
Mind the Sex Gap: Bridging Sexual and Reproductive Health and HIV Prevention for Young Heterosexual Males



Jacqueline Gahagan, Ph.D.
Laurene A. Rehman, Ph.D.

School of Health & Human Performance
Dalhousie University

November 2004

www.thebuddystudy.com



The Buddy Study - Final Discussion Paper

Acknowledgements

We would like to thank the Canadian Foundation for AIDS Research (CANFAR) for funding this research as well as the project research team for their hard work and dedication to the project. The project team consisted of: Dr. Jacqueline Gahagan and Dr. Laurene Rehman (co-principal investigators); Aideen Reynolds, Tanara Pickard, and Susan Dixon (project coordinators); and Sue McWilliam, Nick Robinson, and Joel Durling (research assistants).

Recognition should also be given to the Advisory Board members who provided feedback on the methodology, assisted with recruitment, and shared reflections on the final report. Some of the members of the Advisory Board included: Rick Gilbert (Executive Director, NS Youth Secretariat), Martina Munden (Research Associate, Health Law Institute, Dalhousie University), and Sandra McFadyen (Policy and Research, Nova Scotia Advisory Council on the Status of Women).

The Atlantic Centre of Excellence in Women's Health (ACEWH) should also be recognized for their support and ongoing partnership in this project. The research team is extremely grateful to ACEWH for hosting two luncheons to assist in the dissemination of project findings.

Thank you also to the participants who shared their thoughts and experiences regarding young males' sexual and reproductive health and HIV. Their insights provided important information to assist in developing best practices.

Merck Frosst and Bristol Myers-Squibb both assisted with funding development of a web site to share information regarding the research project (www.thebuddystudy.com). Corbett Cyr Consulting developed the website and have continued to update and refine it. As well, Durex and Trojan donated free condoms to the young males to recognize their involvement.

Abstract

Healthy sexuality campaigns designed to promote 'safer sex' have been in place for decades. However, most efforts to encourage healthy sexual behaviour have been focused on young heterosexual women and homosexual men. In fact, the majority of Canadian health campaigns aimed at preventing serious sexually transmitted infections like HIV/AIDS leave out young heterosexual men. There is considerable evidence showing that young Canadians are becoming less and less knowledgeable about HIV/AIDS and ways of protecting themselves against sexually transmitted infections.

HIV infection rates in young heterosexual women are rising at an alarming rate across Canada. Health Canada statistics demonstrate that sexual contact with an HIV-infected male partner is a key factor in this increase. If unchecked, HIV could become an epidemic among sexually active youth all across the country. There is a definite link between gaps in knowledge about HIV/AIDS and increasing infection rates.

The Buddy Study was designed to explore young men's perceptions of sexual behaviours, roles, and responsibilities, and to pinpoint obstacles and gaps in their sexual health decision-making. A series of 30 one-on-one interviews and 9 focus group discussions was held in 2003 and 2004 with young men and young women. Additionally, 13 interviews were held with sexual and reproductive health educators.

Study Findings:

- young men were less likely than young women to talk openly about sex or to get accurate sexual health information because of embarrassment or a fear of feeling foolish, stupid, or unmanly
- most participants did not regularly use condoms
- young women were more likely than their partners to take responsibility for safer sex because they felt they would face greater personal consequences from pregnancy or infection
- most participants believed that 'society' puts more pressure on young women than on young men to be responsible and practice safer sex
- the major sexual health priority for the participants was preventing pregnancy
- most of the participants believed they were not at risk of getting HIV

It is obvious that gender plays an important part in shaping sexual behaviours, roles, and responsibilities. Gender differences must be taken into consideration by those who plan and provide HIV education and resources. The Buddy Study final report explores the study findings in detail, and includes a list of recommendations to policy makers and sexual health practitioners for improving HIV/AIDS prevention services for young men and women.

Executive Summary

Introduction

Healthy sexuality initiatives aimed at promoting 'safer sex' and preventing unwanted pregnancy and certain sexually transmitted infections have been in place for decades. However, the majority of these initiatives were designed for and directed toward young heterosexual females and homosexual males¹. In fact, most Canadian health campaigns and interventions geared toward the prevention of HIV infection fail to include or address young² heterosexual males, in spite of Health Canada statistics which demonstrate a clear correlation between the increase in HIV infection among females and sexual contact with an HIV-infected male partner. A significant body of evidence suggests that levels of knowledge about HIV/AIDS and the prevention of sexually transmitted infection have declined significantly among young people in Canada in recent years.

Rates of HIV infection in young heterosexual females are steadily escalating. If unchecked, HIV/AIDS could soon reach epidemic proportions among sexually active youth all across Canada. There is a definite link between gaps in knowledge about HIV/AIDS and increasing infection rates. Clearly, it is essential to seek new ways of providing healthy sexuality education and resources for all youth, especially young males.

A New Approach

The Buddy Study was designed with a view to exploring and contextualizing young heterosexual males' perceptions of their sexual behaviours, roles, and responsibilities, and to pinpoint specific barriers and gaps in sexual health decision-making amongst youth. To that end, a series of 30 one-on-one interviews and 9 focus group discussions was held with young men and young women over a period of two years (2003-2004). Additionally, 13 interviews were held with sexual and reproductive health educators. The data were then compiled and explored for emerging patterns and themes. This report presents a synthesis of the research process, along with key findings and a series of sector-specific recommendations for enhancing best practices for healthy sexuality resources.

In carrying out thematic analysis of the focus group and interview transcripts from both years of the study, the relationship between gender and sexual health became strikingly clear.

¹ Stephenson, J.M., Strange, V., Forrest, S., Oakley, A. et al. *Pupil-led sex education in England (RIPPLE study): cluster-randomised intervention trial. Lancet.* 2004 Jul 24; 338-46.

² For the purposes of this document, the terms 'youth,' 'young,' and 'young people' will refer to individuals aged approximately 15-23 years

The three main themes were:

- (1) The nature and extent of **risk-taking behaviours** are linked to gender;
- (2) Sex and sexuality are **taboo**, and sociocultural comfort levels and restrictions around taboo topics **differ according to gender**;
- (3) **Roles, responsibilities, and expectations** within the context of a heterosexual relationship are often **unequally divided** between male and female partners.

Summary of recommendations to practitioners for enhancing best practices:

- Develop **accessible, youth-friendly, gender-appropriate** sexual and reproductive health facilities
- Ensure that **adequate, detailed information** about HIV and other STIs is provided to all youth
- Provide **condoms** in locations which are easily accessed by all youth

Summary of recommendations to policy makers for enhancing best practices:

- Focus on **primary health care** for all Nova Scotians as a means of improving overall health and wellness and reducing HIV infection among youth
- Focus on **gender-based sexual norms** in developing HIV prevention messages and intervention strategies by conducting gender-based analyses
- Create a **forum for youth** to discuss gender differences in sexual decision-making and sexual health education needs in an effort to increase open dialogue

From Ideas to Action

In light of the ideas and evidence presented in this report, it is obvious that gender plays a central role in shaping sexual behaviours, roles, and responsibilities, and must be taken into consideration when developing, planning, and implementing HIV/AIDS initiatives. To promote capacity-building within the sexual and reproductive health sector, the Buddy Study research team has put together an inventive strategy for translating knowledge into action: (1) the publication and extensive dissemination of this report and related materials; (2) the creation of a series of Fact Sheets aimed at policy makers, practitioners, and youth for the purpose of generating discussion and making meaningful recommendations to key stakeholders; (3) the development of a national framework for capacity-building around HIV/AIDS education, prevention, and outreach to young heterosexual males. When implemented, this proposed project will serve as a blueprint for developing and implementing programs and services in the future.

This report highlights several ideas for enhancing programming and policies aimed at increasing knowledge and prevention of HIV/AIDS among young heterosexual males and females. Building capacity across the sexual and reproductive health spectrum will improve HIV/AIDS education, prevention, and services for all young Canadians. In mounting a cohesive, coordinated effort, it will be possible to stem the impending AIDS epidemic in Canada.

Table of Contents

Acknowledgements	i
Abstract	ii
Executive summary	iii
Table of contents	v
Introduction	1
What is gender and why does it matter?	1
HIV and the heterosexual gap	2
Purpose	2
Methodology and approach	3
Research team	3
Participants	4
Year I	4
Key informants	5
Year II	6
Coding and analysis	7
Insights for future research	7
Recommendations for recruitment	8
Major themes	9
Gender and risk behaviours	9
The pill as sufficient protection	9
Challenges accessing and using condoms	10
More than a feeling	11
Hormones take over	12
Don't you trust me?	12
Relational sex vs. recreational sex	13
Alcohol and other substance use	13
Sex is taboo	14
Sexuality and HIV discourse	14
HIV: An intangible threat	15
The body is taboo	16
Taboo as a gendered issue	16
Sex and the double standard	17
It's time to talk	18
If not now, when?	18
Just sex?	19
Taboo as modeled behaviour	20
Gender and responsibility	21
Girls, boys, and sexual health	21
Contraception and gender politics	22
They talk the talk...	22
Sex and society	23
Just don't get pregnant	24
Myths of responsibility	25
Lingering Questions	26

Strategic directions	27
Policy	27
Practice	28
Next steps	30
Website development	30
Capacity building: A national approach	30
Conclusions	31
References	32
Appendices	
Appendix A: Glossary of terms	34
Appendix B: Background demographics tables	36

Introduction

Sexual and reproductive education and 'safer sex' campaigns have existed for decades. However, the majority of these initiatives were designed for and directed toward heterosexual female youth and young homosexual males (Stephenson et al., 2004). A wide variety of initiatives aimed at promoting healthy sexuality and preventing unwanted pregnancy and certain sexually transmitted infections (STIs) are in place all across Canada. The concept of 'healthy sexuality' encompasses the safe, open exploration of human sexual potential within a framework of sound decision-making, informed by appropriate, personalized, and accessible information (Blonna and Levitan, 2000).

There are many determinants of sexual health, including socioeconomic factors, physical environment, individual capacities and coping skills, and access to information and resources (Health Canada, 1996). Another factor which can have significant impact on sexual health is gender.

What Is Gender and Why Does It Matter?

Before launching into an examination of the relationship between gender and healthy sexuality, it is essential to step back and define this complex, culturally-constructed concept. Firstly, *gender* must be distinguished from *sex*. Gender "refers to the widely shared expectations and norms within a society about appropriate male and female behaviour, characteristics, and roles. It is a social and cultural construct that differentiates women from men and defines the ways in which women and men interact with each other." (Rao Gupta, 2000). The concept of gender extends beyond biological sex (the anatomical and genetic features which characterize males and females), and addresses the effects of psychosocial roles and rules on individuals within a given cultural context. Culturally-based gender norms can influence priorities and best practices within the health system, as "Many health issues are a function of gender-based social status or roles" (Health Canada, 2002). Therefore, sexual health is inextricably linked to gender.

Sexuality operates independently from gender. Sexuality is understood to be a fundamental aspect of being human, and should "be celebrated as a dynamic and creative element of our whole being, with mental, spiritual, physical, and emotional aspects [...] Programs and services should take into account all aspects of the individual's situation and the environment." (Health Canada, 1999, p.12). Sexuality can refer to behaviours, roles, and practices, as well as to feelings, emotions, and drives.

