

Pride, Prejudice & Determinants of Health

What's trending with young gay men?

Sex Now Survey 2011

- n=8,607 online participants
- National Comparison Study
- Men seeking men online
- All provinces and territories represented
- Average age 43

Sex Now 2011(SN11) was Canada's first survey of *social determinants of health* in gay and bisexual men. 1,899 men under 30 years of age responded, representing a 26% increase in participation from this age group over the previous year's pilot study. CBRC's young "Investigaytor" team collaborated on the design of the questionnaire and recruitment strategy that produced such robust youth participation.¹ This report compares results from both the pilot study and determinants survey to corroborate their findings and to explore what more we have learned about the lives of young gay and bisexual men.

With SN11 we aimed to gather as much evidence covering the ground of social determinants of health as could be managed in a popular survey format on the Internet. The survey repeated many questions from the pilot study related to sexuality, mental health and experience with prejudice.² We also probed gay men's experience with employment and working conditions, childhood sexuality, social networks and exclusion, general health status, access to services, and participation in civic life.³ In particular SN11 zoomed in on the influence of "gender" with questions about masculine self-presentation and performance.⁴

EMERGING REALITIES

As a decade of Sex Now surveys have been noting, digital media have precipitated momentous social change in gay life and communities – in parallel with trends seen throughout society. Gay men's sexuality has become more accessible than ever before. Ideas and images are more available than ever before: by anyone, anytime, anywhere. Internet and smart phones, not bars and cafés, have become the main means of connection between gay men under 30.

SN11 sought more information about young men's Internet and cell phone use. The results showed that gay men under 30 are substantially more tied-in to digital media than older men. Even though older men reported vigorous use of the Internet for sexual hookups, young men's widespread use of social media in the form of smart phones,

Facebook, Twitter, Skype and YouTube suggests that, for their generation, digital communities have largely displaced gay ghettos of previous eras.

Table 1: Comparing Internet use

	SN10		SN11	
	<30	≥30	<30	≥30
View explicit images	98.2%	91.4%	99.2%	95.0%
Look for hookups	79.2%	86.6%	81.9%	90.2%
Sexual health info	76.8%	59.1%	74.7%	61.7%
Find a boyfriend	54.7%	41.3%	58.0%	47.0%
Buy gay gear	24.0%	25.9%	26.3%	27.8%
Read gay news	–	–	75.9%	77.6%

Table 2: Comparing website use

	<30	≥30
Squirt	66.5%	85.3%
Manhunt	44.1%	35.9%
Facebook	94.2%	66.0%
Twitter	44.3%	18.7%
Skype	66.4%	36.8%
Wikipedia	88.2%	58.9%
YouTube	97.2%	78.4%
Netflix	33.7%	16.7%
iTunes	73.7%	43.7%
Amazon	44.2%	33.9%

Table 3: Comparing cell phone use

	<30	≥30
Texting	94.0%	67.9%
Surf Internet	70.4%	41.2%
Use apps	65.0%	31.1%
Sex seeking	36.1%	18.0%
No cell phone	3.8%	12.8%

Studies suggest that digital media have altered gay neighbourhoods and community groups irrevocably. Since Sex Now survey began in 2002, measures of community engagement – time spent with gay friends and membership in gay organizations – have declined precipitously. In our most recent national surveys, a third of men under 30

expressed interest in gay community activities but only 16% considered themselves members of gay organizations.

Table 4: Community Involvement

	SN10		SN11	
	<30	≥30	<30	≥30
Low gay space satisfaction	69.9%	64.9%	–	–
Would join a gay group	35.8%	32.8%	–	–
>50% gay free time	25.7%	30.9%	23.1%	22.1%
HIV positive friends	24.7%	45.6%	–	–
Involved in gay group	–	–	16.1%	12.5%
Involved in civic activities	–	–	63.6%	57.7%

**Some questions were not asked in both surveys*

The instant accessibility of digital media has allowed emerging gay youth to bypass community physical spaces to connect with each other. Little wonder why, since as many as 70% of young men in past surveys expressed dissatisfaction with gay physical spaces. While the long term effects are still unknown, it seems that sexual norms may be altering. For example, SN11 corroborated previous findings showing that men under 30 were substantially more likely than earlier generations of that age to have a monogamous partner or to be “dating” as a way of finding a future partner.

