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Lieberman, Lisa D., "Relationships and Context as a Means for Improving Disease Prevention and Sexual Health Messages" (2012). *Department of Public Health Scholarship and Creative Works*. 161.
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Relationships and Context as a Means for Improving Disease Prevention and Sexual Health Messages

Health Education & Behavior
39(3) 255–258
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Health Education
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sagepub.com/journalsPermissions.nav
DOI: 10.1177/1090198112446337
http://heb.sagepub.com


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In many ways, the HIV epidemic changed the discourse about sex in the United States and worldwide (Ehrhardt, 1992; Everett, 1986) and continues to drive approaches to sex education. After a period of rapid growth in the late 1980s (approximately 150,000 new infections per year), by the late 1990s HIV rates in the United States slowed to some 40,000 new infections annually (Centers for Disease Control and Prevention [CDC], 2001), and new HIV infections continue to hover around that number. The first successful examples of behavior change that resulted in decreased HIV transmission emerged from communities of men who have sex with men (MSM; Coates, Richter, & Caceres, 2008). However, although the past decade has been marked by longer survival rates, and significant reductions in new infections in some population groups, MSM remain the largest HIV transmission category in the United States and the only one associated with an increasing number of HIV/AIDS diagnoses (CDC, 2008). In 2010, some 61% of newly diagnosed HIV infections were attributed to male-to-male sexual contact (CDC, 2012).

Over this same period, school-based sex education programs have varied widely in focus and content (Kirby, 2007; Santelli et al., 2006). The political landscape from the 1990s through 2008 yielded the largest investment of federal funds in abstinence-only-until-marriage programs. In 2009, however, funds awarded in the Teen Pregnancy Prevention initiative were primarily for comprehensive sex education programs, with some funds for abstinence education programs appropriated in the 2010 health reform legislation (Boonstra, 2010), despite their limited effectiveness. Currently, state standards for school curricula vary widely, with 18 states requiring instruction on the importance of engaging in sexual activity only within marriage, whereas 19 others require instruction on condoms and contraception (Guttmacher Institute, 2011).

Within this highly politicized context, questions remain as to how to stem the tide of disease and teen pregnancy, while addressing the needs of both youth and adults, heterosexual and non-heterosexual, as they seek healthy sexual relationships and protection from harm over their life course. It may be that our very efforts to point lasers at disease, with abstinence (Guttmacher Institute, 2011) or condoms (Warner, Gallo, & Macaluso, 2012) as a central focus, rather than at the context in which sexual behavior occurs, has limited our vision to find messages that more effectively lead to the kinds of outcomes we seek.

This issue of *Health Education & Behavior* carries six articles focused on sexuality within the context of various types of relationships, providing important implications for sex educators and others addressing risks related to sexual activity. The articles highlight several specific population groups and the unique aspects of their sexual relationships and risk taking. Together they suggest the limitations of prevention messages that focus solely on sexually transmitted infections and HIV, that promote either abstinence or condom use as their nearly universal emphasis, and that do not take relationships and other social contexts into account.

Prevention Among MSM

Lessons learned from adolescent risk reduction point to the importance of accounting for relationship characteristics in seeking to reduce HIV transmission. Among adolescents, despite a strong and continuous “mantra” focused on consistent condom use, discontinuation of condom use has been associated with relationship characteristics such as duration, quality, and trust (Manning, Flanigan, Giodano, & Longmore, 2009); low perceived risk of infection, trust, pleasure, and intimacy (Bolton, McKay, & Schneider 2010); and relationship quality, duration, and higher sexual frequency (Sayegh, Fortenberry, Shew, & Orr, 2006). Relationship quality and higher self-efficacy also influence disclosure of STD diagnosis among teens (Fortenberry, Brizendine, & Katz, 2002).

In this issue, Wilkerson, Smolenski, Morgan, and Simon Rosser (2012) report on their study of “presexual agreements” among 1,188 HIV-positive and HIV-negative gay and bisexual men in four U.S. metropolitan areas. These data, from the first wave of a study designed to assess the larger contextual influence of community characteristics on risk behaviors, specifically address one interpersonal relationship issue—presexual agreements about anal sex. Among HIV-negative men, the most common categories of

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presexual agreements were either for sex with a condom or no anal sex. Among HIV-positive men, however, the largest group (59%) reported presexual agreements to have anal sex without a condom. This was particularly true of older HIV-positive men. Among both HIV-negative and HIV-positive men, substance abuse increased the rate of unprotected anal sex, regardless of the presexual agreement. The authors suggest that classifying MSM on the basis of their previous presexual agreements may assist in tailoring prevention messages at the individual, group, and community levels.

