



**sex NOW**  
**by the numbers**

A statistical guide to  
health planning for gay men

**Terry Trussler**

**Rick Marchand**

**Andrew Barker**

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For additional copies of this report contact:

Community-Based Research Centre

Suite 122 - 1628 West 1<sup>st</sup> Avenue

Vancouver, BC, V6J 1G1

tel: 604.736.0091

[www.cbrc.net](http://www.cbrc.net)

or

Download the report at:

[www.sexnowsurvey.com](http://www.sexnowsurvey.com)

Graphic design: Leon Phillips [www.leonphillips.ca](http://www.leonphillips.ca)

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## Executive Summary

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*Sex Now* was a survey of BC's gay men and other men who have sex with men, conducted by the Community Based Research Centre, during the summer of 2002. The purpose of the survey was to investigate the state of sexual safety in response to an apparent rise HIV infection rates. At least 158 gay men were infected in 2002, a 52% increase since 1999 when rates were at their lowest.

The Community Based Research Centre is a non-profit society specializing in knowledge development for community health planning. *Sex Now* was one of the more successful gay men's health initiatives ever mounted in BC. The level of participation was unprecedented, reaching 1,900 men. Such willing participation and other evidence within the survey provides a reassuring indication that sexual safety is still robust and an important concern for gay men.

On the other hand, *Sex Now* shows local evidence of widely noted changes in gay men's culture associated with increased risks for HIV infection. The survey found a 25% increase in the proportion of men reporting risk sex between 2000 and 2002. *Sex Now* disclosed that at least 27% of participants had reported at least one occasion of risk sex with an unknown status partner in the last year.

Given this backdrop *Sex Now* provides a broad description of BC's gay population in its current state, information that will be helpful in addressing the emerging situation.

### Demographics

The critical demographic variables of *Sex Now* where differences of sexual risk and safety could be observed were age, sero-status and relationship status. *Sex Now* found little variation in sexual health practices according to education, ethnicity, rural-urban residency, or sexual identity.

### Sexual Practice

*Sex Now* found associations with risk sex (unprotected anal sex with an unknown status partners) increased among "single men" (OR = 1.403, 95% CI: 1.128 - 1.744,  $p = .002$ ) "positive men" (OR = 2.710, 95% CI: 2.026 - 3.624,  $p = .002$ ) "sex venue users" (OR = 3.254, 95% CI: 2.542 - 4.171,  $p = .000$ ) and with "men with larger numbers of partners" (OR = 5.673, 95% CI: 3.982 - 8.08,  $p = .000$ ). Even so, *Sex Now* also showed that younger men under thirty have dramatically more unmet prevention needs and therefore

more vulnerabilities than older generations. The survey also disclosed patterns of risk in some gay relationships.

### **Prevention needs**

*Sex Now* found that general knowledge about HIV was strong but of syphilis weak. The data also show that about 70% of participants may be expecting HIV disclosure unrealistically. About a third of participants found it difficult to talk about sexual safety with their partners. One in five younger men found it difficult to access gay health information.

### **New directions**

*Sex Now* portrays local gay culture on the edge of a critical turn in the HIV epidemic. While sexual safety remains robust, *Sex Now* makes it clear that changes in sexual practice have intensified the risk of increasing HIV infection among gay men. Years of poorly supported gay-dedicated prevention programs are partially responsible for the current situation. There is an urgent need to recommit policy and resources to gay men's sexual health.

The evidence makes a strong argument for an "information-based" approach to the situation: allowing gay men to make appropriate changes in sexual practice based on up-to-date, culturally relevant, and locally sensitive sexual health information. Discussions surrounding *Sex Now* prior to publication revealed that the facts about rising HIV infections were inconsistently known by health professionals and average gay men alike. Reliable information about such trends should be at least one element of a strategy for change.

Prevention services for gay men need stable funding and support to be able to accomplish what is required. To deny support for such prevention needs will likely only worsen the situation. *Sex Now* describes in detail what is known about men who most need to be reached and the types of programs and messages that need to be delivered.

*Sex Now* makes a strong recommendation for a community message intervention based on perceptions and misperceptions of HIV risks. A special program to deal with the poorly met needs of younger gay men is also recommended. Because participation in *Sex Now* has been so strong, the report argues that a periodic survey is feasible, makes an important contribution to the situation and should be conducted at least every two years.



# 1. Introduction

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## Why survey *Sex Now*?

Beginning in March of 2001, the Community Based Research Centre (CBRC) began responding to news of rising HIV infections in British Columbia.

The BC Centre for Disease Control (BCCDC) recorded a 33% increase of HIV positive tests among known men who have sex with men (MSM) – a reversal of a five year downward trend – up from 107 in 1999 to 142 in 2000 (BCCDC, 2001).

The British Columbia Centre for Excellence in HIV/AIDS reported increases in its Vanguard cohort study of 750 young gay men. Annual incidence rates rose from an average of .9% to 3.7% in 2000 (Hogg et al., 2001).

Canada-wide, the estimated number of infections for MSM also increased by 30%, from 1240 in 1996 to 1610 in 1999. (Health Canada, 2001).

As events unfolded, the CBRC undertook initiatives to respond to the emerging situation. We organized several meetings of community health leaders and professionals working with gay men to discuss what needed to be done. These meetings revealed an obvious shortage of reliable knowledge that could explain the increases. With only anecdote and opinion to work with, it was difficult to know how to respond.

Recognizing the lack of good information, BCCDC commissioned a rapid assessment of the situation in the fall of 2001 (Marchand, 2001). The assessment uncovered a state of erosion surrounding prevention activities in British Columbia. Major shifts of attention and budgets to other emergent groups had left little to work with for gay men's prevention.

The study showed that less than 0.1% of the 11 million dollar provincial AIDS program – one full-time salary and an impossibly limited program budget – was all that was being applied to gay men's prevention in BC. Except for Health Canada's support of Asian men's outreach in Vancouver (which has since been withdrawn) and one gay

men's outreach worker in Victoria, all other funding was otherwise allocated. More alarmingly, the study showed that ordinary gay men on the street no longer saw AIDS organizations as welcoming and interpreted the absence of dedicated prevention programs as an indication that HIV was no longer a gay issue. Many in positions of responsibility had either assumed gay men's needs were being addressed or were otherwise unaware of the state of erosion and the ever widening gap.

Given the state of the field, in early 2002, the CBRC began to organize the existing community health leadership to undertake research that would uncover the circumstances surrounding HIV increases as well as concerns over new outbreaks of other sexually transmitted diseases (STD). With the collegial assistance of Sigma Research in London UK, an organization with a decade of experience in community-based HIV prevention surveys, the CBRC designed *Sex Now*, a questionnaire that would appeal to wide participation among gay men while developing evidence about the most appropriate way to respond.

As this process got under way, more news from BCCDC appeared to confirm that HIV infection rates were rising. During 2001, HIV test data showed 145 positive results among MSM, a slight increase over the previous year (BCCDC, 2002).

Sensing a continuing upward trend, the BCCDC supported CBRC's summer survey initiative for a target sample of 1,500 gay men. The survey proved so successful that we actually reached 1,900. This original report describes in detail what we did, what we uncovered and what we believe should be done to respond.

The situation should not be left unchallenged. Before this report could be completed, BCCDC reported that confirmed positive tests among known MSM had climbed to 158 in 2002 – now representing a 52% increase since HIV infections began rising (BCCDC, 2003). Allowing gay men's prevention to remain impoverished and eroded is obviously the wrong policy path.

### **Project objectives**

- ∞ Measure the extent of gay men's sexual health and prevention needs.
- ∞ Describe the relevant cultural conditions, sexual practices, sexual health knowledge, attitudes, perceptions, and patterns of community participation that would inform health promotion planning.
- ∞ Identify messages that should be conveyed through policy, practice and action for specific prevention issues within the population.
- ∞ Promote dialogue on sexual safety within the population based on survey participation and feedback.

- ∞ Assess the feasibility of a periodic sexual health survey involving a large segment of the gay population at least every two years.

## **Review of recent literature**

The main trend signaled in most recent literature on men having sex with men (MSM) and HIV is that unprotected sex has been steadily increasing in large urban gay centres worldwide since the mid 1990's (Adam, 2001; Stall et al., 2000). Until late in 2000, however, there seemed to be no corresponding rise in HIV infection.

The absence of rising infections may have been at least partially responsible for a widespread misinterpretation of the situation: that HIV was a lessening threat (Stall et al., 2000). However, as might have been predicted, increases in HIV infection and other STD's eventually showed up, though later than expected, in several cities including Amsterdam, New York, San Francisco, Toronto and now Vancouver (Adam, 2001).

Explaining why unprotected sex increased so rapidly has exposed some critical weaknesses in prevailing prevention theories and thus their capacity to address the current situation (Parker et al., 2000; Wohfeiler, 2000; Waldo and Coates, 2000). Much of prevention "science" was built on psychological theories exploring individual behavioural change or describing the traits of "risk takers" who engage in unprotected sex.

Psychology's narrow focus on individuals created a problem for real prevention conditions in the community (Waldo and Coates, 2000). For instance, research that might have broadened prevention discourse to include the relative safety of unprotected sex under certain conditions, was slowed by conservative values embedded in the behavioural change approach (Kippax, 1997).

Many investigators recognized that gay culture itself needed to be addressed to reshape HIV prevention, (Dowsett, 1996; Flowers, 1996; Kippax, 1996; Myers et al., 1996; Parker et al., 1999) but the momentum of prevention science remained with the individual. Still, in searching for productive ways to address emerging trends, some researchers have been exploring the impact of shifts in gay culture on sexual safety and prevention, work that shed important insights. (Dowsett, 1998; Flowers, 2001; Parker et al., 1999; Stall et al., 2000).

Gay culture has undergone several evolutionary turns since the beginning of the AIDS epidemic, prompted in part by new scientific conceptualizations of the illness and the introduction of HIV testing technologies and medications (Flowers, 2001). Each shift brought with it a challenge to earlier versions of sexual safety. New generations of men, who joined the gay population with little prior experience of AIDS, also cast doubt on earlier conceptions of "safer

sex” and specifically the need to use condoms “every time” (Adam, 2001; Stall et al., 2000).

Anti-retroviral therapies brought about another revolution. Positive men were well enough to rejoin sexual life. Lighter “viral loads” and decreasing infection rates shaped the hopeful impression that the epidemic was in decline. Unprotected sex became talked about more openly. Risk reduction strategies for sex without condoms were deployed such as “sero-sorting” and “positioning” (see Sexual Practices) to minimize remaining risks (Race, 2002). These strategies could actually be working to some extent, but there is little documented evidence (Stall et al., 2000). As some observers have suggested, the social and behavioural responses among MSM are at least as complicated as the HIV virus itself (Stall et al., 2000).

The situation for gay men and HIV prevention has thus become quite complex. Key observers now agree that current conditions are a set-up for tragedy: a pattern of endemic HIV infection among MSM with occasional rapid increases in HIV incidence as factors shift according to cultural trends (Stall et al., 2000). What can be done?

Socially oriented prevention scientists have been pointing toward approaches which would broaden prevention. The established, behavioural science position accounts for unprotected sex as the end product of individual attributes affecting self-control such as low self-esteem, weak self-efficacy, and depression (Hart and Boulton, 1995). The ‘socially informed’ view accounts for sexuality in general and risk in particular as a product of interpersonal dynamics within a sexual culture where individual behaviour is delimited by local practices, norms and power differentials (Hart and Boulton, 1995).

The psychological and social positions are not mutually exclusive nor necessarily in competition with each other. But both are necessary to account for the emerging situation and what to do about it. Widespread misperception begs a social solution. Even so, individuals need psychological support to deal with the impact of their own thinking (Berkowitz, 2000).

Among suggested interventions are those that would affect gay culture internally (Stall et al., 2000). Few gay communities have much of substance to sustain the social cohesion that gay men experienced during the worst of the HIV epidemic, when building organizations to respond to illness and death brought so many together in a common bond. Now many of the organizations gay men built in those times are either distracted by the persistent need for care services by other groups or shifts in values that de-emphasize gay men’s prevention (Wohfeiler, 2000).

It seems obvious that in order to address the social context of sexual safety and prevention, that gay men need dedicated organizations and spaces in which to encounter each other productively (Hickson et al., 2000). In reality, few such spaces exist in Vancouver and BC, a persistent theme in all of prior

research (Healy, 2001; Marchand, 2001; Samis and Whyte, 1998; Trussler, Perchal & Barker, 2000; Trussler, 2000; Trussler, 2002).

Another theme arising in the literature is the need to approach gay men's HIV prevention more holistically to take into account the wider realities affecting gay men's health such as male partner relationships and gay men's social status within society (Adam 2001; Stall et al., 2000).

In considering prevention messages, the literature has increasingly recognized the importance of social research in crafting interventions. Prevention messages need to address what people actually experience and how they speak about it, rather than how prevention professionals speak of it. But under conditions where prevention is failing, people's experiences may be based on webs of misperception, wrong information and rumour (Berkowitz, 2000). The role of social research in these conditions is to sort out the difference between perception and reality.

Our reading of the literature and what it suggests led us to conclude that a community-based survey of gay men could be a significant contribution to the current situation and a community-level intervention in its own right. Sigma's large-scale surveys, for example, now reach 18,000 gay men annually in the UK. Mass participation conveys an important message to survey respondents, that sexual safety remains a concern and that community leaders care about gay men's sexual health interests. Widespread participation has its own cultural impact and becomes incorporated into the lives of the people that most need to be reached (Hickson, 2002).

