SAFER SEXUAL BEHAVIOUR AMONG UNIVERSITY STUDENTS: RELATIONSHIP TO SEX ROLES ATTITUDES, ASSERTIVENESS AND COMMUNICATION, AND POWER BALANCE

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Safer Sexual Behaviour Among University Students: Relationship to Sex Role Attitudes, Assertiveness and Communication, and Power Balance

by

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Abstract

Background: University students are vulnerable to contracting HIV/AIDS because some of their behaviours are known HIV risk factors. Because HIV/AIDS is preventable, it is important to understand the factors associated with risk behaviors. Sex role attitudes, communication and assertiveness, and power balance in relationships are associated with safer sex behaviour.

Hypotheses: 1. Respondents who hold more traditional thoughts about the rights and roles of women are less likely to practice safer sex behaviour. 2. Respondents who are not assertive about HIV and do not communicate effectively about HIV/AIDS and sexuality are less likely to practice safer sex. 3. Respondents who are in an unbalanced relationship with respect to power distribution are less likely to practice safer sex.

Methods: The study was descriptive in nature. A 69-item questionnaire was administered to a convenience sample of 86 second- year university students enrolled in an undergraduate psychology course. The questionnaire consisted of sections on the roles of men and women, communication and assertiveness, safer sex behaviour, power balance, and demographics. Descriptive statistics, Pearson's correlation, test of equality of means and a multiple regression were used in the data analysis.

Results: Traditional thoughts about the roles of men and women were negatively correlated with safer sex behaviour as was hypothesized. Assertiveness and communication was positively correlated with safer sex behaviour as was hypothesized. Power balance was negatively correlated with safer sex behaviour. Assertiveness and communication were found to be the most important statistical contributors to safer sex behaviour.

Conclusions: Assertiveness and sexual stereotypes play an important role in one's ability to practice safer sex behaviour. Assertiveness training and training geared towards eliminating sexual stereotypes may give young people the awareness and confidence to protect themselves from HIV/AIDS. Power balance may also play a role in the prevention of HIV/AIDS but it is less evident in this sample.

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1. Rationale

The Acquired Immunodeficiency Syndrome (AIDS) epidemic has brought with it a consideration of the character of sexual relationships and how they are negotiated. Power balance in relationships, gender stereotypes about the roles of sexual partners, and issues of assertiveness and communication are intricately linked to safer sex behaviour of young people (Holland, Ramazanoglu, Scott, Sharpe, & Thomson, 1992). It is through attempting to understand these linkages that we can uncover valuable information about the risk behaviour of young people. This information, in turn, can enable the development of effective interventions for young people to prevent the spread of the Human Immunodeficiency Virus (HIV) which causes AIDS.

The purpose of this research was to examine and describe the relationship between power balance and safer sex behaviour as it relates to the prevention of HIV/AIDS among university students. This research was undertaken for several reasons. First, the relationship between power balance and safer sex behaviour had been relatively little studied among a university population. Holland et al.(1992) studied power balance among females 16-21 years of age which may have included some university students. However, the research was not specifically undertaken among this population. Similarly, Wingood, Hunter-Gamble and DiClemente (1993) focused on power balance among African-American females aged 18-25 years but not specifically among the university population.

Also, these studies were undertaken on females only. Davis, Emerson and

Williams (1997) researched power balance and safer sex behaviour in African American male and female professionals. However, there were no studies which focussed on the perceptions and experiences of male university students with respect to both safer sex behaviour and power balance.

The variables studied in this research study were (1) the roles of men and women in sexual relationships (2) sexual assertiveness and communication as it relates to safer sex behaviour (3) sexual behaviour (4) safer sex behaviour (5) power balance (6) education (7) financial variables (8) age. Also, the relationships between safer sex behaviour and the roles of men and women; sexual assertiveness and communication; and power balance were studied.

Studying the relationship between safer sex behaviour and power balance among university students was an opportunity to explore gender differences among a sample which would otherwise be very similar with respect to key determinants of health, such as income and education. This allowed for the exploration of select social determinants of health, such as gender roles, and aspects of culture and personal coping such as assertiveness and communication, and power, and their relationship to risk behaviour for acquiring HIV and other sexually transmitted diseases (STDs).

University students engage in several risk behaviours for acquiring HIV/AIDS. The most crucial of these is sexual intercourse without using a condom (Myers & Clement, 1994). Studying the relationship between power balance and safer sex behaviour among university students adds to knowledge of these issues. This knowledge,

in turn, may be used to develop and implement effective interventions to prevent the spread of HIV/AIDS among university students.

2. Background

AIDS is defined by the United States Centers for Disease Control and Prevention (CDC) as a "reliably diagnosed disease that is at least moderately indicative of an underlying cause of cellular immune deficiency in a person who has had no known underlying cause of cellular immune deficiency nor any other cause of reduced resistance reported to be associated with that disease." (McClain & Matteoli, 1989). HIV can be transmitted by blood, sexual intercourse and perinatally from mother to unborn child (Mulvihill, 1996).

Prevalence of HIV among university students is believed to be lower than that of populations known to be at high risk (Gayle, Keeling, Garcia-Tunon, Kilbourne, Narkunas, Ingram, Rogers & Curran, 1990). A blinded HIV-seroprevalance survey was undertaken at 19 universities throughout the United States. Testing for the HIV antibody was performed using blood collected for routine medical purposes through the student health centres. The prevalence rate of HIV infection among the sample was found to be 0.2 percent which accounted for 30 out of 16,863 specimens being positive for HIV (Gayle et al.). In contrast seroprevalence rates among groups known to be at high risk have been substantially higher (Gayle et al.). Studies of homosexual and bisexual men treated in clinics for STDs have found rates ranging from fourteen to fifty percent. Similarly, rates for intravenous drug users across the U.S. ranged from one to fifty-seven percent (Gayle et al.).

The American College Health Association has reported that more than 25,000

college students in the U.S. may be infected with HIV (Mahoney, Thombs, & Ford, 1995). Due to the prevalence of known risk behaviours among this group, it is widely recognized that there is potential for the spread of HIV in this population and that preventive measures are needed (Gayle et al, 1990).

There have been few Canadian studies of prevalence of HIV among young people (Health Canada, 1999). A survey of attendees at a STD clinic in Ontario found an HIV prevalence rate of 0.1% among males aged fifteen to nineteen and 0.04% among females of the same age (Fearon, Major, Notenboom, Galli, Prytula, Demshar et al, 1992). Sentinel hospital surveillance of HIV infection in Quebec found prevalence rates of 1.3% among males, 0.3% among females and 0.8% overall for young people aged fifteen to twenty-four years of age (Alary, Joly, Parent, Fauvel, & Dionne, 1994). Although the prevalence rates may be low, adolescents are a group which could experience an increase in HIV infection. This merits attention from the public health community because HIV infection is preventable, fatal and very costly to treat (Health Canada). Additional background information about the AIDS epidemic and its effect on society can be found in Appendix A.

2.1 Theoretical Framework

There are various theories surrounding behavioural risk factors for acquiring HIV/AIDS. Two major models are the social cognitive model and scripting theory. The major social cognitive theory which attempts to explain behaviour change is the Health

Belief Model. Several other social cognitive theories such as the AIDS Risk Reduction Model (ARRM), Bandura's Social Cognitive Theory, the Theory of Reasoned Action (TRA) and the Theory of Planned Behaviour (TPB) are all intricately linked to the Health Belief Model and some were actually developed from elements of the Health Belief Model. These social cognitive theories were not specifically formulated to be used with youth. They are broader theories which encompass the behaviour of all individuals in society, and can be applied to youth. These models are on the intrapersonal level and focus on cognitions and motivations influencing the preventive action of the individual (Maticka-Tyndale, 1995).

The theory of Cultural or Sexual Scripts which was specifically formulated in accord with the needs and behaviour of youth may be included in scripting theory. It is on the interpersonal level where the focus is on the interaction and communication between sexual partners who are members of a community (Maticka-Tyndale, 1995).

2.2 Social Cognitive Models

2.2.1 The Health Belief Model

The Health Belief Model was formulated in the 1950s mainly as a tool to gain knowledge about noncompliance with screening procedures (Carmel, 1991; Brown, DiClemente & Reynolds, 1991). Eventually it was applied to other preventive behaviours and to compliance with medical regimens (Carmel; Brown et al.). Since then, theoretical constructs have been added or modified to assess general health motivation, enabling

factors, and self-efficacy (Brown et al., 1991).

The Health Belief Model implies that preventive health behaviour can be understood as a function of an individual's beliefs about a particular disease in terms of the following: (Carmel, 1991).

(i) perceived susceptibility of acquiring the disease - the individual's subjective perception of risk or vulnerability to a health threat

(ii) perceived severity of the disease - the individual's perceptions of the seriousness of the health threat

(iii) perceived benefits to be realized by engaging in a particular preventive behaviour - the individual's beliefs about the effectiveness of strategies designed to decrease vulnerability or reduce the threat of illness

(iv) perceived barriers - the assessment of potential negative consequences (physical, psychological, and financial) that may result from taking a particular health action (Brown et al., 1991; Carmel, 1991; Janz & Becker, 1984).

The underlying assumption of the Health Belief Model is that individual attitudes and beliefs are important determinants of health action (Brown et al., 1991). The components of susceptibility and severity combine to provide the motivation for health-related action while the preferred course of action is determined by a cost-benefit analysis of perceived benefits and assessed barriers (Brown, DiClemente & Reynolds, 1991). When a cue to action is present, such as information or advice that focuses the attention on a specific preventive behaviour, the appropriate health behaviour may be invoked

(Carmel, 1991; Brown, DiClemente & Reynolds).

In an attempt to increase the predictive ability of the Health Belief Model, Rosenstock, Strecher and Becker (1988) expanded the model to include self-efficacy which is an individual's perception that he/she can successfully execute the behaviour desired to produce the desired outcomes (Brown et al., 1991).

2.2.2 Bandura's Social Cognitive Theory

This theory states that perceptions of self-efficacy and expected outcomes of behaviour are the key determinants of behaviour. It defines self-efficacy as people's judgements of their abilities to organize and execute courses of action required to attain certain types of performances. It is concerned not with the skills one has but with judgements of what one can do with whatever skills one possesses (Uddin, 1996; Bandura, 1990). This self-knowledge comes from four major sources. These are: enactive attainment - performing a task oneself ; vicarious experience - observing another perform a task; verbal persuasion - being convinced by another of one's ability to perform a task; and physiological states of arousal - reading the body's physical responses to external stimuli (Uddin).

Self-efficacy may play a role in safer sex behaviour. People who are fully aware of HIV risk factors may not take measures to prevent HIV unless they perceive themselves as being capable of doing so (Uddin, 1996). Also, perceptions of positive or negative social norms concerning sexuality influence feelings of self-efficacy to negotiate safer sex

and influence outcome expectancies regarding the use of condoms. Therefore, perceptions of social norms on sexuality may influence safer sex behaviour (Raj & Pollack, 1996).

2.2.3 AIDS Risk Reduction Model (ARRM)

ARRM, developed by Catania, Kegeles and Coates (1990), is a psycho-social model used to explain people's efforts to avoid contracting HIV through sexual transmission. ARRM is derived from prior models concerning social psychological problem solving and integrates elements of the Health Belief Model, efficacy theory, emotional influences, and interpersonal processes. It is composed of three stages:

(i) Stage 1: Problem Perception

In this stage the individual is responsible for recognition and labelling of one's sexual behaviours as high risk for contracting HIV. Three factors are hypothesized to influence labelling of sexual behaviour as problematic by individuals who objectively exhibit high-risk sexual behaviours (Catania, Kegeles & Coates, 1990). They are:

(a) Knowledge of sexual activities associated with HIV transmission - It is hypothesized that the knowledge of the risk factors involved in HIV transmission is necessary in order to determine personal risk accurately and to develop perceptions of personal susceptibility.

(b) Perceived susceptibility - If individuals do not perceive themselves to be susceptible to HIV, they are unlikely to alter their high risk behaviour.

(c) Social networks, norms and labelling - Social networks and norms may guide the labelling process through disapproval of high risk behaviours and approval of safer sex practices.

(ii) Stage 2: Commitment to Change

This decision-making stage involves the individual making both a firm decision for behavioural change and a strong commitment to reduce high risk sexual contacts and increase low risk activities. This stage may also include alternative outcomes of remaining undecided, waiting for the problem to resolve itself or resigning oneself to the problem situation (Catania, Kegeles & Coates, 1990).

Three factors influence the commitment to change. They are:

(a) Costs and benefits - Analysis of the costs and benefits of changing high-risk sexual behaviour will impact upon the commitment to change primarily through two means. First, the perceived effectiveness of the behaviour change in reducing negative health effects will be considered. If it is assessed that changing the behaviour in question will not reduce negative health effects, commitment to change is inhibited. Second, the enjoyment factor of the behaviour will be considered. Enjoyment associated with a particular high-risk sexual behaviour may inhibit commitment to reduce that behaviour

(Catania, Kegeles & Coates, 1990).

(b) Self-efficacy - An individual must believe in his/her own abilities in order to reduce high-risk sexual behaviour. A high degree of self-efficacy contributes to reductions in high-risk behaviours and increases in low risk activities.

(c) Knowledge of social influences on commitment - Knowledge of health utility and enjoyment of sexual practices impact upon the cost-benefit analysis process and the commitment to change. Social factors such as social support and reference group norms may also influence cost-benefit assessments and self-efficacy beliefs. Social conditions which foster change are hypothesized to be those that reinforce expectations that change will be beneficial and not too costly. Belief in the ability to accomplish change may be influenced by others who have successfully accomplished such change (Catania, Kegeles & Coates, 1990).

(iii) Stage 3: Taking Action.

In this stage the individual begins to take steps to reduce high-risk sexual behaviours. This stage is hypothesized to be composed of three phases. They are:

(a) Information seeking - Individuals may begin gathering ideas and advice on how to change behaviour. This can be gathered through friends, family, media and health education.

(b) Obtaining remedies - Some individuals may decide to opt for self-help or may seek assistance from friends or professionals.

(c) Enacting solutions - The social nature of sexual behaviour is a most relevant consideration in enacting solutions to reduce high-risk sexual behaviour as this behaviour may occur in a sexual context. When reducing high-risk sexual behaviour is identified by both partners as a need there is a basis for enacting solutions to change the behaviour (Catania, Kegeles & Coates, 1990).

However, some individuals may have partners that are reluctant to change their sexual behaviour. This may significantly diminish the possibility of either partner reducing high- risk sexual practices. Communication skills become of upmost importance in this situation as an individual who wishes to change his/her behaviour may need to convince the partner to change also.

Movement from stage to stage: Several internal and external motivators may play roles in maintaining the movement from stage to stage over time. These motivators include emotional states, and both formal and informal environmental cues that stimulate thinking about sexual behaviour and opportunities for change (Catania, Kegeles & Coates, 1990).

2.2.4 Theory of Reasoned Action (TRA)

This theory proposes that behaviour directly follows from the formation of an

intention to act. These intentions are determined by an individual's attitudes and subjective norms. Attitudes are formed from an individual's beliefs about the consequences of a particular action multiplied by their evaluations of those consequences (Abraham, Sheeran & Orbell, 1998; Fishbein & Ajzen, 1975). Subjective norms combine the perceptions of the extent to which certain other individuals would approve of one's performing the behaviour. The TRA proposes that an individual is more likely to intend to use condoms, if he/she has a positive attitude towards condom use and believes that significant others would approve of his or her using a condom (Abraham et al.; Fishbein & Ajzen). The major assumption of the TRA is that individuals will use the information that they possess in a reasonable fashion to make decisions about behaviour which is believed to be under their control (Joffe, 1996). It is this assumption that is often targeted by critics of this theory.

2.2.5 Theory of Planned Behaviour (TPB)

This theory is a descendant of the TRA but differs by having a measure of perceived behavioural control which is essentially the same concept as perceived self-efficacy (Abraham et al., 1998; Ajzen, 1985). This refers to an individual's confidence in his/her ability to successfully complete the intended action. If people feel confident about their success in completing their intended behaviour, such as using condoms, there is a greater likelihood that they will successfully complete the behaviour (Abraham et al.; Ajzen).

Various research studies have explored the usefulness of these social cognitive models in predicting behaviour change as it relates to HIV-related risk behaviours in adolescents and university students. The results have been mixed. Ford and Norris (1995) took constructs from both the Health Belief Model and the TRA and interviewed 1435 African American and Hispanic young men between the ages of 15-24 using a household probability sample. These young men were from low-income areas of Detroit and reported casual female sex partners. Respondents were assessed on casual partners, condom use, communication about condom use, attitudes towards condom use, condom beliefs, susceptibility, sexual history and demographics. The response rate was 85%. They found that variables related to both the Health Belief Model and the TRA were found to be related to condom use (Ford & Norris). The sample for this study was not random and was drawn from certain cultural groups. Thus, the results cannot be generalized.

Lollis, Johnson and Antoni (1997) examined the ability of the Health Belief Model to predict condom usage and risky sexual practices among 122 white heterosexual college students aged 17-33 years who were attending a university in the Southeastern United States. Stratified cluster sampling was used within the department of psychology to draw a sample. Self-reported questionnaires were utilized in the study and used to operationalize Health Belief Model constructs. Results showed that the Health Belief Model did not meaningfully predict condom use during vaginal or oral sex in the 58 men and 64 women surveyed. However, it did partially explain the variance in sexual risk behaviours. They concluded that the Health Belief Model has differential and limited

ability for predicting sexual practices among university students (Lollis et al.).

Carmel (1991) conducted a review of AIDS related Health Belief Model studies. She found that the diversity of the population groups, research designs, and behaviours investigated significantly limited the ability to reach sound conclusions about the Health Belief Model's usefulness in predicting preventive behaviours for AIDS. In her critique of the Health Belief Model she stated that one of its major limitations is the assumptions of the model which derive from Western culture. She stated that human behaviour, especially risk behaviour, is not always motivated by rational calculations and that the Health Belief Model cannot explain variance related to other social influences which are often effective in behaviour change such as social pressures (Carmel).

Other researchers concur. In a commentary about the prevention of HIV in adolescents and the utility of the Health Belief Model, Brown et al. (1991), identified several limitations of the Health Belief Model for use among this group. These include difficulty in accounting for change of habitual behaviours, relative exclusion of emotional reactions and peer group influence, and lack of maturational constructs (Brown et al.).

Godin and Kok (1996), examined the theory of planned behaviour using metanalysis to verify the efficiency of the theory to explain and predict health-related behaviours. The results indicated that the theory performed very well for explanation of intention. Intention was the most important predictor found, but in half of the studies reviewed, perceived behavioural control significantly added to the prediction of health-related behaviours (Godin & Kok). They concluded that the efficiency of the model

seemed to be good for explaining intention. Also, perceived behavioural control was as important as attitude across health-related behaviour categories. However, the efficiency of the theory varied between health-related behaviour categories (Godin & Kok, 1996). Richardson, Beazley, Delaney and Langille (1997) examined factors influencing condom use among 295 male and 345 female students aged 13-19 years. They used a convenience sample of students attending the town's only high school in Amherst, Nova Scotia. Using the TPB as a framework, student's attitudes, social normative beliefs, perceived control and intentions regarding condom use were assessed through use of a self-administered questionnaire. Actual condom use was then predicted for this group. Their findings were not fully consistent with the TPB. The variable 'attitudes towards condoms' was significant in the regression analysis of predictors of intentions to use condoms. Also, when all variables were used to predict actual condom use, both attitudes and intentions were significant. However, perceived behavioural control was not associated with intentions to use condoms or with condom use. Also, no relationship was found between social normative beliefs and intentions, or with actual condom use (Richardson et al.).

Perhaps the best predictor of HIV preventive behaviour among young people is self-efficacy. Wulfert and Wan (1993) surveyed, using a convenience sample, 350 sexually active undergraduate college students from advanced psychology classes at the State University of New York at Albany. They gathered information about condom use, self-efficacy, outcome expectancies, sexual attitudes, peer group influences, AIDS knowledge, and perceived vulnerability to AIDS. On the basis of Bandura's social

cognitive theory, they formed a structural model with self-efficacy as the central mediator in order to predict condom use among this group. Their model explained 46% of the variance in condom use from judgements of self-efficacy and effects attributable to peers and 53% of the variance in self-efficacy from outcome expectancies and peer group influences. Sexual attitudes, AIDS knowledge and perceived vulnerability did not predict condom use in this group (Wulfert & Wan). Other studies conducted among university students, such as studies by Raj (1996), and Uddin (1996) found similar results; that self-efficacy is associated with safer sex behaviour and condom use among this group.

2.2.6 Critique of Intrapersonal Models

There are several critiques of these models. First, that none of the models was specifically developed to address sexual behaviour. Their application to the prevention of STDs such as HIV is based on the assumption that sexual behaviours are no different than other lifestyle behaviours such as alcohol or tobacco use (Maticka-Tyndale, 1995). Research undertaken in this area indicates that this is not the case. Rather, sexual activity is imbued with different layers of meanings and shifts and changes over the course of an individual's life in a manner unlike these other behaviours (Maticka-Tyndale).

Another criticism is that in these models, safer sex is viewed as the only rational decision and that barriers to using condoms are flaws in cognitive processing. This does not account for circumstances where the choice to engage in high-risk sexual behaviour is involved with elements of power imbalance or coercion (Maticka-Tyndale). This is why

it is important to consider factors external to the individual such as the influence of the sexual partner and the dynamic relationship with this partner when assessing the sexual activity of an individual (Maticka-Tyndale).

2.3 Cultural or Sexual Scripts

Scripting theory espouses that human interaction is directed by preexisting scripts that are clues to understanding social behaviour (Simon & Gagnon, 1986). Behavioural scripting occurs on three levels. These are: cultural scenarios, scripts developed by members of a group; interpersonal scripts, an individual's use of a cultural scenario; and intrapsychic scripts, the psychological management of an individual's private wishes and desires (Simon & Gagnon; Uddin, 1996). Cultural or sexual scripts is a theory on the interpersonal level which examines sexual behaviour and risk reduction within the context of an individual's personal and sexual histories and cultures (Maticka-Tyndale, 1995).

The theory of cultural or sexual scripts involves the use of both cultural scenarios and interpersonal scripts and attempts to look at behaviour in the sociocultural environment of our world where gender stereotypes are usually the rule rather than the exception. This theory has been proposed as an explanation of HIV transmission among young people as an alternative to a lack of emphasis of social influences in social cognitive theory models. Considerable attention has been placed on the risks that women face from heterosexual contact. In response, various prevention strategies have been

developed. These prevention strategies often treat women's risk behaviour as opposite to the behaviour of their male partners without acknowledging gender power differences (Campbell, 1995). The focus is often on the individual rather than the sociocultural context in which the individual interacts. The theory of cultural or sexual scripts looks at sexual behaviour within the sociocultural context in which it takes place and emphasizes social influences on sexual behaviour.

The term cultural scripts comes from Dr. Rafael Diaz in his work preventing HIV with Latino gay men and can be defined as the set of ideas and norms that prescribe ways of thinking and acting in the world and can encompass a range of topics such as body ideals, violence, and power. Sexual scripts refer to the specific cultural scripts which regulate sex and sexuality (Somera & Laub, 1997). Sexual scripts are involved in learning the meaning of internal states, organizing the sequences of specifically sexual acts, decoding novel situations, setting limits on sexual responses and linking meanings from non-sexual aspects of life to specific sexual experiences (Gagnon & Simon, 1973; Reed & Weinberg, 1984). A script defines a person, and a set of behaviours appropriate for that type of person (Reed & Weinberg).

One specific sexual script is the Traditional Sexual Script (TSS) which outlines specific traditional dating roles for males and females. Somera and Laub (1997) hypothesize that young people engage in risky sexual behaviour because their behaviour is being regulated by sexual scripts that are much more powerful than the facts and skills they know they should use. They believe that empowerment is teaching young people to

identify and become critical of the cultural scripts that regulate their sexual behaviour. These sexual scripts are not just a set of external forces but a way of thinking, seeing the world, and seeing your role in the world that is socially constructed and internalized. Sexual scripts enforce a system where people do not feel free to act in unscripted ways. A basic premise of this theory is that if young people were informed and truly free to make choices, then they would be less likely to engage in risky behaviour (Somera & Laub).

Scripting theory relates to the variables in this research project there are specific scripts existing in society which regulate the roles of men and women, assertiveness and communication, safer sex behaviour and power balance in relationships. The literature review will explore specific societal scripts with respect to these variables and the TSS will be used in the discussion of this thesis for means of comparison.

3. Literature Review

The literature review investigated the issues of gender and sexuality, power balance, assertiveness and communication regarding safer sex, and safer sex behaviour among university students. The literature was reviewed for relevance to safer sex behaviour and the prevention of HIV among youth. The state of the literature varied depending on the variable researched. There was extensive research completed with respect to safer sex in university students. However, the majority of the research was completed in the U.S. There was little dealing with Canadian university students. The research relating to the roles of men and women, and assertiveness and communication was quite extensive. Again, the majority of the research was American. There was a paucity of research completed on power balance with respect to dating individuals both in the U.S. and in Canada and research relating to the young, male heterosexual response to safer sex behaviour was limited.

The majority of studies cited in the literature review used non-random samples. Thus, the results of the studies are not generalizable to the population as a whole. The only studies cited which utilized random sample methodology were Hawkins, Gray, and Hawkins (1995), Uddin (1996), and Caron, Davis, Halteman, and Stickle (1993). These random sample designs were subject to their own particular limitations as is stated in the text of this review. Also, all studies cited were subject to self-report and recall bias.

3.1 Gender Roles and Sexuality

Sex refers to the biological state of being male or female or to sexual intercourse itself (Lear, 1995), whereas gender means defining certain characteristics as feminine or masculine, certain activities as appropriate for women and for men, and certain norms for relationships between men and women (Gordon, 1995). It has been recognized that these gender roles are dimorphically assigned and more or less adhered to and accepted within any culture (Lear).

Historically, women were described as having a sole role in reproduction (Ehrenreich & English, 1979). However, they did not become sexual beings from their role in reproduction as female sexuality was viewed as unwomanly and perhaps detrimental to a woman's reproductive role (Ehrenreich & English). Women were seen as dysfunctional if they were sexually responsive (unless they were sex trade workers) (Adesso, Reddy & Fleming, 1994). Thus, women were denied their own identity with respect to sexual pleasure and sexual intercourse was viewed as a duty to be performed upon request of the husband for the purpose of reproduction (Taylor, 1995).

This way of thinking led to the expectation held by both men and women that the man's sexual pleasure is vital in a sexual encounter (Wight, 1992). This commonly held expectation has been labelled with respect to women as the 'missing discourse of desire' (Fine, 1988) and has been documented in various studies.