Sexual orientation refers to a person's romantic and/or sexual feelings for individuals of a given gender. It is distinct from other aspects of sexuality, including gender and social gender roles (e.g. adherence to cultural norms for 'feminine' or 'masculine' behaviour). Sexual orientation is understood to exist along a continuum ranging from exclusive homosexuality to exclusive heterosexuality, including various expressions of bisexuality. Sexual orientation is different from sexual behaviour in that it refers to feelings, drives, and self-concept rather than actions or practices.

HIV and the Heterosexual Prevention Gap

Education and awareness initiatives specifically concerning HIV/AIDS infection and prevention emerged in the 1980s, reaching their zenith in the early 1990s (Darroch et al., 2001). Most Canadian health campaigns and interventions geared toward the prevention of HIV infection fail to include or address young³ heterosexual males, in spite of Health Canada statistics which demonstrate a clear correlation between the increase in HIV infection among females and sexual contact with an HIV-infected male partner. In fact, the rate of HIV infection amongst Canadian women has been steadily escalating in recent years. Infection rates for females soared from 9.7% (1995) to almost 25% in 2001, with 67.4% of those infections being directly ascribed to heterosexual contact with an infected partner. In 2001, females accounted for 44.5% of HIV-positive test results among people aged 15 to 29 years, an increase from 41% in 2000 (Health Canada, 2002).

According to the *Canadian Youth, Sexual Health, and HIV/AIDS Study* (2003), there has been a significant decrease in knowledge pertaining to HIV and AIDS between 1989, when the study was initiated, and 2002, when new data were collected and analyzed. Surprisingly, young people appeared to have considerably less knowledge regarding transmission, prevention, and treatment of HIV/AIDS in 2002 than was demonstrated in 1989. Moreover, there were marked differences between males and females in terms of knowledge about STI testing, condom usage, the relationship between risk behaviours such as drug and alcohol use and unprotected sex, and general awareness of HIV/AIDS transmission, prevention, and treatment (Council of Ministers of Education, Canada, 2003). In light of a growing body of epidemiological data and qualitative evidence, it seems clear that new strategies and approaches to sexual health education and disease prevention are required to stem an impending HIV/AIDS epidemic in Canada.

Purpose

The rise in HIV infection rates amongst young heterosexual males and females in Canada appears to have been met with a corresponding decline in awareness and knowledge of HIV/AIDS within that population. Based on the findings of the *Canadian Youth, Sexual Health, and HIV/AIDS Study*, it is obvious that levels of knowledge about HIV/AIDS, along with fundamental sexual health attitudes and practices, have taken a dramatic downturn. This startling reversal is also evident in the most recent Health Canada statistics which reveal a spike in the number of HIV infections among heterosexually active young adults resulting from sexual contact with an infected partner (Health Canada, 2004). Moreover, according to *Nova Scotia's Strategy on HIV/AIDS* (2003), "the median age for HIV infection has also been dropping steadily (from age 32 before 1983, to age 23 between 1985 and 1990)," and in 2001, among youth aged 15-19, heterosexual contact accounted for the majority (35%) of new infections.

Local survey statistics reveal that over 50% of grade 12 students in Nova Scotia have

³ For the purposes of this report, the terms 'youth,' 'young,' and 'young people' will refer to individuals aged approximately 15-23 years

had sexual intercourse (Langille, 1998). Furthermore, 40% of sexually active adolescents reported having had two or more sexual partners within the year preceding the survey (*ibid.*). A second survey carried out in 2002 revealed that 11.8% of female participants had had intercourse before age 15, and that among the participants who had ever had intercourse, those who did so before age 15 were less likely to have used a condom or contraceptives in their most recent incidence of intercourse (Langille and Curtis, 2002). In view of this evidence, it may be argued that further research into the relationship between gaps in sexual health knowledge, patterns of sexual behaviour, and HIV transmission within young heterosexual Canadian populations is warranted.

The principal purpose of the Buddy Study was to identify information gaps and obstacles to healthy decision-making among young heterosexual males in relation to their female sexual partners. A secondary goal of the project was the exploration and contextualization of young heterosexual males' perceptions of their HIV risk-taking behaviours, responsibilities and roles in order to determine the factors that affect the sexual behaviours that make them and their sexual partners vulnerable to HIV infection. In order to meet these objectives, a two-year qualitative exploratory study was undertaken, aimed at seeking out the voices of heterosexually active youth and the sexual and reproductive health care providers and educators who serve that population in Nova Scotia through a series of one-on-one interviews and focus groups. This report will highlight the key themes and ideas which emerged during the course of the interviews and focus group discussions and subsequent analysis, culminating in the presentation of a series of recommendations for best practices.

Methodology and Approach

The Buddy Study was designed with a view to exploring and contextualizing young heterosexual males' perceptions of their sexual behaviours, roles, and responsibilities, and to pinpoint specific barriers and gaps in sexual health decision-making amongst youth. To that end, a series of one-on-one interviews and focus group discussions was held with young males, young females, and sexual and reproductive health service providers and educators over a period of two years (2003-2004). The discussions were iterative, and followed an established list of questions [see appendix C].

Research Team

The Buddy Study project was first developed by principal investigators Dr. Jacqueline Gahagan and Dr. Laurene Rehman, as a response to contemporary conventions in HIV epidemiology, the rise in heterosexual transmission of HIV/AIDS among Canadian youth, and the overall lack of inclusion of sexually active heterosexual males in healthy sexuality interventions in the country.

The principal investigators endeavored to create a dynamic research team which could effectively reach out to members of the target population, namely young heterosexual males. Each member of the research team asserted the importance of conducting community consultations prior to beginning the project as a means of connecting with the target population and discovering ways of meaningfully engaging youth and community members throughout the course of the study. An advisory committee

incorporating locally-based youth representatives was struck to review the research project as a whole, its methodology, and the recruitment strategy.

In the first year of the study, all focus groups conducted with young males were facilitated by Nicholas Robinson, a student in his early twenties working on a Master's degree at Dalhousie University in the School of Health and Human Performance. With a history of volunteer work as a peer health educator at J.L. Ilsley High School, as well as academic research experience, he was ideally placed to build rapport with youth and to carry out the focus group discussions. Sue McWilliam, an MA student in her mid-twenties, was hired to assist with tool development, data analysis and report writing. Additionally, Aideen Reynolds was subcontracted from the Atlantic Centre of Excellence for Women's Health to serve as the Research Coordinator.

During the second year of the project, two young investigators were added to the team to conduct interviews with male and female youth. Joel Durling, a recent high school graduate and past peer health educator at J.L. Ilsley, was hired to facilitate the male youth interviews. Tanara Pickard, a second year graduate student in her mid-twenties, was hired to conduct focus groups and interviews with young females.

Participants

Year I

In year I of the study, a series of 6 focus groups was carried out with 47 males aged 15-23. These discussions were held in a number of regions across Nova Scotia, and the sample group represented a cross-section of males who were in high school, in the post-high school workforce, and in postsecondary programs. Because of the sensitive nature of the research topic, there was some reluctance on the part of youth-centred organizations and institutions to participating in recruitment initiatives. As a result, the research team focused on recruiting young male participants through community-based youth centres, teen health centres, and provincial sexual and reproductive health organizations. Over one hundred such organizations were contacted with regard to the project. The majority of these contacts were made with organizations located within the Halifax Regional Municipality (HRM), although the team also established relationships with several individuals and agencies across the nine provincial health districts of Nova Scotia.

Additional demographic information was collected from the participants through the voluntary completion of anonymous, confidential written surveys [see appendix D]. Respondents were asked a variety of questions, ranging from age, level of education, and 'ethnicity' to sexual orientation, sources of sexual health information, and frequency of certain sexual activities.

In all, 47 individuals aged 15-23 (mean age=18) completed the background survey. The majority of the respondents (77%) were Caucasian, although it is interesting to note that most of the young males described themselves simply as 'Canadian.' Approximately 9% self-identified as African Canadian, 10% as Aboriginal, and 4% as 'other.' 95% of respondents identified English as the language spoken at home. 4% spoke Mi'kmaq and

1% were from Arabic-speaking families. Respondents represented a number of regions in the province, with the bulk living in the Halifax Regional Municipality (61%), Sydney (17%), Truro (6%), Antigonish (6%), and Eskasoni (10%).

The majority of the respondents identified their marital status as either 'single' or 'dating.' One respondent was married, and another was living in a common law relationship. One hundred percent of the respondents self-identified as heterosexual. It must be noted that recruitment of young male participants targeted heterosexual males, and that young males who self-identify as heterosexual may participate in homosexual activity but not report it. This sort of concealed behaviour can be a risk factor for HIV infection for young males and their female sexual partners if unsafe sex practices are used with an infected partner.

When asked where they would go to obtain sexual health information, the respondents listed the Internet, school, friends, and parents. Those respondents who used the Internet to obtain information had done so on only one or two occasions. The majority of the youth had never used the Internet as a sexual health resource. The respondents stated they would feel most comfortable approaching a doctor or school nurse with sexual health concerns, followed by friends and sexual partners. Interestingly, this data proved to be contradictory to what young males said in the course of the focus groups. During those discussions, the majority of participants identified the Internet as a key resource for sexual health information. Participants also stated that while they may have wanted to approach health practitioners with their questions, they generally did not feel comfortable doing so as "only girls go there" and they were too embarrassed or nervous to seek out sexual health services. The discrepancy between what was reported in the written surveys and what was articulated during the focus group discussions merits further exploration. Because young males consistently identified web-based resources as valuable sources of sexual health information, the Buddy Study has placed significant emphasis on the development of an appealing, accessible, useful project website.

More than 50% of respondents stated that they had worried about HIV at one point or another, but the majority of participants was more concerned with other STIs and unplanned pregnancy. When asked about safer sex practices, the participants identified condom use and knowing their partners as the safest options. However, when asked about condom use, the males reported only sporadic condom usage and often did not discuss their sexual histories with their partners.

Approximately 33% of respondents said they always wear condoms when engaging in sexual intercourse. Approximately 17% said they never wore condoms, and equal proportions stated that they 'sometimes' or 'mostly' used condoms. About 23% of respondents said they had engaged in anal sex with a female in the last 6 months, and of those the majority (63%) had used condoms. 96% of respondents stated that they had received oral sex from a female partner within the last 6 months, but only 2 individuals said that they sometimes used condoms when engaging in oral sex.

Key Informants

Additionally, 13 key informant interviews were held with individuals working in the area of sexual and reproductive health. In total, 8 female and 5 male sexual and reproductive health experts were recruited from across Nova Scotia. They provided critical

background information with regard to professional perceptions of the accessibility and relevance of sexual health services to young males and youth in general.

Eleven of the interview participants (mean age=43) completed an anonymous written background survey. The majority of the respondents (91%) were Caucasian, while 9% self-identified as Aboriginal. 82% of the key informants identified English as their primary language. 9% spoke Mi'kmaq, and 9% were French-speaking. The sampling targeted representatives from across Nova Scotia, including the Minas Basin (45%), Cape Breton (27%), Halifax Regional Municipality (18%), and the South Shore (10%). Participants included sexual education coordinators and sexual health nurses and educators.

