THREE-CITIES NATIONAL PROJECT

MONTRÉAL SITE

Health needs assessment of gay men in Montréal

Research Report

prepared by

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OVERVIEW OF RESULTS

A large proportion of the gay men in the Montréal region who took part in this study appear:

- To have chosen to live in Montréal;
- To live more often alone than as couples;
- To have a rather high educational profile;
- To have mostly earned less than $30,000 in the past year;
- To have ”come out”, on average, in their early twenties;
- To live among a large proportion of people who are aware of their sexual orientation;
- To have mostly all taken the HIV test;
- To smoke more than the average male Quebecer;
- To consume more alcohol per week than the average male Quebecer;
- To mostly visit gay bars every week;
- To consume more soft drugs rather than hard drugs;
- To mostly indulge in low-risk sexual practices even if a significant number exposed themselves to high risks of HIV infection;
- To use more the services provided by the public health authorities;
- Not to have – in a large majority – been vaccinated or have all taken the doses recommended against hepatitis;
- To feel more the need to reveal their sexual orientation to public health providers;
- To feel the need to obtain the services of someone of their own sexual orientation particularly among public health providers;
- To believe mostly that health workers are fairly/moderately well-trained to meet their needs;
- To want mostly to have access to services that are specially intended for them;
- To believe – in quite a large majority – that their rights are respected in the health services networks;
- To believe mostly that their health needs are not any different from those of the general public;
- To believe themselves – in a large majority – to be in good health;
- To have a moderate level of satisfaction with regard to their sex life;
- To have mostly been subject to numerous life-stressing situations;
- To have been significantly exposed to numerous forms of violence during their lives.
Overview of results elicited from themes raised in focus groups on health and services

Many participants of the focus groups were in agreement about several subjects:

➤ Mental and physical health are interrelated;
➤ Mental and psychological health is the most important item when talking of “gay health”;
➤ The health of gay men is little or no different from that of heterosexual men except for the mental health aspect;
➤ The lack of services in the areas outside Montréal was deplored;
➤ The notion of feeling at ease is often associated with the expression of health needs in all situations;
➤ The need to reveal one’s sexual orientation to a healthcare provider always depends on the situation;
➤ The importance of provider being openminded and having adequate training was stressed;
➤ The Village meets certain needs (e.g. need to break off loneliness);
➤ The lack of role-models for young people was condemned as well as the lack of support in their environments;
➤ The need was stressed to provide more services for older gay men;
➤ There was general agreement on the need to provide adapted as well as specific services.
ACKNOWLEDGMENTS

We would like to express our gratitude to the numerous people who helped to bring about this health needs assessment. Firstly, the work of collecting data through a questionnaire would not have been possible without the sustained efforts of many volunteers and workers from Séro Zéro. A special thank-you to Dominique Audot, Luc Chartrand and Paul du Bois de Nevele for their active contribution and their perseverance throughout these three weeks of intense work in bars, cafés and saunas. We would also like to point out the precious assistance of Maurice Gaudreault, Roger Noël and Joanne Otis of the Oméga Cohort for their help in preparing the questionnaire and the statistical analyses. Thanks too to Yves Desjardins for his contribution to the data processing and the production of this research document. Finally, we wish to thank Michael Hendricks, Yves Jalbert and Roger Leclerc of the COCQ-Sida for their work in the coordination of the project on the national level.

FOREWORD

During 1999, representatives of gay community organizations in Toronto, Montréal and Vancouver came together to share views on the health status of gay men in Canada. One of the main objectives was to discuss the possible methods of advancing the promotion of the health of gay men in their community, to counter the fact that the adoption and maintenance of safe sexual practices among gay men had reached a ceiling and were even dropping back. Various questions were raised, such as: What steps should be taken next in the work of HIV/AIDS prevention? What can be done more or done differently with gay men?

From these discussions and question sessions a consensus was achieved to the effect that the concept of “gay health” should be at the heart of future orientations in the work of health promotion and prevention with gay men. That is how the Three Cities project was born.

It is therefore a community research project which included the three largest Canadian cities where the largest concentrations of gay men are found, i.e. Montréal, Toronto and Vancouver. As a first step, each city received the instruction to conduct a health needs assessment specific of gay men in their environment and to document the health needs of gay men. A theoretical and methodological approach was used for each urban reality.

In Montréal the project was under the leadership of Action Séro Zéro, a community HIV/AIDS prevention organization among the gay community. The project was coordinated by the Coalition des organismes québécois pour la lutte contre le sida (COCQ-SIDA) (Coalition of Québec Anti-AIDS Organizations).
INTRODUCTION
HEALTH NEEDS OF GAY MEN AND “GAY HEALTH”
AS A GLOBAL APPROACH TO PREVENTION

Talking of a global approach to the health of gay men is far from new. Already in Québec during the seventies, the Ville Marie Social Service Centre (CSSVM) was discussing it widely in the recommendations it presented in order to start the adaptation of the social services to the realities of homosexuality\(^1\). Already negative social attitudes to homosexuality were denounced, as well as the phenomenon of self-oppression frequent in gay men, the lack of specialized and non-discriminatory services on both physical and psychological levels, and many other factors linked to the welfare of these people. But the context of budget restrictions as well as the appearance of HIV/AIDS in the early eighties made for priorities to be centered more on the urgency for action by proposing health promotion campaigns based on the adoption of safe sexual practices and support for HIV-infected individuals.

So, the global approach to “gay health” was to all intents and purposes put aside until the early nineties when a timid return to the subject was noted, notably in the United States. In Canada, we had already been able to see the return of “gay health” in speeches on prevention for some years. Nevertheless, only a handful of organizations working with gay men have really started on a work-plan including a “turning point” in gay health. One of the reasons brought forward to explain this situation is the difficulty of obtaining financing for projects of this type. However, more recently, several departments, such as Health Canada and the Ministère de la Santé et des Services Sociaux du Québec (MSSS), have adopted policies and strategies which are pointed in this direction. For example, the MSSS in its document published in 1997 entitled *Department Orientations: Adapting Health and Social Services to Homosexuals* identifies several lines of action including improving knowledge and intervention.

Hence, in this project we are exploring the concept of “gay health” in order to learn more about the health needs of gay men in Montréal. The information collected will enable people working with gay men to better direct their work and to start up new services if required.

\(^1\) It must be noted that at that time the anglophone gay community had already been receiving the benefit for several years of a range of adapted services provided via the Gay Social Service Project (GSSP), which was not the case for francophones who came under the Centre des services sociaux du Montréal métropolitain (CSSMM).
CHAPTER I

METHODOLOGY OF THE NEEDS STUDY

What kind of questions is the needs study trying to get answers to?

Firstly, what is "gay health"? Those spoken to, whether gay men in Montréal or people or organizations working with them, had at their disposal several ways of expressing their opinion. Then, acting on Carter’s model of needs (see Appendix II), we asked for example the following questions: What are the needs as stated by Montréal gay men? What services are available? What services are not available? What are the needs Montréal gay men have not stated? Amongst those, what needs are recognized by the community? Is it possible to identify needs which are not recognized either by the community or by gay men?

Needs study - used methodology and approaches

The aim of this study was to obtain an explicit definition of the conditions for the health needs of gay men in Montréal. The principal objective was to obtain a better grasp and evaluate the needs of gay men in Montréal in the context of the promotion of gay health and community development.