One of these, the Women's Risk and AIDS Project (WRAP) undertaken between

1988-1990 by Holland Ramazanoglu, Scott, Sharpe, and Thomson, was a sociological study of the sexual beliefs and practices of two samples each of 75 young women between the ages of 16 and 21 in the cities of London and Manchester in the UK. Holland et al. conducted in-depth interviews and utilized a pre-selection questionnaire. Convenience samples were taken at schools, colleges, youth clubs, young mothers groups, a range of workplaces, and through magazines aimed at the relevant age group. This process resulted in the collection of 500 questionnaires. The women were asked to provide a contact address if they were willing to be interviewed.

Holland and colleagues found overwhelming documentation of the missing discourse of desire in the WRAP project. They identified that heterosexual sex is often a site of inequality where male needs and preferences predominate. This study raised some valuable evidence of the lack of the discourse of desire among young women.

Maxwell and Boyle (1995) explored the risky heterosexual practices amongst women over thirty years of age who lived in London, UK and found much evidence of the centrality of male pleasure and the missing discourse of desire. Focus groups were held with twenty-three women over the age of thirty. Only one woman indicated that female pleasure had been the focus of her sexual relationships. Conversely, most of the women felt that their entire sexual experience had been a battle against the centrality of male pleasure (Maxwell & Boyle). Many felt that female pleasure was merely a by-product of male pleasure.

This concept was probed further by asking the groups if women would use

condoms more often if they increased sexual sensation for men and decreased it for women. Most groups exhibited confused silence or changed the subject when confronted with this question while one group responded immediately with the notion that condoms would be used more. The question was repeated for the other groups and made more clear to them that, hypothetically, women's pleasure would decrease. Participants then expressed shock at how female needs and pleasure are subordinated in sexual relationships (Maxwell & Boyle, 1995).

This study was qualitative in nature and clearly illustrates the central concept of male pleasure and the missing discourse of desire. A limitation of the study was difficulty with recruitment of volunteers to participate in discussions about sexuality. The women who volunteered for this study were, thus, probably fairly confident about their sexuality and sexual matters. To find evidence of the centrality of male pleasure and the missing discourse of desire to such an extent among this group certainly illustrated the depth of these concepts in western society.

The expected roles of men and women have a profound effect on sexual health and often make it difficult for either sex to adopt safer sex behaviour (Gordon, 1995). These roles can be characterized as sexual scripts which detail the who, what, when, how and why of sexual situations and depict the sequence in which these behaviours occur within sexual situations (Byers, 1996). The most pervasive sexual script in North America is deemed the 'traditional sexual script' (TSS) and it holds very different expectations for both males and females (Byers).

The TSS depicts men as the initiators in sexual situations (Byers, 1996; Reed & Weinberg, 1984; Cate & Lloyd, 1988; Edgar & Fitzpatrick, 1993; Lottes, 1993; Rose & Frieze; 1989). Traditional socialization teaches 'real' men to initiate sex and to be in charge from the beginning to the end (Campbell, 1995).

The TSS prescribes that women are expected to place limits on the level of sexual activity in which they engage with their male partners (Byers, 1996). Women are expected to play the role of sexual gatekeeper by limiting access to their bodies and deciding to what extent the sexual encounter will proceed (Reed & Weinberg, 1984; Cate & Lloyd, 1988; Edgar & Fitzpatrick, 1993; Lottes, 1993; Rose & Frieze; 1989). Women are trained not to be knowledgeable about sex and not to let their sexual needs and preferences be known to their partners (Campbell,1995). Women are to be the passive recipients of sexual activity (Reed & Weinberg; Cate & Lloyd, Edgar & Fitzpatrick; Lottes; Rose & Frieze).

The TSS also decrees that a woman's worth is enhanced by being in a romantic relationship (Byers, 1996). Women are expected to be emotional, sensitive, and nurturing in relationships whereas men are expected to be unemotional, relatively insensitive, and self-focussed (Byers). Men are expected to be more interested in sex and are cautious about becoming emotionally involved and making commitments (Lottes, 1993). However, women are expected to value romance, affection, love, and commitment more than sex and to make sexual activity contingent upon them (Lottes). These scripts and stereotyped gender roles have been examined in various studies. Lottes (1993) surveyed

411 students at an eastern state university in the United States of America. Data were collected using a questionnaire administered to convenience samples of students during regular class periods. The purposes of the study were 1) to specify gender differences and similarities in sexual beliefs and experiences, 2) to determine the prevalence of women enacting traditional male roles in dating and sexual interactions, and 3) to examine the relationship between women's enactment of traditional male roles and their sexual experience (Lottes, 1993). She found that 65% of males and 92% of females indicated that emotional involvement was 'always' or 'most of the time' necessary for them to participate in sexual intercourse. A majority of both males (76%) and females (78%) indicated that men and women should be equal initiators of a sexual relationship. However, more females than males reported that the male partner should initiate sexual relationships. From this study, Lottes drew the conclusion that gender roles, while still existing, are converging to a single standard of sexual behaviour for both males and females. The study was representative of the university population from which the sample was drawn and served as a good illustration of the part that gender roles play in governing sexual behaviour in a university population.

O'Sullivan and Byers (1992) used a self-monitoring technique among dating couples at the University of New Brunswick to investigate the stereotypes of initiations of sexual activity by men and restrictions on sexual activity by women. Fifty male and fifty-five female heterosexual unmarried undergraduate students were recruited from introductory psychology courses to complete a survey. The median age of the sample was

19 years. They found that men initiated sex more than the women did, which is consistent with the TSS. However, initiations by women were not rare. The women initiated sex about half as frequently as the men and these initiations were most likely to occur in a steady dating relationship (Byers, 1996). The results also found that in steady dating relationships women are not serving a restrictive role. O'Sullivan and Byers concluded that the TSS is a common dating script which is frequently employed for heterosexual dating interactions. It accurately described behaviours that are characteristic of men and women. However, certain aspects of the script, such as men initiating sexual activity and women serving a restrictive role, were not as pervasive and all encompassing as would be expected. They cited evidence of considerable overlap in men's and women's roles in sexual situations and a convergence in what is perceived as ideal sexual behaviour for men and women (Byers).

LaPlante, McCormick and Brannigan (1980) used self-reported questionnaires to survey 124 unmarried college students at a Northeastern state college in the U.S.A. about dating attitudes. Their hypotheses were that students would 1) stereotype initiating sexual intercourse as a masculine activity and refusing to have sex as a feminine activity, 2) both personally experience dates using more indirect strategies to have sex and more direct strategies to avoid having sex, and 3) that internally oriented students with respect to locus of control, defined as being below the median response for age and gender, would more likely report being the influencing agent and less likely to report being the influencee within a sexual encounter than externally oriented students (LaPlante et al.,

1980).

They found that, as expected, students stereotyped all strategies for having sex as being used predominantly by men and all strategies for avoiding sex as being used predominantly by women (LaPlante et al., 1980). However, they also found that both men and women reported behaving and being influenced in attitudes and behaviour by these stereotypes independent of their personality or the type of strategy considered. In addition, students' personal use of power adhered strictly to the dictates of the sexual script of men seeking sexual intercourse and women attempting to avoid having sex. Men reported that they personally use both direct and indirect strategies significantly more than women to have sexual intercourse. Conversely, women indicated that they personally used both indirect and direct strategies significantly more than men when the goal was to avoid sexual intercourse. LaPlante and colleagues concluded that the traditional sexual script thrives even in an era of increasingly liberal sexual attitudes. This study gave a good picture of how this particular group of college students was influenced by gender stereotypes and sexual scripts during this particular time frame.

Rose and Frieze (1989) surveyed 58 women and 39 men between the ages of 18 and 22 from undergraduate psychology classes at a large midwestern Unites States public university. Convenience samples were taken from introductory psychology classes. Participants were asked to list 20 expected actions involved in a first date for a woman and for a man. The actions with high agreement among the sample were said to constitute a script with the script for women comprised of 19 actions and the one for men comprised

of 27 actions. The scripts for women and men were found to be very different with the women's being primarily confined to the private sphere (concern about appearance, conversation and controlling sexuality). In contrast, the script for the men focussed on the public domain (planning, paying for, and orchestrating the date). It was found that traditional gender roles were more prevalent in the scripts of experienced daters as compared to those considered to be novice daters. Rose and Frieze concluded that interpersonal dating scripts of young adults maintain the traditional gender-power relationship. This study provided further evidence of how encompassing the influence of gender roles was among students.

Lear (1997) conducted thirty interviews and surveyed 129 undergraduate students using convenience samples at the University of Berkeley. Interviewees and respondents to the survey were both recruited from a lower-division introductory health education and a sociology of sexuality class. One area assessed related to the TSS. It is the issue of balancing risk versus reputation. Lear found that both men and women were aware that women risked their reputations by acknowledging their sexual desires. Women found it difficult to tell their partners they wanted sex because of messages from society about the risks involved and about appropriate behaviour for women. Lear stated that women still set the pace for sexual intimacy because they worry about their reputations.

These traditional scripts may impact on safer sex behaviour in several ways. Since men are trained to appear as though they are always ready and willing to have sex, and women are trained to control men's sexual appetite by saying no to sex, safer sex

behaviour may be inhibited as sex is tied to male performance and condoms are seen as interfering with that performance (Campbell, 1995).

Women are expected to be decision makers with respect to the use of contraception. Young men feel that it is up to young women to recognize their own personal needs, to choose contraception or to decide whether or not to have unprotected intercourse (Wight, 1992).

Women still set the pace for sexual intimacy. Men are expected to initiate the first sexual encounter, with women deciding how far things will go, and being responsible for contraception or refusal (Lear, 1995). However, men are expected to be prepared to produce a condom at the appropriate moment. Because of women's inability to articulate their desire, men can hope for sex, but neither men nor women plan for it realistically (Lear).

Within heterosexual relationships, sexual intercourse is socially located in gendered power relations. Sexual encounters may be sites of struggle between the exercise and acceptance of male power and male definitions of sexuality and of women's ambivalence and resistance. Using or not using a condom is not a simple practical question about dealing rationally with risk; it is the outcome of negotiation between potentially unequal partners (Lear, 1995). Condoms are not neutral objects about which a straightforward decision can be made on health grounds. The idea that women are free to choose the most rational form of protection ignores the material and symbolic nature of condoms and their place in relationships between women and men (Lear).

In summary, research on gender roles and sexuality indicated the following major findings:

1. The absence of a discourse of desire for females and the centrality of male pleasure in sexual relationships. 2. The existence of the TSS and which aspects of it were relevant in today's society. 3. A convergence to a single standard of sexual behaviour for both males and females as opposed to males and females behaving in a stereotypical manner with respect to sexual behaviour.

3.2 Power Balance

For the purpose of this study, power is defined as the capacity of an individual to control, influence, or manipulate another's behaviour whether this person wishes to cooperate or not (Kopinak, 1988). Several factors seem to tip the balance of power in favour of one partner rather than the other. Mackie (1991) summarizes these as:

1) **Social convention:** The belief that the male partner has the right to be the leader often gives this partner the advantage in a particular relationship.

2) **Relative resources of the partners:** Men are more likely to control money, status and brute force, and women, sex. Also, the woman's educational and career goals can be an important predictor of power in university students relationships. Specifically,

women who aspired to a bachelor's degree or less more frequently reported that the man had greater power. However, women who planned an advanced degree less frequently reported that the man had greater power.

3) **One partner's involvement or dependence upon the other:** This dependence may be emotional or financial. The principle of less interest holds here (Sprecher, 1985; Waller, 1937). It states that the partner who cares less about the quality of the relationship or if it even continues, has an advantage over the other. This involves having alternatives to the relationship. This principle can vary over the lifecycle with females generally experiencing the peak of this power during dating and courtship (Mackie, 1991).

4) **Physical coercion:** Dating violence often occurs when women challenge their partner's right to control them and men respond with violence (Stets & Pirog-Good, 1987). Violence occurs most often in more serious relationships where partners are more emotionally dependent on one another, and issues of control arise because more is at stake (De Keseredy, 1989; Mackie, 1991).

Harrison, Norris, Kay, Dixon, Peters & Moore (1996), defined the determinants of power as education, employment, and relationship factors including decision-making, commitment, investment, perceived alternatives to the relationship and physical and verbal abuse.

Decision-making (Blood & Wolfe, 1960; Gray-Little & Burks, 1983) and

emotional involvement (Caldwell & Peplau, 1984; Sprecher, 1985; Waller 1937) have been linked theoretically and empirically to power in intimate relationships. Felmlee (1994) measured power balance in a convenience sample of heterosexual dating individuals from several lower and upper level undergraduate sociology classes at two large midwestern universities in the United States. Her initial sample consisted of 598 students, 185 males and 413 females, who filled out a questionnaire during class time at the beginning of the semester about their romantic relationships. Only students who were currently involved in a romantic relationship were surveyed. At the end of the semester, 447 of the original sample completed a shorter follow-up questionnaire to test for longevity of their romantic relationships as this was another of Felmlee's objectives. Only students who completed both questionnaires were included in the data analysis. The final sample size, after exclusion of questionnaires with missing data on relevant variables, was 413. Felmlee used Likert scales to measure power, equity, emotional involvement, and decision-making in intimate relationships. Felmlee defined equity as the overall fairness in a romantic relationship or a measure of the outcome of power balance in a relationship. She used the Hatfield global measure of equity (Hatfield & Traupmann, 1981) to indicate a level of equity within romantic relationships.

Felmlee (1994) found that less than half of the respondents (46.1%) perceived their relationships to be equal in the distribution of power. Fifty-four percent (53.8%) of respondents indicated that their relationship was unequal with respect to power. Thirty-seven percent (36.5%) of respondents said that their relationships were unequal with the

male having had more power while 17.3% reported their relationships were unequal with the female having had more power. Imbalances were also evident in decision-making, emotional involvement, and equity. A higher proportion of both women and men said that the male partner, rather than the female partner, made more of the decisions, was less emotionally involved, and in general was 'getting a better deal'.

This study was one of the few studies which dealt with power balance among unmarried university students. It demonstrated the extent of power (im)balance among members of a sample who would be perceived by society as having "equal" status because their education and income would be the same.

The WRAP study (Holland et al., 1992), which undertook in-depth interviews and questionnaires with 75 young women between the ages of 16 and 21 in the U.K., produced some broad findings and conclusions with respect to the relationship between power balance, sex role stereotypes, assertiveness and communication, sexual behaviour and the spread of HIV. There was overwhelming documentation of inequalities of power in sexual relationships and negotiation in sexual relations, which took place within a framework of social constraints, ranging from male pressure to male violence, a passive femininity, women's responsibility for male sexuality, and the missing discourse of desire. Also, there was an identification of femininity, as defined by society, as an unsafe sexual strategy and a demonstration of sexual practice as contradictory and unpredictable.

This study contained valuable evidence of the existence of power inequalities, the degree to which they occur in society and the framework in which they operate among the

young women in the sample.

Wingood, Hunter-Gamble & DiClemente (1993), undertook a pilot study of sexual communication and negotiation among young African American women. Focus groups were conducted with African American women aged 18 to 25 to explore the process of sexual communication and barriers toward sexual negotiations of condom use. The final sample size was 18. Most of the women (n=13) indicated that they were able to initiate a discussion regarding safer sex with their sex partners; only a minority of the women (n=4) reported being able to negotiate condom use. Most of the women (n=16) did not perceive themselves as having the power to make their partner wear a condom (Wingood et al.). When asked who has more control over whether a condom is used, over 90% (n=16) indicated that the male partner has more control. The women who were either fearful of exercising their power or ineffective in resisting their partner's power were more likely to engage in unsafe sex (Wingood et al.)

This study was qualitative in nature and differentiated between sexual communication and sexual negotiation, explored the barriers to negotiating safer sex among a sample of young women, provided further evidence of the impact of power balance on the use of condoms and the potential spread of HIV among a group of young women, and generated numerous other research issues. The major issue of value as it related to the current research was that this study illustrated the often overlooked distinction between sexual communication and sexual negotiation. The study highlighted that just because one feels able to communicate about safer sex, this does not always

mean that one can negotiate condom use.

These studies illustrated that power balance in relationships may impact upon the spread of HIV. This notion is further supported by Du Guerny & Sjoberg (1993), who stated that power imbalance between genders facilitates the spread of the HIV epidemic. By identifying the strong and the weak points of each gender role, focal points for intervention may be identified. Salt, Bor & Palmer (1987), concluded the following in their article entitled "Dangerous Liaisons: Issues of gender and power relationships in HIV prevention and care":

> Negotiating risk as it pertains to sex presupposes that both (or however many) partners are equally empowered to consent to sex and to make decisions pertaining to risk. Many women report that their first sexual experience (and indeed, subsequent ones) involved their male partner coercing them to have intercourse (Holland et al, 1992). There is often an expectation that men will take the initiative in sexual behaviour. Women, on the other hand, are often expected to make decisions about contraception, particularly since the advent of the contraceptive pill. Although the female partner may therefore be 'invested' with the prime responsibility for ensuring proper contraception, she may not be empowered to insist that her male partner use a condom for barrier protection. Paradoxically women may feel less able to refuse sex because, with the advent of reliable forms of contraception, they have lost the 'excuse' of the risk of pregnancy in order to avoid unprotected intercourse. Unless they are prepared to discuss the

> risk of HIV, which may give rise to a multitude of issues for the couple, women are thus at risk of HIV if they feel powerless to insist on a condom being used. (p.157).

In summary, the research identifies the importance of power balance in sexual relationships, what factors determine the power balance in relationships, the assessment that the male partner has the most power in the relationship, the lack of perceived power by females to insist on their partner's condom use, and the distinction between sexual communication and the negotiation of safer sex.

3.3 Assertiveness and Communication

Lack of assertiveness and communication about sexual matters has been linked to both safer sex behaviour and power imbalance in relationships. Campbell (1995), stated that it is a lack of communication between partners, rather than male opposition, that usually accounts for failure to use condoms.

The WRAP project (Holland, Ramazanoglu, Scott, Sharpe, & Thomson, 1992) stated that for many women, talking about sex and asserting their needs is an extremely difficult matter. This finding was also reported by Maxwell and Boyle in 1995. They conducted focus groups with twenty-three women over the age of thirty who lived in London, UK and found that many respondents still found it difficult to assert themselves in sexual relationships.

It is not only women that have difficulty with communication and assertiveness.

Wendt and Solomon (1995) used a questionnaire to assess gender differences in condom use among 198 female and 89 male heterosexual college students enrolled in undergraduate psychology classes at the University of Vermont during spring 1990. Convenience samples were used. One barrier assessed was communication or concern about how to talk to your partner about condom use. They found that barriers to condom use, identified by both male and female students, included difficulty discussing condom use with their partner and poor communication and assertiveness skills.

Hays, Kegeles and Coates (1990), identified variables associated with HIV risk-taking among younger gay men. They distributed questionnaires to gay men aged 18-25 living in three medium-sized West Coast communities in the United States. Two hundred and forty-three surveys were distributed to men in areas identified as frequented by young gay men. Ninety-nine questionnaires were returned. Forty-three percent (43 %) of the men indicated that they had engaged in unprotected anal intercourse in the past six months. Young gay men who had engaged in unprotected anal intercourse differed from those men who had not engaged in unprotected anal intercourse on five dimensions. They reported greater enjoyment of unprotected anal intercourse; perceived less risk of unprotected anal intercourse; labelled themselves as more at risk for AIDS; had poorer communication skills with sexual partners; and were more likely to have a boyfriend/lover. This study illustrated that poorer communication skills is associated with high-risk sexual behaviour. A major limitation of this study was that response rate of only 35% may have affected the results.

In a sexual encounter, there tends to be very little verbal communication during the transition from sexual intercourse being a possibility to it becoming a reality (Kent, Davies, Deverell & Gottesman, 1990). Ralph DiClimente stated that the best predictor of condom use was communication with a sex partner requesting condom use (DiClimente, 1992). However, other researchers have shown that this open communication among partners often does not take place.

Ingham, Woodcock & Stenner (1991) found that only a minority of young people discuss their partner's sexual history before having sex and it almost never involves details of condom use. Those who do discuss it usually do so because of other relationship issues rather than because of a fear of infection.

Practising safer sex involves a complicated process of sexual negotiation, requiring a degree of open communication about sexual desire and intent that is not widely available in this culture, particularly among young people (Lear, 1995). Risk and how sex is negotiated is assessed differently by gender, and varies further according to the degree of intimacy in the relationship or the sex act being contemplated (Lear).

Denial of sexuality and sexual behaviour combined with double standards in the acceptance of certain behaviours, especially for women, make communication about sex between men and women extremely difficult. In combination with stereotyped norms for female/male sexual behaviour, this encourages risky behaviour and perpetuates the spread of HIV (Du Guerny & Sjoberg, 1993). This may have direct consequences on sexual health. Gordon (1995) states that a lack of communication and equality between the sexes

makes it difficult for either to enjoy sexual health.

Assertiveness and communication are related to power imbalance through the negotiation of safer sex between partners. If one partner is more dominant, then his/her wishes will prevail. For example, Lear (1997), stated that men exert power when ... they refuse to use a condom when asked. This leads to unsafe sexual practices.

Byrne (1983) suggested five behavioural steps to successful contraception. These are to acquire, process, and retain accurate contraceptive information; acknowledge the likelihood of engaging in sexual intercourse; obtain the relevant contraceptive; communicate with the sexual partner about contraception; and use the chosen method of contraception. In 1990, these steps were expanded by Fisher to deal with the prevention of STDs. He expanded the number of steps to seven by adding an active decision- making step and a step dealing with learning to shift to preventative scripts. The behavioural step pertaining to communication was included for the prevention of STDs (Caron, Davis, Halteman & Stickle, 1993).

Lack of communication has serious consequences in relation to HIV transmission. Without communication, it is impossible to know sexual histories before having sex and it greatly constrains the negotiation of sexual behaviour.

The major findings from the literature review pertaining to assertiveness and communication may be summarized as follows: difficulty communicating about sexual matters is common among both males and females; poor communication between sexual partners about sexual matters is associated with high-risk sexual behaviour; and

communication can impact upon a person's sexual health as good communication skills are vital to the negotiation of safer sex behaviour.

3.4 Safer Sex Behaviour

There have been several studies carried out to assess the safer sex behaviours of university and college students. Hawkins, Gray & Hawkins (1995) surveyed a random sample of 315 sexually active college students from a university in the Northwest of the United States to assess reported safer sex behaviours. The safer sex behaviours assessed were: discussion of contraceptives, being more selective, reducing the number of sexual partners, discussion of partner's sexual health, using condoms or dental dams, having only one sexual partner, and abstaining from sexual intercourse.

The most frequent safer sex behaviours included discussion of contraceptives with 58.6% of respondents indicating that they engaged in this activity. Being more selective with sexual partners was chosen by 46.5% of respondents while reducing the number of sexual partners was indicated by 43.6% of respondents. The least frequent safer sex behaviours were discussion of partner's sexual health prior to sexual behaviour with 26.1% of respondents indicating this, using condoms or dental dams chosen by 24.4% of respondents, having only one sexual partner indicated by 22.6% of respondents, and abstaining from sexual intercourse as a safer sex precaution with only 12.3% of respondents choosing this option (Hawkins, Gray & Hawkins). Limitations of this study included that the response rate (44%) may have affected the results and that there was

omission of questions pertaining to type of contraception discussed with partner.

Santelli et al.(1996) used a street survey to interview women aged 17-35 from two inner-city neighbourhoods in the American city of Baltimore. A modified street-intercept approach was used with a daily quota filled by interviewers in each age category. A total of 625 women were interviewed. Because of the use of a five dollar cash incentive, there was only a five percent refusal rate. The stages of behaviour change model was used to explore various factors as they relate to using condoms. It was found that a woman's relationship with her main partner appears to be an important factor in understanding the use of condoms both with her main partner and with other partners (Santelli et al.). Also, it was found that support of the male partner for condom use facilitated both women's intentions to use condoms and the consistency of their use.

A survey of 265 college students was conducted by Dekin (1996) in New York state in the U.S. to determine HIV-related knowledge, attitudes, behaviour, and perceived self-efficacy with regard to engaging in HIV-protective behaviours. Although HIV knowledge was high, perceived self-efficacy differed significantly by gender, with men describing themselves as less likely to insist upon condom use ($p<.00001$). Men were also significantly more likely to believe that monogamy eliminates the need for condoms ($p<.01$). Approximately 13 men (5% of the sample) and 15 women (5% of the sample) said that they do not use condoms because they are protected from pregnancy by the pill (Dekin).

Misovich, Fisher, and Fisher (1996) assessed the extent to which college students believed that knowing their partner eliminated the need to practice safer sex. Questionnaires were distributed among undergraduate students from the University of Connecticut. Results from the 563 respondents indicated that more than half of them appear to feel that knowledge about a partner's sexual history allows one to decide whether or not to practice safer sex with them and that serial monogamy (defined as a sequence of exclusive sexual relationships) is a sufficient condition for unprotected sexual practices (Misovich, Fisher & Fisher, 1996).

In 1990, DiClemente, Forrest, and Mickler investigated the knowledge and attitudes about AIDS and changes in HIV-preventive behaviours in 1127 students at geographically diverse universities and colleges in the United States in 1990. Their findings indicated that while students possessed a high level of knowledge about the transmission of HIV, they were likely to possess many misconceptions about casual contact as a means of transmission of HIV. Students reported a mean of 3.9 misconceptions about casual contact of HIV from the six item scale measuring misconceptions. Thirty percent (30%) agreed that you could get AIDS from kissing, while sixteen percent agreed that you could get AIDS from sharing a drinking glass (DiClemente et al.).

A substantial portion of respondents, 37%, reported never using condoms during sexual intercourse while 43% indicated having had multiple sexual partners in the year before the survey took place. Level of knowledge about AIDS was not found to be

significantly related to student's HIV-preventive behaviour change. Changes in HIV-protective behaviour were reported more commonly by those with low knowledge scores than those with high scores (DiClemente et al., 1990). However, perceived risk of HIV infection was strongly related to a self-reported increase in health protective behaviours. Students who perceived themselves to be more vulnerable to contracting AIDS, reported increased condom use and reduction in the number of sexual partners (DiClemente et al., 1990). This study gave valuable information about the lack of association between AIDS knowledge and HIV-preventive behaviour change that confirmed results of similar studies (Baldwin & Baldwin, 1988; Becker & Joseph,1988; Bishop & Lipsitz, 1988 cited in DiClemente et al., 1990). Levy, Samson, Lopez, Picod-Bernard and Maticka-Tyndale (1993) surveyed 404 sexually active students between 17 and 21 years of age living in Lyon (France), Montreal (Quebec), and Salamanque and Madrid (Spain). The students completed questionnaires dealing with their contraceptive patterns, their perceptions of AIDS and their risky sexual behaviours (Levy et al.). Results showed that in France and Quebec, those who had their first intercourse before age 17 used oral contraceptives rather than condoms. Also, girls from Quebec had a higher level of risky sexual behaviours for AIDS than did girls from France, but the opposite was true for boys. Both girls and boys from Spain adopted safer sex behaviours at a higher rate than those in the other setting.

