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Determinants of Risk for HIV:
Findings from Eight Qualitative Community-Based Research Studies

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This document was written by Carl Bognar, under contract, for Health Canada, under the Canadian Strategy on HIV/AIDS. The opinions expressed in this document are those of the author and contributors and not necessarily the official views of Health Canada.

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Également disponible en français sous le titre:
Déterminants du risque d'infection à VIH :
Résultats de huit études qualitatives de la recherche communautaire

Cat. Number H39-535/2000E
ISBN 0-662-29004-6

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Table of Contents

Introduction

During the National AIDS Strategy II, research on the determinants of HIV-related risk behaviour was identified as a priority for Health Canada. The Prevention and Community Action Programs (PCAP) funded eight innovative studies which brought together communities and researchers to carry out qualitative studies among two populations at risk of acquiring HIV infection: marginalized women, and gay men and other men who have sex with men (MSM). This document is a summary and synthesis of those eight studies. The purpose of this document is to present the findings of the studies to community-based organizations which develop and implement AIDS prevention programming, and the research and public health communities.

A Brief History

In the National AIDS Strategy I (NAS I), Health Canada research focussed on studies of the knowledge, attitudes and behaviours of Canadians that make them susceptible to acquiring HIV infection. Through these types of studies, much was learned about individuals' knowledge levels of, attitudes towards and behaviour al responses to HIV/AIDS and HIV risk reduction.

In 1993, HIV/AIDS Prevention and Community Action Programs (PCAP) undertook a consultation about directions for future research. Findings from the NAS I studies made it clear that knowledge about HIV transmission provides a critical foundation for preventing risk behaviours, but that knowledge alone is not enough. It was becoming apparent that risk behaviours are also influenced by social, cultural, physical and environmental factors, and that these need to be addressed to ensure effective programming. The need for in-depth, qualitative studies of the determinants of HIV-related risk behaviours was identified during the consultation.

In 1994, the National Health Research and Development Program (NHRDP) and PCAP launched a joint request for proposals. Eight studies were funded and were completed in 1998. These eight studies looked beyond knowledge and attitudes, and focussed on why people continue to engage in behaviours that place them at risk for HIV. Factors leading to risk behaviours were investigated in four studies with gay men and other men who have sex with men, and four with women considered to be at high risk for HIV. All eight studies were qualitative and exploratory in nature, and focussed on examining the social and emotional aspects of sexual experiences and relationships. Information was collected in many different ways, including interviews, focus groups, toll-free telephone lines, written diaries, field observations and questionnaires.

This document is organized into the following sections:

- *The Research Projects* – a summary of the findings from each of the eight studies
- *Key Issue*s – common themes about HIV risk behaviours emerging from the studies
- *Implications of the Findings for Prevention Programs* – what these studies mean for HIV education and prevention
- *Final Words* – what these studies show about joint efforts between researchers and communities
- *Endnotes: About the Research Methodology* – technical details about each of the eight studies.

The Research Projects

In this section, the eight qualitative studies about risk behaviours are summarized. Four studies focus on women and four focus on men. Although the studies are organized by gender, there are many significant areas where gender is not the key issue.

The summary of the research projects begins with the four studies about women. First is "Young Women at Risk", a study of teenage girls who have problems at home and school, and who join a rebellious peer group in order to find acceptance. Then, the issues that single women face are discussed in "Single Women Looking for Partners". "High Risk Women's Understanding of HIV" looks at the meaning of HIV in women who are particularly at risk: women from lower socioeconomic backgrounds, women who inject drugs, and women who work in the sex trade. "Exotic Dancers" looks at the particular risks to women in that occupation.

The four studies with men start with "Coming to Terms with Being Gay", followed by "The Effects of Sexual Abuse". In "It's about a Lifetime", issues of coming out and sexual abuse are discussed as they impact on gay men throughout the adult lives. "Gay Men, Intimacy and Sex" looks at men's on-going sexual lives, and factors that lead to risk behaviours.

Can We Generalize the Findings of These Studies?

Social scientists rarely consider that a single research study proves anything conclusively. A research study is carried out with participants who live in a particular place at a particular time, and each participant has unique experiences. Social scientists discuss the *generalizability* of studies – for example, how do we know that the findings of this particular study, which included relatively few people, represent the experiences of all gay men, or all poor women, or all people who have been abused?

There are several ways that social scientists deal with this issue of generalizability. In order to be considered generalizable, findings of a particular study should fit with the theory on which the research is based. (In this document, we have used the theory known as "determinants of health" to organize the findings.) The findings of a research study are also considered to be more valid if they fit with the findings of other studies.

In addition, researchers deal with the issue of generalizability by using tentative language in their writing about research findings. Researchers usually use terms such as "the gay men (or poor women, or people who have been abused) *who participated in these studies said that...*", anchoring the statement in the context of the particular study, and using the past tense to indicate that the findings may not apply to all similar people in future.

In order to present the results of these eight ethnographic studies as clearly and concisely as possible, this document makes general statements such as “many gay men feel...” and “some young women believe...”. The reader should keep in mind, however, that the findings of each research study will have varying degrees of generalizability to people in their own communities. The themes arising from these eight studies may not apply to all individuals, but do provide a starting point for understanding key issues in risk-taking behaviours. While the findings of these studies will be useful in program design, it will still be important to consult with people who are part of the program’s target group.

Young Women at Risk[1]

Some young women who have difficult relationships with their parents and who are not well integrated at school become members of peer groups where a great deal of risk behaviour takes place. Feeling distanced from their families and their schools, these young women look for acceptance through peer groups which support rebellious attitudes. "Partying" together is a frequent activity, and may be followed by unprotected sexual activities. Alcohol and marijuana are widely used while partying, and sometimes there is same-sex experimentation within the peer group.

All our friends have family problems, in some way.

I don't like staying at home. I'm always going out all the time. Weekends are always filled with parties and just chilling out.

Like most Canadians, these young women tend to practice "serial monogamy" (that is, having one sexual partner at a time), but their relationships tend to be shorter. Because these relationships may involve unprotected sexual activity, there is a high risk of acquiring HIV.

She was a friend... We were both curious and very much attracted to each other.

In most cases, these young women started experiencing difficulties early in their lives. Most come from homes where the parents are divorced or where there were long separations. Parental discipline was often uneven and inconsistent. Conflicts with parents – especially the father – mark many of these relationships. Relationships with the mother were often strained, because the daughter thought the mother withdrew her love as a punishment for "bad" behaviour. Sometimes these young women were encouraged by their parents to leave home, and they felt their parents had given up on them.

We don't have much communication. We don't know each other.

I don't think my mother cares about me anymore.

The difficulties these girls experienced at home were mirrored in social and academic difficulties at school. These problems often started while the girl was in elementary school, and escalated dramatically in the early secondary years. The foundation is then set for detachment from school – failure to complete homework, poor attendance, and withdrawal from extra-curricular activities. At this point, many of these young women started socializing with a group of young women who had similar experiences. The peer group becomes the place where acceptance and support can be found.

I refused to do my school-work because I was shy about reading.

1 "Young Women at Risk" is based on: King, A.J.C., Connop, H., and Warren, W.K. (1998). **Young women at high risk: An exploratory study**. Kingston: Social Program Evaluation Group, Queen's University.

In the peer group, girls engage in many behaviours posing a risk to health: smoking, drug and alcohol use, and unprotected sex. Young women are at the core of this type of peer group, with males at the edges of the group. Despite a great deal of sexual activity with the males around the group, these young women do not generally consider themselves to be at risk of acquiring HIV. More attention is paid to the risk of acquiring STDs, but these are not viewed as serious: they may be inconvenient, but they can be treated.

I'm usually with my friends all weekend, getting wasted and sleeping anywhere that we can.