We greatly appreciated the contribution of two impressive reviews of recent research which we recommend as additional reading. Ron Stall and colleagues of the Centre for AIDS Prevention Studies (CAPS) published a summary of the main findings of empirical research on gay men's prevention just prior to the current increases in HIV incidence (Stall et al., 2000). The CAPS group predicted HIV increases as an outcome of changes in gay men's sexual culture. Barry Adam's review provided a critical examination of prevention strategies which may have unwittingly contributed to the increases (Adam, 2001).

## **D e s i g n   a n d   m e t h o d o l o g y**

The purpose of *Sex Now* is to identify sexual health and prevention needs of BC's gay population. By comparing relationships between demographic factors, sexual practices, sexual health knowledge, risk indicators and participation in community venues, the design is distinctively practical in the information it seeks to provide health promotion planning.

The survey is not intended to inform theories about gay culture, but rather to describe what is happening and to provide indicators of the "who, what and

where” of sexual safety and prevention needs. This enriched description of the local situation is intended to inform future policy, practice, messages and community action.

We designed the questionnaire to fit on two sides of one page using 5 blocks of questions: 1) demographics, 2) sexual practices, 3) sexual health knowledge, 4.) risk/need indicators and 5) participation in community venues. The one page format allows easy completion on a clip board in about five to seven minutes time. The English questionnaire was translated into Spanish and Chinese.

Following the experience of our colleagues at Sigma Research in London, we organized our survey participation to take place at Pride Festivals in Victoria, Vancouver and Prince George. Sigma’s approach to sampling at Pride Festivals has already been validated with corroborating studies (Hickson, et al., 1999). Those studies found that Pride participants provide a robust sample of the gay population that would only be reproduced if other sampling techniques were used. The sheer convenience and economy of accessing the experiences of a large volume of gay men at one event were ample motivations for us to emulate Sigma’s approach.

To stimulate participation, we advertised *Sex Now in Xtra West*, our local gay newspaper, for several weeks in advance. During Pride, volunteers, representing a variety of age groups and subcultures, wearing distinctive apparel, distributed the questionnaire into the crowd of festival participants. To maintain anonymity, respondents deposited the completed questionnaires personally into sealed containers. Information forms about the nature of the research were available on site.

In addition to canvassing Pride events, we sampled specific events held for both Chinese and Spanish speaking gay men. We also sampled Spectrum Clinic, where many gay men of Vancouver attend primary care. The completed questionnaires were forwarded to a coder who developed a coding system and entered the data into *SPSS* software. In the end we acquired a useable sample of 1,854 men from the 1,900 that participated.

The size of our sample does not necessarily suggest that the sample is truly representative of BC’s gay population. There are many problems associated with obtaining a random sample of gay men, however, a large sample does offer considerable diversity and the statistical power to analyze subgroups.

Aside from these methodological considerations, wide participation simply verifies the intervention objective of the survey. The more men who complete the survey, the more we can confirm have experienced some form of participation in a community sexual health and prevention activity.

The questionnaire’s design in five blocks allows for a cross analysis based on “differences between groups” suggested by demographics such as education, income, ethnicity, relationship status, sero-status and other factors that emerge

from insights during the analytical process. Consistent with the non-probabilistic sampling procedure, where the actual population size is unknown, the analysis uses descriptive level statistics (Argyrous, 2000). The analytical procedure is an exhaustive bivariate analysis using cross tabulations to examine differences and repetition of patterns.

Beyond data from *Sex Now* we also probed results from *Gay Health Vancouver*, a survey conducted by the CBRC in 2000 (Trussler, 2000). The two surveys were quite different in design but we repeated some questions in *Sex Now* for comparison with earlier findings. These comparisons helped to corroborate sample proportions such as sero-status, ethnicity, identity and education which turned out to be similar (see Demographics). Comparing surveys also pointed out a significant increase in unprotected sex with casual partners between the two years (see Sexual Practice).

### Reading the results

There are a few key principles to bear in mind while reviewing the data in this report, most of it presented in tables.

Most statistical procedures imply a proportional relationship between the sample and the whole population. However, large as the *Sex Now* sample may be, it is possible that some elements of the population are missing. Survey participation is always voluntary so it is conceivable that even random samples may have some of the same problems. We were aware, for instance, that some potential participants were at work or occupied in other aspects of the Pride festival. Presumably, more “closeted” MSM would not consider participating in Pride events. Nevertheless, we watched participation very closely with a team of three observers who visited each site and found that the sample offered a broad cross section of BC’s gay men.

In conducting the analysis, we used a level of confidence of 95%, a recognized statistical standard that allows a 5% error rate. Descriptive analysis measures statistical “differences between groups”(Argyrous, 2000). This process involves identifying groups within the sample, based on demographic or behavioural features, and comparing them. We used chi-square (test for independence) analysis to measure differences. This test generates a number known as a “*p* value” to indicate whether there is a “significant” difference between groups. A *p* value of .05 or less indicates at least a 95% probability that variation between groups was not due to chance or random variation and is therefore a “significant” difference.

For example, our analysis found little statistical difference due to education relative to most of the sexual health indicators we examined. Chi-square analysis, comparing patterns of sexual activity among groups of men varied by “less than high school”, “high school”, “college” or “university” education, produced *p* values higher than .05. This evidence suggests that patterns of

safety and risk among men of every education level were quite similar. Or, in other words, the differences were not significant. On the other hand there were significant differences relative to age and these were indicated by *p* values less than .05. That evidence suggests age did make a significant difference to involvement and tolerance of risk in sexual activities.

When reading the larger tables you will notice that the *p* values are recorded whether there were significant differences or not because both help to describe conditions. It may be just as important to know there was little difference between groups on a certain issue as it is to know there were significant differences. To make the information easier to read, the larger tables repeat *p* values between some lines even though they are from the same chi-square test. Note that all percentages are column percentages. In some cases cumulative percents may vary from 100% by plus or minus .1% due to rounding.

We also used Odds Ratio (OR) analysis to confirm discrete results. This analysis reduces the terms down to two columns by two rows. We used ORs to confirm such features as the strength of association between crystal use and risky sex (OR=1.820, 95% CI: 1.323-2.503, *p* = .000). The OR statistic produces a number higher or lower than one. A value of one suggests there is no association. The strength of association increases with values either higher or lower than one. The OR is always stated within a 95% confidence interval. For comparison, we also report the chi-square *p* value associated with each table.

In most cases the analysis of differences provides “direction” to the description of conditions. For example, knowing that a significantly larger proportion of men under thirty use crystal as a recreational drug suggests that the appeal of the drug is toward younger men.

Nevertheless, other features of the data suggest it may be just as important to observe “proportions” such as minorities and majorities. Especially, in circumstances where misperception may be contributing to the research problem, it may well be crucial to observe the difference between direction and proportion. When we examined crystal users as a group, for example, we found that half were actually in the 30-44 age group even though comparing age groups suggested that a larger proportion of younger men were users.

Knowing the proportional value can help to challenge myths built up around misperception. For example, though some men may feel that “barebacking is everywhere”, this survey found, that while it may well be on the increase, the majority continue to maintain consistent sexual safety.



## 2. Demographics

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So little is known about the gay population of BC that it would be difficult to evaluate what proportion is represented in *Sex Now* or whether the sample's demographic parameters such as age, ethnicity or sero-status match the actual population. What would be fair to say is that the *Sex Now* sample appears to match what can be seen with the “naked eye” in the crowd of Pride participants.

Current estimates of the size of the region's gay population suggest there may be at least 25,000 or more in Vancouver (Archibald et al., 2001). The true figure would be difficult to obtain. An estimate of 5% applied to about 2 million men in BC (Statistics Canada, 2003) would suggest 100,000 may be MSM. Perhaps as many as 60,000 live in the Vancouver and the Lower Mainland Region.

The size of the community in Victoria is even less known though it is obviously well established. Experience from Prince George, Kelowna, Cranbrook and Nelson suggests that many gay men are living throughout the region, though less visibly, and that there is considerable migration between these smaller centers and Vancouver. Though identification as “gay” is an issue for a minority of rural men, most represented in the *Sex Now* sample live gay culture day by day in what they read, where they go and what they do.

The distributions shown in Table 2.1 represent the characteristics of the *Sex Now* sample to bear in mind throughout this report.

### Residence

The survey visited Victoria, Vancouver and Prince George Pride Festivals but there were visitors in each from other parts of BC and outside of BC. We included all participants in the general analysis assuming that all men present were part of the scene *Sex Now* was observing. Visitors were separated and excluded for comparisons between BC locations.

## Age

The largest portion of the sample was thirty-something with a mean (average) and median (mid-point) of 37 and a mode (most often stated) of 36. Age was a critical variable in *Sex Now*, as it described significant differences of sexual practice, knowledge, and community participation.

## Education

The *Sex Now* sample was relatively well educated with about 77% having completed tertiary level (college or university) education. This feature, however, is not dissimilar to samples from other gay centers (Myers et al., 1993). One explanation is that higher education permits MSM to feel more confident about self-identifying as gay and perhaps secure enough to participate in a survey. We found that there was very little variation in sexual practice, knowledge or participation due to education in the *Sex Now* sample.

## Ethnicity

The *Sex Now* questionnaire was translated into Chinese and Spanish to encourage participation where dedicated outreach workers were available. It would be difficult to judge to what degree the sample represents the ethnic and aboriginal distribution of BC's MSM population though we have presumed that minority groups are under-represented.

*Sex Now* found proportionately fewer HIV positive men among visible minority participants. Nevertheless, we found very little variation in sexual practice, knowledge or community participation due to ethnicity in *Sex Now*.

The general pattern, including variation by age and sero-status, was repeated in every ethnic group. A majority of participants who used the "other" option, indicated they were "Canadian". As such we grouped visible minorities and compared them to men grouped as European-Canadian and found little variation in sexual practice. Prevention planners might expect to see similar patterns and proportions among gay men of most ethnicities we studied, however, the delivery of prevention services in appropriate language and culture remains a critical issue.

## Sero-status

Little concrete information has been available about HIV prevalence in BC's MSM population. *Sex Now* asked participants about the result of their most recent HIV test to determine the distribution of "reported sero-status" in the sample. Prior research in Canada has shown little difference between what gay men report and actual sero-status as confirmed by saliva test (Myers et al., 1995). *Sex Now* probed what participants believed their status to be and found no significant difference between reported status and belief about it.

We also compared the *Sex Now* sample to *Gay Health Vancouver*, our earlier survey (Trussler, 2000) and found no significant difference in distribution between the two years. We interpreted this to be an indication that the proportions of positive, negative and untested men in the sample may reflect the actual distribution in the population. Each survey used different methods and widely varied sample sizes so these data should be approached cautiously.

Table 2.4 shows that there were disproportionately more positive men living in Vancouver relative to other regions in the *Sex Now* sample. The size of “unknown” group at 11.3% was relatively small compared to other centers such as London, UK, where as many as 46% are untested (Reid et al., 2002). Nevertheless, the untested group may well represent a large group of men in BC’s MSM population. Reported sero-status was a critical variable in *Sex Now*, defining significant differences of sexual practice and community participation.

### **Income**

Previous research published by the CBRC has shown that gay men’s apparently comfortable income, especially in Vancouver, was somewhat misleading due to the high cost of living on the west coast (Trussler, 2002). Those earlier studies described how many gay men felt trapped between their emotional attachment to the city and their ability to keep up to its lifestyle. We did observe some differences of participation in gay culture due to income in *Sex Now*, though not always as expected. Current models governing health policy, for example, suggest greater risk with lower income, however, we found little variation in experience with risky sex between higher and lower income groups in *Sex Now*.

### **Relationships**

Knowledge about gay male relationships and sexual safety was all but ignored by HIV prevention studies until the mid 1990’s (Hickson et al., 1992; Kippax et al., 1997). The *Sex Now* sample has about half of participants in a relationship which is similar to our earlier survey in 2000. Interestingly, this ratio is roughly similar to the distribution of single and married males in the total Canadian population (Statistics Canada, 2003). We also found that about half of positive men were in a relationship, and about half of them with a negative partner. There were fifteen participants in relationships who did not know their partner’s HIV status. Because this group was so small, we included them as discordant couples in further analysis. Prior research by the CBRC has shown that many more men want long term relationships than actually have them, about 70% in general and about 87% of younger men. In both studies, men in relationships had higher incomes (Trussler 2000; 2002). This also suggests that dual higher incomes provide a better quality of life for couples than for many single men living in Vancouver.

## Identity

The *Sex Now* questionnaire collected information about identity. About 76% of participants described themselves as gay. We observed little variation in terms of sexual practice, knowledge, need/risk indicators or cultural participation according to other identity terms such as “homosexual”, “bisexual”, “queer” or “no term” as used by the balance of participants.

## 2. Demographics: Sex Now Findings

### Summary

Little variation was observed according to sexual practice, knowledge, need/risk indicators or community participation according to:

- ∞ residence
- ∞ education
- ∞ ethnicity
- ∞ identity

Age and sero-status were critical variables.

Income was associated with limited access to condoms and increased community participation.

