

**MASCULINITY, HETERONORMATIVITY AND YOUNG MEN'S SEXUAL HEALTH IN  
BRITISH COLUMBIA, CANADA**

by

Rodney Eric Knight

B.A., University of Alberta, 2004

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF  
THE REQUIREMENTS FOR THE DEGREE OF

Master of Science

in

The Faculty of Graduate Studies

(Health Care and Epidemiology)

THE UNIVERSITY OF BRITISH COLUMBIA  
(Vancouver)

APRIL 2011

© Rodney Eric Knight, 2011

## Abstract

**Background:** Young men account for a substantial proportion of reported sexually transmitted infection (STI) and HIV cases in Canada. However, STI/HIV testing rates remain low among young men. While men's health-related behaviour have been linked to masculine expectations that demand stoicism, independence and denial of illness, little is known about how dominant masculine and/or heteronormative expectations may affect men's sexual health-related practices that can put them at both an elevated risk of acquiring an STI(s)/HIV and/or affect their ability to access STI/HIV testing services. The **objectives** of this thesis are to: (1) explore how heteronormative and heterosexist discourses function within clinical settings where young men access STI testing services to better understand the extent to which dominant masculine ideals are (re)produced or resisted in these clinical contexts; (2) identify the social and contextual conditions which facilitate or create barriers to effective sexual health communication amongst men, paying special attention to how idealised masculinities influence these interactions; (3) develop recommendations for sexual health services and future research to improve the sexual health of young men in BC. **Results:** The findings drawn from this research highlight how idealized masculinity influences young men's sexual health, including their sexual health-seeking behaviour, sexual practices and the ways in which they talk about sexual health. Specifically revealed are instances in which dominant heteronormative expectations 'hurt' all men in clinical encounters (e.g., by stereotyping gay men as 'risky', thereby alleviating STI/HIV concern for straight men by virtue of their sexual identity). Men's conversations about sexual health focused primarily around their sexual

encounters (e.g., using ironic/teasing humour to embody masculine identities that neither dismiss nor actively express concerns about sexual health), amid processes of 'manning up' to break with dominant masculinity (e.g., stoicism) to permit talk about sexual health with peers or sex partners. **Discussion:** By examining situations in which men (and clinicians) align with or socially reconfigure idealized notions of masculinity related to sexual health, theorists and interventions will better understand how more equitable gender relations can be produced, thereby improving the sexual health of men (and women).

## Preface

The research in this thesis was conducted according to the guidelines of the University of British Columbia Behavioural Research Ethics Board. Interviews of human subjects and secondary data analyses were approved by UBC BREB H10-00132. Data is drawn from an ongoing program of research investigating youth's sexual health in British Columbia, led by Dr. Jean Shoveller (PhD, UBC). These studies included: (1) *Investigating the Structural and Socio-economic Forces Affecting STI Testing and Treatment Among Youth in Northeastern BC* (UBC BREB H05-1198); (2) *Sex, Gender and Place: An analysis of youth's experiences with STI testing in British Columbia* (UBC BREB H05-81000); and (3) *Young Men and Sexually Transmitted Infections* (UBC BREB H10-00132). Under the primary supervision of Dr. Jean Shoveller (PhD, UBC) and co-supervision of Drs John Oliffe (PhD, Deakin University) and Dr. Mark Gilbert (MD, University of Ottawa; MHSc, UBC), Knight conducted the following research activities:

1. **Data collection.** Knight conducted 40 qualitative, in-depth interviews with young men (out of a total of 77 involved in this thesis) and 7 clinicians (out of total of 25 involved in this thesis).
2. **Data analysis.** Data analysis was primarily conducted by Knight, with ongoing research team consultation. Feedback from Drs Shoveller, Oliffe and Gilbert were subsequently incorporated into the thesis.
3. **Manuscript preparation.** Each manuscript was written by Knight; theoretical feedback was sought from Drs Shoveller, Oliffe and Gilbert and incorporated into subsequent and finalized versions. Shira Goldenberg (MSc, UBC) provided feedback related to men

interviewed in the study *Investigating the Structural and Socio-economic Forces Affecting STI Testing and Treatment Among Youth in Northeastern BC* in Chapter 2 of this thesis.

# Table of Contents

Abstract.....	ii
Preface .....	iv
Table of Contents .....	vi
List of Tables .....	viii
Acknowledgments.....	ix
Dedication .....	x
Chapter 1.0 Introduction.....	1
1.1 Young men and sexually transmitted infections in British Columbia, Canada .....	1
1.2 Young men and STI/HIV testing.....	2
1.3 Men and masculinities .....	4
1.4 Men, masculinities and sexually transmitted infection testing.....	5
1.5 Masculinities, sexual health and men’s sexual practices .....	6
1.6 Thesis objectives .....	8
1.7 Thesis outline .....	9
Chapter 2.0 Heteronormativity Hurts Everyone .....	10
2.1 Introduction .....	10
2.2 Study setting.....	13
2.3 Methods .....	14
2.3.1 Recruitment of participants .....	14
2.3.2 Interview procedure.....	15
2.3.3 Study participants.....	16
2.3.4 Interviews.....	17
2.3.5 Data analysis.....	18
2.4 Results .....	18
2.4.1 The ‘relativity of risk’ .....	19
2.4.2 Alleviating men’s anxieties .....	22
2.4.3 (Re)producing the heterosexual status quo .....	26
2.5 Discussion.....	31
Chapter 3.0 Masculinities, ‘Guy Talk’ and ‘Manning Up’: Young men’s discussions about sexual health .....	38
3.1 Introduction .....	38
3.1.1 Background.....	38
3.1.2 Young men’s sexual health.....	39
3.1.3 Masculinities and men’s sexual health practices .....	40
3.1.4 Men talking about sexual health .....	41
3.2 Methods .....	42
3.2.1 Recruitment .....	42
3.2.2 Study setting.....	42
3.2.3 Interviews.....	43
3.2.4 Data analysis.....	43

3.3 Findings .....	44
3.3.1 Study participants.....	44
3.3.2 ‘Guy talk’ .....	45
3.3.3 ‘Manning up’: Talking about STIs and health .....	52
3.4 Discussion.....	56
Chapter 4.0 Discussion .....	60
4.1 Summary of findings.....	60
4.2 Implications for theory .....	62
4.3 Implications for men’s sexual health interventions and future research.....	63
4.4 Strengths and limitations .....	65
4.5 Interpretation of findings and reflexivity .....	66
References .....	68
Appendices.....	76
A.1 Interview guide for young men.....	76
A.2 Interview guide for clinicians .....	82
A.3 Interview guide for young men.....	87

## List of Tables

<i>Table 1. Self-identified characteristics of young men.....</i>	16
<i>Table 2. Characteristics of clinicians.....</i>	17
<i>Table 3. Self-identified characteristics of young men.....</i>	45



## Acknowledgments

*I would like to thank the young men and service providers that took part in this study. I would also like to especially thank Drs Jean Shoveller, John Oliffe and Mark Gilbert for their support, wisdom and guidance. I also thank the Youth Sexual Health Team investigators, staff and trainees for their ongoing training support. Funding for this study was provided by the Canadian Institutes of Health Research (Grant number: 205444). My financial support was generously provided by a Frederick Banting and Charles Best Canada Graduate Scholarship from CIHR and a research stipend from Dr. Jean Shoveller.*

**Dedication**

***To mom and dad***

# Chapter 1.0 Introduction

## 1.1 Young men and sexually transmitted infections in British Columbia, Canada

In British Columbia (BC), Canada, sexually transmitted infections (STIs) are high and rising; and, young men account for a disproportionate amount of infections. For example, between 2000 and 2009, genital Chlamydia rates among young men ages 15 to 24 years doubled, with 1110.4 cases per 100,000 men (compared to the BC average of 251.1 per 100,000) (British Columbia Centre for Disease Control, 2010). In 2009, men between the ages of 20 to 24 experienced the highest rates of genital gonorrhoea in the province; and, these rates have more than doubled since 2000 (from 45.5 to 111.6 cases per 100,000) (British Columbia Centre for Disease Control, 2010). In 2009, HIV incidence rates for men between the ages of 20 to 24 were significantly higher than the provincial average at 11.2 per 100,000 cases (compared to the provincial average of 7.6 per 100,000) (British Columbia Centre for Disease Control, 2010). Of concern, the STI surveillance data indicate the potential for a significant increase of HIV spread among this cohort in the near future (Larkin, Andrews & Mitchell, 2006).

If left untreated, STIs in men can lead to conditions, such as chronic hepatitis B, infertility, arthritis, skin lesions, epididymitis (a painful 'clogging' of the ducts attached to the testicles) and inflammation of the urethra (Reiter's syndrome) (United States Centre for Disease Control, 2011; Public Health Agency of Canada, 2011). Moreover, STIs are synergistic, meaning that acquiring one can increase the risk of others, including HIV (United States Centre for Disease Control, 2011; Public Health Agency of Canada, 2011). Infected men often

do not experience symptoms and are less likely to seek treatment and therefore contribute to further disease spread (British Columbia Centre for Disease Control, 2010). For example, it is estimated that approximately 60% of Chlamydia infections in men are asymptomatic (LaMontagne, Fine & Marrazzo, 2003). As a result, the higher reported rates of STIs among young women, such as genital Chlamydia, have largely been attributed to asymptomatic cases in heterosexual men who have not been tested and therefore not treated (British Columbia Centre for Disease Control, 2010), or who are treated for their symptoms but not tested (and therefore remain unreported in the surveillance data).

## **1.2 Young men and STI/HIV testing**

As a result of the high and rising rates of STI/HIV, there is a strong public health impetus to test<sup>1</sup> and treat infected men to prevent and/or reduce further disease spread. Unfortunately, STI/HIV testing rates among young men in BC remain disproportionately low, with many clinics reporting that young men represent only 5 to 10 percent of youth clientele accessing testing services (Shoveller, Knight, Johnson, Oliffe & Goldenberg, 2010; Shoveller, Johnson, Rosenberg, Greaves, Patrick, Oliffe, et al., 2009; Goldenberg, Shoveller, Koehoorn & Ostry, 2008). The low rates of testing among young men have often been attributed to

---

<sup>1</sup> The terms *testing* and *screening* are often used interchangeably. Whereas *diagnostic testing* involves medical investigation that results from a patient's symptoms or reports of specific conditions (Wilson, 1971), *screening* refers to testing on individuals who have no apparent symptoms, but are among a population that has been identified as 'at risk' (Wilson, 1971). For the purpose of the current thesis, *testing* is used as an umbrella term for STI/HIV clinical testing and screening services.

structural deficiencies within health care services and systems that focus on women's reproductive health, while ignoring men's sexual and reproductive health (Alt, 2002). For example, asymptomatic women are encouraged from a young age to frequently engage with reproductive health services (thus presenting opportunities for STI/HIV testing), whereas men are not routinely encouraged to engage in sexual health services (especially when they are feeling well) (Rieg, Lewis, Miller, Witt, Guerrero et al., 2008).

Recently, research attention has turned towards men's experiences and behaviour patterns as means for better understanding their health-seeking patterns. For example, in Canada, men experience higher rates in 14 of the 15 leading causes of mortality (Oliffe, Robertson, Frank, McCreary, Tremblay et al., 2010). Although many of these causes are considered modifiable through behavioural change (e.g., HIV incidence), researchers argue that gender reduces the likelihood that men will engage in behaviour change (Robertson, Galdas, McCreary, Oliffe & Tremblay, 2009). Men are thought to be more likely to avoid regular contact with health services (Courtenay, 2000). When experiencing health-related symptoms, men often deny illness because they fear they might be considered weak or effeminate (O'Brien, Hunt & Hart, 2005). Men also engage in 'risk-taking' behaviour (e.g., excessive consumption of alcohol; excessive speeding) more frequently – perhaps to elevate their masculine status (Giordano, Longmore & Manning, 2006). Ultimately, these factors increase their risk of health-related problems (e.g., liver disease; injury) (Robertson, Galdas, McCreary, Oliffe & Tremblay, 2009; Oliffe, Robertson, Frank, McCreary, Tremblay et al., 2010).

### 1.3 Men and masculinities

Sociological theories link men's health behaviour to performances of masculinity (Courtenay, 2000; Robertson, 2007). Connell (1987 and 1995) defined masculinity as a structure of social performances that influences men's identities and practices. Masculinities function hierarchically, with hegemonic masculinity representing the most socially dominant masculinity. Within this framework, hegemony refers to the cultural dynamics that allow a social group to sustain dominance; hegemonic masculinity is the culturally "exalted" gender practice that enables male dominance (Connell, 1995). Masculinity theorists often position hegemonic masculinity as an 'idealized' masculinity that is "just barely out of reach for all men" (Numer, 2009, p. 383). In other words, while hegemonic masculinity is unattainable to all men, some men are able to align more closely with idealized notions of masculinity, whereas others 'fall short' – but never quite give up – thereby constituting a social ordering of men.

Connell (1995) suggests that hegemonic masculinity is constituted by oppositional relationships consisting of the subordination of 'others' (i.e., women and some men) through heterosexual patriarchy. Subordination transpires through cultural stigmatization, violence and inequitable distribution of capital/material wealth (Connell, 1995). Subordinated masculinities also are disadvantaged by virtue of their 'other' intersecting social identities (e.g., gay identities; racialized identities). While Connell explains that gay masculinities are the most conspicuous among subordinated masculinities, he also acknowledges that heterosexual men embodying weak or effeminate characteristic (e.g., 'sissies') can be subordinated. Some men become marginalized by normative masculine ideals; though, as Connell (1995) explains,

there may be no overt attempts to marginalize these men through masculine social practices. Nonetheless, marginalized men can experience material deprivation; as Robertson (2007) argues is often the case for men who have physical (dis)abilities.

Most men are unable to fully embody and practice the hegemonic definitions of masculinity; but, they nonetheless benefit from the 'patriarchal dividend' as a result of the subordination of women and marginalized men (Connell 1995). Therefore, many men, according to Connell, embody a complicit masculinity. *Dominant* and *normative* masculinities also are terms used to relate to hegemonic masculinity. These terms have been employed by theorists to account for the disparity between the culturally exalted hegemonic masculinity (at an overall, cultural level) and the masculinities that men experience as dominant and normative in their everyday lives. Despite being subordinated to the culturally "exalted" hegemonic ideal, men who align with dominant and normative masculinities derive benefit (Coles, 2009), especially within the realm of sexual practices. For example, many men, regardless of their alignment with dominant and normative masculinities, may align with masculine ideals that valorize (and benefit from) men's role as a sexual pursuer.

#### **1.4 Men, masculinities and sexually transmitted infection testing**

Within the masculinities theoretical framework, men's health-seeking behaviour is positioned as a performance of masculinity (Robertson, 2007). The high and rising rates of STIs among young men have been linked to normative masculine behaviour; and, an emerging literature details how these behaviour often present barriers to men's engagement with routine STI/HIV testing (Shoveller et al., 2009 and 2010; Goldenberg et al., 2008a and

2008b). For example, Shoveller et al (2010) highlighted how factors (e.g., STI testing procedures, such as the 'swab') disrupt idealized notions of heterosexual masculinity to prevent men from accessing services (e.g., 'real men' penetrate and should not be penetrated by a urethral swab). Clinical encounters also are underpinned by gendered and heteronormative expectations that, when transgressed, can present potentially emasculating outcomes (Shoveller et al., 2004; Shoveller et al., 2010 and 2009). For example, Shoveller et al (2010) described how men's heteronormative expectations sometimes cause them to avoid a woman clinician (for fear of getting an erection) or to avoid seeing a man clinician (for fear of a 'homosexual' gaze). Shoveller et al (2009) described how heteronormative assumptions employed by clinicians within clinical encounters can frequently result in young men being presumed as heterosexual – thereby presenting missed opportunities for discussing sexual health for men who are not engaging in heterosexual sex. And, while emerging literature detail how dominant heteronormative masculine ideals negatively impact heterosexual men (e.g., stereotypes subjecting heterosexual adolescents to homophobic encounters, including 'fag discourse') (Brown & Alderson, 2010; Pascoe, 2007; Yep, 2002), the health literature has yet to address how the impacts of heterosexism and/or homophobia might also negatively affect heterosexual men in STI/HIV clinical encounters (Bryant & Vidal-Ortiz, 2008).

### **1.5 Masculinities, sexual health and men's sexual practices**

Male sexual practices are located at the pinnacle of a complicated nexus of dominant masculine expectations. The sexual practices in which men are 'permitted' to engage are governed by normative masculinities that can put men (and women) at increased risk of



getting STI(s)/HIV. For example, dominant masculine expectations among young men valorise frequent sexual activity, multiple sex partners, a focus on (self) pleasure, and sexual 'risk-taking' practices (e.g., avoidance of condoms) (Larkin, Andrews, & Mitchell, 2006; Giordano, Longmore & Manning, 2006; Korobov, 2005 and 2008; Numer & Gahagan, 2009; Numer, 2008 and 2009; Duck, 2009). In addition, Numer and Gahagan (2009) describe how gay men's dismissal of health promotion messaging related to "safer sex" is an enactment of hegemonic masculinity that rejects concern or fear for one's (or others') sexual health.