I had chlamydia. I could be at risk. It doesn't cross my mind.

Some of these young women become pregnant in an attempt to develop or stabilize a relationship: over 40% of women in this study had at least one pregnancy.

I know who his last partner was. I know he is the type of person who would not endanger my life if he was HIV-positive.

Condoms are used about half of the time when having sexual relations with a new partner. The rationale these young women use for unprotected sex is that they believe they know the entire relationship history of all group members.

Single Women Looking for Partners[2]

Living alone is increasingly common. At the same time, the proportion of women living with HIV has been increasing steadily across Canada.

Whether they have never married, or are separated or divorced, many single women interviewed in this study are looking for a partner and are potentially at risk of acquiring HIV. Their reasons for looking for a partner vary: they may want a permanent and stable relationship, or a sexual relationship without emotional commitment, or a companion for social activities. Many single women view themselves as independent, however, and do not view living alone as a problem in itself. What is problematic is the search for sexual fulfilment and intimacy in the face of HIV. The vast majority of single women, however, see very little risk that they will acquire HIV.

It's not living alone that's the problem. The problem is feeling lonely.

I have a solid and loving family, and I have long-time friends, but not having a sexual partner weighs you down.

Because of the nature of condoms, women are without a means of protection under their own control, and they often find themselves in a vulnerable situation. While many women report having changed their behaviour since the advent of AIDS, few use condoms in every sexual encounter. Less than one-third of single women in this study consistently use condoms for vaginal intercourse, and only one-quarter of those who engage in anal intercourse regularly use condoms. The reasons behind this are complex, and are related to loneliness, the challenge of finding love, and difficulties in negotiating safer sex with men.

Finally, he put a condom on. But then he had a problem with his erection, and the condom didn't hold. After that, I accepted making love without a condom. But you know the risks and dangers.

What a woman knows about HIV and risk behaviours is not always related to a decision to use a condom. Knowing someone who is HIV-positive does not always lead women to reduce risk behaviours either. Risk behaviours seem to be more influenced by other factors: for example, age, marital status, and perceptions about whether their partners have had sex with many other women.

2 "Single Women Looking for Partners" is based on: Dedobbeleer[1], N., and Morissette[2], P. (1998). **Le SIDA et le contexte des relations sexuelles des femmes seules à la recherche d'un partenaire au Québec**. Montréal: [1]Département de médecine sociale et préventive, [2]Ecole de service social, Université de Montréal.

Age is an important factor. Younger women, and those with more sexual partners, do tend to practice safer sex more often than older women. At age 30, for example, 30% of sexually active women report that they never use sexual protection – a number which is cause for concern – but among women over 50, *more than half* report that they never protect themselves.

I don't ask about his sexual history. It's not the first question I ask. After talking with someone, you know how he lives and you know other information.

Women who are separated or divorced take more sexual risks than women who have never married. They may be less skilled in negotiating condom usage than women who have never married.

A woman whose sexual partner is married to another woman may protect herself less often, believing that she is not running a risk of acquiring HIV. Women who believe that their partner has more than one sexual relationship are more likely to protect themselves.

The ways women meet men are also related to safer sex practices. Women who are least likely to protect themselves have met their partners in apparently "safe" social settings, for example, through parents or friends. Women who meet partners through dating services, chat lines and voice mailboxes are also less likely to protect themselves systematically. Women who meet their sexual partners at school, work or on vacations are most likely to practice safer sex.

The nature of the relationship is also an important factor in women's safer sex practices. Protection is used less in closer relationships, and less in relationships that have been continuing for a longer period of time. The longer they are in a relationship, the more women tend to expect that their partner will be faithful sexually. Women may feel that they are protected from HIV because their relationship is stable, and safer sex may be stopped altogether.

I protect myself at least the first few times, and after that, well... Even if he doesn't want to, it's just too bad, until there is something serious starting.

Feelings of unattractiveness may also increase risk behaviours. The majority of women feel that they are judged by standards of beauty imposed by society in general and reflected in the media. The feeling of not meeting these standards of beauty leads to increased risk-taking. Women who do not feel confident about their attractiveness are less likely to protect themselves.

I've never met a man who was worried about condoms. They act as if they have never heard of them, until the moment when you begin to talk about it.

Men's wishes about safer sex also influence women's risk behaviours. When the man does not want to use a condom, over half of women report that they have given in, feeling that they trust their partner. Women who were previously married may lack the skill to negotiate condom usage, or there may be shame or fear of the partner's reaction. Women tend to feel that insisting on condom usage creates a sense of doubt and insecurity in a relationship. They may want unprotected sexual activity as a demonstration of trust and the importance of the relationship. Insisting that the man use a condom may seem to be inconsistent with the stable and trusting relationship desired by many women.

He says, "I don't feel anything when I use a condom. You don't trust me."

Condom usage is highest among women who are at greatest risk of acquiring HIV, but there is a significant minority of single women who engage in risk activities. These women are most likely to be older, have experienced loneliness, be searching for love and a stable relationship, and have difficulty negotiating condom usage with their partners.

High Risk Women's Understanding of HIV[3]

This study looked at risk factors for women who inject drugs, whose partners inject drugs, sex trade workers, and women with limited financial and social resources.

My lifestyle was exactly what AIDS was looking for.

Women at risk think about HIV transmission in many different ways, and this may change over time. Some women at risk are quite fatalistic about their risk behaviours: they don't care (anymore), or think that it is inevitable that they will become infected. Some deny their possible risks in the past, or deny their level of risk in the present.

Three years ago I decided I was going to die from something sexual. So why should I bother to protect myself?

Women have responded to the epidemic of HIV in various ways. For some women, the experience of HIV risk has had a negative impact on their sexual desires and their level of sexual activity. Some have stopped having sex altogether. For others, awareness and knowledge about HIV transmission have not resulted in any changes in risk behaviours.

You might think I'm paranoid, but I'm going to live, so having sex right now is out of the question.

Partners and Risk

Some women at risk talk about the risk behaviours of their partners: the partner is an injection drug user, or is having sexual relations with others. For sex trade workers, condoms may be regularly used with clients, but not with partners. Some women describe a sexual assault as the only situation where they have been placed at risk.

My partner does intravenous drugs. And behind my back. I don't know if he shares the needles or if he sleeps with people.

For some women, stopping the use of condoms is viewed as indicating that a level of stability and intimacy have been achieved in a relationship.

Some women report having engaged in risk behaviours with people who were diagnosed with HIV only a few months later. Some of those who were HIV-positive were conscious of behaviours which might have placed others at risk. A few talked about knowing of occasions where others had deliberately infected other people.

There are people like that, who've been abused sexually and so turn their anger and go into the trade. And they're selling death.

3 "High Risk Women's Understanding of HIV" is based on: Leonard, L. (1998). **Women's accounts of the social construction of HIV risk**. Ottawa: Community Health Research Unit, University of Ottawa.

Abuse During Childhood

When a person is emotionally starved early in life, this often lives on in the form of poor self-esteem, and can be linked to a lack of concern about reducing risk behaviours. In situations where a woman is feeling "down" or depressed, it is more difficult for her to ask or insist on what she needs, and therefore more difficult to protect herself.

I remember thinking I can't say no. And I needed to say no because I could get AIDS, and I did it anyway.

Like early emotional deprivation, childhood sexual abuse can have significant impacts in adult life. Survivors of abuse may have trouble caring for themselves. Some survivors come to see their only value as sexual. As a result, adults who were sexually abused as children are more likely to participate in activities that increase their risk of acquiring HIV. Many women agree that sexual abuse – more than the need to support a drug addiction – will drive a woman into the sex trade.

I've been sexually abused. It seemed to make me not care a lot about myself.

Most people are on the street because they've been victimized by whatever, sexual or physical abuse.