Year II

In December 2003, the Buddy Study team decided to include young females as well as young males in focus group and individual interview discussions. Recruitment of participants was modeled after the approach taken in the first year of the study. Participants were recruited through youth group leaders and public health offices, and through organizations suggested by the youth group leaders, public health agencies, and as discovered through an Internet search. Over 50 recruitment packages were sent out to interested organizations and individuals. A series of 15 interviews were scheduled and carried out with young males aged 15-23 (mean age=18), and 15 interviews and 3 focus groups were scheduled and carried out with young females aged 15-26 (mean age=19.5). The participants represented several regions of the province, including the Halifax Regional Municipality (30%), the Minas Basin (40%), the South Shore (17%), and Cape Breton (13%).

Demographic data were collected from male and female participants through the completion of anonymous written surveys. Participants were given the option of answering questions relating to their knowledge of safer sex techniques, available sources of sexual health information, sexual activities they engaged in, and use of safer sex practices in the context of those activities. The participants also answered specific demographic survey questions including age, highest level of education, total annual household income, ethnocultural background, language spoken at home, and residency (city/town).

The majority (84%) of individuals who responded to the survey were Caucasian (here it is interesting to note that, as in year I, most of the youth described themselves simply as 'Canadian,' and one participant self-identified as 'Protestant'), with only a few participants self-identifying as African Canadian or Aboriginal. 100% of respondents declared English as their first language. 60% of all respondents stated that their annual household income was less than \$20,000. Approximately 27% of females did not know what their annual household income was. The same proportion of males stated that their household income was greater than \$80,000 per annum. The reporting of household income may be skewed by misinterpretation of the question (in cases where youth live with their parents or live in school residences) or perhaps even male bravado (several males reported their annual household income as being significantly greater than \$100,000, while females were likely to report relatively low income levels).

The majority of both males and females stated that they were either 'dating' (50%) or 'common law' (30%), while a minority of respondents categorized themselves as 'single' (20%). One female participant was married. Approximately 67% of females described themselves as heterosexual, while 27% stated that they were bisexual. One female respondent self-identified as 'experimental.' Almost all of the male respondents self-identified as heterosexual, with only one self-identifying as bisexual. When asked where they would go to obtain sexual health information, the respondents listed the Internet, doctors, youth health clinics, and school health nurses. To a lesser extent, participants identified friends, parents, guidance counsellors, and pamphlets as possible resources. The respondents who used the Internet to obtain information were likely to have done so more than twice. 60% of females and 40% of males had accessed the Internet as a sexual health resource. Like the year 1 participants, over 50% of respondents acknowledged that they had worried about HIV at one point or another, although the majority were more concerned with other STIs and unplanned pregnancy. When asked about safer sex practices, the participants identified condom use and knowing their partners as the safest options. Abstinence was only cited by a few of the respondents as a means of preventing HIV infection in their own lives.

All of the female respondents and all but one of the male respondents reported having engaged in vaginal sex within the last 6 months. 20% of females and 40% of males stated that condoms were always used, 53% of females and 40% of males stated that condoms were sometimes used, and 33% of females and approximately 6% of males reported never using condoms during vaginal intercourse. Approximately 13% of females and 27% of males said they had engaged in anal sex in the last 6 months. Of those, 100% of the females and 50% of the males reported never using condoms during anal sex. 100% of the female respondents and all but one of the male respondents reported having received oral sex from an opposite-sex partner within the last 6 months, and only 3 males stated they sometimes used condoms when receiving oral sex.

Coding and Analysis

All of the interviews and focus groups were recorded on audiocassette and transcribed verbatim, with all personal identifiers (names of individuals, names of schools/communities) being removed prior to coding. Appropriate consent was obtained from all participants, in accordance with the ethics protocol laid out by the Health Sciences Human Research Ethics Board at Dalhousie University.

Once the transcripts had been prepared, they were uploaded into a qualitative data management software program (N-5) and coded according to a set of themes developed by the research team. Subsequently, the researchers conducted thematic analysis of the coded data, exploring the central themes presented in this report.

Insights for Future Research

There is an overall paucity of data regarding young heterosexual males' knowledge of HIV prevention, gender-based risk behaviours, and perceptions of responsibility. It may be argued that this lack of information is linked to the challenges faced when conducting research with young males.

There were two main challenges in involving male youth in the Buddy Study. First and

foremost was the challenge of making contact with young males and attempting to interest them in taking part in the project. Due to the overall demographics of the target population (including age and access to transportation), there were many limitations in reaching a broad sample group. When attempting to access a young (and predominantly adolescent) population, an obvious point of contact would be through the public school system. However, due to ethics concerns and current policies in place at most of the school boards in the province, this was an impossibility. In fact, in order to satisfy the different school boards' specific ethics requirements, a separate ethics proposal would have had to have been created for each. Due to a lack of the resources necessary to meet the needs of the individual boards, the Buddy Study team was unable to recruit male youth through public school channels.

Due to what was seen by some as the controversial nature of the research topic, many community groups and sites were unwilling to permit the researchers to advertise or actively recruit at public locations frequented by youth, such as restaurants, shopping malls, recreation centres, cultural centres and community centres. With these potential avenues for recruitment eliminated, the researchers focused their efforts on local health centres and clinics. This was problematic as the majority of young males do not access these centres, a gap which this study was intended, in part, to address. Consequently, the research team had to establish key contacts within each of the centres and request their assistance in seeking out prospective participants.

This also proved problematic, in that most of the youth recruited by the key contacts had a history of accessing the health centre or clinic in some way, and so individuals who did not access health centres and clinics were being overlooked. Moreover, individuals working in these facilities were often overburdened, and adding to their workload by asking them to assist with recruitment was, at times, an unreasonable or unrealistic demand. As a result, many health service facilities could not agree to participate and youth from certain communities could not be located. Furthermore, some communities did not have health centres or clinics at all, which made recruiting youth from such areas virtually impossible.

Another challenge lay in securing the attention and interest of potential participants, and ensuring their attendance at the scheduled meeting time. A fundamental matter at the core of the Buddy Study is that the majority of young males appear to lack interest in issues related to sexual and reproductive health. In attempting to overcome this lack of interest, the researchers had to offer incentives that would encourage young males to participate while respecting the ethical guidelines laid out in the tri-council policy.

Recommendations for Recruitment

Five strategies were useful in attracting the interest of youth: (1) financial remuneration for time and any inconvenience related to participation; (2) offering food to participants as part of the interview or focus group; (3) making condoms available to participants; (4) holding discussions in easily accessible locations; (5) showing sensitivity and flexibility with regard to the participants' schedules.

Major Themes

In conducting qualitative analysis of the focus group and interview transcripts from years I and II of the study, it became clear that gender was a key determinant of sexual health. The three main themes which emerged were: (1) gender and risk behaviours; (2) gender and the hierarchy of taboos; and (3) gender and responsibility.

1. Gender and Risk Behaviours

A variety of risk behaviours were identified by both male and female participants in years I and II of the study. The participants described risk behaviours of which they had knowledge either through active participation or through secondhand observation of friends and peers. Behaviours were identified as 'risky' by the researchers if they placed the individual at a greater risk of transmission of HIV or other STIs, and/or unplanned pregnancy. Unprotected sex and use of alcohol and/or substances - especially marijuana and, to a lesser extent, ecstasy - were commonly identified risk-related practices. Most of the male and female participants also identified a number of instances in which they had engaged in unprotected sex. Use of oral contraceptives, challenges accessing or using condoms, and use of alcohol or other substances were factors contributing to such risky behaviour.

Interestingly, the participants did not always identify these kinds of behaviours as being risky. It may be argued that this perceived safety was in related in part to an overarching sense of invincibility or, at a minimum, resilience.

1.1 "The Pill" as Sufficient Protection

Both young males and females felt that the use of oral contraceptives provided sufficient protection when engaging in sexual intercourse. If a female was using 'the pill,' they contended, no other forms of protection were necessary. In fact, males frequently asked their females partners if they were using oral contraceptives in order to avoid condom use. This perception is highlighted in the following discussion between a research assistant and several female participants:

Interviewer: *So they do that? Ask you if you are on the pill?*

Female 1: Yes.

Interviewer: *And yourself?*

Female 2: Yeah, I was, like, pressured and stuff.

Interviewer: *You were pressured. What about you guys? Have you ever been involved in unprotected sex? Like, have you ever had sex without a condom?*

Female 3: Yes.

Interviewer: *And if so, why?*

Female 3: They just weren't on me, I guess. I was on the pill and I just didn't have a condom.

Interviewer: *Did the guy ask about it?*

Female 3: Yes.

Interviewer: *He asked whether he should use a condom?*

Female 3: No, he asked if I was, like, on the pill and stuff.

For both young males and females, primary sexual health concerns often seemed to be related to pregnancy. As a result, little discussion occurred between partners about the possibility of transmission of HIV or other STIs. As one participant explained, he simply

did not "think about it."

Interviewer: Do you have any concerns about, you know, getting an STI or maybe getting a girl pregnant, or getting HIV?

Male: Um, I don't want to get any diseases, but I guess I don't really think about it that much. You know, it's...no, I just don't think about it, I guess. I don't know.

Interviewer: Why would you say you don't think about it? Is it just...is it important to you? Like...

Male: Uh, yeah. Like if I sat down to think about it, I wouldn't want that at all, but it's just, I never think about it, I guess. I don't know. It's just not there.

Interviewer: Other events or situations that you go through that concern you? Sometimes, like, you look back on and go, "Oh, you know, now, I could've got HIV or I could've got an STI, or maybe I could have got a girl pregnant." So do you ever look back and does that bother you?

Male: Yeah, a little bit, but that's the past. There's nothing I can do about that, right?

Another male participant also seemed unconcerned about the transmission of STIs through unprotected sex. He explained,

The girl I was just dating...[name] [laughter] uh... the first four or five times we would use condoms... one-night we went out, got drunk, went back to her place and it wasn't an issue, and after that point. Then only half the time you use condoms...and you know its stupid when you're doing it, but at the same time you just... sometimes you just don't give a crap, and it's a giant danger, but you don't. Like it's the same thing, you...jay walk, and...like, the bus is going to hit me... you just are not necessarily always thinking about it in those terms and especially if you've got a partner that is being just as ambivalent about it. Sometimes you just don't care, you're, like, "Screw it," and don't wear it.

Although he recognized the risk associated with transmission of STIs through unprotected sex, it was not at the forefront of his thoughts. As a result, if an opportunity arose where he could engage in unsafe sex, he sometimes chose to do so.

Several of the female participants had also engaged in unsafe sex; however, they seemed to be more fearful of STIs and unplanned pregnancies than their male peers. One of the young women expressed her thoughts relating to an incident where only oral contraceptives were used for protection:

Interviewer: What were you thinking?

Female: I was hoping I didn't catch anything, one. Hoping I wasn't pregnant, two. Yeah, it happened. But yeah, a little timid afterwards.

Clearly, for many of the participants condoms were available but were deemed unnecessary or unappealing. In other cases, however, reasons for not using condoms related directly to challenges associated with using them or accessing them.

1.2 Challenges: Accessing and Using Condoms

For the participants, condom use was not always possible during sexual activity. Many of the participants stated that they wanted to use condoms, but were prevented from doing so due to a variety of obstacles. Lack of access to condoms was a significant factor in the prevalence of unprotected sex amongst the participants. When asked what might stop someone from using a condom, one participant stated, "Not having one, or not being able to get one."

The inability to obtain condoms was cited by several of the participants, a gap which was often linked to the expense associated with purchasing them.