While many men recognize that sexual practices related to hegemonic masculinity may threaten their ability to be sexually healthy (e.g., if they become infected with STI/HIV), actions that would restrict their sexual practices (e.g., getting tested and being diagnosed with a STI/HIV) are frequently rejected as 'unmanly' (Duck, 2009). By avoiding testing services, men's masculinity is protected from "bad health news" (Duck, 2009). Men's reticence to engage in discussions around health have been linked to dominant and hegemonic expectations that preserve more valued enactments of masculinity over others (e.g., sexual activity as more valued than actively taking care of one's sexual health and that of others) (O'Brien, Hunt & Hart, 2005, p. 1). As a result, men who align with masculinities that require stoicism, independence, self-reliance and disinterest in health frequently position 'health' as a 'normal' condition that does not warrant discussion in the absence of illness or symptoms (Robertson, 2007). Unfortunately, men who avoid discussing sexual health are at increased risk of becoming infected by an STI (as well as other health problems) (Alt, 2002; Courtenay 2000a; Brook Advisory Centres 2005; Pearson 2003). Yet, there is little empirical

and/or theoretical literature examining the contextual and social conditions that affect men's ability to talk about sexual health.

## **1.6 Thesis objectives**

In the current thesis, the ways in which heteronormativity and idealised notions of masculinity affect men's sexual health-related practices are examined (e.g., how men discuss their sexual health; experiences accessing services). An in-depth examination will be provided to detail the social and structural conditions that allow men to 'do' sexual health. Young men's (ages 15 to 25 years) perspectives represent a starting point for gaining a better understanding of men's health practices, as well as their conceptualizations of masculinity related to sexual health (Robertson, 2007). By distilling the ways in which young men (dis)align with masculinities, much needed advances can be made regarding theory and practice. The objectives of the current thesis are to:

- (1) Explore how heteronormative and heterosexist discourses function within clinical settings where young men access STI testing services to better understand the extent to which dominant masculine ideals are (re)produced or resisted in these clinical contexts (Chapter 2);
- (2) Identify the social and contextual conditions which facilitate or create barriers to effective sexual health communication amongst men, paying special attention to how idealised masculinities influence these interactions (Chapter 3); and
- (3) Develop recommendations for sexual health services and future research to improve the sexual health of young men in BC.

## 1.7 Thesis outline

The current thesis includes an introductory chapter (Chapter 1), two manuscripts (Chapters 2 and 3), and a discussion of the overall findings (Chapter 4). Chapter 2, *Heteronormativity Hurts Everyone*, draws on qualitative interviews with 45 men (15-25 years-old) and 25 clinicians (e.g., doctors; nurses) collected in 2006 to 2008 in British Columbia, Canada, to examine how heteronormative discourses affect STI/HIV testing experiences for young men. Chapter 3, entitled *Masculinities, 'Guy Talk' and 'Manning Up': Young men's discussions about sexual health*, draws on 32 qualitative interviews collected in 2010 to 2011 with young men (ages 17-24) to explore how idealised masculinity can 'shut down' or facilitate effective sexual health communication (e.g., with peers; sex partners). The discussion (Chapter 4) highlights the need for future men's sexual health research to attend to a variety of men's masculine identities and describes future research directions.

## Chapter 2.0 Heteronormativity Hurts Everyone

### 2.1 Introduction

Young men's sexual health and well-being is affected by an array of social interactions and structural conditions, which can put their sexual health at risk (Shoveller, Johnson, Langille, & Mitchell, 2004). The heterosexist, heteronormative and homophobic<sup>2</sup> nature of many social contexts can be especially problematic for gay and bisexual men, who either hide their sexuality or cope with a stigmatised identity (Ryan & Futterman, 2001). Young gay and bisexual men in many locales including British Columbia (BC), Canada, are at increased risk of social isolation and alienation, including rejection, discrimination and violence from their families, schools and communities (McCreary, 2007). Dominant heteronormative cultural ideals can also negatively impact heterosexual men in ways that are particularly harmful to

---

<sup>2</sup> Each of these terms – *heteronormativity* and *heterosexism* – are useful tools for naming, understanding and responding to anti-homosexual (or heterosexual-focused) attitudes and actions (Bryant & Vidal-Ortiz, 2008), yet are each fundamentally different. Historically, the term 'homophobia' has been used as a tool for collectivities (e.g., the 'gay rights' movement) and individuals to name and respond to oppression (Bryant & Vidal-Ortiz, 2008). The mind-set of homophobia is backed by a belief in the notions of heteronormativity and heterosexism. The terms have similarities: heterosexism describes the conviction "that everyone is or should be heterosexual" (Yep, 2002); heteronormativity suggests that being heterosexual is the social norm, natural, and the only way one can be fully human (Yep, 2002). These two attitudes legitimatise and render possible *homophobic* behaviour. In this article we use each term to delineate particular aspects of heterosexual privilege and 'non-heterosexual' subordination.

youth (e.g., social norms inhibiting men from forming close and meaningful relationships with each other; stereotypes subjecting heterosexual adolescents to homophobic encounters, including 'fag discourse') (Brown & Alderson, 2010; Pascoe, 2007; Yep, 2002). That said, for the most part, the health literature has yet to address how the impacts of heterosexism and/or homophobia affect heterosexual men (Bryant & Vidal-Ortiz, 2008).

There is an emerging literature exploring men's experiences with sexual health services. For example, identified predictors of gay and bisexual men's *engagement* in sexually transmitted infection (STI) testing include individual factors (e.g., knowledge levels), psychosocial factors (e.g., fear of homophobic reactions from clinicians), socio-cultural influences (e.g., stigma of having a 'non-heterosexual' identity), and/or heteronormative assumptions in the health care system (e.g., presuming patients are engaged solely in heterosexual relationships) (Shoveller, Knight, Johnson, Oliffe, & Goldenberg, 2010; Hoffman, Freeman, & Swann, 2009; Makadon, Mayer, Potter, & Goldhammer, 2007). The literature examining the predictors of heterosexual men's participation in STI testing services has revealed psychosocial factors (e.g., fear of exposing one's penis) (Shoveller et al., 2010) and socio-cultural influences (e.g., dominant forms of masculinity that idealise the male body as robust) (Connell, 1995), as well as structural and institutional factors (e.g., the public health system's focus on the reproductive health needs of women) (Alt, 2002).

Men's sexual health and masculinity are strongly linked to notions of 'risk' in which men must reconcile sexual risks and pleasure (Robertson, 2007). Sociological critiques of masculinities and men's health have identified a myriad of influences related to their health-seeking behaviours and experiences, including denial of illness, reluctance to access health

care services and self-monitoring and -treatment of symptoms (Courtenay, 2004; Lee & Owens, 2003; Robertson, 2007). These critical analytical perspectives suggest that men's sexual health experiences should be understood as occurring within a wider set of social relations (Shoveller, Johnson, Savoy, & Pietersma, 2006; Shoveller, Johnson, Rosenberg, Greaves, Patrick, Oliffe, et al., 2009; Shoveller et al., 2010; Lindberg, Lewis-Spruill, & Crownover, 2006; Goldenberg, Shoveller, Koehoorn, & Ostry, 2008), detailing the connections between structure, identity and agency. An emerging sociological framework explores how these interactions are underpinned by gendered and heteronormative societal expectations (Shoveller et al., 2004; Shoveller et al., 2010). Under this framework, threats to men's health can occur due to one's identity (e.g., gay masculinities subordination to dominant and hegemonic heterosexual masculinities), and these 'external' risks can have negative consequences on men's health (e.g., limited job opportunities; physical violence) and access to health services (Connell, 1995; Robertson, 2007). However, there is a dearth of empirical studies to substantiate how heteronormativity 'functions' to influence men's sexual health experiences and outcomes.

To date, most research pertaining to re-conceptualisations of social norms and men's sexual health (e.g., sexual identities as 'fluid' rather than 'fixed') have largely focused on men's experiences negotiating sexual encounters (Maxwell, 2007). Some studies have provided insights into men's gender relations that demonstrate the techniques that they employ to reproduce gendered (and especially heterosexist and heteronormative) discourses (Pascoe, 2007; Korobov, 2005); however, additional insights are needed to better understand how heteronormative discourses are (re)produced within clinical settings where men seek

sexual health services, such as STI testing. These settings represent a space (both physical and social) where heteronormative assumptions and heterosexist stereotypes can profoundly shape men's experiences (Kehily, 2002; Holland, 2008). These settings also represent a pivotal juncture in which men and clinicians reify or resist heteronormative assumptions by: (1) engaging in emancipatory/transformational practices and discourses in relation to sex and gender diversities, equity and power relations; or, (2) (re)producing dominant and hegemonic forms of masculinities, while perpetuating heterosexist beliefs and heteronormative assumptions (Pascoe, 2007; Holland, Ramazanoglu, Sharpe, & Thomson, 1998).

In this study, heteronormative and heterosexist discourses are examined to explore how they function within clinical settings where men access STI testing services. Both men's and clinicians' stories are analysed to describe the extent to which heterosexist or heteronormative discourses are (re)produced, resisted or reified in these clinical contexts. In doing so, the contextual and structural conditions which may facilitate or waylay opportunities to express alternative, more equitable gendered power relations and sexual identities in STI testing clinical settings are described.

## **2.2 Study setting**

Data collection took place in 2006 in five communities in BC: Vancouver is surrounded by roughly 20 suburban communities with a total population of 2,116,581. Richmond, population 174,461, borders Vancouver directly to the south. Located approximately 780 kilometres north of Vancouver, Prince George, population 70,981, is the economic hub of northern BC. Located approximately 115 kilometres south of Prince George, Quesnel,

population 9,326, is a rural community. Fort St. John, population 17,402, is an economic hub for oil/gas in northeastern BC, 478 kilometres from Prince George (Statistics Canada, 2007).

In Canada, STI testing is available through clinics that specialise in sexual health and/or youth health, as well as through general medical clinics, hospital emergency rooms, and family doctors. Each community had a clinic (or clinic hours) that specialised in providing sexual health services, including STI testing; although, male participation at these clinics was often very low (accounting for approximately 5% of youth clientele) (Shoveller et al., 2010), and STI testing is available by appointment or drop-in. Health services in Canada are publicly funded and, in BC, services are available to all residents who pay a monthly premium to the province's Medical Services Plan (CDN\$54 per person). Youth clinics did not require proof of being registered in the Medical Services Plan.

## **2.3 Methods**

### **2.3.1 Recruitment of participants**

Forty-five men between the ages of 15 and 25 years old were recruited to participate in in-depth, semi-structured interviews (lasting approximately 1 to 1.5 hours) through recruitment posters and pamphlets. Men less than 19 did not need their guardian's assent. Research staff recruited at clinical (e.g., sexual health clinics, walk-in clinics) and non-clinical (e.g., bus stops, universities and colleges, community centres) sites to include men who had previously accessed STI testing, as well as those who had considered being but were not previously tested. To be eligible for an interview, men were: between the ages of 15-25; HIV



negative; sexually active; and English speaking. A purposive sampling strategy included men from a variety of socioeconomic and cultural backgrounds, as well as self-identified gay, bisexual and heterosexual men. A total of 25 clinicians (i.e., physicians and nurses) were recruited from clinics and completed in-depth, individual interviews to detail their experiences of providing sexual health services (particularly STI testing) to young men. Research staff recruited clinicians from the clinic sites that men said they accessed for STI testing. Ethics approval was obtained from the University of British Columbia.

### **2.3.2 Interview procedure**

Research staff scheduled interviews to take place at a time and place convenient for the participant, and all interviews were conducted in private spaces (e.g., research team's offices; private clinic spaces). The purpose of the interviews was explained to participants to *'better understand the experiences of young men who have undergone STI testing, as well as those who have not, to guide planning in the area of men's STI testing.'* The interview was started after the study was explained and participants had read and signed a written consent form, along with a brief socio-demographic questionnaire. At the end of the interviews with men, participants were provided with a list of STI testing clinics, as well as other information about sexual health resources. Six interviewers (five female; one male) conducted the interviews, and participants had the choice to have a male or female interviewer. The youth participants received a CDN\$25 honorarium.

### 2.3.3 Study participants

In total, 45 young men including 40 heterosexual, 4 gay and 1 bisexual participated (*table 1* provides the young men socio-demographic characteristics). Twenty-five interviews were conducted with female ( $n=19$ ) and male ( $n=6$ ) clinicians (*table 2* provides the clinician socio-demographic characteristics).

*Table 1. Self-identified characteristics of young men*

AGE GROUP	(n)	Percent
15-18	9	20%
19-25	36	80%
ETHNICITY		
Aboriginal	11	24%
Black	1	2%
Chinese	1	2%
South Asian	3	7%
South East Asian	2	4%
Latin American	1	2%
Euro-Canadian	26	58%
COMMUNITY		
Fort St. John	12	27%
Prince George	10	22%
Richmond	8	18%
Quesnel	5	11%
Vancouver	10	22%
TESTED		
Never	14	31%
1 time or more	31	69%
SEXUAL RELATIONSHIP STATUS		
Currently involved	29	64%
Not currently involved	16	36%
SEXUAL ORIENTATION		
Heterosexual	40	89%
Homosexual	4	9%
Bisexual	1	2%

Table 2. Characteristics of clinicians

	Male (n=6)		Female (n=19)	
	(n)	Percent	(n)	Percent
<b>AGE GROUP</b>				
25 to 40	1	4%	5	20%
>40	5	20%	14	56%
<b>ETHNICITY</b>				
Euro-Canadian	6	24%	19	76%
<b>OCCUPATION</b>				
Nurse	2	8%	12	48%
Physician	4	16%	7	28%

### 2.3.4 Interviews

Men shared perceptions about their community’s socio-cultural ideals and norms (e.g., gender roles; attitudes towards straight, gay and bisexual men), and the effects these norms had on their engagement with STI testing services. Men who had been tested (n=23) were asked to reflect on interactions in clinic spaces, including discussions, experiences and procedures (e.g., comfort level with clinician’s questions). Young men were also asked to describe how their sexual identity might affect experiences with STI testing services, and how the experiences might differ for a man who’s sexual identity differed from their own. See Appendix 6.1 for the interview guide that was used with young men.

Clinicians described practice guidelines and were asked to discuss gendered power dynamics with the young men they serve (e.g., developing rapport with youth). Clinicians discussed in detail their perspectives on clinical encounters with men seeking STI testing, including patient reactions to risk assessments. Clinicians described the ways their own attitudes of men or the socio-cultural norms of the community in general, influenced the provision of sexual health services. Each clinician was asked to describe their professional

background, education, and professional practice history. See Appendix 6.2 for the interview guide that was used with clinicians.

### **2.3.5 Data analysis**

Interviews were audio-recorded and transcribed with identifying details removed. Each transcript was checked for accuracy. *QSR NVivo 8™* was used to code and manage the data. A constant comparative technique was used to develop the initial set of codes that represented key individual level processes described in the interviews (Dey, 1999). This consisted of an open coding approach, using participants' language, and avoiding, where possible, the imposition of preconceived theoretical constructs (Glaser & Strauss, 1967). As additional interviews were completed, coding was organised into 'trees' to group the open codes into more abstract conceptual categories. Additional codes were developed as new themes emerged and data collection continued. In developing the coding schema, particular attention was paid to the ways in which gender norms and heteronormative assumptions influenced young men's and clinician's experiences with STI testing.

## **2.4 Results**

The findings are presented in three thematic segments in which I distil how heteronormativity functions within STI clinical encounters: (1) *The 'Relativity of Risk'*; (2) *Alleviating men's anxieties*; and (3) *(Re)producing the heterosexual status quo*.

### 2.4.1 The 'relativity of risk'

Most clinical encounters related to STI testing began with an assessment of symptoms and a patient's risk for exposure to STIs/HIV. Solicited by clinicians were details about STI history, substance use, sexual relationship status and psycho-social history (e.g., sexual abuse), and sometimes the men's sexual identity was also questioned. Questions about sexual identity were understood by heterosexual men as a strategy to identify other men – in particular, gay men. Consequently, heterosexual men often reasoned that although their straight identity was obvious, questions around sexual identity guided what STI testing was required. For example, a 20-year-old heterosexual man was asked if it was important to him that his clinician knew his sexual identity. He responded: *'Well, 'cause I'm straight, so I don't really care. 'Cause in society, straight is what's considered normal, right.'* Others described having been 'assumed' – or having wanted to be 'assumed' – heterosexual early on in the clinical encounter.

Although most men experienced some discomfort being asked about their sexual identity, participants interpreted this as a 'necessary' component of their sexual health assessment. In a manner similar to clinicians, the youth participants agreed that men who engaged in same-sex sexual practices had a greater risk of STI/HIV transmission and needed to be identified for their own good and for public health reasons (e.g., collecting data for population-based STI trends) and to order particular STI tests. For example, a 24-year-old heterosexual man explained, *'I was asked if I was a drug user or a homosexual. If I wasn't, then I was in a much lower risk category [...] and my chances of having it [HIV] were seriously low.'* Justifying the inclusion of questions about sexual identity was an important part of the

STI/HIV risk assessment process that connected ‘risk’ and ‘sexual identity.’ Within these explanations heterosexuality was situated as a ‘default’ normative discourse aligned with less risky sexual practices. Embedded here are understandings that the clinical rationale for asking identity questions was all about finding the ‘other’ (e.g., gay men).