Resources and Self-Esteem

Many women explain their HIV risk behaviours in terms of their lack of access to resources to reduce unsafe drug injection practices. Sharing of equipment can be accidental or conscious, but adequate supplies of drug "works", especially syringes, would go far to eliminate risky practices associated with drug injection.

Many women agree that the development of a sense of self-worth, self-esteem and self-confidence should be the central message to protect women from HIV. Self-confidence will give women the ability to defend their needs and to protect themselves.

Exotic Dancers[4]

Many women who do exotic dancing begin with the idea that dancing will be a temporary job, and at first they usually have very precise limits about what they will do as part of their job. For most dancers, these limits excluded sexual contact with customers. It is easy for women to keep these limits as long as dancing remains a temporary part of their lives.

But exotic dancing isolates dancers from mainstream society, and the financial rewards can be attractive. As a result, what started out as a temporary job easily turns into a career.

I don't look at it like a career, so it's kind of like a means to an end. You know how you put yourself on a program, like a five-year program.

There are differences between dancers who consider their work as temporary, and those who view it as a career. Dancers who view their work as temporary tend to keep their original goals in mind, and find ways to keep the limits they have set for themselves, including avoiding sexual contact with customers. They expect that they will leave dancing once they have made enough money. Dancers who think of their job as temporary tend to keep their contacts with other people in the dancing industry to a minimum, and may try to hide their activities from others, feeling shame and guilt for choosing to dance.

It's hard to get back out into the real world once you're in there. What else can I do? I make good money, so why go work for minimum wage?

Career dancers, on the other hand, tend to become more involved in the "dancer life", developing personal relationships with others in the industry. These relationships often involve heavy substance use. Sometimes the dancer's original sexual limits are extended, and they become involved in lap dancing and other forms of sex work, such as escorting. Those who engage in sexual activities with clients may do so in more private areas of the club, or go on "dates" with club patrons. For these women, "sex for money" is part of the job of exotic dancing.

Women who are exotic dancers are vulnerable to HIV from voluntary sexual contact and from sexual assault. Vulnerability is increased by substance use, the presence of private areas in strip clubs, and lack of support from management.

4 "Exotic Dancers" is based on: Lewis, J., and Maticka-Tyndale, E. (1998?). **Erotic dancing: HIV-related risk factors**. Windsor: Department of Sociology and Anthropology, University of Windsor.

Alcohol Use

Exotic dancers work in an environment where alcohol use is the norm. Dancers are expected to socialize with the customers and to "keep them happy". Many dancers use alcohol to reduce their inhibitions at work, or to escape problems and stresses in their personal lives. Some dancers, however, stop consuming alcohol at work, feeling that it might compromise their safety or their ability to control situations they might encounter in the course of their work.

My first dance, I shot back three tequilas before going up. I couldn't have done it otherwise.

Drug Use

While most strip clubs do not have an active drug trade, marijuana and hard drugs are available from staff and customers in some clubs. Marijuana is the most commonly-used drug, and is used in much the same way as alcohol: to relax, as an escape from dancing, and to reduce inhibitions. Most of the dancers in this study used marijuana before becoming dancers. For some, marijuana is an alternative to alcohol, to avoid the potential for alcohol addiction. Some women also use cocaine, and a few use other drugs, although needle-sharing was not common among women in this study.

Power, Money and Access to Resources

Financial need and potential earnings are compelling reasons for some women to enter exotic dancing. Few other jobs offer women the possibility of earning as much income as exotic dancers, particularly those with little education or job training. For some women, exotic dancing is an act of resistance in the face of poverty. Where the woman has children, a career in dancing provides an income along with the opportunity to spend time with her children.

I had all these bills, and I needed to feed my kids, and well, what was I going to do? I do what I have to do to get by.

The way some exotic dancers are paid can take power away from women and can encourage them to place their health and well-being at risk. Since most dancers' earnings come directly from their clients, they have to dancer must "work their customers" to maximize the tips they make. This may encourage some dancers to exchange sex for money, which may be especially a problem in clubs where lap dancing is available. Lap dancing may make it

He decided he was going to try to grab me and lick me.

particularly difficult for dancers to avoid sexual contact with customers. Many dancers feel that they are forced to engage in lap dancing by the demands of club owners and that customers expected lap dancing as part of the dance. This leaves some women feeling victimized.

It was like you're a cow, as if you're mechanical. They just assumed they could do things.

A few dancers in this study said that they are not provided with the support they need to avoid or stop harassment or assault, because the management did not want to jeopardize profits. Dancers may experience sexual harassment and coercion as daily occurrences, both on and off the job. Dancers are particularly vulnerable in the private areas of clubs, although this varies widely between clubs. Some clubs make efforts to protect women far more than others.

Vulnerability to harm extends outside the club, with dancers reporting being stalked, harassed and assaulted by customers and others. Dancers say that police often do not respond to their complaints.

What do you expect? You're a dancer.

Although most dancers do not view themselves as sex workers, they share many experiences with other sex workers: stigmatization, harassment and sexual assault.

Coming to Terms with Being Gay[5]

There are stages of development in the "coming out" processes of gay men and other men who have sex with men:

> "cluing in" to the desire for other men
> awakening to the meaning of being gay
> emerging from the closet, and integrating.

Men often move forward and backward in these stages. Fear may cause a man to become stuck at one point, or even to move backwards.

Homophobia

People walked by and yelled "Homo!".

For gay and bisexual men, homophobia presents a major challenge to coming to terms with their sexuality. Most gay males have experienced insults, ridicule and public harassment. Some have experienced "gay bashing" which is an act of violence.

Young gay men usually try to conform to society's expectations about their sexuality, and they experience feelings of shame and guilt about their desires and sexual activities. Men must confront their own homophobia in order to "come out" and to begin being open about their sexual orientation.

Homophobia slows gay men's understanding of their sexual feelings and identity, and prevents them from identifying with the gay community, where emotional support and information are available. Many men initially have sex with other men in hidden ways, rarely using safer sex techniques.

Sexual Abuse

For men who were abused as children, there is an additional burden in coming to terms with sexual orientation. Being sexually abused violates a boy's sense of choice and identity, leaving him ashamed and trying to prevent others from finding out about his "secret".

I was afraid and I didn't know what to do.

5 "Coming to Terms with Being Gay" is based on: Getty, G., Allen, R., Arnold, K., Ploem, C., and Stevenson, J. (1999). **Atlantic community-based study of the determinants of sexual risk behaviours for men who have sex with men**. Fredericton: University of New Brunswick.

Feelings about these sexual experiences can be quite conflicted, a combination of attraction and repulsion, fear and desire. Abuse can have a profound effect on later ability to form intimate relationships, and therefore on sexual risk behaviours. Men who were sexually abused as boys usually have a decreased sense of self-worth, and are more prone to promiscuity, substance abuse and suicide. In this study, 83% of those who were sexually abused during childhood are HIV-positive.

I never really ever felt good about myself ... You grow up feeling inadequate, so whenever you get those moments that someone is going to hold you, even though you know in your gut that they want to fuck you and leave you — it is better to have that for fifteen minutes than not to have it at all.

Cluing In

Most gay men remember being attracted to other males during adolescence. They felt different from their friends, and tried desperately to fit in. At first they felt lost and isolated, although many engaged in sexual activities with other boys. Many tried to "go straight", by dating and "making out", and some married. Some took on the label "bisexual" before being able to accept the label "gay".

I started to be really attracted to other men, thinking that it was completely and totally and horribly wrong.

For males who have not come to terms with their sexual orientation, sexual activities may be largely unplanned and spontaneous, and many of these boys and men take part in high-risk activities.

