

Socialising and Sexual Health: An evaluation of the needs of gay and bisexual men and men who have sex with men in Sheffield

Introduction

These findings are a result of collaboration between the Centre for HIV and Sexual Health (CHIV) in Sheffield, Sheffield Hallam University (SHU), and diva (a social marketing agency based in Sheffield). The findings will inform a subsequent social marketing campaign and wider service development aimed at local gay and bisexual men and men who have sex with men (MSM). The work builds upon an international literature review of sexual health interventions and health promotion with MSM, commissioned by CHIV to inform their service provision (Formby, 2007).

Method

The report is based on findings from ninety detailed self-completion surveys and a small number of follow-up in-depth interviews with men who identified as gay, bisexual or men who have sex with men and who lived, worked or socialised in Sheffield. The survey was advertised and distributed through a local press release, CHIV networks, personal contacts, and CHIV outreach workers on the commercial gay scene in Sheffield. Completed surveys were returned to SHU using freepost envelopes, or via an online survey website established for the project. The face-to-face interviews were carried out by an experienced SHU researcher. The survey and interviews covered a number of themes, including socialising; seeking sex; sexual health information, services and support; and wider society.

The participants

The majority of participants described their ethnicity as white (97%), and 7% reported that they had some form of disability. Of those who identified their social class, 46% described themselves as working class, and 52% said middle class (2% were 'other', such as 'underclass' or 'student'). Respondents' ages ranged from those under 21, to those over 65, though a majority were in the younger categories (70% 34 years and under, of which 47% were 25 and under). This is perhaps a product of the success of survey completion on the gay scene rather than a reflection of the age profiles of gay and bisexual men and MSM in Sheffield as a whole. The majority of participants described themselves as gay (84%), with 10% saying bisexual, 3% heterosexual, and 3% identifying as MSM; 42% reported that they were in a relationship, and 58% said that they were not. In the last twelve months the majority of participants had had sex with only men (82%), with 12% having sex with men and women, 4% only women, and 2% having no sex or solo sex. The largest numbers of participants lived in postal code districts S10 and S11 (both more affluent areas near the two universities), followed by S1 and S2 (city centre locations). Extracts from the data are used to illustrate the summary of findings below. Brief information on age and status are included with quotations from the interviews.

Socialising in and out of Sheffield

Respondents socialised in a range of locations, including gyms, cinemas, and bars, pubs and clubs both on and off the gay scene. This raises issues on the sites for health promotion, such as information and condom distribution, targeted at gay and bisexual men. Sheffield gay and bisexual men and MSM also reported socialising outside Sheffield, for example in Leeds, Manchester, Brighton and London: this also has implications for the health promotion that CHIV is able to offer.

Sheffield was seen to be 'gay friendly' by the majority of participants, though 60% identified experiencing homophobia regularly or occasionally. The majority of respondents (69%) thought that Sheffield had become more 'accepting' in the last few years. In part, this may reflect changes in equalities legislation for gay people at a national level, which may have influenced perceptions of overall social equality.

Meeting sexual partners and having sex

The gay scene and the Internet were very popular ways of meeting men for relationships and/or sex: 65% of respondents had used the Internet in this way. This included a range of websites (both gay-orientated and non gay-specific) e.g. Gaydar, Facebook, Fitlads, Myspace.

Safer sex was largely associated with using a condom when having anal sex (and conversely not using a

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condom in unsafe sex), with perceptions of partner choice the second most dominant factor. These perceptions were often based on assumptions about age and ethnicity in relation to the prevalence of HIV. This may point to educational needs for gay and bisexual men about the reliability of 'risk assessments' (often solely based on level of acquaintance, or appearances) in relation to sexual practices. Health promotion materials, for example, might usefully highlight the diverse identities of people living with HIV to combat some of these beliefs.