In order to attain our objective we have had recourse to a mixed methodology of data collection (both quantitative and qualitative). The quantitative component was divided in two: the deductive approach and the approach by indicators. The deductive approach contributed to the identification of the needs of gay men in Montréal through a questionnaire which was distributed in gay circles, i.e. the numerous gay shops and service and aid organizations. The approach by indicators enabled an analysis to be made of writings on the situation of gay men via the various documents published by the provincial and federal departments of health, the Human Rights Commission, the Régie régionale de la santé et des services sociaux de Montréal, the Santé publique de Montréal, etc., in order to obtain a clear understanding of the present situation of gay men with regard to health and social services.

As for the qualitative component of the project, it included several methods for collecting the opinions of different people about the health needs of gay men. With the help of the key informers, through the call for essays in the gay media, through the focus groups, through the discussion groups composed of experts, and through the community forum, we wanted to encourage public participation in order to make it easier for all the partners in the gay community to take part (i.e. from the community, the health and social services environments).

Here is a summary of the calendar of the project as it occurred:

1999

Key informers October/November/December
Call for essays in the gay media November/December
Survey in gay environments (anonymous November/December
questionnaire about "gay health")

2000

Focus groups with gay men March
Discussion group with experts April
Community forum May
CHAPTER II
DESCRIPTIVE PROFILE OF RESPONDENTS IN THE QUANTITATIVE COMPONENT

This chapter presents, firstly, the methodology followed for collecting quantitative data from the questionnaire on gay health. Then we present the main descriptive results of the sample (averages combined). The reader can refer to the tables supplied in the appendices for more details. Besides, the main differences between the samples are touched on in the discussion (Chapter V).

2.1 Descriptive results relating to the methodology of the questionnaire on gay health

The collection of data with the help of the questionnaire took place in two phases. The first was to contact a sample of gay men in the milieu of gay businesses in Montréal, i.e. bars, cafés and saunas. Altogether, 24 businesses were visited by volunteers and workers from Séro Zéro during the period November 23rd through December 16th 1999. Trained for this exercise to adhere to a strict approach method to the respondents, the survey team visited the collection centers every day of the week at different hours of the day.

The second phase consisted in contacting gay men in the community setting, i.e. those who go to organizations that offer socio-cultural activities as well as those providing other types of services. Thus, about ten organizations were visited. These were for example discussion groups for young or older gay men, sports or university student organizations. Amongst these were also organizations providing support services to those living with HIV and to young people in the process of coming out. The table that follows gives some details of the results of the two collection phases of quantitative data.

Table I: Results of the collection of data with the questionnaire on gay health, and the number of questionnaires used for the analyses.

<table>
<thead>
<tr>
<th>Type of collection</th>
<th>Total collected</th>
<th>Total used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase I – Business Circle (24 businesses)</td>
<td>n=591</td>
<td>n=474 (78.3%)</td>
</tr>
<tr>
<td>Phase II – Community Circle (10 organizations)</td>
<td>n=151</td>
<td>n=131 (21.7%)</td>
</tr>
<tr>
<td>Total phases I and II</td>
<td>n=742</td>
<td>n=605 (100%)</td>
</tr>
</tbody>
</table>

The total number used is explained by the selection criteria of the questionnaires. The subjects were selected in relation to their sexual identity and their place of residence. As this needs study has as its objective to identify the health needs of gay men in the Montréal area, we were obliged to set aside respondents who considered themselves as bisexual (n=49) or heterosexual (n=12) or those who did not reside in the Center South/Village but elsewhere on the island of Montréal or in the suburbs (n=46). Other questionnaires had to be rejected because their completion level were inadequate (less than 75%) or because the subjects had not replied to the questions related to other selection criteria (n=41).

Analyses will be made with these respondents in a more detailed research report.
2.2 Descriptive results with a sociodemographic and socio-sexual character

This section presents the main results linked to questionnaires for the combined sample. A comparison between sub-samples (business sample vs. community sample) is shown where the results are significantly different.

The average age of the respondents was 34.6 years (standard deviation 10.8). The community sample respondents were significantly older than those of the business sample, being 37.7 and 33.6 years old.

Nearly half had received a university education (47.9%) and more than half were in full-time employment (54.4%). Respondents at the community level were of significantly higher educational standard (81.3% vs. 44.4% for the business sample had a university education). However, almost one gay man out of ten (9.3%) was unemployed at the time of the survey, irrespective of sub-sample.

In the past year, more than half (58%) of the respondents stated they received an income of less than $30,000 per year, and 14.7% less than $10,000. A significant difference was noted with regard to place of response. In fact, the respondents in the business sample stated their income last year was lower than those responding in the community circle.

French is the principal mother tongue and language used. The majority (67.5%) of respondents considered themselves Quebecers. No significant difference was noticed between the sub-samples.

Nearly two-thirds (62.5%) of the respondents were single and more than a quarter (27.9%) were living a couple relationship with another man. The community sample respondents were however significantly more numerous to declare they were living with someone (38.1% compared with 25.1% for the business sample).

More than the majority of respondents lived at present on the island of Montréal and more than one-third (36%) the Center-South area of Montréal or the gay Village. The business sample respondents living in the Center-South area of Montréal or the gay Village were significantly more numerous (40.7% business sample vs. 19.1% community sample). More than half (56.7%) declared having lived outside Montréal or its suburbs during adolescence. This trend was observed in both business and community samples.

The average age for declaring their sexual orientation (coming out) was 21.94 years (standard deviation 7.54). A significant difference was noted in the sub-samples. The average coming-out age of gay men responding was much lower in the business circle than in the community circle (20.9 vs. 25.5 years). The sexual orientation of the respondents was known in proportions which varied considerably between mother (82.5%), father (74.8%), all brothers and sisters (78.5%) and all workmates or fellow students (49.5%). No difference with respect to the sub-samples was observed except in the case of sexual orientation known by all workmates or fellow students (53% business sample vs. 36.8% community).

A little more than one person out of ten (11.7%) declared having contracted an STD during the six previous months, and a large majority (78.9%) stated they had already taken an HIV screening test. 54.8% of respondents stated having received one or more doses of vaccine against hepatitis A, and 56.2% against hepatitis B.

At the same time, half (50.3%) of respondents pointed out they had taken an HIV screening test in 1999. Among those declaring they had already taken the HIV test 15.1% declared they were
HIV-positive. A significant difference was noted with relation to the sub-samples. In fact, 16.7% of business respondents stated they were HIV-positive compared to 9.2% of those responding in the community circle.

2.3 Descriptive results of life habits

More than half (58.5%) of the respondents stated they were “moderately” and “enough” physically active. On the other hand, 7% said they were not at all active (8.0% of the business sample and 3.1% of the community sample). Anyhow, no significant difference was observed between the sub-samples.

More than four respondents out of ten (44.9%) are smokers and a little more than one respondent out of ten (12.8%) declared themselves to have given up smoking. Analysis by sub-samples uncovers a very significant difference with regard to tobacco use. In fact, 53.6% of respondents in the business sample are smokers compared to 13.7% in the community sample.

As for alcohol consumption, half (50.8%) of the gay men stated they have on average 1 to 10 drinks per week. Yet 16.8% replied that they had between 11 and 34 drinks, and 5.2% more than 35 drinks per week. The business sample respondents drank considerably more. In fact, more of them stated they had more than 11 drinks per week (26.3% compared with 6.3% for the community sample). 28.6% of them even felt they were drinking too much compared to 3.6% of the respondents coming from the community circle.