Awakening

As they are "coming out", some men have many sexual encounters. At the same time, many young men want a role model to guide them through their entry into gay life. But many men report feelings of having "been used" when they were first coming out. Loneliness and fear can result, and this may lead to drug or alcohol abuse, heightening the danger of sexual coercion.

I just went absolutely wild. I started to come to the city and it was just one man after another.

I walked right into the bar the very first time, and met and brought home and slept with this guy. He could have had AIDS, and I could have been, like, let's do whatever you want.

Still, it is at this stage of awakening that most gay men begin to build a network of gay friends, and many begin to search for a stable relationship with another man.

Emerging

Before this stage, most gay and bisexual men conceal their sexual orientation. But many gay men grow tired of "living in two separate worlds", and want or need to tell others. Lack of acceptance by family and friends may lead men to continue their attempts at hiding.

We wouldn't show affection in front of my parents, who didn't know what kind of relationship we had.

Men who define themselves as bisexual or heterosexual, but who still have sex with other men, may remain at this stage of awakening, where they live apparently heterosexual lives but continue to hide their sexual attractions and activities.

During this stage, many men start to develop strategies for assessing the risk that a potential partner might pose for exposure to HIV. Sometimes, however, these strategies are not based on sound knowledge. Partners may be chosen because they are young, they look clean, healthy or straight, or because they are known.

In this stage of "emerging", men are more likely to set limits and to take responsibility for their sexual activities. Information about risk behaviours becomes important, and men start to learn how to negotiate safer sex.

I have made my life work.

Integration

Gradually, some gay men achieve a sense of pride in their sexual orientation. They have a sense of community, and feel complete in their lives. They make healthy choices about their sexual partners and experiences, and feel a sense of control over their lives. They understand the forces that promote and maintain homophobia, and are able to improve their own lives and those of others by standing their ground, and by working to limit the effects of homophobia.

The more respect you have for yourself, the more respect you have for your partners. And safer sex is part of that respect.

The Effects of Sexual Abuse[6]

What patterns of behaviour place young men who were sexually abused at risk of acquiring HIV? Five main themes are common among men who were abused as boys. In various combinations and at various times, these themes lead to four different behaviour al profiles.

The five themes common among men who were abused as boys are:

learning about sex and sexuality – Sexual abuse often results in fear and guilt, sometimes combined with curiosity and pleasure. This is a confusing mix to deal with, especially since sexual abuse often represents the boy's first sexual encounter – it can be thought of as an "apprenticeship".

The abuse disconnected me from myself.

damaged self-esteem – Poor self-esteem, both as an abused boy and as a boy attracted to other boys, is a common story told by young men who were abused. They may want to be loved, but are suspicious that others have ulterior motives.

I thought it was normal to do things that were not normal to someone like me, since I wasn't normal.

confused identity – Many survivors of abuse develop confusion over love and sex. They question themselves: What is my real sexual orientation? Would I be straight if I hadn't been abused? What do I really want? Am I gay because I was abused, or did my abuser take advantage of my gayness?

I did not feel I had the right to be loved by a man. I told myself, "if someone loves me, it's only for the sex, and he'll dump me eventually." I loved my father, and he abused me.

problems with self and others – Sexually abused boys may be uncomfortable with the attractiveness of their own bodies, and may try to make their bodies ugly (for example, through excessive eating or anorexia) so that they will be left alone. They may also have difficulties with masculinity, such as fearing masculine men, obsessively searching for masculine men, or becoming hyper-masculine themselves. They may stop trusting authority figures, because it recalls the context of their abuse.

6 "The Effects of Sexual Abuse" is based on: Dorais, M. (1997). **Patterns of Intimacy: HIV transmission risk behaviours of young men who are victims of past sexual abuse and who have sexual relations with men**. Quebec City: School of Social Work, Laval University.

difficulty setting limits – Guilt and shame can lead a survivor of abuse to feel that he is not deserving of love. When someone pays attention to him, then, it may be difficult to say "no". Or, feeling that he is not deserving of love, he may want to "self-destruct". This leaves the survivor of abuse open to risk behaviours.

These common themes are present in various combinations and to various degrees among men who were abused as boys. These themes can combine in four behaviour al patterns:

- zombie
- disoriented
- rebel, and
- reconciled.

The zombie pattern and the disoriented pattern tend to occur earlier in life. The rebel pattern and the reconciled pattern tend to occur later, as a response to dealing with and moving away from being a zombie or disoriented.

I never chose my partners. The important thing was to have someone.

Zombie

A "zombie" feels powerless, a victim of events. He does not attempt to gain control over his own sexuality. He believes his sexual urges are stronger than he is, and he feels the same is true of other men. His desire to be loved leads him to be not very selective in his choice of sexual partners, and unable to negotiate sexual activities with them. He might dissociate and not even "feel present" during sexual encounters.

I started dying at the age of five, the first time I was abused sexually. All that's left now is for someone to finish me off.

This is a high-risk pattern for acquiring HIV. These men may feel that acquiring HIV is inevitable, and because they give all responsibility for their sexual activities to their partners, they are at great risk. Men who were abused as boys tend to exhibit this pattern in their younger years, when first becoming sexually active.

Why did I let it happen to me? Why didn't I react differently?

Disoriented

A man with this behaviour pattern blames himself for being abused. He may be tormented by shame and guilt and uncertainty about his sexual orientation.

Men exhibiting this pattern often lead "double lives": a secret, guilt-ridden homosexual life, at the same time as a marriage or other heterosexual relationships. The hidden nature of their homosexual activities means that they are generally limited to casual relationships. Their sexuality may be viewed as "exploratory", and not set in stone. While these men tend not to have as many sexual partners as "zombies", their sexual partners are more often male than female. These men tend not to worry about AIDS prevention, being much more concerned with their other problems.

The Rebel

I wanted to defy AIDS. I felt invincible.

A rebel believes only in his own standards, and is suspicious of institutions and authority figures. He is aware of the risk of refusing to protect himself against HIV, but feels that the AIDS epidemic and AIDS prevention programs undermine his sexual freedom. He has been angry since childhood, when he was unable to do anything about being abused. He values non-conformist behaviours. Feeling excluded from mainstream society, a rebel develops his own moral code.

They want to control my sex life, just like my abuser did.

Reconciled

After following one or more of the three previous patterns, a man who is reconciled generally has gone through some sort of major experience which has forced him to change the manner in which he sees life. Therapy may have helped him reach this state of better adjustment. Not surprisingly, men who exhibited this pattern were among the oldest in the study.

A reconciled man has learned to avoid his past roles. He wants to be sure that he will no longer be used against his will. He is usually more accepting of his sexual orientation, although this may still be a bit "muddy" in sexual situations. Although this man has reduced his greatest anxieties, he may still feel vulnerable: a man can learn to live with his history, but he cannot rewrite it. It is very difficult to escape totally from the legacy of abuse.

It's About a Lifetime[7]

For gay men, there are a number of important and highly inter-related factors that influence HIV risk behaviours: self-worth, coming out, homophobia, substance use, sexual abuse (especially childhood sexual abuse), and social support.

Homophobia and self-worth

Self-worth, or self-esteem, refers to how we feel about ourselves. Self-worth can change over time, or can vary in different settings, for example, with our families, friends, or at work. The majority of gay and bisexual men feel a strong sense of guilt, shame and fear about their sexuality, especially when entering puberty, growing up and becoming sexually active. Many men felt alone through this experience: it is painful and frightening to "come out" to friends or family. Some received threats of violence from family members, friends or others because of their sexuality.

The ridicule, the dirty comments, the fag jokes — these things had a tremendous impact on keeping me in the closet.

This internalized homophobia is often, but not always, stronger in older men. It has an impact on men's feelings of self-worth and self-confidence, and may create a "void" which only sex can fill.

I was promiscuous, extremely promiscuous. It was always this eternal search for love, for someone to love me.