### Sample Demographics (table 2.1)

#### Ethnicity by Residence (table 2.2)

*Most visible minority participants were Vancouver residents.*

#### Sero-status by Residence (table 2.3)

*The distribution of reported sero-status differed by residence.*

#### Sero-status by Vancouver or Other BC Residence (table 2.4)

*A higher proportion of positive men were residents of Vancouver.*

#### Sero-status by Age (table 2.5)

*The distribution of sero-status varied by age group.*

*Having tested positive was associated with middle age.*

#### Age by Sero-status (table 2.6)

*The largest proportion of HIV positive participants was 30-45.*

*The largest proportion of tested negative participants was 30-45.*

*The largest proportion of untested participants was 15-29.*

#### Sero-status by Ethnicity (table 2.7)

*There were proportionately fewer HIV positive men among visible minority participants.*

#### Income by Age (table 2.8)

*Lower income was associated with youth.*

**Income by Sero-status** (table 2.9)

*A greater proportion of untested men earned lower income than those tested.*

**Income by Sero-status** (table 2.10)

*Almost as many HIV positive men made over \$30K as under.*

*A greater proportion of non-positive men reported higher income.*

**Duration of Relationship** (table 2.11)

*The sample had a relatively even distribution of men in short, medium and long term relationships.*

**Income by Relationship** (table 2.12)

*A larger proportion of men in relationships reported higher income than single men.*

**Relationship by Sero-status** (table 2.13)

*As many HIV positive men were in relationships as non-positive.*

**Sero-concordance** (table 2.14)

*Most men in relationships were HIV negative concordant.*

*About one quarter of relationships were sero-discordant.*

**Positive partner's sero-status** (table 2.15)

*About half the positive men in relationships had a discordant partner.*

Table 2.1

Demographics	Frequency	Percent
<b>Residence</b> n=1842		
Victoria	263	14.3%
Vancouver	1182	64.2%
Prince George	59	3.2%
Other BC	80	4.3%
Outside BC	258	14.0%
<b>Age</b> n=1820		
15-29	464	25.5%
30-44	935	51.4%
45+	421	23.1%
<b>Education</b> n=1846		
Some high school	80	4.4%
High school	346	18.7%
College	572	31.0%
University	848	45.9%
<b>Ethnicity</b> n=1834		
Aboriginal	53	2.9%
African	11	.6%
Asian	158	8.6%
European	1135	61.9%
Latin American	88	4.8%
Middle Eastern	19	1.0%
South Asian	22	1.2%
Other	348	19.0%
<b>Sero-status</b> n=1830		
Positive	236	12.9%
Negative	1387	75.8%
Unknown	207	11.3%
<b>Income</b> n=1827		
Under \$10,000	221	12.1%
\$10,000-29,999	490	26.8%
\$30,000-49,999	554	30.3%
\$50,000 Plus	562	30.8%
<b>Relationship status</b> n=1829		
Single	947	51.8%
Partnered	882	48.2%

**Table 2.2**

<b>Residence/ ethnicity</b>	Vancouver	Other BC
	n=1168	n=399
	n=1567	
Euro-Canadian	951 (81.4%)	306 (76.7%)
Visible minorities	217 (18.6%)	93 (23.3%)

OR = 1.332, 95% CI: 1.012 – 1.753,  $p=.041$

*Most visible minority participants were Vancouver residents.*

**Table 2.3**

<b>Residence/ sero-status</b>	Victoria	Vancouver	P. George	Other BC	Outside BC
	n=259	n=1167	n=59	n=79	n=255
	n=1819				
Positive	6.9%	14.7%	8.5%	16.5%	10.6%
Negative	77.2%	74.3%	78.0%	69.6%	82.4%
Untested	15.8%	11.1%	13.6%	13.9%	7.1%

$p=.002$

*The distribution of sero-status differed by residence.*

**Table 2.4**

<b>Residence/ sero-status</b>	Vancouver	Other BC
	n=1167	n=397
	n=1564	
Positive	14.7%	9.1%
Not Positive	85.3%	90.9%

OR = 1.722, 95% CI: 1.178 – 2.515,  $p=.005$

*A higher proportion of positive men were residents of Vancouver.*



**Table 2.5**

<b>Age/ sero-status</b>	15-29	30-44	45+
	n=1800	n=457	n=928
Positive	3.7%	15.9%	15.9%
Negative	72.9%	77.7%	75.2%
Unknown	23.4%	6.4%	8.9%

*p* = .000

*The distribution of reported sero-status varied by age group.*

**Table 2.6**

<b>Sero-status/ age</b>	positive	negative	unknown
	n=1800	n=231	n=1366
15-29	7.4%	24.4%	52.7%
30-45	64.1%	52.8%	29.1%
45+	28.6%	22.8%	18.2%

*p* = .000

*The largest proportion of HIV positive participants was 30-45.*

*The largest proportion of tested negative participants was 30-45.*

*The largest proportion of untested participants was 15-29.*

**Table 2.7**

<b>Ethnicity/ sero-status</b>	Euro- Canadian	Visible Minorities
	n=1811	n=351
Positive	13.9%	8.0%
Not Positive	86.1%	92.0%

OR = 1.863, 95% CI: 1.232 – 2.817, *p* = .003

*There were proportionately fewer HIV positive men among visible minority participants.*

**Table 2.8**

<b>Age/ income</b>	15-29	30-44	45+
	n=1795	n=451	n=930
	n=414		
Under \$10,000	29.9%	5.6%	6.8%
\$10,000-29,999	38.8%	24.1%	20.0%
\$30,000-49,999	21.5%	35.9%	27.3%
\$50,000 Plus	9.8%	34.4%	45.9%

*p* = .000

*Lower income was associated with youth.*

**Table 2.9**

<b>Sero-status/ income</b>	positive	negative	unknown
	n=1806	n=231	n=1372
	n=203		
Under \$10,000	8.7%	10.3%	27.1%
\$10,000-29,999	42.4%	23.5%	31.5%
\$30,000-49,999	25.5%	32.0%	25.1%
\$50,000 Plus	23.4%	34.1%	16.3%

*p* = .000

*A greater proportion of untested men earned lower income than others.*

**Table 2.10**

<b>Sero-status/ income</b>	HIV Positive	Not Positive
	n=1806	n=231
	n=1575	
Under \$29,999	51.1%	37.1%
Over \$30,000	48.9%	62.9%

OR = 1.772, 95% CI: 1.443 – 2.339, *p* = .000

*Almost as many HIV positive men made over \$30K as under.*

*A greater proportion of non-positive men reported higher income.*

**Table 2.11**

<b>Relationship duration</b>	Frequency	Percent
n=850		
≤1 year	270	31.8%
1-5 years	288	33.9%
>5 years	292	34.4%

*The sample had a relatively even distribution of men in short, medium and long term relationships.*

**Table 2.12**

<b>Relationship/income</b>	Single	Partnered
n=1802		
Under \$29,999	42.1%	34.6%
Over \$30,000	57.9%	65.4%

OR = 1.375, 95% CI: 1.136 – 1.665,  $p = .001$

A larger proportion of men in relationships reported higher income than single men.

**Table 2.13**

<b>Sero-status/ relationship</b>	HIV positive	Not positive
n=1806		
single	53.7%	51.3%
partnered	46.3%	48.7%

$p = .5$

*As many HIV positive men were in relationships as non-positive.*

**Table 2.14**

<b>Sero-concordance</b>	Frequency	Percent
n=865		
Positive + Positive	49	5.7%
Negative + Negative	589	68.1%
Discordant	212	24.5%
Don't know	15	1.7%

*Most men in relationships were HIV negative concordant.  
About one quarter of relationships were sero-discordant.*

**Table 2.15**

<b>HIV Positive partner's sero-status</b>	Frequency	Percent
n=110		
HIV Positive	51	46.4%
HIV Negative	53	48.2%
Don't know	6	5.5%

*About half the positive men in relationships had a discordant partner.*

### 3. Sexual Practice

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We have adopted the term “practice” in our discussion of sex, in keeping with the “socially informed” analysis of *Sex Now*. This standpoint accounts for sexual behavior as social rather than individual conduct, learned through participation in sexual culture. Consequently, in thinking about gay men’s sexual practices, no-one is truly autonomous. In order to participate, some form of adoption of local practice is involved.

Thinking about sexual practice in this way opens new pathways for considering sexual health, safety and prevention. While the predominant psychological models of the HIV prevention field have shown some success with individuals, critical observers have suggested that they offered very little to community-level prevention efforts (Stall et al., 2000). The steady increase of unprotected sex in gay centres worldwide is at least one sign of the failure of individual based models to either account for the cultural side of sexual practice or to do much with it.

Obviously, psychology has its place in sexual research and individual behaviour is at least one way to locate prevention. *Sex Now* found, for example, that many men lack the confidence to say “no” to unwanted sex and that there is an association with risky sex in that group. Those men may welcome opportunities for counseling or group work to overcome their personal inefficacy.

On the other hand, the “socially informed” model of sexual practice would suggest that an understanding of what an individual encounters in cultural participation is at least as important as understanding personal efficacy. It has been shown that the perception of what others are doing can outweigh personal motivation (Berkowitz, 2000). As such, commonly held perceptions about how many other gay men are “barebacking” could play a role in adoption of the practice even though the perceived norm may be quite distorted.

*Sex Now* findings should help to disclose the realities of sexual practice among the men of BC. A national survey of gay men in 1991 showed that Vancouver’s men were more likely to engage in unprotected anal sex (UAI) than others in the country (Myers et al., 1993). So

little research has been conducted since then that it is difficult to judge whether this remains so.

Nevertheless, CBRC's research found a 25% increase in UAI with multiple partners between 2000 and 2002 (table 3.2). About 27% of the *Sex Now* sample reported UAI with one or more partner of "unknown sero-status" within the previous year (table 3.1).

While the magnitude of involvement has grown, it is still important to keep in mind that the great majority of gay men in BC have maintained consistent sexual safety. Those who do report unprotected anal sex with an unknown status partner may well be reporting a single occasion. Evidence of the social pressures that may be involved in unprotected encounters is the subject of the next chapter of this report. What we deal with in this segment is a "snap-shot" description of overall sexual practice of a population as we uncovered it in the summer of 2002, the magnitude and proportions of involvement and the trends suggested by the data.

In reading the tables and observations there are several terms and their meanings to bear in mind:

### **Risk sex**

We use the term "risk sex" to refer to acts in which the risk is a "chance of HIV transmission occurring" (McClure and Grubb, 1999). In emulating the work of our colleagues at Sigma Research, we adopted their description of transmission risk as "sero-discordant unprotected anal intercourse" (sdUAI). This description assumes that exposure or infection may occur only in the context of unprotected sex between positive and negative men. There is absolutely no risk of HIV infection between two confirmed negative men, so unprotected sex by itself can not be considered risk sex. In addition, sdUAI may describe potential for exposure but not necessarily transmission. It is understood that exposure does not always lead to infection and that there is greater risk of infection if the uninfected partner is receptive.

We have also taken up current discourse in HIV social science to describe a chance occurrence of sdUAI as "UAI with a partner of unknown sero-status" or simply "UAI unknown status". This distinguishes risk sex from UAI with a partner or partners of "known concordant sero-status". Following this logic "UAI unknown status" is neither an indicator of exposure or infection though either occurrence is obviously possible by chance.

While the term risk sex may be descriptive from a prevention perspective, it is clearly not the way gay men think or talk about sex. Our use of the term is simply a convenient shorthand.

*Sex Now* collected data only on anal sex for the sake of brevity of the questionnaire and the prevention perspective that oral sex is very low risk for

HIV infection. Obviously, for other sexually transmitted diseases, oral sex may be as risky as anal sex.

### **Sexual safety**

Given the above, sexual safety must be more diverse than consistent use of condoms, a conscious practice that involves deliberate thought, communication and action. As described earlier, gay men have already deployed “risk reduction” strategies for sex without condoms into their collective repertoire (Race, 2002). As such sexual safety needs to be understood as more than individual practice, extending to the collective practice of a sexual culture. Understanding the boundaries of sexual safety may need to account for some of the following features.

**Negotiated safety.** One form of safe sex without condoms, described as “negotiated safety” is based on the sharing and confirming of sero-status concordance which might occur in a male relationship over a period of months (Kippax et al., 1997). *Sex Now* describes the proportion of men who know their partner’s sero-status, the concordance of the relationship and the kind of agreements they make about sex outside their relationship.

Previous CBRC research (Trussler, 2002) has shown that younger men are more likely to be interested in “serial monogamy” at least partially for sexual safety without condoms. The principles of negotiated safety guide the arrangement: confirmation of sero-status by testing and re-testing and agreement of the terms of sex outside the relationship. *Sex Now* confirmed that younger men were more likely than those over thirty to have a “no sex” outside the relationship agreement.

**Sero-sorting.** One manifestation of sero-sorting involves positive men seeking only other positive men. The safety of UAI in this situation is a matter of debate but quite obviously there is no risk of HIV transmission to an uninfected partner. Another expression of sero-sorting is negative men seeking only negative men, however, the safety of the situation is doubtful due to the potential for transmission during the HIV “window period” before the presence of HIV antibodies can indicate one’s actual sero-status.

**Strategic positioning.** Another aspect of sero-sorting might involve men in making a “harm reduction” decision, in a situation where the status of the other partner is unknown, by taking the less risky role. The positive man might assume a receptive position and the negative man the insertive. Obviously, from the discussion above, this is a risk sex situation but it is important to understand that the occurrence is not completely reckless. There is some evidence in *Sex Now* of these practices, though unfortunately the data are weak and incomplete.