Table 5: Sex in the previous 12 months

	SN10		SN11	
	<30	≥30	<30	≥30
Internet hook-ups	49.1%	53.1%	50.3%	47.0%
Sex buddies	48.7%	49.6%	42.8%	45.8%
Dating	44.6%	20.4%	43.2%	15.9%
Partner only	27.6%	16.1%	28.4%	16.4%
3 way, group	25.6%	27.4%	21.3%	22.4%
Partner plus	24.3%	30.4%	19.8%	31.4%

HEALTH INFORMATION & KNOWLEDGE

Generally, men under 30 seemed to know as much or as little as older men about current details of gay men’s health. Most knew personal prevention ideas like “bottoms” being most at risk for HIV. A majority understood a “treatment as prevention” concept concerning the lower infectivity of positive men under treatment for HIV. Beyond that, few men, young or old, seem to understand much about the current state of the epidemic or how it is being addressed. Less than half knew about the availability of one-hour-wait “rapid” HIV testing and just over a third knew about the existence of “early” testing after

a window period of ten days. Rapid and responsive testing are now thought to be crucial strategies to wind down new HIV infections in gay men but a strong majority were unaware of their existence.

A lack of reliable population data has been cited as one of Canada’s major policy barriers to improving conditions for gay men’s health. The majority of survey respondents were unaware of the absence of census data on gay men in Canada or the lack of any mention of sexual orientation in most Canadian health policies. Some health scholars have noted that little about gay men’s overall circumstances can change without community action, however, SN11 suggests that few gay men comprehend the situation let alone its politics.

Worse, few gay men seem to understand current circumstances specific to HIV, arguably their most important health concern. The majority did not know that HIV infection rates remain high or are rising among gay men despite decreasing by as much as half in other Canadian groups. Fewer than a third knew of the extent of HIV infection among gay men living in urban areas (about 1 in 5) or that about 1 in 40 gay men have an HIV infection without knowing it. These findings are sobering in themselves, however, they are also indicative of low general awareness about critical issues affecting gay men’s health.

Table 6: Sexual health knowledge

SN 2010	<30	≥30
Bottoms more HIV risk	80.8%	81.3%
ARVs reduce viral load	65.3%	68.8%
Low viral load reduces risk	59.5%	58.3%
“Rapid” HIV testing	47.8%	42.0%
“Early” HIV testing	39.1%	39.3%
SN 2011		
	<30	≥30
No gay population census	43.2%	48.1%
Few health policy references	37.9%	41.9%
No decline in gay men’s HIV	42.3%	44.7%
1 in 5 gay men have HIV	29.4%	30.4%
1 in 40 unaware of Infection	28.6%	33.2%

In line with other findings about digital media, young men under 30 were much more likely than older men to have learned what they know about gay health on the Internet. But what do they learn, from whom and where? The general state of knowledge that the survey uncovered raises substantial concern about the level of attention and quality of available Internet content on gay men’s health. For example, while there appear to be many popular sources of information about personal health practices, very few if any cover what is shaping the context of gay men’s health, how that is being addressed or what is actually happening overall.

SEXUAL PRACTICES

So how does this affect young men’s sexual practices? Similar to older men, about 22% of men under 30 told us that they had had sex that could have risked HIV transmission in the 12 months prior to the survey— 8% weren’t quite sure. That means a 70% majority thought they had managed HIV risks fairly well over the year. More young men reported consistent condom use than older men but about 30% of both younger and older men reported one or more incidents of sex without condoms in the prior 12 months with someone whose HIV status was unknown to them. These rates are consistent with Sex Now surveys since 2006.

Table 7: Sexual safety

	SN10	
	<30	≥30
Consistent condoms	56.9%	46.0%
Check HIV status	55.2%	39.5%
Top only	18.7%	18.7%

Table 8: Sexual risk

	SN10		SN11	
	<30	≥30	<30	≥30
UAI* (12 months)				
Top	23.2%	19.9%	19.7%	19.3%
Bottom	23.4%	18.4%	22.9%	19.1%
Any	32.7%	28.3%	29.5%	28.3%

*UAI: unprotected anal intercourse

Table 9: Sexual risk in men under 30 by region

Alberta	35.3%
Ontario	30.5%
BC	28.3%
Quebec	27.9%
Atlantic	26.8%
Prairie	24.4%

On average there was little statistical variation in reported condom-free sexual activity among men from various regions. However a look at how this measure intersects with age revealed a somewhat different story. In fact, there was considerable regional variation among men under 30.

