Enacted Stigma and HIV Risk Behaviours among Sexual Minority Indigenous Youth in Canada, New Zealand, and the United States

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Abstract
Enacted stigma has been linked to increased HIV risk behaviours among sexual minority youth, but despite higher rates of HIV and other STIs, there is very little research with Indigenous youth. In this study, secondary analyses of three population-based, school surveys were conducted to explore the associations between HIV risk and enacted stigma among sexual minority Indigenous youth in Canada, the US, and New Zealand. Data were analyzed and interpreted with guidance from Indigenous and sexual minority research team members, Indigenous advisory groups, and community consultations. In all three countries, Indigenous sexual minority youth were more likely to experience enacted stigma (such as bullying, discrimination, exclusion, harassment, or school-based violence) and report increased HIV risk behaviours (such as lack of condom use, multiple sexual partners, pregnancy involvement, and injection drug use) compared to heterosexual peers. Data were analyzed by age, gender, and sexual orientation, and for some groups, higher levels of enacted stigma was associated with higher HIV risk. The findings highlight the need for more research, including identifying protective factors, and developing interventions that focus on promoting resilience, addressing the levels of stigma and homophobic violence in school, and restoring historical traditions of positive status for Indigenous sexual minority people.

Key words: Indigenous adolescents, HIV risk behaviours, sexual orientation, stigma, population survey

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Finally, we would like to dedicate this paper to one of our original research team members, Roxanne Struthers, PhD, RN, Ojibway of the University of Minnesota, for their assistance with analyses, and to the advisory groups in all three countries for sharing their guidance and wisdom in conducting this research.

Dr. Struthers passed away of an unexpected illness in November 2005 in the midst of our project. Her ideas and her passion for Indigenous young people continue to inspire us in this work.
(Friedman et al., 2011). The stress that gay, lesbian, bisexual, and questioning teens face as they cope with sexual orientation stigma and violence may partly explain their higher rates of substance use and risky sexual behaviours that can increase their risk for HIV and other sexually transmitted infections (STIs) (Saewyc, 2011). However, although Indigenous young people have disproportionately higher rates of STIs and HIV in Canada (Marshall et al., 2008) and the United States (Kaufman et al., 2007), very little of the research about HIV risk behaviours has focused on Indigenous youth, and even less has explored enacted stigma and the link to these risks for sexual minority Indigenous teens.

Although the research is limited, many of the studies in Canada, the United States, and New Zealand have identified similar risk and protective factors related to sexual risk behaviours among Indigenous adolescents. For example, a population-based study of risk and protective factors for consistent contraceptive behaviours among sexually active Māori students in New Zealand identified depressive symptoms, marijuana use, suicidal ideation and attempts as significant risk factors, while spending enough time with family, having caring teachers and other adults in their lives, and safe neighbourhoods are significantly associated with consistent contraception use (Clark et al., 2006). A similar study of Aboriginal students in Canada identified patterns of risky sexual behaviours and condom use (Devries et al., 2009a), and risk and protective factors associated with pregnancy involvement (as a proxy measure of unprotected sexual risk) and self-reported STIs separately for Aboriginal boys and girls (Devries et al., 2009b). Like the New Zealand studies, Devries and colleagues in Canada found substance use was associated with sexual risk behaviours and STIs, but they also found, for both boys and girls, a history of sexual orientation stigma as a risk factor, and no family and school connectedness were associated with lower odds of sexual risks. In five rural American Indian schools in the United States, Chewing and colleagues (2001) also identified a variety of protective factors associated with abstaining from sex or consistent contraception, including strong parental support, having friends who do not engage in risky behaviours, both valuing and having higher academic performance, and higher self-efficacy for safer sex practices.