Several men who identified as gay/bisexual explained they had experienced significant anxiety about the risk assessment questions that clinicians asked. Some men experienced these questions as intrusive and refused to respond or provided inaccurate information about their sexual identity and/or practices. For example, a 19-year-old bisexual participant explained that he was uncomfortable self-disclosing such details to a stranger:

*I don't think they [clinicians] have any right, really. I mean, you can volunteer [this information], but I don't think there's any right or reason for them to [know] your identity...even your activity. I don't really - I mean it doesn't make that much of a difference.*

This man’s discomfort appeared rooted both in the stigma he faced in disclosing his bisexual identity and the range of risky sexual practices typically assigned to that identity. He did not accept that these questions were used by clinician’s to gauge one’s potential risk for STI exposure. As a result, the man withheld information arguing that being ‘assumed straight’ by the clinician had no impact on the specificity of his STI testing. Some gay participants suggested that STI tests were prescribed based on preconceived identity-specific risk profiles rather than their self-reported sexual practices. A 21-year-old gay man explained his

dissatisfaction about having an HIV test because he had not engaged in 'risky' behaviour associated with HIV transmission (e.g., receptive anal intercourse):

*I'm a little uncomfortable with the fact that gay people are the ones who get HIV... and that kind of reflects on the tests. It's like, 'Okay, you're gay so I have this for you. You're straight, this is for you.' And I think that that's how it works. Maybe not. Honestly, I don't know. But it made me feel, I'm part of a certain type, therefore I need to answer all these kinds of questions. They don't apply to me but I still do it. Because I'm gay.*

While this man was not engaging in practices that would elevate his risk for acquiring HIV, he explained (and for the most part accepted) that by virtue of his gay identity he was 'required' to routinely test for HIV. Similarly, a gay 22-year-old man who had worked for several years as a peer sexual health educator explained that his own risk assessment was based on his sexual identity. Though he had not been sexually active between the results of his last test and the current test, he thought that, as a peer educator, he should test every six months 'no matter what,' so he could be a role model to his friends. He described the sexual health counselling he received:

*The nurse was giving me some tips on how to have a healthy sex life and be as safe as possible. And I, I didn't really feel like saying, 'Oh, well I've been a sex educator for several years; I'm pretty well informed.' And she said, 'You know, some people use two condoms at the same time.' As if this was some kind of an excellent option for me!*

Illustrated here is the degree to which 'externalised' risk can impact men's 'internalised' assumptions and practices. The man's insistence that he needed to test frequently in order to be a gay role model, regardless of his sexual activity, reveals how dominant social constructions of risk can influence gay men's STI practices. The clinician's advice also seemed founded on assumptions of 'externalised' risk of gay men by disregarding the man's abstinence and providing inaccurate and potentially injurious information (wearing two condoms causes friction which increases the risk of tearing (Alexander, LaRosa, Bader, Garfield & Alexander, 2010)).

For many men the clinical encounter for STI testing represented a unique and often times intense interaction whereby their sexual identities and practices were overtly interrogated. In what might be construed as positive discrimination, both the straight and gay/bisexual men (usually) answered these questions as a means to assist clinicians in assessing risk. Yet, also evident was a leap of logic whereby the sexual practices of straight men and gay/bisexual men were assumed to be clearly delineated, flowing in unitary and straightforward ways from their sexual identity. Within these assumptions there seems great potential to over-screen the 'other' (i.e., gay and bisexual men) while concomitantly under-screening heterosexual men.

#### **2.4.2 Alleviating men's anxieties**

Almost all of the clinicians recognised that men experienced discomfort when being asked questions about sexual identity and practices, and three key strategies for alleviating



men's concerns emerged. First, some clinicians explained how they eliminated (or de-emphasised) questions of sexual identity to reduce men's anxieties. These clinicians also acknowledged sexual identity as a crude marker of risk because it did not necessarily inform the 'risky' sexual practices that men engaged in (e.g., anal sex). Clinicians often described their approach to sexual health service provision as 'gender neutral', which they perceived to be a good way to provide comprehensive impartial services for all sexual identities (both men and women). One nurse also boasted how her clinic purposely provided gender-neutral services:

*I mean we try to keep it really gender neutral, so the interview for women, we go through the pelvic exam because it is a little more invasive. For men – and we don't have to ask menstrual history on men so it does shorten some of the questions down a little bit. But they can expect the same thing- confidentiality, give them all their options and then we go through our assessment. Yeah it's really...it's very similar for both. [...]  
So we'll ask you know, "When you have sex, do you have anal sex?"*

This nurse's explanation of 'gender neutral' services focuses primarily around the patient's anatomical sex differences (e.g., women menstruate and require a pelvic exam). Few clinicians recognised how this approach might fail to respond to men's different gendered (and heteronormative) expectations and that these behavioural-based questions are themselves inherently gendered (e.g., 'When you have sex, do you have anal sex?'). Uninterrogated here are the ways in which clinical practices and interactions (and clinicians

and patients themselves) are inextricably 'gendered' and 'sexed' or how supposedly gender-neutral approaches are potentially co-produced by the men's and clinicians' heteronormative assumptions.

Second, some clinicians said that they would explain to their patients, in detail, *why* they needed to ask questions around sexual practices. This strategy was described as an important method to help alleviate men's anxieties with these questions, as a male public health nurse explained:

*Some of these questions might be embarrassing, so we tend to explain the questions.*

*So we'll ask you know, 'When you have sex, do you have anal sex? Somebody's penis in your bum or your penis in somebody's bum.' 'The reason I need to know this is...' so we try- that's why it takes a long time too is because we do a lot of 'Why am I asking you?' You know, here I am, a stranger, asking if you take it up the ass? Like it's...not polite conversation usually.*

By describing questions around sexual practices (e.g., anal sex) as 'not polite conversation', this clinician acknowledges that transgressing men's heteronormative assumptions and expectations (e.g., inquiring about anal sex) can negatively affect men's comfort levels. While the use of the pronoun 'we' reveals the institutional power and imperative to identify 'risky' men, this clinician justifies these 'heteronormative transgressions' by providing biomedical and epidemiological rationale (e.g., the rectum provides a route into the bloodstream for STI/HIV-infected fluids or blood).

Lastly, some clinicians emphasised that it is important to discern both a patient's sexual practices and identity. Failing to do so was positioned as a missed opportunity for tailored sexual health promotion strategies. For these clinicians, sexual identities and practices were 'clues' for determining the social supports and/or contexts of their patients, rather than exclusive markers of STI risk. Several clinicians gave the example of patients who identify as straight that also have sex with men, identifying the unique sexual health needs and support that these men require. As one clinician explained about this group of men: *By the time they get to an STD Clinic, probably...they're there because they're at risk and sometimes it's not so much what they're doing, it's the fact that they can't get any support for it.* This scenario illustrates how men's individual management and perceptions of health risks (e.g., health-seeking behaviours) are influenced by and interact with external circumstances (e.g., heteronormative expectations that heterosexual men have sex exclusively with women) and how these can in turn affect clinical interactions. Therefore, sexual identity was described by some clinicians as an important factor to inform strategies for communicating (e.g., educating and counselling) with patients using a tailored, nuanced and sensitive approach. One public health nurse described how he tailored his language to the patient he was seeing:

*You use different words, less formal or whatever kind of way that people talk, that's the way you talk, you know. Guys come in, 'anal sex' is fucking, I mean it's just more natural to say it because certainly that's what they're calling it. And [otherwise] you're going to have come up with some 'prissy' word to describe it. That kind of thing, I think it's... much more focused on the immediate need of the client.*

While many clinicians acknowledged that individualising their communication strategies took time and required experience and thoughtful consideration (e.g., tailoring language to each man's vernacular), it was positioned as key to improving the quality of information gathered while concurrently alleviating men's discomfort. Interestingly, this public health nurse's avoidance of using 'prissy' words depicts how gendered power relations are (re)produced within clinical encounters and illustrates how aligning to dominant masculine ideals (e.g., avoiding 'prissy' feminine language) can potentially alleviate men's discomfort in clinical settings (for both patients and clinicians).

These strategies for alleviating men's anxieties were enacted through either the disavowal or acknowledgement of men's gendered and heteronormative expectations. While both methods present opportunities for potentially (re)producing harmful stereotypes, both premised on the belief that sexual identity is not sufficient for assessing STI risk. However, the latter strategy appreciated men's management of health risks (e.g., individual choices; health-seeking behaviours) are influenced by external 'moral elements' (Robertson, 2007) (e.g., heteronormative expectations).

### **2.4.3 (Re)producing the heterosexual status quo**

The heterosexual status quo was (re)produced through heteronormative enactments whereby men embodied various straight masculinities. Interestingly, within the research interviews, details around sexual identity were accompanied by the occasional reactive homophobic remark (e.g., *'I'm not a fag'*). Youth also implicitly 'othered' gay men when asked

about their own sexual identity or practices, as illustrated by a 21-year-old heterosexual interviewee:

*Interviewer: Did the receptionist or the nurse or the doctor ask you whether you're straight or gay or bisexual?*

*Participant: Yeah they did.*

*Interviewer: Okay. And were you comfortable being asked that?*

*Participant: Yeah, it's – I thought it was funny!*

*Interviewer: Yeah?*

*Participant: [laughs] Yeah I'm straight, I said "I'm straight", you know, it's just funny, I thought it was funny [laughs].*

This man's production of heterosexual masculinity and his embodiment of these norms rendered the idea that anyone would *really* need to question his 'obviously' straight identity as implausible and absurd, thereby positioning the questions as emerging from a clinical protocol that asks everyone their sexual identity – even when the answer is 'obvious'.

There were also more subtle reassertions of men's masculinities and reproductions of the heterosexual status quo. For example, some men suggested that society has 'moved beyond' sexual identity issues, arguing that equality had emerged, and many explained that they were comfortable with all sexual identities. For example, a 20-year-old heterosexual man explained: *Like, myself...I know, like I got buddies who were in high school and, turns out, they're gay...like I really don't have a problem with that. As long as no lines get crossed or*

*anything like that.* While seemingly resistant to dominant or hegemonic masculine ideals (e.g., explicit homophobia as a foundation for heterosexual identities), this man concurrently reaffirmed his own straight identity, implicitly laying claim through a disclaimer that simultaneously serves heterosexual privilege. His readiness to interact with gay men is contingent on the condition that *'no [heterosexual] lines get crossed'*. Other men were less conditional in their acceptance of sexual diversities. For example, a 22-year-old heterosexual man explained:

*I think the majority is okay with sexuality and not just homosexuality, any type. Like more openness or even talking about it. It's kind of like when I say majority, it's almost like this is how it is, we're open and whoever doesn't agree is just like, so few of them, that you're kind of like 'Catch up or we're going to ignore you otherwise!'*

While downplaying the possibility of masculine hierarchies within men's social relations, this man's explanation is somewhat paradoxically claimed from a position of heterosexual privilege. By explaining *'we're open'*, this man positioned himself within the (heterosexual) *'majority'*, revealing a tolerance-versus-inclusion dichotomy with respect to subordinate gay masculinities and his own enactments of a complicit masculinity. These narratives reveal how men who do not embody hegemonic masculinity can nonetheless benefit from *the social organisation of masculinity*; the (heterosexual) *'majority'* of men aligned to complicit ideals of masculinity in which they benefited from the patriarchal dividend without taking the *'frontline'* hegemonic position (e.g., explicit homophobia) (Connell, 1995).

Men who embodied subordinate gay masculinities were also complicit in reproducing the heterosexual status quo. One example involved a 21-year-old gay man who contested two recent clinical encounters. First, he went for testing at a clinic that was known to be 'gay-friendly', but was anxious when he realised he would be seeing a female clinician:

*I felt comfortable because I thought he [a male clinician] was going to see me. But then when I saw this person coming in and I was like, 'Oh! A woman, okay! She's really butch, so whatever.' [...] Okay... she looked totally butch. I was like 'Ah, I'll go with her.'*

Because this man read the female doctor as 'queer' (i.e., butch lesbian), he was comfortable being treated by her. By contrast, when he accessed STI testing at a different clinic that specialised in STI testing (although, it did not explicitly specialise in 'gay-friendly' testing), he said:

*I was uncomfortable in the second [clinic] when I was talking to a med student, because the context is not [a queer-friendly neighbourhood], not talking with a butch doctor. I wasn't sure if she was comfortable. I was more worried about her [laughs] hearing all these, like, things that many people are not used to hearing. [...] I was worried or afraid to mention to this straight, really 'girly' straight med student. You don't know whether they really feel comfortable with you in the room.*

This situation illustrates the degree to which heteronormative assumptions influence (and are (re)produced within) clinical interactions. In each scenario, the man (re)positions himself with a heteronormative lens. Based solely on his clinician's appearance, he explains he is far more comfortable openly discussing his sexual history with a woman who appears 'butch, lesbian'. On the other hand, he explains a 'straight' 'girly' clinician will experience significant discomfort around discussions of his same-sex sexual practices. His responses reveal how gender relations in clinical encounters can be underpinned by heteronormative assumptions – not only for those who identify as heterosexual – but also by those who identify as gay and embody subordinate masculinities.

The degree to which institutionalised heterosexuality (re)produced the distribution of heterosexual power was revealed within some clinics through their attempts to create 'gay-friendly' services. For example, one nurse explained that she hung a poster promoting safe sex depicting two gay men embracing in the STI clinic where she worked. Shortly after, she received a complaint from a clerical worker at the clinic:

*A lot of the front line staff have no- they're clerical. You know, and they're very good at what they do, but that doesn't mean they were- they didn't necessarily come here knowing what they were getting into, and knowing that they may have to, you know, be aware of some issues around that.*

The nurse filed a complaint about the incident to clinic management, but no action was taken.

As the nurse explained:



*I would have liked to have seen it be kind of an instigation of change. Like, something made them really uncomfortable, so we need to deal with that because that's not fair to them either, to be uncomfortable, and not have some resolution. Most of these people are pretty good, solid people, and they wouldn't say something like that if they weren't feeling threatened or scared. Something was really upsetting them, on some level.*

This scenario illustrates how transgressing heteronormative expectations can be *threatening*, *uncomfortable* and *scary* for people who work in clinics that are accepting of diversity in principle, as well as how institutions can fail to mobilise emancipatory opportunities and perhaps, inadvertently, reinforce the heteronormative discourse. These situations reveal how reproductions of the heterosexual status quo can be enacted not just by the heterosexual men accessing STI testing, but also by gay men, clinic staff and institutional policies.

## **2.5 Discussion**

Hetero-patriarchal societies depend on the binary of Self-Other (e.g., homosexuals positioned as the deviant 'Other') (Schilt & Westbrook, 2009). It is in response to heteronormativities that men shape their sexualities, rendering visible the discourses of power and how power is socially organised to benefit heteropatriarchy. These findings reveal the complex processes that govern heteronormative power distributions and the heterosexual status quo during STI clinical encounters. Ever present in the data were examples illustrating how gay and bisexual men respond to heteronormative expectations in

STI clinical encounters by deferring to the authority of heterosexuality and complying with the rules of 'successful heterosexuality,' (re)producing institutionalised gender. These performances of 'the hetero in the head' parallel with Holland et al.'s (1998) notion of 'the male in the head' whereby women were considered collaborators and enablers in the production of male-dominated heterosexuality. These findings illustrate how gay men can be complicit and perhaps collude with the reconstructions of institutionalised heterosexuality, thereby portraying a 'hetero in the head'.

Similar to qualitative interviews that attempted to elicit responses related to gendered behaviour by Haines, Johnson, Carter, & Arora (2009) participants avoided acknowledging the possibility of (male) heterosexual privilege. While these discourses appeared resistant to explicit homophobia, many participants concurrently reaffirmed their heterosexual masculinity through disclaimers about readiness to interact with gay men (e.g., contingent on the condition that '*no lines get crossed*'), underscoring the notion that dominant forms of masculinity are often contradictory and inconsistent (Connell, 1995). This nuanced, yet pervasive, construction of normative masculinity is consistent with previous masculinities work where homophobia and sexism can be mitigated through disclaimers, innuendos or humour (Korobov, 2005). The resistance to acknowledge that gay and bisexual men might experience barriers to accessing STI testing often enabled a more liberal and egalitarian masculinity (Korobov, 2005) (e.g., suggesting that there is equality for all sexual identities). However, the disavowal of gay and bisexual men's subordinated social positioning represents a gap between reality and rhetoric that is underpinned by a neoliberal political discourse that positions gender and sexuality as 'no longer mattering' (Brodie, 2008). As Brodie (2008)

points out, this discourse can threaten gender equality efforts by de-legitimising subordinate groups (e.g., gay men).

Bonding identities to moral accounts of health helps to maintain self-surveillance (e.g., to prevent men from engaging in 'risky' same-sex relations) through *technologies of the self* (Foucault, 1988). As Connell (1995) explains, these discourses may play part of a larger socio-political function to promote surveillance and regulation *by* the individual, thereby taking responsibility out of the realm of the State. This function situates agency, rather than structural (e.g., help-seeking versus health service and systems) and socio-cultural influences (e.g., sexual diversities in heteronormative cultures), as the most influential determinant of sexual health outcomes (e.g., STIs). As a result, the 'public health' medical system and the State are focused on providing sexual health information on which men should choose to act (e.g., make healthy choices) and be rewarded for choosing the 'safe' or 'correct' (heterosexual) lifestyles (Robertson, 2007; Peterson & Lupton, 1996). Under this framework, clinicians are positioned as authorities that define and regulate the behaviour of people who belong to "risky groups" (Shoveller & Johnson, 2006; Rosenfeld & Faircloth, 2006). These *technologies of the self* produce a moral understanding of sexual identities - not solely at a clinical level, but also at macro-societal levels (e.g., community norms). Although self-surveillance *technologies* are frequently relied upon as a same-sex sexual risk behaviour reduction strategy, the current findings indicate a dearth of similar STI/HIV prevention discourses for heterosexual men. Consequently, these findings demonstrate how *technologies of the self* function differentially across sexual identities and may contribute to the 'pronounced silence' around the sexual health needs of heterosexual men while

reproducing the status quo of heterosexual men's disengagement with discussions around sexual health practices and promotion.