Male 1: I bought 12 condoms the other day and it was like \$11 or something.

Male 2: Yeah, especially if you get it with like spermicide and lubricants and...ribbed for her pleasure.

As another young male explained, "Not a lot of people want to spend their money on something that - Hey, it ain't going to happen to me! So I'll just be careful, you know?"

Many of the males explained that females had more opportunities for 'free' access to condoms, obtaining them through 'women's centres,' for example. Many of the participants argued that young males are intimidated to enter such facilities and are also intimidated to ask for condoms if they are 'too shy.' As one participant explained, "Yeah. Like... people don't like to come up and ask for condoms, really. I don't see it very often here."

Beyond basic access to condoms, the mechanics associated with using one was also a concern for participants. As one participant admitted, some young males "Don't know how to put a condom on." During one focus group discussion, the male participants explained how a lack of knowledge regarding usage can become a barrier to safer sexual practices.

Male 1: A lot of males that I know would rather go have sex without a condom because they don't know how to put a condom on.

Male 2: And they won't learn how to put one on.

Male 1: And they won't go ask you how to do it 'cause that would look kind of weird.

Male 2: Yeah, exactly.

Male 1: Either that or try to do without a condom and use the pull-out method which isn't effective.

Therefore, providing basic information regarding the correct application of a condom may contribute to increased usage.

1.3 More Than a Feeling

Some male and female participants indicated that they did not routinely use condoms because of a reduction in pleasurable sensation. That is, condoms were believed to 'take away the feeling.' Interestingly, many of the male participants affirmed that females were more likely to be concerned about this dulling of sensation, while several of the females identified males as being impacted to a greater degree. The perception that sexual intercourse is 'better' without a condom must be addressed if usage is to increase.

Male 1: If the girl says, "Don't put it on, it will feel better without," or, like, "I want to feel it when you come," or, if you don't have one on you, or if it's at a part of her cycle where she's really unlikely, like the day before and after, or a few days before and after, and she'll just say, like, "Don't bother."

Male 2: Yeah, but you're the one who has to wear the condoms.

Male 1: It's no big deal putting them on, it's just the feel of them actually on.

Male 2: Yeah, and let's have sex without the condom. It feels better, you know?

Male 3: But it doesn't actually do anything...

Male 2: It's the feeling, okay?

Male 1: Shut up, man!

Male 3: Some people feels it ruins the fun I guess you would say.

1.4 Hormones Take Over

The thrill of the moment also affected participants' decisions regarding condom use. Participants felt that their intellectual or rational decision making was likely to be impaired by their emotional or instinctive behaviours.

You know, you go down on her... and at first...neither of you want sex at all and you get into the mood and you just go...and...you get down, she goes nuts, and she just puts herself over on you and... are you really going to go, "Wait, wait. Don't do that 'cause I don't have a condom"? Yeah, she's already half-way on top of you and you're, like, "Well, I'm not going to give this up."

Another male described the challenge of disrupting the moment in order to find a condom.

Yeah, just rushing towards it, yeah. It's not thinking. You're in there. There is foreplay and stuff like that, and then it just leads to it. And you are not really thinking. You just go along with the flow, and not really thinking what is going to happen until after it happens. And you are, like, "Wow, why didn't I think about that before?" Like, it's on your mind. You are just actually not really caring about it at the point because your hormones kind of take over your mind and block it out, as if they wanted to.

Finding methods of making condom usage more of a natural non-cognitive decision is necessary in order to tackle the challenge of emotions and 'hormones' affecting decision making behaviours. Arguably, this challenge will be particularly problematic to overcome as several participants indicated that *not* using a condom illustrated greater commitment to their partners.

1.5 Don't You Trust Me?

Condoms tended to be used more frequently during 'one-night stands' or casual sexual encounters. However, once a 'relationship' had developed, they were used less frequently. Participants felt that once they had developed a sense of intimacy or 'trust' with a partner, then a higher level of commitment to the relationship was demonstrated through not using condoms.

Male 1: I think it's a level of the relationship. I mean, if it's a one-night stand, you are more likely that you will use a condom, but if you are with someone that you trust and, like, you have feelings for, then it means more to you to do it without a condom. Not only means more, but it's better for [both] parties involved.

Male 2: Yeah. And, you know, you know them well enough to trust them to not have STDs or...I would say if I had asked them before if they had them, if you've known them long enough then...

There was a perception amongst the participants that if a partner had an STI or HIV that it would be easily identifiable. This perception was echoed by many of the participants who felt that people with whom they were sexually active were 'clean.' A relationship was differentiated from a one-night stand by the duration and 'quality' of social interactions

between the two partners. Interestingly, the definition of the terms of a relationship was wholly subjective, and could range from four days to several months or years.

1.6 Relational Sex versus Recreational Sex

A noteworthy finding was the differential description of sexuality and sexual information and resource needs for recreational vs. relational sex among youth. One male stated, "Yeah. And, you know, you know them well enough to trust them to not have STDs or...I would say if I had asked them before if they had them, if you've known them long enough, then..."

According to one key informant, it is important to remember that a 'relationship' does not always denote caring or mutual responsibility. The sexual health expert explained, "If you...if you want to protect yourself, wouldn't you want to protect your partner? Although, even within that there is an assumption of some kind of...there is that assumption of caring and of relationships which doesn't always exist."

However, length of time spent in a relationship is not necessarily a predictor for level of trust. A statement made by a young male focus group participant underscored this fact. 'Back on the trust issue, I've been with my girlfriend for five years and I don't trust the bitch. [laughter] I just don't."

1.7 Alcohol and Other Substance Use

Use of alcohol was frequently highlighted by the participants as impairing their safer sex decision making. In fact, many youth had engaged in unprotected sex while intoxicated.

Interviewer: What kinds of things prevent you from using condoms, or prevent your friends from using condoms when you are sexually active, do you think?

Male 1: If you are really, really drunk...

Interviewer: So alcohol definitely prevents people from using condoms? Why do you think that is?

Male 1: Because they could care less.

Male 2: No, they wouldn't care less.

Male 3: They just don't care.

Male 2: They just want to have their orgasm and..

Male 1: Or half of the time they don't know what they are doing.

Male 2: That's one thing, like, teen pregnancies are from alcohol. People partying and stuff...and drunk...will take advantage of them if they are drunk and... unsafe sex with no condoms and then a couple of weeks later they find out they are going to be a parent.

Frequency of and tendency toward participating in casual sexual encounters was often associated with the use of alcohol and/or other substances. As one male explained, "Then again one-night stands, they usually happen when you are at the bar, and you'd be impaired at that time."

A few youth also identified other substances which affected their safer sex practices, such as marijuana and ecstasy, but drug use seemed to impede the ability of young males to engage in sexual intercourse. As a result, most participants did not feel drug use had as significant an impact upon unsafe sex behaviours as alcohol use.

Male 1: Like, a friend that I know, he was drunk and some girl seduced him.

Male 2: I wouldn't say on drugs, but...

Interviewer: But alcohol...

Male 2: Alcohol definitely.

Male 1: Definitely...People pass out and throw up when they have alcohol. If you're standing next to a girl kissing her and then automatically you wake up the next morning in a bed.

Male 2: And if you're in that mood when you're getting drunk, there is a better chance that mood is going to stay the whole night, so [you] can be with the ugliest girl you've ever seen and you wouldn't think about birth [control] or you wouldn't be thinking about STDs or...

Male 1: You'd just be, like, "Yeah, I'm gettin' laid tonight."

Male 2: It was the spur of the moment type of thing....Screw the condom, I'm too drunk to go get it.

Addressing techniques for maintaining safer sex behaviours while intoxicated requires attention by sexual and reproductive health educators. As intoxication was frequently identified as a significant inhibitor to having protected sex - even if the individual had ready access to condoms at the moment of intercourse - greater attention needs to be directed toward the relationship between substance use and unsafe sex, and the potential health implications of engaging in unprotected sex.

As revealed through the interviews and focus group discussions held with young males and females, as well as from conversations with key informants from the sexual and reproductive health service sector, there is a distinct relationship between gender and risk-taking behaviours. In attempting to enhance healthy sexuality education and HIV prevention interventions for youth, gender-based differences must be acknowledged and addressed.

2. Sex is Taboo

Another significant theme to emerge through interviews and focus group discussions in both years of the study was that sex continues to be an uncomfortable or taboo topic for the vast majority of people. Analysis of the data collected during interviews and focus groups with young males and sexual and reproductive health service providers in the first year of the Buddy Study brought to light some of the reasons underlying how and why sex and sexuality can be difficult for some males to talk about. Interviews and focus groups with young females in the second year of the project brought a broader perspective to the relationship between youth, taboos, and barriers to healthy sexuality.

Several of the key findings which arose through the thematic analysis process shed light on the ways in which male and female youth articulate issues and concerns related to sexuality. These insights help to reveal the impact that taboos of sexuality can have both on young people's relationships and on their use of available health resources.

2.1 Sexuality and HIV Discourse

As evidenced by the interview and focus group data, it is clear that the youth who participated in this study generally did not feel they were at risk for HIV. This may be due to: a lack of direct experience with or proximity to the disease; a sense of invincibility; and a preoccupation with avoiding unplanned pregnancy. Even the risk of unplanned pregnancy and STIs did not appear to pose a 'real' threat in the absence of direct personal experience or through a vicarious experience shared with a close friend or relative. Many participants - particularly youth from rural areas - described HIV as a 'big city' or 'gay' disease which was not relevant to their peer group. For this reason, HIV discourse is not a significant aspect of the reality of the youth who were interviewed, beyond that which is taught in school-based health classes. Pop culture references were occasionally cited as a source of HIV information, but often just in terms of naming

celebrities living with the disease, with little or no additional educational value. In general, HIV was not something that youth regularly thought about or discussed. Because of the highly stigmatized nature of HIV, misinformation and myths often go unchallenged and are likely to grow. From the perspectives of two young male participants:

Again, I think it is a systemic thing. HIV prevention as well. It depends on where you live. I mean, around here in Cape Breton, and it being such a small community, HIV prevention doesn't seem to really factor into a lot of people. Because we live in such a small community that people just assume that nobody around here is going to have AIDS or no one here is going to contract it. So because we live in a more rural area, that is one thing around here specifically that would just not encourage males to go out and take steps for HIV prevention.

Yeah. We know everybody, and everybody is okay, and nobody here has AIDS so we are fine and dandy. But yes, I think that is a big thing. And I think that would even stretch across this province as a whole because Nova Scotia in general is a small province. Even Halifax, the biggest part of the province, is small. You still know most of the people in your school or whatever. So it is one of those things where, "Oh well, I don't live in the big city so it won't affect me." I think that has a big impact on HIV information and our use of it.

2.2 HIV: An Intangible Threat

A lack of discourse identifying HIV as a tangible threat allows youth to dismiss it as a possible health concern or risk. During the majority of interview and focus group discussions, when sexuality was discussed more broadly, the participants focused on pregnancy prevention and safer sex negotiation. Female respondents in the second year of the project expressed a higher level of experience in discussing sex and sexuality and seeking out sexual health information and resources than males. Unfortunately, however, of the youth who reported discussing sexuality with partners, few had utilized HIV/STI testing services, relying instead on assumptions regarding their partners' past sexual experience. Young males made the following assertions:

This age, too, now...like, when you talk to your friends it's usually not about prevention, it's kind of like stuff you did or just jokin' around.

