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### Recommended Citation

Egan, John P. (2007). "The Social Construction of Safe: Young Queer Men and HIV Knowledge," *Adult Education Research Conference*. <https://newprairiepress.org/aerc/2007/papers/30>

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# **The Social Construction of Safe: Young Queer Men and HIV Knowledge**

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**Abstract:** Part of an international comparative ethnography of queer young men in Sydney Australia and Vancouver Canada, this paper examines these men's learning about HIV/AIDS. Both the specifics of HIV infection (how) and the means by which to reduce one's vulnerability to HIV (what) are analyzed. Overall these men showed consistently accurate understanding of the what, even when their understanding of the how was flawed. This knowledge was almost entirely acquired from queer programs and services.

Young queer men are among the most highly vulnerable to HIV infection in the Western world (UNAIDS, 2006). A rich understanding of younger queer men's lives is needed to foment effective and relevant prevention strategies. As nascent members of the broader queer community, exploring their sexuality for the first time, young queer men's understanding of HIV/AIDS—including HIV science and ways to avoid HIV transmission—is critical to maintain both physiological and psychological wellness. Thus I endeavoured to ascertain what knowledge queer young men in two anglophone, Pacific rim cities possessed, where and how they acquired it, and their experiences implementing it, in terms of sexual practice. This study examines these men's knowledge about HIV/AIDS as an example of queer subjugated knowledge. Queer knowledges are often constructed in resistance to mainstream society's homophobia and heterocentrism (Egan, 2006). Largely isolated until adulthood, queer young men often begin their sexual lives without access to relevant, tangible sexual health knowledge. Thus their "coming out" often involves exploring their sexuality through practice, despite a dearth of relevant knowledge to help them remain HIV-negative (as well as sexually transmitted infection-free).

## **Theoretical Framework**

My analysis is informed by post-structural theory, specifically Michel Foucault's work on knowledge and power (1980), and sexuality (1990). According to Foucault, subjugated knowledges (1980, p. 81) are possessed and valued by those excluded or marginalized by society. Foucault's notion of subjugated knowledges positions knowledge as fluid with respect to both resistance and power, and their manifestations complex. Somewhat paradoxically, although Foucault rejected the notion of an identity constructed around one's sexual orientation - despite an ascendant queer rights movement throughout Europe and North America in his lifetime - his critique of hegemonic heteronormative notions of sexual expression as "restrained, mute and hypocritical" (1990, p.3) bears particular relevance to any analysis of nascent queer men's knowledge about HIV/AIDS—particularly when queer community constructed around queer identities is the source of that knowledge.

## Research Design

This ethnography used participant observation and semi-structured key informant interviews (Bernard, 2000) for data collection. Two cohorts of men aged 17-24 at time of recruitment in 2003, self-identifying as queer, and resident in either Sydney or Vancouver were eligible to participate. Data were analyzed via the constant comparative method (Glaser and Strauss, 1967) using Atlas/ti software. Consent procedures were reviewed and ethics forms signed. Member checks were used to verify transcript accuracy; these checks, and a confirmatory interview with a queer youth service provider, were used to triangulate the findings..

### *The Men*

In total 27 men participated in the study, 12 Vancouverites and 15 Sydneysiders. One-third of each cohort still lived with their parents, with the rest living with roommates or alone; none were living with a partner. Two men (one in each cohort) were HIV positive. Most self-identified as gay (85%), with four percent bisexual and 11 percent queer. Mean age in Sydney was slightly higher: 20 years versus 18.5 years in Vancouver. With the exception of one Asian man in each cohort who were recent arrivals as international students (and who aspired to remain in Canada or Australia), all identified at least partially as “Canadian” or “Australian”.

### *Risk*

Half of each cohort had *ever* engaged in unprotected anal intercourse (UAI), with rates slightly higher (53 vs. 50%) in Sydney. One-third of each cohort have only engaged in UAI after negotiating safety (after HIV testing) or when both men were virgins—leaving an adjusted HIV risk of 13% in Sydney and 16% in Vancouver. Only one of the participants routinely engaged in UAI at the time of recruitment. In fact, about half held idealized notions about sex and love and anal intercourse (AI) as an activity to be reserved for being in a relationship, rather than during casual sex “hook-ups.” For most of the men AI was especially intimate and meaning-laden—and looked at quite differently than any other sexual act such as oral sex.

