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A qualitative inquiry of the sexual health activities of service industry workers in Alberta's mountain park resort communities

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A Qualitative Inquiry of the Sexual Health Activities of Service Industry Workers in Alberta's Mountain Park Resort Communities

by

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled "A Qualitative Inquiry of the Sexual Health Activities of Service Industry Workers in Alberta's Mountain Park Resort Communities" submitted by Laurie Jean Fownes in partial fulfilment of the requirements of the degree of Master of Science.

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Abstract

The purpose of this study was to gain an understanding of the sexual health activities of service industry workers (SIW) in the Alberta Rocky Mountain Park (the Rockies) communities. This research investigated: 1) the sexual activities of SIW; and 2) their associated risks and protective measures. This was an exploratory and descriptive qualitative study. A purposeful sampling strategy was used to recruit SIW who were aged 18 to 29 years. In-depth, individual, open-ended interviews were conducted. A thematic analysis of the data was carried out. Four main themes were identified, including: 1) the lure of the Rockies; 2) finding a sense of belonging; 3) access to adventure; and 4) health outcomes and resources. The socio-ecological theoretical framework was used to discuss the results. The migratory settlement model and the social determinants of health were integrated into the framework. The Ottawa Charter for Health Promotion was introduced to discuss proposed next steps.

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Dedication

To Peter, for your love, friendship, and support. Your belief in me was unconditional and, despite the late nights and the early mornings, you continued to bring a light and energy to our home that made the completion possible. To Kinta, who entered our lives mid-way through my studies: your late night walks and early morning wake up calls kept me rejuvenated and on track! You were a *travelling companion extraordinaire* for our road trips to the Rockies (making sure we stopped to take in a short hike or scenic view along each journey)!

Finally, to my wonderful family. Thanks for always *checking in*! Your patience and unrestricted love helped to guide me through to the end!

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List of Symbols, Abbreviations and Nomenclature

Symbol	Definition
AADAC	Alberta Alcohol and Drug Abuse Commission
ABV	AIDS Bow Valley
ACCH	Alberta Community Council on HIV/AIDS
AIDS	Acquired immune deficiency syndrome
AHW	Alberta Health and Wellness
ASO	AIDS service organization
BNP	Banff National Park
BSIN	Banff Service Industry Network
CAH	Centre for Advancement of Health
CBC	Canadian Broadcasting Corporation
CBR	Community based research
CCS	Canadian Campus Survey
CDC	Communicable Disease Control
CDCP	Centre for Disease Control and Prevention
CHREB	Conjoint Health Research Ethics Board
CTV	Canadian Television Network
CHR	Calgary Health Region
CTFPHE	Canadian Task Force on Periodic Health Examinations
DR	Dominican Republic
FCSS	Family and Community Support Services
FPTACPH	Federal, Provincial, Territorial Advisory Committee for Public Health
GUM	Genito-urinary medicine
HBM	Health belief model
HBSC	Health Behaviour in School-aged Children Study
HHA	Headwaters Health Authority
HIV	Human immunodeficiency virus
HPV	Human papilloma virus
HSV	Herpes simplex virus
IDU	Injection drug use
MPC	Mucopurulent cervicitis
NGU	Nongonococcal urethritis
PHAC	Public Health Agency of Canada
PID	Pelvic inflammatory disease
PPFC	Planned Parenthood Federation of Canada
QSR N6	Quality Solutions and Research software, N6 version
RHA	Regional health authority
SAFV	Society Against Family Violence
SES	Socio economic status

SIW	Service industry worker
SNA	Social network analysis
Staff accom.	Staff accommodation
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TBP	Theory of planned behaviour
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
US	United States
WHO	World Health Organization

Epigraph

As the traveller who has once been from home is wiser than he who has never left his own doorstep, so a knowledge of one other culture should sharpen our ability to scrutinize more steadily, to appreciate more lovingly, our own.

Margaret Mead, Coming of Age in Samoa (1928)

CHAPTER ONE: INTRODUCTION

Research Purpose

The spread of the human immunodeficiency virus (HIV) and sexually transmitted infections (STIs[1]) has been influenced by the ease in international travel (Abdullah, Fielding, & Hedley, 1998; Barnett, 1996; Egan, 2001; Forsythe, 1999; Gillies, Slack, Stoddart, & Conway, 1992; Hamlyn & Dayan, 2003; Hawkes, Hart, Bletsoe, Shergold, & Johnson, 1995; Mabey, 1995; Memish & Osoba, 2003; Mullhall, 1993, 1996; Wright, 2003). Tourism is the world's largest industry (Memish & Osoba, 2003). In order to meet the demands of tourism, the industry actively recruits and hires a workforce of mainly young, single, and mobile individuals (Forsythe, 1999; Hennick, Cooper, & Diamond, 1999; Memish & Osoba, 2003). The success of the tourism industry is impacted by the health, services, and skills of those working and living within tourism-based communities (Barnett, 1996). The sexual health[2] of the young workforce is one of the many determinants that influence their well-being and it is identified as an important issue in the context of tourism, international travel, and temporary employment (Barnett, 1996; Bellis, Hughes, & Lowey, 2002; Bellis, Hughes, Thomson, & Bennett, 2004; Forsythe, 1999). Travellers, including young adults, may be placing themselves at increased risk

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[1] Sexually transmitted diseases (STDs) are considered synonymous to STIs for the purpose of this research. STIs will be used throughout this research because it is more encompassing (Public Health Agency of Canada (PHAC), 2002a). STIs are a group of infections that are spread through unprotected sexual contact (Alberta Health and Wellness (AHW), 2003b). Several infectious organisms, including bacteria, viruses, protozoa, and ectoparasites, cause STIs (AHW, 2003b).

[2] Sexual health is defined by the WHO (2002) as "a state of physical, emotional, mental, and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity" (p. 1). Sexuality is defined as "knowledge and attitudes about sexuality and sexually-related illnesses, romantic relationships, sexual experiences, and avoidance behaviour regarding unintended pregnancies and STIs" (Boyce, Doherty, Fortin, & MacKinnon, 2003, p. 1). Although sexual health is not limited to "absence of disease" (WHO, 2002, p.1), this study explicitly explores STI and unplanned pregnancy.

for contracting HIV and STIs while working and visiting these highly transient tourism environments (Barnett, 1996; Bellis et al., 2004; Gallagher, 1997; Hennick et al., 1999; Matteelli & Carosi, 2001; Memish & Osoba, 2003; Mullhall, 1996).

A relationship between tourism, sexual risk activities[3], and substance use is demonstrated (Bellis, Hale, Bennett, Chaudry, & Kilfoyle, 2000; Maticka-Tyndale, Barrett, & McKay, 2000; Maticka-Tyndale, Herold, & Oppermann, 2003; Mullhall, 1996). The role of alcohol and illicit drug use has been studied in the context of tourist environments and they have been linked with increased sexual activities and decreased use of protective measures (Bellis et al., 2000; Bellis, Hughes, Bennett, & Thomson, 2003). Past research has focused largely on concepts surrounding vacation subcultures[4] and the unique experiences that individuals encounter while on holidays. There has not been an emphasis on those working in tourism, nor have studies focused on workers who remain in tourist destinations for varying lengths of time.

The Rockies[5] encompasses both provincial and national park boundaries. Tourism is one of the main industries and a central driving force of the economy. In order to support the tourism trade, there are abundant work opportunities including both seasonal and year-round employment positions. The most frequently visited park in Canada is

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[3] Sexual risk activities were summarized from the 2003 Canadian Youth, Sexual Health, and HIV/AIDS study as "risky sexual behaviours, such as use of alcohol/drugs prior to sex, inconsistent use of contraception, multiple sexual partners, and lack of protection against STIs, [that put youth] at the greatest risk for negative health outcomes such as unplanned pregnancy, STI contraction, exploitation and abuse" (Boyce et al., 2003, p. 123).

[4] Participation in vacation subcultures often includes travel to environments that differ from individual's typical life circumstances. Within these subcultures, individuals may participate differently from their typical daily activities and responses.

[5] The term the "Rockies" in this study refers to the Canadian Rocky Mountain Park resort communities located in the province of Alberta.

Banff National Park (BNP). In 1999, *Rolling Stones Magazine* gave the Town of Banff the dubious distinction as the STI capital of Canada (Bartlett & Binelli, 1999). The Rockies communities have been anecdotally linked with sexual risks, substance use, and endless party scenes with one of the local mottos *come and take your chances* (AIDS Bow Valley, 2004; Blair, Morrison, & Patten, 2002). Banff's reputation continues to grow with references to its workers as *dirty* and *unclean*. This reputation has spread to other communities such as Lake Louise, which has been referred to as *Lake Disease* (AIDS Bow Valley, 2004). Despite these and other sexual risk claims linked with the communities of the Rockies, there have been no studies conducted to assess their validity or to determine what factors influence the health and sexual activities of those working within the tourism trade.

The purpose of this research is to increase the understanding of the sexual risk activities of those working in tourism through a descriptive and exploratory research framework. Service industry workers (SIW) who were aged 18 to 29 years were recruited from the communities in the Rockies. The sexual risk activities that SIW engaged in while living in the Rockies, the associated factors that influenced the actions and decision-making processes of SIW, and the protective measures that influenced the risks of contracting HIV or STIs are described.

Background to the Problem

Populations of Alberta's Rockies Mountain Park Communities

The communities in the Rockies are composed of tourists, residents, and SIW. Employers actively recruit SIW throughout the year to serve tourists. Thousands of workers arrive in search of employment and *the magic of the Rockies* (AIDS Bow Valley,

2004). For the purposes of this research, individuals who are working in the tourism industry were identified as SIW. SIW was determined as the most appropriate language for the target population for the study based on consultation with key informants from the research communities (Davies, 2004). A number of different labels have been applied in other studies in reference to workers within tourism destinations, including: seasonal workers (Ford & Inman, 1992; Hennick et al., 1999); hotel workers and entertainment staff (Forsythe, 1999; Forsythe, Hasbun, & De Lister, 1998); migrant workers (Aranda-Naranjo, Gaskins, Bustamante, Lopez, & Rodriquiz, 2000); temporary workers (Nemoto, Yokota, & Takenaka, 2001); and shadow populations (Gallagher, 1997).

SIW in Alberta's Mountain Park Resort Communities

AIDS Bow Valley (2004) identified traits of SIW in the Rockies as the following: young, single, and transient; may engage in a party scene; may participate in drug and alcohol use; represent a diversity of cultures; and speak different first languages other than English. Gallagher (1997) completed a thesis research project on young summer workers in Jasper National Park and her results, along with anecdotal findings from AIDS Bow Valley (2004), identified the following factors which influenced the vulnerability of workers in the Rockies: inadequate coping skills; inability to access health and social services appropriately; live away from home (often for the first time); sense of anonymity; inadequate housing; participate in a party atmosphere; indulgence in alcohol and drug use; acquire piercing and tattoos; engage in sexual activities; experience loneliness; lack social support; encounter intense peer pressure; have a limited number of affordable, healthy activities; earn less income than anticipated; experience a high cost of living; unable to afford to do the activities they came for; and feel unsupported by

employers. These factors may be disproportionately placing SIW at risk of negative health outcomes associated with their activities, including a reduction or lack of safer sexual practices, an increased number of sexual partners, and lack of connection to supports and services (AIDS Bow Valley, 2004). The factors identified by Gallagher (1997) and AIDS Bow Valley (2004) informed the decision to focus on SIW as the study's target population and identified issues that may be influencing their health status while living in the Rockies.

Demographic Information

Nestled in the Alberta Rockies are a number of communities including Canmore, Banff, and Lake Louise, Alberta (Cavicchi, Nixon, & Tutty, 2002). These communities are located within the borders of the Bow Valley (Cavicchi et al., 2002). Economically, the tourism industry employs a large proportion of the permanent population and creates an enormous demand for seasonal workers (Cavicchi et al., 2002). Typically, the lower level employment positions are filled by young adults between the ages of 16 and 30 years, the majority of whom travel from across Canada and abroad to take part in the resort town experience (Cavicchi et al., 2002).

A large emphasis of the Rockies is centred on BNP [6], which was established as Canada's first national park in 1885 (Tazim & Eyre, 2003). BNP attracts more people per annum than any other National Park in Canada (Scott, 2005). Annual visitation is estimated at three million people[7] (Scott, 2005), an increase from the 459,000 in 1950 (Banff Bow Valley Study, 1995). Visitation is estimated to reach 19 million people by the

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[6] BNP encompasses over 6,600 square kilometres (Scott, 2005).

year 2020[8] (Banff Bow Valley Study, 1995; Jamal, 1997). The majority of human and economic activity of BNP is related to tourism (Tazim & Eyre, 2003) and the Town of Banff (2005 as cited in Scott, 2005) reported an estimated annual generation of over C$700 million in direct tourism expenditures[9].

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[7] An estimated 80 percent of tourists visiting BNP are Canadian (Scott, 2005).
[8] Scott (2005) projected more modest visitation rates in the Banff National Park (BNP) area due to climate changes, with estimates at approximately 4.5 million visitors in the 2020s.
[9] In order to support the tourism demand, approximately 74 percent of residents in the Town of Banff are working in the industry (AIDS Bow Valley, 2004).

Table 1.1: Comparison of 2001 Summary Statistics: Banff and Alberta (Statistics Canada, 2004)

Location	Banff				Alberta[10]			
Resident population	7,135 (<1% of Alberta population)				2,974,807 (total Alberta population)			
	Men: 3,665 (51%)		Women: 3,465 (49%)		Men: 1,486,590 (50%)		Women: 1,488,220 (50%)	
Median age	29 years				35 years			
	Men: 30 years		Women: 29 years		Men: 34 years		Women: 36 years	
Age distribution	≥15 years: 6,385 (89%)				≥15 years: 2,357,215 (79%)			
	15-19 years: 470 (7%)	20-24 years: 1,305 (18%)	25-44 years: 3,110 (43%)	≥45 years: 1,495 (21%)	15-19 years: 222,960 (7%)	20-24 years: 214,125 (7%)	25-44 years: 948,740 (32%)	≥45 years: 970,380 (33%)
Average earnings[11]	Average earnings: $26,530		Average full-time earnings: $33,467		Average earnings: $32,603		Average full-time earnings: $44,130	
	Men: $30,564	Women: $21,921	Men: $37,391	Women: $28,081	Men: $40,797	Women: $23,218	Men: $51,133	Women: $33,437
Rep. by visible minority groups	1,230 (17%)				329,930 (11%)			
	Japanese: 720 (58%)		Latin American: 110 (9%)		Chinese: 99,095 (30%)		South Asian: 69,580 (21%)	
Marital status[12]	Single: 3,980 (62%)	Common-law: 655 (10%)	Married: 1,710 (27%)		Single: 770,340 (33%)	Common-law: 184,185 (8%)	Married: 1,224,050 (52%)	

[10] The Alberta column is inclusive of statistics from the entire province including Banff.
[11] *Average earnings* are estimates from the total resident population. *Average full time earnings* are estimates from all persons with all types of reported earnings.
[12] Estimates are based on the total population ≥ 15 years.

Table 1.1 provides a comparison of Alberta demographics with the Town of Banff[13]. The Town of Banff was the first incorporated official municipality within a national park in Canada (Town of Banff, 2006). Due to its unlimited potential for growth, the Town of Banff created a fixed boundary of 4.87 kilometres and imposed federal legislation of no freehold land availability[14] (Town of Banff, 2006).

The Town of Banff imposed a population cap of 10,000 permanent residents (Town of Banff, 2006). Statistics Canada (2004) reported a resident population in Banff of 7,135[15] people in 2001, with 6,385 (89 percent) of these residents aged 15 years or older. This is compared to 79 percent of Albertans who were aged 15 years or older in 2001. Alberta and Banff both reported equal distributions of men and women (Statistics Canada, 2004). However, the median age of residents in Banff was 29 years, which was six years younger than the Alberta median age of 35 years (Statistics Canada, 2004). Banff reported a larger proportion of singles with 62 percent compared to 33 percent in Alberta (Statistics Canada, 2004). Banff reported lower average income earnings than Alberta and a larger proportion of visible minority groups. Overall, the resident population of Banff is more likely to be younger, single, of a visible minority group, and in a lower income bracket. All these factors influence the dynamics of the populations and relate to the social health determinants of SIW.

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[13] The Town of Banff was selected for this comparison as it has a well-known reputation globally and information is available to use for comparative purposes.
[14] The Town of Banff has no option to grow outward with a leased land-base and no freehold land availability (Town of Banff, 2006). Under federal legislation, only those people who demonstrate a *need to reside* in the national park community can remain (Town of Banff, 2006).
[15] Banff is projected to reach its maximum residential capacity of 10,000 in 2006 (Scott, 2005).

Developmental Literature and Theoretical Perspectives that Influenced the Research

Developmental Literature

There were several developmental and theoretical perspectives that influenced the development of this research study. Health is a phenomenon that develops over time (Grzywacz & Fuqua, 2000) and the young SIW who arrive in the Rockies are often going through developmental transitions. This transitional development period for youth, between childhood and adulthood, encompasses more changes biologically, psychologically, and socially than any other stage with the exception of infancy (Holmbeck, 2002). This is a critical stage in terms of creating life-long health behaviours, including patterns for risky activities (Holmbeck, 2002). Maticka-Tyndale (2001) identified that social and cognitive development factors relate to how societies are structured in terms of education, information, resources, transitions to adult status, and economic independence or dependence. For young SIW, all of the above factors affect them as soon as they arrive, as they make the transition to adulthood, and as they attempt to integrate into the resort community.

Many SIW who arrive in the Rockies are away from home for the first time and away from their social support networks and familiar social and physical environments. Some youth are in the process of making a transition from adolescence into adulthood. Many influences have been identified in the literature as affecting their adaptations. For example, most are biologically ready for engaging in sexual activities and for reproduction. The biological preparedness of young people has shifted with women's

mean age of menarche[16] having declined significantly from 14.8 years of age in the 1890s (Wyshak & Frisch, 1982 as cited in Maticka-Tyndale, 2001) to 12.5 years of age in 1998 (Forrest, 1993 as cited in Maticka-Tyndale, 2001). As well, a woman's fertility has started to biologically decline in her mid-twenties (Maticka-Tyndale, 2001). Young men have demonstrated similar declines such as earlier spermarche[17] (Atwater, 1992 as cited in Maticka-Tyndale, 2001). As a result, many young people are physically capable of reproduction regardless of their social or mental preparedness (Maticka-Tyndale, 2001).

In addition to the biological markers that are used to assess the development of youth, the age of first intercourse has been examined for adolescents in Canada. For example, the median age of first intercourse for females declined from 20 years between 1942 and 1946 to 17 years from 1972 to 1976 (Maticka-Tyndale et al., 2000). Similarly, the median age of first intercourse for males declined from 18 years to 17 years over the same timeframe (Maticka-Tyndale et al., 2000). Maticka-Tyndale et al. (2000) indicated that recent trends might depict a younger median age of first intercourse for women than men. Rotermann (2005) assessed data from a representative sample from the 2003 Canadian Community Health Survey (n=18,084). The average age of first intercourse for both males and females was 16.5 years (Rotermann, 2005). As well, at least two thirds of young adults had their first experience with intercourse during their teenage years (Rotermann, 2005).

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[16] Menarche refers to the average age of first menstruation for females and the subsequent body progressions through the stages of puberty (Finley, 2003).
[17] Spermarche is the onset of production of spermatozoa and basis of achievement of reproductive capacity in males (Nielsen et al., 1986).

The Society of Obstetricians and Gynaecologists of Canada (2005) summarized that when the short, medium, or longer term trends are compared, "the average age of first intercourse has consistently yet gradually declined." However, when the age and grade cohorts were compared between the results from the 1988 Canada, Youth and AIDS Study (King et al., 1988) and the 2003 Canadian Youth, Sexual Health, and HIV/AIDS Study (Boyce et al., 2003), recent cohorts of teens were not more likely to have had intercourse than in the past (The Society of Obstetricians and Gynaecologists of Canada, 2005). The comparison between the 1988 Canada, Youth and AIDS Study (King et al., 1988) and the 2003 Canadian Youth, Sexual Health and HIV/AIDS Study (Boyce et al., 2003) revealed that sexually active youth in the latter study reported fewer sexual partners than in the former (The Society of Obstetricians and Gynaecologists of Canada, 2005).

With knowledge of the Rockies' reputation as the STI capital (Bartlett & Binelli, 1999) preceding most young people's arrival, SIW arrive with mixed messages about their sexual health and are exposed to different pressures related to sexual activities. Ross, Godeau, and Dias (2000) examined the sexual health of young people (n = 162,000 aged 11, 13, and 15 years) from survey data from the international 2000/2001 Health Behaviour in School-aged Children (HBSC) study. Ross et al. (2000) identified that sexual health is a component of well-being for adolescents and can be described as "the positive integration of the physical, emotional, intellectual, and social aspects of sexuality" (p. 153). The development of sexuality for youth includes the consolidation of their identity, including: physical changes (e.g., puberty); psychological changes; and interpersonal events (Ross et al., 2000). The concepts of resiliency and protective factors

are also connected to experiences of young people and are relevant to their development and adaptations. According to Resnick (2000), protective factors are gained by "events, circumstances, and life experiences that can help to protect young people from harm across categories of race, ethnicity, social class, gender, and geography" (p. 1).

Young people who arrive in the Rockies experience changes on many levels and their developmental processes, in combination with their resiliency and protective mechanisms, can influence their adaptations. Gallagher's (1997) study of the young workers (*shadow population)* in Jasper highlighted factors that increased the vulnerability of young adults in one of the Rockies tourist destinations (e.g., lacking supports, away from home, and inadequate housing). Despite the multiple factors that could be negatively influencing SIW adaptations to life in the Rockies, young workers in the Rockies also display resiliency and protective factors that enabled them to make the move to the new, dynamic communities in the first place. The journey to the Rockies can be exciting and risky for young people as they attempt to integrate into a dynamic environment.

Theoretical Frameworks

There are several theoretical frameworks that informed the research project. The socio-ecological framework is a population-based approach (Bauer et al., 2003). This approach provides comprehensive coverage of social and environmental factors that influence health. It is useful when exploring health influences from multiple levels. There are five main levels of influence, including: individual, such as knowledge, attitudes, and behaviours; interpersonal, such as social networks and social support; organizational, such as social institutions and organizations; community, such as relationships; and

public policy, such as state laws and regulatory systems (Health Promotion and Disease Prevention, n.d.). The socio-ecological framework is also an effective framework when exploring complex health issues (Bauer et al., 2003). Health is recognized as an interdependent notion along with diverse conditions in the socio-physical environment (Grzywacz & Fuqua, 2000). This framework enables the researcher to review the results from a wide scope. Since it is comprehensive, it can be interconnected with other frameworks, some of which are explored below, to highlight in more detail sections that are particularly salient for a given study.

A population health approach, including the social determinants of health, is one of the main theoretical frameworks influencing this research process. Population health aims to improve the health of populations and reduce inequities among population groups (Frankish, Green, Ratner, Chomik, & Larsen, 1996). The World Health Organization (WHO) (2003) identified the social determinants of health as integral components in a population health framework and they include: income and social status; social support networks; employment and working conditions; education; physical environments; social environments; biology and genetic endowment; personal health practices and coping skills; healthy child development; health services; gender; and culture (WHO, 2003).

Health promotion is synergistic with a population health approach (Health Canada, 2002a) and is defined as "the process of enabling people to increase control over, and to improve their health" (WHO, 1986, p. 1). The main health promotion strategies for action are interrelated with the complex interactions of individuals, groups, communities, and populations (McLeroy, Bibeau, Steckler, & Glanz, 1988). Population health and

health promotion approaches, described in-depth in the discussion chapter, allow for the recognition of the broad components that influence these unique tourism contexts.

Harm reduction has been identified as a key approach that guides the work of stakeholders in the communities of the Rockies in the contexts of HIV, STI, and substance use programming. Harm reduction seeks to reduce the harms and risks associated with activities through small, incremental steps (Riley, 1993). Harm reduction approaches recognize that there is some level of harm associated with the activities in which people are engaging. The harm reduction model supports the provision of full, factual information, resources, education, and skills in order to minimize the negative consequences of risk activities on individuals (White, 1994).

The theory of public participation includes the fostering of public participation and it is one of the key tenets outlined in the Epp Framework for Health Promotion (Health Canada, 1986; MacKean & Thurston, 1996). The theory of public participation is identified as a key strategy for addressing the main health challenges in Canada (Health Canada, 1986; MacKean & Thurston, 1996). The encouragement of public participation means enabling people to assert control over the factors that affect their health (Health Canada, 1986; MacKean & Thurston, 1996).

The theory of public participation is complementary to a community based research (CBR) approach, which was integrated into the formative stages[18] of the research study. A CBR approach is defined by Health Canada (2002b) as "the application of principles of community involvement and collaboration by using scientifically

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[18] The CBR activities are described in the methods chapter.

accepted research methods" (p. 1). The integration of a community perspective in the development of the research helped to ensure the results and discussions were appropriate for the local context (UNFPA, 1998).

Significance of the Research

Due to the ease of global mobility and its impact on the spread of infectious diseases, many developing countries have placed increasing emphasis on the link between travel, tourism, and the spread of HIV/STIs (Forsythe, 1999; Hamlyn & Dayan, 2003; Herold & Van Kerkwijk, 1992; Mullhall, 1993, 1996; Wright, 2003). Despite the increasing emphasis on this issue in developing countries, little attention has been given by developed countries, such as Canada, to the sexual risk-taking activities of SIW while employed in the tourism industry. Increasing evidence suggests that a relationship exists between the tourism trade and increased sexual risk activity by those working and living in tourism destinations (Bellis et al., 2004; Egan, 2001; Forsythe, 1999; Hennick et al., 1999; Mullhall, 1996); however, there is limited evidence to substantiate these claims. In the Rockies' communities there has been anecdotal information emerging from key informants and health care professionals proposing a link between SIW and high risk sexual activities (AIDS Bow Valley, 2004; Blair et al., 2002). This research allowed for an exploration of the sexual health of SIW in order to inform program development and future intervention strategies.

This research was significant in terms of the timeliness in the Rockies as there appears to be a growing concern among health care professionals and advocates that the well-being of young workers may be compromised due to the combination of high-risk sexual activities, substance use, mobility of tourist environments, the sense of

invincibility, and overarching health determinants that influence SIW in the Rockies. Local media have added to these rising tensions by airing stories that highlight potential health risks for young workers. For example, in October 2005[19], the Canadian Television Network (CTV) aired a two-part special on the Town of Banff on their Calgary channel (CFCN, 2005a, 2005b). The producers highlighted that there are approximately 3,500 young adults aged 18 to 35 years who arrive in the Rockies each year. They stated that these young adults are "working at low-paying minimum wage jobs. Bars serve until 2 am and shut the doors at 3. That can make for a volatile combination" (CFCN, 2005b, p. 1). However, they highlighted some of the proactive steps that the community has taken to support young workers including a program entitled Bar Watch and alternatives to the bar scene (CFCN, 2005a, 2005b)**.** Also in October 2005, the Canadian Broadcasting Corporation (CBC) aired a story entitled *Banff Wildlife* on their program *Country Canada.* This story highlighted the "potent combination of young people being away from home, and, ready access to alcohol, drugs, and the opposite sex" (Canadian Broadcasting Corporation, 2005, p.1). Thus, the sexual health of young workers in the Rockies is an issue on the radar of local and national media. Local health professionals have identified this research area as an important topic in order to determine if risk-taking is an issue among SIW and what factors influence their activities (Blair et al., 2002; Davies, 2004).

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[19] October 22nd and 23rd two short segments that followed the Banff party scene for SIW was aired on the evening news.

This study explores the sexual activities of SIW, associated risks, and protective measures and provides information on the sexual risk activities of SIW and the factors that influence their decision-making. This research provides a voice to young SIW who visit the Rockies and involved key stakeholders in the research process. This thesis research project increases the understanding of the sexual risk activities of SIW and contributes to the small body of literature that exists within Canada and developed countries on this topic. This research increases the understanding for a variety of audiences including key informants in the mountain parks (Lincoln & Guba, 1985). Overall, this research project provides a unique perspective toward improving the health services in the tourism industry, particularly among highly visited tourist destinations.

Organization of Thesis

The thesis is organized in six chapters. Chapter one is the introduction and includes the rationale, background, and significance of the research study. Chapter two contains the literature review and includes an overview of pertinent literature related to STIs, HIV, tourism, substance use, migration, and factors influencing sexual health of young adults. Chapter two also contains the research questions. Chapter three includes the methods, data collection, and data analysis strategies along with ethical considerations and rigour. Chapter four contains the thematic results. Chapter five includes the discussion through the socio-ecological framework including the social determinants of health and migratory experiences of SIW. Chapter six contains the conclusion for the study, health promotion strategies for action, and recommendations for future areas of study.

CHAPTER TWO LITERATURE REVIEW

Travel, Tourism, STIs, and HIV/AIDS

The spread of infectious diseases, including HIV/STIs, has been facilitated through the ease in international travel and population movement (Abdullah et al., 1998; Barnett, 1996; Egan, 2001; Forsythe, 1999; Gillies et al., 1992; Hamlyn & Dayan, 2003; Hawkes et al., 1995; Mabey, 1995; Memish & Osoba, 2003; Mullhall, 1996; Rodriquez-Garcia, 2001; Wright, 2003). Sexual activities have been linked with risks for contracting and transmitting STIs while travelling (Abdullah et al., 1998; Allard & Lambert, 1992; Broring, 1996; Egan, 2001; Hawkes & Hart, 1998; Hawkes et al., 1995; Mullhall, 1993, 1996). The spread of HIV/STIs during travel has been influenced by different factors including geographical mobility, which has created a bridge between scattered sexual networks (Carter et al., 1997; Hawkes et al., 1994; Lau & Thomas, 2001). People may also experience behavioural changes when they are travelling including increased sexual risk-taking (Carter et al., 1997; Noone, Gill, Clark, & Porter, 1991).

The practice of high-risk sexual activities during travel has provided opportunities for epidemics to spread (Lau & Thomas, 2001). Abdullah et al. (1998) summarized that sex and travel is an important public health issue because of the high risk of acquiring and transmitting a STI. According to the WHO (2006), although the burden from STIs is greatest in developing nations, "industrialized nations can also be expected to experience an increased burden of disease attributable to the prevalence of non-curable viral STIs, to sexual behavioural trends, and to increased travel and interaction of populations across the globe" (p. 2). Despite the ease in global mobility and its impact on the spread of

infectious diseases, there has been very little attention focused on the sexual health of those working in the tourism industry.

Tourism has been identified as the world's largest industry (Memish & Osoba, 2003). An estimated 10 percent of the global workforce is employed in tourism (Mullhall, 1996). According to the WHO (2001b), the annual number of flight passengers reported by the International Civil Aviation Organization exceeded 1,562 million in 1999 and 1,647 million in 2000. Every day an estimated two million people cross national borders (Katz & Hirsch, 2003). Ostroff and Kozarsky (1998) concluded that virtually anyone can reach any destination after only 36 hours of travel, creating an opportunity for the rapid spread of microbial agents.

STI Overview

Population movement globally has influenced the spread of STIs. Many concerns have emerged pertaining to the globalization of HIV/STIs including the spread of these infections to and from travellers (Carter et al., 1997; Egan, 2001; Hawkes & Hart, 1998; Hawkes et al., 1995; Hawkes, Malin, Araru, & Mabey, 1992). STIs have reached pandemic[20] proportions and they are one of the most common reportable infectious conditions in the world (Genuis & Genuis, 2004; Mullhall, 1993, 1996). Worldwide, the highest rates of STIs are found among those aged 15 to 24 years and over half (60 percent) of all newly reported HIV infections are in this age range (Dehne & Riedner,

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[20] A pandemic was defined by the WHO (2005) as "an outbreak that affects the entire world" (p. 7) and it was defined by MedicineNet (1996) as "an epidemic (sudden outbreak) that becomes very widespread and affects a whole region, continent, or the world" (p. 1). An epidemic "affects more than the expected number of cases of diseases occurring in a community or region during a given period of time" (MedicineNet, 1996, p. 1). A disease that is endemic is present in a community at all times but in low frequency (MedicineNet, 1996).

2005). There are many factors that influence the incidence and prevalence of HIV/STIs including: demographic differences; socio-economic differences; cultural differences; and variation in accessibility to effective treatment and condoms (Mabey, 1995). The spread of STIs is influenced by patterns of sexual behaviour including: sex (male or female); frequency and type of intercourse (vaginal or anal); number and characteristics of sexual partners; extent of condom use; risk of violence; and STI epidemiology within local settings (Dehne & Riedner, 2005).

The WHO (2001a) estimated that 340 million new cases of STIs occurred worldwide among adults aged 15 to 49 years in 1999. According to the WHO (2006) an estimated one million people are infected with a STI each day. The presence of a STI greatly increases an individual's risk for acquiring or transmitting HIV (WHO, 2006). There are more than 30 bacterial, viral, and parasitic pathogens that are sexually transmissible (WHO, 2006). A breakdown of some common STIs among adults in 1999 around the globe illustrates: 172 million cases of trichomoniasis; 92 million cases of chlamydia; 62 million cases of gonococcal infections; 12 million cases of syphilis (WHO, 2001a). *Chlamydia trachomatis* is the most common bacterial STI worldwide, with the highest rates of chlamydia occurring among those aged 15 to 24 years (Bavastrelli et al., 1998; Miller, 2005). Chlamydia has been identified as one of the major causes of reproductive tract morbidity in women including tubal infertility, pelvic inflammatory disease, chronic pelvic pain, and ectopic pregnancy (Corey & Handsfield, 2000; Genuis & Genuis, 2004; Miller, 2005). In men, chlamydia has also been implicated in infertility (Miller, 2005).

Herpes simplex virus (HSV) and human papilloma virus (HPV) rates have increased significantly over the last decade (Memish & Osoba, 2003). HSV and HPV are viral infections that can be transmitted during sexual encounters (Corey & Handsfield, 2000; Kapiga et al., 2002). HPV is considered the most widespread STI today (Genuis & Genuis, 2004; Richardson et al., 2000). According to estimates by the Centre for Disease Control and Prevention (CDCP) (2001), an estimated 50 to 75 percent of adults in the United States (US) who are sexually active (male and female) will contract HPV during their lifetimes. In Canada, a secondary study of women aged 15 to 49 years (n=307) was conducted to determine the rates of incident and cleared carcinogenic HPV infection and to explore risk factors (Sellors et al., 2003). Incident infection with carcinogenic HPV occurred in 11 percent of women in the study and was highest among women aged 15 to 19 years who had an incident rate of 25 percent (Sellors et al., 2003).

HSV is one of the most widespread STIs worldwide (Genuis & Genuis, 2004) and HSV type two (HSV-2) is the most common cause of genital infections (Kapiga et al., 2002). Genuis and Genuis (2004) summarized that at least one-fifth of adult Americans are living with HSV-2. According to Kapiga et al. (2002), women are four times more likely to be HSV-2-seropositive than men are and the prevalence of other STDs, including HIV-1, was higher among women than men.

There has been a steady increase in Canada since 1997 of reported STI cases, particularly among young adults, including: chlamydia; gonorrhea; and infectious syphilis (Egan, 2001; PHAC, 2002a). There has been a 60 percent increase of chlamydia from 1997 to 2002 in Canada, with over half of the reported cases in the young adult age group (15 to 29 years) (PHAC, 2002a). Davies, Wang, and the Canadian Task Force on

Periodic Health Examinations ((CTFPHE), 1996) conducted a search of MEDLINE articles with the use of the major MeSH heading "chlamydial infections" between January 1983 and December 1995. They summarized from their review of past studies that at least 64 percent of cases of tubal infertility were attributable to chlamydial infections, as were at least 42 percent of ectopic pregnancies (Davies et al., 1996). Gonorrhea has increased by over 50 percent with the 15 to 29 year age group comprising 64 percent of total cases (PHAC, 2002a). Syphilis was rare in Canada in the 1990s; however, in 2002 there were four times as many cases as in 1997 and the number of cases continued to rise in 2003 (PHAC, 2004b). Across Canada localized cases of syphilis have contributed to an increased national rate (PHAC, 2004b). Maticka-Tyndale et al. (2000) used the data from the 1996 National Population Health Survey to track the age of first intercourse, number of intercourse partners, and condom use at last intercourse for youth at various age groups (n=44,744 aged 15 to 49 years). Maticka-Tyndale et al. (2000) stated that STIs disproportionately affect young adults in Canada.

Alberta Health and Wellness (AHW) (2005) identified that there has been a progressive increase of notifiable STIs in Alberta since 1997. Some STI trends in Alberta have surpassed national trends[21] (AHW, 2005). In 2004, STIs accounted for nearly two-thirds (62%) of all notifiable communicable diseases in Alberta (AHW, 2005). Among the reportable STIs in Alberta, chlamydia was the most frequently reported, followed by gonorrhea, nongonococcal urethritis (NGU), mucopurulent cervicitis (MPC), infectious syphilis, and non-infectious syphilis respectively (AHW, 2005).

The rate of reported chlamydia in Alberta has been on the rise[22]. The provincial chlamydia rate has increased from 215 cases per 100,000 population in 2001 to 262 cases per 100,000 population in 2004 (AHW, 2005). The reported genital chlamydia rates for Alberta were higher than the national rates[23] (AHW, 2005). Females have consistently shown higher rates than males; however, the rise in chlamydia has been demonstrated for both sexes. Between both sexes, the highest rates of chlamydia are among those aged 20 to 24 years (AHW, 2005). The next highest rates among females are those under 19 years of age compared with the next highest rate for males are those aged 25 to 29 years in Alberta (AHW, 2005).

The incidence rate of gonorrhea in 2004 was nearly doubled from the year 2001 in Alberta[24] (AHW, 2005). More alarming is that the 2004 Alberta provincial gonorrhea rate of 43 per 100,000 population is higher than national rates of 28 per 100,000 population for the same period (AHW, 2005). Gonorrhea cases were more common in males (867 male cases compared to 508 female cases) (AHW, 2005). For males in Alberta, the highest rates of gonorrhea are among those aged 20 to 24 years followed by those aged 30 to 39 years (AHW, 2005). For females, the highest rates have been reported among those aged 15 to 19 years and second highest among those aged 20 to 24 years (AHW, 2005).

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[21] Notably, the rates of chlamydia and gonorrhea are higher for Alberta than national incidence rates (AHW, 2005).
[22] The number of chlamydia cases in Alberta for 2004 were 8,339 compared to 6,485 in 2001 (AHW, 2005).
[23] The 2004 Alberta genital chlamydia rates were 261/100,000 compared to the Canadian rates of 208/100,000 (AHW, 2005).
[24] In 2004, there were 1,376 cases of gonorrhea in Alberta (rate of 43 per 100,000) compared with 2001 when there were 794 cases (rate of 26 per 100,000) (AHW, 2005).

STI rates may be affecting disproportionately those travelling to the Rockies compared to some of the other regions in the province. Banff and Canmore, which are the two largest communities in the Headwaters Health Authority[25] (HHA), accounted for the majority of STIs in the region in 1999 (HHA, 2002 as cited in AIDS Bow Valley, 2003). There was an increase[26] in the number of reported STIs in HHA prior to the health region changes in Alberta in 2003[27]. The HHA had reported a 22 percent increase in the number of chlamydia cases reported from the year 2002 to 2003 (AHW, 2003b, 2004). This was an increase from 134 cases in 2002 (AHW, 2003b) to 167 cases of chlamydia in 2003 (AHW, 2004)). HHA reported a rate of 168 chlamydia infections per 100,000 population in 2002[28], an increase from 137 per 100,000 population in 2000 (AHW, 2003b). The HHA had a reported a 33 percent increase in the number of gonorrhea cases between the year 2002 and 2003 (AHW, 2003b, 2004). There was eight reported cases of gonorrhea in 2003 (AHW, 2004), which was an increase from six cases of gonorrhea in 2002 (AHW, 2003b). HHA reported a rate of eight gonorrhea infections per 100,000 population in 2002[29] compared to a rate of four per 100,000 population in 2000 (AHW, 2003b). There was a four percent increase in NGU/MPC between 2002 and 2003, with a reported 78

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[25] The Calgary Health Region (CHR) includes the communities of Banff, Canmore, and Lake Louise as of April 1, 2003. Before the health region changes, these communities were part of the Headwaters Health Authority (HHA).

[26] The STI statistics are descriptive in nature and, for the purposes of this exploratory study, they were investigated to determine if there were statistically significant different changes in rates.

[27] Prior to the health region changes, the province administered the STD services. After the changes, the STD services in Alberta became regionalized. This process led to better reporting, more accessible STI detection, and more health professionals focused on these issues within each health region.

[28] Based on the chlamydia rate in HHA, the towns of Banff, Canmore, and Lake Louise would have an estimated rate of 16.8 chlamydia infections per 10,000 population.

[29] Based on the gonorrhea rate in HHA, there is a rate of 0.8 people per 10,000 population with gonorrhea in HHA.

cases of NGU/MPC in 2003 in HHA (AHW, 2004) compared to 75 cases of NGU/MPC in 2002 (AHW, 2003b).

The increasing rates of STIs on local, provincial, national, and international levels are alarming. Youth are particularly vulnerable to acquiring and/or transmitting a STI based on many factors including their development, physical and biological preparedness, and emotional health. The next subsection is a review of HIV/AIDS and rates among young adults.

HIV Overview

Broring (1996 as cited in Forsythe, 1999) purported that an interrelationship exists between HIV and tourism, suggesting that people may be at increased risk of contracting HIV when they engage in risk activities while they are on holidays. Wiggers et al. (1994) summarized that a significant risk for HIV infection is "contingent on the extent to which individuals engage in risky sexual behaviours" (p. 431). Since the beginning of the HIV pandemic, there have been more than 60 million people infected (UNAIDS, 2003). Elwy et al. (2002) identified that heterosexual transmission of HIV has increased globally.

There are approximately 56,000 people living with HIV/AIDS in Canada and an estimated 13 new infections every day (Health Canada, 2003b). There are approximately 4,000 individuals living with HIV/AIDS in Alberta (AHW, 2003c). In Alberta, 23 percent of new HIV infections during 2002 were among those under the age of 29 years (AHW, 2003c). According to AHW (2003c), of all the new HIV infections in Alberta in 2002, the highest exposure categories for HIV infection were injection drug use ([IDU], 37 percent), heterosexual contact (23 percent), and men having sex with men ([MSM], 20 percent) respectively.

Sexual Activities and Tourism Destinations

According to Lee, Bell, and Hinojosa (2002), a number of studies have described how the transmission of disease, including STIs, is socially organized around geographic travel and migration patterns. Sexual risk activities among those who travel abroad have been examined and are considered causal factors in the spread of HIV/STIs (D. Lee et al., 2002). Matteelli and Carosi (2001) reviewed STI and travel research. A proportion of short-term travellers, estimated from five to 50 percent, engage in casual sex while travelling. This proportion may be higher when longer-term travellers are considered (Matteelli & Carosi, 2001).