These findings are important for clinical practice and promoting sexual health equity among men (and women). Clinical discourses linking sexual identity to risk through superficial markers is inefficient and reproduces and reinforces gay and bisexual men as the risky 'Other' and heterosexual men as the (hetero)normal patient. While assessing risk based on history of intravenous drug use and anal intercourse are important factors for determining the level of STI/HIV risk exposure (Public Health Agency of Canada, 2006), assessing risk solely on the basis of sexual identity (as was described by some participants) (re)produces a discourse that implicitly links risk with gay identities. Concurrently, this discourse 'frees' heterosexual men from being at high risk for STI/HIV by virtue of their sexual identity, rather than taking into account the sexual risk behaviour in which they engage. As Robertson (2007) argues, such 'externalizing of risk' occurs as a result of social positioning and identity and uses moral elements to promote individual 'responsibility' for safety (e.g., creates a system which systematically identifies, monitors and 'corrects' gay and bisexual men's sexual behaviour). Concurrently, these discourses threaten the sexual health of heterosexual men, as heterosexual men can remain disengaged from their sexual health because as a collective they are at 'minimal risk'. This inevitably results in missed opportunities for sexual health promotion for heterosexual men and may 'sell short' the epidemiology of STI/HIV as rates continuously changes over time across social characteristics (e.g., sexual identity; ethnicity).

These findings do not imply sexual identity should be discarded from clinical discussions related to STI/HIV testing. Sexual identity provides important clues with respect to

STI/HIV prevention counselling (e.g., can help the clinician better understand each patient's social contexts, networks or group affiliations and social norms) (Young & Meyer, 2005). It is also useful and efficient to target STI/HIV population intervention and prevention programmes (e.g., STI testing or screening programmes) to vulnerable populations based on epidemiology (e.g., because of higher HIV prevalence among gay men, HIV awareness efforts have been focused on this population subgroup). However, clinical protocols (e.g., STI risk assessments) targeting sub-groups based *primarily* or *solely* on a man's membership to a particular subgroup (e.g., gay men) may inadvertently sabotage well-intentioned efforts to practice medicine in gender and culturally competent ways (Numer & Gahagan, 2009; Makadon et al., 2007; Holmes & O'Byrne, 2006). These findings point to the need for clinicians to consider the wider set of social relations that men experience in their everyday lives (Shoveller et al., 2010) and incorporate into their clinical practices strategies that unpack harmful stereotypes about 'non-heterosexual' sexual identities (Holmes & O'Byrne, 2006; Browne, 2007).

Many clinicians in the study claimed to have implemented 'gender-neutral' services. The use of the term 'neutral' fails to recognise the influences of a wider set of social relations (e.g., gender norms) that everyone is exposed to (and contributes to) in their everyday lives. A theoretically 'neutral' position often translates into yet another sphere within which heteronormative social norms are re-enacted and remain unquestioned (Snively, Kreuger, Stretch, Wilson, & Chadha, 2004). Moreover, *sexual* health services represent a special case for men's interactions with and reproduction of (heterosexual) masculine discourses. As these findings illustrate, these are unique encounters where the "natural binary" (Butler, 1990) of

biological sex and socially constructed genders are explicitly 'interrogated'. Censoring, denying or 'neutralising' gender affirms and gives prominence to the repressive power that heteronormative gender relations currently impose (Foucault, 1978). Clinics must also address the reality that some staff members (*including* clerical staff) enact heteronormative, heterosexist and homophobic beliefs. Educating *all* staff members, including clerical and administrative staff who interact with patients (e.g., scheduling appointments; checking patients in upon arrival) may help promote safe and inclusive environments for everyone and could help relieve anxieties for those staff members who are uncomfortable or uncertain about how to engage with sexual diversities (Potter, Goldhammer, & Makadon, 2007).

The current study has several strengths and limitations. Obviously, heterosexism and heteronormativity are not unilateral or monolithic concepts that are isolated from other social hierarchies (e.g., gender, class, race) (Bryant & Vidal-Ortiz, 2008). The current study's design offers a contextualised and analytical approach that can describe these forces within cultural contexts and how they interact with other areas of social lives (e.g., gender relations in their communities). However, the findings are not claimed as generalisable to all men's experiences or other STI clinical settings.

In conclusion, this analysis offers theoretical and empirical insights into how discourses that (re)produce or naturalise heteronormative cultural assumptions 'hurt everyone', including those 'privileged' by embodying heterosexual identities. These findings reveal discourses within STI clinical settings which systematically shut down discussions around heterosexual men's sexual health and contribute to heterosexist stereotypes for gay and bisexual men. They also highlight the role sexual health clinical services can play in which

clinicians and men either (re)produce dominant and hegemonic forms of masculinities or create transformative, more equitable gendered relations. Ultimately, these findings point toward the need for men-centred sexual health services to provide services that attend to a diversity of social contexts and structural conditions.

## Chapter 3.0 Masculinities, ‘Guy Talk’ and ‘Manning Up’: Young men’s discussions about sexual health

### 3.1 Introduction

#### 3.1.1 Background

Popular portrayals of sex and sexual health often claim that women talk too much (with each other) and men talk too little (with anyone) (DeVore, 2009). Some authors relate men’s reticence to engage in discussions around health in general to dominant masculine ideals that prescribe stoicism, independence, self-reliance and disinterest in self-health (Connell, 1995; Courtenay, 2000a and 2000b). For example, men are depicted as more likely to deny illness than engage in discussions about their health and well-being (Robertson, 2007). A few studies rooted within the contexts of men’s coping with illnesses (Olliffe, 2010a) and chronic disease (Charmaz, 1995) show that some men engage one another in meaningful conversations about their health. Most studies that have examined young men’s *sexual* health-related discussions focus on their communication within and about health care service provision situations (e.g., patient-doctor communication) (Carlisle, Shickle, Cork & McDonagh, 2006). To date, there is little empirical and/or theoretical literature examining men’s talk and discussions with one another regarding their sexual health (e.g., sex practices; contraception; sexually transmitted infections; ‘healthy’ relationships).



### 3.1.2 Young men's sexual health

Despite decades of public health intervention, sexually transmitted infections (STIs) and HIV remain a serious health problem among young men. For example, in 2007 in the United Kingdom, men below the age of 25 represented 57% of all Chlamydia cases (34,626 cases) at a rate of 1,100 per 100,000 among men aged 20-24 (Health Protection Agency, 2011). In the United States in 2009, men between the ages of 20 to 24 had the highest rate of Chlamydia at 1,120 cases per 100,000 (compared to the national average of 409 per 100,000) (US Centers for Disease Control and Prevention, 2007). In Canada, as elsewhere, young men's STI rates are high and rising. For example, in British Columbia (BC), Canada's most western province, between 2000 and 2009, genital Chlamydia rates among young men, 15 to 24 years old, doubled, with 1,110.4 cases per 100,000 men (compared to the BC average of 251.1 per 100,000) (British Columbia Centre for Disease Control, 2010).<sup>3</sup> Those who are racialised, economically disadvantaged as well as men who have sex with men (MSM) bear the largest burden of STIs (British Columbia Centre for Disease Control, 2010; US Centres for Disease Control and Prevention, 2007). In 2009, HIV incidence rates for men between the ages of 20 to 24 were significantly higher than the provincial average at 11.2 per 100,000 cases (compared to the provincial average of 7.6 per 100,000) (British Columbia Centre for Disease Control, 2010). Moreover, the STI surveillance data indicate the potential for a significant

---

<sup>3</sup> While women ages 15 to 24 experience higher rates of STIs such as as genital Chlamydia, these disparities have largely been attributed to asymptomatic cases in heterosexual men who have not been tested and therefore not treated, or who are treated for their symptoms but not tested (and therefore remain unreported in the surveillance data) (British Columbia Centre for Disease Control, 2010).

increase of HIV spread among young men (Larkin, Andrews, & Mitchell, 2006). As a result, there is a strong public health impetus to improve young men's sexual health outcomes.

### **3.1.3 Masculinities and men's sexual health practices**

Men's *sexual* health-related practices have been associated with a plurality of masculinities and emerge as complex, often in contradictory and inconsistent ways. The high and rising rates of STIs among men have been attributed to their disengagement with sexual health services, a reticence around self-help and a lack of meaningful discussions around sexual health informed by masculine ideals (Robertson, 2007). Men who avoid discussing sexual health are at increased risk of becoming infected by an STI (as well as other health-related consequences) (Alt, 2002; Courtenay 2000a; Brook Advisory Centres 2005; Pearson 2003). An emerging literature details how the connections between masculinities and social contexts can influence young men's sexual health-related practices (Shoveller *et al.* 2009 and 2010; Gautham *et al.* 2008; Goldenberg *et al.* 2008; Mantell *et al.* 2006; Shoveller *et al.* 2006; Shoveller and Johnson 2004 and 2006). For example, Goldenberg *et al.* (2008) described how structural conditions (e.g., location and hours of STI clinics) amid hyper-masculine oil/gas worker occupations and social contexts intersected to create significant barriers for men's engagement with STI testing services, while at the same time, creating social situations that put men (and women) at elevated risk for getting an STI.

Other critiques have begun to explore how aligning with dominant masculine ideals may also produce *health-enhancing* behaviour for men. For example, men whose jobs require strength and endurance (e.g., firemen) may idealise a healthy body and therefore be more

likely to engage in health-promoting behaviour (e.g., exercise; healthy diet) (O'Brien, Hunt & Hart, 2005). These 'healthy masculinities' are typically positioned as a means to "*preserve or restore* another, more valued, enactment of masculinity" (O'Brien, Hunt & Hart, 2005, p. 1). Practices of preserving or restoring preferred enactments of masculinity also have been identified in the realm of men's sexual health practices. For example, hegemonic masculinity is associated with the valorisation of frequent sexual activity and sexual 'risk-taking' practices (e.g., avoidance of condoms) (Numer & Gahagan, 2009). However, some men who embrace these ideals also worry about the potentially emasculating effects of 'falling ill' (e.g., getting STIs/HIV) (Duck, 2009), revealing the complex relationships between masculinities and men's health practices (Oliffe *et al.*, 2007).

#### **3.1.4 Men talking about sexual health**

Some studies have described how portrayals of masculine ideals vary according to contextual features, such as the audience (e.g., within and among men versus women) (Pascoe, 2007; Allen, 2003), conversational subjects (Allen, 2003), historical context (e.g., across time) and/or socio-political milieu (Guzman, 2006). Emerging analyses suggest that men's access to cultural and economic capital (e.g., ethnicity; social class; geopolitical contexts) can bolster or limit their capacity to embody dominant masculine ideals that may put their health at risk (e.g., discussing sexual health with peers) (Shoveller et al, 2010; Duck, 2009; Allen, 2003). These approaches view men's health-related behaviour as operating under socio-cultural influences (e.g., gender norms) as well as structural-level determinants (e.g., access to capital). In the current study, I examined descriptions of the social and

contextual conditions which facilitate, forbid or 'shut down' sexual health communication among and by men. I pay special attention to how idealised masculinity influences young men's social interactions as they discuss their sexual health practices with their peers and/or sex partners.

## **3.2 Methods**

### **3.2.1 Recruitment**

Using posters to advertise the study, men 15-24 years-old were recruited from youth STI clinics, bus stops, community centres as well as online forums including Facebook™.

Interested participants telephoned or emailed the research office and were screened for eligibility. The criteria for sampling was sexually active, English speaking men 15-24 years-old who had previously tested or considered STI testing. Young men of various ethnicities, sexual identities, ages and socioeconomic statuses participated in individual, semi-structured, in-depth interviews. Ethics approval was obtained from the University of British Columbia.

Participants under the age of 19 did not require their parent's/guardian's assent; all participants provided informed consent.

### **3.2.2 Study setting**

Young men were recruited in Metro Vancouver, Canada. Vancouver is located on Canada's south west Pacific coast and has a population of 2,116,581 people with approximately 215,000 men ages 15 to 24 years old (Statistics Canada, 2007). Approximately

40 percent of Vancouver's population are immigrants. Vancouver markets itself as being one of the most 'gay-friendly' cities in the world (Tourism Vancouver, 2011).

### **3.2.3 Interviews**

The individual, in-depth, semi-structured interviews lasted approximately 1 to 1.5 hours and took place at private settings (e.g., research offices). Interviews were scheduled at a time convenient to the participants. During the interviews, participants were asked to describe the situations in which they engage in conversation or discussion about sexual health with their peers and/or sex partners. The interview questions addressed a variety of topics that might arise in conversations with peer and/or sex partners, including STI testing, sexual practices and contraception. In order to better understand how their conversations played out, I asked the participants to describe the social contexts in which these conversations took place (e.g., location; comfort levels; topics; tone of conversations; reactions of their peers/sex partners). See Appendix 6.3 for the interview guides used during these interviews. All participants were offered a \$25 honorarium and the opportunities to "member check" their transcripts.

### **3.2.4 Data analysis**

Interviews were transcribed, checked for accuracy and uploaded to NVivo 8<sup>TM</sup> for coding and analysis. Using a modified grounded theory approach (Strauss and Corbin, 1998), interviews were compared to identify broad themes across interviews (Have, 1995) with special attention on men's narratives about the discussions they have with peers and sex partners.

This analytic method was chosen to enable the development of descriptions of young men's uses of language, rather than the specific grammatical and/or linguistic use of language (Hodges, Kuper & Reeves, 2008). From these emergent themes, I developed an initial set of codes. The masculinities literature was consulted to develop conceptual themes and to identify coherent patterns within and across the data (Sandelowski, 1995). As data collection and analysis continued, coding occurred iteratively within and across interviews to test emergent ideas about the connections between concepts and to identify new themes.

### **3.3 Findings**

#### **3.3.1 Study participants**

I draw on an analysis of 32 qualitative, semi-structured in-depth interviews with young men between the ages of 17 to 24. The average age of participants was 20.5 years. All participants had previously had sex (oral, anal, and/or vaginal). See *Table 3* for the socio-demographic characteristics of the participants.

**Table 3. Self-identified characteristics of young men**

<b>AGE GROUP</b>	<b>(n)</b>	<b>Percent</b>
<b>15-19</b>	16	50%
<b>20-24</b>	16	50%
<b>ETHNICITY</b>		
<b>Aboriginal</b>	4	13%
<b>Black</b>	1	3%
<b>South Asian</b>	6	19%
<b>South East Asian</b>	4	13%
<b>Latin American</b>	1	3%
<b>Euro-Canadian</b>	15	47%
<b>Middle East</b>	1	3%
<b>SEXUAL ORIENTATION</b>		
<b>Heterosexual</b>	20	63%
<b>Homosexual</b>	7	22%
<b>Bisexual</b>	5	16%

The following provides illustrative quotes from participants related to the discussions they have with peers and sex partners about sexual health. The findings are divided into two thematic sections: (1) “Guy talk” and (2) ‘Manning up’.

### **3.3.2 ‘Guy talk’**

I asked participants to describe the situations in which they were able to discuss their sexual health with peers. Most participants explained that their discussions about sex typically consisted of descriptions about their sexual encounters (e.g., whom they had sex with; what sex acts they engaged in), and several participants called this ‘guy talk’. Few said they had ever talked about sexual health-related issues (e.g., STI testing; condom

negotiation). As Milo, a straight 19-year-old East Asian man, explained, when he and his friends talk about sex, it is:

*Just ‘guy talk’, I guess. Whatever. Like, if I had sex with a girl last night, I’ll like call my buddies and be like “Yo, last night was fun!” and he’d be like “Oh what’d you do?” Stuff like that. But we don’t really talk in terms of like sexual **health** [emphasis added to indicate Milo’s voice inflection], like getting STI tests.*

The inflection in Milo’s voice confirms sexual “*health*” as taboo and irrelevant, a side issue that could only serve to distract or dilute the details of his sexual conquest and pleasure. Talking about sexual performance (i.e., who did what to whom and where) is afforded the most airtime within these interactions because these details most readily engage the listener[s]. Inversely, the concept of sexual *health* is inextricably tied to STIs (e.g., getting tested), which is a subject not conventionally included in conversations with male friends.

Some participants surfaced stereotypes regarding the idea that gay men can more freely or openly engage in conversations about sexual health (e.g., because they are assumed to ‘talk about sex all the time’). Although these data revealed a more complex set of practices, the gay men in this study were more likely to have talked about sexual *health*, but only with their gay friends. As Bill, a 22-year-old Euro-Canadian gay man, said:

*For gay guys like me, my best resources are my gay best friends. Gay guys talk about sex all the time. Sometimes it’s just, you know, a story....But, if you want advice on*



*something, you're probably going to get it. Because somebody probably experienced the same thing.*

Conversations about sexual *health* among gay men were also aligned within a dominant masculine discourse around men's talk relating to sexual performance where descriptions of sexual acts and partners are used to signal virile gay masculinities, marking hierarchies within those masculinities. Many gay participants also acknowledged that heterosexual men tend to focus their 'guy talk' primarily on their sexual encounters (but with women), relying on the use of humour and/or derogatory remarks to relay their stories. As Bill, a 22 year old gay man, acknowledged:

*It's like they [heterosexual men] just make fun. It's not sexual **health**....My best friend is straight and I hang out with straight guys all the time. When they start talking about sex, I slowly turn myself off....I don't want to hear them talking about pussy....Girls are gross....I don't want to hear a string of short stories about their "times with women". And, then, they'll come up with some kind of gay, orgy fantasy. And, I'm just like [pause]: "I don't even dream about that shit!" Where do they come up with these things?*

Talking about sexual encounters (including fantasies about gay sexual encounters) in ways that reify hyper-masculinity tended to dominate participants' accounts (even in groups that include a mix of gay and straight men). Revealed here is an example of how patriarchal power

can be (re)produced by a set of ritualistic masculine practices (e.g., hyper-sexualized hegemonic ideals) which can also be operationalized by (heterosexual) men to include the subordinated 'other'.