The most popular places for meeting and socializing were, respectively, in order: gay bars, saunas, other bars and raves. As for gay bars, the majority (57.9%) said they went there every week. One respondent out of five (20.5%) said he went there three times or more each week. If the saunas were visited on a weekly basis by 8.1% of the respondents, 44% had visited them on a monthly basis during the previous six months. For other bars (e.g.: hetero bars), the respondents stated they visited them weekly in a proportion of 10.1%, whereas nearly half (48.6%) went monthly. As for raves, very few went weekly (1.4%). However, 19.3% stated they went monthly. Important differences were noted between the places for meeting and socializing according to sub-samples. Men from the business circle stated they went more often to gay bars, other bars and raves. With saunas, no significant difference was noted. However, men from the business circle were slightly more likely to go to a sauna 3 times or more per week (3.0% for the business sample vs. 1.5% for the community sample).

With regard to sexual behaviours, 6.6% of the participants stated they had had no sexual partner during the six previous months, and 21.5% said they had had only one partner. For those who said they had had several, 33.2% had had between 2 and 5, 12.9% between 6 and 9, and 25.1% more than 10 different partners. Significant differences were noted in the sub-samples. In fact the participants taken from the community circle were far more numerous to declare having had only one partner (36.5%) in the previous six months, compared to those from the business circle (17.5%).
With regard to sexual practices in the previous six months, we point out that 41.6% of the participants stated having had oral genital intercourse (with ejaculation) with a regular partner, and 26.5% with a casual partner. Significant differences were observed between the sub-samples. Community circle respondents were markedly more numerous in declaring having oral genital intercourse with ejaculation irrespective of type of partner (46.6% business sample vs. 29.8% community sample for regular partners; 33.2% vs. 10.0% for casual partners).

In the case of anal intercourse, 22.2% of respondents stated having during the course of the previous six months had passive anal intercourse without condoms with a regular partner, and 9.8% with a casual partner. Similarly, 23.2% of respondents said they had had active anal intercourse without condoms in the previous six months with a regular partner, and 10.7% with a casual partner. Significant differences were apparent with regard to the data collection points. Respondents taken from the business circle indulged in more unsafe sexual practices, irrespective of the type of practice (passive, active), or type of partner (regular, casual). In fact, whereas 26.0% of the gay men encountered in the business circle said they had passive anal intercourse without condoms with a regular partner in the previous six months, and 12.2% with a casual partner, these percentages drop to 13.8% and 3.9% for gay men from the community circle. Furthermore, whereas 25.7% of the gay men in the business circle say they had active anal intercourse without condoms with a regular partner, and 12.9% with a casual partner, once again these percentages drop to 17.7% and 5.4% for gay men from the community circle.

2.4 Descriptive results on the use of services during the previous year

At the time of the survey 67.7% of respondents stated they had been using the physical health services (routine medical exam). In other respects, 22.4% stated they had used the psychotherapy services during the previous year (1 to 3 times, or more than 3 times). No significant difference was noted between the types of sample, except for those services associated with mental health. In fact, 20.4% of gay men from the business circle stated they had taken advantage of the psychotherapy services, compared to 30.0% in the community circle.

Discussion groups were used by more than 22% of respondents, and 10.6% stated having attended workshops. Respondents taken from the community circle were significantly more likely to have taken part in discussion groups and workshops during the previous year.

2.5 Descriptive results on other variables linked to needs

Exposure to life-stressing situations

The analysis of the statements associated with exposure to life-stressing situations reveals that 20.5% of the participants had been "seldom, sometimes, fairly or very frequently" faced with situations of incest or sexual abuse during their lives, 58% with suicidal ideation or attempts, 74.7% with partner problems and 56.6% with problems related to their sexual orientation. No significant difference was noted between the sub-samples, except however for sexual orientation problems. In fact, 51.4% of gay men taken from the business circle stated having had problems associated with their sexual orientation during their lives, compared to 74.6% of those from the community circle.

41.3% of gay men stated having been victims of verbal violence during their adolescence (e.g. insults, sarcasms), 12.4% of physical aggression, and 12.9% of sexual aggression. No significant difference was noted between the sub-samples. However, nearly 3 times more gay men taken from the business circle stated having been victims of sexual violence during their adolescence (15.0% vs. 5.3% for the community sample).
CHAPTER III
SPECIFIC ANALYSES OF EXPRESSED NEEDS

By making descriptive statistical analyses, other significant differences were detected. We present in this chapter the most important results linked to expressed needs, i.e. those of questions 25 & 26 of the questionnaire on gay health (see appendix). These two questions will enable us to obtain useful data as a response to the following series of questions:

When they use the various services, how much do gay men feel about:

1. The need felt to reveal their sexual orientation? (Q25);
2. The need felt to obtain the services of a person of the same sexual orientation?(Q26);

3.1 Needs expressed according to age of respondent and sample type.

We carried out these analyses by comparing first of all two age groups: 30 and under and 31+ (tables 3.1 & 3.2). Then we drew comparisons between the two types of samples obtained through the questionnaire on gay health, i.e. the business and the community samples (tables 3.3 & 3.4). From a perusal of the 4 tables on the next two pages, it can be noted that there are many significant differences which have been detected by the descriptive statistical analyses.

As for the need felt to reveal themselves (Q25), according to age, we note that there are decided differences between the responses from the two age groups for all respondents. Among workers in the institutional and private health network (doctor, psychologist, psychotherapist), the most noticeable gap is to be found at the level of the psychotherapist. As for the need felt to obtain the services of a person of the same sexual orientation (Q26) according to age, there are also differences noted between the two age groups, but only in the case of five workers, i.e. doctor, psychologist, psychotherapist, social worker and community aid worker. Among the workers from the institutional and private health network (doctor, psychologist, psychotherapist), the largest gap is to be found at the level of the psychologist.

The third table presents the results with regard to the need felt to reveal sexual orientation according to sample type. Significant differences can be noted in the replies for the psychologist, the psychotherapist, the social worker, the community aid worker and the accountant. Among the workers from the institutional and private health network (doctor, psychologist, psychotherapist), the largest gap is to be found at the level of the psychotherapist. Finally, on the level of the need felt to obtain the services of a person of the same sexual orientation (Q26) according to sample type, there are distinct differences noted in the responses of the samples concerning the doctor, the psychologist, the psychotherapist, the social worker and the (community) aid worker. Among the workers from the institutional and private health network (doctor, psychologist, psychotherapist), the largest gap is to be found at the level of the psychologist.
Table 3.1: Need felt to reveal sexual orientation (Q25) according to age

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Doctor</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 and –</td>
<td>27.2</td>
<td>14.9</td>
<td>22.8</td>
<td>35.1</td>
</tr>
<tr>
<td>31 and +</td>
<td>16.3</td>
<td>7.6</td>
<td>27.4</td>
<td>48.7</td>
</tr>
<tr>
<td><strong>Psychologist</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 and –</td>
<td>32.8</td>
<td>8.2</td>
<td>9.8</td>
<td>49.2</td>
</tr>
<tr>
<td>31 and +</td>
<td>22.2</td>
<td>4.0</td>
<td>11.1</td>
<td>62.6</td>
</tr>
<tr>
<td><strong>Psychotherapist</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>30 and –</td>
<td>42.7</td>
<td>9.4</td>
<td>7.3</td>
<td>40.6</td>
</tr>
<tr>
<td>31 and +</td>
<td>30.1</td>
<td>4.0</td>
<td>10.4</td>
<td>55.5</td>
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<tr>
<td><strong>Social worker</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>30 and –</td>
<td>53.4</td>
<td>11.4</td>
<td>10.2</td>
<td>25.0</td>
</tr>
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<td>31 and +</td>
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<td>5.0</td>
<td>19.5</td>
<td>43.4</td>
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<tr>
<td><strong>Community aid worker</strong></td>
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<tr>
<td>30 and –</td>
<td>58.1</td>
<td>10.5</td>
<td>11.6</td>
<td>19.8</td>
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<tr>
<td>31 and +</td>
<td>37.0</td>
<td>5.2</td>
<td>20.0</td>
<td>37.8</td>
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<td><strong>Accountant</strong></td>
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<tr>
<td>30 and –</td>
<td>70.7</td>
<td>15.2</td>
<td>8.7</td>
<td>5.4</td>
</tr>
<tr>
<td>31 and +</td>
<td>55.4</td>
<td>15.9</td>
<td>12.1</td>
<td>16.6</td>
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<tr>
<td><strong>Lawyer</strong></td>
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<tr>
<td>30 and –</td>
<td>64.9</td>
<td>17</td>
<td>10.6</td>
<td>7.4</td>
</tr>
<tr>
<td>31 and +</td>
<td>48.7</td>
<td>10.5</td>
<td>13.2</td>
<td>27.6</td>
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<tr>
<td><strong>Dentist</strong></td>
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<td></td>
</tr>
<tr>
<td>30 and –</td>
<td>64.6</td>
<td>15</td>
<td>6.8</td>
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*(p<0.05), **(p<0.01).