No one I ever knew personally ever had AIDS. Like, I don't know anyone.

Me personally, no. I don't know why. The information is out there, but for some reason I take the 'it will not be me' attitude type deal. It just doesn't hit me.

Yeah, I'd rather not think about that.

From the perspective of one key informant, "Sexual and reproductive health information is just too huge. Because sexuality is taboo, and it is not important and it is controversial, and those are reasons why people avoid it."

One young male respondent commented that he felt a general sense of apathy with regard to HIV in his community. He stated, "We had an AIDS awareness day in our school but... nothing too extravagant. Like, no... there wasn't really anything set up for it, or... it's like, "This is AIDS awareness day." There was really no information."

As another male participant explained, "I don't really worry about AIDS that much. Like, I would never think anybody...like, if one the people I live with have it or anything, so I just... I don't know... it doesn't seem like a threat to me at all."

2.3 The Body as Taboo

Interviews and focus group discussions revealed that this lack of comfort in discussing sex and sexuality extends even to conversations about sexual and reproductive anatomy and general health. Overall, females were perceived by the males and sexual and reproductive health service providers who participated in the research as being more open to discussing sexual topics than their male counterparts. Males were depicted as having a tendency to make jokes about sex and sexuality, and as being extremely hesitant to expose any hint of a lack of sexual knowledge by seeking out information about sex. As these young males expressed:

Males don't want to talk about sex - or penis size.

I don't know if it's really educational though. I don't think it is like, "You should use a condom because you might get this." It's like, "Man, I had her in this position, and then she..." It's not like, "Well, we used a condom so it prevented disease."

One key informant highlighted the relationship between maturity and comfort in discussing sexual issues.

It's interesting. I find that guys up to the age of seventeen, eighteen are pretty well linear. They tend to be - generally speaking - immature. And sometimes it's not the case, but the stereotype fits, they tend to be very inwards around their sexual... talking about sex, certainly they would never... I'll give an example... it's nothing to have two teenagers talking about breast size and talking about, you know... this and that in clothing, and belly rings and what have you, pierced bodies, tattoos... Boys, I mean, you never hear them talking about their penis size or cock size or anything to do with their body image whatsoever. They are very closed, and of course males are very similar. It doesn't change a lot.

2.4 Taboo and Gender-related Issues

The responses of the young males and females who participated in this study underscore an interesting question: Are males and females differentially supported in their dis/comfort in discussing particular types of sexual health information? Rather than developing educational tools and interventions which support partner communication, are males being 'let off the hook' while their female peers are learning lessons they may not be able to put into practice? If males are less educated about sexual health matters than their female partners, this may in fact be the case. As one young male stated:

I think marketing regarding sex...Like, marketing regarding condoms is not done all that well as far as encouraging males to use them and whatnot. I really don't think there is a lot out there that encourages males to be sexually informed on the whole. Like, I think it is a systemic thing. I think it is not just one thing that you can really point at. It's everything. It makes it almost not necessary for a male to be sexually informed. It's not just all he has to do is put on his condom and away he goes. But, yeah, I think it's the whole system of things. I can't think of any one thing. I can't think of why a guy wouldn't pick up a pamphlet, other than just the social training he has received his whole life. Because our society as a whole kind of gets us to that point. Sex is a taboo topic. Even now, it is still a taboo topic to talk about. It's just ridiculous because, like I said, for ten years it's been seen on TV and in the movies. And things have become more racier and more explicit and more open but at the same time, sex is still a person-to- person taboo topic. Which is kind of ridiculous, but it's a systemic thing. And that, I think, more than anything is what stops guys from picking up pamphlets about HIV and about condoms and about safe sex. And that, I think, more than anything stops us from talking about sex. It's that systemic belief that sex is a taboo topic, and it's not really talked about.

2.5 Sex and the Double Standard

This ongoing sexual double standard also suggests that males should inherently be knowledgeable about sex, and should therefore never have to ask questions about it. Many of the male participants regarded HIV and 'sex talk' more generally as female topics of conversation. In most situations where it was available, sexual health education and information was provided by female educators and service providers, reinforcing the notion that sexual health is a women's issue. Young male participants made the following observations:

The male... male people just aren't comfortable talking about stuff like that.

Here you are, trying to learn about sexual reproduction and they give you a picture of a vagina and a penis, and you won't look at the penis because you're gay if you look at the penis, so you can't learn anything about the male side. Just for fear that...

A lot of males that I know would rather go have sex without a condom because they don't know how to put a condom on.

Female participants echoed the statements made by their male counterparts.

No, I think the girls definitely care more about safer sex. The guys aren't worried about getting pregnant, so...They should be. They should be more involved with their partners and what they are doing.

I don't know. I've never seen any. They are too macho and they don't want to...I don't know, ego, I guess.

I just think males traditionally tend to be more personal about those types of things.

This notion was reiterated by several of the key informants. As one sexual health service provider said:

I think it is a challenge because traditionally...and still, not just traditionally...males are socialized in a different way and sexual reproductive health issues, HIV prevention, is not part of that socialization. It seems a female issue.

A common theme articulated by many of the male participants and some of the key informants was that males feel sociocultural pressures to appear 'instinctively knowledgeable' about sex. Some of the male participants disclosed that they felt their male peers would mock them if they asked questions about sex. According to the participants, discussions about sex between males tend to focus on describing experiences and knowledge, not on expressing lack of knowledge or revealing inexperience. For all of the youth participants, the influence of peer-norms had an immense effect on establishing parameters around sexual issues, including misinformation about sexual health.

Male 1: Like, I think about problems with sexuality and HIV and such and such, and if I want to have sex...I don't want to get AIDS and stuff like that. And I know, hey, my friends are going through the same thing I am but I can't approach them about it.

Male 2: No.

Male 1: In fear of looking stupid.

For many of the participants, discomfort in seeking out sexual health information seemed to be tied up in concerns over image and public perception. Many of the youth expressed that 'a friend' had had difficulty asking questions or seeking sexual health services because of how it might be perceived by their peers. This seemed to be a matter of concern for males vis à vis their fears of looking inexperienced, and a matter of concern for females as they feared appearing overly experienced. This disconnect could lead to a lapse in communication and might result in a reliance on misinformation, myths, and misconceptions. As noted by two male respondents:

Well if you go, it's like there is something wrong with your wiener and you go there, and you wouldn't want anyone to know about that, and so it's, like, a confidential issue.

Because some people just, like... "I wouldn't be caught dead in there," you know? That is the problem with the [health service facility].

2.6 It's Time to Talk

If an issue is socially supported as being 'taboo' or difficult to talk about, individuals will likely experience awkwardness when trying to learn more about it, making even readily available sexual health services likely to be underutilized. Sexual references and images are ubiquitous in popular culture; however, there remains a lack of open discourse around sex and sexuality which is fundamentally rooted in education or factual information. Young males offered the following observations:

I think a lot of it was embarrassment. Like, when looking of information. Like, my sex ed. teacher was our guidance counselor, so we kind of didn't have to go looking for it, it was just right there. But after we get that class, it was, like, two years after that, and you had to go get it yourself. And, like, there is a special office for health care and it is right by the main door, and not a lot of people were getting access to, like, sexual information. Like, if [name of drugstore]...if you go to [drugstore], it was always, like, right in the middle of the aisle, so people are less embarrassed by it. It took me a while to go get it.

A lot of males that I know would rather go have sex without a condom because they don't know how to put a condom on. And they won't learn how to put one on. And they won't go ask you how to do it 'cause that would look kind of weird.

Guys love to brag about their sex lives and want to brag about what they have or haven't done, but guys are scared to death to talk about actual sexual problems or issues, or whatever. I mean, they're embarrassed. They're...if it's them, they're embarrassed. If it's their friends, they're embarrassed. It's just not a topic guys are very comfortable talking about unless it's to say, "Oh, I got with thirty women, you know, over the summer." Easy. They can...of course they can talk about that. I mean, that's just the way...society's made it quite comfortable for a guy to do that, but not in terms of anything else. I think it's ten times worse for the guys. They don't have any information, I don't think, 'cause they don't know where to get it. They don't talk amongst their friends about problems. They talk amongst their friends about what they have or haven't done, like, but a guy would never...that I know...a guy would never say to another guy, you know, "Oh geez, I think I might have got something from so and so."

2.7 If Not Now, When?

Another issue which confounds discussions about sex and sexuality is the timing of the introduction of sexual health information to youth. Parents, teachers and health care providers continue to struggle with the notion of what constitutes age-appropriate sexual health education. One young female participant observed,

Yeah, because people believe that teenagers shouldn't be involved in sexual intercourse. Yeah,

or they should have sex when they are married. Yeah, like, a lot of parents believe that. They would rather not think of the fact that their children could be having sex. They'd rather not. Yeah, because that's "growing up too fast"...Yeah, and that's what makes it hard to go to your parents and talk about it, because you don't want to see their expression or..."You're not old enough to deal with that stuff yet."

Some male participants made similar statements, such as:

But back in high school...I don't know how it is now, but, I mean, like, to hear it more [inaudible] here... you're a 16 year old guy, you don't want to hear "Don't have sex."

I talk to my mom about decision making, but... my mom and my dad, as far as, like, STIs go or anything like that, they're pretty quiet. Like, they think AIDS is, like, a big gay disease and stuff like that, so I would never go to my parents for information like that.

Yes, the earlier the better. Because, I mean, I've heard of kids having sex, like, in grade five and six. That is as young as I have heard it. It could even be lower than that, I really have no idea. So I would say the earlier the better. But of course there is a lot of... That is a pretty touchy subject. For some parents, they might not want their kids to learn about it at that young of an age. I mean, I don't know, I think it definitely has to come in at grade seven at the latest. I mean, that is when the problem becomes that much more apparent, I guess, is in grade seven. And they are open to so many more choices once they get to junior high than in elementary school. So I would have to say they definitely would have to be addressed and educated about it at that age.

2.8 Just sex?

One key informant emphasized the fact that youth often have difficulty discussing health issues which extend beyond sex and sexuality. Further research is necessary to discover ways of deconstructing taboo subjects in general, making such topics more acceptable and easier to approach. New strategies for building trust between youth and health service providers and educators must also be developed. The period separating childhood from adulthood is characterized by rapid physical and emotional changes. In an ideal scenario, all youth would feel comfortable in discussing their health and wellness with health professionals, parents, and other care providers. As explained by one key informant:

He said it was too much information, I said, "You are telling me you can sit here and talk about sexually transmitted diseases, but you can't talk about whether or not you are constipated or not?" I said, "I don't get it." That was an odd thing to me. So it wasn't against sexuality that he couldn't talk, it was against other body functions.

2.9 Taboo as Modeled Behaviour?

In trying to make sexuality less taboo, educators have a difficult task at hand. An educator's comfort level can easily be read by students who will, in turn, take cues from this lesson in the management of sexuality information. As noted by one young male, "...in grade eight we had a gym teacher and he was really good at it, and in grade nine there was this fairly new teacher, and so he was kind of iffy about talking about stuff to thirteen and fourteen year-olds about... but in high school it was just bad... [inaudible] we didn't do anything."

The sexual and reproductive health service provider key informants also described obstacles around offering sexual health education to youth.