Some men described experiencing negative social repercussions if they discussed sexual health. By breaking the taboo, those who broached the topic of sexual health with their men peers were frequently subjected to ridicule. For example, Christopher, a Black 17-year-old straight man, expressed frustration with the teasing he was subjected to by peers after he tried to discuss sexual health. Christopher explained that he has since avoided talking about sexual health, for fear of further mocking:

*Well... [talking about sexual health] with guys, no, because I don't know where the conversation is going. I don't want it to be that I'm going to ask an intelligent question, and at the end of it, I'm being made fun of for being a virgin or something silly like that. [...] It's going to be twisted around and then I hear from the next girl I'm trying to date that she thinks I'm gay or that I might have an STD.*

Christopher's narrative reveals the masculine codes that can filter and censor men's talk. At risk in the moment and in the aftermath is gossip and rumour invoking an irretrievable suspect and subordinate masculine status. For Christopher, his attempts to discuss sexual health with peers were refuted, and instead suspicion was roused among his peers for which they reacted by assigning an array of subordinate masculinities – gay, virgin or a 'dirty' diseased man with an STD. Without the groups permission Christopher learned to keep silent

about sexual health as a means to avoiding emasculating ridicule and far-reaching rumour. Christopher's narrative also demonstrated how masculine ideals around heterosexual desire and the capacity to deliver a strong, confident performance muted the 'talk' with which he wanted to engage about sexual health. Many participants suggested the interview was unique and, for some, the first opportunity to discuss and reflect on issues related to their sexual health. Indeed, several participants, including Christopher, explained that the primary reason for participating in the study was to have the opportunity to confidentially and anonymously discuss, and learn more about sexual health.

Some participants explained that conversations about sexual health (e.g., condom and/or contraception negotiation) were particularly difficult to have with sex partners because issues of trust and fidelity would inevitably arise. As a result, some men explained that they avoided these discussions, thereby deferring to their partners the responsibility of initiating relevant conversations and/or taking relevant action(s). For example, Johan, a straight 22-year-old Euro-Canadian man was not monogamous, and he explained that while his preference was to use condoms he often felt uncomfortable discussing this topic with sex partners:

*I just find myself not making good decisions around it [using condoms] more often than I'm comfortable with. It- the pleasure is definitely a huge part of it. I think another part of it might be that I- I don't like talking about... It is just... [pause] [...]  
Like, I don't want to stop to necessarily to bring it up – like if I bring it up, it's like, almost like... Talking about condoms is almost like discussing having sex, and like...*

*you know, if it's just happening, then like, I don't wanna feel like I am having to discuss it. [...] I really do appreciate it when girls bring it up... because yeah, just, it takes that pressure off a bit.*

Here, negotiating condom use is positioned as a worrisome conversation rooted in expectations about feminine ideals that value health over pleasure and take the lead in that discussion. As a result, initiating this conversation reveals Johan as concerned about safety rather than spontaneity and pleasure. While acknowledging he should care about condom use, Johan's silence renders him complicit in sustaining masculine ideals around stoicism and hedonism. This places him in a position where he is reliant on his female partners to take care of sexual health decision-making.

Some men explained that, although it was difficult, they infrequently engaged in discussions about sexual health with their peers and/or sex partners (e.g., STI symptoms or testing; notifying sex partners of potential infections). When asked how these conversations 'played out', most participants explained that humour was the lynchpin to engaging such discussions – especially when they had talked with male peers. When I asked Tyler, a 23-year-old straight Euro-Canadian, described how he discussed sexual health with his friends, he explained:

*Once in a while one of my friends will get with somebody very questionable and we'll kind of poke him and prod him to go get, go get tested. [chuckles] That does happen sometimes.*

*[Interviewer: What do you mean by “questionable”?]*

*Um, well, first of all, someone we don't know. Someone we may have heard that sleeps around. Somebody who insists on not using protection.*

*[Interviewer: Okay. And how does the ‘poking and prodding’ go?]*

*Usually we tease him and tell him he probably has AIDS. It really gets him going.*

By employing teasing humour in these conversations, the ‘friend’ is encouraged to seek STI testing, while Tyler (and the wider group) implicitly disclaim ‘really’ caring about the man’s sexual health. Teasing humour can serve to prompt men to reflect upon, and perhaps recognise and reconsider ‘risky’ sexual practices while not explicitly challenging sexual pleasure and conquest as key hyper-masculine performance indicators.

A few participants explained that they were able to discuss sexual health in a more serious way, but only with friends that they trusted deeply. For example, Jameel, a straight 21-year-old man of Middle-Eastern descent, described how he discussed STI symptoms with his closest friends:

*It depends on the background of the guys first of all and how long you've known the friends for. Like I usually can't talk to a friend that I've just met on campus for like a month or two. Usually I can't talk about that with him. But I usually prefer to talk to my male guys that I've known for six, seven years that I've known like my brothers. So I just talk to them with my concerns and they usually come up with some advice and they're usually like, if I am concerned with some symptoms or if I'm just paranoid they*

*tell me: "Hey, just calm down and go get tested. Don't worry about it and hopefully it's nothing serious."*

For Jameel, discussions about STI symptoms (and the like) could only be conducted with friends that he trusted "like brothers".

### **3.3.3 'Manning up': Talking about STIs and health**

Some men described situations in which they admitted to having an STI. For example, Jameel said that although it would be difficult to reveal an STI diagnosis to even his closest friends, he would self-disclose about the details after he was treated and 'cured':

*As time goes on, I think things tend to be less intense; so, I would actually let them know after a while that "Yeah, I've been diagnosed with that like several months ago; but, I'm getting treated or I'm under some kind of treatment," and then would actually let them know. But at the instance, I don't think I would be able to. I wouldn't have the courage to tell them, yeah.*

Like Jameel, most participants indicated that they would need time to must the strength to break with an idealised masculine performance round stoicism to talk about having an STI. The process of developing the courage to more openly discuss sexual health problems emerged as an important theme during the interviews; however, for the most part, men aligned with Jameel's suggestion that, when first faced with illness, autonomy and self-reliance trumped the necessity to talk with or seek the counsel or support of others.

Many participants positioned the strength and courage to ‘man up’ as residing in particular actions. For example, Zachary, a gay 22-year-old Euro Canadian explained that when he tested positive for STIs, he notified his sex partners directly rather than ask the health department to contact them (in BC, clients have the option to do either):

*My sexual partners, I don't exactly know very well. I always try to keep... I always try to contact them if I ever do come down with something. That's hard. But they have that service available here where you can just give the clinic the phone numbers of the people and they'll call, which is kinda good. But, I mean you should 'man up' and tell them yourself.*

Zachary's decision to notify his sex partners seemingly contravenes masculine ideals that men deny illness and care for another person's health. However, by ‘manning up’, Zachary *repositions* what it means to take responsibility for others' sexual health by emphasizing his decisive honourable actions aimed at doing the principled and perhaps protective thing. Notifying sex partners (which in Zachary's story is positioned as an act of courage) is characterized as something that ‘real men’ have the power and control to do, for greater good with reckless abandon for the implications and potential repercussions for their own safety. In privileging and performing this version of ‘manning up’, many study participants were complicit in sustaining a specific set of masculine ideals. For example, their language positioned ‘real’ men as dominant and capable, facing up to a problem for which they might

be implicated, amid steely resolve to withstand any potential conflict or estrangement (e.g., being blamed for the STI by sex partners). As Tyler, a 23-year-old straight guy, confirmed:

*You should just man up and call them yourself... Straight up. No. No email, no doctor calling you.*

*[Interviewer: So you wouldn't prefer the doctor or nurse to call your sex partners?]*

*Hell no. No. Go tell them yourself. Quit being a pussy.[...] I think you should call them yourself. Really, I think you should implicate yourself. I think you should put it right out there, yeah. Uh, "I had sex with you. Um, if it wasn't protected, I may have given you something." Own up to it.*

Other forms of 'manning up' emerged during the interviews, whereby feminine ideals (e.g., caring; helping) were re-shaped in more subtle ways to reflect masculine ideals (e.g., taking charge; being strong). For example, Cody, a 23-year-old straight Aboriginal man, explained how he helped his young cousin who was experiencing STI symptoms:

*My little cousin, man, he had Chlamydia and VD [Gonorrhoea] and it was bad, man. It was Christmas time. I'm driving around looking for a clinic to get him fixed, man.*

*That's the pain he was in. Yeah, Gonorrhoea, man, it fuckin' hurt him. It's like, 'Aw, dude, man.' I found a doctor's office that was open and they gave him the pills [...] He was 16! He was 16 when he caught both of those diseases, man. Like the dude was in*



*pain, man! [...] He was like, "Yeah, I have something..." And I told him, yo, man, I just got rid of Chlamydia myself. There's pills for it, man."*

Here, Cody disregards the conventions of 'guy talk' and reveals his Chlamydia diagnosis in order to empathize with his young cousin. Cody's narrative also positions him as a 'fixer' –a man that is strong and wise enough to take charge handle the problem. Emphasizing his capacity to 'man up' in any crisis, Cody also told us that his best friend had recently 'come out' as being homosexual. Cody explained that he was able to support his friend through this process because he had been hardened up (by previous life experiences) and, as a result knew how to behave in difficult situations, especially in those circumstances requiring 'straight up' actions in order to protect his friend:

*Just, everybody just thinks I'm cool, man. I'm a good guy to hang out with, like. I'm straight up, there's no fuckin' lying or anything. I'm straight, man, and you know? If I don't like someone in the fuckin' crowd, I'll fuckin' tell 'em straight, "Yo man, you know, you're being an asshole, man, you know? Like, fuck, no one likes you." [...] Plus I stick up for my friends. [...] I've seen some fucked up things, man. Especially for my age, too, man. I can't believe all the shit, but hey man, out of the fast style, the lifestyles. I've done a lot of things in my life and probably will do more.*

Cody's narrative demonstrates a complex (re)negotiation of idealized masculinity and what it means to be a 'real' man. Cody takes pride in being a man that can transcend heterosexist

stereotypes (e.g., embracing his friend as a homosexual man). Cody also takes risks both in and around adopting behaviour associated with feminized traits (e.g., caring about others; accepting gay men); but, rather than having his masculinity questioned, Cody deploys these traits in ways that ultimately bolster his ubiquitous hyper-masculinity. Whereas for 'weaker' men, these situations would present dangerous and emasculating risks, for Cody, these situations elevate his masculine status.

### **3.4 Discussion**

Dominant masculinity produces and governs the ways in which knowledge can be meaningfully discussed (Foucault, 1978). The ways in which men talk about sexual health draws on and (re)produces idealised masculine expectations (e.g., what it means to be a 'real' man). For the men in this study, discussions about sexual health revolved primarily around their sexual encounters. As Flood (2008) explains, men's homosocial discussions about sex are often the medium in which male bonding is enacted and internal "pecking orders" of the masculine hierarchy are (re)enforced.

Most men in this study employed what Korobov (2005) terms ironic teasing humour which is used to neither cancel out an expression of concern for other men, nor explicitly disavow concern about a male friend's sexual health. As Korobov describes, this equivocation makes it difficult to determine if men are complying with or resisting normative masculinity. Nonetheless, the focus on men's sexual exploits through the use of humour reproduces group solidarity between men, thereby reconstituting a form of patriarchal power in which women

and men are often dominated and marginalised (e.g., through the use of derogatory language).

‘Manning up’ permits men to break the silence and move beyond superficial humorous ‘guy talk’ about sexual encounters in order to engage in action-oriented discussions aimed at remedying the situation. These data reveal two techniques by which men can ‘man up’: (1) deploying *power over* others with disregard for the potential repercussions; and (2) deploying *power to* assist others in ways that reify features of their hyper-masculine identity. ‘Manning up’ by deploying power over others emphasises the masculine power of the speaker/performer (e.g., being tough enough to say anything) and their embodiment of idealized masculinity. For example, the use of ‘manning up’ serves to position some men as being sufficiently strong as to not need to worry or care about the repercussions of partner notification – a form of damage control to preserving masculinity (O’Brien et al., 2005). ‘Manning up’ is also enacted by using one’s personal power (e.g., power derived from hyper-masculine status) to help others. While deploying power may permit some men to disrupt some aspects of hegemonic masculinity (e.g., by permitting them to care for others), its use is not intended to disrupt the hegemony. Rather, this form of ‘manning up’ has a symbiotic relationship with idealised features of the dominant male (e.g., the ‘fixer’). Both of these ‘manning up’ techniques rely on men’s ability to use discourse to position themselves at the ‘top’ of an idealised masculine hierarchy which suggests that those who do not (or cannot) ‘man up’ are, in fact, subordinate (and, therefore, unable to attain a status as ‘real’ men). By reconfiguring and reproducing notions of hegemonic masculinity, ‘manning up’

remains an option viable only for some men (e.g., those who have attained an idealised masculine status).

What men *cannot* say about their sexual health also operates as a mechanism of power (Foucault, 1978): in breaking these 'rules' (e.g., talking about STI/HIV testing; condom negotiation), men might be teased or mocked and have their masculinity questioned. As a result, for some men, discussions about sexual health are neither possible, nor desirable. Moreover, the practice of relying on female sex partners to take care of sexual health decision-making highlights how some men consider taking care of sexual health as a feminine ideal. Still, other men in the study expressed frustration with the silences imposed by the limits of 'guy talk', but they described only a few conditions (e.g., using humour; 'manning up') under which silence can be broken using techniques to 'man up' in ways that protect and/or bolster masculine status.

This study has several strengths and limitations. Describing the contextual and social conditions that facilitate or waylay men's discussions about sexual health is only helpful under theoretical frameworks that emphasise the diversity within the group "men" (Numer and Gahagan, 2009). Masculine hierarchies represent complex social milieux that are not separate from other social identities (e.g., socio-economic status; racialised bodies) (Connell, 1995). While the current analysis offers some rich insights into these social and cultural forces, I was unable to fully address other important issues (e.g., the classed relations of these men within their communities). While the findings are not claimed as generalisable to all men's discussions about sexual health, I identified several ways in which men resist, accommodate or transform idealised masculinity as they engage in discussions or remain

silent about sexual health. These practices may have important implications for interventions that aim to promote men's sexual health (e.g., sexual health services; education); but, we do not fully understand the mechanisms through which masculinities (particularly the social practices and relations derived from hegemonic masculinity) interact with interventions in ways that might enhance or detract from men's sexual health.

## Chapter 4.0 Discussion

The current thesis demonstrates how hegemonic and idealised masculinities and/or heteronormative expectations affect men's sexual health-related practices. These analyses provided an in-depth examination of the ways in which heteronormative and heterosexist masculine discourses function within clinical settings where men access STI/HIV testing, as well as the social and contextual conditions which allow men to talk about sexual health. These findings advance the empirical and theoretical knowledge about young men's sexual health.

### 4.1 Summary of findings

Chapter 2, *Heteronormativity Hurts Everyone*, provided insights into how heteronormative discourses may be (re)produced in clinical settings and influence gay, bisexual *and* heterosexual men's health-seeking experiences/behaviour. The STI/HIV testing experience emerged as a unique situation whereby men's (hetero)sexuality was explicitly 'interrogated'. STI/HIV risk assessments discursively link sexual identity to risk in ways that reinforced gay men as the risky 'Other' and heterosexual men as the (hetero)normal and, therefore, relatively low-risk patient. This in turn alleviates concern for STI/HIV exposure in heterosexual men by virtue of their sexual identity (rather than their sexual practices), which mute discussions around their sexual behaviour. To alleviate men's discomfort with questions around sexual identity, some clinicians implement 'gender-neutral' services. However, few acknowledge the influences of social relations (e.g., heteronormativity; idealized notions of

masculinity) on men's *and* clinicians' everyday lives. Finally, some clinicians confound sexual identities with sexual practices, relying on their assumptions as 'clues' for determining how they will approach clinical communication about risk. Thus, heteronormative assumptions can 'hurt' *all* men (including those who identify as heterosexual) in sexual health clinical encounters. Heteronormative assumptions systematically 'shut down' discussions around heterosexual men's sexual health, while concomitantly contributing to heterosexist stereotypes about gay and bisexual men. The findings in Chapter 2 also highlight the role that sexual health clinical services can play by either (re)producing dominant and hegemonic forms of heteronormative masculinities or creating transformative, more equitable gendered relations during and beyond the clinical encounter.

Chapter 3, *Masculinities, 'Guy Talk' and 'Manning Up': Young men's discussions about sexual health* identified social and contextual conditions which facilitate or 'shut down' effective sexual health communication amongst young men (e.g., with peers; sex partners), with an emphasis on idealized notions of masculinity. Men use 'guy talk', including ironic and teasing humour, to take up impartial, manly positions that neither dismiss nor actively express concern for the sexual health of male friends. Opportunities for in-depth discussions about sexual health (e.g., asking advice about STI testing or symptoms) typically give way to boasting about hyper-masculine sexual performances and encounters. 'Manning up' is a technique that permits men to break with masculine ideals of stoicism and self-reliance to talk about sexual health issues and concerns via two processes: (1) exerting *power over* others with disregard for potential repercussions; and (2) deploying *power to* affirm and reify men's hyper-masculine identities.

## 4.2 Implications for theory

The current thesis explores the ways in which hegemonic masculinity influences young men's sexual health, including their sexual health-seeking behaviour, sexual practices and the ways in which they talk about sexual health. The findings reveal instances in which hegemonic masculinity 'hurts' all men – including those who are subordinated as well as those complicit in sustaining hegemonic ideals. While these findings provide support for theories, suggesting that men's health is at risk if they align and/or interact with hegemonic masculinity, they also reveal instances in which hegemonic masculinity produces opportunities for more socially 'just' outcomes (e.g., 'manning up', in which power is exerted *in order to help* others). These social interactions represent instances in which hegemonic masculinity is disrupted, then reinstated, through performances to *preserve* or *restore* another, more valued, enactment of masculinity (O'Brien, Hunt, & Hart, 2005). Indeed, hegemony, as argued by Howson (2006), is unlikely to be de-gendered, but may represent a potential for overcoming, redistributing (and, reinstating) a more socially just hegemony. As Howson (2006) argues, by focusing on the negativity of hegemonic masculinity, instead of the potential for "progressive equivalential unity" within gender relations, theorists will "...ensure that the politics of gender continues to operate conceptually around the mutual exclusivity of hegemony and social justice" (p. 6-7). By examining situations in which men (and clinicians) can socially reconfigure notions of hegemonic masculinity related to their sexual health, theorists will also better understand the ways in which more socially just systems of hegemony can be produced (Howson, 2006).



