1 to 13.4 percent. The corresponding figures for the prior use of the diaphragm were 9.7 percent versus 4.4 to 7.0 percent. There was less previous use of foam, rhythm and withdrawal, but women in British Columbia also reported higher levels of having used these techniques. Taken together, these findings indicate that the previous use of all types of contraception was the highest among the patients in British Columbia, while patients who lived in other regions had a lower and generally more uniform level of the previous use of birth control techniques.

Discontinuing the use of contraception

The general dislike of most methods of birth control among the women in the *national patient survey* inhibited their more widespread use. For each method there are known disadvantages which vary from physical and psychological side-effects, a reduction of sexual pleasure and spontaneity, and in some instances, a lack of adequate control over accidental conception. Each patient was asked if she liked, disliked or did not know each of seven methods of family planning. Opinions about methods of conception control are likely to be affected by the personal experiences which each woman had had in use of each method as well as the reports which they may have obtained from other women, physicians, books and magazines or other sources. Accordingly, the opinions of the women who had used any method were separated from those women who had not used a particular contraceptive means.

Half of the patients (49.5 percent) who had used the pill said they liked this method as did 46.1 percent of those who had used the IUD. Between 25.7 and 32.4 percent of women who had previously used the condom, rhythm, diaphragm and foam liked these methods. In contrast, 16.3 percent of women who had used withdrawal said that they liked that method. Among the *women who had never used any method*, 30.6 percent said they liked the pill and 10.5 percent liked the IUD. There was a small group of women who liked other methods which they had never used, but most women in this category were undecided.

The social circumstances of the patients had a limited impact on their opinions about each method of birth control. The effect of age, marital status, primary social role and place of birth showed that for women who used the pill,

the proportion who liked this method was inversely associated with their education and age. Women who were younger and who had less education more often said they liked the pill as a method of birth control. More women born in Southern Europe endorsed the use of condoms, while females born in the United States and United Kingdom generally disliked this method. None of a woman's other social characteristics were related to her preferences about the use of condoms or the IUD.

More women who had been born abroad held favourable opinions about withdrawal and rhythm, while women who had been born in Canada had less favourable views of these methods. Foreign-born women were also more likely to approve the use of the diaphragm as a contraceptive. The proportion of women who preferred the diaphragm increased with the level of education among the patients. Despite these several trends, in general, the social and demographic attributes of the patients who had abortions did not much influence their opinions about these measures. Their age, their level of education and where they lived were only partly related to their opinions about contraceptive methods. These trends were neither strong nor consistent. More important was their actual use of the various methods. When contraceptive methods had been used, this fact sharply influenced their opinions about these measures and transcended the effects of the social and demographic attributes of the patients.

Because of their needs, experience and preferences, women at different stages in their lives may and do change the types of contraceptive methods which they use, or stop using these methods altogether. What is known from fertility surveys which have been done in other nations is that the risks of an accidental conception are increased during the intervals between the non-use of methods and the initial stages of adopting new techniques. These higher risks result from a lack of knowledge and experience with these new contraceptive means and in some cases, they are inherent in the method itself as many physicians, for instance, counsel their patients who use the pill and IUD to use alternate methods during the initial phase of using these two means of contraception.

In examining the reasons why a woman or her partner in the patient survey stopped the use of birth control prior to conception which resulted in an abortion, the Committee obtained information about the use of these methods, the type of medical advice which had been given, and the perceived, changing needs cited by these women for fertility control. The side-effects associated with the use of the pill and the IUD were mentioned by a large number of abortion patients. A second reason often given for stopping the use of these methods was the advice reported to have been given by a physician that a woman should discontinue its use. A further reason involving oral contraceptives was that some women were afraid to continue the use of this method over a considerable period of time. The hormonal effects of the pill have been raised in the media. According to these patients, some physicians had advised them to "take a rest" from the pill after they had used this method for a few years. Stopping the use of condoms among abortion patients prior to conception was associated with objections to its use which had been raised by the partners of

some of these women. The unavailability of condoms was also cited by a few women as a reason for stopping its use. Among some couples a further reason for stopping the use of condoms was the belief that these women thought they could not get pregnant by having sexual intercourse.

Many women who had stopped using the pill and the IUD said they had made this decision because they had been advised to do so by their physicians and because they were afraid of its long-term physical side-effects. The reasons which were given for stopping the use of the condom were more closely tied to the sexual rather than the medical dimensions of contraception. The females who were still in school were more likely to have stopped the use of condoms. Women who were living at home had high rates of discontinuing the use of the IUD. More of the women who were working had previously used the pill. The trend involving the discontinuation of the use of the pill was particularly high in the Prairies, Ontario and the Maritimes. Of the 9.7 percent of the women in the national patient survey who had discontinued the use of condoms, the rate was the highest (17.3 percent) among the patients in the Maritimes. This trend occurred particularly among women who were still in school in the Maritimes. The pill was the method which previously had been the most commonly used birth control measure in each region.

Reflecting the general patterns in the use of contraception, younger and single women were more likely to have stopped the use of the pill, while women over 25 years of age and those women who were married had previously used other contraceptive methods. No strong regional patterns within the age groupings emerged in the previous use of these methods. However, when a woman's age, her marital status, her primary social role and the number of live births which she had had were considered together, several trends emerged. A significant proportion of the women between 16 and 25 years who were living at home or were working had previously been using the pill. Beyond age 25, there were no variations by their primary social role. Among the patients who were under 25 years old, and who were still in school, a sizeable number had relied on the use of the condom for protection against pregnancy. Among the women who were single, a high proportion who were working or who were living at home had been using the pill, while more of those females who were still in school had been using the condom. There was no significant variation in the methods which had been used by type of social role among the other marital groupings. A single woman's other social circumstances, such as her number of live births or her level of education were not related to her prior use of birth control methods. This was also the case among married women who had stopped using contraceptive methods. Women over the age of 25, regardless of their marital status or their primary social roles, had no strong preferences about the use of specific methods.

Motivation regarding pregnancy

To see if a woman's level of motivation regarding her pregnancy had changed since conception had occurred, each woman in the national patient

survey was asked if she had wanted to become pregnant at the time of conception, whether she did not want a child now but would want a pregnancy later, or if she never wanted to be pregnant. In some fertility studies the extent to which a pregnancy is wanted by a woman has been found to be a strong indicator in limiting the frequency of coitus. If the extent to which a pregnancy was wanted remained the same during the period of contraceptive use and when conception occurred, it might be expected that more women who least wanted to become pregnant might be using birth control measures more often, and in addition, using methods which are recognized for their effectiveness. There was no evidence in the findings of the national patient survey to support this idea. To the contrary, there was a slight tendency for the use of the more ineffective contraceptive methods as often among the abortion patients who never wanted to be pregnant as among those women, a much smaller group, who at the time of conception had wanted to become pregnant. The results did not support the view that differences which may exist in the level of motivation among the women who had abortions determined their use of effective methods of contraception. Among the abortion patients, 7.8 percent of those women who had previously stopped the use of contraception, said they had wanted to become pregnant when conception occurred. These women, though few in number, did not reflect "contraceptive failure". Relatively little is known about this group of women, why they changed their minds or the implications for their medical care. It is equally unknown how many women who had not wanted to become pregnant carried their pregnancies to term.

The time involved in resolving these decisions contributes both to the postponement by some women in seeking out a physician at an early phase of their pregnancies and is also a factor cited by many physicians why they provide an interval between their initial contacts with abortion patients to allow them time to reconsider their decisions. Final and irrevocable decisions about an abortion may not be fully made until an operation has in fact been done. This fact was tacitly recognized by the medical staff of some of the large hospitals visited by the Committee. At some of these hospitals which did a high volume of day surgery abortion operations, there was an unstated and internal policy of the "extra-booking" of patients which was based on the premise that some patients who had been approved for the operation would not turn up on the day which had been scheduled for the operation. Some of these patients may "double-book" applications at hospitals but the extent to which this may happen is discounted by the time involved for appointments with physicians. From the information received from women who went to the United States, there was no indication that any of these women had had an abortion approved at a Canadian hospital, and then gone to the United States for this purpose.

At 19 large hospitals in 1974, which did 35.8 percent of all abortions in the country that year, there was a difference of 7.8 percent between the number of approved abortion applications and the number of the abortion operations which had been done at these hospitals. Once their application had been approved to be done in a Canadian hospital, these "no-show" patients represented the proportion of women who had changed their minds about obtaining an induced abortion. **When the number of women who withdrew from having an abortion after obtaining approval from a hospital committee (7.8**

percent) are considered with the number of women who initially had wanted to become pregnant and then decided to seek an abortion (7.8 percent), then 1 out of 6 women changed their decisions one way or another about having an induced abortion.

Use of contraceptive means

One out of four females (24.6 percent) in the *national population survey* did not have coitus. This finding does not mean that these females may not have had coitus in the past or might not do so in the future. What this finding means is that at the time of the 1976 survey these women in their present circumstances never had sexual intercourse. Over half of these women used contraceptive means (13.2 percent), a fact which indicates the possibility or anticipation of coitus. The remainder (11.4 percent) never had coitus and did not use contraceptive means.

In comparison with sexually active females, women who did not have coitus were predominantly young and single. More of these women had an elementary and a high school level of education and there were slightly more Catholics than members of other religious denominations in this group. Because they were sexually inactive, the women who never had coitus and did not use contraceptive means are not considered in the review of the use of contraceptive means. In epidemiological terms, these women were not "at risk" of becoming pregnant. It is unknown whether the size of this group has remained constant or has fluctuated over a period of time. Depending upon its proportions and the direction of its incidence, the number of sexually inactive females has implications for the rate of population growth and programs involving family planning.