In addition to these large-scale studies of Indigenous youth in school, a few qualitative studies have explored Indigenous young people’s perspectives about sexual health, HIV and STI risks, and in the process have identified other structural and social determinants of vulnerability to sexual health risks. In Canada, Aboriginal youth described how their sexual health was influenced by gendered stereotypes and as well as less expected patterns of behaviours, such as young men being coerced into sex, and young women sometimes persuading partners not to wear condoms (Devries and Free, 2010). Other studies in Canada identified the legacy of colonialism, and stigma related to HIV and STIs within Indigenous communities, as factors that contribute to youth vulnerability around sexual health (Larkin et al., 2007; Flicker et al., 2008), while in the United States, one study identified social pressures for Native youth to have sex early, often in the context of alcohol or other substance use, and the lack of economic adversity or social disapproval for early childbearing (Kaufman et al., 2007). None of these studies have included a focus on two Spirit or sexual minority youth; indeed, there have been very few studies that have examined sexual health and risk behaviours by sexual orientation among Indigenous youth in any country. More than a decade ago, one of our team published two papers about sexual minority Native American youth and their sexual health from a national survey of Native American adolescents conducted in reservation schools across the US in 1991 (Saewyc et al., 1998a, 1998b), but there have been no similar population-based studies examining these same issues in Canada, New Zealand, or in the United States since then. There are also very few qualitative studies of Indigenous sexual minority youth; one focus group study from Toronto found that high levels of homophobia in remote or reserve communities in Canada motivated Two Spirit youth to migrate to the city, for example (O’Brien-Frenes and Travers, 2006). However, these young people encountered racism in urban gay/lesbian/bisexual communities, homelessness, and violence exposure, which all contribute to sexual risk among Two Spirit youth; they also said the LGB communities they did connect to were often party scenes, with increased risk for substance use and related risky sexual behaviours.

Therefore, as part of a larger study exploring the links between stigma, substance use, and HIV risk behaviours, the purpose of this analysis was to explore the experiences of enacted stigma among sexual minority Indigenous high school students in Canada, New Zealand, and the US, and to compare the prevalence of HIV risk behaviours to those of their heterosexual Indigenous peers.

Methods

The study samples included all self-identified Indigenous students answering the sexual orientation questions in three population-based, school surveys of youth. The sample in Canada consisted of First Nations, Inuit, and Métis (Aboriginal) Canadians who participated in the British Columbia Adolescent Health Survey of 2003, a province-wide random cluster stratified survey of more than 30,000 students in grades 7–12. Data were weighted to adjust for differential probability of selection across regions. The US sample included Native American teens in the Minnesota Student Survey of 2001, a state-wide census of 9th and 12th graders. The New Zealand sample included Māori teens in the New Zealand Youth Health Survey of 2001, a national population-based random survey of grades 9–13 (ages 12–17, Adolescent Health Research Group, 2003). All three surveys were administered in public schools during a single class period; the BC and MN surveys were pencil and paper, while the NZ survey was a multimedia computer-assisted survey, completed on individual laptops in classrooms. Each survey had a different measure of sexual orientation. The BC survey asked about self-identified gender label, with definitions in parentheses that described being either mostly or 100% attracted to the opposite sex, or both sexes, or mostly or 100% attracted to the same sex. The MN survey asked two questions about the number of female sexual partners and the number of male sexual partners in the past year, recoded as opposite-gender only, same-gender or both

| Table 1. Select Demographic Characteristics of Indigenous Youth in each Data Source |
|---------------------------------------------|----------------|----------------|----------------|
| Sexual orientation measures | Self-labeling/attraction | Sexual partners in the past year | Attraction |
| Age range | % who are girls | % LGB among boys | % LGB among girls |
| 12–19 years | 53 | 7.8 |
| 13–18 years | 52 | 4.5 |
| 12–17 years | 16.1 | 4.4 |
| 8–17 years | 8.4 |

*Weighted to adjust for differential probability of selection, proportional enrolment, and cluster stratified sampling