Hawkes et al. (1995) conducted a study on clients (n=386) attending a STD clinic in the UK. Hawkes et al. (1995) found that travellers are more likely to engage in risky sexual behaviour, including multiple partners and unprotected sex. Specifically, Hawkes et al. (1995) found that one-fourth (25 percent) of male travellers and nearly one-fifth (18 percent) of female travellers reported a new sexual partner on their most recent trip away. Those who were more likely to report a new sexual partner while abroad were typically male, single, young, and travelling without a partner (Hawkes et al., 1995).

Mabey (1995) assessed the importance of international travel as a risk factor for HIV among heterosexuals in the United Kingdom (UK) and strategies for prevention. Travellers, especially young people travelling alone, were found to be more likely to have casual sexual liaisons than their peers who do not travel (Mabey, 1995). Mabey (1995) identified that STI infections among travellers may be asymptomatic, undiagnosed, and unreported.

Carter et al. (1997) summarized that international travel can facilitate STI transmission based on several factors including behavioural change and the possibility of increased risk-taking while travelling. The majority (92 percent) of the heterosexual male travellers who remained in the travel destination for work purposes reported a sexual contact with a person from the local community (Carter et al., 1997). This is compared with one fourth (23 percent) of those who travelled purely for a holiday. Men were less likely to use condoms the longer they spent in the location of work (Carter et al., 1997).

Hennick, Cooper, and Diamond (1999) conducted a longitudinal qualitative study on seasonal workers (n=50) and their contraceptive behaviour while living and working on the south coast of England. Hennick et al. (1999) described that seasonal workers in holiday or tourism centres "have been shown to experience different social and sexual behaviour while at a holiday centred compared to that followed in their home environment" (p. 45). Workers in the tourism industry were typically young, single, sexually active, and reported a highly social environment. While residing at holiday centres, seasonal workers reported significant sexual risk-taking.

Mullhall (1993) summarized global epidemiology for STIs and provided broad guidelines for treatment. Mullhall (1993) identified core groups of people who are efficient transmitters of STIs. These core groups are based on observation that certain STIs are *endemic* among sub-populations of highly sexually active people (Mullhall, 1993). Examples of core groups identified by Mullhall (1993) include seafarers, truck drivers, and migrants. These "groups of travellers, by virtue of their unusual living and working conditions that could be at an increased risk with respect to ST[I]s/ HIV" (Mullhall, 1993, p. 404). Travel itself has not been found to be a risk factor, travel has

facilitated the spread of infectious conditions (Mullhall, 1993). The level of sexual knowledge among travellers was identified as having minimal impact on their sexual behaviours (Mullhall, 1993). As well, international travellers are at a heightened risk of leaving the tourism location during the incubation period for STIs/HIV (Mullhall, 1993). In turn, these individuals may have several sexual contacts before symptoms appear and their infections may remain asymptomatic (Mullhall, 1993). Many infections go undiagnosed, unreported, and may lead to transmission to others (Mullhall, 1993).

Several theories have been studied related to sexual risk activities and tourism destinations. The notions of *liminality* and *situational disinhibition* have been extensively studied in the context of tourism and sexual health literature (Apostolopoulos, Sonmez, & Yu, 2002; Eiser & Ford, 1995; Maticka-Tyndale, Herold, & Mewhinney, 1998; Memish & Osoba, 2003; Ryan, Robertson, Page, & Kearsley, 1996). Shields (1990 as cited in Maticka-Tyndale et al., 2003) coined the term *liminality* for instances when people experienced a temporary loss of social bearings and a sense of *in-between-nes*s. The notion of *situational disinhibition* was described by Eiser and Ford (1995) as experiences of those engaging in behaviours that they do not typically engage in at home. Memish and Osoba (2003) reviewed literature on STI and travellers. Travellers may experience a freedom from normal societal values and practices and these experiences may increase sexual risk activities including more casual sexual encounters (Memish & Osoba, 2003). According to Shields (1990 as cited in Maticka-Tyndale et al., 2003), vacation goers may engage in activities that contradict the personal norms that typically guide their everyday lives. Herold and van Kerkwijk (1992) identified that international travel reduces

inhibitions and facilitates a sense of freedom from regular constraints and this freedom, combined with alcohol consumption, can create opportunities for risk-taking.

Maticka-Tyndale, Herold, and Mewhinney (1998) conducted research in Canada that explored the notion of *situational disinhibition* of students on spring break. Peer group role modeling of casual sex during spring break was found to be a strong predictor of sexual activity (Maticka-Tyndale et al., 1998). Apostolopoulos, Sonmez, and Yu (2002) found that contranormative settings, such as spring break, provide ideal conditions for interactions for sexual risk-taking, substance use, and drug consumption. According to Maticka-Tyndale et al. (2003), participating in sexual activities is an expectation for many students on vacation. Herold and Van Kerkwijk (1992) identified that individuals encounter a sense of freedom when they are away from home, such as relaxed inhibitions, substance use, and a focus on having a good time.

Eiser and Ford (1995) conducted a cross-sectional study to assess the role of *situational disinhibition* on sexual risk-taking of tourists (n=1,033) on holiday in a seaside resort in southern England. People in the study reported a greater openness to socio-sexual contact with new friends, a removal of constraints on behaviour, and an enhanced recklessness with sexual encounters (Eiser & Ford, 1995). Eiser and Ford (1995) stated, "within the framework of social learning theory, such disinhibition might reflect an imperfect generalization to a new environment of norms and constraints acquired at home" (p. 326). In general, people reported an increased likelihood of engaging in sexual activities with new partners in holiday settings (Eiser & Ford, 1995).

The *sexual intentions* of travellers were explored by Mullhall, Hu, Thompson, Lin, Lupton, et al. (1993) in a cross-sectional survey of Australian patients (n=213)

attending private clinics to seek pre-travel medical advise before travelling to Thailand. Over half (57 percent) of patients sampled identified a definite intention to have sex while in Thailand. The majority of Australians planned to have sex with travellers of other nationalities (70 percent), sex with other Australians (58 percent), sex with Thai nationals (46 percent), sex with bar girls (14 percent), and sex with others (15 percent) (Mullhall et al., 1993). Of those who responded to questions on condom use (n=194), the majority (82 percent) stated they planned to use condoms all of the time. There was no significant difference between men and women. The risk perception of participants for contracting HIV was not significantly different from their risk perception of contracting the virus while at home, despite participants clearly recognizing an increased magnitude of HIV in Thailand (Mullhall et al., 1993). Mullhall (1993) concluded that despite the reasonable awareness of the HIV risks in Thailand, participants did not identify a perception of personal risk. The study sample was composed of a group of young Australians who were not travelling for purposes of sexual tourism (Mullhall et al., 1993).

Josiam, Hobson, Dietrich, and Smeaton (1998) examined the sexual activity, alcohol, and drug use of US college students (female, n=442; male, n=341) during spring break in Florida. Josiam et al. (1998) discussed the theoretical perspective on unrestrained behaviour during spring break provided by *scripting theory.* This theory posits that social life is based on *scripts,* which are defined as "sets of implicit rules that determine how individuals behave in social contexts" (Josiam et al., 1998, p. 503). Josiam et al. (1998) summarised that spring break tourism for college age students

presents an opportunity for young adults to "freely indulge in activities that are considered unacceptable at home" (p. 503).

Mewhinney, Herold, and Maticka-Tyndale (1995) investigated the sexual perceptions, attitudes, and behaviours of Canadian university students on spring break in Daytona, Florida. People on spring break may experience "freedom from responsibilities and home constraints, a sense of anonymity, and drinking" (Mewhinney et al., 1995 p. 284). The factors collectively can contribute to the notion of *sexual scripts* for their behaviour. In general, tourism environments may be settings where sexual activities that are considered unacceptable at home are explored and, in some instances, acted upon (Josiam et al., 1998).

Students and Sexual Risk-Taking while Travelling

A large focus of travel and sex literature has been on commercial sex and sex tourism. However, a growing body of literature has focused on students who partake in sexual activities while on spring break[30] (Josiam et al., 1998; Maticka-Tyndale & Herold, 1997; Maticka-Tyndale et al., 1998; Maticka-Tyndale et al., 2003; Mattila, Apostolopoulos, Sonmez, Yu, & Sasidharan, 2001; Smeaton, Josiam, & Dietrich, 1998). The spring break phenomenon is a "unique North American phenomenon that attracts hundreds of thousands of students to a setting that brings together all forms of high risk behaviour" (Josiam et al., 1998, p. 504). Within this subculture, permissive sexual scripts and uninhibited behaviour may be commonplace (Josiam et al., 1998). Josiam et al.

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[30] Spring break has been identified as a unique, North American tourism phenomenon (Josiam et al., 1998); however, other forms of school breaks in the literature include examples such as Schoolies week in Australia (Maticka-Tyndale et al., 2003).

(1998) suggested that students engage in more sexual activity and report more new sexual partners during holiday than at home. Alcohol consumption and drug use have also been linked with higher-risk sexual activities for students during spring break, including risks for STIs (Josiam et al., 1998). Those who travelled to holiday destinations with the intention to be involved in the party scene were also found to consume more alcohol compared to those who reported other travel motivations (Josiam et al., 1998).

Maticka-Tyndale and Herold (1997) conducted a cohort study on a sample of Canadian students (n=681) aged 18 to 30 years who travelled to a beach resort in Florida during their spring vacation. The authors found that over one-fourth of males and females (28 percent and 25 percent respectively) reported sexual intercourse on spring break, with over half (50 percent) of these with casual partners.

Maticka-Tyndale et al. (2003) conducted a cross-sectional survey on Australian high school students (n=1,446) during their *Schoolies* week trip to Surfers Paradise in Queensland, Australia. Participants completed a self-administered questionnaire of their experiences on their holiday. The study identified that three fifths (60 percent) of men and nearly two-fifths (40 percent) of women who engaged in sexual intercourse during Schoolies week did so with a casual partner (Maticka-Tyndale et al., 2003). More men than women in the study intended to, and engaged, sexual intercourse (Maticka-Tyndale et al., 2003). These results accentuated gender differences that were found in past studies (e.g., Maticka-Tyndale et al., 1998). For women in the study, as experiences and participation in activities at Surfer's Paradise increased, their likelihood of casual sex increased (Maticka-Tyndale et al., 2003). For men, their past casual sex experience increased their likelihood of engaging in casual sex while in Surfer's Paradise.

Apostolopoulos et al. (2002) conducted a cross-sectional study on undergraduates (n=534) from two US universities who went on spring break vacations to determine the efficacy of the modified TIB model. The authors found that strongest predictors of casual sexual activities while on vacation included: alcohol consumption prior to sexual activity; impulsivity in decisions involving sex; peer influences (primarily pre-vacation pacts to have casual sex); and prior experience with casual sex during previous spring breaks (Apostolopoulos et al., 2002). The strongest predictors of condom use and unprotected sexual intercourse were the availability of condoms and the impulsivity in decisions regarding sex (Apostolopoulos et al., 2002). Apostolopoulos et al. (2002) stated that excessive alcohol consumption, combined with illicit drugs, the "cloak of anonymity that spring break provides" (p. 741), and permissive social interactions facilitate risk-taking among students. Apostolopoulos et al. (2002) highlighted that "the spring-break vacation becomes an incubator for young adults' HIV-risk behaviours" (p. 741).

Sexual Activities and Risk-Taking While Travelling

Increased sexual risk-taking activities have been linked with alcohol consumption (Corcoran, Franklin, & Bennett, 2000; Rodgers, Kaplan, & Martin, 1990; Tveit & Nilsen, 1994). Tveit, Nilsen, and Nyfors (1994) conducted a study on people attending a STI clinic in Norway and found that there was a decrease in condom use and increased likelihood of casual sexual activity when alcohol was consumed. It has also been demonstrated that tourists take risks that they would not necessarily engage in when they are away from home (Forsythe, 1999). For example, tourists consume more substances, such as alcohol and drugs, and describe being more adventurous while travelling

(Forsythe, 1999). This has created a bridge between risk taking and travel for those visiting tourism destinations (Forsythe, 1999).

Smeaton et al. (1998) identified that the majority (approximately 90 percent) of college students consume alcohol. In 1998, the first Canadian Campus Survey (CCS) was conducted to assess alcohol and drug use among university students (Smeaton et al., 1998). On at least one occasion during the fall semester, nearly two thirds (63 percent) of respondents reported consuming five or more drinks and over one-third (35 percent) reported consuming eight or more drinks (Smeaton et al., 1998).

Binge drinking[31] has been identified as a significant student health issue on campuses (Smeaton et al., 1998). Smeaton et al. (1998) summarized studies by Wechsler and Isaac (1992), Presley, Meilman, and Lyerla (1993; 1995; 1996), and Douglas, Collins, and Warren (1997). Binge drinking among college students in these studies ranged from 44 to 55 percent for men and from 27 to 35 percent for women (Smeaton et al., 1998). Smeaton et al. (1998) conducted a cross-sectional study on college students (n=783) at Panama City Beach, Florida, to assess for the effects of gender[32], age, fraternity or sorority membership, and travel motivation on alcohol consumption and binge drinking during spring break. Almost all the men (92 percent) and the majority of women (78 percent) reported binge drinking behaviour the day before they participated in the study, averaging 18 drinks for men and 10 drinks for women[33] (Smeaton et al., 1998).

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[31] Binge drinking has been defined as five or more drinks in a row, regardless if male or female (Smeaton et al., 1998).
[32] Study included assessment of differences between male and female college students (Smeaton et al., 1998).
[33] The reported number of drinks identified by participants far exceeded past findings of consumption (Smeaton et al., 1998). Spring break binge drinking activities were significantly higher than on-campus binging (Smeaton et al., 1998).

Those who described their motivation to travel to party also consumed significantly more alcohol than those who cited other reasons for their travel (Smeaton et al., 1998). Sexual risks and the potential for contracting or transmitting a STI are potential consequences of binge drinking (Smeaton et al., 1998). Additionally, patterns of binge drinking among college students may increase when they go on holidays (e.g.. spring break) (Smeaton et al., 1998).

Carter et al. (1997) conducted a cross-sectional study of people (n=325) attending a genitourinary medicine clinic between 1993 and 1994. Participants were those who had travelled abroad within three months of visiting the clinic (Carter et al., 1997). The study found that one-fifth (20 percent) of women and nearly one-third (31 percent) of heterosexual men had sexual contact with a new partner while abroad (Carter et al., 1997). Of those who had a new sexual partner, half (50 percent) of the women and over half (59 percent) of heterosexual men identified inconsistent condom use (Carter et al., 1997). Those who spent the most time abroad were found to be the least likely to use condoms consistently (Carter et al., 1997). The mean time away from home for those who reported new sexual partners and consistent condom use was three weeks (Carter et al., 1997). In comparison, those who described inconsistent condom use had been away from home for a longer time (Carter et al., 1997). Condom use at home was a good predictor of condom use abroad (Carter et al., 1997). Those who travelled for business or work abroad reported the highest sexual risks with two-fifths (41 percent) of business travellers reporting at least one new sexual partner (Carter et al., 1997).

Bloor, Thomas, Hood, Abeni, Goujon, Hausser, et al. (1998) conducted a study on United Kingdom (UK) residents (n=400 case; n=568 controls) aged 18 to 34 years

who had travelled abroad to determine characteristics of people who engage in sexual risks behaviour while travelling abroad most frequently. People in the study were more likely to engage in high risk sexual activities when travelling than at home (Bloor et al., 1998). Bloor et al. (1998) found that one in ten who travelled abroad engaged in sexual intercourse with a new partner, with an average of two new sexual partners per trip. Specific risks of those travellers who are most likely to engage in high risk sexual activities, included: those travelling alone; those who reported inconsistent condom use at home; and those who stayed away for three weeks or more (Bloor et al., 1998). Three-quarters (75 percent) of participants reported consistent condom use with new sexual partners. Condom use at home was significantly predictive of condom use abroad for male participants, whereas condom use for females while abroad was significantly predicted by the background of their sexual partner (Bloor et al., 1998). The variables associated with engaging in four or more episodes of unprotected sex included: being female; travelling alone; travelling for purposes other than holiday; not carrying condoms; no recent history of condom use at home; SES; and previous attendance at a STI clinic (Bloor et al., 1998). In situations where sexual intercourse occurred with fewer than four episodes, variables that were significantly associated with new sexual partners while travelling abroad were: being male; travelling with friends; being on holidays; carrying condoms; being single; having casual partners at home in the previous two years; first sexual activity at less than 16 years of age; taking a trip for longer than 15 days; expectation to have a new sexual relationship; and alcohol consumption more than twice on trip (Bloor et al., 1998). Bloor (1998) suggested that those who travel may represent a “convenient proxy group for people who are most sexually active” (p. 1668)

and health promotion efforts targeted at this population may enable messages to reach those reporting the most new sexual partners abroad as well as at home.

Abdullah et al. (1998) conducted a structured interview with people (n=383) in a Hong Kong departure lounge to inquire about their travel risks and sexual behaviour. Abdullah et al. (1998) found that people may become involved in high risk sexual activity when away from their normal environments. Travellers who reported the highest risk sexual activities (inconsistent or lack of condom use with new sexual partners), were also those that reported the lowest perception of risk for infection (Abdullah et al., 1998). Those in the study who were most likely to report sex with strangers during their travel included: youth (18 to 25 years); men; Caucasian or other non-Chinese; and those who approved of having multiple sex partners (Abdullah et al., 1998). Those in the study who were most likely to engage in high risk sexual activities, including inconsistent condom use, were: middle aged (26 to 45 years); married; not previously tested for HIV; and not afraid of HIV infection (Abdullah et al., 1998). The results cited by Abdullah et al. (1998) were generally consistent with Bloor et al. (1998); however, Abdullah et al. (1998) found that young people were more frequently sexually active while travelling. They also found that middle age travellers, particularly married men who held low perceptions of HIV risk, were engaging in the highest-risk sexual activities (Abdullah et al., 1998). They argued that sexual health promotion strategies should target not only young travellers, but also those who are middle aged and in stable relationships (Abdullah et al., 1998).

Egan (2001) conducted a study on backpackers (n=504) travelling within Canada. In the study by Egan (2001), one-fourth (26 percent) of backpackers engaged in sexual

intercourse with a casual partner while on their trip. The majority (94 percent) of backpackers reported the planned use of condoms; however only two-thirds (64 percent) used condoms with their most recent sexual partner (Egan, 2001). Those who reported the lowest perceived risk for HIV were also those most likely to report a casual sexual encounter (Egan, 2001). Alcohol was identified as a factor influencing casual sex activities for both men and women (Egan, 2001). In another Canadian study by Allard and Lambert (1992 as cited in Abdullah et al., 1998), 14 percent of travellers did not think that avoiding sex was protective, and these travellers were also more likely to report that condoms were more effective if they were used with fellow travellers rather than with local residents.

In a study of travellers (n=3,100) at a Zurich airport by Gehring, Widmer, Kleiber, and Steffen (1998), participants described their sexual risk activities either before departure or upon arrival. Participants reported inconsistent condom use despite their knowledge that condom use reduces the risk of contracting a STI (Gehring et al., 1998). This result was consistent with findings by Ford (1990 as cited in Hennick et al., 1999), who conducted a study on tourist workers and residents aged 16 to 24 years in Torbay, England. Among seasonal workers that reported having sexual intercourse, 40 percent had not used a condom (Ford, 1990 as cited in Hennick et al., 1999). Seasonal workers who reported four or more sexual partners reported the lowest level of condom use (Ford, 1990 as cited in Hennick et al., 1999).

Migration and STI/HIV Research

In addition to research on travel and tourism, migration has been a focus of STI and HIV research as many migrants experience health disparities that place them at

increased health risks. Migration is a global term for movement and carries political, ethical, psychological, social, and medical ramifications in terms of the spread of epidemics such as HIV (Sherr & Farsides, 1996). According to Haour-Knipe and Grondin (2003), there are an estimated 175 million migrants worldwide, with one in every 35 persons worldwide being an international migrant. Each year, an estimated 700 million travellers cross international boundaries (Haour-Knipe & Grondin, 2003). The international community first focused on mobile populations and HIV with truckers and sex partners in East and Central Africa (Haour-Knipe, Fleury, & Dubois-Arber, 1999). Subsequently, many studies have been conducted in developing countries on migration, risk of HIV transmission (such as the communities of Africa, Asia, Latin America, Caribbean) (Haour-Knipe et al., 1999). Past studies have found that migrant labourers (namely seasonal farm workers) are a high risk group for HIV (Organista & Organista, 1997).

A focus of North American migration and HIV/STI research to date has been on those employed in agriculture work in the US (Weatherby & McCoy, 1997). Fitzgerald, Chakraborty, Shah, Khuder, and Duggan (2003) conducted a cross-sectional study in nine communities in rural Ohio to determine the HIV/AIDS knowledge of female migrant workers (n=106). They estimated that there are approximately 6,400 migrant farm workers in Northwest Ohio and over four million migrant farm workers in the US alone (Fitzgerald et al., 2003).

Aranda-Naranjo, Gaskins, Bustamante, Lopez, and Rodriquiz (2000) conducted a qualitative study on the health-seeking experiences of migrant seasonal farm workers (n=13) in south Texas. Migrant agricultural workers have been identified as a high risk

group for contracting HIV (Aranda-Naranjo et al., 2000). Migrant workers in the US have experienced deplorable health conditions (Weatherby & McCoy, 1997) and there is a "confluence of migration related factors [that] increase the HIV risk for migrant labourers" (Organista & Organista, 1997, p. 83). These factors include: education; culture; language; geographic barrier to health services; low wages; chronic underemployment; substandard housing (Organista & Organista, 1997); social and economic factors (Sherr & Farsides, 1996; Wolffers, Fernandez, Verghis, & Vink, 2002); race; ethnicity; gender; age (Weatherby & McCoy, 1997); inadequate housing; poverty; racism; unemployment; lack of adequate health care (Haour-Knipe, 1995); low SES; lack of access to safer sexual information; and inaccessible health education and medical care (Aranda-Naranjo & Gaskins, 1998). Migrant workers may be at increased risk for contracting STIs/HIV and many migrants work within highly visited destinations, such as tourism milieus.

The fit of the literature outlined in this chapter was assessed in relation to the fit to SIW in the Rockies. For example, the migration and HIV/STI literature was reviewed and included for several reasons. SIW are consistent with the definition of migrants as those who move within or between borders (Thurston & Vissandjee, 2005). SIW arrive from around the world, including diverse high-income countries. SIW represent different languages, cultures, and traditions. SIW arrive in the Rockies with intentions to stay either temporarily or permanently. Many travel by themselves, arrive with limited or no supports in place, and need to re-establish themselves in a new context. Often they are experiencing adaptations in terms of new beliefs, values, and norms. Despite the similarities between the populations of SIW and immigrants, there are inherent

differences that are important to acknowledge when comparing the populations. Although research has demonstrated that long-term immigrants in Canadian communities can experience health disparities, newly arriving immigrants in Canada often experience the *healthy immigrant effect*[34]. Hyman (2001) found that newly arriving immigrants "enjoy many health advantages over long-term immigrants and native born population in terms of overall health status and prevalence of certain chronic diseases" (Hyman, 2001, p. v). Taking into considerations the health of immigrant populations arriving in Alberta (not including refugees), SIW may in fact be more disadvantaged when they first arrive than the immigrant populations. Caution is warranted when comparing SIW and immigrant population as SIW and immigrants may be travelling for different reasons and intentions. Research on immigration should be carefully assessed in terms of the transferability. However, this literature is useful in informing researchers about established factors that influence immigrants' health and their settlement processes.

In terms of the literature within university contexts, there are many similarities between SIW and students, including the age range, shared living arrangements, and party subcultures. However, the length of time students spend in university is often bound by the duration of their degree or diploma program; whereas the experiences of SIW in the Rockies are not fixed. SIW can remain permanently or depart at any time. The literature outlined in this chapter helped to provide some context to issues that SIW may encounter but should be reviewed with caution.

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[34] *Health immigrant effect* refers to the observation that many immigrants are often in superior health to many native born residents when they first arrive in Canada but lose this advantage over time (Hyman, 2001).

Researcher's Background

The researcher's[35] background influenced the development of the research topic. For six years prior to the commencement of the study, the researcher worked at local AIDS Service Organization (ASO) in Alberta. During this time, the researcher collaborated with key stakeholders and service providers in the Rockies communities. Repeatedly, these key stakeholders articulated the need for exploration and research related to STIs and the sexual health of the young workers in their communities. As the media began to focus more closely on the communities, service providers felt that the growing perceptions of STI risks were not evidence based. The need for a study that could uncover the issues that SIW faced became more and more apparent. At the same time, a community based research (CBR) assessment was conducted with all ASOs in the province of Alberta. Several held mandates in the Rockies communities and health professionals within these organizations identified SIW and sexual risk taking as an area that warranted further research.

Summary

Bellis et al. (2004) concluded that "action to protect the sexual health of millions of young people travelling abroad is urgently needed and requires investment from local health services, policy development at regional and national levels, and collaboratively working with those in the travel and nightlife industries" (p.47). Despite the increasing emphasis on this issue among travellers and migrant populations, little attention has been given by countries such as Canada to the sexual risk-taking activities of people who are

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[35] The researcher refers to the graduate student.

employed in the tourism industry. Increasing evidence demonstrates the relationships between the tourism trade and sexual risk activities by those visiting tourism destinations (Bellis et al., 2004; Egan, 2001; Forsythe, 1999; Hennick et al., 1999; Mullhall, 1996). In the communities of the Rockies, there has been anecdotal information emerging from key informants and health care professionals proposing a link between people working in the service industry and high risk sexual activities (AIDS Bow Valley, 2004; Blair et al., 2002).

Research Question and Sub-Questions

The literature tells us that many of those who travel to tourist destinations assume a certain degree of risk. However, the only data that is available is report data and there is a lack of first hand accounts of how SIW themselves describe their sexual risk activities. To date, there has been speculation about the actual levels of risks that are encountered by SIW. There is also a lack of evidence as to what SIW attribute their risks and how they make decisions regarding their use of protective measures. The literature review, research gaps, and researcher's background informed the nature and substance of the research questions. An exploratory and descriptive study was designed to answer the following research questions:

For SIW who have engaged in sexual risk activities:

a) How do they describe their experiences?

b) How do they describe the associated risks and protective measures?

These broad questions have not been previously explored and this study will enable an open ended description of the experiences of SIW in the Rockies.

The answers to these questions should have implications for future research studies and service delivery approaches to enhance the sexual heath of young SIW in the Rockies. On a broader level, understanding the sexual activities of SIW will help to understand the unique tourism context and suggest approaches to enhance the experiences for those visiting, residing, and working in this unique destination.

CHAPTER THREE: RESEARCH METHODS AND DESIGN

This chapter describes the qualitative research methods used in the study to explore the sexual activities of SIW in the Rockies. Since this research topic had not been previously studied, a descriptive and exploratory study was designed to gain an understanding of the sexual activities of SIW while working in the Rockies. This chapter includes: an overview of the socio-ecological framework; the qualitative inquiry including sampling strategies, data collection, and data analysis; quality and rigour; and the ethical considerations.

A Qualitative Inquiry

A descriptive and exploratory qualitative method was used in the research. A qualitative method has been defined as "multimethod in focus, involving an interpretative, naturalistic approach to its subject matter" (Denzin & Lincoln, 1998, p. 3). An inductive approach to data collection and analysis allowed for an exploration of the phenomenon in its natural setting (Denzin & Lincoln, 1998) and for an emergent and adaptive study design. The researcher purposefully decided not to integrate a specific tradition, such as phenomenology or ethnography as little was known about the experiences of SIW in general, and there was no previous research on SIW in this particular context. Lincoln and Guba (1985) outlined several reasons why an emergent design is appropriate for qualitative research, including: one, because not enough information can be known at the beginning of the study in order to design another study adequately; two, the emerging design is a function of the interaction between the researcher and area of study; and three, the results and interaction are largely unpredictable. This study was developed with the intention of providing information back

to the community organization. This qualitative method enabled the researcher to adapt to "dealing with multiple realities… because qualitative methods are more sensitive to and adaptable to the many mutually shaping influences and value patterns that may be encountered" (Lincoln & Guba, 1985, p. 40). An emergent qualitative design allowed the research to "flow, cascade, unfold… rather than to construct it preordinately (*a priori*)" (Lincoln & Guba, 1985, p. 41). A qualitative approach allowed the research process to adapt and respond to new developments of information and interactions (Creswell, 1998). A qualitative approach enabled an exploration of the social contexts in which sexual risk activities occurred in the Rockies and allowed for in-depth discussions of the associated risks, experiences, and protective measures as defined and lived by SIW.

The socio-ecological framework was integrated into the study during the analysis[36] process of this study for many reasons. A socio-ecological framework is useful in the context of complex health issues (Bauer et al., 2003). It emphasizes more than a medically oriented model, incorporating the social and ecological dimensions of health (Bauer et al., 2003). Well-being and health are acknowledged as interdependent notions that are interconnected with the diverse conditions in the socio-physical environment (Grzywacz & Fuqua, 2000). It provides a comprehensive understanding of health that requires a multidimensional and multidisciplinary approach to well-being (Grzywacz & Fuqua, 2000). It can be applied in the context of young people's lives and the exploration of their sexual health (Morgan, 2000). During later stages of analysis the congruence between migration experiences of SIW and of immigrant women as described by

Thurston and Vissandjee (2005) was discussed. This led to the integration of their model in the analysis phase and a review of how other aspects of the model were or were not discussed. Each component of the framework is discussed in the final chapter; however, only those components that emerged most prominently in the analysis are explored in depth. Other components of the model, such as institutions, may identify areas that could be explored in future research.

Purposeful Sampling Strategy

A purposeful sampling strategy was used to recruit and select participants based on deliberate choice of study inclusion and exclusion criteria (Creswell, 1998, 2003; Kuzel, 1999; Lincoln & Guba, 1985; Morse & Richards, 2002; Pope & Mays, 1995). A purposeful approach enabled the researcher an opportunity "to learn a great deal about issues of central importance to the purpose of the research" (Patton, 1990, p. 169). This approach led to a selection of individuals who were knowledgeable about the topic of the study. The participants that were recruited provided different perspectives and experiences and they were willing to reflect on the phenomena of interest through their participation (Creswell, 2003; Spradley, 1979 as cited in Morse & Richards, 2002).

Sample Size

This research study recruited a small[37] sample, which is typical of qualitative research methods. According to Patton (1990) a qualitative study "typically focuses in-depth on relatively small samples" (p. 169). A purposeful sampling approach seeks

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[36] Since the socio-ecological model was applied during the analysis process, there were components of the model that were not specifically looked for during data collection. H

individuals who can provide information-rich accounts of their experiences. The number of interview participants included eleven participants. The sample size grew until the investigators had confidence that the analysis was strong based on repeated categories in data analysis and redundancy of new information (Creswell, 1998; Hennick et al., 1999; Kuzel, 1999; Lincoln & Guba, 1985; Morse & Richards, 2002). An additional sampling size consideration was the ability of participants to report and reflect on their experiences (Morse & Richards, 2002).

Sample Inclusion Criteria

The researcher used a purposeful sampling strategy to target SIW in the Alberta Rocky Mountain Park communities to gain different perspectives. The sample included male and female participants. The sample inclusion criteria were developed in consultation with community-based organizations and key informants. The sampling strategy sought SIW who met the following criteria: they had been employed in the service-industry; they had engaged in sexual risk activities[38]; they were between the ages of 18 to 29 years; they were able to communicate in English; and they provided informed consent. The researcher sought to capture a variety of experiences within the sample participants including the following characteristics: employment types; living conditions (e.g., on site staff accommodation, off site staff accommodation, or independent living

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[37] "The validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information-richness of the cases selected and the observation/analytical capabilities of the researcher than with sample size" (Patton, 1990).

[38] The inclusion criteria for study participants specified that they needed to tell the researcher that they had engaged in sexual risk activities in order to be eligible to participate in the study. During the interview, participants were asked by the researcher to describe their sexual activities in depth as well as the factors they perceived as influencing their sexual risks. These descriptions are included in the results chapter.

arrangements); countries of birth (foreign born or Canadian born participants); and length of time living and working in the Rockies.

The decision to focus on SIW in Banff, Canmore, and Lake Louise, Alberta was made for several reasons, including: the transient nature of this population; the large proportion of SIW who were between the ages of 18 to 29 years; the diversity found in this sample; the differences between the research sites (resort size, location, number of seasonal employees, and management styles); and the current lack of research that explores the sexual risk activities of SIW (AIDS Bow Valley, 2003). SIW in the Rockies include people from around the world and each arrives in the Rockies with different beliefs, experiences, and knowledge about sexual activities and risks (Blair et al., 2002).

The decision to focus on young adults aged 18 to 29 years was made for several reasons including the rise in reported STI infection rates in Canada for those aged 18 to 29 years (AHW, 2003c). The PHAC (2002b) found that the highest rates and increases of STIs in Canada were among people between the ages of 15 to 24 years. As described in the literature review, the rates of chlamydia in Canada had increased by 60 percent in Canada from 1997 to 2002 and over half of the reported cases of chlamydia were among those aged 15 to 29 years (PHAC, 2002a). As of June 2003 in Canada, 26 percent of all reported HIV tests were among those aged 20 to 29 (PHAC, 2004a).

At the provincial level, AHW (2003c) reported that the majority of those infected and affected by STIs in 2002 were aged 15 to 29 years. Since 1998, the 20 to 24 year old age group has had the highest infection rates for the STI chlamydia in both males and females (AHW, 2003c). For infection rates among women, the 15 to 19 year old age group had the second highest reported chlamydia rate, which had almost doubled since

1998; for rates among men, the 25 to 29 year old group had the second highest rates, which was an increase of one and a half times since 1998. The rates for males aged 20 to 24 had increased one and a third times since 1998 for chlamydia.

Recruitment of Participants

A purposeful sample of SIW from the Alberta Rockies who were aged 18 to 29 years and who had engaged in sexual risk activities were recruited for interviews. Study participants were recruited in the communities of the Rockies through the following approaches: key informants and community based organizations in the source communities; health professionals, including recruitment at clinics and physician's offices; recruitment posters and information sheets that were disseminated in areas frequently by SIW; and word of mouth. The times of day and locations for interviews were flexible and were selected based on appropriate context or location for each participant. Based on the sensitive nature of discussion topics and the transient nature of the target communities, the researcher acknowledged the potential for repeat, rescheduled, or missed interviews. Participants were asked to be involved in the study if they met the inclusion criteria and if the researcher felt they were an appropriate fit for the research.

Confidentiality was enhanced for the participants in order to minimize their concerns of disclosing sensitive sexual information through their participation. Identifying information was removed prior to transcribing and analysis. The researcher asked participants to share follow-up contact information if they were interested and comfortable participating in a follow-up interview. All participants in the study identified

a comfort with sharing contact information and a willingness to be involved in a second round of interviews if required.

The researcher was someone external to the community. The researcher collaborated and consulted with SIW, gatekeepers, and key stakeholders in the community in order to assist with the recruitment of participants. Several key stakeholders from community-based organizations were involved from the beginning of the research project. The researcher collaborated with these health care professionals to determine locations and approaches to engage SIW in the Rockies in the study. The recruitment efforts included four main key stakeholders: the Banff Service Industry Network (BSIN)[39]; AIDS Bow Valley; Family and Community Support Services; and the STD Clinic[40] in Calgary. These four organizations were identified based on their current or potential connection to SIW who were engaging in risk activities.

In addition to recruitment in collaboration with key stakeholders, the researcher participated in several community events and spent time in the Rockies communities in order to recruit directly from SIW who were not necessarily connected to the formalized health services in the area. Other key stakeholders identified in the Rockies included: Planned Parenthood Federation of Canada (PPFC); Alberta Alcohol and Drug Abuse Commission (AADAC); hospitality industry employers and venues; community-based organizations; nightlife industry; and health practitioners.

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[39] BSIN seeks to enhance the quality of life for young people in the Rockies (Cavicchi et al., 2002) and has an advisory committee of SIW who were consulted by program staff in the recruitment and design stages (Davies, 2004).

[40] Health professionals in the Rockies often refer people for STI testing to the STD clinic in Calgary (an option in addition to local testing services). It was believed this method could entice people identified as high risk for acquiring a STI who were not connected to local services in the Rockies.

The researcher distributed information to those working with, or connected to, SIW in the Rockies. Recruitment letters and posters were circulated both in person by the researcher at local events and within organizations, as well as by stakeholders in the target communities. People who met the inclusion criteria and were interested in participating were asked to contact the researcher. AIDS Bow Valley provided some office space for the researcher, including a confidential voice mail where people could call locally and leave a message. As well, an email account was established for those people who wished to contact the researcher electronically. BSIN also provided assistance with interviews and if people were comfortable, they were able to communicate with one of their program staff about their interest and provide contact information. These options enhanced the comfort of participants and attempts were made throughout the study to ensure that there was no coercion of participants to become involved. The researcher consulted with each person who expressed an interest in participating. Not all people who contacted the researcher were included in the study.

Data Collection

This study included in-depth, one-to-one, open-ended interviews conducted by the researcher through an iterative process with reference to an interview guide (Creswell, 1998). The interview guide (see Appendix A) included a grand tour question along with several open-ended, probing and guiding questions. According to Patton (1990), an interview guide can "… simply serve as a basic checklist during the interview to make sure that all relevant topics were covered" (p. 280). The purpose of the interview was to engage the participants in a discussion of their experiences (Morse & Richards, 2002). The interviewer used an open-ended interview approach and the majority of the

discussions were led by themes and topics identified by participants. The informal, interactive nature of the interviews allowed for meaningful topics to emerge from the participants (Creswell, 1994) and participants were able to tell their experiences with minimal interruption by the researcher (Morse & Richards, 2002). Through this approach, unplanned and unanticipated questions were used as the researcher learned from the participant and probed for clarification (Morse & Richards, 2002).

During the interview discussions on sexual risk activities, participants were also provided with the option of completing a tick-box sexual risk sheet. This was a method used by Hennick et al. (1999) to ensure that participants shared their sexual activities in a systematic way. However, all participants in this research study identified that they were comfortable talking about their sexual activities and no participants opted to complete a tick-box sheet in lieu of answering questions informally with the researcher. The researcher acknowledged that the completion of the tick box sheet would have ensured the same level of information was identified on specific sexual risk activities by participants; however, this information would have been gained at the risk of losing an informal dialogue between the researcher and participant, disabled an open-ended interview process, and influenced the flow and dynamics of the exploratory research process.

The process of operationally defining the concepts of sexual risk, sexual health, and sexual activity in this research study used three approaches. The first approach was to review the published literature and to include definitions of these concepts in the introduction chapter. The second approach was to journal the preconceived beliefs of the researcher prior to beginning the study. These journal entries were reviewed throughout

data collection and analysis processes to ensure they were not directing the assignment of themes and sub themes. Sexual health was interconnected with well-being and included physical, social, mental, and spiritual aspects of sexuality and sexual activities. The researcher operationalized sexual health as being negatively influenced by STI and unplanned pregnancy. The researcher understood sexual risk to be any activity that was sexual in nature and carried a risk of transmission or acquisition of a STI or unplanned pregnancy. Sexual activity was operationalized as any body-to-body contact that carried the risk of STI transmission or acquisition; or vaginal intercourse in the case of pregnancy. The third approach was to describe these concepts through the perceptions of participants. There was a deliberate process to be open to the perceptions and interpretations of the participants in the study. This enabled the researcher to learn from SIW and to understand sexual risk, sexual health, and sexual activities through the lens of the SIW who participated in the study. The descriptions provided by SIW are integrated in the results chapter.

For this research, additional data collection strategies included the use of field notes in a journal and the creation of memos during data analysis. Field notes were compiled in a field diary and included information that was not captured in the verbatim transcripts from the interview including information on the dynamics that were observed in the field. The field notes included: the interview setting; non-verbal information exhibited by the interview participants; feelings that were evoked; comments about the researcher-participant interactions; the emergence of major themes or key phrases at the time of the interview; and the identification of major points expressed by the participant (Patton, 1990).

Each interview was tape recorded with informed consent from participants. Each participant provided a pseudonym for the research. The participants were asked to use a pseudonym that was not known in the community to further protect confidentiality. The pseudonyms were used consistently throughout the data analysis. Any identifying information was removed from the transcripts by the researcher to ensure confidentiality prior to commencing data analysis (Morse & Richards, 2002).

Data Analysis

Data analysis began during data collection and continued throughout the research process. The researcher transcribed each of the audio-taped interviews verbatim. The researcher also kept a field journal and typed these journal entries into text files. The text files from the transcribed data (journals and interviews) were imported by the researcher into Quality Solutions and Research (QSR) N6 software in order to develop, manage, and support the qualitative data analysis process (Creswell, 1998; Morse & Richards, 2002). The researcher used this data management tool to store and organize data, including transcripts, memos, and field notes (Creswell, 1998). The researcher began the analysis process by creating free nodes of topics from the data. As topics became clear, such as a when units of text encapsulated complete thoughts or ideas, the researcher assigned labels to the nodes (Swenson, MacLeod, Williams, Miller, & Champion, 2003). If preliminary interpretations of topics included more than one thought or idea, the researcher would copy and label the idea or thought according into different tree nodes until the topics were clarified after further collection and analysis of the data. These units of text were labelled and saved as nodes and they were then organized in an evolving hierarchical tree structure. This allowed the researcher to organize the data into meaningful and

manageable categories. These categories created were based on commonalities and relationships within the data (Lincoln & Guba, 1985; Morse & Field, 1995; Morse & Richards, 2002). The thematic analysis of the data included the creation and linkage of crosscutting themes through the tree nodes and the establishment of a visual pattern of categories (Patton, 1990). This also allowed for a visual depiction of the interconnected categorization process (Creswell, 1998).

The researcher created and updated memos throughout the analysis to keep track of coding decisions, particularly as categories were redeveloped, recoded, and relabelled in an iterative process (Morse & Richards, 2002). The memos were written directly in the computer software program as the decisions were made during the inductive data analysis process (Lincoln & Guba, 1985). The memos also included the use of the researcher's tacit knowledge (Lincoln & Guba, 1985). Included in the memos were initial ideas about nodes and were updated as categories and themes emerged during the analysis process. Memos included definitions of concepts and terms along with descriptions of ideas, topics, and concepts as they emerged. Memo writing became an ongoing process of working up from the data. Categories were updated and decisions were documented to demonstrate how themes were reworked and revised. The use of memo writing allowed the researcher to track the analysis process and have an audit trail of how decisions were made.