Uddin (1996) surveyed a random sample of 238 heterosexual undergraduate women enrolled in a California university in 1993. Her purpose was to determine levels

of perceived self-efficacy to engage in safer sexual behaviour. She predicted that perceived self-efficacy levels were related to stereotyped attitudes, assertiveness, communication, and safer sex and that these levels may play a role in decreasing women's risk of sexually contracting HIV infection. She hypothesized that participants with high levels of perceived self-efficacy would report significantly more sexually assertive responses than participants with low levels of perceived self-efficacy. This hypothesis was confirmed through data analysis (Uddin, 1993).

Limitations of this study included that the response rate (42%) may have affected the results, and that those women who were more comfortable practising safer sex may have been more comfortable completing the survey which may have biased the results. Finally, the results cannot be generalized extensively beyond the population chosen.

Wendt and Solomon (1990) investigated barriers to condom use among 198 female and 89 male heterosexual college students sampled conveniently from three undergraduate psychology classes at the University of Vermont during spring 1990. Participants were divided into three groups based on their reported condom use. These groups were consistent users, inconsistent users, and nonusers. Barriers to condom use which were assessed included 1) pleasure: concern that condoms interfered with the pleasure of sex; 2) intimacy: concern that condoms interfered with emotional intimacy; 3) partner's perception: concern about what a partner would think if you suggest using condoms; 4) friends' perceptions: concern about what friends would think if they knew you used condoms; 5) communication: concern about how to talk with your partner about

condom use; and 6) low perceived need: the belief that you have no need to use condoms. Factor analysis on male and female responses revealed similar barriers for each gender. However, the barriers explained more of the variance in condom use among women than men. Of the predictors assessed, the low perceived need barrier was the most powerful predictor of condom use for both men and women. Men and women who were nonusers of condoms, in a current monogamous relationship, and using oral contraceptives were more likely to report a low perceived need to use condoms (Wendt & Solomon, 1990).

A limitation of this study was that the variance accounted for in women was greater than in men which suggests that other factors may play a role in condom use for men. Also, the study did not assess high-risk sexual practices such as anal intercourse, and did not assess the STD history of sexual partners.

Caron et al.(1993) assessed predictors of condom-related behaviours among 330 first-year college students attending the University of Maine in 1993. They assessed frequency of condom use, reasons for using condoms, and attitudes toward condoms, sexuality, and the double standard through use of a simple random sample of 800 first-year students. It was found that 86.4% of the 330 respondents had engaged in sexual intercourse, and 34.2% of those subjects reported two or more new sexual partners since arriving at college. While 80.3% of those who had engaged in sexual intercourse since arriving at college reported using a condom, only 20.7% of students who had ever engaged in sexual intercourse reported always using a condom. When asked about specific condom-related behaviours with their most recent sexual partner, few

respondents provided a condom, suggested using a condom, or thought that their partner wanted to use a condom.

Attitudes toward the traditional double standard and condoms were found to be predictive of condom-related behaviours, however, these behaviours were different for men and women. Among women, those with less traditional attitudes toward the double standard were more likely to provide and suggest using condoms and more likely to think that their partner wanted to use a condom. Among men, attitudes toward the double standard were not found to be predictive of condom-related behaviours. However, those with more positive attitudes towards condoms were more likely to suggest, provide and use condoms (Caron et al., 1993). This study used a random sample mailout. However, the response rate (41%) may have affected the results. Also, only one university was sampled which limits the generalizability of the results.

There were several findings from the literature review with respect to safer sex behaviour. First was the low rate of consistent condom use among university students. Also, self-efficacy and the relationship with the sexual partner were shown to be factors in condom use. Level of knowledge about AIDS was not significantly associated with HIV-protective behaviours while low perceived need was the most powerful barrier to condom use.

3.5 Aims and Hypotheses of Study

As has been shown in the literature review, power balance in relationships, gender stereotypes about the roles of sexual partners, and issues of assertiveness and communication are intricately linked to safer sex behaviour by young people (Holland, Ramazanoglu, Scott, Sharpe, & Thomson, 1992). Also, the TSS is a major scripting theory linking all these variables. Thus, this study had several aims. They are as follows:

1. To describe sexual behaviour among a sample of university students.
2. To describe the frequency of communication and assertiveness behaviour, safer sex behaviour, traditional thought about the roles of men and women, behaviour related to power balance, and adherence to the Traditional Sexual Script (TSS) among a sample of university students.
3. To examine gender differences with respect to frequency of communication and assertiveness behaviour, safer sex behaviour, traditional thought about the roles of men and women, behaviour related to power balance, and adherence to the Traditional Sexual Script (TSS) among a sample of university students.
4. To explore the relationships between traditional thoughts about the roles of men and women, assertiveness and communication, power balance and safer sex behaviour.

The specific hypotheses for this research are as follows:

1. Respondents who hold more traditional thoughts about the roles of men and women are less likely to practice safer sex behaviour.

2. Respondents who are not assertive and do not communicate effectively about HIV/AIDS and sexuality are less likely to practice safer sex behaviour.

3. Respondents who are in a less balanced relationship with respect to power distribution are less likely to practice safer sex.

4. Methods

4.1 Participants

The population of the study consisted of male and female students over the age of nineteen, the legal age of consent for participation in surveys in Newfoundland and Labrador, who were attending Memorial University of Newfoundland. Sample size was determined following the guidelines of Norman and Streiner (1994) which suggests using ten subjects per study variable. This study contained eight variables which were (1) the roles of men and women (2) sexual assertiveness and communication as it relates to safer sex behaviours (3) sexual behaviour (4) safer sex behaviour (5) power balance (6) education (7) financial variables (8) age. This placed the sample size to be approximately eighty. Ninety questionnaires were collected, however, three had to be discarded due to respondents not being nineteen years of age or older. The final sample size was eighty-seven.

4.2 Procedure

Primary research was undertaken through the use of a self-completed questionnaire which was administered in the fall semester of 1997 to a sample of undergraduate students nineteen years of age or older who attended Memorial University of Newfoundland. The study design tested hypotheses utilizing convenience samples taken from both male and female students who were enrolled in a second level psychology course with two psychology prerequisites. This ensured that the majority of

students enrolled were over the age of nineteen. This course was not a required or 'core' course for the psychology degree program. Thus, students from a wide variety of academic backgrounds were available for the sample.

Permission to use class time to collect the data was obtained from the professor of the course. The professor was then given a letter to read aloud to the class informing them that a graduate student was coming in the next class to distribute questionnaires and collect data for the purposes of a Masters thesis. At this time, the topic of the research was given to the class. They were told that participation was voluntary and that they must be over the age of nineteen to participate. Upon arrival in the classroom setting, the researcher once again explained the rationale of the research and that participation was voluntary.

4.3 The Questionnaire

A sixty-nine item questionnaire was developed by the researcher for the purpose of this study. The questionnaire consisted of seven sections. These were: the roles of men and women, sexual behaviour, assertiveness and communication, safer sex behaviour, power balance, partner demographics, and personal demographics.

Questions pertaining to the roles of men and women, assertiveness and communication, and safer sex behaviour were adapted from research of a similar nature (Uddin, 1996). The questions about power balance in relationships were adapted from Diane Felmlee's research as well as from the Hispanic Condom Use Study (Marin

VanOss, Gomez & Tschann, 1991). Questions which pertained to the sex of respondents sexual partners and the type of sexual relationship that respondents were involved in were selected from the Sydney Men and Sexual Health Study (National Centre in HIV Social Research, Macquarie University, Australia, 1996). Other questions were devised by the researcher.

4.3.1 Likert Scales

Four sections in the questionnaire consisted of Likert-scaled items asking the respondents to indicate the frequency with which they believed the behaviour should occur or the frequency of which they engaged in the behaviour. The sections dealt with the roles of men and women, assertiveness and communication, safer sex, and power balance.

1) **Roles of Men and Women:** This section consisted of questions adapted from the work of Uddin. Uddin's questionnaire contained five sections. They are stereotyped attitudes, assertiveness, communication, safer sex behaviour, and perceived self-efficacy. Due to the nature and scope of the current research, five questions dealing with dating behaviours were chosen from the stereotyped attitudes section for inclusion in this section.

These questions were chosen as they were the most relevant to sex role stereotypes with respect to dating relationships and provided the best fit within the scope

and nature of the current research. These questions were adapted to reflect the behavioural approach of the research. Also, Uddin's work was with females only. Thus, the questions had to be adapted to refer to both male and female respondents.

This section was designed to measure the occurrence and depth of traditional thoughts about specific dating behaviours of men and women. The respondents were asked to indicate the extent of their agreement or disagreement with the statement by indicating how often the behaviour occurs. The five-point Likert scale had "always" corresponding with the number "1", "often" with "2", "sometimes" with "3" "almost never" with "4" and "never" with "5". The scores on the five questions were added to obtain a score for the roles of men and women. A low score would indicate that the respondent held more traditional thoughts about the roles of men and women.

2) **Assertiveness and Communication:** For this section pertaining to assertiveness and communication, six questions were chosen from Uddin's assertiveness section and two questions from her communication section. These two sections were combined into one because all of the questions chosen about assertiveness and communication were closely related to the issue of sexual negotiation between partners. Questions were adapted to reflect the behavioural nature of the research and for use with both male and female respondents.

The Likert scale for this section was the same as for the previous section with "always" being designated a value of "1" and "never" being designated as "5". The

scoring for one question was reversed to allow for consistency of the scoring method. The scores on the eight items were added to obtain an overall value for assertiveness and communication with a low score indicating that the respondent was more assertive and communicated better about sexual matters than a respondent with a higher score.

3) **Safer Sex Behaviour:** Five questions in this section of the questionnaire were adapted from Uddin's findings pertaining to safer sex behaviour. Questions were chosen that reflected the most frequently cited safer sex behaviours and the most common modes of transmission of HIV and adapted them to suit both the behavioural nature of the research and male and female respondents. Three questions were also chosen from Uddin's section on perceived self-efficacy. This was done because the questions were closely related to the issue of negotiation of safer sex behaviour between partners. These questions were adapted to reflect the behavioural nature of the research and for use with both male and female respondents.

The Likert scale for this section was the same as for the previous two sections with "always" being designated a value of "1" and "never" being designated as "5". The scores on the eight items were added to obtain an overall value for safer sex behaviour with a low score indicating that the respondent practised more safer sex behaviour than a respondent with a higher score.

4) **Power Balance:** The final section of the questionnaire which utilized a Likert scale was the section pertaining to power balance. The questions in this section were adapted from the work of Felmlee (1994) and from the Hispanic Condom Use Study (questionnaire for use with females) (Marin VanOss et al., 1991). The questions dealing with power, decision-making, emotional involvement and getting a "better deal" than your partner are directly from the work of Felmlee. These questions were included because the literature supports the integral linkage of these four issues to power balance in relationships. These questions were adapted slightly for ease of understanding and to account for either a present sexual partner or a past sexual partner if the respondent had no present sexual partner. The other seven questions were taken from the questionnaire for use with females from the Hispanic Condom Use Study. These questions surround the issues of power balance in relation to negotiating condom use between partners and, as such, were chosen for inclusion in this section.

The Likert scale for this section had "always" being designated as "1" and "never" being designated as "5". Only the questions from Felmlee were included in the correlational analysis. These questions were scored with the "sometimes" category given a value of 1, the "often" and "almost never" categories designated a value of 2, and the "always" and "never" categories given a value of 3. The other questions in this section were analyzed for frequencies only. This section was designed to indicate balance in the relationship.

4.3.1.1 Validity

The questionnaire was assessed for both face and content validity. Face validity was assessed by students in the Community Health program at Memorial University and professionals in non-health related fields. This was done through a pretest which occurred in the fall semester of 1997. Five students were asked to assess the questionnaire for face validity.

Content validity was assessed by five experts in the healthcare field (Aday, 1989). These included a physician who is a Director of Student Health, two academic physicians with advanced degrees in public health, a practising physician with an advanced degree in public health, and an academic psychologist with a doctorate degree and expertise in health psychology. In addition, the questionnaire was reviewed by the members of the Human Investigation Committee, which is composed of professionals from various disciplines. All of these individuals gave helpful suggestions as to the relevance of the questions and ease of understanding of the questionnaire. Revisions were completed as necessary.

4.3.1.2 Reliability

Reliability was assessed by using Cronbach's alpha (Mitchell & Jolley, 1999) as a measure of internal consistency. Also split-half reliability was used. Both of these measures were calculated using SPSS after data collection and data entry took place. The results of these measures will be discussed later in reference to the specific findings

generated by different sections of the questionnaire.

4.4 Ethical Considerations

Prior to data collection, this study was reviewed and approved by the Memorial University of Newfoundland Faculty of Medicine Human Investigation Committee (Appendix). Because of the sensitive nature of this study, several steps were undertaken to preserve the confidentiality and anonymity of both respondents and non-respondents. The questionnaires did not contain any personal identifiers. Thus, there is no manner in which the researcher could know who answered which questionnaire. The questionnaires were distributed with letters of consent informing the students that by completing the questionnaires, they had given their consent to be part of this study. They were also informed in this letter that they did not have to complete all questions contained in the questionnaire if they did not choose to do so.

Respondents were seated in individual desks which afforded them the opportunity to shield their responses from their peers around them. Envelopes were provided with the questionnaires so that respondents could place their answered questionnaires in the envelopes and seal them before returning them to the researcher. This lessened the chances of participants seeing each others' responses.

Questionnaires were distributed to all students present. However, they were advised that if they did not wish to participate, they should place the unanswered questionnaires in the envelopes provided, seal them and return them at the end of the data

collection period. This ensured that there was no embarrassment encountered by those who chose not to participate and the confidentiality of non-respondents was preserved. After data collection, the questionnaires were kept in a locked drawer in a locked office at Memorial University of Newfoundland. This further ensured the confidentiality of the participants.

4.5 Data Analysis

All questionnaires were coded and entered into SPSS version 7.5 for data analysis. Frequencies were calculated on the group as a whole a well as for males and females separately. Both parametric and non-parametric statistics were utilized in this study. Pearson's correlation was used as a measure to assess the relationships among variables as outlined in the hypotheses for this study. The chi-square test was used to determine differences in responses between males and females and the t-test was used to determine the differences in means between male and females. Multiple regression was used to predict the relationship between safer sex behaviour, power balance, assertiveness and communication, and the roles of men and women.

5. Results

In this section the results of this study will be presented by giving details of the characteristics of the sample and by providing an indepth analysis of the data collected. All frequencies will be presented based upon the responses from the total sample. Some frequencies will also be broken down based upon sex for comparison of male and female responses.

Several questions in the questionnaire had exclusion criteria. They were only to be completed by those respondents whose experience was in accord with the criteria. Where this occurs, frequencies will be presented based upon the subset only (n=number of respondents eligible for response). However, the number of eligible responses will be indicated so that the reader will be aware that the frequencies are based on only a subset of the sample.

5.1. Description of Respondents

5.1.1 Demographics of the Sample

The sample consisted of both male and female students nineteen years of age and older and enrolled in a second level psychology (non-core) course. Ninety people attended lectures on the day allotted for data collection. This was approximately half of those enrolled in the course. Ninety questionnaires were collected from the sample. Three questionnaires had to be discarded as it was found that the participants were under

nineteen years of age, the legal age of consent in Newfoundland and Labrador. Thus, the final sample size was 87.

The sample was composed of 19 males and 64 females while four respondents did not indicate to which sex they belonged. Thus, the sample was approximately 23% male and 77% female. Eighty-three respondents indicated their age with 34.9% being 19 years of age. Nineteen percent (19.3%) indicated they were twenty years old while twenty-one percent (20.5%) indicated that they were twenty-one years old. Thirteen percent (13.3%) indicated that they were twenty-two years of age while the rest of the respondents (12.0%) were between the ages of twenty-three and thirty-six years old.

Eighty-one respondents indicated their permanent residence, with 45.7% stating that their permanent residence was large urban (greater than or equal to 10, 000 people). Thirty-seven percent (37.0%) indicated small urban (between 2000 and 9999 people), while seventeen percent (17.3%) indicated rural (less than 2000 people).

Some questions pertaining to personal financial indicators of the individuals in the sample were also asked. Respondents were asked if they were working in addition to studying. A total of eighty-one people responded to this question with approximately thirty-six percent (35.8%), or 29/81, indicating that they were working, while sixty-four percent (64.2%), or 52/81, indicated that they were not working. Respondents who indicated that they were working as well as studying, (n= 29) were asked to indicate how many hours per week they spend working at their job. A majority of respondents indicated that they spend ten to fourteen hours per week working at their jobs.

Respondents were asked to indicate the particular year of study in which they were enrolled. A total of seventy-seven respondents answered this question with fifty-two percent (51.9%), or 40/77, saying that they were in their second year. Approximately twenty-nine percent (28.6%), or 22/77, said that they were in their third year while twenty percent (19.5%), or 15/77, said they were in fourth through seventh year.

Respondents were also asked to state their academic major. Seventy-seven respondents answered this question. As is shown in Table 1, most students indicated that they were either science (24.7%) or psychology (18.2%) majors. Another 49% were spread among seven other academic majors while 8% of respondents indicated that they were undecided.

Table 1: Academic Major

	N	Percent (%)
Science	19	24.7
Psychology	14	18.1
Arts	9	11.7
Business	9	11.7
Pre-professional Programs	7	9.1
Social Work	5	6.5
Education (including Physical Education)	3	3.9
General Studies	4	5.2
Nursing	1	1.3
Undecided	6	7.8
Total	77	100.0

5.1.2 Sexual Behaviour

A total of 89% of the respondents (n=73) answered yes to the question 'Have you ever had sexual intercourse?'. This was 100% of male respondents and 85.5% of female respondents. The seventy-three respondents who indicated that they had sexual intercourse were then probed further about other aspects of their sexual behaviour. They were asked to state the number of sexual partners they had over their lifetime. The results are displayed in Table 2. Thirty percent of the sample indicated that they had only one sexual partner over their lifetime. Female respondents had slightly more sexual partners over their lifetime than the male respondents. A total of 44.6% of males, or 8/18, had greater than two sexual partners over their lifetime whereas 49.0% of females, or 25/51, had greater than two sexual partners over their lifetime.

Table 2: Number of Sexual Partners over Lifetime.

# of Partners	Frequency	Percent (%)	Male Frequency	Male Percent (%)	Female Frequency	Female Percent (%)
1	21	30.4	7	38.9	14	27.5
2	15	21.7	3	16.7	12	23.5
3	8	11.6	1	5.6	7	13.7
4	6	8.7	1	5.6	5	9.8
5	4	5.8	2	11.1	2	3.9
6	7	10.1	1	5.6	6	11.8
7 or more	8	11.4	3	16.7	5	9.9
Total	69	100.0	18	100.0	51	100.0

Respondents were asked to indicate if their sexual partners had been men only, women only, or both men and women. No one indicated ever having had a same sex sexual partner. Only heterosexual relationships were indicated.

Respondents were also asked to categorize their sexual relationships at present. As

is shown in Table 3, the majority categorized their sexual relationship at present as being monogamous with one partner only. Percentage wise, almost twice as many female respondents (68% or 34/50) indicated this as male respondents (38.9% or 7/18).

The subjects were then asked to indicate if they had engaged in sexual intercourse in the past twelve months. Seventy-two persons responded to this question. There was little difference between males and females and 87.5% of the sample, or 63/72, indicated that they had engaged in sexual intercourse in the past twelve months.

Table 3: Sexual Relationship(s) at Present

	All	Percent %	Male	Male %	Female	Female %
None	19	27.5	8	44.4	10	20.0
Casual Sex Only	6	8.7	3	16.7	3	6.0
Monogamous relationship with one partner	41	59.4	7	38.9	34	68.0
Other Type of Relationship	3	4.3	0	0	3	6.0
Total	69	100.0	18	100.0	50	100.0

** One respondent did not specify sex

The respondents who indicated that they had engaged in sexual intercourse in the past twelve months were then asked to specify the number of sexual partners they had in

the past twelve months. This is displayed in Table 4. Almost 69% of respondents, or 42/61, said that they had only one partner in the last twelve months as over 70% of the males, or 10/14, and 67% of the females, 31/46, indicated this. Thirty-one percent (31.1%) of the female respondents, or 14/46, had two or more partners in the past twelve months as compared to 28.6%, or 4/14, of male respondents.

Table 4: Number of Sexual Partners in Past Twelve Months.

# of partners	Frequency	Percent (%)	Male Frequency	Male Percent (%)	Female Frequency	Female Percent (%)
1	42	68.9	10	71.4	31	67.4
2	11	18.0	2	14.3	9	19.6
3	5	8.2	2	14.3	3	6.5
4	2	3.3	0	0	2	4.3
5	1	1.6	0	0	1	2.2
Total	61	100.0	14	100.0	46	100.0

** One respondent did not specify sex

5.1.3 Roles of Men and Women

One of the objectives of this study was to investigate and describe traditional thoughts about the roles of men and women within the sample. Aspects explored in this section included:

- financial responsibility for a date
- sexual experience
- perception of how a lack of sex would affect males and females
- primary responsibility for protecting against pregnancy
- primary responsibility for protecting against sexually transmitted diseases

Because this section wasn't sensitive in nature and had no exclusion criteria (answering was not dependent upon sexual experience) this section appeared at the beginning of the questionnaire. This section contained five questions. Responses for all the sample as a whole (A), and for males (M) and females (F) separately will be presented (Table 5).

When attempting to interpret these data, however, one must bear in mind that there were only 19 male respondents. This leaves few responses in some categories. Also, some respondents answered the questions without indicating which sex they were. Thus, the combined number of responses for men and women may not add up to the number of group responses. These responses as well as missing responses will be indicated by using the letter "O" representing "other responses".

Table 5: Responses to Questions about the Roles of Men and Women by Percent

Roles of Men and Women	N	Always (%)	Often (%)	Some times (%)	Almost Never (%)	Never (%)	$\chi 2$	p
Men should take financial responsibility for a date	All (85) Males (19) Females (64) O (2)	1.2 5.2 0.0	4.7 5.3 4.7	64.7 84.2 60.9	11.8 0.0 14.1	17.6 5.3 20.3	9.215	.056
Men should have more sexual experience than women	All (84) Males (19) Females (63) O (2)	0.0 0.0 0.0	2.4 0.0 3.2	19.0 31.6 15.9	16.7 10.5 19.0	61.9 57.9 61.9	3.108	.375
A lack of sex takes a greater toll on men than women	All (84) Males (18) Females (63) O (3)	2.4 5.6 1.6	23.8 55.6 15.9	15.5 5.6 19.0	19.0 22.2 17.5	39.3 11.1 46.0	16.042	.003*
Women should bear the primary responsibility for protecting against pregnancy	All (85) Males (18) Females (64) O (3)	1.2 5.6 0.0	4.7 5.6 4.7	14.1 27.8 10.9	8.2 11.1 7.8	71.8 50.0 76.6	7.672	.104
Women should bear the primary responsibility for protecting against sexually transmitted diseases	All (86) Males (19) Females (64) O (3)	4.7 10.5 3.1	1.2 0.0 1.6	14.0 21.1 12.5	8.1 0.0 10.9	72.0 68.4 71.9	4.806	.308

Mean All	20.05	t	significance	Standard deviation All	3.69
Mean Male	17.79			Standard deviation Male	3.51
Mean Female	20.69	-3.211	.002*	Standard deviation Female	3.44
Cronbach's alpha	.61			Split-half reliability	.45

* significant at the $p < .05$ level

Noteworthy findings were responses to the questions pertaining to lack of sex, financial responsibility, and responsibility for protecting against pregnancy and STDs. In the response to 'A lack of sex takes a greater toll on men than women,' significantly more males than females agreed to the statement. The sex difference in the responses to the statement about men being financially responsible for a date approached significance. The female students were less likely to agree with this statement. There also appeared to be some sex difference, however it was not significant, in response to the statement pertaining to responsibility for pregnancy. The majority of females, 76.6%, said that women should 'never' bear the primary responsibility for protecting against pregnancy. The majority of males, 50.0%, also said this. However, only 10.9% of the females responded 'sometimes' while 27.8% of males chose 'sometimes' as their response.

The majority of both male and female respondents, 68.4% and 71.9% respectively, said that women should 'never' bear the primary responsibility for protecting against sexually transmitted diseases. However, 10.5% of the males responded 'always' to this statement while only 3.1% of female respondents chose 'always.' Furthermore, 21.1% of the males responded 'sometimes' and only 12.5% of the females chose 'sometimes' as their response.

Two measures of reliability were calculated separately to provide a degree of utility for the scale. These were Cronbach's alpha and the split-half reliability test. Cronbach's alpha was 0.61 and the split-half reliability was 0.45. This level of reliability suggested that the individual scale items could be summed in a correlation analysis to

provide a measure of 'perceived roles of males and females'. A high score on the correlation analysis would indicate a less traditional attitude. The overall mean scores indicated that females have a less traditional attitude than males to the roles of females. This difference in means was found to be significant at the $p<.05$ level.

5.1.4 Assertiveness and Communication

In this section, assertiveness and communication as they relate to safer sex behaviour were assessed. Aspects explored included:

- responsibility for supplying condoms
- suggesting using a condom
- initiating discussions about safer sex with a partner
- having sex just to please a partner
- discussing condom use with a partner before engaging in sex
- discussing sexual history honestly with a partner
- telling a partner when they are getting more physically intimate than they would like and
- refusing sexual activity with someone, even if they have had sex together before.

This section had the exclusion criterion of not having had sexual intercourse in the past twelve months. A time frame of twelve months was chosen to give respondents a context in which to respond to the statements and to help reduce any recall bias in the sample. The responses to the statements in this section are displayed in Table 6.