*Sexually active youth only

Indigenizing Research Approaches

The research team members included Aboriginal Canadian (Lilroot First Nation and Metis), Māori, and Native American (Ojibway and Lakota) Indigenous researchers; the team also included sexual minority researchers, both Indigenous and non-
Indigenous. Prior to developing this study, the team also consulted with other Canadian Aboriginal, New Zealand Māori, and Native American researchers about the purpose, design, sampling, and measurement issues. In New Zealand, the Adolescent Health Research Group’s Māori co-investigators, alongside a Māori advisory group for the project, approved the associate research partnership and the project, and were consulted throughout the study about the interpretation and dissemination of the results. In Canada, a research advisory group was convened to provide guidance on analysis, interpretation, and dissemination; the study also included consultation with Aboriginal community groups working on the issues of HIV/AIDS, and results were presented to Aboriginal youth in two focus groups for their comments and suggestions. In Minnesota, the research project was presented to Native American researchers, health care providers, preliminary results, were also presented at a national Indigenous HIV/AIDS conference for additional comments and feedback from Native researchers and Native health care providers.

**Measures**

For these secondary analyses of existing survey data, measures were chosen for their similarity in the different surveys, but none of the surveys had completely identical measures, so of necessity, there were adaptations to create scales. For example, in NZ, the filter question about bullying frequency was used to measure enacted stigma, dichotomized as experiencing bullying at least weekly or more often in the past year. Among those who reported having been bullied, there were 6 specific types of bullying that could be reported, such as being called hurtful names, being kicked or punched, being threatened, or being ignored or left out of things; this was recoded to 0 types, 1–2 types, and 3+ types of bullying experienced. In BC and MN, an enacted stigma scale was developed by combining the various items that focused on discrimination, exclusion, harassment, or violence experienced at least last year. The enacted stigma index was a summed score of different types of harassment, assault, and discrimination experienced in the past year, and did not measure perceptions but behaviours, which can differ in how severe they are, some of which are quite rare (i.e., being shot or stabbed at school).

For BC and MN, an HIV risk score was a summed score of different types of behaviours known to increase risk for HIV infection. Examples of items included a lack of condom use at last intercourse, multiple sexual partners in the past year, and pregnancy involvement (a proxy of unprotected intercourse) in both BC and MN, and injected drug use in BC. For NZ, an HIV risk measure was created with 3 major categories: those who had never had sex or used drugs, those who had sex but not unprotected or risky sexual behaviours or who used drugs but did not inject them, and those who either engaged in risky sexual behaviours or used injection drugs.

**Analyses**

Analyses for each country were conducted based on the type of data collected, adjusting for the sampling strategies, and using the team’s standard approaches. Analyses were done separately by gender, except for NZ, where analyses first tested for gender interactions, and adjusted for gender only when relevant. Analyses were also adjusted for age (NZ and BC) or grade (MN) to address the wide range of ages in the surveys and normative increases in sexual behaviours with increasing age among adolescents. Mean enacted stigma scores and HIV risk scores included for BC and MN were compared between sexual minority and heterosexual peers using ANCOVAs, while for NZ, weekly bullying was compared using age-adjusted logistic regressions, as well as a multinomial logistic regression of the 3-category bullying types and for the 3-category HIV risk measure. As well, the likelihood of the individual enacted stigma items and individual risky sexual behaviours were compared using estimated prevalence and 95% confidence intervals in NZ, while they were compared using age-adjusted logistic regressions in BC and MN. To explore the link between enacted stigma and HIV risk, we performed linear regression analyses, separately by sexual orientation group, for BC and MN, but this was not possible with the categorical NZ measure. All analyses in MN and BC were conducted in SPSS, while analyses for NZ were conducted in SAS.

**RESULTS**

**Experiences of Enacted Stigma**

In all three countries, Indigenous LGB boys and girls were more likely to experience enacted stigma than their HET peers. For example, in New Zealand, LGB youth had nearly 3 times the odds of being bullied weekly or more often (AOR=2.8, 95% CI=1.5–5.3), the multinomial regression showed significant age effects (Wald X^2=58.34, df=2, p<0.001), gender effects (Wald X^2=13.03, df=2, p<0.01) and sexual orientation effects (Wald X^2=12.06, df=2, p<0.01). Among those who were bullied, LGB Māori youth and HET youth had nearly similar rates of each type of bullying, with overlapping confidence intervals of the estimates of prevalence, but LGB Māori youth were more likely to experience multiple types of bullying than HET youth, although there were only significant age and sexual orientation effects (age, Wald X^2=56.32, df=2, p<0.001; sexual orientation, Wald X^2=7.12, df=2, p<0.05).