For some men, negative feelings about themselves override the importance of practising safer sex. Sometimes this causes men to be passive and submissive in sexual encounters, and therefore they cannot say "no" to unwanted sexual advances, or negotiate or demand safer sex.

Staying in the closet means having a steady relationship with a man isn't an option.

For the majority of gay and bisexual men, self-acceptance and coming out are lengthy and difficult journeys, but coming out results in greater feelings of self-confidence and a sense of control over their lives and their sexual experiences.

I am least careful about sex when I am feeling lowest about myself.

7 "It's About a Lifetime" is based on Samis, S.M. and Whyte, K. (1998). **It's About a Lifetime: Men's Stories about Sexuality, Relationships and Safer Sex**. Victoria: AIDS Vancouver Island.

Self-worth and Substance Use

I suddenly realized it was up to me to be happy... nobody else was going to make me happy.

For many men, alcohol and drugs are used to enhance sexual activity. Sometimes men drink or use other recreational drugs to relax in the company of other men, or to gather the "courage" to approach someone new. Many men have had unsafe sex after using alcohol or drugs, and are worried that this may happen to them again.

Alcohol is certainly an ice-breaker for a lot of people.

The Effects of Sexual Abuse

About one-third of the men in this study volunteered information about having experienced sexual abuse – a high proportion, as they were not asked directly about this. This abuse was usually perpetrated by an older figure, sometimes an authority figure, most often known to the participant (for example, father, uncle, other relative or friend of the family).

Men who experienced sexual abuse as children or adolescents felt a sense of powerlessness in relation to their abuser, and this lack of power produced fear. These experiences lead to guilt, shame and a sense of self-blame.

It really frightened me, and it hurt.

For many who have experienced abuse, the psychological pain recurs in the form of flashbacks to the abusive event. Flashbacks may occur long after the event and after an extended period of healing. Many men who were abused describe being in a dissociated state when having sex with other men – feeling as if they are "not there" – and this has a negative impact on their ability to practice safer sex. For some men, sexual abuse leads to compulsive promiscuity: they engage in sex whenever and wherever they can.

He was calling me a faggot after he did it, and placed the blame on me.

The Importance of Social Supports

One of the things I decided to do years ago was to develop a gay family, a gay support group.

Social supports contribute to self-worth, stronger relationships, and a reduction in risk behaviour. Friendships present opportunities for discussing sexuality and relationships. Some gay and bisexual men find support within the gay community, which contributes to

their feelings of self-worth and provides opportunities for meeting other men. Others do not find support in the gay community, and some do not want it, especially some younger men, who seek a more "mainstream" life.

Talking about my sexual practices is something I can do now, whereas before I had only my self, and not even my doctor.

Condoms and Intimacy

Despite public health campaigns, some gay men do not use condoms consistently. The ability to talk about safer sex and condoms with a sexual partner sometimes comes with a sense of intimacy and commitment to the other person. Most men do not talk about safer sex, particularly with new partners. Decisions to use condoms are statements about trust, commitment and the stability of the relationship. Unprotected sex is often a marker of intimacy and commitment between men. Condoms introduce a barrier to commitment and intimacy.

I couldn't go that far into talking about safer sex — it was a casual one-night deal, and that was the end of it.

I don't like condoms. I have tried to sexualize it, or make it fun or romantic, but I don't like them. Period.

Many men view anal sex with special importance: it may mean that a relationship is significant, and anal sex is an expression of commitment. But for many gay and bisexual men, there is a tension between the attraction to anal sex and the fear associated with HIV. While older men speak in terms of frustration and a sense of loss and grief about the dangers of getting HIV, many younger men view anal sex as something they would like to experience. Anal sex is a very emotional and special experience for many men, and is a complex and deeply meaningful activity.

I've been angry, like thousands of other gay men, that one of the most fun things of sex has been taken away or has been associated with death.

I have evolved into a person where anal intercourse means something other than a one night stand.

Who's Responsible?

Some HIV-positive men feel that they should be more responsible for safer sex than their potential partners, because they do not want to infect anyone else. Others believe that each man must take personal responsibility for his own well-being, and they may be less likely to reveal their HIV status.

Many HIV-negative men also believe that all sexual partners share equally in responsibility for safer sex, and as a result they do not talk about it. Some mistakenly believe that if a potential sex partner does not say that they are HIV-positive, that they must be negative and therefore unprotected sex is safe. They may also base this assumption on the fact that the other man is young, or is good-looking, or appears to be healthy or straight.

Gay Men, Intimacy and Sex[8]

Most gay men know how HIV is transmitted, and their sex lives have been influenced to a great degree by safer sex practices. But occasionally men "lapse", and there are certain conditions which make unsafe sex more likely. Knowledge and attitudes — the usual targets of public health campaigns — cannot account for all instances of unsafe sexual practices.

Couples: Negotiated Safety

Many gay men have unprotected anal intercourse in a continuing relationship. Many of these men have agreed on strategies to make this unprotected sex safer. One possible solution is for the two partners to decide that they will still have sex with casual partners, but that they will only have safer sex outside their primary relationship. Another solution is to agree not to have sex with other partners at all. These are both methods which allow HIV-negative men to have unprotected yet safer sex with each other.

The mutual agreement is that sex between us is unprotected, but we must absolutely trust each other to have protected sex with anyone else.

He didn't want to use condoms. For him, practicing safe sex meant admitting that he'd been playing around.

For negotiated safety to be effective, both partners must be willing to talk honestly and openly about sexual activities inside and outside the relationship, and they must decide how to minimize risks. Talking openly about sex outside the relationship can be difficult if it is contrary to what one or both partners believe about monogamy and fidelity. One or both partners may expect sexual monogamy, and monogamy may be equated with trust. When unprotected sex is seen as a sign of commitment and honesty, using or requiring a condom creates doubt about the security of a relationship.

We took a break and had a little snooze. Then I decided, in my semi-sleep state, I guess, that I was going to pull off the condom.

Control and Sexual Activity

There are many reasons why unsafe sex takes place.

I guess I simply enjoy sex and pleasure, and the excitement of the moment should be much more important than safety to me.

Unsafe sex is sometimes seen as a result of intense passion: it may be thought of as being "carried away" in the "heat of the moment". This sense of abandonment and escape, giving up control, can be an important component of

8 "Gay Men, Intimacy and Sex" is based on: Adam, B.D., Schellenberg, E.G., and Sears, A. (1998). **Sexual meanings and safer sex practices**. Windsor: Department of Sociology and Anthropology, University of Windsor.

desire. Occasionally, it may be believed that a partner is wearing a condom, when in fact he is not. It appears, however, that these simple "lapses" in safer sexual behaviour are relatively rare.

Unsafe sex has happened a couple of times because I've felt very lonely and sad, and I allowed myself to go beyond my boundaries and my own limitations.

Sexual activity is sometimes an escape from everyday life. The need to escape may contain elements of joy or depression, or both — ranging from a simple break from the mundane routines of everyday life, to the manifestation of a self-destructive desire. Personal crises, whether related to sexuality or not, may lead to unsafe, reckless, escapist or even self-destructive behaviour.

I used the danger of unsafe sex to try and get AIDS. It was a disguised form of suicide.

Sometimes unsafe sex occurs in the context of first-time (or early) sexual encounters, which are often unplanned and spontaneous, especially for younger men. Social taboos against talking about sex — and sex between men in particular — may mean that early sexual activity occurs in the absence of knowledge. Early sexual encounters may be largely unplanned, leaving the man uninformed and unprepared.

It was the first time I ever had real intercourse. He took me to his place and we had unsafe sex.

Men who experience guilt about their sexual orientation may have difficulty dealing with the need for safety. For them, AIDS might be viewed as punishment for homosexual activity. The coming out processes of married and conservative, religious men, in particular, may involve a great deal of personal turmoil, leaving the person open to unsafe sexual practices.