Table 6: Responses to Assertiveness and Communication Statements by Percent

Assertiveness and Communication	N	Always (%)	Often (%)	Some times (%)	Almost Never (%)	Never (%)	χ^2	p
I assume that I am responsible for supplying condoms if the need arises	All (60) Males (14) Females (45) Other (1)	35.0 64.3 26.7	5.0 0.0 6.7	41.7 28.6 44.4	6.7 7.1 6.7	11.7 0.0 15.6	8.252	.083
During sexual situations, I am the first to suggest using a condom	All (60) Males (14) Females (45) Other (1)	15.0 28.6 8.9	28.34 2.9 24.4	41.7 14.3 51.1	8.3 0.0 11.1	6.7 14.3 4.4	8.335	.080
I am the first to initiate discussions about safer sex with a partner	All (60) Males (14) Females (45) Other (1)	10.0 7.1 8.9	20.0 28.6 17.8	50.0 50.0 51.0	11.7 0.0 15.6	8.3 14.3 6.7	1.957	.744
I will have sex just to please a partner	All (61) Males (14) Females (46) Other (1)	3.3 14.3 0.0	3.3 7.1 2.2	29.5 21.4 32.6	26.2 28.6 26.1	37.7 28.6 39.1	8.165	.086
I discuss condom use with a partner several dates before engaging in sex	All (57) Males (14) Females (43) Other (0)	17.5 14.3 18.6	17.5 14.3 18.6	22.8 35.7 18.6	22.8 14.3 25.6	19.3 21.4 18.6	1.913	.752
I discuss my sexual history honestly with a partner	All (60) Males (14) Females (46) Other (0)	61.7 71.4 58.7	18.3 7.1 21.7	8.3 7.1 8.7	10.0 14.3 8.7	1.7 0.0 2.2	6.672	.154
I tell my partner when we are getting more physically intimate than I would like	All (59) Males (14) Females (45) Other (0)	55.9 35.7 62.2	11.9 0.0 15.6	22.0 28.6 20.0	5.1 21.4 0.0	5.1 14.3 2.2	22.808	.000*

I feel comfortable refusing sexual activity with someone, even if we've had sex together before	All (60) Males (14) Females (46) Other (0)	50.0 50.0 50.0	18.3 7.1 21.7	18.3 7.1 21.7	8.3 28.6 2.2	5.0 7.1 4.3	5.336	.255
Mean All Mean Male Mean Female Cronbach's alpha	20.25 20.79 20.30 .92	t .377	significance .708		Standard deviation All Standard deviation Male Standard deviation Female Split-half reliability			4.33 5.00 3.92 .50

*** significant at the p< .05 level**

All of the questions in this section produced noteworthy responses. With respect to group responses, 'I discuss condom use with a partner several dates before engaging in sex' is split almost evenly among the five response categories. There was a total of fifty-seven respondents to this question with almost eighteen percent (17.5%) of respondents choosing 'always' and the same percentage choosing 'often'. Almost twenty-three percent (22.8%) chose the responses 'sometimes' and the same percentage chose 'almost never' while nineteen percent (19.3%) of respondents chose 'never' as their response to this statement.

When asked to respond to the statement 'I discuss my sexual history honestly with a partner' the majority of respondents (61.7%) said that they 'always' honestly discuss their sexual history with a sexual partner. Only 1.7% of respondents said that they 'never' honestly discuss their sexual history with a sexual partner.

Participants were also asked to respond to the statement 'I feel comfortable refusing sex with someone even if we've had sex together before.' Fifty percent of the sixty respondents to this statement indicated that they 'always' feel comfortable refusing

sex with someone even if they have had sex together before. Approximately eighteen percent (18.3%) of respondents said 'often' and another eighteen percent (18.3%) chose 'sometimes' as their response. About eight percent (8.3%) said that they 'almost never' feel comfortable refusing sex with someone even if they had sex together before. Five percent said that they would 'never' feel comfortable refusing sex with someone even if they had engaged in sex together before.

When responses are broken down by sex several differences in the male and female response emerge. One of these is the response to 'I assume that I am responsible for supplying condoms if the need arises.' The majority of the males (64.3%) responded 'always' while a large portion of the females (44.4%) responded 'sometimes.' Also, the percentage of males that said that they 'never' assume that they are responsible for supplying condoms was zero. However, about fifteen percent (15.6%) of the females responded in this manner. With respect to group responses, thirty-five percent indicated that they 'always' assume that they are responsible for supplying condoms if the need arises. However, the largest portion of responses (41.7%) was in the 'sometimes' category.

Also noteworthy is the response to the statement 'During sexual situations, I am the first to suggest using a condom.' Here, the male response is clustered primarily around 'always' and 'often' with 28.6% and 42.9% respectively. On the other hand, the female response is centred primarily in the 'sometimes' category with 51.1% of the respondents choosing this option.

Also, respondents were asked to respond to the statement 'I will have sex just to please a partner.' More males than females indicated that they would 'always' have sex just to please a partner. The male response in the 'always' category is 14.3% while for the females it is zero. A large portion of females (39.1%) chose 'never' as their response to this statement.

Another issue in this section deals with the response to the statement 'I tell my partner when we are getting more physically intimate than I would like.' The female response is primarily in the categories 'always', 'often', and 'sometimes' with 62.2%, 15.6% and 20.0% respectively. A portion of males (35.7%) also chose 'always' as their response to this statement. However, twenty-eight percent (28.6%) of males indicated that they 'sometimes' tell their partner when they are getting more physically intimate than they like, while thirty-six percent (35.7%) of males said that they 'almost never' (21.4%) or 'never' (14.3%) tell their partner when they are getting more physically intimate than they like. This sex difference was statistically significant.

Cronbach's alpha and the split-half test were used as measures of reliability on the scale used to assess assertiveness and communication. The result of Cronbach's alpha was 0.92 and the split-half test was 0.50 indicating a cohesive scale. Low summed scores on this scale indicate a high level of assertiveness and communication. There was no sex difference in the overall scores.

5.1.5 Safer Sex Behaviour

This section also had the exclusion criterion of not having had sexual intercourse in the past twelve months. Participants were asked to indicate their response to various statements dealing with safer sex behaviour. They were asked to indicate if they 'always', 'often', 'sometimes', 'almost never', or 'never' engage in the safer sex behaviours described. The aspects of safer sex behaviour explored in this section were:

- questioning a partner about his/her sexual history
- delaying sex until knowing a partner well enough to practice safer sex
- limiting sexual activity to less risky practices
- using condoms during sexual activity
- carrying condoms on a date
- refusing to have intercourse if no condom was available, and
- insisting on condom use even if a sexual partner did not want to use one

The results of the statements in this section are detailed in Table 7.

Table 7: Responses to Statements about Safer Sex Behaviour by Percent

Safer Sex Behaviour	N	Always (%)	Often (%)	Some times (%)	Almost Never (%)	Never (%)	$\chi 2$	p
I question a partner about his/her sexual history	All (60) Males (14) Females (46) Other (0)	46.7 57.1 43.5	26.7 14.3 30.4	18.3 21.4 17.4	6.7 0.0 8.7	1.7 7.1 0.0	4.934	.294
I delay sex until I know a partner well enough to practice safer sex	All (58) Males (14) Females (44) Other (0)	48.3 42.9 50.0	25.9 21.4 27.3	19.0 21.4 18.2	5.2 7.1 4.5	1.7 7.1 0.0	6.572	.160
I limit my sexual activity to practices known to be less risky	All (59) Males (14) Females (45) Other (0)	33.9 35.7 33.3	28.8 35.7 26.7	28.8 21.4 31.1	6.8 0.0 8.9	1.7 7.1 0.0	4.477	.345
I use condoms during sexual activity	All (60) Males (14) Females (46) Other (0)	28.3 42.9 23.9	21.7 28.6 19.6	33.3 14.3 39.1	10.0 0.0 13.0	6.7 14.3 4.3	4.480	.345
I carry condoms with me on a date	All (58) Males (14) Females (44) Other (0)	13.8 42.9 4.5	5.2 7.1 4.5	24.1 14.3 27.3	15.5 7.1 18.2	41.1 28.6 45.5	13.976	.007*
I would refuse to have intercourse with a partner if no condom was available	All (58) Males (14) Females (44) Other (0)	36.2 35.7 36.4	20.7 21.4 20.5	31.0 28.6 31.8	10.3 14.3 9.1	1.7 0.0 2.3	2.848	.584
I would insist on using a condom even if my partner did not want to use one	All (58) Males (14) Females (44) Other (0)	44.8 35.7 47.7	20.7 35.7 15.9	22.4 14.3 25.0	10.3 7.1 11.4	1.7 7.1 0.0	7.065	.132

Mean All	15.88	t	significance	Standard deviation All	5.22
Mean Male	16.07	.153	.879	Standard deviation Male	6.75
Mean Female	15.83			Standard deviation Female	4.75
Cronbach's alpha	.95			Split-half reliability	.85

*** significant at the p< .05 level**

With respect to group responses, a total of sixty people responded to the statement 'I question a partner about his/her sexual history.' Of those who responded, almost forty-seven percent (46.7%) said that they 'always' question a partner about his/her sexual history. Another 26.7% responded 'often' while 18.3% responded 'sometimes.'

Almost thirty-four percent (33.9%) of respondents indicated that they 'always' limit sexual activity to practices known to be less risky. While about fifty-eight percent (57.6%) said that they 'often' (28.8%) or 'sometimes' (28.8%) limit their sexual activity to practices known to be less risky. However, 8.5% of respondents said that they 'almost never' (6.8%) or 'never' (1.7%) limit their sexual activity to practices known to be less risky.

Respondents were also asked to indicate their response to the statement 'I would refuse to have intercourse with a partner if no condom was available.' A total of fifty-eight persons responded to this statement with a substantial portion (36.2%) indicating that they would 'always' refuse to have intercourse with a partner if no condom was available. Fifty-two percent (51.7%) of respondents indicated that they would 'sometimes' (31.0%) or 'often' (20.7%) refuse intercourse with a partner if no condom was available. However, about twelve percent of respondents said that they would 'almost

never' (10.3%) or 'never' (1.7%) refuse to have intercourse with a partner if no condom was available.

Almost forty-five percent (44.8%) of respondents indicated that they would 'always' insist on a condom even if their partner did not want to use one. Close to twenty-one percent (20.7%) of respondents said that they would 'often' insist on a condom if their partner did not want to use one. However, again 12% said that they would 'almost never' or 'never' insist on a condom if their partner did not want to use one.

Participants were asked to respond to the statement 'I carry condoms with me on a date.' Fourteen males and forty-four females responded to this statement. A large portion (42.9%) of the male respondents indicated that they 'always' carry condoms with them on a date. Only four and a half percent of the females responded that they 'always' carry condoms with them on a date. Most of the female respondents (45.5%) indicated that they 'never' carry condoms with them on a date. Almost twenty-nine percent (28.6%) of the male respondents also indicated that they 'never' carry condoms with them on a date. Overall, the major portion of the group (41.1%) also said that they 'never' carry condoms with them on a date. The sex difference in response to this statement was found to be significant at the $p < .05$ level.

With respect to using condoms during sexual activity a total of forty-six females and fourteen males responded. Again, a major portion of the males (42.9%) indicated that they 'always' use condoms during sexual activity. A lesser percentage (23.9%) of females indicated that they 'always' use condoms during sexual activity. The largest portion of

females (39.1%) chose 'sometimes' as their response to this statement. Overall as a group, only about twenty-eight percent (28.3%) indicated that they 'always' use condoms during sexual activity. The largest portion of the group (33.3%) indicated that they 'sometimes' use condoms during sexual activity.

Cronbach's alpha and split-half test were used as reliability measures. The result for Cronbach's alpha was 0.95 and for the split-half test was 0.85. Lower summed scores indicated a higher level of safer sex behaviour. There was little sex difference in the overall safer sex behaviour scores.

Respondents were then asked to complete three other questions. The first of these was 'Have you ever experienced difficulty in negotiating safer sex (using condoms) with a sexual partner?' A total of fifty-seven persons responded to this question (forty-six females and eleven males). Over eighty percent (81.7%) of respondents indicated that they had not experienced any difficulty in negotiating safer sex with a partner while eighteen percent (18.3%) of respondents, 21.4% of males and 17.4% of females, indicated that they had experienced difficulty with negotiating safer sex with a partner.

Those respondents who indicated that they had experienced difficulty negotiating safer sex with a partner were then asked to describe what the difficulty was and how they resolved it. A total of eight persons responded. Because of the small number of responses to this question, a quantitative analysis will not be given. A complete listing of responses to this question can be found in Appendix B. Some responses to this question include the three males who answered that they were the partner that did not want to use

condoms. For example:

- "Didn't want to use condom. I prefer the pill as a safer sex precaution." Male, age 21.
- "The condoms are too uncomfortable and I didn't want to use it. But I tried for a while, then I quit." Male, age 22.

Five females indicated that their partner was the one that didn't want to use condoms. For example:

- "When I was a teenager, my partners did not want to use a condom; it took away from the moment. Didn't know if it would work anyway. They said it took away from sexual feeling. Sometimes I took chances anyway." Female, age 36.
- "Problem: he wouldn't use condoms. It was never really resolved. I couldn't make him see my point and he'd just get mad and complain." Female, age 19.

Respondents were then asked to detail their approach to negotiating safer sex with a sexual partner. Forty-six respondents answered this question. Complete responses to this question can be found in Appendix B. Some typical responses include the following:

- "Either a condom is used or there will be no sex." Female, age 21.
- "Decision was agreed upon by me and my partner from the beginning. It was a priority for both of us." Female, age 19.
- "Unless I know the person very well, I will not engage in sex without negotiating." Male, age 22.

- "My main approach, as well as his, is to practice every caution to discourage the chance of possible pregnancy." Female, age 19.
- "I ask if they have a condom. If they don't, in most cases, I have refused to have sex. However, there have been times when I have had sex without using a condom."

  Female, age 21.

Respondents usually wrote more than one statement or expressed more than one theme in response to this question. Responses were broken down into themes and the results are displayed in Table 8. The most common strategy was outright refusal to have sexual intercourse without condoms. Some comments were:

- "No glove, no love." Female, age 22.
- "Condoms." Male, age 21.
- "Let them know I will not have sex unless they use a condom." Female, age 19.
- "Talking openly and choosing the safest practice with regard to sex and safe sex." Male, age 21.

Table 8: Approach to Negotiating Safer Sex

	Frequency	Percent (%)
Refuse to have sex without a condom	18	25.0
Discussion of safer sex and the risks	10	13.9
Both partners responsible for protection	8	11.1
Choose partners who agree with safer sex	6	8.3
Ask partner if they have a condom	5	6.9
Using a condom with a partner you do not know well (ie. new partner)	3	4.2
Using condoms	3	4.2
Partner was tested	2	2.8
Other	17	23.6
Total Responses	72	100.0

As can be seen in Table 8, a substantial portion (25.0%) of the fifteen respondents approach negotiating safer sex by refusing to have sex without a condom. Almost fourteen percent (13.9%) indicated that they discuss with a partner about safer sex and the risks while eleven percent (11.1%) indicated that both partners are responsible for protection.

5.1.6 Power Balance

The statements in this section explored various aspects of power balance in relationships. For this reason, the exclusion criterion of not having had a steady sexual partner in the past twelve months was chosen. Steady sexual partner was defined for the sample as being 'a person one has sex with in an ongoing relationship and may include a spouse.' This was done to ensure clarity of response by the sample.

The aspects explored included:

- having more power than a partner
- making more of the decisions about joint activities than a partner
- getting a 'better deal' in a relationship than a partner
- feeling comfortable asking a steady partner to use condoms
- being more emotionally involved in the relationship than a partner
- whether partner would become angry if asked to use condoms
- whether partner would refuse sex if asked to use a condom
- whether partner would become violent if asked to use a condom

- whether it would bother respondent to have partner become angry
- whether it would bother respondent to have partner refuse sex, and
- whether it would bother respondent to have partner become violent.

The responses to these statement are displayed in Table 9.

Table 9: Responses to Statements about Power Balance by Percent

Power Balance	N	Always (%)	Often (%)	Some times (%)	Almost Never (%)	Never (%)	$\chi 2$	p
In my relationship I have/had more power than my partner	All (53) Male (13) Female (40) Other (0)	7.5 7.7 7.5	0.0 0.0 0.0	56.6 61.5 55.0	20.8 23.1 20.0	15.1 7.7 17.5	.019	.891
In my relationship I make/made more of the decisions about what we do together than my partner	All (53) Male (13) Female (40) Other (0)	5.7 7.7 5.0	18.9 23.1 17.5	47.2 46.2 47.5	18.9 23.1 17.5	9.4 0.0 12.5	1.192	.275
I am/was more emotionally involved in the relationship than my partner	All (51) Male (12) Female (39) Other (0)	2.0 0.0 2.6	0.0 0.0 0.0	47.1 66.9 41.0	21.6 25.0 20.5	29.4 8.3 35.9	3.709	.054
I get/got a "better deal" in this relationship than my partner	All (52) Male (12) Female (40) Other (0)	1.9 8.3 0.0	7.7 8.3 7.5	21.2 33.3 17.5	25.0 25.0 25.0	44.2 25.0 50.0	.313	.576
I wouldn't feel comfortable asking a steady partner to use a condom ·	All (52) Male (13) Female (39) Other (0)	7.7 7.7 7.7	5.8 7.7 5.1	5.8 0.0 7.7	13.5 30.8 7.7	67.3 53.8 71.8	.955	.328

If I asked my partner to use condoms, he/she would be angry ·	All (53) Male (13) Female (40) Other (0)	1.9 0.0 2.5	1.9 0.0 2.5	5.7 7.7 5.0	3.8 0.0 5.0	86.8 92.3 85.0	.931	.335
If I asked my partner to use condoms, he/she would refuse to have sex ·	All (52) Male (13) Female (39) Other (0)	0.0 0.0 0.0	1.9 7.7 0.0	3.8 0.0 5.1	7.7 0.0 10.3	86.5 92.3 84.6	.306	.580
If I asked my partner to use condoms, he/she would become violent ·	All (52) Male (13) Female (39) Other (0)	0.0 0.0 0.0	0.0 0.0 0.0	0.0 0.0 0.0	3.8 0.0 5.1	96.2 100 94.9	.117	.732
It would bother me to have a steady partner become angry ·	All (53) Male (13) Female (40) Other (0)	37.7 23.1 42.5	28.3 38.5 25.0	18.9 23.1 17.5	7.5 7.7 7.5	7.5 7.7 7.5	.381	.537
It would bother me to have a steady partner refuse to have sex with me ·	All (53) Male (13) Female (40) Other (0)	18.9 15.4 20.0	17.0 23.1 15.0	39.6 38.5 40.0	11.3 15.4 10.0	13.2 7.7 15.0	.027	.869
It would bother me to have a steady partner become violent ·	All (53) Male (13) Female (40) Other (0)	83.0 61.5 90.0	9.4 15.4 7.5	1.9 7.7 0.0	0.0 0.0 0.0	5.7 15.4 2.5	.298	.585
Mean All Mean Male Mean Female Cronbach's alpha	7.32 6.42 7.59 .97	t -1.517	significance .135		Standard deviation All Standard deviation Male Standard deviation Female Split-half reliability			2.38 2.57 2.28 .88

· excluded from calculation of mean, standard deviation, correlations and regression

Noteworthy aspects of this section include the responses to the statements 'If I asked my partner to use condoms, he/she would be angry', 'If I asked my partner to use condoms, he/she would refuse to have sex', and 'If I asked my partner to use condoms, he/she would become violent.' The vast majority of respondents replied 'never' to these

statements. The percentage of respondents choosing 'never' was 86.8%, 86.5%, and 96.2% respectively. A high percentage (83.0%) also said that it would 'always' bother them to have a partner become violent. Also noteworthy here is the 17.0% that would not 'always' be bothered by a violent partner.

For the most part, the male and female response to the statements in this section showed few differences. However, some statements showed some difference between male and female response. The first was 'I get/got a better deal in this relationship than my partner.' Over eight percent (8.3%) of males said 'always' while no females said this. Exactly fifty percent of female respondents indicated that they 'never' get/got a better deal in their relationship than their partner while twenty-five percent of the males indicated this. The second statement was 'I am/was more emotionally involved in the relationship than my partner'. Sixty-seven percent (66.9%)of males said 'sometimes' while forty-one percent of the females indicated this. While the responses to this statement were not found to be significant, they approached significance at the $p < .05$ level.

To test the reliability of the power balance scale, both Cronbach's alpha and the split-half test were used. The result of Cronbach's alpha was 0.97 and for the split-half test was 0.88. This indicated that the results could be summed with low scores indicating more balance in relationships. The females had a higher overall mean score suggesting that they were more likely to have a high level of power imbalance in their relationships although this difference was not statistically significant.

5.1.7 Partner Demographics

After the section about power balance in relationships, respondents were asked to answer some demographic questions about their steady sexual partner. The first of these was partner's age. As can be seen in Table 10, the total number of respondents was 50. Twenty-four percent of respondents said that their partner was 20 years old and most respondents (68.0%) indicated that their partner was between 20 and 24 years old.

Table 10: Age of Steady Sexual Partner

Age in years	Frequency	Percentage
17	1	2.0
18	5	10.0
19	4	8.0
20	12	24.0
21	9	18.0
22	3	6.0
23	6	12.0
24	4	8.0
25 or older	6	12.0
Total	50	100.0

With respect to male and female differences, the results indicated that in general, males have younger steady sexual partners while females have older steady sexual partners. Forty-two percent (42.2%) of females indicated that they were nineteen years of age while sixty-nine percent (68.5%) of females said that their partner was between 20

and 24 years of age. Only sixteen percent (15.8%) of females indicated that their partners were the same age or younger. Forty-three percent (42.6%) of males indicated that they were twenty-one or twenty-two years of age while seventy-five percent of males said that their partner was twenty years old or younger.

Respondents were also asked if their partner was currently attending or had attended a post-secondary institution. Fifty-one respondents answered this question with almost seventy-five percent (74.5%) of them saying that their partner was currently attending or had attended a post secondary institution. Ninety-two percent (91.7%) of the males and almost seventy percent (69.2%) of the females indicated that their partner was currently attending or had attended a post secondary institution. The majority of respondents (54.9%) indicated that their partner had some post-secondary education while almost twenty-four percent (23.5%) of respondents indicated that their partner had completed post-secondary education.

The next demographic aspect assessed was partner's employment. Out of fifty-one respondents, almost sixty-one percent (60.8%) said that their partner was employed. As can be seen in Table 11, the largest occupational category is sales/clerical with 39.3% of respondents choosing this category for their partner's occupation.

Table 11: Occupational Category of Partner

Occupational Categories	Frequency	Percentage
Professional	1	3.6
Business	1	3.6
Sales/Clerical	11	39.3
Skilled	5	17.9
Unskilled	10	35.7
Total	28	100.0

5.2 Relationships between Variables

Correlational analysis was undertaken by adding the scores on the statements from each section and correlating the total scores from each section against each other section as outlined in the hypotheses. Pearson's correlation (Norman & Streiner, 1994) was calculated for the group as a whole and for both male and female respondents separately. For calculations of power balance correlations, the responses to several questions were not included because of suspected socially desirable bias. These questions and their responses can be seen in Table 9.

Table 12: Correlations Between Variables for Females.

	Roles of Men and Women	Communication and assertiveness	Safer sex behaviour	Power balance
Roles of Men and Women	1.000			
Communication and assertiveness	-.063	1.000		
Safer sex behaviour	-.340*	.606**	1.000	
Power balance	.367*	-.131	-.166	1.000

*Correlation is significant at the p<0.05 level (2-tailed)
** Correlation is significant at the p< 0.01 level (2-tailed)

Table 13: Correlations Between Variables for Males.

	Roles of Men and Women	Communication and assertiveness	Safer sex behaviour	Power balance
Roles of Men and Women	1.000			
Communication and assertiveness	-.263	1.000		
Safer sex behaviour	-.476	.876**	1.000	
Power balance	.097	-.351	-.502	1.000

** Correlation is significant at the p< 0.01 level (2-tailed)

Table 14: Correlations Between Variables for All the Sample.

Pearson Correlation	Roles of Men and Women	Communication and assertiveness	Safer sex behaviour	Power balance
Roles of Men and Women	1.000			
Communication and assertiveness	-.056	1.000		
Safer sex behaviour	-.364**	.698**	1.000	
Power balance	.337*	-.191	-.168	1.000

* Correlation is significant at the p< 0.05 level (2-tailed)
** Correlation is significant at the p< 0.01 level (2-tailed)

5.2.1 Relationship between Roles of Men and Women and Safer Sex Behaviour

For the group as a whole, there was a significant correlation between the roles of men and women and safer sex behaviour at the $p < .01$ level, two-tailed. Pearson's correlation was calculated as -.364 between the roles of men and women and safer sex behaviour. Respondents who were more traditional in thought about the roles of men and women were less likely to practice safer sex behaviour.

With respect to male and female respondents separately, there was a significant linear relationship found between the roles of men and women and safer sex behaviour for females but not for males. Pearson's correlation was calculated as -.340 at the $p < .05$ level, two-tailed between the roles of men and women and safer sex behaviour for females. Females who were more traditional in thought about the roles of men and women were less likely to practice safer sex behaviour. Males who were more traditional in thought about the roles of men and women were neither more nor less likely to practice safer sex behaviour.

5.2.2 Relationship between Assertiveness and Communication and Safer Sex Behaviour

For the group as a whole, there was a significant correlation between assertiveness and communication and safer sex behaviour at the $p < .01$ level, two-tailed. Pearson's correlation was calculated as .698 between assertiveness and communication and safer sex behaviour. Respondents who were more assertive and communicated well about

sexual matters were more likely to practice safer sex behaviour. This was also the case when males and females were analysed separately.

The male respondents showed a significant correlation at the $p < .01$ level, two-tailed. Pearson's correlation was calculated to be .876 between assertiveness and communication and safer sex behaviour. Male respondents who were more assertive and communicated well about sexual matters were more likely to practice safer sex behaviour. With respect to female respondents there was also a significant relationship of .606 found at the $p < .01$ level, two-tailed between assertiveness and communication and safer sex behaviour. Female respondents who were more assertive and communicated well about sexual matters were more likely to practice safer sex behaviour.

5.2.3 Relationship between Safer Sex Behaviour and Power Balance

For the group as a whole, there was no significant correlation found between power balance and safer sex behaviour. Respondents who are in relationships that are balanced in terms of power are not more or less likely to practice safer sex. This was the same when males and females were analysed separately also.

5.2.4 Relationship between Roles of Men and Women and Power Balance

A significant linear relationship was found for the group as a whole between the variables of power balance and the roles of men and women at the $p < .05$ level, two-tailed. Pearson's correlation was calculated as .337 between the roles of men and women

and power balance. Respondents who hold more traditional thoughts about the roles of men and women are in relationships that are more balanced with respect to power. This correlation was also found for the females separately. Pearson's correlation was calculated as .367 between the roles of men and women and power balance. Female respondents who hold more traditional thoughts about the roles of men and women are in relationships that are more balanced with respect to power.

5.2.5 Prediction of Safer Sex Behaviour

A multiple regression analysis was conducted to examine the relationship between safer sex behaviour, the roles of men and women, assertiveness and communication, and power balance and sex considered simultaneously. For calculations of power balance in the regression, the responses to several questions were not included because of their socially desirable responses. These questions and their responses can be seen in Table 9. Safer sex behaviour was chosen as the dependent variable with the other variables chosen as being independent. The hypotheses for this test is as follows:

Ho: There is no linear relationship between the variables. (We cannot use the values of the independent variables to predict the value of safer sex behaviour.)

Ha: There is a linear relationship between the variables. (We can use the values of the independent variables to predict the value of safer sex behaviour.)

Ho should be rejected if $F \geq 2.58$, $\alpha = 0.05$. The value of F calculated as part of the analysis of variance with 3 and 48 degrees of freedom was 16.606. Thus, we reject the null hypothesis and conclude that there is a linear relationship between safer sex behaviour and the roles of men and women, assertiveness and communication, power balance and sex.