"You automatically kind of gauge a level of risk and I think there's several factors come into play there... You would perhaps synonymise a black gay man with HIV more than a white gay man and pretty much the same... with an older gay man than a young gay man. They're the factors which probably impact some people's decision of condom use." (Simon: gay student in a relationship in his early twenties)

"It can be awkward, if you're really drunk and that you don't tend to care whether you are or you're not gonna [use a condom]... you don't know how they're gonna take it... sometimes I've met someone out and not even spoke to them until I've got in taxi or something like that" (Dave: single, employed gay man in his late teens)

Alcohol and/or drugs were the most common factors cited in increasing the likelihood of unsafe sex and/or not using a condom: this came out strongly in both the survey and interview data. Interviewees also discussed confidence and oral communication skills in relation to negotiating safer sex methods, and specifically using a condom. Access to condoms where men meet men to have sex was also highlighted as important, with a range of locations identified, including public sex environments, saunas, the gay scene, and other pub/bar/club venues.

"Packets of condoms and lube do make a big difference... it's the availability of condoms and lube and the fact that they're free as well... you don't have to go to the petrol station and get all embarrassed" (Matt: late twenties employed gay man in a relationship)

"They're an absolute god-send. Like me and my boyfriend never have condoms. It's not something you go and buy in a shop, or at least it's not something I'd go and buy in the shops, and lube especially" (Simon)

Information on sexual health

The Internet was also a very popular source of sexual health information, and raises concerns about the reliability of non-specialist websites such as Google and Wikipedia. The regular use of different websites also led some men to identify contradictory or confusing information, for example around the safety of oral sex. Low numbers of men participating in the survey recognised the specified campaigns (e.g. Get It On, Essential Wear, Proximity). This may point to the need to mainstream some health information if promotion in gay venues and/or publications does not always work. Sexual health workers have a hard balance to strike in relation to the provision of information on the commercial gay scene, as some participants did not like the intrusion of health promotion into their socialising space. This may also account for the low recognition rates of particular campaigns if men choose to 'switch off' (consciously or unconsciously) and do not look at the information available. Participants were most comfortable discussing sexual health with peers (partners and friends), though not all men felt comfortable discussing sexual health, particularly with older people, Doctors and/or other health professionals.

"I'm not big on advertisement. I think it's important in some places like, you know, saunas... but you don't want to be bombarded with it. I'm fed up of turning pages of gay magazines and just seeing another 'wear a condom' advert. They're all the same after a while, aren't they?" (Simon)

Experiences of local sexual health services

Generally, participants appeared to have faith in their ability to access sexual health services in Sheffield, and believed that they were adequately provided for. GUM Clinic was accessed the most, and had largely positive feedback. When discussing potential barriers to accessing sexual health services, however, participants described a variety of factors, including: fear and/or stigma attached to accessing sexual health services, lack of



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SHARPENS YOUR THINKING

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awareness of sexual health services, concerns about confidentiality in health settings (e.g. with receptionists) and/or coming out to a health professional, and practical problems around the times of service delivery. There was also some uncertainty about the identity and role of CHIV, particularly involving the outreach workers. The vast majority of participants accessed condoms via CHIV (a total of 75%), including free condoms in local gay venues, from outreach workers, and using the free postal scheme. There were relatively few concerns raised about the current free condom packaging, though some respondents identified wider sources where it would be useful to access free condoms, particularly in local straight pubs, bars and clubs, or through their GP. There appear to be some ongoing barriers about the acceptability of carrying condoms and appearing to 'plan' for sexual activity, which could usefully be addressed in future health promotion activities.

"And you see people around and you think, shit what if they overheard? I've never been that ashamed of being gay but it's that actual act of coming out is the worst thing! ... I tell myself that coming out is easy and really fine and then I meet a new person and I just don't want to, just because, especially with older people"
(Peter: single, gay student in his early twenties)

Future sexual health services

The importance of a central location and evening opening hours were raised in relation to accessing local sexual health services, particularly for testing services (with prompt results). Posters were also suggested as more acceptable than leaflets within the gay commercial scene, particularly those that clearly advertise the opening times of local services.