### **3. Sexual Practice: Sex Now Findings**

#### **Sex practices (Table 3.1)**

*Percent anal intercourse (AI) in the year: 84%*

*Percent AI with multiple partners: 58%*

*Percent any unprotected AI (UAI) status unknown: 27%*

*Percent UAI status unknown with multiple partners: 15%*

*A 73% majority reported practices consistent with sexual safety even among those with larger volume of partners.*

*While 27% reported occurrences of risk sex,*

*a smaller (15%) fraction reported more than one partner.*

#### **Change in UAI multiple partners (Table 3.2)**

*Reported UAI with multiple partners increased by 25% over the two years between surveys.*

#### **Sex partners in the year (Table 3.3)**

*Percent reporting only 1 partner: 22%*

*Percent reporting 10 or less: 75%*

#### **Risk sex by Partners in the year (Table 3.4)**

*The likelihood of risk sex increased with number of partners.*

#### **Risk sex by Partners in the year (Table 3.5)**

*Men with larger numbers of partners had a much higher likelihood of risk sex.*

*The “men with larger numbers of partners” group was nearly split between consistent sexual safety and one or more occasions of risk sex.*

#### **Sex practices by Age (Table 3.6-7)**

*Men under thirty reported proportionately less risk sex than older men.*

#### **Sex practices by Sero-status (Table 3.8-9)**

*Positive men reported disproportionately more “UAI unknown status” than other men.*

#### **Sex practices by Relationship (Table 3.10-11)**

*“UAI with multiple partners” was as likely for partnered men as single men.*

*“UAI unknown” was significantly more common among single men than partnered.*



**External sex agreement** (Table 3.12)

*Percent who had not discussed sexual safety in their relationship: 16%*

*Percent agreed to “no sex” outside the relationship: 45%*

**Sex agreement by Age** (Table 3.13)

*Younger men were more likely to have a “no sex” outside the relationship agreement.*

*Older men were more likely to have a “no UAI with others” agreement.*

**Sex agreement by Sero-status** (Table 3.14)

*Positive men were more likely to have an “any kind of sex” agreement.*

**Sex practices by Relationship concordance** (Table 3.15)

*Little difference of practice was reported according to sero-concordance of relationships.*

*About 16% reported “UAI unknown status” outside the relationship.*

**Risk sex by Income** (Table 3.16)

*There was little difference in experience with risk sex between high and low income groups.*

**Recreational sex venue popularity** (Table 3.17)

*While the bathhouse was the most popular venue, the internet rivals it in participation.*

**Sex practices by Venue use** (Table 3.18-19)

*Risk sex increased with increasing types of venues used.*

*A thin majority of multiple venue users reported practices consistent with sexual safety.*

*Risk sex was associated with venue use.*

**Sex practices by Cultural attachment** (Table 3.20-21)

*Risk sex was associated with higher cultural attachment, however, a wide majority of culturally attached men reported no risk sex.*

**Table 3.1**

<b>Sex Practices</b>	<b>Frequency</b>	<b>Percent</b>
<b>Anal Intercourse (AI)</b> n=1714		
none	274	16.0%
any	1440	84.0%
multiple partners	986	57.5%
<b>Unprotected AI (UAI)</b> n=1655		
none	743	44.9%
any	912	55.1%
multiple partners	391	23.6%
<b>UAI unknown status</b> n=1713		
none	1257	73.4%
any	456	26.6%
multiple partners	245	15.0%
<b>UAI positive partner</b> n=1622		
none	1409	86.9%
any	213	13.1%
multiple partners	103	6.4%

*A 73.4% majority of participants reported practices consistent with sexual safety.*

**Table 3.2**

<b>Change in UAI multiple partners</b>	<b>2000</b>	<b>2002</b>
	n=537	n=1041
> 1	18.8%	23.5%
≤ 1	81.2%	76.5%

OR = 1.3278, 95% CI: 1.025 – 1.722,  $p \leq .05$

*Reported UAI with multiple partners rose from 18.8% to 23.5% representing an increase of 25% over the two years between surveys.*

**Table 3.3**

Sex partners in a year	Frequency	Percent	Cumulative percent
n=1726			
none	121	7.0%	7.0%
1	385	22.3%	29.3%
2-5	509	29.5%	58.8%
6-10	263	15.2%	74.0%
>10	448	26.0%	100.0%

**Table 3.4**

Partners in a year/ risk sex		1	2-5	8-10	>10
n=1509		n=363	n=470	n=249	n=427
UAI unknown status	any	5.8%	13.8%	28.5%	47.5%
	none	94.2%	86.2%	71.5%	52.5%

$p = .000$

*The likelihood of risk sex increased with number of partners.*

**Table 3.5**

Partners in a year/ risk sex		one	>10
n=790		n=363	n=427
UAI unknown status	any	13.8%	47.5%
	none	86.2%	52.5%

OR = 5.673, 95% CI, 3.982 – 8.08,  $p = .000$

*Men with larger numbers of partners had a much higher likelihood of risk sex.*

*The "men with larger number of partners" group was almost split between consistent sexual safety and one or more occasions of risk sex.*

Table 3.6

Age/ sex practices	15-29	30-45	45+	p value
<b>Anal Intercourse (AI)</b>	n=436	n=864	n=388	n=1688
none	18.1%	11.9%	23.5%	.000
any	81.9%	88.1%	76.5%	.000
multiple partners	56.7%	60.1%	52.6%	.043
<b>Unprotected AI (UAI)</b>	n=422	n=840	n=369	n=1631
none	47.6%	41.7%	48.5%	.034
any	52.4%	58.3%	51.5%	.034
multiple partners	19.0%	25.0%	25.7%	.032
<b>UAI unknown status</b>	n=436	n=870	n=382	n=1688
none	74.5%	72.3%	74.9%	.535
any	25.5%	27.7%	25.1%	.535
multiple partners	11.1%	17.1%	14.4%	.019
<b>UAI positive partner</b>	n=419	n=828	n=351	n=1598
none	94.7%	84.5%	83.2%	.000
any	5.3%	15.5%	16.8%	.000
multiple partners	2.9%	7.4%	8.3%	.002

Men under 30 reported less UAI with multiple unknown status partners.

Table 3.7

Age/ risk sex		30-45	other age
	n=1613	n=830	n=783
<b>UAI unknown status</b>	>1	17.1%	12.6%
	≤1	82.9%	87.4%

OR = 1.426, 95% CI: 1.080 – 1.882,  $p = .012$

Disproportionately more men 30–45 reported risk sex with multiple partners.

Table 3.8

<b>Sero-status/ sex practices</b>	positive	negative	unknown	<i>p</i> value
<b>Anal Intercourse (AI)</b>	n=220	n=1292	n=187	n=1699
none	12.7	14.2	31.6	.000
any	87.3	85.8	68.4	.000
multiple partners	68.6	58.3	40.1	.000
<b>Unprotected AI (UAI)</b>	n=218	n=1241	n=183	n=1642
none	33.9	45.0	56.8	.000
any	66.1	55.0	43.2	.000
multiple partners	43.6	21.1	17.5	.000
<b>UAI unknown status</b>	n=220	n=1293	n=187	n=1700
none	54.1	76.3	75.4	..000
any	45.9	23.7	24.6	.000
multiple partners	31.3	13.1	9.4	.000
<b>UAI positive partner</b>	n=212	n=1216	n=180	n=1608
none	51.9	92.1	92.8	.000
any	48.1	7.9	7.2	.000
multiple partners	34.9	1.8	3.3	.000

Table 3.9

<b>Sero-status/ risk sex</b>	positive	not positive
n=1700	n=220	n=1480
<b>UAI unknown status</b>		
any	45.9%	23.9%
none	54.1%	76.1%

OR = 2.710, 95% CI: 2.026 – 3.624, *p* = .000

Positive men reported disproportionately more UAI with unknown status partners than other men.

**Table 3.10**

<b>Relationship/ sex practices</b>	single	partnered	<i>p</i> value
<b>Anal Intercourse (AI)</b>	n=870	n=824	n=1694
none	23.3%	8.1%	.000
any	76.7%	91.9%	.000
multiple partners	62.2%	52.2%	.000
<b>Unprotected AI (UAI)</b>	n=840	n=795	n=1635
none	54.8%	34.1%	.000
any	45.2%	65.9%	.000
multiple partners	25.4%	21.8%	.087
<b>UAI unknown status</b>	n=831	n=785	n=1616
none	70.3%	76.9%	.002
any	29.7%	23.1%	.002
multiple partners	17.9%	11.8%	.001
<b>UAI positive partner</b>	n=823	n=780	n=1603
none	87.6%	86.0%	.349
any	12.4%	14.0%	.349
multiple partners	6.7%	6.0%	.590

*UAI with "multiple partners" was as likely for single men as those with partners. UAI with "unknown status partners" was more common among single men than partnered.*

**Table 3.11**

<b>Relationship/ risk sex</b>	single	partnered
n=1692	n=866	n=826
<b>UAI unknown status</b>		
any	29.7%	23.1%
none	70.3%	76.9%

OR = 1.403, 95% CI: 1.228 – 1.744, *p* = .002

**Table 3.12**

<b>Sex agreement</b>	Frequency	Percent
n=797		
Haven't talked	130	16.3%
No external sex	358	44.9%
No AI	40	5.0%
No UAI	172	21.6%
Any sex OK	97	12.2%

*Almost half had a "no external sex" agreement.*

**Table 3.13**

<b>Age/ Sex agreement</b>	15-29	30-45	45+
n=782	n=173	n=447	n=162
Haven't talked	19.1%	14.1%	17.3%
No external sex	61.3%	45.0%	28.4%
No AI	4.0%	4.0%	8.6%
No UAI	10.4%	23.9%	27.8%
Any sex OK	5.2%	13.0%	17.9%

$p = .000$

*Younger men were more likely to have a "no external sex" agreement.*

**Table 3.14**

<b>Sero-status/ sex agreement</b>	positive	not positive
n=791	n=97	n=694
Haven't talked	17.5%	16.3%
No external sex	36.1%	46.3%
No AI	3.1%	5.0%
No UAI	11.3%	23.1%
Any sex OK	32.0%	9.4%

$p = .000$

*Positive men were more likely to have an "any kind of sex with others" agreement.*

**Table 3.15**

<b>Concordance/ sex practices</b>	poz+poz	neg+neg	discordant	<i>p</i> value
<b>Anal Intercourse (AI)</b>	n=40	n=534	n=214	n=788
none	15.0%	15.5%	14.0%	.871
any	85.0%	84.5%	86.0%	.871
multiple partners	47.5%	55.2%	54.2%	.633
<b>Unprotected AI (UAI)</b>	n=40	n=502	n=212	n=754
none	47.5%	46.8%	50.9%	.600
any	52.5%	53.2%	49.1%	.600
multiple partners	15.0%	19.7%	14.2%	.184
<b>UAI unknown status</b>	n=42	n=544	n=215	n=801
none	83.3%	83.9%	86.0%	.740
any	16.7%	16.1%	14.0%	.740
multiple partners	5.0%	8.9%	7.7%	.647
<b>UAI positive partner</b>	n=41	n=491	n=207	n=739
none	92.7%	89.2%	90.3%	.735
any	7.3%	10.8%	9.7%	.735
multiple partners	—	5.9%	4.3%	.215

*Little difference of practice was reported according to concordance of relationships.  
Appreciable UAI with both unknown status and positive partners outside relationship was reported.*

**Table 3.16**

<b>Income/ risk sex</b>	<\$29,999	>\$30,000
n=1691	n=660	n=1031
<b>UAI unknown status</b>		
any	28.8%	25.5%
none	71.2%	74.5%

OR = 1.180, 95% CI: .984 – 1.470, *p* = .138

*There was little difference in experience with risk sex between high and low income groups.*



**Table 3.17**

Venue Popularity	Active	Inactive
n=1767		
1. Baths	35.1%	64.9%
2. Internet	32.4%	67.6%
3. Park	28.4%	71.6%
4. Phone	17.0%	83.0%
5. Sex Party	14.9%	85.1%

"Inactive" includes "not active in the last year" and "never active"

*The internet competes with the baths in popularity.*

**Table 3.18**

Venue use/ sex practices	1 venue	2 venues	3 venues	p value
<b>Anal Intercourse (AI)</b>	n=443	n=343	n=140	n=926
none	10.6%	8.2%	7.9%	.000
any	89.4%	91.8%	92.1%	.000
multiple partners	69.5%	79.0%	83.6%	.000
<b>Unprotected AI (UAI)</b>	n=428	n=334	n=136	n=898
none	42.3%	41.6%	35.3%	.008
any	57.7%	58.4%	64.7%	.008
multiple partners	27.6%	36.5%	39.0%	.000
<b>UAI unknown status</b>	n=446	n=339	n=140	n=925
none	69.5%	62.2%	52.9%	.000
any	30.5%	37.8%	47.1%	.000
multiple partners	17.2%	26.8%	32.4%	.000
<b>UAI positive partner</b>	n=420	n=320	n=133	n=873
none	86.4%	79.7%	75.9%	.000
any	13.6%	20.3%	24.1%	.000
multiple partners	4.5%	13.1%	17.3%	.000

*Risk sex increased with increasing types of venues in participant repertoire.*

*A thin majority of multiple venue users reported practices consistent sexual safety.*