Table 15: Regression Analysis

Model	B	Std. Error	Beta	t	Significance (p)
Constant	7.406	4.515		1.640	.108
Assertiveness and Communication	.780	.126	.637	6.191	.000*
Power Balance	-9.885E-02	.166	-.071	-.594	.555
Roles of Men and women	-.295	.182	-.193	-1.626	.111

Dependent variable: Safer Sex Behaviour

*** Variable is significant at the $p<0.05$ level**

The regression model summary indicated that 50.9% of the observed variability in safer sex behaviour can be explained using the roles of men and women, assertiveness and communication, power balance and sex as variables. It also indicated that assertiveness and communication is the only significant variable with a calculated significance of .000.

6. Discussion

In this section the discussion of the research findings will be presented. Reference will be made to other studies addressing similar variables. Studies used for comparison include, but are not limited to, the Canada Youth & AIDS Study (King et al., 1988), Uddin (1993),and Felmlee (1994).

6.1 Response Rate and Bias

The overall response rate for this study was 99%. Out of ninety-one persons attending class on the day of data collection, ninety chose to participate. Three questionnaires had to be discarded due to the fact that these participants were not nineteen years of age or older, the legal age of consent in Newfoundland and Labrador. They were deemed ineligible to participate. Thus, the sample size was 87. Total enrollment in the class was 160 students. This consisted of 122 females and 38 males.

The fact that many students enrolled in the class didn't attend class that day and subsequently, did not participate in the data collection period may have been because the students had been told beforehand the nature of the research and when it would take place. Sex is a private activity and people sometimes feel embarrassed or threatened when asked to reveal sexual encounters (Catania, McDermott & Pollack, 1986; Herold & Way, 1988; Catania, Gibson, Chitwood & Coates, 1990). Because of the advanced notification to the class about the data collection, one could expect to obtain some bias in the survey

as anyone uncomfortable with sexual matters may have chosen not to attend the class at the time noted for data collection.

This participation bias may have affected the results of this survey as nonresponders have been found to have less sexual experience than responders, and thus, may be more sexually inhibited than responders (Catania et al., 1986; Catania, Gibson, Chitwood & Coates, 1990). This may have led to an underrepresentation of sexually inhibited respondents in the sample and an inaccurate report of the assertiveness and communication skills related to sexual matters in university students.

Also, some students may have felt threatened by a survey that would cause them to focus on their safer sex behaviour. Some students who perform high-risk sexual activities may not have wanted to acknowledge their risk for HIV infection and may have avoided participation in the study (Catania, Gibson, Chitwood & Coates, 1990). This would have lead to an underrepresentation of high-risk sexual behaviours among the sample.

6.2 Demographics

6.2.1 Personal

The sample was composed of 64 females and 19 males. The ratio of female students to male students enrolled in the class was 3:1. Thus, my sample was representative of the class as a whole as the ratio of female to male respondents was also approximately 3:1. In view of the small number of males in the sample, care should be

taken in the interpretation of the male responses.

6.2.2 Partner

Respondents were also asked to answer some questions pertaining to their steady sexual partner. These questions were asked to identify a source of unequal distribution of power between partners in the relationship.

The first of these variables was age. An age difference of several years has been shown to cause the power in a relationship to shift to the older partner (Felmlee, 1994). Age is a personal resource that is associated empirically with social power (Felmlee). This is also stated by a participant in the 'Listen to What America's Kids are Saying' study. She says 'the young girls are intimidated by older guys. They will do anything to satisfy them (Collins, 1997)."

As indicated in the results section of this report, the male participants in the study had younger steady sexual partners while the female participants indicated that they had older steady sexual partners. The largest group of females (42%) indicated that they were nineteen years of age while only five percent indicated that their partner was also nineteen years of age. The largest group of males was aged twenty-one or twenty-two with 26% of the response each, while 42% indicated that their partners were 20 years of age. As this age difference was only one or two years not several, age was not seen as a potential source of power imbalance among the sample.

Respondents were also asked questions about their sexual partners. One of these

was partner's highest educational level. In this study, about fifty-five percent of the sample indicated that their partner had some post-secondary education while about twenty-four percent indicated that their partner had completed post-secondary education. This is almost eighty percent of the sample indicating that their partner's had at least some post-secondary education. Educational level may be a source of power imbalance between partners (Mackie, 1991). However, in this study it was not possible to assess this due to the lack of cases with educational difference between partners.

Another demographic variable was income. This may be a source of power imbalance among partners in a relationship. This is derived from resource theory which maintains that a person's power is a function of the number of resources he or she possesses (Blood & Wolfe, 1960; Felmlee, 1994). Money is a resource and when one partner earns more than the other, the balance of power may shift in the direction of the partner who earns more money.

To assess this variable the participants were asked if their partner was employed. A high percentage of both male and female partners were employed in the lower wage areas of sales/clerical and unskilled employment which indicated that income may not have been a relevant source of power imbalance for this sample. However, this is not unexpected as the majority of the sample had partners within one or two years of their own age. Thus, they would not be expected to have acquired an income differential large enough to cause a power imbalance in their relationships.

In summary, the sample was asked to respond to questions about demographic

variables to assess potential areas of power imbalance in their relationships. Age, education and income were not considered to be contributing factors to power balance among the sample.

6.3. Sexual Behaviour

6.3.1 Sexual Demographics

Eighty-nine percent of the sample indicated that they had participated in sexual intercourse. This accounted for one hundred percent of the males and about eighty-five percent of the females. This is higher than that reported by the Canada Youth & AIDS Study (King et al., 1988). In that study first year university students were sampled with seventy-seven percent of males and seventy-three percent of females reported having had sexual intercourse. Dekin (1996) conducted a study of 265 college students, predominantly freshman and sophomore, and found that eighty percent had participated in sexual intercourse.

There may be several explanations for this higher percentage. One is that some students who have not had sexual intercourse stayed away from the data collection period feeling that it was pointless for them to complete a study about HIV risk. However, it has also been noted by the Canada Youth and AIDS Study - Newfoundland Report (King et al., 1988) that youth in Newfoundland are more sexually active than youth in the rest of Canada. In Newfoundland, the percentage of grade eleven youth who had engaged in sexual intercourse was 56% as compared to 47% for the rest of Canada.

The results from this university sample were also approximately ten percent higher than that indicated for university students in the rest of Canada. According to the Canada Youth & AIDS Survey (King et al., 1988), youth in Newfoundland start having sex earlier than their Canadian counterparts. Thus, it can be expected that the results of this would be shown in the results of a university sample.

Approximately thirty percent of the respondents indicated that they had only one partner over their lifetime. This accounted for 38.9% of males and 27.5% of females. Female respondents had slightly more sexual partners over their lifetimes than did the male respondents. One explanation for this is that females generally initiate sex at an earlier age than males. Depending on the age at which this question is asked, females may have more partners simply because they have been sexually active longer (Donovan, 1998). Otis, Levy, Samson, Pilote and Fugere (1997), also found this in their stratified cluster sampling of 2828 students who attended CEGEP in Quebec. They found that females began having sexual intercourse at an earlier age than males and had a higher number of sexual partners. The finding of females having more sexual partners than males is in direct contrast to the Traditional Sexual Script (TSS) theory mentioned previously. Using that theory as a framework, female respondents, operating under the scripts of sexual gatekeeper and the diminishment of status due to sexual experience, should have indicated fewer sexual partners than the males. These results indicate that these aspects of the TSS were not relevant among this sample of second-year university students.

In a study conducted in the U.S. among 1200 college students, Hawkins et al. (1995) asked about the number of sexual partners in the past five years. They found that 22.6% of the sample had only one partner in the past five years. Also 46.3% said 2-4 sexual partners, 22.9% said 5-10 sexual partners, and 8.3% said 11 or more sexual partners. There were no differences found between males and females in the number of sexual partners in the past five years. Converting the categories in this study to match those proposed by Hawkins et al.(1995) reveals that 30.4% of this sample said that they had only one partner, 42% had 2-4 partners, 21.6% had 5-10 partners, and 5.7% had 11 or more sexual partners. Although Hawkins et al. did find an increased number of students with a greater number of sexual partners, their results do approximate the results of this study, and give further evidence that certain aspects of the TSS are not relevant to all university students.

Respondents were asked to indicate if their sexual partners had been men only, women only, or both men and women. No one indicated ever having had a same sex sexual partner. The Canada Youth & AIDS Study (King et al., 1988) reported that in a study of 386 university students, ninety-five percent reported being heterosexual, one percent homosexual, and four percent bisexual. About 2% reported homosexual activity.

Attitudes toward homosexuality may have influenced the results of this study. The Canada Youth & AIDS Study - Newfoundland Report (King et al., 1988) found a higher percentage of Newfoundland youth agreeing that homosexuality is wrong than the Canadian average. Forty-four percent of grade eleven students in Newfoundland felt that

homosexuality is wrong as compared to 38% of Canadian youth. Prevailing negative attitudes towards homosexuality may have influenced those engaging in homosexual behaviour either to not attend the data collection period or to answer the question in a socially desirable manner. This result may also have been influenced by students' fear of someone else, such as classmates and/or the researcher, discovering their homosexual behaviour (Catania, Gibson, Chitwood & Coates, 1990).

6.3.2 Relationship Status

The majority of the subjects (59.4%) categorized their sexual relationships at present as being monogamous. This accounted for sixty-eight percent of the females and almost thirty-nine percent (38.9%) of males. For the females, this is consistent with Dekin's study (1996) where almost sixty-five percent (64.5%) of females said that they were currently in a monogamous relationship. However, over fifty percent (51.4%) of the males in her study also indicated that they were in a monogamous relationship. Respondents in this survey were asked to identify how many sexual partners they had. A timeframe of the past twelve months was given to respondents for ease of recall. About sixty-nine percent of the sample indicated that they had only one sexual partner in the above mentioned timeframe. This indicated that the sample showed some commitment to monogamy. This is in keeping with a review of Canadian research on the social and behavioural correlates of sexually-transmitted diseases which identified a pattern of sexual relationships as one of serial monogamy, particularly among young women which

typically results in a population modal number of one partner in any one year period (Maticka-Tyndale, 1997).

Almost seventeen percent (16.7%) of the males in this survey indicated that they had casual sex only, while six percent of the females said that they had casual sex only. The TSS explains these results by stating that dating and gender role scripts dictate that women's worth is enhanced by being in a romantic relationship.

Holland et al. (1992) found results of pressure to define a relationship as steady among seventy-five young women aged 16-21 years in the U.K in the WRAP study. They state "Many of the women we spoke to experienced social pressure to define their relationships as steady. The term casual has negative connotations so that very few described themselves as having such relations." (p. 277). This may have played a role in the results of this study where a much higher percentage of females than males reported their relationship to be monogamous.

The stability of the relationship influences a person's risk for contracting HIV. The Canada Youth and AIDS survey (King et al., 1988) states:

> The stability of sexual relationships in which young people are involved determines indirectly their chances of contracting AIDS and other STDs. Those in long-term, serious relationships are generally more concerned about each other and better able to talk about birth control and about strategies to prevent AIDS and other STDs. Short-term casual encounters ('one-night stands') involving sexual intercourse are less likely to involve mutual respect or provide the

> opportunity for either partner to deal effectively with these concerns. A large majority of college/ university females think of their relationships as long-term and serious. Females may define their relationships as more stable than their partners do. More males, on the other hand, indicated they have short-term, casual relationships and 'one-night stands.' Because safer sex may be more difficult to negotiate in these types of relationships, young men, in general, may be at greater risk for contracting and transmitting AIDS and other STDs.
>
> (p. 92)

The results of this study indicated that male participants were at higher risk of contracting STDs including HIV/AIDS than female participants due to their higher levels of participation in casual sex.

6.3.3 Safer Sex Behaviour

6.3.3.1 Questioning a Partner

The sample was asked to respond to the statement 'I question a partner about his/her sexual history.' As a group, over forty-six percent said that they always question a partner about their sexual history. More males (57.1%) than females (43.5%) indicated that they always question a partner about their sexual history.

In Uddin's study (1996), the sample was asked to respond to the statement 'I have intentionally questioned my partners about their sexual history.' She found that 32.9% of the sample strongly agreed with the statement, 11.8% agreed with the statement, and

7.2% somewhat agreed with the statement. This is a total of 51.9% expressing at least some agreement with the statement.

It is suggested in the study entitled 'Listen to What America's Kids are Saying' (Collins, 1997), that although young people ask about the past sexual histories of their partners, they do not do so directly. Many of the young people interviewed in Collins' study described detailed strategies for gathering information about their partners' sexual histories. In their attempts to assess risks or raise issues relating to the use of protection, few asked direct questions. When they did, they asked their partners how many people they have slept with, who these people were and where they are now, whether condoms were used and less often, whether they have been HIV-tested. Those who approached the subject indirectly often did so by dropping hints or by revealing small details about their own sexual experiences with the hope that their partners would reveal something about themselves as well (Collins).

The percentage of students in this study who always questioned a partner about his/her sexual history is higher than those in Uddin's. This may be attributed to the high percentage of students who indicated monogamy in this study. Monogamous relationships would be characterized by both a higher level of knowledge between partners and an openess that would not necessarily be present in casual sexual relationships.

6.3.3.2 Delaying Sex

Close to half of the respondents indicated that they delay sex until they know a

partner well enough to practice safer sex and another twenty-five percent said that they often delay sex until they know a partner well enough to practice safer sex. Uddin (1996) asked her sample to respond to the statement 'I have delayed sex until I knew my partner well enough to practice safer sex with him.' She found that 48% strongly agreed or agreed with the statement.

Comparing these responses with Uddin's (1996), in this matter, it appears as though these results were about thirty percent higher than hers. An explanation for this is that a large percentage of this sample (52%) had had only one or two sexual partners. Sexual inexperience may have lead this group to delay sex until they were more comfortable and knew their partners better (Lear, 1997).

6.3.3.3 Condom Use

The sample was asked to respond to the statement 'I use condoms during sexual activity.' Only about twenty-eight percent of this sample indicated that they always use condoms during sexual activity. Over forty-percent of males said this while only about twenty-four percent of females indicated that they always use condoms during sexual activity. This is fairly consistent with the results of the study conducted by Caron et al. (1993). They found that only about twenty-one percent of their sample of 330 male and female first-year college students in the U.S. always use condoms during sexual activity. The male percentage in the present study (40%) may be a little high compared to other studies. This could be due to the small number (19) of male respondents in the sample.

In a study of 5,514 Canadian first-year college students, researchers found only 24.8% of males and 15.6% of females reporting always using a condom during sexual intercourse (Dekin, 1996). This discrepancy between males and females and condom use was also displayed in this study. The implication of this lack of condom use is a higher risk of STDs including HIV. Also, females may be more at risk for STDs as they indicated a lower response to always using condoms than males.

The next statement was 'I carry condoms with me on a date.' About forty-one percent of this sample indicated that they never carry condoms with them on a date. This accounted for about forty-six percent of females and almost twenty-nine percent of males. Almost forty-three percent of males indicated that they always carry condoms with them on a date whereas less than five percent of females said that they always carry condoms with them on a date. The responses by the males and females to this statement were found to differ significantly at the $p < .05$ level.

This discrepancy between males and females was also shown in a study undertaken by researchers at the University of British Columbia. Three-hundred and seventy-six college students were asked how likely they were to carry a condom at a bar, a concert, a party, and a first date. At the bar, party, and first date, twice as many males as females indicated that they would carry a condom. Fifty percent of the males and twenty-six percent of the females indicated that they would carry condoms to a bar. Fifty-nine percent of males and thirty-two percent of females indicated that they would carry condoms to a party. Twenty-two percent of males and only eleven percent of females

indicated that they would carry condoms on a first date. Nineteen percent of males and fifteen percent of females indicated that they would carry condoms to a concert (Sex & Health, 1998).

However, these researchers also found a discrepancy between intent and action. When they went to a campus bar and asked another 346 patrons if they could produce a condom, they found that less than five percent of the patrons could. Researchers found that the females indicated that they didn't carry condoms because they feared being seen as promiscuous, or they felt that they were a man's responsibility. Also, having a condom on one's person indicates a lack of sexual innocence, an unfeminine identity, that of a woman actively seeking sex (Lear, 1995). These reasons may have played a role in the low percentage of females in this study who indicated that they always carry condoms with them on a date.

Here, it is also interesting to revisit the response to the statement 'I assume that I am responsible for supplying condoms if the need arises.' A much higher percentage of the group as a whole, and the males and females separately, indicated that they always assume that they are responsible for supplying condoms than indicated that they always carry condoms with them on a date. Students may want to take the responsibility for supplying condoms without wanting to seem too prepared for sex by carrying condoms with them when they go out on a date.

The next statement was 'I would refuse to have intercourse with a partner if no condom was available.' Approximately thirty-six percent of the group as a whole, and

males and females separately indicated that they would always refuse to have intercourse if no condom was available. About twenty percent of the group as a whole and the males and females separately indicated that they would often refuse to have intercourse if no condom was available. In Uddin's (1996) study she asked her sample to respond to the statement 'I can refuse to have intercourse with my partner if no condom was available.' She found that 68.7% of her sample indicated that they were extremely confident that they could refuse to have intercourse if no condom was available.

About forty-five percent of the group as a whole indicated that they would always insist on using a condom even if their partner did not want to use one. This accounted for about thirty-six percent of males and over forty-seven percent of females. A higher percentage of females than males felt that they would always insist on using a condom even if their partner did not want to use one.

About seven percent of males said that they would never insist on a condom. Zero females said that they would never insist on a condom if their partner did not want to use one. These results are consistent with Uddin's study (1996) where she asked her sample to respond to the statement 'I can insist that my partner wear a condom, even when he doesn't want to.' She found that 62.2% of her sample indicated that they felt extremely confident on insisting that their partner wear a condom, even when he doesn't want to.

Gender roles and social norms may come into play here. The TSS depicts men as being highly motivated to engage in sexual activity and willing to pursue any opportunity made available by a woman. This may account for males not insisting on condom use

when a sexual partner does not want to use one. These aspects of the TSS may have been operant among some of the males and females of this sample.

6.3.3.4 Negotiation of Safer Sex

Respondents were asked if they had ever experienced any difficulty negotiating safer sex, defined as using condoms, with a sexual partner. Over eighty percent of respondents indicated that they had not experienced any difficulty in negotiating safer sex with a partner. About eighteen percent of respondents indicated that they had experienced difficulty in negotiating safer sex with a partner. The respondents who indicated that they had experienced difficulty negotiating safer sex with a partner were then asked to detail the difficulty and what they did to resolve it. Only eight respondents answered this question. In the responses, there was an emphasis on condoms taking away sexual sensation. This is consistent with Collins' (1997) study 'Listen to What America's Kids are Saying'. This study indicates that young people generally say that condoms diminish the pleasure that men derive from sex and that young women reported feeling pressure not to use condoms because they believe it would decrease the sexual pleasure experienced by their partners.

In the response to this question there was also some suggestion that the birth control pill was a measure of safer sex; that if you were using the pill you didn't need to use condoms. This emphasis on prevention of pregnancy rather than disease prevention has been well documented among young people. The 'Listen to What America's Kids are

Saying' survey (Collins, 1997) found that all of the young people interviewed were aware that unprotected intercourse puts them at risk for HIV. However, they were more likely to associate unprotected intercourse with increased risk of pregnancy. Also, Maticka-Tyndale (1991) found evidence of this among a stratified sample of 1000 French and English students attending seven Montreal colleges. The results displayed that young adults were scripting condoms as contraceptives. Also, the young adults were relying on their own 'believed' ability to avoid sexual intercourse with infected partners as a major preventive mechanism for contracting STDs such as HIV (Maticka-Tyndale, 1991).

Respondents were asked to answer the question 'What is your approach to negotiating safer sex with a sexual partner?' Twenty-five percent of respondents indicated that their approach to negotiating safer sex was that they would refuse to have sex without a condom. This high percentage may be attributed to response bias as social bias would dictate that the 'correct' response to this question is to use condoms. Also, one must wonder if there is any discrepancy between intent and action. Although it was meaningful to ask the sample about their approach to negotiating safer sex, one cannot help but wonder if it would have been more meaningful to ask them to detail their response to a partner who refuses to use a condom.

It may also have been very helpful to ask the respondents for their definition of safer sex, as there were comments which indicated that pregnancy prevention was their main concern as opposed to disease prevention. It could have proved useful to know if a large portion of the sample viewed pregnancy prevention as synonymous with safer sex.

Almost fourteen percent (13.9%) of this sample indicated that they discuss safer sex and the risks with their partner in response to the question 'What is your approach to negotiating safer sex with a sexual partner?' Young people seem to be very comfortable with this strategy, however, the Canada Youth and AIDS study (King et al., 1988) shows that this is not always the best strategy for negotiating safer sex. The study states that asking sexual partners about their health or sexual history is not a reliable means of avoiding AIDS, because many people lie. One third of sexually experienced male college students and ten percent of women in this national study admitted that they have lied to get someone to sleep with them (King et al., 1988). Susan Cochran, associate professor in the psychology department of California State University at Northridge concurs. She said that asking partners about risk factors is probably not a very good strategy for reducing the risk of AIDS (King et al., 1988).

Some young people realize that this may not be the best strategy. A participant in the Women Risk and AIDS Project (Holland et al., 1992) states "If you want to have relationships then you've got to trust them. Otherwise it's no good from the start. You have to believe what they tell you. You just hope they tell the truth. You can't know if its lies or not." (p.277).

Also of note is that over four percent indicated that their approach to negotiating safer sex with a partner was to use a condom with a partner that you do not know well (ie. new partner). In the study 'Listen to What America's Kids are Saying' (Collins, 1997), heterosexual partners consistently report that condoms were used for the first time they

had sexual intercourse. However, usage drops as the relationship matures, which for some young couples may be within a week (Collins). This approach alone may not prove to be effective against acquiring STDs such as HIV. The percentage of this sample relying on this method may be leaving themselves at risk for HIV and other STDs.

Key points in this section include the following:

- A higher percentage of respondents than that found in other studies indicated that they had engaged in sexual intercourse. This is consistent with other studies which show that a higher percentage of Newfoundland youth, as compared with youth in other provinces, have engaged in sexual intercourse.
- More females than males defined their sexual relationship as monogamous. This is consistent with the literature which details social pressure on females to define their relationships as steady.
- A higher percentage of respondents than that found in other studies indicated that they delay sex with a partner until they know them better. This may be due to the high percentage of respondents who indicated that they had only one or two sexual partners.
- A higher percentage of males than females indicated that they always use condoms which indicates a higher risk of STDs for the females of the sample. However, a lower percentage of males indicated that they would always insist on condom use even if their partner did not want to use one. The TSS may have played a role here as men are encouraged in society to always pursue any sexual opportunity given by a woman. This puts men at risk for acquiring STDs such as HIV/AIDS.

- There was a discrepancy among the sample between assuming the responsibility for supplying condoms and actually carrying condoms on a date. This was especially evident among the females of the sample. The responses of the males and females differed significantly with respect to carrying condoms on a date. Carrying condoms is seen as evidence of being sexually experienced which is stigmatizing for females.
- As is consistent with the literature, an emphasis on pregnancy prevention versus prevention of STDs, such as HIV, was found among the sample.

6.4 Roles of Men and Women

6.4.1 Sexual Stereotypes

This section generated a statistically significant sex difference. The male and female responses to the statement 'A lack of sex takes a greater toll on men than women' were found to be statistically significant at the $p < .05$ level. The males were more likely to agree with this statement than the females with 61.2% of males versus 17.5% of females expressing agreement with the statement.

The TSS may be used to explain this result. It characterizes males as having strong sexual needs and being obsessed with sex, whereas, females are depicted as having few sexual needs. These sexual stereotypes may have been playing a role in the response to this statement.

The statement was adapted from Uddin (1996). She found that 9.8% somewhat disagreed with this statement, 27.7% disagreed with this statement and 25.5% strongly

disagreed with this statement for a total of 63% who expressed disagreement with this statement. These findings are consistent with the finding of 63.5% expressing disagreement with the statement in this study.

The male and female responses to the statement 'Men should take financial responsibility for a date' were found to approach statistical significance at the $p < .05$ level. Again, the males were more likely to agree with this statement than the females. This result may be explained through the social roles and norms concerning dating which are prevalent in society. The male has traditionally taken on the role of financial provision for dates and this result confirms the existence of this role among young males of the sample.

A higher percentage of females than males indicated that women should never bear the primary responsibility for protecting against pregnancy whereas equitable percentages of males and females indicated that women should never bear the primary responsibility for protecting against sexually transmitted diseases. This finding supports other researchers' findings that pregnancy prevention is viewed by many to be the responsibility of females in the relationship (Scott & Griffin, 1989).

These two particular statements were adapted from the work of Uddin (1996) who surveyed female students only. She also found more disagreement with the statement pertaining to pregnancy than the one pertaining to sexually transmitted diseases. Uddin found that 7.6% somewhat disagreed, 28.6% disagreed, and 54.6% strongly disagreed with the statement 'Women should bear the primary responsibility for protecting against

pregnancy.' This is a total of 90.8% of the sample expressing at least some disagreement with the statement. Uddin (1996) also found 16.6% somewhat disagreed, 30.6% disagreed, and 28.5% strongly disagreed with the statement 'Women should take primary responsibility for practicing safer sex.' A total of 75.7% of her sample expressed at least some disagreement with the statement.

This is consistent with this study, as a larger portion of the females (84.4%) in the survey also expressed disagreement with the statement pertaining to pregnancy than for the statement pertaining to sexually transmitted diseases. However, the discrepancy in responses between the two statements is larger in Uddin's study.

The difference between the means of male and female respondents was found to be statistically significant with the female mean being higher than the males. Overall, females were less traditional about stereotyped roles of men and women than the males.

6.4.2 Relationship between Roles of Men and Women and Safer Sex Behaviour

The differences in response between males and females with respect to the roles of men and women may influence their safer sex behaviour. As was consistent with the hypothesis, a linear relationship was found for the sample between the roles of men and women and safer sex behaviour. The strength of this relationship ($r = -.364$) can be considered to be fair. This linear relationship was also found for the females of the sample. The strength of this relationship ($r = -.340$) can also be considered to be fair.

Respondents, especially females, who are more traditional in their thinking about

specific roles of men and women are less likely to practice safer sex behaviour. Holding specific traditional thoughts about which roles belong to men versus which roles are women's can be considered a risk factor for HIV among this sample. Holding stereotypes of the aggressive male with strong needs for sex and the passive female willing to consider her partner's needs before her own, as is outlined in the TSS, may lead to high risk sexual practices if the male partner feels no need to use condoms. Males who are more traditional in thought about sexuality and sexual roles have a greater influence on sexual decisions made by the couple than those with less conventional attitudes (Otis et al., 1997). Also, women who adhere to a more traditional ideology with regard to sexual roles have less influence over sexual decisions than more unconventional women (Otis et al.). If a traditional male makes the decision not to use condoms, or if a traditional female defers to her male partner who decides not to use condoms, this increases the chance of acquiring an STD such as HIV.