## Findings

The local knowledges possessed by these two cohorts were remarkably consistent. In fact, there were no discernible differences between the Sydneysiders and Vancouverites: equal numbers in each cohort conformed to the descriptions that follow. The knowledges broadly fit into two categories; how and what. However, these men’s experiences implementing these subjugated knowledges are equally important.

### *How*

Overall knowledge of HIV transmission varied, although about two-thirds of the men had a clear and concise understanding of how HIV is transmitted during sex, which sex acts are higher risk than others, and the basics of HIV infection (“AIDS 101” as it is known in HIV prevention discourses). Both Alan and Tom gave comprehensive and detailed explanations for HIV virology, transmission and disease progression, using precise scientific language to do so. Most of the other men used more quotidian language, but provided responses that indicated a solid laymen’s knowledge of AIDS 101. Cory, for

example, knew that “basically all the touching that isn’t penetrative or doesn’t exchange body fluids” is low risk for HIV transmission.

The remaining participants demonstrated inconsistent or inaccurate understanding of AIDS 101. Jeff thought persons newly infected with HIV were asymptomatic for six months and would test HIV negative until then (many experience “seroconversion flu”; most HIV anti-body tests are positive between one and four months). Karl thought an HIV antibody test showed “a T-cell count” (T-cells help the body’s immune system: HIV, in fact, kills T-cells). Wes thought the absorption of semen in the digestive track during AI was a mechanism of HIV infection (it isn’t; direct semen to blood contact is). Eric and Lorne both thought kissing was low risk (it is zero risk). James thought HIV was rarely transmitted saliva-to-blood (it never is). Bruce thought oral sex had only a “slightly, marginally lower risk than anal intercourse,” whereas oral sex is considered much lower risk. Few of the men addressed whether vaginal intercourse was high risk (it is), though when asked about it all knew it to be.

### *What*

All of the men received some sexual health education while in high school, where some technical competencies about sexual risk reduction for HIV and other sexually transmitted infections (STIs) between men and women were addressed: two educated in Catholic high schools were only taught abstinence. A minority in each cohort recalled discussions about queer sexuality in those classes: however, the discussions avoided specific sexual acts, and did not candidly address issues of sex between men—whereas frank discussions about vaginal intercourse were common. Therefore these men had to wait until they left school to access relevant sexual risk reduction information unless they could access queer spaces while still in high school. Two spaces figured prominently in these men’s seeking specific knowledge about HIV risk reduction: online and queer youth groups. Most of the men initially used the Internet to seek both information and queer community. Embedded in most of the online spaces they visited (including Mogenic.com, Gay.com, and Gaydar.com.au) is detailed, queer male-specific information about HIV/AIDS risk reduction. Later they sought out real time queer spaces. In both spaces the knowledge was clear and consistent: to reduce HIV transmission risk during any sex acts avoid ejaculating inside one another; during AI use condoms.

Some men’s understanding of AIDS 101 was poor, yet they were no more vulnerable to HIV exposure because their understanding of HIV risk reduction was accurate. For Gordon it was “always imperative” that condoms be used for AI. He felt it “was just never an option to even consider not using them. “ Steve “always knew” to use condoms for AI “even when I was 14,”; in fact, he was the only participant who knew this before accessing queer subjugated knowledges. Terry didn’t understand the science of HIV/AIDS “at all,” yet he understood how to reduce HIV transmission risk. Brian arrived in Canada from Southeast Asia. He had chosen to study in Vancouver because of its large, diverse Asian and queer communities. But he knew little about HIV/AIDS before his arrival:

*I think working with [an HIV/AIDS organization] affected me big time in that sense. I know about [HIV/AIDS] and I won’t get [HIV/AIDS], you know? Now I feel like there’s the potential for me to getting [HIV/AIDS] so for me it’s better to be safe. And it’s right for everyone, [they] should be safe too.*