It's not easy. You know...it's not easy, but it is not impossible. And it requires a lot of work, it requires establishing trust. Sometimes there is a distrust among young men of...just looking specifically at sexual and reproductive health or HIV prevention organizations, um, or programs... you know, these sort of agencies who incorporate that kind of work...there can be a distrust which is perhaps complicated, as it is, but also perhaps related to the fact that there hasn't been much attention to males' programming in places, so it does require a lot of outreach, or a lot of...making the effort to make young men feel involved and, you know, again, if they are...establishing, sort of, trust...making sure that young men are involved.

Another touchy subject relates to the location of responsibility for sexual education. Some would argue that parents should take more responsibility in discussing sex with their children, while others maintain that school is the best vehicle for sexual health interventions. As articulated by one young male, "I really think they do. I mean, some parents are claiming that it should be the responsibility of the parent to teach their child about that. But to be honest, not every parent is educated about it. They might not have the answers. They might have a biased opinion about, maybe, homosexual relationships for example." However, in the view of a female participant, parents are not always consistent in the sexual health messages they communicate to their children.

I think they should stop talking to their fathers. I really do, because I think... I've noticed, and it's still an issue today, the way some guys, even young guys our age, they talk, "Well, if it was my daughter or my sister, I don't want a guy going near her." But I know for a fact that fathers are telling them, "Yes, go on, go ahead. Did you get laid? Good stuff." I know a guy...I have a good friend like that. I know his father was quite happy that his son was getting sex. He was quite happy about it. But when his daughter got pregnant, he wasn't happy at all. I said, "You are very stereotypical, aren't you? You like that double standard, don't you?" He didn't like that.

For youth living outside urban centres, taboos around sexuality in general - and HIV in particular - can present enormous barriers to sexual health information and services. One young male participant underscored a serious issue related to the disparity between urban and rural resources:

I don't think that getting tested for HIV, especially in a small town...it just isn't that easy, I don't think. People say, "Let's go get tested," but it's not that easy because you have to get a blood order. And unless you have a really serious...The question I got from him was, "Unless you have a really serious scare, like, you know, you had sex with someone that you know has HIV, they are not going to do it for you." I thought you could just go in and say, "Can I get a blood test?" They'll do the swab thing for gonorrhoea and things like that. But if you want an HIV test, that is a blood test. And you have to get, like, a doctor's order to get the test ordered from the hospital. And I don't think that is right because that goes in your record and stuff. It's not as easy as it says on the prevention thing...to go get a blood test. It's not that easy.

In examining the data collected in years I and II of the Buddy Study, it is apparent that sex is a taboo subject. Lack of open discourse about sex and healthy sexuality, deficiencies in sexual health education, and gaps in access to resources and information can impede young males and females from receiving the services they need. If the spread of HIV/AIDS amongst young heterosexual males in Nova Scotia is to be averted, the veil of silence enveloping sexuality and other traditionally taboo subjects must be lifted.

3. Gender and Responsibility

In carrying out qualitative analysis of the focus group and interview data, one overarching theme to emerge was the correlation between gender and responsibility. All of the participants related scenarios in which gender imbalances related to responsibility for safer sex, contraception, disease prevention, and sexual behaviours in general played a significant role.

3.1 Girls, Boys, and Sexual Health

There was a perception amongst the participants that it is non-normative for young males to discuss safer sex. Furthermore, the majority of participants maintained that the onus is predominantly on females to take responsibility for the sexual health of both partners in a heterosexual relationship. As one young female explained, "But I can't picture guys doing that. Girls will sit around in a big group and... Like my friends, we'll tell each other everything. It's gross actually. But I can't picture guys telling their friends."

During a one-on-one interview, a young male stated, "...like, my girlfriend is way more adamant about it than me so I kind of just slack off and forget about it, like I have no concern about it at all, because anytime anything happens, she's adamant. But if I had a partner that was just like, whatever, I don't care, I'd probably kind of step up and take more responsibility." Males seemed to be unlikely to broach the subject of safer sex with their partners. Many of the male participants made statements such as:

No, like, um, that subject doesn't come up very much, so I wouldn't think it would be too difficult, but I don't know. Like I've never actually sat down and said, like just started talking about HIV and stuff, you know what I mean? So I don't know.

As evidenced by the interview and focus group data, in the majority of situations, safer sex discussions between young heterosexual partners are instigated by females. Many of the female participants declared that they maintain control of sexual decision-making with their male partners because "guys don't really see it as a big deal."

Interviewer: *Did he say anything about...like, did you use a safer method?*

Female: Yes, we used a condom.

Interviewer: *Who brought that up?*

Female: Me. I was just like, "Here you go." I hate to say no glove, no love kind of thing but it was basically that is what I was like. "We are doing this or we are not," kind of thing. And then it was like two am, and he left. And I felt really kind of used. I was like, "Wow, this isn't really so great." Because I hear about a lot of people who just like celebrate. Like a guy saying, "Yeah, I can be with a different girl every night. It's great."

3.2 Contraception and Gender Politics

The onus was also often on females to protect themselves from unintended pregnancy. There was a general assumption shared by the participants that most young women in Nova Scotia use some form of oral or injectable contraception. In cases where both condoms and oral contraceptives were used, females were very likely to provide them for their male partners.

Well, I prefer Trojans. Yeah, and I'm on the pill. And I try to always have condoms. If I'm getting any or not, I always... You never know so I always have them. I always make sure that there are some in my bedside table. I always have them. Like today, you know, you hear so many things about oh, the guy should have the condom. I'm like, "What! What! I have them." I know a lot of other... I have a lot of friends who have them too. They get condoms. And exactly, you need them just in case.

The fact that so many young females are prescribed some form of contraceptive raises questions about control and autonomy in relation to female reproductive health. Because there are no male equivalents to oral or injectable contraceptives, females often, by default, are forced to take responsibility for contraception. The majority of respondents expressed the belief that females have 'more to lose' if contraception fails because they are the ones who get pregnant.

Guys, I think they, in some cases, again not all, but based on speaking with some of them, they are just so happy to not use a condom. And I'm like do you understand the... And to them, a lot of them, it's just, "Well, she's on the pill." And I'm like, "Well, that is great. You're not going to get her pregnant but what if she has something that you don't know about? What if she has gonorrhoea? What if she has HIV?" And they don't think about that, I think that is a big issues, for guys and girls. I think there are some... I have some chick friends who think like that too. They are, like, "Well, I'm on the pill." You don't know what he has.

The guys can just basically leave you if they don't want to have a kid, they can just basically break up with you 'cause the girl's the one that's gotta deal with it more than the guys.

It's...the girls usually get more upset if they're pregnant than the guys. The guys don't really see it as a big deal.

3.3 They Talk the Talk...

Although many of the female participants made statements about managing sexual health behaviours within the context of their relationships, they often contradicted themselves, revealing the enormous power which young males can wield with regard to determining whether to use protection and what sort of protection to use.

Female: Pregnancy I'm worried about. I was pregnant last year and I lost it.

Interviewer: *And that has changed the way you view safer sex?*

Female: I was on the pill actually and it didn't work so I've got the needle now.

Interviewer: *But you don't use condoms?*

Female: No.

Interviewer: *Do you ever think about it?*

Female: Yeah, we tried it and it didn't really work.

Examination of focus groups with young males revealed a significant amount of rationalizing with regard to displacement of responsibility for sexual health to females.

Interviewer: *Okay, so there is laziness, and kind of that, "It's not going to happen to me," or if you don't have one...*

Male 1: Or she is on the pill, so it doesn't...

Male 2: Gee, I'd like to not have to deal with a condom, I know I'm safe.

[several voices]

Male 1: [inaudible] not STDs, people say it can't happen to me, like you just said, but it is more pregnancy, so.. "You got the pill?" We're fine!

3.4 Sex and Society

The majority of female participants also related their sense that 'society' places the burden of sexual responsibility on women, stating that men are not expected to take responsibility for their own sexual health, or for the sexual health of their partners. Interestingly, the female participants often cited 'providing protection, buying condoms' as the predominant male role in responsible sexual behaviour. In some ways, it may be argued that the archetypal male-as-provider role has permeated the participants' understandings of the concept of responsibility, so that providing financial support (i.e. purchasing condoms) is perceived to be equivalent to demonstrating caring or nurturing behaviour. This is a critical issue which merits further examination.

I think they feel it is more our responsibility. I don't know why but it's just kind of how society puts the emphasis on it, being the female. Like okay, the guy brought the condoms. Okay, we did our part, now you guys, you have to do all your stuff, and you've got to get your pap test and you've got to make sure... All that.

As well, we've had discussions in our human sexuality class about protection and things like that, and the responsibility is almost always put on the female. Or that is how it seems. And I think it is important to stress that the male has a very important part in providing protection, buying condoms and whatnot. Because I don't know how many times I've heard carry a condom in your purse, make sure... But I never hear anybody say, "Guys, have a condom, guys do this, guys do that. Make sure your girlfriend is on birth control." It's always the female, the female, the female. I think it has to be pushed on the male more as well. I never really thought about it until it was brought up in class but it's true. In courses in school, I think a lot of the responsibility is put on the female.

Several participants highlighted the lack of consistency and precision in the information and resources available to young males as a significant issue affecting sexual health behaviour among youth.

I think a lot of guys are getting mixed messages because at first I heard, "Okay, guys, keep a condom in your wallet." And then it's like, "Well, wait, no, you can't keep it in your wallet because you'll ruin it." Like, it will pop or something, right? So I don't know, I think females get specific knowledge, get specific information, like, "This is how you get pregnant, this is how you prevent it, this is the pill, blah, blah, blah." But guys, it's like, "Here is a condom." Like, they don't...I don't know if they know how to use them properly or that kind of thing. So maybe they need more specific information.

Many of the key informants who provide sexual and reproductive health services to youth acknowledged that engrained sociocultural norms and attitudes are pervasive within sexual health education, and that assumptions about normative gender-based behaviour can limit the kinds of resources made available to young males.

I think the attitudes of staff who are doing...whether it is sexual health or HIV education or providing services...and I don't mean that it is blatant, but I think that you know a lot of us have those attitudes and it is natural...it is difficult to not sort of take in some of the messaging from the culture that you live in, from the society that you live in. So I think that although, you know, there

are some staff that might think that they are inclusive, or approachable to young men...sometimes in organizations they still have attitudes like, "Oh, they won't be interested. He'll never wear a condom." Um... and so I think that it... the onus is upon organizations...institutions to look at those attitudes and values. And it is a hard thing to do. You know? Particularly when people are in a place where they feel like they are inclusive, or they feel like they are gender neutral. It is important work for all of us to do, no matter what the population is, to continually do that processing and reflect on our attitudes and values and how are they impacting the work that we do, and how are they part of...or what role do they play in the fact that we are not reaching these certain populations? But it is challenging to do.

3.5 Just Don't Get Pregnant

Analysis of the data from both years of the study revealed that the main sexual health concern for young males and females is pregnancy. Youth were so preoccupied with preventing pregnancy - and avoiding the embarrassment and stigma that can go along with it - that they did not give much thought to disease prevention or avoiding HIV/AIDS. One interchange between young females in a focus group was particularly illustrative of the relationship between gender and responsibility as it relates to sexual health:

Female 1: I find that the thing guys think about the most is pregnancy. They are more worried about you getting pregnant. But as long as they know you are on the pill then they are not so worried. But if they thought you were not on the pill, they usually went out and bought some condoms. But they are more worried about....