6.4.3 Relationship between Roles of Men and Women and Power Balance

A linear relationship was found for the sample between the roles of men and women and power balance. The strength of this relationship ($r = .337$) can be considered to be of fair strength. This means that respondents who are more traditional in thought about the roles of men and women were in relationships that were more balanced with respect to power. This result may be explained through Mackie (1991). Mackie found that those who were very traditional about the roles of men and women were in more stable

and longer lasting marriages than those who were not as traditional in thought about these roles. When roles are clearly defined in a relationship it tends to last longer and be perceived as being more stable by those who are involved in the marriage (Mackie, 1991). This result was even stronger for the females separately. A correlation of .367 was found between the two variables for the females of the sample. This correlation can be considered to be of fair strength. However, no correlation between the variables was found for the males of the sample. How males and females think about safer sex and condom use and how they perceive these issues with respect to the roles of males and females may affect both the power balance and the prevalence of safer sex behaviour in a relationship.

Key points in this section include:

- Differences in male and female responses to the statement "a lack of sex takes a greater toll on men than women" were found to be statistically significant. This may be explained by the TSS which prescribes males as having strong sexual needs.
- Differences in male and female responses to the statement "men should take financial responsibility for a date" approached statistical significance. This may be explained by the societal dating roles and norms which describe males as having strong sexual needs.
- Pregnancy prevention was seen by males as a female responsibility while STD prevention was seen as more of a joint responsibility. This finding was consistent with the literature.

- Difference in the mean for males and females was significant suggesting that females were less traditional about the roles of men and women than were the males.
- A relationship between the roles of men and women and safer sex behaviour was found for the sample as a whole and for females separately. Traditional thinking about the roles of men and women can be considered as a risk factor for STDs among the sample.
- A relationship between the roles of men and women and power balance was found for the sample as a whole and was found for the females of the sample. This may impact upon the prevalence of safer sex behaviour in the relationship.

6.5 Assertiveness and Communication

The main study for comparison of this section is Uddin's work as several questions were adapted from her study primarily for use in this section. However, it should be noted that Uddin surveyed females only. This, coupled with the lack of research on the heterosexual male response to safer sex issues, leaves no basis of comparison for the males.

6.5.1 Personal Responsibility for Condoms

The sample was asked to respond to the statement 'I assume that I am responsible for supplying condoms if the need arises.' Almost sixty-five percent of the males indicated that they always assume that they are responsible for supplying condoms if the need arises. This is a much higher percentage than the females. Only about twenty-seven

percent of females responded 'always' to this statement.

This result may best be explained by the influence of social norms and gender roles. For the most part, females assume the role of pregnancy prevention in a relationship (Scott & Griffin, 1989). However, it is still frowned on by society if a female seems too ready for sexual intercourse (Byers, 1996). This eagerness may be interpreted to include supplying condoms or taking responsibility to ensure that there is a supply of condoms on hand.

This places females in a difficult situation. They may want to use condoms, but are leaving the responsibility for supplying condoms to their male partners (Otis et al., 1997). In order for condoms to be used, the male partner must have already recognized the risk of HIV and procured condoms.

6.5.2 Initiation of Discussion about Safer Sex, Condoms, and Sexual History

When asked to respond to the statement 'During sexual situations, I am the first to suggest using a condom,' once again a higher percentage of males said 'always' than females. About twenty-nine percent of the males indicated 'always' while only about nine percent of the females indicated this. Over seventy percent of the males indicated 'always' or 'often' while over fifty percent of the females said that they are sometimes the first to suggest using a condom during sexual situations. Wingood, Hunter-Gamble and DiClemente (1993) found similar results in their qualitative study of African American females. They found that while a majority of the women were able to initiate a discussion

about safer sex with their partners, only a small minority were able to negotiate condom use.

Female respondents seem to have been relying on their male partners with respect to condom use. The implications of this are that they may be placing themselves at risk by depending on another person to recognize the need to use condoms and also to procure condoms beforehand. Otis et al. (1997) concur. They state that their findings suggest that initiatives relating to condom use are taken by men and that women delegate the responsibility for condom use and for their direct protection against AIDS to their male partners.

This can be explained through social norms and gender roles. The females may be taking care not to appear too eager for sexual intercourse. Concern about reputation constrained condom use for young Australian women (Lear, 1995). This result is also explained through the TSS which says that a woman's worth is decreased by seeming too interested in sex. Female respondents may have thought by being the first to suggest using condoms that they would seem too interested in sex.

A slightly higher percentage of females (18.6%) than males (14.3%) always discuss condom use with a partner several dates before engaging in sex. About forty-three percent of the sample as a whole said that they never or almost never discuss condom use with a partner several dates before engaging in sexual intercourse. The largest percentage of males (35.7%) said that they sometimes discuss condom use with a partner several dates before engaging in sexual intercourse, while the largest portion of the females

(25.6%) indicated that they almost never discuss condom use with a partner several dates before engaging in sexual activity.

Uddin asked her sample to respond to the statement 'I specifically discuss condom use and safer sex with my partner several dates before engaging in sexual activity.' She found that a total of 29.8% of the sample expressed at least some disagreement with the statement. This finding is consistent with other research studies.

A qualitative research study entitled 'Listen to What America's Kids are Saying,' and conducted jointly by Micheals Opinion Research, the Center for AIDS Prevention Studies, and the Harvard AIDS Institute found that most young people do not discuss the use of condoms prior to their first sexual encounter (Collins, 1997). The approach to condom use is reactive rather than proactive. Condom use is not planned prior to the sexual encounter and young people are relying on their instincts to be able to insist upon using a condom during the 'heat of the moment.' The norm for those who do not discuss the use of protection before having sex with someone for the first time is that condoms were used and mentioned 'at the moment.' According to couples they interviewed, one partner or the other said 'I have a condom,' either while they were undressing or just prior to sexual intercourse. Some young women who want to ensure that a condom is used say they simply hand one to their partner with the clear implication that either it is used or there will be no sex (Collins, 1997). Other young women who want to use condoms rely on their partners to have them and ask, 'Do you have a condom?' Some young women also report that their partners have asked, 'Do I have to use a condom?' with the obvious

hope that they will not insist (Collins). This is consistent with Kent, Davies, Deverell and Gottesman (1990), who found that there tended to be little verbal communication during the transition from sexual intercourse being a possibility to it becoming a reality.

Participants were asked to respond to the statement 'I discuss my sexual history honestly with a partner.' The majority of both males (71%) and females (59%) indicated that they always discuss their sexual history honestly with a partner. Uddin, 1996, asked her sample to respond to the statement 'I discuss my sexual history frankly and honestly with my partner.' She found a total of 73.1% expressing at least some agreement with the statement.

Ingham et al (1991) found through qualitative research that only a minority discuss each other's sexual history before having sex and the discussion amounts to nothing more than sexual experience and almost never includes details of past condom use.

Upon hindsight, the researcher is left to ponder if the respondent's discussions about sexual history included prior condom use or if it was limited to each other's level of sexual experience only. It may have been better to ask the sample if the discussion about sexual history included condom use with prior sexual partners.

6.5.3 Sexual Boundaries and Limitations

The greatest percentage of both males and females said that they would never have sex just to please a partner. This was almost forty percent of females and almost

twenty-nine percent of males. However, there was also a higher percentage of males than females who indicated that they would always have sex just to please a partner. Almost fifteen percent of males indicated this while not one female said that they would always have sex just to please a partner. Uddin (1996) asked her sample to respond to the similar statement 'I will sometimes have sex just to please a partner.' She found 32.1% of her sample expressed at least some disagreement with the statement.

The discrepancy between males and females may best be explained by social norms and gender roles. Social norms and gender roles, as outlined in the TSS, suggest that males should always be ready for sexual intercourse and not refuse sexual intercourse, whereas, it is suggested to females that they be the sexual gatekeeper of the relationship and to not have sexual intercourse just for someone else (Byers, 1996).

This is also displayed in the responses to the statement 'I tell my partner when we are getting more physically intimate than I would like.' Almost sixty percent of the females responded 'always' to this statement while only about thirty-six percent of males said the same. The responses by the males and females to this statement differed significantly at the $p < .05$ level.

Otis et al. (1997) state that in the sexual realm, females appear to be more able to exercise relative control with regard to certain types of sexual decisions such as refusing to engage in sexual activity when not desired. Females have been taught to restrict access to their bodies and to speak up when they feel that they are going too far sexually whereas males are to be willing to pursue any sexual opportunity made available by a woman.

This is further shown in the response to the statement 'I feel comfortable refusing sexual activity with someone, even if we've had sex together before.' Fifty percent of both males and females indicated that they always feel comfortable refusing sexual activity with someone even if they've had sex together before. However, over thirty-five percent of males versus about seven percent of females indicated that they would never or almost never feel comfortable refusing sexual activity with someone, even if they've had sex together before. This finding further reinforces the TSS which says that males must be willing to pursue any sexual opportunity made available by a female (Byers, 1996). The reluctance of the male respondents to speak up about their sexual limits may place them in a sexually vulnerable position and at higher risk for STDs, such as HIV.

6.5.4 Relationship between Assertiveness and Communication and Safer Sex Behaviour

As was consistent with the hypothesis, a linear relationship was found for the sample between assertiveness and communication and safer sex behaviour. The strength of this relationship ($r = .698$) can be considered to be moderate. Respondents who are more assertive about sexual matters and communicate more effectively about sexual matters are more likely to practice safer sex behaviour. Being more assertive about sexual matters and communicating effectively about sexual matters may be considered as having a preventive effect on the risks for HIV among this sample.

With respect to males and females separately, a linear relationship was found for

the males between assertiveness and communication and safer sex behaviour. This relationship was much stronger than the one for the group as a whole. The relationship ($r = .876$) can be considered of very good strength.

A significant linear relationship was found for the females of the sample as well. This relationship ($r = .606$) was smaller than the one found for males and for the group as a whole but can be considered moderate in strength. The females who are assertive about sexual matters and communicate effectively about sexual matters practice a higher level of safer sex behaviour.

Wendt & Solomon (1995) found that barriers to condom use included difficulty discussing condom use with partners and poor communication and assertiveness skills. Poor assertiveness and communication skills may have serious consequences in relation to HIV as it makes it difficult to know sexual histories and to negotiate condom use (Wight, 1992).

Being more assertive may be considered a preventive measure against HIV for both the males and the females in this sample.

Key points in this section include:

- A higher percentage of males than females are involved with condom-related behaviours, such as assuming responsibility for supplying condoms, carrying condoms and being the first to initiate discussions about condom use. These findings are consistent with the literature that suggests that society stigmatizes young women if they seem too prepared for sexual intercourse by carrying condoms or being first to suggest their use.

- A higher percentage of males than females indicated that they always have sex just to please a partner. Also, a lower percentage of males than females indicated that they always tell their partners when they are becoming more physically intimate than they would like. The response to this particular statement was statistically significant. These findings are consistent with the TSS which prescribes that males must be willing to pursue any sexual opportunity given them. This may be a risk factor for STDs among males in the sample.
- The relationship between assertiveness and communication and safer sex behaviour was stronger for the males than for the sample as a whole which reflects their higher participation in condom-related behaviours.

6.6 Power Balance

This section showed few differences between the responses of males and females. The first four statements in this section were adapted from the work of Dianne Felmlee (1994). The statements were rephrased for present and past tense to allow the student to answer even if he/she had a relationship in the past twelve months but was not currently involved in a relationship.

6.6.1 Perception of Personal Power in Relationship

The first statement was 'In my relationship I have/had more power than my partner.' The majority was clustered in the 'sometimes' category with about fifty-seven

percent of the group response. Female response in this category was fifty-five percent and male response was about sixty-two percent.

6.6.2 Decision-Making

One slight difference which emerged was in the response to the second statement "In my relationship I make/made more of the decisions about what we do together than my partner.' About thirteen percent of the females indicated that they never make/made more of the decisions about what they do/did together than their partner. No males indicated that they never make/made more of the decisions than their partner (The reader is reminded of the small number of males participating in this study). It seems as if some of the males had more control of their relationships than some of the females. However, about forty-seven percent of the group as a whole, and the males and females separately, indicated that they sometimes make/made more of the decisions. Decision-making is thought to be a main indicator of power in relationships and has been linked empirically to power in intimate relationships in previous studies (Felmlee, 1994). As such, a large group of both males and females indicated that they sometimes make/made more of the decisions, this indicates an equitable balance of power with respect to this measure.

6.6.3 Emotional Involvement

Another small sex difference was in response to the statement 'I am/was more emotionally involved in the relationship than my partner.' More of the males (67%) than

the females (41%) indicated that they are sometimes more emotionally involved than their partners. The response to this statement approached significance at the $p<.05$ level. Otis et al. (1997) also found that emotional commitment was more significant for men. This finding gives strength to the hypothesis proposed by Allgeier and McCormick (1983), that men are more likely than women to become emotionally involved in a relationship and to suffer when it ends. As emotional involvement is a key component of power in relationships, this finding suggests that the balance of power, with respect to this measure, lay with the females in this sample.

6.6.4 Equity

Respondents were asked to give a measure of equity in their relationships. They were asked to respond to the statement 'I get/got a "better deal" in this relationship than my partner.' Half of the male respondents indicated that they get/got a better deal than their partner at least some of the time. Only twenty-five percent of the females indicated the same.

This finding is similar to the one discovered by both Felmlee (1994) and Davis, Emerson and Williams (1997). In separate studies using this measure of equity, they found that women reported perceiving less equity in their relationships. As equity is a component of power in relationships, the male respondents in this study seemed to wield more power in this area.

6.6.5 Level of Comfort

Another small difference between male and female response was to the statement 'I wouldn't feel comfortable asking a steady partner to use a condom.' Over seventy percent of females said 'never' to this statement whereas only fifty-four percent of males indicated this. A greater percentage of females than males would feel comfortable asking their partner to use a condom.

The rationale which the researcher surmises is that the sample contained many females who were in monogamous relationships of long duration with one partner whereas more males were not in a present relationship or were in casual relationships only. The results of the survey showed that over sixty percent (61.1%) of the males categorized their relationships at present as none (44.4%) or casual sex only (16.7%) whereas forty percent (38.9%) of males indicated that they were in a monogamous relationship. With respect to females, only twenty-six percent categorized their relationships at present as none (20.0%) or casual sex only (6.0%) while sixty-eight percent indicated that they were in a monogamous relationship. The females may have dated their partner for many years before becoming sexually involved and trust was well established between them (Lear, 1997) in contrast to the number of males in casual relationships only. The relationship may have had time to evolve to a point where she would feel comfortable asking her partner to wear a condom.

This is also stated in the Canada Youth & AIDS Study (King et al., 1988, p.92). "The stability of sexual relationships in which young people are involved determines

indirectly their chances of contracting AIDS and other STDs. Those in long-term, serious relationships are generally more concerned about each other and better able to talk about birth control and about strategies to prevent AIDS and other STDs. Short-term, casual encounters involving sexual intercourse are less likely to involve mutual respect or provide the opportunity for either partner to deal effectively with these concerns". However, as Otis et al. (1997) stated, the responsibility for condom use is often delegated to the male partner.

This high percentage of female respondents being comfortable with asking their steady partner to use condoms indicated that there may have been a deep level of trust present in these relationships. Being comfortable enough with partners to be able to discuss difficult issues such as sexuality is a measure of power balance in the relationship. The percentage of female respondents indicating this level of comfort suggests that the power balance in their relationships with respect to this variable is equitable.

6.6.6 Partner's Response to Request to Use Condoms

The most striking aspect of this section is the response to the statements concerning partner's response to a request to use condoms. These four statements were answered in the same manner by almost all of the sample.

Participants were asked to respond to the statement 'If I asked my partner to use condoms, he/she would be angry'. Over eighty-five percent of the group as a whole as

well as males and females separately, indicated that their partner would never become angry if asked to use condoms. Again, over eighty-five percent of the group as a whole as well as the males and females separately, indicated that their partner would never refuse to have sex if asked to use a condom. At least ninety-five percent of the group as a whole and the males and females separately indicated that their partner would never become violent if asked to use a condom. Ninety-percent of the females and over sixty percent of the males indicated that it would bother them to have a steady partner become violent. The difference in response to this statement by males and females was found to approach significance.

Upon reflection concerning these statements it is likely that some of these may have been answered in a socially desirable manner. Because people wish to present themselves in a positive light, self-presentation bias may lead to underreporting or overreporting of particular behaviours depending upon whether that behaviour is viewed as positive or negative by society (Catania, Gibson, Chitwood & Coates, 1990). For example, few would want to admit that their partner would become violent if asked to use a condom. One would not want to think that way about their partner and if it was true, they may not want to admit it as this behaviour is deemed by society to be unacceptable. It may have proved more fruitful if the sample had been asked what their partner would do if asked to use a condom. Also, with respect to the statement 'It would bother me to have a steady partner become violent', it is logical to think that a majority of people would be upset if their partner became violent, as this would be a socially acceptable

reaction to violence.

Also, cultural scripts may have played a role in responses to the statement 'It would bother me to have a steady partner become violent'. Only sixty-two percent (61.5%) of males responded 'Always' to the statement versus ninety percent of the females. For some males it may not be culturally desirable to admit to being bothered by violence from their female partners (Somera & Laub, 1997).

6.6.7 Relationship between Safer Sex Behaviour and Power Balance

There was no significant linear relationship found for the sample between safer sex behaviour and power balance. This means that respondents who practice safer sex less often are not more or less likely to be in relationships that are balanced with respect to power distribution between partners.

Key points in this section include:

- There were few differences in response found between males and females with respect to power balance. However, the response to'I am/was more emotionally involved in the relationship than my partner' approached statistical significance.
- No relationship was found between safer sex behaviour and power balance for the sample.

6.7 Predicting Safer Sex Behaviour

There was a linear relationship found between the dependent variable safer sex

behaviour and the independent variables of roles of men and women, assertiveness and communication, power balance, and sex (male or female). The regression model accounted for 50.9% of the variance with only assertiveness and communication making a significant contribution to the prediction of safer sex behaviour. Specifically, respondents with a higher level of assertiveness and communication were more likely to practice safer sex behaviour and respondents with a higher level of traditional thoughts about the roles of men and women were less likely to practice safer sex behaviour. As discussed in previous sections of this thesis, a higher level of assertiveness and communication about sexual matters can be considered a preventive measure for acquiring HIV and other STDs, on the other hand, holding more traditional thoughts about the roles of men and women can be considered to be a risk factor for acquiring HIV and other STDs.

6.8 Limitations

There were some limitations in this research design. The first of these is that the study design was not random in nature but utilized a convenience sample. Thus, any findings cannot be readily generalized to the population of second year university students attending Memorial University of Newfoundland. They are indicative of the sample only. However, the consistent findings between this study and studies using random samples such as Uddin's (1996) gives a measure of confidence in the results.

Although random sampling would have produced the best results in terms of

generalizability to the university population, it was not the intent of the study to gain a random sample. Rather, this study was to be exploratory in nature and to encourage other researchers to investigate the relationships between the role of men and women, assertiveness and communication, power balance and safer sex behaviour to aid prevention of HIV/AIDS.

Another limitation surrounds the questionnaire design. A definition of safer sex was not explicitly given to the sample. There may have been some confusion about what each participant defined as safer sex. As was discussed previously, some students indicated that safer sex was synonymous with pregnancy prevention. A definition of safer sex should have been given to the sample, or alternately, the sample should have been asked to provide a definition of safer sex. This would have better clarified the research findings.

Also, instead of asking the sample what their approach was to negotiating safer sex with a sexual partner, it may have been more appropriate to set up a scenario wherein they had to deal with a partner who refuses to use a condom. This may have allowed for more specific strategies and tactics to be gathered from the sample. It may also have produced more concrete findings on what percentage of the sample would have engaged in unprotected sexual intercourse.

There was also a problem with the section pertaining to power balance. There were four questions (numbers 36, 37, 38 and 41) that were answered similarly by the sample. These questions should not have been included in the questionnaire as they

produced socially desirable responses.

The selection and use of a university sample also introduced the possibility of bias in the power balance section as females attending university may be more assertive and less traditional in thought than females that do not attend university.

A further limitation concerns the accuracy of self-reported data. The questionnaire asked the sample to recall specific incidents surrounding their relationships and sexual behaviour. Although a time frame of twelve months was given as a context to reduce any recall bias, some may have still remained due to the nature of having to recall specific events over the past year.

Also, respondents with large numbers of sexual partners may have had to work much harder to recall specific behaviours than those in long-term monogamous relationships (Catania, Gibson, Chitwood & Coates, 1990). This recall bias may have been minimized in this study as there was a large number of respondents who reported being in a monogamous relationship at the time of the survey.

The inherent biases such as self-presentation bias and participation bias also may have played a role in the results of this study. As discussed previously, the students may have answered some questions in a socially desirable manner; in a way that they thought society as a whole would want them to answer. Self-presentation bias may have lead to an underreporting of high-risk sexual behaviours. Studies have suggested that the use of self-administered questionnaires may minimize this bias as it avoids face to face contact with an interviewer (Catania, Gibson, Chitwood & Coates, 1990). Thus, the use of

questionnaires in this research may have minimized this bias.

Also, certain students may have chosen not to participate due to embarrassment, fear and/or inability to face their own high-risk sexual behaviour. This may have lead to an underreporting of high-risk behaviours among the sample (Catania et al., 1990). As the level of safer sex behaviour reported by the sample was quite high, the researcher feels that any bias present may have lead to an underreporting of high-risk behaviour.

The small number of male respondents was also a bias in this research. Large percentages in response categories were represented by only four or five respondents. Thus, the reader must be cautious about interpreting the male responses. However, the ratio of female to male respondents was representative of the class as a whole which lends some credence to the male response to the survey.

Also, the evidence of limited numbers of sexual partners and the tendency toward longer term relationships among the females in the sample may have affected the response, especially in the sections relating to condom use and power balance in relationships.

7. Recommendations

There are several recommendations which arose from this research. These recommendations were primarily concerned with the areas of research and education. The first is that more research be undertaken in the area of safer sex practices, such as condom use among male heterosexuals. In some instances in this study the males appeared to be at greater risk than the females for acquiring STDs such as HIV. Also, the body of research dealing with male heterosexual safer sex practices is limited. As heterosexual sexual relations occur in a dyad between both a male partner and a female partner, the male response is vitally important in the protection of both partners.

Power balance in relationships as a risk factor for HIV among young people should also be explored further. Further research in this area may provide a clearer position with respect to the relationship between power balance and HIV.

Recommendations concerning the education of youth arose from this research survey. First, a better understanding of safer sex is needed among youth. Several individuals in this survey equated safer sex with pregnancy prevention. To find this in a sample of university students indicated that there must be some misunderstanding among today's youth about safer sex practices. Health educators, teachers and other professionals who are involved in educating youth must make an effort to ensure that youth fully understand that safer sex is not equated with pregnancy prevention only, but rather, includes the prevention of STDs such as HIV. This may help to alleviate the emphasis placed on pregnancy prevention by today's youth.

As traditional thinking about gender roles was associated in this study with a lower level of safer sex behaviour, one recommendation is that there should be education around gender roles for today's youth. Helping to alleviate traditional gender roles may have a protective effect on youth with respect to acquiring STDs such as HIV. Furthermore, both males and females appeared influenced by the TSS which, in turn, influenced their risk behaviour. More research should be undertaken in this area to further clarify these issues.

Also, education should focus on assertiveness and communication training as strong assertiveness and communication skills with respect to sexuality were found in this study to be associated with a higher level of safer sex behaviour. Negotiation of safer sex between partners should also be an educational emphasis. This survey showed that some youth are relying on negotiation methods which are not always sound such as using condoms primarily with partners that they don't "know well." Education about more effective methods of safer sex negotiation may prove beneficial to youth.

8. Conclusion

After conducting research of this nature, there are several conclusions one can make about the sample. Males and females who were more assertive and communicated better about sexual matters indicated practicing a higher level of safer sex behaviour as was hypothesized. Also, females who hold more traditional thoughts about the roles of men and women indicated practicing a lower level of safer sex behaviour as was hypothesized. Power balance in relationships was not found to impact upon safer sex behaviour as was contrary to the hypothesis of this research study.

There was a high level of safer sex behaviour reported among the sample. However, there was still a sizable portion of the sample who did not report effectively practicing safer sex. This was displayed in the answers to both the specific behaviourally oriented questions and the open-ended questions where some respondents emphasized pregnancy prevention over disease prevention.

Communication and assertiveness about sexual matters may have a protective effect against HIV for the sample as respondents who scored high on the scale pertaining to assertiveness and communication about sexual matters also displayed a higher level of safer sex behaviour. Conversely, holding traditional thoughts about gender roles may be considered a risk factor for HIV among the sample as those respondents who held more traditional beliefs about the roles of men and women also displayed a lower level of safer sex behaviour.

While some gender roles and stereotypes as outlined in the TSS played a role

among members of the sample, not all of the aspects played a role. The results suggest that the movement towards convergence of a single sexual standard for both males and females may be starting.

A linear relationship between power balance and safer sex behaviour was not found for the sample. However, female respondents who indicated a lower level of safer sex behaviour were found to be more traditional in thought about the roles of men and women and female respondents who were found to be more traditional in thought about the roles of men and women were more likely to be in equal partnerships with respect to power distribution.

This may have been affected by the limited numbers of sexual partners and the tendency towards longer term relationships among the females in the sample. As a relationship matures, the level of comfort arises, trust deepens, and the practice of using condoms is often discarded for more convenient birth control, such as oral contraceptives. It may also have been affected by the nature of the females in the sample itself.

Better questionnaire design may have enriched the results of this survey. A definition of safer sex may have helped the sample to better clarify the key concepts involved and may have provided more accurate data. Asking the sample if they discussed past condom use during the discussion of sexual history may have provided more clarity to the sexual history results. Also, there was an inherent volunteer bias within the procedure which may have provided inflated results with respect to safer sex behaviour.

There are lessons to be learned from the results of this survey. One involves the

future direction of research into safer sex behaviour. The heterosexual male perspective about safer sex behaviour has not been well researched. There are very few studies dealing with heterosexual men only (Campbell, 1995). The danger in this lies in treating the female response to negotiating safer sex behaviour without dealing with the male response. This ignores the partnership in which sexual negotiation takes place and sends a message to society that safer sex is a female responsibility (Campbell, 1995) rather than the responsibility of both partners in a sexual relationship.

9. Works Cited

Abraham, C., Sheeran, P., & Orbell, S. (1998). Can social cognitive models contribute to the effectiveness of HIV-preventive behavioural interventions? A brief review of the literature and a reply to Joffe (1996; 1997) and Fife-Schaw (1997). British Journal of Medical Psychology, 71, 297-310.