Participation rates in community-based organizations providing specific services for queer youth were similar in both groups (47% Sydney; 43% Vancouver). These groups served as their other primary source for HIV/AIDS knowledge. Interactive in nature, these groups afforded the men opportunities to ask questions, discuss specific scenarios and issues, and fostered membership in a community of practice that normalized *sexual risk reduction* rather than *sexual risk taking*. A critical difference between these groups' role in HIV education from the online resources is their equal emphasis on both *technical competencies* to reduce HIV risk, and *negotiation skills* in terms of how to implement them—particularly when one's sexual partner is either ignorant on matters of HIV risk, or asserts a desire to forgo sexual risk reduction despite the risks. All of the men acquired the queer subjugated knowledge needed to reduce the risk for HIV transmission during sex between men.

### *Implementation*

Overall these men embraced the idea of sexual risk reduction and implemented risk reduction strategies consistently with both boyfriends and casual sex partners. None of the men described any difficulties with condom usage: how to open, put on, and remove a condom without breakage, leakage or slippage was not an issue for any of them. However, inconsistent use, including negotiation condom use with sexual partners, proved to be significant challenges for a minority of the men. Most found other men equally committed to using condoms for AI, although Tom encountered a few men who do not want to use condoms. To them he said, “well fuck doing this, goodbye sunshine, [because] that's my principle.” Similarly Eric had been told a couple of times that his partner didn't have HIV or any STIs—in other words, it would be safe to not use condoms. “Well too bad, we're using one anyway” was his response; he found those men “were cool” about using a condom once he insisted. Ted was making out with someone after a dinner date. When his date tried to penetrate him without first putting on a condom. Ted asserted his requirement of using a condom during AI:

*I pushed him to the other side of the car and I looked at him and I'm like “No, not without a condom.” And he looked at me and I'm like, “No, I'm serious. I will not. This is not going to happen.”*

Some men reported isolated incidents of unprotected anal intercourse (UAI). Walter remembered once when he and a friend had AI without a condom, though he had “no idea why” it happened. Lorne had not used condoms “on occasion” and felt guilty about it, but was unwilling to elaborate any further. Terry had used condoms inconsistently when he was drunk: he subsequently avoided drinking alcohol. Larry mentioned one incident where he and his partner “used a condom for *most of* [emphasis added] the intercourse”, but couldn't recall any further details.

Many queer men consider their first experience with receptive AI as their sexual début (Middelthun, 2001)—in other words, losing their virginity, even if they had previously engaged in oral sex or active AI. Many had their début with peers as teenagers, where none used condoms. However, given the extremely low prevalence of HIV among persons 10-19 years of age in both BC (Public Health Agency of Canada, 2006) and NSW (NSW Health, 2006), the risk for HIV transmission was negligible. When both men were virgins, it was zero.

For those whose débuts came with older (25 years old or higher) partners, the stakes were quite different: HIV rates in both NSW and BC rise precipitously from age

26 onwards (Public Health Agency of Canada, 2006; NSW Health, 2006). A few of the men in the study did not use condoms during their début, despite knowing their importance in reducing HIV transmission risk. They described a need to trust and rely on their début partner, often choosing an older man specifically for those reasons. Bruce's debut was with an older partner who was "more conscientious" and who insisted they use condoms. Alan frequently engaged in UAI with older men during his teen years, due to both a lack of knowledge and a lack of self-esteem. Eventually he removed himself from such situations entirely; he has consistently used condoms for AI ever since. Brian's first casual sex experience (hook-up) was also his début. He did not use condoms, which he realized was "wrong, completely wrong" the next day. He had known about using condoms for AI, but had "never practiced it or anything because I never had sex before":

*I was so naïve ... he told me "oh I'm, I don't have HIV" and I just trusted him right away. I was stupid, and I was desperate as well. Because I wanted to know, how it feels. Because everybody is talking about it. [Now] I've always practice safe sex and I will not ever have sex with strangers. I will not ever have sex without a condom [again].*

Brian's début served as a critical learning experience for him. As a result he more deeply examined his beliefs, actions and intentions regarding sex. He identified key areas where he could have made informed choices rather than mere decisions.