Data analysis through a qualitative lens included a constant comparison method of participant interviews and field notes. A constant comparative method is an iterative process that enabled the researcher to link categories into themes and sub-themes. During the analysis, the researcher looked back at field notes to ensure personal biases were not

being imposed on the results. The researcher compared these documents with the evolving results to ensure that personal opinions and beliefs to ensure the participants' perspectives informed the interpretation. The researcher conducted an iterative and inductive method of inquiry throughout the data collection and analysis (Creswell, 1998; Hennick et al., 1999; Morse & Richards, 2002). The decision to stop further data collection and processing was made when there was an emergence of repeat categories. A saturation point was reached when no new categories emerged, there was a redundancy of new information, and as the themes and sub-themes were rich and thick[41] (Lincoln & Guba, 1985; Morse & Richards, 2002).

During the analysis process, the iterative nature of the qualitative study allowed the researcher to go through a verification process referred to as member checking (Lincoln & Guba, 1985; Morse & Richards, 2002; Strauss & Corbin, 1990). The coding of the qualitative data was an ongoing process and allowed the researcher to go back into the community to conduct interviews and member checks during the analysis process. The use of member checks enabled the researcher an opportunity to solicit the views of the participants to enhance the credibility of the results and interpretations (Creswell, 1998). According to Lincoln and Guba (Lincoln & Guba, 1985), the process of member checking is considered to be a critical technique for establishing credibility. When member checking was possible[42], the researcher discussed an overview of the results emerging from the data analysis with participants. In total, three follow-up interviews

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[41] Rich and thick descriptions allow any reader an opportunity to make decisions on the transferability of the results (Creswell, 1998).

[42] Efforts were made by the researcher to conduct follow-up interviews with several of the participants; however, some participants could not be contacted.

were conducted that allowed the researcher to seek input from participants as well as to probe further into areas that required further exploration. The results of the research were then summarized and reconnected to the literature.

Quality and Rigour

There were several considerations for the study's quality and rigour. Five main criteria were identified by Creswell (1998) for assessing quality and rigour, including: 1) to determine the influence of the researcher on the descriptions; 2) to assess the accuracy of the transcripts and to reflect the true meaning; 3) to assess if there were conclusions other than those offered by the researcher; 4) to account for the analysis from the original transcripts; and 5) to determine if the results were specific to the context or generalizable to other situations. The focus in this study was on transferability, in lieu of generalizability, which is often used in quantitative studies.

Trustworthiness and Authenticity

Trustworthiness, which is sometimes referred to as reliability or dependability, means results of the data in the study are replicable (different observers) and consistent (assignment of categories and themes) (Creswell, 2003; Morse & Richards, 2002; Silverman, 2000). Ensuring that the results of the analysis are trustworthy was based on several processes throughout the research. The researcher had an external audit completed by co-supervisor, Dr. Ardene Robinson Vollman. This audit included an assessment of the accuracy and trustworthiness (Poland, 1995) of the transcripts and enabled a review of the coding categories including the emerging themes and sub-themes. This process enhanced the corroboration of findings (Creswell, 1998; Lincoln & Guba, 1985). Included in the review were three audio tapes (to assess the accuracy of the

transcription), hard copies of the interview transcripts with identifying information removed, a hierarchical tree diagram from NUD*IST, and an overview of the coding themes and sub-themes that had been analyzed by the researcher. The co-supervisor assessed the appropriateness of the results, the accuracy of interpretations, as well as identified any potential discrepancies in the data recording and analysis processes.

Authenticity means that the study results accurately reflect and appropriately represent the phenomenon under study (Maxwell, 1992 as cited in Morse & Richards, 2002). The use of member checking as a verification process enhanced the investigation (Lincoln & Guba, 1985; Morse & Richards, 2002; Silverman, 2000). Follow-up questions that emerged during the research questions for those SIW who were able to participate in a second round of interviews were adapted as the inquiry process proceeded so the research could explore findings and assess the appropriateness of interpretations (Moustakas, 1994 as cited in Creswell, 1998). The use of member checks was completed through two approaches: the first, summaries of the analysis were shared with three participants and discussions ensued on how these results met with their experiences and perceptions; the second, results from the research were shared with AIDS Bow Valley staff and board members at the completion of the project to determine how results met with preconceived notions. It is important to clarify that the board of directors were not involved to assess the strength of the research project; rather, they were involved in order to gain insight into the research findings and share their perspectives on how the results either related or differed from their experiences in the Rockies. Questions posed to AIDS Bow Valley included: To what extent have the results confirmed their understanding of SIW? What did they learn? How might the information be used?

Credibility (Internal Validity)

Credibility relates to the integrity of the research and includes the accuracy of the results according to various standpoints including the researcher, participants, and gatekeepers (Creswell, 2003; McLaren, 2005). Credibility assesses the link between methods, results, and conclusions drawn. The researcher used an iterative approach to enhance the credibility of results including rich and thick descriptions of all stages of the research process. Triangulation was a method used in order to corroborate evidence and cross validate findings (Creswell, 1998) and to increase the strength and rigour of the qualitative investigation (Patton, 1990; Sogoric, Middleton, Lang, Ivankovic, & Kern, 2005). Triangulation included multiple approaches to data collection and assessment and included: a purposeful sampling method; data including one-to-one interviews, memos, and the field journal; consultation with AIDS Bow Valley board of directions; collaborative recruitment of study participants in consultation with community organizations; and the tacit knowledge of the researcher.

Transferability (conceptual generalizability, external validity)

The transferability of the research was assessed by the degree to which the results can be applied or transferred to other contexts or settings (Trochim, 2005). The results, including descriptions and presentation of findings, were shared with key stakeholders in the Rockies and informed those working directly with SIW in the Rockies. Stakeholders can transfer the results to their contexts though the shared descriptions including workplace development, workshop delivery, and program initiatives (McLaren, 2005).

Reflexivity

Reflexivity is an awareness of self and how the self is incorporated and accounted for in the research process (Meadows, 2004). Reflexive reporting is an interaction between the researcher and the research process and acknowledges that the two are not distinct (Lincoln & Guba, 1985). A reflexive approach allows for greater transferability of findings and greater conceptual generalizability (Stake, 1980 as cited in Lincoln & Guba, 1985).

According to Meadows, Lagendyk, Thurston, and Eisener (2003), the researcher needs to be reflexive as the "realities of the fieldwork unfold" (p. 14) and recognize the sensitive topics that may emerge from the dialogue. The researcher used several reflexive approaches during the data collection and analysis phases. The research process included the creation and analysis of field notes through a reflexive journal by the researcher. The reflexive journal had personal descriptions of the interview process including an overview of the study logistics (e.g., interview schedules), and a methodological log in which decisions and rationales were recorded. In addition to the reflexive journal, memos were created in the computer software program during data analysis by the researcher on decisions and thought processes.

Reciprocity

An important consideration for the research process was the identification of reciprocal benefits for the researcher, SIW, and key informants. This research incorporated a community-based research (CBR) approach in the formative stages of the thesis topic. This included an initial consultation stage and interaction with different service providers who had a vested interest in the health of SIW in their communities. In

addition, the researcher had in-depth consultations with AIDS Bow Valley and engaged members of their board of directors in discussions on the utility of such research and the potential integration of results. The researcher and a staff representative of AIDS Bow Valley also presented the research at a quarterly meeting of the Alberta Community Council on HIV/AIDS (ACCH) in June of 2004 in order to seek input into the design and developing research plans. At the completion of the study, the researcher shared the key results from the study with AIDS Bow Valley in order to inform their developing work plans and initiatives.

Ethical Considerations

Ethical review of the research is ongoing, multi-faceted, and is not limited to the researchers' institution (Meadows et al., 2003). Below is an overview of the ethical considerations identified during this research project.

Conjoint Health Research Ethics Board and Centre for Advancement in Health

The research commenced by seeking and receiving ethics approval through the Conjoint Health Research Ethics Board (CHREB) and the Centre for Advancement in Health (CAH). An application to CAH was necessary since one location identified for participant recruitment was at the STD Clinic in Calgary[43], a program of the Calgary Health Region.

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[43] People living in the Rockies can travel to the STD Clinic in Calgary for confidential and anonymous STI testing and presented as an opportunity to recruit those who were identifying STI risk behaviours but not seeking services in the Rockies communities directly.

Informed Consent of Study Participants

Participants were asked for their informed consent prior to participating in the study. Participants were asked to sign an approved form to demonstrate their consent for involvement in the research process and were provided with a duplicate copy of the informed consent form (see Appendix B). The letter of informed consent included a description of the research purpose, procedure, and expected duration. Participants were informed of their right to withdraw at any point during the research process. Informed consent was considered an ongoing process and those participants who were involved in subsequent interviews were reminded of their prior consent as well as their right to withdraw.

Sensitive Nature of the Subject Matter

There were minimal risks for participants who participated in the research study. The sexual health research topic was sensitive and negative health outcomes such as HIV/AIDS and STIs have been historically linked to marginalization and discrimination among those who are living with or affected by these illnesses. The researcher was aware of the importance to not further stigmatize or marginalize the target population during the research process. Prior to conducting the interviews, the researcher consulted with community-based organizations and key informants in the target communities and created a community resource list that was provided to all participants prior to commencing their individual interviews (see Appendix C). If the research process led to further questions or a quest for further information by the participants on the research topics discussed, they had access to some examples of resources and supports available in

the community. This document was not exhaustive and the researcher did not endorse the list.

Confidentiality and Data Storage

For this study, the confidentiality of the subjects was protected by six main approaches. The first, the researcher asked the participants to either provide or be assigned a pseudonym for the research. Second, all identifying information was excluded from the transcripts. The researcher transcribed the interviews directly from audiotapes and no external individuals to the research committee listened to the audio tapes or did any of the transcriptions. Information that may have compromised an individual's identity was removed or aggregated (Morse & Richards, 2002). The demographic details of participants were presented in tables in an aggregated, summary form (Morse & Richards, 2002). Third, data were stored in a locked box in a locked cabinet in the student's home. Fourth, all signed consent forms, audio tapes, and a master contact list was securely stored in the Supervisor's lab in the Department of Community Health Sciences at the University of Calgary. Fifth, the computer used for data analysis was password protected along with a password encoded external drive (jump drive). Sixth, a confidential voice mail system in Banff was password protected. These resources were stored in a location that was not exposed to extreme temperatures, static electricity, or magnetic fields. The data will be kept for a minimum of seven years (at least until March 2013) following the study completion (Creswell, 1998; Morse & Richards, 2002) according to the University of Calgary guidelines.

CHAPTER FOUR: RESULTS

Introduction

The purpose of this chapter is to present the thematic results from the qualitative research study conducted between January 2005 and August 2005. The data presented in this chapter address the main research questions posed at the beginning of this paper: for SIW who had engaged in sexual activities, how did they describe their activities, and how did they describe the associated risks and protective measures?

There are two main sections in this chapter. The first section is a review of participant characteristics and their social context in the Rockies. The second is a review of the four major themes and sub-themes including:

- Theme one: *lure of the Rockies*;
- Theme two: *sense of belonging*;
- Theme three: *access to adventure*; and
- Theme four: *health outcomes and resources*.

The results presented in this chapter consist of interview data and descriptive summaries. The participant quotations[44] illustrate themes and sub-themes and pseudonyms or initials from pseudonyms identify the speaker. Selected quotations either accompany descriptive summaries or they describe themes directly. The primary researcher, also the interviewer, is identified as R = Researcher.

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[44] Since the linguistic nuances and style are not being examined in this study, some of the interview quotations have been cleaned up by correcting grammar, removing pauses in speech, repetitions, and utterances such as “um”, “uh”, and “you know”.

Section One: Participant Characteristics and Social Context

Study participants differed based on many characteristics including age, home origin, education, length of stay, employment, and living situation. Table 4.1 provides a review of participant characteristics in the study and reflects the purposeful sampling strategy used by the researcher. The majority of participants (7 out of 11) were female and the rest (4) were male. The researcher selected male and female participants that each represented different backgrounds, including: age, length of stay, education, employment, and living situations. For example, of the seven female participants in the study, two had been in the Rockies between six months and one-year duration, one had been there for less than six months, two had been there between one- and five-year durations, and two had been in the Rockies for five years or longer[45]. Of the 11 participants in the study, 10 were within the target age range of 18 to 29 years. One participant was over the age of 29 years; this participant was included based on this participant's potential to contribute to the research questions[46].

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[45] The researcher did not include a sex specific breakdown of characteristics from male and female differences in order to enhance the confidentiality of participants in the study.
[46] Participant was 32 years of age. This participant had encountered the legal system due to a drug trafficking violation and provided a unique perspective.

Table 4.1: Participant Characteristics		
Characteristics		**# of Participants**
Sex	Male	4
	Female	7
Age Range	≤25	2
	26-29	8
	≥30	1
Home/Origin	Western Canada	7
	Eastern Canada	1
	United States	1
	Australia	2
Education	High School Graduate	11
	Post Secondary Courses / Graduated	10[47]
Length of Stay in the Rockies	< 6 mths	3
	6 mths - 1 yr	2
	1-5 yrs	2
	> 5 yrs	4
Employment Types (not mutually exclusive)	Hotel	6
	Food & Beverage	6
	Retail	4
	Tourism	3
Employment Locations (not mutually exclusive)	Banff	8
	Canmore	5
	Ski Resorts / Villages	4
	Kananaskis	2
Living Type (not mutually exclusive)	Hostel / Camping	2
	Staff Accommodation	7
	Shared Housing	9

[47] Four of these ten participants were post-secondary graduates (e.g., university or college).

Home Origins

Participants arrived in the Rockies from a range of home origins. The majority (8) of the research participants were Canadian, while a few (3) of the participants originated from other countries. Among the Canadian participants, one participant was from an eastern province, while the remainder (7) were from western provinces.

Education

Participants reported high levels of education. All had completed high school and almost all (10) reported taking at least one post-secondary education course. Participants who reported post-secondary education had attended courses either prior to travelling to the Rockies or over the duration they had been in the Rockies (e.g., they had left the Rockies to attend during certain semesters or they had taken courses by correspondence). Four participants had graduated from a post-secondary institution such as a college, university, or trade school.

Length of Stay

The length of stay for participants in the Rockies ranged from one month to 11 years. The majority of participants (7) had lived in the Rockies for less than five years. Among these participants, the majority (5) had lived there for one year or less. The remainder of the participants (4) had lived in the Rockies for more than five years. Their durations were five, seven, eight, and 11 years respectively. The length of participants stay was discussed in the context of participant's characteristics as well as when they described their social status in the local communities. Participants who described secure and well-established social supports tended to be those who had been in the Rockies for

longer durations. The social networks and social identities of participants are explored further under the second theme entitled finding a sense of belonging.

Employment

Participants worked in a variety of employment positions and locations including hotel (e.g., housekeeping), food and beverage (e.g., restaurant and bar), retail (e.g., shops), and tourism contexts (e.g., local tourist services). Participants described different service industry opportunities including different positions and locations to work. Participants described several benefits that were available for those SIW who stayed in the Rockies for extended lengths of time. Some of these work benefits included opportunities to advance in the workplace and to gain new experiences:

> John: I am just here to make some money. This a good place with good opportunities. Everyone is leaving so you can get a good job. If you are going to stick around, you get pushed up the ladder pretty quick.
>
> Cindy: [The Rockies] is the kind of place you can get into somewhere with no skills. It is good because they need staff… I just got a chance to change jobs and they require [a] six-month commitment, which I would be willing to give because it is a new experience. A new skill.

However, there were also negative aspects to work in the Rockies described by participants. For example, Sara identified that the transient nature of the workforce can lead to "turnovers in the businesses here." Other challenges included the reality that some SIW were not motivated toward employment success in the Rockies and their attitudes had an effect on the workplace environment. For example, Sara highlighted that there "are people that are not very well motivated… not going to move up from the dishwashing position."

Participants also described that employment conditions varied according to the workplace environment. For example, participants experienced different power dynamics among coworkers and employers. These dynamics had an influence on the stability of their workplace:

> Dan: [T]he hotel that I worked at - it was a big conspiracy as far as I was concerned. They loved firing people just before their contract was up so that they would not have to pay them - because they held back fifty percent of your gratuities. More often than not, somebody was fired a week before their contract was up over some silly infraction of staff accom.

Employment opportunities in the service industry of the Rockies enabled young adults a chance to travel and live in the mountains. Participants approached their employment role(s) with varying perspectives and different aspirations. They described opportunities in the workplace to advance quickly and, in many instances, beyond their education or experience levels. On the other hand, if they were unwilling or unable to commit to their work responsibilities, or if they violated regulations, other workers could immediately fill their positions.

Housing Options

There were different housing options identified by participants; however, the majority lived in either a staff accommodation or a shared housing arrangement. Two participants described hostelling and camping as short-term housing options they had used while living in the Rockies. Many employers catered to their workers by providing housing options such as on-site staff accommodation and food services for those employees who were not locally resident. The majority of participants (7) described living in a staff accommodation arrangement at some point during their time in the

Rockies. John described staff accommodation as a way to meet a "lot of cool people" and highlighted the financial benefits to this type of living by referring to it as "dirt cheap." Sara recommended moving into staff accommodation to "a lot of the young adults that are coming out" to the Rockies. She elaborated on the pros and cons of living in staff accommodation:

> Sara: I think it is more affordable. But it has its ups and downs. [It] means [that] if you pay a little bit extra to live in an apartment - you are going to have a kitchen to cook in. But a lot of those young adults are not going to be cooking regardless. They are going and eating out or eating at staff cafeterias where things are precooked.

In general, participants described staff accommodation as the most economical approach to living in the Rockies. Sara described how workers living in staff accommodation arrangements could have "all their living expenses coming right off their paycheque, so it is all budgeted for them." Staff accommodation also created opportunities for workers to build instant social support networks and provided access to a social scene. For example, Dan described staff accommodation as a "non-stop party":

> Dan: Well, the staff accommodation that I lived in was a non-stop party. Because everybody that works at the same hotel lives in the same building. That was the set-up that I had. And so everybody knew everybody and it was just mayhem and chaos on a daily basis.

There was a variety of staff accommodation experiences described by participants. According to Sara, staff accommodation "standard[s] ha[ve] gone up" since she arrived; however, she highlighted that "there are lots of companies that have better staff accommodation than others", suggesting that there were different standards of living

in different living contexts in the Rockies. However, staff accommodation was not an ideal situation for all participants, and John described how it was not appropriate for him:

> John: It was brutal [laughing]!
> R: Really?
> John: Yes, it was like a hotel room with three beds. And you are just crammed [in there with] three guys. You had a kitchen and a lounge room for everybody on each floor… It is pretty small and pretty cramped.

For some participants, staff accommodation served as a temporary living situation. In these instances, staff accommodation was described as an affordable and convenient housing option until they were ready to move into a shared housing arrangement:

> Mia: It is not perfect - but you are not paying a lot for it… If you want to be living cheap, I do not think you really complain too much. But for somebody like me - I was just doing that temporarily until I found another place to live.

For those in the study who had moved out of staff accommodation and into the community, returning to staff housing was uncommon. For example, Sara stated "I think once you move out of staff accommodation … you will never go back to staff housing" and she went on to say that living in staff accommodation was "fun for being that young."

Shared housing was the other main option sought by SIW and was often perceived as a 'next step' for SIW. The majority (9) of the participants had lived in a shared housing arrangement at some time in the Rockies. Participants described the rental costs as high in the Rockies and identified independent living situations as implausible for most SIW. No participants in the study had lived in an independent living situation and Dan reiterated this reality by stating, "you kind of have to have roommates." Dan had

moved several times and "sort of bounc[ed] around from apartment to apartment since it is so expensive out here." Living with multiple roommates was typical for most participants in order to make ends meet:

> MJ: I think, unless you have roommates, it is [sigh] extremely hard to find a place that is affordable - especially with what employers pay their employees.

For those who lived in shared housing arrangements, they described fewer rules and regulations. However, participants cited different challenges to living in a shared housing situation, such as a decrease in stability and continuity. John described living scenarios in the Rockies as environments where "everyone comes and gets displaced" due to issues with high roommate turnovers, changes to rental agreements, and high rental costs. As a result, participants described having to move frequently and often with little preparation time. Cindy reflected on her recent experience with instability in her living situation:

> R: So do you think you will stay in your living accommodations? And do you like your situation?
> Cindy: I did. It all shifted last night… I finish work - there is 'Bang! Bang!' on the door at work. Two of my housemates are there and I am like 'Oh! Come in'. And one of them says 'I am leaving' and I say 'Yes, I know you are leaving - in like four weeks!' - 'No-no. I am leaving tomorrow morning!' 'Ok!'[Laughing] Right! Great!

Cindy indicated that the transient nature of workers has an impact on living scenarios. John described how his own living scenario had recently changed:

> John: We have to move out at the end of the month. Lease is up. They are not going to renew our contract.

Participants described a variety of benefits and challenges to living in either staff accommodation or shared housing arrangements. As soon as SIW arrive, they are faced

with the choice to decide their housing scenario. A staff accommodation arrangement can be arranged quickly and can ease budgeting concerns for workers who are adapting to a new environment; however, workers in these scenarios describe entering living situations that are often bound by rules and regulations and describe infringements on their independence. In terms of shared housing arrangements, finding roommates and moving out into the community was rewarding with respect to gaining independence and freedom; however, workers were immediately required to budget and to cope with the dynamics of living in a transient community milieu.

The social context for SIW in the research study was interconnected with many of the participant characteristics including their age, home origin, education, length of stay, employment, and living situations. These characteristics were intertwined with the four main themes that were identified in the study and these interconnections are weaved throughout the exploration of the study results and discussion.

Section Two: Presentation of Descriptive and Exploratory Results

Rationale for the Major Themes and Sub-themes

In this section, the results are described including the major themes and sub-themes. Table 4.2 provides a visual depiction of these exploratory and descriptive findings. The four major themes were summarized in the analysis from a review of the open-ended interviews[48].

[48] A total of 14 individual interviews were conducted with 11 participants.

Table 4.2: Analysis - Themes and Sub-themes

Themes	Sub-themes
Theme one: Lure of the Rockies	Reasons for being in the Rockies
Theme two: Sense of belonging (social supports and adaptations)	Social networks and cliques
	Social and community supports
	Adaptations and transitions
Theme three: Access to adventure	Sexual activities
	Factors contributing to sexual activities (including protective measures)
Theme four: Health outcomes and resources	Rocky STI reputation
	STI and unplanned pregnancy, abortion knowledge and experiences
	Health seeking activities

Themes Reviewed

Theme one, the *lure of the Rockies*, describes a variety of factors of the Rockies that enticed each of the workers to travel and work in the service industry. This theme was established because of the overlapping elements from the participants' descriptions of the unique features of the Rockies that brought the young workers to the mountains and highlights what they found when they arrived. Theme two, *finding a sense of belonging*, reflects the participant's adaptation processes. This theme informed the research study on interconnectedness of the adaptation processes of participants with other aspects of their Rockies' experiences. Theme three, *access to adventure,* summarizes the different activities that participants engaged in and had access to in the Rockies including outdoor excursions, sexual encounters, and party lifestyles. Theme four, *health outcomes and resources*, reviews the implications of potential health outcomes that participants encountered when they participated in a variety of activities that were available to them in the Rockies. This theme also includes a discussion of participant's experiences with local health resources and services.

Theme One: The Lure of the Rockies

There are unique characteristics about the Rockies that lured young SIW each season. Participants described aspects of the Rockies that enticed them to travel to the area and to work in the service industry. One participant explained that a growing international reputation attracts young workers to seek life experiences and adventures in the Rockies:

> Cindy: [P]robably the one place everyone cares about.
> They say, 'you must go [to the Rockies]!' 'You must go to

> [to the Rockies]!' They will not tell me why. 'But you must go there.' So I ended up here.

Beyond the lure of travelling to a new place, participants described the lure of the mountains and the outdoors in the Rockies:

> Jake: Well, since I fell in love with the mountains. Since I first came out here … I knew then that I would definitely want to work in the mountains.

The Rockies were often referred to in terms of the physical beauty they embody. Mia described how she "kept coming out to the Rockies all my life. I mean for a quick fix, I had to come back. I couldn't stay away from the Rockies."

As soon as participants arrived they described having access to different Rocky Mountain activities. Jake described the breadth and range of experiences that were available:

> Jake: I do think that if somebody comes here, the first night here they can have sex and the next day they can go scrambling. I think it is right at the doorstep. The fact that there are mountains at the backyard and there are two nightclubs down Banff Ave. They have access.

In addition to the variety of activities accessible as soon as SIW arrive, other factors can influence their experiences including an abundance of young workers and a level of independence that many encounter for the first time:

> Dan: [A]nd everybody is young. And most of the people just cut the umbilical cord from their parents and it is the first time they are away from home so you are really ready to sort of let loose and have a good time.

Participants described their individual intentions for travelling to the Rockies and the unique features that attracted them to the community. MM stated that "everybody is out here for a kind of reason of their own. Finding themselves. Partying. Just living.

Nothing serious." According to participants, SIW were an eclectic group and MJ stated that "everybody is so different - so there is no norm." Despite the unique features of each individual SIW in the Rockies, there were common threads identified by participants that lured them including the following three sub-themes: making a change, life is short – live hard, and squeezing the most out of life.

Making a Change

Moving to a new community represented either a temporary or permanent major life change for many participants. MJ stated that she was "brought out [to the Rockies] just simply because I wanted a change of life." MJ further stated that she "could not sit behind a desk eight hours a day." Her decision to "take that step ahead" was fraught with challenges; but her move to the Rockies enabled her to make the life change she desired. Mia described the "speed bumps in life" she was experiencing prior to her decision to move to the Rockies. She described her need for "a break from the field that I was working in" and the Rockies presented that opportunity:

> Mia: But yes, it was a tough thing for me … to do something for the first time ever without having somebody do that with me.

For many of the research participants, the Rockies represented the first time they did something on their own.

Participants described venturing to the Rockies in order to take a break from their previous routines or, as Layla stated, get "a fresh start." MM commented that everyone is out "for their own reason… nothing serious" when they travel to the Rockies. John described his plan to return to his education after "I putz around for a bit." Cindy similarly identified her reason for being in the Rockies:

> Cindy: This is supposed to be my gap year.
> R: Ok. What is a gap year?
> Cindy: [T]ake a break from what you have done. Take a chance to do something else.

Making a change for most of the participants required that they take steps out of their comfort zone, often by themselves. The Rockies provided opportunities to break away from their patterns and try something new, if even for a short while.

"Life is Short – Live Hard"

For several participants in the study, moving to the Rockies represented a time to live their lives to the fullest. Sophie stated one of her mottos while living in the Rockies was "life is short - live hard." This was a consistent message for many participants, particularly as they reflected on the experiences they had when they first arrived. In fact, many participants described becoming immersed in the party scene when they first arrived. Mia described the Rockies as "a party town" and indicated that SIW "come out here and party hard." The party subculture was one of the main lures for young people.

Participants explored the notion of "partying hard." They clarified that this notion was not unique to contexts like the Rockies; nor was partying in general unique to the target age group of the study (young adults between the ages of 18 to 29 years):

> Sara: I think at that point in my life - 18, 19 - I think I would have found the party no matter where I was.

However, participants identified unique aspects to the party scene in the Rockies, such as the abundance and diversity of young people who arrived to "party hard", that enhanced the experiences and opportunities. Layla stated that SIW in general were "here to party and they are here to have fun." According to Mia, the abundance of young people increased party accessibility:

> Mia: I think that since there are a lot more young adults out here and a lot more people that come out here for the partying and, that [includes] tourists as well, then there is a lot more of it. But I think it is just more people doing it.

According to participants, there were large numbers of young people recruited to work in the Rockies, particularly during the high tourism seasons. The party scene opportunities were almost endless. Dan described how the prevalence of partying had not diminished since he first arrived:

> R: Do you think you have shifted or has the nightlife shifted?
> Dan: No - the nightlife is definitely still there. So I think it is almost like a migration of service industry workers: they all get off; they go to the pub; they have a few; and then if they choose to - [they] go on from there and go to the nightclubs. That is a pretty regular occurrence.
> R: How regular would you say?
> Dan: Every night! [laughs]
> R: Just kind of go with the flow?
> Dan: Um-hum. Literally, a migration. If you stood on Banff Ave for three hours, and watched it, you would see. Yes. It is just like hundreds of people going from one place to the next all at the same time or within a short period of time.

Regardless of people's intentions when they travelled to the mountains, Jake stated many were "living in the moment." At a time when people were exploring, many described the role of combining their play or work with partying:

> Sara: Play hard and party hard for sure. A lot of them are young and they can party hard, get up in the morning, and play hard. [A]nd a lot of them will do that.

Participants also described how intertwined and immersed the party culture is with the service industry work environment in the Rockies. John identified how easy it is to find reasons to party with other workers:

> John: It is always been that [way] ... It is always somebody's last night. It is always somebody's first day! You can fairly easily fit into the party scene all the time. There is always something to party about.

Sara described some of the challenges that are associated with the combined work and party atmosphere for workers:

> Sara: I think most people who are coming to this area are coming here because of the outdoors pursuits but they can get off track because of the expenses and not getting stoked right away on the sport. And starting to get into that party scene. So their main intention was not to be partying their money away and their ass off the entire time the are here.

Sara depicts some reasons why SIW may change or shift their focus after they arrive in the Rockies. Many workers described their own experiences living life to the fullest. In some instances, participants described losing track of their original intentions and finding ways to redefine their goals along the way.

"Squeeze the Most out of Life"

SIW in the study described their journey to the Rockies as an opportunity to, as Jake stated, "squeeze the most out of life." Others described similar notions of trying to find more in their Rockies experience than just work opportunities. MM described his main intentions for travelling to the Rockies as being his mountaineering pursuits and meeting like-minded people:

> MM: Yes. So backcountry- meeting new people, this I found somewhat difficult I guess in XXX [city, Western province] - to meet the type of people I am trying to meet I guess. Like people who are outdoorsy. I found a lot more of a community here.

MJ described her rationale for moving to the Rockies and finding new work along with new life experiences:

> MJ: I will never be one of those people that will work at a job just because it pays well. I got to be passionate about what I do.

MJ also described that, in her experience, "you got to have a personality and you got to have that drive" when living and working in the Rockies. Participants demonstrated their adventurous spirits when they made a life change and travelled to the Rockies. For the participants in the study, the actual work experience was not described as the main reason for travelling to the Rockies. However, SIW in the Rockies were not described by participants as extremists[49]. Sara described that a misperception about the Rockies is that it attracts individuals seeking extreme adventures. Sara stated that the majority of people in the Rockies "would want to learn and they love the outdoors and they like the forests and they like being around nature"; however, most SIW "would not be extreme." Despite intentions to squeeze the most out of life, SIW in the study described work as a necessary means to participate in the Rocky Mountain activities.

The Rockies as an Open and Accepting Place

Regardless of their intentions, participants described the Rockies as an open and accepting place to live once they had adapted to the community. MM stated that it was "very open to everybody and different cultures and it is enjoyable." Others shared insights on the joys they had discovered:

> MJ: But it is the happiest place I have been.
> R: What contributes to it being a happy place?
> MJ: It is just so laid back. It's friendly. You walk down the trails and people say, "hi". It doesn't matter where you are as soon as you have got that eye contact and even sometimes when you are in a daze when you don't have the eye contact somebody will be like 'hello, how are you?'

[49] Extremist is someone who advocates or resorts to measures beyond the norm (TheFreeDictionary, n.d.). In the Rockies, this may refer to an extreme mountain sports athlete.

> Cindy: [T]he ones that I have met they find - what would you call it? An openness. People that are open towards them and not judging them for what they have done.

The aspects of the Rockies that lured young SIW reflected some of the spirit of their eclectic experiences. People decided to make changes in their lives and to travel to the Rockies for different reasons. Among study participants, their intentions included maximizing their opportunities to experience changes in new life circumstances and living in the moment. For those who adapted to life in the Rockies, they described finding an open and accepting place. These aspects of their Rockies experiences provided a foundation on which the next themes will be explored.

Theme Two: Sense of Belonging - Social Support Networks, Transitions, and Adaptations

This theme includes a review of the how participants adapted to life in the Rockies. They described a process of seeking a "sense of belonging" and their adaptations were interrelated with the other themes in the study. The discussion starts with an overview of their social networks.

Social Networks

The social networks of participants influenced their experiences on many different levels including their social support, their integration into the local community, and their sense of belonging in the Rockies. The social networks participants described changed over time, particularly as they integrated and became connected with the different communities:

> R: Do you find that there are niches or groups of people - I mean you have been here for a long time - or close networks of people?
> Dan: Yes, I guess it is somewhat clique-y. But I mean even in [the] different cliques - like I think that people cross over

> into different cliques. And everybody knows everybody. I mean if you spend any amount of time out here, you are going to get to know people. If you go out, even when I was going out all the time, I mean I still - I know the people that go out and party all the time and I also know the people that get up and go rock climbing or go snow boarding. Those are definitely two, I mean there is a not a lot of co-mingling among that.

Participants often described the Rockies as being "a small community"; however, participants acknowledged that different "cliques" existed within the Rockies' settings. Jake shared his experience of the different social groups:

> Jake: I think that some of those scenes kind of match the age group. People who have been out here for ten years kind of match their own scene for sure. Then there are different establishments. Like cliques and things.

Regardless of the social group of SIW, they described ongoing access to the nightlife and party scenes. Several factors were identified as influencing which party scene participants accessed including the type of social network(s) they were affiliated with and the locations where they partied. Jake described the different social networks and scenes in the Rockies:

> R: I know you said earlier how the nightlife industry may be different to people who are outside this context. Is there a sense of exclusivity? Or if someone came into the community, they may not be able to get to know what the real nightlife is like?
> Jake: Well yes, I think there is. I mean because anyone can come here and go out and have their own nightlife but there is definitely is kind of like a scene of [the Rockies]. There are little cliques and things. I would not say that would limit their ability to party excessively by any stretch. They will still have access to all the same things that people that live here would.

Jake highlighted that people in the Rockies, regardless of their social network, had access to the "party scene" but that their experiences differed according to with whom people were connected.

Each of the participants experienced a process of integration differently. Those who had been in the community for an extended period (e.g., longer than one year duration), described increasingly tightly knit groups of friends over time and as they became more connected. Participants reflected that there were several social networks and three of the main networks are summarized as the following: locals (insiders, old-timers), local-transients (insiders, newcomers), and transients (outsiders, newcomers). These are non-exhaustive categories; they are described in the next section.

Local.

The identity as a *local* was a label reserved for people living in the Rockies and was intertwined by participants with terms including "Banfitte", "old-school regular", and "lifer." A variety of factors influenced the local status for those in the service industry. They included if people were born in the community, if they resided there for an extended amount of time, or if they had made it their long-term home. Participant described their perceptions of being a local:

> R: And how do you become a 'Banffite'?
> Sara: I would say if you have been here or if you are living here.
> R: Yes.
> Sara: Yes, you are a Banffite. I would say everybody wants to be a local. But you will find it funny people's definitions of being a local in this town. So I think I started feeling more local after probably after a certain amount of time. Some people say that if you are not born in Banff that you are not local but I disagree.

> R: Do you identify yourself as a … local?
> Mia: [Laughing]. I do by now. I mean I am definitely part of the community. I am not just walking around it. I am actually very involved in it.

Sara and Mia described their local status in terms of being there for a length of time and being involved in the community. MJ described her own process of becoming a local and her identification as a local was reflected by the length of time she had resided in the area and her decision to stay on a permanent basis:

> R: Do you feel - would you identify yourself as a local?
> MJ: Oh yes. Oh yes.
> R: When did that happen?
> MJ: Probably about a year and a half ago. When I decided to stay full time and not go back…
> R: Did that change how people perceive you in the community?
> MJ: Good question. I think more people know of me in the community. So I guess on that aspect I guess it has changed.

Participants described different party or social experiences dependent on the social status of SIW. For example, the party and social scenes were different depending on if SIW were "local" or "transient":

> R: What is the nightlife like in [the Rockies]?
> Jake: It is definitely a familiar scene where a lot of people know each other and the places are the same. So the locals are the same. With kind of experienced partiers. I think a lot of people spend a lot of time, or know the nightlife-type scene. Especially how it is here. Maybe, definitely maybe a little bit closed to the rest of the world for people who don't ever even party in other places but I think for a large part of people I guess I hang out with too, we definitely like to definitely do party and do party excessively.

Jake's description of the Rockies as a "little bit closed to the rest of the world" was suggestive that, as people are more integrated into the community, they experience

different aspects of the Rockies social scene. John described his process of learning of the different niches in the party scene:

> John: Seems like more the older crowds and the people who have been here a little bit longer go hang out like at the [pub] or with a little bit older crowd. The beer is a little bit more expensive.

John's suggestion that people who have been in the Rockies for a little longer are often a little older and have access to resources such as "more expensive" alcohol. Dan described that people who are "your old school regulars that are at the pub at four… ok, right after work and they are there until eight or nine" and these crowds differ from the young workers. Maturity was often described as parallel process to becoming a local and Sara said that, over time, "The party scene will get old. Loses it - like after a while."

Local-transient (insider, newcomer).

Although some participants indicated that there are those in the Rockies that argue "if you are not born in [the Rockies] - that you are not a local." For the majority of participants, a social network continuum emerged during the discussions that suggested as SIW adapted into the community over time. They shifted from being a *transient* to a *local-transient* and finally to a *local* in the community with time and experience. In this transition process, participants described the local-transient stage:

> Sara: Well there are local-transients too. Like they are only here for … maybe some only four months five months so.

Sara described how, despite the possibility of having relationships, such as friendship or past sexual encounters, with local-transients, her social support network consisted mainly of other "like-minded locals." As a local-transient, they had access to some elements of the *local* lifestyle, but they had not earned the reputation or identification as a *local*.

Layla was a local-transient in the Rockies community and she depicted how she was not yet a local but that she had definitely moved past being identified as "a transient". She described her past living arrangements with "transient" workers:

> Layla: Rented a room from a friend of mine. Loved the place it was just too transient. Five people were living there and a lot of the people were younger [than] myself. Just a lot of noise and no respect and people coming home at four o'clock in the morning. My room was near the front door so it was too bad because the guy who I rented from was a really good friend but I just couldn't handle living with six or four or five eighteen-year-olds. Just did not work.

Jake described that certain social groups naturally congregate together when they first arrive. Over time, they became more ingrained in the community and adapted to the local-transient subculture*:*

> Jake: The Aussies sort of stick together. And yes - the scene - the Brits sort of hang out too. And I mean eventually if they are here long enough - they kind of amalgamate to friends in other [groups] here and … they are welcome … but I think when there are groups coming they definitely sort of hang out together. I think that is right across the board pretty much. In terms of - it is not uncommon to see - like you would probably see a group of Aussie or Brits or Japanese hanging out in the corner. I think that has happened. But with time that changes.
> R: Become more engrained in the community hey?
> Jake: Yes, maybe not as a large group, but maybe as individuals from those groups.

Participants described the processes through which workers may be connected, such as those who arrive from the same country of origin or who share certain characteristics. Over time, they may diversity from their specific social networks. Cindy described that it is common for people with an "accent" to be categorized together:

> Cindy: …they say ‘another Australian and, at the same time, the girl… is just British, and they will call her Australian… simple as that.

Cindy added to this discussion on social networks by stating that it was uncommon to meet locals in the communities as she had “not really met any Canadians in town… all seem to be backpackers.”

Transient (outsider, newcomer).

Young workers who were new to the community were often labelled *transient* when they first arrived. Many arrived with limited work and life experience. Dan described his experience in staff accommodation with the newly arriving “transient workforce”:

> Dan: [E]verybody is young. And most of the people just cut the umbilical cord from their parents and it is the first time they are away from home so you are really ready to sort of let loose and have a good time.

MJ observed the transient workforce on a daily basis at the ski hill:

> MJ: When I was up at XXX [ski hill], now that is transient. That is I think I had 90 percent Australians working for me. And they had a one-year visa.

MJ expanded that it was “becoming more and more transient”. She alluded to the recruitment of a transient workforce as having potential negative consequences for the community in terms of safety and stability. Layla described working conditions in the Rockies and how her employer sought out young workers, particularly during the busy seasons:

> R: What sort of age group works in the hotels?
> Layla: For the lets say housekeeping and front desk anywhere from eighteen to twenty-five is the main sort of line of people.

Layla self-defined as "one of the transients" and she described her identification as transient based on the short amount time she had been in the Rockies. She highlighted that workers "have to be here more than two years to be a local… at least ten or fifteen."

In the process of discussing the different social networks of workers in the Rockies, participants also described a social hierarchy. John described his experiences of the hierarchy:

> John: [T]he 18-year-old kids go and hang out and scrounge up their money. A little bit of a hierarchy if you work in the service industry compared to say a housekeeper. You can afford to take and spend five dollar or six dollars for a pint. But if you are going to go to happy hour at six o'clock and start drinking to get three drinks for six bucks and that whole scene.
> R: And the end goal is different?
> John: Yes, well most people are here… most people from out of town are here for a year and here to have a good time. Like snowboarders and especially for six months to a year and they do not care as much.

Cindy summed up the transient nature of the community by stating, "it is easy in a town like this because you will come back in two years time and you will not know a single person here because they were all travellers anyways." The high turnovers and shifts in the workforce contributed to the number of transient workers and provided some unique lifestyle context in the Rockies tourist destination.

Additional social networks.

Additional labels that were suggested by participants included those who were *"vagrant"-transient* or *other-local*. The latter, *other-local* (outsider, old-timer[50]),

[50] Lack of inclusion in the study could be a reflection of the young age group for the study sample.

depicted someone who had been in the Rockies for several years or who was born there, but they had not yet been integrated into the *local* community:

> Mia: There are definitely some people who have been out here for 10 years plus. But it is so sad that some of those people are by themselves - not connected with people.

A *vagrant-transient*, on the other hand, was a label that described someone who had arrived and who was not working. These individuals were depicted as needing support from others in order to stay. Sophie stated, "I mean you get vagrants in the summer but most people know better than to let them stay with you." She went on to describe how easy it is to find work in the Rockies and she warned that if a "vagrant shows up and says 'I want to stay on your couch and do a [lot] of drugs and waste my time', then most people shut their doors to them."

Social and Community Supports

SIW considered social networks and community supports as factors that helped to build connections. Mia described her appreciation of the Rockies communities:

> Mia: I think those of us that truly appreciate what [the Rockies] is about and to connect to it. Or always make the connections with people no matter what group they are in. I think that one of the best things about living in [the Rockies] is the small town feel about it and that so many new people come through town. And I think that if you really appreciate it.

There were different support networks established by participants. Factors identified by participants that influenced support systems included the length of time they had been in the Rockies, their place and type of employment, and their living situations. For those SIW who identified as a local, they described a stable support system that they had

developed over time. Sara described how, as a *local*, her support networks had changed over time to include fewer friends and less diverse social groupings:

> R: Who would you say is in your support network?
> Sara: In my support network? I would say it is definitely the type of place where there are people leaving. So if you do have your support network it is usually tinier than it would be at home. So I think that the longer that you live the more likely you are to embrace the people that live here. I am definitely not as likely to become best buddies with international workers. It is like a natural evolution when you live here. Is you do start, I feel within my friends, I feel I can trust them.