Three out of four females (75.4 percent) had sexual intercourse with a frequency which ranged from a few times each year to more than four times each week. The highest coital frequency was among women between 24 and 29 years and those who were married. **Among sexually active women in the national population survey slightly less than a fifth (17.8 percent) did not use any form of contraception when they had coitus.** The characteristics of females in the national population survey who had coitus regularly but who did not use contraceptive means varied by their social circumstances. In particular, **more females in the reproductive years who were young, single, and had an elementary and high school education never used contraceptive means.** By age, the proportions of sexually active women not using contraceptive means were: 33.3 percent, 15 years ; 17.2 percent, 16 to 17 years; 14.6 percent, 18 to 23 years; 11.4 percent, 24 to 29 years; and 16.6 percent, 30 to 49 years. **Contraceptive means were not used by 28.2 percent of the sexually active single women.**

Males used contraceptive means slightly less often than females. The experience of females and males was similar for those individuals who were over 30 years. Young males and those with less formal education far less often than females in these categories used contraceptive means. The general trend

of this information indicates that women having coitus took more precautions involving the use of contraceptive means, but the contraceptive practices of young and single females and males made them a high-risk group in terms of becoming pregnant.

TABLE 14.4

CHARACTERISTICS OF NON-USERS OF CONTRACEPTIVE MEANS WHO HAVE COITUS

NATIONAL POPULATION SURVEY

Characteristics of Individuals	Percent of Individuals Having Coitus Who Do Not Use Contraceptive Means	
	Females	Males
AGE	percent	
15 years	33.3	66.7
16-17 years	17.2	28.1
18-23 years	14.6	21.7
24-29 years	11.4	15.1
30-49 years	16.6	16.9
50 years & older	32.2	31.8
EDUCATION		
elementary	25.1	33.0
high school	16.8	22.6
technical	10.2	15.1
college/university	14.5	13.8
MARITAL STATUS		
single	28.2	27.1
married	23.0	26.4
widowed, divorced, separated	14.5	4.0
RELIGIOUS AFFILIATION		
Catholic	18.8	24.1
Jewish	0.0	19.1
Protestant	16.8	18.2
Other	16.4	14.2
AVERAGE	17.8	21.1

In the general research on coitus, contraception and pregnancy, several different approaches have been used to estimate the frequency of pregnancy relative to the frequency of unprotected coitus. In-depth and exact information has on occasion been obtained from small groups of fecund women which in general suggests that pregnancy results from approximately 2.0 percent of the times when coitus occurs. Such detailed information was not obtained by the Committee, but on the basis of the general information on the sexual behaviour of females, somewhat lower rates were derived. Two general methods were used. The first approach considered the average weekly frequency of coitus

prorated to an annual rate by the proportion of females not using contraception. On this basis, for each 1,000 females, there were 61,360 times of coitus of which 10,922 had not involved the use of contraception. On an age-specific basis, the number of pregnancies for each 1,000 Canadian women between 15 and 49 years was calculated by taking into account the number of live births, stillbirths, the total of all officially reported abortions (therapeutic, spontaneous, and other categories) and unreported abortions (illegal in Canada and out-of-country). The rates per 1,000 women between 15 and 49 years in 1974 were: 60.6 live births, 0.63 stillbirths; 11.9 reported abortions, and 1.7 unreported abortions for an accumulative total of 74.8 pregnancies per 1,000 women in these ages. On this basis, 0.12 percent of the frequency of coitus resulted in pregnancy and when contraceptive means were not used, pregnancy occurred 0.68 percent of the time. Put another way, there was one pregnancy for every 820 times of coitus, and one pregnancy for every 146 times of coitus when contraceptive means were not used.

The second approach took into account only the coital experience of sexually active females. The frequency of pregnancy was lower among these women, with the overall rate being 0.10, and for females not using contraceptive means, 0.59. In terms of becoming pregnant, for all sexually active women, one pregnancy would be expected for every 1,028 times of coitus and among those women who did not use contraceptive means, one pregnancy for every 169 times of coitus. These findings outline general trends. It is recognized that the biological capability to become pregnant varies particularly among younger and older women in the reproductive years, and with the extent of the fertility of males.

TABLE 14.5

FREQUENCY OF COITUS
BY THE TYPE OF CONTRACEPTIVE MEANS USED

NATIONAL POPULATION SURVEY

Type of Contraceptive Means	Frequency of Coitus							
	Females				Males			
	None	Once a month or less often	Weekly	Several times each week	None	Once a month or less often	Weekly	Several times each week
Pill	4.8	13.0	26.1	56.1	0.9	14.9	27.7	56.5
Condom*	1.8	19.6	28.6	50.0	0.7	36.8	27.9	34.6
I.U.D.	1.9	9.4	26.4	62.3	2.2	4.4	32.6	60.8
Withdrawal*	5.9	29.4	20.6	44.1	5.0	20.0	37.5	37.5
Rhythm	2.1	14.9	31.9	51.1	3.2	3.2	16.1	77.5
Foam	12.5	8.3	37.5	41.7	5.6	11.1	22.2	61.1
Diaphragm	0.0	25.0	20.0	55.0	0.0	16.7	58.3	25.0
Sterilization*	2.3	6.8	32.1	58.8	0.6	7.2	30.5	61.7
Other	13.2	15.8	36.8	34.2	10.0	20.0	40.0	30.0

* The use of these contraceptive methods refers to their use either by women or men at the time of coitus.

TABLE 14.6

CONTRACEPTIVE USE OF FEMALES HAVING COITUS

NATIONAL POPULATION SURVEY

Characteristics of Individuals	Type of Contraceptive Means									
	Pill	Condom*	I.U.D.	Withdrawal*	Rhythm	Foam	Diaphragm	Sterilization*	Other	Total
	percent									
AGE										
15-17 years	55.2	10.4	3.4	13.8	0.0	3.4	7.0	3.4	3.4	100.0
18-23 years	76.2	9.8	4.1	4.9	2.5	1.6	0.9	0.0	0.0	100.0
24-29 years	63.0	4.8	7.9	2.2	3.5	2.2	0.9	14.1	1.4	100.0
30-49 years	25.9	5.5	6.2	3.0	7.2	3.0	2.5	40.8	5.9	100.0
50 years and over	16.0	20.0	4.0	16.0	8.0	0.0	16.0	12.0	8.0	100.0
EDUCATION										
elementary	37.9	6.9	2.3	4.6	6.9	6.9	2.3	21.9	10.3	100.0
high school	45.1	5.8	6.1	4.3	5.2	1.3	2.5	26.3	3.4	100.0
technical	50.7	11.5	5.8	1.5	2.8	1.5	1.5	23.2	1.5	100.0
college/university	41.9	6.8	8.5	1.7	6.8	4.3	2.6	24.8	2.6	100.0
MARITAL STATUS										
single	67.3	10.2	5.5	6.1	3.4	2.0	2.7	1.4	1.4	100.0
married	39.2	6.0	6.0	3.4	6.1	2.5	2.2	30.5	4.1	100.0
widowed, divorced, separated	38.8	2.0	10.2	2.0	2.0	4.1	4.1	28.6	8.2	100.0
RELIGIOUS AFFILIATION										
Catholic	49.7	5.1	4.8	3.7	8.0	1.3	0.3	23.4	3.7	100.0
Jewish	66.7	0.0	33.3	0.0	0.0	0.0	0.0	0.0	0.0	100.0
Protestant	37.5	7.5	6.2	3.5	3.5	3.0	4.0	30.0	4.8	100.0
Other	51.0	10.6	8.5	6.4	4.3	4.3	4.3	10.6	0.0	100.0
AVERAGE	44.0	6.5	6.2	3.8	5.3	2.5	2.4	25.5	3.8	100.0

* The use of these methods refers to their use either by women or men at time of coitus

TABLE 14.7

CONTRACEPTIVE USE OF MALES HAVING COITUS

NATIONAL POPULATION SURVEY

Characteristics of Individuals	Type of Contraceptive Means									
	Pill	Condom*	I.U.D.	Withdrawal*	Rhythm	Foam	Diaphragm	Sterilization*	Other	Total
	percent									
AGE										
15-17 years	30.2	44.2	4.7	9.3	4.7	2.3	2.3	0.0	2.3	100.0
18-23 years	54.4	30.6	0.8	6.0	3.7	1.5	2.2	0.0	0.8	100.0
24-29 years	64.5	12.5	8.0	1.7	1.4	4.0	0.5	7.4	0.0	100.0
30-49 years	33.1	10.9	6.6	4.8	5.3	1.3	1.3	35.2	1.5	100.0
50 years and over	25.8	15.5	3.5	12.1	1.7	3.5	3.5	32.7	1.7	100.0
EDUCATION										
elementary	38.8	5.6	5.6	11.1	5.6	0.0	1.4	30.5	1.4	100.0
high school	40.0	20.9	4.4	5.4	3.2	2.9	1.0	21.0	1.2	100.0
technical	49.0	10.8	5.9	2.0	2.0	2.9	2.0	24.5	0.9	100.0
college/university	48.2	15.6	8.5	2.5	4.5	1.0	2.5	16.2	1.0	100.0
MARITAL STATUS										
single	52.7	28.8	4.6	5.9	2.9	1.3	1.7	1.3	0.8	100.0
married	38.9	12.0	6.4	4.6	4.2	2.6	1.3	28.7	1.3	100.0
widowed, divorced, separated	47.3	5.3	0.0	5.3	0.0	0.0	5.3	36.8	0.0	100.0
RELIGIOUS AFFILIATION										
Catholic	53.2	13.1	0.0	8.2	0.0	2.0	1.0	22.2	0.3	100.0
Jewish	6.8	13.6	27.3	0.0	47.7	2.3	0.0	0.0	2.3	100.0
Protestant	36.1	20.9	7.3	3.3	2.1	3.0	1.8	25.2	0.3	100.0
Other	54.9	18.2	11.0	2.5	2.4	0.0	0.0	11.0	0.0	100.0
AVERAGE	43.0	16.8	5.6	5.1	3.8	2.2	1.5	20.9	1.1	100.0

* The use of these methods refers to their use either by women or men at the time of coitus.