If I got it, well, God was just punishing me, and that was it.

Submission to a man who looks and acts in control can be highly erotic for some men. The very act of submission, however, works against the negotiation that may be needed to protect oneself against HIV.

He was older, he was a cop, and he told me what to do, what was going to happen. It was a fantasy thing.

The Boundaries of Safer Sex

The interviews carried out in this study indicate that the difference between "safe" and "unsafe" is ambiguous for:

- anal intercourse without ejaculation
- oral sex, and
- rimming.

I didn't swallow, if that's what you mean by safe.

Most men recognize that anal intercourse without ejaculation is risky for both partners, but there is some ambiguity about the level of risk. Sometimes unprotected anal intercourse is interrupted before orgasm as a strategy to reduce risk.

The question of swallowing semen during oral sex remains a concern for many gay men. Some men have made a decision to avoid ejaculation during oral sex as a way of coping with the lack of scientific precision on this issue. Others have devised routines (such as mouthwashing after taking semen in the mouth) which they hope will reduce the risk.

I don't feel it was unsafe because I don't feel that I am HIV-positive and I don't think he is, because he is young and relatively inexperienced, and just in the fact that I am fucking him.

For oral sex and rimming, the safer sex strategies used by many men are a combination of scientific, "official" knowledge and folk knowledge.

What's Safe?

Some men have a false sense of safety about their sexual activities, because they base their decisions on factors which are irrelevant. For example, some men believe that they are practicing safer sex by seeking out younger partners, those who appear to be healthy, or those who have less sexual experience. Some bisexual men and gay men tend to believe that heterosexual men — or men who *look* heterosexual — are "safer" than gay men. There may still be the belief among some gay men that taking the active role in anal intercourse is a safe activity.

Key Issues

These eight studies demonstrate that knowledge alone is not enough to prevent people from engaging in behaviours which place them at risk for acquiring HIV. While effective and on-going education and prevention programs are needed to ensure that people know the basic facts about HIV transmission, other factors must be considered in designing effective and appropriate prevention programs. A number of highly inter-related issues were identified in the studies, including the importance of social supports, alcohol and drug use, homophobia, childhood sexual abuse and emotional deprivation, and features of adult relationships (for example, communication, trust, and power imbalances).

Social Supports

Strong, positive social supports can decrease HIV risk behaviours. Social supports increase a person's sense of self-worth and build strong relationships. Social supports include family and friends, as well as larger support networks. The good communication which is a feature of strong social supports can give people the emotional and practical resources they need to make healthy choices.

Social supports are important all through life, and their lack at any time can make a person more prone to risk behaviours. Social supports within the family are important for children as they grow up. Children who are emotionally deprived or abused may lack the self-esteem and the self-confidence to take control of their own sexuality and health. Young teens who have difficulty in school or who do not receive support from their parents may rebel and withdraw, and may instead seek support from peers.

Supports from friends and community continue to be an important part of people's lives as they mature. For example, 'coming out' can lead a gay man to identify with the gay community, where support and information about safer sex practices are available. As an accepted member of a community, one can develop a network of friends and acquaintances who face similar interests and challenges, and where ideas and problems can be safely discussed.

For adults, the social support that can be found in an intimate relationship is also important in reducing risk behaviours. Communication, trust, respect and equality between partners are essential for practising safer sex. An unsupportive partner can undermine the intention to practice safer sex. Adults who do not have an intimate relationship – and who are lonely or feel unattractive – appear to be more prone to risk behaviours.

Childhood Experiences: Sexual Abuse and Emotional Deprivation

Sexual abuse and emotional deprivation may leave long-lasting effects which make people more likely to engage in unsafe sexual behaviours later in life.

Childhood sexual abuse may result in feelings of shame and guilt, and very often fear. Abuse violates a child's sense of choice and identity. It can decrease a person's feelings of self-worth and self-esteem. The effects of childhood abuse often persist into adulthood.

People who have been abused may, for example, develop problems with body image, and over-eat or under-eat in an attempt to make their body less attractive to others. Survivors of abuse may see their only value as sexual, and distrust the motives of others who try to get close to them. It may be difficult for survivors to form intimate relationships, and compulsive promiscuity may result. Self-destructive behaviours – such as substance abuse – can result as well.

The person who was abused as a child may have a confused sexual identity, and may wonder "Am I gay or straight?", and "Am I gay because I was abused, or did the abuser take advantage of me because I am gay?". These feelings may make it difficult for the survivor to come to terms with his or her sexual identity, and therefore isolate the survivor from other gay people and from sources of information about safer sex. A survivor may continue to feel guilty about sexuality, and may feel that becoming infected with HIV is inevitable.

In sexual activities, the person who was abused may relive the sense of powerlessness experienced as a child. This may lead a person to be less selective in their choice of sexual partners, and they may have difficulty setting limits with others in sexual activities. In more extreme cases, a person may dissociate during sexual activities – that is, they may feel that they are "not really present". These factors can work together, making it extremely difficult for a person to negotiate safer sex activities.

Early emotional deprivation, where a child does not experience a loving and nurturing home life, may result in similar personality and behaviour al problems as sexual abuse. The absence of a loving, secure home life may result in poor self-esteem and a lack of concern about risk behaviours. Children and parents need to be able to communicate with each other. Some young people who do not experience a secure home life withdraw from their parents and their school life, and may join a peer group where rebellious behaviour is considered normal, including drug and alcohol use, and sexual risk behaviours. The majority of women who work in the sex trade report that they grew up in homes where there was no emotional support from parents, or where there was abuse.

Homophobia and Heterosexism

Homophobia is the "fear of homosexuality". In its more extreme forms, homophobia may lead to ridicule, insults and even "gay bashing". Virtually all gay men have experienced ridicule and insults because of their sexual orientation. Our society is largely "heterosexist": it is simply assumed that everyone is heterosexual. Sex education tends not include any teaching about homosexuality.

When homophobia and heterosexism are internalized, they become a barrier to people accepting and learning about their own sexuality. Most males who are attracted to other males experience a sense of guilt and shame about their sexuality as they are growing up. A young gay man who is having difficulty coming to terms with his sexuality may be reluctant to openly discuss sexual issues with others. As a result, he will have few supports, including role-models, who can help him come to terms with his sexual orientation. Internalized homophobia can hinder identification with the gay community, where emotional support and information about safer sex are available.

Sexual activity may become hidden, and it may be more spontaneous and less planned than it could be. A gay man may engage in high-risk behaviours because of lack of knowledge and a lack of preparation. Because of poor self-esteem, he may be unable to say "no", may become submissive and passive in relationships, and he may lack knowledge about how to negotiate safer sex. He may use alcohol or drugs to reduce inhibitions about sexuality, which in turn may lead to increased risk behaviour.

Power Imbalances in Relationships

A power imbalance can result from psychosocial factors, such as low self-esteem, lack of self-confidence or loneliness, or it may result from a lack of honesty and open communication in a relationship, or from a gap in age between two people. At the extreme, the most serious type of power imbalance is sexual, emotional or financial abuse. Where there is a power imbalance between two people in a relationship, one partner may be forced to engage in practices putting them at risk of contracting HIV. The person with less power may fear losing the attention or love of the other person, or in more extreme forms, may fear being harmed in some way by the other person.

A power imbalance in a relationship can also result from economic need. For example, a person working in the sex trade may be offered a larger payment for engaging in unprotected sexual activities.