For those who were newer and identified as transient, they experienced a less stable support network and a high turnover of friends. MM described his lack of a support network:

> R: What would you describe as your support network out here? Who would that be?
> MM: Myself pretty much I guess.
> R: Or do you have a support network here?
> MM: I do not think I would really say I have one out here I guess.

For those who were not connected, they described the challenges in adapting to the community and the importance of building connections.

Building connections.

Building connections, such as friends and supports in the community, were identified as integral components for participants in terms of finding a *sense of belonging* in the Rockies. Friendships played an integral role as they adapted to life in the Rockies. Many factors influenced the ability of participants to make connections and build support networks. The process of building friendships was facilitated for some participants by their living situation. Sara moved into staff accommodation and stated, "you were really

taken care of." Cindy's living situation provided access to an instant support network, albeit transient. She described connecting with people as soon as she arrived in town:

> Cindy: Got into the [hostel] and … there were six of us and we all clicked on the first night. All started hanging out. Everyone was just talking about what they were up to and they were looking for work … so they were telling me where the jobs were and everything else and, yes, just everything sort of fell into place. It was really good.

On the other hand, participants described the lack of social supports as a barrier to their adaptation process. For these individuals, the formation of a support network was not a simple process. For example, MM moved directly into an independent staff accommodation arrangement when he arrived in the Rockies and he had limited access other workers. He reiterated, "if something went wrong, I would resort back to friends or family or whatever back home. Yes. I guess it has not been that long a time here."

Dan described how friendships were essential for people arriving in the Rockies and when he first arrived, he "convinced a few friends of mine to come out and just check it out" and, as a result, "I got them to come out and they have been out here ever since. We are a pretty tight crew." Participants also described how, over time, they were drawn to people who shared similar characteristics and values. For example, Sara described similar characteristics between herself and her long-term friends as well as her reluctance to form friendship with those who may be departing:

> Sara: I am sure now most of my friends are Canadian. It just kind of turned out that way. I used to have a lot of like Australian friends and Kiwi friends. And now it is all my friends are Canadian. They are all in [the Rockies].
> R: And what sorts of ethnicities?
> Sara: Caucasian. Similar backgrounds to me.

Mia identified the role that social support systems could play for workers who were contemplating departing early on in their experiences in the Rockies:

> Mia: Everybody needs to know that we support each other and see that we can fix their lives. It is funny because I have seen so many people leave [the Rockies] because their life is like the worst they have ever seen it before. I came to [the Rockies] at a time that my life could not have been any worse.
> R: How did you get through that?
> Mia: Making friends with the right people.

In addition to building friendships and connections, participants described their friends and family from home as alternate support systems; however, the participants were separated from these ties by physical distance and had been apart for different lengths of time. John described that since his family was "not coming from …a long way - there are lots [of supports] here. If something goes wrong." He summarized that workers who had family closer to the Rockies in terms of physical distance may also have stronger support networks than those who had travelled further distances.

Community.

The community played an important role in the transition process for participants. MJ highlighted that she found a real sense of community in the Rockies, which was something she had never previously experienced. She stated, "there is no judgement here" and she described the unique community-feel of the Rockies:

> MJ: You can walk down the street wearing a silk kimono and gosh darn it … You will not get extra looks. You can totally be yourself. And XXX [location, Rockies] is so good at that. There is no stigma attached to your physical appearance. You are who you are and that is ok.

The Rockies was considered by participants as a unique community context and MJ went on to describe, “we are in our own little world here.” Sophie also reiterated that the “community is different. A lot different. A lot tighter in some ways than the city. It is more like a country-community.” She highlighted that despite the “drifters” and the “high turnovers” that there are some “lifers here” and, overall, a “very tight community.”

Adaptations and Transitions

Participants described different processes of adaptation when they arrived in the Rockies and as they attempted to integrate into the community. Participants described the influence of their initial experiences on their decisions to either remain in the community or to depart. Participants described that some SIW departed the Rockies prior to having a chance to integrate into the community:

> Sara: I think make or break time can be even in your first three months of being here – I think that is a very critical time. If they are going to stay long-term - like for a year. That will be a critical time for them. To either stay if they have had a good experience or not. Generally people who have had really bad experiences I have found have been within the first three months.

Social networks and community support were integral components in participants’ processes of adaptation. A variety of challenges were described by participants in the development of support systems for SIW. Layla described meeting people as one of the major challenges in the community:

> Layla: The thing this town is bad for is meeting people. It is not very easy. And I know it sounds weird because you think it would be [easy] because it is such a small happy little town. But it is really hard to meet people. And it took me a while… It took me a long time to get really good friends. You do not just get them over night. It is a lot of work.

Other participants described an ease in making acquaintances but a challenge in making longer-term friendships. MJ stated, "it was almost frightening how easy it was … people were just so open to making friends; but, on the other hand, it is hard to make solid friends because everybody is coming and going."

Making connections, whether it be through friendships or community supports, were critical to the experiences of participants when they arrived in the Rockies. For those who were in the early stages of their adaptation, they described challenges to meeting people and making meaningful friendships in such a transient environment.

Participants described that their adaptation processes had an influence on their participation in activities such as sexual activities and the party scene. For example, the majority of participants described their immediate immersion in the party subculture of the Rockies when they first arrived. However, among participants who had been in the Rockies for longer durations, they described shifts in their risk-taking activities and social scenes. Factors that participants identified as influencing their risks extended beyond length of time and included maturity and experience:

> Jake: [T]he biggest shift that like I can see, is that I have grown up a bit and learned through experience, and I don't know if the scene has shifted as much as that I have shifted my thinking of my type of thing.

Additional factors cited by participants as influencing their risk transitions in the Rockies included changes in relationship status, increased fiscal responsibilities, and what Jake described as "feeling the 'cumulative party effects.'" Sara similarly indicated that, over time, her own activities started to "slow down":

> Sara: I think after you have been here for a couple of years, things are going to slow down a bit for you. Also cause you

> are starting to hang out with people that are staying here more long-term. Kind of getting out of the stream of transient that you once were in. So it is not such an awe to be here anymore in the sense of the party-party-party! You kind of get that out of your system. And then you start living more, you become a little bit more part of the community. And living a little bit more low risk I would say after a few years.

Dan identified that he was not connected with the nightlife in the same way he was when he first arrived. However, he still goes to "get a piss on" with friends in the community about once per week:

> Dan: As far as going out now, Tuesday nights are my nights out actually. But, nowadays, it is pretty tame. Back in the day, we were partying all the time.
> R: So six days a week? Seven days a week?
> Dan: Four to five days a week for sure. Yes.

When the interviewer inquired if Dan had shifted or if the nightlife itself had changed, he stated, "no the nightlife is definitely still there!" Cindy described how her younger friends were more willing to take "risks" when partying in the Rockies and having sex with new, unknown sexual partners:

> Cindy: My two closest friends here … they take a few more risks than what I will. I will sort of back away from some situations. Yes, usually when I leave, I usually tell someone that I am leaving. Like I will grab one of them and say, I am going now. Whereas with them they will just disappear and you will turn around ten minutes later and be like 'where are my friends'?

Many of the participants described their own adaptations to the party scene.

Sophie's perspective differed in that she didn't "think the risks are different" between her and some of the younger SIW in the Rockies; however, she thinks, "their attitudes have not been socially adjusted yet. Because they are still partially living in fantasyland. Most of them haven't had to do anything for themselves yet." Thus, she

highlighted that many SIW are taking similar risks as other workers but they may interpret their experiences through different perspectives.

In addition to changes in party activities of participants, Dan described how his maturity influenced his ability to talk about his sexual health. For example, he stated that he would not have been able to describe his sexual activities when he first arrived in the Rockies. Sara similarly reflected that her age and maturity influenced her ability to discuss her sexual health. Sara stated that she was unable to discuss sensitive topics with her sexual partners when she was younger:

> Sara: I feel more confident now to be saying or asking those types of [sexual] questions now that [I am] older. But god – no! I would have never asked those types of questions when I was 18….

The transitions and adaptations to life in the Rockies played integral roles in people's experiences. Participants described the importance of building social networks and community supports when they arrived in the Rockies. The Rockies enticed the different participants to experience a wide range and abundance of opportunity. As participants adapted and developed a sense of belonging in the Rockies, their risks and activities similarly shifted and their adventure activities are described under the next theme.

Theme Three: Access to Adventure

This section reviews the third major theme, which is a summary of risk-taking activities identified by participants in the study. Jake highlighted that SIW have "access to adventure" in the Rockies and these discussions included sexual, substance, and non-sexual adventures for SIW.

Sexual Activities

Table 4.3 provides an overview of sexual activities, STI testing experience, substance use, and protective measures of study participants. The majority of participants had engaged in substance-use related activities (although their shifts in substance use activities are not reflected). The participants described different experiences with protective measures during sexual encounters that occurred after consuming alcohol or other illicit substances. Just over half of the participants had been for a STI test in their lifetime (6). Three of these participants had been for a STI test in the Rockies and three had had their STI tests conducted elsewhere (e.g., either home or travelled to another location such as Calgary).

The majority of participants self-identified as heterosexual (10), and one self-identified as bisexual. As a criterion for participating in the study, participants described the sexual activities in which they had engaged. Participants also described factors that they felt influenced their sexual risks during their sexual activities. For example, participants described the use or non-use of protective measures, the number of sexual partners, the nature of their sexual encounters, their use of substances, and their participation in the party culture as risk factors that influenced their sexual activities while living in the Rockies. These risk factors are described in the next sub section.

Table 4.3: Participants' Sexual and Substance Use Activities While in the Rockies[51]		
Characteristics		**# of Participants**
Sex	Male	4
	Female	7
Marital Status	Single	6
	Boyfriend / Girlfriend	1
	Common law	4
Sexual Orientation	Heterosexual	10
	Bisexual	1
Sexual Activities & Protective Measures (not mutually exclusive)	Vaginal Sex No Condom	9[52]
	Vaginal Sex Condom	11[53]
	Anal Sex No Condom	4
	Oral Sex No Barrier	11
STI Testing Experience	STI Testing Conducted (Not in Rockies)	3
	STI Testing (Rockies)	3
Substance Use Activities	Alcohol ≤2 Times / Wk	7
	Alcohol ≥3 Times / Wk	4
	Marijuana ≤2 Times / Wk or past	4[54]
	Marijuana ≥3 Times / Wk	3[55]
	Speed (past or present)	5
	Mushrooms (past or present)	4
	Cocaine (past or present)	4
	Crack (past or present)	1
	Ecstasy (past or present)	5

[51] Table 4.3 does not depict changes in frequency of substance of sexual activities among participants while in the Rockies. It was their reported substance and sexual activities either at the time of the interview or previously while living in the Rockies.
[52] Nine participants engaged in unprotected vaginal intercourse at least once while living in the Rockies.
[53] All participants had engaged in protected vaginal intercourse at least once while living in the Rockies.
[54] Four participants engaged in marijuana use two times per week or less while living in the Rockies (either at the time of the interview or in the past).
[55] Three participants engaged in marijuana use three times or more per week at the time of the interview.

Participation in specific sexual activities varied by individual. All participants had engaged in "sex" and this was defined as "intercourse." All study participants described engaging in vaginal intercourse and oral sex, either past or present, with sexual partners in the Rockies. Several participants described how oral sex is an activity that is more likely to occur within a relationship:

> Mia: I probably would not have oral sex with somebody that I would not have sex with. Like it kind of goes hand in hand for me... I might have sex but not oral sex with them.
>
> Sara: [What] I think about oral sex - [it] would be, definitely, something that was so much more personal to me - then it would be [with] someone I was in a relationship with.

While some participants differentiated their participation in oral and vaginal sexual activities according to their relationship status and their comfort levels with sexual partners, others were indifferent. MM stated that he did not base his decision to engage oral versus vaginal intercourse on which activities posed a greater risk for contracting or transmitting a STI. MM stated that it is "something that I think about but don't take to heart." MM stated that he did not base his decision to engage oral versus vaginal intercourse on which activities posed a greater risk for contracting or transmitting a STI. Participants did not make decisions about their sexual activities according to different gradients of risk.

Other participants described their lack of distinction between their sexual activities:

> R: In your experience when you are involved in a sexual relationship, do you differentiate risks by activities? Like I am willing to give a blowjob but not have sex or am I more likely to have sex?

> Layla: No. Not really. Pretty much fair game! [Laughing].
>
> Jake: I would say they would be just as likely or even more likely, in some cases, you know, to have intercourse rather than just oral sex. Or just… oral sex.

Anal sex and the use of sex toys were other sexual activities described by participants. However, not all participants participated in these activities. Other general activities described by participants were masturbation, manual stimulation, kissing, and massage.

Factors contributing to sexual risk-taking.

This subsection includes factors that contributed to sexual risks and protective measures. Jake summarized sexual risk-taking using a Russian roulette analogy:

> Jake: [L]ike loading a bullet into a gun to play Russian roulette. That would be like using protection or not. And then the amount of different partners - that is the amount of different times you play that game. And you play. That is how I would kind of think it. So the biggest factor is whether or not you load that bullet into that gun, but the number [of times] that you played the game [will] also up the risk.

As highlighted in Jake's quote, there were different sexual risk-taking factors identified by participants. These factors included: the use or non-use of protective measures, "like using protection or not"; the number of sexual partners, "amount of different partners"; and the number of sexual encounters, "amount of different times you play that game". Protective measures included methods that SIW used to reduce the risks of negative health outcomes such as STIs and/or unplanned pregnancy. Participants also identified that different types of sexual partners (e.g., someone who is working in the service industry compared to a tourist) may differentiate the risk of the sexual activity. Finally, workers highlighted that the nature of the sexual encounter also influenced their sexual

risk, citing for example someone who has a one-night stand may be at a higher risk than someone who is in a short or long-term relationship.

Number of sexual partners. There was a variation in the lifetime number of sexual partners participants described, ranging from two to 30. Participants identified an increase in sexual opportunities in the Rockies compared to their home communities. Sophie stated that since she arrived in the Rockies, "I have been more sexually active since I got here than I have been in the whole past year and a half." Participants described accessibility to sexual opportunities in the Rockies:

> Jake: I think I have been more sexually active in the Rockies than I have in XXX [city, Western province]. I do not know if [it is] just dependent on the time of life or the lifestyle or what - but I think those sorts of situations came up way more in the Rockies.

Jake described the social context of the Rockies and the different factors that influenced the increase in sexual encounters. Jake stated that "there is something about here, I do not know" and the notion of "something about here" was consistent across participants in the study. These comments related back to the lure of the Rockies and tacit components of their experiences that could not be captured quantitatively or concretely – but rather part of the experience of living in the Rockies.

The opportunities for sexual encounters in the Rockies varied; Jake described some of the differences in the Rockies experiences to those he had at university prior to arriving:

> Jake: the fact that … there are so many people that are transient that definitely gives it a different feel or that different spin.

In other environments, such as university, there is an underlying set of rules or guidelines that outlines the duration (e.g., courses are each one semester in duration; a degree is a predetermined number of courses, etc.). In the Rockies on the other hand, there are not predetermined durations or requirements in order to work and live in that context. SIW are not bound by the same regulations as others such as students. In general, the nature of the Rockies sets it apart from other contexts including increased sexual opportunities and partners.

Type of sexual partner (SIW, resident, or tourist). Participants described varying levels of perceived sexual risk associated with their type of sexual partner in the Rockies communities. For example, participants described different levels of sexual risk associated with someone who was a tourist compared to someone who was working in, or part of the community. Participants described characteristics of their "type" of sexual partner(s) in terms of their length of time in the Rockies (e.g., if they were new or established), if someone was integrated or isolated from the mainstream community, and if someone was there to work or visit. These distinctions were previously described under the earlier sub theme entitled *sense of belonging*.

The majority of SIW who participated in the study identified that their typical sexual partner was another SIW. Participants reported engaging in sexual activities with other workers:

> R: In your experience with people you had sex with, were they staff, were they locals or were they transient?...
> Sara: Locals. Staff, yes.
> R: Ever any tourists.
> Sara: No! Surprisingly not! … And most girls it would have been a local staff or local workers.
> R: What is that all about?

> Sara: I think when you work with them all day - tourists - the last thing you want to do is hang out with them!

SIW perceived tourists as distinct from others in the community, although these categories were not mutually exclusive. SIW shared some concerns about sex with tourists based on several factors, including: possible employment ramifications (e.g., termination of employment); potential risk for contracting a STI (e.g., unknown sexual history); and safety concerns (e.g., not knowing the person they were going home with):

> Jake: Because I think that a tourist is a bit more of a wild card... But there is also I think even less of a background check then you would do with someone working around here. And you do not know anything about that person.

In follow-up to Jake's suggestion of tourists being "wild cards" when probed about his sexual risk-taking, further probing was conducted in follow-up interviews on this subject. Sex with tourists was described by some as uncommon:

> R: How about your friends. Were there ever many interactions sexually between staff and tourists?
> Mia: I do not think so. I mean I do not know. I think a lot of locals kind of stick to themselves. Every once and a while there will be this one group of Aussies or whatever that are in for the week that - you kind of consider them tourists - but they are friends with people that are here and working. So there is some cross over with that kind of part.
> R: Sort of a grey area some of that hey?
> Mia: Yes but I mean there probably are some of my friends who have or people that I know of that have been with tourists. But in the hotel industry it is pretty much staff.

Sophie described how, despite the inevitable tourist interactions working in the service industry, fraternizing with tourists was "frowned upon":

> R: Do you party with tourists?
> Sophie: There is a little bit -[but] not regular. No. It does happen. I have heard of it. But usually no.
> R: People kind of stick to -

> Sophie: [cuts in] and if you do- there are some pretty heavy consequences for shit like that sometimes.
> R: Job wise?
> Sophie: Job wise. Yes. It is frowned upon. It is fine to like- oh, actually what the rule is- what I have learned is that if you want to party with tourists they have to come to your staff accom or you can go to the bar with them. Whatever. But you cannot party where they are staying. So I cannot party with guests at the XXX [hotel]. If I work here, I cannot party with guests here.

The staff-tourist boundary was further described by John in terms of the "huge cost" if SIW partied with tourists:

> John: No, no. Like that happens a few times, but the same goes if you ever get caught getting into that then you get fired. It is a huge cost.

For other workers in the study, sex with tourists was not unheard of in the Rockies and a couple described the different groups intermingling at the local bars. For example, Cindy disclosed that she had engaged in sexual intercourse with three individuals, and two of these *one-night stands* were with tourists she had met at a local bar. She acknowledged that there was an inherent "danger", such as sexual violence or STI risks, when she and her friends hooked up with "unknown" sexual partners:

> Cindy: [W]hat you try and, as much as you are drunk, you try to still use a bit of common sense. You try and figure out if they are actually a nice person or if you are going to be in danger. Not that you are really going to know - but hopefully. We have all been lucky so far.

The Rockies was described as a diverse place. Sara stated, the Rockies "is like travelling without travelling" and, "when you are travelling, it seems a lot easier for those types of scenarios [sexual encounters] to happen! So you can get involved with someone that

would be gone quick and there is no relationships pursuing." Participants described the sense of anonymity that is linked with sexual encounters among other workers.

Nature of the sexual encounter (one-night stand, short-term, or longer-term).

The description of sexual risks among participants was described in the context of the nature of their sexual encounter or sexual relationship status. As listed on Table 4.3, six participants were single at the time of the initial interviews, one had a boyfriend, and four were in common-law relationships. Participants assigned different levels of risk to their sexual encounters based on if they were one-night stands, short-term relationships, or long-term relationships.

One-night stands. Jake stated, "There is a lot of just promiscuous sexual [laughs] behaviour and there is lots of just hooking up for short term." Respondents used the terms "promiscuous" and "one-night stands" synonymously in several instances. Jake shed some light on his understanding of promiscuity in the Rockies context:

> Jake: I would see that meaning - just kind of having sex with someone when you do not know very well - just on the meeting them inebriated over the course of an evening. That type of thing. I would call that promiscuous. And then just repeat [laugh] and so the ripple, that kind of behaviour being repeated. So then you up and up the number of people. Yes, I would call that promiscuous.

MM described an implicit link between the Rockies' party scenes and one-night stands:

> MM: I have noticed it is a definite association with … partying, one-night stands, and those sorts of dates I guess.
> R: So did you come out expecting to experience some of that?
> MM: No. Not necessarily. I never pushed it away I guess. It definitely was not the reason why I came out. For me it was the opposite of the party scene. The party scene was more of a one-night stand scene to me. And more getting to know

> people, which is kind of a dead end thing here. Not really finding relationships.

MM added that one-night stands were “bad decisions.” When the interviewer probed what "what are bad decisions?" MM responded, "unprotected sex. One-night stands. Yes. You have no idea who this person is or where they are from. It seems right at the time but it is a very bad decision. And before [you know] it, you are in bed."

Other participants described their own one-night stand experiences. For Layla, she had “just one one-night stand once with someone from the bar”; however, she stated that it “happens a lot at the bar I think. A lot of just new people in town and on vacation. Looking to get laid.” For others, it was a more common occurrence:

> Cindy: Just had that drunken sex. Just that stagger back to hotel room or motel room and whatever - get drunken sex and everyone falls asleep. Wake up the next morning- twinge of guilt ‘what did I do that for? Shouldn’t have done it.’ Get dressed. Get a taxi. Go home. Have a shower. Cleanse.

Despite the common occurrence of one-night stands, there was negative stigma embedded with this type of sexual encounter. Cindy described the need to “cleanse” when she returned home after sexual intercourse with someone she had met the night before at the bar. Layla attempted to shrug off her one-night stand experience by stating that “I do not feel so bad” because it happens so commonly among other workers. MM equated one-night stands with “bad decisions”. Sara summed up some of her concerns with one-night stands:

> R: Do you find there is a negative stigma attached associated with one-night stands? How you just kind of said 'uh-oh'!
> Sara: No, I do. No, I do not like the idea.
> R: How come?

> Sara: Because I think it would show me that I did not put sex as something - like [it] did not have anything to do with my self-worth. I think that too many people nowadays, and women are- and men are-, treating it like it is nothing because they - nowadays, in this kind of generation - are having sex way before they married and having multiple partners. So it kind of becomes 'well, I have done it once - who cares now? If you are not a virgin any more, you are never going to go back to being one.' And I think deep down it is something not good for their inner soul to be doing that. Because you just are losing the intimacy part of it. So, I think I can make for a bit of dysfunctional types of relationship - when you are with other people in a long-term relationship.

One-night stands were not the only type of sexual encounters that participants described.

Brief, short-term relationships. Participants differentiated between one-night stands, short term, and longer-term relationships. Another type of sexual encounter identified by workers was brief or short-term relationships. For example, Jake described brief relationships due to the seasonal job opportunities in the Rockies:

> Jake: A lot of people seemed to be in a relationship or something. Yes, there was a little bit of that - it would be more over the course of the summer that I might have a relationship for some time and then, when it would end, it was over. And usually, if not always, going into it, as that was kind of the plan for it anyways. And by both people; that was the ideal situation.

These seasonal relationships may parallel the tourism season, such as Jake described above, and many factors influenced the nature of the sexual relationship. For example, Jake described how the “logistics” of living in a transient environment combined with the end of the main tourist seasons influenced the duration of sexual relationships:

> Jake: I mean the logistics for sure. But also, I found the mentality, my mentality, and the mentality of the people that kind of were out working in those environments. You

> are right - everyone was kind of transient and moving around. But also - people are kind of living for the moment.

Participants described that engaging in sexual activities with new partners occurred quickly in many scenarios; however, there were unique features that influenced the brief sexual relationships and encounters in the Rockies:

> MM: Different I guess. I do not know [if sex] is quicker [in the Rockies]. In XXX [city, Western province], things have progressed quickly I guess. But quickly with more of a mutual understanding that it may go somewhere. Whereas here it is quickly with the mutual understanding, an unspoken mutual understanding [laughing] I guess maybe, that it is not going to go anywhere. It is more just sexual.

Layla described her brief relationship "with a friend that I occasionally had sex with". Participants also identified that one-night stands often progressed quickly into brief or short term relationships in the Rockies context. For example, Cindy described "a week is steady for [the Rockies]" and there were other descriptions of brief relationships:

> Mia: Yes, it may have been not necessarily a one-night stand but maybe like a one–week stand. But somebody that I was probably working with or friends or through friends with. Kind of thing.

> MM: Ok, so I dated an Australian girl for a few weeks. And you just do not know where you can go with a relationship here I guess. Is it worthwhile even putting in the effort for a few days? Or everybody is either going somewhere tomorrow or maybe it is next month or in six months.

MM also indicated that the lack of permanence in the Rockies often lead to perceptions of not knowing "where you can go with a relationship." These shorter-term relationships were convenient and, for many, realistic within the transient nature of the work environment. Sophie stated, "Like with XXX - we will see what happens! Who knows, maybe I will never see him again. Like this is XXX [the Rockies]."

Longer-term relationships. Participants in the study described the progression from short to longer-term relationships as occurring quickly in the Rockies. Several benefits to this transition were identified by participants including convenience, stability, positive health outcomes, and perception of decreased risk related to sexual activities with a "stable" or "monogamous" partner. For example, Dan described how his notions of health are tied in with his monogamous relationship status:

> Dan: This is my health. I want to stay healthy and live a long life. I have definitely made some bad decisions as time went on. But I have always tried to make the right decision. I am in a monogamous relationship right now with a young lady.

For others, such as MJ, entering into longer-term relationships met with personal values and norms as well as the perceived risks for negative health outcomes such as STIs in the Rockies:

> MJ: I am not one to be promiscuous. Go out and find that physical need. So, I think to [add to] that list is some sort of connection or commitment I guess. Especially around here. It is scary. [Laughing]. You hear those stories –
> R: What stories?
> MJ: Oh - the STD capital. It is just - and it is not just a rumour - I mean you see. You see the people come and go and you got to wonder, if you have got common sense in you, you would realize that it is not the place to be promiscuous.

The STI reputation of the Rockies identified by MJ in the quote above was a common perception among study participants and influenced sexual relationship decision-making for some participants. This reputation is explored under Theme 4: health outcomes and health.

For those in the study who were involved in (past or present) common-law and cohabitation arrangements with their sexual partners, moving in together was often an appropriate step. Sara highlighted that the challenges for living in the Rockies, such as the high cost of living and transient nature of the environment, also influenced the decision for sexual partners to move in together:

> Sara: And you will find in [the Rockies] people will live together a lot quicker than they would in other towns. And start living almost like the husband and wife thing. Cohabiting. It is amazing. Here you are going to see so many young girls living with their boyfriends because, for me, someone has moved out and roommates are always moving.

Sara went on to identify that cohabitating with a sexual partner was often based on "'here, it is just easy if I move in with you' and it makes it cheaper." The nature of the sexual encounters of SIW in the study influenced their experiences with sexual risk-taking. The next subsection reviews the use of protective measures and factors that influenced their changes for SIW in the Rockies.

Protective measures and factors that influenced their use.

Condom use. Condoms were identified by participants as one type of protective measure that can be useful in preventing pregnancy and STIs during sexual activities. All participants described the use of condoms during some of their sexual activities; however, the majority also described engaging in sexual intercourse without the use of condoms and other sexual activities with no form of protective measure. Participants described their own reasons for the instances they did not use condoms during sexual intercourse in the Rockies:

> Mia: [S]ometimes the trust factor. I think being young and naïve.
>
> MM: Situation. Times without [a condom] have been after the bar and not having one here I guess. Not thinking that I guess. This kind of situation I was in was a poor decision - drunk.
>
> John: Maybe a couple of times since I have been out here [had unprotected sex]. Not with a person that I know to be promiscuous.

Participants described different reasons for their use, or non-use, of condoms with sexual partners in the Rockies, including: immaturity, "being young, naïve"; perceptions of trust, substance use, "drunk"; knowledge of sexual partner, "not with people that I know to be promiscuous"; and relationship status shifts.

Several participants described experiences of decreasing or eliminating condom use with sexual partners when the status of their relationship changed (e.g., from short term to long-term). Inconsistent or non-existent condom use often paralleled other forms of protective measures such as oral contraceptives. As highlighted above, relationships often progressed *quickly* in the Rockies' context and these shifts in the use of protective measures did not always equate with increased knowledge of their partners' sexual histories. For example, Sara stated that once she and her partner decided to be exclusive, "usually within a month of being in a relationship", condom use would "go out the window" and other forms of birth control would be introduced. However, for others, the quest for knowledge of their partners' sexual history may have influenced their decision to stop using condoms in a progressing sexual relationship:

> R: At what point would you stop using condoms in your different scenarios?

> Mia: Once I know it was a committed relationship. We were each other's only sexual partners and we knew that neither one of us had an STD.

Generally, condom use commenced at the beginning of sexual relationship and diminished over time. Sara reiterated these comments about sexual intercourse without condom use as relationships progressed:

> Sara: … we did use condoms for about six weeks being exclusive and then saying we are boyfriend and girlfriend and then we stopped. Layla described her diminishing use of protective measures as relationship status changed:
>
> Layla: From my experiences [Laughing] – [in] relationships, you start off being protective and then you sort of do not. And I mean it would be great if you were dating someone for two weeks and you really do not want to be like 'hey, do you want to get an HIV test with me?' [Laughing]. I mean it is sort of - I guess it would be a good idea.

Layla suggested that, although the best intentions might be to have STI testing done with each sexual partner, particularly if the relationship status appeared to be progressing, it was not a reality in her experiences.

Participants described trust as a major factor influencing the decision to stop condom use:

> R: What sort of protective measures do you use?
> John: Well, you use - one-night stands are always using a condom. If you have known each other for a long time - may change.
> R: Is that sort of your response in terms of how long before you stopped using a protective measure?
> John: I would not necessarily say how long. It is more a trust issue. If that is what you want to do and more based on your knowledge.

Participants described different rationales for using, or not using, condoms in sexual relationships. Pregnancy and STIs were commonly identified as concerns that motivated workers to use protective measures in sexual encounters:

> Mia: One reason [for condom use] was pregnancy and then the other one was STD. Cause that whole part about - even if [you know] someone, you do not know how well you know them. That was a big part for me. The fear.

For Sophie, being tested for STIs enabled her to inform her sexual partners of her own health status, although she did not require the same information from her sexual partners before engaging in unprotected sex in all instances:

> Sophie: If a partner does ask me when was the last time I [was] tested [for STIs] - I can tell them.
> R: Yes. Do you ask your partners the same thing?
> Sophie: Sometimes. Sometimes I do not. I do not go for that everything is cool bullshit though. Like with XXX, I do not know why I trusted him. Not to be full of herpes or whatever. With the guy I just started seeing - we have not discussed it but we have not had unprotected sex either. Right. So really the ball is still open on that one.

When probed further, Sophie described why she decided to use protection with one sexual partner and not use protection with her other sexual partner since arriving in the Rockies:

> Sophie: [Pause] I think I lost some form of control with XXX where I just did not care. And I regretted it later. Not the fact that I was having unprotected sex because, basically - I know I take pretty good care of myself. But you never know. The thing that bothered me was that I gave him that trust and yet I still did not have what I wanted…
> R: So, do you try [and use condoms] and then the more intimate you feel with someone the less likely you are to use condoms?
> Sophie: Pretty much. Yes.
> R: What helps you to decide?

Sophie: Oh no. It is also a trust issue and stuff.

Participants described varying reasons for condom use during intercourse with sexual partners and many of these were context specific. In general, participants were aware of the role condoms played in reducing risks of pregnancy and STIs; however, participants did not use condoms in all circumstances despite how useful they were perceived to be, and despite their knowledge of the potential negative health outcomes associated with unprotected sex.

Other protective measures. SIW described other contraceptive options including birth control pills (oral) and Depo-Provera (injection). These alternative protective measures were described as helpful in preventing pregnancy; however, they were not used consistently across participants. Some participants specifically stopped or avoided these alterative measures for reasons of their own. Additional protective measures used included insertive devices such as Nouveau-Ring and fertility awareness methods to minimize the risk of pregnancy when alternate methods were not accepted by participants.

Participants did not use protective measures such as condoms or dental dams during oral sex with partners. When describing oral sex activities, Jake stated "well, I do not see that as risky." Layla identified that condoms could be used during oral sex, "but I don't know anybody else doing it!" This was reiterated by Cindy:

> R: Do you … have you ever-used condoms with oral sex?
> Cindy: No I haven't. I don't know why. Just didn't think about it. I have never known anyone to.

In general, participants described intentions to use condoms during sexual intercourse with partners, particularly during instances that they felt particularly at risk for negative

health outcomes. However, participants did not use condoms or other protective measures consistently, and they described different reasons for their inconsistent use of condom.

Sexual risk and substance use.

Underlying many of the discussions on sexual risk-taking were experiences of substance use. Substance use was described by participants as impairing or altering their judgement. Alcohol was identified as the most common substance used by participants:

> MM: [Drinking] is the social main activity. If there was a place that I could go party elsewhere - just listen to old tunes and there was girls around that is what I would be doing. But that is not our society so. But with the bar it is often equated with making poor decisions.

Each participant described their own experiences with alcohol and the party scene in the Rockies. Sara described alcohol as the having the greatest impact on risk-taking activities:

> Sara: [F]rom what I have seen from drugs that would be as associated with high risk behaviour - I think it is alcohol.

MM described his alcohol and risk-taking experiences:

> MM: You get drunk – your inhibitions are lost. You just do not care if you have to work the next day sometimes… a lot more [are] going to make bad decisions.

Participants described substance use and engaging in more risks. They used statements such as “decision-making is impaired” “changed my choices” and “lowered inhibitions” when describing alcohol use in the Rockies:

> Jake: [Y]ou know - drinking would be more a risk for sure. Just because… I think that sometimes you get to the point where decision-making is impaired and that would be the risk part of it.

> Mia: I would say that alcohol definitely curved or changed my choices a bit.
>
> Sara: [Y]eah, lowered inhibitions I think is the number one reasons that we have issues in [the Rockies]. If you could pinpoint it…I think I was generally safe. But there were definitely times that I was not. I would definitely not [have] done what I had did.

Participants described a link between increased consumption of alcohol and decreased use of condoms:

> Sara: I think that when they are sober compared to when alcohol is involved - the rate of condom use goes down. I think for myself and even how educated I am - if you threw alcohol into the mix - I have lowered my inhibitions even knowing all the stats and even being so well informed. So expect that alcohol reduce inhibitions.

Sara highlighted that, despite being knowledgeable about STI risks and being educated in approaches to reduce risks of contracting or transmitting illnesses to sexual partners, sexual risk-taking increased when alcohol was brought into the mix. Dan discussed how substances influenced his risks:

> R: Do you think that is affecting people's sexual risk?
> Dan: It is making it uninhibited.
> R: And what substances in particular?
> Dan: I think definitely, I mean through my experience is using all types of drugs, first it was the alcohol and then it was the drugs. It was never the other way around. So, I think definitely alcohol sort of – makes you want to go to that next step and get high. That was my experience any way.
> R: And how would that translate into sexual risk?
> Dan: [Pause]. I just think you do not - there is no consequence when you are up that high and you are feeling so good. And do not feel there is any consequence.

Dan and Sara described the lack of inhibitions associated with substance use. Sophie identified that her lack of protective measures and more sexual risk-taking activity occurred more commonly when she was “drunk and stoned”:

> R: Does that influence using condoms or not that - you have never contracted an STD?
> Sophie: No, it does not. It does not influence that use that for me. Nope. I do not know what influences that decision. Lack of control. If I am really drunk and stoned I am more likely not to. It just depends. I do not know. I mean I have never used any kind of protection with women either.

While some people disclosed their participation in sexual activities without the use of condoms, others were adamant that, as MJ stated, “No glove, no love baby.” According to Cindy, “I carry protection with me. As condoms - if I do not have it - and you do not have it - that is not going to happen, is it? It is not going to happen.”

Condom use was consistently described as a complex issue. Jake stated, “I actually, on the radio today, I heard that people are becoming less and less cautious.” In general, concerns about associated risks with decreased condom use did not equate change for all participants and their sexual risk-taking:

> Layla: I think a lot of people really are afraid. Because I think a lot of people are not using condoms either. I mean even if you ask them ‘were you safe last night?’ They are always ‘uh-huh’ - and you are just ‘you are just lying’ [laughing]!"

Mia shared that “some people do not even consider any of the risks. They are like ‘yes, whatever. Whatever is supposed to happen – happens. No big deal.” Cindy identified features of sexual risk-taking in the Rockies as including anonymity, lack of rules, and freedom:

> R: what is it about [the Rockies], what is unique, and what differentiates it from … [past experiences]?
> Cindy: I think [the Rockies] is the fact that absolutely no one knows you. And no one is going to know you in six months time. Because you are not going to meet anyone here … there is no one guiding you. There … [are] no rules. No guidelines other than to have fun.

Cindy stated that there was "no one watching you" and "you can just forget about everything else and go out and not be responsible for what happens." In general, participants described engaging in sexual activities with varying degrees of protective measures. They acknowledged the potential negative health outcomes (e.g., STI or unplanned pregnancy) when precautions were not taken.

Substance use: Experiences and exposures in the Rockies.

An overview of substance use activities of participants in the study is provided in Table 4.3. It highlights the commonality of alcohol consumption and cannabis (marijuana)[56] use for participants, along with their range of drug experiences (past or present) are apparent. Depicted also is participant's drug consumption. Changes that participants have made in their substance use activities are not reflected in Table 4.3. Reasons for substance use changes are also not depicted.

Participants described the commonality of consuming alcohol:

> R: How often would you party to point of intoxication?
> John: Usually I go out like two three times or something - a week - tops.
>
> R: How about alcohol? How often would you consume?

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[56] The term *marijuana* is used in this discussion because participants most commonly cited it. Marijuana, from the drug Cannabis, is known by many other names and they include hashish, weed, and pot. The main psychoactive ingredient in marijuana is delta-9-tetrahydrocannabinol (BBC, 2003). Cannabis is most commonly used in herbal, resin, and oil forms (BBC, 2003).

> MM: Probably going out and getting drunk, that kind of thing, once per week or two to three weekends per month.

The amount of alcohol consumed by participants ranged from occasional to daily use. John described how pervasive and integrated alcohol was in the service industry:

> R: What about alcohol? Drinking how much and how often?
> John: … Yes, alcohol just kind of seems - especially because you are [in the] industry - it seems like most of the time that is what you do. You are bored and go for a beer. Well - more like beer drinking! But you are drinking all the time. It is just like 'I am done work - let's go for a beer.' It is just always what you do - kind of. Like more just the social aspect of it going it and the pattern. [Not] like back home where you just go out and just go home.

As John indicated above, "going out" in the Rockies often led to drinking alcohol to the point of intoxication. Cindy described a "big night out" for her and her friends in the service industry:

> Cindy: … there are these drinks called slimes… and they are really cheap - like a dollar seventy-five… If I am out with the girls… We have nine of those… and then we will have one or two shots of something. And depending on whether we mixed, it could be a jug of beer as well… which just, I guess, makes it messy.

Participants described varying types and frequencies of drug use. Participants identified the following substances in addition to alcohol that they had either used commonly or experimented with (past or present): marijuana, speed[57], ecstasy[58], magic mushrooms[59], and cocaine[60].

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[57] *Speed* is an amphetamine (Erowid, 2003) or methamphetamine (Drug-help, 2006). Speed is a psychomotor stimulant (BBC, 2003).
[58] *Ecstasy* is a fabricated psychoactive drug that induces a combination of the effects of amphetamines and hallucinogens. The chemical name for ecstasy is methylenedioxymethamphetamine (BBC, 2003).

The most common drug used by participants next to alcohol was marijuana. Participants used marijuana either in combination with alcohol or on its own. Dan stated that "out of the people that I know, 90 percent of them smoke marijuana on a regular basis" and when the interviewer probed if "regular" meant "a daily occurrence?", Dan stated "yes, basically." According to Sophie, there was "lots of weed - lots of hippies out here - that is to be expected." For MJ, she preferred marijuana as her "substance of choice" to help her unwind. She stated, "I … smoke a little bit of a joint, and play guitar. That was my thing."

MM stated that he smoked about "half a bag of weed a week" but that he kept it "pretty much always solo. Just for work reasons." Although marijuana use was common among participants in the study, participants cited different reasons for concealing or reducing their consumption. For example, Jake had made a conscious effort to decrease his marijuana use from a daily occurrence to a couple or few times a week. He reasoned his transition was for his health and he identified his "…concerted effort not to smoke pot just because I do not like the feeling in my lungs… so I like to keep it as a treat." Marijuana was not linked by participants to increased sexual risk-taking.

Cocaine was described as a substance used next in frequency to alcohol and marijuana:

> Jake: I would say marijuana and cocaine - those would be the most common ones [drugs].

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[59] Magic *mushrooms* produce powerful hallucinogenic effects. The "main type of mushroom used is called liberty cap psilocybe" (BBC, 2003). Magic mushrooms contain the psychedelic chemical psilocybin (BBC, 2003).

[60] *Cocaine*, a substance extracted from the leaves of the coca plant, is a stimulant that affects the nervous system (BBC, 2003).

MM elaborated on the cocaine trade in the Rockies:

> MM: I have heard a lot of talk about coke… off and on coke, but it is usually some guy trying to make a deal or something like that in the bar or something. I just walk away from that kind of thing. I have never seen any transactions of that kind of thing.

In addition, other substances were used in the Rockies including ecstasy, speed, and mushrooms:

> R: What types of drugs were the most common?
> MJ: A lot of marijuana. A lot of ecstasy. Speed. Cocaine.

Sophie highlighted that since she had arrived she has "done a lot of E out here already. From one of my work mates."

Heroin, crack, and injection drug use (IDU) were generally not described by participants as common substances used or accessed in the Rockies:

> Dan: I do not know a single case of injection out here. I do not even know if anybody or it is a rarity - even crack. That was not out here actually. And to tell you the truth, I would be surprised to see it out here as well.
> R: How about Crystal Meth? Do you hear much about it out here?
> Dan: Not here. Obviously, I mean obviously it is just a matter of time.

MM also reiterated that crystal methamphetamine[61] was not available in his experience in the Rockies:

> MM: … surprisingly I have not heard a lot of talk of crystal meth, which I found quite surprising - very addictive. So I do not hear about that out here.

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[61] *Crystal methamphetamine* is a colourless, odourless form of d-N-methamphetamine, a powerful and highly addictive synthetic (fabricated) stimulant affecting the central nervous system (National Drug Intelligence Centre, 2003).