Two major types of contraception were used by women having coitus. The pill, or oral contraceptive, was used by 44.0 percent of these sexually active women; 25.5 percent of these women or their partners had been surgically sterilized. These two methods accounted for 69.5 percent of the contraceptive means used by sexually active women in the national population survey. Six other methods, each of which was less often used, were: 6.5 percent, condom; 6.2 percent, IUD (intra-uterine device); 5.3 percent, rhythm; 3.8 percent, withdrawal; 2.5 percent, foam; and 2.4 percent, diaphragm. Other unspecified means were used by 3.8 percent of women having coitus

There was a direct association between the type of contraceptive means which were used and the frequency of coitus. Among individuals who used withdrawal, 35.3 percent seldom had sexual intercourse or did so only a few times each year. This was also the case among females who used other, unspecified contraceptive methods (29.0 percent). Conversely, the frequency of coitus was highest among women who relied on sterilization, 90.9 percent of whom had sexual intercourse once a week or more often. This higher frequency of coitus (once a week or more often) was also the case for users of the IUD (88.7 percent), the pill (82.2 percent), and the rhythm method (83.0 percent).

Several contraceptive methods such as the condom, withdrawal, and the diaphragm were more extensively used by older rather than younger women or their partners. Few young women used the rhythm method. While this means was used by 5.3 percent of all women using contraceptive means, it was more often used by older women (8.0 percent who were 50 years and older) and by Catholics (8.0 percent). Withdrawal was least used by the partners of married women, those individuals with a higher education, and females between 18 and 49 years. In contrast the partners of 13.8 percent of females 15 years and younger and 16.0 percent of women who were 50 years and older used the withdrawal method.

From information which was available on the sales of pills and other pharmaceutical and mechanical means and the volume of female sterilizations done in Canadian hospitals, the two major methods were the use of pills and surgical sterilization. These were also the methods most frequently used by the women and their partners in the national population survey.

The women who had abortions from whom information was obtained in the *national patient survey* can be divided into three broad groups on the basis of their contraceptive usage. The first group of women (47.3 percent) reported they were using birth control at the time of conception of the present pregnancy. The second group of women (25.5 percent) discontinued use of contraception some time before the present pregnancy. The third group of women (27.2 percent) had not used contraception at any time.

The largest group of women, reporting use of contraception at the time of conception, can be considered to be seeking an abortion as a result of a contraceptive failure. The contraceptive methods used by these women at the time of conception included: pill, 18.0 percent; condom, 26.2 percent; IUD, 9.9 percent; diaphragm, 4.3 percent; foam and rhythm, 15.3 and 14.9 percent respectively, and the remainder, other methods. A proportion of these women were using ineffective methods.

The use of contraceptive methods among the patients obtaining induced abortions was associated to a moderate extent with ethnic and religious factors. The use of oral contraceptives was higher among Catholics (21.6 percent) than all other religions (16.1 percent) and was particularly high among women born in the West Indies (35.1 percent). The use of condoms was somewhat higher at 29.0 percent by the partners of Protestant women compared with 23.8 percent among other religious groups, but it was much higher by the partners of women born in India and Asia than for those females who were born elsewhere. Both the IUD and diaphragm were popular methods among Jewish women and for women born in the United States or United Kingdom. The use of rhythm and withdrawal tended to be higher in Catholic women and among women who were born in Southern Europe.

The pill was more likely to be used by women in the national patient survey: with eleven years or less of education; those between 18 and 24 years; women who were working or at home; and those who were separated. The use of condoms by the male partners of these women was more frequent among females who were: 19 years and under; single women; and females who were still in school. Both the IUD and diaphragm were used more frequently by older women, those with more education and among women who had been widowed, separated or divorced. The reliance upon withdrawal was the highest among women under 17 years, females who were still in school, and women who had eight years or less of schooling.

An unresolved question is why among women reporting the use of a contraceptive method at the time of conception there should have been such a high level of unwanted pregnancies associated with the use of the pill and IUD. Almost 1 out of 5 (18.0 percent) of the women said they were using the pill and another 9.9 percent the IUD at the time of conception. While there is not an appropriate denominator for calculating failure rates for these methods, the high levels of protection generally attributed to their use would suggest lower failure rates. It is unknown whether the method failed, or whether it was used incorrectly. In each instance even the most effective methods did not confer protection from conception for these women.

There were some provincial variations in the use of contraceptive methods among women in the national patient survey. Women who had had an abortion in Quebec and the Maritimes used the rhythm method 21.3 and 24.0 percent respectively in comparison with the use of this method at the time of conception by 13.0 percent of all other patients. The use of the pill and the condom was higher among patients or their partners in the Prairies and Ontario than in the other regions. When use of rhythm, withdrawal and other unspecified methods were combined, 36.6 and 35.0 percent of the patients in Quebec and the Maritimes respectively used these methods compared with 15.2 percent in the Prairies, 27.1 percent in Ontario and 22.5 percent in British Columbia. When the levels of the use of the pill and IUD were combined, there was no significant variation between the provinces. The moderately effective methods, condom, vaginal spermicides, foam and diaphragm, were used by about one-half of the women or their partners in British Columbia, the Prairies and Ontario compared to 37.5 percent in the Maritimes and 37.0 percent in Quebec.

The use of specific contraceptive techniques among the patients by their age, education, primary social roles and place of birth did not differ greatly for any geographic region from the patterns which have been outlined. Within each region married women or their partners were less likely to have used the pill or condom and had higher rates of the use of the IUD and diaphragm than single women. Women who were in school in each region were more likely to be using condoms than those who were working or living at home. A high proportion of patients who were young, single, and had an elementary and a high school education had not used contraceptive means at the time of coitus. Over half of the women (55.1 percent) felt they became pregnant easily, although immediately after conception had occurred over a quarter (26.1 percent) did not think they were pregnant.

Previous abortions

The concern over the occurrence of repeat abortions stems from a number of factors including: the effect of an abortion on a woman's fertility; an increased exposure of the patient to immediate and long-term psychological and physical health risks; the increasing costs of health care assigned to abortion services; and the possibility that some couples may use abortion as a method of contraception. The experience of other nations suggest that in general as abortion services have become more available, there has been a reported increase in the number of second or repeat abortions. Reports for instance from some centres in New York, California and elsewhere in the United States indicate that a small group of women may be involved who have second or more abortions. Based on the experience of these studies the total number of women who have repeat abortions tends to increase as the pool of women who have had a first abortion grows. In reviewing the experience at these centres in the United States, the level of second abortions initially rose, then reached a plateau within each group of patients. The point at which the plateau was reached differed between areas and varied in part with the types of abortion services which were then available.

For 17.9 percent of the patients in the 1976 *national patient survey*, the abortion which they then obtained was their second (or more) induced termination of pregnancy. Exact information on the number of women who have had more than one abortion is difficult to obtain. Unless there is specific medical evidence of a prior induced abortion, the accuracy of reporting a second induced abortion depends upon the willingness of women to provide this information to physicians. In comparison to women either who have not had abortions or for whom the abortion was their first termination of a pregnancy, women who have had repeat abortions may have: an earlier onset of or a higher frequency of sexual activity; a less effective use of contraception; and a higher level of fecundity. Information from the national patient survey did not document the changes through time in the levels of repeat abortions, but it provided a measure of the extent of second or more abortions among a large group of women who were interviewed in 1976. This source was relevant to

distinguish the variations which may occur in the prevalence of repeat abortions and it provides some insights into different abortion practices between the regions of Canada.

Regional variations in the prevalence of previous abortions reported by women in the national patient survey rose from 11.9 percent in the Prairies to 15.6 percent in the Maritimes and to 15.7 percent in Ontario. The highest prevalences of 20.7 and 24.4 percent were among the patients in Quebec and British Columbia respectively. These regional trends were similar, but at a higher level than the prevalence of second abortions reported by Statistics Canada in 1974. At that time the proportion of women who had repeat abortions of all women then having induced abortions was: 3.1 percent, Maritimes; 9.8 percent, Quebec; 7.3 percent, Ontario; 5.0 percent, Prairies; and 11.2 percent, British Columbia. Assuming that the 1976 national patient survey was generally comparable in its scope to the coverage given by Statistics Canada in 1974, it would appear that **the proportion of women having repeat abortions may have more than doubled across the nation (from 7.9 percent in 1974 to 17.9 percent in 1976)** and risen substantially in each region. This change may be wholly spurious. It could result from how the patients in the 1976 survey were selected and in this respect their experience may not represent the actual situation for the country. But the trend would appear to indicate that what may be happening in Canada is following broader trends elsewhere involving an increase in the numbers of women seeking repeat abortions.

In the Committee's judgment there is also another factor which may account for this apparent increase in the proportion of women having repeat abortions. How information is obtained from women who are in this situation may significantly affect the accuracy with which this experience is documented in official statistics. It may well be the case that official statistics substantially under-represent the actual extent of repeat abortions.

In the case of the 1976 national patient survey, the information was obtained directly from women about to have induced abortions. The information was recorded on a confidential basis which assured the anonymity of these patients. It was given freely without any suggestion that it might affect a women's chances of getting an induced abortion. These procedures contrast with how this information is sometimes obtained as part of a medical consultation when such patients may assume, on occasion accurately, that volunteering such information either may jeopardize their chances of getting a second (or more) induced abortion, or invoke a professional prerequisite of giving consent to sterilization as a precondition to getting this operation. Many physicians were reluctant to discuss this aspect of medical practice.

On its site visits to hospitals the Committee was told of a number of instances where approval for abortion was contingent on receiving consent for sterilization. These instances were not confined to any one province, but occurred in nearly all of the provinces. The Committee was told of individual physicians who would only perform abortions on women who agreed to be sterilized. One hospital stated that when a woman had a second abortion approved, she was told that if she wanted to have a third induced abortion she

would be required to be sterilized. The Committee was told at another hospital that women who were to be sterilized when the abortion was performed were not considered to be urgent cases because a hysterotomy was frequently the procedure which was used in these instances. There may be longer delays for these women. Information provided by Statistics Canada for 1974 indicates that of the 3.0 percent of the women for whom the abortion procedure was a hysterotomy, 83.2 percent of these women had concurrent sterilizations. On its visits to some hospitals and community agencies, the Committee was told that these pressures to have concurrent sterilizations usually came from referring physicians and gynaecologists who performed abortions; this policy was never stated explicitly as a requirement by therapeutic abortion committees.