Table 10: Last tested HIV status

	SN10			SN11		
	≤ 24	25-29	≥30	≤ 24	25-29	≥30
HIV positive	1.8%	3.7%	8.8%	1.4%	3.7%	9.7%
HIV negative	56.1%	76.5%	72.6%	55.9%	76.6%	69.7%
Never tested	42.1%	19.8%	18.6%	42.7%	19.7%	20.6%

SN11 asked several questions about HIV and STI testing practices in line with recent efforts to increase routine testing among sexually active gay men and men who have sex with men (MSM). About 50% of men under 30 claimed to have been tested for HIV and STI in the prior 12 months compared to slightly fewer older men. Considering that knowledge of new test technologies measured quite low, this pattern may be difficult to change.

Another way to assess testing practices is to measure the rate of those who have never tested. On average, it appears that about 20% of sexually active men in age groups over 25 have never tested for HIV. However, there is a considerable lag in testing among men under 25 with 42% untested.

Younger men may perceive less personal risk for various reasons so the survey probed skipped or delayed testing. About 43% of men under thirty reported skipping or delaying testing compared to 25% of older men. The chief reasons for skipping were: not knowing where to go; lack of anonymous testing; and simple inconveniences like clinic open hours or having to make an appointment. Interestingly, *those who had been exposed to sexual risk were more likely to skip or delay testing* than those who had not been at risk. Among young men under 30, a 53% majority of those exposed to sexual risk had skipped or delayed HIV testing (compared to 32% of older men).

Young men, as expected, were much less likely to have a diagnosed HIV infection than older men. Sexually transmitted infections were another story. Young men 25-29 had twice the rate of Chlamydia, Gonorrhea and HPV as older men. SN11 also recorded a substantial increase in reported Syphilis diagnoses over the previous year which reflected increases seen in public health clinics. Changes in the rates of STI are commonly taken as bell weathers of condom use.

Table 11: Sexually transmitted infections (STI) last 12 months

	SN10			SN11		
	<25	25-29	≥30	<25	25-29	≥30
Chlamydia	1.9%	5.7%	2.7%	2.6%	4.3%	2.4%
Gonorrhea	3.5%	5.2%	1.7%	3.0%	5.4%	2.9%
HPV (genital warts)	3.5%	4.5%	2.2%	2.6%	3.2%	2.4%
Herpes	1.1%	1.5%	1.5%	1.2%	1.5%	1.8%
Syphilis	0.9%	1.4%	1.6%	1.9%	2.4%	1.9%

PREJUDICE & EMOTIONAL LIFE

In applying a *social determinants* approach to the SN11 questionnaire, we aimed to investigate how the social standing of gay men affects the ultimate health outcomes of the gay population. Such an assessment would not be possible without a comparison group. This is so because, *differences* in exposures and outcomes *between* social groups are considered prime indicators of health impacts that are social in origin.⁵

Analysis conducted on the pilot study showed that there are substantial *structural* differences among men who have sex with men depending on their relationships with women. For example, MSM married to women earned higher incomes with less education than gay men. MSM also had much less exposure than gay men to violence, exploitation and employment discrimination. And, MSM married to women reported much less depression. These and other findings from the pilot study are highly suggestive of the effects of a social disparity on health outcomes. The presence or absence of a woman, by marriage or partnership, made a significant difference in both exposure to prejudice and mental wellness outcomes between gay men and MSM.

Importantly, these studies also showed that MSM who actually were targeted with prejudice had similar odds of depression as gay men. SN11 aimed to expand on these findings by probing gender self-presentation, prejudice events and mental health outcomes in greater detail. While these studies are ongoing, SN11 findings have already corroborated associations found in the pilot study between prejudice events and increased odds of anxiety, suicidality and depression.