Trust and Communication

Several of these studies confirm what has been found in other research: that people may be less likely to have protected sex in longer-term relationships than they are in casual encounters. People who have been in relationships for longer periods of time often stop using condoms altogether. This can be interpreted as a sign of commitment in a relationship, and a sign of trust that both partners are monogamous. It is risky, however, for partners to assume the serostaus of their partner. Decisions to stop condom use should only take place after testing for HIV, and after commitment and trust have been established in a relationship. To reach this point, open communication between the partners are essential. Partners need to be able to talk openly about sexuality. An increased sense of commitment and intimacy in a relationship should increase the ability to talk about sexuality and to negotiate safer sex.

Some early prevention campaigns encouraged people to "know your partner". While trust, honesty and open communication are indeed important in preventing the spread of HIV, the simple "know your partner" approach may have misled some people into feeling safe. For example, people may mistakenly think they know the entire sexual history of their partners because they have been associating with them for a while. Or sexual partners may be chosen because they look clean or healthy, because they are young, or because they "appear" to be straight. None of these strategies guarantee that a potential sexual partner does not have HIV. Real knowledge, based on honesty and open communication, is required.

Alcohol and Drug Use

Alcohol and drug use may influence people's risk behaviours. Alcohol and drugs are widely used in social settings. Some people use it to relax in the presence of others, to give them courage to approach potentially new sexual partners, and to reduce their inhibitions during sexual activity. Under the influence of alcohol or drugs people are more likely to make unwise decisions about their sexual limits.

People who were sexually abused as children may be more likely to use alcohol and drugs, as are gay men and other men who have sex with men. Sexual abuse and homophobia both affect people's self-esteem and self-confidence, leaving them more vulnerable to making poor choices in sexual situations.

For many single people, the lack of places to meet other people outside of bars encourages alcohol use. People who work in these environments, such as exotic dancers, are also exposed to greater risks because of the presence of alcohol and drugs in these settings.

Implications of the Findings for Prevention Programs

Early prevention responses to the epidemic of HIV dealt with the knowledge and attitudes which are required as the foundation for preventing the spread of the virus. This was a reasonable place to start.

The spread of HIV has not stopped, and increasingly it is marginalized people who are at risk. The studies reported in this document show clearly that knowledge and attitudes alone are not enough to halt the spread of HIV. Other factors – broadly called "determinants of risk" – require consideration in designing effective prevention programs. Sexual behaviours are personal and deeply meaningful, and their meaning is a reflection of the individual's current social, emotional, environmental – and even economic – state, as well as their past experiences. Self-esteem, self-confidence, substance use, childhood abuse, ideas about romance and trust and intimacy, images of relationships, loneliness – all of these diverse factors can have important impacts on the ability to negotiate and practice safer sex.

While knowledge about viral transmission is an essential foundation for prevention, it is not enough. Following are some programming implications of the eight qualitative studies.

- *HIV prevention programs need to consider the determinants of risk – emotional, social, cultural and environmental factors* – which may increase risk behaviours. The spread of HIV cannot be halted without attention to a wide range of factors affecting the lives of individuals. Effective prevention programs need to be designed with the recognition that, on its own, knowledge about the facts of HIV transmission is not enough to prevent risk behaviours.

- *HIV prevention programs need to acknowledge and build on the "lived experience" of the target audience*. The difficulties young gay men experience in coming out, the difficulties single women have in meeting men and negotiating safer sex, and the symbolic and emotional importance of anal intercourse between men, are but a few examples of "lived experience" that needs to be acknowledged in the development of prevention programs.

- *HIV prevention programs need to be clearly targetted to a specific audience*. Prevention programming should be targetted towards those at particular risk due to social marginalization and isolation: for example, young gay men, injection drug users, women, sex trade workers, survivors of abuse. Prevention messages need to take into account the specific social, cultural and economic circumstances of the target audience. What may be effective for one audience may not be effective for another.

- *Couples – both homosexual and heterosexual – would benefit from support in understanding and practising "negotiated safety"*. Couples, particularly those in newer relationships, may benefit from information and assistance in dealing with safer sex, especially as it relates to trust and intimacy.

- *There are still some misconceptions in people's knowledge about HIV*, for example, one may believe they can tell who has HIV just by the way someone looks, or that younger people are less "risky" sexual partners.

- *Ambiguities in scientific knowledge need to be acknowledged and dealt with*, for example, concerning the risks of oral sex, and possible differences in risk between insertive and receptive anal intercourse.

Final Words

The eight studies summarized in this document represent the first efforts of Health Canada to support community-based research on the determinants of risk for HIV. A great deal has been learned.

Developing an understanding of people's experiences, and the way people explain those experiences, can enrich HIV prevention programming. Many people are eager to share their experiences about risk behaviours in an environment where their experiences are valued. In a non-threatening environment, people can acknowledge instances of risk-taking and their feelings about them, without judgement. In this way, we can learn a great deal about how people protect themselves. And there may be benefits for participants as well: it appears that providing people with the opportunity to talk about sex may be a good prevention activity in its own right.

Community-based research – where there is genuine collaboration and respect between researchers and communities – can bring richness to our understanding of risk behaviours, and increase our understanding of how to design effective and appropriate prevention programs.

Endnotes: About the Research Methodology

1. "Young Women at Risk" is based on:

King, A.J.C., Connop, H., and Warren, W.K. (1998). **Young women at high risk: An exploratory study**. Kingston: Social Program Evaluation Group, Queen's University.

Participants in this study were 60 young, single women between the ages of 17 and 21, located in an urban centre and a smaller community and its rural environs. Recruitment for the study was through schools, social service agencies and STD clinics, and through "snowballing" techniques. The main criterion for selection was sexual relationships with at least three partners in the past year.

Three sets of interviews were carried out with all participants, the first two approximately six weeks apart, and the third a year later. Five participants were interviewed a fourth time to obtain additional information on sexual event sequences. Observations by a participant observer were also made at three "rave" parties to obtain additional insights into this youth sub-culture.

A model for risk behaviours was developed, and the transcribed interviews were analyzed for major themes and concepts using this framework.

2. "Single Women Looking for Partners" is based on:

Dedobbeleer[1], N., and Morissette[2], P. (1998). **Le SIDA et le contexte des relations sexuelles des femmes seules à la recherche d'un partenaire au Québec**. Montréal: [1]Département de médecine sociale et préventive, [2]Ecole de service social, Université de Montréal.

An approach which combined quantitative and qualitative methods was chosen for this study. In the first stage of the research, information was collected by a self-administered questionnaire which was mailed to and completed by 430 single women.

Women were recruited for the study through advertisements in various neighbourhood, local, provincial and university newspapers, and through various radio announcements, professional associations, and *la Féderation des associations de familles monoparentales et recomposées du Québec*. Women who were interested in participating in the study were asked to contact the researchers by telephone to obtain a questionnaire, which was then mailed out. Return rate was approximately 70%. These women were separated, divorced, widowed or had never married. All were between the ages of 30 and 54, from various socioeconomic levels, and all lived in greater Montreal or Quebec City. All had been sexually active in the past five years, and were looking for a partner; the reasons for looking for a partner were widely varied.

Where women reported that had protected sexual relations less than half the time with one or more of their two previous partners in the past five years, they were asked to return a coupon in a prepaid envelope separate from that used for the questionnaire, in order to maintain their anonymity. Those who voluntarily returned the coupon were contacted by telephone to set up an interview. In this second stage of the research, in-depth interviews using a constructivist, semi-directed approach were conducted with 28 of these women. The interview guide dealt with four stages of relationships: before meeting a partner, searching for a partner, the beginning of a relationship, and sexual intimacy.

3. "High Risk Women's Understanding of HIV" is based on:

Leonard, L. (1998). **Women's accounts of the social construction of HIV risk**. Ottawa: Community Health Research Unit, University of Ottawa.