The prevalence of repeat abortions did not differ much by the social circumstances of the patients in the 1976 national patient survey. One out of six (16.7 percent) of the women who did not have a college or university education had had a prior abortion compared with 21.5 percent of the women who had some university training. Predictably, fewer females (11.4 percent) who attended high school had had a prior abortion compared to 19.5 percent of the women who lived at home or who were working. Catholic and Protestant patients had levels of 17.8 and 15.1 percent respectively, levels which were lower than the prevalence of 22.8 to 27.1 percent among women who were Jewish, of other faiths or who reported no religious affiliation.

The majority of patients in the survey were born in Canada and 16.7 percent of these women, as well as those who were born in India and Pakistan had had previous abortions. Among the women who had been born in other countries, such as in Europe, other parts of Asia, or elsewhere, the prevalence varied between 19.6 and 23.3 percent.

The influence of marital status and number of live births on repeat abortions was not marked. Married and single women were somewhat less likely to have had prior abortions (between 17.8 and 16.8 percent respectively) than those who were widowed, divorced or separated (24.3 percent). Women who had had one or two previous live births were slightly more likely to have been previously aborted, but the differences were not great compared to those women who had had no live births. Not unexpectedly, the rate of repeat abortions increased with age. For the youngest group of patients, females under 18 years, 5.9 percent had had an earlier abortion. The proportion of the women who had had an earlier abortion rose to 11.3 percent among women between 18 to 19 years, and it was 19.7 and 25.8 percent respectively for women between 20 to 24 and 25 to 29 years. For those women who were 30 years and older, the proportion of repeat abortions declined to 18.7 percent.

This information refers to the entire patient survey population and as such, it provides a guide for understanding repeat abortions in the broader population. A more detailed study of the factors which may affect the rates of repeat abortions would require the use of a more restricted population. Specifically, this step would involve an examination of those forces which influence the prevalence of repeat abortions by eliminating from consideration the experience of women who had not previously been pregnant. Such a study

group, or population at risk, could be defined as those women who had had one or more previous pregnancies who were obtaining a first or a subsequent abortion.

About 1 out of 5 women in the national patient survey had had a prior abortion. This group of women was fairly evenly divided between those women who had had an earlier pregnancy (46.0 percent) and the slightly over half of the women for whom this conception was the first recognized pregnancy. Among those women who had been pregnant before, 33.6 percent had had a previous abortion. Regional variations followed the patterns for all abortion patients. In British Columbia 46.2 percent of the women who had previously been pregnant and were having an abortion had had an earlier abortion. The level was lower in Quebec at 37.1 percent, and declined further to between 25.8 and 28.7 percent among the abortion patients who lived in the remaining three regions.

The level of earlier pregnancies and previous abortions was not uniform across the sub-groups of the population in each of the major geographic regions. Although the number of young, previously pregnant women was small, those women under age 20 in this group had a higher rate of prior abortions. In British Columbia (59.3 percent) and Quebec (56.0 percent), this rate included 3 out of 5 of the women in this age group. While the rate was still high in other regions, it was lower involving about 2 out of 5 women. The rate among women who were 20 years or younger for instance was 43.1 percent in Ontario. The declines in previous abortion with age were regular and about one-third of the women in British Columbia and Quebec between 30 and 24 years and one-quarter or less of those who were 35 years and older had had a previous abortion. In the other three regions the proportions were much lower at older ages. The effect of marital status was similar as the highest previous abortion level was among single women. There was some variability within each region, but in general women who were married or had been married had similar levels of previous abortion which was about a half of the rate for women who were single. In each region about half of the single patients had had previous abortions. Correspondingly, 83.4 percent of those women with no prior live births had had a previous abortion compared with between 12.2 and 27.3 percent of women who had had one or more live births.

Among the women who had been pregnant before and who had had an earlier abortion, the lowest number was among females who lived "at home". Among all of the women across the country who were living at home, 24.0 percent had had previous abortions. The prevalence of prior abortion among previously pregnant women was higher among those females who were working. The level varied from a high of 50.0 percent in British Columbia, 42.7 percent in Quebec to between 31.7 and 39.3 percent in other areas. The prevalence of prior abortion among previously pregnant women who attended school was between 55.1 and 63.6 percent for all regions, except in the Prairies where it was 31.8 percent.

With relatively few exceptions the influence of where these women had been born was unimportant. The proportion of women who had had prior abortions was relatively higher among women who had been born in the United

States or United Kingdom and who at the time of the survey lived in British Columbia. This pattern did not occur in other regions. In a similar manner the prevalence was relatively higher among the women from the West Indies who lived in Quebec, but this was not the case elsewhere.

There was a more direct and significant association between the years of education and the prevalence of repeat abortions among the previously pregnant abortion patients. In each region the proportion rose with the level of a patient's education. The effect of schooling was strong in British Columbia where 28.6 percent of females with an elementary school level of education having had a prior abortion compared to 56.8 percent among women with a university degree. As would be expected, the overall level varied between regions, but the difference between women who had different levels of education was unmistakable. **The proportion was double in the highest education category in contrast to women who had less formal education.** There was no association between having had a previous abortion and a woman's length of gestation.

Overall, the experience of the women who had been previously pregnant and had had prior abortions differed from the majority of the women in the national patient survey. **More of these women were single,** they had on an average a higher level of education, **more were working outside the home and fewer had had previous live births.** What these findings suggest is that there is a discernible group of women who have somewhat similar backgrounds who may be at a higher risk of having repeat abortions in the future. It is this group of women as well as women having their first abortion whose patterns of sexual behaviour and contraceptive practices need to be understood if birth control programs are to be effective in reducing unwanted conceptions.

From the upward trend in induced abortions in Canada in recent years, it is likely that the number of women obtaining repeat abortions will also increase in the future until it reaches a plateau. A higher proportion of women who had had second abortions (57.3 percent) than other abortion patients (46.7 percent) had used a contraceptive means at the time of coitus when conception occurred.[4] Like other patients their use of contraception was substantially lower than among sexually active women in the general population (82.2 percent). Their use of contraceptive means rose by their age and level of education. Among females between 16 and 17 years who had had second abortions, 39.1 percent had used contraception. The rate with which these measures were used was 58.1 percent for females between 18 and 23 years, 58.9 percent for females between 24 and 29 years, and 55.9 percent for females who were 30 years and older. A third of women with an elementary school education (32.2 percent) who had had second abortions used contraception in contrast to 55.9 percent who had a high school education, and 68.1 percent who had college or university training. The level of use of contraceptive means varied little by the religious affiliation of Catholic, Jewish, and Protestant

[4] The proportion of *all* women in the national patient survey who used contraception at the time of conception was 47.3 percent.

females, but it was appreciably higher (65.8 percent) among women affiliated with other denominations or who had no stated religious affiliation.

In contrast with all other groups of women, both females who had not had abortions and those individuals who had had first abortions, a substantially higher proportion of females who had had second abortions used oral contraceptives. Overall, among these females 80.5 percent had used the pill at the time of conception; 4.4 percent, condom; 4.4 percent, intra-uterine device (IUD); and 10.7 percent, other methods or a combination of contraceptive means. More women (90.1 percent) between 18 and 23 years than females of other ages had used the pill, while the use of the condom was the highest among females between 16 and 17 years (20.0 percent) and women 30 years and older (10.3 percent). There was a decrease in the use of the pill as the level of education increased, a shift which was complemented by a higher use of the condom and the IUD among women with more educational training.

The reasons why 42.7 percent of females who had had second abortions did not use, or had discontinued, the use of contraception were basically similar to the reasons cited by other abortion patients. A slightly higher proportion (53.7 percent) were afraid of the hormonal side-effects of oral contraception. Comparable proportions to other abortion patients had not used contraception because they had left their partner, they were sexually inactive, or they had not been prepared for coitus (27.6 percent). A quarter (25.3 percent) had discontinued the use of contraception because they had been using a particular method for a long time; and 21.1 percent of these women had stopped on the basis of following their physicians' recommendations. Almost 1 out of 5 (19.1 percent) had felt that they could not become pregnant at the time of coitus. None of the younger females had discontinued the use of contraception because they were afraid their parents would find out.

While fewer younger patients who were having their first abortions were concerned with the side-effects of contraception, there was a uniform concern among all age groups with this issue among patients who had had second abortions. Among these younger patients, a substantially higher proportion had not used contraception because, based on the assumption they were not sexually active, they had been unprepared for coitus. Three out of ten women (29.6 percent) between 30 and 49 years of age who had had second abortions felt they could not become pregnant at the time of coitus.

More of the married women who had had second abortions than either single or once-married females were concerned with the side-effects of the use of contraceptive means. While fewer of these married women than other females had stopped using contraception because they felt they had been sexually inactive, almost a third of them had discontinued this measure on their physician's recommendation. There was a marked difference by the marital status of patients who had second abortions in terms of the proportion who had felt they could not become pregnant at the time of coitus. While few single women (11.1 percent) said this was why they had not used contraception, 23.4 percent of married women gave this reply and 39.1 percent of once-married women had made this assumption.

Sterilization

The birth of a child, the experience of a therapeutic abortion and other gynaecologic events can involve considerable emotional and physical stress for a woman. This fact is also true of surgical sterilization. It marks the end of reproduction for a woman. Sterilization may involve even more stress if it is performed in conjunction with another critical event such as an abortion or a delivery. To minimize these problems, it is the practice of some hospitals and physicians to discourage the simultaneous undertaking of sterilization with a delivery or an abortion. But from the opinions of some of the physicians in the national physician survey and of some patients in the national patient survey, it is apparent that an agreement to be sterilized has been used on occasion as a prerequisite to obtaining an abortion. The emotional vulnerability and the feeling of being under duress of a woman either at the time of a delivery or an abortion makes it somewhat easier for her to agree or to be persuaded to have the sterilization done at the time of these other procedures.