"I think it's good to have stuff like this on weekends. When I had my first STI scare and I didn't want to tell anyone, I did in the end, but I didn't actually want to tell anyone... I didn't do anything about it... things that would have perhaps encouraged me to go would be being open on a weekend so I didn't have to skip school." (Simon)

"it's a bloody hard job they've got... how d'you pitch it? ... How many gay young men knock about with straight young women and go in straight bars? You've got to do your publicity in a way that catches all... A lot of people will start in those other places before they come on the scene... and how d'you catch them in-between the two? ... has got to be heard across the board, has got to be learnt behaviour... which is mainstream services"
(Frank: mid forties gay man in a relationship, works full-time)

Conclusions

On the whole, feedback from survey and interview participants was positive about Sheffield as a place to be safe and socialise as gay, bisexual or MSM. There was some suggestion that the commercial scene could be bigger, or that there could be a broader range of gay social venues. In terms of meeting men, the Internet appeared to be an important source of connection / introduction, which mirrors other research (Elford et al, 2005). A clear finding was that in our study, notions of safer sex appear almost synonymous with condom use during anal sex. The data suggests a conceptualisation of sexual health that is closely connected with preventing fluid exchange and therefore disease or infection, rather than, for example, broader notions of physical safety or harm, or sexual pleasure that does not involve penetration.

Influences on practices around safe sex include alcohol and/or drug use, the availability of condoms, and assumptions and perceptions of risk: the latter may be made solely on the basis of appearance, age, or ethnicity. This suggests concerning beliefs about the ability to 'see' sexual health risks. Other barriers to safe sex highlighted included not feeling comfortable buying condoms, and lacking confidence or ability to ask to use condoms which could relate to broader cultural / attitudinal barriers around initiating safer sex.

The Internet is a significant source in participants' access to sexual health information, or the assumption that they would be able to find appropriate local sexual health services when needed. Barriers to accessing sexual health care or advice identified included:

- fear and/or stigma attached to accessing sexual health services;

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- lack of awareness of sexual health services;
- concerns about confidentiality and/or disclosure within health care settings and amongst health care practitioners, and
- practical problems around the timings of service delivery.

This evaluation showed high use and satisfaction with free condom packs available locally (either from gay venues, through postal services, or from outreach workers). There may be a difficult balance to be reached between responding to feedback on the condom packaging, and keeping the current high recognition factor. Some uncertainty or lack of awareness about wider CHIV services and organisational role and aims, particularly involving the outreach workers, is worthy of further enquiry.

Recommendations

Evaluation results point to a number of potential service developments / refinements, including:

1. Continue and try to expand current free condom provision; consider ways to distribute packs in 'straight' commercial venues, SHU campus locations and/or in GP surgeries. Think about including information on how to use condoms and where to access support and/or information.
2. Consider developing training sessions or health promotion resources for local men on negotiation skills and risk assessments. Target information to combat confusion about oral sex and safety levels.
3. Investigate ways (e.g. joint consultation / planning practices) to have input into GUM service developments.
4. Attempt to link more closely with local universities to address concerns about young people and unsafe sex.
5. Explore strategies for sexual health promotion (education initiatives and/or materials) that reinforce the confidential nature of local health service provision; continue to stress to local health care workers that confidentiality concerns maintain a potential barrier to men accessing health services.
6. Analyse the need for further sexual health promotion, information or resources aimed at young LGBT people specifically, utilising links with other local / CHIV projects (e.g. Fruitbowl, Parent to Parent, PASH); consider peer education opportunities.
7. Begin to promote CHIV services more widely, including specific services such as Indigo, through posters, information on condom tubs, and website links. Consider targeting this within particular postal code areas.
8. Investigate ways to work with local gay and bisexual men who socialise outside Sheffield e.g. providing health promotion information and materials on coaches to regional or national Pride events; also investigate closer partnership working with other relevant organisations working in the region e.g. Yorkshire MESMAC in Leeds, Bradford, Wakefield and North Yorkshire, and the Lesbian and Gay Foundation in Manchester.
9. Hold a feedback session with outreach workers about these findings, focussing on identity and expertise.
10. Investigate the feasibility of setting up a local sexual health telephone advice line, or consider promoting other / national advice lines locally e.g. THT Direct.
11. Explore ways of highlighting the need (at both local and national levels) for LGBT sex and sexual health issues to be raised in sex and relationships education (SRE), along with broader education on sexuality, homosexuality, heterosexism, and homophobia.

References

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