After his début, Jim felt a great deal of remorse and anxiety about not using condoms. He sought medical advice and subsequently went on post-exposure prophylaxis (PEP), a one-month course of anti-retroviral medications to (hopefully) prevent HIV infection, had he been exposed:

*I was sort of a bit emotional after the whole thing for a while. I don't know whether it was so much the medication, but I was very irritable. I didn't have time for people as much. I sort of wanted to be alone. I think maybe that was me sort of being hard on myself, trying to think about what I've done. Things from that time on have altered slightly. I have been giving myself more time for what I want now. I think I was too worried about what other people were doing, you know trying to please people. I realized that that's not gonna make me happy. And so I've spent a lot more time focusing on what I want. Now I'm pretty much taking responsibility for my own body, not leaving it up to anybody [else] no matter what. It's sort of like, "OK, now things aren't gonna happen unless there's condoms involved. I don't want to put myself through that situation again.*

Jim remains HIV negative, and his début (like Brian's) proved to be a critical learning experience. Subsequently Jim felt capable and confident in asserting condom use with others. But Martin's experiences with negotiating sexual risk reduction were more problematic. He inconsistently used condoms for AI. One relationship in particular troubled him:

*We were both under the influence and it just happened, and he said "this can't keep going on." And I go "no it can't keep going on." So we promised ourselves, you know, no more but we'd have unprotected sex [around] five percent of the time. It was a casual sex relationship, but I knew he was having sex with other people. And that's when I thought, "you know, you're being really naïve cause you're trusting him. And you know that he's having sex with other guys--what's*

*stopping him from having unprotected sex with other guys as well.” So when I kinda realized that, we stopped pretty much having sex.*

Martin found it difficult to assert condom use with some sexual partners. He worried that “maybe if I say ‘put a condom on,’ they are going to say ‘no’. And they are going to stop .” Not always knowing how to consistently negotiate condom use reflected Martin’s self-described low self-esteem.

Cory’s understanding of risk reduction involved more than just condom use. For him protection was “a mixture of making sure I use a condom ... but also feeling like I trust someone before I have sex with them.” These principles were at least partially informed by conservative social values learned from his Middle Eastern family. Other men also espoused the need to be in a relationship before having AI. Brian regretted his first sexual experience because it was a casual hook-up, which is “against me, it’s not my idea of sex.” For Brian AI is only appropriate when he is in love with someone. Dave has broken his “rule [about] one night stands” at times; his ideal remains to be celibate until “someone that I really do love” enters his life. Steve and his ex-boyfriend were monogamous and used condoms for the first several months of their relationship. After having gone together for HIV testing—and after a great deal of communication about trust, honesty and responsibility between them—they no longer used condoms until the relationship ended several months later. Their decision – which he has not made with anyone else, before or since – reflected thoughtfulness and significant self-reflection on Steve’s part. Had he describing a relationship with a woman under similar circumstances, their decision would most likely not have been perceived as faulty or problematic—especially if a female partner used oral contraceptives to prevent pregnancy.

### **Implications for Adult Education**

These men’s experiences demarcate how homophobia and heterocentrism leave young queer men especially vulnerable to HIV infection. Their access to reliable, relevant sexual health information is non-existent until they seek out queer spaces (online or real time) where such knowledges are found. However many are sexually active before then, sometimes with older men who are much more likely to already be HIV-positive. That this reliable and relevant information remains queer subjugated knowledge places these young men in jeopardy, since many become sexually active as teenagers. Their homophobia-inflicted ignorance leaves them unnecessarily vulnerable to HIV infection.

Most of the men learned about (and managed) their vulnerability for HIV infection after accessing queer subjugated knowledges that articulate how to minimize that risk—and how to practice effective self-care via negotiating condom use. But for two of the men in the study, this knowledge was acquired too late: they became HIV-positive, in both cases from older men.

These men’s experiences seeking queer subjugated knowledges allowed them to construct positive, affirming identities as queer men, while acquiring technical competencies to reduce their vulnerability. Despite recent acquisitions in legal entitlements like same-sex marriage in Canada, young queer men must nonetheless seek queer and queer-friendly spaces to acquire relevant, affirming knowledges, resulting in an unique and particular construction of the (queer) adult.

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