### **4.3 Implications for men's sexual health interventions and future research**

The current thesis provides new empirical and theoretical evidence to inform STI/HIV interventions to promote and protect young men's sexual health. A variety of interventions have been employed to 'target', test and treat those most at risk and, recently, technological advances have presented new ways to 'reach' young men (e.g., via the internet; on mobile handheld devices). For example, the STI/HIV Division at the British Columbia Centre for Disease Control is developing the new Online Sexual Health Services Program to provide online testing services (e.g., online risk assessment questionnaires; downloadable lab test requisition forms); online counseling and education (e.g., online sexual health counseling through chat, forums, or e-mail; referrals to other services); and, online partner notification (e.g., online greeting cards sent peer-to-peer with personal messages or anonymously). While this program offers new opportunities to reach young men, the current study underscores the reality that men's online sexual health-related practices (e.g., how they discuss sexual health; heteronormative expectations) are likely to be mediated by masculine ideals. As some scholars argue, online communication also is constituted by a social ordering of men and women (Armentor-Cota, 2011). Therefore, we need to better understand how context (including heteronormative expectations) affects engagement with online sexual health interventions such as STI/HIV testing.

While these findings highlight situations in which more 'socially just' forms of masculinity are manifested (e.g., 'manning up'), the current thesis does not fully explicate the mechanisms through which masculinities (particularly the social practices and relations

derived from hegemonic masculinity) may interact with interventions in ways that might enhance or detract from men's (and women's) sexual health. For example, interventions that would seek to reconfigure dominant masculine expectations (e.g., advertising campaigns suggesting young men should 'man up' and take care of one's self and others) may inadvertently reproduce narrow gender role definitions (e.g., stereotypes about men as being sexually irresponsible) and/or contribute to the (re)production of masculine patriarchal hegemony (Larkin, Andrews & Mitchell, 2006). As a result, interventions must take a careful, nuanced approach that focuses on better understanding the intended as well as unintended consequences related to young men's sexual health interventions that attempt to produce more socially just masculinities.

The findings of the current thesis also have implications for future research related to STI/HIV population health interventions that 'target' populations based on socially defined characteristics (e.g., sexual identity). STI/HIV infectious epidemiology frequently relies on a 'population-at-risk' approach, whereby a population's social characteristic (e.g., sexual identity) serves as a proxy for identifying the subgroup of the population thought to be at increased health risk (e.g., men who have sex with men). The findings of the current thesis reveal how risk assessments during clinical encounters that solely focus on discrete social characteristics may unintentionally result in positive discrimination and/or stigmatization (e.g., HIV positioned as a gay concern, thereby alleviating concern for heterosexual men). Nonetheless, clinicians are encouraged to frequently use this approach (e.g., by clinical practice guidelines), assuming that the costs (e.g., stigma; inequitable health outcomes) are justified by the benefits (e.g., improved overall health at the population level and within the

at-risk group) (McLaren, McIntyre & Kirkpatrick, 2010). The ethical implications related to population health interventions that target socially-defined characteristics of population subgroups are only beginning to be examined. Little is known about how this approach to intervention may operate *differentially* within and across ‘targeted’ populations and there is some concern that these approaches may exacerbate health inequity – particularly among the most vulnerable population subgroups (Frolich & Potvin, 2008). As a result, further research is required to examine the bioethical implications of STI/HIV interventions that ‘target’ populations of men.

#### **4.4 Strengths and limitations**

The current study focuses on a substantive issue within a population that is currently undertheorized (Frankel, 2004). To date, the majority of men’s sexual health research and masculinities focuses on homogenous samples of adult and older adult men based on specific social identities such as race or sexual identity. Most previous work has tried to distil the ways in which subordinated or marginalized masculinities (e.g., gay masculinities) ‘function’. While the sample size of the current study limits the capacity to examine in detail the intersections of gender, race and/or class (Kimmel and Messner 2007; Connell & Messerschmidt, 2005; Duck, 2009), study participants described diverse experiences and masculine identities. The analyses included here are based on the premise that masculinities do not mean the same thing to all men (Coles, 2009). For example, by including men of various sexual identities, this study was able to extend beyond some contemporary masculinity theories that label men subordinated masculinities by virtue of other intersecting ‘subordinate’ social identities (e.g.,

racialized bodies; 'non-heterosexual' identities). Instead, the current thesis is aligned theoretically with new emerging theory that explores masculinities and its functioning by suggesting that "*hierarchies within hierarchies*" of masculinities must be accounted for in theory (Numer & Gahagan, 2009). Lastly, while the raw data available across 77 interviews with young men and 25 interviews with clinicians offer rich and varied perspectives, the quotes that are included in this thesis are intended to serve as exemplars of the key concepts and themes featured in the empirical analyses presented in Chapters 2 and 3.

#### **4.5 Interpretation of findings and reflexivity**

In interpreting the results of this thesis, my role as an interviewer should be considered. I identify as a gay man; I am white; at 6'6", I am significantly taller than the average man and I am, on average, about 8 years older than the participants in this study. Overall, I perceived that most of the young men I interviewed seemed to be comfortable talking about their sexual health histories with me. Nonetheless, in writing detailed reflexive field notes, I frequently explored how my own appearance, non-verbal communication and other potential power dynamics (e.g., age; race; class) could affect the results of the interview processes. For example, in reflecting on my own gendered performances, I frequently wondered how my sexual identity was being 'read' by the participants and how this might affect the interview dynamics with respect to discussions about sexual identities. My research office space displays several *Positive Space Campaign* signs (a UBC campaign that strives to create safe spaces for all sexual and gender identities) – though, it is questionable as to whether participants would recognise the purpose of these signs. During interviews, some of

the men expressed explicitly heterosexist (as well as misogynistic) attitudes, beliefs and sentiments. During these discussions, I did not reveal my own discomfort with their beliefs (in the same way that I avoided acknowledging my agreement when my own thoughts aligned with men's attitudes/beliefs). Instead, my reactions focused on exploring 'why' and 'how' men expressed these attitudes and how this might influence their sexual health-related practices. To do this, I frequently relied on probing, prompting and looping – interviewing techniques that have been described elsewhere (Oliffe & Mroz, 2005) as being useful for interviewing men about their health behaviour. In the situations in which men expressed homophobic or misogynistic sentiments, I may have appeared to condone and/or support their heterosexist and misogynistic accounts by neither 'shutting down' nor avoiding these conversations and, instead, acting interested as I probed to learn more. However, similar to an account reported by Flood (2008) in which the men he interviewed frequently denigrated women, my discomfort was only diminished through the acknowledgement that these narratives provided an opportunity to better understand how idealized notions of masculinity are embodied, experienced and lived out in men's daily practice. Understanding men's experiences in relation to idealised notions of masculinity is critical to advancing social justice that promotes gender equity and improved sexual health among young men and women. By exploring these narratives, I hope that these sorts of stereotypes and practices that underpin hegemonic masculinity can be problematised and contribute to pathways toward more equitable gender relations.

## References

- Alexander, L., LaRosa, J. H., Bader, H., Garfield, S. & Alexander, W. J. (2010). Chapter 5: Reproductive health. In *New Dimensions in Women's Health* (5)89-130. Sudbury, MA: Jones & Bartlett Publishers, LLC.
- Allen, L. (2003). Girls want sex, boys want love: Resisting dominant discourses of (hetero)sexuality. *Sexualities*, 6(2) 215-36.
- Alt, R. L. (2002). Where the boys are not: A brief overview of male preventive health. *Wisconsin Medical Journal*, 101(4), 22-7.
- Armentor-Cota, J. (2011) Multiple Perspectives on the Influence of Gender in Online Interactions. *Sociology Compass*, 5(1) 23-6.
- Bottorff, J. L., Oliffe, J. L., Kelly, M., Greaves, L., Johnson, J. L., Ponc, P. & Chan, A. (2010). Men's business, women's work: Gender influences and fathers' smoking. *Sociology of Health and Illness*, 32(4) 583-96.
- British Columbia Center for Disease Control STI/HIV Prevention and Control. (2010). 2009 annual surveillance report: HIV and sexually transmitted infections.
- Brodie, J. (2008). We are all equal now: Contemporary gender politics in Canada. *Feminist Theory*, 9(2), 145-164.
- Brook Advisory Centres. (2005). Brook warns against overlooking men's sexual health. *Brook [Website]* July 31. Retrieved on June 17, 2008 from <http://www.brook.org.uk>.
- Brown, T. L. & Alderson, K. G. (2010). Sexual identity and heterosexual male students' usage of homosexual insults: An exploratory study. *The Canadian Journal of Human Sexuality*, 19(1/2), 27-42.
- Browne, A. (2007). Clinical encounters between nurses and First Nations women in a Western Canadian hospital. *Social Science and Medicine*, 64, 2165-76.
- Bryant, K. & Vidal-Ortiz, S. (2008). Introduction to retheorizing homophobias. *Sexualities*, 11(4), 387-396.
- Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity*. New York, NY: Routledge.

- Carlisle, J., Shickle, D., Cork, M. & McDonagh, A. (2006). Concerns over confidentiality may deter adolescents from consulting their doctors. A qualitative exploration. *Journal of Medical Ethics*, 32(3), 133-37.
- Charmaz, K. (1995). Identity dilemmas in chronically ill men. In D. Sabo & D. Gordon (Eds.), *Men's Health and Illness: Gender, power and the body*, 266-91. Thousand Oaks: Sage.
- Coles, T. (2009). Negotiating the Field of Masculinity: The Production and Reproduction of Multiple Dominant Masculinities. *Men and Masculinities*, 12(1), 30-44.
- Connell, R. W. & Messerschmidt, J. (2005). Hegemonic masculinity: Rethinking the concept. *Gender and Society*, 19, 829-59.
- Connell, R.W. (1987). *Gender and power: society, the person, and sexual politics*. Stanford University Press: Stanford.
- Connell, R.W. (1992). A very straight gay: Masculinity, homosexual experience, and the dynamics of gender. *American Sociological Review*, 57, 735-51.
- Connell, R. W. (1995). *Masculinities*. Berkeley, CA: University of California Press.
- Courtenay, W. H. (2000a). Behavioural factors associated with disease, injury, and death among men: Evidence and implications for prevention. *Journal of Men's Studies*, 9(1), 81-142.
- Courtenay, W. H. (2000b). Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social Science and Medicine*, 50(10), 1385-1401.
- Courtenay, W. H. (2004). Making health manly: social marketing and men's health. *The Journal of Men's Health and Gender*, 1(2-3), 275-76.
- DeVore, J. (2009). How men talk about sex. Tuesday, September 1, 2009. *CNN*. Retrieved from <http://www.cnn.com/2009/LIVING/personal/09/01/tf.how.men.talk.sex/>
- Dey, I. (1999). *Grounding grounded theory: Guidelines for qualitative inquiry*. London: Academic Press.
- Duck, W. (2009). Black Male Sexual Politics: Avoidance of HIV/AIDS Testing as a Masculine Health Practice. *Journal of African American Studies*, 13(3), 283-306.
- Fee, D. (2000). Gay men's friendships with straight men. In P. Nardi (Ed.), *Gay masculinities*, 44-65, London: Sage.

- Flood, M. (2008). Men, Sex, and Homosociality: How Bonds between Men Shape Their Sexual Relations with Women. *Men and Masculinities*, 10(3), 339-59.
- Foucault, M. (1978/1990) *The History of Sexuality: Volume I*. Random House: New York.
- Foucault, M. (1988). Technologies of the self. In L. H. Martin, H. Gutman, & P. H. Hutton (Eds.), *Technologies of the self*, 16-49. Amherst: University of Massachusetts Press.
- Frankel, L. (2004) An Appeal for additional research about the development of the heterosexual male sexual identity. *Journal of Psychology and Human Sexuality*, 16(4), 1-16.
- Frohlich, K.L. & Potvin, L. (2008). The Inequality Paradox: The Population Approach and Vulnerable Populations. *American Journal of Public Health*, 98(2), 1-6.
- Galdas, P. M., Cheater, F. & Marshall, P. (2005). Men and health help-seeking behaviour. *Journal of Advanced Nursing*, 49(6), 616-623.
- Gautham, M., Singh, R., Weiss, H., Brugha, R., Patel, V., Desai, N. G., Nandan, D., Kielmann, K. & Grosskurth, H. (2008). Socio-cultural, psychosexual and biomedical factors associated with genital symptoms experienced by men in rural India. *Tropical Medicine & International Health*, 13(3), 384-95
- Giordano, P. C., Longmore, M. A. & Manning, W. D. (2006). Gender and the meaning of adolescent romantic relationships: A focus on boys. *American Sociological Review*, 71(2), 260-87.
- Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory*. Chicago: Aldine Publishing Company.
- Goldenberg, S., Shoveller, J., Koehoorn, M. & Ostry, A. (2008a). Barriers to testing among youth in a Canadian oil and gas community. *Health & Place*, 14(4), 718-29.
- Goldenberg, S., Shoveller, J., Koehoorn, M. & Ostry, A. (2008b). Sexually transmitted infection testing among young oil/gas workers: the need for innovative, place-based approaches to STI control. *Canadian Journal of Public Health*, 99(4), 350-54.
- Goldenberg, S., Shoveller, J., Ostry, A. & Koehoorn, M. (2009). Youth Sexual Behaviour in a 'Boomtown': Implications for the Control of Sexually Transmitted Infections. *Sexually Transmitted Infections*, 85(5), 397-401.
- Guzman, M. (Ed.) (2006) *Gay Hegemony/Latino Homosexualities*. Routledge: New York.



- Haines, R., Johnson, J. L., Carter, C. I. & Arora, K. (2009). "I couldn't say, I'm not a girl" – Adolescents talk about gender and marijuana use. *Social Science & Medicine*, 68(11), 2029-36.
- Have, P.T. (1995). Medical Ethnomethodology: An overview. *Human Studies*, 18, 245-61.
- Health Protection Agency. (2009). Sexual Health: Chlamydia Rates Continue to Rise. Retrieved February 16, 2011 from: <http://www.statistics.gov.uk/cci/nugget.asp?id=412>.
- Hodges, B.D., Kuper, A. & Reeves, S. (2008). Discourse Analysis. *British Medical Journal*, 337, 570-2.
- Hoffman, D., Freeman, K. & Swann, S. (2009). Healthcare preferences of lesbian, gay, bisexual, transgender and questioning youth. *Journal of Adolescent Health*, 45(3), 222-29.
- Holland, J. (2008). Understanding the sexual lives of young people. In: Furlong, A (Ed). *Handbook of Young Adulthood*, New York: Routledge.
- Holland, J., Ramazanoglu, C., Sharpe, S. & Thomson, S. (1998). *The male in the head: Young people, heterosexuality and power*. London: The Tufnell Press.
- Holmes, D. & O'Byrne, P. (2006). The art of public health nursing: using confession techné in the sexual health domain. *Nursing and Healthcare Management and Policy*, 56(4), 430-37.
- Howson, R. (2006) *Challenging Hegemonic Masculinity*. Routledge: New York.
- Kehily, M. J. (2002). *Sexuality, Gender and Schooling: Shifting Agendas in Social Learning*. London: Routledge.
- Kimmel, M. S. & Messner, M. A. (2007). Men as gendered beings. In Kimmel & Messner (Eds.), *Mens lives*. New York: Pearson.
- Korobov, N. (2005). Ironizing masculinity: How adolescent boys negotiate hetero-normative dilemmas in conversational interaction. *The Journal of Men's Studies*, 13(2), 225-46.
- Korobov, N. (2008). Expanding Hegemonic Masculinity: The Use of Irony in Young Men's Stories About Romantic Experiences. *American Journal of Men's Health*, 3(4), 286-99.
- LaMontagne, S., Fine, D. & Marrazzo, J. (2003) Chlamydia trachomatis Infection in asymptomatic men. *American Journal of Preventive Medicine*, 24(1), 36-42.

- Larkin, J., Andrews, A. & Mitchell, C. (2006). Guy talk: Contesting masculinities in HIV prevention education with Canadian youth. *Sex Education: Sexuality, Society and Learning*, 6(3), 207-21.
- Lee, C. & Owens, R.G. (2002). Issues for a psychology of men's health. *Journal of Health Psychology*, 7(3), 209-17.
- Lindberg, C., Lewis-Spruill, C. & Crownover, R. (2006). Barriers to sexual and reproductive health care: Urban male adolescents speak out. *Issues in Comprehensive Pediatric Nursing*, 29(2), 73-88.
- Makadon, H. J., Mayer, K. H., Potter, J., & Goldhammer, H. (Eds.). (2007). *The Fenway guide to lesbian, gay, bisexual, and transgender health*. Philadelphia: ACP Press.
- Mantell, J. E., Dworkin, S. L., Exner, T. M., Hoffman, S., Smit, J. A. & Susser, I. (2006). The promises and limitations of female-initiated methods of HIV/STI protection. *Social Science and Medicine*, 63(8), 1998-2009.
- Maxwell, C. (2007). 'Alternative' narratives of young people's heterosexual experiences in the UK. *Sexualities*, 10(5), 539-58.
- McLaren, L., McIntyre, L. & Kirkpatrick, S. (2010). Rose's population strategy of prevention need not increase social inequalities in health. *International Journal of Epidemiology*, 39(2), 372-7.
- Mutchler, M. G. (2000). Seeking Sexual Lives: Gay Youth and Masculinity Tensions. In Nardi, P. (Ed.), *Gay Masculinities*, 12-43. London: Sage.
- Numer, M. (2008). The Sexual Health of Gay Men: Exploring the Intersections of identity, masculinities and sexual health promotion. *The International Journal of Diversity in Organisations, Communities and Nations*, 8(3), 249-54.
- Numer, M. (2009). The Dilemma of Young Gay Men's Sexual Health Promotion and Homosexual Hegemonic Masculinity. In J. Chamberland, J. Ristock & B. Frank (Eds.), *Diversité sexuelle et constructions de genre/Sexual Diversity and Constructions of Gender*. Québec: Presses de l'Université du Québec.
- Numer, M. S. & Gahagan, J. (2009). The Sexual Health of Gay Men in the Post-AIDS Era: Feminist, Post-Structuralist and Queer Theory Perspectives. *International Journal of Men's Health*, 8(2), 155-68.
- Oliffe, J. L., Gerbrandt, J., Bottorff, J. L. & Hislop, T. G. (2009a). Health promotion and illness demotion at prostate cancer support groups. *Health Promotion Practice*, published January, 2009.