Information from Statistics Canada for 1974 indicated that 5,065 cases or 12.3 percent of the total terminations of pregnancy had been concurrently sterilized. Tubal ligation was the leading surgical procedure used to sterilize 59.0 percent of the sterilized cases. This procedure was followed by tubal coagulation (19.7 percent); bilateral salpingectomy (16.7 percent); hysterectomy (3.9 percent); and other procedures (0.7 percent) of the sterilized cases. For the women who obtained abortions in 1974 for whom information was available, 57.3 percent of the women who were subsequently sterilized were under 35 years of age. The frequency with which this procedure was performed rose directly with the number of previous deliveries which these women had had. It was more often performed for patients who had their abortions done earlier in their length of gestation.

The sterilization experience of the women in the 1976 *national patient survey* parallelled many of the trends for 1974 documented by Statistics Canada. The proportion of women who had a concurrent sterilization operation at the time of their abortion rose directly with their age and the number of their previous live births. Few women under age 25 had this operation. While only 1.0 percent of the patients under age 20 were to be sterilized, this rate rose to 9.4 percent of women between 25 and 29 years, 26.8 percent between 30 and 34 years, and 47.0 percent of women who were 35 years and older. This rate closely approximated the 52.2 percent of the women over 35 years who had concurrent sterilizations with their abortions in 1974 across Canada. Similarly, it was only at the level of two or three or more previous live births that the proportion of women who were to be sterilized rose to 24.5 and 47.1 percent respectively.

Married, widowed, and divorced women were more likely to be sterilized. A majority of the women having this operation said they lived at home and were neither at school nor had a job. However, 38.8 percent of the women who were to be sterilized were working. Protestant and Catholic women were both moderately likely to be sterilized and those women who reported either no religious faith or who were Jewish were slightly more likely to be sterilized. Where a woman had been born made little difference. Among the women who

had been born in Canada, 7.8 percent were to be sterilized. Women who had been born in other countries did not differ greatly in this respect, except for those who came from Southern Europe of whom 18.1 percent were to be sterilized after the abortion operation. Women who had had a previous abortion were no more likely to be sterilized than the women who were having a first therapeutic abortion.

The level of education of women having induced abortions was inversely related to the occurrence of sterilization, involving 17.7 percent of females with an elementary school level of education, 9.4 percent who had attended high school and 6.2 percent who had been to college or university. The prevalence of sterilization was significantly higher for those women who were less well educated. Only 1.0 percent of the sterilizations were performed on women under 20 years of age. The education of the women who were to be sterilized was in most cases completed. Women who were to be sterilized in British Columbia had the smallest range between the levels of education with 12.8 percent of women who had an elementary school education and 6.6 percent with a university education who had the operation. This gap by the level of education of abortion patients and their concurrent sterilization was greater in other regions with the Prairies and the Maritimes having the largest discrepancies. In each region those women with fewer years of schooling were more likely to be sterilized. Excluding British Columbia, the proportion of women with an elementary school level of education who were to be sterilized varied between 16.7 and 21.7 percent, while the proportion of women with a university education who were to be sterilized was between 2.9 and 8.3 percent. Women with a high school education were between these levels, but they were closer to the experience of university-trained women.

One-quarter of the women in the national patient survey were still attending school. This fact might affect the relationship among the women between their level of education and who was to be sterilized. A separate analysis was done which reviewed the experience of the women who were to be sterilized in each educational level by how old they were. Predictably, there were significantly few sterilizations among women under age 20. For women between 20 and 35 years there was a pronounced association between the extent of sterilization and the level of education. Women who had a university education were less likely to be sterilized than were those women who had an elementary school education. The general proportion of women who were to be sterilized increased with each age group, but within each age category the trend was evident that less well educated women were consistently more likely to be sterilized. For women between 20 and 24 years, the proportions rose from 1.1 percent of the women with university training to 10.4 percent of women who had an elementary school education. The proportions of women who were to be sterilized among the older age groups were 2.8 percent among university graduates who were between 25 and 29 years and 13.2 percent for women of these ages who had an elementary school education. Among women between 30 and 34 years, 19.3 percent who had university training and 46.3 percent who had an elementary school education were to be sterilized. This trend by education did not occur among women who were 35 years or older. For these women, the proportion who were to be sterilized was relatively high at each

educational level with no indication for any educational group to have a higher prevalence.

Several factors may account for the finding that the education of a woman seeking an abortion had such a clear role in determining the probability of her sterilization. The women who were less well educated may have had other characteristics which acted in concert to increase the chances of their sterilization. It is also possible that their relative lack of education protected them less from the advice which was given by physicians, who in deciding that these women were less effective in controlling their fertility, may have more strongly counselled their sterilization.

While there were minor variations in the national patient survey in the regional occurrence of the concurrent sterilization of women obtaining abortions, there were substantial differences by the age and parity of these women. There were also significant differences when the regional analysis was set aside and the experience in this respect of the individual provinces was considered. These several differences were influenced partly by the attributes of the women who were involved, but a more important consideration was the nature of the various guidelines set by the medical staff and the hospital boards in different parts of Canada involving their sterilization policies of abortion patients.

Based on information provided by Statistics Canada about abortion patients who were concurrently sterilized in 1974, the regional occurrence was: 8.3 percent, the Maritimes; 9.5 percent, Quebec; 13.4 percent, Ontario; 15.6 percent, the Prairies; and 9.7 percent, British Columbia, the Yukon and the Northwest Territories. These broad regional groupings mask significant provincial differences, such as the one-third (32.6 percent) of the women who obtained abortions in Newfoundland in 1974 who were concurrently sterilized, or the 1 out of 5 such women (20.5 percent) in Manitoba who had both of these operations done together. The proportion of the women who had abortions and were concurrently sterilized for each province in 1974 was: 32.6 percent, Newfoundland; 6.0 percent, Prince Edward Island; 5.4 percent, Nova Scotia; 5.5 percent, New Brunswick; 9.5 percent, Quebec; 13.4 percent, Ontario; 20.5 percent, Manitoba; 12.8 percent, Saskatchewan; 14.8 percent, Alberta; 9.8 percent, British Columbia; and 6.5 percent, the Yukon and the Northwest Territories.

While there is a difference of two years between the 1974 information provided by Statistics Canada and the 1976 national patient survey, it would appear that among women who had a concurrent sterilization at the time of their induced abortion, this experience was matched for the Maritimes and British Columbia. There may have been either an under-representation in the 1976 survey in other regions or an actual shift in the occurrence of this procedure may have taken place.

	Statistics Canada, 1974	National Patient Survey, 1976
	percent	percent
Maritimes	8.3	9.2
Quebec	9.5	5.8
Ontario	13.4	9.2
Prairies	15.6	9.8
British Columbia	9.7	9.7

There was greater regional variation among the married women having induced abortions of whom 45.9 percent were to be sterilized in the Maritimes and in the Prairies where the corresponding level was 39.7 percent. The level in other areas was lower with 12.6 percent of married women who were obtaining abortions in Quebec concurrently having the sterilization operation. Among the women who were widowed or divorced, 27.6 percent were to be sterilized in British Columbia and 28.6 percent in Ontario. These levels were twice the rates for each of the remaining three regions. Fewer separated women were sterilized at the time of their abortions. The influence of religion on the sterilization of abortion patients in the survey was pronounced for Catholics in some regions. In Quebec and the Maritimes, 5.0 and 4.7 percent respectively of the Catholic women were to be sterilized compared to between 9.6 to 11.2 percent of the Catholic women living in other areas. There was little variation in the proportion of women who were scheduled to be sterilized by their religious affiliation among women who lived in other regions. About 1 out of 10 Protestants, Jews and those women who reported no religious affiliation were to be sterilized in each of the regions outside Quebec. However, 1 out of 20 of the Protestant women in Quebec had this operation. These findings indicate that there may be factors other than the religious affiliation of the women who lived in Quebec which affected the extent to which they were sterilized.

Within each geographic region, sterilization was rare among younger and low parity women. Beginning with the 25 and 29 age group and those women who had two children, the proportion who were to be sterilized rose in the regions outside Quebec. The proportion who were to be sterilized in the other four regions was between 9.7 percent and 14.0 percent for women who were between 25 and 29 years; it rose to between 47.2 percent and 67.6 percent among women who were 35 years and older. The proportion of women who were to be sterilized rose from a low of between 2.6 to 6.6 percent among women who had had none or one birth to about 1 out of 3 of the women who had had two live births who lived in Ontario, the Prairies and British Columbia. About a half of the women who had had three or more live births were to be sterilized in all regions except Quebec which performed fewer sterilizations on any women who had had less than three live births and the Maritimes where few women were to be sterilized, except those who had had three or more live births (57.1 percent).

The need for a further analysis of the effects of age, the number of live births and marital status of women on the likelihood of sterilization is indicated by these findings. On its site visits to hospitals, the Committee found that these factors were given considerable weight in the decision which was made to sterilize a patient. Among the hospitals visited by the Committee, 44.9 percent based the decision for sterilization on the agreement of a woman and her physician, 23.1 percent used the "rule of 100" or the age of a woman multiplied by the number of children to whom she had given birth, 20.5 percent reviewed such requests before a hospital committee, and the remainder either used other formulae or approved sterilization only for medical reasons. There was a definite east-to-west trend in these review procedures. The age-parity mathematical formula (e.g., age of woman—35 years $\times$ 3 children = 105; or age 25 $\times$ 4 children = 100) was most extensively used in Quebec, where 55.6

percent of the hospitals visited by the Committee followed this procedure[5]. The decision that sterilization was solely a matter between a woman and her physician at the hospitals visited by the Committee was followed by: 40.0 percent, Maritimes; 25.9 percent, Quebec; 41.7 percent, Ontario; 59.1 percent, Prairies; and 66.7 percent, British Columbia, the Yukon and the Northwest Territories.