Crystal methamphetamine was generally not reported by participants as a common drug in the Rockies; however, the perspectives identified above conflicted with Cindy's experience in the Rockies. Cindy described an acquaintance in town that had an apparent addiction to this substance:

> R: What drugs do you commonly see?
> Cindy: Commonly see speed. Meth has been in the town for a little bit. Which I was a bit shocked about. But they are probably two common ones.
> R: Interesting. That has come up before – meth - but not very many people have seen it. I have been asking if it has been out here.
>
> Cindy: I was just watching - there was a group of us watching one of our extra friends - she seems to be addicted. So - not much you can do when they do not think they are.

Despite the conflicting perspectives on this specific drug, several participants described the ease in accessing drugs. They depicted some of their experiences and exposure to drug opportunities:

> Mia: I was exposed to [drug use] a lot. I had some friends that moved out here and - cocaine, ecstasy, were not with me – but friends tried it. Every night. It was cocaine, ecstasy, mushrooms, something. It was always there.
>
> John: Well, not everywhere - but you know that cocaine is pretty prevalent. There is [an] abundance of drugs that you could get at any time you want. Just like anywhere else. You see the same drugs in XXX [City, Western province], but just not - overall, it seems like there is a lot more people that are on them at the bars or doing them and going out afterwards. Or you can go to a house party and people are doing lines. That is a common occurrence.

Layla indicated that "in a matter of speaking, [drugs are] more accessible here because everybody knows who has it here." The use of substances in the Rockies was often integrally linked by participants to the nightlife and party subcultures.

A night in the life of a SIW. The party subculture descriptions reflected that, in most instances, locals partied with locals, tourists partied with tourists, and transients partied with transients. Occasionally these groups overlapped. Participants described that as they became more integrated, they became more enmeshed with the local community. Some of participants described distinctions between party scenes in terms of the establishments they frequented in the Rockies. For example, John described his nightlife and how he differentiated his activities from "all the young new kids" where he worked and how he stayed away from the "trendy clubs":

> John: Yes, we come downtown. Well most people from XXX [hotel], they usually go to [the local clubs]. Like all the young new kids.
> R: And where do you spend your time? What does your 'night out' look like? Or activities like?
> John: Well, I am not big into the whole - like I will go out and I will go to the clubs here and there - but not very often. I usually go to the [pub] and have some beers. … Some nights are more lively than others. Some places more relaxing. Just do not deal with the crowds. I kind of sway away from the loud, trendy clubs.

Several participants described the different bars in town and how they tailor to different crowds on different days of the week. For example, Cindy described specific evenings during the week that are tailored to service industry workers on a "budget":

> Cindy: … Tuesday and Thursday and Sundays are cheap nights in town -
> R: At the pub?
> Cindy: Yes or the several of the drinking places have cheap drinks on those nights. And they are the only nights you can afford to go out. Because - with the rate of pay and everything else that you got to afford - you just cannot. But the drinking is a social thing as well. Those days require going into work around eight and heading straight out after work or quickly going home to change and then heading and then not coming home until 3:30 in the morning. I just

> - it is really stupid. I am drinking way too much. It seems to be what everyone does.

These experiences were shared by others in the study. These events were sometimes referred to as "industry nights". Alcohol was served during these occasions at reduced cost and participants identified that these "cheap nights" provided them with access to the party scene when they were living on strict budgets. Sophie described her experiences with partying:

> Sophie: Thursday is jam night, like local musicians… Friday night is dance night - so everybody will go and everybody will get drunk or stoned or both. Or people [are] on E. And then people who work tomorrow will be high and then people who do not work tomorrow will be high! [Laughing]! Higher. Yes - because they can keep going, right? They do not have to stop. Actually, people do not stop here for anything really.
> R: Not for work. Work is just there to pay bills.
> Sophie: Work is just something you have to go to a lot. But it does not matter in what condition. As long as you can like do your job. They really do not give a shit.

According to participants, some SIW spent significant amounts of time in the bars and Layla stated, "I probably spent more time in the bars than I should have – in all honesty. But I have had fun. It is not like it has all been bad."

Participants described how their personal experiences with substances had gone through transitions over time. For example, the participants who had been in the Rockies for more than five years described how their alcohol consumption had decreased as did their drug use:

> R: And how often, when you first moved here and lived in staff accommodation compared to now, would you drink?
> Dan: Well, back then I used regularly. And now - I mean obviously I still drink, but I do not use drugs anymore. Not every night. But once in a while I will go out and get a

> good piss on. The important thing is to worry about right now for me.
>
> Sara: I would say it would be more like an average of three drinks a night for five nights a week. And then, on average, some nights it would be more. But at least getting completely intoxicated two or three times [laughing]. To be honest, [it] slowed down after a few [years] - after a while because you party-party-party. And then got it out of your system.

Not all participants in the study who were newer to the Rockies sought the endless party scene and night life opportunities when they first arrived. For example, MM sought the opposite of the party scene; however, he did participate in the nightlife and consume alcohol (to the point of intoxication) about once per week. Layla described her substance use transitions since she has been in the Rockies:

> Layla: [W]ell I actually started drinking a little bit more after [arriving]. One of the reasons that I came out here [was be]cause I used to do a lot of drugs. And I came out here and I quit. I came out here and I have only slipped up a couple of times. But there is a lot of that in this town. A lot of drugs. I mean it is any town there is a lot of drugs it just depends on where you are.

The party scene and nightlife in the Rockies were perceived by participants as accessible for workers and tailored to their varying budgets and social networks.

Seasonal substance use. The summer and winter months were identified as the main tourism seasons and, despite the availability of the nightlife year round, these seasons provided the most opportunity for "adventure". Sara described that "in the summer you are going to get more people that are not motivated to do anything. I have seen. Or you are more likely to find a lot more alcohol being consumed." The summer was described as the busiest season:

> Jake: And there is equally exciting and risky activities to do in either season. I think, generally, the kind of party scene … it seems to me increases in the summer. Ok. People are wearing less clothes… it is warm out. That whole feel of the summer, a lot of the places, I mean there is a way bigger mass of new people coming in, like working for the summer season. Things are busier. So I do think there is an upswing in the summer and downswing in the winter.
>
> MM: I think the summer more provocative dress as well that should influence things too.
> R: That has come up before too. How does that change things?
> MM: Well, both men and women are dressing down and much more sexual interaction on their minds compared to the winter factor. And you go into a bar right now it is toques and sweaters kind of thing. In the summer it is short tops and more attraction.

Participants described the summer as the biggest recruitment season for employers and identified the most sexual risk-taking at this time. While risk-taking was also common among participants during the winter months, the approach may have shifted:

> MJ: It kind of swings both ways. Because in the summer time for sure people are out and people having more of a good time. But in the wintertime people are looking to shack up … it sounds silly, but people do that.

The spring and fall were often referred to as the "shoulder seasons". These were the seasons with the least tourism and least demand for SIW. Sara defined shoulder season:

> Sara: October and May. It is when … we are [on the] cusp of another season and the ski hills have not quite opened and you cannot camp anymore.

John described his own experiences in the slower shoulder seasons:

> John: [I]t slowed down there from October to November. November was really slow. Then it picked up. And December and January picked up. February - then it was a

> little bit slower. Now it is starting to pick up again. And then April - just gets busier and people start coming. And then May it all starts to get going pretty good. The place will be hopping.

MM arrived in the Rockies during the shoulder season and he was not "prepared" for the "idle time":

> MM: It was my idle time in September/ October. And I did not know what to do… I thought it was a really tough time to come here… I came because winter was coming summer had ended and everyone was moving out after the summer and activities were dying off. There was no skiing or backcountry skiing or anything like that yet. So it was just the town was kind of dead. I definitely felt very alone during that time. So and I did not know where to go whatsoever. I had no idea.

In general, the shoulder seasons were described as challenging, particularly among new workers who were attempting to adapt to the Rockies context.

Substances use and party scene concerns. There were issues that SIW in the study identified related to staff accommodation and the accessibility to the party subculture. For example, staff accommodations provided opportunities for party activities to take place for people working in the service industry:

> Mia: Well, I think when I lived in staff accommodation in XXX - it was my first time like being away from the friends that I grew up with and being away from my family. I fell right into that party scene. Cause everybody was going.

> Sara: Like I definitely drank a lot more than I would have normally when I was up there [ski resort]. Those young adults that are not living with their parents anymore that are quite young and so lot of times it is there first time away from home. So it can be very exciting.

Participants described that participation in the nightlife could have led to excessive partying and resulted in people lacking a sense of life balance. Jake described excessive

partying as "when I am not balancing out with other things in my life." Jake stated that excessive partying could not be measured by "a number of drinks, or the amount of hang over, the amount or which drugs I did, or what happened"; however, excessive could be described when partying was "taking too much control and is a negative thing." Cindy shared her experience with "binge drinking":

> Cindy: I know that you should not drink so much but, in this environment, it just does not mean anything to you anymore.
> R: So that way you feel that, it is binge drinking when you go out?
> Cindy: It is.
> R: Yes?
> Cindy: Because you know yourself that you are going out to get drunk. You are not going out to have a couple of drinks. You are doing - everyone is out to get drunk. You know [it] is wrong but it is weird because you keep doing it. Everyone is just sitting.

In addition to binge drinking and excessive partying, addiction issues surfaced for people who were actively involved in the party subculture. Dan stated that there was "abuse that is going on here" and these activities were influenced by the active drug trade.

> Dan: I mean if you want it, it is really easy to find it [drugs] out here. I mean whatever you want. You can either go to somebody or you can go to seek it out on your own. It is amazing how prevalent it is out here. And, I mean you have to be involved to see, but once you get involved, then you really notice the scope and the extent of the abuse that is going on out here. It is incredible.

Participants identified that addiction issues existed in the Rockies. Cocaine was identified as a drug associated with addiction concern:

> Sara: Cocaine I think is highly addictive and it can completely change a life. I have seen it ruin people's life in town.
> R: And you have some good friends experience that?

> Sara: Oh yes. I tell people to avoid coke at all costs. And I bring it up often…. Like I say… 'avoid. Avoid it. Avoid it.'

For other workers, the realities of cocaine addiction were very real. John described watching coworkers trying to deal with their addictions:

> John: I know two or three people who are trying to get off of [cocaine]. They are saying how hard it was. They said they had [tried] so hard to get away from friends and everybody who is doing it.

As a result, the experiences of the Rockies party scenes were met with excitement as well as potential negative health concerns and varying consequences for workers.

Compromises in the Rockies.

Participants in the study made sacrifices as they prioritized their goals. For many, this prioritization process meant they had had to compromise in some other activity or aspect of their life. Participants described their conscious process of deciding either to party or to focus on outdoor pursuits such as a backcountry excursion:

> Jake: [T]he times I like the most to get drunk and party is the after I have done something that I feel an accomplishment. But I guess so do a lot of the people I hang out with. I definitely find that to be my healthiest surrounding. That is the thing I like most. I see there are people here that are definitely lacking the healthy balance. Not to say that I have it dialled but there are a lot people here that do not do a lot else besides work and party, and especially when those are the same place.

Participants described how easy it was to find someone to party with; however, they identified the challenges in planning other activities:

> Mia: Like it is so easy to find someone to go for a drink with. But it takes a little bit more work to find someone to go for a hike with.

> MM: I have found I can easily sink into the party scene itself. Yes, it is very easy to do. You just start making those

> contacts. It is a lot easier to go party on a Friday night than to organize a backcountry trip for the weekend and get everybody all together.

For those determined to pursue outdoor activities, the party scene may have overshadowed their mountaineering goals. Layla described her experience:

> Layla: Honestly, I lived here [and] I never really did all the fun stuff that I wanted to. And that is why - if I did come back - I would. I probably spent more time in the bars than I should have. In all honesty. But I have had fun. It is not like it has all been bad. It is just sometimes it is just that you are tired at the end of the day - go have some beers.

In order to achieve some of the outdoor goals, Sara described her compromises:

> Sara: Well, the main reason I would not go out and booze every night is that - the next day - I cannot handle it nearly as much. Like I feel awful. And I generally will not do anything the next day. So if I know that I want to go on a hike and I want to do something, that is definitely going to make me think that night or I only want to go out and have a couple beers cause I am going to hike Brundle tomorrow. So the outdoor pursuits mostly would make me not drink.

Compromising party life for outdoor pursuits or other activities was a dilemma that many participants encountered. Some SIW sought the outdoors but instead found the party scene. Others made compromises in order to attain their alternate goals. SIW described several of the challenges in prioritizing outdoor pursuits:

> Layla: I mean there is so much to do in town but a lot of people cannot afford it.
> R: Outdoorsy stuff?
> Layla: [P]eople have to own a bike or you got to rent a bike or borrow a bike and not everybody has friends who do that so finding people to go out and do it. You do not want to go by yourself. You need the motivation to do that.

MM described his party sacrifices to attain his outdoor goals, including forgoing the bar in order to purchase backcountry equipment:

> MM: Um-hum. Like the backcountry - to get the gear or to rent the gear is very costly. Yes. Like it is not your typical gear. Working and partying here I have dumped a lot of paycheques into being able to do it and sacrificed in a lot of areas to do it. It is not a cheap activity... Just do not save any money. Spend everything. Definitely cut down on partying and that out here. Sacrifice that – not that is necessarily a sacrifice - but I try not doing that up here. So not getting into the … bar scene.

Participants described their access to the party scene and the sacrifices they had to make in order to prioritize partying with play. For Jake, although he acknowledged that outdoor pursuits can be a bit of a "restraint" in terms of finances, he highlighted that "it does not cost anything to hike" and his comments suggested if these activities were something people really wanted to, it was literally "at their door step."

For some people, substance use and partying served as a strategy to cope with the different life stressors they experienced. For example, Jake described SIW using substances to fill a void:

> Jake: And I think often times it is those kinds of drugs [cocaine, ecstasy], just from my own observations, is that those kinds of drugs people are using to fill that void. And so there is not that balance.

According to Layla, she has seen many young kids in the Rockies who have started to use drugs for one reason and then become addicted. She described one young girl who used cocaine and quickly lost herself in a drug addiction. She stated that she was "trying to figure out who she is" with her drug use and she reiterated, "which she won't" and stated, "I hope she doesn't do it anymore but I mean she was willing to sleep with someone so they would give it to her." Sophie identified that she and others sought out substances for a variety of coping reasons:

> Sophie: And it is not just about drug trips - it is everything. Shit at work. Shit with friends. Shit with partners. Just sometimes the girls just have a bad day and they just want to do something bad to themselves. And they are like 'well maybe I will do this tonight just to get revenge on myself I guess'.

Sara summarized that substance use was the "number one reason that things happen to young adults in the Bow Valley" and highlighted that they were "not handling their booze properly."

Theme Four: Health Outcomes (STI and Unplanned Pregnancy) and Health Resources

Participants consistently described the Rockies and STIs in the same breath. Banff was coined "the STD capital of Canada" in a 1999 Rolling Stones magazine (Bartlett & Binelli, 1999), and this is only one example of the STI distinctions that have been linked with the Rockies. Participants described other STI slogans such as "Banff, come and take your chances" or "Lake Louise is called 'Lake Disease' cause of all the STDs, right?" The STI reputation of the Rockies did not deter participants in their travel plans. However, the reputation has left lasting imprints on the community, as these widespread mottos have not diminished over time. John described learning about the Rockies reputation while living in a Western province. He stated, "well, it is the STD capital of Canada. Pretty much so."

The Rockies' STI reputation had obvious negative connotations and Cindy disclosed that the reputation was known internationally:

> Cindy: [The Rockies] has the most sexually transmitted disease in Canada.
> R: Is that the reputation?
> Cindy: Yes.
> R: I mean I have heard it and it is obviously a lot -

> Cindy: [cuts in] and it goes by place on this one 'that the Brits bring it and the Aussies spread it' or 'the Aussies bring it and that the Brits spread it.'

Cindy elaborated on her comment by stating that the reputation "makes sense because there are so many back packers here." Participants did not dispute the reputation and identified that the transient nature of the workforce and the sexual risk-taking experiences in the Rockies were likely factors that influenced these perceptions. John provided insight on the link between the Rockies and STIs:

> John: [I]mpossible for knowing STDs of people who are coming in. And they are people who are here to party and have sex. I do not think it is [that they] know all the risks with the STD capital.

Participants linked sexual activities with transient workers to an increased risk of STI transmission:

> John: Like I do not think that local people that have them. It is more the people that are coming in and out. Like the big STDs and percentage or prevalence here and why that it is here - I do not think it is that much to do with locals that live here though. I think that it is just people that come in and out. And your percentage of which have it.
> R: What do you think is influencing that?
> John: Well there are people who are just leaving. Like all the people who have left - like I am not sure the staff you guys get as far as impossible for knowing STDs of people who are coming in.

Protective measures, such as condoms, were reported by participants as important measures towards reducing the risk of contracting a STI:

> Sara: I carried [condoms] with me. Always. Always. Since back then of hearing about [the Rockies] and when I first arrived and the STIs were high. I was cautious. I did not [use condoms] all the time. [Laughing]!

Dan described the importance of being "careful":

> Dan: I think anywhere you need to be careful. I mean it is different in the sense that you get a lot of young people coming here at one time. And they might not [have] been out of the home before, and really now they are away from the folks and it is very transient. So I mean if they are getting it here or bringing it here, they are taking it with them wherever they are going.

Despite these negative associations and potential long-term implications for sexual risk-taking in the Rockies, Jake exerted caution by stating "I do not think it should be overly negatively portrayed either... there are a lot of young people having fun and loving to be out in the mountains." Jake summarized by stating that many of the young people are "just loving the time of life they are in."

STI, Unplanned Pregnancy, and Abortion Knowledge

This section reviews STI, pregnancy, and abortion knowledge, experience, and health seeking services among participants in the study. Participants were in the Rockies for varying periods of time and, despite the breadth of experience and combined durations they had spent in the community, there was an overall lack of STI experiences. Despite the wide spread STI reputation, participants did not describe personal STI experiences in the Rockies:

> Jake: [Y]ou hear about those things about [the Rockies] and this area and it is a pretty small town and it is still, in all the times, I cannot say that I have ever known about a [STI] situation or no one has ever approached me about a situation. It has never been a topic that I have heard about or known directly. That kind of surprised me if it is so prevalent... If it is such a big thing and it is so rampant and it is so common, then why don't [we] see it at all or why don't [we] hear about it all?

Participants, such as Jake, were "surprised" by the lack of STI disclosures in the context of the Rockies, particularly in light of the perceptions of the area being "rampant" with infections. Others similarly reflected on the lack of disclosures in the Rockies:

> John: I don't know of anyone personally. I am sure there probably are. Information that is not really out there.

However, Sophie acknowledged that she did not think people would share this type of sensitive information with others:

> R: Do you hear a lot about STDs out here? … Who has them and who does not?
> Sophie: Actually. No, I do not. To be quite honest, I do not. I do not think people would broadcast it either. That would not go over well here. But no I have not heard. Like I know that there are diseases here but I have not - nobody has been honest enough to tell me that they are carrying or not.

Sophie described that people may be wary of disclosing their own STI experiences due to concerns of confidentiality. Mia elaborated on why she and her friends might be more inclined to discuss other topics such as substance use than to disclose STI experiences:

> Mia: No, I mean not a lot. And I don't whether it is that people don't talk about that as much. I think people are more prone to talk about you know if they think they have a problem with drugs more than if they think they have an STD because it is such a personal thing.

STI experiences and knowledge.

In general, SIW did not describe personal STI experiences and they described a limited number of indirect (word of mouth) STI experiences. Sara disclosed her close friend's experience contracting and being treated for chlamydia:

> Sara: I have known of a good friend that did get chlamydia in XXX [Rockies]. That was the only person I have known. Even though it is prevalent, a lot of people don't talk about it.

When Sara was asked why her friend disclosed her STI, she stated:

> Sara: I am just one of her good friends. We were roommates and I am one of her best friends. She actually had the guy - they were dating - call her to tell her he tested because the guy had more symptoms. He had symptoms so then he called her as a friend to say 'listen, go get tested.'

After Sara's friend was tested and treated in the Rockies for her infection, she described her process of deciding whether or not to follow-up with her sexual contacts (contract tracing):

> Sara: She was pretty promiscuous…. but she was so thankful for the one guy she slept with after that - they had used a condom. But it was because he had wanted to wear one. Cause she didn't care.

Cindy described her friend's experience contracting and living with genital warts. She described how they were transmitted:

> Cindy: I was sure there was almost nothing you could do [to protect against genital warts] because you had to rely on the person being honest with you because you may or may not see them. And then they could be a carrier and then they could flare[62] up. And I am trying to think - I have a friend that has them.

Cindy stated that her friend had contracted the genital warts "from her boyfriend" and she highlighted that she "didn't know about it until she went to the doctor one day and got the test and she was devastated."

Participants discussed their own STI knowledge levels in the context of sexual health discussions. Among those who participated in the study, the lack of specific STI

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[62] According to the National Institute of Allergy and Infectious Diseases (2004), certain types of sexually transmitted human papilloma virus (HPV) can cause genital warts. Genital warts may appear in the genital area within weeks or months after infection. Approximately two-thirds of people who contract genital warts will develop warts. Genital warts sometimes appear in clusters that resemble cauliflower-like bumps, and are either raised or flat, small or large (National Institute of Allergy and Infectious Diseases, 2004).

experiences also led to disclosures on a lack of specific STI knowledge for some individuals. Mia described her general STI concerns; however, when specifics were sought, she divulged that she was unaware:

> R: ...If you were to tell someone new coming here, which sexually transmitted infection do you think they would most need to know about?
> Mia: I think with how many people come through [the Rockies] and all the different kind of lifestyles, I don't think there is any that they shouldn't know about. … I think people should be educated on everything they possibly can be.
> R: Which do you think would be the most common out here?
> Mia: I really don't know. No. That is pretty bad for me say. I probably should know.
> R: No. That is one of the areas that I am interested in cause we kind of talk generally about sexually transmitted diseases or infections, but I am curious what if you have heard anything about things like chlamydia specifically or had any education. If someone were to ask you, could you describe what chlamydia was and how it was transmitted?
> Mia: Yes. No, I probably couldn't. Yeah. Laughing.
> R: And how about things like herpes?
> Mia: No. I mean like I have read what there is some of those little pamphlets where it gives you a brief description of some of them. But if one of my friends came up to me and said I have got this problem I think I would be like 'I would have no idea'. You know I would be like go see a doctor. I am not even going to make a guess.

Mia's descriptions were indicative of the general information that participants had in terms of STIs and an area that had not emerged earlier in the data collection process. Following Mia's disclosure of her lack of examples of STIs, future participants described similar knowledge gaps. Sara elaborated on some reasons why people may not know each STI:

> Sara: I have read – like I have got a lot of access to - you know, if someone asked me about it. I could look up in my

> little book. It is always on my desk of what it is. But I don't have them memorized what the symptoms are. But I know some of the symptoms. Like you can definitely look at discharge – something you would want to look for. But the female symptoms are so slight some of those STDs or STIs is worrying you know.

Other participants like Sara had some background in specific risks or concerns about which STIs were more prevalent among young adults. Jake described specific STI risks and transmission:

> R: And what is your understanding of sexually transmitted infections?
> Jake: Well, I think there is - like different infections have or are transmitted in different ways - but I think it ranges from anything to contact to like the exchange of body fluids and some would need access to open wounds or access to get in there - so then depending on what the infection would be. It would be somewhere along that spectrum.

When Jake was probed for specific examples, he shared his background knowledge on STIs:

> R: Can you give me an example.
> Jake: So things like. That is what I would guess. Are things like herpes or things like genital warts, so they would be passed just through contact? And other things like, I am not sure which one, but I am not sure which would require the transmission of body fluids. Like semen or saliva or what have you. And things like HIV need some, the way I understand it, you would need some sort of abrasion or some sort of lesion. It would need access past the skin.

In general, STI experiences and knowledge varied by participants. When participants were probed for examples of STIs in the Rockies, many were unable to disclose examples from their own lives or the lives of those around them. Upon further exploration it became apparent that their STI knowledge was often limited to basic information. More specifically, awareness of STI symptoms, modes of transmission, and treatment for

different types of infections varied. The impact of the lack of awareness among study participants could influence their perceptions of sexual risk-taking, their use of protective measures, and their sexual health overall.

Unplanned pregnancy and abortion experiences.

Participants described the occurrence of unprotected sexual activities and their direct or indirect pregnancy and abortion experiences. There were two participants who disclosed their abortion experiences and several other participants who knew of other SIW in the Rockies who had experienced abortion. Mia described her experiences with friends who went through the decision-making processes to either follow through with their unplanned pregnancy or have an abortion:

> R: Have you ever had any experiences around abortion and pregnancy.
> Mia: In [the Rockies] with friends, I have. Yes. One of my roommates who was a lot younger than us … She got pregnant and it was kind of hard to deal with. But, I have had another friend just recently get pregnant - who is not married yet - but she is with the man who she thinks she will be with. And she just found out she is having twins. So, I mean I have had the sad side of it and which ended up being a decision of abortion and I have also been at the positive side of it where, even not just this friend of mine now who is living with the person she is planning on being with for forever.

Cindy described her friend's situation and her quest for STI and pregnancy information:

> Cindy: Oh yes. She actually came to me a couple of weeks ago and she was concerned and she was 'do you know where I could go and get some tests done'. I am like 'oh, what tests do you want done?' she was like 'oh I want to go get some disease testing' and I am like 'are you kidding me?' She said 'no'. I was like 'aren't you being careful' and she is like 'oh, I know I should be but I am just not'. I am

> like 'come on - there are number of reasons you have got to be careful' and she is like she was worried that she was pregnant and I am like 'come on - stop it - start being careful'. And I know at the moment that she is not.

MJ described a recent experience with a young adult who had challenges in accessing information and services for an abortion in the Rockies:

> MJ: I was talking with one of the girls last year … and her friend needed to get an abortion… And it was really hard for her to get that information on where to go and how and phoned the clinics and the hospitals and nobody could really give her any information. And it was kind of a run around.

When pregnancy experiences were explored further, Sophie also described that people might have to travel to seek abortion services:

> R: Do you know of other people here [and] where someone [could] go to get an abortion out in XXX [Rockies]?
> Sophie: [T]hey might even have to go to Calgary. I do not even know.

Sophie described a young worker's experience of being pregnant and her decision to return home to have the baby:

> Sophie: [T]here is a girl who is nineteen, XXX, who is such a cutie. She is seven months pregnant right now. She is seven months pregnant and she works at the XXX [hotel] and is going home on Sunday…
> R: So she is going home on Sunday for good?
> Sophie: Yes, she is going home on Sunday for good. And she is taking the car… and her boyfriend is staying here… I do not know - unless he got his two weeks notice today too.

These experiences identify that abortion and pregnancy experiences are more commonly discussed among workers and support participants' disclosures that unprotected sexual intercourse is occurring in the Rockies.

Participants shared their experiences of other potential health outcomes associated with sexual risk-taking including unplanned pregnancies and abortion. Participants described their knowledge of, and in some instances personal experiences with, unplanned pregnancy and abortion.

Participants highlighted that STIs were more stigmatizing than pregnancy and indicated that their own concerns about these health outcomes shifted over time and changed in different contexts. For example, some participants were more concerned with getting pregnant if they practised unprotected intercourse; whereas others were more worried about the potential for contracting or transmitting a STI:

> R: [W]hen you first starting coming out to [the Rockies] … when you were having sex with a new partner, what would you be more concerned with - pregnancy or contracting a sexually transmitted infection? Or would they even pop up?
> Jake: Oh yes, they would pop up. I think - both. But probably more with sexually transmitted infection.
> R: Alright.
> Jake: But both for sure. But I think that the risk - the probability would be higher with some types of infection. That would just be what I would think.

Sophie highlighted that in terms of pregnancy and STIs, "both are going to hurt you" and she stated that "some women freak more about pregnancy and some women more about STDs." Cindy described her concern with STI compared with other young women in the tourism industry:

> Cindy: [M]ost young girls tend to be worried about falling pregnant and that is it. They are not worried about getting a disease, which I tend to look the other way around. Least worried about getting pregnant and [more worried about] getting a disease.

Cindy's description highlighted that factors such as age and maturity can influence the perceptions regarding STIs and unplanned pregnancy. Mia and Sara each disclosed that, when they first arrived to the Rockies, they were more concerned about contracting a STI. Over time, their concerns about STIs have diminished. They attributed this change in perspective to the fact they were in longer-term relationships:

> Sara: No, I would be worried. I would be more upset if I got - upset more of a disease health wise. And now, I am kind of at an age when I realize where I am quite certain I am his only partner and so I am not really concerned about getting an STI now. And so that is why my concern would be more pregnancy. Whereas before it would have been STDs when I was younger.

Mia described how her concerns had shifted from an initial STI worry to pregnancy concerns:

> Mia: Oh I would say probably - yes - transmitting, or contracting a sexually transmitted disease. For sure. Just because you hear all those stories about [the Rockies] before you get here… so then as life goes forward a bit, just like when you were a teenager you probably wouldn't have thought about STDs at all, but then as your life moved into a new teenage stage, oh 'I cannot get pregnant I am just going or continuing high school and going on to university'. So I think when you first move out here the first thought is the STD part but then as your life gets settled and you are enjoying [the Rockies] and there is nothing that is going to make you want to leave right now and it is like 'ok, I cannot get pregnant.' And it probably comes higher in my mind at least.

Pregnancy and STI concerns may have shifted over people's life situations and experiences.

STI and stigma/ shame.

In general, STIs were surrounded by a shroud of silence. The stigma and discrimination associated with STIs were reflected in the next quote:

> Mia: [B]ecause it was even that sexually transmitted diseases come up - when you talk about having lice in school. It was some - if children in the class - if a bunch of them [have] lice, some of the parents would still think of it as 'which one was dirty one that brought it in.' kind of thing…. Oh and it is the same with STDs. It is like 'oh, who is the bad one.'

Sara described that, despite STI risks being "ingrained" in her when she first arrived, there was a greater social acceptance in discussing pregnancy and abortion:

> R: It sounds like it is more socially acceptable to talk about abortion than sexually transmitted diseases.
> Sara: Oh, it is for sure. That would be the main - a lot of people come here - I am certain I do not know the numbers but I definitely - I have had young women coming up and saying asking me where they can get abortion information. So and that is probably like way more than anyone asks about STIs information. Interesting.

Cindy, who disclosed that a friend had experienced genital warts, described the shame she encountered with her diagnosis:

> R: Do you think there is a lot of shame associated with sexually transmitted infections?
> Cindy: I think there is and I don't think there should be because most of the time, you don't know that you have got it. And it is not because you are dirty. It is just cause they happen. Not as if you put your hand up and said 'I want one.'

Shame and stigma were introduced by participants as factors that influence the lack of disclosure of STIs in the Rockies.

Personal STI testing experiences.

In general, testing for STIs was inconsistent across study participants. Participants described a range of experiences from no testing through to regular STI check ups. Among those that had been for STI testing, they typically travelled outside of the Rockies to have their assessments conducted. Most had either travelled to a nearby city or had sought testing prior to coming to the Rockies. In a few instances, participants described going in for other tests with their health care professional and assuming that some STI testing had been conducted during their other periodic health examinations. Three participants described accessing STI testing in the Rockies at one point or another.

Participants identified several different factors that influenced their decision to have STI tests conducted in the Rockies. One motivator that Dan identified was his health and wellness:

> Dan: I think I am the first to, I mean, this is my health, I want to stay healthy and live a long life. I have definitely made some bad decisions as time went on. But I have always tried to make the right decision… was just recently tested in October and all systems are clear. So, I mean I am really pretty confident about my health right now.

Sophie described her routine physical and having STI tests conducted at the same time:

> Sophie: [I have a] whole summer of [sex] ahead of me so I am just going to make sure everything is good now. And it is just - I just take it on as my responsibility. It is my responsibility.

When the interviewer inquired if she asked her sexual partners about their STI status, she stated, "sometimes. Sometimes I do not. I don't go for that everything is cool bullshit though."

Layla had sought out STI testing in the Rockies and been deterred by the physician she saw:

> Layla: [He asked me] 'Well, are you gay?' I was like 'um…' 'Have you been sleeping with a druggie or someone who has been having sex with a man?' and I am 'like, no - I do not know' and he sort of looked at me like I was crazy. And I am just like 'I am here for a test'.

Layla insisted on having the STI tests performed, despite her doctor's attempts to dissuade her. According to Layla, there were not a lot of people going for testing at all and many of her friends would rather "just not know."

Several participants described their discomfort with having STI testing conducted locally, despite their knowledge that physicians and health care professionals are bound by confidentiality requirements. Participants described their reasons for not being comfortable with STI testing in the Rockies. Dan recently travelled out of town for STI tests and he commented on the STI testing and small community concerns:

> Dan: I have been in town for a while and I know people and people know me. I know it is all confidential but I just felt better going to XXX [city, Western province] where I didn't know anybody.

John stated that he was not comfortable having STI tests conducted in the Rockies because they were such small communities. He had not previously been tested for STIs, but he described an Alberta city as a more appropriate setting. MM shared that he was a bit "more skittish here" to have testing done in the Rockies and, when this was explored further, he stated, "here you just kind of - it is a smaller community right? So it would be a lot more intimidating I guess." Sophie summarized that there were "no secrets" in the community:

> Sophie: No. Well that depends. With the doctors - for sure it is not an issue. In [the Rockies] there are no secrets out here and if people tell me stuff and I tell people stuff - I say 'keep it to yourself' and if they do and I will. And those are

> the kinds of people I make friends with. So I do not hang out with the people who would go blab everything anyways.

In general, SIW were aware of the confidentiality of health system yet often sought alternate locations for STI testing.

STI testing misconceptions.

Several participants identified that, although they had not specifically requested STI testing, they believed they have had STI testing conducted at certain times in their lives. For example, Jake described having extensive blood work completed to seek the cause of an unknown illness. At that time, he believed that HIV testing was conducted, although he had not discussed this explicitly with his physician:

> Jake: I have had a couple times like that where I have had a bunch of blood work done and I kind of count - for me - I counted that as testing. I don't know if is right or not, but that … would be the reason I did not go testing for HIV mainly…
> R: So did you specifically go in for HIV testing?
> Jake: No, that is what I was saying. It was blood work for like for my knees and stuff and then they were doing blood test and such. And so I thought that would be included because they were looking for every kind of oddball type thing. So they could figure it out so. But I don't know.

When Jake was asked if he had done any follow-up testing, he stated that since the tests in the past had not found anything, he assumed he was STI free.

In the previous sub section on STI experiences in the Rockies, Sara described her friend's chlamydia diagnosis. Sara had indicated that since her friend had practised sexual intercourse with a condom, she had not felt it necessary to tell this sexual partner about her chlamydia infection. Based on her understanding of the bacterial infection, she

did not feel this sexual partner was at risk of contracting the infection because they had used a condom in their last sexual encounter:

> Sara: … so she was glad that she wouldn't have to call him then and say 'go get tested.'

Sara's friend was unaware that chlamydia can be transmitted through other means, such as oral sex.

MJ described her yearly "general pap smears" with her physician and she perceived these examinations as all she needed in terms of assessing her health. She had never specifically sought STI testing:

> MJ: No - cause I have never had any. I go every year. And it is just been a general test that they do on - I do not know exactly what they test for - but everything has always come out clean. I have never had any symptoms of any type - except for maybe - you know - a yeast infection. From stress. That is about it.

Cindy, on the other hand, asked for specific STI tests on a regular basis. After these were completed and no STIs were present for her or her sexual partner, she might have "sex without a condom". She described instances where she might not want to use a condom, but shared that she "can't afford to not wear anything." Participants each described varying knowledge and testing experiences related to STIs. Although they were unable to identify personal STI experiences, many had never been tested specifically for infections of this nature or asked their sexual partners to do the same. Many described misconceptions related to what tests are conducted when they visit their physicians and described barriers to accessing testing in the Rockies context.

Health Seeking Activities: Access, Education, and Knowledge

Health services in the Rockies were not consistently accessed by participants. When they did access existing services, they described a variety of reasons for so doing. Generally, participants described health service access in terms of having a family physician, having a general understanding of existing local health resources and services, and depicting their knowledge levels on health topics.

Physician access.

In general, participants described physicians as accessible in the Rockies and Dan stated, "there are a few doctors that are good"; however, they also acknowledged that it might take some time to find the right one:

> Layla: It took me a while to find a good [doctor]. I have had a few of them.
>
> Jake: I have seen a couple different doctors. But I think that I do have a doctor now that I would go to.

Participants described seeing physicians for general health concerns and rarely accessed them for things like STI or sexual health discussions. Layla indicated that a lot of her friends do not stick around long enough to use the health care system. Layla stated "a lot of people don't even go for their yearly physical" and her statement demonstrated the disconnection between workers and the services available in the community.

Resources and community orientations.

SIW in the study described that when they first arrived, they lacked a social support system including health services access. In some instances, participants received no staff orientation at their place or work or within their local community; in others, participants received extensive orientation sessions. For example, MM walked into a job

with no knowledge of existing community resources and he said "where do you start?" when you first arrive. MM described his personal challenges in making the transition and connecting to resources in the Rockies:

> MM: So it was really tough… [T]here was nothing provided when I walked in [to my job]. You just kind of take it for granted and that is ok.

MM highlighted that a staff orientation session would have helped to connect him to community resources and would have made the "transition easier". He acknowledged that a lot of SIW are in similar scenarios where they "are coming out and so a lot of them do the solo venture." Layla, on the other hand, did receive a staff orientation; however, information on community resources and health services were not included in the session provided by her employer.

Where to access protective measures.

Typically, participants described purchasing condoms locally or accessing them occasionally at community organizations free of charge. For some participants in the study, protective measures included the use of oral contraceptives by themselves or their sexual partners and highlighted the need for a prescription for this type of resource. Some service providers in the Rockies were identified as providing protective measures at a reduced-cost (e.g., oral contraceptives) or free (e.g., condoms) in order to increase accessibility to SIW.

Summary

When SIW first arrived, they described being at highest risk for participating in activities that involved risk. Initially, they may have lacked a balance and participants described spending disproportionate amounts of time in the party scene. For those who

continued their involvement in the party subculture, they risked longer-term consequences such as substance addictions and increased risk of contracting a STI or unplanned pregnancy. Many described a lack of STI awareness or access to testing in the Rockies, despite their general knowledge of potential risks for contracting or transmitting infections. For those who described a reduction in substance use and party activities, many described their involvement in activities as helpful in terms of balancing their lifestyle. Participants who had been living in the Rockies for more than a year tended to describe it as an open and accepting environment. For many, it became their home.

The next two chapters are discussions of the study results. Chapter Five is a review of the results through the socio-ecological framework. This includes a review of the migratory experiences of SIW in the Rockies. Included in this framework are the social determinants of health and five societal institutions that influence the systems in the Rockies. Chapter Six is a connection of the results to the 1986 Ottawa Charter for Health Promotion. Included in this discussion are the five action strategies for health. Chapter Six includes an overview of the study's strengths and limitations. Chapter Six concludes with recommendations for future studies.

CHAPTER FIVE: DISCUSSION & MODELS

Introduction

This chapter starts with an overview of the socio-ecological framework. Then, the settlement experiences of SIW in the Rockies are explored through a migratory model. Results are discussed through the macro-, meso-, and micro-systems levels, including a review of five societal institutions and the social determinants of health. In both chapter five and chapter six there is a connection of the results back to research and published literature.

Socio-Ecological Model of Health

The socio-ecological theoretical framework is a useful framework for integrating results from the study[63]. The framework integrated into the discussion chapter builds on the framework introduced at the beginning of the study. The version described in depth in this chapter has been adapted from the work of Thurston and Vissandjee (2005). Thurston and Vissandjee (2005) integrated an ecological framework to explore the impact of migration for immigrant women and to understand culture as a determinant of women's health. The framework originates from the work of Giddens (1984) and Bronfenbrenner (1979; 1986).

Overview of the Socio-Ecological Model

Figure 1.0 is a visual overview of the adapted socio-ecological framework. It depicts two dimensions of interconnected elements. The connecting lines between each of

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[63] As indicated in the methods section, the socio-ecological model was applied during the analytic process. This model provided a broad framework through which to explore the experiences of SIW in the Rockies. This chapter includes a brief overview of all the components of the model and focuses the discussion on specific components that were most pertinent in the study results.

the components demonstrate the links between the structures, systems, levels, and processes (Grzywacz & Fuqua, 2000). Along the right vertical axis of the figure are Bronfenbrenner's (1979; 1986) three main levels of interacting variables which include the macro-, meso-, and micro-systems[64]. Each of these systems affects the other systems (Bronfenbrenner, 1986). Located on the macro- and meso- levels of the model are five societal institutions, which include: *Symbolic*; *State*; *Welfare*; *Institutional Civil Society*; and *Economic Institutions*. These institutions were adapted by Thurston and Vissandjee's (2005) in their ecological model of immigrant women's health. They were informed by the work of Giddens (1984 as cited in Thurston & Vissandjee, 2005) and Kleinman (1980 as cited in Thurston & Vissandjee, 2005).

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[64] Bronfenbrenner's (1979) exo-system is a setting where individuals do not directly interact. This level was not included in this research study's model.