Skinta, Murphy, Paul, Schwarcz, and Dilley (2012) report on a qualitative study that examined the “self-justifications” of 182 MSM who engaged in behaviors with high transmission risk. Data suggesting increases in high-transmission-risk sex among MSM led the authors to seek to explain the rationales of HIV-positive men who engage in unprotected anal intercourse. In their previous work, HIV-negative men had reported the feeling of sex without a condom, passion of the moment, or reduced perception of risk as their justifications for unprotected anal sex. Among HIV-positive men in this study, however, the most common rationales for unprotected anal sex were the assumption that the partner was also positive or was not worried about transmission risk. That is, nondisclosure was assumed to imply seroconcordance, or was simply a deferral of responsibility, that is, “it was his responsibility to ask.”

Thus, in both studies, HIV-positive men subscribed to high-risk behavior and/or deferred responsibility for prevention to their partners, suggesting the importance of targeting prevention messages by serostatus and relationship status. In addition, as noted by Skinta and supported by Wilkerson’s finding that unprotected anal sex was more common among older HIV-positive men, interventions should address issues of intimacy or loneliness among HIV-positive men, as these factors may influence risk behaviors over the life course.

Furthermore, total number of partners, whether concurrent or successive (Gorbach & Holmes, 2003), makes an indisputable contribution to facilitating the spread of HIV (Kalichman & Grebler, 2010). The work of both Wilkerson et al. and Skinta et al. suggests that the focus of messages on consistent condom use is insufficient and, perhaps, may even be inappropriate for the highest risk group of MSM, because it does not take account of the social and relationship contexts of sexual behavior in this population. The Seropositive Urban Men’s Intervention Trial, an intervention specifically designed to target HIV-positive MSM, found similar contextual issues regarding reduced likelihood of disclosure to nonprimary partners and recommended targeted harm reduction efforts beyond condom use for this special population (Wolitski et al., 2005). One example of such a targeted small group approach (Wilton et al., 2009) demonstrated a reduction in unprotected anal intercourse with casual male partners, a decrease in number of partners, and increased HIV testing among Black MSM.

Pathways to Sexual Risk Taking

The article by Fisher (2012) explores risk taking among sexual minority males, that is, young men whose attractions, behaviors, relationships, and orientation are non-heterosexual, regardless of their self-identification. The Information–Motivation–Behavioral Skills (IMB) model suggests that knowledge about HIV transmission and prevention, motivation to prevent infection, and perceptions of capability to enhance prevention behaviors will predict lower HIV risk. With data from a convenience sample of 156 males attending drop-in programs at a Midwestern LGBT community center, Fisher used the IMB framework to explore pathways between sexual identity development and sexual risk behaviors. Sexual risk behaviors were partially explained by differentiating between a sex-centered sequence (in which non-heterosexual behaviors precede self-labeling as LGBT) and an identity-centered sequence (in which self-labeling precedes sexual behavior). A sex-centered developmental sequence, less favorable attitudes toward LGBT people, more frequent alcohol use, and lower levels of HIV prevention information and motivation predicted higher sexual risk behaviors. The finding that a sex-centered developmental sequence predicted greater sexual risk is critical to tailoring messages regarding risk behaviors, because young people who have a first sexual encounter before they self-identify as LGBT may not benefit from school- or community-based prevention messages aimed explicitly at LGBTs.

Sexual Initiation

In their study of sexual initiation among more than 3,000 Ghanaian youth, McQuestion, Ahiadeke, Posner, and Williams (2012) explored the contributions of peer attitudes toward sex, parental sex communication, and adult social support, along with reproductive knowledge, socioeconomic status, and a range of parent/family variables. Parent/family variables, including church attendance and higher socioeconomic status, peers reportedly having more permissive attitudes, and, among males, more adult communication about sex, were associated with lower sexual initiation. Parent communication and support moderated knowledge differently for males and females, reducing the influence of knowledge on sexual initiation among females and increasing it among males. Notably, perceptions of permissive peer attitudes about sex were inversely associated with sexual initiation. Age of sexual initiation was similar to youth in the United States. Like other research among U.S. youth (Buhi & Goodson, 2007) demonstrating that intentions, environmental constraints, and peer influence predict sexual initiation, McQuestion et al.’s study suggests the need for approaches that tap into family and peer support mechanisms. These findings, along with other studies in this issue, support interventions that move beyond individual-level factors, to address contextual and relationship factors, in this case peer and family relationships.