With the exception of Quebec, most hospitals in other provinces required the consent of a married woman's husband prior to her sterilization (65.4 percent), her former partner, if she was separated or divorced (3.8 percent) or if she was single of her male partner (7.7 percent). In Quebec, about half of the hospitals which were visited (44.4 percent) required only the consent of a woman, while the extent of this requirement in other regions was: 12.5 percent, Maritimes; 13.3 percent, Ontario; 20.0 percent, Prairies; and 15.8 percent, British Columbia, the Yukon and the Northwest Territories.

Among the women in the national patient survey the proportion to be sterilized according to the number of their previous pregnancies was analyzed by their ages. For women under 20 years there had been 10 sterilizations, but there were no trends in their distribution. Among the women who were over 20 years, there was a strong and consistent pattern of sterilization associated with their number of prior live births. The prevalence of sterilization increased with age and increased with the number of live births in each age category. For women between 20 and 24 years, the proportion of sterilizations for those females with none or one live birth was 1.1 percent. This rate rose sharply from 15.6 to 16.7 percent among women who had two or three and more children. The same pattern occurred among women who were between 25 and 29 years. The increase was from 2.8 percent of all women with none or one live birth to approximately one-quarter of those women who had two or more live births. The trends in the sterilization of the women who were over 30 years of age did not display the same sharp increase among those who had two or more live births. For these women the proportion who were to be sterilized was relatively high, even if they had had no live births and rose to over half of those women who had had three or more previous live births. Twenty percent (20.0) of the women with no live births and who were 35 years and older were to be sterilized; the proportion of these women to be sterilized who had three or more live births was 58.7 percent.

The effects of marital status were also examined. This factor had a less pronounced effect. To explore the interaction of these factors a further statistical analysis was undertaken.[6] The findings of this further analysis support the results described above. In examining the relative impact of age and the number of live births on the extent of sterilization, the findings from the hospital patient survey indicate that a woman's age was the most important factor. Regardless of their number of live births, relatively few women were to be sterilized at the time of their abortions who were under age 25. However,

---

[5] This type of formula was used by relatively few of the hospitals visited by the Committee in other regions with its overall occurrence being: 75.0 percent, Quebec; 4.2 percent, New Brunswick; 12.5 percent, Ontario; 8.3 percent, Saskatchewan.

[6] See Appendix 1, *Statistical Notes and Tables*, Note 5.

for women over age 35, a high proportion of the women who had had no previous live births were scheduled to have the operation at the time of their abortions. Married, widowed or divorced women were more likely to be sterilized with those women who were separated being less likely to have the operation. Between 1.1 and 2.0 percent of single women receiving an abortion were to be sterilized compared with 22.6 to 45.9 percent of the married women living outside Quebec. For married women in Quebec, the level was 12.6 percent.

Predictably, few women who were attending school were to be sterilized. Less certain was the level of sterilization among women who were working or who lived at home. A comparison of the regional findings found that working women were unlikely to have the operation. Most of those women who were to be sterilized said that their main responsibility was "at home" and their regional distribution was: 12.1 percent, Quebec; 15.1 percent, British Columbia; 20.8 percent, Ontario; 26.8 percent, Maritimes; and 27.8 percent, the Prairies.

The findings on the sterilization of abortion patients showed consistent patterns for a variety of social and demographic factors across the five regions in Canada. **The typical woman having an abortion who was to be sterilized had an elementary school level of education, spent most her time at home, was over 30 years of age and had two or more children.** With the exception of Quebec, a woman's religion played a less important role in determining who would be sterilized. In general, the pattern in Quebec was consistently lower than the rates in other areas in Canada for each of the groups which were considered.

Sexual behaviour and abortion

Among females in the *national population survey*, those **women who had had abortions were on an average more sexually active than the other women** in the survey. While 24.6 percent of women in their reproductive years did not have coitus, 4.2 percent of women who had had abortions said that at the time of the survey that they then never had sexual intercourse. In almost equal proportions, 16.0 percent and 16.7 percent respectively, both groups of women had coitus once a month or less often. Among women who had not had abortions, 59.4 percent had coitus once a week or more often while 78.1 percent of women who had had abortions had sexual intercourse with this weekly frequency. **The overall weekly frequency of coitus for the two groups was 1.18 for all women and 1.62 among women who had had abortions.** The difference in the usual frequency of coitus was 27.2 percent.

The difference in the frequency of coitus between women who had had abortions and women who had not had abortions was consistent by their marital status. In particular, single women (1.63 times per week) and once-married women (1.35 times per week) who had had abortions were between 3 to 4 times more sexually active than all women in these categories (0.44 and 0.49 respectively) in the national population survey, while there was less of a

difference between married women in each group (1.78, abortion; 1.57, no abortion). Young women between 15 and 17 years who had had abortions were the most sexually active (2.00 times per week) of all females whether they had had or not had this operation. In comparison, the weekly coital frequency of young females who had not had abortions was 0.12. A higher level of coital frequency also characterized women between 18 and 23 years who had had abortions. Beyond the age of 24 years the usual weekly frequency of coitus was similar for both groups of women, a change which was related to a larger number of women who had had abortions in these older age groups who were married. This pattern remained about the same for all women over 23 years of age including those individuals who were 50 years and older.

TABLE 14.8

CONTRACEPTIVE MEANS USED BY ABORTION EXPERIENCE OF WOMEN WHO HAVE COITUS

NATIONAL POPULATION SURVEY & NATIONAL PATIENT SURVEY

Type of Contraceptive Means	Experience with Abortion		
	Not Had an Abortion (Population)	Had an Abortion (Population)	Had an Abortion (Patient)
	percent		
Pill	44.0	47.0	18.0
Condom*	6.5	2.0	26.2
I.U.D.	6.2	9.8	9.9
Withdrawal*	3.8	3.9	9.4
Rhythm	5.3	5.9	15.3
Foam	2.5	3.9	15.3
Diaphragm	2.4	2.0	4.3
Sterilization*	25.5	25.5	0.4
Other	3.8	0.0	1.2
TOTAL	100.0	100.0	100.0

*The use of these contraceptive methods refers to their use either by women or men at the time of coitus.

Four out of five women (82.2 percent) in the national population survey who were sexually active used contraceptive means. Excluded from this group of women were those females who at the time of the survey never had coitus. If these women in the reproductive years are included, then 47.0 percent of all women in the national population survey used contraceptives. In comparison with *all* of the women in the national population survey, 86.0 percent of women who had had abortions and who were sexually active at the time of the national population survey were using contraceptive means. While the characteristics of

both groups were generally comparable, a higher percentage of younger and single females who had had abortions were using contraceptive means than was the case for women of similar ages who had not had this operation. It is unknown whether the women in the national population survey who had had abortions had been using contraceptive means at the time of conception. What is apparent from these findings is that their current use of contraceptive means was higher than for all women in the national population survey.

The type of contraceptive means used by the 47.3 percent of the patients who had abortions in Canadian hospitals in 1976 differed from the contraceptive practices of women in the national population survey who had not had abortions and of women who had previously had abortions. Less than 1 out of 5 (18.0 percent) of these patients used oral contraceptives, or the pill, a proportion which contrasted with the 44.0 percent of women in the national population survey who had not had abortions who used the pill and the 47.0 percent of women who had previously had abortions. In contrast with the two other groups of women in the national population survey, the patients who had had abortions in 1976 used: the diaphragm twice as often; their partners had used the withdrawal method 2.4 times more often; the rhythm method about three times more often; vaginal spermicides five times more often; and their partners had used condoms above four times more often.

When the findings from the two national surveys are considered together, what emerges are distinctive differences in the usual sexual behaviour of women who have not had abortions and women who have had abortions. These differences are in terms of: (1) their usual level of coital frequency; and (2) the types of contraceptive means which were used, in particular by young and single females. What is needed in considering the patterns of sexual behaviour involving women who have had abortions are in-depth studies done over a period of time which compare what they do relative to the experience of other women in terms of: their sexual experience; the attributes of their male partners or marital cohabitational circumstances; and their use of contraception. The findings obtained by the Committee are only a first step in a comparison of the sexual behaviour of these two groups of women.

Sources of information about contraception

In the *national population survey* women and men were asked from whom they had obtained information about contraception. What the findings indicate is that: **a sizeable number of Canadians have had no formal instruction on the use of contraceptive means; the physician is seen as the chief source of such information for women and men; and learning about these methods from all other sources is very much a hit-or-miss affair in Canada.** The findings on the sources of information about contraception confirm from the perspective of women and men whom these programs were intended to serve that there was little coordination between these programs. Their impact has been diffuse and minimal. From the receiving end—the people who were to be informed and counselled—the work of voluntary associations, churches, schools, and public

health units had reached about 1 out of 10 individuals. Overall, 4 out of 10 women and men looked to physicians for this type of information. An almost equal number either did not know about the use of contraception or had been informed, or misinformed, by casual and informal sources.

The major sources of information about contraception cited by the women and men in the national population survey were:

Source	Females	Males	Total
		percent	
physician	45.9	33.5	39.7
none	35.5	43.2	39.4
school	6.5	9.3	7.9
other	5.5	6.7	6.0
multiple	3.2	3.3	3.3
church	2.2	1.8	2.0
community agency	0.6	1.2	0.9
public health	0.6	1.0	0.8

Almost half of the women (45.9 percent) and a third of the men (33.5 percent) said their main source of information about contraception was from physicians. In recent years some Canadian medical schools have initiated instruction on the usual sexual behaviour of women and men. Most of these programs were started since 1970. In general, little curriculum time was assigned to instruction on contraception, and there was no uniform syllabus used by the 16 medical schools dealing with the full range of sex-related medical issues. In some medical schools there was only minimal coordination between the various academic departments in the development of a curriculum on these issues. Because the formal academic instruction of medical students on the sexual behaviour of women and men has only been recently started, a majority of physicians now in medical practice in Canada have had no formal preparation on these issues. This point was made by many physicians to the Committee on its site visits to hospitals across Canada. For these reasons the basis of the counsel on sexual behaviour and contraception use given by many physicians to their patients may be a blend of professional experience and personal views. These factors affect what type of advice is given, how it is given, and when it is given.