**Table 3.19**

<b>Venue use/ risk sex</b>		Active	Inactive
n=1610		n=925	n=685
<b>UAI unknown status</b>	any	35.7%	14.6%
	none	64.3%	85.4%

OR = 3.254, 95% CI: 2.542 – 4.171, *p* = .000

*Risk sex was associated with venue use.*

*No data was collected on actual practice within venues.*

*A wide majority of venue users reported practices consistent with sexual safety.*

**Table 3.20**

<b>Free time with gay men/ sex practices</b>	< half	half	> half	<i>p</i> value	
<b>Anal Intercourse (AI)</b>	n=569	n=367	n=749	n=1685	
	none	25.0%	11.4%	11.5%	.000
	any	75.0%	88.6%	88.5%	.000
	multiple partners	47.3%	57.5%	64.9%	.000
<b>Unprotected AI (UAI)</b>	n=538	n=358	n=728	n=1624	
	none	54.5%	41.3%	39.8%	.000
	any	45.5%	58.7%	60.2%	.000
	multiple partners	17.8%	24.6%	27.3%	.000
<b>UAI unknown status</b>	n=568	n=369	n=744	n=1681	
	none	76.9%	74.8%	69.8%	.011
	any	23.1%	25.2%	30.2%	.011
	multiple partners	11.4%	13.6%	18.7%	.001
<b>UAI positive partner</b>	n=538	n=350	n=704	n=1592	
	none	90.1%	86.0%	85.4%	.035
	any	9.9%	14.0%	14.6%	.035
	multiple partners	3.7%	4.6%	8.9%	.000

*Risk sex was associated with greater cultural attachment.*

Table 3.21

Attachment/ risk sex		High	Low
n=1681		n=1113	n=568
<b>UAI unknown status</b>	any	28.6%	23.1%
	none	71.4%	76.9%

OR = 1.334, 95% CI: 1.055 – 1.687,  $p = .016$

## 4. Prevention Needs

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Because *Sex Now* was specifically designed to investigate needs associated with current sexual practice for health planning, we surveyed men on several key prevention issues: HIV testing patterns, cultural factors, sexual health knowledge and need/risk indicators. Prior CBRC studies have shown that at least one reason BC's gay men's prevention needs have remained unmet has been due to considerable erosion of dedicated prevention services and budgets (Marchand, 2001).

The CBRC draws on health promotion as a working model of prevention (Trussler and Marchand, 1997). The fundamental principle underlying health promotion's approach to prevention is to increase the control people have over the factors affecting their health (WHO, 1986). Health promotion takes the social context of health as seriously as the personal, which brings in a range of potential ways of working with prevention problems beyond individuals and specific behaviours.

In general, health promotion encourages multi-layered action between people, the community and the health system, which means there may be many players having roles in prevention and many ways to accomplish sexual safety goals. Given health promotion as a framework, we undertook our survey to provide up-to-date evidence for health planning in the belief that the baseline knowledge would guide the development of a relevant prevention strategy for the appropriate people.

### Testing patterns

HIV testing offers a critical technological contribution to sexual safety and prevention for gay men. *Sex Now* queried the recentness of the last HIV test, the result of the test, what men believed their status to be and what they knew their partner's status to be.

Obviously, testing has been well incorporated into BC gay men's prevention routines. In British Columbia 11% of the sample was untested compared to 46% in London (Reid et al., 2002). Whether increased testing can help reduce new infections in BC may be a matter of priorities in a prevention strategy. *Sex Now* found that younger men were less likely to have tested and that at least 1 in 5

men under 30 were unaware of free HIV testing. These findings indicate that younger men should be considered a priority for information and messages about testing.

### **HIV knowledge**

*Sex Now* found that basic factual knowledge of what HIV is and how it is transmitted was very strong. What is much less clear and a potential avenue of future research is knowledge about current conditions such as “increasing infections”, “increasing prevalence” and the relationship these notions have with “increased risk”. As we shared *Sex Now* findings, during the development of this report, it became quite evident that knowledge about the extent of recent increases of HIV infection was, at best, inconsistent.

### **Syphilis knowledge**

In designing the survey, we included several questions about syphilis as outbreaks were occurring among gay men in the United States and Europe. *Sex Now* found syphilis was generally less well known than HIV, especially among younger men. This finding seems indicative that messages featuring syphilis may be a priority to prepare men in advance for the best possible prevention outcomes.

### **Cultural factors**

The social-environmental focus of the health promotion model suggests that there may be factors beyond individual control that may affect personal health outcomes like sexual safety. From this perspective *Sex Now* probed several key indicators of social vulnerability that may be affecting gay men in a variety of ways.

**Anti-gay violence.** *Sex Now* used anti-gay violence as an indicator of stigma and oppression known to affect both personal and collective prevention efforts. We found that a third of gay men had experienced some form of overt verbal abuse during the year which seems to indicate that stigma is very much present in the lives of gay men. We did not find a strong association between anti-gay experience and risk sex. However, in sharing results of *Sex Now* prior to publication, we began to wonder what role stigma continues to play in more subtle ways such as social policy gaps like the funding and support of adequate prevention programs for gay men.

**Forced sex.** *Sex Now* used forced sex as an indicator of vulnerability to exploitation within MSM culture. While prevalence was generally very low, we noted that 15% of younger men reported such experiences. This finding fits a general pattern of greater vulnerability experienced by men under 30 found in *Sex Now* data.

**Drugs and Crystal.** *Sex Now* probed any drug use as well as crystal methamphetamine which is a recognized problem drug currently affecting gay culture (Heredia, 2003). A third or more gay men reported using “drugs with sex” but we did not probe which drugs. There was some association between risk sex and drug use. A much smaller group of 11% reported using crystal and the link to risk sex was clearer. *Sex Now* found a greater proportion of men under 30 reported crystal use, however, 50% of crystal users in the overall sample were in the 30-44 age group.

### **Risk/need indicators**

*Sex Now* used several “indicator” questions to probe details about prevention needs and risks associated with current practices among gay men. These indicators were designed to probe self-efficacy, the perceived confidence to maintain control of sexual safety. *Sex Now* found that the majority of gay men believe themselves to be quite confident according to the questions we asked. Those whose efficacy was weak by these measures, however, appeared to have more problems with sexual safety and risk.

**Easy to say “no”.** This question probed participant efficacy to turn away from “unwanted sex”, a prime indicator of confidence to control a safe encounter. *Sex Now* found that at least 1 in 5 younger gay men experienced difficulty with unwanted sex. There was also an association with risk sex among those who reported it. From a social perspective, this might also be taken as an indicator of the degree of perceived social pressure linked to unprotected sex with unknown status partners.

**Condoms as “needed”.** This indicator was meant to probe availability and access to condoms. *Sex Now* found that, while the majority reported no difficulty with having condoms available, it was an issue for at least 1 in 5 men in general and 1 in 4 younger men.

**Safe as wanted.** This question probed efficacy in another way by measuring the “degree of desired control” of sexual safety experienced by participants. *Sex Now* found that about 9 out of 10 gay men did feel that the sex they were having was as safe as wanted. Both younger and positive men expressed more doubts about it. Though low in proportion, the number who are worried about the safety of their own practices is indicative of a need for specific counseling and group work.

**Hard to talk about sexual safety.** Another measure of confidence we wanted to measure was participant experience with negotiating sexual safety verbally. *Sex Now* found that at least 1 in 3 men expressed difficulty with talking to partners

about sexual safety. This seems to be an indicator of a large collective need, because sexual safety depends so much on clear communication between partners.

**Expect HIV disclosure.** We also probed the expectation that a positive man would disclose his sero-status prior to an encounter. *Sex Now* found this expectation was held among a 70% majority of men. The result indicates that a great majority of men feel they should be informed, however, it seems a great many men leave the onus on the other man, apparently without considering how easily they relinquish their own responsibility. This indicator appears to affect so many that it seems to beg a mass media approach to correct the situation.

**Can access information.** This indicator probed the ease with which participants were able to access gay health information. *Sex Now* found that a great majority had no difficulty but that there appeared to be gaps especially for men under 30. At least 1 in 5 younger men had difficulty with access to the basic tools of sexual safety; reliable information from credible sources. Those who have yet to test, and who live outside of Vancouver appeared more vulnerable. This indicator suggests a need for more creative ways to empower younger men for confident control of sexual safety.

## **4. Prevention Needs: Sex Now findings**

### **HIV knowledge by Age (table 4.1)**

*Overall, basic HIV knowledge appeared well established.*

*Men under 30 were disproportionately less certain than older men.*

*1 in 5 men under 30 were unaware of free HIV testing.*

### **Syphilis knowledge by Age (table 4.2)**

*Syphilis was generally less well known than HIV.*

*1 in 3 younger men showed little knowledge of syphilis.*

### **Test frequency by Partners in a year (table 4.3)**

*Test frequency increased with number of partners.*

### **Test frequency by Age (table 4.4)**

*Younger men were more likely to have tested within six months than other age groups.*

### **Cultural factors by Age (table 4.5)**

*More men under thirty experienced more anti-gay violence (most of it verbal) than older men.*

*About 1 in 3 gay men of all ages reported anti-gay violence during the year.*

*Forced sex (indicates power disadvantage) was more common among younger men.*

*About 1 in 3 men reported using recreational drugs with sex.*

### **Age by Crystal use (table 4.6)**

*Crystal use was more common among younger men.*

*The majority of crystal users were in the 30-44 age group.*

### **Sero-status by Crystal use (table 4.7)**

*About 1 in 5 crystal users were HIV positive.*

*The majority of crystal users were HIV negative.*

### **Risk sex by Crystal use (table 4.8)**

*Crystal use was associated with risk sex.*

### **Cultural factors by Sero-status (table 4.9)**

*Positive men reported disproportionately more anti-gay violence than others.*

*Experience with forced sex was similar regardless of sero-status.*

*Positive men were more likely than others to use recreational drugs with sex.*

*A majority of positive men reported using recreational drugs with sex.*

*Positive men reported disproportionately more crystal use than other men.*



**Prevention need indicators by Age** (table 4.10)

*Overall, prevention indicators were strong, but for some, needs are poorly met. Youth had disproportionately more prevention needs. About one third of all ages found talking about sexual safety difficult. A wide majority of all ages expected disclosure of positive status.*

**Prevention need indicators by Sero-status** (table 4.11)

*Having condoms available may be more of an issue than recognized. Untested men (who also tend to be younger) had generally greater needs. 1 in 3 men, tested or not, had difficulty talking about sexual safety. Wide disagreement about HIV disclosure: 74% negative men expected it, 47% positive men disagreed. A slim majority of positive men said they expect disclosure. Access to sexual health information was difficult for men in most need of it.*

**Easy to say “no” by Sex safe as wanted** (table 4.12)

*38% of men, uncertain about the safety of the sex they were having, also found it difficult to say “no” to unwanted sex. Current issues of sexual safety appear to be more about confidence and communication than knowledge.*

**Risk sex by Sex safe as wanted** (table 4.13)

*48% of men who were uncertain about the safety of the sex they were having reported experience with risk sex.*

**Easy to say “no” by Age** (table 4.14)

*1 in 5 younger men reported difficulty saying “no” to unwanted sex, an indicator of low confidence in ability to control sexual safety.*

**Easy to say “no” by Can access health info** (table 4.15)

*1 in 5 men with low access to sexual health information also had low confidence in controlling sexual safety. Men who had more access barriers appeared to have more vulnerabilities and greater sexual health needs.*

**Disclosure expectations by Venue use** (table 4.16)

*Venue users were less likely to expect HIV disclosure than non users. Nevertheless, a wide majority of venue users expected disclosure.*

**Risk sex by Condoms as needed** (Table 4.17)

*Having problems with condom availability was associated with risk sex.*

**Condoms as needed by Income** (Table 4.18)

*Having problems with condom availability was associated with lower income.*

**Access to health information by Age** (table 4.19)

*1 in 5 men under 30 reported difficulty accessing gay health information.*

Table 4.1

Age/ HIV knowledge	15-29	30-44	45+	p value
<b>Passed on by sex</b>	n=454	n=911	n=413	n=1778
know it	96.3%	97.9%	99.3%	.010
not sure	3.7%	2.1%	.7%	.010
<b>Have without knowing</b>	n=456	n=913	n=414	n=1783
know it	96.5%	98.0%	99.0%	.031
not sure	3.5%	2.0%	1.0%	.031
<b>Med side-effects</b>	n=449	n=908	n=413	n=1770
know it	84.6%	92.0%	92.3%	.000
not sure	15.4%	8.0%	7.7%	.000
<b>No proven vaccine</b>	n=452	n=905	n=414	n=1771
know it	87.2%	92.4%	94.2%	.000
not sure	12.8%	7.6%	5.8%	.000
<b>Free text available</b>	n=452	n=907	n=413	n=1772
know it	79.4%	83.5%	88.1%	.003
not sure	20.6%	16.5%	11.9%	.003

Abbreviations:

HIV is a virus sometimes passed on during sex.

People can have HIV without knowing it.

HIV treatments can have serious side effects.

There is no proven vaccine against HIV.

You can get a free HIV test in BC.