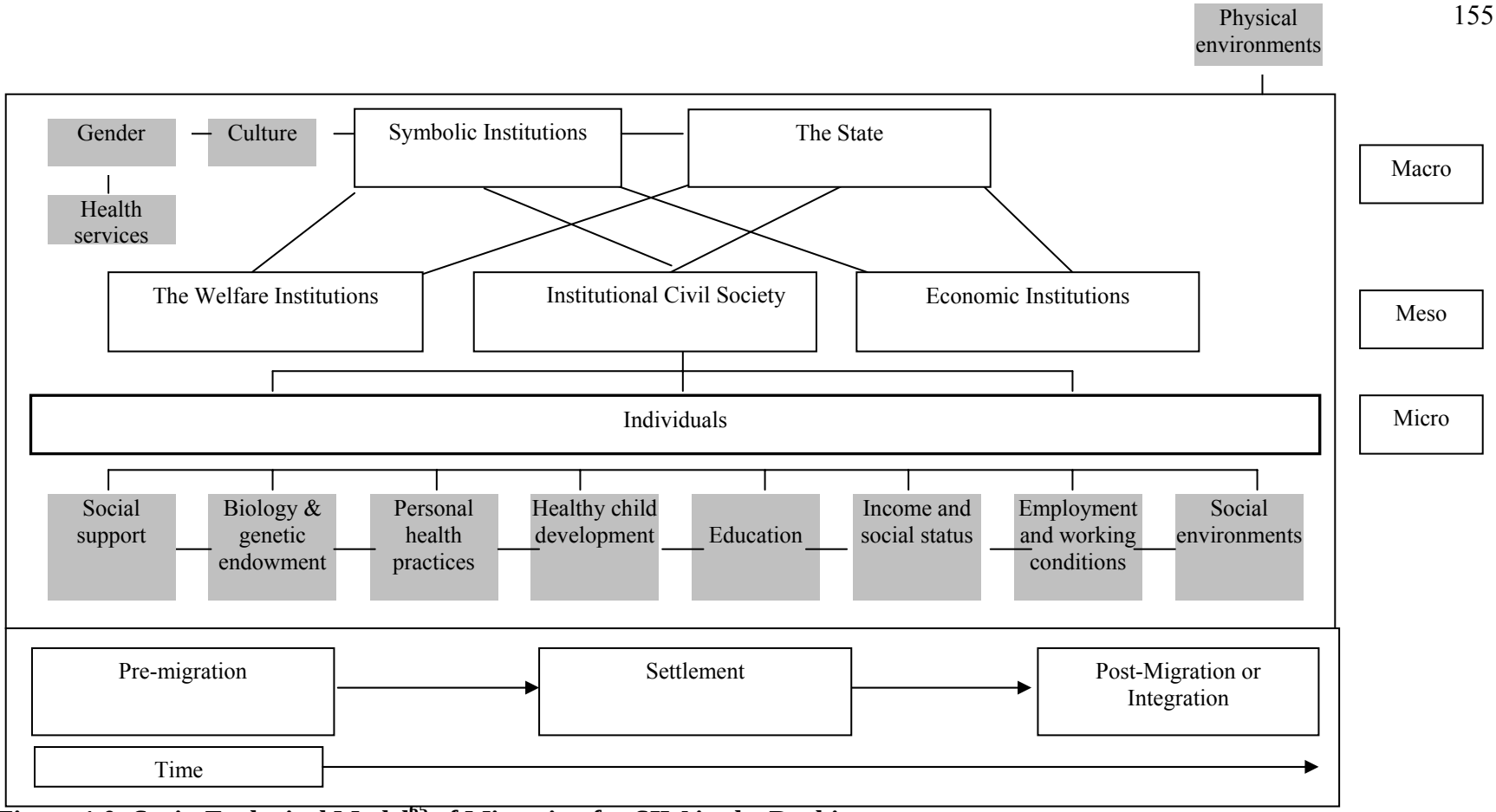

Figure 1.0: Socio-Ecological Model[65] of Migration for SIW in the Rockies

[65] Note: From "An Ecological Model for Understanding Culture as a Determinant of Women's Health" by W. E. Thurston and Vissandjee, B., 2005, Critical Public Health, 15 (3). Copyright 2005 by W. E. Thurston. Adapted with permission.

Giddens (1984 as cited in Thurston & Vissandjee, 2005) described four main institutions in society, "namely symbolic orders and modes of discourse, and political, economic and regulatory institutions" (p. 230). Institutions are "the more enduring features of social life… giving solidity [to social systems] across time and space" (Giddens, 1984 as cited in Parto, 2003, p. 22). Institutions are manifestations of interactions among humans based on rules, norms, and values. As such, institutions are (re)produced and modified by human behaviour (Scott, 2001 as cited in Parto, 2003). Institutions were defined by Jessop (2000) as "sets of chronically reproduced, deeply sedimented rules and resources that constrain and facilitate social actions and that also bind social actions in time and space so that more or less systematic action patterns come to be generated and reproduced" (p. 1).

Thurston and Vissandjee (2005) combined Gidden's regulatory institutions and political systems under the *State Institution*. *Economic Institutions* remained from Gidden's original work. *Institutional Civil Society* was identified separately because of "its importance to the creation of health" (Thurston & Vissandjee, 2005, p. 230). *Symbolic Institutions* are "clusters of rules and resources that are sustained across time and space within and among social systems" (Giddens, 1984 as cited in Thurston & Vissandjee, 2005, p. 230). The work of Kleinman (1980 as cited in Thurston & Vissandjee, 2005) informed the integration of the *Welfare Institution*.

The socio-ecological framework draws on the broad determinants of health (Lewis, 1998). Twelve determinants of health have been adopted into official policy in Canada (Health Canada, 1996). Four of these health determinants are located on the macro- and meso-systems levels, including: gender; culture; physical environments; and

health services. The remaining eight health determinants are located on the micro-systems level, including: social support; biology and genetic endowment; personal health practices and coping skills; healthy child development; education; income and social status; employment and working conditions; and social environments.

The migratory experience is depicted along the bottom, horizontal axis of the framework. The migratory experience has been identified as a significant health determinant (Meadows, Thurston, & Melton, 2001; Thurston & Vissandjee, 2005). This includes the pre-migratory, settlement, post-migratory/ integration experiences (Berry, 1990; Thurston & Vissandjee, 2005). The timeline for each of the four phases is represented along the bottom horizontal axis (Thurston & Vissandjee, 2005).

Migration for SIW in the Rockies Explored

Researchers have described migration as a significant health determinant (Hattar-Pollara & Meleis, 1995; Meadows et al., 2001; Thurston & Vissandjee, 2005). Study participants described health components that were influenced by their migratory and settlement experiences. This subsection reviews the settlement processes of SIW as they adapted to the tourism milieu of the Rockies.

As depicted in Table 4.1, participants had been in the Rockies for varying lengths of time, ranging from one month to 11 years. Nearly half had lived in the Rockies for less than one year; nearly one-fifth had lived there between one and five years; and over one-third had lived there five years or more. The diversity found in study participants was consistent with a Banff census compiled by Ketterer (2005). The range of time spent in the Rockies by participants suggests that they were at different stages of their settlement experience. These stages are comparable to the phases outlined in Figure 1.0.

SIW are defined as permanent and non-permanent migrants for this discussion. All participants were born outside of the Rockies and had moved there as young adults. Their movement was consistent with Thurston and Vissandjee's (2005) definition of migrants as those who move within or across borders. Immigrants include those people who are legally entitled to enter and remain permanently in Canada[66] (Alberta Government, n.d.). Non-permanent residents include those who hold a student or employment authorization, Minister's permit, or who are refugee claimants and their families (Statistics Canada, 2001).

Participants described themselves as local, local-transient, or transient members of the community. These descriptions referred to their length of stay, their social support systems, and their connections to the community. These identities are integrated into the settlement phases of the migratory model. These identities overlapped with Long and Weinert's (1998) rural health concepts of *outsider*, *insider*, *old-timer*, and *newcomer*. Outsider attributes include being different, unfamiliar, and unconnected (Bailey, 1998). Insider attributes include group membership, access to privileged information, and awareness of the social context (Myers, 1998). Old-timer attributes include age, length of time spent in community, and establishment of relationships within community (Caniparoli, 1998). Newcomer attributes include recent immigrant, and a lack of awareness of the social structure and history (Sutermaster, 1998).

Participants were in their *pre-migratory experience* prior to travelling to the Rockies. This experience was described as the moment migrants decide to emigrate

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[66] This does not include temporary foreign workers.

(Thurston & Vissandjee, 2005). Among participants who identified as members of the *transient* community, their descriptions were similar to the *settlement experience*, which has been described as when migrants first arrive (*newcomer, outsider)* to a new community and attempt to settle down. This experience often occurs between the time of arrival and several years into the new community (Thurston & Vissandjee, 2005). The first year, and in particular the initial few months in the Rockies, was the timeframe described by some participants as the most challenging. As they sought to establish themselves in the community, many simultaneously went through developmental changes, including: physical; emotional; and psychological adaptations.

Despite the fact that the majority of the study participants were age 25 years or older at the time of the interview, most had arrived in the Rockies when they were in their late teens or early twenties. Settertobulte and de Matos (2004) examined exposure to peer influences of young people (n=162,000 aged 11, 13, and 15 years) from survey data from the cross-national Health Behaviour in School-aged Children (HBSC) study. Settertobulte and de Matos (2004) identified that a critical development period for young people occurs when they are adjusting to body changes, exploring their sexual identities, and seeking more independence. The majority of the participants first arrived in the Rockies during their teenage years and they were going through the latter part of their development period.

Among participants who identified as members of the *local-transient* community, their descriptions were similar to the *post-migration* experience, which has been described as a time when people have been in the community for several years *(newcomer, outsider-insider)* and have attempted to establish themselves. For those

participants who identified as part of the *local* community, their descriptions were consistent with the *integration* experience. They have been in the community for many years (*old-timer, insider*) and described a sense of belonging in the community. Among participants who described themselves as an *insider*, attributes included the length of time they spent in the community and their connections with other locals.

Participants identified an interconnection between their migratory experience and health. The integration of the settlement model facilitated an exploration of the different experiences of SIW as they adapted to the Rockies communities. Migration as a determinant of health has been suggested in past studies and describing the health of SIW cannot be adequately conducted without an exploration of this integral health area.

Macro-Systems Level

The Symbolic Institution.

SIW in the Rockies who participated in the study were affected by broad, macro-system level influences. The macro-system includes the Symbolic Institution[67]; the Symbolic Institution is defined as "clusters of rules and resources that are sustained across time and space within and among social systems" (Giddens, 1984 as cited in Thurston & Vissandjee, 2005, p. 230). Symbolic Institutions, which include dimensions such as gender, culture, and justice, are described as "coordinated and intersecting

[67] In the early work of Hume (1969 and 1965 as cited in Burgwin, 1997), the notions of institutions as symbolic forms served as bridges for conventional life. For example, "signs and symbols were instituted through regular practice to form the language of the covenant or promise" (Burgwin, 1997, p. 145). Durkheim (1973 as cited in Burgwin, 1997) wrote, "institutions are not established by decree but result from social life and merely translate it externally through overt symbol" (p. 145).

processes taking place at multiple sites" (DeVault & McCoy, 2001 as cited in Thurston & Vissandjee, 2005 p. 230).

Gender.

Gender is a social determinant of health that is interrelated with the Symbolic Institution of the socio-ecological theoretical framework. Sex is a biological construct whereas gender is socially constructed. Gender is defined as a "socio-historical construct essentially social and temporal in nature" (Thurston & Vissandjee, 2005, p. 6). The social construction of gender includes "identities, personal qualities and traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis, with differing results" (Carlson, 2000, p. 1). Gender varies according to the roles, norms, and values of a given society (Phillips, 2005). As a result, gender identities are informed, created, and defined differently in each context (Thurston & Vissandjee, 2005). The impact of gender as a population level social determinant of health is described by Phillips (2005) as "likely a composite of the effects of relative power, autonomy, poverty, and marginalization, within, and across, societies and cultures" (p. 3).

Although the study methods did not include a gender-based analysis, sexual health issues have an inherent connection to gender. Participants in the research study described sexual practices and roles for sexual negotiation as gender related topics. In terms of sexual negotiation, participants described different perspectives on who is responsible for discussing and using protective measures within each sexual encounter. These perspectives were influenced by their underlying belief systems and ideologies. For example, while some participants described women as the sex more likely to bring

and negotiate safer sexual precautions, others were adamant that men were equally or more committed to taking on these responsibilities.

Wight et al. (1998) outlined some key theoretical insights, including the role of gender, that were gained in development of a new sex education programme for Scottish schools. Wight et al. (1998) identified the importance of understanding the contexts in which behaviours occur and the processes that influence the complex sexual health experiences of young people (e.g., sexual negotiation and decision-making). Three main themes on young people's sexual health were identified: the first, sexuality is to a large extent learnt and learnt differently depending on one's gender; the second, management of heterosexual relations is dependent upon culturally maintained and individually learned gendered power relations; and the third, the perception of health risks is culturally defined (Wight et al., 1998).

Participants identified STI risks and long-term health implications as another issue that differed for men and women. Among those participants who described a basic understanding of how STI risks differed for the two sexes, they identified that women may be more at risk of contracting some types of STIs. This was corroborated by the WHO (2000) who state that women are "much more vulnerable biologically, culturally, socio-economically" (p. 1) to STIs than men. Elwy, Graham, Hart, Hawkes, and Petticrew (2002) conducted a systematic review of the effectiveness of intervention to prevent transmission of STIs (intervention studies[68], n=27). Elwy et al. (2002) summarized from the literature that "women are twice as likely as men to become

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[68] The rigorous inclusion criteria was met by only 27 intervention studies.

infected by a variety of sexually transmitted pathogens, and the efficiency of male-to-female transmission of HIV is approximately four times higher than female-to-male transmission" (p. 1818). In addition to women's increased biological risks, social and cultural norms further heighten their risk for contracting a STI (Elwy et al., 2002).

Genuis and Genuis (2004) encouraged a re-evaluation of present day approaches to STI prevention and management. Genuis and Genuis (2004) identified that STIs can have damaging psychosocial and physical health implications. For example, untreated and undiagnosed STIs can have long-term consequences. The link between STIs and serious negative health outcomes for men and women were reviewed. STIs can manifest and present differently in men and women. Examples of long-term negative health implications of STIs for women include pelvic inflammatory disease (PID), ectopic pregnancy, and tubal infertility (Genuis & Genuis, 2004).

Sexual health service delivery in the Rockies is not tailored for male and female SIW. Dawson and Gifford (2003) examined and compared narratives on the lives of Chilean women living in Australia and the lives of Chilean women living in Chile. They reviewed the social changes women experienced when they migrated (Dawson & Gifford, 2003). Dawson and Gifford (2003) concluded that sexual health promotion strategies for STIs have not appropriately acknowledged gender differences or people's social and cultural backgrounds. These challenges can reinforce issues such as cultural biases, stereotypes, and discrimination (Dawson & Gifford, 2003). Although none of the participants in the study was from the country of Chile, SIW arrive in the Rockies from all corners of the globe. For example, 17 percent of the resident population in the Town of Banff is a visible minority group (Statistics Canada, 2004). The ethnocultural diversity

of residents and workers in the Rockies is an area that sexual health promotion strategies may have inadequately addressed to date in the Rockies communities.

Past studies on the sexual health of travellers in tourist destinations have assessed the sexual risk differences for men and women. Bloor et al. (1998) conducted interviews with United Kingdom (UK) residents aged 18 to 34 years who had travelled abroad without a partner in the previous two years. Bloor et al. (1998) compared results between a group of travellers who reported a new sexual relationship (n=400) with a control group of people who did not report a new sexual relationship during their travels (n=568). Logistic regression indicated that there were differences between men and women related to unsafe sexual practices while travelling (Bloor et al., 1998). For example, women's risk behaviours were associated with patterns of condom use of their sexual partners ($p<0.001$); whereas men's risk behaviours were associated with their patterns of condom use at home ($p<0.001$) (Bloor et al., 1998). Sexual health promotion interventions should be adapted to reflect gender specific health considerations.

Abraham, Sheeran, Abrams, and Spears (1996) examined data from a longitudinal study conducted on youth (n=258) aged 16 to 18 years from Scotland. The study was designed to determine the extent to which one of the socio-cognitive behaviour models, entitled the Health Belief Model (HBM[69]), can predict the sexual activity and condom use of these teenagers (Abraham et al., 1996). Results indicated that condom use differed

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[69] HBM includes benefits and barriers to health (Becker, 1974; Guthrie et al., 1996). Benefits and barriers constructs refer "to how knowledge of the benefits that come from engaging in health-related behaviours may reduce the likelihood of engaging in health-compromising behaviours" (Guthrie et al., 1996, p. 320). Four main components: 1) perceived susceptibility to; 2) perceived severity of; 3) perceived benefits; and 4) perceived costs (Bish, Sutton, & Golombok, 1999).

between the male and female youth (Abraham et al., 1996). Young men's intentions to use condoms and their subsequent condom use were correlated; whereas women's intentions to use condoms and their actual use were not (Abraham et al., 1996). These results suggested that the sexual intentions, influences, and actions of young people are different for men and women (Abraham et al., 1996).

Gender and sex for SIW in the Rockies influence their sexual health. There are different experiences and pressures that influence the sexual activities of male and female SIW in the Rockies including their use of protective measures. SIW described different experiences in negotiations with their sexual partners. SIW have different risks for contracting and transmitting STIs as well as different short and long-term health implications associated with infections. Health interventions need to be tailored to meet the needs of men and women in the Rockies.

Culture.

Culture is a social determinant of health that is integrated with the Symbolic Institution. Culture includes people's customs, traditions, values, and beliefs (Canadian Health Network & Health Canada, n.d., p.2). Culture and ethnicity are influenced by a variety of factors such as situational, social, political, geographical, and economic realities (Health Canada, 2003a; Labonte, 2003). Culture influences people's health risks. For example, "some persons or groups may experience additional health risks due to the socioeconomic environment, which is largely determined by the dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language or culture, and lack of access to culturally appropriate health care and services" (Conceptual Framework Subgroup on Population Health of the

Working Group on Population Health Strategy, 1996 as cited in Thurston & Wilson, 1998).

Kosic (2002) conducted a study of two immigrant groups (n=172 and n=179) to determine their need for cognitive closure in their adaptation process in a new community. Kosic (2002) integrated Berry, Kim, Power, Young, and Bujaki's (1989 as cited in Kosic, 2002) model of acculturation experiences among study participants. Berry et al. (1989 as cited in Kosic, 2002) postulated four different acculturation experiences: assimilation; integration; separation; and marginalization. An underlying assumption held by Kosic (2002) was that people have the freedom to choose to acculturate. Kosic (2002) identified that minority groups seek opportunities to either assimilate[70] or integrate[71] into mainstream society.

In the context of the research study, SIW who have recently migrated to the Rockies described their desire to find a sense of belonging. Past studies have focused on immigrant populations and their transition processes. The researcher acknowledges that there are inherent differences between populations of immigrants relocating and SIW who arrive either temporarily or permanently in the Rockies cultural system. However, there are areas that warrant reflection. For example, SIW are arriving at a new destination, in the context of new cultural systems, and they are often away from home for the first time and they are commonly travelling by themselves. Many arrive without work or housing prearranged and need to become established in order to remain in the

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[70] Assimilation is a time when migrants and/or immigrants have completely acquired the culture of the dominant group (Kosic, 2002).

[71] Integration into society has been defined as those who migrated or immigrated could retain some of their original culture while also feeling accepted within the host community (Kosic, 2002).

community. This is particularly relevant in the context of the Rockies where people need to work in order to reside in the community on an ongoing basis. These acculturation stages may influence SIW as they adapt to the new community.

Young SIW in the Rockies develop different social supports and are exposed to different norms, values, and beliefs as soon as they arrive in the Rockies. Guthrie, Wallace, Doerr, Janz, Schottenfeld, et al. (1996) conducted a quasi-experimental design on females (n=146) aged 13 to 19 years in the US to compare results from those who attended a peer education intervention compared with an adult-led intervention program. Guthrie et al. (1996) described that young people are "socialized within a variety of contexts [and] they assimilate [to] the cultural norms and values of family, peer referent group, community and media" (p. 321). For SIW in the Rockies, many arrive at the age of 18 years and as they make the transition into adulthood. The adaptation process they go through when they arrive in the Rockies may be influenced by the cultural norms of the new community they enter along with the peer referent groups with whom they associate.

Understanding the context in which they are attempting to integrate and the factors that influence them as soon as they arrive can inform their transition process. For example, participants are entering into the subculture of the service industry, in communities where tourism is the main economic industry. They arrive in communities where there is a party reputation and they move into a new living situation (e.g., either shared staff accommodation or housing arrangements). Depending on their acculturation experiences within these various contexts, SIW described different levels of satisfaction with their adaptation. Kosic (2002) found that people who acculturate transition through a

range of psychological and psychosomatic stress. For example, people who had *integrated* into the community described the lowest levels of stress; people who had *assimilated* felt intermediate levels of stress; and those who felt *marginalized* or *separated* felt the most stress (Kosic, 2002). For SIW who are going through their own processes of acculturation experience different levels of stress and these changes have implications on their overall well-being.

The State Institution.

The macro-system also includes the State Institution. Thurston and Vissandjee (2005) combined Gidden's regulatory institutions and political systems under the *State Institution*. Although the discussion does not focus in-depth on this institution, the lives of SIW in the Rockies are directly and indirectly influenced from many aspects of the State Institution including the regulations they encounter. Examples of regulatory systems including the immigration process at the federal and provincial levels. The employment system is another area that is regulated in part by the State Institution. SIW are paid according to the federal and provincial laws that regulate paid work, such as minimum wage, hours of work, and health and safety standards (Citizenship and Immigration Canada, 2003). All people employed in Canada must have a federally issued social insurance number to work (Citizenship and Immigration Canada, 2003). Canadian citizens and permanent residents have access to the public health care system and they are eligible for provincial health insurance coverage after they make an application[72] (Citizenship and Immigration Canada, 2003). SIW arriving in the Rockies need to ensure

they are meeting requirements for work, health, and income according to the various regulatory systems in place. However, SIW may not follow through on all these required processes and these could have an impact on their experiences if they need to access the health or employment systems.

When SIW arrive to the Rockies, they either enter into municipal, provincial, and/or federal systems that include national or provincial park boundaries. As well, SIW in the studied moved into the Calgary Health Region, which is a specific regional health authority (RHA) that includes the towns of Canmore, Banff, Lake Louise**,** and Kananaskis. The Calgary health region is the third regional health authority[73] in the province of Alberta. As such, SIW are bound by regulations and systems that are established for effective health services provision. These regulatory systems influence the health of SIW.

Physical environment.

The physical environment is a social determinant of health that influences all systems levels and health determinants (Thurston & Vissandjee, 2005). Physical environments include clean air and water, healthy workplaces, safe housing, communities, and roads (Canadian Health Network & Health Canada, n.d.). At the macro-systems level, physical environments include geographical and natural elements such as weather, water, and air. At the meso-systems level, physical environments

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[72] There are certain provinces and territories in Canada that have a three-month waiting period. People need to purchase private insurance during this time frame (Citizenship and Immigration Canada, 2003).
[73] Regional Health Authorities Act defines the roles and responsibilities for regional health authorities in delivering hospital and health services (AHW, 2003a).

include human built settings such housing and safety (Atzaba-Poria, Pike, & Deater-Deckard, 2004; Grzywacz & Fuqua, 2000; Labonte, 2003).

The Rockies includes physical environments in which the tourism operates as a major industry in conjunction with other systems. Western Management Consultants (2001) stated, "the tourism industry in Canmore is the dominant industry that sustains the community's employment and income base" (p. 4). This is consistent with other communities in the Rockies. For example, the Banff Community Plan (Town of Banff, 1998) described tourism as a "key driving factors in the regional economy" (p. 32). As a primary industry, tourism influences the socio economic status (SES[74]) of permanent, non-permanent, and temporary residents in the Rockies. Year-round career opportunities are available for workers; however, those working in the service industry often report insufficient funds to meet the high costs of living. For example, the Job Resource Centre (2005) has offices in Banff and Canmore and tracks wage ranges for employment positions in the Rockies. They identified that service industry positions in the Rockies earn less than workers in similar positions in other parts of Canada (Job Resource Centre, 2005).

When SIW migrate to the Rockies, they need to re-establish themselves. Hattar-Pollara and Meleis (1995) conducted a phenomenological study on Jordanian American women (n=30) and described an in-depth account of their perceived stressors as related to their immigration experience. Hattar-Pollara and Meleis (1995) identified that the

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[74] SES variables are frequently combined to assess and predict the health of populations and include economic status (income), social status (education), and work status (occupation) (Boyce & Dallago, 2000).

establishment of income for immigrants during the settlement process was a major immediate stressor. In order to gain a comprehensive understanding of health phenomena among immigrant women, multiple dimensions and levels of SES need to be assessed including the implications of SES on their health (Hattar-Pollara & Meleis, 1995). Although the study of Jordanian American women included a different sample population than SIW, it was included in order to highlight the immediate stressors that immigrant populations face in new contexts and some of the commonalities that may be faced when people move to new environments. SIW who participated in the study described intentions to live in the Rockies either on a temporary or permanent basis. All participants described their arrival and initial transition in the Rockies as a stressful time as they sought to meet their basic needs and find a sense of belonging. For example, SIW needed to find housing, employment, and food while they were attempting to make the transition through changes in their social status, income, social support, and health services.

Discussions about SES are important to explore for SIW in the context of the Rockies. The SES of SIW prior to arriving in the Rockies was not explored in this study nor was their previous health status. However, participants arrived in the Rockies to job positions that were low paying and moved into housing that was often beyond their financial means and required multiple roommates or subsidized housing options. In the process of SIW reestablishing themselves in the Rockies, they were often disconnected from health systems. As well, they lacked the social status that they may have previously enjoyed in their home contexts. Past studies have demonstrated that low-income Canadians are more likely to suffer illnesses than high-income Canadians, even after

controlling for factors such as age and sex (Federal Provincial and Territorial Advisory Committee on Population Health (FPTACPH), 1999). Marmot, Ryff, Bumpass, Shipley, and Marks (1997) compared results from three large sample studies (Whitehall II, Wisconsin Longitudinal Study, and National Survey of Families and Households) to determine if a relation existed between socio economic position and health status. Marmot et al. (1997) found that features of adults' SES do have a causal connection with health in adult life. For example, all three studies demonstrated that the worst health outcomes were found along the bottom of the socio-economic distribution (Marmot et al., 1997). All three studies showed a social gradient that ran across the population and "the lower the social status the greater the physical and mental ill health and the worse the psychological well-being" (Marmot et al., 1997, p. 906). Although not as prominent as SES on the health of adults, the studies identified that as social position decreased, the likelihood of ill health increased and the chances for well-being decreased (Marmot et al., 1997).

SIW who migrate to the Rockies experience changes in their meso- and macro-systems levels related to their physical environment. Immediately, they need to meet their basic physical survival needs (e.g., food, shelter, and clothing). In addition, they need to support these needs through income, work, and transportation requirements. They often confront these issues with limited financial resources. The process of settlement for SIW means that they often arrive and enter into low paying positions at minimum wage. Immediately, they are confronted with the need to find housing, often not affordable, and adapt to their new context. The party scene is an immediate environment that entices workers and provides opportunities to socialize and connect with others going through

similar adaptation processes. Participants linked this early state in the settlement process with higher risk activities. SIW who remain in the community throughout their immense transitions described becoming more connected. Further, they depicted an improved quality of life, a sense of work satisfaction, and reduced risk-taking activities**.**

Housing is a basic need and part of the physical environment with which SIW continuously interact. SIW live in either a shared housing or staff accommodation arrangement. The decision to move into shared accommodation or staff housing has implications for the social support networks of SIW, their expendable income, and accessibility to resources in the community. Housing options for SIW are influenced by several factors including the high cost of living, transient nature of workers, and lack of affordable options. Study participants described staff accommodation as the most economical option for workers; however, it also meant less independence and less responsibility. Alternatively, SIW lived in shared rental accommodations. Participants in the study indicated that home ownership for SIW in the Rockies is uncommon.

The housing experiences of SIW were corroborated by Ketterer (2005) and Praxis (2002). Ketterer (2005) prepared the 2005 Banff Municipal Census. The majority of residents in Banff lived in rental dwellings; the most common type of rental dwelling was an apartment (Ketterer, 2005). Praxis (2002) assessed the housing issues and housing requirements for the Banff Housing Corporation. Praxis (2002) multistage research study included: four survey instruments (employee survey n=168; organization survey n=24; residents survey n=78); three focus groups (n=3); and a series of personal interviews (n=9). The studies by Praxis (2002) and Ketterer (2005) focused on the Town of Banff and did not include reference to the other communities in the Rockies, such as Canmore

or Lake Louise, Alberta. There are some notable differences in the community statistics that distinguish Canmore from the towns of Banff and Lake Louise. For example, Statistics Canada (2004) reported in the 2001 national census that the majority of residents in Banff (70 percent) and Lake Louise (91 percent) lived in a rental dwelling.

These results differ from Canmore where almost one third (31 percent) of residents lived in a rental arrangement. However, there is evidence that demonstrates housing trends in Canmore are gaining similarities to other communities in the Rockies such as Banff. For example, Mauws (2005) conducted a study on a random sample of households (n=500 households) on the shortage of affordable housing in Canmore in 2004. Housing costs in Canmore are rapidly increasing and now far exceed national housing prices (Mauws, 2005). According to Mauws (2005), "the possibility of owning a home in Canmore is disappearing" (p. 4) for wage earners. As housing prices in Canmore continue to ascend at a rate that does not match income increases, the percentage of homeowners may continue to descend and renters may increase (e.g., may be moving towards similar trends in Banff and Lake Louise).

Cavicchi, Nixon, and Tutty (2002) conducted a qualitative study of young adults and stakeholders (n=60) in the Bow Valley[75]. The research study had two main objectives: first, to assess the quality of life, violence, and non-violence related issues in the Bow Valley for young adults; and second, to determine the awareness of programs and initiatives among young people regarding the Society Against Family Violence (SAFV) (Cavicchi et al., 2002). Respondents identified the prominent issues influencing

[75] The Bow Valley area included Canmore, Banff, Lake Louise (Cavicchi et al., 2002).

their quality of life as the following: housing; workplace issues; cost of living; lack of informal support; limited social activities; and not being able to meet their original goals in the Rockies (Cavicchi et al., 2002). Housing was identified as the top issue of young adults in the study (71 percent of respondents ranked housing as their number one concern that had a detrimental impact on their quality of life) (Cavicchi et al., 2002). Cavicchi et al. (2002) also found that a large proportion of young adults live in staff accommodation or high-density housing[76] arrangements. Factors that influenced the high-density living for young adults included the high cost of living and low wages in the Bow Valley (Cavicchi et al., 2002).

Access to the party scene and sexual risks occurred for SIW regardless of their living arrangement (e.g., in both staff accommodation and shared housing arrangements). However, the opportunities for risk-taking were described as more accessible for those SIW who lived in staff accommodation arrangements. For example, staff accommodation arrangements were interconnected with increased access to party subculture and sexual risk opportunities. Hennick, Cooper, and Diamond (1999) conducted a longitudinal qualitative study of the contraceptive behaviour of seasonal workers (n=50) at five different holiday centres along the south coast of England. Hennick et al. (1999) described that seasonal workers in holiday or tourism centres "have been shown to experience different social and sexual behaviour while at a holiday centred compared to that followed in their home environment" (p. 45). For example, in live-in or staff

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[76] High-density housing was identified as living scenarios where a disproportionate number of people to bedrooms exist (Cavicchi et al., 2002).

accommodation arrangements, workers demonstrated a "predominance of short-term, casual relationships, a greater number of sexual partners, a higher incidence of casual sex, and, for some, experience of sexual risk-taking" (Hennick et al., 1999, p.45). These results are consistent with descriptions by participants of the influence of accommodation on sexual risk-taking.

Meso-Systems Level

Institutional Civil Society.

Institutional Civil Society was included in the ecological model of women's health used by Thurston and Vissandjee (2005). Civil societies serve as *mediating structures* between the private and public spheres (Caragata, 1999). As such, civil societies have created and enhanced the bridge between and among the various systems levels. For example, the work of many non-governmental organizations has been influential in examining the relevance and appropriateness of policies and interventions. Caragata (1999) stated that civil society is "inclusive of the voluntary sector which provides the organizing base for much of community development" (p. 280). Caragata (1999) identified two main actions of civil society: one, to directly impact the state or marketplace (e.g., demand social benefit); or two, impact public sphere through means outside of the state or marketplace (e.g., collective process).

Institutional Civil Society in the Rockies bridges between the work of local stakeholders, such as BSIN and ABV, along with governmental organizations, such as the public health system. An example in the Rockies is the creation of multidisciplinary teams or initiatives from different sectors. Both ABV and BSIN are influenced and informed by board members who represent a range of service providers, stakeholders,

and consumers from different sectors in the community. Collectively they bridge the various systems and services.

The Economic Institution.

The notion of the Economic Institution originates from the work of Giddens (1980 as cited in Thurston & Vissandjee, 2005). Economic Institutions constitute "any correlated behaviour of agents… that reoccurs under the same or similar conditions" (Dopher, 1991 as cited in Parto, 2003). Economic Institutions relate to the distribution and allocation of goods and services (Darkwa, n.d.). The Economic Institution is interrelated with well-being in many areas (e.g., social services, finances) (Darkwa, n.d.). In the Rockies context, tourism the main Economic Institutions. SIW work in the tourism industry and support the local economy. The tourism industry relies on other social institutions and is interrelated with the social determinants of health.

The Welfare Institution.

The Welfare Institution has been adapted from Kleinman's (1980 as cited in Thurston & Vissandjee, 2005) health systems conceptualization. Kleinman (1978 as cited in Lee, 2000) purported that people deal with three social arenas of health care systems: the popular, the professional, and the folk. The popular arena includes family as well as the social and community networks. The professional arena comprises professional, scientific medicine. The folk arena consists of non-professional healing specialists or approaches (Kleinman, 1978 as cited in Lee, 2000).

The notion of social welfare institutions includes references to the full range of organized activities of voluntary and governmental organizations that "seek to prevent, alleviate, or contribute to the solution of recognized social problems, or to improve the

well being of groups, individuals, or communities" (Darkwa, n.d., p. 14). This institution deals with the well-being and functioning of individuals and communities (Darkwa, n.d.). For example, the Welfare Institutions include the provision of supports to sustain or attain improved quality of life (Darkwa, n.d.). It includes social and health services. Labonte (2003) states that the health of populations is affected by access to services that prevent disease as well as those that maintain and promote health (Labonte, 2003).

Health services.

Health services are social determinants of health and they include preventative, primary health care services, and education programming (WHO, 1998 as cited in Thurston & Wilson, 1998). Health services treat illness and injury, promote and maintain health, and prevent disease (Carlson, 2000). All these services can influence the health of individuals and communities. Health services help to coordinate different components of health for people and groups including their physical, mental, spiritual, and emotional well-being. Health services have many roles including treatment, rehabilitation, maintenance, and enhancement of health.

Health services in the Rockies are influenced by the Canadian health care system. In Canada, there is a publicly funded health care insurance system in place called Medicare (Citizenship and Immigration Canada, 2003). Under this system, universal medical and social welfare programs are available to assist people to meet basic health needs (Chinook Health Region, n.d.) and include medically necessary services (AHW, 2003a). For SIW in Alberta, the Alberta Health Care Insurance Plan is operated by the Department of Health and Wellness and is administered by the Minister of Health and

Wellness (AHW, 2003a). The principles of the health system are based on the Canada Health Act, and include: public administration; comprehensiveness; universality; portability; and accessibility (AHW, 2003a). Health care insurance is available to all citizens of Canada and permanent residents[77] (Citizenship and Immigration Canada, 2003). Health services are delivered through provincial systems, while the federal government sets the standards (Citizenship and Immigration Canada, 2003).

Access and use of health services is a theme in the research study. Participants did not perceive health services to be inaccessible; however, many SIW in the study had not sought medical services during their time in the Rockies. In most circumstances, SIW described minimal interactions with the health system including professionals and services unless they had experienced an imminent health issue. SIW held different knowledge levels in terms of local resources, such as where to access STI testing and information. Generally, there was a disconnection between SIW needs and existing local resources. Hennick et al. (1999) found that migrants or seasonal workers may have particular difficulties in accessing contraception and sexual health services. Reasons cited for their difficulties included a lack of knowledge of local health infrastructure and health services (Hennick et al., 1999).

SIW in the research study identified their sexual risk activities and their potential risks for contracting or transmitting a STI. Examples they described included unprotected

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[77] Newcomers can access health insurance for a fee. They need to apply for a health insurance card as soon as they arrive (Citizenship and Immigration Canada, 2003). Persons moving permanently to Alberta from another part of Canada are eligible for coverage on the first day of the third month following their arrival, provided they register within three months of arrival (AHW, 2003a). Persons moving permanently from outside Canada are eligible for coverage if they are landed immigrants, returning landed immigrants, or returning Canadian citizens. Temporary residents may also be eligible for coverage, provided their entry documents are valid for at least 12 months (AHW, 2003a).

sexual intercourse and sexual activities with partners of unknown STI status. Despite their acknowledgements of potential STI risks, it was uncommon for SIW in the study to use health services for STI testing. As depicted on Table 4.3, there were six participants in the study who described past STI testing experience, and three of these STI tests were conducted in the Rockies and three were conducted in an alternate location. Participants did not typically describe STI testing as a regular component of their sexual health, although one participant did explicitly seek STI testing on a regular basis.

Participants' inconsistent or lack of STI testing experience was similar to findings by Misovich, Fisher, and Fisher (1997). Misovich et al. (1997) highlighted that relatively few people in long-term relationships have been tested for HIV. People in monogamous relationships engaged in unprotected sexual intercourse and often with partners who have not been tested for HIV (Misovich et al., 1997). In general, safer sexual norms applied to those in shorter-term or casual relationships; however, when relationships advanced to longer-term monogamous relationships, these safer sexual norms did not necessarily apply (Misovich et al., 1997).

Anonymity, and the lack thereof, has been identified as a key concern in terms of access and use of health services for those living in sparsely populated areas (Long & Weinert, 1998). Rural people may have a perceived reduction in privacy while residing in small towns and surrounding areas (Long & Weinert, 1998). In the context of this research, many SIW described personal barriers to seeking STI testing in the Rockies and these barriers included concerns with anonymity and confidentiality in the small towns. Hennick et al. (1999) identified that confidentiality was a key issue for seasonal workers and their access to health services. In this regard, the provision of health services such as

on-site medical and testing facilities might violate the workers' ability to use those services if confidentiality concerns are present (Hennick et al., 1999). Seasonal workers identified off-site services as more appropriate for workers to enhance confidentiality and comfort (Hennick et al., 1999). These are important considerations in the development of future initiatives in the Rockies in order to not further marginalize young SIW.

Banff Life, a program run by the BSIN, is one example of a health resource created for SIW and an example of an *Institutional Civil Society* in the Rockies. BSIN is a collaborative network of service providers in the Rockies that collectively addresses community concerns, advocates for SIW, and educates workers in orientation sessions. BSIN's orientation session includes a review of what services are accessible to SIW in order to assist them during their adaptation process and informs them of potential health risks while living in the Rockies. The International Hotel and Restaurant Association (1999) created a guide to help employers in the hospitality industry support workers who may be at risk, or living with, HIV/AIDS. In their guide, they suggest that workplaces should provide prevention education regarding HIV/AIDS on topics including: basic information about treatment, prevention and resources; discussion of prevention methods and provision of protective measures to staff (free or low cost); and discussion of specific risks for those working in the hospitality industry (International Hotel and Restaurant Association & The Joint United Nations Programme on HIV/AIDS, 1999). Specific to the Rockies, Cavicchi et al. (2002) recommended that a mandatory orientation for all new employees, regardless of the company or organization of employment, should be provided in the Bow Valley. However, the BSIN orientation is not mandatory and not all

new employees in the Rockies participate in an orientation session of this nature. Some workplaces alternatively provide an internal orientation.

Participants generally did not access sexual health services in the Rockies. Health services were not described as inaccessible among SIW in the study; rather, they were not used. Participants acknowledged that these harm reduction tools were available through health professionals for free or reduced cost. However, they generally described purchasing harm reduction tools, such as condoms, directly at locations such as local pharmacies. Despite efforts that have been made by key stakeholders in the community to make resources more accessible (e.g., condom blitzes at bars and condoms for free at health clinics) to SIW, the gap between use and availability has not been closed.

Micro-Systems Level and the Social Determinants of Health

The micro-system includes the development of individual characteristics and roles (Bronfenbrenner, 1979; 1986). Under the micro-system levels, eight[78] of the twelve social determinants of health are listed because they are often explored at the individual level; however, they remain interconnected with all the meso- and macro- levels, social institutions, and health determinants.

Social support.

Social support is a determinant of health that is integral to the health and well-being of individuals and communities. Social support includes the social resources that a person has to help them avoid or cope with challenges. Support can take many forms

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[78] While the results from the study would support an exploration of all the social determinants of health in the discussion, this section focuses on the health determinants that emerged from the results.

including emotional, informational, or practical. Support from communities, friends, and family is linked to better health (Canadian Health Network & Health Canada, n.d.). For example, individuals who are connected through social networks report better health outcomes such as longer life expectancy, improved immune functions, and are more likely to incorporate health promoting behaviours (Grzywacz & Fuqua, 2000; Labonte, 2003). Social support can act as a buffer against "stressors that cause one to be more susceptible to disease" (Turnbull, 1998, p. 195). Social networks include the relations and connections that bind people together within communities (Labonte, 2003). These relationships include families, peers, and neighbourhoods (Labonte, 2003). Hawe, Webster, and Shiell (2004) described social networks as the "relationships that exist between groups of individuals or agencies, and the resources to which membership of such groups facilitates access" (p. 971).

SIW who were living away from formal family support systems described their social support in terms of their relationships with friends, peers, sexual partners or significant others, and family. According to Settertobulte and de Matos (2004), young people's abilities to cope with challenging situations are affected by their peer support networks and, as their interactions with their peers improve, their coping skills are enhanced. Social support networks of SIW in the Rockies influence many aspects of participants' lives including the places they socialized and their activities. Settertoboulte and de Matos (2004) also found that specific behaviours are influenced by young people's peer networks including activities such as smoking, alcohol consumption, and sexual risks. Participants highlighted that linking with friends to participate in activities such as partying was easy in the Rockies; however, they described challenges to

participation in activities such as outdoor excursions that required more commitment and planning.

Participants who had been in the Rockies for several years or more described that their relationships had strengthened as they developed stronger social support in the community; however, they also became less likely to seek new friends. The experiences described by participants were similar to findings by Ross, Godeau, and Dias (2000) who assessed the sexual health items from the 2001/2002 HBSC cross-national study. Several factors were found to influence the development of peer networks of young adults, including: peer group size; frequency of contact; and community influence (Ross et al., 2000). Participants described that the Rockies communities provide opportunities to meet a wide variety of people; however, participants cited the transient nature of the population and high mobility of within these communities as factors that limited their ability and desire to develop social networks.

SIW in the study also described their social support in terms of their length of stay in the Rockies. For example, the longer time they spent in the community, the more social support they established. SIW also described social support in terms of their employment. For example, this was reflected in their job satisfaction, the stability in the workplace, and the potential to grow. Participants also described the influence of their living situation on their perceptions of social support. Staff accommodation was described as a method for participants to make friends. However, there were many challenges described by participants while living in staff accommodation such as a loss of independence, personal space, and. In general, people's physical and social environments provided a forum for people to meet and network with others in the community.

Social support as a health determinant was interconnected with housing as a physical environment health determinant for SIW in the study. For example, participants described their relationship status in terms of brief, short, or long-term. For those in long-term relationships, these were often synonymous with cohabitation with their sexual partner. Cohabitation presented a convenient and realistic housing option for those who had experienced a relationship transition to long-term. SIW in the study described that relationships progressed into cohabitation arrangements quickly in the Rockies for many reasons. The lack of affordable housing options, the insufficient income, and the high turnover of roommates were all reasons cited by participants as influencing their decision to cohabitate. SIW may opt to move in with their sexual partners into shared housing. This movement towards earlier cohabitation is consistent with Canadian trends reporting increased cohabitation rates as well as decreased marriage rates, and increased extra marital births (Teitler, 2002). These shifts have been linked to many factors including changes in values such as greater social acceptance (Oppenheimer, 2003), gender roles, economics (Ermisch, 1996; Kiernan, 1996), and modern contraceptive methods (Teitler, 2002).