In the national survey of family physicians and obstetrician-gynaecologists, physicians were asked at what age they usually began to provide contraceptive counselling to their patients. A small number of these physicians said they would provide contraceptive counselling to patients regardless of their age whenever in their professional judgment they felt such advice was required (12.2 percent gynaecologists; 7.9 percent family physicians).[7] The ages of

[7] This group of physicians is included in the listing of physicians who would provide contraceptive counselling to females 13 years and under.

patients at which these two groups of physicians would start providing contraceptive counselling were:

	Gynaecologists	Family Physicians
	percent	
13 years and under	13.8	12.8
14 years	16.5	19.6
15 years	12.0	13.3
16 years	22.4	24.8
17 years and over	34.7	27.6
never, non-applicable to type of medical practice	0.6	1.9
TOTAL	100.0	100.0

Although there is considerable individual variation among females and males by their ages when puberty starts, this change usually occurs for females between 12 and 13 years and for males at about 14 years of age. About a third of both groups of physicians (30.3 percent of gynaecologists and 32.4 percent of family physicians) in the survey of physicians were prepared to provide contraceptive counselling to teenagers who were 14 years and older. About 2 out of 5 physicians in each specialty (42.3 percent gynaecologists, 45.7 percent, family physicians) would be prepared to start this type of counselling for females who were 15 years and older. Two-thirds of the physicians (64.7 percent of gynaecologists and 70.5 percent of family physicians) were prepared to give such information to teenagers who were 16 years and older. About a third of the physicians were reluctant to provide contraceptive counselling to young teenagers who were under 17 years because they were uncertain whether such information could legally be given to minors, they did not want to do so without parental knowledge or consent, or in some instances, they did not want to contribute to what they felt was the promiscuous sexual behaviour of teenagers.

Between the ages of 15 and 17 years, females in the national population survey had coitus on an average of once every two months and males in this age group once every five weeks. Among females between 15 and 17 years who had had abortions, their average frequency of coitus was twice a week. A substantial number of the females in this age group who had had abortions (national patient survey) had not used contraceptive means. Many of these young females, while having made one or more visits annually to physicians, had not sought or received contraceptive counselling.

There were sharp differences in the sources of contraceptive information which females had involving the use of contraception resulting from medical consultation and their use of other methods. Approximately three-quarters of women who used the pill (77.3 percent), the intra-uterine device (82.1 percent), the diaphragm (68.2 percent), or who had been sterilized (71.1 percent) said that physicians were their main source of contraceptive counselling.

Other sources of information about these four methods had had little impact and were not extensively cited by women in the national population survey. A small number of women said they had had no advice from any source about these methods.

In contrast with women who used the four methods requiring medical consultation, about half of the females who used other means had not had medical consultation on the use of these techniques. Despite the reports given by public health and community agencies, few individuals in the national population survey had obtained contraceptive information from these sources. Less than half of the women (47.5 percent) whose partners used condoms during coitus had obtained information from any formal public or community program. A substantial number of females (44.0 percent) and males (55.0 percent) who used the withdrawal method had had no formal instruction about this means of contraception.

What these findings about the sources of information and the use of contraception indicate is that **a substantial number of women and men across Canada have had no formal instruction about any method of contraception.** Among the individuals who used a particular method, a large proportion had had no instruction on its effective use. **The physician was seen by the women and men in the national population survey as the major source of contraceptive advice. All other programs including those operated by schools, churches, community agencies and public health departments were seldom cited as the sources of contraceptive information. Notable by its absence was the role of the mass media—newspapers, radio, and television.** These sources of information were seldom, if ever, mentioned. Overall, **schools were cited by 7.9 percent of women and men, the churches by 2.0 percent, community agencies by 0.9 percent, and public health programs by 0.8 percent.** While some community agencies have developed active family planning programs which include contraceptive counselling, in terms of the broad cross-section of the population which was represented in the national population survey, these programs had had a minimal impact on the individuals whom they were intended to serve.

In recent years federal and provincial programs of family planning have become more extensive and have received increased financial support. Eight provinces operated family planning programs in 1976; four of the provinces had appointed full-time staff as family planning consultants or coordinators. These provincial programs were intended to encourage the development of family planning measures, increase the involvement of public health personnel in this field, and on occasion, to provide contraceptive information and counselling for the public.

The Committee received information from 137 provincial public units about the different phases of their family planning activities which variously involved: family planning counselling; pregnancy counselling; or the operation of family planning clinics. The provincial distribution of these programs was:

	Family Planning Counselling	Pregnancy Counselling	Family Planning Clinic	Responses from Provincial Health Units/Programs
Newfoundland	—	—	—	—
Prince Edward Island	1	1	—	1
Nova Scotia	5	4	2	5
New Brunswick	3	2	—	3
Quebec	13	14	8	25
Ontario	31	27	23	34
Manitoba	11	10	4	11
Saskatchewan	9	9	2	9
Alberta	26	20	2	27
British Columbia	15	15	5	18
Northwest Territories	3	3	2	4
TOTAL	117	105	48	137

Based on the replies which were received from the 137 public health units, their administrators felt that sex education programs were inadequate in 93 regions served by these units. Many of these programs involved the distribution of pamphlets, instruction given at pre-natal classes by public health nurses, visiting on maternity wards by public health nurses, or programs combining health promotion with other health services. Taken together, these public health programs were not associated directly as a source of contraceptive counselling for the women and men in the national population survey. Not only were these public health programs not reaching a sizable number of individuals, but among senior hospital staff including physicians, nurses and administrators whom the Committee met with across the country, these programs were often seen to be expensive and ineffective. Many of these provincial and municipal programs were located in difficult-to-reach sites, scheduled their family planning clinics at times which were convenient for staff but not for individuals to be served, or combined these efforts with other programs such as venereal disease clinics. There was seldom any coordination between these public health programs and the family planning work done in hospitals. Little effort was evident to effect such an integration. Likewise, there was often little coordination between the churches, the schools, or the community agencies which were involved in family planning. In some instances there was an open hostility between public health programs and community agencies, a conflict based on establishing or maintaining a territorial imperative of an institution rather than achieving an accommodation to use effectively scarce resources to assist individuals whom it was intended to serve.

Relatively few of the hospitals visited by the Committee had established family planning clinics or programs. While there was a much broader interest expressed by hospital administrators and senior medical staff about the need for such programs, the reason usually given why they had not been started were the constraints of existing health budgets. The few hospitals which had started family planning programs have had some difficulty in their operation

and the medical and nursing staff have not been satisfied with their effectiveness. The work of two hospital clinics illustrates how the programs are organized and some of their difficulties.

Hospital One

Our clinic has operated weekly throughout the year except for the month of August and is held each Wednesday evening from 7:00 p.m. in the Outpatient Gynaecology Clinic. The medical and nursing staff were initially volunteers from the Department of Obstetrics and Gynaecology including fellows and residents from the Department assisted by a small group of volunteer registered nurses. Through the active assistance of the Medical Officer of Health representations were made to the Board of Health for financial support as it was soon realized that an ongoing and growing facility could not indefinitely survive as a volunteer operation.

It was our early impression that we would attract several types of patients, namely the hospital-clinic-oriented patient, the patient who either lacked a family physician or, having one, was not finding her needs in this area met by him; the young woman who would not approach the family physician, newcomers already accustomed to clinic programs in their own homeland. All applicants without regard to race, colour or creed, with or without insurance and regardless of ability to pay are welcomed.

From the outset we have tried to draw a clear distinction between "Family Planning" and "Therapeutic Abortion". Patients attending our clinic under the impression that they could obtain an abortion have been referred to morning gynaecology clinic. Patients have come from a number of sources. No actual advertising program has ever been used. Our major source has been patient referrals from the gynaecology clinic, the postnatal clinic and, latterly, referrals from the therapeutic abortion program. A number of patients used to be referred from the Planned Parenthood Association and from the university. Both of these sources have ceased. A number of cases have come from outside physicians; a surprising number came from outside. A fairly large number are now simply self referred.

The number of patients who have been seen are:

VISITS TO CLINIC

	New Patients	Totals
1968	591	1,592
1969	679	1,749
1970	628	1,546
1971	713	1,589
1972	798	1,874
1973	671	1,790
1974	589	1,615

On arrival, a patient is registered and interviewed by the public health nurses. We use a film about family planning as an educational aid. Brochures and other reading material are provided as part of the educational program. Interviewing and counselling are provided by the public health nurses. The

patient is then called by name in order of arrival for an interview by the physician. The medical history is reviewed along with the hospital record, if any.

Initial examination consists of a brief general physical and a detailed gynaecological examination. Pap smears are done routinely on an annual basis. Vaginal cultures for G.C. etc., are carried out as indicated. Any general medical or surgical condition encountered is referred to the appropriate specialty clinic, family practice, general surgery, urology, etc. Simple gynaecological problems are treated in the clinic but major gynaecological problems are referred to morning gynaecology clinics or admitted as an in-patient to our service.

From discussion with and examination of the patient, the physician selects the appropriate contraceptive method desired and/or indicated along with explanation, advice and a return appointment. If further explanations are desired the patient is referred back to the public health nurse.

Follow-up of cases needing further supervision and who fail to keep appointments has been and remains difficult, frustrating and disappointing. Cases most in need of this service are the ones least likely to make use of it.

Operating under the above constraints of time and space, our clinic appears to have reached a plateau in attendance figures. Family planning services though needed in the community continue to be hampered by apathy, inertia, fear and suspicion on the part of potential users of these services. Nor are we being helped by the negative nature of publicity we have been receiving.