- Oliffe, J. L. (2009b). Health behaviours, prostate cancer and masculinities: A life course perspective. *Men and Masculinities*, 11(3), 346-66
- Oliffe, J. L., Robertson, S., Frank, B., McCreary, D. R., Tremblay, G. & Goldenberg, S. (2010). Men's health in Canada: an update. *Journal of Men's Health*, 7(3), 189-92.
- O'Brien, R. K. Hunt, K. & Hart, G. (2005). 'It's caveman stuff, but that is to a certain extent how guys still operate': men's accounts of masculinity and help seeking. *Social Science and Medicine*, 61(3), 503-16.
- Pascoe, C. J. (2007). *Dude, you're a fag: Masculinity and sexuality in high school*. Berkeley, CA: University of California Press.
- Pearson, S. (2003). Promoting sexual health services to young men: findings from focus group discussions. *Journal of Family Planning and Reproductive Health Care*, 29(4), 194-98.
- Peterson, A. & Lupton, D. (1996). *The New Public Health: Health and Self in the Age of Risk*. London: Sage.
- Potter, J., Goldhammer, H., & Makadon, H. (2007). Clinicians and the care of sexual minorities. In H. J. Makadon, K. H. Mayer, J. Potter, & H. Goldhammer (Eds.), *The Fenway guide to lesbian, gay, bisexual, and transgender health*, 3-24. Philadelphia: ACP Press.
- Public Health Agency of Canada. (2006). *Canadian guidelines on sexually transmitted infections (STI)* (2006 ed.). Ottawa: PHAC.
- Public Health Agency of Canada. (2011). *Sexual Health and Sexually Transmitted Infections*. Retrieved on February 16, 2011 from: <http://www.phac-aspc.gc.ca/std-mts/index-eng.php>.
- Rieg, G., Lewis, R.J., Miller, L.G., Witt, M.D., Guerrero, M. & Daar, E.S. (2008). Asymptomatic Sexually Transmitted Infections in HIV-Infected Men Who Have Sex with Men: Prevalence, Incidence, Predictors, and Screening Strategies. *AIDS Patient Care and STDs*, 2008, 22(12), 947-54.
- Robertson, S. (2007). *Understanding men and health: Masculinities, identity and well-being*. Open University Press: New York.
- Robertson, S., Galdas, P. M., McCreary, D. R., Oliffe, J. L. & Tremblay, G. (2009). Men's health promotion in Canada: Current context and future direction. *Health Education Journal*, 68(4), 266-72.

- Rosenfeld, D. & Faircloth, C. A. (2006). Medicalized Masculinities: The Missing Link? In D. Rosenfeld & C. A. Faircloth (Eds.), *Medicalized Masculinities*, 1-20. Philadelphia: Temple University Press.
- Ryan, C. & Futterman, D. (2001). Social and developmental challenges for lesbian, gay and bisexual youth. *SIECUS Report*, 29(4), 5-18.
- Sandelowski, M. (1995). Focus on qualitative methods, qualitative analysis: What it is and how to begin. *Research in Nursing & Health*, 18, 371-75.
- Schilt, K. & Westbrook, L. (2009). Doing gender, doing heteronormativity: "Gender normals," transgender people, and the social maintenance of heterosexuality. *Gender & Society*, 23(4), 440-64.
- Shoveller, J., Johnson, J., Rosenberg, M., Greaves, L., Patrick, D., Oliffe, J. & Knight, R. (2009). Youth's experiences with STI testing in four communities in British Columbia, Canada. *Sexually Transmitted Infections*, 85(5), 397-401.
- Shoveller, J. A. & Johnson, J. L. (2004). Socio-cultural influences on young people's sexual development. *Social Science & Medicine*, 59(3), 473-87.
- Shoveller, J. A., & Johnson, J. L. (2006). Risky groups, risky behaviour, and risky persons: Dominating discourses on youth sexual health. *Critical Public Health*, 16(1), 47-60.
- Shoveller, J. A., Johnson, J. L., Savoy, D. & Pietersma, W. A. W. (2006). Preventing sexually transmitted infections among adolescents: An assessment of ecological approaches and study methods. *Sex Education*, 6(2), 163-83.
- Shoveller, J. A., Knight, R., Johnson, J., Oliffe, J. L. & Goldenberg, S. (2010). 'Not the swab!' young men's experiences with STI testing. *Sociology of Health & Illness*, 32(1), 57-73.
- Snively, C. A., Kreuger, L., Stretch, J. J., Wilson, J. W. & Chadha, J. (2004). Understanding homophobia: Preparing for practice realities in urban and rural settings. *Journal of Gay & Lesbian Social Services*, 17(1), 59-81.
- Statistics Canada. (2007). *British Columbia 2006 Community Profiles*. 2006 census. Ottawa: Canada.
- Strauss, A. & Corbin, J. (1998). *Basics of Qualitative Research : Techniques and Procedures for Developing Grounded Theory*, 2nd ed. Thousand Oaks: Sage Publications.
- The McCreary Centre Society. (2007). *Not yet equal: The health of lesbian, gay and bisexual youth in BC*. Vancouver: The McCreary Centre Society.

Tourism Vancouver. Gay-Friendly Vancouver. Accessed on February 20, 2011 at [http://www.tourismvancouver.com/visitors/about\\_vancouver/gay-friendly\\_vancouver](http://www.tourismvancouver.com/visitors/about_vancouver/gay-friendly_vancouver)

United States Centre for Disease Control and Prevention. (2011). *Sexually Transmitted Diseases*. Retrieved February 16, 2011 from: <http://www.cdc.gov/std/>.

Wilson, J. M. G. (1971). Principles of Screening for Disease. *Proceedings from the Royal Society of Medicine*, 64(12), 1255-56.

Yep, G. A. (2002). From homophobia and heterosexism to heteronormativity: Toward the development of a model of queer interventions in the university classroom. *Journal of Lesbian Studies*, 6(3&4), 163-76.

Young, R. M. & Meyer, I. H. (2005). The trouble with "MSM" and "WSW": Erasure of the sexual-minority person in public health discourse. *American Journal of Public Health*, 95(7), 1144-49.

# Appendices

## A.1 Interview guide for young men

### Interview Guide for Youth

### Sex, Gender & Place: An Analysis of Youth's Experiences with STI Testing

#### Review the informed consent and interview structure:

- This session will be audio taped and will last about 1.5 hours. We'll begin our interview by completing a brief questionnaire (5 mins). The information we collect through the survey will be used to describe the characteristics (e.g., age, education, current sexual activity level) of the overall group of study participants. Then I will ask you some questions about your experiences with STI testing. While we're talking, I'll ask you to tell me about your symptoms, what you had to do when you went for your STI test, and the treatment you received (if any was required). During the interview, I'll be taking a few notes about the events and experiences you describe to me.
- Review options for referrals to counseling services.
- Any questions about how we're going to spend our time today?

#### Opening Questions

1. Please tell me why you decided to volunteer for our study.

#### Reasons for Getting STI Testing

1. Tell me the story about how you came to get tested for STIs. Start anywhere you want.

#### Examples of Probes:

- What kinds of symptoms did you experience, if any?
  - What kinds of symptoms did your partner experience, if any?
    - *If yes:* Did you notice that your partner had symptoms that s/he didn't tell you about? Did you speak to your partner about this? Did your partner's symptoms influence your decision to get an STI test?
  - What did you know about STI testing at that time? Where did you learn about this information? What kinds of information did you want [or need] to know?
  - What did you know about places where you can get STI testing?
2. Some young people have told us that they get tested when they end a sexual relationship, even if they do not experience any symptoms. Others have told us they get STI testing

before they start having sex with a new partner, and ask their partners to do the same. Tell me what you think of these reasons for getting tested.

### **Descriptions of the Clinic(s)**

3. Tell me about the clinic where you were tested. If you have visited more than one clinic, please tell me about each of them.

Examples of Probes:

- How would you describe the clinic?
- What was it like when you walked into the clinic? How was it organized in terms of the reception area, the waiting area, the clinic rooms, the toilets, etc.?
- Tell me what it was like to be in the waiting area? What was it like to be in the examination room – when you were waiting for the doctor, after your exam, etc.?
- How did you find/locate the clinic? How did you get to the clinic?
- Tell me what you know about the clinic's operating hours and how that fits with your schedule.
- What made you decide to get tested at this particular clinic instead of another one? Or, did you have a choice?
- When did you get testing at this clinic?
- Was this your first visit to the clinic? Have you ever been tested before? Where? When?

### **Experiences at the Clinic(s)**

4. When you think back on the procedures that you underwent at the clinic, how would you describe those procedures? What took place? Reminder: You do not have to tell me what the results of your STI test(s). If you have visited more than one clinic, please tell me about each of them.

Examples of Probes:

- Do you remember what STIs you were tested for?
- Were your interactions with female or male health care workers (e.g., nurses or doctors) or both? Tell me about what it was like to interact with those service providers.
- What kinds of discussions did you overhear at the clinic:
  - Between staff and clients?
  - Between staff themselves?
  - Between clients?
- Tell me whether you have a preference to be seen by a woman or a man. Did you have a choice or did you *feel* like you could have a choice? How were those choices presented to you?
- What kinds of questions did you get asked: at the reception area? When you saw the nurse? When you saw the doctor?
  - Did you have questions about the reasons they were asking you those questions? About the testing procedures themselves? About follow-up?
- Did any of the staff ask what your sexual orientation is?

- Did you volunteer this information or did you feel you had to tell staff what your sexual orientation is? How did this make you feel?
- How important is it to you to have staff know your sexual orientation?
- What kinds of questions did *you* ask or want to ask: the receptionist? (did you ask them?) the nurses (did you ask them?) the doctors (did you ask them?)
  - How well did the health care providers answer your questions?

### **Waiting for Results of the STI Test**

5. How did you feel:

- a. Right before you arrived at the clinic?
- b. While at the clinic?
- c. Right after you left the clinic?
- d. What did you do after you left the clinic?

6. How long did you wait to find out your results? How did you feel during that time that you were waiting to hear about the results?

Examples of Probes:

- How did you actually learn about your results? Who told you?
- How did you feel when you received the results of your test?

### **Being Treated** [If the participant discloses that s/he had a positive test]

7. What kind of treatment, if any, did you have to undergo?

Examples of Probes:

- Tell me about what it was like for you physically to receive that treatment?
- When did you first notice that your symptoms went away?

### **Reactions – Post-STI Testing**

8. Some people experience emotional difficulties related to STIs (e.g., lack of trust; depression; being labeled or stigmatized). Others feel more confident or in control of their sexual health because they are getting tested. What kinds of feelings did you experience as a result of having an STI test?

**Examples of Probes:**

- What concerns did/do you have about being blamed or rejected by your current or future sexual partners?
- How did/do you think your sex partner (family, friends, peers) would react if they were to find out?
- How would you react if sex partner (family, friends, peers) found out that you have had STI testing?
- How did your experience with STI testing affect how you think about yourself socially? Psychologically? In any other ways? Do you still feel that way?



- How does the fact that you got tested make you feel/think about yourself sexually (e.g., more or less “sexy” or “desirable”)? What do you think it means to be sexually desirable?
- How do you think you might feel about a partner if you learned that s/he has had STI testing? Would that change how you feel/think about that person sexually (e.g., more or less “sexy” or “desirable”)?
- What about in terms of your sexual practices after being tested? And, when I say “sexual” or “sex” it doesn’t just mean penetration or oral sex; it also includes all kinds of things like sexual touching, kissing, phone sex, and use of sex toys. Keeping this in mind, how did your experience with STI testing change how you think about sex and/or your sexual practices (i.e. types of sexual activity, negotiating safer sex, condom use, or choice of sexual partner)?
- How would these reactions affect your decision whether or not to get STI testing in the future?

### **STI Counseling & Education**

9. When people visit a health care professional (e.g., a doctor’s office, a youth clinic, or an STI clinic), they are often receive some counseling about STIs. What kind of counseling did you ask for or receive after you went for your test?

Examples of Probes:

- If you received counseling after you went for your test, what was useful about the counseling? Not useful?
- What do you think are important issues that need to be included in STI counseling?
- If counseling was available but you did not receive it, tell me why.
- What kinds of counseling do you think are essential for all young women [men] to receive after having an STI test?

### **Record Keeping**

10. When people go for STI testing and treatment, records are kept at each location where people access services (e.g., at the clinic or doctor’s office, the pharmacy, the public health unit, the BC Centre for Disease Control). When you had your STI test done, what were you told about how your records would be kept and who had access to them?

Examples of Probes:

- Is this something you are concerned about? What are your concerns?
- How did these concerns influence your decision to get STI testing?

11. [If the participant lives with her/his family:] How might living at home with your family affect your experience getting STI testing? Examples of Probes:

- What would you think about the chance of having the clinic contact you at home by phone or mail about your test results or other issues related to your test?

## Where Youth Live

12. Where we live affects our experiences in many ways. This includes both the geographic location (e.g., your town, your neighbourhood) as well as your social standing (e.g., income level, age, class, ethnicity) within your community. How would you describe the ways in which the place where you live affected your experiences with STI testing?

Examples of Probes:

- Privacy issues?
- Anonymity? Confidentiality?
- Transportation issues?

13. If STI testing was not available or accessible in your community, what would you do?

Examples of Probes:

- What do you think it might be like trying to access STI testing or treatment services if you lived in a small town [or big city]?

14. In some communities, some ideas about sexuality have changed a lot in the past 30 years. Tell me about some of the changes that you think that your community has experienced related to this idea.

Examples of Probes:

- How do you think that attitudes toward sexuality have changed in your community since your parents were your age?
- How do you define your community?
- How would you describe the way your community feels about young men being sexually active? What about young women?
- What does your community define as “acceptable” or “normal” sexual behaviour for young men? For young women?
- What happens when a young woman in your community is thought to be engaging in “unacceptable” sexual behaviour?
- What happens when a young man in your community is thought to be engaging in “unacceptable” sexual behaviour?
- How might your community’s ideas of “acceptable” sexual behaviour differ depending on a young person’s sexual identity? their ethnicity? their religious beliefs? or their peer group?

## Sociocultural & Religious Attitudes and STI Testing

15. Some people have talked about the influence of their religious beliefs or spirituality or cultural background (i.e., if you’re Irish, Filipino, Indo-Canadian) on decisions around their sexual health.

Examples of Probes:

- How do you think your own cultural background and/or religious/spiritual beliefs affected your experiences with STI testing?

- How do you think that the cultural background and/or religious/spiritual beliefs of a STI testing service provider might affect your interactions with them?

### **STI Testing Supports**

17. Thinking back about to your STI testing experience and to what we have discussed today, what would you tell someone else who was thinking about getting STI testing? Young women [men]?
18. How can service providers do a better job of supporting young women [and men] who:
  - Are getting STI testing?Have been diagnosed with an STI?

### **Closing Remarks**

19. Is there anything else you want to tell me about your experiences with sexual health behaviour and outcomes?
20. Are you interested in participating in a follow-up interview to give us feedback on our preliminary findings?
21. Do you know of another youth who might be interested in completing an interview like this? If so, please give them this card and ask them to call our toll-free number.

## A.2 Interview guide for clinicians

### Interview Guide For Use With Service Providers

#### Sex, Gender & Place: An Analysis of Youth's Experiences with STI Testing

#### Review the informed consent and interview structure:

- This session will be audio taped and will last about 45 minutes to 1 hour. I will ask you some questions about your experiences working with youth who seek STI testing. During the interview, I'll be taking a few notes about the events and experiences you describe to me.
- Any questions about how we're going to spend our time today?

#### Professional Background & Education

To begin, I'd like you to tell me a bit about your professional background and education.

- What's your current role here at the clinic [or what is your professional role]?

Examples of Probes:

- Where did you receive your training? Qualifications?
- When did you graduate? When did you start your career?
- How long have you been practicing your current profession?
- How long have you been practicing in this particular community? At this clinic?

#### Accessing STI Testing

2. Now, I'd like to hear about the kinds of sexual health services that are available to young people in your community.

- What kinds of services do you offer within your clinic?
- What other kinds of services are available through your clinic?
- How do you determine what STIs each of your clients should be tested for?

Examples of Probes:

- Where can young women go to receive testing for STIs? Have you ever referred a young woman to one of these services?
  - What did you tell them?
  - What kind of feedback have you received from these young women about their experiences seeking an STI test?
- Where can young men go to receive STI testing? Have you ever referred a young man to one of these services?
  - What did you tell them?
  - What kind of feedback have you received from these young men about their experiences seeking an STI test?