Table 3.2: Need felt to obtain the services of a person of the same sexual orientation (Q26) according to age

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**(p<0.01), n.s.: not significant
### Table 3.3: Need felt to reveal orientation (Q25) according to sample type

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bus: business sample, com: community sample, *: (p<0.05), n.s.: not significant

### Table 3.4: Need felt to obtain the services of a person of the same sexual orientation (Q26) according to sample type

<table>
<thead>
<tr>
<th>Sample Type</th>
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<th>Rarely %</th>
<th>Sometimes %</th>
<th>Often %</th>
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bus: business sample, com: community sample, *: (p<0.05), **: (p<0.01), n.s.: not significant
CHAPTER IV
SYNTHESIS OF THEMATIC CONTENT ANALYSIS
FROM THE QUALITATIVE COMPONENT

This chapter will enable the reader to take note of the main results of the qualitative component of the needs study. This is intended to provide above all an outline of the whole of the large amount of data collected. A more detailed research report will be available in Autumn 2000 and will cover the topics collected in a more exhaustive manner.

4.1 The key informers encountered

During the period between Autumn 1999 and Winter 2000, the researchers met with several key informers with the following aims in mind: firstly to obtain a better understanding of the various issues linked to the services provided in the Montréal area, as for example the way the different resources cooperate in order to supply services to gay men. Later, we collected comments made from different viewpoints in relation to the strengths and weaknesses of the health networks, be they community, institutional or private. At the same time, every person encountered was questioned on his/her opinion with regard to a more global view of the health of gay men and on the concept of "gay health”.

In all we met with ten different people working with gay men in various specialties, such as the management of community organizations, psychology, social work, the law, environmental intervention and journalism.

Their comments enabled us to arrange for the tools for data collection, both quantitative and qualitative, to take into account current issues with regard to the health needs of gay men. We therefore took into consideration their comments when designing our questionnaire on gay health as well as for the discussion grids intended for setting up focus groups.

4.2 The essays on gay health received

In November 1999, a call for essays including questions on the subject of health and services in the gay community was published in two recognized gay medias, the magazines RG and Fugues. This appeal to the public was intended to collect opinions both from individuals and organizations concerned with the health needs of gay men.

In all, ten essays were received in response to this appeal, five from individuals and five from organizations working in the gay community. The comments were varied, and several convergent subjects were noticed during the analysis by subject. For more details, the reader can consult the synthesis of these essays in the appendix.
4.3 The focus groups held

For the qualitative component of the needs study, several focus groups were held. One of the objectives was to collect observations on the needs of many types of gay men. We gave preference to a methodological approach which would enable the needs appropriate to specific sub-groups to be distinguished. The first series of four focus groups thus allowed us to collect qualitative data on the health needs of HIV-negative gay men, and the second series, held on an exploratory basis, was able to pick up trails leading to the particular needs of other sub-groups.

Discussions lasting two hours were chaired by a professional moderator. Group participants were found through advertisements in gay publications and posters put up in gay businesses. People interested were invited to answer several questions so as to obtain their profile. In order to obtain a suitable mix in the groups as well as a diversity of candidates, people were selected with regard to several criteria, such as their sexual orientation, their place of residence, age, mother tongue, ethno-cultural identity, and serological status.

Once more, the following sections present only an outline of the various themes raised in the discussions. Extracts from the focus groups can be found in the appendices accompanied by the discussion guide they adhered to.

4.3.1 Descriptive results regarding the methodology of focus groups on health and services

Participants of the focus groups lived in the Montréal area, and were separated into two series of groups, i.e.

1st series: groups of HIV-negative gay men according to age (4 focus groups):
- 16-25 years
- 26-35 years
- 36-45 years
- 46 years and above

2nd series: groups of men of mixed age groups (4 focus groups) held for exploratory purposes for the needs study
- bisexual men
- anglophone gay men
- gay men of various ethnic origins
- HIV-positive gay men

Total number of focus groups: 8
Average number of participants per focus group: 7
Total number of participants: 59

4.3.2 The four groups of HIV-negative gay men

These four focus groups made up of HIV-negative gay men are actually the core of the qualitative component of this needs study since they enabled us to collect data which go to explain several results from the questionnaire on gay health. We present here the main convergent subjects which emerged from the discussions in the four groups, i.e. as much from young as from older gay men.
Perception of health
Notions of stability, mental health, feeling good, mental and physical health interrelated, i.e. “if for example one isn’t right, then the other will give way if you do nothing about it.”

Factors which are good for health
Friends, finding oneself, not worrying too much, wider social acceptance of gay realities.

Factors which are not good for health
Stress, lack of role models especially for the young, the gay scene, stereotypes, prejudices, loneliness.

Opinions on the different/specific health needs of gay men against those of the general public
No difference noticed compared with heterosexuals except for mental health (consensus in several groups).

Specific needs identified
Need for support during the “coming out” process, especially for young people, consensus on the need to talk about it in schools, need for role models.

Opinion on the relevance of talking about “gay health”
Fairly mixed opinions. No for health in general but yes for mental health… Need for talk about "gay health” now... "so long as we are not completely integrated and accepted by society”.

Knowledge about organizations providing health services specifically for gay men
Obvious lack of knowledge of the services provided by the community network. Most of the discussions related to the public health network (CLSC, hospitals and medical clinics).

Opinions on the services provided by the health networks. Are these services meeting the needs?
It all depends on the situation. Numerous examples of difficult episodes experienced by participants when they went to see doctors, psychologists, etc. where they tell that they suffered from prejudices (diagnoses and/or treatment influenced by sexual orientation, insults, discharge of patient, etc.). There were also several positive and negative experiences at the hands of the health services provided by community organizations. On the other hand, there were also some participants who had never had any such problems.

Importance given to the fact that health professionals/workers know the sexual orientation
Important especially with regular doctor and for services linked to mental health. Little or not at all important for minor health problems (e.g. treatment of minor injuries at CLSCs). Some participants stated they felt no need to talk to their doctor about their sexual orientation. With regard to the expression of personal barriers, some people were afraid to talk for fear of getting poor treatment and of having bad experiences.

Opinions on the training of aid workers needed for a good understanding of realities and for giving adapted services
The subject of the quality of the training of aid workers recurs in almost all of the groups. The importance of the training of workers is judged according to the situation. Several participants stated that openness must be included with the subject of training.