With SN11, we aimed to put gender status differences between men under our lens. We designed a series of questions to sort sexual identity, sexual attraction and primary relationships. In this way we were able to establish a usable model of sexual identities composing MSM: 85% bisexual, 10% gay, 5% straight. Sexual categories are difficult to specify as this array suggests. According to intersectionality theory, people commonly adjust their identities to suit different social locations, exemplified in this case by otherwise “straight” men who seek sex with men.⁴

Younger men, gay or bisexual, were much less likely to be partnered or married with a woman or another man. SN11 showed that young, unmarried, bisexual men were as likely as their gay peers to be targeted with prejudice and violence. However, indications throughout the survey suggested that young bisexual men were considerably more apt than gay men to conceal their sexual orientation in most social contexts. Young gay men, by contrast, were more apt to be out about their sexual orientation in most social contexts including the workplace. Thus young gay men had elevated odds of employment discrimination over young bisexual men. And employment discrimination dramatically increased their odds of suicidality and depression.

Table 12: Sexual orientation at work in men under 30

	Gay	Bisexual
Everyone knows	45%	8%
Some know	30%	10%
Most don't know	12%	10%
No-one knows	14%	72%

Table 13: Prejudice events in men under 30

	Gay	Bisexual
Rumors	61%	63%
Verbal violence	49%	47%
Teased	44%	42%
Excluded	44%	43%
Bullied	42%	44%
Called "Fag/Homo"	23%	20%
Raged at	21%	22%
Cyber bullied	14%	18%

Table 14: Emotional life

	<25	25-29	≥30
Suicidality	61.8%	54.8%	47.7%
>25% sadness	27.8%	27.2%	26.7%
>25% loneliness	38.4%	35.2%	34.3%
Depression Care	42.3%	43.2%	42.5%
Depression Rx	28.8%	28.6%	27.4%
Anxiety Care	53.4%	52.9%	54.9%
Anxiety Rx	23.1%	22.9%	22.6%

As SN11 again confirmed, young gay and bisexual men undergo an intense passage with their emerging sexual identities. More than half reported suicidal feelings. Nearly a third reported periods of intense sadness and loneliness. More than 40% reported seeing a doctor or counselor for depression and more than half of those were prescribed medication. Half sought medical care for anxiety and about half of those were prescribed medication. These findings are indicative, despite evolving change, of the intense social climate around sexual orientation that continues to have an impact on individuals and whole populations.

Nonetheless, being completely open about sexual orientation is a burgeoning trend among young gay men. Ambient signs and signals strongly suggest the social climate is warming, yet obviously, as shown by the widespread extent of bullying, still hostile at the

same time. Thus the workplace appears to be a site of an inevitable clash of values, particularly among young men expecting to be “out” at work without recrimination. From analyzing factors associated with employment discrimination, for example, we found that 25% or 1 in 4 men who were out to some or anyone in the workplace had experienced workplace discrimination – compared to 9% among those whose orientation was undisclosed. The odds of discrimination among those who were “out” were more than 3 times the odds of those undisclosed.

The survey showed that only 45% of gay men could definitely claim they had not been subject to workplace discrimination compared to nearly 80% of bisexual men. Comparing employment discrimination between gay and bisexual men, we found that less than 5% bisexual men claimed workplace bias compared to 22% of gay men. The odds of employment discrimination among gay men were more than 4 times the odds among bisexual men.

To disclose the health effects of employment discrimination, we compared those who reported it against those who did not in a logistic regression model, controlling for age, education and sexual orientation. The results linked employment discrimination with younger men, higher education and gay sexual orientation.

The only significant correlate among many self-presentation predictors we tested was being “out” at work. We found no particular link to having been previously teased, rumoured about, bullied or targeted; nor, slim, average or stocky body type; nor self-presentation stand-outs like piercings or painted finger nails. The only significant predictor was being “out” at work. Considering health effects, employment discrimination nearly doubled the odds of suicidality and care seeking for depression while significantly increasing the odds of sexual risk.

While gay men were considerably more likely than bisexual men to be out at work we compared the health effects of employment discrimination on both groups. Similar to what the pilot study found in targeted MSM, bisexual men had elevated odds of employment discrimination *if they were out at work* – which substantially elevated the odds of suicidality and depression *among those targeted*.