*Overall, basic HIV knowledge appeared well established.*

*Men under 30 may be less certain about what they know.*

*1 in 5 men under 30 were unaware of free HIV testing.*

**Table 4.2**

<b>Age/ syphilis knowledge</b>	15-29	30-44	45+	<i>p</i> value
<b>Three infection sites</b>	n=448	n=903	n=412	n=1763
know it	65.2%	78.1%	89.8%	.000
not sure	34.8%	21.9%	10.2%	.000
<b>Have without knowing</b>	n=449	n=903	n=413	n=1765
know it	71.7%	77.9%	86.4%	.000
not sure	28.3%	22.1%	13.6%	.000
<b>Blood test available</b>	n=448	n=906	n=413	n=1767
know it	67.4%	77.8%	92.3%	.000
not sure	32.6%	22.2%	7.7%	.000
<b>Untreated serious</b>	n=446	n=908	n=415	n=1769
know it	82.1%	91.1%	97.1%	.000
not sure	17.9%	8.9%	2.9%	.000
<b>Antibiotic treatment</b>	n=447	n=910	n=415	n=1772
know it	63.3%	75.8%	92.0%	.000
not sure	36.7%	24.2%	8.0%	.000

Abbreviations:

You can get syphilis of the throat, ass or cock.

You can have syphilis without knowing it.

A blood test can detect syphilis.

Untreated syphilis can cause serious problems.

Syphilis can be treated with antibiotics.

*Syphilis was significantly less well known than HIV.*

*1 in 3 men under 30 showed little knowledge of syphilis.*

**Table 4.3**

<b>Partners in a year/ test frequency</b>	none	one	2-9	10+
n=1715	n=120	n=384	n=633	n=578
never tested	38.3%	13.8%	10.7%	7.4%
over a year ago	29.2%	35.4%	24.6%	27.3%
within a year	15.8%	18.0%	20.7%	18.7%
within six months	16.7%	32.8%	43.9%	46.5%

*p* = .000

*Test frequency generally increased with number of partners.*

**Table 4.4**

<b>Age/ test frequency</b>	15-29	30-44	45+
n=1802	n=462	n=926	n=414
never tested	24.0%	7.3%	10.4%
over a year ago	10.8%	34.1%	33.3%
within a year	15.8%	19.8%	20.5%
within six months	49.4%	38.8%	35.7%

*p* = .000

*Men under 30 were more likely to have tested within six months than other age groups.*

**Table 4.5**

<b>Age/ cultural factors</b>	15-29	30-44	45+	<i>p</i> value
<b>Anti-gay violence</b>	n=460	n=927	n=418	n=1805
yes	44.6%	33.3%	30.1%	.000
no	55.4%	66.7%	69.9%	.000
<b>Forced sex</b>	n=459	n=929	n=420	n=1808
yes	15.7%	5.0%	2.4%	.000
no	84.3%	95.0%	97.6%	.000
<b>Drugs with sex</b>	n=459	n=929	n=420	n=1808
yes	32.5%	39.4%	36.4%	.041
no	67.5%	60.6%	63.6%	.041
<b>Crystal</b>	n=458	n=929	n=419	n=1806
yes	15.1%	10.5%	6.4%	.000
no	84.9%	89.5%	93.6%	.000

*Men under 30 experienced disproportionately more anti-gay violence (most of it verbal).*

*About 1 in 3 gay men of all ages reported anti-gay violence during the year.*

*Forced sex ( an indicator of power disadvantage) was more common among men under 30.*

*About 1 in 3 men reported using recreational drugs with sex.*

**Table 4.6**

<b>Crystal use/ age</b>	Yes	No
n=1799	n=457	n=1342
15-29	35.6%	24.1%
30-44	50.5%	51.6%
45+	13.9%	24.3%

$p = .000$

*Crystal use was more common among men under 30, however, the majority of crystal users were in the 30-44 age group.*

**Table 4.7**

<b>Crystal use/ sero-status</b>	Yes	No
n=1817	n=194	n=1623
positive	23.2%	11.6%
not positive	76.8%	88.4%

OR = 2.291, 95% CI: 1.589 – 3.305,  $p = .000$

*About 1 in 5 crystal users were HIV positive.*

*The majority of crystal users were not positive.*

**Table 4.8**

<b>Crystal use/ risk sex</b>		Yes	No
n=1701		n=185	n=1516
<b>UAI unknown status</b>	any	37.8%	25.1%
	none	62.2%	74.9%

OR = 1.820, 95% CI: 1.323 – 2.503, *p* = .000

*Crystal use was associated with risk sex.*

**Table 4.9**

<b>Sero-status/ cultural factors</b>	positive	not positive	<i>p</i> value
<b>Anti-gay violence</b>	n=231	n=1585	n=1816
yes	41.6%	34.4%	.033
no	58.4%	65.6%	.033
<b>Forced sex</b>	n=234	n=1584	n=1818
yes	6.4%	7.1%	.711
no	93.6%	92.9%	.711
<b>Drugs with sex</b>	n=234	n=1584	n=1818
yes	58.5%	33.8%	.000
no	41.5%	66.2%	.000
<b>Crystal</b>	n=234	n=1583	n=1817
yes	19.2%	9.4%	.000
no	80.8%	90.6%	.000

*Positive men reported disproportionately more anti-gay violence than others.*

*Experience with forced sex was similar regardless of sero-status.*

*Positive men were more likely to use recreational drugs with sex.*

*A majority of positive men reported using recreational drugs with sex.*

*Positive men reported disproportionately more crystal use than others.*

Table 4.10

Age/ prevention needs	15-29	30-44	45+	p value
<b>Easy to say “no”</b>	n=457	n=924	n=418	n=1799
yes	80.7%	87.9%	92.1%	.000
no	19.3%	12.1%	7.9%	.000
<b>Condoms as needed</b>	n=455	n=921	n=417	n=1793
yes	74.7%	80.9%	84.2%	.000
no	25.3%	19.1%	15.8%	.000
<b>Safe as wanted</b>	n=457	n=924	n=419	n=1800
yes	86.9%	92.2%	93.1%	.001
no	13.1%	7.8%	6.9%	.001
<b>Hard to talk “safety”</b>	n=459	n=920	n=410	n=1789
yes	34.4%	34.2%	33.2%	.912
no	65.6%	65.8%	66.8%	.912
<b>Expect disclosure</b>	n=457	n=925	n=415	n=1797
yes	76.1%	70.1%	70.1%	.045
no	23.9%	29.9%	29.9%	.045
<b>Can access info</b>	n=459	n=925	n=416	n=1800
yes	76.9%	85.0%	88.7%	.000
no	23.1%	15.0%	11.3%	.000

Abbreviations:

I find it easy to say ‘no’ to sex I don’t want.

I always have a condom available when I need it.

The sex I have is always as safe as I want it.

I find it hard to talk to my partners about sexual safety.

I’d expect a man with HIV to tell me he is positive before we had sex.

I find it easy to get info about gay sexual health.

*Overall, basic prevention indicators were strong, but for some, poorly met.*

*Men under 30 had disproportionately more prevention needs.*

*About one third of all ages find talking about sexual safety difficult.*

*A wide majority of all ages expected positive men to disclose their status.*



Table 4.11

Sero-status/ prevention needs	positive	negative	unknown	p value
<b>Easy to say “no”</b>	n=231	n=1372	n=206	n=1809
yes	84.8%	88.1%	82.5%	.047
no	15.2%	11.9%	17.5%	.047
<b>Condoms as needed</b>	n=231	n=1369	n=204	n=1804
yes	75.3%	81.9%	73.0%	.002
no	24.7%	18.1%	27.0%	.002
<b>Safe as wanted</b>	n=232	n=1372	n=205	n=1809
yes	87.1%	92.6%	84.4%	.000
no	12.9%	7.4%	15.6%	.000
<b>Hard to talk “safety”</b>	n=233	n=1365	n=202	n=1800
yes	35.6%	33.8%	34.2%	.870
no	64.4%	66.2%	65.8%	.870
<b>Expect disclosure</b>	n=232	n=1370	n=204	n=1806
yes	53.0%	73.5%	79.9%	.000
no	47.0%	26.5%	20.1%	.000
<b>Can access info</b>	n=230	n=1374	n=204	n=1808
yes	83.9%	85.2%	71.6%	.000
no	16.1%	14.8%	28.4%	.000

Abbreviations:

I find it easy to say ‘no’ to sex I don’t want.

I always have a condom available when I need it.

The sex I have is always as safe as I want it.

I find it hard to talk to my partners about sexual safety.

I’d expect a man with HIV to tell me he is positive before we had sex.

I find it easy to get info about gay sexual health.

*Having condoms available may be more of an issue than recognized.*

*Untested men (who also tend to be younger) had generally greater needs.*

*A third or more men, tested or not, had difficulty talking about sexual safety.*

*There was wide disagreement about disclosure.*

*The majority of positive men say they expect disclosure.*

*Access to sexual health information was difficult for men in most need of it.*

**Table 4.12**

<b>Safe as wanted/ easy to say no</b>		Yes	No
n=1820		n=1655	n=165
<b>Easy to say no</b>	yes	89.5%	61.8%
	no	10.5%	38.2%

OR = 5.291, 95% CI: 3.724 – 7.158,  $p = .000$

*Current issues of sexual safety may be more about confidence and communication than practical knowledge.*

**Table 4.13**

<b>Safe as wanted/ risk sex</b>		Yes	No
n=1695		n=1544	n=151
<b>UAI unknown status</b>	any	24.5%	48.3%
	none	75.5%	51.7%

OR = .346, 95% CI: .247 – .486,  $p = .000$

*Less confidence with sexual safety was associated with involvement in risk sex.*

**Table 4.14**

<b>Age/ easy to say no</b>		15-29	older
n=1799		n=457	n=1342
<b>Easy to say no</b>	yes	80.7%	89.2%
	no	19.3%	10.8%

OR = .508, 95% CI: .380 – .678,  $p = .000$

*1 in 5 men under 30 reported difficulty saying "no", an indicator of low confidence in controlling sexual safety.*

**Table 4.15**

<b>Can access info/ easy to say no</b>		Yes	No
n=1818		n=1518	n=300
<b>Easy to say no</b>	yes	88.9%	76.7%
	no	11.1%	23.3%

OR = 2.446, 95% CI: 1.790 – 3.341,  $p = .000$

*1 in 5 men with barriers to sexual health information also had lower confidence with controlling sexual safety.*

*Men who had more access barriers, had more vulnerabilities and greater sexual health needs.*

**Table 4.16**

<b>Venue use/ expect disclosure</b>		Yes	No
n=1714		n=984	n=730
<b>Expect HIV disclosure</b>	yes	68.5%	77.7%
	no	31.5%	22.3%

OR = .625, 95% CI: .502 – .779,  $p = .000$

*Venue users were less likely to expect HIV disclosure than non users.*

*Nevertheless, a wide majority of venue users expected disclosure.*

**Table 4.17**

<b>Condoms as needed/ risk sex</b>		Yes	No
n=1692		n=1358	n=334
<b>UAI unknown status</b>	any	23.0%	41.6%
	none	77.0%	58.4%

OR = .418, 95% CI: .325 – .538,  $p = .000$

*Having problems with condom availability was associated with risk sex.*

**Table 4.18**

<b>Income/ Condoms as needed</b>	Low	High	
n=1800	n=695	n=1105	
<b>Condoms as needed</b>	yes	76.5%	82.0%
	no	23.5%	18.0%

OR = .717, 95% CI: .568 – .905,  $p = .005$

*Having problems with condom availability was associated with lower income.*

**Table 4.19**

<b>Age/ access to info</b>	15-29	older	
n=1800	n=459	n=1341	
<b>Can access info</b>	yes	76.9%	86.1%
	no	23.1%	13.9%

OR = .536, 95% CI: .411 - .700,  $p = .000$

*1 in 5 men under 30 had problems accessing sexual health information.*

*A majority felt they have adequate access to information.*

## 5. Access and Participation

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We devoted a block of questions in *Sex Now* to probe levels of participation in various community activities and venues for eventual guidance in health promotion planning. The survey found differences in community participation with respect to age and reported sero-status.

As might have been expected, younger men were less involved in community life and thus may be less accessible to future prevention activities unless specific work is done to reach them. The data suggest a need for dedicated activities, supportive conditions and creative approaches to attract the attention and enthusiastic participation of younger men.

*Sex Now* also described participation in community AIDS organizations. A quarter of the sample indicated they had visited an AIDS organization in the year but organizers, who work in the region's AIDS organizations, felt participants overestimated actual involvement. In any case, the level of involvement suggests a strong need to break out of habitual patterns with health promotion and STD prevention activities to reach the majority of gay men where they are, on their own cultural ground.

We undertook some features of the *Sex Now* project, including the name of the survey, its logo branding, participation marketing campaign and promotional "give-away" items as popular culture experiments in community response. It was overwhelming. We were actually unable to meet the demand for participation in both Victoria and Vancouver. Overall, the experience left us with the impression that, approached in the right way, HIV prevention can still gain the attention of the audience it needs to reach.

*Sex Now* also demonstrated that gay dedicated media are supported by very large majorities which suggests strong potential for message interventions. There is, however, a major dilemma. Few publications can afford to offer much assistance pro bono. Likewise, prevention budgets have been so slim that programs have been unable to pay for basic printing let alone ad space in gay media. Experience suggests

there is a strong need to improve the financial support and budgeting of future prevention activities.

As might have been expected, positive men were far more likely to participate in AIDS organizations. They were also more likely to regularly attend primary care. These indications suggest a good probability of being able to reach positive men within the organizations and activities they rely on.