Importance of the fact of knowing the sexual orientation of health care professionals
There was general agreement that participants felt more at ease if for example they have access to a doctor who is gay himself. The idea of feeling comfortable is one of their major preoccupations.
Opinions on barriers or obstacles for gay men on access to health services
Discrimination, fear of being judged, homophobia and heterosexism of health care providers, services too centralized in Montréal.

Ways to solutions identified in order to guarantee that the health needs of gay men are well served in Montréal and out in the regions
1. Improve services outside the city as gay men are penalized there compared with those in Montréal.
2. In Montréal, there ought to be more adapted services to support young gay men and demystify homosexuality in their environments.
3. Find ways of providing positive role models to the young people.
4. Ensure the training and openmindedness of health care workers. Ensure the financing of the community organizations working in these environments.
5. Continue changing laws so that gay men are more respected.
6. Satisfy the need for access to free psychological treatment for those who cannot afford it.
7. Make gay realities better known and more widespread, so that the realities become non-marginalized.
8. Provide more services for older gay men.

4.3.3 The four focus groups held for exploratory purposes.

As mentioned above, the second series of focus groups had the objective of identifying ways to ascertain the particular needs of some sub-groups. As this needs study has concentrated more on documenting the largest demographic sub-group of gay men (i.e. HIV-negative men) and the saturation level of content for the exploratory groups has not yet been reached, we have not shown them here. The reader will find some extracts from them in the appendix. Besides, the specific needs of these sub-groups are touched on in the discussion in Chapter V.

4.4 The group of experts

This tool for collecting data for the qualitative component had as its principal aim the accumulation of comments from various types of health care providers who work with gay men, or who are involved through their work in sectors concerned with providing health services supplied to satisfy their needs.

This discussion involved two psychologists, two workers from Séro-Zéro, two public health managers, two doctors, an aid worker involved with gay men of ethnic origin, a psychiatrist and a youth worker. The meeting was chaired by a professional social worker.

A discussion guide enabled it to cover all aspects dealing directly or indirectly with the health of gay men. Four main subjects arose from this discussion, i.e. homosexuality, health, type of intervention and services.

Many relevant points were touched on in the component dealing with Homosexuality. Several important differences between the homosexual and the heterosexual man were first of all clarified so as to be better able to define later on the terms ‘gay man’ (or homosexual), ‘bisexual man’, and ‘man having sexual relations with other men’ (MSM). Several other aspects were also touched on in connection with the gay community in general, legislation concerning the gay reality, the medicalization of homosexuality, ‘coming out’, homosexuality as it is lived outside the city, and the integration of gay men into society.
In the *Health* component, the participants tried to define what was special about the health of gay men, and wondered if you could speak about *gay health* as such. The problems of stress, suicide, and of course the aftermath of AIDS, were also touched on. They also identified a certain number of factors of physical and psychological health as well as questions arising from prevention.

When it comes to *Intervention*, the main debated topic was the importance for the different types of health care providers to know the sexual orientation of the client as well as the usefulness of the provider going on to reveal his own orientation to his client, or more widely, to the community as a whole. Various points were also brought up regarding training health care providers from the gay milieu.

Finally, the *Services* provided to the gay community were also debated: those which are already in place and the use that is done of them, and those which could be developed in the future as well as the conditions required before they can be established. They also sought, amongst other things, to evaluate the services specifically provided for the community and those adapted for it. Details on the discussion points can be found in the appendix.

### 4.5 The forum on the health of gay men

The final data collection exercise during the needs study was the forum on the health of gay men. Around sixty people came to take part in this one-day event where one of the aims was to present the preliminary results of the study, and the other to permit exchanges of ideas in different workshops on subjects previously selected according to the major issues which had been identified through the needs study, i.e. the life habits, the coming-out process, relationships between gay men and health care providers and professionals, and the strengths and weaknesses of the networks which provide services (for more details see the program in the appendix). The day concluded with a full session which allowed for summaries of the results of the workshops to be made.

Another objective of the forum was to collect impressions, reactions and comments with regard to the preliminary results. This was in effect a process of debating the data which would guarantee enhanced credibility and validity to the study on needs. Furthermore, the exercise was also aimed at starting a process of sensitization and dialogue with the community with regard to the matter of gay men’s health. In fact, the participants coming from the various environments were able to debate on their respective views around these issues and they took away with them data relevant to their respective fields of interest.

During the workshops and the plenary session, several subjects which converged with those of other data collection tools were also raised. Other subjects were more definite and arose no doubt from the fact that a fair number of the participants already had appreciable experience in the issues discussed. The most important subjects are given in the appendix.
CHAPTER V
DISCUSSION

The objective of this discussion was to highlight the main important facts from the needs study.

Firstly, we took up the results from the questionnaire on gay health which appear to be the most revealing about the health needs of the gay men who took part in this study. We also take this opportunity to point out the most pronounced differences between the business and community samples as well as the factors which act upon the needs of the respondents.

The discussion was enhanced by the qualitative component of the study which enabled us not only to pick up the subjects raised which reinforce some of the results of the questionnaire, but also those which suggest some slight variations which may explain some apparent contradictions. Moreover, these data suggest other avenues for research and intervention which are feasible in the near future.

In other respects, we gave throughout the discussion comparative results coming from other studies which were quoted because of their similarities or differences in relation to the Séro Zéro needs study.

The migration of gay men to Montréal as they become adult

Data on the place of residence of the respondents today and during their adolescence suggest that they chose to come and live on the island of Montréal at a particular moment in their lives. In fact, whereas more than half (60.2%) lived when young in the suburbs of Montréal or elsewhere in Québec, more than three-quarters (84.4%) have chosen to live in the Center-South or in the Village or elsewhere on the island of Montréal.

These data tend to support the comments of numerous participants of the focus groups who often stated that the Village and Montréal fulfill needs such as the necessity to dispel the loneliness they often feel outside the city, or to be able to live more freely as a gay man.

In couples or single: links with life habits?

On the other hand, living your life as a gay man in greater freedom is maybe reflected in the fact that almost two-thirds of the respondents are single (62.5%) whereas little more than a quarter live in couples (27.9%).

It is here however that we notice a noteworthy difference between the two samples of the questionnaire, i.e. the business and community circles. In fact, if more than two-thirds (66.3%) of the respondents in bars, cafés and saunas are single, this proportion drops to less than half (48.9%) for the community circle. Hence, nearly four respondents out of ten (38.1%) live in couples in the community circle versus one-quarter (25.1%) in the same situation among respondents from the business circle. This difference is noteworthy for what is doubtlessly an important explanatory factor reflected in the life habits of respondents to be discussed later on.

Men of above-average education but who earn less?

Data on schooling, employment status and gross income the previous year give rise to some questions. In fact, if in general nearly half (46.9%) the respondents had a gross income last year of $25,000 or less, more than a quarter (27.2%) were below the poverty line! It was also noted that
nearly one-tenth (9.3%) were unemployed. If these data are compared to education, it is however almost the majority (47.9%) who completed their university studies.

Age for coming-out: results comparable to other studies.

If the average coming-out age for gay men in the Séro Zéro needs study is close to 22 years (21.94) for both samples combined (n=605), this figure is identical to the average found within the participants of the Oméga Cohort (n=1200).

Gay men’s places for meeting and socializing

An analysis of data concerning the attendance at bars and other places is revealing of the life habits of the men who took part in the study. In fact, visits to gay bars 3 times weekly or more during the six previous months were noted for more than a quarter of respondents (25.9%) from the business circle. It was also interesting to note that nearly one-third of respondents (30.3%) stated they go to other bars (e.g. hetero bars) on a monthly or weekly basis.