Female 2: My boyfriend right now is really not concerned about anything because I worry enough for us both. And I'm more concerned about pregnancy than diseases.

Female 3: Yes, the same here. My boyfriend kind of relies on me to take the pill every day and everything will be fine. But sometimes I still get kind of worried. And once I even bought a pregnancy test just for the hell of it because I was like, "Oh my God...." But I was fine. And then I kind of reassured all my fears that the pill actually works, and you won't get pregnant if you use it properly.

As articulated by one young female, "Pregnancy is a big deal because it's noticeable, and everybody knows about it, and your parents and everybody."

Most of the male participants said they felt that the responsibility for sexual health should be shared in the context of a 'serious' relationship. The meting out of responsibility, however, was rarely equal. In several cases, it appeared that young males were shrugging off their responsibility, or 'passing the buck.' The following exchange between young males in a focus group reveals the core belief that it is 'really not hard' for females to use contraceptives and to take responsibility for pregnancy prevention.

Interviewer: *Who do you think is responsible for the prevention of pregnancy?*

Male 1: I think 60% is the female, 40% is the male.

Male 2: Yeah, that works. Because the female has more options than the guy does. I mean, well there are two for the guy, get a vasectomy, or wear a condom, for the girls there is...you can get birth control, you know, which is really not hard, but its kind of a pain in the ass to take the pill every day at the same time, you know girls with birth control, they can carry condoms on themselves, they can have other forms of contraceptive, they go and get something [inaudible]. But yeah, I'd say 60/40 and if you are dating a girl, then I would say its 50/50 and if you are in an actual relationship it is 50/50, but if you are just getting it on with a girl, then its 60/40. But I think for the most part guys should supply the condoms because I mean it goes on them, it doesn't go on the girl, so I mean if a guy is going out or a guy invites the girl back to his house, the guy should have the condoms there.

3.6 Myths of Responsibility

Young males' discussions about responsibility exposed many myths and misconstructions of responsibility as a concept, unearthing an interesting facet of the participants' understanding of what healthy sexual behaviour means. For the majority of the young male participants, 'behaving responsibly' is only necessary for males and females who know they have an STI or HIV, or for females who know they might become pregnant because they are not taking oral or injectable contraceptives.

I mean if you have an STD, you just should always... and if you are having sex with a girl and you got serious issues, then it rests with you, I mean, the girl should know if you have one and then of course you should wear two condoms - you know. But, it depends who has the STD or...

Anybody who knowingly has HIV and has sex with someone who doesn't know is 100% responsible for sure. They are not giving that person a fair chance at all.

You tell the person before you have sex with them, and I think if you give someone else AIDS you are solely responsible. Like, the other person has done nothing wrong. Like, it is your fault. Like, if I gave someone else AIDS...if I know I have it, it is my fault.

Young males also often seemed more concerned with protecting themselves than with being sensitive to their female partners' sexual health needs.

If you don't want to get an STI, if you are with somebody make sure they are tested, and if you really don't want to get one, then just don't go screwing a bunch of girls. Watch your own ass.

I mean, it would probably be not as much as, like, the girls...how they have to worry about getting pregnant. It would probably be each individual person and how much they take responsibility for their own health, how much they want to care about it.

There is a distinct relationship between gender-based normative behaviour, pervasive sociocultural paradigms, and understandings of responsibility. In order to address the sexual health needs and concerns of young males, educators and service providers first must address the close connection between gender norms and sexual behaviours.

Lingering Questions

Overall, the themes which emerged through transcripts from both years of the study were consistent. There were no significant contradictions between the statements made by young males in year I versus year II, and the addition of young female voices in the second year of the study brought new light to the data collected in the first year.

One question which grew out of analysis of the year II data, and which merits further exploration, revealed itself in discussions with young females about STI testing and responsibility. A large proportion of the female respondents made statements indicating that they believed Pap testing to be tantamount to STI testing.

Uh, for STIs...basically just for the Pap test [...] we wanted to make sure just in case, so we're not actually harming any other person before we decide not to use condoms.

I have been tested... Like, I've had regular Paps, so whatever they do with that, yes.

I had it during my Pap test but I didn't realize at the time that they only test for certain STIs. But I have not been tested for the rest.

Interviewer: *And why did you decide to go and get a Pap done?*

Female: Just to be safe, I guess.

Interviewer: *Was it you who decided, or your mom who decided, or...*

Female: Me.

Interviewer: *And you heard it through friends that it was a good idea to...*

Female: Yes. You are advised to. And after a certain amount of time on the pill, you are supposed to. They will not give you any more pills until you get it.

A statement made by a key informant in year I of the study may give some insight into the underlying causes of this erroneous belief:

Well I couldn't say, in so far as here it is non-gender-specific. I apply the same amount of responsibility or onus on both females and males and more particularly, I guess, I would slant it more to females in that they bear the greater consequence for not only getting pregnant, but in disease treatment or what have you. It is more complicated, such as you need a Pap in order to determine whether or not you have a sexually transmitted disease. Where men get urinate in a cup, so it is more complex.

Arguably, if sexual and reproductive health service professionals and educators lead females to believe that by having regular Pap tests they are also being tested for STIs other than the virus it is intended to screen for, they are not getting the kinds of appropriate or complete information necessary to enhance healthy sexuality.

Strategic Directions

The following strategic directions provide practical recommendations to practitioners, policy makers, researchers, youth, and others committed to promoting youth sexual health. It is hoped that these strategic directions will help guide the translation of the ideas expressed in this report into action.

Policy

1. Young people are more likely to receive sexual health information about prevention and treatment if they have regular access to a health care provider.

Strategic direction:

Focus on primary health care for all Nova Scotians as a means of improving overall health and wellness and reducing HIV infection among youth.

2. Many participants stated that HIV was not a priority in school-based sexual health education, and that this lack of concern was reinforced at home and in the broader community. As a result, seeking HIV prevention education and information was not a priority for youth.

Strategic direction:

Develop ways of delivering confidential, easily accessible, peer-driven HIV prevention messages tailored to the complex biopsychosocial needs of sexually active youth.

Youth must be consulted in creating policy and practice around sexual health education. The participants identified peer-led learning as an effective means of getting healthy sexuality education. An electronic and print media campaign regarding the rise in HIV infection rates among heterosexual youth in Canada could contribute to raising public awareness and creating dialogue about sexual health issues.

3. Males and females have distinct sets of needs and expectations regarding sexual health education and resources.

Strategic direction:

Focus on gender-based sexual norms in developing HIV prevention messages and intervention strategies.

4. Youth voices must be included in enhancing and improving sexual health resources.

Strategic direction:

Create a forum for youth to discuss gender differences in sexual decision-making and sexual health education needs in an effort to increase open dialogue.

Young male participants stated that outside of the study's focus group discussions and interviews, they would not have talked about sex and sexuality with their friends or other male youth so openly. However, they also said they found it helpful and useful to have that kind of discussion. In creating opportunities for young males to share their opinions

and thoughts with researchers, policy makers, or practitioners, more discussion may be generated, helping to lift some of the silence.

5. The study participants did not believe they were at risk for HIV infection.

Strategic direction:

Create opportunities for research exploring best practices for addressing socially stigmatized topics with youth in a non-threatening, confidential, age-appropriate, gender-appropriate, non-judgmental, education-based manner.

In order to reach out to young males about HIV prevention and healthy sexuality, researchers, policy makers, and practitioners must first determine better means of communicating with them.

Practice

1. Condoms are a simple form of protection against HIV infection. If youth do not have ready access to condoms, they will not use them.

Strategic direction:

Provide free condoms in locations which are easily accessible to all youth.

Youth identified school-based health centres, school guidance offices, youth health centres, and shopping centres as accessible spaces where they would feel comfortable getting condoms. Young males and females also need specific information and visual demonstrations of how to use condoms correctly. Young males will not typically ask for this kind of information. It must be provided to all youth in a matter-of-fact manner within a standardized classroom context.

2. If they are misinformed, youth are likely to spread misinformation and myths about sexual health and ways of preventing infection and pregnancy within their peer group.

Strategic direction:

Ensure that adequate, detailed information about HIV and other STIs is provided to all youth in formats which are appealing, accessible, and effective.

Learning styles differ by gender and by individual. What works for young females may not work for young males. In general, the participants identified electronic media-based resources (websites, television, educational films) as effective learning tools. Some youth preferred to learn by reading books or pamphlets. Some youth identified peer-led education as the best method for learning about sexual health. Therefore, it is essential to provide a variety of resources which are gender-neutral and which present matter-of-fact information clearly and concisely. Scare tactics such as gory images and descriptions of the effects of sexually transmitted infections were seen by youth as highly effective tools.

3. There is an urban/rural divide in accessibility of sexual health education and resources in Nova Scotia.

Strategic direction:

Develop new approaches to providing services and education to all youth in Nova Scotia, focusing on outreach to young people living in rural areas.

4. If youth do not feel comfortable accessing sexual health services, they are unlikely to get the information and resources they need.

Strategic direction:

Develop youth-friendly sexual and reproductive health facilities where young males and females can obtain:

- ***Education about transmission of STIs and HIV and the 'invisibility' of certain diseases/infections***
- ***Education about proper condom usage and application***
- ***Education about the inhibitory effects of alcohol and other substances***
- ***Education about healthy sexuality within a relationship and techniques to use in order to communicate with a partner about safe sex practices***

Next Steps

An essential component of any research project is Knowledge Translation (KT), or the transformation of knowledge into practical applications. The KT strategy for the Buddy Study is threefold: (1) the publication and dissemination of this report, including a plain-language Executive Summary accessible to policy makers, practitioners, media, and the general public; (2) website development and the creation of a series of sector-specific Fact Sheets aimed at policy makers, practitioners, and youth for the purpose of generating discussion and making meaningful recommendations to key stakeholders; (3) the development of a national framework for capacity-building regarding HIV/AIDS education, prevention, and outreach to young heterosexual males.

Website Development

Because Internet-based resources were identified by the majority of male participants as primary sources of sexual health and HIV/AIDS information, the Buddy Study will continue to maintain, develop, and promote the project website (www.thebuddystudy.com).

In addition to enhancing the youth-friendly, gender-neutral design, the project team has already begun development of a series of sector-specific Fact Sheets which highlight key themes and ideas to emerge from the research. These Fact Sheets will be made available as PDF attachments on the Buddy Study website.

Capacity-Building: A National Approach

The research team is currently seeking funding from Health Canada and the Canadian Institutes of Health Research (CIHR) to support a framework for expanded research and capacity-building across Canada. In light of the findings of the Buddy Study and recent Health Canada statistics, it is evident that there are some significant gaps in sexual health knowledge among young heterosexual males in this country. The proposed capacity-building initiative is aimed at stimulating primary HIV prevention efforts for young people in Canada.

This project will:

- identify existing programs and services which have demonstrated success in addressing sexual health and prevention needs of young heterosexual males and females;
- build a model for capacity-building with several key agencies and organizations;
- develop a comprehensive blueprint for HIV/AIDS prevention training resources for sexual and reproductive health practitioners and HIV educators from organizations which target young males and females.