Social support and good social relations influence important health contributions for young people in terms of emotional and practical resources (WHO, 2003). Settertobulte and de Matos (2004) highlighted that peer referent groups influence social norms of young adults including values, attitudes, preferences, knowledge, and behaviour. In turn, these peer networks influence the health activities of young people including their socially and culturally constructed notions of acceptable behaviours and health practices (Settertobulte & de Matos, 2004). Peer networks have proven to be both

protective for young people as well as risk factors. For example, young people seek acceptance and integration among their peers and these are key components to their healthy development. Those youth who lack social integration may encounter difficulties in attaining a sense of physical and emotional well-being (Settertobulte & de Matos, 2004). This may be influencing the study participants in terms of their social support and connections to their peers, particularly when they first arrive and attempt to integrate into the community. As well, those that they associate with when they first arrive may influence their risk-taking behaviours and opportunities.

Personal health practices and coping skills.

Personal health practices and coping skills are social determinants of health that have a direct influence on the health of individuals and populations (Chinook Health Region, n.d.). Personal health practices and coping skills are "those actions by which individuals can prevent diseases and promote self-care, cope with challenges, and develop self-reliance, solve problems and make choices that enhance health" (Frankish et al., 1996). Personal health practices include eating habits, physical activity, drinking, smoking and sexual behaviour (Canadian Health Network & Health Canada, n.d.). Coping skills include people's abilities to handle life stressors and challenges (Canadian Health Network & Health Canada, n.d.). These health determinants are interrelated with other health determinants (Chinook Health Region, n.d.).

Personal health practices and coping skills are health determinants that are intertwined with all of the study's themes and sub-themes. The sexual activities and associated risks that participants described in the study included personal health practices and coping skills. Sexual risk-taking is a health topic that participants described

throughout the study. Participants described different influences on their risks, either perceived or actual[79], that they engaged in during their sexual encounters. Some of the risks they associated with their sexual encounters included: their level of alcohol consumption or illicit drug use; their sexual negotiation skills; the quantity and type of sexual partner; and the nature of their sexual encounter.

Sexual risk-taking was an underlying topic of discussions with participants and exploring the notion of *risk-taking* is important to this discussion. According to Holton (2004), it is impossible to operationally define *risk* because it is intuitive. Holton (2004) stated, "all we can hope to define operationally is our *perception* of uncertainty" (p. 24). Chicken and Posner (1998) defined risk as hazard[80] times exposure[81]. Risk is a subjective concept, where one person may describe a situation as a risk where another may not (Greene, n.d.). Douglas (1992) identified social settings, norms, and experiences all influence the understanding and construction of risk. These complex concepts are influenced by a multitude of factors (Health Education Unit, 1986). For example, young adults' risk activities change as they develop biologically, psychologically, and socially. Price (2005) indicated that people's calculations of risk are often influenced more by the context in which they occur than by objective assessments. In order to inform people's risk calculations, Price (2005) advocated for skills to critically assess their sexual activities and decision-making processes.

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[79] Risks are either perceived or actual (Price, 2005). Perceived risks relate to people's motives and values; whereas actual risks relates to the types of behaviours people engage in and the subsequent implications of their actions (Price, 2005).

[80] Hazard was defined as "…way in which a thing or a situation can cause harm" (Chicken & Posner, 1998, p. 17).

Participants described the Rockies as an environment that was conducive to sexual opportunities for SIW. Many workers arrive to work in the Rockies and have access to these sexual opportunities at a very young age. Maticka-Tyndale (2001) assessed the sexual health status of Canadian youth (STIs, pregnancy rates, sexual practices) and drew international comparisons with reference to adolescent sexual health indicators. The majority of adolescents in developed countries initiate vaginal intercourse in their teens (Maticka-Tyndale, 2001). The sexual lives of young adults are embedded in what Maticka-Tyndale et al. (2000) describes as the social systems of the dominant culture, which include societal attitudes and values. In the Rockies, SIW are immediately exposed to social systems embedded in the tourism industry. The values and attitudes of people in their work and living environments may influence SIW in terms of which behaviours and activities are appropriate. The reputation of the Rockies is related to a permissive sexual environment; however, participants described varying perspectives on the appropriateness of different sexual activities.

Participants in the study defined *sex* as sexual intercourse. Ross et al. (2000) found that most young people interpret sex in this way. Participants in the research study described vaginal intercourse as their main sexual risk activity; however, they each described other sexual activities in which they participated such as oral sex, manual stimulation, and the use of sex toys. These non-vaginal sexual activities are considered *outercourse* activities and provide people with different forms of sexual pleasuring. Oral

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[81] Exposure was defined as "…the extent to which the likely recipient of harm can be influenced by the hazard" (Chicken & Posner, 1998).

sex in particular was identified as a main outercourse activity that participants had engaged in; however, participants did not necessarily equate oral sex with risks for contracting STIs. Price (2005) indicated that people "fail to appreciate that oral sex carries risks because they believe it is not 'real' or 'proper' sex" (p. 48). Maticka-Tyndale (2001) summarized that much of the published sexual health research has neglected these other forms of sexual activity despite each posing varying degrees of risk for negative health consequences.

Participants generally described engaging in sexual activities with other workers. Sex with tourists was perceived by some participants as a higher risk sexual encounter because of factors such as a lack of awareness of their sexual histories. Many SIW in the study described their typical sexual partner as either a casual, one-night stand, or a short-term sexual encounter(s) while living in the Rockies. These brief or short-term encounters were generally perceived by participants as higher risk activities for negative health consequences. However, several participants had experience in longer-term relationships in the Rockies. They described lower risk perceptions in terms of engaging in sexual activities with longer-term sexual partners than when they had casual or brief sexual encounters. Participants held these beliefs despite describing changes to the use of protective measures as their relationship status progressed from brief to longer-term (e.g., reducing, eliminating, or changing the protective measures they used). Understanding the sexual relationship perspectives and experiences of workers is important towards learning about the context in which their personal health practices and coping skills occur.

Participants identified the Rockies as an environment that is conducive to substance use and party scene activities. Alcohol was the most common substance cited

by participants. Alcohol and the use of other substances has been demonstrated to reduce inhibitions and critical thinking (Desiderato & Crawford, 1995; Graves, 1995; McEwan, McCallum, Bhopal, & Madhok, 1992; Schmid & Gabhainn, 2000). Alcohol use has also been linked to unprotected sex and an increased likelihood of engaging in sexual intercourse after consumption (Guthrie et al., 1996; Kerr & Matlak, 1998). Guthrie (1996) identified that young people are more commonly reporting multiple sex partner experiences and inconsistent use of condoms (Guthrie et al., 1996). Participants in the study identified that they engaged in more sexual risk activities, such as unprotected sexual intercourse, when they were under the influence of alcohol or other substances than when they were sober. However, participants described that their sexual risks decreased as their substance use and party scene activities diminished. These decreases in sexual risks often paralleled other improvements in their social determinants of health including the establishment of social support networks, working in stable environments, and improved housing scenarios.

Participants described several influences on their substance use activities including their housing situation and their peer networks. For many participants, when they first arrived in the Rockies they moved into a staff accommodation arrangement and became immersed in the party subculture immediately. They were often surrounded by other workers who were similarly experiencing the nightlife of the Rockies including excessive consumption of substances and increased sexual risk-taking activities. Ter Bogt, Fotiou, and Gabhainn (2000) conducted a study on cannabis use among adolescent youth. Although this study sample was younger than the participants in the Rockies were, the results were useful in terms of identifying predictors of substance use for young

people. Ter Bogt et al. (2000) identified peer group as the strongest predictor of individual substance use for young people including their attitudes, opinions, and behaviours.

Research on staff accommodation, substance use, and sexual risk-taking among workers in tourist environments is limited; however, there have been studies conducted on college students and their patterns of substance use. Bartholow, Sher, and Krull (2003) assessed changes in heavy drinking for college fraternity and sorority students (n=318). The social environment, such as a fraternity and sorority house, was found to be an important determinant of heavy drinking for college students (Bartholow et al., 2003). Bartholow et al. (2003) described two distinct stages of development including emerging adulthood (college years) and young adulthood (immediately following college years). They summarized that alcohol use increases during emerging adulthood and peaks during early twenties. Associated with heavy drinking during these years are potential sexual health risks (Bartholow et al., 2003). Bartholow et al. (2003) describes the change from emerging adulthood to young adulthood as a process of *maturing out*. The *maturing out effect* has been described as a steady but slow drop in heavy drinking levels following an individual's early twenties (Bartholow et al., 2003). Bartholow et al. (2003) found that a sharp drop in heavy drinking occurred in post college years among men, while women's heavy drinking declined to a relatively low and stable level by college graduation.

Sher, Bartholow, and Nanda (2001) conducted a study on fraternity and sorority membership and specific consequences for heaving drinking later in life. Results indicated that those with membership in sororities and fraternities consistently drank more heavily during college; however, this membership status did not predict post

college levels of heavy drinking. These results indicated that the social environment in which young people live plays a key role in determinant heavy drinking. However, these results did not reflect the substance use changes over time.

Baer (1994) conducted a study on college students' perceived social norms for alcohol use prior to their enrolment and across the first year in college. Similar to the results by Sher et al. (2001), Baer (1994) identified that members of fraternities and sororities rated drinking norms as more extreme; however, they found that there was a decreasing acceptance of drinking reported over the first year of college. These results indicated that young students experience life changes when they enter and when they depart residential settings. These studies on fraternities and sororities demonstrated that it is valuable to gain insight into the social norms of drinking patterns as well as the context in which activities occur. Beyond these factors, it is important to explore additional changes that youth experience such as the notion of maturing out or a diminishing tolerance for extreme drinking patterns over time.

Participants described a range of illicit drug use experiences (e.g., from experimentation through to addiction). Participants described increasing opportunities to participate in sexual risk activities when they were under the influence of alcohol or other substances. Bellis, Hughes, Thomson, and Bennett (2004) conducted a cross-sectional study on visitors to Ibiza between 2000 and 2002 to determine trends in their sexual behaviour, levels of sexual risk-taking, and substance use. Bellis et al. (2004) found that young visitors in Ibiza, Spain had significantly altered their behaviours specific to the consumption of drug, alcohol, and tobacco, as well as with sexual activities while on holiday compared to behaviours they reported at home. Nearly one third of respondents

reported the use of multiple drugs over a one or two-week stay, and just over half reported having sex while on the island (Bellis et al., 2004). Of those who engaged in sex, one quarter had sex without a condom and nearly one quarter had more than one sexual partner (Bellis et al., 2000). Many new users of illicit drugs were also identified (Bellis et al., 2003). Bellis et al. (2003) noted that substance use was linked with the drug use activities in their home of origin; however, the unique nightlife in Ibiza presented tourists with increased drug consumption and experimentation opportunities.

Different sexual risk concerns influenced the sexual activities and decision-making of SIW in the study. For example, participants in the research study were concerned about different risks associated with sexual activities (e.g., pregnancy compared with STI). Hennick et al. (1999) identified six styles of sexual protection and the factors that influenced the use of protective measures. They include: one, *pregnancy prevention*, whereby contraceptive devices are used to prevent pregnancy with little or no concern for STI risks; two, *relationship orientated,* whereby the use of protective measures is determined by sexual relationships; three, *determined*[82]*,* whereby condoms are used to protect against STIs; four, *situational,* whereby protective measures are intended to be used, however actual use could have been affected by external influences (e.g., alcohol or sexual pleasure); five, *passive,* whereby the decision to use protective measures is made by sexual partners; and six, *unconcerned,* whereby protective measures are not likely to be used (little or no worry for prevention of either STI or pregnancy)

[82] Most common style identified in study of seasonal workers (36 percent of respondent).

(Hennick et al., 1999). Understanding these styles of protection could be a useful tool in terms of approaches to tailor sexual health promotion strategies.

Among those participants who had experience in longer-term relationships, they described changes in their patterns of protective measures. These transitions were consistent with other results that revealed attitudes towards condom use became unfavourable as relationships strengthened, as they became more serious, and as an awareness of sexual partners increased (Conner & Sparks, 1996; Misovich et al., 1997). Maticka-Tyndale (2001) added that condom use is most often reported during casual sexual encounters or sex with new partners. Misovich et al. (1997) reviewed research on HIV risk behaviour among people in intimate relationships. Misovich et al. (1997) summarized that heterosexual adults and adolescents are less likely to practice safer sex with close relationship partners compared to those they believe to be casual sexual encounters. Misovich et al. (1997) stated that unprotected sexual intercourse with partners of unknown STI status is an unrecognized source of HIV risk and could pose a major health concern.

All of the participants described more than one sexual encounter in their lifetime. According to Misovich et al. (1997), the notion of one sexual partner is virtually incomprehensible (Misovich et al., 1997). *Serial monogamy*[83] is a relationship trend consistent with some of the longer-term relationship patterns described by participants and has grown in popularity at the same time that marriage rates have decreased and

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[83] The label of realistic monogamy was introduced by Misovich, Fisher, and Fisher (1997) in lieu of sexual monogamy and was defined as a "combination of serial monogamy with occasional instances of sex with a short term sexual partner, often between long-term relationships" (p. 73).

common law rates have increased (Maticka-Tyndale, 2001). Serial monogamy is defined as a series of exclusive relationships over a person's lifetime (Misovich et al., 1997). Youth generally move through patterns of serial monogamy, have one sexual partner for a period, and then move into another (Maticka-Tyndale, 2001).

The progression of a relationship from short-term status to longer-term status often occurs simultaneously with a decrease in safer sexual activities. For people who have experiences with serial monogamy, they may be unaware of their sexual partner's STI status and may be at an increased risk for negative health outcomes as the number of serial monogamous relationships increases. Misovich (1997) demonstrated that people in secure relationships, for instance, believe it is unlikely for a sexual partner to engage in activities that could place them at risk for HIV.

Health professionals working in the field of HIV/STIs have integrated different examples of harm reduction programs to reduce the risks of transmission. HIV/STI initiatives have included an emphasis on educating people about gradients of risk associated with their activities. For example, some activities may pose greater risks for HIV transmission than others. Gaining an understanding of these risks may, in turn, influence behaviour. Through the provision of harm reduction programs and initiatives that describe the gradients of risk associated with activities, service providers felt that people might make informed choices based on their understanding of levels of risks. As well, these programs acknowledge that activities that involve risk are going to occur, particularly among young adults, and they allow people opportunities to express their sexuality. For example, the Canadian AIDS Society (2004) established the HIV transmission model for assessing risk as an approach for people to make informed

choices about their sexual activities. This model is integrated into their transmission guidelines and it includes four main categories of risk, ranging from no risk through to high risk activities (Canadian AIDS Society, 2004). According to this model, oral sex without a latex or polyurethane barrier is classified as a low risk activity for contracting HIV compared with unprotected anal sex and unprotected vaginal sex, which are classified as high risk activities. Other programs have established recommendations to minimize risk. For example, there are three topics (abstinence, be faithful, and use condoms - *the ABCs*) that have been integrated into many international HIV/STI prevention efforts. These initiatives have been met with both praise and criticism as many people continue to take risks regardless of the levels of risk associated with their activities.

In the context of the study, SIW did not explicitly describe their sexual activities in terms of harm reduction or gradients of risk approaches. The results suggest that participants did not process purposefully their sexual activities accounting for levels of risk. However, there were examples of risk reduction strategies that emerged in their discussions. For example, participants described long term, monogamous relationships as a form of lower risk for contracting a STI. In fact, participants who were in long term relationships did not feel that protective measures against STI infections were necessary although strategies to prevent pregnancy were used (e.g., oral contraceptives). Long term relationships could be viewed as a safer sexual alternative in lieu of multiple brief or short term sexual encounters. Through this lens, the transition of a relationship from a brief or short term encounter to sex solely with one partner for a period of time could be viewed as a harm reduction approach. However, a limitation to this HIV/STI prevention

effort is that many young people experience serial monogamy and this may pose health impacts when participating in sexual activities with sexual partners of unknown STI status or sexual history (Misovich et al., 1997).

Another example of a risk reduction strategy suggested by participants in the study was the notion of different risks associated with different types of sexual partners. For example, participants described other workers or locals as relatively safe sexual partners in comparison to tourists, who represented more of a "wild card". As such, their understanding of sexual partners could be influenced by the notion that a tourist is not known in the community, their sexual histories are unknown, and there are no measures to determine if the tourist poses health threats beyond what SIW might feel is acceptable among other workers in the community.

The strategies that SIW used to reduce their sexual risk could also be explored through the lens of resiliency and protective factors, two concepts that were introduced in Chapter One. Protective factors, which include "events, circumstances, and life experiences that can help to protect young people from harm" (Resnick, 2000, p. 1), could have influenced SIW strategies in reducing their sexual and substance related risk activities. Participants described ongoing access to the party scene and an open sexual atmosphere in the Rockies. Despite these opportunities for risk taking, participants also described their resiliency in terms of finding ways to reduce their risk taking. Protective factors may have played a role in buffering against risks they encountered (Mangham, McGrath, Reid, & Stewart, 1995; Resnick, 2000).

Participants highlighted that relationships in the Rockies progress quickly and the use of protective measures decrease after a short time. This was consistent with Fisher,

Misovich, and Fisher (1995 as cited in Misovich et al., 1997) who found that those in monogamous relationships of at least one-month duration were less likely to use condoms than those who were in briefer relationships, or those who had sexual intercourse with someone outside of the relationship. As condom use decreased and relationships lengthened, perceptions of risk for HIV or STI have been found to decrease (Zimmerman & Olson, 1994 as cited in Misovich et al., 1997). Finally, changes in the use of protective measures by participants (e.g., condoms to oral contraceptives) during relationship status transitions were consistent with results by Misovich et al. (1997). Misovich et al. (1997) found that many couples had switched from condoms to birth control pills without HIV testing as the relationship status progressed. They also found that less than one third reported safe[84] sexual behaviour with their current relationship partner (Misovich et al., 1997).

Seasonal variation influenced the migratory settlement process for SIW in the Rockies. This included fluctuations in the number of people seeking work and the number of job opportunities at different times of the year. The peak tourist seasons are summer and winter. The Town of Banff (1998 as cited in Scott, 2005) reported that the Rockies typically has as many visitors in the three month summer season as it does in the five-month winter season. Parallel to these seasonal influxes of visitors and workers are variations to the party subculture in the Rockies for workers. Past studies have reported increased sexual activities during the busier tourism seasons. Ford (1990 as cited in Hennick et al., 1999) conducted a comparative analysis of the sexual lifestyles of workers

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[84] 'Safe' includes the use of condoms as a protective measure.

in the tourist industry in Britain. Patterns of seasonal sexual variations were reflected in the increased demand for family planning services, such as emergency contraception and terminations of pregnancy services, during the busy tourism months (Ford, 1990 as cited in Hennick et al., 1999). The seasonal patterns of sexual activity for SIW in the Rockies have implications for sexual health services and interventions.

The personal health practices and coping skills of SIW in the Rockies are intertwined with the other social institutions and health determinants. Sexual risk-taking is influenced by many factors including the substance use, relationship status, seasonal variation, and perceptions of associated risks. Each of these factors explored in this section incorporates other components of the socio-ecological framework. The health practices and coping skills of SIW are integral to their sexual health.

Education.

Education is a social determinant of health that has a direct association with the health of populations. Education includes equipping people with the information and skills they need to deal with challenges in daily living and to participate in the community (Frankish et al., 1996). Education plays a role in increasing people's capacity to make informed choices and to take action to improve their health (Chinook Health Region, n.d.; Labonte, 2003). As people gain more education, they report improved access to employment, opportunities, sense of control, and income (Chinook Health Region, n.d.; Labonte, 2003). People who have more education are often healthier and live longer (Chinook Health Region, n.d.). Not all education is based on formal learning settings and Labonte (2003) specifies that 'critical learning' in real life scenarios is a key

component towards increasing the understanding of how health is shaped both personally and socially.

Participants all held the perception of the Rockies as the STI capital of Canada. Despite this common perception, there was a lack of direct STI testing and treatment experiences. Participants also demonstrated limited STI knowledge. For example, they were generally aware that unprotected sexual intercourse placed them at risk for negative health outcomes; however, they were unaware of the extent to which they were at risk or what factors enhanced their risks. When participants were probed for specific examples to demonstrate their understanding of STIs (e.g., types of infections, symptoms, modes of transmission, and treatment), most were limited to general knowledge. Participants consistently described their risk perceptions related to intercourse activities. Their sexual actions also depicted an underlying sense of invulnerability.

Participants described instances when they engaged in unprotected sexual intercourse (sexual intercourse without a condom) despite their knowledge of the potential risks. Price (2005) highlighted that critical thought, a process that evolves through stages and dimensions to influence knowledge into action, "may not invariably lead to the adjustment of established behaviours, it does serve to alert the individuals to choices being made and risks taken" (p. 49).

Income and social status.

Income and social status are the most important determinants of health influencing the well-being of populations (Chinook Health Region, n.d.; FPTACPH, 1999; Labonte, 2003). Income and social status relates more to the relative distribution of wealth, rather than the quantity of wealth (Frankish et al., 1996). The greater the gap

between the income distribution in society, the greater the influence on health (Canadian Health Network & Health Canada, n.d.). Health is influenced by the control people have over their life, their health, and their ability to take action (Frankish et al., 1996). SES, which was discussed above under macro- and meso- systems levels, has been found to influence the health of populations. SES is directly linked with health behaviours including smoking, dieting, and alcohol consumption and it has been associated with psychological characteristics such as self-esteem and coping abilities (Boyce & Dallago, 2000). Specific to young adults, SES has been identified as a major social basis for inequality (Boyce & Dallago, 2000).

In terms of income earnings for those in the Rockies, residents in the towns of Banff and Canmore have reported lower average income earnings[85] when compared to the province of Alberta (Statistics Canada, 2004). The average income earnings for Banff were reported as the lowest of them all[86] (Statistics Canada, 2004). Participants linked the social determinants of health to income and social status by describing that social hierarchies exist in the Rockies and people's ability to participate in certain peer networks are influenced by their income in terms of where they can afford to hang out. Several other participants described the lack of opportunities to save money in the Rockies. Participants in the study described opting for staff accommodation in order to make ends meet versus the high cost of living in the community in shared accommodation.

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[85] Income earnings include those working full time for one year and for those working with all types of earnings (Statistics Canada, 2004).
[86] Compared to Canmore and Alberta (Statistics Canada, 2004).

Maticka-Tyndale et al. (2000) identified that social disadvantage, defined in their study by SES and labour force participation, were both associated with more permissive sexual behaviours including earlier age of first intercourse and an increased number of reported sexual partners among youth. However, permissive sexual behaviours did not mean a lack of protective measures. For example, those who reported the lowest household income quintiles were also those who were the most likely to report condom use during their last sexual intercourse (Maticka-Tyndale et al., 2000). Grzywacz and Fuqua (2000) cautioned that SES needed to be assessed in the context of other health determinants. A more comprehensive understanding of the multiple dimensions and levels of SES is needed in order to account for the sexual health and related issues for SIW in the Rockies (Grzywacz & Fuqua, 2000).

SIW described varying subcultures in the Rockies that related to their social status in the community. When they first arrived, they typically entered low paying positions and had access to the local party scene. Over time, SIW described opportunities to work in employment positions that provided higher levels of income and or job stability, along with improved accommodation and social supports in the community. Participants described changes in their participation in the party scene and improved connections with the local community over time. In general, SIW in the study engage in risk activities to a lesser extent over time. Their decreased participation in the party scene and increased connection to local community was reflected in reduced risk experiences and increased quality of life.

In terms of social status for SIW in the Rockies, travelling and re-establishing themselves in a new community meant that they may not have experienced the same

social status, privilege, or position in society that they held in their place of origin. Many SIW described their social status in terms of the length of stay in the community (newcomer compared to an old timer) and their immersion or acculturation processes in the community (insider or outsider). As SIW settled into life in the Rockies, their sense of social status and identify shifted and influenced their evolving self perceptions while living in the Rockies context. The arrival in the Rockies meant many SIW needed to settle into their new surroundings and deal with the varying changes in income and social status on all levels including the micro-, meso-, and macro-systems levels.

These discussions also highlight the interconnected components within the socio-ecological framework and among the social determinants of health. Income and social status are connected to the physical environments, such as housing, for SIW along with their social environments, such as the places they socialize in the community. The income of SIW also influences their accessibility to the different adventures available in the Rockies. Personal health practices and coping skills within the social and physical environments have a direct influence on health and are linked to income and social status. These results warrant further research to explore specific links between the sexual activities of SIW and income and social status.

Employment and working conditions.

Employment and working conditions are social health determinants. Meaningful employment, work stability, and supportive work environments are conducive to health (Frankish et al., 1996). Health status has consistently been associated with employment and working conditions (Grzywacz & Fuqua, 2000; Labonte, 2003). Those who are employed tend to be healthier, particularly when they have more control over their

working conditions (Canadian Health Network & Health Canada, n.d.). Labonte (2003) found that those who reported more control over their work and less stress-related issues also reported better health than those who reported unemployment and underemployment. Grzywacz and Fuqua (2000) highlighted that working in a supportive environment, having job prestige, experiencing stability in the workforce, and the potential for growth were all employment factors that were linked with better health outcomes. Studies have demonstrated that supportive work milieus are linked with decreased chronic illness (Ferrie, Shipley, Marmot, Stansfeld, & Smith, 1998) and improved health behaviours (Wickrama, Lorenz, Conger, Matthews, & Elder, 1997).

Participants in the study experienced a variety of employment opportunities and the service industry represented one of the largest industries in the Rockies. SIW entered into a system with many factors that influenced their health. According to the Job Resource Centre (2005), the hospitality industry is the largest employer in Bow Valley. The service industry[87] represented the majority (77 percent) of all positions, with the largest numbers of jobs reported in food and beverage services, housekeeping, and hotel services (Job Resource Centre, 2005). In addition to the variety of employment positions, there are hierarchies inherent in each work environment and SIW are often at the bottom of the scale, with people entering into low paying positions with varying levels of stability. The high overturn of workers can also lead to concerns of job security and, combined with the seasonal variation of the Rockies, can influence SIW as they adapt. As

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[87] The service industry positions were: food and beverage (30 percent); hotel, including guest services and cleaning (31 percent); sales and services (12 percent); travel and tourism (4 percent) (Job Resource Centre, 2005).

indicated in the results, participants can enter into work scenarios that offer quick advancements; however, many enter into positions that are low paying, not challenging, and lead to changing employment positions and work responsibilities frequently over time.

There are abundant work opportunities in the high tourist seasons of summer and winter, and fewer opportunities in the slower spring and fall seasons as the number of tourists' declines. According to the Job Resource Centre (2005), which has offices located in Banff and Canmore, the highest recorded number of job seekers in the Bow Valley was in the winter season (February 2005). This was compared with the highest number of job orders recorded in the summer season (July 2005). Thus, the greatest demand for employees in the Bow Valley was during the summer tourist season (July 2005) when the number of job orders rose to 21 percent and the number of job seekers decreased to 12 percent. During the winter season (February 2005), there was a reversed trend when the number of job seekers increased to 21 percent and the number of job orders decreased to 11 percent (Job Resource Centre, 2005).

For those SIW who arrived in the Rockies for the first time, they were confronted with a new environment in which they had to find work and enter into a new employment position. As a result, they are often confronted with a lack of awareness of overall supports that are in place and past studies, such as the work of Hennick et al. (1999), have identified that sexual risk activities were correlated to work in the tourism trade. First time workers in Hennick et al. (1999) experienced the greatest difficulties in accessing sexual health services and contraceptives as well as lacking local knowledge of facilities and health services available. New workers are likely to be those that also require the

most support in terms of connecting with supports that are in place. As described in the migration section of this chapter, the initial settlement stage is often the most challenging for people and income and their social play important roles in their processes. Those SIW who had been in the Rockies for an extended timeframe had built stronger connections and improved their social status in the community. They described that their sexual activities had changed over time and they reported fewer sexual partners, an increase in their longer-term relationships, and a reduction in alcohol and substance use.

Social environments.

The social environment is a determinant of health that includes the "strength of social networks, social stability, recognition of diversity, safety, good working relationships within a community, region, province, or country" (Canadian Health Network & Health Canada, n.d., p.1). Social environments that are supportive help to reduce and prevent potential risks to good health (Canadian Health Network & Health Canada, n.d.). Social environments are influenced by the values, norms, and rules of society (Labonte, 2003; Thurston & Wilson, 1998). Supportive social environments influence the stability of the community and cohesive settings have been found to be more conducive to good health outcomes (Labonte, 2003).

An overarching theme that emerged from all participants in this study was the unique social context of the Rockies. The descriptions participants provided in terms of the characteristics of the Rockies that lured them were rich and depicted that there was something almost magical (the magic of the Rockies) about their experiences. Participants described how, despite the obstacles they faced when they arrived in the Rockies, there was something open and accepting in the environment that provided many

with an immediate sense of community. However, not all participants adapted as quickly as others and for some, they were immediately faced with multiple issues as they attempted to adapt and fit in with the diverse communities.

In addition to the characteristics that drew SIW in from around the globe, participants also had access to adventures that ranged from the social and nightlife scenes, to outdoor excursions and work opportunities that transcended their skills and education in some instances. Opportunities were perceived as "at your doorstep" when they arrived. Participants were able to engage in different aspects of the social milieu depending on their resources (often limited), their access, and their adaptations. This study has demonstrated that when SIW first arrive in the Rockies, they are outside of their normative frameworks. Many factors influence how they adapt to the Rockies context. For some SIW in the Rockies, the initial decision to move to the Rockies shifts from a temporary resettlement adventure to a permanent home in a dynamic community. For others, the social environment provides temporary opportunities for adventure. SIW remain in the communities for varying time. Regardless of their duration in the Rockies, the social environment of the Rockies provides a unique context in which SIW can grow.

Summary

The Rockies presents unique contexts in which young SIW are exposed to sexual and non-sexual adventures. Young SIW who were lured to the Rockies joined thousands of other young workers who had similarly made life changes as they sought to squeeze the most out of their experiences. Participants described their adaptation to the Rockies as an important process that enabled them to find a sense of belonging. Compared to their sexual and substance use activities prior to arriving in the Rockies, participants engaged

in increased risks when their first arrived. The Rockies context provided endless access to the party scene, substance use, and sexual risks. Over time, and with improved connections to social support and health systems, SIW described a process of settling into the life in the Rockies, establishing connections in the community, and decreasing their sexual and substance activities.

The migratory settlement model provided a lens through which to explore their transition processes of SIW as they adapted to the Rockies. The SIW in the study were influenced by factors at all systems levels and the socio-ecological framework provided a lens through which to explore the interconnected elements of their health. Population health's social determinants of health provided a useful framework through which to describe the main determinants that influenced their well-being over time. The next chapter will include a discussion of the five action strategies outlined in the 1986 Ottawa Charter for Health Promotion. Finally, there is a review of the study's strengths and limitations. The thesis concludes with recommendations for future research.

CHAPTER SIX: STRATEGIES & IMPLICATIONS

This chapter starts with an overview of the health promotion action strategies as outlined in the 1986 Ottawa Charter (WHO, 1986). Then, there is a review of the study's strengths and limitations. Finally, this chapter concludes with an overview of recommendations for future studies.

Sexual Health Promotion – Strategies for Action

The Ottawa Charter for Health Promotion, created in 1986, defined health promotion as "the process of enabling people to increase control over, and to improve, their health" (WHO, 1986, p. 1). Health promotion includes physical, mental, and social well-being of individuals and communities. In order to achieve well-being, individuals or groups "must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment" (WHO, 1986, p.1). The prerequisites for health are "peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity" (WHO, 1986, p. 1). Equity in health, advocacy for health, and mediating between the different interests, are key aims of health promotion (WHO, 1986).

Figure 2.0 is the Ottawa Charter for Health Promotion Model (WHO, 1986). The Ottawa Charter was created as a call for action to achieve Health for All by the year 2000 (WHO, 1986). Figure 2.0 incorporates the three main health promotion activities of advocating, enabling, and mediating (WHO, 1986).

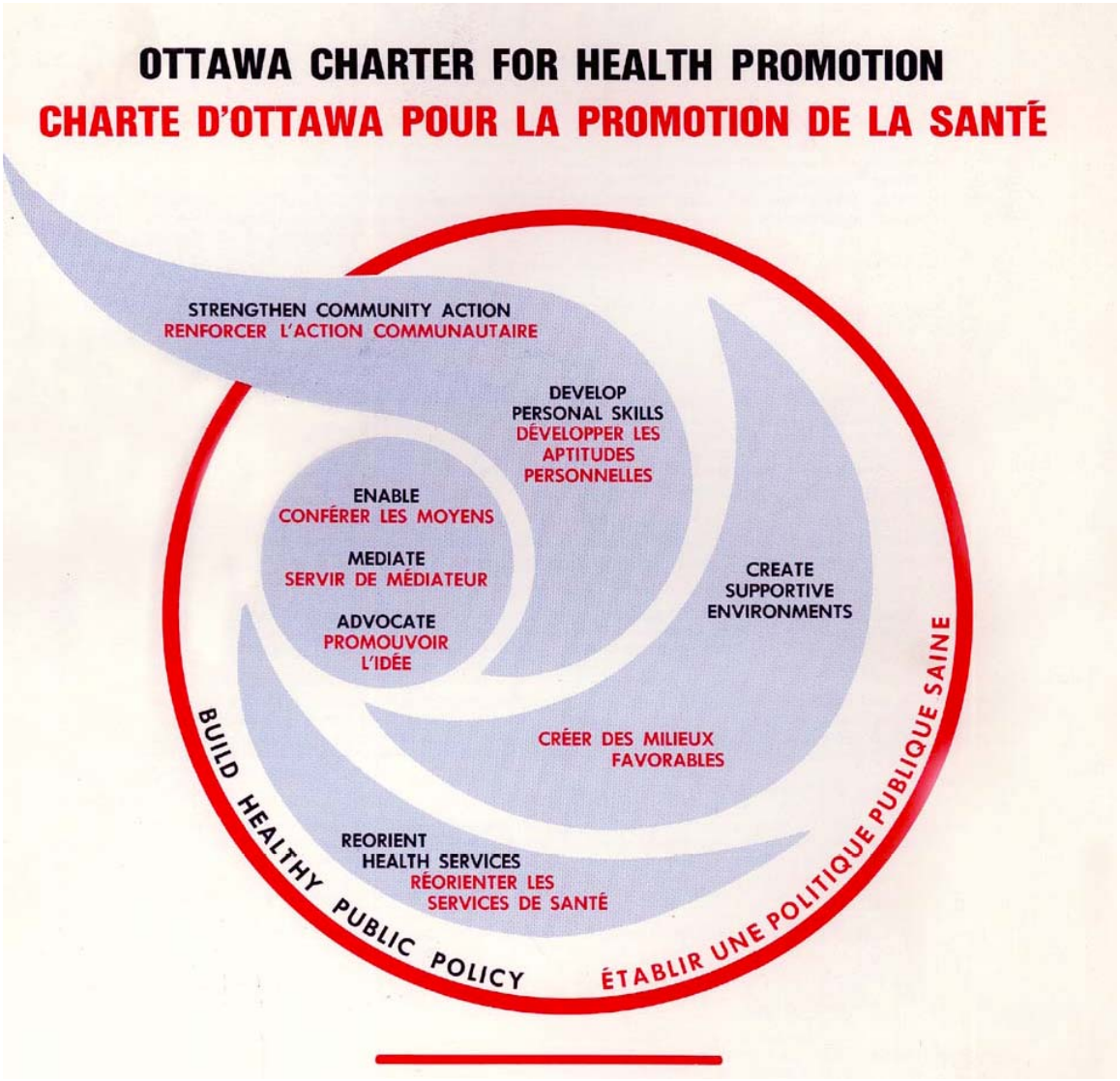

Figure 2.0: The Ottawa Charter for Health Promotion Model[88] (WHO, 1986)

[88] Note: From "The Ottawa Charter for Health Promotion" by WHO, 1986, accessed March 31, 2006 at http://www.who.int/healthpromotion/conferences/previous/Ottawa/en/index4.html. Copyright 1986 WHO.

The Ottawa Charter Model depicts the five action strategies for health promotion, which include: building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and reorienting health services (WHO, 1986). These action strategies are interrelated with the complex interactions of individuals, groups, communities, and populations (McLeroy et al., 1988). Health promotion is synergistic with a population health approach (Health Canada, 2002a).

Mullhall (1996) conducted a global review of sexual behaviour, disease, and health promotion among international travellers. Mullhall (1996) described sexual health promotion strategies as being in their infancy in tourist destinations. Ramella and Bravo de la Cruz (2000) used a case study method in their assessment of a community-based adolescent sexual health promotion in Peru. Although their study did not focus on tourists in Peru, it focused on adolescent sexual health promotion. They acknowledged the need for adolescents in the design, implementation, and evaluation of issues that concern them. The promotion of sexual health among young adults was described as one of the most challenging ventures in public health (Ramella & Bravo de la Cruz, 2000).

In the Rockies, there are many factors implicit to the tourist destination that limit the integration of health promotion strategies, such as: the mobility of the tourist population; the large number of workers, many of whom are transient; and the broad range of people living within the tourist context. Despite these challenges, the importance of sexual health promotion approaches for young SIW has never been more critical. Key issues outlined by Wight (1998) included: youth are engaging in sexual risks earlier in life; the rates of STIs are increasing; and protective measures are used inconsistently

despite people's knowledge of potential negative health outcomes. These issues may be influencing SIW in the Rockies. The enhancement and integration of sexual health promotion strategies that are responsive to the unique Rockies context will help to create a supportive tourist milieu for individuals and communities. Health promotion strategies in the Rockies should to be responsive to the particular challenges and diverse needs of young adults in the dynamic tourism destination. The next sub sections review the five main action strategies for health promotion in the Rockies context.

Building Healthy Public Policy

Building healthy public policy[89] is the first action strategy for health promotion identified in the Ottawa Charter (WHO, 1986). Healthy public policy "goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health" (WHO, 1986, p. 2). Health promotion policy incorporates "diverse but complementary approaches including legislation, fiscal measures, taxation, and organizational change" (WHO, 1986, p. 2).

The Adelaide Conference on Healthy Public Policy in 1998 focused on strategies for healthy public policy action (WHO, 1998). The Adelaide Conference identified the main aim of healthy public policy as the creation of supportive environments in which people can lead healthy lives (WHO, 1998). Healthy public policy includes "people's involvement, cooperation between sectors of society, and primary health care as a

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[89] Public policy was defined by Howlett and Ramesh (1995) as "a set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals and the means of achieving them within a specified situation where those decisions, should, in principle, be within the power of those actors to achieve" (p. 5). Public policy is composed of interrelated components and actors.

foundation" (WHO, 1998, p. 1). Healthy public policy requires that the different sectors, including levels of government, business and corporate sectors of society, nongovernmental bodies, and community organizations, work collaboratively to promote people's health (WHO, 1998). The building of healthy public policy "establishes the environment that makes the other four [health promotion action strategies] possible" (WHO, 1998, p.1). Healthy public policy needs to "assign high priority to underprivileged and vulnerable groups…a healthy public policy recognizes the unique culture of indigenous peoples, ethnic minorities, and immigrants" (WHO, 1998, p. 1).

Health promotion policies in the Rockies context need to be meaningful and relevant to the experiences of those living, working, and visiting this tourist destination. In order to be effective, the programs and policies in the community should be informed by the different sectors including SIW, community stakeholders, and businesses as well as the governmental sectors. One of the fundamental components to building healthy public policy is collaboration and development of partnerships (WHO, 1998). Finding approaches to improve collaboration between various levels of government and the different systems and organizations in place, along with clarifying the roles and responsibilities of different political bodies, are integral components to building on this action strategy for health (WHO, 1998).

SIW are one group in the Rockies that may be an underprivileged and vulnerable group. The public policies that SIW encounter in the Rockies need to be supportive of their experiences. SIW encounter various systems as soon as they arrive and attempt to settle into the local communities. Their individual and group experiences are influenced by different factors, including: their country of origin (e.g., language barriers, health

insurance policy); their length of stay (e.g., regulations and rules for work permits/ visas); and their employment experiences (e.g., working conditions, wage, contract). Those SIW who arrive in the Rockies from other countries of origin encounter some different policies than those who are Canadian-born. For example, new residents or temporary workers need to deal with policies and systems surrounding work permits, health insurance, and the rules and regulations in the new context.

The key stakeholders in the Rockies communities need to examine the impact of public policy on SIW. Ideally, the public policy will become responsive to the issues that may disproportionately influence the health of workers. Addressing these issues will help to build on the concept of responsible tourism where local communities, along with organizations and all levels of government, are working collectively to provide responsive and appropriate policies and programs for all people within its borders.

Creating Supportive Environments

Creating supportive environments is the second action strategy for health promotion identified in the Ottawa Charter (WHO, 1986). The Ottawa Charter outlined the "inextricable links between people and their environment constitutes the basis for a socio-ecological approach to health" (WHO, 1986, p. 2). Integral to this approach is the reciprocal notion of taking care of each other including other individuals, communities, and the environment (WHO, 1986). Health promotion "generates living and working conditions that are safe, stimulating, satisfying and enjoyable" (WHO, 1986, p. 1).

Epp (1986) elaborated on this action strategy by stating that the creation of healthy environments "means altering or adapting our social, economic or physical surroundings in ways that will help not only to preserve but also to enhance our health. It

means ensuring that policies and practices are in place to provide Canadians with a healthy environment… It means communities and regions working together to create environments which are conducive to health" (p. 7). In 1991, the Sundsvall conference on supportive environments for health was held (WHO, 1991). This conference called on nations around the globe to engage people in making environments more supportive to health (WHO, 1991). This action strategy includes reference to health on "physical, social, spiritual, economic, and politics dimensions" (WHO, 1991, p. 2). Two basic principles identified at the Sundsvall Conference include equity and public action in creating supportive environments (WHO, 1991).

The creation of supportive environments for workers can be enhanced by sexual health resources that are tailored to SIW and built directly into the community action plans and health service infrastructures in the Rockies. For example, the Town of Banff (1998) has integrated the pillar of a "balanced community" into their community plan. Under this pillar, the town acknowledged that "tourism will continue to be the driving force of the local economy and it is essential that appropriate tourism activities be accommodated within a balanced social and environmental framework" (Town of Banff, 1998, p. 18). Key issues identified in the Town of Banff (1998) plan, that are consistent with issues identified by participants in the study, include: affordable housing; community services; stable labour force; and facilities and services to meet basic needs of residents and visitors (Town of Banff, 1998).

A primary goal identified in the Banff community vision was to ensure that medical, educational, emergency, protective, and social services were maintained and built upon for the community and visitors (Town of Banff, 1998). Under the auspices of

community and visitor services, they identified that services need to be geared to local residents along with the over three million annual visitors (Town of Banff, 1998). Thus, identifying and integrating approaches that acknowledge the diversity of the populations who access the Rockies for tourism, travel, work, and lifestyles can create supportive environments.