Aday, L. (1989). Designing and Conducting Health Surveys. San Francisco, CA: Josey-Bass Inc.

Adesso, V., Reddy, D., & Fleming, R. (1994). Psychological Perspectives on Women's Health. London:Taylor and Francis.

Ajzen, I. (1985). From intentions to action: A theory of planned behaviour. In Action control: From cognition to behaviour. Berlin: Springer-Verlag.

Alary, M., Joly, JR., Parent, R., Fauvel, M., & Dionne, M. (1994). Sentinel Hospital Surveillance of HIV Infection in Quebec. Canadian Medical Association Journal, 151(7), 975- 980.

Allgeier, E., & McCormick, N. (1983). Changing boundaries: Gender roles and sexual behaviour. Palo Alto, CA: Mayfield.

Bandura, A. (1990). Perceived self-efficacy in the exercise of control over AIDS infection. Evaluation and Program Planning, 13, 9-17.

Blood, R., & Wolfe, D. (1960). Husbands and Wives. New York: Free Press.

Brown, L., DiClemente, R., & Reynolds, L. (1991). HIV prevention for adolescents: utility of the health belief model. AIDS Education and Prevention, 3(1), 50-59.

Byers, E. (1996). How well does the traditional sexual script explain sexual coercion? Review of a program of research. Journal of Psychology and Human Sexuality, 8(1-2), 7-25.

Byrne, D. (1983). Sex without contraception. In Adolescents, sex, and contraception. Hillsdale, NJ: Erlbaum.

Caldwell, M, & Peplau, L. (1984). The balance in lesbian relationships. Sex Roles, 10, 587-599.

Campbell, C. (1995). Male gender roles and sexuality: Implications for women's AIDS risk and prevention. Social Science and Medicine, 41(2), 197-210.

Catania, J., Gibson, D., Chitwood, D., & Coates T. (1990). Methodological problems in AIDS behavioral research: Implications on measurement error and participation bias in studies of sexual behavior. Psychological Bulletin, 108(3), 339-362.

Catania, J., Kegeles, S., & Coates, T. (1990). Towards an understanding of risk behavior: an AIDS risk reduction model (ARRM). Health Education Quarterly, 17(1), 53-72.

Catania, J., McDermott L., & Pollack, L. (1986). Questionnaire response bias and face-to-face interview sample bias in sexuality research. Journal of Sex Research, 22, 52-72.

Carmel, S. (1991). The health belief model in the research of AIDS-related preventive behaviour. Public Health Reviews, 18, 73-85.

Caron, S., Davis, C., Halteman, W., & Stickle, M. (1993). Predictors of condom-related behaviors among first-year college students. The Journal of Sex Research, 30(3), 252-259.

Cate, R., & Lloyd, S. (1988). Courtship. In Handbook of personal relationships. New York: John Wiley.

CDC. (1982a). Update on Kaposi's sarcoma and opportunistic infections in previously healthy persons - United States. MMRR, 31, 294-301.

CDC. (1982b). Pneumocystis carinii pneumonia among persons with hemophilia A. MMRR, 31, 365-367.

CDC. (1982c). Possible transfusion-associated acquired immune deficiency syndrome (AIDS) - California. MMRR, 31, 652-654.

CDC. (1982d). Unexplained immunodeficiency and opportunistic infections in infants - New York, New Jersey, California. MMRR, 31, 665-667.

CDC. (1983). Immunodeficiency among female sexual partners of males with acquired immune deficiency syndrome (AIDS) - New York. MMRR, 31, 697-698.

Collins, C. (1997). Dangerous inhibitions: How America is letting AIDS become an epidemic of the young. UCSF AIDS Research Institute and The Center for AIDS Prevention Studies,University of California, San Francisco.

Community Health. (1996). Young adults shunning AIDS info. In The Evening Telegram, Dec. 1996, 1.

Davis, L., Emerson, S., & Williams, J. (1997). Black dating professionals' perceptions of equity, satisfaction, power, and romantic alternatives and ideals. Journal of Black Psychology, 23(2), 148-164.

Dekin, B. (1996). Gender differences in HIV-related self-reported knowledge, attitudes, and behaviors among college students. American Journal of Preventive Medicine, 12(4), 61-65.

DeKeseredy,W. (1989). Woman abuse in dating relationships:The role of male peer support. Toronto: Canadian Scholar's Press.

.DiClemente, R., Forrest, A., & Mickler, S. (1990). College students' knowledge and attitudes about AIDS and changes in HIV-preventive behaviors. AIDS Education and Prevention, 2(3), 201-212.

DiClemente, R. (1992). Psychosocial determinants of condom use among adolescents. In Adolescents and AIDS: A Generation in Jeopardy. Newbury Park, CA: Sage.

Donovan, C. (1998). Personal Communication. Medical Officer of Health, Health & Community Services - Eastern Region, Newfoundland, Canada.

Du Guerny, J., & Sjoberg, E. (1993). Inter-relationship between gender relations and the HIV/AIDS epidemic: some possible considerations for policies and programmes. AIDS, 7(8), 1027-1034.

Ehrenreich, B., & English, D. (1979). The sexual politics of sickness. In For Her Own Good: 50 Years of the Experts Advice to Women. London: Pluto Press.

Edgar, T., & Fitzpatrick, M. (1993). Expectations for sexual interaction: A cognitive test of the sequencing of sexual communication behaviours. Health Communication, 5(4), 239-261.

Elmer-Dewitt, P. (1996). Turning the Tide. TIME, 148(29), 22-23.

Fearon, M., Major, C., Notenboom, R., Galli, R., Prytula, A., Demshar, H., et al. (1992). HIV Prevalence in Syphillis Submissions from Individuals at Risk for Sexually Transmitted Diseases. 2nd Annual Canadian Conference on HIV/AIDS Research.

Felmlee, D. (1994). Who's on Top? Power in romantic relationships. Sex Roles, 31(5/6), 275-295.

Fine, M. (1988). Sexuality, schooling, and adolescent females: the missing discourse of desire.Harvard Educational Review, 58(1), 29-53.

Fishbein, M., & Ajzen, I. (1975). Belief, attitude, intention and behaviour: An introduction to theory and research. Reading, MA: Addison-Wesley.

Ford, K., & Norris, A. (1995). Factors related to condom use with casual partners among urban African-American and Hispanic males. AIDS Education & Prevention, 7(6). 494-503.

Gayle, H., Keeling, R., Garcia-Tunon, M., Kilbourne, B., Narkunas, J., Ingram, F., Rogers, M., & Curran, J. (1990). Prevalence of the human immunodeficiency virus among university students. New England Journal of Medicine, 323(22), 538-1541.

Gagnon, J., & Simon, W. (1973). Sexual Conduct: The Social Sources of Human Sexuality. Chicago: Aldine.

Godin, G., & Kok, G. (1996). The theory of planned behavior: a review of its applications to health-related behaviors. American Journal of Health Promotion, 11(2), 87-98.

Gordon, G. (1995). Incorporating a gender perspective into sexual health promotion. AIDS/STD Health Promotion Exchange, 11-13.

Gorman, C. (1996 December 30). The Disease Detective. TIME, 148(29), p.24-31.

Government of Newfoundland and Labrador. (1993). Towards the development of a comprehensive HIV/AIDS strategy for Newfoundland and Labrador.

Gray-Little, B., & Burks, N. (1983). Power and satisfaction in marriage: A review and critique. Psychological Bulletin, 93, 513-538.

Harrison, Norris, Kay, Dixon, Peters, & Moore. (1996). Heterosexual risk for HIV among Puerto Rican women: Does power influence self-protective behaviour? Abstract presented at 11th International Conference on AIDS, Vancouver, BC.

Hatfield, E., & Traupmann, J. (1981). Intimate relationships: A perspective from equity theory. In S.W. Duck & R. Gilmour (Eds.), Personal relationships 1: Studying personal relationships. London: Academic Press.

Hawkins, M., Gray, C., & Hawkins, W. (1995). Gender differences of reported safe sex behaviors within a random sample of college students. Psychological Reports, 77, 963-968.

Hays, R., Kegeles, S., & Coates, T. (1990) HIV risk-taking among young gay men. AIDS, 4(9), 901-907.

Health Canada. (1997). HIV/AIDS Epi Update. [On-line]. Available: http://www.hc-sc.gc.ca/hpb/lcdc.

Health Canada. (1998). HIV/AIDS Epi Update. [On-line]. Available: http://www.hc-sc.gc.ca/hpb/lcdc.

Health Canada. (1999). HIV and AIDS in Canada. Surveillance Report to June 30, 1999. Division of HIV/AIDS Surveillance, Bureau of HIV/AIDS, STD and TB, LCDC.

Herold, E., & Way L. (1988). Sexual self-disclosure among university women. Journal of Sex Research, 24, 1-14.

Hogg, R., Heath, K., Strathdee, S., Montaner, J., O'Shaughnessy, M., & Schechter, M. (1996). HIV/AIDS mortality in Canada: Evidence of gender, regional and local area differentials. AIDS, 10(8), 889-894.

Holland, J., Ramazanoglu, C., Scott, S., Sharpe, S., & Thomson, R. (1992). Risk, power and the possibility of pleasure: young women and safer sex. AIDS CARE, 4(3), 273-283.

Hughes, W. (1998). Prologue to AIDS: the recognition of infectious opportunists. Medicine, 77(4), 227-232.

Ingham, R., Woodcock, A., & Stenner, K. (1991). Getting to know you...young people's knowledge of their partners at first intercourse. Unpublished paper, Department of Psychology, University of Southhampton.

Janz, N., & Becker, M. (1984). The health belief model: A decade later. Health Education Quarterly, 11, 1-47.

Joffe, H. (1996). AIDS research and prevention: a social representational approach. BritishJournal of Medical Psychology, 69, 169-190.

Kent, V., Davies, M., Deverell, K., & Gottesman, S. (1990). Social interaction routines involved in heterosexual encounters: prelude to first intercourse. Paper presented at 4th Conference on Social Aspects of AIDS, South Bank Polytechnic, London.

King, A., Beazley, R., Warren, W., Hankins, C., Robertson, A., & Radford, J. (1988). Canada Youth & AIDS Study. Queen's University at Kingston.

Kopinak, K. (1988). Gender differences in political ideology in Canada. Canadian Review of Sociology, 24(1), 23-28.

LaPlante, M., McCormick, N., & Branningan, G. (1980). Living the sexual script: college students' views of influence in sexual encounters. The Journal of Sex Research, 16(4), 338-353.

Lear, D. (1995). Sexual communication in the age of AIDS: The construction of risk and trust among young adults. Social Science and Medicine, 41(9), 1311-1323.

Lear, D. (1997). Sex and Sexuality: Risk and Relationships in the age of AIDS. Thousand Oaks: Sage Publications

Levy, JJ., Samson, JM., Lopez, F., Picod-Bernard, C., & Maticka-Tyndale, E. (1993). Risky sex and contraception in students in France, Quebec and Spain. Contracept Fertil Sex, 21(12), 914-919.

Lollis, C., Johnson, E., & Antoni, M. (1997). The efficacy of the health belief model for predicting condom usage and risky sexual practices in university students. AIDS Education & Prevention, 9(6), 551-563.

Lottes, I. (1993). Nontraditional gender roles and the sexual experiences of heterosexual college students. Sex Roles, 29(9/10), 645-669.

McClain, J., & Matteoli, T. (1989). Confronting AIDS On the Campus and in the Classroom: A Guide for Higher Education. Washington, D.C.: College and University Personnel Association.

Mackie, M. (1991). Gender Relations in Canada. Markham: Butterworths Canada Ltd.

Mahoney, C., Thombs, D. & Ford, O. (1995). Health belief and self-efficacy models: Their utility in explaining college student condom use. AIDS Education and Prevention, 7(1), 32-49.

Maticka-Tyndale, E., (1995). Can we? Have we? Prevention of sexual transmission of HIV. The Canadian Journal of Human Sexuality, 4(2), 79-102.

Maticka-Tyndale, E., (1997). Reducing the incidence of sexually transmitted disease through behavioural and social change. The Canadian Journal of Human Sexuality, 6(2), 89-104.

Maxwell, C., & Boyle, M. (1995). Risky heterosexual practices amongst women over 30: Gender, power and long term relationships. AIDS Care, 7(3), 277-293.

Marin, B.VanOss, Gomez, C., & Tschann, J. (1991). Condom use among hispanic men with secondary female sexual partners. Public Health Reports, 108(6), 742-750.

Misovich, S., Fisher, J., & Fisher, W. (1996). The perceived AIDS-preventive utility of knowing one's partner well: A public health dictum and individuals' risky sexual behaviour. The Canadian Journal of Human Sexuality, 5(2), 83-90

Mitchell, M., & Jolley, M. (1999). Research Design Explained. New York: Harcourt Brace.

Mulvihill, C. (1996). AIDS education for college students: Review and proposal for a research-based curriculum. AIDS Education and Prevention, 8(1), 11-25.

Myers, T., & Clement, C. (1994). Condom use and attitudes among heterosexual college students. Canadian Journal of Public Health, 85(1), 51-55.

National Centre in HIV Social Research, (1996). Macquarie University, Australia.

Norman, G., & Streiner, D. (1994). Biostatistics: The bare essentials. St. Louis: Mosby.

O'Sullivan, L., & Byers, E. (1992). College students' incorporation of initiator and restrictor roles in sexual dating interactions. The Journal of Sex Research, 29, 435-446.

Otis, J., Levy, J., Samson, J., Pilote, F., & Fugere, A. (1997). Gender differences in sexuality and interpersonal power relations among french-speaking young adults from Quebec: A province-wide study. The Canadian Journal of Human Sexuality, 6(1), 17-28.

Public Health Laboratory. (1999). St. John's Health Care Corporation. St. John's NF.

Raj, A., & Pollack, R. (1996). Factors predicting high-risk sexual behaviour in heterosexual college females. Journal of Sex & Marital Therapy, 21(3), 213-224.

Reed, D., & Weinberg, M. (1984). Premarital coitus: developing and established sexual scripts. Social Psychology Quarterly, 47(2), 129-138.

Richardson, H., Beazley R., Delaney, M., & Langille D. (1997). Factors influencing condom use among students attending high school in Nova Scotia. The Canadian Journal of Human Sexuality, 6(3), 185-196.

Rose, S., & Frieze, I. (1989). Young singles scripts for a first date. Gender & Society, 3(2), 258-268.

Rosenstock, I., Strecher, V., & Becker, M. (1988). Social learning theory and the health belief model. Health Education Quarterly, 15, 175-183.

Santelli, J., Kouzis, A., Hoover, D., Polacsek, M., Burwell, L., & Celentano, D. (1996). Stage of behavior change for condom use: The influence of partner type, relationship and pregnancy factors. Family Planning Perspectives, 28(3), 101-107.

Salt, H., Bor, R., & Palmer, R. (1987). Issues of gender and power relationships in HIV prevention and care. In R. Connell (ed) Gender and Power.

Scott, A., & Griffin, H. (1989). Concept testing the Dundee 'Condom in AIDS prevention' initiative. Report in Tayside Health Board, Advertising Research Unit, University of Strathclyde.

Sex & Health. (1998 September). Glamour, p.113.

Simon, W., & Gagnon, J. (1986). Sexual Scripts: Permanence and Change. Archives of Sexual Behavior, 15(2), 97-120.

Somera, D., & Laub, C. (1997). Breakin' down sexual scripts: Empowering youth in HIV prevention education. AIDS Prevention Program at the YWCA of the Mid-Peninsula, California.

Sprecher, S. (1985). Sex differences in bases of power in dating relationships. Sex Roles, 12, 449-462.

Stets, J., & Pirog-Good, M. (1987). Violence in dating relationships: Emerging social issues. New York: Praeger.

Taylor, B. (1995). Gender-power relations and safer sex negotiation. Journal of Advanced Nursing, 22, 687-693.

Uddin, M. (1996). College women's sexuality in an era of AIDS. Journal of American College Health, 44, 252-261.

UNAIDS. (1997). World Health Organization Report on the Epidemic.

UNAIDS. (1999). AIDS epidemic update: December 1999.

Waller, W. (1937). The rating and dating complex. American Sociological Review, 2, 727-734.

Ward, J., & Drotman, D.P. (1992). Epidemiology of HIV and AIDS. In Gary P. Wormser (Ed.) AIDS and Other Manifestations of HIV Infection. New York: Raven Press.

Wendt, S., & Solomon, L. (1990). Barriers to condom use among heterosexual male and female college students. American Journal of College Health, 44, 105-110.

Wight, D. (1992). Impediments to safer heterosexual sex: a review of research with young people. AIDS CARE, 4(1), 11-23.

Wingood, G., Hunter-Gamble, D., & DiClemente, R. (1993). A pilot study of sexual communication and negotiation among young African-American women: Implications for HIV prevention. Journal of Black Psychology, 19(2), 190-203.

Wulfert, E., & Wan, C. (1993). Condom use: A self-efficacy model. Health Psychology, 12(5), 346-353.

10. Appendices

Appendix A

1. Medical and Historical Overview of HIV/AIDS Epidemic in North America

AIDS is caused by HIV which affects the body's immune system. The immune system identifies, isolates, and eliminates foreign invaders from the body (McClain & Matteoli, 1989). HIV affects the T4 helper cells of the immune system. These T4 helper cells are primarily responsible for recognizing, activating and proliferating in response to a foreign invader. Also, these cells regulate other immune responses by signalling other cells of the immune system such as T8 cells, B cells, and macrophages and by controlling their action. The destruction of these T4 cells causes the collapse of the body's immune system (McClain & Matteoli).

HIV alone does not cause a definable illness (Hughes, 1998). HIV causes people to become more susceptible to certain infections as their immune systems cannot function properly. These infections are called "opportunistic infections" and take advantage of the weakened immune system. Two of the more prevalent opportunistic infections associated with HIV/AIDS are Pneumocystis carinii pneumonia (PCP), a form of pneumonia found in immunosuppressed individuals, and Karposi's sarcoma (KS) which is a cancer originating from the cells of the lining of blood vessel walls. A primary manifestation of KS is raised dark purple skin or mucous membrane lesions (McClain & Matteoli, 1989). A person acquires an opportunistic infection that, in turn, causes the syndrome of illness (Hughes, 1998). These opportunistic infections would rarely cause disease in a person with a normal immune system. However, to a person with AIDS these infections can be

fatal (McClain & Matteoli).

Between October 1980 and May 1981, five young men, all sexually active homosexuals, were treated for PCP at three different hospitals in Los Angeles, California. Two of them died (McClain & Matteoli). By 1980, most physicians were aware that PCP occurred only in individuals with immunosuppression as it had occurred primarily among cancer patients who had undergone chemotherapy (Hughes, 1998). Also, KS was a disease found primarily among men of Mediterranean origin which was rarely fatal (McClain & Matteoli). Thus, physicians searched for an underlying disease process that damaged immune systems (Hughes).

In 1982, the CDC published a report about the incidence of KS and PCP among homosexual men in the states of New York and California. The report said that during the past thirty months, KS had been diagnosed in 20 homosexual men in New York and six in California. Eight of these patients died within two years of a KS diagnosis. Four of these were also diagnosed with PCP.

One month later, the CDC reported that the majority of PCP and KS cases had occurred in homosexual and bisexual men aged 25-49 years (McClain & Matteoli, 1989; Ward & Drotman, 1992). The CDC also reported the mortality rates for persons diagnosed with PCP to be fifty percent and seventeen percent among those diagnosed with KS. Among those diagnosed with both KS and PCP, the mortality rate was forty-three percent (McClain & Matteoli). Other serious opportunistic infections were found among persons diagnosed with KS and/or PCP. Thus, the CDC concluded that the

combination of KS and PCP among homosexual men suggested an association with immunosuppression (McClain & Matteoli).

Subsequent reports from the CDC in 1982 and 1983 (CDC, 1982a,1982b,1982c,1982d; CDC, 1983) identified persons with hemophilia, recipients of blood and blood products, intravenous drug users, and their heterosexual partners and children who had opportunistic infections associated with immunosupression (Ward & Drotman, 1992).

Labratory testing revealed that the patients' immune systems had failed for no apparent reason (McClain & Matteoli, 1989). In late 1981, with less than a dozen cases, the underlying problem was determined to be an acquired immunodeficiency, and the CDC established a surveillance case definition that formally listed the opportunistic infections indicating immunosuppression (Ward & Drotman, 1992; Hughes 1998). Beginning in 1982, the immune disorder and the associated illnesses became known as the acquired immunodeficiency syndrome, or AIDS (Ward & Drotman).

During this period, three hypotheses were being proposed as follows: immune overload, multifactorial, and single agent. Immune overload was the first theory to be proposed and initially appeared to provide a possible explanation for the occurrence of AIDS (McClain & Matteoli, 1989). Researchers proposed that repeated infections from STDs and the use of recreational drugs combined to overload the immune system. This theory was disregarded when AIDS occurred among persons not engaging in certain sexual practices or drug use (McClain & Matteoli).

The multifactorial theory suggested that exposure to infectious agents and/or immunosuppresive agents could induce cellular dysfunction. The combination of further infection, drug use, alcohol abuse and genetic and environmental factors would eventually cause the immune system to fail (McClain & Matteoli, 1989). The fault of this theory was that not all homosexual men nor others with AIDS fit the multifactorial profile (McClain & Matteoli).

Because AIDS appeared in populations besides homosexual men researchers suspected that AIDS could be caused by a single infectious agent rather than by the sexual behaviour of a particular group and that this infectious agent was transmitted in blood and/or body fluids of infected individuals (McClain & Matteoli, 1989). Researchers explored the suggestion that AIDS could be a retrovirus, a unique class of viruses because of the reversal of direction in genetic material from RNA to DNA (McClain & Matteoli, 1989). Dr. Robert Gallo was the first to isolate a retrovirus from humans in 1980. This retrovirus displayed a pre-disposition for human T lymphocytes. When a related virus was isolated from a leukemia patient the viruses were designated as human T cell lymphotrophic virus Type I and II (HTLV I and II). Researchers thought that AIDS might be related to HTLV I and II (McClain & Matteoli).

In May of 1983, a scientific breakthrough was made when Dr. Luc Montagnier and his team at the Pasteur Institute in Paris, France reported that they had found a retrovirus that may cause AIDS. He named his discovery lymphadenopathy-associated virus (McClain & Matteoli, 1989). Shortly after this, Dr. Robert Gallo of the National

Cancer Institute in Bethesda, Maryland, declared that his laboratory had also isolated the AIDS virus (Gorman, 1996). Gallo named his discovery human T cell lymphotropic virus type III (HTLV III) (McClain & Matteoli). Jay Levy at the University of California, San Francisco, independently isolated what was a third agent which he named AIDS-related virus (McClain & Matteoli). Evidence revealed that the three retroviruses were essentially the same and caused AIDS. In 1986, the International Committee on Taxonomy of Viruses proposed that the AIDS virus be called Human Immunodeficiency Virus or HIV as it is called today (McClain & Matteoli; Ward & Drotman, 1992).

The first Canadian case of AIDS was identified in 1982 (Health Canada, 1998). By 1985, the Red Cross had instituted a mandatory blood screening program for all blood donated in Canada. (Government of Newfoundland and Labrador, 1993). In 1984, two people tested positive for HIV in Newfoundland and in 1986, the first case of AIDS was reported (Government of Newfoundland and Labrador).

The increasing numbers of people infected with AIDS led to the issuing of a landmark report in October of 1986 by the U.S. Surgeon General C. Everett Koop. This report urged public health measures and sex education to help prevent the transmission of AIDS (Gorman, 1996).

During 1987 scientists continued to search for both treatment and methods to prevent HIV. AZT (zidovudine) was approved as a treatment for AIDS during this time and experiments began with the hope of finding a vaccine for AIDS. July of 1992 hailed the first report of a combination drug therapy for AIDS (Gorman, 1996). After a couple of

more years of laboratory testing, these protease inhibitors were used in combination with AZT and another drug 3TC to combat the AIDS virus. This was thought to be a good treatment for HIV as it would be increasingly difficult for the virus to simultaneously resist the therapy on three different fronts (Gorman). Mathematical models suggest that patients diagnosed and treated early enough might be virus-free within two or three years (Elmer-Dewitt, 1996).

This represents some hope for those involved in the fight against AIDS. The virus may not be invincible after all. However, this hope is not all encompassing as the treatment does not address those in the late stages of the disease, the cost of the therapy is beyond the reach of many of those infected, and the treatment is not available to those who live in underdeveloped and developing countries which compose the majority of the HIV-infected (Elmer-Dewitt, 1996).

2. Prevalence of HIV

The United Nations estimates, based on a country by country analysis, indicate the number of HIV infections worldwide is 30 percent higher than previously thought (UNAIDS, 1997). In 1999, there were 5.6 million new HIV infections (UNAIDS, 1999). There are currently 33.6 million people living with HIV/ AIDS and 2.6 million individuals died last year due to HIV/ AIDS (UNAIDS). The cumulative number of deaths worldwide due to HIV/AIDS to December 31, 1999 was 16.3 million (UNAIDS).

In North America there were 44,000 new infections in 1999 and 920,000 people

living with HIV/ AIDS (UNAIDS, 1999). The adult prevalence rate was 0.56% with 20% of HIV positive people being women (UNAIDS).

There were 44,427 positive HIV tests in Canada from November 1, 1985 to June 30, 1999 (Health Canada, 1999). Of these, 36,275 were male, 5371 were female and 2781 were reported without gender. Up to June 30, 1999 16,628 AIDS cases had been diagnosed in Canada (Health Canada). Of these, 15,336 were male, 1292 were female (Health Canada). The ratio in Canada of male to female cases was 12:1. The percentage of AIDS cases attributable to heterosexual contact with a person at risk was 5.9% (Health Canada).

In Newfoundland, there were 200 positive HIV tests between November 1, 1985 and September 30, 1999. Of these, 153 were male and 47 were female. This was a ratio of 3:1 of positive male tests to female tests (Health Canada, 1999). In Newfoundland, there were 77 cases of AIDS diagnosed up to September 30, 1999 (Public Health Laboratory, 1999). Sixty of these were male and 17 were female. This was a ratio of 4:1 of male cases versus female cases (Health Canada). Of the77 cases, 34 were attributable to men who have sex with men, 20 to heterosexual contact with a person at risk, 12 to receiving blood products, 4 to perinatal transmission, 2 to injection drug use only, 1 to men who have sex with men and injection drug use (Public Health Laboratory). The percentage of AIDS cases attributable to heterosexual contact with a person at risk was 26.0%. (Public Health Laboratory).

Over the period of January 1, 1987 to December 31, 1992, deaths from HIV/AIDS accounted for 3.6% of potential years of life lost (PYLL) before age sixty-five in men and 0.4% of PYLL in women in Canada (Hogg et al., 1996). In 1992, HIV/AIDS was the third leading cause of male PYLL in Canada. In Montreal, Toronto, and Vancouver HIV/AIDS was the leading cause of PYLL and was responsible for a significant decrease in life expectancy at birth in men over the study period of January 1, 1987 to December 31, 1992 (Hogg et al.).