In both BC and MN, Indigenous LGB boys and girls had higher mean scores of enacted stigma experienced during the past 12 months than their HET peers (see Table 2). For some types of enacted stigma, the differences were profound (see Table 3). For example, in BC, gay or bisexual Aboriginal boys were 19 times more likely than their HET peers (report that they had experienced discrimination because of their orientation. Likewise, lesbian or bisexual Aboriginal girls were 17 times more likely than their HET peers to report sexual orientation-based discrimination. Compared to HET students of the same gender, LGB Aboriginal boys in BC were more likely to purposefully exclude at school; LGB Aboriginal girls in BC were more likely to be physically assaulted at school. In MN, LGB Native American boys were 5 times more likely than HET Native American boys to report that another student had embarrassed them or fired a gun at them (see Table 4). Among Native American girls in MN, LGB girls were 3 times more separated than HET girls to have been pushed, shoved, or grabbed by another student.

It should be noted that most schools in these surveys included several ethnic groups, not just Indigenous youth, so the enacted stigma may have

### Table 3. Logistic Regressions of Enacted Stigma and Sexual/HIV Risk Behaviours: British Columbia Adolescent Health Survey

<table>
<thead>
<tr>
<th>Outcome</th>
<th>LGB Boys*</th>
<th>LGB Girls*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AOR</td>
<td>95% CI</td>
</tr>
<tr>
<td><strong>Enacted stigma individual items experienced in the past 12 months</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal sexual harassment</td>
<td>1.98</td>
<td>[0.92, 4.27]</td>
</tr>
<tr>
<td>Physical fights</td>
<td>0.81</td>
<td>[0.53, 1.37]</td>
</tr>
<tr>
<td>Teased at school</td>
<td>1.01</td>
<td>[0.90, 2.66]</td>
</tr>
<tr>
<td>Purposefully excluded at school</td>
<td>2.85</td>
<td>[1.18, 6.92]</td>
</tr>
<tr>
<td>Physically assaulted at school</td>
<td>2.45</td>
<td>[0.98, 6.18]</td>
</tr>
<tr>
<td>Discriminated against due to race</td>
<td>1.72</td>
<td>[0.67, 4.42]</td>
</tr>
<tr>
<td></td>
<td>18.75</td>
<td>[6.96, 50.41]</td>
</tr>
<tr>
<td></td>
<td>[&lt; 0.001]</td>
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*p < 0.05. **p < 0.01. ***p < 0.001.
In MN, LGB boys and girls were more likely to report higher levels of bullying, harassment, and discrimination than their heterosexual peers, and they also reported higher likelihood of sexual violence exposure and sexual behaviours that put them at risk for HIV. This research has both limitations and strengths that should be considered. One of the primary limitations is that these are cross-sectional surveys, so all the associations identified are correlational, not causal. As well, only Indigenous students who were in school on the days the surveys were held contributed to their information; since in all three countries, Indigenous youth are less likely to complete their secondary education, and LGB youth are also more likely to skip school because they feel unsafe, who these experience the greatest enacted stigma or the highest sexual and HIV risks may not be represented.