The Rockies communities have the reputation of the STI capital of Canada (Bartlett & Binelli, 1999). This reputation has many negative connotations and is one area that the community could work towards addressing. The Rockies communities could work collaboratively to address this issue. Ideally, the Rockies could become a very proactive tourist destination that actively promotes the sexual health of those working in the tourism industry. The Rockies could take a leadership role in making the communities oriented towards health and wellness. This does not mean they would devalue or diminish the lure of the Rockies in terms of providing access to adventure; however, it could enhance the supportive environments specific to sexual health context. Through this approach, the Rockies could actually build on the momentum that has been gained through all the media and word of mouth publicity related to sexual risk-taking and provide programs, services, and supports to address these concerns.

An example of how the Rockies could address the issues and shed some light on tourism destinations would be to compare the Rockies to similar international tourism destinations. This may prove to be a more valid comparison in terms of sexual risk taking and STIs than to compare to other communities in Canada. This approach could address the moral panic that has been created by *Rolling Stones* magazine and further perpetuated by the media coverage surrounding the reputation as the STI capital of Canada. The rise

in STI rates in Canada and in Alberta is an issue that warrants attention. However, it is also important to view these issues in comparison to similar context where people arrive from around the globe with the intent to find and participate in adventures.

If an international comparison were conducted between similar indicators from the Rockies with other renowned travel destinations, the Rockies may in fact emerge as one of the safest travel destinations. For example, the rate of STIs/HIV in Canada is not as high as the rates in other countries that have well established tourist destinations, such as Thailand and the Caribbean. Comparing the Rockies to other tourist destinations could be useful in terms of establishing relative risks of this tourist destination in comparison to others.

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as Thailand and the Caribbean. Comparing the Rockies to other tourist destinations could be useful in terms of establishing relative risks of this tourist destination in comparison to others.

Forsythe, Hasbun, and Butler de Lister (1998) conducted a study in the Dominican Republic (DR) on tourism, HIV/AIDS, and prevention campaigns. Forsythe et al. (1998) summarized results from six data collection instruments[90] that were administered to participants including tourists, hotel workers, and commercial sex workers in the DR. One of the main study objectives was to assess how tourists are likely to react to HIV prevention campaigns (Forsythe et al., 1998). The majority of tourists (85 percent) would respond positively to HIV/AIDS prevention campaigns and would not be discouraged from visiting a country because of prevention initiatives (Forsythe et al., 1998). Those deemed most at risk were those who were also the most receptive to prevention efforts (Forsythe et al., 1998). The sexual health of tourists is only one area where supportive environments could be enhanced; however, this could definitely create a foundation on which to build further initiatives in the Rockies.

Strengthening Community Action

Strengthening community action is the third action strategy for health promotion identified in the Ottawa Charter (WHO, 1986). The Ottawa Charter outlined that "health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies, and implementing theme to achieve better health"

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[90] Survey instrument with tourists, n=738; survey instrument with hotel workers, n=239; survey instrument with entertainment staff, n=100; interviews with managers, n=8; survey instrument with commercial sex workers, n=381; focus group participants, n=38.

(WHO, 1986, p. 2). Integral to this action strategy are the notions of empowerment, ownership, and community control (WHO, 1986). Community development is also central to this action strategy and draws on people working collaboratively to address issues that are meaningful and relevant to their lives. To strengthen the action of communities, "community development draws on the existing human and material resources in the community to enhance self-help and social support and to develop flexible systems for strengthening public participation and direction in health matters" (WHO, 1986, p. 2).

Agencies and service providers in the Rockies are committed to the health of those in the community. Stakeholders in the Rockies have identified an interest in strengthening their community action. For example, community advocates are interested in using the results of this research towards enhancing services and approaches to better support the SIW in the Rockies. The results of the research were shared with key stakeholders in the Rockies communities in order to be informed of the experiences of participants in the study and to determine how services and programs can be tailored to address some of the gaps and to honour the successes in the community. Stakeholders have identified that the research will play a role in several areas including: program planning and implementation; integration of results into developing proposals for program initiatives, funding, and reporting; validation of the need for sexual health service and interventions; and identification of collaborative partnerships that could strengthen the action of the community in supporting the health of those in the Rockies communities.

This community-based approach to sharing the study results built on the notion of public participation, one of the tenets outlined in the Epp Framework for health promotion (Health Canada, 1986). It was an important follow-up strategy to ensure the research results were connected back to the community and had an opportunity to be integrated into future initiatives. The encouragement of public participation means community members in the Rockies are empowered to effect change and improve their health. Partnerships with community partners, residents, and the tourism industry are a central area for future health promotion.

Developing Personal Skills

Developing personal skills is the fourth action strategy for health promotion identified in the Ottawa Charter (WHO, 1986). The Ottawa Charter outlined that health promotion includes "personal and social development through providing information, education for health and enhancing life skills" (WHO, 1986, p. 3). Through development in these areas, people are able "to exercise more control over their own health and over their environments, and to make choices conducive to health" (WHO, 1986, p. 3). The development of personal skills includes both individual level interventions as well as broader system level approaches.

SIW need to be equipped with the skills to adapt to the opportunities and stressors that accompany their eclectic Rockies experiences. Personal health practices and coping skills are determinants of health that influence the activities of SIW. Sexual and substance-use activities for SIW in the Rockies can include different levels of risk for negative health outcomes, such as STIs/HIV. There were many factors outlined that influenced the sexual decision-making of SIW, including: party scene and nightlife;

sexual encounters and relationships; and protective measures. SIW could be equipped by service providers with resources and skills that enable them to make informed, healthy choices about their sexual health. Resiliency and protective factors could also be integrated into approaches to develop and enhance the personal health practices and coping skills of SIW. Protective factors could include skills and tools to better equip young SIW with tools to cope and adapt to life in the Rockies context. Participants described approaches to reduce risks, such as longer term relationships with sexual partners who are known in the community, as well as reflections on who may be more 'risky' for negative health outcomes, such as a tourist with an unknown sexual history. A component towards enhancing resiliency among young SIW in the Rockies is to reflect on the assumptions and beliefs of SIW regarding the Rockies STI reputation and to determine what information is based on fact and evidence compared with what is based on popular media and fiction.

Health promotion strategies need to enable workers to make informed choices in the context of their sexual encounters. Information, education, and interventions to date have been insufficient in enacting behaviour changes for SIW in different sexual situations. As such, there is a gap between knowledge and behaviour among SIW. For example, among participants who were aware of the potential for negative health outcomes associated with certain sexual activities, there was not always a direct translation into safer sexual practices. Guthrie et al. (1996) identified that the connection between knowledge of HIV/STI and actual self-protective sexual behaviour for young adults is not clear. Workers may not be equipped with the skills to negotiate safer sexual activities in certain contexts such as when they participate in excessive alcohol

consumption and when their relationships transition to longer-term. Broad sexual health interventions are needed to address factors beyond the biomedical and physical sexual health issues of young SIW. Strategies could focus on building SIW skills in sexual negotiation and decision making in social contexts such as bars, nightclubs, and staff accommodation. Interventions need to go beyond the provision of sex education and health information to include approaches that will translate into practice for SIW.

Hennick et al. (1999) recommended that sexual health interventions include topics such as feelings, arousal, foreplay, making choices, and confidentiality as well as the use of harm reduction tools (e.g., condoms and other contraceptive resources). Social contexts, including where risks occurred among SIW, influenced their use of, and perceived need for, protective measures. Watney (1994 as cited in Warr, 2001) highlighted that if safer sex strategies are to be effective, they need to be "culturally intelligible to people for whom they are intended" (p. 242). Warr (2001) considered the problems and pleasures of romance in safer sexual health promotion strategies. Warr (2001) suggested that sexual health strategies need to be informed by more than the notions of risk and risk-taking. Sexual health strategies could incorporate concepts such as love, pleasure, and desire along with safer sexual negotiation (Warr, 2001). The integration of these constructs could be influential in tailoring approaches that are relevant and meaningful to young people (Warr, 2001). These factors need to be integrated into initiatives that enhance the personal health practices and coping skills of SIW.

Some participants described their sexual encounters evolving to longer-term relationships. Subsequently, the use of protective measures often changed (e.g.,

diminished or changed). These shifts in the use of protective measures were described by many participants as occurring without knowing the sexual history or STI status of their sexual partner. Approaches to address the shifts in relationship status and the implications on other areas of health could be a focus of future intervention efforts. Topics that could be included in health promotion strategies to enable young workers to negotiate safer sexual practices include: discussions with sexual partners on beliefs about changes to the use of protective measures (e.g., when and how should protective measures be stopped or changed); discussions with sexual partners about topics such as monogamy and relationship status; identification of factors that are important to consider with sexual partners (e.g., sexual history, STI status). Overall, approaches that seek to increase the use of condom and improve the use of STI testing and resources need to be tailored for those who are sexually active (Misovich et al., 1997). These approaches need to be combined with discussions on how to address issues such as violations of monogamous relationships and the window period for some STIs (e.g., HIV) (Misovich et al., 1997). Relationship discussions are integral to the development of personal skills for SIW in the Rockies.

Substance use and the accessible party scene in the Rockies is a significant factor that influences the lifestyle and activities of workers. For those who are active in the social scenes of the Rockies, binge drinking and excessive partying have been identified as two key areas of concern when it relates to sexual decision making. The local bars and nightclubs tailor to SIW by providing alcohol at reduced cost during evenings (e.g., industry nights). Weitzman, Nelson, and Wechsler (2003) identified factors that were associated with the uptake of binge drinking in a random sample of full-time

undergraduate students (n=1,894) from participating colleges (n=119) in the US. Weitzman et al. (2003) identified that the provision of discount pricing of alcohol was an environmental risk factor for binge drinking among college students. Turrisi, Wiersma, and Hughes (2000) examined drinking beliefs that influence binge-drinking consequences among freshman students (n=266) in the US. Turrisi et al. (2000) identified that heavy episodic binge drinking has been associated with higher incidences of unplanned sexual activity. The development of personal skills for SIW in the context of their sexual encounters should incorporate issues that are inherent to the nightlife subculture, including the excessive consumption of alcohol, and the use of illicit substances.

Norman, Bennett, and Lewis (1998) explored the motivational and attitudinal factors underlying binge drinking in a sample of undergraduate students (n=136) through the theory of planned behaviour (TPB). Norman et al. (1998) suggested that formal education programs need to engage youth in a dialogue on what constitutes appropriate and inappropriate drinking behaviour. Binge drinking and frequent alcohol consumption activities are engrained in the social environment of the Rockies and initiatives need to target more than one area in order to address the underlying issues that perpetuate the risks for youth. Weitzman et al. (2003) referred to the notion of *wet* environments which include "friendship networks and affiliations within which binge drinking is common and endorsed, social, residential, and marking surroundings in which drinking is prevalent and alcohol easy to access and cheap" (p. 33). Norman et al. (1998) suggests introducing measures to reduce the emphasis on alcohol consumption in order to reduce intoxication and binge-drinking behaviours. These approaches also need to acknowledge the role of

peer influence on the pressure to binge drink. An example of a community-led program in the Town of Banff to address binge drinking activities of young workers is the outdoor pursuits program (Davies, 2004). BSIN provides SIW with the option to participate in various outdoor excursions at reduced costs as alternatives to the party and bar scene (Davies, 2004).

In addition to approaches to address binge drinking issues for SIW in the Rockies, other substances (e.g., cocaine, ecstasy) and their influence on sexual risk-taking experiences of SIW need to be explored. Bellis et al. (2003) cautioned that unilateral approaches that address issues such as recreational drug use and associated harms are not as likely to be as successful. Collaborative approaches to address these issues with key stakeholders in tourism destinations are encouraged. This is of particular importance when there are diverse groups of people engaging in drug use and sexual risks including people from different localities and countries who all come together to share what Bellis et al. (2003) refers to as a *global nightlife*.

Reorienting Health Services

Reorienting health services is the fifth action strategy for health promotion identified in the Ottawa Charter for Health Promotion (WHO, 1986). According to the WHO (1986), "the responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions, and governments" (p. 3). All these systems must work collaboratively under this action strategy in order to create an effective health system. Traditionally, individual-level health service delivery was the dominant paradigm in health (Lalonde, 1974). The Ottawa Charter advocated that health services incorporate more than the biomedical paradigm,

such as clinical and curative services, and to "embrace an expanded mandate which is sensitive and respects cultural needs" (WHO, 1986, p. 3). Included in this expanded mandate of health services are the needs of individuals and communities and the broad aspects of health including social, political, economic, and physical components (WHO, 1986).

A recommendation of the study is to reorient health services to reach SIW who are at risk of negative health outcomes. In particular, emphasis could focus on those SIW who are not connected to existing health resources in the community. Situations identified by study participants that placed them at increased sexual risk included: when they first arrived in the Rockies (e.g., had lived there for less than six months); when they had not established a social support network; when they first became immersed in the party scene; and when they participated in excessive substance use such as binge drinking. This study highlighted that SIW engage in sexual risks in different settings and in different relationships. Some of the sexual risks participants described included: engaging in unprotected sexual intercourse; having sex with different sexual partners; having sex with partners of unknown STI status; decreasing their use of condoms and other protective measures when they entered into sexual relationships; and decreasing their condom use when they consumed alcohol. The immediate access to sexual adventure for SIW could be paralleled with efforts to connect them to health services immediately.

A reorientation of the health services in the Rockies could benefit SIW, local residents, and tourists. The Rockies attracts a transient population throughout the various tourism seasons. Health services could target those working seasonally and who plan to

return to their home origins at the end of the season. The integration of preventative and supportive treatments tailored to SIW could extend not only to the Rockies communities, but also to places where SIW originate.

There are several service delivery challenges that exist in the Rockies. The population of workers that is lured to the Rockies are transient. Participants described the mobility of workers as both a benefit to the context as well as a hindrance. Participants described one of the lures of the Rockies as their freedom and ability to squeeze the most out of the moment as soon as they arrived. However, this freedom and mobility came at the cost of stability, which was reflected in the transience of their work and living situations. As a result, participants also described the challenges in having high turnovers in the workforce (e.g., lack of continuity), in accommodation arrangements (e.g., lack of stability), and among peer support networks.

One area that the health services of the Rockies could incorporate into health systems programming is the arrival locations. Although there is no centralized location for all new visitors, workers, and residents in the Rockies, many SIW arrive through formal mechanisms (e.g., Greyhound transportation, National Park Gate). These venues could be targeted locations for interventions, particularly when SIW first arrive. Key stakeholders could work collaboratively with SIW and local organization in identifying and integrating approaches that meaningfully engage workers when they are attempted to adapt and integrate into the community.

Health services should be reoriented to acknowledge the difference between men and women. Although this study did not include a gender-based analysis, it introduced some of the differences experienced by male and female SIW in the Rockies such as roles

during sexual negotiation, sexual limits and boundaries, and the use of protective measures. Health promotion strategies and prevention efforts need to acknowledge differences in sexual risk-taking activities between men and women and among different cultural groups (Abraham et al., 1996; Bloor et al., 1998; Vorakitphokatorn, Pulerwitz, & Cash, 1998). Sexual health promotion methods need to empower both sexes to make informed decisions about their sexual health. Orton (2002) wrote a follow-up commentary on the analysis of research and media reports related to adolescent sexual health conducted by McKay, Fisher, Maticka-Tyndale, and Barrett (2001). Orton (2002) highlighted that women may face additional challenges when it comes to sexual negotiation. Approaches to sexual health need to address topics such as power differentials in sexual relationships and female-controlled methods for protection and contraceptive measures (Orton, 2002). Health promotion efforts need to acknowledge gender differences and incorporate strategies to address these issues for SIW.

Health services could be reoriented to address sexual risk issues of high risk populations. The results of this research study indicate that participants engaged in more sexual risk activities during the early settlement stage of their migratory experience. Thus, targeting workers who are newer to the Rockies, along with those who have high risk sexual histories (e.g., multiple sexual partners, inconsistent condom use), might be an effective way to reach those most at risk. Bloor et al. (1998) noted that young people who are travelling may be a "convenient proxy group for the people who are the most sexually active" (p. 1668). Results from Forsythe et al. (1998) on the tourists in the DR indicated that most people are receptive to HIV prevention efforts. Ford and Inman (1992) cautioned that prevention efforts should not further marginalize or isolate workers from

mainstream society. Health services could be reoriented to identify and address high risk SIW and equip them with the tools to improve their sexual health.

STIs continue to be a major health issue for young adults globally. In the Rockies, participants described that young SIW participate in sexual activities that place them at risk of contracting or transmitting a STI. Health service providers in the Rockies provide services such as screening, prevention, and treatment services; however, these services have not reached all those who are at risk. Reorientation of the health services in the Rockies could be directed towards addressing this gap between services available and those used by those at risk. Several different initiatives have been undertaken around the globe to integrate national screening protocols for specific STI infections. Miller (2005) found that a limitation to national screening strategies for STI infections such as chlamydia is that they rely on young people to present themselves to clinics or other locations for screening. Many young adults do not present to health care services for screening and they are subsequently missed by the health services systems that are established or underway (Miller, 2005). Miller (2005) suggested that health services need to incorporate innovative strategies in order to reach a broader population than those presenting at clinics for screening services.

Study Strengths

The research process was enhanced by the use of qualitative research methods. Sogoric et al. (2005) stated "qualitative techniques can be as credible and complement quantitative techniques, if scientific rigor is applied throughout the research, and advocates its wider application in health promotion studies" (p. 160). This was the first study to explore and describe the sexual activities of SIW in the Rockies. It allowed for a

better understanding of the social context in which sexual risk activities occur in the Rockies and for in-depth discussion on the associated risks, experiences, and protective measures as defined and lived by SIW.

The open-ended research questions led to rich and meaningful descriptive results. The researcher engaged participants in discussions on their sexual activities. Participants provided in-depth descriptions of their sexual activities while living in the Rockies. Their descriptions included information on their use of protective measures during sexual encounters and the risks they associated with their sexual activities. The researcher acknowledged that participants might encounter personal barriers in disclosing sensitive sexual information and informed participants of their right to terminate the interview at any time and to respond only to those questions they were comfortable answering. However, participants identified an overall comfort with the research process and they described the interview topic as relevant and interesting.

Some of the benefits of conducting the in-depth interviews included: rapport was built between the interviewer[91] and the participant and elicited more in-depth reflections; the interviewer was able to carefully select respondents based on their experience and knowledge of the research topic; the interviewer gained large amounts of rich data; the interview process led to more sensitive questions; throughout the interview process, there was the option to use visual cues (such as the tick box sheet on sexual risks) if participants preferred; and no formal literacy levels were required by the participants in order to effectively participate (Patton, 2002). In addition, using in-depth interviews

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[91] The 'interviewer' and 'researcher' referred to in the methods section was a graduate student.

enabled detailed personal information on sensitive sexual health topics (Hennick et al., 1999).

Participants were forthcoming in their disclosures of sexual activities and their responses to the study questions. All SIW who participated in individual interviews shared their contact information with the researcher. They expressed their willingness to be involved in a follow-up interview if necessary. Participants that were involved in a second interview reflected on the developing themes and sub-themes from the study results as a form of member checking and verification. Not all participants were involved in a second interview for two main reasons: the first, their original were deemed rich; or the second, they were unavailable for a follow-up due to their departure from the Rockies or a change in their contact information. This second reason relates to the transient nature of workers in tourism environments and provides a realistic perspective of the dynamic population of SIW in the Rockies.

A purposeful sampling strategy enabled the deliberate recruitment of study participants based on inclusion and exclusion criteria and their abilities to contribute to the research topic (Morse & Richards, 2002). The research participants were recruited either directly by the primary researcher or by key stakeholders[92]. Participants were able to identify times that were accessible for the research interviews. The researcher considered the appropriateness of these interview locations prior to meeting with the participants in order to enhance their confidentiality and comfort. The small sample size

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[92] Key stakeholders who facilitated the recruitment of SIW for the study included service providers, health professionals, SIW, and gatekeepers in the target communities.

enabled the researcher to explore individual experiences rather than to aggregate the results across individuals or situations (Maxwell, 1996).

Information and discussions flowed during the individual interviews. Participants were engaged in the interview process and their reflections led to meaningful exploration of emergent topics. The open-ended nature of the interviews allowed the discussions to evolve naturally. As a result, the researcher rarely referred to an interview guide as a facilitation tool. Participants identified discussion topics that were relevant to their experiences. The information shared by SIW informed subsequent research questions posed by the researcher and provoked discussions. The researcher paraphrased and reflected on comments made by SIW during the interviews in order to clarify ideas and summarize their key themes.

Maticka-Tyndale, Herold, and Oppermann (2003) conducted a study on the casual sex partnering of Australian high school students (male, n=570; female, n=776) on *schoolies* week vacation to Surfer's Paradise in Queensland, Australia. Maticka-Tyndale et al. (2003) identified that much of sexual health research on youth has been atheoretical. The integration of the socio-ecological framework in this research study added to the use of theory as a method to inform the discussion of the study results. As well, this study integrated health promotion strategies for action to frame recommendations for knowledge transfer or uptake by community organizations. This responds to the growing recognition among social scientists of the need for the integration of models that are inclusive of more health determinants than the traditional biomedical model (Lewis, 1998).

This research allowed results to be based on the unique experiences of SIW who are living in the Rockies. The Rockies is a context that is the most commonly visited tourist destinations in Canada despite its STI reputation. As a Canadian-based research study on sexual risk-taking and sexual health, instead of "borrowing conclusions from research in other countries that may not apply to Canadian youth" (Maticka-Tyndale, McKay, & Barrett, 2001, p. 14), it provided a unique perspective towards understanding the sexual health of youth in the tourism industry in Alberta's Rockies.

This research increased the understanding of sexual health for a variety of audiences. These audiences included health providers, key informants, and gatekeepers in the Rockies. Service providers can use these results to inform prevention, education, and support efforts that are tailored for SIW. The study results have been shared with local service providers in the Rockies. These stakeholders have identified their intention to use the information to inform future program development and implementation in the Rockies communities. As a result, the voice of young SIW will be used to inform how services, research, and resources will be adapted to meet their needs effectively. This research will help to build capacity among organizations in the Rockies and to create supportive environments within organizations and settings that are accessed by SIW for their sexual health needs.

Study Limitations

A purposeful recruitment method was used and a potential sampling bias (self-selection bias) and threat to the study's credibility (internal validity) was based on the voluntary nature of the sample. There was a potential for the study sample to be composed of participants who felt comfortable talking about sexual issues agreeing to

participate. Although study participants met the inclusion and exclusion criteria, those who agreed to participate "may have more positive attitudes and comfort in their sexuality" (Catania, McDermott, & Pollack, 1986 as cited in Egan, 2001, p. 52). Participants who perceived themselves at a decreased risk of a negative health outcome may have volunteered their time for the research. However, all participants disclosed their sexual risk activities. As well, participants in the study described health issues on sensitive topics related to their sexual activities including abortion and unplanned pregnancies, although these topics were described as less stigmatized.

One limitation of the methods was the reliance on subjective interpretations in qualitative research (Patton, 1990). However, the challenge of obtaining *objectivity* in qualitative research studies is overcome by the acknowledgement that the ideals of "absolute objectivity and value-free science are impossible to attain in practice and of questionable desirability" (Patton, 1990, p. 55). As such, the researcher is an integral component to the experience and insights of the results.

A limitation of the study was the lack of young people involved that were under the age of 20 years in the research study. Participants described their age and maturity as factors that enabled them to participate in the study. In terms of the developmental literature, young adults aged 18 and 19 may be experiencing developmental adaptations that make their voice important to understanding their sexual activities and decision-making processes. However, many of the participants had arrived either in their late teens or early twenties in the Rockies and were able to reflect on their activities over time. Future studies may seek to involve a sample of youth under the age of 20 years in order to ensure their voice is included in these important discussions.

The lack of direct STI experience in the Rockies among the study participants could be perceived as a study limitation. However, the lack of direct STI experience was anticipated based on the rates of STIs in Headwater Health Region (HHR). For example, the rate of chlamydia was 137 per 100,000 population. The Town of Banff is composed of approximately 10,000 people and that would mean about 14 people would have a chlamydia infection. Thus, it could not be expected that of the 11 participants in this study there would necessarily be a direct STI experience. Direct STI experience was not an inclusion criterion in the study for several reasons. One, not all people who have contracted a STI are aware of their infection. Thus, participants in the study may have had a STI and been asymptomatic or unaware of their infection. There were minimal STI testing experiences among participants and that suggested that diagnosis and treatment were not common. Two, this study included a small number of participants and based on rates in the CHR for notifiable STIs, it was not expected that of the eleven participants one would necessarily have a STI experience. Although not a goal of this descriptive study, future studies could include STI experiences as an inclusion criterion if researchers are interesting in learning about how services are utilized and factors that may influence STI diagnosis, treatment, and prevention among SIW.

The socio-ecological framework can be challenging to communicate results into a way that can inform program delivery and services (Grzywacz & Fuqua, 2000). This framework has not been perceived as practical for researchers and practitioners who have limited resources. However, a researcher using this framework can gain a more comprehensive understanding of health and recognize that people live in the context of

complex environments (Grzywacz & Fuqua, 2000). As such, it can provide a broader foundation for effective interventions.

Future Research Opportunities

Epidemiological Study

Research on STI prevalence and incidence among young adults working in tourist destinations is lacking. Participants in this study did not have STI experience and this could be a reflection of the small sample size and the prevalence rates of notifiable STIs in the CHR or it could suggest that STI rates may not be as high as perceived in the Rockies. A quantitative, epidemiological study to determine the incidence and prevalence of STIs among specific target groups in the Rockies[93] would provide a better understanding of the rates of STI and HIV in the communities. A study of this nature would help to inform discussions on the Rockies' reputation as the STI capital of Canada. Participants in the study described the occurrence of sexual risk activities that placed them at risk for negative health outcomes such as STIs. This research would help to inform program and service development and addressing the issues.

Cross-Sectional STI Study

There is little empirical data available to demonstrate the variables that are associated with the risks of SIW in the Rockies for acquiring or transmitting a STI. Several cross-sectional studies have assessed sexual risk activities either through patients visiting genito-urinary medicine (GUM) (Carter et al., 1997), pre-travel medical clinics

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[93] Actual numbers of STIs are not known, except for those who are diagnosed with a 'reportable infection'. Reportable infections are defined by the Public Health Act and Communicable Disease Regulations and in Alberta they include gonorrhea, chlamydia, syphilis, NGU/MPC, chancroid, and lymphogranuloma venereum (AHW, 2003b).

(Mullhall et al., 1993), or airports (Abdullah et al., 1998; Bellis et al., 2003; Bellis et al., 2004; Gehring et al., 1998) prior to or returning from travels to tourist destinations. Conducting a cross-sectional study on the sexual risks of SIW would be an opportunity for further research and to expand on themes and sub-themes identified in this study. Although limitations to a cross-sectional study design include the potential for reporting bias and the inability to determine causality, patterns of association could be determined (Weitzman et al., 2003).

Longitudinal, Prospective Cohort Study

A prospective cohort study on the risks for SIW in the Rockies is a study design that would demonstrate temporality of sexual risk-taking. Longitudinal data are challenging to obtain with populations because of the transient nature of the workers in the Rockies destination. However, if there is a way to obtain data from samples prior to their travel, when they arrive, and then follow them prospectively, this would offer valuable information. Maticka-Tyndale et al. (2003) suggested that a longitudinal study could incorporate a study design that collects data at different times during a vacation. Maticka-Tyndale et al. (2003) acknowledged that "such a design would help in establishing the time ordering of variables such as vacation experiences and sexual activity and would make it possible to understand the progression of events and experiences" (p. 167).

Assessing the migratory experiences of SIW as they adapt to their settlement processes could be conducted through a prospective, longitudinal study. However, Wright (2003) warned that longitudinal studies in tourist destinations may be difficult to initiate because of the constraints on participants in their travel destinations (e.g., limited

time, resources). As well, studies that require follow-up may be extremely expensive and time intensive. Romer and Stanton (2003) conducted a study the sexual initiation behaviour of adolescents in high-poverty urban environments (n=355). The authors found that the majority of past sexual health research has been conducted with cross-sectional methods (Romer & Stanton, 2003).

Social Network Analysis

Social Network Analysis (SNA) is a quantitative tool that is used to map relationships among people and organizations as well as to capture changes over time (Hawe et al., 2004). SNA is a research method that could be applied in the context of relationships among SIW in the Rockies. This method could examine the social network influences on the sexual behaviours of SIW, including how they changed over time. Liebow, McGrady, Branch, Vera, Klodvadal, et al. (1995) conducted a SNA on young teenagers living in settings that may place them at higher risk for HIV. Social network analysis is a "substantial up-front investment in ethnographic fieldwork to develop a locally meaningful taxonomy of salient social distinctions" (Liebow et al., 1995, p. 267). Maticka-Tyndale et al. (2000) highlighted that future research on sexual risk and tourism destinations could focus on topics such as sexual partnering and networks, frequency of sexual activities, and partner changes.

Bush (2003) mapped STIs in the Calgary Health Region (CHR) for her thesis study. In the geographic areas where STI transmission rates are highest, the existence of localized sexual networks at the neighborhood level was identified (Bush, 2003). One study recommendation for the results was for STI control programs to be targeted at areas where highest rates are determined in order to have a greater impact on the prevalence of

infections among group members (Bush, 2003). Bush (2003) identified that mapping of sexual networks would provide a picture of how sexual network function geographically so that STI prevention programs may be adapted to these social networks. Bush (2003) indicated that sexual network analysis in communities of the CHR could enable STI prevention efforts to be targeted at the appropriate geographic locations.

Gender, Sex, and SIW

The role of sex and gender in sexual risk-taking of SIW warrants further research. For example, the role of gender in the context of the migratory experience of SIW and their sexual activities could be explored. This could include a critical feminist perspective and a gender-based analysis. Results from this study suggested several areas where SIW encounter differences in their experiences based on gender and sex. Results would help to inform how interventions and services could be tailored to address the different experiences of male and female SIW in the Rockies.

Conclusion

This is the first study to focus on the unique subculture of SIW in the Rockies and their sexual activities. Tourism, young adults, employment, migration, and sexual risk-taking are all critical public health issues. This research described and explored the sexual activities of people aged 18 to 29 years who were working in the service industry in the Rockies. The complexities of sexual risk activities were explored under the socio-ecological framework for health and the migratory settlement model for SIW. Through these lenses, the multi-faceted social determinants of health were reviewed and their roles in influencing the well-being of SIW were discussed. This study provided an overview of

the sexual realities of SIW within their unique social contexts and identified a multitude of factors that influenced their risk-taking activities.

The Rockies is a unique environment that provides access to adventure the moment SIW arrive. For some, the travel to the Rockies is temporary; however, for others, they transition through a migration experience. During their adaptations, they are influenced by the different social determinants of health, the different systems levels, and the social institutions in the Rockies. Despite the lack of personal STI experiences disclosed by study participants, sexual risk activities occurred and placed SIW at risk for health outcomes such as STIs and unplanned pregnancy. The inconsistent use of protective measures during sexual intercourse and the use of substances including alcohol and drugs influenced their sexual risk-taking among SIW and compounded their health issues. This study, like other research, has demonstrated that there are long-term consequences associated with the activities youth engage in and some of these have lasting implications for the future.

Health providers in the Rockies have taken steps towards creating supportive environments for the dynamic SIW population in the tourism industry. However, the steps that have been taken thus far have been inadequate at addressing the underlying issues that may be perpetuating the STI concerns in this tourist destination. To date, sexual health education, information, and educational campaigns have raised awareness of the issues including potential for STIs and unplanned pregnancy; however, this knowledge has not translated into behaviour change in many instances. Many underlying health disparities were identified by participants that place SIW disproportionately at higher risk for negative health outcomes associated with their sexual activities. This study

allowed for an exploration of these underlying issues and provided a forum for SIW to have a voice in describing their sexual activities, tapping into the spirit of their experiences.

This research also provided a unique perspective on the sexual risk activities of participants at different stages of their migratory experience. Past studies have focused on tourists and workers within tourism destinations that were temporary. This study targeted SIW who had been living in the Rockies for varying durations. Over time, SIW described adapting, maturing, and gaining new life experiences and all these factors had an impact on their sexual risk-taking. Approaches to addressing the health of this population need to account for the various experiences and transitions they encounter in order to be relevant and meaningful.

The results of the study have been shared with key stakeholders, gatekeepers, and services to inform health promotion strategies and future research studies. Key stakeholders and communities have an opportunity to work collaboratively to address the elements of the tourism milieu that may be disproportionately placing SIW at risk of negative health outcomes. Innovative, population appropriate, community-led initiatives are needed to improve the sexual health of SIW in the Rockies. These steps need to go beyond education and equip young workers with the tools and skills to make informed, sexual health decisions that are relevant in their diverse Rockies adventures.

These initiatives need to be targeted at the micro-, meso-, and macro-systems levels and ensure that timely, relevant, and meaningful interventions are provided to improve the sexual health of SIW. Strategies to improve the health of this dynamic population also need to account for the transient nature of the environment, the high

turnover of staff, the disproportion health status they experience, the social determinants of health, the settlement and migratory stages of integration, and the individual factors such as developmental stages of the young workers. Integrating approaches that address the five action strategies for health promotion is an integral step towards improving the health status of SIW in the Rockies. The well-being of those living and working in the Rockies' communities is vital and investments should focus on approaches to responsible and responsive tourism.

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Appendix A: Interview Guide

Individual, unstructured, interactive interviews

Each individual interview will commence following the completion of the informed consent form and the distribution of the community resource sheet.

Grand Tour Question:

I am very interested to learn about your experiences as a SIW in Banff, Canmore, or Lake Louise, Alberta and how they relate to the sexual activities you have engaged in during your time working in the service industry. Can you tell me about your experiences and describe your sexual activities[94]?

Potential Probes/Guiding Questions:

Through open-ended interviews, the interview questions will emerge and adapt as the interview progresses. Below is a range of broad, open-ended guiding questions. These questions will help the researcher (as needed) in exploring and describing the experiences of SIW while working, living, and participating in the communities of Banff, Canmore, and Lake Louise, Alberta.

Can you describe for me…

1. **Tell me about yourself:**

- How old are you? Where are you from? What is your background? Can you tell me about yourself while living and working in Banff, Canmore, or Lake Louise, Alberta (as a SIW)?
- ***Work/ employment:*** What type of work are you involved in? How many employment positions have you held in this area? Over what period of time? Why did you come to this area to work?
- ***Residence:*** How long have you resided in this area? What type of living / household accommodation do you have (hotel accommodation, staff accommodation, hostel, independent, other?)? How has your living accommodation changed? Do you live with roommates? How many? What factors have affected your living situation? Can you describe some of the pros and cons of your living situation? Can you describe your living expenses?

2. **Can you describe your current relationships with others in Banff, Canmore, and Lake Louise, Alberta?**

- Can you share your current relationships with friends, family, others?

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[94] The interviewer may also refer to a sexual risk activities form if preferred by participant (optional).

- What is your relationship (marital) status? Are you married, single, attached, partnered? How have your relationships evolved during your time working in these areas?

3. Can you describe the social or recreational activities for SIW in Banff, Canmore, and/or Lake Louise, Alberta?

- Can you describe the nightlife in Banff, Canmore, and Lake Louise, Alberta? How does that differ from daytime activities? Do activities include partying? What happens during these parties? What situations do you or others commonly use drugs or alcohol?
- Can you talk about your experiences with drugs and alcohol? Can you share the types of drugs or alcohol used (self and others)? How frequent/often? If you use drugs, how do you take the drugs (orally, with a needle)? How does the use of substances affect your activities? Sexual activities?

4. Can you share with me your knowledge of sexual risks associated with experiences while working and living in Banff, Canmore, and/ or Lake Louise, Alberta?

- What is your knowledge of HIV/ STIs? Do you think HIV/STIs are concerns in this area? Do you think they are concerns specifically for service industry workers (SIWs)? Residents? Other travelers or tourists? What do you think the factors are that influence sexual activities in these areas?

5. Can you share with me what resources and services are available for SIW in the community?

- ***Support, health care, treatment, and testing resources:*** Where would you (or have you) gone for support? Where have your (or would you) go for health care? Are there any barriers to health care? What makes services accessible?
- ***STI/ HIV testing and resources:*** If you thought you might have been exposed to HIV or an STI, would you go for a test (to a healthcare provider)? Why or why not? Where would you go?
- Is there anyone you can talk to about sex and STIs/HIV? If yes, who can you talk about these topics? Can you talk to this person/these people whenever you need to/want to? What aspects of sex and STIs do you need/want to talk about? Do you feel comfortable talking to them about these issues?
- Can you talk to your sexual partners about these issues? Where might you go to discuss these topics (linked back to relationship question)?

6. Can you share your knowledge and beliefs about measures and approaches that can be used to reduce your risk of contracting a STI or HIV?

- ***Protective measures, preventative measures:*** What would you do to prevent, reduce, and/or address HIV/ STI exposure/infection during sexual activities? What measures would be protective for different sexual activities? How often do you use protective measures? What influences your decision-making? Does your use of protective measures depend on the type of scenario you are in? For example, does your behaviour change if you are in a relationship versus casual sex?

7. **Can you share your experiences in terms of the education you have received or gained access to while working in Banff, Canmore, and Lake Louise, Alberta?**

- Have you ever had any education while living and working here about sex and STIs? If yes, how did you feel about it if so? Did you find it useful?
- Have you ever sought out education and information while working in these communities? Where have you gone and what were your experiences?

8. **Can you share some non-sexual risk activities that are occurring that may be placing individuals at risk of HIV or other infections/ diseases?**

- ***Non-sexual risks:*** Have you had any piercing or tattoos done while living and working in this area? If yes, where did you have them done? Did they use new or sterile equipment? Did that influence your decision to go there?

9. **How would you describe the differences between experiences and risk activities by those who work in the winter versus summer season?**

- ***Seasonal variation/ temporality:*** Do you feel that your experiences have change or would change dependent on the summer versus winter season? What differences do you experience or notice over the different seasons? Are there other "key" seasons in Banff, Canmore, and Lake Louise, Alberta?

10. **Do you have any questions for me or things you would like to discuss that we have not?**

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Appendix B: Informed Consent

FORM 1.0

TITLE: A qualitative inquiry of the sexual health activities of service industry workers in Alberta's mountain park resort communities.

INVESTIGATORS:
Dr. Wilfreda Thurston, Principal Investigator (PI)
Dr. Ardene Robinson Vollman, Co-PI
Dr. Catherine Worthington, Co-Investigator (CI)
Laurie Fownes, CI *student

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something that was mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

BACKGROUND

We have reason to think that people working in tourism might engage in risky sexual activity. However, no one has done research to see if this is really true. Tourist trade workers, also known as service industry workers, and health care providers tell us stories about sexual activity, but we do not know what kind of risky activities are happening. We need to look at this in a systematic way so we can be sure that workers have the support they need from community services and health care providers. We plan to look at these topics within the communities of Banff, Canmore and Lake Louise, Alberta.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to increase the understanding of the sexual activities of service industry workers. This research will seek to gain an understanding of your experiences as a service industry worker employed in Banff, Canmore, or Lake Louise, Alberta. Information will be collected through individual interviews. Approximately ten participants will be involved in the research. This research will happen between January 2005 and December 2005.

WHAT WOULD I HAVE TO DO?

- You will be asked to do a two hour one-on-one interview.
- Each interview will be tape recorded.
- You may use a fake name (pseudonym) during the interview or you will be given a fake name by the researcher.

- By helping in this study, you will be asked to provide your first name and your contact information. An example of contact information includes your phone number and your email address. Your information may be used for a second interview that will last about one hour. It is your choice what contact information you provide.
- You can choose to stop or withdraw at any time.

WHAT ARE THE RISKS?

The risks in helping in this study are very small. If you become upset or wish to get help while talking about private (sensitive) topics such as sexual activities, you can contact support services. The interviewer will hand out a list of services before your interview begins. This list includes information on support and counselling services. The interviewer is not able to provide one-on-one support or counselling.

If at anytime you feel uncomfortable, you can choose to end the interview or ask to move on to another topic.

WILL I BENEFIT IF I TAKE PART?

This research study may be helpful to you. You may find the resource list of support services and information useful. Also, you might find it helpful to talk about your experiences.

DO I HAVE TO PARTICIPATE?

It is your choice to participate in the study (voluntary). You may leave or withdraw yourself from the study at any time. If you want to withdraw, please contact the co-investigator*, Laurie Fownes.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

No. It is your choice to participate (voluntary). There is no cost and no payment for participating in the study.

WILL MY INFORMATION BE KEPT PRIVATE?

The Principal Investigator, the Co-Investigators, and the University of Calgary Conjoint Health Research Ethics Board may look at the information collected. Steps have been taken to make your information private. For example, fake names will be used for people involved in the study; information that is collected will be locked; computers and voice mail will be password protected; and individually identifying information will be removed.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators,

sponsors, or involved institutions from their legal and professional responsibilities. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research, please contact:

Dr. Wilfreda Thurston, Co-PI
Department of Community Health Sciences, University of Calgary
Telephone: (403) 220-6940

Dr. Ardene Robinson Vollman, Co-PI
C/O Marilyn Ostryznik, Administrative Secretary
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Laurie Fownes, CI *student
Department of Community Health Sciences, University of Calgary
C/O AIDS Bow Valley (Banff number):
Telephone: (403) 762-0690
Email: ljfownes@ucalgary.ca

If you have any questions concerning your rights as a possible participant in this research, please contact Pat Evans, Associate Director, Internal Awards, Research Services, University of Calgary, at 220-3782.

Participant's Name	**Signature and Date**
Investigator/Delegate's Name	**Signature and Date**
Witness' Name	**Signature and Date**

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

A copy of this consent form has been given to you to keep for your records and reference.

Appendix C: Community Resources

COMMUNITY RESOURCES

SERVICES	CONTACT PHONE #
AIDS Bow Valley	1.403.762.0690 (Banff)
Mental Health 24hr Crisis Line	1.877.303.2642
The Samaritans 24hr Help Line	1.800.667.8089
Alberta Mental Health	1.877.303.2642 (crisis line) 1.403.678.4696 (Canmore) 1.403.762.4451 (Banff)
AADAC (Addictions/ substance)	1.403.678.3133
Victims Services	1.403.760.0197
Community Services	1.403.762.1251 (Banff)
FCSS Resource Centre	1.403.609.3743 (Canmore)
YMCA Resource Centre	1.403.760.3200 (Banff)
The Living Room	1.403.760.2423 (Banff)

Note: the researcher does not recommend the resources listed on this contact sheet. Resources are provided for each participant based on services identified within the research communities as options in the event support is desired. This list is not exhaustive.

Reference: *Society Against Family Violence (2002)*