## **5. Access & Participation: Sex Now Findings**

### **Access by Age (table 5.1)**

*Wide majorities reported visiting their physician at least once in the year.*

*Men under 30 may be more accessible in health clinics.*

*Men under 30 may be more interested in support groups.*

*About 25% say they participated in AIDS organizations.*

*Help-lines reached about 6%.*

*Gay oriented media enjoy wide popularity.*

*Local gay press (Xtra West) enjoys wide readership, though less so with men under 30.*

### **Access by Sero-status (table 5.2)**

*Positive men are most reachable in their physician's office.*

*Untested men are less available to most usual health venues.*

*Gay oriented media are widely accessed by all.*

### **Cultural participation by Age (table 5.3)**

*Sex Now found the greatest participation to be in bars and social events.*

*There may be both differences and similarities to prevention strategies based on age.*

### **Cultural participation by Sero-status (table 5.4)**

*Untested men may be more difficult to reach in the community settings.*

Table 5.1

Age/ access	15-29	30-44	45+	p value
<b>Doctor</b>	n=442	n=905	n=404	n=1751
active	71.9%	86.1%	85.9%	.000
inactive	28.1%	13.9%	14.1%	.000
<b>Health clinic</b>	n=443	n=892	n=390	n=1725
active	64.3%	48.5%	33.1%	.000
inactive	35.7%	51.5%	66.9%	.000
<b>Support group</b>	n=445	n=889	n=393	n=1727
active	29.7%	17.3%	23.9%	.000
inactive	70.3%	82.7%	76.1%	.000
<b>AIDS organization</b>	n=447	n=895	n=390	n=1732
active	25.5%	24.0%	24.6%	.837
inactive	74.5%	76.0%	75.4%	.837
<b>Help-line</b>	n=448	n=896	n=393	n=1737
active	5.6%	4.8%	3.3%	.285
inactive	94.4%	95.2%	96.7%	.285
<b>Gay magazines</b>	n=449	n=897	n=400	n=1746
active	85.7%	90.0%	89.0%	.069
inactive	14.3%	10.0%	11.0%	.069
<b>Xtra West</b>	n=446	n=901	n=397	n=1744
active	73.3%	84.0%	83.4%	.000
inactive	26.7%	16.0%	16.6%	.000

*Wide majorities reported using primary care at least once in the year.*

*Men under 30 may be more accessible in health clinics.*

*Men under 30 may be more interested in support groups.*

*About 25% say they participated in AIDS organizations.*

*Help-lines reached about 6%.*

*Gay oriented media enjoy wide popularity.*

*Local gay press (Xtra West) enjoys wide readership, though less so with men under 30.*

Table 5.2

Sero-status/ access	positive	negative	unknown	p value
<b>Doctor</b>	n=222	n=1335	n=199	n=1756
active	93.2%	84.5%	56.3%	.000
inactive	6.8%	15.5%	43.7%	.000
<b>Health clinic</b>	n=212	n=1325	n=195	n=1732
active	51.4%	51.6%	31.8%	.000
inactive	48.6%	48.4%	68.2%	.000
<b>Support group</b>	n=215	n=1324	n=196	n=1735
active	34.0%	20.4%	20.4%	.000
inactive	66.0%	79.6%	79.6%	.000
<b>AIDS organization</b>	n=217	n=1326	n=196	n=1739
active	59.0%	21.4%	8.2%	.000
inactive	41.0%	78.6%	91.8%	.000
<b>Help-line</b>	n=219	n=1327	n=198	n=1744
active	9.1%	4.5%	2.0%	.002
inactive	90.9%	95.5%	98.0%	.002
<b>Gay magazines</b>	n=225	n=1330	n=197	n=1752
active	90.7%	89.5%	80.2%	.000
inactive	9.3%	10.5%	19.8%	.000
<b>Xtra West</b>	n=222	n=1330	n=199	n=1751
active	86.5%	81.8%	72.9%	.001
inactive	13.5%	18.2%	27.1%	.001

*Positive men are most reachable in primary care.  
 Untested men are less available to most usual health venues.  
 Gay oriented media are widely accessed by all.*



Table 5.3

Age/ participation	15-29	30-44	45+	p value
<b>Bar</b>	n=445	n=895	n=398	n=1738
active	85.6%	91.3%	84.7%	.000
inactive	14.4%	8.7%	15.3%	.000
<b>Social event</b>	n=443	n=880	n=396	n=1719
active	79.7%	84.7%	82.3%	.073
inactive	20.3%	15.3%	17.7%	.073
<b>Sports &amp; recreation</b>	n=447	n=886	n=390	n=1723
active	23.7%	31.0%	29.2%	.020
inactive	76.3%	69.0%	70.8%	.020
<b>AIDS volunteer</b>	n=444	n=893	n=395	n=1732
active	18.5%	20.8%	25.1%	.061
inactive	81.5%	79.2%	74.9%	.061
<b>Attachment</b>	n=449	n=914	n=419	n=1782
high	60.4%	69.6%	61.3%	.001
low	39.6%	30.4%	38.7%	.001

*Prevention messages need to insert themselves where they are likely to reach a wide audience and the right audience.*

*Sex Now found the greatest participation to be in bars and social events.*

*There may be both differences and similarities to approaches based on age.*

Table 5.4

<b>Sero-status/ participation</b>	positive	negative	unknown	<i>p</i> value
<b>Bar</b>	n=221	n=1328	n=197	n=1746
active	91.4%	89.2%	77.7%	.000
inactive	8.6%	10.8%	22.3%	.000
<b>Social event</b>	n=220	n=1311	n=198	n=1729
active	86.8%	83.8%	71.7%	.000
inactive	13.2%	16.2%	28.3%	.000
<b>Sports &amp; recreation</b>	n=217	n=1315	n=199	n=1731
active	38.7%	29.6%	14.6%	.000
inactive	61.3%	70.4%	85.4%	.000
<b>AIDS volunteer</b>	n=221	n=1321	n=198	n=1740
active	42.5%	19.6%	8.1%	.000
inactive	57.5%	80.4%	91.9%	.000
<b>Attachment</b>	n=227	n=1358	n=204	n=1789
high	72.7%	66.1%	52.5%	.000
low	27.3%	33.9%	47.5%	.000

*Untested men may be more difficult to reach in the community settings.*

## 6. Guidelines for Health Planning

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### **Summing up *Sex Now* What it all means...**

We undertook *Sex Now* to build a description of gay culture and the state of sexual safety at a time when increases in HIV infection pointed to an urgent need. Since the survey, positive HIV tests rose again in 2002. The continuing upward trend suggests that the factors underlying increasing infection remain in force. *Sex Now* has provided some useful points of departure with which to approach the situation systematically with survey evidence.

### **Demographic snapshot**

*Sex Now* has provided a demographic profile of gay culture in BC on a scale that has little precedence. The data provide useful knowledge about education, income, ethnicity, relationships, HIV sero-prevalence, and testing patterns covering a range of age groups from teens to seventies. To date, little has been previously available that would provide much support for planning on such simple issues as the extent of HIV testing in the population. *Sex Now* has shown that a small proportion of gay men have not tested and that they are among the youngest.

### **Increase in UAI**

Certainly, one of the critical findings related to increasing infection was the statistically significant 25% increase in UAI we discovered by comparing data from *Sex Now* with a previous CBRC survey, *Gay Health Vancouver*.

### **Extent of risk sex**

*Sex Now* introduced a range of sexual practice questions that were beyond the scope of our earlier survey. In probing “UAI unknown status” *Sex Now* showed that 27% of gay men appeared to have had at least one risk sex partner in the year and that 15% had multiple partners.

### **Status of sexual safety**

Looking at the majority, however, *Sex Now* has also shown that 73% of gay men appear to have maintained practices consistent with sexual safety, taking into account a broad interpretation. The cultural agreements underlying sexual safety are still robust and have not disappeared. *Sex Now* has shown, for example, that many gay men make agreements about sex without condoms methodically and not out of complacency. Though opportunities for infection may arise when agreements fail, the culture of the day continues to practice sexual safety.

### **Unmet prevention needs**

*Sex Now* has helped to point out where unmet prevention needs continue to weaken sexual safety. Some of them are widespread throughout the population and some of them experienced by small groups of men. The weak self-efficacy some men may be experiencing, for example, can be addressed in prevention programs and messages such as those in the UK featuring “sexual assertiveness”.

### **Perception and reality**

*Sex Now* has also pointed out how taken-for-granted assumptions may be playing a role in undermining sexual safety. The 70% who expect positive status disclosure provides a window into the perceptual complexities of maintaining sexual safety in the current environment.

Several other misperceptions may well be active that we did not explore in *Sex Now* but which surfaced in our presentation of results. For instance, there is a tendency to presume men under 30 are more involved in risk than those in their 30's. One of the more common and possibly the most damaging misperceptions has been the tendency to minimize the extent of continuing infections among gay men as if a certain “level” is tolerable. Many men seemed to believe that “barebacking” was more common but knew little about the true extent of risk sex with unknown status partners.

Now that these commonly held perceptions have been disclosed they can be explored with future research to determine what role they may be playing in sexual safety.

## **D i r e c t i o n   s e t t i n g**

If the results of *Sex Now* suggest one general direction for change it is this: strengthen the availability of up-to-date information about factors affecting gay men's sexual health. While we did not deal with awareness of current information directly in *Sex Now*, we certainly uncovered critical gaps when we discussed our findings with various groups prior to publication. Information

that HIV infections were on the increase locally was at best inconsistently held even among health care providers. There was little awareness of increases in other cities such as Amsterdam, Berlin or San Francisco where many gay men travel. Few were aware that there had been recent syphilis outbreaks among gay men in many of the same cities.

These are only some of the indications we had that current information affecting gay men's health was not widely known or understood. We assume that this is because gay men's prevention programs have been impoverished and unable to keep up to the costs. Gay men need such information and there are good reasons for public funding to support activities that provide it. In short, prevention information saves lives and money (Holtgrave, 2003).

In sharing our results, we were reminded by our colleagues at Sigma that "HIV prevention messages do not reduce infections. Men do". If given the information resources, we believe gay men will take the appropriate steps to strengthen sexual safety on their own.

### **Defining target audiences**

*Sex Now* has helped to describe segments of the MSM population having particular prevention needs. In general, *Sex Now* found little variation according to education, ethnicity or identity, however, such issues need to be taken into account to deal with appropriate language and culture, especially among new immigrant groups.

A consistent pattern *Sex Now* uncovered was an association between larger numbers of partners and risk sex, an association shown to be predictive of HIV infection in many studies elsewhere (Stall et al., 2000). *Sex Now* showed the strongest association with risk sex was among "men with larger numbers of partners" (OR = 5.673, 95% CI: 3.982-8.08,  $p = .000$ ) comparing "men with one partner" with "men with greater than 10 partners" in a year. In terms of reaching those "most at risk", this evidence suggests men with larger numbers of partners are top priority. Other priority groups showing strong associations with risk sex include "HIV positive men" (OR = 2.710, 95% CI: 2.026 - 3.624,  $p = .002$ ) and "single men" (OR = 1.403, 95% CI: 1.128 - 1.744,  $p = .002$ ).

*Sex Now* has also shown that younger men have so many unmet prevention needs that they should be considered a priority because the future of the epidemic is with them. Men in relationships are also a concern and should be seen as a target group.

Given this understanding, *Sex Now* results suggest the following potential groupings for future health promotion and prevention planning.

**Cruisers.** While *Sex Now* has shown that men with higher numbers of partners are more likely to engage in risk sex, they also test more frequently. This is at least one indication of interest in sexual safety. However, the composition of this

group may not be so clear. Men may move in and out of phases of increased sexual activity depending on circumstances in their lives. Other associations within *Sex Now* are suggestive: age 30-45, single, sex venue users. This group needs an environmental approach which would take messages to the places they meet.

**Positive men.** *Sex Now* has shown that about 46% of HIV positive men may be engaging in unprotected sex with unknown status partners, though presumably with the intention to reduce the risk of infection as much as possible through sero-sorting (see Prevention Needs). Positive men were also more likely to participate in community organizations such as BCPWA, so it is within that membership group where the greatest potential to address the situation exists. Some positive men reported feeling that the sex they were having was not always as “safe as they wanted it to be” which suggests a particular need to explore. Another potential venue, suggested by *Sex Now*, would be the physician’s office where regular visits are pre-scheduled by treatment regimens.

**Singles.** This group may not be static as men may move in and out of single status depending on changes in work, residence and relationships. Nevertheless, active sexuality is a condition of single gay culture and, as such, men in this situation have prevention needs, especially during life-transitions.

Men who experience the loss of a relationship, a move between cities or transfer with work are likely to have greater vulnerabilities (Trussler, Perchall & Barker, 2001). Even so, all men have basic prevention needs such as up-to-date information about increased infection rates in the local environment. *Sex Now* data suggests these men may be reached in many gay oriented venues and there is good potential for mass media communication on universal issues such as disclosure expectations.

**Young men “coming out.”** *Sex Now* demonstrates that men under 30 have more unmet prevention needs and thus more HIV vulnerabilities than older men. Earlier CBRC studies have shown that young men “coming out” (making their debut in gay culture) have little realistic or even appropriate education in sexual safety from high-school. *Sex Now* shows that the youngest of them may well be learning the ropes of gay sexuality without adequate information about STDs, risks or even available testing. Given the high probability that school-based programs will continue to fail young gay men, group work in which they would learn from community mentors and supportive health professionals is likely the best we can do.