Efforts to provide post-operative follow-up and supervision of the patients coming through the therapeutic abortion program have so far been ineffectual. Although these patients are most in need of contraceptive counselling, between 70 and 80 percent of the appointments made for these women are not kept. This occurs in spite of an in-hospital educational program being provided by our department of these as well as post-natal patients. The substantial numbers of "repeat offenders" now seeking another abortion is evidence of the magnitude of this unsolved problem requiring more attention and effort on our part.

Hospital Two

The system was designed to produce what we hoped was a maximum impact on continuing contraception for the individual seeking termination and also to allow a realistic amount of pre and post-abortion counselling to go on. We found that this activity along with post-partum contraceptive counselling could in fact keep one individual busy full-time. Consequently, for the past three years we have utilized the services of a full-time family planning nurse in this role. The majority of our therapeutic abortions are undertaken through our clinic representing probably the lower socio-economic class in the community.

The therapeutic abortion and family planning clinic is held in a relatively new facility. The personnel consists of a nurse in charge, a family planning nurse who does all the counselling, a secretary and part-time nursing aide. Other things go on in this clinic in that we have special diagnostic services such as colposcopy and endocrinology, infertility, and so on, but at different hours. The family planning nurse has a small office for private counselling. There is a generous waiting room, a secretarial post, and four consulting and examining

rooms. Immediately adjacent is our ultrasound facility which is primarily designed for research and the clinical management of high risk pregnancy.

The hospital renovated this area in 1972, the personnel are paid by the hospital and also by the active obstetrical staff. The active obstetrical staff through its staff association also provides monies for equipping this and the high risk pregnancy unit.

Our current financial commitment to this is in the order of $30,000 per year. My own feeling is that this method of financing is the best of both worlds. It is apparent in the private sector that provincial health insurance will not support by itself an extensive counselling or follow-up mechanism. Also, the hospital budgets will not support the extra personnel which are required to produce this kind of service. Hence, the cooperative agreement between staff and hospital to produce funds from both professional services and hospital budget produced this capability.

We accept patients on referral and on direct application by patients themselves. The patient who comes to our clinic is registered by our secretary and is seen first by our family planning nurse. She discusses with them the reasons for seeking termination and the attitude of the patient and her husband if he also attends. She notes a short social history on the chart, and at the same time begins to introduce some family planning education in the form of a contraceptive choice.

The patient is then seen by the professional staff. This professional staff in our clinic consists of a professional staff member, a resident, and a junior or clerk who is there for educational purposes occasionally. The social history is noted and clarified by discussing this with the professional staff. A physical examination is undertaken with the usual smears, cultures, and so on and the dating of the gestation. If the circumstances are such that the professional staff is going to recommend termination, such a recommendation is made at the time, and the patient is made aware of such a recommendation. In view of the fact that house staff do change, we felt it important to have a consistent attitude towards this and have a local house rule that no patient is sent from the clinic without a recommendation for termination unless this is confirmed by the attending staff member. In other words, it is the attending staff who produce a consistency of attitude. No house staff is required to undertake an abortion which they are not willing to recommend. If the rare occasion arises that house staff members aren't willing to make a recommendation and a staff member is willing to make a recommendation, then the procedure is done by the staff member.

Following this portion, the patient is once again seen by the family planning nurse who informs her of the therapeutic abortion committee procedure, the time of its meeting and gets all the details (on how to contact the patient quickly). Our clinics are held Mondays and Wednesdays, and the therapeutic abortion committee meets on Thursdays. Also, the particular procedure recommended is explained to the patient and her hospital stay is also explained.

The therapeutic abortion committee then meets and the family planning nurse attends this meeting to bring to the committee the full range of information available on the patient. If a recommendation is made for termination by the committee, the family planning nurse then contacts the patient and through the resident staff, arranges for her admission and her procedure.

When the patient is admitted to the hospital, the family planning nurse visits her before or after the operation. The morning following the procedure she holds her class on contraception where the particular method prescribed for the patient is discussed and explained. This will at times occur on a private basis at the bedside of the patient if she is reticent to join a group. The contraception, usually the pill or IUD, is initiated immediately. The follow-up visit is then given.

The patient is requested to return to our family planning clinic for our follow-up in six weeks time. Once again, when she comes she is seen by the family planning nurse who reviews her first six weeks experience with the method of contraception and she is then seen by the professional staff who do her post-operative check, and appropriate continuance or changing of her contraception method is undertaken.

Following this visit, the patient is then followed on an annual basis, either by her family physician or at our clinic, whatever is her choice.

The system is designed, of course, to put one knowledgeable person with some rapport as the prime and continuing contact with the patient. We felt that this would assure a more reasonable follow-up and acceptance. We have been somewhat disappointed since our follow-up rate does not yet equal 50 percent. We sometimes make ourselves feel better that the patients are being followed up by their family physicians, but I think this is a phenomenon common to many units, that once the procedure is done, the patient is loath to return for follow-up.

In addition to the clinic patients about ten therapeutic abortions are done weekly, generated by 11 staff physicians. These patients are almost always on referral from general practitioners and the physician does his own assessment, makes the recommendation and undertakes the procedure. The family planning nurse visits these patients while they are in hospital, discusses their contraception and gives them their class on family planning. They are, however, followed by the private physician. It is my feeling that the follow-up in this group, which is largely middle-class, is greater than in our clinic.

It is obvious to us all, I think, that the family planning nurse is the key person in the operation of this facility. The technology is largely at hand in any well organized gynaecology department, but in this particular therapeutic situation, an extensive amount of patient contact, time and counselling is required. This is best done by a person who is skilled and interested in this, and particularly well done by a woman. The family planning nurse's activity is also extended to our post-partum patients to undergo family planning education during their post-partum stay. It has been our feeling that probably one of the most sensitive times to introduce responsible contraception to patients is at the time of a recently completed pregnancy either by childbirth or abortion. In addition, our family planning nurse also is responsible for organizing the childbirth education program in the hospital. All in all, we feel that she makes about 3,000 interventions in a year in the field of contraceptive counselling information and family planning in general.

It is my feeling that if municipalities are going to get into the business of spending money on family planning, they had best forget about renting or building shining edifices full of examining tables and doctors. The technology and the facility to provide this is already at hand for the most part. The

funding is also readily at hand for this activity through provincial health insurance. What is not available through this means or hospital sources is the provision of key counselling personnel of this type who can be spotted in key places.

The number of accidental pregnancies reported in fertility surveys and the volume of requests for induced abortion have prompted some experimental programs which are aimed at reducing unwanted conception by the promotion of contraceptive education. The assumption on which these programs were based is that the level of motivation for use of methods of fertility control and the knowledge of human sexual behaviour and contraception were low among many individuals in the population. The general intent of these programs is to increase these levels of motivation and knowledge so that the likelihood of unwanted pregnancies could be reduced. **There are significant implications in terms of costs in time and the allocation of personnel and money if such measures were to be implemented more broadly on a regional or national basis. Before embarking on such ambitious programs, it would be necessary to review the effectiveness of the programs which are underway.** The findings of the national patient survey may have a bearing on the effectiveness of current programs. Questions were included about whether a women had had sex education in school, and if that curriculum had included contraceptive education.

Method Used at Time of Conception	Had School Sex Education Program	Not Had School Sex Education Program
	percent	percent
pill	19.5	17.0
condom	27.5	25.3
IUD	8.8	10.6
withdrawal	3.7	4.7
rhythm	15.0	15.0
diaphragm	11.3	8.2
foam	13.1	16.6
other	1.0	2.6

Overall, there was a slight trend, but just that, which indicated that sex education which had been received in school by women in the national patient survey led to their greater use of more effective methods of contraception such as the pill, the condom and the diaphragm when conception occurred. But in looking at the experience of the women who had abortions and who had no sex education in school, their use was marginally higher of the IUD, withdrawal, foam and other contraceptive means. The findings indicate a slight trend toward the use of more effective contraceptive means, but the major conclusion is that for the women who had such programs in school, they had made little real difference to their subsequent use of contraception. **In almost equal numbers, women who were having induced abortions who had no instruction used the same types of contraception as the women who had such instruction in schools. The findings for these women do not lend support for the usefulness**

of current contraceptive and family life education programs undertaken at schools across Canada.

Among individuals in the national population survey, most sexually active women and men used a contraceptive method during coitus. The number of women who had abortions was considerably higher, particularly for younger females, among those women who never used contraception. This was a predictable outcome. But a substantial number of women in the national patient survey had used a contraceptive means at the time of coitus when conception occurred. Why the use of this preventive measure had failed was accounted for by the fact that these women and their male partners had not known enough how to use effectively these contraceptive means. A sizeable number of other women who had abortions either were afraid of the side-effects of the use of contraception, or they had been counselled by their physicians not to use such methods.

Many women and men had no formal instruction on the use of contraceptive methods. By having coitus under these circumstances, the chances of an unexpected, and for many women, an unwanted pregnancy were sharply raised. This fact stands out starkly as a major factor contributing to the number of induced abortions across Canada. Like Russian roulette, by not using contraception, or by not knowing how to use the means which were tried, many Canadian women and men took chances which had profound implications for themselves and for society.

The options are few concerning induced abortion. There is no evidence that its volume is decreasing. To the contrary, its reported incidence has increased in recent years. Believing or wishing it were otherwise will not change this situation. The critical social choices are between two sensitive issues, induced abortion and family planning. In the Committee's judgment, the evidence is conclusive. When effective contraceptive means are appropriately used, the chances of conception occurring are sharply reduced, if not eliminated, for most women. The extent of induced abortions in the future can be expected to remain the same as at the present time, and it may gradually rise, unless there are effective changes made in the contraceptive practices of Canadians, particularly among high risk groups. Made in the context of known family planning and population policies, these changes may be brought about by increased efforts through research to find more effective and acceptable methods of contraception and by coordinated programs of public education and health promotion. There is no surety that such steps will be fully effective, but without taking them, there is virtually no likelihood that the volume of induced abortion will be reduced, or even contained, at its present level.