This proposed initiative will promote capacity-building among individuals currently working in the field by bridging the gap between sexual health and HIV prevention, particularly among young adults. The process will connect a number of Planned Parenthood affiliates and AIDS Service Organizations (ASOs) in Nova Scotia, Ontario,

and Alberta. The documents and resources developed through this project will be made available in both French and English, including the finalized capacity-building and training resource materials. These materials will be available across Canada through a number of sexual and reproductive health and ASO websites, as well as in PDF and paper formats in both official languages.

Conclusions

The primary purpose of the Buddy Study was the exploration of obstacles to sexual health decision-making among young heterosexual males, and of the factors underlying sexual behaviours, roles, and responsibilities which make young males and their female partners vulnerable to HIV infection. Because of the conventional tendency to focus HIV/AIDS education and prevention initiatives on young heterosexual females and homosexual males, young heterosexual males have often been left out of the picture. The thoughts and ideas expressed by the young participants in this study underscore the need to make sexual health education and resources accessible to all youth, including young heterosexual males.

Despite the difficulties related to involving males in a study of this nature, it is clear that it is essential let their voices be heard. Qualitative research regarding HIV/AIDS transmission in youth - and sexual and reproductive health in general - must actively incorporate both males and females in order to ensure gender sensitivity and awareness in preventing the further spread of HIV among young heterosexuals in Canada.

In carrying out careful analysis of the focus group and interview transcripts from both years of the study, the relationship between gender and sexual health became strikingly clear. The three main identified themes were:

- (1) gender and risk behaviours;
- (2) gender and the hierarchy of taboos;
- (3) gender and responsibility.

Clearly, gender plays a central role in shaping sexual behaviours, roles, and responsibilities, and must be taken into consideration when developing, planning, and implementing HIV/AIDS initiatives. The proposed project for capacity-building among sexual and reproductive health service providers and educators in Canada draws on this key finding. When implemented, it will create a framework for the enhancement of resources in the future.

This report has drawn attention to several ideas for improving and enhancing programming and educational efforts geared toward young heterosexual males. Arguably, the most critical immediate next step will be the dissemination of results in useful, practicable, and meaningful ways. It is the hope of the research team that in working to build capacity across the sexual health resource continuum, there will be a corresponding improvement in HIV/AIDS education, prevention, and services for all young Canadians. In mounting a cohesive, coordinated effort, it will be possible to stem the impending AIDS epidemic in Canada.

References

- Banister, E.M., Jakubec, S.L. & Stein, J.A. (2003). "Like, what am I supposed to do?": adolescent girls' health concerns in their dating relationships. *Canadian Journal of Nursing Research*. Jun; 35(2):16-33.
- Blonna, R. & Levitan, J. 2000. *Healthy Sexuality*. Englewood: Morton Publishing Co.
- Byers, E.S., Sears, H.A., Voyer, S.D., et al. (2003). An Adolescent Perspective on Sexual Health Education at School and at Home: I. High School Students. *Canadian Journal of Human Sexuality*. 12: 1-17.
- Council of Ministers of Education, Canada. (2003). *Canadian Youth, Sexual Health and HIV/AIDS Study*. Ottawa: Council of Ministers of Education.
- Coyle, K.K., Kirby, D.B., Marín, B.V. et al. (2004). Draw the Line/Respect the Line: A Randomized Trial of a Middle School Intervention to Reduce Sexual Risk Behaviors. *American Journal of Public Health*. May; 94(5): 843-51.
- Darroch, J.E., Frost, J.J. & Singh, S. (2001). *Teenage sexual and reproductive behaviour in developed countries: Can more progress be made?* Occasional Report, New York: Alan Guttmacher Institute. 2001: No. 3.
- Fisher, J.D., Bryan, A.D. & Misovich, S.J. (2002). Information-motivation-behavioral skills model-based HIV risk behavior change intervention for inner-city high school youth. *Health Psychology*. Mar; 21(2): 177-86.
- Government of Canada. (2003). *Canadian Guidelines for Sexual Health Education*. Ottawa: Public Health Agency of Canada.
- Health Canada. (2002). *HIV and AIDS in Canada: Surveillance Report to December 31, 2001*. Ottawa: Minister of Public Works and Government Services Canada.
- Health Canada. (2002). *Including Gender in Health Planning: A Guide for Regional Health Authorities*. Ottawa: Minister of Public Works and Government Services Canada.
- Health Canada. (1999). *Report from Consultations on a Framework for Sexual and Reproductive Health*. Ottawa: Minister of Public Works and Government Services Canada.
- Health Canada. (1996). *Strategies for Population Health: Investing in the Health of Canadians*. Ottawa: Minister of Public Works and Government Services Canada.

Health Canada, Surveillance and Risk Assessment Division. (2004). *HIV/AIDS Epi Update May 2004*. Ottawa: Public Health Agency of Canada.

Langille, D.B., Beazley, R., Andreou, P., Delaney, M. (1998). Reproductive Health Knowledge of Students at a High School in Rural Nova Scotia. *Canadian Journal of Public Health*. 89:85-89.

Langille, D.B. & Curtis, L. (2002). Factors Associated with Sexual Intercourse Before Age 15 Among Female Adolescents in Nova Scotia. *Canadian Journal of Human Sexuality*. 11:91-99.

Panchaud, C., Singh, S., Feivelson, D. & Darroch, J.E. (2000). Sexually Transmitted Diseases Among Adolescents in Developed Countries. *Family Planning Perspectives*. 32(1) :24-32 & 42.

Provincial HIV/AIDS Strategy Steering Committee. (2003). *Nova Scotia's Strategy on HIV/AIDS*. Halifax: The Nova Scotia Advisory Commission on AIDS.

Rao Gupta, G. (2000). *The what, why, and how of gender, sexuality, and HIV/AIDS*. Plenary Address: XIIIth International AIDS Conference; Durban, South Africa.

Stephenson, J.M., Strange, V., Forrest, S., Oakley, A., Copas, A., Allen, E., Babiker, A., Black, S., Ali, M., Monteiro, H., Johnson, A.M.; RIPPLE study team. (2004). Pupil-led sex education in England (RIPPLE study): cluster-randomised intervention trial. *The Lancet*. Jul 24; 364 (9431): 338-46.

Appendix A

Glossary of Key Terms

Accessibility

Consistent, ready access to services and resources. Access should be unhindered by geographic, financial and social barriers or other obstacles.

Acquired Immune Deficiency Syndrome (AIDS)

A condition which causes the immune system to become depressed, rendering the affected individual unable to fight infection. AIDS is the most serious outcome of Human Immunodeficiency Virus (HIV) infection [see definition].

Capacity Building

Enhancing and supporting the capability of individuals, organizations, and communities for strategic planning, development, and implementation of services and resources. Capacity building "can include learning new skills; collaborating with other groups or sectors to share knowledge and resources; institutional and legal reforms; and direct provision of resources (e.g. money, staff, office space, expertise)." [Nova Scotia's Strategy on HIV/AIDS, 2003]

Human Immunodeficiency Virus (HIV)

The virus associated with AIDS. A confirmed positive result from the anti-HIV means that the person has been exposed to the AIDS virus, has developed antibodies to the virus and may be a carrier of the virus. Infection occurs through exposure to infected blood or bodily fluids. Risk factors for transmission include unprotected sexual contact with an infected partner and injection drug use.

Incidence of HIV/AIDS

The number of new diagnoses which have occurred within a specific population during a specific time period.

Gender

Gender must be differentiated from sex. "It refers to the widely shared expectations and norms within a society about appropriate male and female behaviour, characteristics, and roles. It is a social and cultural construct that differentiates women from men and defines the ways in which women and men interact with each other." [Rao Gupta, 2000] Furthermore, "Gendered norms influence the health system's practices and priorities. Many health issues are a function of gender-based social status or roles." [Health Canada, 2002]

Sexuality

Sexuality is understood to be a fundamental aspect of being human, and should "be celebrated as a dynamic and creative element of our whole being, with mental, spiritual, physical, and emotional aspects. It is an intensely personal experience and one that shapes many of our social interactions and significant relationships. Recognizing that sexual experiences are not always positive, we should aim to promote and celebrate

diverse, healthy sexual relationships and identities that are free from coercion, abuse, guilt, and shame. Programs and services should take into account all aspects of the individual's situation and the environment." [Health Canada, 1999]

Sexually Transmitted Infection (STI)

A communicable disease transmitted by sexual intercourse or genital contact.

Sexual Orientation

In an anonymous and confidential written background survey, study participants were asked to identify their sexual orientation as: heterosexual (romantic and/or sexual feelings for persons of the opposite gender), homosexual (romantic and/or sexual feelings for persons of the same gender), or bisexual (romantic and/or sexual feelings for persons of either gender). Recruitment of participants specifically targeted individuals who self-identify as heterosexual in order to gain their perspectives on healthy sexuality education and resources for young heterosexual males.

Social Determinants of Health

A wide range of factors and conditions influence the health of individuals, families, and communities. These factors are commonly sorted into 4 broad categories: (1) social and economic environment; (2) physical environment; (3) individual capacities, coping skills, and health practices; and (4) access to health services. [Health Canada, 1996]

Taboo

Understood in its 'common sense' connotation, a taboo is an unmentionable or unacceptable subject. Sex and sexuality are taboo subjects for many Canadians, and are therefore not generally discussed freely and openly. Some topics around sex and sexuality are perceived to be more taboo than others (e.g. anal sex is more taboo than vaginal sex). As a result, discussing healthy sexuality and the prevention of sexually transmitted infections with children and youth (at school or in the home) can be seriously impeded.

Appendix B

Background Demographics Tables

**Buddy Study background survey respondents (youth):
Males and females aged 15-26 (n= 77, mean age = 18.5)**

Ethnic Background	Language	Region	Marital Status	Sexual Orientation
Caucasian 79%	English 97%	Halifax Regional Municipality 49%	Dating 52%	Males (n=62): Heterosexual - 99% Bisexual 1%
African Canadian 10%	Mi'kmaq 2.5%	Minas Basin 23%	Single 35%	Females (n=15): Heterosexual -67% Bisexual - 33%
Aboriginal 9%	Arabic 0.5%	Cape Breton 22%	Common Law 12%	
Other 2%		South Shore 6%	Married 1%	

**Buddy Study background survey respondents (Key Informants):
Males and females (n= 11, mean age = 43)**

Ethnic Background	Language	Region
Caucasian 91%	English 82%	Minas Basin 45%
Aboriginal 9%	Mi'kmaq 9%	Cape Breton 27%
	French 9%	Halifax Regional Municipality 18%
		South Shore 10%

Year I Buddy Study background survey respondents (males)
Males aged 15-23 years (n= 47, mean age = 18)
Sexual behaviours & condom usage

	vaginal sex	oral sex	anal sex
	96%	96%	23%
condom usage			
always	33%	0%	63%
sometimes/mostly	50%	4%	17%
never	17%	96%	20%

Year II Buddy Study background survey respondents (males)
Males aged 15-23 years (n= 15, mean age = 18)
Sexual behaviours & condom usage

	vaginal sex	oral sex	anal sex
	93%	93%	27%
condom usage			
always	40%	0%	20%
sometimes/mostly	20%	20%	30%
never	40%	80%	50%

Year II Buddy Study background survey respondents (females)
Females aged 15-26 years (n= 15, mean age = 19.5)
Sexual behaviours & condom usage

	vaginal sex	oral sex	anal sex
	100%	100%	13%
condom usage			
always	20%	0%	0%
sometimes/mostly	47%	0%	0%
never	33%	100%	100%