3. An Epidemic Getting Younger

A recent study from the National Cancer Institute in the United States warns that while the rate of new AIDS cases reported among people born before 1960 appears to be reaching a plateau, the rate among younger Americans born after 1960 continues to escalate (Collins, 1997). In young people more than any other group, HIV is spread sexually. Two groups of young people at risk for sexual exposure to HIV account for roughly three-quarters of the adolescent epidemic: men who have sex with men and women infected through heterosexual sex (Collins).

In Canada, more and more infections are occurring in young people. The Bureau of HIV/AIDS and STD had estimated that between 1975 and 1984, the median age of HIV infection in Canada was 29.6 years. Between 1985 and 1990, the median age of infection in Canada was 24.5 years (Health Canada, 1997). As of June 30, 1999, a total of 16,438 AIDS cases had been reported to the Laboratory Centre for Disease Control

(Health Canada, 1999). Of these, eighty had been among adolescents between the ages of ten and nineteen years and 2752 were among those aged twenty to twenty-nine years (Health Canada). Many of those in the latter group were probably infected with HIV as teenagers as there may be a lag of ten years or more between HIV infection and the onset of AIDS (Health Canada).

An increasing trend is also noticed toward heterosexual transmission of AIDS. Before 1990 only 2.2% of all AIDS cases in Canada could be related to heterosexual transmission. Between 1990 and 1995 5.6% of AIDS cases were attributable to heterosexual transmission (Health Canada, 1997). In the first six months of 1999, 18.3% of all positive HIV tests among adults for which exposure category was known were attributable to heterosexual contact (Health Canada, 1999).

The rate of HIV infection appears to be growing faster among young women than any other group. The proportion of U.S. adolescent AIDS cases among females has tripled from 14% in 1987 to 46% of the reported cases in the year preceding July 1996. Heterosexual sex accounts for three quarters of the cases in young women. The pattern of infection among North American youth is consistent with the evolving global epidemic (Collins, 1997).

In Canada, as of June 30, 1999, adult women accounted for 13.0% of all positive HIV test reports for which age and gender are known, 24.0% of positive HIV tests among all adults and 12.4% of diagnosed AIDS cases (Health Canada, 1999). As of June 30, 1999, 4.7% of positive HIV reports and 7.0% of diagnosed AIDS cases were among

female children under the age of fifteen (Health Canada).

4. Economic Impact of HIV/AIDS

It is very difficult to estimate an exact dollar cost of HIV/AIDS in Canada. However, there are direct costs, indirect costs and societal costs associated with HIV/AIDS (Government of Newfoundland and Labrador, 1993).

Direct costs related to HIV/AIDS such as diagnosis, hospital care, continuing care, physician care, drug costs and the cost of using other health professionals may increase exponentially as more people become infected with HIV. The costs of HIV testing and counselling are also increasing as public awareness of HIV increases. In 1998 there were 11731 HIV screening tests performed in Newfoundland (Public Health Laboratory, 1999).

The screening of donated blood, the use of universal precautions, and public education have a monetary cost to society. In 1992, the cost of screening 34,300 blood donors in Newfoundland and Labrador was about $125,000 while approximately $220,000 was allocated from the budget of the Health Promotion Division towards public education (Government of Newfoundland and Labrador, 1993).

5. Canadian Strategy on HIV/AIDS

In an attempt to alleviate the economic and societal costs associated with HIV/AIDS the Canadian government launched the National AIDS Strategy in 1990. The National AIDS Strategy provides a framework for federal leadership and facilitates the

implementation of various initiatives to help society better cope with the demands of HIV/AIDS (Health Canada, 1998). Phase I committed $112 million over three years to support a variety of research, surveillance and community development initiatives. Substantial progress was made in education, prevention, care and treatment (Health Canada).

Phase II of the National AIDS Strategy was launched in 1993. Phase II provided $211 million over five years or $42.2 million a year. Phase II responded to the growing complexity of HIV/AIDS in Canada and the need for extended commitment of time and funding (Health Canada, 1998). The partnerships started during Phase I were built upon and further developed during Phase II. Significant accomplishments were made during Phase II with respect to educating Canadians and health care professionals about HIV/AIDS. Also, National surveillance systems were established, new models of individual and family care and support were developed, and more effective drugs and therapies were found and made available (Health Canada). Phase II ended on March 31, 1998. On May 28, 1998, the Federal Minister of Health announced details of a new Canadian Strategy on HIV/AIDS. This includes the annual funding of $42.2 million a year to be allocated primarily for prevention, community development, treatment, surveillance, and research.

The goals of the strategy are to:

- prevent the spread of HIV infection in Canada
- find a cure

- find and provide effective vaccines, drugs and therapies
- ensure care, treatment and support for Canadians living with HIV/AIDS, their families friends and caregivers
- minimize the adverse impact of HIV/AIDS on individuals and communities
- minimize the impact of social and economic factors that increase individual and collective risk for HIV (Health Canada, 1998).

A Ministerial Council on HIV/AIDS has also been formed to provide ongoing advice to the Minister of Health pertaining to keeping the strategy flexible and responsive to the changing nature of HIV/AIDS, promoting alliances and joint efforts, reaching and responding to the groups at risk, and assisting in the development of long-term plans for future action on HIV/AIDS (Health Canada, 1998).

6. HIV/AIDS Strategy for Newfoundland and Labrador

During the summer of 1992 the Provincial Minister of Health gave a mandate for the province to coordinate the development of a comprehensive HIV/AIDS Strategy for Newfoundland and Labrador (Government of Newfoundland and Labrador, 1993). The objectives were to:

- devise a framework for the development of a comprehensive HIV/AIDS Strategy for Newfoundland and Labrador.

- develop recommendations related to HIV Prevention and Education, Testing and Treatment, and Care and Home Support.
- develop a comprehensive HIV/AIDS Strategy for Newfoundland and Labrador.
- devise a proposed implementation plan with the necessary human and financial resource implications.

(Government of Newfoundland and Labrador, 1993).

Meeting these objectives involved an extensive consultation process. Consultants included members of the HIV Prevention and Education, Testing and Treatment, and Care and Home Support advisory groups, experts in the field of HIV/AIDS, community health personnel, members of aboriginal communities, and government representatives from across Canada. This consultation process resulted in twenty-three recommendations to the Provincial Government for dealing with HIV/AIDS in Newfoundland and Labrador (Government of Newfoundland and Labrador, 1993). An update of the Newfoundland and Labrador HIV/AIDS Strategy to bring it in line with the new national strategy is on the agenda at the provincial government level. However, there has been no timeline given for the completion of this update.

Appendix B

28. What was the difficulty in negotiating safe sex with a sexual partner and how did you resolve it?

When I was a teenager my partners did not want to use a condom. It took away from the moment. Didn't know if they would work anyway. They said it took away from sexual feeling. Sometimes I took chances anyway. **Female, 36 yrs**

The problem was my first boyfriend so eventually I left him. **Female, 19 yrs**

Allergies. Just didn't like condoms. **Female, 19 yrs**

The difficulty was that he didn't like to use condoms because it didn't make sex feel the same; it's not as good. I told him I was really nervous and we have to use condoms or we can't have sex right now. I say let's just try them. **Female, 19 yrs**

Problem: he wouldn't use condoms. It was never really resolved. I couldn't make him see my point and he'd just get mad and complain. **Female, 19 yrs**

The feel wasn't the same. She went on the pill. **Male, 19 yrs**

Didn't want to use condom. I prefer the pill as a safe sex precaution. **Male, 21 yrs**

The condoms are too uncomfortable and I didn't want to use it. But, I tried for a while

then I quit. **Male, 22 yrs**

29. What is your approach to negotiating safe sex with a sexual partner?

If I think we are going to have sex, I'll ask if he has a condom, and in the process or maybe before it will take place either on past dates or that night when it was an issue, ask about his sex history. I wouldn't have sex with someone who is known to have a lot of sex partners. **Female, 20 yrs**

Talk logically, assess risk for both partners. Make a mutual discussion a success. Consider alternatives. **Female, 19 yrs**

My sexual partners are usually very intelligent well-educated males who strongly agree with safer sex to reduce the chance of STDs and pregnancy. Either my partner or I will take the responsibility for condoms, in my relationships. I can and have talked openly about safe sex. I take responsibility, obviously, for oral contraceptives. If one has an open relationship, one can talk about anything in an understanding and meaningful way. **Female, 19 yrs**

Talk about it beforehand. **Female, 19 yrs**

My approach to negotiating safe sex was never difficult with my partner because we both

have similar feelings about sex and the risks. **Female, 19 yrs**

In the past my partners were always responsible enough to ensure protection. Currently, I am married with one child and another on the way so I find some of these questions hard to apply. **Female, 25 yrs**

Before having sex, I make sure he knows that if there won't be a condom, there won't be any sex. The fact that I'm on the pill means nothing. I want him to use a condom. **Female, 19 yrs**

My approach would be safe sex or no sex. Why take the chance of becoming pregnant or getting an STD for the sake of a night of pleasure. **Female, 19 yrs**

Both partners responsible for protecting against pregnancy and STDs. Insist on knowing sexual history of partners. Suggest having STD test done before having sex. **Female, 21 yrs**

No glove, no love. **Female, 22 yrs**

Tell him be safe or no sex! **Female, 19 yrs**

Let them know I will not have sex unless they use a condom. **Female, 19 yrs**

Refuse unless condom is used. **Female, 19 yrs**

If we don't use a condom or other means of protection, I'm not participating. Be assertive. **Female, 21 yrs**

My boyfriend and I know the risk. Neither is ready for a family or wants a STD. My main concern is pregnancy. I was a virgin and he was tested before we ever had intercourse. He is very understanding and until we are ready to have a family we agreed to be as safe as possible. **Female, 20 yrs**

I ask them to wear a condom. If they say no, then I say we have to stop. If they say yes, I ensure that it is a condom that is not expired, latex, and has N-9. **Female, 20 yrs**

I inform my partner that I am simply not willing to take the risks associated with unprotected sex. **Male, 23 yrs**

For me, it's either safe sex or no sex and I let my boyfriend know this. **Female, 20 yrs**

Simple - no condom no sex. **Female, 23 yrs**

Using condoms. **Female, 19 yrs**

Talking and reasoning with them; pros vs cons. **Female, 20 yrs**

With a new partner it is always assumed that a condom will be worn. **Female, 21 yrs**

Well, to be totally honest, my partner was tested and is fine. I am on the pill but do not use condoms regularly. **Female, 19 yrs**

Both have to agree. **Female, 22 yrs**

I believe that if you are seeing a person you don't know well you should want that partner to wear a condom. I say either wear a condom or forget it! **Female, 21 yrs**

My main approach as well as his is to practice every caution to discourage the chance of possible pregnancy. **Female, 19 yrs**

I say that without condoms available, I would refuse to have sex with a new partner, unless we had known each other for a period of six months or longer and knew each other's sexual history. If they had something or weren't quite sure if they had something, I

would make sure they got tested. If they had something serious (HIV, Herpes), I would not have sex with them. **Female, 21 yrs**

At a certain point in my life I realized (I guess you could say I started to use my intelligence) that sex without protection could possibly mean my life. Now its "no condom, no sex". **Female, 19 yrs**

Decision was agreed upon by me and my partner from the beginning. It was a priority for both of us. **Female, 19 yrs**

Unless I know the person very well, I will not engage in sex without negotiating. **Male, 22 yrs**

I ask if they have a condom. If they don't, in most cases, I have refused to have sex. However, there have been times when I have had sex without using a condom. **Female, 21 yrs**

Talk about the risks involved without safe sex. Make sure we understand the safe sex methods which are available. Make sure we are both ready to engage in sexual activity. **Male, 21 yrs**

Condoms. **Male, 21 yrs**

Either a condom is used or there will be no sex. **Female, 21 yrs**

It's never been a negotiation - always a given for both parties. **Female, 22 yrs**

Open, honest, no negotiations. My way or the highway! **Female, 19 yrs**

Be open and honest. **Male, 21 yrs**

There is not too much negotiating. If he is not into using a condom, I refuse to sleep with him. **Female, 19 yrs**

Negotiations are unnecessary. We are both strong believers in the most adequate, safe, and sure methods of contraceptives. **Male, 19 yrs**

Q. Do you want to wear a condom?

A. Yes. **Male, 20 yrs**

Safe sex or no sex!! **Female, 19 yrs**

I just say, you may not want what I may have. **Male, 21 yrs**

Talking openly and choosing the safest practice with regard to sex and safe sex. **Male, 21 yrs**

In partners I've experienced negotiating safe sex has never been a problem. Safe sex is a priority for both of us. **Female, 19 yrs**

No sex. **Female, 19 yrs**

I usually tell the person I feel nervous about getting pregnant and I would feel much better if we had all the protection against pregnancy as possible. **Female, 19 yrs**

Simply ask. **Female, 22 yrs**

Appendix C

A. Roles of Men and Women N=87

Statement	n	Always (%)	Often	Sometimes	Almost Never	Never
1.Men should take financial responsibility for a date	85	1 (1.2)	4 (4.7)	55 (64.7)	10 (11.8)	15 (17.6)
2.Men should have more sexual experience than women	84	0	2 (2.4)	16 (19.0)	14 (16.7)	52 (61.9)
3.A lack of sex takes a greater toll on men than women	84	2 (2.4)	20 (23.8)	13 (15.5)	16 (19.0)	33 (39.3)
4.Women should bear the primary responsibility for protecting against pregnancy	85	1 (1.2)	4 (4.7)	12 (14.1)	7 (8.2)	61 (71.8)
5.Women should bear the primary responsibility for protecting against STDs	86	4 (4.7)	1 (1.2)	12 (14)	7 (8.1)	62 (72.1)

B. Sexual Behaviour

6. Have you ever had sexual intercourse? n=82

73 (89.0) ☐ Yes - ***Please continue with Question 7***
9 (11.0) ☐ No - ***Go to Section G***

7. Over your lifetime, approximately how many sexual partners have you had? n=69

Number of partners	Frequency	Percent of respondents (%)
1 partner	21	30.4
2 partner	15	21.7
3 partners	8	11.6
4 partners	6	8.7
5 partners	4	5.8
6 partners	7	10.1
7 partners	3	4.3
10 partners	1	1.4
12 partners	2	2.9
13 partners	1	1.4
20 partners	1	1.4

8. Have your sexual partners been n=74

55 (74.3)	❑ Men only (55 female)
19 (25.7)	❑ Women only (19 male)
0	❑ Both men and women

9. How would you describe your sexual relationship(s) at present? n=69

19 (27.5)	❑ None
6 (8.7)	❑ Casual sex only
0	❑ Regular relationship plus both partners have casual sex
0	❑ Regular relationship plus I have casual sex

0	❑ Regular relationship plus partner has casual sex
0	❑ Regular relationships with several partners
41 (59.4)	❑ Monogamous relationship with one partner
3 (4.3)	❑ Other (please specify)_____
0	❑ Don't know

10. Have you had sexual intercourse in the past twelve months? n=72

63 (87.5)	❑	Yes -	***Continue with Question 11***
9 (12.5)	❑	No -	***Go to Section G***

11. Approximately how many sexual partners have you had in the past twelve months? n=61

Number of partners	Frequency	Percent
1	42	68.9
2	11	18.0
3	5	8.2
4	2	3.3
5	1	1.6

C. Assertiveness and Communication

Statement	n	Always	Often	Sometimes	Almost Never	Never
12. I assume that I am responsible for supplying condoms if the need arises	60	21 (35.0)	3 (5.0)	25 (41.7)	4 (6.7)	7 (11.7)
13. During sexual situations I am the first to suggest using a condom	60	9 (15.0)	17 (28.3)	25 (41.7)	5 (8.3)	4 (6.7)
14. I am the first to initiate discussions about safer sex with a partner	60	6 (10.0)	12 (20.0)	30 (50.0)	7 (11.7)	5 (8.3)
15. I will have sex just to please a partner	61	2 (3.3)	2 (3.3)	18 (29.5	16 (26.2)	23 (37.7)
16. I discuss condom use with a partner several dates before engaging in sex	57	10 (17.5)	10 (17.5)	13 (22.8)	13 (22.8)	11 (19.3)
17. I discuss my sexual history honestly with a partner	60	37 (61.7)	11 (18.3)	5 (8.3)	6 (10.0)	1 (1.7)
18. I tell my partner when we are getting more physically intimate than I would like	59	33 (55.9)	7 (11.9)	13 (22.0)	3 (5.1)	3 (5.1)
19. I feel comfortable refusing sexual activity with someone, even if we've had sex together before	60	30 (50.0)	11 (18.3)	11 (18.3)	5 (8.3)	3 (5.0)

D. Safer Sex Behaviour

Statement	n	Always	Often	Sometimes	Almost Never	Never
20.I question a partner about his/her sexual history	60	28 (46.7)	16 (26.7)	11 (18.3)	4 (6.7)	1 (1.7)
21.I delay sex until I know a partner well enough to practice safer sex	58	28 (48.3)	15 (25.9)	11 (19.0)	3 (5.2)	1 (1.7)
22. I limit my sexual activity to practices known to be less risky	59	20 (33.9)	17 (28.8)	17 (28.8)	4 (6.8)	1 (1.7)
23. I use condoms during sexual activity	60	17 (28.3)	13 (21.7)	20 (33.3)	6 (10.0)	4 (6.7)
24. I carry condoms with me on a date	58	8 (13.8)	3 (5.2)	14 (24.1)	9 (15.5)	24 (41.4)
25. I would refuse to have intercourse with a partner if no condom was available	58	21 (36.2)	12 (20.7)	18 (31.0)	6 (10.3)	1 (1.7)
26.I would insist on using a condom even if my partner did not want to use one	58	26 (44.8)	12 (20.7)	13 (22.4)	6 (10.3)	1 (1.7)

27. Have you ever experienced difficulty in negotiating safer sex (ie. using condoms) with a sexual partner? n=60

11 (18.3) ❑ Yes - ***Continue with Question 28***

49 (81.7) ❑ No - ***Go to Question 29***

28. What was the difficulty and how did you resolve it? n=8
(*See Appendix B for complete results*)

29. What is your approach to negotiating safer sex with a sexual partner? n=46
(*See Appendix B for complete results*)

30. In the past twelve months have you had a ***steady*** sexual partner?

For the purposes of this questionnaire, a steady sexual partner is defined as a person one has sex with in an ongoing relationship and may include a spouse.

52 (86.7)	☐	Yes	-	***Continue with Question31***
8 (13.3)	☐	No	-	***Go to Section G***

For the next two sections, please answer the following questions based your relationship with a steady sexual partner.

E. Power Balance

Statement	n	Always	Often	Sometimes	Almost Never	Never
31. In my relationship I have/had more power than my partner	53	4 (7.5)	0	30 (56.6)	11(20.8)	8 (15.1)
32. In my relationship I make/made more of the decisions about what we do together than my partner	53	3 (5.7)	10 (18.9)	25 (47.2)	10(18.9)	5 (9.4)
33. I am/was more emotionally involved in the relationship than my partner	51	1 (2.0)	0	24 (47.1)	11(21.6)	15 (29.4)
34. I get/got a "better deal" in this relationship than my partner	52	1 (1.9)	4 (7.7)	11 (21.2)	13(25.0)	23 (44.2)
35. I wouldn't feel comfortable asking a steady partner to use a condom	52	4 (7.7)	3 (5.8)	3 (5.8)	7 (13.5)	35 (67.3)
36. If I asked my partner to use condoms, he/she would be angry	53	1 (1.9)	1 (1.9)	3 (5.7)	2 (3.8)	46 (86.8)
37. If I asked my partner to use condoms, he/she would refuse to have sex	52	0	1 (1.9)	2 (3.8)	4 (7.7)	45 (86.5)
38. If I asked my partner to use condoms, he/she would become violent	52	0	0	0	2 (3.8)	50 (96.2)
39. It would bother me to have a steady partner become angry	53	20 (37.7)	15 (28.3)	10 (18.9)	4 (7.5)	4 (7.5
40. It would bother me to have a steady partner refuse to have sex with me	53	10 (18.9)	9 (17.0)	21 (39.6)	6 (11.3)	7 (13.2)
41. It would bother me to have a steady partner become violent	53	44 (83.0)	5 (9.4)	1 (1.9)	0	3 (5.7)

F. Partner Demographics

42. What is/was the age of your steady sexual partner? n=50

Years	Frequency	Percent
17	1	2.0
18	5	10.0
19	4	8.0
20	12	24.0
21	9	18.0
22	3	6.0
23	6	12.0
24	4	8.0
25	1	2.0
26	2	4.0
27	1	2.0
38	1	2.0
40	1	2.0

43. Is/was your partner attending a post-secondary institution (university, college, trades school)? n=51

38 (74.5) ❑ Yes 13 (25.5) ❑ No

44. What is the highest educational level your partner has attained? n=51

4 (7.8) ❑ Less than high school
7 (13.7) ❑ Completed high school
28 (54.9) ❑ Some post-secondary
12 (23.5) ❑ Completed post-secondary
0 ❑ Don't Know

45. Is/was your partner employed? n=51

31 (60.8)	❑	Yes -	***Continue with Question 46***
20 (39.2)	❑	No -	***Go to Section G***

46. What is/was your partner's occupation/job? n=28

Category	Frequency	Percent
Professional	1	3.6
Business	1	3.6
Sales/Clerical	11	39.3
Skilled	5	17.9
Unskilled	10	35.7

G. Personal Demographics

47. Your sex is: n=83

19 (22.9)	❑	Male
64 (77.1)	❑	Female

48. Age: n=82

Years	Frequency	Percent
19	29	34.9
20	16	19.3
21	17	20.5
22	11	13.3
23	3	3.6
24	2	2.4
25	2	2.4
31	1	1.2
36	1	1.2

49. Is your permanent residence n=81

37 (45.7)	❑	large urban -	Greater than or equal to 10 000 people
30 (37.0)	❑	small urban -	2000 - 9999 people
14 (17.3)	❑	rural -	Less than 2000 people

50. Is your mother employed? n=81

44 (54.3)	❑	Yes	-	***Continue with Question 51***
32 (39.5)	❑	No	-	***Go to Question 54***
0	❑	Don't Know	-	***Go to Question 54***
2 (2.5)	❑	Mother is deceased	-	***Go to Question 54***
3 (3.7)	❑	Mother is retired	-	***Go to Question 54***

51. How long has your mother been employed outside of the home? n=35

Years	Frequency	Percent
0-4	7	20.0
5-9	6	17.1
10-14	5	14.3
15-19	6	17.1
20-24	6	17.1
25-29	3	8.6
30-34	1	2.9
50-54	1	2.9

52. What is your mother's occupation/job? n=42

Category	Frequency	Percent
Professional	6	14.3
Business	6	14.3
Sales/Clerical	13	31.0
Skilled	10	23.8
Unskilled	7	16.7

53. Is your mother's work: n=43

13 (30.2)	❑	Part-time	-	***Go to Question 58***
27 (62.8)	❑	Full-time	-	***Go to Question 58***
3 (7.0)	❑	Seasonal	-	***Go to Question 58***

54. Was your mother employed? n=36

29 (80.6) ❑ Yes - *Continue with Question 55*
7 (19.4) ❑ No - *Go to Question 58*

55. How long was your mother employed outside of the home? n=25

Years	Frequency	Percent
0-4	6	24.0
10-14	6	24.0
15-19	2	8.0
20-24	5	20.0
25-29	1	4.0
30-34	3	12.0
35-39	2	8.0

56. What was your mother's occupation/job? n=28

Category	Frequency	Percent
Professional	6	21.4
Business	1	3.6
Sales/Clerical	7	25.0
Skilled	2	7.1
Unskilled	12	42.9

57. Was your mother's work: n=28

8 (28.6) ❑ Part-time
16 (57.1) ❑ Full-time
4 (14.3) ❑ Seasonal

58. Is your father employed? n=79

60 (75.9)	❑	Yes	-	***Continue with Question 59***
8 (10.1)	❑	No	-	***Go to Question 62***
0	❑	Don't Know	-	***Go to Question 62***
2 (2.5)	❑	Father is deceased	-	***Go to Question 62***
9 (11.4)	❑	Father is retired	-	***Go to Question 62***

59. How long has your father been employed? n=47

Years	Frequency	Percent
10-14	2	4.3
15-19	4	8.5
20-24	9	19.1
25-29	13	27.7
30-34	10	21.3
35-39	2	4.3
40-44	6	12.8
55-59	1	2.1

60. What is your father's occupation/job? n=53

Category	Frequency	Percent
Professional	9	17.0
Business	12	22.6
Sales/Clerical	3	5.7
Skilled	15	28.3
Unskilled	14	26.4

61. Is your father's work: n=58

4 (6.9)	❑	Part-time	-	***Go to Question 66***
45 (77.6)	❑	Full-time	-	***Go to Question 66***
9 (15.5)	❑	Seasonal	-	***Go to Question 66***

62. Was your father employed? n=19

19 (100)	❑	Yes	-	***Continue with Question 63***
0	❑	No	-	***Go to Question 66***
0	❑	Don't Know	-	***Go to Question 66***

63. How long was your father employed? n=15

Years	Frequency	Percent
0-4	1	6.7
20-24	4	26.7
25-29	3	20.0
30-34	6	40.0
35-39	1	6.7

64. What was your father's occupation/job? n=20

Category	Frequency	Percent
Professional	7	35.0
Business	2	10.0
Sales/Clerical	0	0
Skilled	2	10.0
Unskilled	9	45.0

65. Was your father's work: n=20

2 (10.0) ❑ Part-time
16 (80.0) ❑ Full-time
2 (10.0) ❑ Seasonal

66. In addition to studying, are you working a job? n=81

29 (35.8) ❑ Yes - ***Continue with Question 67***
52 (64.2) ❑ No - ***Go to Question 68***

67. If yes, how many hours per week do you work at your job? n=29

2 (6.9)	❑	5 or less
6 (20.7)	❑	6 - 10
15 (51.7)	❑	11 - 15
3 (10.3)	❑	16 - 20
3 (10.3)	❑	more than 20

68. In what year of study are you currently enrolled? n=77

Year	Frequency	Percent
2	40	51.9
3	22	28.6
4	12	15.6
5	2	2.6
7	1	1.3

69. In what course of study are you currently enrolled? n=77

Course	Frequency	Percent
Psychology	14	18.2
Science	19	24.7
Arts	9	11.7
Business	9	11.7
Social Work	5	6.5
Education (including Physical Education)	3	3.9
Nursing	1	1.3
Pre-professional programs	7	9.1
Undecided	6	7.8
General Studies	4	5.2

Place the completed questionnaire in the envelope provided and seal the envelope. At the appropriate time, the class will be instructed to place the package in the collection box at the front of the class.

Thank-you very much for your time. It was greatly appreciated!