As for “raves” which according to popular belief are very well patronized by gay men, it seems that the data tell us that this is not the case, as only 5.3% of respondents from the business circle went 1 to 3 times a month during the previous six months. On the other hand, one man in six stated he went to them less than once a month, which suggests that maybe they prefer the big annual rave events which are very popular amongst gay men (Black & Blue, Wild & Wet, etc.).

With regard to saunas, nearly one respondent in five (18.2%) from the same sample visited them 1 to 3 times a month whereas nearly one person out of ten (8.4%) went there on a weekly basis. On the other hand, nearly half the respondents (45.5%) declared they had never gone to a sauna in the previous six months.

The data from the community circle provide a strong contrast to those above. In fact, the respondents from this sample visited these places for meeting and socializing in a far lower and sometimes even astonishing proportion. For example, they visited gay bars much more on a monthly rather than a weekly basis (33.8% against 21.2%). In other respects, very few gay men from this milieu visited gay bars 3 times a week or more (2.3% against 25.9%). With regard to saunas, however, the proportions are quite similar to those from the business sample, and over the whole scale of proposed visiting frequencies, save on the level of visits three times weekly or more (1.5% against 3.0%).

These data give the impression that gay men from both samples had very different habits for visiting places for meeting and socializing. In fact, gay men from the community circle seem to choose to use their free time differently.

At the same time, significant differences are noted when comparison is made by age group (under 30 and 31+). For example, more of the youngest visited gay bars once or twice a week (44.4% against 28.2%), other bars 1-3 times per month (24.7% against 12.1%) and raves less than once a month (24.2% against 8.6%). On the other hand, they went less to saunas 1-3 times a month (12.1% against 20.2%).

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3 The Oméga Cohort is a longitudinal cohort which is interested in the psycho-social factors linked to HIV infection among MSM.
**Tobacco consumption**

The data on tobacco consumption among the gay men of the needs study reveal that more than half of them (53.4%) are smokers. This percentage is high when compared to the figures of Santé Québec which indicate that, in general, 30% of men in Québec are regular smokers. In other respects, an American study conducted among gay and bisexual men in Oregon and Arizona and including also samples from business and communities reveals in a similar way that 50% of men who go to gay bars are smokers.

Séro Zéro’s community sample finds a much lower proportion of smokers, only 13.7%. Surprisingly, this information is very different from the American study which counted 41% of smokers among the men who were taken for the study from across the community. What can we conclude from this? Is this linked to the fact that the community sample of the needs study included a fair number taken from sports organizations?

However, the percentage of gay men who smoke in bars, cafés and saunas is high and reveals an important health issue associated with the life habits of gay men in Montréal who go to these places for meeting and socializing.

In terms of comparison of percentages of smokers among the age groups, we can point to no significant difference.

**Alcohol consumption**

When it comes to alcohol consumption, a proportion of 8.3% of men in general have more than 14 alcoholic drinks a week, according to Santé Québec. Even if the scale of measurement employed in the questionnaire on gay health is a little different, it appears nevertheless that 6.2% of gay men in the business sample say they had more than 35 drinks per week on average during the previous six months. If this is linked to the proportion of men who had between 11 and 34 drinks per week (21.1%), we obtain a total of more than a quarter of the subjects (26.3%). This is to say that there would be almost three times as many gay men in the higher average strata of alcohol consumption on a weekly basis than the average male Quebecers.

These data should nevertheless be compared with heterosexual men who go to bars. Without seeking to be alarmist, these data should also give us cause for worry, since if we consider other studies which deal with alcohol consumption among gay men, Séro Zéro’s needs study points in the same direction.

With regard to alcohol consumption in the community sample, the proportions as for tobacco are much lower. In fact, 1.6% of subjects stated having had more than 35 drinks a week and 4.7% from 11 to 34. These two percentages combined (6.3%) give us a total which is even lower than that for the average male Quebecker.

Finally, it is important to note that no significant difference was apparent in alcohol consumption between age groups.

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4 The data of Santé Québec mentioned in the discussion come from the *Indicateurs socio-sanitaires* of the MSSS published in 1997.
**Drug use**

With regard to average drug use frequency during the six previous months, the substances mostly used in general on a weekly and monthly basis were, in order: marijuana/hash/pot, poppers, cocaine and ecstasy. Again there were marked differences between the two samples. Over the whole consumption frequency scale proposed, respondents from the community circle used these substances far less frequently. For example, the proportion of those who said they smoked marijuana seldom or sometimes was half that of the business sample (15.7% against 31.8%). With poppers, the proportion was one-third (8.0% against 25.8%) for the same frequency and proportions also varied considerably for cocaine (4.0% against 19.4%) and ecstasy (5.6% against 14.8%).

As for differences between age groups in the combined sample, there were some significant differences with regard to the monthly use of marijuana/hash/pot and ecstasy, with the 30 and under using more.

**The prevalence of HIV and STDs among gay men: links with the use of screening services**

According to Public Health Office estimates the prevalence of HIV among men in Montréal is about 15%. In the questionnaire on gay health, fifteen per cent of respondents (15.1%) were HIV-positive. However, significant differences were noted between the two samples. In fact, nearly seventeen percent of respondents (16.7%) were HIV-positive out of the business sample. This percentage drops to a little under one person out of ten (9.2%) from the community sample. It must however be noted that in this sample there are HIV carriers who for that very reason go to the organizations which provide services specifically intended for them. If these subjects are excluded, the prevalence of HIV is practically nil in the community sample. Does this mean that HIV-positive men have little or no use for the services provided by the community networks? From the scope of this study, it is difficult to state this with certainty, given the size and nature of the sample. Additional research ought to be done at this level.

As for the prevalence of other STDs, nearly fourteen per cent (13.7%) declared having contracted one or more STDs during the previous six months. For the community sample, however, the rate for STDs contracted dropped to 4%.

When it comes to dealing with the use of screening services we find substantial differences between the two samples. Whereas one-tenth (11.1%) of the gay men in the business sample used STD screening services more than 3 times during the previous year, only 1.6% of respondents from the community circle did.

**High-risk sexual practices**

With regard to high-risk sexual practices such as unprotected anal intercourse, there are also substantial differences between respondents from the two milieux. For example, whereas respondents from the business circle practiced unprotected anal intercourse with a casual partner in the proportion of around 12% (either in active or passive role), this proportion dropped to around 4.7% (average for both roles) for the community circle. As for anus-licking (received or given) with a casual partner, the same trend was observed, men from the business circle acknowledging this practice in 41.7% of cases compared to 18.7% for the other sample.

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7 It is also interesting to note that although 78.9% of the respondents in general have taken a screening test for HIV, 50.3% took their last test in 1999.
What conclusions can we draw from these data? According to us, there is an evident link between the sexual practices of the respondents of both circles and the prevalence of STDs and the use of screening services.

It is however difficult for us to draw conclusions on the increased risk of HIV transmission as the questionnaire did not ask respondents whether they knew the serological status of their partners whether they be casual or regular. We could at best speculate on the basis of the number of partners, which obviously constitutes an indicator of high risk. In any case, it was not one of the main aims of the needs study even if the HIV transmission remains today a major issue in gay men’s health. On the other hand, the data from this needs study become useful when compared for example with those from the Oméga Cohort.

Use of mental health services: links with exposure to stressful situations and violence endured due to sexual orientation.

As mental health is a major aspect raised throughout the whole collection of data for the needs study, it is interesting to note the difference between the two samples regarding the use of psychotherapy services during the previous year. In fact, whereas one respondent in five (20.2%) from the business sample took advantage of the psychotherapy services during the previous year, this proportion rises to nearly one-third (30%) in the community sample. Here we can see a link with the data on exposure to life-stressing situations. In the items listed in this section, we asked respondents to measure the frequency of problem situations experienced during their lives arising from their sexual orientation. In the part of the scale quite often or very often, there is a marked difference between the two samples: 8.6% for the business circle and 17.7% for the community circle.