Sex Information on the Internet

In Magee, Bigelow, DeHaan, and Mustanski (2012), LGBT young people described their use of the Internet for sexual health information. Among the 32 LGBT youth interviewed, all sought facts and statistics about STIs and HIV, some about application of information such as where to get tested or actions to reduce risk, and only a few about the mechanics of sexual behavior and/or pleasure. An expressed “need to know” or the presence of symptoms drove most of the information-seeking about STIs. Despite concerns about misinformation and stigma associated with getting “caught” on a gay website, youth in this study suggested that social media websites could be improved to include social networking and online support and information about where they could attend LGBT events. These findings contribute to the importance of larger social and relational contexts, even when privately seeking sex information on the Internet. The “Internet as sex educator” may be an important tool for targeting interventions for specific populations, such as LGBT youth, for whom school-based programs may not address their concerns, and parents may be less willing or able to meet their needs.

Together with Fisher’s finding that many young people engaged in sexual behaviors before they self-identified as LGBT, this work points to the potential for online sites to play a promising protective role. Personalized and tailored education can offer a safe and reliable resource (Barak & Fisher, 2001) to promote sexual health for LGBT youth, or for those who have not yet self-identified. Notably, in a study of older men who used gay Internet sites primarily to find sexual partners or contact with other gay men, more than 80% indicated that they would welcome health workers in Internet chat rooms and would click on banners about sexual health (Bolding, Davis, Sherr, Hart, & Elford, 2004). Thus, the Internet can be an important prevention tool for HIV transmission and other sexual health issues across the life course, not just among youth.

Sex Education Mastery

Moving from the Internet to more traditional school-based sex education, Jensen (2012) describes the development of a taxonomy for how secondary teachers of sex education “know” they have done a good job. Although much has been written about the development of students’ self-efficacy to engage in health promoting behaviors such as safer sex, Jensen posited that the self-efficacy of sex educators, which may play a role in teaching effectiveness, had not been studied. “Enactive mastery,” actual performance accomplishments in a natural setting, is considered the most influential source of self-efficacy (Bandura, 1997). Fifty sex educators in a Midwestern state described their enactive mastery experiences, which Jensen categorized as three types: *Growth experiences*, in which mastery had to do with learning as a result of earlier experiences; *Interactive experiences*, in

which mastery depended on interacting with others (e.g., student participation, itself, was described as success); and *Endorsed experiences*, in which mastery was described as doing something they believed was important. Endorsed experiences were the most commonly described examples of mastery, that is, the largest group of teachers described their mastery experiences in terms of having taught something *they* believed in and that *they* believed would help students. This finding suggests the importance of including teachers in choosing or developing curricula and activities and assuring that training directly addresses their own beliefs about what should be taught.

School programs have varied widely in how or whether they include discussion of relationships and healthy sexual development, whether they include sexual identity development, and whether or not contraception and/or other harm reduction techniques are taught. Most important, school-based sex educators’ descriptions of what they actually teach are not always consistent with their schools’ or states’ requirements or limitations regarding contraception and abstinence (Landry, Darroch, Singh, Higgins, & Donovan, 2003). This provides an important lens for Jensen’s study, in which teachers felt most successful if they had “buy-in,” that is, taught something they perceived was important for students to learn.

Conclusion

What do these studies tell us? First, they tell us that context, itself, is critical to understanding and reducing risk. Family and peer relationships, sexual partnerships, and social contexts outside of the relationship influence and must be considered in prevention efforts and messages.

Second, with respect to reduction of HIV transmission among the highest risk population of MSM, these studies point to the need to address relationship characteristics, as well as serostatus and age, and that intervention must move beyond the singular mantra to “always use condoms” to more risk- and relationship-sensitive messages. For example, although the predominant prevention approach has focused on preventing individuals from becoming infected (i.e., condoms will protect you), much more focus is needed on helping people with HIV from spreading it (Coates, 2008).

Finally, messages that focus only on risk reduction may do so at the expense of healthy sexual development and the role of sexual expression across the lifespan and across various relationship contexts. Whether explaining sexual initiation in Ghana, building a sense of responsibility to protect one’s partner from HIV, understanding the role of presexual agreements for protection, improving the availability of relevant and accessible information on the Internet, development of teaching mastery for sex educators, or the influence of sexual identity development and substance use on sexual risk behaviors, taken together, these studies call for greater attention to social context, relationships, and sexual health and a move away from the disease-focused “abstinence or condoms” messages that have dominated our efforts.

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