Determinants research originates with Michael Marmott’s “Whitehall Study” on the health effects of the workplace.⁶ That research showed that workplace status hierarchies have a significant impact on health and chronic illnesses. Higher status, better health. SN11 has shown that workplace experience may well be a critical area of study in gay men’s health which could also disclose important new knowledge about sexual orientation as a social determinant of health.

RESILIENCE

Despite these findings, we noted evident signs of resilience among young gay men of 2011-12. The drive to be free of a socially awkward sexual mystery has taken root in gay youth and, as survey findings have shown, young men are “out” as never before. They are

more apt to feel that their career paths will be positive despite their openness. While the social risk of disclosure persists, the great majority of young men are neither daunted by prejudice, nor suicidal, nor depressed. And even while urban gay ghettos may be declining, we found other promising signs of social resilience.

We compared involvement in gay community organizations to participation in general civic life such as education, arts, culture, sports, religion and politics. Remarkably, the results showed very robust participation among Canada’s gay population in general civic activities – even though membership in gay community organizations was relatively scarce. A comparison of regions showed that British Columbia ranked highest in participation rates in both gay community and general civic activities. Interestingly, rates of civic and gay community participation appeared to remain in proportion among provinces, suggesting more general regional differences in social participation. Certainly, these are hopeful signs and a majority of young gay men say they feel optimistic about the future.

Table 15: Resilience

	<30	≥30
Involved in gay group	16.1%	12.5%
Involved in civic activities	63.6%	57.7%
Out @ work all	32.2%	26.6%
Out @ work some	54.1%	44.2%
Optimistic	76.3%	77.8%

Table 16: Community Involvement

	Civic	Gay org
BC	63.2%	19.4%
Prairie*	60.1%	11.7%
Ontario	58.7%	11.1%
Alberta	56.8%	13.6%
Atlantic*	54.9%	11.0%
Quebec	51.8%	10.7%

**Some provinces and territories were combined for comparison*

DISCUSSION

Studies of gay men’s prevention commonly end with practice recommendations for new messages, changing behaviour or providing health services. Determinants of health research, however, does not aim to bring about these types of remedial strategies directly because its primary focus is on populations rather than individual people. More effective, from a social determinants point of view, would be to consider strategies for multiple levels of social organization, such as; political (macro), institutional (meso), and interpersonal (micro) levels of social order.

In this way, SN11 findings, correlating antigay prejudice with mental distress, are not necessarily indicators of newly recognized mental health service needs for gay men, although more appropriate counseling services may well be desirable. Our primary focus is on describing the extent of bullying and employment discrimination as independent measures of homophobia-heterosexism in Canadian society – a pervasive social prejudice having a measurable health impact in the extent of anxiety, suicidality and depression that it produces in Canada’s gay population.

Social determinants are *structural drivers* of health. Remedies are needed for the sources that produce prejudice—the social institutions that collude to maintain oppression and denial—not necessarily just for those they harm. These findings call for new directions in organizing gay men’s health activities, framed by collaborative action on breaking down institutional stigma and prejudice, not just renewed sexual health and testing campaigns.

According to a special issue of the Lancet in July 2012, HIV remains out of control in gay men and MSM virtually everywhere.⁷ Biology appears to be the main vulnerability but *structural factors* are thought to be the most serious barrier to progress. After 30 years since the discovery of HIV in gay men, for example, no complete epidemiological data exist on MSM anywhere, no population-based measures of the prevalence of same-sex practices, no reliable census estimates of the size of MSM populations, and little understanding of MSM diversity. To a greater or lesser degree, this insidious bias has pervaded Canadian life as well to such an extent that health systems have faltered on every front to reduce new HIV infections in gay men and MSM.

SN11 attempted to fill some gaps by obtaining a large enough national sample to demonstrate the population health effects of prejudice stemming from sexual orientation. Ultimately, the results point out evident social inequities underlying gay men’s experience with HIV in Canada. As the data describe, the tide of social media is flowing and change continues to evolve with the inevitable explorations of new generations of young gay men. It all suggests a critical need to re-examine the structural drivers that have sustained HIV in gay populations.

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