These surveys were conducted several years ago, and so changing populations, and shifts in programs and practices in schools, may influence the current contexts and experiences of Indigenous young people, although a more recent survey of Aboriginal youth in Canada has documented ongoing inequities, both among youth who live on reserves (Jurusda et al., 2012). Yet another limitation is that the measures varied across the countries, in terms of the measure of sexual orientation, enacted stigma, and sexual and HIV risk. Despite this variation, however, the results were quite similar across countries, which argues for the robustness of the findings. One of the strengths of this study is that each of these were large-scale population-based surveys, drawing representative samples of Indigenous youth; at the same time, it should be noted that these were general population surveys, and so the measures of sexual orientation and enacted stigma were not specific to Aboriginal, Native American, or Māori cultures or experiences. There may be additional types of enacted stigma or other risk factors, such as the legacy of colonization, for example, that may contribute further to Indigenous youth’s vulnerability, but which were not captured in these surveys. Another strength was our ability to conduct multivariate analyses, rather than simple bivariate comparisons. However, these analyses focused on exposure to enacted stigma as a risk factor, and did not include potential protective factors that may help buffer that exposure for LGB youth; other studies of sexual risk behaviours among Indigenous youth generally (Clark et al., 2006; Clark et al., 2012; Devries et al., 2009a, 2009b; Chewing et al., 2001; Jurusda et al., 2012; Saewyc et al., in press), or in general populations of LGB youth (Saewyc et al., 2008), have found protective factors like family or school connectedness can help lower the odds of sexual risk behaviours, even among those who have experienced violence.

**Discussion**

Despite different national contexts and cultural backgrounds, and different research methods and measures, our findings demonstrate significant consistency among the results. Indigenous sexual minority youth in all three countries reported higher levels of bullying, harassment, and discrimination than their heterosexual peers, and they also reported higher likelihood of sexual violence exposure and sexual behaviours that put them at risk for HIV. Beyond vulnerability and risk, however, we also need to identify protective factors that may foster resilience among sexual minority Indigenous youth, despite their experiences of stigma and rejection. The relatively limited research among general populations of Indigenous youth has identified such supportive resources as nurturing family relationships, friendships with caring peers, connectedness to safe and supportive schools, and reconnecting to Indigenous culture (Clark et al., 2006; Devries et al., 2009a, 2009b; Chewing et al., 2001;
Tsuruda et al., 2012; Sarewyt et al., in press). Whether these same protective factors work for sexual minority
Indigenous youth is still unclear. In a grounded theory study of Canadian youth where about half the
participants were Indigenous adolescents, Ungar and colleagues (2008) found “adherence to cultural traditions” was an important aspect of resilience, to the extent it was able to help young people develop the capacity to engage with culturally safe health
resources, but this was not something measured in our study. Greater sensitivity to culture and context in
testing effective sexual health promotion programs for Indigenous sexual minority youth is warranted, but we also need effective measures of cultural connectedness to measure the interplay of
culture and health for Indigenous youth.

Interventions to promote sexual health for all Indigenous youth also need to include a focus on
reducing violence exposure in school settings, especially for sexual minority youth. Interventions that
target both racism and homophobia and address the unique historical inequities Indigenous people face
are likely needed. Programs which share traditional knowledge and historical information about sexual
minority roles within Indigenous communities, not only with sexual minority youth but throughout the
community, may help attenuate the negative legacies of colonization and assimilation policies, and
reduce homophobic attitudes. This in turn may help healthy, holistic, young Two Spirit, takatāpui, gay,
lesbian, bisexual, and questioning Indigenous young people.

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Dana Brunanski, MA, comes from a diverse cultural background including Métis, Czech, Hungarian, British, and Danish ancestors. After completing undergraduate studies in psychology, women’s studies and sociology, including a self-reflective thesis on women’s bisexual identity development, Dana began working with at-risk and street-involved youth in East Vancouver in 1997. Over the past 15 years she has worked with many Indigenous youth as a lifeskills group facilitator, street outreach worker, addictions counsellor, and, since completing her Master’s in Counselling Psychology (University of British Columbia, 2009), an assertive outreach mental health clinician with “hard-to-engage” Indigenous youth. Her current work is an enactment of her master’s research which used an indigenizing narrative methodology to explore Indigenous street youths’ experiences with counselling. In addition to direct clinical service on the Vancouver Coastal Health Youth Outreach Mental Health Team, Dana is the chair of a committee charged with improving community mental health services for Indigenous children, youth, and their families. She also continues to be involved in research activities, serving as a community research affiliate with the Stigma and Resilience among Vulnerable Youth Consortium, and as an Aboriginal Advisory Committee member for the McCreary Centre Society’s ongoing research on Indigenous youth health in British Columbia.

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