3. In previous studies, some young women have told us that they have requested pap tests with the expectation that they would also be tested for STIs without having to necessarily ask for an STI test.

- How often do you think this situation happens at the clinic where you work?
- When young women request pap tests at your clinic, what kinds of information about the test do you discuss with them?

4. Do staff at your clinic ask clients about their sexual orientation? What about clients' sexual behaviours?

- In what ways would this information affect the services that are provided to young women [men]?

### **Observations About Clinic-based Experiences**

5. We're interested in hearing about your observations and interpretations of young women and men's interactions with one another and with staff in your clinic. Tell me about some of the things that come to mind when you think about their interactions with one another? What about their interactions with staff?

Examples of Probes:

- We'd like to ask you about some of the observations that you've made in terms of the gender dynamics amongst young women and young men. For example, how would you describe the gender dynamics between partners [or amongst young women/men in general] in the waiting area?
- What about young women's [men's] interactions with staff? At reception? In the clinical examination areas?
- What kinds of options do you offer youth in terms of choosing to be examined by a particular service provider (e.g., same-sex service provider)? How and when is that choice presented?

6. We're also interested in the gender dynamics amongst the clinic staff itself. What kinds of things do you think are important for us to know about in terms of this issue and the way your workplace functions?

Examples of Probes:

- How might those dynamics affect the ways in which you offer services to young women [young men]?
- How might those dynamics affect the ways in which your clinic is perceived in the wider community? by young women [men]?

### **Reactions – Post-STI Testing**

7. How do you and your staff inform clients of their test results? I'm sure you've seen a variety of reactions among the young women and men to whom you provide STI testing services in terms of the feelings that they associate with the idea of getting an STI and/or getting an STI test. Tell me about those reactions.

Examples of Probes:

- Relief?
- Concerns about being blamed or rejected by current or future sexual partners?
- Feelings about their sex partner(s) (family, friends, peers) and their reactions if they were to find out?
- Social effects? Psychological effects? In any other ways?
- How might “getting testing” make them feel/think about themselves sexually (e.g., more of less “sexy” or “desirable”)? What do you think it means to young women [men] to be sexually desirable?
- What about in terms of their sexual practices after being tested? And, when I say “sexual” or “sex” it doesn’t just mean penetration or oral sex; it also includes all kinds of things like sexual touching, kissing, phone sex, and use of sex toys. Keeping this in mind, how might an experience with STIs and/or STI testing affect how young women [men] think about sex and/or their sexual practices (i.e. negotiating safer sex, condom use, types of sexual activity, or choice of sexual partner)?
- How could these reactions affect young women’s [men’s] decisions whether or not to get STI testing in the future?

8. How satisfied are you, as a service provider, with your ability to follow-up with youth regarding their STI testing results?

9. How do young women [men] react when you discuss their test results with them?

**Record Keeping**

10. Describe for me the kinds of record keeping activities that your clinic engages in.

Examples of Probes:

- Who does it? Who’s responsible for it?
- Who has access to the records? How are they stored? Who do you share the records with?
- What are you obliged to do with the records?

11. What kinds of information do you provide to young women [men] about how their health records will be kept?

Examples of Probes:

- What kinds of things do you tell them about who will have access to this information?
- Is this something that youth have expressed concerns about? What were their concerns?
- How do you think that these concerns might influence their decisions about STI testing in the future?

12. What kinds of discussions do you have with young women [men] about how they want to receive their test results? What kinds of options are presented/available to them?

- a. Since many youth live at home with their family, how does that affect your approach to providing follow-up after STI testing? (e.g., contacting youth?)

13. Has you ever faced a situation where a client's confidentiality was breached?

- a. *If yes:* What happened and how was this dealt with?
- b. *If no:* How would you deal with such a breach?

### **Where We Live and Work**

14. The communities where we live and work can affect our experiences in many ways. This includes both the geographic location (e.g., your town, your neighbourhood) as well as your social standing (e.g., income level, age, class, ethnicity) within your community. How would you describe the ways in which the community where you live affects young women's [men's] experiences with STI testing?

Examples of Probes:

- Privacy? Anonymity? Confidentiality? Transportation?

15. How would you describe the ways in which the community where you practice affects young women's [men's] experiences with STI testing? How would you describe the ways in which the community where you live affects young women's [men's] experiences with STI testing?

Examples of Probes:

- Privacy? Anonymity? Confidentiality? Transportation?

16. How does the community where your clinic/office is located affect the way you practice?

17. In some communities, some ideas about sexuality have changed a lot in the past 30 years.

Examples of Probes:

- How would you describe the way your community feels about young men being sexually active? What about young women?
- What similar or different (often unspoken) "rules" or expectations do women and men live under in your community when it comes to sex or their sexuality?
- What happens when a young woman doesn't obey or follow the rules or expectations in your community?
- What happens when a young man doesn't obey or follow the rules or expectations in your community?
- How might these rules or expectations differ depending on a young person's sexual identity, ethnicity, religious beliefs, or peer group?
- What kinds of discussion have you and your colleagues here had about these kinds of issues? How have your approaches to providing services to young women [young men] been affected by these discussions?

### **Sociocultural & Religious Attitudes and STI Testing**

18. Some people have talked about the influence of their religious beliefs or spirituality or cultural background (i.e., if you're Irish, Filipino, Indo-Canadian) on decisions around their sexual health.

Examples of Probes:

- How do you think your ethnic identity and/or religious/spiritual beliefs affected your experiences with providing STI testing to young women [men]?
- How do you think that the ethnic identity and/or religious/spiritual beliefs of a young woman [or man] might affect your interactions with them?
- What kinds of discussions have you and your colleagues here had about these issues?

### **Tour of Clinic**

Invite them to take us on a "tour" of their clinical spaces. Ask permission to keep the tape running during the tour. This is also where we'll be taking photos of the spaces themselves (no people will be photographed).

### **Closing Remarks**

- Are there further insights you would like to share (e.g. any opinions, feelings)?
- Do you know of another key stakeholder who might be interested in completing an interview like this? If so, please give them this card and ask them to call our toll-free number.



### A.3 Interview guide for young men

#### Interview Guide for Use with Young Men

#### Young Men and STIs

**Review the informed consent and interview structure:** This session will be audio taped and will last about 1 to 1.5 hours. We'll begin our interview by completing a brief questionnaire (3-5 minutes). Then I will ask you some questions about your experiences with STI testing. While we're talking, I'll ask you to tell me about your symptoms, what you had to do when you went for your STI test, and the treatment you received (if any was required). During the interview, I'll be taking a few notes about the events and experiences you describe to me.

---

#### Introduction

1. **Where did you hear about our study?**
2. **Can you tell me why you decided to volunteer for our study?**

---

#### Experiences with STI Clinical Services

So now I'd like to talk about some of your experiences with testing.

3. **Tell me the story about how you came to get tested for STIs. Start anywhere you want. Remember, you don't have to answer any questions you don't want to.**

#### *Examples of Probes:*

- What did you know about STI testing at that time? Where did you learn about this information? What kinds of information did you want [or need] to know? What did you learn specifically about men's sexual health?
  - Where do you get your sexual health information from? For example, the internet, a family member, friends?
4. When you think back on the procedures that you experienced at the clinic, how would you describe those procedures? What took place? Reminder: You do not have to tell me what the results of your STI test(s).

*Examples of Probes:*

- If you can recall, what STIs you were tested for?
- Tell me about what it was like to interact with those nurses or doctors. How did they respond to your needs and questions?
- Did any of the staff ask what your sexual orientation is? Did you volunteer this information or did you feel you had to tell staff what your sexual orientation is? How did this make you feel? How important is it to you to have staff know your sexual orientation?
- How do you think this experience would have differed if you were/for a woman?

**5. How long did you wait to find out your results? How did you feel during that time that you were waiting to hear about the results? How did you feel when you received the results of your test?**

- How would you prefer to receive your results?
- How did this influence how you look after your sexual health after finding this information.

**6. Some men have told us how they would not want a male nurse or doctor because they would not want another guy touching or seeing their penis. Others have said they would not want a women nurse or doctor because they were scared they could get an erection.**

**What do you think of these issues?**

*Examples of probes:*

- Why do you think some guys feel that way, and others don't?
- How do you think this situation could be made easier for young men?
- From your experience, what have nurses or doctors done in order to make these sorts of situations easier for you?
- Tell me whether you have a preference to be seen by a woman or a man. Did you have a choice or did you *feel* like you could have a choice? How were those choices presented to you?
- Do you think there is anything that can be done to make this easier for young men?
- How would the age of the nurse or doctor affect how you feel about getting an exam? For example, a young female doctor versus an old female doctor? A young male nurse versus an old male nurse?

**7. Thinking back to your experiences with STI testing, what sorts of questions do you remember your nurse or doctor asking you during the examination?**

*Examples of probes:*

- Who asked you those questions and where were you when they asked these questions?

- Was this done on a form as well? Did your clinician ask these questions again in the exam room?
- How did these questions make you feel?
- Are there any examples of some 'risky' behaviours you've been involved with that you felt were important to tell your doctor/nurse?

8. Some young men have told us that certain groups of men are at higher risks for STIs.

**What do you think it is that puts a young man 'at risk' for having an STI?**

***Example of probes:***

- How do you think one's ethnicity or cultural background might affect their STI 'risk'?
- How do you think someone's religious beliefs might affect their STI 'risk'?
- How do you think one's age might affect their STI 'risk'?
- How do you think one's sexual orientation might affect their STI 'risk'?
- How do you think where one lives might affect their STI 'risk' (e.g., if they live in a 'rich' neighbourhood versus a poorer neighbourhood)?
- How do you think not having housing might affect their STI 'risk'?

9. Some men have told us that gay men are targeted in health campaigns, so, as a result, they're more likely to access STI testing than heterosexual men. Others have told us that it might be very difficult to access STI services for gay men because of stigma they would experience.

**What are your thoughts on how sexual orientation might affect the way men take care of or talk about their sexual health?**

- How could sexual orientation affect one's experiences accessing STI testing?
- Do you think it's easier for straight men or gay men to talk about sexual health with their guy friends? What about with friends that are girls?

**Vignettes**

Now I'd like to tell you a story about a young man from a previous study we conducted several years ago. This is about his experiences accessing STI testing in Vancouver. This young man's name has been changed for the story, along with some of the other details, so that his identity remains confidential.

**"Tim"**

This story is about "Tim," a 24-year-old White heterosexual male. Tim lived and worked in downtown Vancouver.

When we met Tim, he and his girlfriend had just begun their relationship and they decided together that they should both go for testing before having sex. Tim said that it was fairly easy for him to get to the clinic. There was a walk-in clinic that he knew of downtown near his office, and his boss didn't mind if he took a couple of hours off now and then.

**10. How does Tim's STI testing story compare to you and your STI testing story?**

***Examples of probes:***

- Tim said his experience was relatively easy. How does this compare to your experiences?
- Tim said it was easy to get to the clinic. How does this relate to your experiences?

**11.** Let me tell you a bit more about Tim's story. Tim said that he and his girlfriend are able to negotiate more equal attitudes and behaviours related to their sexual health compared to lots of other (heterosexual) couples (e.g., as in the brief story I just read, they **both** agreed testing was a good idea so they **both** went for testing). This was different than a lot of the other stories young men (and women) told us about (e.g., we heard that guys sometimes pressured their partners that they shouldn't use condoms; and, we also heard that some girls pressured their partners not to use condoms).

**What do you think it is that helped Tim and his girlfriend relate to each other so well, and have that kind of relationship?**

***Examples of probes:***

- How does Tim's relationships compare to most of the other relationships that you're familiar with?
- Why do you think some couples decide to get tested at the beginning of a relationship?

**12.** Tim also said that he was able to talk about sexual health pretty easily with his guy friends.

**Why do you think some guys are able to talk about sexual health (e.g., STI testing), whereas, other guys find it difficult or embarrassing?**

***Examples of probes:***

- What do you think it could be about Tim's situation that makes him feel more comfortable talking about sex with his friends?

- Are you able to talk with your guy friends about sexual health? What about your friends who are girls? What about your sex partners? Tell me about this.
- How do you think getting an STI might affect how guys talk to each other about sexual health?
- Some men have told us that gay men might be better able to talk about their sexual health. Do you think this is the case?
- Would you feel more comfortable talking about your sexual health to somebody that shares your sexual orientation? Why?

**13. What do you think could have happened to Tim if he hadn't been able to or didn't access testing?**

***Examples of probes:***

- How do you think this could have affected his motivation to get tested in the future? Do you think NOT testing would make it easier or more difficult to go in the future?
- What would have happened to Tim if he had an STI that was left untreated? How do you think this would have affected his relationship if his girlfriend became infected?

**14. How do you think this experience might have been different for Tim's girlfriend, as she accessed STI testing?**

***Examples of probes:***

- How might the experiences of a young woman accessing testing differ for a man?
- What do you think about couples going for STI testing together?
- Do you think there would be more or less stigma associated with Tim's girlfriend accessing services? [Note: By stigma, we mean the disapproval society might associate with testing because it goes against what's considered "normal"]. Why or why not?

**"Don"**

Now I'd like to provide you with another example from our previous studies. "Don", again, a false name to protect confidentiality, was a 16-year-old Aboriginal Vancouver man who identified as gay. He had recently had sex and he wanted to get tested, just to be on the "safe side." However, Don was very concerned about testing in his own neighbourhood.

Don explained how he thinks if people in his neighbourhood saw him going into the local clinic that they would think – and these are Don's words - "He's a "dirty little Indian... Probably getting tested for his dirty stuff there."

He also was worried that he would get a male nurse or doctor, and hoped for a female. Don didn't want to be tested by a male service provider. As he explained, he's only naked with other men if they're going to have sex. Thankfully, Don's doctor turned out to be a woman.

**15. How does Don's STI testing story compare to you and your STI testing story?**

**16.** Let me tell you a little more about Don's story. As you remember, Don didn't want to get tested in his own neighbourhood. He also didn't want to ask his parents to take him to a clinic, since they considered him to be a "good kid," and he didn't want them to know that he's sexually active. So, Don took himself across the city to a youth clinic, outside of his neighbourhood.

**Please tell me what you think of Don's perception that he could be seen by someone he knows if he went for testing in his neighbourhood.**

**17. What do you think could have happened to Don if he hadn't been able to access testing because he was too anxious about going to a clinic?**

***Examples of probes:***

- Do you think this could make testing in the future more difficult for Don?
- What would have happened to Don if he had an STI that was left untreated?

**18.** As Don's story illustrates, it's hard for many young people to get testing.

**From the 16-year-old guys you know (or have known), what sorts of actions would they have to go through to get an STI clinic?**

***Examples of probes:***

- How do you think Don's story might have changed if Don were older, so let's say 23 or 24 years old?

**19. So, thinking about all of the things we've just talked about, and based on the stories of Tim and Don, who do you think might be more at risk for having an STI: Don or Tim? Why?**

***Examples of probes:***

- What is it that puts [Don or Tim] at an elevated risk?
  - Do you think that testing being easy versus hard for someone would make a difference to their risk of having an STI?
-

## **Sexed/Gendered Stereotypes/Implications/Issues**

**20.** Don and Tim’s stories featured a lot of stereotypes, and we’d like to talk a little bit more about some of these. For example, men are expected to be strong, confident, assertive and behave in sexually aggressive ways.

**How have these expectations influenced you?**

### ***Examples of probes:***

- How have these expectations, or your rejection of these expectations, influence your sexual-health decisions and behaviour? For example, using condoms, getting tested for STIs?
- How do you think these sorts of expectations affect women you know?

**21. If sexual health services could be specifically tailored for young men, what do you think those services should look like?**

### ***Examples of probes:***

- What kind of hours would they have? Where would they be located? Would they serve all genders, or be just for men or just for women? What would the testing be like? How would you get your results? Etc
- Do you think your experiences with STI testing have been tailored for you as a man, or, do you think they were trying to provide you with “gender-neutral” services (i.e., not especially made for men; not especially made for women)?

---

## **Online Sexual Health Services Program**

So we’ve talked a lot about what it’s like for young men accessing STI testing services. Now we’d like to tell you a bit about a new program that is trying to address some of the difficulties young men might have in getting tested. There is a new program being developed that will bring STI testing online. Patients will be able to fill out an online risk assessment then download a lab requisition for urine/blood tests at a lab (a lab requisition is the sheet that lets the lab know what tests you need to do).

Patients will also be able to obtain negative results online, and they will also have online access to sexual health counselors. And, lastly, this program will offer anonymous email-based partner notification for those patients who have tested positive and need to let their partners know.

**22. How comfortable would you feel filling in an online risk assessment questionnaire?**

***Examples of probes:***

- How comfortable would you be filling in an online risk assessment questionnaire?
- How do you think this might compare to answering the questions 'in-person' with your doctor/nurse?
- Would you trust that the online system would recommend the right tests for you?
- How would you feel using the internet to download a lab requisition?

**23. How comfortable would you be using online sexual health counseling (e.g., chatting) with a nurse to get more information about sexual health?**

**24. How do you think young men might respond to being able to use an anonymous email-based partner notification system to let their partners know that they tested positive for an STI and that they should get tested right away?**

- Is this something that you would be interested in? Why?
- How would you feel about receiving one of these notifications? How would it compare to receiving the same notification via telephone from a nurse?
- How would you feel about sending one of these notifications anonymously? What about non-anonymously?

---

**Closing Remarks**

**25. Is there anything else you want to tell me about your experiences with sexual health services?**

**26. Lastly, we'd like to ask you if you'd be interested in us contacting you at a later date to see if you could take part in a one-day Participatory Summit on February 3? In what way would it be okay to contact you to ask if you are interested?**