**Couples.** *Sex Now* has also shown good reasons to consider partnered men in health promotion planning. Studies from Amsterdam and Toronto have shown that HIV infections often stem from a primary partner (Calzavara, 2001). Some

of those infections occurred because basic information was never discussed between partners prior to dropping condoms from their routine. Both *Sex Now* and *Gay Health Vancouver* have shown that about half of gay men are involved in relationships and many more want one. Such large numbers suggests mass media messages but, due to the intimacy involved, group work might be especially helpful.

### **Activating multiple domains**

Proceeding from *Sex Now* into new health promotion and prevention ventures should be undertaken comprehensively, with well planned messages, programs and activities that take into account what has been learned from the survey. In view of the general state of erosion of HIV and STD prevention, more must be accomplished by more people than have commonly taken responsibility for these activities. *Sex Now* data will be helpful for all who have a role to play in the outcome. We suggest the following domains of action:

**Universal.** *Sex Now* has shown that there are universal needs experienced by a majority of men such as the difficulty many have with talking to their partners about sexual safety. These are mass audience needs that may be best suited to social marketing and message campaigns using community events and media.

**Groups.** Some *Sex Now* findings describe needs of specific groups such as youth, HIV positive men or men having difficulty dealing with unwanted, unprotected sex. These issues are suggestive of workshop and group counseling activities as main vehicles for messages and health promotion.

**Individuals.** *Sex Now* also demonstrates that there may be men who have difficulty controlling situations where sex is not as safe as they wish it to be. These men may require one on one counseling to deal with such issues. Primary care practitioners could play an important role in prevention with all men they see by including sexual safety among the topics raised in regular office visits.

### **Messages from *Sex Now***

One of the main goals behind *Sex Now* was to identify unmet prevention needs that could be addressed through interventions such as messages. These in turn could help reduce risk sex and subsequently new infections. Throughout the planning and development of the survey we have understood that prevention messages could be delivered in multiple ways in multiple domains. In this way a message theme could be delivered by coordinating many different practitioners beyond the community prevention sector such as physicians, nurses, social workers, psychologists and counselors. All have roles to play in message delivery beyond the more common media methods.

*Sex Now* has raised suggestions about what messages are currently needed.

## Knowledge Messages

- ∞ Infections are on the increase.
- ∞ Increased infections means increased risk of infection.
- ∞ Risks are increasing not decreasing.

Working with *Sex Now* raised many discussions that brought to light far more than the survey itself could. One of the facts that became increasingly obvious was how few gay men knew anything about current sexual “risk conditions” in BC, the increase of HIV infections or the concern this was raising among people monitoring the situation. Coincidentally, during those discussions, several avalanches took several lives in BC’s ski mountaineering region. One of the main needs identified in those incidents was a better description of “risk conditions”. The seemingly obvious is often the most overlooked item in many prevention situations and recreational sex is probably one of them.

## Normative Messages

- ∞ Risk sex may seem more common but 73% play safe.
- ∞ 70% expect disclosure which may not be safe.
- ∞ 6 out of 10 expect disclosure at the baths (but never talk there).

*Sex Now* has helped to show the extent of existing threats to sexual safety. As the data have shown, risk sex may well be on the increase but it has not yet taken over as the norm. Increases in risk sex could be the effect of a misperception that barebacking is the norm. One approach to messages arising from *Sex Now* findings would be to re-establish or correct perceptions about sexual safety norms.

## Lifestyle Messages

- ∞ Testing is free, testing stops STD’s.
- ∞ Couples are at risk without an agreement they can live by.
- ∞ Talk over HIV status supportively.

*Sex Now* has also made several prevention needs more explicit such as basic information about where to get testing or how to discuss sexual safety. Specific identifiable groups need these messages which makes it all the more possible to deliver them appropriately.



Going Public with *Sex Now*. The situation that inspired the *Sex Now* survey has not disappeared. It has apparently worsened with a 52% increase in annual positive tests since 1999. We propose the following action:

## **R e c o m m e n d a t i o n s**

### **1. Disseminate *Sex Now by the Numbers* report**

We have designed the report for continued analysis and discussion. This opportunity should be used to strengthen professional networks, correct misperceptions and establish goals for a well co-ordinated response to the situation.

### **2. “Do the math” campaign**

We have also designed a feedback link with gay men to share *Sex Now* data through an information campaign. This activity should be seen as the beginning of a range of message work inspired by *Sex Now*. It should also be seen as a way to build a relationship with participants in preparation for a future survey in the summer of 2004.

### **3. Perceptions campaign**

*Sex Now* has shown how important commonly held perceptions may be in sustaining sexual safety. Several misperceptions should be addressed but the most urgent message is that “risks are increasing”, not decreasing as many gay men have presumed. We recommend undertaking a carefully planned social marketing campaign using data from *Sex Now* to establish the grounds. The primary objective of the campaign would be to address gay men directly to re-establish perceptions that HIV-STD risks are real and rising.

### **4. Develop workshops**

*Sex Now* has also provided important information to guide existing programs. Group work may be needed for men having difficulty with unwanted sex or sex as safe as they want it to be. Within the overall themes of related messages it would be possible to advertise group workshops but popular education needs special attention in development. We recommend two workshops should be designed, supported and evaluated: 1) health in gay relationships 2) sexual assertiveness.

### **5. Coming out ground-school**

*Sex Now* has shown that younger men have more unmet prevention needs and therefore greater vulnerabilities. Specific attention is needed to compensate for the lack of appropriate institutional education in BC. A special program should

be designed that would attract young men into a popular education activity dealing with sexual safety and health issues. A proven model for such a program already exists in Sydney, Australia. Activities are organized in two hour segments over several weeks. The BC format should include follow-up evaluation that would adequately describe and measure the merit of this intervention in local conditions.

#### **6. Develop the next *Sex Now* survey**

Finally, we recommend periodic monitoring to strengthen the connection with gay culture and information about the state of sexual safety. With new questions coming forward, *Sex Now* should be repeated at least every second year. Our experience has shown that the survey in itself is an important way to reinforce sexual safety. To that end we recommend an evaluation of the evidence-based planning process that would take into account the collaborative process as well as the outcomes of *Sex Now*.

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# Glossary and Abbreviations

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## Organizations

BCCDC: British Columbia Centre for Disease Control

CBRC: Community Based Research Centre

CIDPC: Center for Infectious Diseases Prevention and Control, Health Canada

## Sexual Practice

MSM: men who have sex with men

AI: anal intercourse

UAI: unprotected anal intercourse

UAI unknown status: unprotected anal intercourse with a partner of unknown sero-status

sdUAI: serodiscordant unprotected anal intercourse

Risk sex: unprotected anal intercourse (UAI) where there is a chance of HIV transmission due to the uncertain sero-status of the partner or the potential for sdUAI.

## Statistics

CI: confidence interval. The statistical limits within which a sample finding may represent the population with 95% confidence.

n: sample size. The sample size may vary according to the number of participants who answered each question of the survey.

OR: odds ratio. This statistic measures the strength of association between two binary (yes/no) variables and the relative strength among such associations.

p: probability value. The measure that a given result was due or not due to random variation or chance.

Significance. A statistically robust difference between sample groups that was not due to random variation or chance. Set at 95% confidence, the critical p value for significance is less than or equal to .05.

# Original Questionnaire



This survey is about sex between men.  
It is completely VOLUNTARY and ANONYMOUS.  
We are investigating sexual safety for future community health planning.  
The questions are frank and explicit. Please give us the truth as you live it.  
The survey visits Victoria, Vancouver and Prince George during the  
summer of 2002. Please fill in this form just once.



- 1. How old are you?** \_\_\_\_\_ years
- 2. What city do you live in (or closest to)?**  
 Victoria  Vancouver  Prince George  
 Outside BC  
 Other BC: please specify  
\_\_\_\_\_
- 3. What education have you completed?**  
 Some high school  College/ Technical  
 High school  University
- 4. What term do you use for yourself?**  
 Gay  Homosexual  
 Bi  Two-Spirited  
 Queer  I don't use a word  
 Another term - specify:  
\_\_\_\_\_
- 5. What best describes your background?**  
 Aboriginal  European  
 African  Latin American  
 Asian  Middle Eastern  
 Chinese  South Asian  
 Other: please specify  
\_\_\_\_\_
- 6. What was your income in the last year?**  
 Under \$10,000  
 \$10,000 to \$29,999  
 \$30,000 to \$49,999  
 \$50,000 and above
- 7. Who have you had sex with in the last year?**  
 No one  
 Women only  
 Men only  
 Both men and women
- 8. Are you in a relationship at the moment?**  
 Yes, with a man.  
 Yes, with a woman.  
 No; if "no" go to 12
- 9. How long have you been together?** \_\_\_\_\_ years
- 10. Do you know your partner's HIV status?**  
 Yes, HIV-positive  
 Yes, HIV-negative  
 Don't know
- 11. Do you have an agreement with your partner about sex with other men?**  
 No, we haven't talked about it  
 Yes, no sex at all with other guys  
 Yes, no fucking (anal sex) with other guys  
 Yes, no fucking other guys without condoms  
 Yes, any kind of sex with other guys is okay  
 Other, please specify:  
\_\_\_\_\_
- 12. How often are you on recreational drugs when you have sex?**  
 Never  Sometimes  Usually
- 13. How often have you used crystal meth in the last year?**  
 Never  1 time  2-5 times  6-9 times  
 10+
- 14. How recent was your last HIV test?**  
 Never tested  within six months  a year  
 over a year
- 15. What was your last HIV test result?**  
 HIV-Positive  
 HIV-Negative  
 I've never had an HIV test result
- 16. What do you believe your HIV status is currently?**  
 Definitely HIV-positive  
 Probably HIV-positive  
 Couldn't say/don't know  
 Probably HIV-negative  
 Definitely HIV-negative
- 17. How many guys have you had sex (any kind) with in the last year?**  
Number of men \_\_\_\_\_
- 18. FUCKING (TOP) in the last year...**  
How many men *have you fucked*?  
 None  1  2-5  6-19  20+  
How many men have you fucked *without a condom*?  
 None  1  2-5  6-19  20+  
How many men have you fucked without a condom *whose HIV status you did not know*?  
 None  1  2-5  6-19  20+  
How many men have you fucked *without a condom who you know were HIV positive*?  
 None  1  2-5  6-19  20+

CONTINUE OVER



**19. GETTING FUCKED (BOTTOM) in the last year...**

How many men *have fucked you?*

- None  1  2-5  6-19  20+

How many men have fucked you *without a condom?*

- None  1  2-5  6-19  20+

How many men have fucked you without a condom *whose HIV status you did not know?*

- None  1  2-5  6-19  20+

How many men have fucked you *without a condom who you know were HIV positive?*

- None  1  2-5  6-19  20+

**20. The following statements are TRUE.**

**Were you previously aware of them?**

Yes No Not sure

- HIV is a virus sometimes passed on in sex.  
   People can have HIV without knowing it.  
   There is no proven vaccine against HIV.  
   HIV treatments have serious side effects.  
   You can get a free HIV test in BC.  
   Syphilis can infect the throat, ass or cock.  
   You can have syphilis without knowing it.  
   A blood test can detect syphilis.  
   Untreated syphilis causes serious problems.  
   Syphilis can be treated with antibiotics.

**21. Have you experienced anti-gay violence in the last year?**

- yes, verbal threats, insults  
 yes, physical assault  
 no

**22. Have you been forced to have sex when you didn't want it in the last year?**

- Yes, physically  
 Yes, emotionally  
 No

**23. "I find it easy to say 'no' to sex I don't want."**

- Strongly agree  
 Agree  
 Not sure  
 Disagree  
 Strongly disagree

**24. "I always have a condom available when I need it."**

- Strongly agree  
 Agree  
 Not sure  
 Disagree  
 Strongly disagree

**25. "The sex I have is always as safe as I want it."**

- Strongly agree  
 Agree  
 Not sure  
 Disagree  
 Strongly disagree

**26. "I find it hard to talk to my partners about sexual safety."**

- Strongly agree  
 Agree  
 Not sure  
 Disagree  
 Strongly disagree

**27. "I find it easy to get info about gay sexual health."**

- Strongly agree  
 Agree  
 Not sure  
 Disagree  
 Strongly disagree

**28. "I'd expect a man with HIV to tell me he is positive before we had sex."**

- Strongly agree  
 Agree  
 Not sure  
 Disagree  
 Strongly disagree

**29. When have you done the following? In the last...**

Mo Yr Yr+ Never

- Went to a park for casual sex  
    Went to a gay bathhouse  
    Used the internet to meet sex partners  
    Participated in a sex party  
    Phoned a gay sex line to meet partners  
  
    Went to your family doctor/GP  
    Went to a health clinic  
    Went to an AIDS organization  
    Participated in a gay support group  
    Phoned an HIV/AIDS help-line  
    Phoned a gay help-line  
  
    Read a gay magazine  
    Read Xtra West  
    Went to a Gay Pride event  
    Went to a gay bar  
    Participated in a gay social event  
    Joined a gay sports or recreation group  
    Went to a gay community centre  
    Volunteered for an AIDS organization

**30. How much of your free time do you spend with other gay men?**

- very little  25%  50%  75%  most

**31. Who do you think is the hottest man in the world?**

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Thanks for participating! Please fold this form and deposit it yourself in the sealed container provided. For Info Call: 604 736-0091 or email Sex\_Now@telus.net