These data make it appear that as the respondents from the community circle have suffered from problem situations more frequently on account of their sexual orientation, they therefore made greater use of mental health services (e.g. psychotherapy) during the previous year.

Other data linked to the mental health of respondents shed light on their needs. Thus, on the level of violence endured on account of sexual orientation at different periods of their lives, it is nonetheless surprising to note that more than four respondents out of ten (41.3% - average of both samples) had endured verbal violence (insults, sarcasms) during adolescence. This violence continued even into adult life and during the previous year to a lesser but nonetheless significant degree (11.7% and 12.6%). In other respects, more than one gay man out of ten (12.4%) was the subject of physical violence (attacks) during adolescence. As for sexual violence, one perplexing piece of information is that three times more men in the business circle were subjected to sexual violence during adolescence (15% against 5.3% for the community circle).

So we could wonder why these men in the business sample who suffered abuse do not use the aid services (e.g. psychologist) more often than their counterparts from the community circle? Is it because they do not know about these services, or that they do not know where to find them (lack of availability and/or cost of services)?

Here, the qualitative component of the study can cast some light on this. On the one hand, with the participants of the focus groups we note an obvious lack of awareness of what mental health services are available in general; but also the experts and key informers point out the scarcity of these services and their poor accessibility for a good number of gay men who for example cannot afford to pay for these services in the private network.
The need felt to reveal one’s sexual orientation: a central item in the needs study that is qualified by the qualitative component

One of the central questions of the needs study and which was inspired by Carter’s model (see Appendix II) deals with the need felt to reveal one’s sexual orientation when gay men come to use the services of various professionals and providers. Where the quantitative component measures the degree of need felt per type of provider, the qualitative component as such provides explanations of particular situations where this need is more or less strongly felt.

With the professionals of the institutional health care network, the percentages revealed by the questionnaire on gay health tell us that about half the respondents feel a pressing need to reveal their sexual orientation to a doctor, psychologist and psychotherapist in the proportions of 43.7%, 57.5% and 46.3% respectively (averages for both samples combined).

The contribution provided on this felt need by the qualitative component is most enlightening. In fact, the participants of the focus groups inform us on the contexts where this need is indeed felt but also on the factors connected with them. Thus, the factors influencing the need to reveal themselves are for example: the reasons for seeking help, the perceived idea of feeling comfortable in the relationship with the aid worker and other personal and structural barriers which may arise. On the other hand, as we have noted in the analytical results of the questionnaire, these are extremely significant differences when gay men are compared using the age group, those over 30 feeling a much greater need to reveal themselves. Differences were also noted in the case of other variables such as the level of education.

To sum up, gay men over 30 feel a greater need to reveal their sexual orientation. What should we conclude from these data? Evidently, chronological age makes a gay man feel a greater need to assert himself in his relations with other people, including the health care professionals he goes to see. The needs study does not however bring out significant links with the lapsed time since the start of the ‘coming-out’ process. 8

The need felt to obtain a service from a person sharing the same sexual orientation: links with the degree of awareness to health needs?

Even if the percentages for this need are quite lower than those dealing with the need to reveal oneself, some noteworthy differences among others are apparent in both samples. It seems indeed that in the community sample more respondents feel a very strong need to obtain a service from someone of the same sexual orientation. In other respects, as in the case for the need to reveal oneself, we note that gay men of over 30 feel this need more in general. What should we conclude from these data? Once again the qualitative component of the study sheds useful light on the subject. In fact, as we can see in Chapter IV, several participants of the focus groups feel more comfortable when in the presence of a health care professional who is himself gay, and this feeling increases with the age of the gay men.

But another question now seems obvious here. Why don’t the people in the business sample feel this need as much? A plausible hypothesis might be that the gay men taken from the community circle are more aware than the others about their health needs. This hypothesis is however strengthened by the discussion which follows.

8 Note: other statistical analyses will soon be made in order to validate this statement.
Quality of training of aid workers, perceived respect for rights and acknowledgment of gay men’s particular needs: links with the desire to obtain specific services.

In the category of expressed needs and opinions regarding different themes surrounding health needs, the two components of the needs study provide some revealing indicators regarding participants’ opinions. Both the questionnaire on gay health and the focus groups provide data on this subject.

On the opinions of gay men about the quality of training of aid workers, the data from the questionnaire indicate that the majority of respondents (52.9%) believe in general that they are moderately or quite well trained to respond to their health needs. This information is certainly reflected in opinions regarding the perceived respect for their rights when services are used since almost three-quarters (70.3%) believe that their rights are quite or very well respected.

As for an opinion in general on the specific nature of the health needs of gay men, we note that here there is a considerable difference of opinion. In fact, where almost half of the respondents (45.2%) believe their needs are not at all or a little different, about one-third (30.3%) believe the opposite, that they are quite a lot or very much different.

However, we notice that with regard to the desire to obtain specific services, opinions are clearer. In fact, we note that the majority of gay men (51.6%) wish to obtain very much or quite a lot the services which are directed toward them. In opposition to them, a quarter (25.2%) have little wish or none at all to that respect.

Thus, where a fair number of gay men believe that aid workers are in general well trained and that their rights are being respected, how is it that they are so divided about the recognition of their special needs and that they want so much to have access to services intended for them? Here the focus groups are able to supply us with explanatory data on the conditions of needs and the contradictions in the results of the questionnaire. Thus, on the training of aid workers, the participants of the focus groups consider that the training of aid workers must be accompanied by openmindedness which will allow for confidence to be established and the possibility of talking freely. At the same time, this is the moment when the gay man perceives his wishes are fulfilled as completely as possible and he feels himself respected in his rights.

At the same time, where participants of the focus groups acknowledge little or not at all the special nature of physical health needs, they do acknowledge the special needs of gay men with regard to mental health. It is especially in this field that gay men see more of the services which should be intended specially for them. Moreover, in several groups we found general agreement on the needs linked to the mental health of young gay men in the process of coming out.

It is also important to point out the differences in the results of the questionnaire between the two samples. It appears in fact that the respondents from the community circle were better informed about their health needs since more of them believed there were gaps in the training of aid workers, and fewer believed that their rights were being respected. On the other hand, more of them recognized their specific needs and wanted to have access to services intended specially for them.

Barriers to expressing needs: important facts to consider

If we look at Carter’s model, there are factors which can have an adverse effect on the expression of needs. In the needs study, we have identified two types of barrier, personal and structural. The focus groups are best able to inform us about these. In fact, several participants told us how, in certain circumstances, they felt the fear of being judged or of receiving less acceptable services in cases where they were considering revealing they were gay when asking for health services. When
they actually decided to reveal their sexual orientation, a fair number of them had to live through some difficult experiences. Most often these were prejudices related to homophobia and heterosexism whether sensed or real from aid workers.

In other respects, we indicate the difficulties which we call structural barriers. Thus, several participants report that services are often too centralized in Montréal at the expense of the regions, which creates barriers to accessibility. The slowness with which some of our institutions move towards adapted and/or specific services was also deplored. The education environment is doubtless the most quoted example, and we will speak about this later on.

**Special needs of young and older gay men.**

The needs study has enabled age groups of gay men with special needs to be identified. With regard to the needs of the young, here several data collection tools in the qualitative component offer us some help. Thus, whether from key informers or essays on gay health, the focus groups and the community forum have raised convergent subjects. When reference is made to young gay men in the process of coming out, the lack of support services in their environments is often deplored. There is also a broad consensus on the lack of positive role models and the need to demystify homosexuality in the school environment, both with the young people and the professionals in charge of them.