Purposive sampling was employed to determine the sample size, where events, incidents and experiences, not people *per se*, are typically the objects of the sample. Sampling to maximize the variation in women's situations was adopted as the strategy for this study. Recruitment strategies were designed to ensure that women who were injection drug users or whose partners were injection drug users, sex trade workers, and women from resource poor environments were included in the study.

Posters placed in community agencies were *not* particularly successful in recruiting women to join the study. Presentations by the researchers at drop-in centres and breakfast and lunch programs were more successful, especially when these were followed by immediate on-site interviews. Active support from a volunteer women's support group also proved to be very successful in obtaining the participation of women who would otherwise not have been included in the study.

In-depth exploratory interviews were carried out by a woman researcher, and were audiotaped with the participant's consent. Interviews typically lasted between one and two hours. Women were compensated $20 for their time, and bus tickets and child-minding expenses were provided as required.

The women participating in this study were straight, lesbian and bisexual women aged 15 to 58 years, whose lives have included activities posing higher risk of acquiring HIV infection. Some women were HIV-positive, others negative; some caucasian, some aboriginal; some poor and some privileged. About half made reference to a mental health diagnosis, or described themselves as recovering addicts or alcoholics, and nearly all had spent time in therapy or counselling.

4. "Exotic Dancers" is based on:

Lewis, J., and Maticka-Tyndale, E. (1998?). **Erotic dancing: HIV-related risk factors**. Windsor: Department of Sociology and Anthropology, University of Windsor.

Observations were made at ten strip clubs in southern Ontario, and in-depth interviews were carried out with thirty female exotic dancers and eight other strip club employees (for example, DJ, waitress, bouncer, shooter girl and doorman) to explore the work and careers of exotic dancers. Purposive sampling was used to maximize the diversity within the small sample. Participants were recruited through key informants (university students working in strip clubs, and a dancer who was paid to recruit other dancers), members of the research team during field trips to the clubs, and through "snowball" sampling. Interviews, which were audiotaped, lasted from one to four hours and took place in a variety of venues. All interviews followed a set of open-ended questions, but were conducted in an informal manner to allow participants to freely express themselves and to allow for the introduction of new questions that arose during the interview. Observational data were used primarily to supplement the interview data and to allow for descriptions of the physical settings.

Participants ranged in age from 18 to 38 years, with a median age of 26. These women had been dancing for periods of time ranging from less than a year to seventeen years, with a median of four and a half years. Half were single or divorced, and half had partners, but only one-quarter of the participants were currently living with a partner. Latin American and Asian women brought to Canada specifically for the purpose of working in strip clubs were not included in the study, nor were women who work in establishments referred to as "biker bars".

5. "Coming to Terms with Being Gay" is based on:

Getty, G., Allen, R., Arnold, K., Ploem, C., and Stevenson, J. (1999). **Atlantic community-based study of the determinants of sexual risk behaviours for men who have sex with men**. Fredericton: University of New Brunswick.

This community-based study carried out by gay men was founded on the belief that participants are the experts about their experience, and that subjective experience is valid data. Members of the community participated at all stages of the study. A grounded theory methodology was used. Recruitment for participation in the study was undertaken through posters in gay bars and AIDS service organizations, gay and lesbian associations in New Brunswick, Nova Scotia and Prince Edward Island, and local (non-gay) newspapers. Interviews began with young men ranging in age from 17 to 25, an age group where risk behaviours are more common and new infections are still occurring. Theoretical sampling (that is, sampling on the basis of concepts

that have arisen in the data) was undertaken, and led to a range of other interviews and focus groups:

- two focus groups for young men
- interviews with two heterosexual men in their early twenties, to allow the researchers to contrast their experiences with those of young gay men
- a focus group of men who dress in "drag"
- interviews with older gay men, the oldest of whom was in his mid-70s
- a focus group with rural gay men, ranging in age from their early 20s to their 40s
- a focus group for men who participate in S&M activities
- telephone and in-person interviews with married or bisexual men.

In addition, eight respondents completed a questionnaire which was posted on the internet.

In all, 94 men participated in the study, sixteen of whom are HIV-positive. At least six current or former sex trade workers were included. Education levels varied dramatically, from grade 2 education to a PhD. Twenty of the men were interviewed a second time, to clarify the understanding of some of the themes and categories emerging from the data.

6. "The Effects of Sexual Abuse" is based on:

Dorais, M. (1997). Patterns of Intimacy: **HIV transmission risk behaviours of young men who are victims of past sexual abuse and who have sexual relations with men**. Quebec City: School of Social Work, Laval University.

This study included a sample of 40 volunteers. Most were recruited to join the study through advertisements in gay magazines and gay businesses, but a few became involved in the research through therapy groups. These men were interviewed in a confidential face-to-face interview for up to two hours. Interviews were tape-recorded and transcribed verbatim. On-going comparative analysis (grounded theory) was undertaken as the data were gathered.

The average age of participants was 34 years, and the average age at first sexual abuse was eight years. The types of abuse varied among participants. In 38 cases it was perpetrated by older people (father, uncle, teacher as perpetrator), and in 11 by older youth (older brother, cousin, or other older adolescent). Abusers were more often related to the victim. 49 of 52 abusers were male. Three participants reported that they were HIV-positive, but one-third had never undergone HIV-antibody testing.

7. Lifetime: "It's About a Lifetime" is based on:

Samis, S.M. and Whyte, K. (1998). **It's About a Lifetime: Men's Stories about Sexuality, Relationships and Safer Sex**. Victoria: AIDS Vancouver Island.

This qualitative study used a narrative approach made up of in-depth interviews and focus groups. 84 men living in urban and rural settings on Vancouver Island and the Gulf Islands of British Columbia participated in the study. Two focus groups were conducted in Victoria, one with a group of men who signed up at the project table at the Gay and Lesbian Pride Day Festival, and the second with men who were participants in a "staying negative" support group at AIDS Vancouver Island. With the exception of two telephone interviews, all participants were interviewed face-to-face in interviews lasting from 45 minutes to two-and-a-half hours. The project had a highly-publicized launch, and recruitment was through promotional materials (advertising in gay and non-gay newspapers, posters, business cards, stickers and matchbooks) and a "snowballing" technique where participants were encouraged to take promotional materials and pass them on to others who might be interested in participating in the project. Volunteers left messages in the voice mailboxes of men who had placed ads in "men seeking men" personals, asking them to participate. A few men participated in this way. An unstructured approach to interviewing was used, where men were encouraged to tell about themselves in a comfortable, non-judgemental, accepting environment.

40% of the participants were less than 35 years old, 52% were between 35 and 54, and the remainder were 55 and over. 85% were caucasians.

80% identified as gay or homosexual and 14% as bisexual. The others identified as heterosexual, or could not easily classify their sexual orientation. 64% identified themselves as "very out", and 25% as "somewhat out", while the rest indicated that there were "not out at all".

8. "Gay Men, Intimacy and Sex" is based on:

Adam, B.D., Schellenberg, E.G., and Sears, A. (1998). **Sexual meanings and safer sex practices**. Windsor: Department of Sociology and Anthropology, University of Windsor.

102 gay and bisexual men were recruited through advertisements in the gay press, through gay organizations, and through leaflets distributed at gay bars. Participants were from Ottawa, Windsor and Toronto. They were asked to participate in open-ended, in-depth interviews to obtain information about their sexual activities, including choices, preferences and desires. Interviews typically lasted between one and two hours and were based on a series of pre-determined open-ended questions. Participants also completed a separate questionnaire asking for information about their sexual activities over the past five years and the past six months. A rating scale for perceived risk of various sexual activities with respect to HIV-transmission was also included.

Participants ranged in age from 19 to 72, with an average age of 35. Most men identified their sexual orientation as gay or homosexual, while some identified as bisexual and a few as heterosexual. About half reported that they were single or not dating. The sample was relatively well-educated. Some of the men knew themselves to be HIV-positive.