Data from the qualitative component also touch on the special needs of older gay men. In addition to deploring the lack of places for meeting, they often speak of the impact of the cult of the body and the negative image associated with aging in the gay community. At the same time, many people think it is now time to have real housing accommodations for gay men who become less autonomous.

**The necessity to provide adapted and specific services.**

Among the subjects in the qualitative component, convergent opinions can also be found on the nature of the services which must be provided to fulfill gay men’s health needs. These opinions come mainly from the group of experts and from the focus groups who come to similar conclusions. In fact, a fair number of the study’s participants adhere to the idea that it is necessary to provide adapted and specific services both in the institutional and private networks as within the community networks, since some people do not feel comfortable enough to go to places with a “gay label”, and prefer to use adapted services seen to be more “neutral”.

**HIV-positive gay men, gay men of different ethnic origins and bisexual men: clues of particular needs which demonstrate the necessity for further research.**

Whereas this study allows the health needs specific to gay men to be brought out, we tried even harder up to this stage of the analysis to identify needs by drawing few distinctions apart from the sample types and age groups. However, it is with the intention of finding paths leading to the specific needs of some sub-groups that we held the exploratory focus groups to work on HIV-positive gay men, gay men of different ethnic origins and bisexual men.9

Even though the aim here is not to go into details about the subjects raised by each of them, we still wish to stress some examples in order to bring out the relevance and usefulness of further research.

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9 Let it be mentioned that we also held a focus group made up of anglophone gay men, but as the subjects raised were very similar to those of the francophone groups, we considered it more useful to combine them.
Among the subjects linked to the health needs of HIV-positive gay men, we have noticed that health in general is often considered in a different way. We find for example remarks on ‘everyday’ needs such as the moral support of a social network and of domestic help services when physical health is affected by sickness. Mention is also made of tensions, not only those created by the acceptance process of serological status but also by that of the medication to be taken. Money problems created by physical incapacity and the difficulty of finding affordable lodgings in such circumstances were also touched on.

Regarding gay men of different ethnic origins, the focus group demonstrated the impact of the culture of origin on several aspects of their lives, especially the difficulty of integrating as a double minority in a new cultural environment. Lack of information on the resources available for gay men upon arrival in the country was also deplored.

The focus group composed of men who as such considered themselves bisexual enabled difficulties linked to the lack of social recognition of their identity to be demonstrated. In fact, the majority of them encountered difficulties in integrating themselves in either the gay or the heterosexual worlds, both sides insisting they make a ‘choice’.

*Opinions of participants on “gay health”*

We would like to continue this discussion on one of the main subjects of the needs study: i.e. the relevance of speaking of “gay health” as a concept suggesting a global view of health going beyond the HIV issues. This concept incorporates five aspects linked to gay men’s health needs, i.e. physical, mental, sexual, social and political health.

When questioned on the relevance of such a concept when the subject of differences perceived between gay men and the population at large was touched upon, the majority of participants saw few or no differences between them and the population in general with regard to physical health. Spontaneously, they identified more closely particular needs in the field of mental health, especially regarding guidance in the coming-out process.

However, without being able to identify problems linked to the ‘social health’ aspect for gay men, they still mentioned some factors which can be associated with it. For example, several identified a more restrictive ‘cult of the body’ among gay men as well as the explosion of commercialization in the gay media and cultural activities.

To summarize, even if some were a little frightened by the categorizing/separation aspect of the concept, there was general agreement about the current necessity of speaking of "gay health", especially in order to contact and/or support people suffering from psychological distress, and to underline the specific nature of the mental health needs of gay men in general.

However, the opinion of the health care professionals who took part in the study contrast somewhat with those quoted above. In fact, where they too recognize special needs in mental health, their expert knowledge indicated special needs in physical health also. Basing themselves on epidemiological data they underlined the necessity of making gay men aware of other health problems such as types of cancer (e.g. cancer of the anus) which seem to affect them more frequently than the general population.

We would also mention that several experts felt more comfortable with the concept of “gay men’s health” rather than “gay health”, as that would avoid creating the impression that the particular health needs of lesbians were being excluded, as these too are at present state of knowledge very poorly documented.
By way of a conclusion to the discussion

Findings about the services available

What also comes out of this needs study is the knowledge that although there exist in Montréal a fair number of services in the community network provided by socio-cultural organizations (e.g. leisure and peer group activities, etc.), there are on the other hand very few organizations which provide other types of services (e.g. psycho-social services) and these are not well known. Consequently, they are probably underused in particular by gay men from the business circle. Several participants believed that is is necessary here to consolidate the financing and coordination of existing services and then to promote them.

We would like to end this discussion by stressing other question themes as well as help routes which were nurtured by the needs study.

Other question themes suggesting complementary research routes:

Are the particular needs of young gay men identified by this needs study representative of their real needs?

In fact, as the needs study included only one focus group per category of age, we were unable to reach saturation point in the various topics raised, including the needs of young people. On the other hand, many older gay men expressed their own perceptions as to what they felt were the needs of the young. Thus, we may suppose that a certain level of projection was achieved during these discussions. As such, some more acute research ought to be done here on the special needs of the young in order to ensure that the real needs have been identified as expressed by young gay men themselves.

Training of professionals and helpers: integration in all disciplines or additional training?

Although the needs study has enabled the collection of varied opinions on the quality of training of helpers, it has not been able to supply a complete answer to this question.

Let us say at this point that several participants of this study believe that basic training on homosexual realities may be necessary in all disciplines connected with health, and that several are doubtful as to the relevance and the usefulness of imposing or offering an option of a ‘few hours’ extra training.

However, very few participants of the study had any knowledge or opinions which were sufficiently explicit about this complex issue linked to structures which are known for their slow-movingness. It is here that complementary research becomes necessary.

Possible avenues of interventions

In a pilot project yet to be developed, we would like to explore other means of solution to the difficulties brought out by the research in general while at the same time heeding the various points of view expressed in this needs study. We would suggest the avenues for setting up an intervention pilot project to address health services needs of gay men. This could take place over a two year period.
The intervention pilot project could take three forms:

1. Intervening on specific issues (suicide, sexual abuse, isolation, drug addiction) tied in with people’s mental health. These issues to be guided by the results of the study on gay men’s health needs and items coming from other research carried out with homosexuals, especially the Oméga Cohort. These interventions could take various forms, either individual assistance or again approaches encouraging group intervention. They could, for example, take the form of a clinical unit for individual assistance specially developed for a particular type of problem. As for group intervention, that could also take on various aspects - more formal such as group therapy or more informal such as peer help groups. Intervention should be tried out over a certain time and with a varied selection of people in order to validate the content. Finally, it is imperative to maintain these different forms of assistance and in order to do this achieve a transfer of expertise to different community organizations or to the networks so that the content can be taken up and included in their regular scheduling.

2. Lobbying of the various government authorities (MSSS, Régie régionale, network institutions), in order to obtain financial support which would allow the creation of specific services for the gay community. These financial resources could help to consolidate the work already done at present by community gay organizations or allow the development of specific activities in the community structure or the health care network, mainly in CLSCs.

3. Support for community gay organizations presently providing activities so as to strengthen their actions (e.g. gay fathers, discussion groups). Special support for the training of volunteers, to the creation of a programming which at the same time takes into account the needs expressed by the participants and the issues raised by the different research studies. Moreover, support for writing and presenting intervention projects to various sponsors would be a priority.
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